Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Wednesday 4 November 2015**
Time	**9.30 am**
Venue	**Committee Room 2, County Hall, Durham**

Business

Part A

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

1. Apologies
2. Substitute Members
3. Minutes of the meeting held on 9 October 2015 (Pages 1 - 10)
4. Declarations of Interest, if any
5. Media Issues
6. Any Items from Co-opted Members or Interested Parties
7. Quality Accounts Updates - County Durham and Darlington NHS FT; Tees Esk and Wear Valleys NHS FT and North East Ambulance Service NHS FT. - Report of Assistant Chief Executive and presentations by NHS Trusts (Pages 11 - 16)
8. North Durham CCG and Durham Dales, Easington and Sedgefield CCG Clear and Credible Plans Updates - Joint Presentation by representatives of North Durham CCG and Durham Dales, Easington and Sedgefield CCG
9. County Durham and Darlington NHS Foundation Trust - Care Quality Commission Inspection Report - Report of the Assistant Chief Executive and presentation by Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust (Pages 17 - 32)
10. Public Health Update Report - Report of the Director of Public Health, presented by Anna Lynch, Director of Public Health, County Durham (Pages 33 - 46)

11. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration

Colette Longbottom
Head of Legal and Democratic Services

County Hall
Durham
27 October 2015

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

Councillor J Robinson (Chairman)
Councillor S Forster (Vice-Chairman)

Councillors J Armstrong, R Bell, P Brookes, J Chaplow, P Crathorne, M Davinson, K Hopper, E Huntington, P Lawton, H Liddle, J Lindsay, O Milburn, M Nicholls, L Pounder, A Savory, W Stelling, P Stradling and O Temple

Co-opted Members:

Mrs B Carr and Mrs R Hassoon

Contact: Jackie Graham **Tel: 03000 269704**

DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Council Chamber, County Hall, Durham on **Friday 9 October 2015 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:

Councillors J Armstrong, R Bell, P Brookes, P Crathorne, M Davinson, S Forster, E Huntington, M Nicholls, L Pounder and O Temple

Also Present:

Councillor L Hovvels

The Chairman informed Members about the funeral taking place today of Mary Butterwick. She sold her home to fund the Butterwick Hospital and he placed on record his thanks her for her commitment and support.

1 Apologies for Absence

Apologies for absence were received from Councillors J Chaplow, K Hopper, P Lawton, H Liddle, J Lindsay, O Milburn, A Savory, W Stelling, P Stradling, Mrs B Carr and Mrs R Hassoon

2 Substitute Members

There were no substitute Members in attendance.

3 Minutes

The minutes of the meeting held on 30 June and of the special meeting held on 1 September 2015 were confirmed as a correct record and signed by the Chairman.

4 Declarations of Interest, if any

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 Media Issues

The Principal Scrutiny Officer provided the Committee with details of the following items which had appeared in the press:-

- GPs across the region given clean bill of health – Northern Echo 07/09/15
  Access to GPs in the region reported to be better than elsewhere in the Country and in particular in Durham, Darlington and Tees
- North East Ambulance Service looking to recruit 118 paramedics amid national shortage – Northern Echo 25/09/15
  This was an issue raised by the Committee at the last meeting as part of the Quality Accounts process.
- North East health trust 'requires improvement', according to new report – Journal 29/09/15
  A report will come forward to the next meeting to receive an update on the trusts action plan.
- Nurses speak out as fears grow for Town's hospital – Teesdale Mercury 30/09/15
  Closure of a ward at the Richardson Hospital in Barnard Castle.
- Baby unit bombshell: Major concerns over plans to downgrade care – Hartlepool Mail 05/10/15
  The Chairman informed Members that the Regional Health Scrutiny have discussed and expressed concerns regarding the issue of the neo-natal movement and the consultation taking place. He said that more people were travelling from East Durham and Hartlepool to North Tees Hospital and to move to Bishop Auckland was an area for concern.

Councillor R Bell expressed concern about the closure of a ward at Richardson Hospital. He understood the need for health trusts to make changes but said that this was an example of where no consultation had taken place. He explained that Richardson Hospital was a convalescent hospital caring for mainly the elderly and that they rehabilitate patients to enable them to return to their own homes. He went on to say that it had been classed as a temporary closure however reported that all of the equipment had been removed. He was concerned that local members and this committee had no previous knowledge of the closure and it had been the nurses from the hospital who had brought it into the public domain. He appreciated that no one from the Trust was present at the meeting but asked for the Committee's support to ask for a full report asking what they are doing and why and what their long term intentions would be.

Councillor J Armstrong endorsed Councillor Bell's request and highlighted the importance of local members and the Committee having early knowledge and being consulted on such matters. He added that he found it very frustrating to learn these things from a newspaper.

Dr S Findlay, Chief Clinical Officer of DDES CCG said that the last thing the CCG wanted to see was the closure of the ward and that they were working with the trust to seek an alternative use. He advised that there was a shortage of nursing home beds in the area and that the ward could potentially be used.

Councillor Bell felt that it had been a surprise to most people and asked that the trust be invited to the next meeting to give an explanation.

Resolved:-
That the Chair of the Committee write to County Durham and Darlington NHS Foundation Trust to invite a representative to the next meeting of the Committee to give an

explanation about the ward closure and to give assurances around the future of the Hospital.

7 County Durham and Darlington Urgent Care Strategy

The Committee received a report and presentation from the Chief Clinical Officer, Durham Dales Easington and Sedgefield Clinical Commissioning Group and the Commissioning Manager, North of England Commissioning Support Unit on behalf of County Durham and Darlington System Resilience Group, about the development of the County Durham and Darlington Urgent Care Strategy 2015-20 (for copy see file of Minutes).

The Committee was asked to note that the:-

- strategy will be amended with any errors or omissions noted from the recent round of engagement;
- final Urgent Care Strategy 2015-20 is scheduled to be approved by the System Resilience Group on 9th October 2015;
- governance and implementation of the Urgent Care Strategy will be through the System Resilience Group;
- Urgent Care Strategy 2015-20 is scheduled to go back to the Health and Wellbeing Board for endorsement on 3rd November 2015.

Dr S Findlay, Chief Clinical Officer of DDES CCG added that a lot of consultation had been undertaken with stakeholders, the public and Healthwatch and that Members may recall that the draft strategy was presented a year ago. As NHS England have also been working on a new strategy this has meant continually having to adapt to national changes. The final draft has been shared with a number of organisations and a further exercise to consult with the public has commenced. He introduced Anita Porter, Commissioning Manager and praised her for the fantastic job undertaken on the strategy.

Ms Porter gave a detailed presentation to Members that highlighted the following:-

- What is urgent care?
- Scope of the strategy
- What's the problem with urgent care?
- Increasing admissions – all types
- Increasing admission – emergency
- Not just a local problem
- County Durham and Darlington System Resilience Group
- Local Strategy Development
- Local Vision
- Objectives
- Local Model for urgent and emergency care
- Governance process
- Key feedback

Councillor J Armstrong found the document very comprehensive but hard to follow. He referred to page 11 of the strategy that was supposed to give clarity of the vision but felt that this was difficult to demonstrate given that specific proposals were not included. He

found that it was difficult to determine the differences between urgent and emergency care and that trying to summarise the key changes into development proposals very frustrating.

Councillor P Brookes highlighted that he was Chair of Sedgefield Patient Reference Group and they had wrote to Anita Porter with their concerns. He shared Councillor Armstrong's concerns about needing to understand the detail and felt that the triangle model had given no clarity about urgent care. He said that his group had timescale concerns about patient cancer treatments and that there were frustrations around GP appointments. He added that it would be helpful to see how community services would be transformed.

Dr Findlay advised that the nature of a high level strategy meant that the finer details would not be worked out at this stage. This would be the next step and would involve GPs and PRG's. He said that there had been delays due to the development of the national strategy but that now they have the national strategy they would start to look at changes that need to be met locally. The details would come via the CCGs. He agreed the current system was confusing as all 3 CCGs in DDES have a different set up and need to be rationalised. He advised that Ms Porter was working on a summary document and emphasised that the thrust of the strategy was to deliver as much care as possible. He welcomed feedback from all parties and recognised the feedback from Sedgefield PRG. With regards to cancer care he advised that the intention as to keep it separate in the future. He appreciated the frustration with GP availability and had spoken to NHS England about setting up an alliance group to improve access to general practice. He went on to say that we were doing well compared to the rest of the country and were doing more to extend opening hours. Data was collected daily from GP surgeries and they were adapting to change and were improving accessibility.

With regards to Easington PRG, Councillor S Forster said that the biggest problem was that people did not know the difference between services. She said that it would be helpful for all centres in the area to deliver the same services and to give some clarity.

Councillor P Crathorne agreed with the concerns expressed by Councillors Armstrong and Brookes and felt that there were a number of holes in the strategy. She said that a lot of people who needed care was out of hours and she had concerns that as the University Hospital in Durham expands they need to ensure that there was a sufficient bed ratio.

Referring to the strategy, Councillor E Huntington felt that the same old stories and old aims had been duplicated in relation to providing care closer to home, preventing duplication of services, the number of GPs. She understood the good intentions and felt that it was a good strategy however felt that it falls apart at implementation level. She asked who would monitor the delivery.

Dr Findlay agreed that services need to be aligned in the Seaham area and that local improvements may be different depending on the outcome required. He advised that they were working with GPs and the PRG in Easington to coordinate services.

With regards to beds in hospitals, Dr Findlay advised that the main issue is that hospitals become full of elderly people with complex needs and improving the flow of care would ensure they are discharged from hospital more quickly.

Dr Findlay confirmed that it was his responsibility to ensure the Strategy worked this time and that now that there was a national strategy to follow it would be more aligned. He advised that Vanguard status had been awarded in the North East. The System Resilience Groups would ensure the strategy was delivered and implemented quickly.

Councillor M Nicholls said that feedback was crucial to ensure the strategy was implemented right and welcomed the importance of the System Resilience Group. He referred to training of paramedics and asked if there was any indication as to when they would be available.

Referring to the strategy, Councillor O Temple expressed concern about the risks of people falling through the cracks as the changes were implemented. He asked what the role of the community hospital would be in terms of delivery.

The Chairman said that it can be frustrating for members of the public when using the 111 service and after several hours being referred to urgent care. He welcomed the addition of members of the public being part of the System Resilience Group and asked what the relationship would be between them and this Committee and if they would report to us. He also asked about the timeline for implementation. He noted the seven objectives and asked when the action plan would be reported to this Committee.

Dr Findlay explained that it was a real problem attracting, recruiting and retaining paramedics. He hoped that the Vanguard status would help to co-ordinate the work force in the area so that staff would not be poached from one service into another. He advised that NEAS were working really hard and had a better chance than ever of recruiting the staff required through Health Education in the North East advice.
He said that hospitals and the issue of when to make changes was a risk. In the south of the region, SeQIHS had started to look at how we continue to deliver. He explained that the strategy had been developed clinically by specialists to ensure delivery and that the Community Hospital would form part of the strategy. He emphasised the need to do this properly and without compromise. As an example he referred to stroke services carried out in London and Manchester after being reconfigured. Mortality rates were looked at after a year and there had been a drop in London but Manchester had stayed the same as the national average. Hence the need to set out clearly from the beginning what must be achieved and not to compromise.

Referring to the 111 service Dr Findlay advised that it was frustrating but that people should use the services responsibly. In future the clinical input into 111 would be strengthened with more appropriate advice being offered to ensure people get the right care and the right place.

With regards to the timeline of implementation he advised that it would be a matter for each CCG and that they would come back to Committee when they had more concrete local data. He added that the SRG would be happy to come back to this Committee at any time.

Ms Porter said that there was still a lot of work to do and confirmed that they would come back to Committee.

The Chairman thanked Ms Porter and Dr Findlay for their presentation. In referencing the recommendations within the report, the Chairman asked members to note that;-

- the strategy would be amended with any errors or omissions noted from the recent round of engagement be noted;
- the final Urgent Care Strategy 2015-20 was scheduled to be approved by the System Resilience Group on 9th October 2015 ;
- That the governance and implementation of the Urgent Care Strategy would be through the System Resilience Group;
- That the Urgent Care Strategy 2015-20 was scheduled to go back to the Health and Wellbeing Board for endorsement on 3rd November 2015.

Resolved that:-

(i) The County Durham and Darlington Urgent Care Strategy 2015-20 be endorsed;

(ii) Further detailed reports from the Systems Resilience Group and Clinical Commissioning Groups outlining the detailed proposals for implementation of the strategy and any service changes together with associated consultation and engagement proposals be brought back to future meetings of this Committee.

8 Review of Care Connect

The Committee received a joint report of the Assistant Chief Executive and Corporate Director of Regeneration and Economic Development that informed of the proposed Medium Term Financial Plan (MTFP) savings associated with the Care Connect Service and to advise upon proposals agreed by Cabinet for consultation on the said proposals (for copy see file of Minutes).

The Head of Transport & Contract Services informed Members that Care Connect was a 24/7 monitoring preventative service with 20,000 customers. The current budget was £5m made up of a grant from CAS and self-funding customers. The MTFP savings have identified a reduction of spend by £750k by April 2016.

At present the users are made up from those who receive the community alarm for free. This was for those on benefits but has been phased out since this option ceased in April 2014. It was proposed to introduce a contributory charge of £2.80 per week. Self funders pay £4.60 per week and it was proposed to increase this to £4.80 per week. As a non-statutory service the costs must be covered by charging.

