The Integrated County Durham & Darlington NHS Foundation Trust:

Delivering excellent care and support to patients at home, in the community and in hospital - first time, every time.

1.0 Introduction

The aim of this paper is to set out the case for a broad discussion on health care provision in County Durham and Darlington and our options for reconfiguring hospital and community services locally.

1.1 Background

County Durham and Darlington Foundation Trust (CDDFT) is the preferred management partner for County Durham and Darlington Community Health Services (CDDCHS). Subject to due diligence, this will create an integrated acute and community foundation trust serving our local community from April 2011.

The scale and scope of the newly formed integrated FT from 1st April 2011 will offer tremendous opportunities for clinical teams to work together in radically different ways. National and regional changes in workforce and care standards mean we need to consider how further improvements in specialist hospital care can be delivered.

CDDFT is a top performing organisation having successfully delivered a complex and demanding agenda over the last few years. Our ambition for the next 3-5 years is to further build and improve on this success by continuing to enhance our regional and national reputation for excellence. To do this we will need to innovate constantly in order to guarantee the delivery of high quality patient services with the best possible clinical outcomes at the lowest possible cost. This will mean leaner services and a stronger focus on improving clinical processes across the whole of the patient pathway so that services become even more accessible 24/7.

Over the next 18 months we intend to establish the Foundation Trust as a leading edge integrated care provider. This will create even greater opportunities to improve the experience of patients and outcomes; by shifting care closer to home.
These developments will be taking shape against the backdrop of the radical changes being introduced by the Coalition Government and in the most challenging of economic circumstances for more than a decade.

CDDFT and CDDCHS agree that the new organisation requires a new clinical strategy, to make sure we seize the opportunity to improve patient experience and outcomes, and this discussion document is the first step in this process.

1.2 Stakeholder Engagement
We want to engage our stakeholders in developing our clinical strategy, including:

- Our present commissioners – the Primary Care Trusts
- Our future commissioners – the GP consortia/PBC groups
- Care partners in Durham County and Darlington Borough Councils
- Our community – represented by our Governors, LINKs and the Overview and Scrutiny Committees

This will help ensure that we meet the Government’s four tests for assessing plans for future service changes:

- Support from GP commissioners
- Strengthened patient and public engagement
- Clear clinical evidence
- Consistent with promoting patient choice

We would welcome your thoughts and comments on this discussion paper – see Section 7.1 “Your Views”.
2.0 Our Vision

CDDFT and CDDCHS see the creation of a new integrated provider as an opportunity to:

“shift the centre of gravity from hospital to community and develop fully integrated care pathways”.

We want our clinical teams to be the first choice for patients, and to provide a service which embraces the principle of “no decision about me without me”.

Our principal target outcomes are:

- The best health outcomes for patients
- An excellent patient experience
- High quality, low cost services for commissioners

Our vision for the future integrated FT is:

- To be the premier provider of healthcare in County Durham and Darlington including:
  - Prevention and enablement
  - Community Services
  - Planned and emergency hospital care
- To be a major provider of women’s and children’s services in the North East
- To build on our reputation for excellent specialist services including:
  - Plastic surgery
  - Dermatology
  - Colorectal surgery and bowel function
  - Cardiology
  - Rehabilitation
  - Long term conditions
- To develop a national profile as a pathfinder for new ways of offering health services in hospital, home and community, supporting the development of social enterprise approaches as a key part of future care provision.

3.0 Clinical strategy - priority areas for discussion

We have identified six priority areas for discussion which are central to our clinical strategy, or have an important influence upon it:

- Prevention first
- Community services
- Acute care
- Workforce
- Estates
- Economics
3.1 Prevention first

The integrated FT will, as part of its core offer, put prevention first to support health improvement.

CDDCHS has a dedicated Health Improvement Service that has developed the “Prevention First” strategy for 2010-14 to provide dedicated health improvement services and to integrate preventative solutions into all clinical areas and pathways. The strategy involves a preventative approach to improve the well being of communities and key vulnerable groups, addresses the growing demands for clinical health care in an ageing population and looks to avoid the need for clinical interventions.

