STRATEGY FOR ADULT PALLIATIVE AND END OF LIFE CARE SERVICES

Contents

Executive Summary

1.1 Purpose of Strategy

This Joint Commissioning Strategy for End of life care has been developed by NHS County Durham and Darlington, Durham County Council and Darlington Borough Council for the improvement of End of Life and Palliative Care in County Durham and Darlington.

The Joint Commissioning Strategy informs service users, carers, providers and other agencies about the current services that currently prevail in County Durham and Darlington, and the future direction of travel over the next five years. The strategy outlines:

- National and local guidance
- Issues of demography
- Future demand
- Current services
- Analysis of the market
- Identification of gaps or over provision of services
- Design of future services
- Monitoring arrangements for the implementation of the strategy

This strategy sets out clear guidelines for future service provision, so that people approaching end of life will be able to have a good experience in their preferred place of death, be that hospital, hospice or home.

We set out on page 56 of this strategy the national guidelines for the improvement of end of life care services and this strategy builds on these guidelines to give a clear direction of travel for end of life services across County Durham and Darlington with clear achievable outcomes.

Around half a million people die in England each year, of which almost two thirds are aged over 75. The large majority of deaths at the start of the 21st century follow a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. Most deaths (58%) occur in NHS hospitals, with around 18% occurring at home, 17% in care homes, 4% in hospices and 3% elsewhere. (End of Life Care Strategy. Department of Health, July 2008.)

Approximately 10,500 North East people under the age of 75 die every year. Death rates for major causes of death are higher than elsewhere in England reflecting the fact that there are significant health needs in the region.

Although evidence suggests many more people would like to die at home the majority around 60% of deaths occur in hospitals. 20% die in their own homes and a further 15% in care homes. In the North East care homes provide places for around 25,500 people.

The demographics of death in relation to age profile, cause of death and place of death have changed radically over the course of the past century. Around 1900 most people died in their own homes. At that time acute infections were a much more common cause of death and a far higher proportion of all deaths occurred in childhood or early adult life. (End of Life Care Strategy. Department of Health, July 2008.)

With these changes, familiarity with death within society as a whole has decreased. Many people nowadays do not experience the death of someone close to them until they are well into midlife. Many have not seen a dead body, except on television. As a society we do not discuss death and dying openly. (End of Life Care Strategy. Department of Health, July 2008.)

Although every individual may have a different idea about what would, for them, constitute a ‘good death’, for many this would involve:

- Being treated as an individual, with dignity and respect;
- Being without pain and other symptoms;
- Being in familiar surroundings; and
- Being in the company of close family and/or friends.

(End of Life Care Strategy. Department of Health, July 2008.)

Some people do indeed die as they would have wished, but many others do not. Some people experience excellent care in hospitals, hospices, care homes and in their own homes. But the reality is that many do not. Many people experience unnecessary pain and other symptoms. There are distressing reports of people not being treated with dignity and respect and many people do not die where they would choose to.

How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and it is a litmus test for health and social care services.

In the past, the profile of end of life care within the NHS and social care services has been relatively low. Reflecting this, the quality of care delivered and investment has been very variable. Implementation of this strategy will make a step change in access to high quality care for all people approaching the end of life. This should be irrespective of age, gender, ethnicity, religious belief, disability, sexual orientation, diagnosis or socioeconomic deprivation. High quality care should be available wherever the person may be: at home, in a care home, in hospital, in a hospice or elsewhere.

The themes set out in the strategy have built on the best available research evidence and on existing experience from:

- The NHS End of Life Care Programme (2004–2007), which has contributed significantly to the rollout of programmes such as the Gold Standards Framework (GSF), Liverpool Care Pathway for the Dying Patient (LCP) and the Preferred Priorities for Care (PPC).

- Voluntary hospices, many of which have been beacons of excellence in end of life care since the foundation of the modern hospice movement by Dame Cicely Saunders at St Christopher's Hospice in 1967.

To ensure that the populations of County Durham and Darlington have the levels of health and healthcare that they deserve, we will deliver: ***"Excellence today for a healthier tomorrow"*** This means that our population will receive excellent local healthcare that meets individual needs.

NHS County Durham and Darlington, Darlington Borough Council and County Durham Council aspire to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients, their carers, public, staff, stakeholders and the use of public resources.

The aim is to develop improved end of life and palliative care services in a way that meets patient needs by providing a seamless pathway, and to develop and deliver a model of service that is effective for at least the next five years and ensures that patients are treated and cared for in the place of their choosing. The strategy builds upon national, regional and local policies.

The nature of palliative care is such that many different agencies may be involved in responding to a patient's needs within a relatively short period of time and often in circumstances that are distressing for the patient and those closest to them. County Durham and Darlington wish to design an approach that means that all those involved can focus upon treating the patient's problem rather than dealing with communication and other issues that can currently occur when different agencies' responsibilities combine.

The lead Executive Director at the PCTs for this review is Amanda Hume, Director of Performance and Delivery and queries regarding this review should be addressed to her at:

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1.2 Summary of Need

Research suggests that the majority of people (between 56 and 74 per cent) express a preference to die at home, although this proportion may decline as death becomes more imminent and people want access to more extensive support. Mortality statistics for 2006 show, however, that 35 per cent of people die at home or in a care home. Fifty eight per cent of all deaths occur in a hospital, although this figure varies from 46 per cent to 77 per cent between PCTs. Place of death also varies by condition, and cancer patients are more likely than others to die at home or in a hospice; the majority of deaths from dementia occur in care homes; and the vast majority of deaths from heart disease and pulmonary disease occur in hospital.

For some people approaching the end of their life, however, there will be clinical reasons for admission to hospital, and for some it is their preferred place of care.

A lack of prompt access to services in the community leads to people approaching the end of their life being unnecessarily admitted to hospital. The absence of 24 hour response services and timely access to advice and medication leads to unplanned admissions. In addition, information on patients is not always captured or shared effectively between the different agencies involved in delivering care. This can lead to Do Not Attempt

Resuscitation orders not being known or recognised to providers such as out of hours GPs and the ambulance service, resulting in inappropriate admissions to hospitals.

For the purposes of this strategy End of Life care involves adults with any advanced, progressive, incurable illness (e.g. advanced cancer, heart failure, COPD, stroke, chronic neurological conditions, end stage organ failure, and dementia)care given in all settings (e.g. home, acute hospital, residential/care home, nursing home, hospice, community hospital and other institution) care given in the last year(s) of life; and patients, carers and family members (including care given after bereavement) given the breadth of patient conditions in which end of life care is relevant it is recognised that this Strategy will need to be linked into and placed in the context of other networks and protocols and other joint strategies where work is already ongoing.

Services will need to be commissioned across a number of different settings; hospital, home address, community, prison, care home, sheltered/extra care housing or hospice. On some occasions they will also be needed in other locations such as hostels for the homeless and independent living homes for people with learning disabilities and mental health problems. Children's end of life care needs are excluded from this strategy, however, a pathway to access palliative and short break provision from the two local childrens hospices is agreed and in place. The pathway is agreed between the NHS and County Durham Council and Darlington Borough Council and involves multi-agency assessment of need and a review of that need through the auspices of the complex care panel. Links to the higher regional services and pathways are made, but will need to be reviewed over time as service at all levels develop and evolve.

Long Term Conditions

Over fifteen million people in the United Kingdom report living with a long term condition. Due to an ageing population, the number of people with a long term condition is set to rise by a quarter in the next 25 years. Long term conditions are those conditions that cannot, at present, be cured, but can be managed

by medication and other therapies. They include diabetes, asthma, heart failure, enduring mental health problems and chronic obstructive pulmonary disease. Of those affected, many live with a condition that limits their ability to cope with day-to-day activities.

Cancer

Everyone knows someone affected by cancer. One person in three will get cancer during their life and one in four will die of it. When asked, most people with advanced cancer want to stay at home with their family for as long as possible. In practice only about a quarter actually dies at home

People with Learning Difficulties (LD) and Mental Health (MH) Issues

People with a learning disability are recognized as being one of the most socially excluded groups in Britain today (DH, 2001). There is widespread agreement that they have poorer health than the general population and face particular barriers when they come to be in need of end of life care. More than 50% of people with a learning disability may have some form of communication impairment (Kerr et al, 1996) and often, due to their communication problems, neither they nor their personal and professional carers become aware that the person with a learning disability has entered a phase where they require end of life care. Those people with a learning disability who are identified as having a palliative care need then face being treated by professionals, who whilst being trained in end of life care, may have little understanding of learning disability and lower confidence in working effectively with them. Recognition and management of pain for some who have a learning disability and for those who have dementia requires staff with additional skills and knowledge to ensure the same level of pain management is available to these groups

Depression / Dementia and Severe Mental Illness

It is estimated that at least 20% of older people have diagnosable mental health needs and 10-15% of all older people meet the clinical criteria for diagnosis of depression. It is also shown that mental health problems increase with age and the highest prevalence of depression is found in people aged 75 years and over. Dementia is the most costly medical condition in the UK and it is the group that will see the largest increase in numbers, mainly as a result of an increasingly ageing population. As people get older their physical needs will increase and the impact of these physical health problems will also contribute to the likelihood of older people seeking support for mental or emotional complaints.

People with Sensory Impairments

People with sensory impairments often have difficulty accessing health care and communicating their needs and concerns to many health professionals. Like other people approaching end of life, they and their carers must:

- Have their needs assessed by a professional or professionals with appropriate expertise
- Have a care plan which records their preferences and choices
- Be involved in decisions about their treatment
- Be able to access information and advise as required
- Have coordination of their care needs

Black Minority and Ethnic (BME) Population

BME groups generally have worse health, with higher rates of limiting long term conditions than the general population. It has been identified that BME groups have reduced access to palliative care services mainly because perceptions of palliative care still focus on cancer and BME groups have lower risk of cancers but higher risk of long term conditions (Goodman ML, 2007). It is emphasised in this strategy that end of life care is for all end of life conditions not only cancer.

Equality and Diversity

NHS County Durham and Darlington want to promote diversity as a positive force for everyone who lives and works in County Durham and Darlington; this includes the diversity of the population as a whole. We can only do this by working in partnership with other agencies, our community, patients and employees.

Equality of opportunity means that an individual's diversity is viewed positively and in recognising that everyone is different, valuing equally the contribution that individual's experience, knowledge and skills can make.

Further information of all these conditions is included in appendix 2.

This strategy uses the following definitions:

Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;

- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications. (WHO; 1998a)

'Relief of pain: the treatment and relief of mental and physical pain without curing the causes, especially in patients suffering a terminal illness.' (Encarta)

End of Life Care

End of Life care can be more difficult to define precisely. It encompasses 'the period of time marked by disability or disease that is progressively worse until death'. (About.com), however a commonly accepted clinical view is the last 24 hours of life. This strategy will use the definition adopted by the National End of Life Strategy Board 2007 and the SHA's End of Life Clinical Working Group which states that:

'End of Life Care helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support'.

There can be confusion as to when 'End of Life' begins. It may be interpreted as care in the last days and hours of an individual's life. Professional opinions often vary due to the complexity of giving a prognosis in conditions such as heart disease and dementia, where the disease trajectory is unpredictable. The SHA's End of Life Clinical Working Group has adopted a pragmatic approach to defining 'end of life'. It has endorsed the use of '***The Surprise Question'***. This is **"W*ould you be surprised if this patient died in the next 6-12 months?"*** If the answer is '**no'** then planning care for end of life should begin. This corresponds with the special Disability Living Allowance benefit authorisation via DS1500 which can be issued if a patient is suffering

from a potentially terminal disease and is not expected to live longer than 6 months.

Using the definition and context above, we believe that it is logical for the scope of palliative and end of life care services within this document to include:

- Acute and Continuing care
- Crisis Intervention and fast response
- Coordination and Quality Control
- Hospice and hospice at home care
- Community and Primary care

Introduction

2.1 What is meant by Commissioning

Commissioning is defined as the strategic activity of assessing needs, resources' and current services and developing a strategy of how to best make use of available resources to meet needs" **(DOH 1995 an introduction to joint commissioning)**

The development of this commissioning strategy provides a framework for partners to review and develop services and agree priorities. It is the beginning of a process that sets out local strategic aims, links these to targets and policy initiatives and works towards removing geographical and organisational barriers to accessing services based on age or diagnosis. The strategy will identify the gaps in services, responsibilities and priorities for future developments in line with Government guidance and with the aim of sharing a joint vision.

2.2 Purpose of this Commissioning Strategy

The strategy will:

- Describe a vision for end of life and palliative care services
- Describe the key national and local priorities for developing end of life and palliative care services in County Durham and Darlington
- Identify the responsibilities of NHS County Durham and Darlington Durham County Council and Darlington Borough Council to provide services that aims to develop improved end of life and palliative care services for all those with advanced, progressive, incurable illness to live as well as possible until they die.
- Describe existing services for end of life and palliative care patients
- Identify the shape of future services and determine the strategic priorities necessary to their achievement

- Determine the effectiveness of current monitoring and performance management systems and identify how the strategy and services will be monitored in the future
- Based on all the above, the strategy will propose a set of commissioning intentions which outline the services that NHS County Durham and Darlington, Durham County Council and Darlington Borough Council will address between 2010 and 2015.

2.3 Vision Aims and Outcomes for the Service

A public consultation event took place at St Cuthbert's Hospice on the 18th July 2008 to enable the development of an end of life commissioning strategy. The aim of the event was to;

- Identify what a fit for purpose end of life service should look like.
- Map existing service arrangements.
- Develop the patient pathway to inform commissioning intentions.

The event was well attended by a wide range of providers, commissioners and service users.

This strategy will be widely consulted upon through a number of public consultations held throughout the summer of 2010

This strategy, developed in collaboration with local stakeholders that states a whole systems approach is needed. Within this, a care pathway approach both for commissioning services and for the delivery of integrated care for individuals has seen 12 standards of care produced. These standards of care follow the national guidelines as identified in the end of life strategy that sets out the key areas, with the related actions and recommendations. These key areas will see and road map from now to the year 2015 for End of Life Care within County Durham and Darlington. The aim is to strengthen the commissioned arrangements responding to the needs of patients and carers in planning for end of life and ensuring that their preferences on place of care are met.

- To ensure that all those with advanced, progressive, incurable illness are allowed to live as well as possible in the place in their preferred place of care
- To ensure that they receive equal access to the whole range of services and opportunities available regardless of their place of care
- To ensure that these services are provided by agencies working in partnership to provide a multi-disciplinary / multi-agency approach from appropriately qualified staff in enabling environments.

The key themes of this strategy are:

- Putting patient and family at the centre of developing a modern and comprehensive service for all people with end of life and palliative care needs in County Durham and Darlington
- Rebalancing the allocation of resources towards preferred place of care that promote independence and support people to live in their own homes as long as possible
- Ensuring that services are culturally appropriate and can positively and effectively meet the needs of all members of the community
- Promoting equity of access to services and support based on individual and population needs
- Strengthening partnership working to develop a more integrated service with shared ownership and joint leadership
- Offering options for future commissioning in order to deliver the proposed vision and meet the objectives of service users and carers and the national expectations of inclusion and choice
- Satisfying the requirements of national policy and local priorities

Although this strategy is for End of Life and palliative care, it also includes adults with learning difficulties, mental health, depression/dementia and severe mental illness, these will all be covered in the separate Adult Mental Health Strategy. People with long-term conditions and their carers, may find that their needs are considered in both this strategy and the Long-term

Conditions or Carers strategy. For that reason this strategy should also be read in conjunction with other County Durham Joint Commissioning Strategies, People with a Sensory Impairment, Mental Health, Older People, Learning Disabilities, Urgent Care and Intermediate Care.

National and Local Guidance

3.1 The importance of national and local guidance

A joint commissioning strategy aimed at improving the care of people with end of life or palliative care should also enhance the quality of life for carers as well as increase the effectiveness and efficiency of health and social care services, thus allowing resources to be reinvested. It is integral that a joint commissioning strategy also delivers on national priorities in order to:

- Reduce the number of avoidable hospital admissions
- Enable safe and timely discharge from hospital
- Increase the number of people supported in their own homes for longer
- Reduce the number of people entering residential and nursing care through increasing the number of people supported in sheltered accommodation
- Increase the range and availability of services within local communities
- Provide an integrated service which is responsive to needs

3.2 National Priorities

End of Life Care Strategy

July 2008

Promoting high quality care for all adults at the end of life

'How people die remains in the memory of those who live on'

Dame Cicely Saunders, founder of the Modern Hospice Movement

The end of life strategy builds on the vision and expertise of hundreds of people and organisations from all walks of life. The national strategy can genuinely be said to have been developed from the bottom up. This strategy provides a framework on which local health and social care services can build. It also sets out a commitment from the government to enhance funding for end of life services. As a result of this we can be confident that the quality of end of life care, which matters to us all, will improve year on year.

3.3 Our Health our Care, our say: a new direction for Community Services 2006

This white paper sets a new direction for the whole health and social care system. It confirms the vision ser out in the Department of Health Green Paper, Independence, Well-being and Choice. It proposes a radical shift in the way that services are delivered, ensuring that they are more personalised and that they fit into people's busy lives.

3.4 The local Government and public involvement in health act 2007

This Bill introduces a number of measures relating to local government as well as involvement of local communities. One of these measures is the establishment of Local Involvement Networks (LINks), which replace Patients' Forums and the Commission for Patient and Public Involvement in Health in 2008. The Bill also clarifies and strengthens the existing duty on NHS bodies to involve and consult patients and the public in the planning and provision of services.

3.5 Local Plans and Guidance

It is important to recognise the links with other relevant local commissioning strategies, as the task of services for end of life care is a cross cutting issue. The following strategies and reviews include, or are likely to include, actions that relate to care for people approaching end of life, some of which will link with actions in this strategy:

- NHS County Durham and Darlington five year strategic plan
- DBC Commissioning for Citizenship (2009 – 2029)
- DCC and NHS County Durham Joint Older People Commissioning Strategy (due 2010)
- DBC Joint Older People Later Life Commissioning Strategy
- DCC and NHS County Durham Joint Commissioning Strategy for Mental Health Services for Adults aged 18 – 64
- DCC, DBC and NHS County Durham Joint Adults with Physical Disabilities and/or Sensory Impairment Strategy (due 2010)
- DCC, DBC and NHS County Durham Joint Strategy for Long Term Conditions (due 2010)
- DCC and NHS County Durham Joint Strategy for Intermediate Care
- DBC and NHS County Durham Joint Commissioning Strategy for Older People and Mental Health (2009)
- Review of Older Prisoners' Provisions

More detailed information is included in the individual strategies.

3.6 County Durham and Darlington Borough Council's Local Area Agreements (LAA) 2008-11

County Durham's 2008-11 LAA is an agreement between local partners and the Government. It is a delivery plan that sets out the most pressing priorities for the county for a three year period to work together and achieve the outcomes that have been agreed, namely:

- Improving satisfaction with local areas
- Promoting thriving communities
- Ensuring that people have a say about local services

3.7 Darlington Borough Council Local Area Agreement (LAA) 2008-11

Darlington Borough Council LAA is a three year agreement which sets out local priorities for Darlington, agreed between central government, Darlington Partnership and Darlington BC.

- strengthen social cohesion in Darlington;
- improve educational outcomes and life chances for children and young people;
- reduce anti-social behaviour and the fear of crime;
- reduce health inequalities for children and young people;
- enable all sectors within the Local Strategic Partnership (LSP) to focus better on the needs of individuals, families and communities;
- provide a model of service improvement which we can roll out to other themes in the future.

3.8 County Durham and Darlington's Borough Council's Joint Strategic Needs Assessment's (JSNA)

County Durham Council Joint Strategic Needs Assessment's (JSNA)

Durham County Council, NHS County Durham and other organisations have been working together to develop the first County Durham Joint Strategic Needs Assessment. The JSNA provides a holistic overview of the health and wellbeing needs of the population of County Durham. It underpins the priorities and targets set by the Local Area Agreement. The JSNA also informs Durham County Council's and NHS County Durham's planning and commissioning activity throughout the County to help provide more effective and targeted social care and health services.

Darlington Borough Council's Joint strategic needs assessment (JSNA)

Darlington's JSNA has drawn data from a variety of sources in health and the local authority to describe the health and wellbeing needs of the local population. The JSNA is a resource which can inform the delivery plans of the "One Darlington: Perfectly Placed" (SCS) themed Groups. The JSNA is an ongoing process and future assessments will inform the delivery of the Local Area Agreement.

3.9 Key Themes of Local and National Guidance

The key themes of recent policy relevant to the development of this strategy include:

- Promoting social inclusion and well-being
- Embedding service user and carer involvement into the planning and delivery of services
- Empowering people to have greater influence over services through a stronger voice and greater choice and control
- Developing community resources
- Responding to people on the basis of need, not age
- Delivering holistic, person-centred health and care services that address mental as well as physical health needs
- Developing sustainable preventable services
- Involving local authorities, NHS and other agencies, including the voluntary sector and independent providers in the provision of resources
- Developing local leadership
- Enabling cooperation across statutory agencies, improving coordination and communication at all levels.

Future Demand

There are several factors that must be addressed when developing and commissioning services. These include profiles of the service users, demography, health, and the socio-economy of the area.

4.1 General Service User Profile

Each year around 500,000 people die in England. We know that although some people receive excellent care at the end of life, many do not. One of the fundamental problems is that services are not always joined up and as a result communication between staff and agencies can break down. From surveys of the general public we know that, given the opportunity and right support, most people would prefer to die at home. In practice, only a minority manage to do so. Many people die in an acute hospital, which is not their preferred place of care.

4.2 Current State

On behalf of the PCT a baseline review of services for end of life care was submitted to the Department of Health in February 2008 which took into account local demographics and population. The following tables from the document demonstrate the community health profile in relation to deaths from all causes.

Total number of deaths in Darlington, all ages, all causes, 2003-5	3369
Deaths from all cancers, 2003-5	864
Deaths from all accidents, 2003-5	66
Deaths from diseases of the circulatory system, 2003-5	1281
Deaths from ischemic heart disease, 2003-5	647
Deaths from stroke, 2003-5	350
Deaths from chronic liver disease, 2003-5	33
Deaths from bronchitis, emphysema and other COPD, 2003-5	170
Deaths from pneumonia, 2003-5	180

Source: Compendium of Clinical and Health Outcomes Knowledge Base/Office for National Statistics

Total number of deaths in County Durham, all ages, all causes, 2003-5	16683
Deaths from all cancers, 2003-5	4505
Deaths from all accidents, 2003-5	295
Deaths from diseases of the circulatory system, 2003-5	6252
Deaths from ischemic heart disease, 2003-5	3261
Deaths from stroke, 2003-5	1723
Deaths from chronic liver disease, 2003-5	197
Deaths from bronchitis, emphysema and other COPD, 2003-5	984
Deaths from pneumonia, 2003-5	878

Source: Compendium of Clinical and Health Outcomes Knowledge Base/Office for National Statistics

One of the key findings from this document and from follow up activities by various providers and commissioners identifies the lack of appropriate availability of up to date data to support assessment of equitable efficiencies.

Local Demographic profile can be seen in appendix 5

4.3 Key areas addressed by the strategy

This strategy set out the ambitious targets to achieve:

- Increasing the number of patients that have recorded preferred place of care by 2015
- Increasing the number of patients with an advanced care plans by 2013
- Increase in the baseline of percentage of patients that talk and plan their death
- All patients to have a key worker

key worker" is defined as,

"A*n individual responsible for the coordinated activity of care to palliative patients, ensuring all of their holistic needs are met at specific points in the care pathway. This may require one or more key workers at different stages of the pathway*."

Improving end of life care will involve NHS County Durham and Darlington working in partnership with Darlington and County Durham and Local Authorities (LAs) to how best engage with their local communities to raise the profile of end of life care. This may involve engagement with schools, faith groups, funeral directors, care homes, hospices, independent and voluntary sector providers and employers amongst others.

There is sensitive and appropriate end of life support provided, beginning at the time illness is identified and continuing throughout illness, during death and in bereavement to ensure that the principles of the 'Good Death' Charter is widely consulted upon and then used to allow patients, loved ones and carers to discuss and plan for a good death.

This strategy will follow the national guidelines and the twelve key areas identified are highlighted below.

- Raising the profile – links to the 'Good Death' Charter
- Strategic Commissioning – End of Life CPG **(Clinical programme group)** – clinicians involved in commissioning process – links to the provider partnership board
- Identifying people approaching the end of life – Link to QOF **(Quality outcome framework)** palliative care register and ensure it is inclusive of long term conditions, learning disabilities and dementia – Regional wide to support 24/7 delivery.
- Care Planning – Advanced directives and ICP **(Integrated care pathway)** / Liverpool Care Pathway
- Co-ordination of Care – Development of coordination of care. Region wide versus local
- Rapid access of care – 24/7 care in the preferred place of care. Workforce that is flexible to meet demand

- High Quality Services – Reduction of inequity in services in all locations. No postcode lottery. Development of KPI's to ensure quality is monitored
- Last days of life and care after death – Audit of the use of ICP, and further development of the bereavement model
- Involving and supporting patients – continued support to information centres. Mapping exercise to understand any gaps in information need
- Education and training and continuing professional Development
- Measurement and research – Develop localised measures of quality of care and understand whether research can improve end of life care
- Funding – Ensure that funding can released to invest in end of life care and the funding invested provides the best value for money

Market Analysis

5.1 Current Health Care Services

This analysis of current provision will provide a map of existing services. However. The rural nature of County Durham and Darlington must also be taken into account in considering future service and commissioning development with particular reference to issues such as:

- Accessing services
- Transport
- Social isolation
- Increased costs of operating in rural areas

Below is a summary of County Durham and Darlington's market analysis for End of Life Care. This has been extracted from the North East Healthcare Market Analysis; it provides a snapshot of current market management issues within End of Life Care.

Metric	PCT		Cluster	SHA Ave.	Nat. Ave.	PCT and SHA average vs. national average
	CDPCT	DPCT				Worse / Better
VSC15 - Proportion of deaths at home registered in the respective calendar year	22.91 (8.7%)	21.85 (3.7%)	22.38	21.08	-	
Palliative care prevalence	0.15 (-6.2%)	0.27 (68.8%)	0.21	0.16	-	
No. of GPs signed up to Gold standard framework, %	95.89 (0.5%)	100 (4.8%)	97.95	95.4	-	
Cost of end of life care per patient	2321.74 (-53.6%)	1666.67 (-66.7%)	1994.2	5008.7	-	

5.2 County Durham Council and Darlington Borough Council Care Homes Residential Nursing Beds

County Durham Council

There are presently 58 Independent Sector Care homes contracting with Adult Well Being and Health Services in County Durham providing 2575 residential and nursing beds for older people with mental health needs. Many homes provide a combination of both residential and nursing care with beds that may be available for any category of care of mental illness. Currently there are 1040 exclusive beds for older people with dementia (DE) in County Durham with an occupancy rate of 85% (885 service users).

As well as Independent Sector Residential Care providers in County Durham, there are some providers who are situated out of County and who are contracted to provide both residential and nursing care for older people with mental health needs. Out of county placements tend to occur because of the geography of the locality and its proximity to another area and as older people with mental health needs and their families are offered choice in the location of their residential or nursing home, in most instances they request a placement that is close to their existing residence. The majority of service users who are currently placed in out of County residential and nursing homes originate from Chester le Street district which borders both Sunderland and Gateshead Local Authorities.

Further information is included in appendix 3.

Darlington Borough Council

There are presently 22 Independent Sector Care homes contracting with Darlington Borough Council providing 1145 residential and nursing beds for older people. Eight of the Care homes are dual registered/registered for residential or nursing, the remainder offer residential only. Ten homes have designated beds for EMI (Dementia). There is a total of 258 EMI Residential beds (occupancy level 85%) and 109 EMI Nursing Beds (occupancy level 70%).

As well as Independent Sector Residential Care providers in Darlington, there are some providers who are situated out of County and who are contracted to provide both residential and nursing care for older people. Out of county placements tend to occur because of the geography of the locality and its proximity to another area and as older people and their families are offered choice in the location of their residential or nursing home, in most instances they request a placement that is close to their existing residence.

Further information is included in appendix 3.

5.2.1 Prison Health

There are six prisons that accommodate older prisoners within the geographical area covered by North East Offender Health Commissioning Unit. The North East Offender Health Commissioning Unit Review of Provisions for Older Prisoners identified a varying number and proportion of older prisoners accommodated within each of these establishments.

The Primary Care Organisations represented by the NEOHCU recognise the significant challenge of delivering fair, personalised, effective and safe healthcare within custodial settings. The aim is to **"Establish an equivalence of care to improve health and support justice"**

Further information is included in appendix 3.

5.2.2 Hospice and Hospice at Home Care

- Hospices – access to beds in St Cuthbert's in Durham, St Teresa's in Darlington, Hartlepool Hospice, and Willow Burn Hospice in Lanchester – Durham. All patients in County Durham and Darlington have the opportunity to access these beds on an equal basis dependent on their assessed needs.
- Palliative and End of life beds are also available for County Durham and Darlington residents in Richardson, Weardale and Sedgefield Community Hospitals
- Specialist Beds – access to hospice specialist beds at Marie Curie in Newcastle, St Oswald's in Gosforth and St Benedicts in Sunderland.
- Day Hospice is provided in each of the local hospices and at the three community hospital sites by Butterwick Hospice (Weardale, Sedgefield and Richardson Community Hospitals)
- Hospice at home is provided from Willowburn hospice & PCT across North Durham although this is a limited service based on individual patients needs. St Teresa's Hospice based in Darlington also provides a comprehensive Hospice at home service to residents (to both cancer and non-cancer patients) in Darlington & District. Marie Curie provide a home service for planned care to ensure patients are cared for in their place of choice.
- Complementary therapies are offered as part of a package of care delivered in the Hospice and through Hospice Day care. St Teresa's Hospice also offers these facilities to outpatients and to immediate carers (Care for the Carer)
- Lymphoedema services are provided in the hospices and also in patients home.

5.2.3 Community and Primary care

- District Nurses – provide 24 hr cover although this is delivered differently across County Durham and Darlington. In Darlington staffs work a 24hr system to cover out of hours. In County Durham the service is currently provided with a mixture of out of hour's district

nursing and twilight shifts with on call district nursing provided for out of hour's emergencies.

- Macmillan carer's team in Easington – Health care Assistants – currently covers Easington. This team is not available outside of the Easington Locality at the moment although this may be rationalized across the PCT and a bid for expanding the service has been submitted to ensure equal access for all patients in PCT. The expansion of the service will take into account the other services that dovetail with it for example Hospice at Home and Marie Curie Services to ensure there is no duplication of service. There is the scope to provide equitable services from various excellent providers within Durham & Darlington
- Crossroads – works into Easington and Durham to provide career support.
- Macmillan Nurses operate across all localities – access to Marie Curie seems to be variable across Durham and Darlington. Some areas have better co-ordination within the team for accessing and brokering the service to reduce the amount of time spent by the District Nurse or Macmillan nurse in accessing the service.

5.3 Acute Care and Community Care

- Acute Hospitals in Durham, Darlington, Sunderland, North Tees & Hartlepool provide end of life care.

The community hospitals in County Durham are:

- **Sedgefield Community Hospital** (Sedgefield)
- **Weardale Community Hospital** (Stanhope)
- **Richardson Community Hospital** (Barnard Castle)
- **Shotley Bridge Community Hospital** (Shotley Bridge)
- **Peterlee Community Hospital** (Peterlee)
- **Chester le Street Community Hospital**

Sedgefield Community Hospital

Of the 26 inpatient beds 16 are GP led which offer step up and step down and rehabilitation. 10 beds are medical consultant beds mainly for rehabilitation. The inpatient facility has dedicated physiotherapy and occupational therapy services.

The overnight palliative nursing care service works in collaboration with the Marie Curie service and work in the hospital as well as the community. The registered nurse have admitting rights to enable families in crisis be admitted to an appropriate setting.

Sedgefield community hospital has rehabilitation day hospital services 4 days, a week and is staffed by a multi disciplinary team of nursing staff physiotherapist occupational therapist dietician speech and language therapist

The palliative care day hospital services is delivered in collaboration with the Butterwick Hospice once a week patients are reviewed and assessed as well having access to counselling services.

Weardale Community Hospital

The facility provides inpatient care via its 20 GP and nurse led beds for patients requiring step up and step down intermediate care rehabilitation and palliative care.

Richardson Community Hospital

The Richardson Community Hospital is situated in Barnard Castle and provides access to range of services opened in 2007 as part of the LIFTCo programme which was set up to enable investment in new and improved primary and community health care facilities. The new hospital replaced the original Richardson hospital which was owned by the Robert Taylor Richardson Charitable Trust. The trust remains an integral part of the hospital within the local community.

The hospital has modern facilities with 48 GP and nurse led inpatient beds offering step up and step down, continuing health care and rehabilitation.
The medical cover is provided by a GP practice in Barnard castle in hours and the Urgent Care Centre at Bishop Auckland General Hospital

5.4 Marie Curie Cancer Care

Marie Curie Community Nursing service provides high quality palliative/ end of life care to patient's nearing the end of their life in their own home. Care is provided on a one to one basis and is delivered over a 24 hours period on a shift basis. Referrals are usually made via the District nurse service two weeks in advance.

The Marie Curie Hospice in Newcastle provides access to Specialist in Patient care for those patients with complex needs requiring input from a specialist Multi Disciplinary team available over 24 hours.

Marie Curie Nurse specialists are able to support rapid discharge home for palliative/ end of life patients from hospital and hospice, this model is established in Newcastle hospice.

5.5 Urgent Care centres

The urgent care service provides treatment or advice for people who have a minor injury or suddenly feel ill. It is a network linking doctors, nurses and others who work across hospitals and health centre's based in the community. Services are provided from six urgent care centres staffed by GPs and highly qualified staff skilled in emergency care. Patients can walk in without an appointment but are advised to call 0300 1110111 first. The centre's are in Bishop Auckland General Hospital, Shotley Bridge Community Hospital, Dr Piper House, Darlington, University Hospital of North Durham, Seaham Medical Centre and Peterlee Community Hospital.

These are open 24 hours a day apart from University Hospital of North Durham which operates an out of hour's service between 6.00pm and 8.00am

Monday to Friday and from 6.00 pm Friday to 8.00 am Monday, and Seaham Urgent Care Centre which is open 8.30am – 6.00pm Monday to Friday.

5.6 Bereavement support

The County Durham Hospices Consortium Delivers of a comprehensive integrated County Wide Bereavement and Family Support Model which provides a service when and where the patient and family needs it most regardless of locality or setting. The model is Hub and Spoke with the specialist teams based at the Hospice available to patients and their families dependent upon need and a comprehensive education program in Primary and Secondary care and other care settings (nursing homes, prisons, schools etc) to ensure every patient and their family has access to good quality support when needed.

The Cancer Information and Support Service is available to all people affected or worried by cancer, and offers advice and information on coping and living with cancer, prevention and screening. The service offers emotional support and a listening ear.

The service, which is run by NHS County Durham and Darlington Community Health Services, offers support, advice and information at the Pioneering Care Centre in Newton Aycliffe and also in the Cancer Information Centre at Peterlee.

5.7 Current Adult Well Being and Health Services

A wide range of social care services is available to older people with mental health needs and their carers.

5.7.1 Domiciliary Care – County Durham

Many older people with mental health needs will have their needs met at home through the provision of intensive and non-intensive home care support.

Home care or domiciliary care provides personal and domestic care to older people with mental health needs.

Currently there are 43 Independent Sector domiciliary care providers registered to provide care in County Durham as well as In-house domiciliary care provision.

5.7.2 Domiciliary Care – Darlington

Within Darlington there are ten Independent Providers registered to provide care and a further four registered under a spot purchase contract. Darlington also provides domiciliary care within the four extra care facilities, from its In-house domiciliary provision.

Table 5.4b: Number of Older People with Mental Health Needs receiving Home Care Services – 1st April 2006 to 31st March 2007

Area	Total number of people
North East (whole of region)	2,900
Of which provided to people with dementia (national %)	51%
County Durham	830
Darlington Borough Council	Approx 180

Source: Community Care Statistics 2006/7 – Health and Social Care Information Centre

5.7.3 Intermediate Care

Intermediate care is the intensive rehabilitation and treatment provided for a short period (normally no longer than 6 weeks) in order to prevent avoidable deterioration in medical conditions, enable patients to return home following hospitalisation thus preventing delayed discharge and also prevent admission to hospital or to long term residential care.

There are currently six Intermediate Care Services in County Durham and Darlington:

- Intermediate Care North Durham
- Intermediate Care Easington
- Sedgefield Home Assessment Rehabilitation Partnership (SHARP)
- Durham Dales Rapid Response
- Darlington Hundens Nursing – Eastbourne Care Home Community Support
- Darlington Social Care Residential – Ventress Care Home

5.7.4 Community Home Treatment Teams

A Community Home Treatment Team is a multidisciplinary team (comprising staff such as community psychiatric nurses, social workers, support workers, occupational therapists, physiotherapists, psychology input etc) that offers specialist assessment, treatment and care specifically to older adults with mental health needs in their own homes and the community. The community Home Treatment Teams also provide in reach services to nursing and residential units across County Durham and Darlington. Community Mental Health Teams are situated in Easington, Derwentside, Sedgefield, Wear Valley, Teesdale, Durham and Chester le Street.

Both Durham and Darlington Local Authorities have local care homes who care for patients with a range of mental health issues including dementia, Learning disabilities and physical disabilities.

5.8 Coordination and Quality Control

- SHA managed End of Life Program Facilitator.
- GP Macmillan Facilitators are available in Easington, Sedgefield and the Dales.
- Gold Standards Framework - 100% take up in Darlington. This is being implemented across the rest of Durham GP practices although KITE (Keep Improving the Experience) replaces this in some areas to monitor and evaluate practice improvements
- Preferred Place of Care (Preferred Priorities for Care from May 08) PPC – uptake of this is variable across Durham & Darlington. An audit

carried out in Easington demonstrates that 80% of patients achieved their preferred place of care. This has been replicated in Derwentside.

- Liverpool Care Pathway (or integrated care pathway) – all patients cared for by the District Nurse team, hospices, Macmillan nurse, hospital, Care home will be put on the end of life care pathway as appropriate to their identified needs.
- Emergency Drugs Box & Patient Group Directions are available in the PCTs to support out of hours access to drugs commonly used at end of life. Controlled drugs are available held on the premises through the Out of Hours service; procedures are in place to support the use for district nurses if required for patients.
- Cancer Information Service is available in Durham, Easington and Darlington both in acute and community settings.
- 24 hour hospice Professional Advice Lines operates voluntarily (for staff in North Durham and Easington) this will be formalised through appropriate contracting in the coming financial year.
- 6 Carers Centres providing a range of support services, advice and advocacy
- Social Work Support

5.9 Crisis intervention and fast response

Crisis intervention is provided via admission to Hospice, Community Hospital, or Care Home beds, and/or via the Hospice at Home service. Admission to a hospice, however, is only provided Monday – Friday 9-5pm in most areas due to the lack of Medical Support. Admissions to St Teresa's is however, more flexible due to the fact that they have nurse led admissions that can be provided out of hours.

- There are currently no fast response services available. St Teresa's provides rapid response via Hospice at Home
- Sitting Service for Carers

Contracting Mechanisms

Contracts are the mechanism by which both the providers of services and the purchasers of services agree upon the type, range, level, means, cost and quality of care. All service providers that are contracted to provide a service are accredited to provide that service. Accreditation involves the submission of information which includes verification of insurance, health and safety policies and procedures, equal opportunities and recruitment and selection policies, the latest Care Quality Commission report (where appropriate) and price submissions. There are three methods of contracting currently employed by Durham County Council and NHS County Durham:

6.1 Spot Purchasing

Contracts involve a fixed price for services e.g. 1 hour of domiciliary care or 1 day's attendance at a day centre. Spot purchasing allows services to be cancelled as and when required without any guarantee of purchase to the provider. The advantage to the purchaser is that only those services that are required are delivered and paid for. The identification of a range of accredited providers is of paramount importance in ensuring a successful spot purchasing policy, the achievement of cost effective quality services and value for money.

6.2 Framework Agreement

A framework agreement is a general term for agreements with providers which set out terms and conditions under which specific purchases (call-offs) can be made throughout the term of the agreement.

6.3 Block Contracting

Specifies a quantity of services that is to be provided at a fixed price and the total agreed cost is paid irrespective of the level of service that is actually delivered. The advantage to the purchaser is that a guaranteed level of

service will be available although there is also the risk of paying for services that are not required. The advantage to the provider is the security of income the guarantee gives.

6.4 Service Level Contracts (SLCs)

Are less formal types of contracts between the Local Authority and a provider to supply a particular service for an agreed price. They are usually developed jointly and the overall framework of the agreement is of an open and trusting relationship between commissioning agencies and provider organisations. The advantage to the purchaser is the security of a guaranteed level of service being available. It is expected that the purchaser receives value for money and the SLCs stimulate new services or the expansion of services into areas with an under provision. The advantage to the provider is the guaranteed level of income particularly in the early stages of the development of new services where initial start up costs may be high.

6.5 Standard NHS Contract

The contract provides an important tool for assuring accountability between Providers and Commissioners and for improving performance and improving quality and outcomes for patients and service users. All Providers and Commissioners are obliged under the Contract to have regard to the NHS Principles (published in The NHS Plan, 2000) and have regard to the NHS Constitution, subject to amendment by the Secretary of State from time to time.

The Design of future provision

This joint commissioning strategy for the provision of end of life care services throughout County Durham and Darlington is a five year plan that enables the commissioners to respond to both local demographic challenges and the information gathered within this document in order to deliver improvements to

services. It also enables providers to understand the requirements commissioners have to meet the needs of the local population and plan services accordingly.

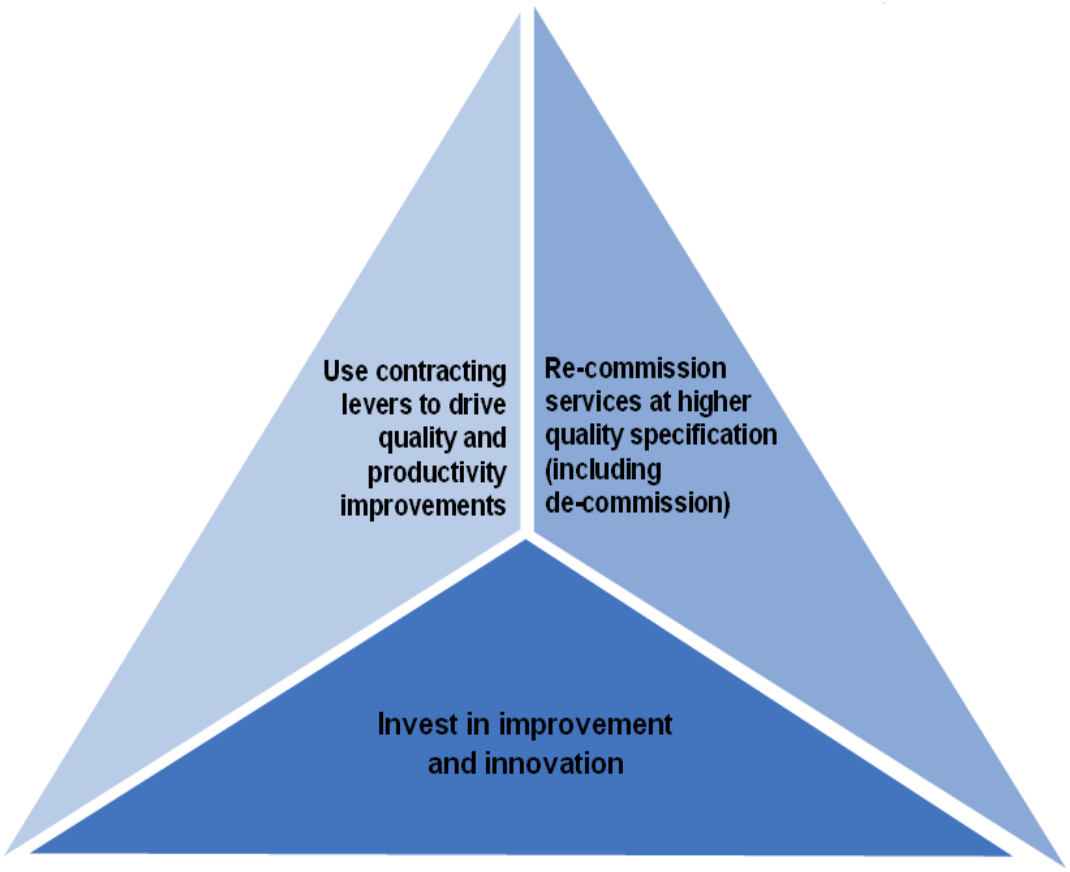
Through the coordination of care patients will have support and care when needed which will result in less hospital admissions, this will lead to more patients obtaining preferred place of care.

To deliver our vision for health and healthcare we have set ourselves a series of goals against our objectives. Each of these goals, supported by delivery programmes, describes where we will gain most benefit from focusing our time and resource.

To help people get the most from later life we aim to:

- Reduce illness in the elderly
- Enable preferred place of death

NHS County Durham and Darlington will focus on three approaches to enable it to achieve the strategic objectives
These approaches are:
1) Investing in improvement and innovation
2) Using contracting levers to drive quality and productivity improvements
3) Re-commissioning service models at higher quality specifications (including de-commissioning poorly performing services).



NHS County Durham and Darlington aims to be at the forefront of innovation and improvement when commissioning new service models. The main reason for innovation and improvement will be driven by the need to commission services or programmes that detect the risk of ill health and disease at an earlier stage to improve health outcomes for our population and ensure efficient use of our resources.

The diagram below shows the commissioning process for County Durham Council as a continuous cycle, the Council are always checking that services commissioned by both health and social care continue to meet local need, is of good quality and valued by the people who use them.

Figure 3: Institute of Public Care framework for joint commissioning and purchasing of public care services

Darlington Borough Council are using the model below to implement joint planning and commissioning Integrated working will be supported by integrated data sets, integrated resources, integrated staff development and by using common processes, such as the common assessment framework.

7.1 Using contracting levers to drive quality and productivity improvements

Whilst we will continue to invest in new services and initiatives that will deliver improvements in health outcomes, we will also use contracting levers, both incentives and penalties to continue to push for improvements in quality and productivity. We will do this by:

- Making best use of Commissioning for Quality and Innovation (CQUIN) payment framework. CQUIN is the contracting lever that allows us to align quality to payment from our acute, community and mental health providers and we will use CQUIN to set stretch targets for quality measures for the benefits of patients. Reviewing services to create detailed specifications that outline best practice, outcome measures

and the level of quality and patient safety we expect for our patients (in line with the regional patient safety strategy Safer Care North East).

- Setting key performance indicators to improve levels of patient experience.
- Making better use of patient experience measurement such as patient reported outcome measures in our contract monitoring frameworks that will allow us to hold providers to account for the levels of satisfaction and safety their services provide, not just the waiting times and costs. Not paying twice for elements of services that we expect to be delivered as part of core contracts. Measuring clinical quality through clinical audit and use of clinical effectiveness key performance indicators linked to National Service Frameworks, NICE guidance and best practice standards.

7.2 Regional CQUIN End of Life measures

Whilst we will continue to invest in new services and initiatives that will deliver improvements in health outcomes, we will also use contracting levers, both incentives and penalties to continue to push for improvements in quality and productivity. We will do this by:

- Making best use of Commissioning for Quality and Innovation (CQUIN) payment framework. CQUIN is the contracting lever that allows us to align quality to payment from our acute, community and mental health providers and we will use CQUIN to set stretch targets for quality measures for the benefits of patients. Reviewing services to create detailed specifications that outline best practice, outcome measures and the level of quality and patient safety we expect for our patients (in line with the regional patient safety strategy Safer Care North East).
- Setting key performance indicators to improve levels of patient experience.
- Making better use of patient experience measurement such as patient reported outcome measures in our contract monitoring frameworks that will allow us to hold providers to account for the levels of satisfaction and safety their services provide, not just the waiting times and costs.

Not paying twice for elements of services that we expect to be delivered as part of core contracts. Measuring clinical quality through clinical audit and use of clinical effectiveness key performance indicators linked to National Service Frameworks, NICE guidance and best practice standards.

Regional CQUIN measures can be found in Appendix 4.

7.3 Re-commissioning service models at higher quality specifications

Sometimes we will need to modernise a current service model by redesigning parts of, or whole, pathways of care within their current funding envelope rather than invest new money into them. We will re-commission current service models in different ways that allow us to improve the levels of quality and experience that patients will receive when using them.

This re-commissioning of services will always be done with the full engagement of patients, carers, our public, clinicians and other stakeholders. In some instances we will look to integrate services to the benefit of patients rather than set up specialist services that are less clinically and cost effective. An example of this would be for patients with a learning disability. We want our providers to adapt the mainstream services we commission from them to make them accessible to patients with a learning disability rather than establish separate stand alone services other than those for a highly specialist need.

We will be looking to integrate services where necessary and to get the most from partnership working, again to improve health outcomes for patients. For example we recognise the link between physical and mental health so will look to develop integrated service models that cross traditional organisational boundaries to provide services that meet both needs.

7.4 Continuing to invest whilst in a "zero growth" scenario

The NHS has not been left unaffected by the recent worldwide economic downturn and subsequent recession. We anticipate that over the lifetime of our strategic plan this will have a significant impact on the way we will achieve our strategic goals. For our health economy to deliver the levels of service quality (in terms of safety, experience and satisfaction) and improvements in health outcomes we need to ensure that we get the best return on investment from our finite resource.

When investing in new services, funding can only come from three areas; growth money, savings and efficiencies released from other services. In two of our three likely future funding scenarios we are not expecting to receive new growth money and as a PCT we do not have the freedom to bank savings other than a 2% contingency that we will hold year on year to deal with in-year pressures. This means that if we want to continue to invest in new service innovations as we do, we must drive improvements in quality and productivity in order to release efficiencies that can be re-invested into services.

To enable us to do this, running alongside programmes of work that are targeted to directly improve specific health outcomes, NHS County Durham and Darlington has established a Quality and Productivity delivery programme. This programme will improve the quality of our current services to make them more cost effective and to make them as productive as possible to give us the biggest return on investment.

If a service fails to meet the levels of quality, experience, safety and outcome that we expect for our patients, we will de-commission them and replace them with a higher quality service. We will be relentless in the way we manage our contracts, seeking to get best value and quality improvements at all times.

7.5 Aligning our delivery programmes to our goals

All our delivery programmes and development capacity have been aligned to the delivery of our strategic goals and to release efficiencies that will allow for continued investment. Figure 18 shows the mapping from our vision for health and healthcare, through our strategic objectives, goals and into the delivery programmes and initiatives that underpin them. It also shows the metrics we will use to judge how implementation is progressing and how successful we have been.

Everybody's Business (2005) states that **"**Whole systems commissioning and leadership are vital to deliver a comprehensive service". The complex nature of end of life care requires a whole systems response, cutting across health and social care services, (linking into housing, the voluntary sector, benefits advice etc) physical and mental health and mainstream and specialist care. Efficiency in health and social care services will improve outcomes for service users and their carers.

The emphasis of Durham County Council, Darlington Borough Council and NHS County Durham and Darlington commissioning intentions is to shift the balance of care to ensure that every person with a need for end of life services is seen and treated as an individual, with specific individual needs and circumstances and that the carer and family are seen as true partners in the decision making and care delivery process.

There will be less emphasis on the use of hospital based care and more of an emphasis on providing services in the person's own home or in the community, supported by a strong integrated community nursing and social care infrastructure.

The Future of End of Life Care

8.1 National Guidelines and Future service provision

The national guidelines, which indicate what patient and carers should expect from local end of life services. The standards are as follows

8.1.1 Raising the profile

Improving end of life care will involve Primary Care Trusts (PCTs) and Local Authorities (LAs) working in partnership to consider how best to engage with their local communities to raise the profile of end of life care. This may involve engagement with schools, faith groups, funeral directors, care homes, hospices, independent and voluntary sector providers and employers amongst others. At a national level, the Department of Health will work with the National Council for Palliative Care to develop a national coalition to raise the profile of end of life care and to change attitudes to death and dying in society.

8.1.2 Strategic Commissioning

As the services required by people approaching the end of life span different sectors and settings, it is vital that an integrated approach to planning, contracting and monitoring of service delivery should be taken across health and social care. A strategic approach to commissioning led by PCTs and LAs is vital and commissioners are reminded of the requirement to conduct equality impact assessments of any planned changes to services. All relevant provider organisations should be involved in the commissioning process.

8.1.3 Identifying people approaching the end of life

Caring for those approaching the end of life is one of the most important and rewarding areas of care. Although it is challenging and emotionally demanding, if staff have the necessary knowledge, skills and attitudes, it can also be immensely satisfying. However, many health and social care staff have had insufficient training in identifying those who are approaching the end

of life, in communicating with them or in delivering optimal care. To address this, a major workforce development initiative is now needed, with particular emphasis on staff for whom end of life care is only one aspect of their work. This will include the provision of communications skills training programmes and other programmes based on the competences needed by different staff groups. Professional regulatory bodies and higher educational institutions will need to be engaged in this endeavour.

8.1.4 Care planning

All people approaching the end of life need to have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan. In some cases people may want to make an advance decision to refuse treatment, should they lack capacity to make such a decision in the future. Others may want to set out more general wishes and preferences about how they are cared for and where they would wish to die. These should all be incorporated into the care plan. The care plan should be subject to review by the multidisciplinary team, the patient and carers as and when a person's condition, or wishes, change. For greater effectiveness, the care plan should be available to all who have a legitimate reason to access it (e.g. out of hours and emergency services).

8.1.5 Coordination of care

Within each local health economy mechanisms need to be established to ensure that each person approaching the end of life receives coordinated care, in accordance with the care plan, across sectors and at all times of day and night. PCTs will wish to consider the work from the Marie Curie Cancer Care Delivering Choice Programme. This demonstrates the effectiveness of establishing a central coordinating facility providing a single point of access through which all services can be coordinated. In addition, it is recommended that PCTs create locality-wide registers for people approaching the end of life, so that they can receive priority care.

8.1.6 Rapid access to care

As the condition of a person may change rapidly, it is essential that services are marshalled without delay. If a person is likely to live for only a matter of weeks, days matter. If the prognosis is measured in days, hours matter. Therefore, PCTs and LAs will wish to consider how to ensure that medical, nursing and personal care and carers' support services can be made available in the community 24/7, including in care homes, sheltered and extra care housing and can be accessed without delay. From the emerging data from Marie Curie Cancer Care and others, it is evident that provision of 24/7 services can avoid unnecessary emergency admissions to hospital and can enable more people at the end of their life to live and die in the place of their choice.

8.1.7 Delivery of high quality services in all locations

Commissioners will wish to review the availability and quality of end of life care services in different settings. These will include services provided in hospitals, in the community, and in care homes, sheltered and extra care housing, hospices and ambulance services. We expect PCTs to build upon current guidance, their baseline review of service provision and findings from their local reviews of end of life care carried out as part of Professor the Lord Darzi's NHS Next Stage Review. Also, commissioners will wish to refer to the quality standards, being developed in collaboration with Strategic Health Authorities (SHAs) End of Life Care Pathway Chairs, which set out what is needed to deliver high quality care at the end of life, adopting a care pathway approach. Consultation on these will commence shortly.

8.1.8 Last days of life and care after death

Increasingly, the LCP, or an equivalent tool, is being adopted by those providing end of life services. The LCP, which was first developed for use with cancer patients, has now been successfully modified for use for people with other conditions. It can be used in hospitals, care homes, hospices and in people's own homes. For people who die suddenly, the care after death module is appropriate. The adoption of this tool is further supported by those

hospitals who have participated in the National Care of the Dying Audit – Hospitals (NCDAH) based on the LCP.

8.1.9 Involving and supporting carers

The family, including children, close friends and informal carers of people approaching the end of life, has a vital role in the provision of care. They need to be closely involved in decision making, with the recognition that they also have their own needs. For many this will have been the first time they have cared for someone who is dying. They need information about the likely progress of the person's condition and information about services which are available. They may well also need practical and emotional support both during the person's life and after bereavement. Carers already have the right to have their own needs assessed and reviewed and to have a carer's care plan.

8.1.10 Education and training and continuing professional development

Ensuring that health and social care staff at all levels have the necessary knowledge, skills and attitudes related to care for the dying will be critical to the success of improving end of life care. For this to happen, end of life care needs to be embedded in training curricula at all levels and for all staff groups. End of life care should be included in induction programmes, in continuing professional development and in appraisal systems.

The health and social care workforce can be segmented into three broad groups in relation to end of life care. Staff who spend the whole of their time caring for those at the end of life, those who frequently deal with end of life care as part of their role and those who care for people at the end of life infrequently. Developing core competences for each of these groups is work best led by organisations such as Skills for Care and Skills for Health, in collaboration with the Academy of Medical Royal Colleges. **SHAs will wish to consider how training can best be commissioned and provided to ensure that relevant staff have the necessary competences.**

8.1.11 Measurement and research

Good information on end of life care is needed by patients, carers, commissioners, clinicians, service providers, researchers and policy makers. Each group will have somewhat different questions to ask and therefore different priorities for information. The NHS Choices website contains information which may be helpful.

Measurement of end of life care provision is a key lever for change and is essential if we are to monitor progress. This will require measurement of structure, process and outcomes of care. Structures and processes will largely be measured through self assessment by organisations against the quality standards, on which consultation will commence shortly.

In addition to information on place of death, which is available through the Office for National Statistics (ONS), outcomes of end of life care will in future be monitored through surveys of bereaved relatives, national audits and regular reviews of complaints.

Development of this strategy has, wherever possible, taken account of the best available evidence, but has also revealed deficiencies in the evidence base. Working with charities and with other statutory funders, the Department of Health now wishes to enhance research into end of life care, especially for those with conditions other than cancer. A new one off initiative will build on the good foundations laid through the National Cancer Research Institute's supportive and palliative care research collaborative.

8.1.12 Funding

It is difficult, if not impossible, to calculate the cost of end of life care in this country. This is partly because of the difficulty in defining exactly when end of life care starts. However, the key elements of expenditure can be identified. These are:

- Hospital admissions;
- Hospices and specialist palliative care services;

- Community nursing services; and
- Care homes.

Across health and social care, the overall cost of end of life care is large (measured in billions of pounds) and there is widespread agreement that these resources are not all being used as well as they might be. In addition, there are costs met by other government departments, such as the Attendance Allowance and Disability Living Allowance. There are also costs to unpaid carers. However, many of the improvements envisioned can be achieved by better use of existing health and social care resources. It is likely, for example, that at least part of the additional costs of providing improved care in the community and in care homes will be offset by reductions in hospital admissions and length of stay. Further work on the cost impact of new end of life care service models, developed through the Marie Curie Cancer Care Delivering Choice Programme, is encouraging, showing a reduction in hospital admissions and increase in home deaths with stable overall costs.

In reviewing local areas, commissioners will need to consider the financial implications of:

- Establishment of coordination centres/facilities;
- Provision of 24/7 home care services;
- Improved ambulance transport services for people near the end of life;
- Additional specialist palliative care outreach services to provide advice and care for non-cancer patients and to increase input into care homes and community hospitals; and
- Improved education and training of existing staff in care homes, hospitals and the community.

8.2 Individual needs

Each individual with end of life care needs will have:

The opportunity to discuss their personal needs and preferences, with professionals who can support them. They will have the opportunity for these to be recorded in a care plan so that every service which will be involved in supporting them will be aware of their priorities. Preferences and choices will be taken into account and accommodated wherever possible:

- All health and social care staff will be trained in communication regarding end of life care;
- Health and social care professionals will be trained in assessing the needs of patients and carers and, where necessary, reconciling differing requirements; and
- A care plan will be offered to every patient and carer, to help ensure services are provided to meet their needs and preferences.

Coordinated care and support, ensuring that patient needs are met, irrespective of who is delivering the service:

- Every organisation involved in providing end of life care will be expected to adopt a coordination process, such as the Gold Standards Framework (www.goldstandardsframework.nhs.uk);
- Local end of life care coordination centres will be established to coordinate care across organisational boundaries; and
- End of life care registers will be piloted and established to ensure that every organisation which will be involved in care is aware of a patient's wishes.

This analysis of current provision will provide a map of existing services. However. The rural nature of County Durham and Darlington must also be taken into account in considering future service and commissioning development with particular reference to issues such as:

- Accessing services
- Transport

- Social isolation
- Increased costs of operating in rural area

Rapid specialist advice and clinical assessment wherever you are:
Patients and carers should have access to dedicated 24/7 telephone helplines and rapid access homecare services; and Specialist palliative care outreach services should be established in every area.

High quality care and support during the last days of your life:
A care pathway approach for management of the last days of life, such as the Liverpool Care Pathway (www.mcpcil.org.uk/liverpool_care_pathway), will be rolled out across England; and Facilities will be provided to support relatives and carers who wish to stay with a patient in hospital.

Services which treat you with dignity and respect both before and after death:
A major programme to provide training in end of life care for health and social care staff should be established, which will include the voluntary sector where appropriate.

Appropriate advice and support for carers at every stage.
To support this, services will be:
Well planned and coordinated, ensuring patients have access to the care they need, when they need it, irrespective of condition or the setting in which the patient is being cared for, and that patient choice is respected and will be taken into account:
PCTs will develop comprehensive local strategic plans for end of life care, based on an assessment of the needs of the population they serve.

Quality assured and delivered to a high standard:
Quality standards covering all providers of end of life care services will be developed.

Monitored and assessed to ensure quality. Best practice will be identified and spread so that others may benefit:
A national intelligence network will be established to collect, analyse and publish data on service quality performance; and A dedicated multiprofessional national support team will work with commissioners and providers to identify and spread good practice.

Informed by the experience of others who have been in a similar situation. Equally your experience will help inform the care of future patients, leading to year on year improvements in quality:
Surveys of bereaved relatives and carers should be introduced, based on the successful Views of Informal Carers – Evaluation of Services (VOICES) programme;

- A comprehensive analysis of complaints relating to end of life care will be undertaken; and
- A national End of Life Care Research Initiative will be launched to further understanding of how best to care for people reaching the end of their life and support those caring for them.

Aim of future service provision

9.1 Following national guidelines

The aim of this strategy is to develop and deliver a model of service that is effective for at least the next five years and ensures that patients are treated in the right place and at the right time. We will achieve this by following and implementing the standards of care identified in the national strategy:

9.1.1 Raising the profile

There is sensitive and appropriate end of life support provided, beginning at the time illness is identified and continuing throughout illness, during death and in bereavement. To ensure that the principles of the 'Good Death'

Charter is widely consulted upon and then used to allow patients, loved ones and carers to discuss and plan for a good death.

9.1.2 Strategic Commissioning

To develop the role of the End of Life Clinical Programme Group to become the strategic lead for commissioning end of life To integrate the partnership board, practice based commissioning and local authorities with the CPG to ensure that alterations and priorities made within end of life have an equality impact assessment

9.1.3 Identifying people approaching the end of life

For all GP practices to have a palliative care register that is inclusive of long term conditions as well as cancer patients. Develop and role out a training package for primary care to ensure there is a more defined approach to placing patients on a palliative care register and that there is a minimum standard of multi disciplinary teams

9.1.4 Care planning

To develop and role out advanced directives / advanced care planning across the locality. To refresh the whole care pathway from diagnosis to Liverpool Care Pathway, this is in line with the recommendations highlighted at the accelerated solutions event (ASE) which set ambitious regional priorities to use the Liverpool care pathway in all care settings and encourage all providers to share results.

9.1.5 Coordination of care

To investigate and develop the most effective way to ensure care is coordinated across health and social care. Review the use of single point of access in coordinating care and facilitating the need to create a locality wide palliative care register, this is in line with the recommendations highlighted at the ASE which set ambitious regional priorities to ensure the development and effective use of the palliative care register in general practice.

9.1.6 Rapid access to care.

All people living in the community with end of life needs, regardless of their terminal illness or care setting and have access to an appropriately training and accredited practitioner who can support them within one hour at any time of night or day. To review and develop the health and social care workforce, ensuring that there is access to a 24/7 services, this is in line with the recommendations highlighted at the ASE which set ambitious regional priorities to ensure 24/7 availability of an appropriately trained nurse who is able to provide practical support responding within one hour.

9.1.7 Delivery of high quality services in all locations.

To ensure that there a quality standards built into all health and social care contracts. To develop key performance indicators and a minimum dataset that would enable the CPG to understand the current market place in more detail and for there to be a performance framework for delivery.

9.1.8 Last days of life and care after death.

To ensure through the use of audit, that all providers participate in the Integrated Care Pathway. To further develop the bereavement model to ensure all loved ones and carers get support after death. To ensure that the links with the coroner are robust to investigate all sudden deaths to review whether there is any genetic link and test family members. To ensure that patients who have a pacemaker or implantable cardiac defibrillator are deactivated as part of a planned pathway.

9.1.9 Involving and supporting carers

To review the Macmillan information centres, to gain an understanding whether information can be provided for non cancer patients.

To undertake a mapping exercise to understand what resource is available to patients with specific reference to any gaps in information. To ensure all patients have a key worker to be able to sign post patients to the information they require or need.

9.1.10 Education and training and continuing professional development

To undertake training needs assessment which will include the need for specific disease groups, so ensuring their needs are catered for. To work with the Strategic Health Authority to ensure that end of life training monies are used to increase the competencies and skills within care homes. All training will ensure that the needs of individual specific disease groups are met to ensure holistic care for all patients.

9.1.11 Measurement and research

To develop robust measures for palliative care and undertake any research that would improve patient care for the residents of County Durham and Darlington.

9.1.12 Funding

To work with the Strategic Health and the Department of Health to assist in developing programme budgeting for end of life / palliative care. To work with local hospitals to understand how expenditure related to end of life and palliative care can be captured money. To develop and role out a minimum dataset that would allow the CPG to understand the current spend against activity to understand / assess value for. To review whether personalised budgets could be used for the care of patients at their end of life.

Anecdotal evidence indicates that non-cancer patients receive inferior support at end of life because they are not on a register

The ageing population will lead to increased demand for palliative care (over 85 population) Between 2007 and 2026 the number of older people over 65, 75 and 85 years old will increase by 49.9%, 71.4% and 115.2% respectively in County Durham. In Darlington it is projected that by 2015 over 19% of the population will be aged 65 years or older.

9.1.13 Workforce

To ensure that staff are suitably qualified, trained and competent to deliver the service to the defined client group. Suitably qualified means staff who have a recognised professional or care service qualification and where necessary are registered with the appropriate Board, Council or College. To ensure that all staff have appropriate induction processes.

To offer current best practice in employment practices and ensure compliance with professional regulation guidance or legislation.

To ensure that staff have access to necessary professional development and statutory training.

To ensure that appropriate and rigorous recruitment and retention policies and systems are in place. Recruitment procedures should emulate those employed within NHS County Durham and Darlington and Darlington and Durham County Council's, it should ensure that full and proper references are taken up and all gaps in practice or employment are scrutinised. The provider must ensure all staff who come into regular contact with vulnerable groups have been subject to the necessary Criminal Records Bureau checks and that these checks are repeated at three yearly intervals.

A clear audit trail detailing the full recruitment process and all subsequent checks should be in place and available at all times.

Way Forward

With the current economic downturn we have had to review our plans and re-focus our priorities for the coming years. We have taken the 12 standards of care and condensed them into to 2 initiatives which will be our focus for the lifetime of this strategy

1. Raising the profile

- Within the Quality and Outcomes Framework all GP practices will have a palliative care register and have regular MDT (Multi disciplinary teams) meetings to discuss these patients**.** Which will include social care and health staff, specialist nurses,district nurses, community matrons and AHP's (Allied Health Professionals), and the voluntary sector where appropriate.
- Role out a training package to assist practices in realising the importance of having a comprehensive palliative care register
- NHS North East launch of 'Good Death' conference
- To implement a series awareness raising events throughout County Durham and Darlington, working with patients, carers, providers and PBC (Practice based commissioning) groups

2. Care Planning

- Using a Kaizen event to refresh the whole care pathway from diagnosis to Integrated Care Pathway, including the standardisation of policies around advanced directives such as Do Not Attempt Resuscitation need to be formalised across all providers and settings
- To investigate the best model for coordinating care
- To review and develop the workforce to ensure that there is access to a 24/7 service in all localities
- Gold Standards Framework within care homes

Delivery Plan

11.1 How Improvements will be achieved

- The creation of a palliative care register will ensure that all patients needing support will be known to providers. Identifying patients in need of palliative care, assessing their needs and preferences and proactively planning their care, are the key steps in the provision of

high quality care at the end of life in general practice. Therefore (Quality outcome framework) QOF indicator set is focused on the maintenance of a register, (identifying the patients) and on regular multidisciplinary meetings where the team can ensure that all aspects of a patient's care have been assessed and future care can be co-ordinated and planned proactively.

A patient should be included on a register if any of the following apply:

1. their death in the next 12 months can be reasonably predicted (rather than trying to predict, clinicians often find it easier to ask themselves 'the
2. surprise question' – 'Would I be surprised if this patient were still alive in 12 months?').
3. they have advanced or irreversible disease and clinical indicators of progressive deterioration and thereby a need for palliative care e.g. they have 1 core and 1 disease specific indicator in accordance with the GSF Prognostic Indicators Guidance
4. they are entitled to a DS 1500 form. (The DS 1500 form is designed to speed up the payment of financial benefits and can be issued when a patient is considered to be approaching the terminal stage of their illness. For these purposes, a patient is considered as terminally ill if they are suffering from a progressive disease and are not expected to live longer than six months.) ***(The register applies to all patients fulfilling the criteria regardless of age or diagnosis.)***

- Roll out a training package to train GPs on the expectations of the Good Death charter and criteria of adding patients to the register, with explicit reference to non-cancer. The Royal College of General Practitioners is the professional membership body for family doctors in the UK and abroad. who are committed to improving patient care, clinical standards and GP training.

- Roll out a series of public, practice based commissioning and provider events around the principles of the 'Good Death' Charter. This charter will guide health, social care, community, voluntary and other organisations, groups or individuals who plan, develop and provide end

of life care or support. It will help to ensure the right services are available at the right time for individuals who are dying, their families and carers.

All care providers should be aware of the charter, and its impact on their work, not only those who work specifically in end of life services.

- Increasing the number of patients who have an advanced care plan will lead to all people approaching the end of life having their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan. In some cases people may want to make an advance decision to refuse treatment, should they lack capacity to make such a decision in the future. Others may want to set out more general wishes and preferences about how they are cared for and where they would wish to die. These should all be incorporated into the care plan. The care plan should be subject to review by the multidisciplinary team, the patient and carers as and when a person's condition, or wishes, change. For greater effectiveness, the care plan should be available to all who have a legitimate reason to access it (e.g. out of hours and emergency services).

Run localised pilot projects working with all providers to review the role of localised coordination centres, which will be evaluated against the national model

- To look at how the single point of access Urgent Care Communication Centre can provide patient care, how care is coordinated across boundaries and how it can provide an electronic system of coordinating patient data. To see if it can provide a multidisciplinary service that best uses clinical skills and responds to varied needs of patients with both acute and long term conditions, from a variety of premises, including their own homes and for patients whose needs are most

suitably met by the tier of provision that sits between that provided by primary care and A&E

- Link local care homes with appropriate hospices which will allow access to palliative care specialists who can offer advice information and support for care home staff, this could lead to less inappropriate referrals to acute settings. Many nursing home residents find acute admission distressing, many hospital admissions are 'inappropriate', and nursing home residents are significantly less likely to survive acute medical admissions than elderly people living in the community.

(Improving end of life care for nursing home residents: an analysis of hospital mortality and readmission rates D J Ahearn, T B Jackson, J McIlmoyle, et al. 2010)

11.2 Achieving preferred place of care

Helping people get the most out of later life is one of our strategic objectives Through the greater coordination of patient care County Durham and Darlington patients will have more support when needed, which will see less hospital admissions and lead to more patients obtaining preferred place of care.

Mechanisms will be established to ensure that each person who is approaching end of life receives coordinated care, in accordance with the care plan, across sectors and at all times of day and night.

When the time comes we will ensure that death is pain free, dignified and within the environment of choice. We will ensure that at the end of life, people will be able to have a good experience in their preferred place of death, be that hospital, hospice or home.

It is forecasted that the age profile of the population in County Durham and Darlington will change significantly, with a greater proportion being over the age of 65, which is more than the increase nationally. This increase in the ageing population will lead to increased demand for palliative care (over 85 population) Between 2007 and 2026 the number of older people over 65, 75

and 85 years old will increase by 49.9%, 71.4% and 115.2% respectively in County Durham. In Darlington it is projected that by 2015 over 19% of the population will be aged 65 years or older

Monitoring and Evaluation

12.1 Current monitoring arrangements

The collection, analysis and monitoring of data on needs, service take up and gaps is essential to the development of a strong commissioning strategy as is the monitoring of the quality and quantity of the service involved in end of life provision.

This Commissioning strategy also has a number of implications related to Equality and Diversity and each of the core strands of equality: age; ethnicity; religion; disability; sexual orientation; gender. Equality and Diversity issues are integrated within the strategy where priorities have been identified to meet the diverse needs of the population within County Durham and Darlington.

All commissioned services are expected to demonstrate a commitment to Equality and Diversity and there will be an assessment of this during the procurement processes used to select provider services. Service level contracts also require that service providers sign up to delivering services that comply with Equality and Diversity legislation and good practices.

All commissioned services will be monitored and reviewed against a set of standards contained within a Quality Assessment Framework. There will be specific standards that relate to Equality and Diversity both within employment practices (e.g. recruitment and training) and also in work with service users (e.g. to ensure fair access to services).

The Care Quality Commission is responsible for the registration, monitoring and inspection of The Care Quality Commission is the independent regulator of health and social care in England, it regulates care provided by the NHS,

local authorities, private companies and voluntary organisations. There has been discussion regarding the Care Quality Commission monitoring day services but at present, no decision has been made on this. Adult Well Being and Health Services Commissioning Unit also monitor services and all contracts for the provision of domiciliary, day, residential and nursing care are monitored to confirm compliance with the terms and conditions of the contract. Providers of services must make available to commissioners any documents and information which demonstrate compliance.

Data about the use of services is collected from the Social Services Information Database (SSID) and work is underway to ensure that this information is kept up to date and is accurate. However, individuals who access services subject to Service Level Contracts may not be included in the data, unless they are recorded as doing so on their individual care plans.

Service providers maintain their own recording systems and their information does not always concur with that of the commissioners. Work is ongoing to improve this, as data collection is an integral requirement for planning purposes.

12.2 Future joint monitoring arrangements

As partners to this strategy, both Durham and Darlington County Council Adult Social Service and Adult Wellbeing and Health Department along with NHS County Durham will be responsible for the implementation and delivery of this strategy via the end of life' Joint Commissioning Group. Progress will then be reported to the relevant management teams within County Durham and Darlington on a 6 monthly basis.

12.3 Monitoring of services

It is important that robust contract management processes for all agencies underpin the joint commissioning strategy for end of life care. Outcomes and standards for services will be jointly monitored using agreed measures of performance.

Any future joint monitoring arrangements must:

- Involve service user and carers, including those 'hard to reach' groups e.g. ethnic minorities. This will ensure that services are both tailor made to individual circumstances and respond to minority needs e.g User Led Organisations (ULOs)
- Continually improve planning, capacity, building and performance information in order to inform the commissioning process and ensure best value
- Include the collection of quarterly information from all service providers regarding capacity, attendance and usage of the service
- Deliver the outcomes as identified in the contract
- Record any individual unmet needs to inform service planning
- Have a robust system for the collection of complaints and compliments regarding the service and a process for ensuring that comments are included in reviews
- Ensure that any concerns regarding the service are investigated and if necessary, a review of the service is undertaken

The main systems for the future monitoring of services will be:

12.4 Performance Indicators

County Durham County Council, Darlington Borough Council and NHS County Durham and Darlington are required to meet set targets and performance indicators (KPI's) relating to services. It is therefore important that any measure and monitoring of the success of service developments and commissioning should include, wherever appropriate, any relevant targets and performance indicators. Performance data will be obtained quarterly from providers of services and performance targets reported in quarterly performance reports at Performance Days.

See appendix 8 for all key performance indicators

12.5 Contract Monitoring

Contracts will be monitored and reviewed by NHS County Durham and Darlington and Durham and Darlington Local Authorities to make sure compliance with the terms and conditions of the contract are adhered to.

Reviews of contracts will be held at a frequency specified in each contract but at least annually. The review will assess the extent to which the service is meeting the contract specification and to discuss any issues and proposed variations. The review will also assess how the service is performing in terms of developments, whether targets are being met, financial information and the quality of management arrangements. It will recommend the review outcome e.g. should the contract be continued, re-negotiated or terminated. Every review will be held in consultation with the provider and will involve service users and their carers.

12.6 Care Quality Commission

The Care Quality Commission is the merging of the Commission for Social Care Inspection (CSCI) and the Health Care Commission. The Care Quality Commission will continue to be responsible for the registration, monitoring and inspection of care provided by the NHS, GP and Community providers, local authorities, private companies and voluntary organisations. the registration, monitoring and inspection of residential care homes and domiciliary care providers.

12.7 Service user and carer feedback

Regular feedback from service users and carers can be obtained through the use of questionnaires, meetings and surveys. This also ensures that service users and carers are assisting in shaping future service provision.

12.8 Staff feedback

Staff will be encouraged to provide feedback on their experiences of services through individual discussion and team meetings. This will be used to both inform the annual review and if there are any concerns, recommend that a review takes place.

Appendix 1

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D J Ahearn,1 T B Jackson,1 J McIlmoyle,2 A J Weatherburn2

See Also:

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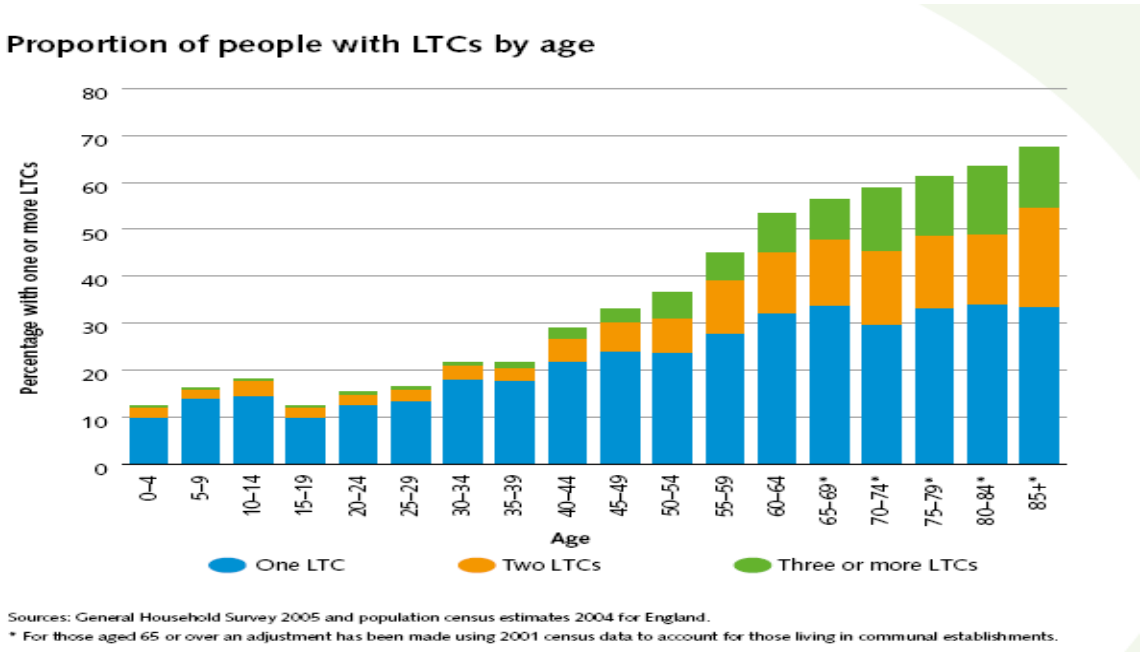
Appendix 2

Long Term conditions

A number of long-term conditions have specific care pathways and it should be acknowledged that the probability of having a long term condition increases with age. As people grow older and as their health declines the probability of having more than one long term condition also clearly increases as the graph below shows.



Source: Raising the Profile of LTC: A Compendium of Information, DoH 2007

This means that in commissioning health and social care services for the future, we need to account for the fact that older people are more likely to be receiving input from more than one long-term conditions pathway.

Locally, the JSNA 2009/10 highlights in Table 2.3e below the prevalence of people of all ages. This information is not currently broken down by age but does indicate that the highest prevalence is in Easington which is substantially higher than other areas within the County and is known to have particularly high level of deprivation. In addition, it is also noted that the percentage of those with a limiting long-term illness in all areas of County Durham is significantly higher than for England as a whole, at 17.3%.

Table 2.3e Limiting long-term illness ratios

	No. of people with a limiting long-term illness	% of people with a limiting long-term illness	Limiting long-term illness ratio
Easington	27991	30.1%	168.7
Sedgefield	21138	24.4%	135.5
Derwentside	20189	24.1%	131.5
Durham Dales	19043	22.6%	118.7
Durham and Chester-le-Street	27626	20.6%	116.3
North East	**546726**	**22.1%**	**123.7**
England	**8369174**	**17.3%**	**98.5**

Source: 2001 Census, National Statistics

A number of key health areas that need to be progressed will be taken forward for all age ranges within the Joint Commissioning Strategy for Adults with Long-Term Conditions 2010-13. This will include areas such as stroke and cardio-vascular disease. Within it's overall commissioning intentions this strategy includes a focus on:

The Joint Commissioning Strategy for Adults with Long-Term Conditions 2010-13 includes in it's overall commissioning intentions:

- A preventative approach to help people sustain independence and live a healthy lifestyle, thereby reducing the number of people likely to develop a long-term condition
- Development of 'self-care' to support independence wherever possible
- To decrease the number of admissions to hospital and length of stay in hospital for people with long-term conditions
- Extend the use of technology (telecare/telehealth) to support people with a long-term condition at home

Given the evidence of multiple long-term conditions suffered by older people and the increased complex nature of the support and multiple care pathways required, a co-ordinated, personal approach is key to supporting older people with long-term conditions. An action has therefore been identified within this strategy to develop robust working links with the development and implementation of the Joint Commissioning Strategy for Adults with Long-Term Conditions 2010-13 to ensure the needs of people with long-term conditions and their families/carers are addressed.

People with Learning Difficulties (LD) and Mental Health (MH) Depression / Dementia and Severe mental illness

Depression

One of the most common mental health problems affecting older people is depression and anxiety and it is estimated that this condition affects one in four of the population at some time in their lives. Data suggests that 15% - 50% of older people in hospital and 30% - 40% of those in residential care are affected by depression (APHO, 2008)

Dementia

Dementia is not the most common condition among older people with mental health needs but it is the group that will see the largest increase in numbers. A report by the Alzheimer's Society (Dementia UK, PSSRU, London School of Economics, February 2007) examines the economic and social impact of

dementia and warns that urgent action is needed to plan for the increase in numbers of sufferer. Late on-set dementia affects approximately 668,563 people in the UK aged 65 years and over (Dementia UK 2005 based prediction). This is 98% of all people with dementia. In 2008, it is estimated that there are 29,770 people living in the North East of England with late on-set dementia, 19,575 females and 10,195 males. Early on-set dementia is defined as the on-set of dementia in people under the age of 65 years. In the UK this accounts for approximately 2.2% of all people with dementia (Dementia UK Report 2009). In the North East in 2008, it is estimated that 684 people under the age of 65 years will have dementia, with 59% (401) being male and 41% (283) being female.

Dementia amongst people with learning disabilities

Dementia can also affect people who already have other disabilities. The Alzheimer's Society in their report 'Leading the fight against dementia' identifies that there is no evidence that dementia affects people with learning disabilities differently to how it affects other people. However, the early stages are more likely to be missed or misinterpreted. The person may find it hard to express how they feel and there may also be problems with communication that makes diagnosis and assessment difficult. About 20% of people with a learning disability have Down's syndrome and this group are at particular risk of developing dementia. Information from one study (Prasher 1995) suggests that the following percentage of people with Down's syndrome have dementia:

30 – 39 years	2%
40 – 49 years	9.4%
50 – 59 years	36.1%
60 – 69 years	54.5%

Appendix 3

County Durham and Darlington Care homes

Tel	Name of Care Home	Category	Total No of Beds Registered with CSCI	Res Beds	Nursing Beds	Either/Or Res or Nursing	Int Care Beds	Res Beds	Nursing Beds	Either/Or Res or Nursing	Int Care Beds	Comments
361166	**Darlington Manor**	OP EMI	59	59				12				**8 EMI**
384646	**Eastbourne**	OP/NUR/ PHYS	26	3	23			0				
281061	**Eden Cottage**	OP	20	20				7				
368256	**Elderwood**	OP	40	40				10				
366897	**Grosvenor Park**	OP/EMI/PHYS	61	61				37				**18 EMI**
366000	**Hundens Park**	OP/NUR	60	30	15	15				6		
332207	**Middleton Hall**	OP /NUR/PHYS	52	32	20			1				
286000	**Lakeside**	OP/EMI/YPD	67	17	38			5	26			**12 YPD res beds**
353592	**Moorlands**	OP	19	19				1				
356000	**North Park**	OP/EMI	60	60				5				**3 EMI**
381135	**Oak Lodge**	OP /NUR/PHYS	28			28		7				
488584	**Riverside**	OP/EMI	61	61				13				**1 EMI**
369329	**Rydal**	OP EMI/NUR/ PHYS	60	10	50				17			**8 EMI**
468048	**Springfield**	OP EMI PHYS	48	48				17				
335425	**St. George's Hall**	OP NUR	21		21				8			
335484	**St. George's Lodge**	EMI/RES	20	20				9				**All EMI**
335484	**St. George's Lodge**	OP/NUR/EMI	43		43				24			**All EMI**
486166	**St. Williams**	OP	22	22				3				
487777	**The Gardens**	OP	44	44				2				
464900	**The Grange**	OP/EMI	74	74				1				
357161	**The Lawns**	OP EMI	62	62				8				**8 EMI**
488399	**Ventress Hall Care Centre**	OP/NUR/PHYS	106	61	35		10			3	1	**not filling res beds**
465770	**Willow Green**	NUR/LD	63		63				27			**2 LD**
353701	**Wilton House**	OP/NUR	26			26				0		

OP = Older Persons
EMI = Demetia
NUR = Nursing Care
PD = Physical Disability
LD = Learning Disability
INT Care = Intermediate Care
PHYS = Physical Disablities
YPD = Young Physically Disabled

			Registered	Beds			Vacant	Beds	
	Name of Care Home	**Category**	**Total No of Beds Registered with CSCI**	**Res Beds**	**Nursing Beds**	**Either/Or Res or Nursing**	**Res Beds**	**Nursing Beds**	**Comments**
Tel No:									
365428	**Lindisfarne**	PSI	13	13			1		
240452	**The Avenue**	LD	3	3			0		
389967	**Firtree**	LD	10	10			0		
261658	**Cornerstone**	LD	12	12			2		
333993	**Middleton Lodge**	LD	10				2		
465770	**Willow Green**	LD	11		11			2	

PSI = Physical Sensory Impaired LD = Learning disabilities

Durham Care Homes

1. All Places

Area	Nursing Places Available	Nursing Places Occupied	OP Nursing Places % Occupied	Nursing EMI Places Available	Nursing EMI Places Occupied	OP Nursing EMI % Occupied	Total Places % occupied
Derwentside	145	94	**65%**	78	59	**76%**	**79%**
Durham	153	136	**89%**	0	0	**0**	**90%**
Ch-le-St	68	54	**79%**	15	8	**53%**	**75%**
Easington	217	170	**78%**	128	116	**91%**	**79%**
Sedgefield	109	74	**68%**	105	85	**81%**	**79%**
Dales	192	159	**83%**	62	54	**87%**	**78%**
Totals	**884**	**687**	**78%**	**388**	**322**	**83%**	**80%**

2. Older People

Area	Res Places Available	Res Places Occupied	OP Res Places % Occupied	EMI Places Available	EMI Places Occupied	OP Res Places % Occupied	Total Places % occupied
Derwentside	444	369	**83%**	226	167	74%	**77%**
Durham	266	222	**83%**	70	48	69%	**83%**
Ch-le-St	176	120	**68%**	104	82	79%	**73%**
Easington	406	343	**84%**	190	145	76%	**82%**
Sedgefield	194	154	**79%**	137	115	84%	**79%**
Dales	281	221	**79%**	178	130	73%	**79%**
Totals	**1767**	**1429**	**81%**	**905**	**687**	**76%**	**79%**

3. Learning Disability

Area	Res Places Available	Res Places Occupied	LD Res Places % Occupied
Derwentside	88	85	**97%**
Durham	0	0	**0**
Ch-le-St	33	33	**100%**
Easington	70	45	**64%**
Sedgefield	68	61	**90%**
Dales	22	0	**0%**
Totals	**281**	**224**	**80%**

4. Physical Disabilities

Area	Res Places Available	Res Places Occupied	PD Res % Occupied	Nursing Places Available	Nursing occupied	PD Nursing % Occupied	Total Places % occupied
Derwentside	24	14	**58%**	15	15	100%	**74%**
Durham	10	8	**80%**	12	10	83%	**82%**
Ch-le-St	0	0	**0**	2	1	50%	**50%**
Easington	35	30	**86%**	44	27	61%	**72%**
Sedgefield	11	11	**100%**	13	3	23%	**58%**
Dales	5	5	**100%**	33	33	100%	**100%**
Totals	**85**	**68**	**80%**	**119**	**89**	**75%**	**77%**

5. Mental Health

Area	Res Places Available	Res Places Occupied	MH Res % Occupied	Nursing Places Available	Nursing Places occupied	MH Nursing % Occupied	Total Places % occupied
Derwentside	38	35	**92%**	0	0	0	**92%**
Durham	0	35	**350%**	0	0	0	**350%**
Ch-le-St	2	2	**100%**	0	0	0	**100%**
Easington	0	0	**0**	16	2	13%	**13%**
Sedgefield	17	15	**88%**	1	1	100%	**88%**
Dales	23	22	**96%**	0	0	0	**96%**
Totals	**80**	**109**	**136%**	**17**	**3**	**18%**	**115%**

Appendix 4

Regional CQUIN End of Life measures

Percentage of palliative care patients on district nurse and community hospital case load with advanced care plan

Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National / Regional indicator	Indicator weighting
	To ensure that an advanced care plan is in place for all palliative care patients on district nurse and community hospital caseloads.	Effectiveness Experience	RMC1	Percentage of palliative care patients on district nurse and community hospital case load with advanced care plan	Regionally mandated	NA

Details of indicators

Description of indicator	Advanced care planning (ACP) is a voluntary process of discussion between an individual and their care providers irrespective of discipline; an advanced care plan is a voluntary record of this discussion.
Numerator	Number of palliative care patients on district nurse and community hospital case load with an advanced care plan in the pilot area. **Metric 1 -** **Actions:** a) Development of an Advanced Care Plan template and standardised care plans – June 2010 *to be agreed* b) Incorporate template and care plans into SystmOne for the purpose of the clinical record and data collection processes – September 2010 *to be agreed* c) Provide and implement Advanced Care Planning training for frontline staff – December 2010 *to be agreed* d) Pilot introduction of Advanced Care Planning – March 2011 *to be agreed*

Denominator	Number of palliative care patients on district nurse and community hospital case load in the pilot area.
Rationale for inclusion	Advance Care Planning (ACP) is a voluntary process of discussion between an individual and their care providers irrespective of discipline. If the individual wishes, their family and friends may be included in the discussions. With the individual's agreement, this discussion should be recorded, regularly reviewed and communicated to key persons involved in their care. ACP is a key part of quality provision of end of life care. Improving the pre-planning of care has been found to be one of the most important ways that we can ensure reliable patient-focused care.
Data source and frequency of collection	Local audit of end of life patients on district nurse and community hospital caseload in pilot area
Organisation responsible for data collection	County Durham and Darlington Community Health Services
Frequency of reporting to Commissioner	Monthly progress report to Community Quality Review Group
Baseline period / date	Our vision, our health, our North East NHS' indicates that the use of advanced care planning is currently less than 10% in most cases (pg. 60)
Baseline value	10%
Final indicator period / date (on which payment is based)	[To be determined by commissioner]
Final indicator value (payment threshold)	[To be determined by commissioner]
Final indicator reporting date	[Insert final indicator reporting date]
Rules for partial achievement of indicator at year-end	[To be determined by commissioner]
Rules for any agreed in-year milestones that result in payment	[To be determined by commissioner]
Rules for delayed achievement against final indicator period/date and/or in-year milestones	[To be determined by commissioner]
Other Information	**Evidence Base** From 'End of Life Care Strategy' 2008 (pg 12): All people approaching the end of life need to have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan. In some cases people may want to make an advance decision to refuse treatment, should they lack capacity to make such a decision in the future. Others may want to set out more general wishes and preferences about how they are cared for and where they would wish to die. These should all be incorporated into the care plan. The care plan should be subject to review by the multidisciplinary team, the

	patient and carers as and when a person's condition, or wishes, change. For greater effectiveness, the care plan should be available to all who have a legitimate reason to access it (e.g. out of hours and emergency services). From 'End of Life Care Strategy' 2008 (pg 57): "All people approaching the end of life, and their carers, should be entitled to… Have a care plan which records their preferences and the choices they would like to make. The care plan should be reviewed as their condition changes Reference for regional strategy From 'Our vision, our health, our North East NHS" (pg. 60): Despite good progress, there remain significant issues to be addressed. The key problem is that, although there is much good practice in the North East, it is not universalised and is too dependent upon which services an individual happens to be involved with. Commissioners also do not recognise the role they need to play in enabling individual end of life preferences to be met. The use of advance care planning is relatively low, being used in less than 10% of cases **Other related Indicators** Transforming Community Services indicator: • Percentage of adults/children with an integrated care plan with the following minimum content (to be defined) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093196.pdf Gold Standard Framework (GSF) Audit Tool – includes measure for: • Proportion of patients offered advance care planning (http://www.goldstandardsframework.nhs.uk/GSFAuditTool/) **For Discussion** Are community service palliative care registers consistently electronic? If so, is the existence of an advanced care plan a field in these systems/ stored in these systems? If not, a manual audit of patient records will be required Definition of advanced care plan: • Who will assess whether ACP in place meets requirements • To include: o Statement of wishes and preferences o Advance decisions to refuse treatment o Date of last review

Percentage of patients 'near to death' on caseload on Liverpool Care Pathway or Equivalent

Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National / Regional indicator	Indicator weighting
	To monitor and measure the percentage of 'near to death' patients that are on the integrated care pathway in order to ensure that all eligible patients are included	Effectiveness Experience	RMC2	Percentage of patients 'near to death' on district nurse and community hospital caseload on Liverpool care pathway or equivalent	Regionally mandated	NA

Goals and indicators

Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National / Regional indicator	Indicator weighting
	To monitor and measure the percentage of 'near to death' patients that are on the integrated care pathway in order to ensure that all eligible patients are included	Effectiveness Experience	RMC2	Percentage of patients 'near to death' on district nurse and community hospital caseload on Liverpool care pathway or equivalent	Regionally mandated	NA

Details of indicators

Description of indicator	Percentage of all 'near to death' patients on the district nurse and community hospital caseload who are also on the Liverpool care pathway or equivalent.
Numerator	Number of 'near to death' patients on a district nurse and community hospital caseload with an integrated care pathway. **Action:** a) Baseline audit (sample to be determined) of case notes of 'near to death' patients on district nurse and community hospital caseload to determine percentage on an integrated care pathway – September 2010 *to be agreed* b) % increase *to be agreed* in the number of 'near to death' patients on a district nurse and community hospital caseload with an integrated care pathway – March 2011 *tba*

Denominator	Total number of 'near to death' patients on the district nurse and community hospital caseload.
Rationale for inclusion	Ensuring that as many as possible 'near to death' patients are on the pathway means that necessary support to patients and family can be provided, and that a more equitable model of care can be provided regardless of setting.
Data source and frequency of collection	District nurse and community hospital caseloads.
Organisation responsible for data collection	County Durham and Darlington Community Health Services
Frequency of reporting to Commissioner	Monthly progress report through the Community Quality Review Group
Baseline period / date	If retrospective data for 2009/10 are available for the integrated care pathways, it is advisable to use that dataset as the baseline.
Baseline value	10%
Final indicator period / date (on which payment is based)	[To be determined by commissioner]
Final indicator value (payment threshold)	[To be determined by commissioner]
Final indicator reporting date	[Insert final reporting indicator date]
Rules for partial achievement of indicator at year-end	[To be determined by commissioner]
Rules for any agreed in-year milestones that result in payment	[To be determined by commissioner]
Rules for delayed achievement against final indicator period/date and/or in-year milestones	[To be determined by commissioner]
Other Information	**Evidence Base** The Liverpool Care Pathway (LCP) is an integrated pathway tool which can be used during the last 72 / 48 hours of life. It provides guidance on the different aspects of care required, including comfort measures, anticipatory prescribing and discontinuation of inappropriate interventions. This Fact Sheet provides an introduction to the key elements involved. (NHS National End of Life Care Programme, October 2009) **Reference within regional strategy** Pages 60-62, Northeast NHS – Our Vision, Our Future strategy **Other related indicators** EL3 and EL5, C4 For discussion Collection methodology for data (patients on ICP)

Appropriate nursing care response time for people on an End of Life Care (EoLC) pathway

Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National / Regional indicator	Indicator weighting
6	Access to practical nursing care within one hour at all times for patients on an EoLC pathway is key to providing improved community services and supporting a greater number of home deaths.	Experience, Effectiveness	RMA2	Practical nursing care response time for people on an EoLC pathway.	Regionally mandated	NA

Goals and indicators

Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National / Regional indicator	Indicator weighting
6	Access to practical nursing care within one hour at all times for patients on an EoLC pathway is key to providing improved community services and supporting a greater number of home deaths.	Experience, Effectiveness	RMA2	Practical nursing care response time for people on an EoLC pathway.	Regionally mandated	NA

Details of indicators

Description of indicator	The percentage of requests for care from patients on an EoLC pathway to receive practical nursing care within one hour of request (at any time of day or night).
Numerator	Number of patients on an EoLC pathway receiving practical nursing care within one hour of a request at any time of the day or night. **Action:** a) Develop data collection process to determine time request for practical nursing care received and response time – September 2010 *tba* b) Carry out baseline audit to determine the number of times patients on an EoLC pathway receives practical nursing care within one hour – December 2010 *tba* c) % increase *tba* in the number of patients on an EoLC pathway who receive practical nursing care within one hour of a request at any time day or night – March 2011 *tba*

Denominator	The total number of times patients on an EoLC pathway requests practical nursing care.
Rationale for inclusion	In-line with improving quality of community services and push towards home deaths, there should be a requirement for a patient on the EoLC to receive practical nursing help within an hour for calling for assistance 24/7.
Data source and frequency of collection	District nurse and community hospital caseload clinical records and SystmOne.
Organisation responsible for data collection	County Durham and Darlington Community Health Services
Frequency of reporting to Commissioner	To be discussed – propose a month-long audit each quarter.
Baseline period / date	To be established - First quarter of data collection.
Baseline value	15%
Final indicator period / date (on which payment is based)	[To be determined by commissioner]
Final indicator value (payment threshold)	[To be determined by commissioner]
Final indicator reporting date	[Insert final indicator reporting date]
Rules for partial achievement of indicator at year-end	[To be determined by commissioner]
Rules for any agreed in-year milestones that result in payment	[To be determined by commissioner]
Rules for delayed achievement against final indicator period/date and/or in-year milestones	[To be determined by commissioner]
Other Information	**Population** All patients on a district nurse and community hospital caseload on an EoLC pathway. All calls for practical nursing care over an established time frame. Practical nursing care is defined as (TBD). Responses to calls by other clinicians will not be included in the numerator. Methods of data collection Concurrent logging of all requests for care from patient population and response times. Case ascertainment All requests for care within identified parameters. Data collection time frame Auditors Local provider staff will collect data. Data quality Each provider will have a designated Lead who will have overall responsibility for data quality from the organisation. **Reference within regional strategy** From NESHA, Our Vision, Our Future (pg 62): We will provide the full range of services to support end of life 24 hours a day, seven days a week, as appropriate to individual need. The commissioning and provision of these services will be built around supporting the end of life model.

	Audit Questions/Fields • Date of initial telephone call to services for practical nursing help (DD/MM/YY) • Time of initial telephone call to services for practical nursing help • Date and time of arrival at patient's home (inc. care home)

Appendix 5

County Durham and Darlington Demographics

NHS County Durham and Darlington commission's services on behalf of nearly 600,000 people.

County Durham is characterised by:

• A population of around 500,700 living in a large area of 862 square miles.

• 56.8% of the population live in urban areas, 33.9% in the rural/urban fringe and 9.3% in strictly rural areas.

• A smaller proportion of black and minority ethnic populations (1%) than in England and Wales (8.7%).

Darlington is characterised by:

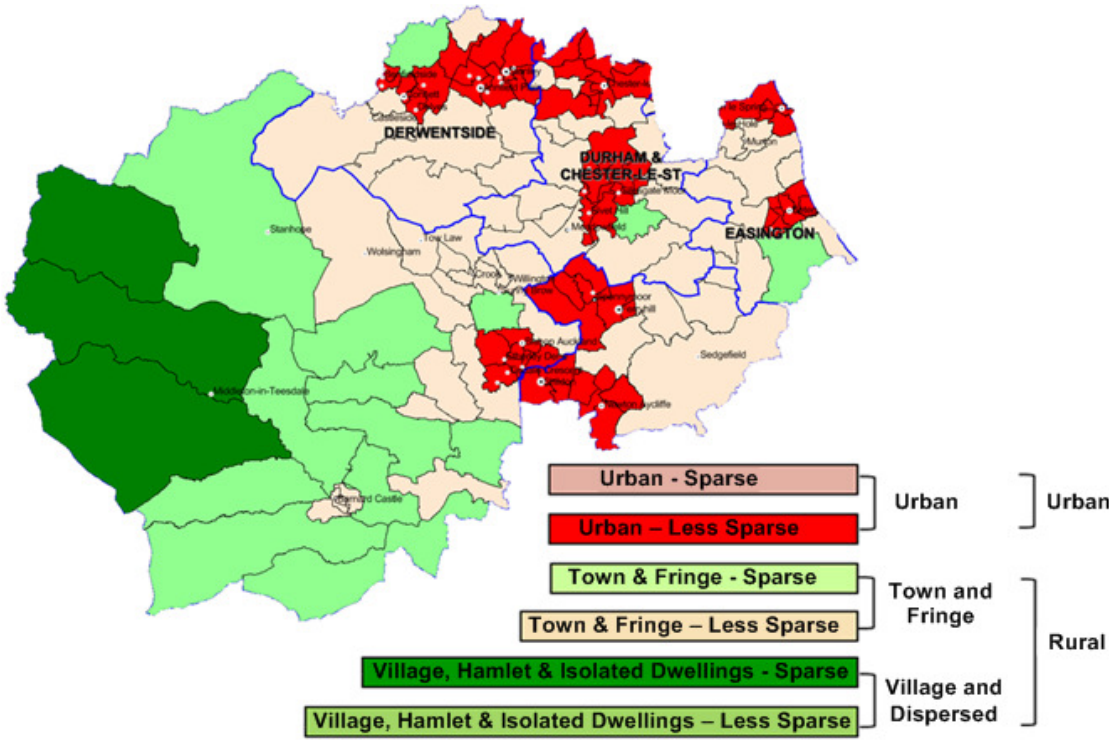
• A population of around 98,600 living in a compact area of 76.2 square miles.

• 88% of the population live in urban areas and 12% live in urban/rural fringe or rural areas.

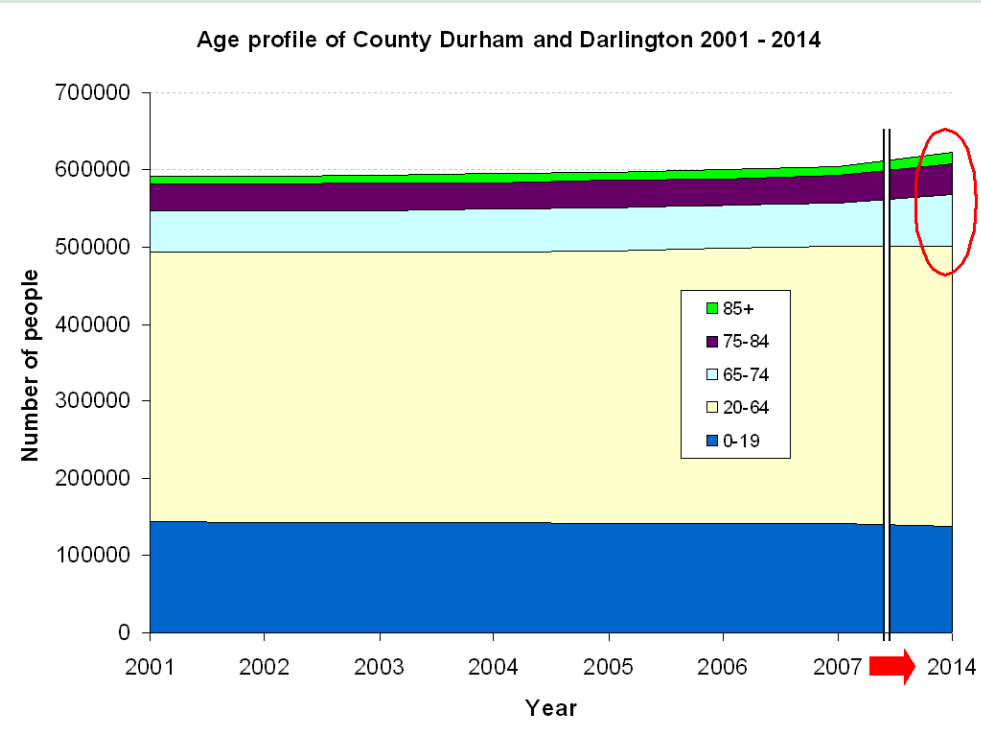
• A smaller proportion of black and minority ethnic populations (2.1%) than in England and Wales (8.7%).

Health inequalities are affected by the socio-economic conditions that exist across County Durham and Darlington 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 or behavioral disorders.

In addition County Durham and Darlington also has significant challenges relating to geography and rurality with issues ranging from transportation and accessibility of services to the use of local facilities. There are also significant pockets of deprivation and disadvantage in our rural areas which are often hidden as inequalities but which manifest themselves very differently to those in the more urban areas.



In common with the rest of the country, County Durham and Darlington's age distribution is becoming older. The numbers of people in the retirement age group are predicted to peak in the year 2037, and the numbers of those aged 85+ will peak in 2056. Within the five year lifetime of the strategy the population will have grown by nearly 18,000 people and the proportion of people over 65 will have risen by over two percent.

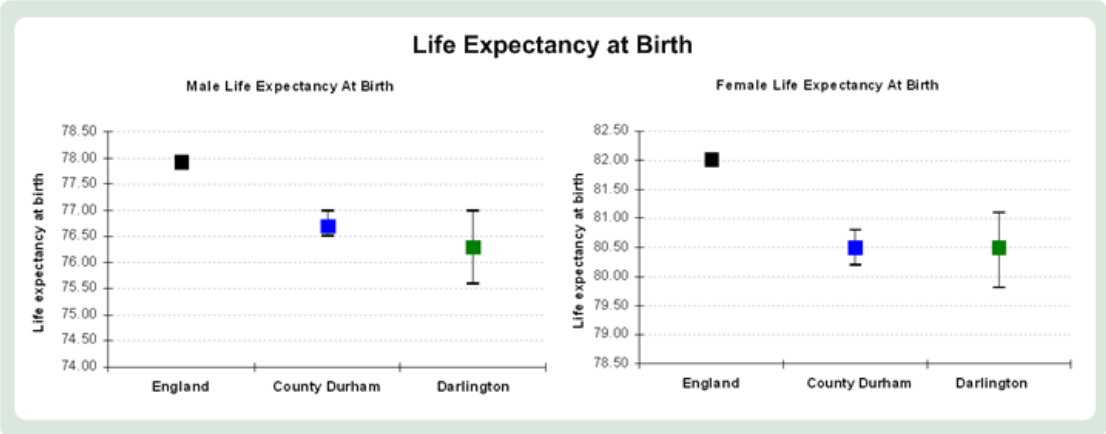


Health need

Life expectancy at birth is a summary measure of all cause mortality that quantifies the differences between areas in unit years of life. It is the average number of years a new-born baby would survive, were he or she to experience the particular area's age-specific mortality rates for that time period throughout his or her life. In using this measure, male and female life expectancy in Durham and Darlington are significantly lower than the national figure.

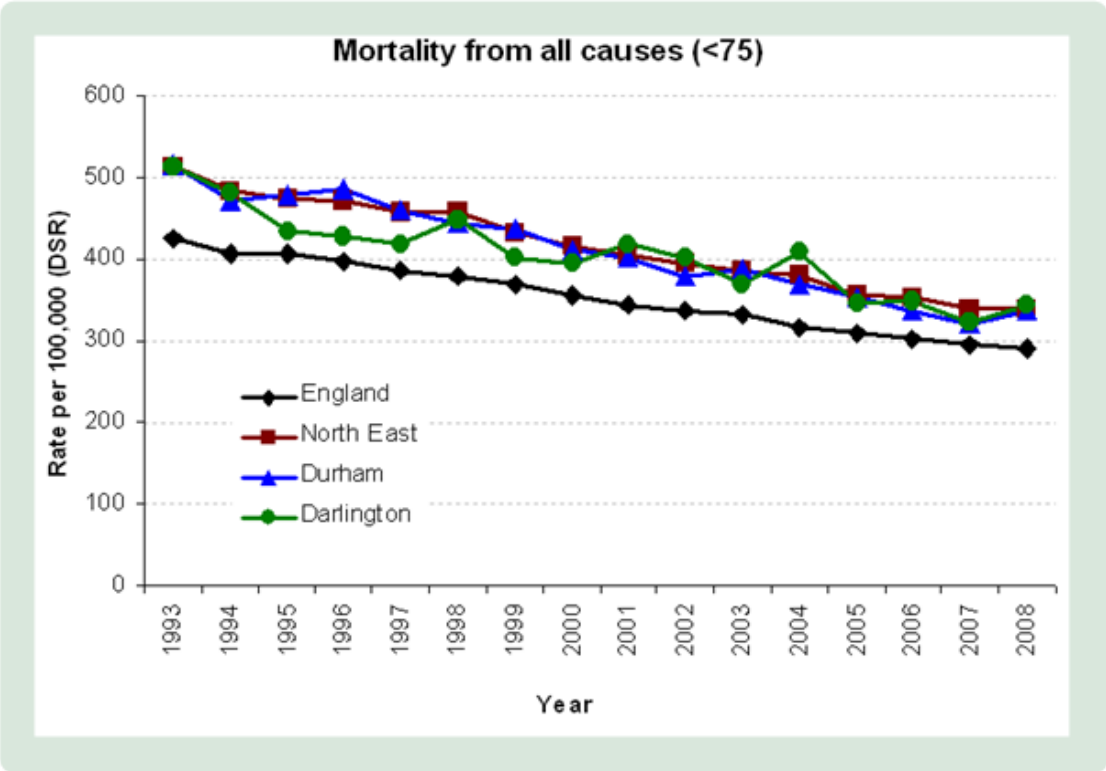
Life expectancy within County Durham and Darlington and the national average

	Male	Female
County Durham	76.70	80.50
Darlington	76.30	80.50
England	77.93	82.02



Life expectancy is considered a valid method of measuring health inequalities at a national level. However, a review by the Department of Health (2006) concluded that as a measure, life expectancy is not well understood and many actions undertaken by local partnerships would not reduce the gap between the fifth worst areas and the national average. In addition to this, there are many complex factors involved in determining how long people live and the long time frames involved in measuring life expectancy. Following the Department of Health review, all age all cause mortality (AAACM) was introduced to make the process of narrowing the life expectancy gap and performance

management more relevant at local levels. AAACM correlates break down mortality rates into the ages and causes of death at local authority level and allows planners of services to understand the main health issues.



The following charts are taken from the national 2009 Community Health Profiles for County Durham and Darlington. They show how the population's health compares to the rest of England. The local result for each indicator is shown as a circle against a range of results for England which is shown as a bar.

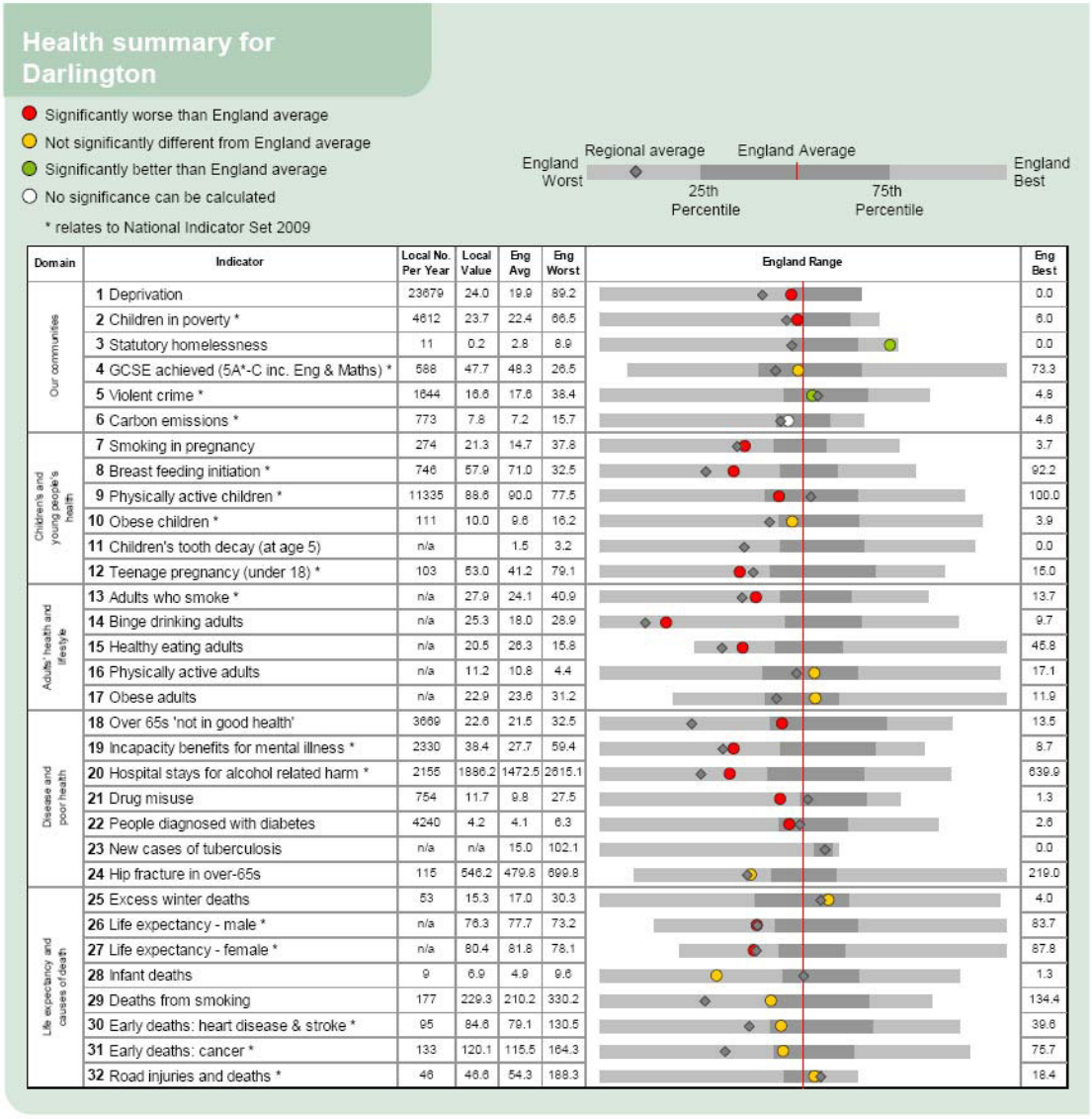
Health summary for County Durham

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

* relates to National Indicator Set 2009

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	154158	31.0	19.9	89.2		0.0
	2 Children in poverty *	21451	23.7	22.4	66.5		6.0
	3 Statutory homelessness	615	2.7	2.8	8.9		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths) *	2791	44.5	48.3	26.5		73.3
	5 Violent crime *	6981	14.0	17.6	38.4		4.8
	6 Carbon emissions *	3482	7.0	7.2	15.7		4.6
Children's and young people's health	7 Smoking in pregnancy	1250	22.5	14.7	37.8		3.7
	8 Breast feeding initiation *	2930	52.9	71.0	32.5		92.2
	9 Physically active children *	54929	90.8	90.0	77.5		100.0
	10 Obese children *	460	9.6	9.6	16.2		3.9
	11 Children's tooth decay (at age 5)	n/a		1.5	3.2		0.0
	12 Teenage pregnancy (under 18) *	455	48.6	41.2	79.1		15.0
Adults' health and lifestyle	13 Adults who smoke *	n/a	24.5	24.1	40.9		13.7
	14 Binge drinking adults	n/a	23.8	18.0	28.9		9.7
	15 Healthy eating adults	n/a	21.0	26.3	15.8		45.8
	16 Physically active adults	n/a	11.1	10.8	4.4		17.1
	17 Obese adults	n/a	25.3	23.6	31.2		11.9
Disease and poor health	18 Over 65s 'not in good health'	23629	29.8	21.5	32.5		13.5
	19 Incapacity benefits for mental illness *	13360	42.6	27.7	59.4		8.7
	20 Hospital stays for alcohol related harm *	10635	1789.2	1472.5	2615.1		639.9
	21 Drug misuse	2114	6.4	9.8	27.5		1.3
	22 People diagnosed with diabetes	20120	4.0	4.1	6.3		2.6
	23 New cases of tuberculosis	18	3.6	15.0	102.1		0.0
	24 Hip fracture in over-65s	560	544.3	479.8	699.8		219.0
Life expectancy and causes of death	25 Excess winter deaths	345	20.5	17.0	30.3		4.0
	26 Life expectancy - male *	n/a	76.5	77.7	73.2		83.7
	27 Life expectancy - female *	n/a	80.2	81.8	78.1		87.8
	28 Infant deaths	29	5.4	4.9	9.6		1.3
	29 Deaths from smoking	1072	274.6	210.2	330.2		134.4
	30 Early deaths: heart disease & stroke *	554	92.5	79.1	130.5		39.6
	31 Early deaths: cancer *	774	131.6	115.5	164.3		75.7
	32 Road injuries and deaths *	227	45.5	54.3	188.3		18.4

Community Health Profile 2009 for County Durham



Health summary for Darlington

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

* relates to National Indicator Set 2009

England Worst | Regional average | England Average | England Best | 25th Percentile | 75th Percentile

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	23679	24.0	19.9	89.2		0.0
	2 Children in poverty *	4612	23.7	22.4	66.5		6.0
	3 Statutory homelessness	11	0.2	2.8	8.9		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths) *	588	47.7	48.3	26.5		73.3
	5 Violent crime *	1644	16.6	17.6	38.4		4.8
	6 Carbon emissions *	773	7.8	7.2	15.7		4.6
Children's and young people's health	7 Smoking in pregnancy	274	21.3	14.7	37.8		3.7
	8 Breast feeding initiation *	746	57.9	71.0	32.5		92.2
	9 Physically active children *	11335	88.6	90.0	77.5		100.0
	10 Obese children *	111	10.0	9.6	16.2		3.9
	11 Children's tooth decay (at age 5)	n/a		1.5	3.2		0.0
	12 Teenage pregnancy (under 18) *	103	53.0	41.2	79.1		15.0
Adults health and lifestyle	13 Adults who smoke *	n/a	27.9	24.1	40.9		13.7
	14 Binge drinking adults	n/a	25.3	18.0	28.9		9.7
	15 Healthy eating adults	n/a	20.5	26.3	15.8		45.8
	16 Physically active adults	n/a	11.2	10.8	4.4		17.1
	17 Obese adults	n/a	22.9	23.6	31.2		11.9
Disease and poor health	18 Over 65s 'not in good health'	3669	22.6	21.5	32.5		13.5
	19 Incapacity benefits for mental illness *	2330	38.4	27.7	59.4		8.7
	20 Hospital stays for alcohol related harm *	2155	1886.2	1472.5	2615.1		639.9
	21 Drug misuse	754	11.7	9.8	27.5		1.3
	22 People diagnosed with diabetes	4240	4.2	4.1	6.3		2.6
	23 New cases of tuberculosis	n/a	n/a	15.0	102.1		0.0
	24 Hip fracture in over-65s	115	546.2	479.8	699.8		219.0
Life expectancy and causes of death	25 Excess winter deaths	53	15.3	17.0	30.3		4.0
	26 Life expectancy - male *	n/a	76.3	77.7	73.2		83.7
	27 Life expectancy - female *	n/a	80.4	81.8	78.1		87.8
	28 Infant deaths	9	6.9	4.9	9.6		1.3
	29 Deaths from smoking	177	229.3	210.2	330.2		134.4
	30 Early deaths: heart disease & stroke *	95	84.6	79.1	130.5		39.6
	31 Early deaths: cancer *	133	120.1	115.5	164.3		75.7
	32 Road injuries and deaths *	46	46.6	54.3	188.3		18.4

Community Health Profile 2009 for Darlington

Appendix 6

Prison Health

Older prisoners aged over 55 years within North East Prisons identified during older prisoner review September to November 2009.

Name of Prison	Total operational capacity of establishment.	Number of older prisoners 55+ years identified during review	Older prisoners as % of total population.

		visits.	
HMP Acklington	1000	181	18.1%
HMP Holme House	994	73	7.3%
HMP Durham	981	*39*	*3.9%*
HMP Low Newton	215	22	10.2%
HMP Kirklevington	283	24	8.4%
HMP Frankland	734	111	15%
Total	**4207**	**450**	**10.6%**

Source- Prison staff interviews.Oct.-Dec.2009

Description of Prisons

HMP. Acklington

HMP Acklington is a former RAF station in Northumberland which was opened as a prison in 1972. The prison accommodates approximately 1,000 prisoners, 500 of whom are Vulnerable Prisoners accommodated within the Vulnerable Prisoner units.

Reception *Criteria:*
Category C Sentence – any Lifers as allocated by Lifer Management Unit.

As a designated training prison the vulnerable prisoner unit accommodates a significant number of prisoners convicted for sexual offences. This is reflected by the number and location of older prisoners within the establishment.

Age and location of older prisoners within HMP Acklington on 18/9/09

Age	Main wings	V/prisoners	Total
50-59 years	11	91	102
60-69 years	5	58	63
70-79 years	0	15	15
80+	0	1	1
Total	**16**	**165**	**181**

Source: Interview with G Harland, Principle Officer Vulnerable Prisoner Unit.

The prison offers a range of purposeful activities spread across the spacious site.

Accommodation is provided within 10 living units of varied age and design.

The healthcare department offers and is supported by a full range of primary healthcare services. However it does not have any 24 hour inpatient facility. As a consequence prisoners requiring care move to local NHS or other prison facilities.

HMP Low Newton

Low Newton is situated approximately 4 miles south west of Durham, and was purpose-built as a Remand Centre in 1965. Additional accommodation was provided in 1975 providing a Certified Normal Accommodation of 215.

Until September 1998, Low Newton accommodated both male and female young persons and adult women. It is now an all female prison serving the courts in the catchment area from the Scottish Borders to North Yorkshire across to North Cumbria.

Reception *Criteria:*

All remand females aged 18 and over are held (apart from Category A prisoners) and all sentenced female prisoners 18 or over can serve out their sentence, including lifers.

Of the 22 women over 50 years of age on 22/9/09, there were 9 prisoners serving a life sentence.

Age and location of older prisoners within HMP Low Newton as of 22/9/09.

Age	**Main wings**
50-59 years	20
60-69 years	2
70-79 years	0
80+	0
Total	**22**

Source: Interview with healthcare manager.

Within the health care centre HMP Low Newton provides a 24 hour staffed inpatient unit. There are a total 5 cells for inpatients on the ground floor. Two of these have CCTV for constant observation and are used for mental health needs. The remaining 3 cells on ground floor are available for other needs. The ground floor cells are located within a busy clinic area and in the absence of a chair lift the 1st floor association area is not accessible for inpatients with a mobility problem.

HMP Frankland

Frankland is located in Brasside, Durham next to HMP Low Newton.

Reception Criteria: Category A and B adult Males serving 4 years and over IPP or Life sentences

High and Standard Risk category A remands.

Age and location of older prisoners within HMP Frankland as at 4/12/09

Age	Number of prisoners
55-60 years	49
60-69 years	54
70-79 years	7
Over 80 years	1
Total prisoners over 55 years	**111**

Location	Number of prisoners aged over 55 years
B1 Specific needs unit	20
Other ground floor landings	23
Upper landings	58

Source: Interviews with healthcare officers.

HMP Durham

Durham was built in the early 19th Century and is the oldest prison in the North East of England. It has been undergoing a major refurbishment programme during the last 10 years.

The prison accommodates approximately 981 prisoners from local courts and receives up to 50 new prisoners a day. Prisoners are accommodated within 6 residential units and a busy first night centre.

Reception Criteria:

Category B, serving the courts in the area and receiving sentenced, convicted and remand males over 21 from Tyneside and Cumbria.

As of 12 November 2009 the total prison population within HMP Durham was 969.

Identified older prisoners within HMP Durham on 12/11/09

Age	Number
41years to 55 years	118
55 years to 65 years	32
65+ years	7
Total	157

Source; Interview with B. Lowson Health and Safety Liaison lead.

Healthcare is provided 24 hours per day. A range of primary care services are provided from within the health care centre. In addition there is a 20 bed inpatient unit, but as it contains some double cells there are usually only 16 inpatients. Although over 2 floors there is a chairlift and association facilities are accessible.
The prison regime includes both full and part time education facilities, workshops offering both production and training.

HMP Holme House
Holme House is a purpose built Category B local prison, which opened in May 1992. The prison primarily serves the communities of Tees Valley, South West Durham, East Durham and North Yorkshire.
Reception Criteria
Unconvicted and convicted male adult prisoners
Unconvicted male young adults.
As of November 2009 prison accommodates approximately 994 prisoners within 3 storey house-blocks. The majority of this accommodation is in shared cells with bunk beds and with stairs to the server.
A further house- block is scheduled to open in March 2010.The new block will have a total of 180 beds with 8 cells designated for people with disabilities.

Identified older prisoners within Holme House on 19/11/09.

Age	No.
50-60 years	42
61-70 years	21
71-80	6
80+ years	4
Total	**73**

The older prisoners represent a small minority of the overall population within Holme House.
Healthcare is available 24/7. The healthcare centre provides a full range of primary care services. In addition there are 28 inpatient beds, the majority of which are used by prisoners with mental health and/or substance misuse issues. Significant numbers of Holme House prisoners are receiving methadone treatment for their substance misuse issues under the Integrated Drug treatment System (IDTS). This is perceived by prisoners, governors and healthcare staff to have a negative impact on the experience of older prisoners within Holme House.

HMP Kirklevington Grange
Kirklevington Grange is a resettlement prison for adult male offenders intending to resettle in the North East of England on release. The catchment area covers Carlisle to Leeds. Prisoners have single rooms with fitted storage cupboards. All rooms have privacy locks, prisoners having their own key.
Reception Criteria
There is an extensive application process for prisoners who should be Category C or D.
Lifers are accepted on allocation following parole board review for open conditions. Determinate sentence prisoners should have a minimum of 8 months and a maximum of 36 months left to serve.
All applicants must demonstrate the following:
- Evidence of a desire to change

- Evidence of a need of a resettlement regime
- Evidence that they are a manageable risk when granted temporary release

After induction and a thorough assessment (OAsys) prisoners are granted temporary licence to enable access to services and employment within the local community. Consequently the healthcare facility offers primary care as a GP practice. Any prisoner requiring healthcare input 24/7 would transfer to another prison. Notwithstanding the absence of 24 hour health care at Kirklevington Grange 8% of prisoners were over 50 years of age on 25/11/09, the oldest being 68 years of age.
Identified older prisoners at HMP Kirklevington Grange on 25/11/2009

Age	Number
50-59 years	18
60-69 years	7
Total	**24**

Source Interview with D. Ryan, Healthcare Manager.

Appendix 7

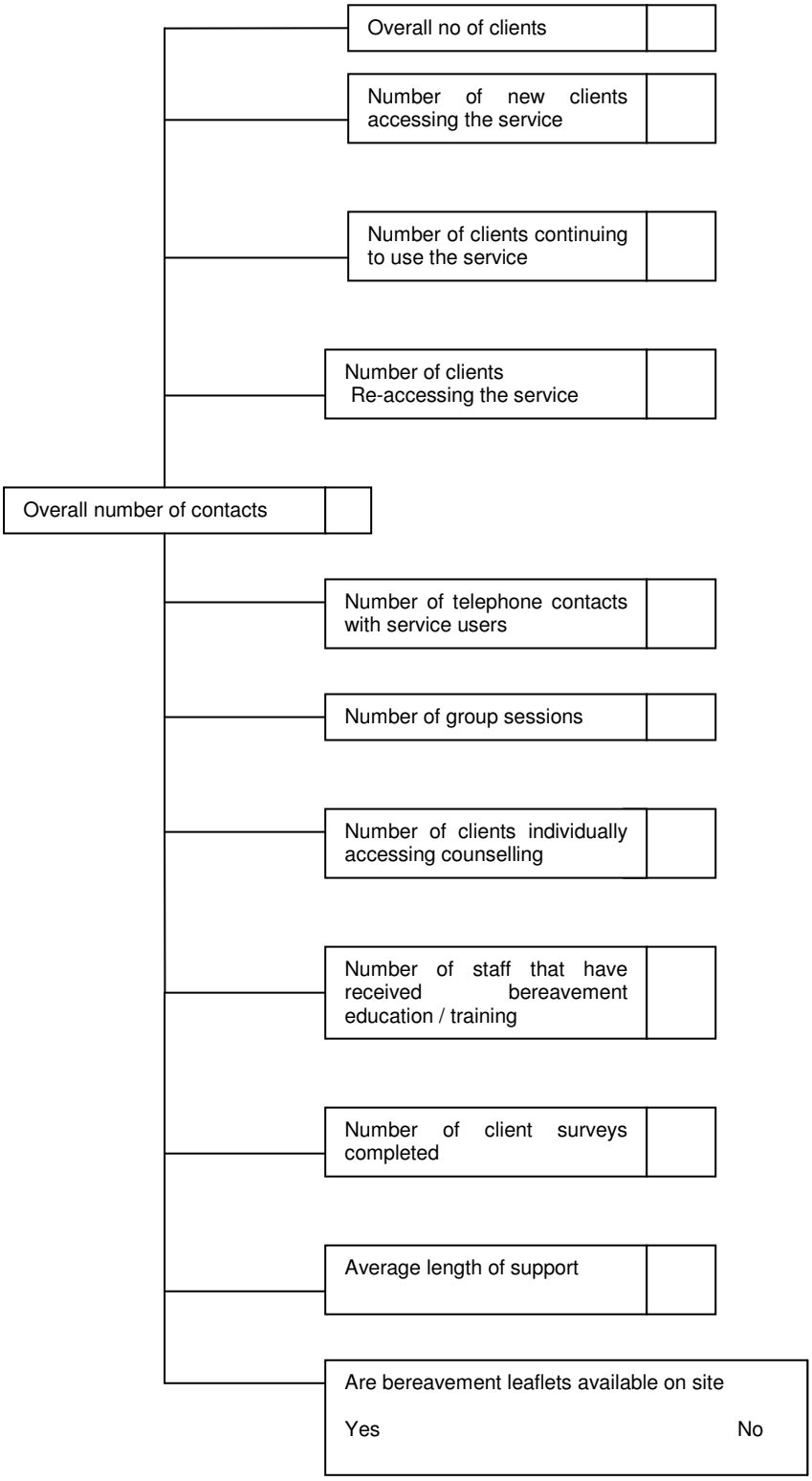
Proposed draft Action Plan (actions to be agreed, tasks, costs, responsibilities and timescales to be determined by Strategy Implementation Group)

Strategic Priority	Action	Tasks	Resp. Org.	Time-scales
Robust palliative care register	To create an inclusive register to ensure that patients needing support will be known to providers and that this is the default baseline on whether preferred place of care is realised.			March 2011
Roll out training for GP;s	Training package,s will be offered by Royal College of GPs, tailored to local needs			
Deliver public awareness events	The results from the public consultations will provide the PCT with an understanding of what the public's expectation is of a 'good death' and that services can be redesigned to ensure they are fit for purpose			Nov 2010
Review national data in August 2010 from the Marie Curie Coordinating centre model in Lincoln	Gathering the data from Lincoln will give the PCT necessary information and merits of replicating a similar model in County Durham and Darlington.			Aug 2010
Run localised pilots working with all providers to review the role of localised coordination centres.	To look at how the single point of access Urgent Care Communication Centre can provide patient care, how care is coordinated across boundaries and how it can provide an electronic system of coordinating patient data. Link local care homes with appropriate			March 2011

	hospices which will allow access to palliative care specialists who can offer advice information and support for care home staff, this could lead to less inappropriate referrals to acute settings.			
Use levers in current contracts and CQUIN to drive efficiency in utilisation of all current contracts.	Through the use of CQUIN and contract management short term efficiencies should be achievable			
Increase in patient numbers in obtaining preferred place of death	To increase in patients who obtain preferred place of care to 98%			2015
Increase in patients on a palliative care register	To increase patients on a palliative care register to 98%			2015
Increase the number of patients who have a advanced care plan	To have 98% of patients with an advanced care plan			2015
To implement the COIN network across the 4 Hospice sites	To enable the 4 hospices to provide information regarding hospice utilisation			March 2011
To Implement 1st phase of the 24/7 model of care	There are gaps within the current workforce and this will be the first phase in introducing 24/7 care across County Durham and Darlington.			March 2010
To Implement the 2nd phase of the 24/7 model of care	To implement the 2nd phase of 24/7 care across County Durham and Darlington			March 2012
To Implement the 3rd phase of the 24/7 model of care	To implement the 3rd phase of 24/7 care across County Durham and Darlington			March 2013

Appendix 8

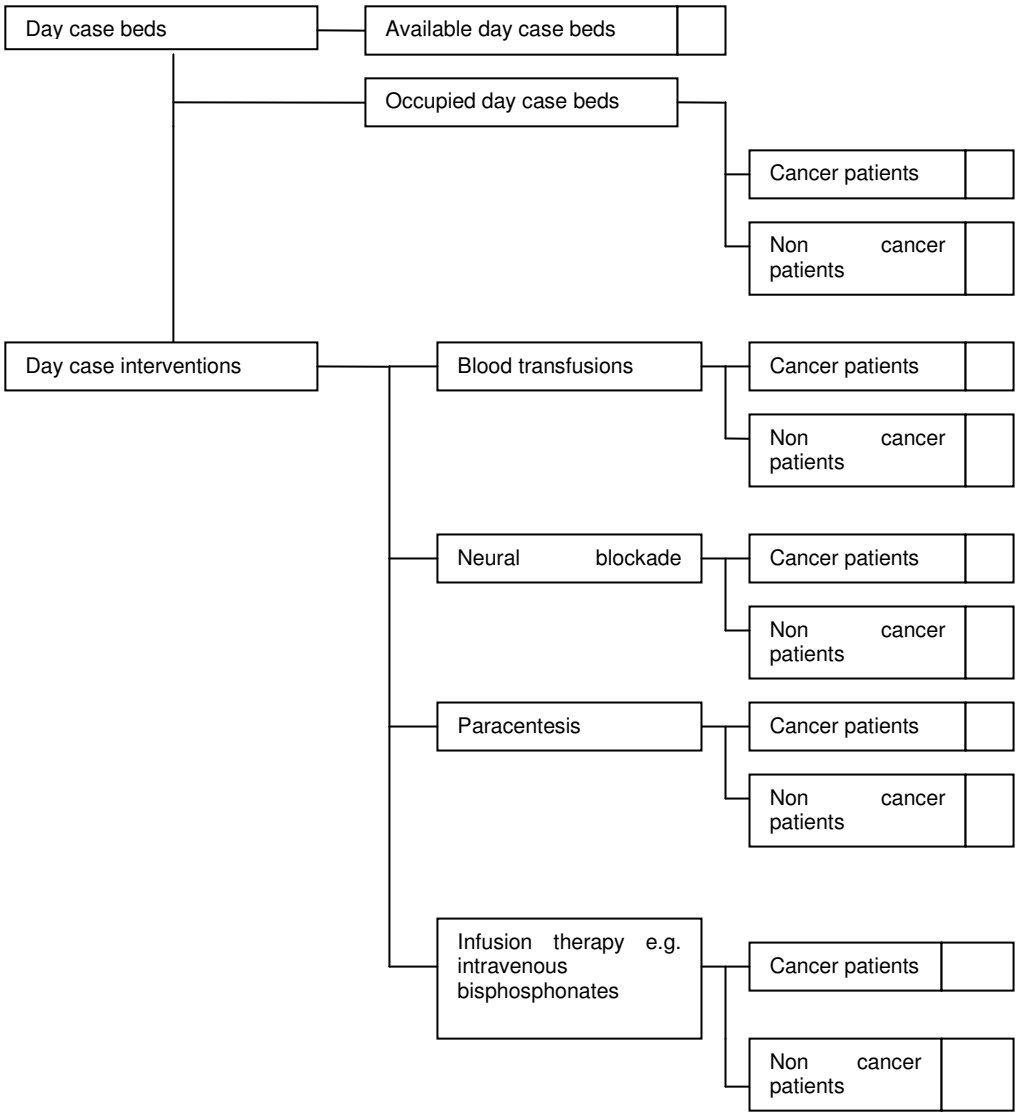
Performance indicators for Bereavement Services



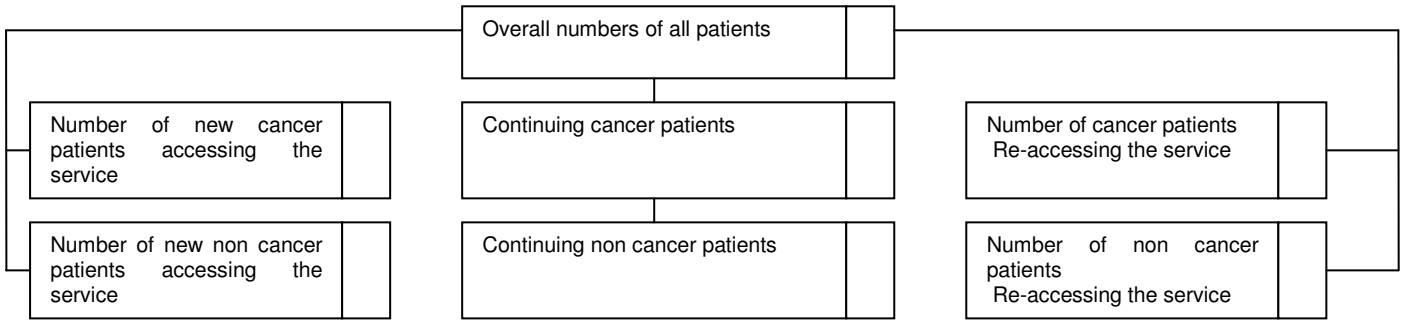
Performance indicators for length of stay in inpatient service

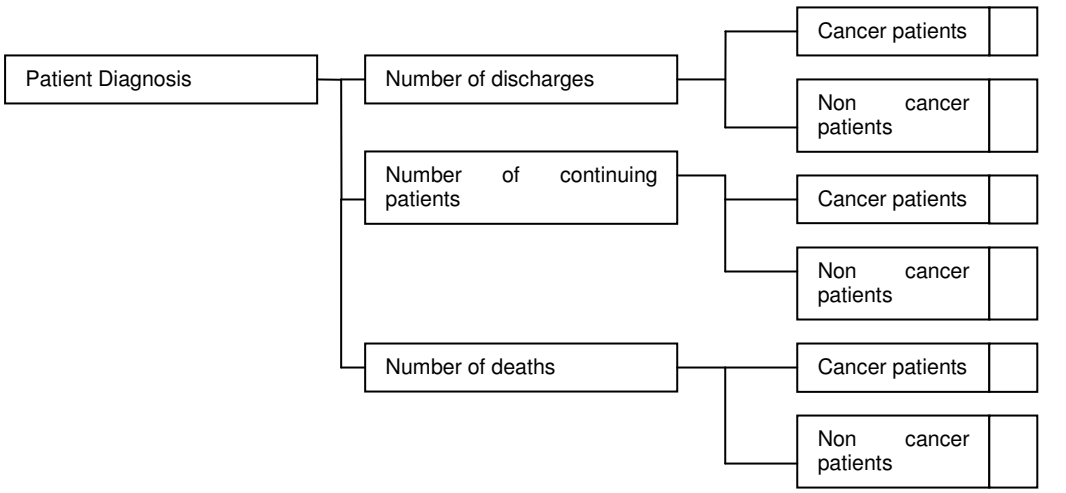
Length of stay	Cancer patients	Non cancer patients	All patients
1 to 4 days			
5 to 8 days			
9 to 14 days			
15 to 21 days			
22 to 28 days			
29 to 42 days			
43 to 84 days			
85 and over			
Average length of stay			
Long stay patients who were in the in patient unit throughout the year			

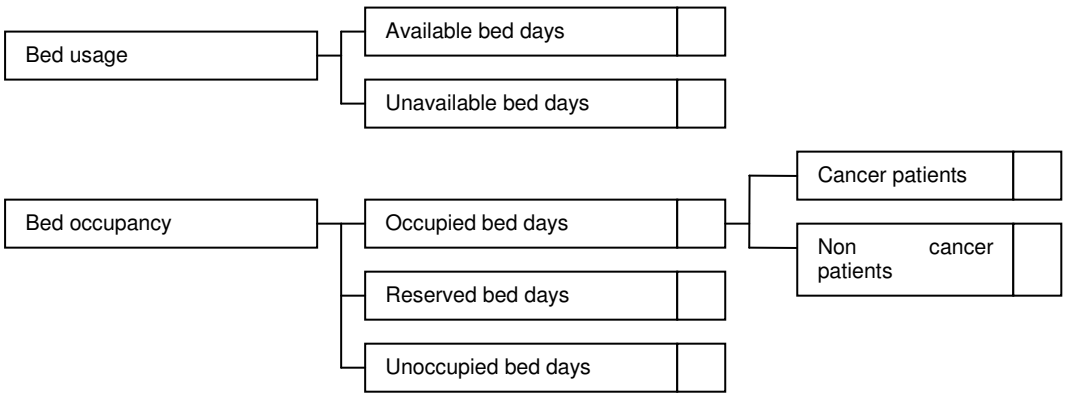
Performance Indicators for the inpatient service



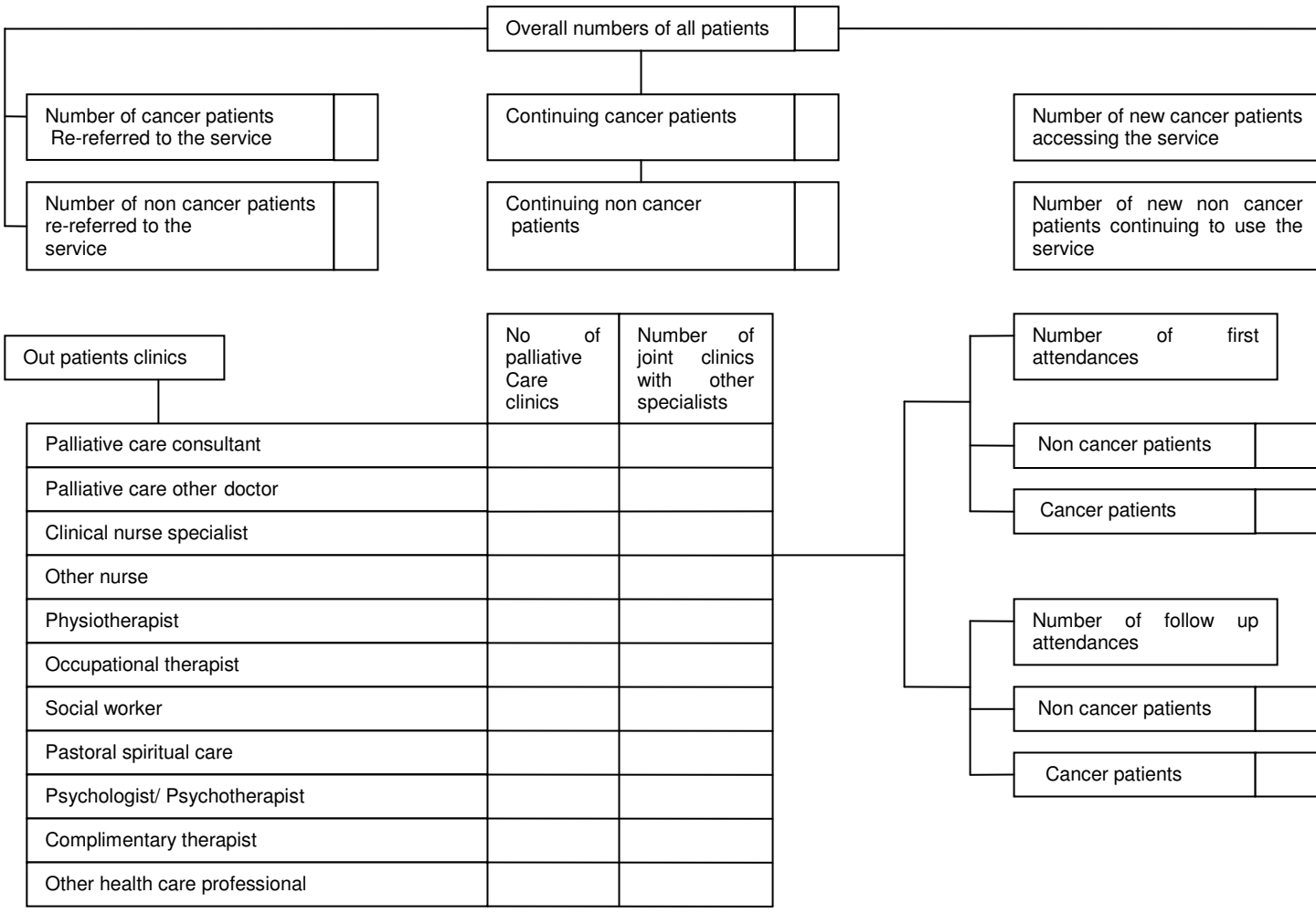
Performance indicators for inpatient services







Performance indicators for out patient service



Performance Indicators for the out patient service