Members were advised that through a benchmarking exercise services differ from one authority to another but the contributory charge of £2.80 compares favourably.

The Head of Partnership & Community Engagement advised that the consultation on the new proposals is being carried out in two phases. The first phase to cover the self-funders with a hard copy questionnaire being sent out to those users. He advised that the authority was confident that the authority knows who receives the service and have allowed a six week period in which to respond. The Committee were informed that advice was available from the Care Connect team on how to complete the questionnaire and that individual visits could be arranged on request. The team would analyse the responses and would report back to Cabinet in December. The second phase of the consultation

would begin shortly and work on that questionnaire was underway. Copies of the proposed letters to service users affected by changes together with the consultation questionnaire were circulated to the Committee.

Councillor R Bell asked if AAP money could be used to offset this saving cost. He understood that there was Public Health money available for each AAP and felt that this would be of benefit.

Councillor P Crathorne commented that it was a good service and asked how the service would follow up on those people who had not responded.

Referring to those people who may drop out of the service if they haven't had to pay before, Councillor S Forster asked if there would be a check to see if these people were accessing services elsewhere. The Chairman added to this by asking who would monitor the drop outs and where they go.

The Head of Partnership & Community Engagement advised that there can be exceptions to where AAP money is spent and advised that Public Health have asked that the money be spent on physical health and mental health improvements. He also explained that there were time limits for funds to be spent within the AAP budgets and that the AAP need to react to local needs and priorities that could differ for each area.

He advised that people can seek help and advice and request home visits where necessary in order to complete the questionnaire. The Care Connect and CCTV Manager added that the service was limited in terms of resources but that they would pick up vulnerable users and access users during annual visits. He assured the Committee that the service would try to retain as many users as possible.

The Head of Transport & Contract Services advised that some people use the service as a means of re-assurance and for those users they may prefer to rely on friends and family rather than pay or increase their payment. There is recognition that there may be more pressure put on the health sector and consultation was taking place with emergency services and the health sector to best understand the impact. He said that the Care Connect and CCTV Manager and her team would continue to monitor closely and assess the drop out of users. The service had estimated a reduction of 40-50% but if this increased further the size of the team may have to be reduced in order to achieve the MTFP saving.

Councillor J Armstrong understood that this was a difficult decision but that every service was being hit by savings in some way. He did not agree that AAP money should be used as this funding may not be available next year or in the future and stipulated that money could not be given to individuals.

In relation to the consultation exercise Councillor M Davinson asked if the service were being pro-active to encourage new users to sign up to it.

Councillor O Temple referred to savings within the CAS budget being made early and asked if these savings need to be made now when they would occur eventually with the decrease of those who received the service free through benefits.

The Head of Transport & Contract Services recognised that it was a difficult decision and advised that the service was promoted in GP surgeries and through the park and ride bus service. He said that the cohort of users was shrinking and that by 2020-2025 there would be very few people receiving the service for free but that the self-funders should have increased.

Resolved:
That the report be received and Committees comments on the proposals, as part of the ongoing consultation in respect of the Care Connect service be noted.

9 Health and Wellbeing Board Annual Report

The Committee received a report of the Corporate Director, Children and Adults Services that presented the Health and Wellbeing Annual report for 2014-15 (for copy see file of Minutes).

The Strategic Manager, Policy, Planning and Partnerships, CAS highlighted the functions of the Board, the relationships with this Committee, the achievements during 2014/15 and the commitments made. She emphasised the comments from the Local Government Association Peer Challenge in that County Durham was in a strong place with areas of best practice being shared with other boards. The relationship with Scrutiny was highlighted as a one of the best in the country.

The Chairman thanked the Strategic Manager for her report and congratulated the Health and Wellbeing Board.

Resolved:
(i) That the report be received; and
(ii) That the work undertaken by the Health and Wellbeing Board during 2014/15, be noted.

10 NHS England 5 Year Forward View Update

The Committee received a Joint Report of North Durham Clinical Commissioning Group and Durham Dales, Easington and Sedgefield Clinical Commissioning Group that advised how the NHS Five Year Forward View was to be implemented within County Durham (for copy see file of Minutes).

Nicola Bailey, Chief Operating Officer, North Durham CCG and DDES CCG presented the detailed report highlighting the key principles, new models of care and the funding challenges. She informed the Members that County Durham was part of the North East Network for Urgent Care Vanguard and explained their vision and principles. The urgent strategy would fit alongside this and would improve patient flow across the region.

The Chief Operating Officer said she would be happy to come back as projects developed.

Councillor S Forster sought clarification on what had happened to federations and was advised that part of the five year forward view was about focusing on primary care. Both

CCGs had federations made up of a group of general practitioners and allow the services to be brought together.

With regards to attracting staff and finding an innovative way retaining them, Councillor M Davinson asked if the organisation could come back to Committee with a report showing how they intend to do this. The Chief Operating Officer said that the Health Education England in the North East were helping to look at different ways of recruiting staff and to help fill in the void in the numbers required. She added that the new immigration laws have not helped as people are trained but cannot stay in the country once qualified.

The Chairman confirmed that this would be monitored closely.

Resolved:

(i) That the information contained within the report be noted; and
(ii) That further updates are brought to future meetings of the Committee

11 Care Act 2014 Update

The Committee noted a report of the Corporate Director, Children and Adults Services that gave an update on the local and national developments in relation to the implementation of the Care Act 2014 and the transformation of Adult Care services, focussing on changes to deliver Phase 1; the new care and support duties from 1st April 2015 (for copy see file of Minutes).

The Strategic Manager – Care Act Implementation, CAS advised that the report also provided an update on the recent announcement by Government to postpone the Phase 2 reforms until 2020 which were due to come into effect from 1st April 2016, which includes the cap on care costs and appeals system.

Councillor M Davinson informed Members of the positive work being undertaken in the South Moor and Quaking Houses area since the wellbeing team were in place and helping advice individuals. He praised the hard work taking place for mainstream areas but asked how hard to reach areas and people were being addressed. The Strategic Manager recognised that there were problems trying to engage some individuals and that the wellbeing team were mindful of that but were trying to draw people in.

Resolved:

(i) That the report be noted.
(ii) That further updates in relation to Adult Social Care transformation be received.

12 Quarter 1 2015/16 Performance Management Report

The Committee considered a report of the Assistant Chief Executive, presented by the Head of Planning and Service Strategy, Children and Adults Services, that updated on progress against the Council's corporate basket of performance indicators for the Altogether Healthier theme and reported other significant performance issues for 2015/16 (for copy see file of Minutes).

The Head of Planning and Service Strategy highlighted the developments since the last quarter and the key developments for this quarter.

Resolved:
That the report be received.

13 2014/15 General Fund Revenue & Capital Final Outturn Report and Forecast of Revenue Outturn Quarter 1, 2015/16

The Committee considered a report of the Head of Finance, Financial Services, which provided details of the updated forecast outturn position for the Children and Adults Services (CAS) service grouping, covering both revenue and capital budgets and highlighting major variances in comparison with the budget, based on spending to the end of June 2015. The Committee received a presentation regarding the Revenue and Capital Outturn Forecast for Quarter 1 of 2015/16 from the Finance Manager (for copy of report and slides see file of Minutes).

Councillor O Temple referred to the underspend of care activity that had appeared in the budget for the last two years and asked if it was a reasonable assumption that this would not be expected to continue in future years. The Finance Manager said that the figures would be much reduced going forward as most of the underspend would be removed.

Councillor Temple asked if a summary of the overall change could be given in terms of the recipients and the improvements to service delivery. The Head of Planning and Service Strategy advised that this was linked to the transformation agenda and case examples would illustrate that. He suggested that this be arranged for a future meeting.

Resolved:
That the financial forecasts included in the report, summarised in Quarter 1 of the forecast of outturn report to Cabinet in July, be noted.

Adults Wellbeing and Health Overview and Scrutiny

4 November 2015

NHS Quality Accounts 2014-15 : Progress against 2015/16 priorities

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose of the Report

1 To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with supporting information to accompany presentations that are to be given by County Durham and Darlington NHS Foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust and North East Ambulance Service NHS Foundation Trust setting out progress made against their Quality Accounts' priorities for 2015/16.

Background

2 At its meeting held on 30 June 2015, the Adults, Wellbeing and Health Overview and Scrutiny Committee endorsed responses to Draft Quality Accounts for 2014/15 from:-

- County Durham and Darlington NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- North East Ambulance Service NHS Foundation Trust

3 As part of each response, the Adults Wellbeing and Health Overview and Scrutiny Committee requested that a six monthly progress report be given by each NHS Trust in respect of delivery of 2015/16 priorities and performance targets.

Local Authority Health Scrutiny – Guidance to support Local Authorities and partners to deliver effective health scrutiny

4 In June 2014, the Department of Health published guidance to support local authorities and their partners to deliver effective health scrutiny following changes made to the NHS as a result of the Health and Social Care Act 2012.

5. The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services.

6. The Guidance reinforced the legitimate role of health scrutiny in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service and in testing this information by drawing on different sources of intelligence.

7. In the light of the Francis report, the guidance states that local authorities need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and Public Health services to health scrutiny bodies.

8. Health scrutiny also needs to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example by seeking the views of the local Healthwatch.

NHS Quality Accounts 2014/15 – Updates against 2015/16 priorities

9. Set against the context of ongoing engagement between NHS Foundation Trust partners and the Adults Wellbeing and Health Overview and Scrutiny Committee in respect of Quality Accounts, 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 will provide presentations to members setting out progress made against their Quality Accounts' priorities for 2015/16.

10. A copy of the North East Ambulance Service summary Annual Report is attached for Member's information. (Appendix 2)

11. During consideration of the presentations members may wish to give consideration to:-

- How NHS Trust partners are delivering against the Quality Accounts priorities for 2015/16?
- How do those Quality Accounts priorities for 2015/16 meet the Commissioning priorities of the Clinical Commissioning Groups and are services being provided which address those CCG priorities?
- The views of County Durham Healthwatch and any other sources of independent information regarding service provision.

Recommendations

12. Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are asked to receive the report and provide comment on the presentations given by County Durham and Darlington NHS Foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust and North East Ambulance Service NHS Foundation Trust.

Background Papers

NHS Quality Accounts Report to Adults Wellbeing and Health Overview and Scrutiny Committee – 30 June 2015

County Durham and Darlington NHS Foundation Trust Draft Quality Account 2014/15

Tees, Esk and Wear Valleys NHS Foundation Trust Draft Quality Account 2014/15

North East Ambulance Service Draft Quality Account 2014/15

Contact: Stephen Gwillym, Principal Overview and Scrutiny Officer Tel: 03000 268140
E-mail : stephen.gwillym@durham.gov.uk

Appendix 1: Implications

Finance – None.

Staffing - None

Equality and Diversity - None

Accommodation – None.

Crime and Disorder – None.

Human Rights – None

Consultation – None.

Procurement – None

Disability Discrimination Act – None

Legal Implications – None.

North East Ambulance Service in numbers:

Area covered
3,200
square miles

Employ more than
2,500
staff

Population served
2.7
million

In 2014-15:

Responded to
302,687
incidents that resulted in a patient being taken to hospital

Treated and discharged
18,144
patients with telephone advice

Treated and discharged
81,990
patients at the scene without the need to convey

Answered
1.107
Million
emergency & NHS 111 calls

Responded to
134,745
red incidents* within
8 minutes

Completed
741,655
PTS journeys

*Red incidents are our most serious, where a patient's condition could be life threatening

Key service developments

Merit April
Our new 'trauma doctor - paramedic' team goes live.

Clinical care hub December
Our existing hub will be reconfigured and significantly expanded to support our ICaT solution. It will continue to develop, drawing in specialists during 2016 in support of the redesign of urgent and emergency care.

Mobile communications
A new communication system will be in place, working across all three emergency services.

Urgent and emergency care March
We will have redesigned our urgent and emergency care system, reducing A&E conveyance and hospital admissions.

Remote monitoring April
There is widespread take up of our telehealth solutions, helping to improve people's independence and quality of life.

2015 | **2016** | **2017** | **2018** | **2019** | **2020**

Investors in People April 2016-2020
NEAS will be a great place to work and we will have made great strides in our journey to reach the highest level of IIP accreditation with a healthy, engaged and motivated workforce.

Electronic dispensing of medicines March
Trial of a new system to make it much easier for our employees to access medicines.

Mobile healthcare April
Point of Care Testing is used routinely to support on scene testing and diagnosis.

ICaT April
Integrating Care and Transport to be expanded across the region subject to final evaluation and funding.

e-PCR July
New solution to support digital patient record keeping and the sharing of relevant information.

If you want to know more about our plans please refer to our Strategic Plan: A New Journey to 2020 at **www.neas.nhs.uk**

Alternatively contact Nichola Kenny, Deputy Director of Strategy & Transformation
E: nichola.kenny@neas.nhs.uk / **T:** 0191 430 2000.

North East Ambulance Service NHS
NHS Foundation Trust

A new journey *For Life*

2015-2020: Strategic Overview
September 2015

This is a start of an exciting new journey for NEAS. The setting of a new mission and vision is a line in the sand, marking a time for change for the better.

As an ambitious ambulance trust we are pleased to share our five year strategy which launches our promise, through our newly set mission, vision and values.