**Prevention First strategy**

The strategic imperatives are to:

- Undertake health monitoring – recognising, anticipating and responding to the changing health needs of the local population. For example, in respiratory disease and cardiovascular disease.
- Foster strategic partnerships – working with partners to tackle the preventative agenda and share responsibility for local wellbeing including adult obesity.
- Implement social marketing – utilising marketing techniques in order to influence and achieve specific, sustainable behavioural change. This will include the establishment of a musculoskeletal single point of access service.
- Embed prevention in care pathways – ensuring that all contacts with the local NHS offer appropriate opportunity to promote better lifestyle choices; for example in atrial fibrillation and heart failure rehabilitation.
- Deliver innovative prevention services – creating a portfolio of preventative healthcare services to deliver improved health outcomes.
- Reduce health inequalities – supporting disadvantaged and vulnerable groups to ensure equality of access to prevention services including the establishment of custody suite health services and end of life care in prisons.

CDDFT is the first World Health Organisation Health Promoting Hospital in the North East; supported by an action plan for extending health improvement activity in the Trust.

Clinical staff from both the acute and community services will play a key role in delivering the prevention first strategy through interventions embedded in the integrated care pathway.

3.2 Community services

We plan to take full advantage of the opportunities of integrating acute and community services, to shift services out of hospital and closer to people’s homes.

Over the next three years, we expect to move a significant proportion of outpatient clinics out of acute hospitals so that at least 50% are provided in community based settings.

We have identified initial services which we expect to move out of hospital. These include:

- Long term conditions
- Older people’s services
- Urgent care
- Child Health
- End of life care

Integration of acute and community services will remove organisational barriers to seamless care pathways and will encourage integration between clinical colleagues in primary and secondary care.

Our local network of community hospitals has seen significant investment over the last ten years. They present an excellent opportunity for development as strategic community hubs, providing a range of locally accessible services, but each will also offer its own distinct services or will host services provided by other organisations.

These will include other NHS organisations, local authorities, third sector, or other interested providers.

For our main population areas we would look to develop Darlington, Durham and Bishop Auckland hospitals as strategic community hubs, alongside their other services.
Part of our strategy will be to encourage the entry of social enterprise organisations into the health pathway. Social enterprise organisations can make an important contribution, not least because of their detailed understanding of the views and experience of service users.

These may be existing charities and voluntary sector, or, where this makes sense, groups of healthcare staff setting up their own social enterprises where they believe a service can be provided more effectively outside the traditional NHS environment, and where patients support this.

The integrated FT could offer social enterprises business and corporate support where they align with local strategies for health services.

3.3 Acute care

3.3.1 24/7 services

When people need hospital care, we want to provide patients with high quality care from the right person, at the right place, at the right time.

Our current acute model operates around the needs of the service, rather than the needs of the patient. We have begun to explore approaches to move from an office hours model to a true 24/7 service.

This includes:

- Developing cost effective medical rotas that allow consultant delivered care 24 hours per day 7 days per week accepting the need for a transition phase towards full implementation
- Developing support services that deliver 24hrs 7 days per week in place of the current 9-5 model
- Aligning the hours of community services staff with hospital service delivery times to ensure support for discharge from acute service settings
- Developing new roles for clinical staff. Utilising and maximising the skills of specialist nurses and allied health professionals
• Making technology work for clinical teams and support patient care by exploring telemedicine, point of care testing, blood pressure monitoring and other innovative technological solutions including mobile working based around electronic records on laptop systems where appropriate.
• Considering physiology based clinical structures which will effectively support integration of clinical pathways across primary and secondary care

Delivering a 24/7 service will mean huge changes for staff and for our whole approach to acute services.

3.3.2 Reducing reliance on hospital beds

We know that there are patients in hospital who could be treated in other settings, if services were designed around their needs.