As experts in the field of urgent and emergency care we have been instrumental in making a number of system and service changes over the last few years, including the development of a regional NHS 111 service and the introduction of leading edge clinical pathways in partnership with our local acute providers for those patients suffering from a heart attack, stroke and more recently sepsis. Ambulance trusts are now being recognised nationally for the role we can play in the overall transformation of urgent and emergency care and the impact we can have on reducing unnecessary journeys to Emergency Departments. It is a role we take seriously and we have already embarked on a transformational programme of work that will enable us to effectively help deliver the NHS England vision for urgent and emergency care.

All in all this is an ambitious, challenging but also an exciting time for us. We need to see how we can redesign what we all do and effectively contribute to a system wide funding gap. We will deliver patient focused, clinically effective and high quality services, whilst striking a balance with the financial challenge. Any changes we commit to will be evidence based, always ensuring the safety and effectiveness of our services.

We can only deliver the best services for patients through our hard-working and dedicated staff. The pressures placed on them can be intense. We are committed to making our Trust a better place to work and increase our pace of change and delivery.

Yvonne Ormston

Yvonne Ormston
CEO

Our commitment to change

The next five years for NEAS are going to be exciting as we drive and lead major system reform, this will be challenging as the reforms are critical to our success and our financial sustainability.

Our landscape
We have welcomed the national response through the review of urgent and emergency care which has called for a "fundamental shift in the way urgent and emergency care services are provided to all ages, improving out of hospital services so that we deliver more care closer to home and reduce hospital attendances and admissions."

The population of the North East is growing and, as a whole continues to have higher than average ill health caused through lifestyle choices, deprivation and an ageing population. There are disparities in life expectancy between the sexes and depending on where people live. Early death from cancer, heart disease and stroke has fallen across the North East, but still remains substantially higher than the rest of the UK.

The health challenges the North East faces are evident in the growing demand and our service patterns are also changing so we now:

- See patients with more complex conditions
- Experience higher demand for NHS 111 services
- Deal with significantly more urgent patients over the phone
- Undertake a lot more same day transport requests

Organisational change
After a consultation exercise in summer 2015, our staff and stakeholders told us we need to:

- Embrace change and react more quickly to develop services
- Look after our staff
- Improve performance of core services
- Innovate alongside other NHS organisations to provide an integrated total care solution

A new vision

Our new mission, vision and values underpin our 2015-2020 strategy.
They are our organisation's principles upon which we will make all our future choices.

Our mission - why we wear our badge
Safe, effective and responsive care for all.
The pride we place in delivering our services marks us out as second to none in terms of reliability, professionalism and compassion. People rely on us for the responsive services we provide all day, every day, throughout the areas we serve.

Our vision - where our badge will take us
Unmatched quality of care, every time we touch lives.
Even in the most challenging situations we will strive to perform to the highest professional standards in a spirit of collaboration and teamwork, no matter what the circumstances. We will be acknowledged as the leading specialist care provider when looking after the patients in our care.

Our badge stands for unmatched quality of care for every life we touch. For life.

Our values - how our badge will take us there.

Respect.
We work in challenging environments and situations. We will treat all our patients, colleagues and customers alike, with the same respect we'd expect to be shown ourselves. We will act as one team and will appreciate one another in facing the future together.

Take responsibility and be accountable.
We will make sure we do what we commit ourselves to, and take responsibility for our actions. In doing this, we will support each other in delivery; and react quickly to lessons learnt along the way. Be only critical of ourselves, not others.

Compassion
To deliver our services effectively, care alone is not enough. We care for our patients and staff with compassion and empathy that marks us out as special. We listen intently to those whose lives we touch, so that our provision is considered to be above and beyond the call of duty.

Pride
This is more than a job, and it's a privilege to serve the patients in our care. We've made a true commitment to our vocation as part of the overall NHS healthcare system. This will drive us with integrity at every turn to help others. In return, we will commit to the recognition, training and development of our team so that they can perform their duties to the best of their abilities.

Strive for excellence and innovation
We will always do our very best. We will learn and constantly innovate wherever we can by embracing change to enhance our service. We will listen to, and collaborate with, our colleagues throughout the NHS, fellow emergency services and patients. This will enable us to remain at the forefront of specialist responsive care, as a dynamic, integrated and sustainable service.

Make a difference - day in day out
We touch people's lives on a daily basis. How we do that can be life saving or life changing. We will always aim to make a positive difference to those people's lives. And we will show the same respect to our colleagues as our patients.

A new focus - reshaping the future

Our 2015-2020 strategic aims will focus on quality within our core business of emergency and urgent care.

Do what we do well
We aim to achieve sustainable service delivery and ongoing improvements, whilst protecting best practice and quality standards through optimum use of all available resources.

We will achieve this through internal reform driven by our transformation projects, including integrating care and transport and developing a clinical hub.

Look after our employees
We aim to nurture a consistent culture of compassion that values and supports employees to deliver exceptional care to patients.

We have conducted an extensive survey of culture and behaviours across the organisation and will use the feedback to support the journey we have already started in making NEAS a better place to work; developing new training and career development programmes; putting in place effective health and wellbeing programmes. The Investors in People framework will underpin what we do.

Develop new ways of working
We aim to drive and shape the future of urgent and emergency care services through effective integration and collaboration.

We will achieve this through the external reform identified in NHS England's Five Year Forward View and being implemented through the new Vanguard programmes in which we participate. NHS 111 will be the "smart call to make" and effectively integrate with services out of hours.

A fundamental part of our transformation programme is to make better use of technology including the use of an electronic dispensing of medicines solution, a new electronic patient care record system (e-PCR) and improving access to clinical information.

Changes we are making - a path to 2020

Integrating care and transport (ICaT)
We are re-configuring our resource base to facilitate access to a single service model responding appropriately to both scheduled and unscheduled care 7 days a week.

This will enhance our responsiveness with a more targeted clinical skill-set and wider range of vehicle resource type leading to:

- Improved use of alternative vehicles to convey patients to hospital
- Timely responses to patients who are at the end of their life or have mental illness
- 7 day patient transport supporting effective hospital flows

Enhanced triage and assessment - mobile healthcare
Through training we will further develop our workforce, introducing advanced practice in critical care and evidence based Point of Care Testing that will enable us to look after many more patients without having to take them to hospital.

Developing NHS 111 and a clinical hub
We will deliver a more wide ranging clinical hub to support NHS 111 and 999 services. This will enable us to fast track patients to relevant experts or services, book an appointment, provide better support for self-care, and provide access to health professionals to support real-time decision making.

Clinical advancements include

- Trialling of a new referral pathway for patients presenting with a Transient Ischaemic Attack (TIA).
- Developing advanced practice in critical care to improve patient survival outcomes following a Cardiac Arrest.
- Development of a Point of Care Test; testing for lactate, to support diagnosis of Sepsis that enables administration of anti-biotics pre-hospital, to improve survival rates.

Adults Wellbeing and Health Overview and Scrutiny Committee

4 November 2015

County Durham and Darlington NHS Foundation Trust – Care Quality Commission Inspection Report

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose of the Report

1 To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with background information in respect of the Care Quality Commission (CQC) inspection of County Durham and Darlington NHS Foundation Trust in conjunction with a presentation by Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust.

Background

2 At the Committee's meeting held on 30 June 2015, members received a presentation detailing the role and function of the CQC including information in respect of its inspection regime and responsibilities.

3 During the course of members' questions on that item, reference was made to recent CQC inspections in respect of County Durham and Darlington NHS Foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust and North Tees and Hartlepool NHS Foundation Trust and the evidence portfolios submitted to the CQC on behalf of the Committee as part of the information gathering processes which accompanied each respective process.

4 The Committee also indicated that it was eager to develop its relationship with the CQC and to ensure that when CQC inspection reports were published that these be considered by the Adults Wellbeing and Health Scrutiny Committee as part of its ongoing role to provide public assurance to continuing health service improvement within County Durham.

County Durham and Darlington NHS Foundation Trust – CQC Inspection

5 The CQC Inspection of County Durham and Darlington NHS Foundation Trust was included in the Quarter 4 2014/15 (January to March 2015) inspection programme with a deadline for the submission of evidence to support the inspection of 5 December 2014 and onsite inspections commencing on 2 February 2015.

6 The CQC published its inspection report for County Durham and Darlington NHS Foundation Trust on 29 September 2015 and assessed the Trust as "Requires Improvement".

7 A copy of the inspection report can be accessed via the following link: http://www.cqc.org.uk/provider/RXP

8 Sue Jacques, Chief Executive of County Durham and Darlington NHS Foundation Trust will be in attendance at today's meeting to present the key findings from the inspection and also to highlight those measures and actions that the Trust are implementing in respect of these findings. A copy of the Trust's action plan is attached to this report (Appendix 2).

Recommendation

9 The Adults Wellbeing and Health Overview and Scrutiny Committee is asked to note the contents of this report and consider the information provided within the presentation in respect of the CQC Inspection of County Durham and Darlington NHS Foundation Trust.

Background papers

Letter from CQC dated 24th October 2014 - Information Request: CQC Inspection Programme for Quarter 4 (January – March 2015)

Minutes of the Adults Wellbeing and Health OSC meeting held on 30 June 2015

Contact: Stephen Gwillym, Principal Overview and Scrutiny Officer
Tel: 03000 268140

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation - None

Procurement - None

Disability Issues - None

Legal Implications - None

This page is intentionally left blank

CQC Draft Action Plan

County Durham and Darlington NHS
NHS Foundation Trust

				CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
1	A&E	A&E Quick Wins	Must Do	Ensure the A&E departments meet cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Chairs and equipment that have deteriorated must be removed and replaced.	UHND now cleaned 24x7 and DMH (currently 12 hours) moving to this shortly. Cleaning audits undertaken weekly by the monitoring officer. Schedules in place for corridors and floors and rooms cleaned as close as possible to schedule given use.	• Implement 24x7 cleaning at DMH	24x7 cleaning to commence at DMH on 1st November 2015. Cleaning audits on going on a weekly basis.	A McCree	31/10/15
2	A&E	A&E Quick Wins	Must Do	Ensure the A&E departments meet cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Chairs and equipment that have deteriorated must be removed and replaced.	UHND now cleaned 24x7 and DMH (currently 12 hours) moving to this shortly. Cleaning audits undertaken weekly by the monitoring officer. Schedules in place for corridors and floors and rooms cleaned as close as possible to schedule given use.	• Replacement of equipment and chairs that have deteriorated.	Chairs ordered - awaiting delivery. Delivery of x20 second-hand wipe-clean, stacking chairs received by ED, UHND.	Shane Longden	31/10/15
3	A&E	A&E Quick Wins	Must Do	Ensure the A&E departments meet cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Chairs and equipment that have deteriorated must be removed and replaced.	UHND now cleaned 24x7 and DMH (currently 12 hours) moving to this shortly. Cleaning audits undertaken weekly by the monitoring officer. Schedules in place for corridors and floors and rooms cleaned as close as possible to schedule given use.	• Effectiveness of implementation of cleaning changes and nursing responsibilities (blood spillages for example are the responsibility of nursing staff to clean up) to be checked on Back to Practice Fridays.	Cleanliness of the ED, UHND was assessed as part of 'Back to Practice' session on 17/09/15 and all areas of the department were found to be clean. Cleanliness will be reviewed regularly by matrons and as part of 'Back to Practice' sessions, and is an agenda item on departmental meetings.	Jayne McClelland	Initial action complete - checks ongoing. 30/09/2015
4	A&E	A&E Quick Wins	Must Do	Ensure all toys are cleaned properly to reduce the risk of infection wihtin the A&E department.	Cleaning schedules in place for toys in both A&E's (cleaned daily and cleaning signed off).	• Review the need for toys in A&E against alternatives e.g. pre-packed and disposable colouring books.	Toys removed and disposable packs in place.	Stephen Cronin / Jayne McClelland	31/10/2015 - Complete
5	A&E	A&E Quick Wins	Must Do	Ensure sharp bins are managed appropriately to reduce the risk of needle stick injury within the A&E department.	Weekly audits of sharps bins and communication of issues to nursing staff at the time of the audit.	• The audit and checking process for sharps bins and resuscitation trolleys / airway kit to be checked on Back to Practice Fridays.	Assurance of actions assessed on 'Back to Practice' session 17/08/15 and this will form part of a regular process. Sharps Bin Audit is conducted monthly and results displayed on Staff Notice Board. Agenda item on departmental meetings and Infection Control to be involved. New sharps bins to be ordered at UHND, which offer greater protection to staff against risk of sharps injury. Intention to be used accross both EDs.	Jayne McClelland	Monitoring - complete New bins - 30/11/2015
6	A&E	A&E Quick Wins	Must Do	Ensure that all resuscitation drugs and equipment within the A&E department are regularly checked, cleaned and in date. This should include all grab bags and anaphylaxis kits.	Resus trolley drugs checked twice daily and equipment daily. At UHND drug expiry dates checked weekly. Checklist in place and signed off. Sample audits also undertaken by the CAP Team.		Back to Practice session 17/9/15 revealed all resuscitation drugs were in date in every drawer and the grab bag. All fluids in date. Grab bags were all kitted correctly as was the anaphylaxis kit. Three members of staff could demonstrate where the difficult airway kit was kept.	Jayne McClelland	Initial action complete - checks ongoing
8	A&E	A&E Quick Wins	Must Do	Ensure that all relevant staff know where the difficult airway kit is kept.	All staff have been advised of where the Difficult Airway kit is kept.	• Location of difficult airway kit to be included in induction and induction to be completed.	Back to Practice session 17/9/15 revealed three members of staff spoken to could demonstrate where the difficult airway kit was kept.	Jayne McClelland	Initial action complete - checks ongoing
9	A&E	A&E Quick Wins	Should Do	Encourage all relevant staff to attend violence and aggression training within the A&E department.	Staff booked on to violence and aggression training on available dates.		Now mandatory training in ED.		Complete
10	A&E	A&E Other	Must Do	Ensure that there are robust risk assessments in place for the paediatric environment within the A&E department. These must be readily accessible and available to all staff in the department. Risk mitigation must be outlined and an action plan to improve the area must be written.	Specific risk assessment in place for the paediatric area at UHND supported by an action plan. Specific paediatric waiting room with CCTV in place and safeguarding nurse on each shift at DMH but children may sit elsewhere with parents and we cannot tell them where to sit.	• Sufficiency of risk assessments and action plans at UHND to be checked on Back to Practice Fridays and assured from September 2015.	Back to Practice/Self Inspections	Jayne McClelland	30/09/15