Across the North East there is too much reliance on acute hospital beds for the provision of healthcare. Based on quarter 1 data from 2010/11, the NHS Institute for Innovation and Improvement’s Better Care, Better Value indicators estimate that the Trust could save over £2m by reducing excess length of stay to within top 25th percentile; the Trust's strategy is to achieve top 10th percentile performance. This money could be better used in other areas of the health and social care pathway.

Shifting care out of hospital will also result in a reduction of the acute hospital “footprint”. We expect that, in three years time, we will be operating with 300 fewer acute beds than in 2009/10, including the reduction of 100 beds in this current financial year.

The key to addressing this challenge is to develop alternative services outside of hospital and CDDFT and CHS are already working to improve efficiency in the acute pathway:

• Reducing avoidable admissions
Since the introduction of RAMAC (rapid access medical assessment clinics) at Bishop Auckland, Darlington and Durham, the Trust has reduced avoidable admissions into acute inpatient beds.

We want to make further progress along the patient pathway using similar approaches that move care closer to home or seek alternatives to hospital admission in line with Transforming Community Services.

• Reducing delays during the pathway
Patients can experience delays - especially out of hours and during weekends - which may lengthen their stay unnecessarily as a result of:
  - Unavailability of diagnostic tests
  - Waiting to see the appropriate specialist
  - Delays in obtaining medicines

We want to address these and other areas to improve the patient pathway, reduce delays and contribute to a reduction in length of stay.
• **Reducing lengths of stay and discharge delays**
  There is a clear opportunity to reduce length of stay and improve the discharge process through a joint acute and community approach involving the integrated teams and better use of intermediate care. A joint working group has already been established to develop the concept of ‘Hospital at Home’ and the virtual ward.

3.4 Workforce

Our staff are our most important asset and there is a bright future for enthusiastic and committed people from across the professions.

Integration of services, more flexible pathways between hospital and community and developing roles for specialist nurses and allied health professionals present new opportunities.

Changes in training will result in fewer junior medical staff within acute services, and more in the community, which will mean redesigned roles for other healthcare staff and a new dynamic between the professions. Both organisations have a workforce profile that shows that there are key clinical staff that are due to retire in the next 5 years.

We want to attract and retain the best staff. The Trust has a long standing commitment to upgrading its educational facilities and attracting training recognition. Educational facilities must be of the highest possible standards and include simulated learning facilities as standard.

Involving staff in developing extended working weeks and more flexible working is also key to meeting the efficiency, productivity and quality challenges.

Although we expect a smaller workforce in future, we will continue to need it to be highly skilled and motivated to provide the best care for patients.

The integration of CDDFT and CDDCHS will allow us to make efficiencies in back office functions of around 20%, helping us protect frontline services.

Overall, we expect workforce could reduce by at least 10% over the next three years, mostly through natural turnover, which is currently 10% per year.

3.5 Estates

With the Foundation Trust currently operating out of five sites and the Community Health Services operating out of over 80 sites there is a clear requirement to rationalise our estate, whilst ensuring that the best use is made out of new and modernised facilities.

We have set the following targets for the physical condition of the acute estate by 2014:
- A minimum of 80% will be condition B (in sound condition) or better
- A maximum of 20% will be condition C (major repairs in 3 years)
• None of the estate will be condition D (imminent breakdown) or X (demolish)
• A reduction of 15% of the Trust’s asset base by area

Although much of the acute and community hospital estate is new, there are significant estate issues to address at Darlington Memorial Hospital and numerous poor quality community staff bases and service delivery points which will need rationalisation and disposal.

The Trust is investing £26 million to secure the infrastructure of Darlington Memorial Hospital and there is a further £30.5 million in backlog maintenance required.

The estates strategy must be aligned with the clinical vision of a shift of care out of hospital, including the development of our community hospitals as strategic hubs for services in our localities, and the resulting reduction in the acute footprint.

3.6 Economics

Our clinical strategy will be developed and implemented during a period of exceptional financial pressure and change for the NHS. It must be both effective and affordable.

This decade is likely to be the most challenging that the public sector has faced to date. Health and social care organisations will need to work together to achieve quality improvements for patients and service users, whilst at the same time, transforming service delivery. The economic climate will require major productivity improvements, coupled with an unprecedented drive for efficiency and cost reduction.

Nationally the NHS needs to save an estimated £20 billion over the next three years.

Locally the impact is estimated as £73 million across acute and community services, although we may see reinvestment of up to £25m of this. Transformational change across the health economy and the potential growth opportunity within community services are key to meeting these economic challenges.

4.0 Market position

A successful clinical strategy will deliver the lowest cost, highest quality services in local settings that are flexible and responsive enough to meet the needs of patients and commissioners.

Attached in appendix 1 is the high level market environment review of the integrated CDDFT/CDDCHS organisation. This review has been conducted as a PEST analysis.
4.1 Competitive services
To allow this service offer and clinical strategy to be competitive in this market it needs to be based upon;
• A flexible, low cost, high quality range of services, pathways and outcomes for patients and commissioners.
• Pathways based on high quality clinical care interventions based on the best outcomes for patients. Distinct packages of care will allow patients to choose individualised, costed care plans to meet their specific needs, with measurable outcomes of quality.
• Clear and well communicated service information, with clear and easy access.
• Regular and wide ranging patient engagement and feedback on experience

4.2 Aligning our services
Our services need to be aligned with national pathways and the needs of patients and commissioners.

In CDDCHS the current configuration of services will need to be realigned from the current professional grouping approach, e.g. district nursing, health visiting, school nursing and physiotherapy, to align more clearly with care pathways.

In CDDFT, services are already organised by service areas, however these may also need to be realigned to be mapped onto pathways.

4.3 Market share
The new integrated Foundation Trust will begin as a monopoly provider of community services, and the provider of 58% of acute services in County Durham and Darlington.

The shape of the local provider landscape will change as a result of three changes:

1) New organisations – independent sector, charities and voluntary sector, and social enterprise - as a result of the “any willing provider” approach to commissioning
2) QIPP (quality, innovation, prevention and productivity) savings, where efficiencies are required by commissioners from existing contracts
3) QIPP savings as a result of moving services to cheaper new providers, and shifting resources

We expect to experience increased competition from other existing and new service providers under the “any willing provider” policy. For some services we will need to decide:

• Whether we stay and compete with other providers
• Work in partnership or joint venture with another organisation
• Integrate with another provider
• Decide that this is no longer core business and that other organisations are better positioned to provide the service.

The Trust aims to sustain its current core business, including the care closer to home market in County Durham and Darlington.

We also aim to achieve annual growth in innovative new services which may include joint ventures with other organisations to increase choice and meet the needs of patients and commissioners.

5.0 Commissioning intentions

The next three years will see the replacement of PCTs as commissioners with GP consortia; building on the existing Practice Based Commissioning (PBC) groups.

Our commissioning PCT has published commissioning intentions for 2011/12, which include intentions of PBC clusters, which indicate their direction of travel.

Locality Commissioning Intentions

PBC cluster commissioning intentions focus on local schemes that will;

• Move care closer to patient's homes
• Improve health outcomes reflecting local needs and priorities
• Target areas of health inequality
• Reflect the views of patients and the public in each locality
• Help manage demand on the local healthcare system
• Improve quality, productivity and prevention through local service innovation

Health Economy Wide Commissioning Intentions

Health economy wide commissioning intentions focus on;

• The improvement of health outcomes reflecting health economy wide needs and priorities
• The 'levelling up' of health inequalities across the health economy
• Responding to the views of patients and the public across the health economy
• The management of demand on the entire healthcare system
• The improvement of quality, productivity and prevention through jointly agreed service innovation across the health economy
• The further development of highly specialised services commissioned through NORSCORE

6.0 Developing the strategy

Clinical teams in CDDFT and CDDCHS have met to discuss many of the issues described above and have identified approaches and options for meeting the challenges ahead, at a specialty level. Before we take this work any further to consolidate into a five year clinical strategy for our new integrated service. We need to include the views of our stakeholders on the right path to take, we also need to agree if, how and when formal consultation is needed.
6.1 Integrating pathways “quick wins”

Locally, work has already begun in the following areas to integrate hospital and community services. This work is in line with the national agenda, where the National Institute for Health and Clinical Excellence (NICE) is to produce 150 examples of integrated care pathways.

6.1.1 Long term conditions & older people’s services with improved access to urgent care

These long term conditions include COPD, Asthma, CHD and neurological conditions. The aims are to improve patient experience and quality of care by reducing waste, duplication and inefficiency whilst integrating the pathway across primary and secondary care. To do this effectively better use will be made of care coordination, single patient records and tools such as telemedicine. It is imperative that exacerbations of chronic conditions are managed effectively and earlier in a community setting (including care homes) with the back up of GPs and community staff. Improving appropriate access to urgent care is also a key focus area and the intention is to introduce an in-reach model whilst also looking at alternatives to acute admission by developing a single point of access and by remodelling intermediate care.

6.1.2 Child Health

The Children’s Trust in Darlington is already an excellent example of integrated working with the development of three geographically based teams which cross integrate between acute, community health, education and social services. The key aim is to identify vulnerable families/ children and offer support mechanisms before actual problems occur. Pooling team resources and information to meet needs of families in this way reduces duplication and improves efficiency whilst improving care quality. It is also widely acknowledged that sharing information improves child protection and prevents harm. Co Durham is implementing a similar model of care.

6.1.3 End of Life Care

This workstream is building on existing partnership working within health and social care and with charities and local hospices. It reflects national, regional and local end of life strategies. The focus is two fold, firstly, to identify patients with complex palliative care and end of life care needs and avoid preventable admissions to acute care by accessing appropriate care packages/resources within the community. Secondly, to identify preferred place of care for complex palliative and end of life patients and fast track supported discharge from acute care within 24 hrs. The patient experience will improve because they will perceive no boundaries and have no needless admissions. They will have a single point of contact for advice especially out of hours and access to a key worker who will ensure continuity of their care. The development of a truly integrated end of life pathway utilising advanced care planning will ensure that the preferred place of care will be met wherever possible. Full implementation will also realise efficiencies by reducing lengths of stay in hospital and concentrating and rationalising resources across the pathway.
6.2 Hospital services – current challenges

The regional ‘Our Vision, Our Future’ project, led by the Strategic Health Authority, has enabled clinicians, managers, service users and key stakeholders to explore some of the key challenges facing the health and social care system across the North East. The FT has played a full part in each of these workstreams.

Significant areas of challenge for hospital services are stroke, child health and maternity and obstetric services. The FT fully intends to provide high quality hospital based services in each of these three areas for the long term, to maintain access as locally as possible and to maintain our portfolio of services. We expect that changes may be needed to these services to ensure this and will therefore be reviewing the organisation and utilisation of all of the current sites.

6.2.1 Stroke

We want to provide an excellent stroke service for our communities and are working with the PCT commissioner and community staff on their review of the stroke pathway. The Trust has plans to deliver 24/7 specialist stroke care, including a robust thrombolysis service by December 2010, although challenges remain with the recruitment of the specialist stroke physicians who are essential to delivering a robust service for the long term.

6.2.2 Child Health

The FT is now recognised as part of the Great North Children’s Hospital Network. Our links with Newcastle are a key part of our strategy to improve our children’s services. However, there is currently a chronic shortfall in middle grade cover for paediatrics both regionally and nationally. The Trust’s service is already dependent upon locum cover, and this reliance will increase as the middle grade cover decreases; adding further to the clinical pressures on already stretched units. A review of paediatric services will be required to look at children’s inpatient and emergency care and the development of paediatric assessment units.

6.2.3 Maternity/Obstetrics

In 2007, the Royal College of Obstetricians and Gynaecologists recommended full time 24/7 consultant presence on the delivery suite & extending midwifery led care. Trust clinicians are looking at how this could be achieved. Delivery of this standard will be a challenge to all trusts, due to national workforce pressures.

6.2.4 Other Services

National and regional changes in workforce and care standards mean we need to consider how further improvements in specialist hospital care can be delivered. Other services with the potential to work differently include:

- Ambulatory care currently provided in hospital moving out, closer to home
- Diverting clinical resources from the treatment of established disease to more effective primary and secondary preventive health care interventions
• Hospital at home and other interventions to avoid acute illness and admission

7.0 Taking the new clinical strategy forward

‘Seizing the Future’ succeeded because it was based on a clinical vision for services and because of the involvement and commitment of our partners.

The key reasons for the success of Seizing the Future, identified in the final report were:

• It was clinically led from the start
• A clear vision of the future service design was developed
• There was full and honest stakeholder engagement
• There was significant external scrutiny and peer review

We need to build on this approach to create a new shared clinical vision and strategy, with all of our health professionals working together supported by managers sharing the responsibility for making the strategy a reality.

We want to do this with our key partners:

• Our present commissioners – the Primary Care Trusts
• Our future commissioners – the GP consortia/PBC groups
• Local authority partners in Durham and Darlington Councils
• Our community – represented by our Governors, LINKs and the OSCs

This will ensure that we meet the Government’s four tests for assessing plans for future service changes. These criteria are:

• Support from GP commissioners
• Strengthened public and engagement
• Clear clinical evidence
• Consistent with promoting patient choice

We also need to meet the requirements of the Health and Social Care Act:

• Section 242 of the NHS Act 2006 (formerly Section 11 Health and Social Care Act 2001) places a statutory duty on both commissioners and providers of services to make arrangements to consult and involve patients and the public
• Section 244 of the NHS Act 2006 (formerly Section 7 of the Health and Social Care Act 2001), local NHS bodies have a statutory duty to consult local Overview and Scrutiny committees on any proposals for significant development and substantial variation of health services

The PCT commissioner has developed an overall process for service change, which was supported by the StF oversight board, for taking forward strategic change.
7.1 Your views

We want to involve our stakeholders in developing our clinical strategy.

We plan to hold a stakeholder event at 12.30pm on 27 January 2011 at a venue to be confirmed, and would like to invite you to attend.

Please contact Gail Clark on 0191 5876043 or by email at gailclark@nhs.net

You can also comment on this paper by writing to: Peter Moncur, Foundation Trust Medical Director at: peter.moncur@cddft.nhs.uk

Peter Moncur
Foundation Trust Medical Director

16 December 2010
Appendix 1

Market position: PEST analysis

Political impact
- GP consortia to be developed as new commissioners, will increase diversity of service requirements and need for more focused and bespoke service offers
- Government objective to drive care moving closer to home for patients. Will require more flexible and innovative delivery of clinical services
- Low probability of receiving major capital investment from central government
- Development of personalised budgets for patients to manage their own care

Economic
- Aggressive national and local competition, new entrants will be present in the health care market. In particular;
  - The opportunity for local primary care providers either in local alliances or with partners (third or private sector) to target specific parts of community services or to develop specialist services is likely to increase under a GP consortia approach to commissioning.
  - The opening up of health care markets to any willing provider will increase competitor base
  - Neighbouring and regional NHS trusts will seek to improve their market share, efficiency and cost effectiveness by pursuing a growth strategy.
  - Healthcare providers within NHS with high salaries and significant overheads will face increased competitive pressures from smaller organisations with better clinical skill mix
  - No growth in health care budgets requiring efficiency and transformation to meet new demands

Social
- Increasing demand and activity from demographic changes in population. More people living longer needing more personalised care packages
- Increasing expectations of access, quality and response time and personalised delivery of services. e.g. web and telephone based care booking
- Increased culture of litigation for errors in health care delivery
- More patient involvement and engagement in care services

Technology
- Rapid technological changes in telehealth improving reliability of remote monitoring and effective virtual hospital in the community approaches
- Ability to make both staff and equipment more mobile reducing need for static delivery points