CQC Draft Action Plan

y Durham and Darlington NHS
NHS Foundation Trust

				CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
11	A&E	A&E Other	Must Do	Review paediatric nurse cover in the A&E department at Durham to ensure all shifts are covered with a paediatric nurse either through service level agreement with the paediatric department or through the appoinment of paediatric nurses to the department, to ensure a consistent approach across the organisation.	• Paediatric nursing in ED being reviewed as part of clinical strategy work.	• Document current paediatric nursing cover in ED and risk assess remaining gaps, both 'as is' and as intended following implementation of the clinical strategy. Propose interim actions to ECL to address any gaps		Stephen Cronin	15/11/15
12	A&E	A&E Other	Must Do	Review consultant levels against CEM guidance.	• Consultant levels being reviewed as part of clinical strategy work.	• Document current consultant staffing against CEM standards and risk assess remaining gaps, both 'as is' and as intended following implementation of the clinical strategy. Propose interim actions to ECL to address any gaps.	Back to Practice session 17/9/15 revealed consultant staffing levels still below CEM guidelines however two further consultants have been appointed.	Shane Longden	15/11/15
13	A&E	A&E Other	Must Do	Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in the urgent care centres	• UCC recruitment on-going and vacant posts being appointed to. Most now in post, all others have start dates or advertised. Training needs being addressed on appointment. Mentorship programme in place for new starters and competency document used across all centres. • Transforming Unscheduled Care programme in place with ECIST support and including actions from Monitor review, with commissioner support. Significant improvements in performance in Quarter 2 (EL – need to include some specifics). "Perfect week" exercises to be completed by December 2015.		Recruitment on-going all remaining vacant posts being appointed to.	Shane Longdon	31/12/15
14	A&E	A&E Other	Must Do	Review the achievements and actions taken to address national targets within the accident and emergency departments (A&E).	Transforming Unscheduled Care Task Group in place. ECIST actions and actions from Monitor visits incorporated in a single action plan managed by this Group - significant improvements in waiting times and ambulance handover times in Q2. Winter resilience actions being coordinated by Medical Director.		• Follow through of actions monitored by the TUC Task Group • Perfect Week exercises taking place at UHND (Nov 15) and DMH (Dec 15)	Carole Langrick Chris Gray	• TUC action plan. Ongoing, benefits expected 31/12/15 • Perfect week 13/12/15
15	A&E	A&E Other	Should Do	Continue to review College of Emergency Medicine (CEM) audit data to ensure patient outcomes are met.	Audit leads review outcomes of CEM audits and present at clinical governance meetings	• Care Group to ensure that CEM audits are on forthcoming clinical governance meeting agendas. These meetings to ensure robust action plans are in place or there is escalation where they cannot be put in place.	An ED consultant carries out regularly and are fedback at DMH ED Governance Meeting. ED Consultants discuss outcomes/progress at ED Governance Meeting at UHND, and currently no outstanding actions.	Jayne McClelland	31/10/15
16	A&E	A&E Other	Should Do	Continue to review College of Emergency Medicine (CEM) audit data to ensure patient outcomes are met.	Audit leads review outcomes of CEM audits and present at clinical governance meetings	• Operational Governance Committee to provide challenge to any action plans which do not address key audit findings.		Warren Edge	31/10/15
17	A&E	A&E Other	Should Do	Implement assessment tools and improve audit activity to monitor quality and patient outcomes within the urgent care centres.	• Audits in UCCs undertaken by Team Leaders and GP Governance Leads.	Programme of pathway audits to be be developed and ensure outcomes shared across urgent care centres		Jayne McClelland Denise Kirkup	15/11/15
18	A&E	A&E Other	Should Do	Review the need for paediatric trained nurses in Urgent Care Centres.		• Review of the need for Paediatric Nurses in Urgent Care Centres, including current arrangements to access cover and support and taking account of national standards. Outcome to be shared with ECL and, potentially, commissioners (depending on outcome).		Stephen Cronin	31/10/15
19	A&E	A&E Other	Should Do	Review staffing at night in Urgent Care Centres	• UCC recruitment on-going and vacant posts being appointed to. Most now in post, all others have start dates or advertised. Training needs being addressed on appointment. Mentorship programme in place for new starters and competency document used across all centres. • Transforming Unscheduled Care programme in place with ECIST support and including actions from Monitor review, with commissioner support. Significant improvements in performance in Quarter 2 (EL – need to include some specifics). "Perfect week" exercises to be completed by December 2015.	• The Urgent Care Service is the subject of a review with commissioners, which includes consideration of revised proposals for overnight service provision, designed to maintain patient access to the service, whilst optimising overnight staffing arrangements. If accepted, these proposals will mitigate the risks associated with lone working overnight. • In the meantime, security risk assessments to be reviewed with Health and Safety colleagues as well as application of the lone worker policy for staff working in urgent care centres at night. Mitigation to be put in place where gaps are identified from risk assessments.	Recruitment on-going all remaining vacant posts being appointed to (consistency issue). Health and Safety risk assessments already reviewed for some Centres.	Shane Longden	31/12/15

			CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
20	Medicine/NIV/ Critical Care	Must Do	Ensure that all resuscitation is checked daily and stored securely, and introduce a monitoring system to ensure that checks take place within the outpatient department	• Tool for daily checking of resuscitation equipment in place within Outpatients Department.	• Quality Metrics audit tool for Outpatients Department is in development to ensure compliance.		Susan Hoare	30/11/15
21	Medicine/NIV/ Critical Care	Must Do	Establish a consistent approach to critical care outreach services across the organisation	• Plans in place to introduce a 24x7 outreach team appropriate to the needs of both acute sites. Plans reviewed by ECL and QHGC in August 2015. Resuscitation and Deteriorating Patient Committee co-ordinating work on business case to be presented to OPG in October 2015.	• Business cases for outreach and pharmacy support to be fast-tracked. ECL to review to expedite through Operational Planning Group.	As per WE comment	R Hixson , P Thurland, J Cram	15/10/15
22	Medicine/NIV/ Critical Care	Must Do	Ensure that there are sufficient numbers of suitable skilled, qualified and experienced staff, in line with best practice and national guidance and taking into account patients' dependency levels on medical wards, particularly where patients are receiving non-invasive ventilation (NIV) and require level 2 intervention.	• Patients on NIV being nursed in cohorts on each ward (1 male 4-bedded bay and 1 female 4-bedded bay on each ward). Eight beds closed on Ward 1 to support staffing arrangements and escalation beds on Ward 44 have been ring-fenced. • Competency framework for NIV initiation and administration revised in line with BTS guidelines.	• Respiratory Intermediate Care plan – complete actions following ED review and bring to ECL.	• NIV patients cohorted on both ward 1 and ward 44 at a ratio 1:4 pending Respiratory HDU and staffing adjusted to suit patient ratios. • Outline Respiratory HDU plan reviewed by ECL. Due back November.	Jayne McClelland	31/10/15
23	Medicine/NIV/ Critical Care	Must Do	Undertake a review of current documentation relating to the care and management of patients receiving NIV to ensure that it is consistent across both UHND and DMH	• Procedure and pathway documentation reviewed and updated in line with BTS Guidelines and approved by Clinical Standards and Therapeutics Committee in August 2015. In use on both wards.	• Further NIV outcomes audit to complete	Audit scheduled. In planning stage.	Neil Munro Denise Kirkup	30/11/15
24	Medicine/NIV/ Critical Care	Must Do	Have arrangements in place for patients receiving NIV that comply with the British Thoracic Society guidelines (2008) for the use of NIV for acute exacerbation of chronic obstructive pulmonary disease.	• Competency framework for NIV initiation and administration revised in line with BTS guidelines.	• Further NIV outcomes audit to complete	Audit scheduled. In planning stage.	Neil Munro Denise Kirkup	30/11/15
25	Medicine/NIV/ Critical Care	Must Do	Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with best practice guidance.	• Patients on NIV being nursed in cohorts on each ward (1 male 4-bedded bay and 1 female 4-bedded bay on each ward). Eight beds closed on Ward 1 to support staffing arrangements and escalation beds on Ward 44 have been ring-fenced.	• Respiratory Intermediate Care plan – complete actions following ED review and bring to ECL.	• NIV patients cohorted on both ward 1 and ward 44 at a ratio 1:4 pending Respiratory HDU and staffing adjusted to suit patient ratios. • Outline Respiratory HDU plan reviewed by ECL. Due back November.	Jayne McClelland	31/10/15
26	Medicine/NIV/ Critical Care	Must Do	Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and of appropriate quality.	• NIV audit completed for all patients initiated onto NIV in January 2015, to be repeated later in year (provisional date w/c 2nd November 2015).	• Further NIV outcomes audit to complete	Audit scheduled. In planning stage.	Neil Munro Denise Kirkup	30/11/15

			CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
27	Medicine/NIV/ Critical Care	Must Do	Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and of appropriate quality.	• Clinical Audit team review of compliance on Ward 1 and Ward 44 completed September 2015.	• Feedback of compliance audit results	Clinical Audit Team reveiwed compliance (Ward 1 and 44) on 9/10 September 2015. Procedure and pathway document in place. Staff were completing the documentation in line with the procedure. Patient cohorting was appropriate, nursing staff on the day had their competency assessments completed. NIV training programme has been developed for 2015/16 for clinical staff.	Warren Edge	linital check completed - 30/09/2015. Further audit planned w/c 2/11/2015
28	Medicine/NIV/ Critical Care	Should Do	Ensure that the intensive care unit has an outreach team to identify and monitor deteriorating patients.	• Plans in place to introduce a 24x7 outreach team appropriate to the needs of both acute sites. Plans reviewed by ECL and QHGC in August 2015. Resuscitation and Deteriorating Patient Committee co-ordinating work on business case to be presented to OPG in October 2015.	• Business cases for outreach and pharmacy support to be fast-tracked. ECL to review to expedite through Operational Planning Group.	Approval of funding of 2 WTE Pharmacists for ITUs. Business case for 24x7 outreach progressing. Expected with ECL in November 2015.	R Hixson , P Thurland, J Cram	30/11/15
29	Medicine/NIV/ Critical Care	Should Do	Ensure that the intensive care unit has an outreach team to identify and monitor deteriorating patients.	• Plans in place to introduce a 24x7 outreach team appropriate to the needs of both acute sites. Plans reviewed by ECL and QHGC in August 2015. Resuscitation and Deteriorating Patient Committee co-ordinating work on business case to be presented to OPG in October 2015.		Approval of funding of 2 WTE Pharmacists for ITUs. Business case for 24x7 outreach progressing. Expected with ECL in November 2015.	R Hixson , P Thurland, J Cram	30/11/15
30	Medicine/NIV/ Critical Care	Should Do	Ensure that there is clinical pharmacist input in the intensive care unit in line with 'Core standards for intensive care' guidelines.	Critical Care Delivery Group and Pharmacy Leads developing a business case to appoint clinical pharmacist support to ITU	• Business cases for outreach and pharmacy support to be fast-tracked. ECL to review to expedite through Operational Planning Group.	Executive Directors have approved funding for two clinical pharmacists (WTE) to cover the Trust's intensive care units. The posts are to be filled / allocated.	G Kirkpatrick	31/12/15
31	Medicine/NIV/ Critical Care	Should Do	Review the patient flow of higher dependency patients throughout the hospital to ensure care is given in the most appropriate setting.	Patient flow will be formailised through adherance to the critical care admission/discharge policy (complete), discharge escalation policy supported by the development of Outreach. • Critical care admission and discharge policy has been approved. • Patient flow team has been invited to discuss the policy at the Critical Care Delivery Group. • The topic of enforcement of the admission and discharge policy is to be discussed at the November 2015 CCDG meeting with a view to writing a letter to all CDDFT Consultants reinforcing the important points.	• To formalise patient flow through adherance to the critical care admission/discharge policy, discharge escalation policy supported by the development of Outreach.	Critical Care Admission & Discharge Policy now approved	Policies - Matt Wayman / CCDG, Outreach - Richard Hixson / Resus Committee	- Discharge policy 30/9/15 - Outreach development 31/10/15
32	Medicine/NIV/ Critical Care	Should Do	Direct medical staff to check resuscitation equipment and drugs before the start of their shift even when nursing staff have completed the checks.	Resus trolley drugs checked twice daily and equipment daily. At UHND drug expiry dates checked weekly. Checklist in place and signed off. Sample audits also undertaken by the CAP Team.	Require all start of shift safety huddle to confirm that the resuscitation trolley and drugs have been checked and confirmation to be recorded on the board. Familiarity of all staff on shift with the location of the trolley and the equipment to be confirmed as part of the huddle.		Professor Chris Gray	31/10/15

			CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
33	Medicine/NIV/ Critical Care	Should Do	The trust should ensure that any out of date medication is removed from stock cupboards once it has expired, in line with the trust medication management policy, and have a process for monitoring this within the outpatient departments.	• Pharmacy policy and checklist implemented in each Outpatients Departments to ensure any out of date stock is removed. • AMU UHND has a medicines management assistant in place who is responsible for checking that medication in cupboards is in date and checking fridge temperatures. AMU at DMH have processes for both medication cupboards and fridges overseen by the Ward Manager.	• Back to Practice Fridays to check medication stocks in cupboards and improve and assure processes for doing so.	Back to Practice checks on compliance carried out on 17th September and further regular sessions being held to continually monitor and reinforce compliance with procedures to ensure medication stocks are in date.	Care Group Lead Nurses	Initial action completed - checks ongoing.
34	Medicine/NIV/ Critical Care	Should Do	The trust should ensure that all fridge temperatures are checked daily and that there is a system in place to monitor that checks are taking place within the outpatient departments. The trust should ensure that the cold chain is robust.	• Checklists in place to ensure all fridge temperatures are checked daily in Outpatients Department. • AMU UHND has a medicines management assistant in place who is responsible for checking that medication in cupboards is in date and checking fridge temperatures. AMU at DMH have processes for both medication cupboards and fridges overseen by the Ward Manager.		Back to Practice checks on compliance carried out on 17th September and further regular sessions being held to continually monitor and reinforce compliance with fridge temporature checks.	Care Group Lead Nurses	Initial action completed - checks ongoing.
35	Medicine/NIV/ Critical Care	Should Do	Ensure that there is a training plan in place, which is delivered to all staff involved in the care of patients receiving NIV, and that it is competency based and in sufficient detail to demonstrate competence in all aspects of NIV.	• Staff on Wards 1 and 44 and staff in ED trained and have documented sign off against the framework. The training package was delivered by the Respiratory Nurses. SOP developed and in place.		Complete. Verified on ward visits. Ward 1, UHND to retain competency assessments in a folder on the ward. Training plan in place with dates available in 2015/2016.	Jayne McClelland	Complete
36	Medicine/NIV/ Critical Care	Should Do	Have an up-to-date standard operating procedure (SOP) which clearly sets out the management of patients admitted to both acute hospitals who require NIV.	SOP has been developed and ratified by the relevant committees, and is in use by staff.	• Final copies of SOP / procedure to be filed in one place on the intranet	Complete.	Jayne McClelland	Complete.
37	Medicine/NIV/ Critical Care	Should Do	Ensure that this guidance/SOP includes clarity on the setting/ specific ward in which patients can be managed	SOP has been developed and ratified by the relevant committees, and is in use by staff.	• Final copies of SOP / procedure to be filed in one place on the intranet	Complete.	Jayne McClelland	Complete.
38	Medicine/NIV/ Critical Care	Should Do	Ensure that this guidance/SOP includes staffing to patient ratios that are in line with current guidance.	SOP has been developed and ratified by the relevant committees, and is in use by staff.	• Final copies of SOP / procedure to be filed in one place on the intranet	Complete.	Jayne McClelland	Complete.
39	Medicine/NIV/ Critical Care	Should Do	Ensure that any guidance/SOP includes an escalation plan that includes action to be taken when a bed is unavailable in an appropriate setting and when patient numbers do not match agreed staffing ratios	SOP has been developed and ratified by the relevant committees, and is in use by staff.	• Final copies of SOP / procedure to be filed in one place on the intranet	Complete.	Jayne McClelland	Complete.

CQC Draft Action Plan

County Durham and Darlington NHS Foundation Trust

			CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
41	Record Keeping, Care Planning & Ward Management	Must Do	Ensure that patient records are kept up to date, are patient-centred and contain relevant information about their treatment and care, including awaiting discharge, to eliminate unnecessary delays.	• E-Obs rolled out to all adult IP areas at DMH, UHND and BAH (except Ward 18). Staff responsible for delivering care and recording of observations, including the nurse in charge of the ward area, are sent an alert if a patients are due or overdue. The frequency of observations is dependent upon the patients Early Warning Score in line with patient need. When an observation set is recorded it is date and time stamped and an electronic signature of the recorder stored against the patient record instantly. • Admission and care planning documentation has been reviewed and revised, piloted on both sites and implemented from 3rd August 2015. • Record-keeping included within Quality Matters audit tool.	- Self Inspection to be carried out to ascertain position. - Back to practice Fridays process to review and spot check. - Clinical Audit monthly independent checks to be scheduled. - Monitoring through Senior Nurses Forum and ECL to be established. - Quality Matters ward audits to monitor formally on an ongoing basis.	Self Inspection Peer Reviews completed on 23 and 29 September 2015. Results being analysed. Back to practice Fridays are being undertaken. Feedback provided to staff in real-time. Quality Matters ward audits continue. Clinical Audit independent checks scheduled from November 2015 (in light of recent Self Inspection Peer Reviews) Monitoring through Senior Nurses Forum and ECL established. Quality Matter ward audits to monitor formally on an ongoing basis. Completed and in place as part of the ward audit process. Nursing documentation reviewed and staff received training on completing the document.	Denise Kirkup Noel Scanlon Denise Kirkup Noel Scanlon Julie Race	30/11/15 Ongoing From 1/11/15 Ongoing Ongoing
43	Record Keeping, Care Planning & Ward Management	Must Do	Ensure that the trust undertakes a review of the skills, knowledge and capabilities of nurses to complete accurate and timely care plans that meet the needs of the patients.	• Staff were trained by Matrons prior to the roll out of the new documentation. • Care Planning now included in the nursing preceptorship.	- Self Inspection to be carried out to ascertain position. - Back to practice Fridays process to review and spot check. - Clinical Audit monthly independent checks to be scheduled. - Monitoring through Senior Nurses Forum and ECL to be established. - Quality Matters ward audits to monitor formally on an ongoing basis.	Self Inspection Peer Reviews completed on 23 and 29 September 2015. Results being analysed. Staff training on the new documentation has been undertaken. Record keeping and care planning part of preceptorship. Workshop held on 19 October 2015; scenario based learning on assessment, planning, implementation and evaluating care planning. Further session planned in six months. Workshops will coincide with University newly qualified staff. Clinical Audit independent checks scheduled from November 2015 (in light of recent Self Inspection Peer Reviews) Monitoring through Senior Nurses Forum and ECL established. Quality Matter ward audits to monitor formally on an ongoing basis. Completed and in place as part of the ward audit process.	Denise Kirkup Noel Scanlon Denise Kirkup Noel Scanlon Julie Race	30/11/15 Ongoing From 1/11/15 Ongoing Ongoing
44	Record Keeping, Care Planning & Ward Management	Must Do	Ensure medical staff record mental capacity assessments for patients who are unable to participate in decisions about 'do not attempt cardiopulmonary resuscitation' (DNACPR).	• The need for MCA has been included in DNACPR audits by the Cardiac Arrest Prevention (CAP) Team. It is only needed where a benefits v burden decision is made (not one re futility).	• CAP team to ensure DNACPR audits consider the MCA within their routine audit programme. • Include consideration of recording of MCA assessments for patients who are unable to participate in decisions about DNACPR in weekly mortality reviews, feeding back any issues to clinicians through the established process.		Lisa Ward Graeme Kirkpatrick	Audits (31/10/15) Mortality process to be adapted (15/11/15)

			CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
45	Record Keeping, Care Planning & Ward Management	Must Do	Ensure medical staff record mental capacity assessments for patients who are unable to participate in decisions about 'do not attempt cardiopulmonary resuscitation' (DNACPR).		• CAP team to assess whether to include in their routine audit programme.	Completed	Lisa Ward	31/10/15
46	Record Keeping, Care Planning & Ward Management	Must Do	Ensure audits of mental capacity assessments are incorporated into audits of DNACPR forms.	• The need for MCA has been included in DNACPR audits by the Cardiac Arrest Prevention (CAP) team. It is only needed where a benefits v burden decision is made (not one re futility).	• CAP team to ensure DNACPR audits consider the MCA within their routine programme.		Lisa Ward	31/10/15
47	Record Keeping, Care Planning & Ward Management	Should Do	Review dedicated management time allocated to ward managers.	• Baseline reports created to monitor supervisory time by ward and individual wards reviewing the outputs.	• Embed reporting and review of supervisory time on wards. • Care Groups to routinely review reports and identify and tackle issues. • Senior Nurses forum to monitor.		Julie Clennell, Jason Cram, Jayne McCelland, Noel Scanlon	30/11/15
48	Record Keeping, Care Planning & Ward Management	Should Do	Ensure patients have their medicines reconciled in accordance with trust targets.	Initial meeting have been held with DMH and UHND Pharmacy site leads to discuss extending the Pharmacy service.	• A review of service provision improvements is being undertaken by the Deputy Chief Pharmacist and site Lead Pharmacists. This will include a review of MR targets.		Jamie Harris	31/10/15

				CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
49	End of Life		Must Do	Ensure that staff know the syringe driver policy and carry out/record syringe driver checks in line with this policy.	• Variation in syringe driver practice was discussed at ECL and key messages issued via a bulletin.	• Additional awareness raising around syringe driver policy and completion of monitoring forms to be raised through Equipment Controller Networks and the Medical Devices Newsletter		Rhona Beecham	31/12/15
50	End of Life		Must Do	Add audits of syringe driver administration safety checks to the annual end of life audit programme.		• Audits of syringe driver compliance to be added to the medical devices annual audit programme and audits to be performed this year. Further audits to be performed, by Matrons, in the current year.		Rhona Beecham Julie Clennell	31/12/15
51	End of Life		Must Do	Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.	• A Band 8 manager has been appointed to support the service and work with the lead MacMillan Nurse and medical consultant clinical lead in providing operational leadership. • The EoL Steering Group has been reviewed and its terms of reference strengthened. A direct reporting line is in place to the QHGC.	• Complete appointment process and finalise EoL Group ToRs	The Band 8a is in post. The Terms of Reference for the End of Life Group have been reviewed and approved by sub-committee of the Board - complete	Julie Clennell	Complete
52	End of Life		Must Do	Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.	• A Band 8 manager has been appointed to support the service and work with the lead MacMillan Nurse and medical consultant clinical lead in providing operational leadership. • The EoL Steering Group has been reviewed and its terms of reference strengthened. A direct reporting line is in place to the QHGC.	• Develop proposals and associated business case to provide a face to face specialist palliative care services from at least 9am to 5pm, 7 days per week		Julie Clennell	31/10/15
53	End of Life		Must Do	Ensure data are available to identify and demonstrate the effectiveness of the end of life service.	• Core data items required to demonstrate effectiveness of the service identified and administrative support approved by Executive Directors. Work on extraction and reporting of data is on-going with Information Services.	• Complete work with Information on metrics, data sources, information gathering and reporting processes		David Oxenham	31/03/16
54	End of Life		Must Do	Address the lack of consultant medical staff cover in end of life community services.	Needs assessment discussed and core reasons for under-provision agreed with commissioners. New funding in place from commissioners for consultant post and middle grade post. • Agreement to develop training fellowship in palliative care. Consultant job descriptions agreed and posts advertised but no applicants	• Revise consultant job descriptions and advertise	First recruitment campaign unsuccessful. Further campaign to be undertaken	David Oxenham	30/09/15
55	End of Life		Must Do	Address the lack of consultant medical staff cover in end of life community services.	• Re consultant cover, needs assessment discussed and core reasons for under-provision agreed with commissioners. New funding in place from commissioners for consultant post and middle grade post. • Agreement to develop training fellowship in palliative care. Consultant job descriptions agreed and posts advertised but no applicants	• Develop proposals and associated business case to provide a face to face specialist palliative care services from at least 9am to 5pm, 7 days per week		Louise Shutt	31/10/15
56	End of Life		Must Do	Develop access to out-of-hours advice for healthcare professionals caring for palliative and end of life patients within the community.	Staff in the community have access to advice out of hours from Speciality Macmillan nurses working in the three hospices in county Durham and Darlington	Seek to enable access for community staff to advice from a specialist consultant. However, it should be noted that those who host the register for the south of the trust locality will not enter into such an agreement with the Trust until the Trust has a minimum of three consultants in post and is able to contribute to the rota. The Trust is, as noted above, actively looking to recruit further consultants.	Action complete (Access to advice from MacMillan Nurses) We will continue to seek recruitment of additional consultants and participate in the out of hours rota as soon as we are able to.	David Oxenham	Complete
58	End of Life		Must Do	Ensure there is effective leadership and management in place to maintain and develop the community end of life service.	• A Band 8 manager has been appointed to support the service and work with the lead MacMillan Nurse and medical consultant clinical lead in providing operational leadership. • The EoL Steering Group has been reviewed and its terms of reference strengthened. A direct reporting line is in place to the QHGC.	• Complete appointment process and finalise EoL Group ToRs	The Band 8a is in post. The Terms of Reference for the End of Life Group have been reviewed and approved by sub-committee of the Board - complete	Julie Clennell	Complete

				CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
59	End of Life		Should Do	Ensure actions in response to the National Care of the Dying Audit (NCDAH) and other identified actions to develop the service are carried out in a planned and timely way with continued evaluation.	• Detailed action plan in place for NCDAH audit and implementation being monitored through the End of Life Steering Group.		Process in place through End of Life Steering Group	Julie Clennell	Complete
60	End of Life		Should Do	Ensure systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.	• Full thematic review of complaints and incidents reported over the last 12 months with an update to the EoL Steering Group.	• Develop an EoL patient / relative experience programme and PE report		Julie Clennell	31/12/15
61	End of Life		Should Do	Ensure systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.	• Full thematic review of complaints and incidents reported over the last 12 months with an update to the EoL Steering Group.	• Develop similar Patient Safety report to Steering Group		Julie Clennell	31/12/15
62	End of Life		Should Do	Ensure systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.	• Full thematic review of complaints and incidents reported over the last 12 months with an update to the EoL Steering Group.	• Complete update of Safeguard to include categories for incidents and complaints which can be identified to EoL		Julie Clennell	31/12/15
63	Maternity & O&G		Must Do	Ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced medical staff within maternity and gynaecology services.	• Job Planning review in Maternity and Gynaecology has commenced	• Conclude job planning for Obs and Gynae staff, providing sufficiently for handover and availability of staff within both O&G (including rota adjustments, and adjustments to PAs, as necessary).		John McDonald	01/12/15
64	Maternity & O&G		Must Do	Ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced medical staff within maternity and gynaecology services.	• Job Planning review in Maternity and Gynaecology has commenced	• Review amended O&G staffing arrangements in practice.		John McDonald	31/03/16
65	Maternity & O&G		Must Do	Ensure that there are processes in place by which to identify, acknowledge and address risks through robust management processes within maternity and gynaecology services.	• Patient Safety and Quality Midwives in post in Maternity and Nurses with allocated time in Gynae to implement risk management processes. Risk management triggers reviewed in line with the NRLS and standards and risk notice boards for each site demonstrating learning and actions.	• Complete Risk Management SOP for O&G (outlines responsibilities for risk management, incident reporting, RCA and duty of candour)		Anne Holt	31/10/15
66	Maternity & O&G		Must Do	Ensure that there are processes in place by which to identify, acknowledge and address risks through robust management processes within maternity and gynaecology services.	• Patient Safety and Quality Midwives in post in Maternity and Nurses with allocated time in Gynae to implement risk management. Risk management triggers reviewed in line with the NRLS and standards and risk notice boards for each site demonstrating learning and actions.	• Patient Safety and Quality Midwives to attend recently established regional meetings of maternity risk managers which is linked to the clinical network.		Anne Holt	31/10/15
67	Maternity & O&G		Should Do	Consider ways of improving engagement between staff and managers with the care closer to home directorate with a view to achieving a joined up approach within maternity and gynaecology services. Also, consider ways of improving responsiveness and efficiency in respect to service-level decisions within this service.	Care Groups are being restructured to align them to Core Pathways and provide smaller **spans** of control. Maternity and Gynaecology will form part of a designated Family Health Care Group from 1st November, facilitating greater responsibilities in decidion making and Care Group governance with respect to this **sense**.	• Complete CG restructuring (top level). • Implement management + governance structures with the Family Health Care Group.		Carole Langrick Maria Willoughby	01/01/2016 31/01/2016
68	Maternity & O&G		Should Do	Consider ways in which it can identify the required standards within the maternity service dashboard.	• Multi-disciplinary team within Maternity, O&G meeting to develop dashboard and time allocated through job planning for labour ward clerks to ensure that dashboards are maintained and risk management processes complied with. • Boards ordered for both Labour Wards to display dashboard statistics which will be updated monthly.	• Finalise the dashboard, identify sources of information and the process for update.	Dashboard has been developed and data sources have been identified. Procedure to be developed	Anne Holt	02/10/15
69	Maternity & O&G		Should Do	Consider within the maternity and gynaecology services clinical and quality strategy for 2014-16 timelines for review and achievement.	• Defined clinical strategy in place for Gynaecology. For Obstetrics, the strategy is being developed in line with Trust priorities alongside the SeQiHS and clinical strategy roadmap work.	• Service strategy to be completed alongside Trust Clinical Services Strategy. Timelines to be determined once the Trust-wide work, and any resulting consultation is complete.		John MacDonald Carole Langrick	1st iterations 31/01/16

			CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
70	Maternity & O&G	Should Do	The trust should consider ways of developing a coherent plan for joint working on improvements in maternity and gynaecology services.	• Defined clinical strategy in place for Gynaecology. For Obstetrics, the strategy is being developed in line with Trust priorities alongside the SeQiHS and clinical strategy roadmap work.	• Service strategy to be completed alongside Trust Clinical Services Strategy. Timelines to be determined once the Trust-wide work, and any resulting consultation is complete.		John MacDonald Carole Langrick	1st iterations 31/01/16
71	Maternity & O&G	Should Do	The trust should consider ways for improving timely and responsive human resource management processes, including personnel issues that impact on service delivery in maternity and gynaecology services.		• HR Directorate restructuring progress to provide more resource for critical priorities (in consultation).	Consultation on new structure taking place.	Morven Smith	31/12/15
72	Children's and Safeguarding	Must Do	Ensure the paediatric high dependency unit room has specific SOPs or protocols available to guide suitably trained staff.	• Paediatric HDU SOP now in place.		Complete	Stephen Cronin	Complete
73	Children's and Safeguarding	Must Do	Ensure advanced paediatric nurse practitioners have a set of SOPs available to guide their practice and care.	APNPs now working to different model. Paediatric index used by APNPs - this is an MDT document but fully inclusive of the relevant SOPs.		Complete	Stephen Cronin	Complete
74	Children's and Safeguarding	Should Do	Ensure that all clinicians have the appropriate level of children safeguarding training within children's community services.	• Community CYP clinicians – 93% compliant with training requirements now. All staff attendance is monitored through performance management and appraisal and support is provided by cover using bank staff and extra hours.	• Continued monitoring of staff not meeting requirements.	Training rates for Safeguarding of Children monitored through monthly OD & Workforce meetings and reported to a Board Committee every quarter	Morven Smith/Lead Nurses	Ongoing - quarterly review from 30/10/15)
75	Children's and Safeguarding	Should Do	Formally nominate an executive or non-executive director to represent children at board level, separate from the safeguarding children executive lead role.	• Professor Paul Keane, Chairman, appointed as the director to represent children at Board level.		Complete		Complete
76	Governance & Strategy	Must Do	Review current governance processes to ensure they are embedded to ensure consistency across acute and community services	• Care Groups being restructured and leadership arrangements being reviewed to support improved engagement and communication between Care Group and specialty level (smaller groups focused on pathways) and improved decision-making. The clinical governance framework is being reviewed, reiterated and as necessary streamlined as part of this process (CL/ WE, first phase from November 2015).	• Complete the roll out of the Care Group restructuring. • Support implementation of consistent governance processes in Care Groups and audit their implementation.		Carole Langrick Warren Edge	• 1st Phase 30/11/15 • 2nd Phase (31/01/15) • Audit of implementation (31/03/15)
77	Governance & Strategy	Must Do	Review and ensure that all members of the board are fully aware of their lead responsibilities within the Board Assurance Framework	• BAF discussed with all Directors individually once a quarter and with EDs as a whole in the month prior to reporting to the Board including confirmation of responsibilities and actions (ED discussions start Sept 2015).	• All Board Committees to receive the BAF and validate their objectives, risk and actions every quarter, as well as considering BAF updates, from business discussed at each meeting.	BAF discussed at all Board Committees + objectives validated, October 2011	Warren Edge	30/11/15

			CQC Required Action	Action To Date	Further Trust Planned Action	Progress	Lead	Target Date
78	Governance & Strategy	Should Do	Review access to patient information in languages other than English.		• Commission and complete review of Patient Information with Healthwatch support		Warren Edge	28/02/16
79	Governance & Strategy	Should Do	Review the complaint process in terms of board oversight, CEO involvement and clinical direction.	• Patient Experience Team (PET) have reviewed the complaints process and CEO will sign off all complaints received through the CEO office going forward and review a monthly summary of complaints. • Board will continue to receive updates on complaints and lessons learned in the Director of Nursing's report. • Peer review process in place in PET to check quality of complaints responses before issue. • Only nominated senior staff in Care Groups can sign off complaints	• Complete review of the complaints process with Healthwatch support.		Noel Scanlon	31/12/15
80	Governance & Strategy	Should Do	Review the complaint process in terms of board oversight, CEO involvement and clinical direction.	• Patient Experience Team (PET) have reviewed the complaints process and CEO will sign off all complaints received through the CEO office going forward and review a monthly summary of complaints. • Board will continue to receive updates on complaints and lessons learned in the Director of Nursing's report. • Peer review process in place in PET to check quality of complaints responses before issue. • Only nominated senior staff in Care Groups can sign off complaints	• Explicitly identify those nominated to sign off complaints in the complaints policy and ensure that they are trained and assessed as competent to do so.		Maureen Grieveson	31/12/15
81	Governance & Strategy	Should Do	Review the complaint process in terms of board oversight, CEO involvement and clinical direction.	• Patient Experience Team (PET) have reviewed the complaints process and CEO will sign off all complaints received through the CEO office going forward and review a monthly summary of complaints. • Board will continue to receive updates on complaints and lessons learned in the Director of Nursing's report. • Peer review process in place in PET to check quality of complaints responses before issue. • Only nominated senior staff in Care Groups can sign off complaints	• Provide samples of complaint responses (post response) to Quality and Healthcare Governance Committee periodically for review.		Noel Scanlon	30/11/15

This page is intentionally left blank

Adults Wellbeing and Health Overview and Scrutiny Committee

4 November 2015

Public Health Update Report

Report of Anna Lynch, Director of Public Health, County Durham

Purpose of the Report

1. This report provides an update on national, regional and local public health developments and demonstrates delivery of the Public Health Pledge signed by the Council in February 2014 (appendix 2)

Background

2. The health of the people in County Durham has improved significantly over recent years but remains worse than the England average. Health inequalities remain persistent and pervasive. Levels of deprivation are higher and life expectancy is lower than the England average and there is also inequality within County Durham for many measures (including life expectancy and premature mortality for example). The links between poor health outcomes and deprivation are well documented.

3. Health inequalities are affected by socio-economic conditions that exist within County Durham such as lower household income levels, lower educational attainment levels and higher levels of unemployment, which lead to higher rates of benefits claimants suffering from mental health or behavioural disorders. Local priorities for tackling these inequalities include reducing smoking, tackling childhood and adult unhealthy weight, promoting breastfeeding, reducing alcohol misuse, reducing teenage conceptions (and promoting good sexual health), promoting positive mental health and reducing early deaths from heart disease and cancer.

4. Much of our population suffer from avoidable ill-health or die prematurely from conditions that are preventable. Lifestyle choices remain a key driver to reducing premature deaths but it is clear that social, economic and environmental factors also have a direct impact on health status and can exacerbate existing ill health. The health profile for 2015 is attached at Appendix 3.

5. The rationale for transferring public health functions to local authorities was made clear in Government and Department of Health reports, the impetus clearly to transform and change the approach to improving the health of the population by a re-focus on tackling the social determinants of health as evidenced in the Marmot Review and to work closer with communities i.e., a focus on people and place.

6. The implementation of the Health and Social Care Act 2012 transferred a number of former PCT public health responsibilities to DCC from 1 April 2013 together with a ring fenced public health grant, the Director of Public Health role and associated public health staff to enable the council to discharge the new statutory duties.

Page 33

7. The former PCT public health commissioned services also novated to the council and for pragmatic reasons and continuity of provision, contract procurement rules enabled the council to extend all commissioned services for one year to 31 March 2014 by means of a waiver.

8. The public health grant allocation is ring fenced which means it must be used to commission, provide and discharge the statutory public health functions and achieve public health outcomes agreed through the joint health and wellbeing strategy and the national public health outcomes framework. These outcomes are wide-ranging to enable local determination of the desired health outcomes and priorities based on the health needs of the population. The grant for 2015/16 totals £45.780m but will be subject to an in year saving (see para 17 below)

9. To support the transformation of public health and required grant realignment a three-year review and procurement programme was developed and is being implemented. This has required detailed work on the identification of priority services to be commissioned for County Durham communities, incorporating reviews of the evidence base, best practice elsewhere, analysis of impact, value for money and the development of a robust prioritisation methodology. Impacting these decisions are requirements for the council to either deliver or commission the public health services mandated i.e., prescribed by the Health and Social Care Act 2012. These are:

    - NHS health checks
    - sexual health services
    - national child measurement programme
    - health protection functions
    - support to CCGs commissioning of healthcare services.

10. Quarterly reports to Cabinet in 2013/14 provided updates on NHS and public health developments following the closure of PCTs and the transfer of PH responsibilities to councils. This report provides a more recent update on the transformation and changes in public health at national, regional and local level.

National developments

11. Both NHS England (NHS E) and Public Health England (PHE) were established on 1 April 2013 following implementation of the Health and Social Care Act 2012. Both organisations either commission or deliver public health functions, complementing and supporting the public health responsibilities of councils. Both have subsequently undertaken reviews and reorganisations that have resulted in a reduced infrastructure across England with staff working across a larger geographical area.

12. NHS England - initially there were nine NHS E area teams working across the North of England. From January 2015 this was reduced to five. One new sub-regional team now covers Cumbria and the North East of England.

NHS E continue to commission a number of population public health programmes including all immunisations and screening programmes (cancer and non-cancer), 0 to 5 years healthy child programme (up to 30th September 2015), child health information services (CHIS), public health services for people in prison and other places of detention including those held in children and young people's secure estate and sexual assault services. The commissioning of the children's public health services (with the exception of CHIS, new born infant physical check and the 6-8 GP check) transfered to councils on 1st October 2015, elements of which are included in mandated responsibilities in secondary legislation.

13. NHS E published the "Five Year Forward View" in 2014 which set out a clear direction for the NHS, showing why change is needed and how it will impact. The report focuses on a greater emphasis on prevention across the system, recognising that deprivation and other social and economic factors drive inequalities and unhealthy lifestyle choices. Secondly, the report details radical new healthcare delivery options that local areas should consider as they review and commission services to improve health.

14. In June 2015 NHS E published a follow up report that highlighted progress made over the first year. The initial developments of the prevention element are being progressed by a national prevention board which has prioritised work to tackle and reduce diabetes. The diabetes prevention programme aims to halt the steady rise in diabetes, delivering at scale lifestyle interventions that have been shown to help individuals at risk of developing type 2 diabetes. Seven demonstrator sites have been identified and these are developing the detail of the early stages of the programme which will be rolled out across England in 2016 (see paragraph 31).

15. Public Health England - initially there were 15 Public Health England local centres across England, including one that covered North East England. Following their restructure, there are now eight local centres, plus a different arrangement for London. The local PHE centre for North East England has been retained and covers the same geographical footprint. The PHE local centres provide the functions related to health protection and work closely with local directors of public health and environmental health services in councils. In addition they support the work of the public health teams in councils specifically related to health improvement programmes and associated functions.

16. PHE has published its business plan for 2015/16 and the following priorities have been identified:

- Tackling obesity
- Reducing smoking
- Reducing harmful drinking
- Ensuring every child has the best start in life
- Reducing dementia risk
- Tackling antimicrobial resistance
- Reducing TB

17. In early June the Department of Health announced there would be an in- year reduction of £208 million to the local authorities public health grant. The detail of this is subject to consultation and the Government's preferred option is a straight cut of 6.2% applied to the 2015/16 public health grant allocation inclusive of the funding for the 0-5 services contract transfer. This equates to an in-year cut of £3.142m for Durham County Council. Three other options have been included which are more complex and timely to calculate and clearly not preferred by the Department of Health. The consultation period of four weeks ended on 28 August 2015. Clearly this will have implications for the public health services commissioned by the council and preparatory analysis of the impact is underway. There is also no indication of whether this cut is one-off for 15/16 or recurrent. At the time of writing no further information on the in-year cut is available.

18. The Advisory Committee for Resource Allocation (ACRA) is currently consulting on a proposed methodology for future public health grant allocations for 2016 onwards. The consultation period runs from 8 October 2015 to 5 November 2015 and DCC will be submitting a response.

Regional Developments:

19. The infrastructure changes to NHS E are being worked through at a local level and impact mainly on the health protection assurance arrangements for councils. New oversight boards for the immunisation and screening programmes and a new Local Health Resilience Partnership for the emergency planning functions are being established at a scale that covers Cumbria and the North East of England. Local authority public health staff are members of these boards.

20. Public health sector led improvement programmes are being developed by the 12 directors of public health working as a network, supported by PHE and a work programme identifies priorities for 2015/16.

21. Fresh and Balance, the North East offices for tobacco control and alcohol respectively and the coordination of the North East workplace award are commissioned collaboratively across the 12 councils and discussions are taking place regarding other public health services that may offer efficiencies if commissioned at scale.

22. There are early discussion between NE Directors of Public Health of the potential impact of devolution with particular interest around the unified public health leadership system in Greater Manchester and its contribution to delivering transformation in Greater Manchester population area.

Local Developments

23. A three year public health contract review and procurement programme was developed in 2013 following the novation/ transfer of the former PCT commissioned public health services to the council. A number of contracts ended and others were recommissioned as part of the public health transformation process into new models of provision following service reviews.

The largest commissions in 2014/15 were an integrated drug and alcohol recovery service, integrated sexual health service (mandated), wellbeing for life service and NHS healthchecks (mandated). Smaller commissions included the innovative health improvement service for the Gypsy, Roma and travelling community.

24. The wellbeing for life service (WB4L) takes an asset based approach to improving health and is targeted at the 30% most deprived communities in the County. A consortium of five providers (County Durham and Darlington Foundation Trust (CDDFT), DCC leisure service, Leisureworks, Community Action Durham and Pioneering Care Partnership) was awarded the tender for the adult element and commenced delivery on 1st April 2015. The children and families element has been commissioned from One Point, CDDFT and includes new resilience worker posts, community parenting pilot, resilience in schools and enhancement to the family initiative supporting children's health (FISCH).

25. New commissions in 2015/16 following service reviews include the stop smoking service and the 0-19 years service which incorporates the health visitor contract (transfered to the council on 1st October 2015), the school nursing service and domestic abuse services.

26. A number of reviews commenced in 2015/16 including all public mental health services, cancer information services and access to health services transport schemes.

27. A new programme to reduce obesity in children is being piloted across the 4 Together Area Action Partnership footprint. This takes a system – wide approach to the issue and involves key local stakeholders who will drive the programme forward.

28. The public health transformation programme includes a shift to closer working with communities in County Durham. This is being progressed by partnership working with the AAPs. A member of the public health team is aligned with each AAP and supports them in the delivery of health related programmes. Examples of the AAP programmes have been presented to Cabinet in earlier update reports from the assistant Chief Executive. The largest public health programmes in partnership with AAPs are in Stanley, with a focus on smoking, Shildon with the Health Express programme, Trimdons with a focus on health trainers in the community, Mid Durham AAP with a focus on older people's health and wellbeing.

29. Public health staff have developed a number of strategies to improve health in collaboration with a range of partner organisations. These include the healthy weight framework which is being implemented by the healthy weight alliance, a cardio- vascular disease strategic framework, drug strategy, public mental health strategy and accidental injury prevention in children and young people. These are implemented in partnership and monitored via the health and wellbeing board governance arrangements. Strategies currently being progressed include the alcohol harm reduction strategy (refresh), an oral health strategy and domestic abuse and sexual violence strategy.

30. A further five mandated responsibilities became operational for the council on 1st October 2015 as the 0-5 years healthy child programme transfered to local authority from NHS England:

Page 37

- Antenatal visits
- New birth visits
- 6-8 week reviews
- One year reviews
- 2-2.5 year review

These are being commissioned through the new 0-19 years service.

31. Public health staff have worked across council service areas to provide specialist support and in many case funding public health related services. These include environmental health and tobacco and alcohol enforcement, housing strategy and housing providers role in improving health, various examples of work with children's and adult services including prevention and early help/ intervention, transport, planning etc..

32. The public health service commission a County wide diabetes prevention programme called Just Beat It and this was awarded demonstrator site status by NHS E, one of only seven in England and the only one being led by a council.

    This programme is informing the commissioning of a national diabetes prevention programme which will be launched in 2016. The two County Durham CCGs, Darlington CCG, Durham County Council and Darlington Borough Council have collectively submitted an application to be an early implementer site for the new programme.

33. The County Durham tobacco control alliance, chaired by Cllr Laing received a national award in March 2015, one of only four awarded by PHE, Action Against Tobacco (ASH) and Cancer Research UK. This is testament to the commitment and progress being made by the alliance.

Recommendations

34. The Adults Wellbeing and Health Overview and Scrutiny Committee is requested to:

    - Note the contents of the report
    - Agree to receive annual updates in relation to the transformation of the Public Health Service.

Background Papers

Health Profile 2015

Contact: Anna Lynch, Director of Public Health, County Durham
Email: anna.lynch@durham.gov.uk **Tel:** 03000 268146

Appendix 1: Implications

Finance
Commissions and staff funded via the public health grant. No implications from this report. There are implications being considered dependent on the public health grant cut.

Staffing
No implications from this report. There are implications being considered dependent on the public health grant cut.

Risk
Public health grant cut will impact on commissioned public health services.

Equality and Diversity / Public Sector Equality Duty
No implications.

Accommodation
No implications.

Crime and Disorder
No implications.

Human Rights
No implications.

Consultation
Public health grant cuts consultation 31 July – 28 August 2015.

Procurement
Implications as a consequence of public health grant cuts.

Disability Issues
No implications.

Legal Implications
No implications.

Appendix 2

Page 39

DURHAM COUNTY COUNCIL
PUBLIC HEALTH PLEDGE

Our Ambition for County Durham

Durham County Council is committed to working with residents across the County to work with them where possible to take ownership of issues that impact on their health and wellbeing. We believe it is simply not acceptable that residents in some of our communities die more than 8 years earlier than residents in other parts of the County. Our ambition is that County Durham residents enjoy good health and wellbeing, equal or better than the average across England.

How will we do this?

The Council is already committed to the Area Action Partnership model of shared planning and community participation and we will build on this in relation to the public health responsibilities that transferred to the Council on 1st April 2013. We will work with these geographical communities as well as our communities of interest and identity, valuing their diversity, building on their strengths and assets and on issues they feel will have the greatest impact on their health and wellbeing. Our way of working will be a co-production between the Council and our communities.

Working Differently

It has long been acknowledged that, factors known as the wider or social determinants of health such as education, income, housing, workplaces, employment etc., have a great impact on the health and wellbeing of our communities. The new public health team will work with members and officers in the Council to ensure that all opportunities to improve health and wellbeing and to reduce health inequalities are taken.

Evidence- based practice

We will ensure that action taken to improve health and wellbeing and to reduce health inequalities is supported by research and best practice and that at the same time we encourage innovative approaches in our communities. We will provide up to date information about the health of our communities and information on ways that health can be improved locally.

Partnership working to improve health and wellbeing

We will work with a range of partner organisations locally, regionally and nationally to galvanise action to improve the health and wellbeing of County Durham residents. This will include the new and existing NHS organisations, local authorities in the North East, our voluntary and community partners, the universities and of course Public Health England, the new national public health organisation that will be supporting and providing professional advice and information to the Council as we work collaboratively to improve health outcomes for our communities.

Strategies to improve health and wellbeing

We will ensure that Council strategies explore opportunities to improve the health and wellbeing of our residents. The County Durham Joint Health and Wellbeing Strategy is our first strategy with a clear vision that makes clear the role of the Council and our partners in working together to improve the health and wellbeing of residents. The current financial challenges for the Council mean that wherever possible, health and wellbeing must demonstrate added value for both the Council, partners and also for our residents. We do believe that everyone has a role to play - health and wellbeing is everybody's business, including individuals and communities as well as the private and voluntary sectors.

Protecting the health of our residents

We will work with experts in Public Health England to ensure that the health of County Durham residents is protected from harm from infectious and communicable diseases. We will ensure that effective immunisations and screening programmes are available to our communities and work with partners to encourage uptake of these highly effective public health programmes.

Who will lead this work?

The Director of Public Health for County Durham and the public health team transferred to the Council on the 1st April 2013 from the NHS. This specialist public health team will ensure the Council develops a clearer understanding of its role in improving health and wellbeing and the actions that can be taken across the organisation to achieve this. The Council will ensure effective use of the public health grant and we will commission services that improve the health and wellbeing of residents. Where it makes sense we will work with our partners across the North East to achieve better health outcomes and be advocates for the health and wellbeing of our residents at every opportunity.

Signed…….. Date……
Leader of the Council

Signed…….. Date……
Portfolio Holder for Safer and Healthier Communities

This page is intentionally left blank

Public Health England

Protecting and improving the nation's health

County Durham

Unitary Authority

This profile was produced on 2 June 2015

Health Profile 2015

Health in summary
The health of people in County Durham is varied compared with the England average. Deprivation is higher than average and about 22.7% (20,100) children live in poverty. Life expectancy for both men and women is lower than the England average.

Living longer
Life expectancy is 7.0 years lower for men and 7.5 years lower for women in the most deprived areas of County Durham than in the least deprived areas.

Child health
In Year 6, 21.3% (1,038) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 69.9*, worse than the average for England. This represents 70 stays per year. Levels of teenage pregnancy, breastfeeding and smoking at time of delivery are worse than the England average.

Adult health
In 2012, 27.4% of adults are classified as obese. The rate of alcohol related harm hospital stays was 788*, worse than the average for England. This represents 4,053 stays per year. The rate of self-harm hospital stays was 287.7*, worse than the average for England. This represents 1,471 stays per year. The rate of smoking related deaths was 381*, worse than the average for England. This represents 1,117 deaths per year. Estimated levels of adult excess weight, smoking and physical activity are worse than the England average. The rate of hip fractures is worse than average. Rates of sexually transmitted infections and TB are better than average.

Local priorities
Priorities in County Durham include tackling health inequalities, improving mental health and wellbeing, and children's health. For more information see www.durham.gov.uk

* rate per 100,000 population

Population: 516,000
Mid-2013 population estimate. Source: Office for National Statistics.

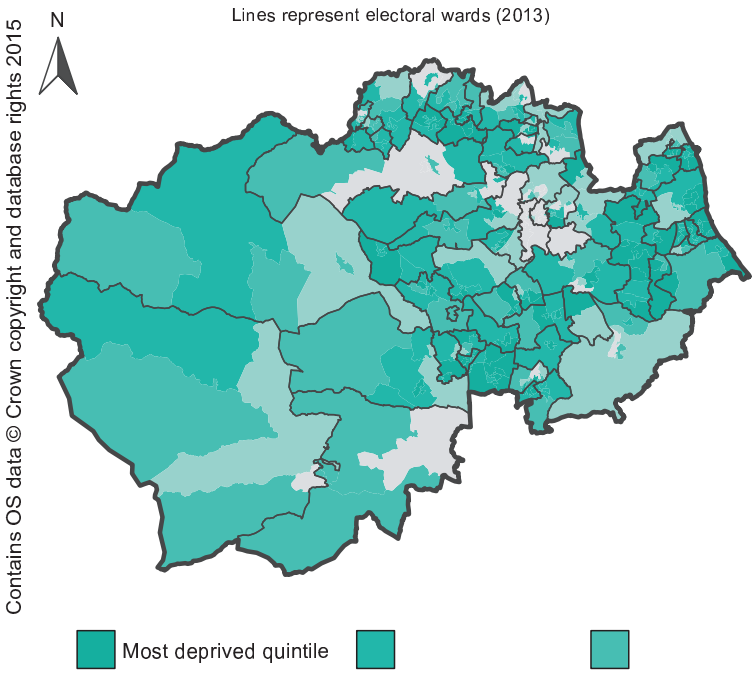
This profile gives a picture of people's health in County Durham. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

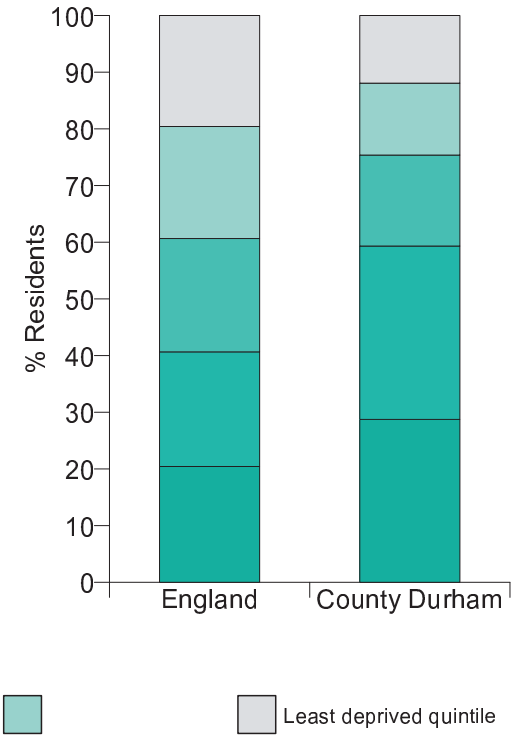
Follow @PHE_uk on Twitter

Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2010, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



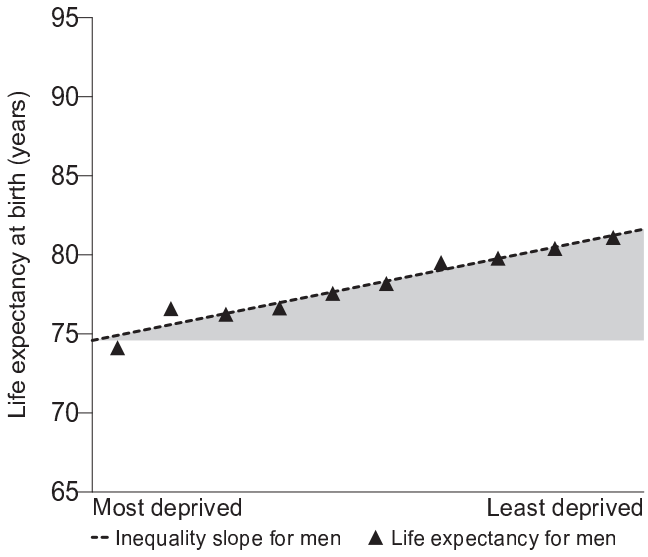
This chart shows the percentage of the population who live in areas at each level of deprivation.



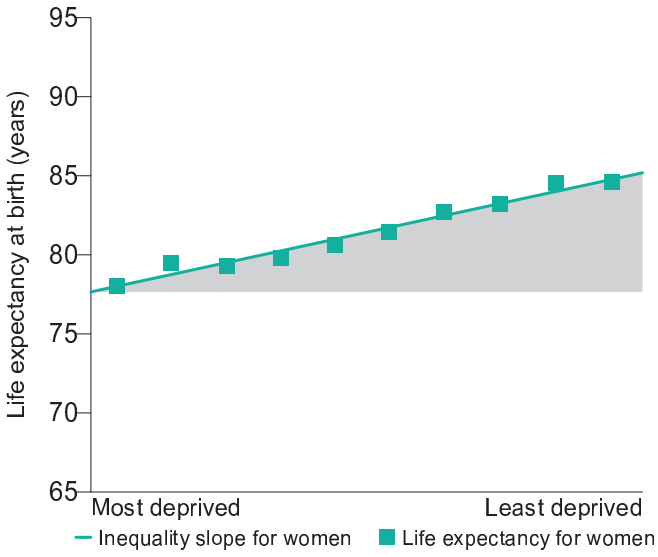
Life expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2011-2013. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life expectancy gap for men: 7.0 years



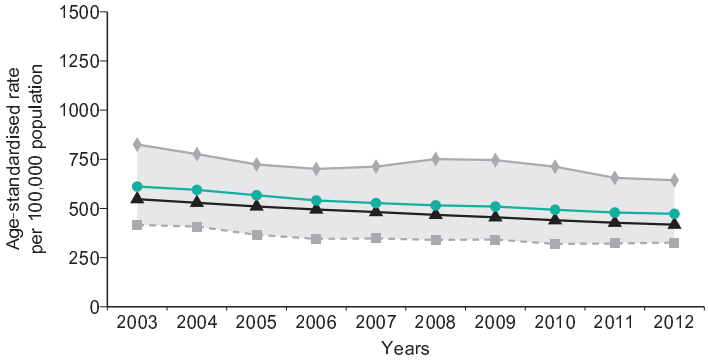
Life expectancy gap for women: 7.5 years



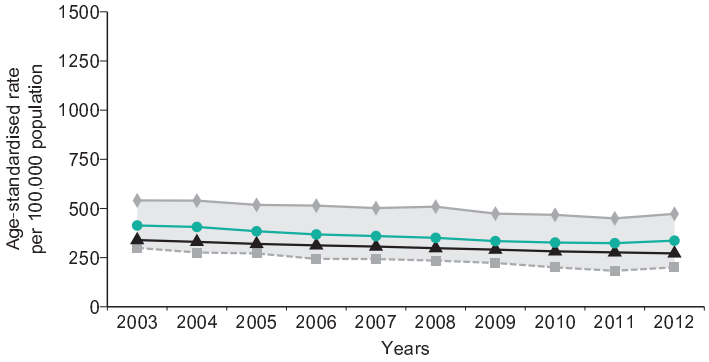
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

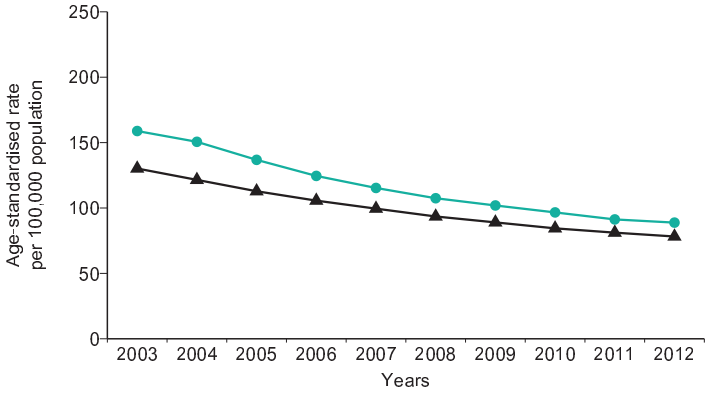
Early deaths from all causes: MEN



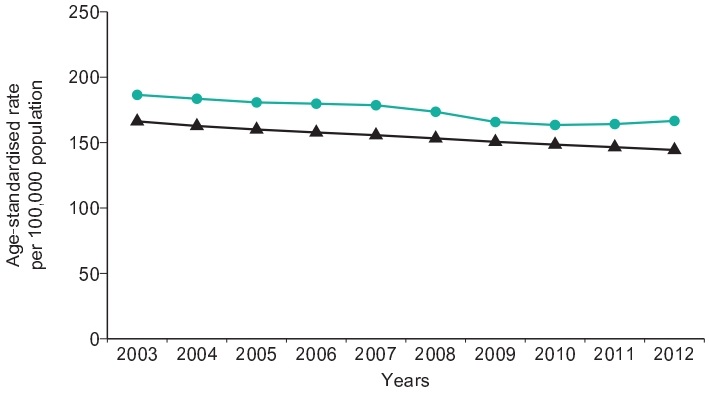
Early deaths from all causes: WOMEN

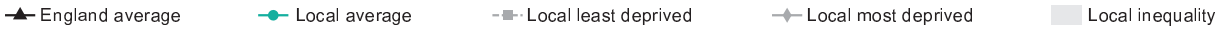


Early deaths from heart disease and stroke



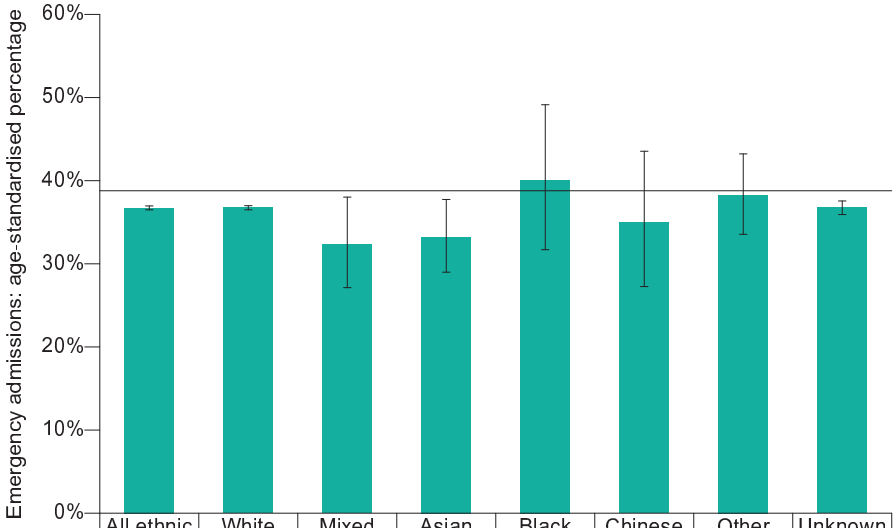
Early deaths from cancer





Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group, 2013



This chart shows the percentage of hospital admissions for each ethnic group that were emergencies, rather than planned. A higher percentage of emergency admissions may be caused by higher levels of urgent need for hospital services or lower use of services in the community. Comparing percentages for each ethnic group may help identify inequalities.

County Durham

England average (all ethnic groups)

95% confidence interval

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
58,681	53,420	101	147	47	47	146	4,773	Local number of emergency admissions
36.7	36.7	32.3	33.2	40.1	35.0	38.3	36.7	Local value %
38.8	39.2	38.3	43.0	42.5	35.2	44.9	30.1	England value %

Health summary for County Durham

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Regional average^ / England Average / England Worst / England Best / 25th Percentile / 75th Percentile / England Range	Eng best
Our communities	1	Deprivation	148,268	28.7	20.4	83.8		0.0
	2	Children in poverty (under 16s)	20,075	22.7	19.2	37.9		5.8
	3	Statutory homelessness	198	0.9	2.3	12.5		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	3,027	57.6	56.8	35.4		79.9
	5	Violent crime (violence offences)	4,204	8.2	11.1	27.8		2.8
	6	Long term unemployment	3,327	10.1	7.1	23.5		0.9
Children's and young people's health	7	Smoking status at time of delivery	1,049	19.9	12.0	27.5		1.9
	8	Breastfeeding initiation	3,006	57.4	73.9			
	9	Obese children (Year 6)	1,038	21.3	19.1	27.1		9.4
	10	Alcohol-specific hospital stays (under 18)†	70.0	69.9	40.1	105.8		11.2
	11	Under 18 conceptions	293	33.8	24.3	44.0		7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	22.7	18.4	30.0		9.0
	13	Percentage of physically active adults	248	51.4	56.0	43.5		69.7
	14	Obese adults	n/a	27.4	23.0	35.2		11.2
	15	Excess weight in adults	970	72.5	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma†	80.0	17.3	18.4	38.0		4.8
	17	Hospital stays for self-harm	1,471	287.7	203.2	682.7		60.9
	18	Hospital stays for alcohol related harm†	4,053	788	645	1231		366
	19	Prevalence of opiate and/or crack use	2,155	6.4	8.4	25.0		1.4
	20	Recorded diabetes	30,506	6.9	6.2	9.0		3.4
	21	Incidence of TB†	10.0	1.9	14.8	113.7		0.0
	22	New STI (exc Chlamydia aged under 25)	2,050	611	832	3269		172
	23	Hip fractures in people aged 65 and over	662	674	580	838		354
Life expectancy and causes of death	24	Excess winter deaths (three year)	314.7	19.0	17.4	34.3		3.9
	25	Life expectancy at birth (Male)	n/a	78.0	79.4	74.3		83.0
	26	Life expectancy at birth (Female)	n/a	81.3	83.1	80.0		86.4
	27	Infant mortality	18	3.2	4.0	7.6		1.1
	28	Smoking related deaths	1,117	381.3	288.7	471.6		167.4
	29	Suicide rate	68	13.4	8.8			
	30	Under 75 mortality rate: cardiovascular	413	88.8	78.2	137.0		37.1
	31	Under 75 mortality rate: cancer	782	166.6	144.4	202.9		104.0
	32	Killed and seriously injured on roads	198	38.5	39.7	119.6		7.8

Indicator notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk