Commissioning Plan

NHS Gateshead Clinical Commissioning Group

2012 -2017

(Incorporating the 2012-13 Integrated Plan and Draft Commissioning Intentions 2013-14)
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Foreword

This document sets out our five year plan for the commissioning of health services for the people of Gateshead and how we will deliver our mission of ‘working together to improve the health of Gateshead’. In developing this plan we have undertaken significant dialogue with local people and representative groups, and had detailed discussions with our partners and local service providers.

As an area, Gateshead faces some specific challenges and there is a turbulent financial outlook for the next few years. We have a growing population of elderly people who have increased needs for health services and have a reliance on hospital care. We face variation within our area with males living in one part of Gateshead expecting to live seven years less than those in other areas. We see fragmentation of services for our patients and part of our vision is to see care delivered in a more seamless way. We hope that by doing this we will start to see a reduction in the variation of clinical care; care should be delivered to the highest standard wherever it is needed. Improving the quality of services across Gateshead is core to our plans.

To meet these challenges we will focus on

1. Preventing people from dying prematurely;
2. Enhancing quality of life for people with long term conditions;
3. Helping people to recover from episodes of ill health or following injury;
4. Ensuring that people have a positive experience of care; and
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

This document sets out our priorities in each of these areas.

The ambitious changes and improvements we are planning to deliver for the patients of Gateshead will only be achieved by working together with partners and patients and we will continue to strengthen and develop these partnerships working across health and social care to meet the health needs of our community.

Dr Mark Dornan
Chair
NHS Gateshead Clinical Commissioning Group (Gateshead CCG)
1. Overview

The White Paper, Equity and Excellence – liberating the NHS (Department of Health, July 2010) set out major organisational change for the NHS, including the development of GP consortia and a new NHS Commissioning Board and the phasing out of primary care organisations and strategic health authorities. After a national process of public consultation, GP consortia were renamed clinical commissioning groups (CCGs) to reflect a broader clinical membership.

Following the passing of the Health and Social Care Act in March 2012, the CCGs will come into place as statutory organisations on 1 April 2013.

The groups will have a strong focus on patient and public involvement and on partnership working with the local authorities and the community and voluntary sector (including the emerging HealthWatch).

Clinical Commissioning Groups are being established to achieve a stronger focus on three areas of critical importance for the delivery of efficient and effective healthcare:

- Real breadth and depth of clinical engagement;
- Strong connection to patients and local communities: no decision about me, without me;
- Rigorous application of the evidence and best practice.

NHS Newcastle North & East Clinical Commissioning Group (Newcastle NE CCG), NHS Newcastle West Clinical Commissioning Group (Newcastle W CCG) and NHS Gateshead Clinical Commissioning Groups (Gateshead CCG) have agreed to work together as commissioners for the benefit of their local populations. The three CCGs, working together, can take advantage of a number of significant common opportunities as commissioners:

- Patient flows to Newcastle Hospitals, Gateshead Hospital, South Tyneside Community Services, Northumberland Tyne and Wear and North East Ambulance Services NHS Foundation Trusts;
- Two local authorities, Newcastle City Council, and Gateshead Council, who work closely together;
- Similar population cultures and issues;
- Critical mass in size to ensure longer term stability;
- Ability to attract high calibre people to work with the CCG’s;
- Greater influence over providers.

Together this will combine the very best primary, secondary and tertiary clinical expertise, delivering the best possible outcomes to the population of Gateshead.

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1 Liberating the NHS: No decision about me, without me (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134218.pdf)
2. Introduction

NHS Gateshead Clinical Commissioning Group (Gateshead CCG) is made up of the 34 GP practices of Gateshead and is currently undertaking a process to achieve Authorisation as a statutory body to commission health services for the population of Gateshead.

The additional scope and responsibility of the new commissioning structure and statutory responsibilities bring with it huge challenge but also opportunity to effect positive change.

Gateshead CCG was established as a Pathfinder Clinical Commissioning Group from April 2011, with responsibility for commissioning a limited set of NHS services for the people of Gateshead. This was the first step towards becoming authorised as a Clinical Commissioning Group from April 2013, commissioning the full range of NHS hospital, community and mental health services for Gateshead and working with Gateshead Council to improve the health of local people.

The Gateshead CCG Pathfinder Board has been elected by the Gateshead GPs, practice nurses and practice managers. The collective clinical experience and expertise of all member practices, together with their detailed understanding of the local health service, is used to commission services. This collective clinical view, and the distributed leadership of the clinical community, is fundamental to the way Gateshead CCG is working to commission new and different services to improve outcomes, safety, effectiveness and the experience of health services for all patients.

Since Gateshead CCG formed, the Pathfinder Board and Executive have worked to develop a shared view of the major challenges the NHS in Gateshead is facing in particular the fragmentation of services and variation in service provision and quality. These challenges are underpinned by the need to develop a greater financial resilience as previous opportunities to share risks with other PCTs across South of Tyne and Wear and between public health and primary care budgets will not be available to the new CCG. This plan therefore addresses:

- The form local NHS services need to take over the next 3-5 years to address these challenges so that Gateshead people get the right services at a consistently high quality;
- How Gateshead CCG can use the clinical expertise and distributed leadership of its 34 GP member practices and the other resources available to commission new and different services to close the gap between existing services and how they need to be in the future;
- How Gateshead CCG will work with Gateshead Council, the alliance member CCG and other local partners to improve the health of Gateshead people through shared plans and collaborative commissioning;
- The detailed arrangements Gateshead CCG will make to deliver changes, in particular relating to reducing fragmentation and variation in clinical services and plans to expand the QIPP programme to release funds and increase financial resilience to face future challenges.
This Commissioning Plan, for the five years from 2012/13 to 2015/17, describes the outcome of this work so far, but this will continue to be an evolving story as Gateshead CCG develops to meet the demands of the ever changing environment it operates within. The Gateshead CCG Governing Body (the Governing Body replaces the Pathfinder Board) will continually work with member practices, the local authority and local people to ensure that commissioning continues to achieve the best outcomes.

In 2012/13, the first year of this plan, Gateshead CCG will be a Pathfinder but will take on increasing responsibility from Gateshead Primary Care Trust for commissioning NHS services. This transition means that the detailed 2012/13 changes described in this plan have been developed jointly with Gateshead Primary Care Trust (PCT). This has been based on the PCT legacy three year Integrated Strategic and Operational Plan (which incorporated pathfinder priorities) and has also been further shaped by the Gateshead CCG Pathfinder Board and Gateshead GP membership.
3. Local Context – The Big Challenges for Gateshead

A range of information and analyses has been used to identify the big challenges facing the NHS in Gateshead.

From this work the challenges which Gateshead CCG needs to address through its commissioning and joint work with practices and partners can be summarised as:

- Excess deaths, particularly from heart disease, cancer and respiratory;
- Health and quality of life generally worse than the rest of England;
- A growing population of elderly people with increased care needs and increasing prevalence of disease;
- An over-reliance on hospital care, with activity exceeding current funds;
- Services which are fragmented and lack integration;
- Unwarranted variation in clinical practice;
- Lean and turbulent economic outlook for the next few years, coupled with the need to increase the savings from an expanded QIPP programme to increase financial resilience for the future.

This section gives a general overview of the population Gateshead CCG serves, describing the age structure, general health and income of the resident population. It summarises the analyses which have been used to identify the major challenges facing the NHS in Gateshead.

Of this list the key challenges facing Gateshead CCG are that of improving integration of services, which in turn will help achieve unwarranted variation in clinical practice. Together this will help Gateshead CCG manage its financial challenges and improve the quality of services across Gateshead.
3.1 Overview of the Gateshead Population

The resident population of Gateshead is approximately 191,000 people with an increase of 12,700 (7%) forecast over the next 20 years. The age structure of the Gateshead population is also forecast to change significantly, as follows:

![Gateshead Forecast Change in Population Compared to 2011](image)

The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five, ten and twenty years. Even if the general levels of health in these age groups can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group. In particular as older people use services more often, have more complex needs and stay longer in hospital. Modelling suggests that in ten years, if nothing is done differently, over 130 extra hospital beds will be required, at a cost of over £14m, which is unaffordable.

3.1.1 Health of Gateshead population

Gateshead is currently in the 20% of Local Authorities with the highest levels of social and economic deprivation (ranked 42nd highest average score for overall index of deprivation out of 326 councils). Levels of health and underlying risk factors in the area are amongst some of the worst in the country.

The 2011 Community Health Profile, prepared by the Association of Public Health Observatories compares health in Gateshead to England averages (see Fig. 1), highlighting in red those measures which are significantly worse and in green those which are significantly better. It is clear that on most high level health measures, Gateshead is significantly worse than the rest of England.

Figure 1: Source: Association of Public Health Observatories, Health profile 2011

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**Health summary for Gateshead**

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

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

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<table>
<thead>
<tr>
<th>Domain</th>
<th>Indicator</th>
<th>Local No. Per Year</th>
<th>Local Rate</th>
<th>Eng Avg</th>
<th>Eng Best</th>
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<tbody>
<tr>
<td><strong>Gateshead</strong></td>
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<tr>
<td>1. Deprivation</td>
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<td>2. Proportion of children in poverty</td>
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<td>3. Statutory homelessness</td>
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<td>4. GCSE achieved (i.e., Eng &amp; Maths)</td>
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<td>5. Violent crime</td>
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<td>6. Long term unemployment</td>
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<td>7. Smoking in pregnancy</td>
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<td>8. Breastfeeding initiation</td>
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<td>9. Physically active children</td>
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<td>10. Obese children (Year 0)</td>
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<tr>
<td>11. Children's tooth decay (at age 12)</td>
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<td>12. Teenage pregnancy (under 18)</td>
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<td>13. Adults smoking</td>
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<td>14. Increasing and higher risk drinking</td>
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<td>15. Healthy eating adults</td>
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<td>16. Physically active adults</td>
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<td>17. Obese adults</td>
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<td>18. Incidence of malignant melanoma</td>
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<td>19. Hospital stays for self-harm</td>
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<td>20. Hospital stays for alcohol related harm</td>
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<td>21. Drug misuse</td>
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<td>22. People diagnosed with diabetes</td>
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<td>23. New cases of tuberculosis</td>
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<td>24. Hip fracture in 65s and over</td>
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<td>25. Excess winter deaths</td>
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<td>26. Life expectancy - male</td>
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<td>27. Life expectancy - female</td>
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<tr>
<td>28. Infant deaths</td>
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<tr>
<td>29. Smoking related deaths</td>
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<tr>
<td>30. Early deaths; heart disease &amp; stroke</td>
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<tr>
<td>31. Early deaths; cancer</td>
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<td>32. Road injuries and deaths</td>
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(Association of Public Health Observatories, Health profile 2011  
3.1.2 Income inequalities of Gateshead population

Income levels are directly related to both life expectancy and health inequalities. The map below shows the variation in income levels across Gateshead compared to the whole of England. There are significant variations in income levels between wards within the area, therefore specific strategies are required to minimise the health gap between the affluent and less affluent members of our population.

(Association of Public Health Observatories, Health profile 2011)

3.2 Challenges identified in the Joint Strategic Needs Assessments

The Joint Strategic Needs Assessment (JSNA) is a continuous process by which the Gateshead Director of Public Health works with partners to identify the health and well-being needs of local people. It sets out key priorities for commissioners and provides the basis for Gateshead CCG’s commissioning plans. A major element of the development of the JSNA is consultation with the community and in 2011 there has been more direct consultation with community groups than in previous years.

The JSNA priorities have been identified using a structured process with clear criteria, involving partners and the public, to identify the main priorities to be addressed in partnership. The dimensions involved in this discussion are: trends, impact of the problem, inequalities, policy context, local views and evidence for what works. The JSNA uses benchmarking, and forecasting tools where possible to help interpret local data. In 2011 this prioritisation process included, for the first time, dialogue with Gateshead CCG.

In 2011, the Gateshead JSNA was jointly signed off by the Directors of Public Health, Adult Services, Children’s Services and the GP Chair of Gateshead CCG. It includes up to date health and wellbeing information; insight into expressed needs of local people and identification of effective interventions including where these are not taking place. The Gateshead JSNA can be viewed in full at www.gateshead.gov.uk/jsna.
The Gateshead JSNA recommends that commissioners of health services in Gateshead should prioritise the following key points:

- Increase life expectancy: infant mortality; screening; long term conditions;
- Children: emotional health and wellbeing, obesity, sexual health, inequalities;
- Adults: emotional health and wellbeing, dementia, obesity, substance misuse (drugs, alcohol and tobacco), sexual health, end of life care;
- Commissioning to tackle inequalities in health, including:
  - address isolation and loneliness in old age;
  - provision of decent homes and suitable accommodation;
  - minimise the impact of domestic violence;
  - address needs of people coming out of prison;
  - maintain equitable services for people with a disability;
  - address needs of both young and ageing carers;
  - ensure services meet the needs of ex-service personnel

Reducing health inequalities also requires a focus on the wider determinants of health (see Fig. 2), including deprivation, employment, education and environment and on identifying the neighbourhoods to target. The ongoing programmes of disease management and lifestyle work need to be joined up with tackling the wider determinants of health and this will be the remit of the Gateshead Health and Wellbeing Board (HWB), chaired by the Leader of Gateshead Council.

Figure 2: The main determinants of health

Gateshead CCG’s membership of the HWB will ensure the work described in this plan is integrated with the wider work in Gateshead and that the wider work in Gateshead continues to shape how the CCG commissions its services moving forward. This will improve health and wellbeing of the population of Gateshead.

Gateshead is developing a prototype strategy ‘Big Shift Plus’, led by the Director of Public Health, and Gateshead CCG will input to this on early detection, secondary prevention and
treatment, alongside Local Authority work to tackle healthy lifestyles, engage with communities and address the determinants of health.

One of the starkest inequalities highlighted by the JSNA is in life expectancy. The local life expectancy gap against England is:

<table>
<thead>
<tr>
<th></th>
<th>England Average Life Expectancy</th>
<th>Gateshead Life Expectancy</th>
<th>Gap (%) *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>78.5</td>
<td>76.7</td>
<td>-2.4%</td>
</tr>
<tr>
<td>Females</td>
<td>82.5</td>
<td>80.9</td>
<td>-2.1%</td>
</tr>
</tbody>
</table>

(Office for National Statistics, life expectancy at birth, 2008-2010)

Over 60% of the gap in life expectancy is caused by cardiovascular disease, cancer and respiratory disease and to address this the Health Inequalities National Support Team\(^3\) has identified five supporting strategies (tobacco control, community engagement, measuring impact, maintaining momentum and working with the Local Authority) and 8 “High Impact Interventions” which Gateshead CCG commissioning and partners are committed to contributing to by:

1. Use of Health Checks to identify asymptomatic hypertensives age 40–74 and start them on treatment;
2. Consistent use of beta blocker, aspirin, ACE inhibitor & statins after circulatory event;
3. Systematic cardiac rehabilitation;
4. Systematic treatment for chronic obstructive pulmonary disease with appropriate local targets;
5. Develop and extend diabetes best practice with appropriate local targets;
6. Best practice access to specialist clinics for stroke;
7. Cancer early awareness and detection;
8. Identification and management of Atrial Fibrillation.

The Combined Predictive Model is one of a suite of tools to help Primary Care identify the group of patients in the practice population most likely to develop urgent care needs, and work pro-actively with them. This work addresses the Pathfinder requirement to reduce unplanned urgent admissions, as well as tackling inequalities in life expectancy.

Gateshead CCG at its Board meeting on the 16\(^{th}\) August 2011 endorsed this approach to tackle inequalities in life expectancy during 2011-12. The role of the Good Medical Practice Group in reducing clinical variation is critical to reducing inequalities in the short term (the next 2-3 years), and leadership on this lies with the Chair of that Group.

### 3.2.1 Expected disease prevalence

Projections of expected disease prevalence have been used to help understand what key disease areas of heart disease, respiratory conditions, stroke and hypertension might look like in Gateshead in five, ten and twenty years, if effective change is not implemented (see Fig. 3). In all four disease areas, Gateshead has a prevalence which is higher than the

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\(^3\) Department of Health, Health Inequalities National Support Team
England average, and is forecast to increase if no effective action is taken. These disease areas are the major causes of premature death and emergency hospital admission in Gateshead, so the health and service implications of an ageing population will be further exacerbated by this increasing burden of chronic disease.

**Figure 3: Projected disease prevalence in adult Gateshead population**

| Key Disease Prevalence at Gateshead, persons aged 16+ |
|----------------|----------------|----------------|----------------|----------------|
|                | 2006 | 2007 | 2008 | 2009 | 2010 | 2015 | 2020 |
| Hypertension   | 30%  | 31%  | 32%  | 33%  | 34%  | 35%  | 36%  |
| CHD            | 2%   | 3%   | 4%   | 5%   | 6%   | 7%   | 8%   |
| COPD           | 8%   | 7%   | 6%   | 5%   | 4%   | 3%   | 2%   |
| Stroke         | 6%   | 5%   | 4%   | 3%   | 2%   | 1%   | 1%   |

*Source: observed or diagnosed prevalence, Quality and Outcomes Framework, NHS Information Centre; predicted prevalence, Association of Public Health Observatories*

3.2.2 Gateshead minority groups needs assessment

As well as assessing the needs of the overall population of Gateshead, the Gateshead JSNA also assessed minority groups individually with the view to identifying and addressing specific needs within these groups. The minority groups assessed by the JSNA include:

- Jewish community
- Black and minority ethnic
- Lesbian, Gay, bisexual and transgender
- Young people
- Offenders and ex-offenders
- Ex-service personal

The needs assessments of each of these groups has identified specific areas where Gateshead CCG can improve services, make access easier and more appropriate and reduce inequality.

The JSNA has identified inequality in areas such as mental health for minority groups and this data feeds into the CCG’s health commissioning and plans.
To date the CCG has made significant progress with identifying representatives from all minority, or seldom heard, groups in Gateshead through its communication and engagement programme.

3.3 Challenges identified by patients, public, clinicians and partners

Development of the JSNA includes extensive public involvement and takes into account both patient and public views. In addition there has been significant work undertaken in Gateshead to gather the views and experiences of local people and use them to identify areas of service where we need to do better.

Clinicians and general practice staff have also been engaged through the Gateshead CCG *TimeIn/TimeOut* events (bimonthly forums for all primary care staff of Gateshead) and the GP Clinical leads.

The challenges identified are summarised in Fig. 4.

**Figure 4: An overview of the health challenges identified for Gateshead by key engagement groups**

<table>
<thead>
<tr>
<th>Group Engaged</th>
<th>Method of Engagement</th>
<th>Challenges identified</th>
</tr>
</thead>
</table>
| Patients and public    | Four Local Engagement Boards (LEB) attended by over 250 people |  - Need for safe, high quality, value for money services delivered in a timely convenient manner, with an increasing emphasis on local access;  
  - Better understanding how they can best manage their own condition;  
  - Improved information and awareness of the choices they may have;  
  - A choice of appointment times;  
  - Good transport links to access services. |
| Clinicians             | *TimeIn/TimeOut* events attended by over 250 primary care staff. Gateshead GP Clinical leads forum. |  - Fragmentation and lack of integration of current services  
  - Proportionally more people are admitted to secondary care compared to other areas of England resulting in budgetary pressures  
  - Limited means of moving funding from secondary care to primary care to allow care to be moved out of hospital  
  - Maintaining momentum and effectiveness during a huge reorganisation of the health care system  
  - Ensuring co-ordinated care for patients when dealing with 2 different Foundation Trusts |
| Partners and Stakeholders | Stakeholder events with healthcare providers, voluntary sector and community sector |  - Concerns about the loss of preventative services  
  - Better Voluntary Community Sector input into the JSNA  
  - More direct work needed with disabled people  
  - Greater focus needed on mental health |
Many patients also commented positively about their experiences and the views expressed by the patient and public helped Gateshead CCG form its Mission, Vision and Values (see section 6)

3.4 Challenges set out in national policy

In addition to the local challenges, there are also a range of national priorities, targets and standards which must be delivered in Gateshead. These are described each year in the NHS Operating Framework\(^4\).

3.4.1 Current performance challenges

Gateshead CCGs current performance against national priorities in the Operating Framework is monitored and managed carefully but there are a few areas where the organisation is not expecting to reach its year-end targets and standards. These are shown in the table below, split between those for which the CCG has a direct commissioning responsibility and those where the CCG will help its partners to deliver through their commissioning:

<table>
<thead>
<tr>
<th>Indicators at risk of non-delivery 2012/13 - Clinical Commissioning Group</th>
<th>Risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateshead Health FT A&amp;E quality</td>
<td>High</td>
</tr>
<tr>
<td>Activity including Outpatient and day-case hospital activity</td>
<td>Medium</td>
</tr>
<tr>
<td>Number of people accessing IAPT who are moving to recovery</td>
<td>High</td>
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<tr>
<td>Number of clostridium difficile infections</td>
<td>Medium</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators at risk of non-delivery 2012/13 - Public Health</th>
<th>Risk rating</th>
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</thead>
<tbody>
<tr>
<td>All age, all-cause mortality</td>
<td>High</td>
</tr>
<tr>
<td>Year 6 child obesity</td>
<td>High</td>
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<tr>
<td>Chlamydia screening</td>
<td>High</td>
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<tr>
<td>Smoking in pregnancy</td>
<td>High</td>
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<tr>
<td>Teenage pregnancy</td>
<td>High</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>High</td>
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</table>

Actions to address these quality challenges, are detailed in the ‘yellow programme sheets’ in Appendix 5 and where risks to delivery are high for 2012/13, there are clear time limited resolution paths in place in the form of recovery action plans, an overview of which are included in Appendix 1. Through these action plans and the close monthly performance monitoring framework in place for Gateshead CCG, the organisation is closely following progress and making adjustments to plans accordingly.

3.4.2 Additional challenges in NHS Operating Framework 2012/13

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The NHS Operating Framework 2012/13 requires Gateshead CCG to continue to meet existing standards and targets, and also details the following areas in which the CCG must make specific improvements in 2012/13:

- Delivery of the QIPP Challenge
- Dementia and care of older people
- Carers
- Military and Veterans’ health
- Health Visitors and Family Nurse Partnerships
- An outcomes approach
- Public Health
- Emergency Preparedness

The Framework emphasises that the experience of patients, service users and their carers should drive everything the NHS has to do. It sets out the key performance measures which will be subject to national assessment:

3.5 Challenges posed by existing provider landscape

As well as the health and service challenges described in this chapter, the services which Gateshead CCG are able to commission are constrained in the short term by the current shape and availability of local services and the major challenges involved in any significant change to this configuration and pattern of service use.

This does not mean that in the longer term Gateshead CCG will not be looking for major changes in the shape of local service supply, but it does place limitations on the speed with
which change can be achieved and this has been taken into account in the development of detailed initiatives for 2012/13.

3.5.1 Current pattern of acute hospital use

The people of Gateshead receive most of their acute hospital care from Gateshead Health NHS Foundation Trust at an annual cost of around £125 million. Gateshead Health provides Accident and Emergency; surgical and medical specialties; therapy services; maternity and paediatric care; Gynaecological Oncology and older peoples mental health services.

Gateshead people also use £40 million of services at Newcastle Hospitals NHS FT each year. Many of these services are specialist, but a significant proportion of Gateshead people also use routine services in Newcastle (see Fig. 5 for an overview of the main providers acute care).

Figure 5: Breakdown of Gateshead acute contract proportions

3.5.2 Current pattern of Community Service use

There are a range of community services such as Community Nursing, Allied Health Professionals and Therapies which are currently commissioned from a range of different providers, including the community services arm of South Tyneside NHS Foundation Trust (FT), the voluntary sector and the independent sector (including care home providers). A number of these services are jointly commissioned with Gateshead Council.

3.5.3 Current pattern of Mental Health Service use

The majority of mental health and learning disability services are commissioned from three different providers: Northumberland, Tyne and Wear Mental Health FT; South Tyneside Hospital FT and Gateshead Health FT. This means provision of these services across Gateshead can be fractured, providing opportunity for both duplication and gaps in the
service provision. Opportunity, therefore, exists to improve service quality and reduce cost through ensuring consistent service provision.

These services are accessed by a population of 1.4 million people working from over 160 sites covering 2,200 square miles in the North East, including Gateshead. Other services include urgent care mental health, Planned care services, Specialist care services and Forensic services.

3.6 Challenges likely in the future

As well as the challenges identified from the analyses and insights into current health and services, Gateshead CCG has used a set of predictive models developed by NHS South of Tyne and wear to identify further challenges the organisation will likely be facing in the future.

The modelling also supports Gateshead CCG’s planning as follows:

1. Contracted hospital and community activity levels reflect the forecasts of demand changes and impacts of planned disinvestment initiatives;

2. The investment and disinvestment plans which underpin the balanced financial position fully reflect the financial consequences of these planned changes in activity levels;

3. Shared understanding with our local providers of the likely workforce implications of both the planned changes in activity levels and the impact of tariff and tariff equivalent efficiencies, with a high level view of how these implications will be managed.

3.6.1 Hospital Activity Model

Gateshead CCG has used an established model to predict likely changes in the use of hospital, community and primary care services. The model applies forecast changes in population age structure to current patterns of age-related use of health services. It also assumes that the past 5 year trend in activity changes related to factors other than population (e.g. clinical and technological developments) will continue at the same rate over the next 10 years.

The annual update of the model continues to show that over the next ten years if Gateshead CCG does not take effective action, the increasing elderly population, with their high use of health services, coupled with the inevitable developments in clinical practice, technology and patient expectations, would result in hospital capacity shortages equivalent to a small general hospital and a financial cost which could not be met.

In the shorter term, if Gateshead CCG does not change the way in which health services are provided, steady growth in hospital activity levels would be expected over the next three years (see Fig. 6 for details). Similar increases in accident and emergency attendances are also expected.
Figure 6: Projected growth in hospital activity for Gateshead

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<th>2012/13</th>
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<tr>
<td>Elective Hospital Spells</td>
<td>1.37%</td>
<td>1.49%</td>
<td>1.59%</td>
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<tr>
<td>Non Elective Hospital Spells</td>
<td>1.34%</td>
<td>1.62%</td>
<td>1.49%</td>
</tr>
<tr>
<td>First outpatient attendances</td>
<td>1.44%</td>
<td>1.56%</td>
<td>1.62%</td>
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However, as detailed in this plan, Gateshead CCG has a range of initiatives in place to reduce hospital activity (elective, non-elective and outpatient) through redesign of services, better care of people with long term conditions and more streamlining of urgent care services.

The charts in Fig. 7 illustrate the expected impact of Gateshead CCGs plans on hospital activity. The blue bars show past activity, the red line shows predicted growth over the next three years if no action is taken and the green lines show expected activity, after the impact of planned actions.

Changes in counting for endoscopies and chemotherapy show artificial growth in elective activity from 2009/10 and artificial reduction in outpatient activity in 2011/12.

Figure 7.1: Predicted impact of Gateshead CCG plans on elective hospital activity
Hospital activity reductions are planned throughout 2012-15 with particular emphasis on elective and emergency admissions. Achieving the planned reductions in hospital activity will require additional primary and community care contacts.

### 3.7 Financial Challenges

CCG funding allocations have not yet been announced, but the areas of commissioning responsibility that will sit with the CCG are those most affected by the risks described in this section. Historically, NHS South of Tyne and Wear has operated a policy of risk sharing between the three constituent PCTs and across budgets for public health, primary care, hospital, community and mental health services. The CCG does not hold all these budgets therefore the ability to absorb risk is greatly reduced.

Gateshead CCG has set a balanced budget for 2012/13, but this has left minimal contingencies or reserves to pay for any unplanned increases in demand for services.
Recognising that Gateshead CCG is a small organisation, and therefore, vulnerable to activity increases, Gateshead CCG has developed an extension to the QIPP savings plan inherited from the PCT, to build financial resilience so that the organisation can fund those actions necessary to deliver the vision. The plan builds upon the many strategies inherited from the PCT and identifies new areas for development and action which align with the CCG vision and strategic objectives. This plan is further described in section 5 and the additional CCG QIPP initiatives are shown in Appendix 3, together with the inherited QIPP schemes.
4. Mission, Vision and Values

The Mission, Vision and Values of Gateshead CCG (see Fig. 8) were developed with the full engagement of stakeholders including the public, patient and carers of Gateshead (through the PUCPI group and LEB) and the GP member practices that constitute the CCG (through the TimeIn/TimeOut events). They were agreed by the Executive and ratified by member practices within the Gateshead CCG constitution. The Mission, Vision and Values have since been circulated to all stakeholders including Local authority, healthcare providers and the Health and Wellbeing Board members.

Figure 8: Diagram showing the Mission, Vision and Values of Gateshead CCG

Mission
The Mission “Working together to improve the health of Gateshead” clearly sets out the fundamental purpose of Gateshead CCG.

Vision
The Vision is driven by the local health challenges of Gateshead, and are:

- Care for people in a seamless way that is not restricted by either organisational or professional boundaries;
- Improve the Quality of health services and ensure the people of Gateshead live longer, happier and healthier lives;
- Ensure commissioning is clinically led and driven by patient and carer involvement.
Values
The Values, identified around the outer edge of the Mission circle, are those Values of the entire NHS. These Values are also shared locally and the belief of Gateshead CCG and its stakeholders.

Culture
To support the Mission, Vision and Values of Gateshead CCG it is essential that the organisation works to develop the right culture, both across the organisation and in partnership with the alliance CCGs.

The following describes the attributes Gateshead CCG will seek in its employees and partner organisations to develop its culture:

- ‘Own’ individual responsibilities and share team objectives;
- Contribute to creating improvement and innovation;
- Contribute to creating a work environment that is marked by pride, enthusiasm and collaboration;
- Manage and/or contribute to financial performance and target delivery;
- Lead by action and inspire others;
- Communicate positively and effectively;
- Actively give and receive feedback in a constructive manner;
- Be adaptable, work with integrity and be trustworthy;
- Show constancy, courage and resolve in the pursuit of the vision and aims of the NHS and local organisations.

4.1 What do we want the NHS in Gateshead to look like in 2017?

Local work to understand the challenges facing Gateshead and to determine how the organisation can tackle these (described in detail within this plan) has led to the adoption of the strategies described in the NHS Outcomes Framework^5 to move towards the vision of better health for Gateshead. These five Domains have set the programmes of work we will adopt over the next 5 years ensuring a focus on safe, quality services for all patients:

1. Preventing people from dying prematurely;
2. Enhancing quality of life for people with long term conditions;
3. Helping people to recover from episodes of ill health or following injury;
4. Ensuring that people have a positive experience of care;
5. Treating and caring for people in a safe environment and protecting them from avoidable harm.

Based on the health challenges outlined in the Gateshead JSNA, Gateshead CCG mapped out how they wanted to look and feel to patients by 2017 for each of these domains. This detailed picture for the future of health in Gateshead was developed by the CCG with comprehensive input from Gateshead GPs, patients and public, Local Authority and other key stakeholders. Collectively they will help the CCG realise its vision and will inform the strategic direction of this plan and the organisation as a whole.

Gateshead CCG will play its part in reducing the number of avoidable deaths, recognising CCGs can be accountable only for the NHS contribution.

**Domain 1 - Preventing people from dying prematurely**

**By 2017:**

**Work with our partners on the Health and Wellbeing Board to increase life expectancy; add life to years for adults; add life to years for children; and reduce health inequalities will result in:**

- increased focus on prevention so future generations adopt healthier lifestyles;
- reduction in poor lifestyle choices such as smoking, alcohol abuse, obesity;
- increase in screening programmes to identify people with risk factors;
- increase in treatment for people with identified risks or established illness;
- work to address the determinants of health which shape future health, especially for children;
- comprehensive, integrated services to address the needs of disadvantaged and vulnerable groups and those in our most deprived areas;
- Effective, whole system work on tobacco control, engaging with high risk communities;
- Earlier diagnosis of cancer through social marketing, professional development, high profile targeted campaigns and community engagement;

**GPs in Gateshead will all routinely**

- help people make healthy choices about smoking, alcohol, diet and exercise;
- Use ‘6 simple rules’ to reduce risk of urgent admission:
  - target Health Checks to identify asymptomatic hypertensives & start treatment;
  - Treat circulatory event patients so that 80% receive a bundle of care that includes beta blocker, aspirin, ACE inhibitor & statins and 90% have an integrated management plan including appropriate rehabilitation;
  - Identify patients with chronic obstructive pulmonary disease earlier and offer pulmonary rehabilitation and self-management guidance;
  - Ensure best practice management of diabetes;
  - Ensure access to specialist clinics for stroke;
  - Consistently identify and manage patients with Atrial Fibrillation.

These changes will be underpinned by a shift in resources from acute care to preventative and community services (the “big shift” described in the Joint Strategic Needs Assessment)
Domain 2 - Enhancing quality of life for people with long term conditions

By 2017, for people with long term conditions:

- More care will have been shifted out of hospital into primary & community settings and primary care capacity will have been expanded to cope with the extra workload;
- Services will be integrated across sectors;
- People at risk of hospital admission will be identified early and managed proactively, including an increase in intermediate care capacity;
- Services will be streamlined to avoid waste, duplication and confusion;
- Services will be easy to access;
- All services will be evidence-based;
- There will be more self-care and self-management;
- There will be more evidence-based cost effective prescribing;
- Patients will have access to rehabilitation services from diagnosis rather than following hospital admission.
By 2017:
Gateshead patients will be treated at the right time in the right place by the right person and will be initially treated in the first service they see. Gateshead NHS will appear as one service with no gaps for patients or costly duplication that is inconvenient to patients. This will be possible because:

- Services will be integrated so all are capable of being first responders;
- All services will be able to manage cases through access to timely diagnostics and advice;
- Services will be streamlined, with improved access so it is clear to patients and GPs where to go;
- There will be a fully integrated acute hub on the Queen Elizabeth hospital site where a seamless team (including alcohol & mental health services) can offer patients care in an easy to access, timely and consistent way;
- All other urgent care services (out of hours GP, nursing and walk in centre) will be fully integrated to this hub to enable easy access to advice when other teams need it and easy transfer of patients to more skilled professionals where needed;
- Everyone will see it as their duty to put patients first and bring down artificial barriers;
- General Practice will be able to treat urgent minor illness so continuity of care & health optimisation can be maintained;
- Services will be proactive and GPs will be able to best manage those at highest risk of deterioration in a planned way and where possible out of hospital;
- Fewer patients will need to go to hospital for routine tests and checkups that can be managed through self-care and General Practice;
- Excellent communication will ensure that all working in Gateshead health and social care teams are clear what the system is and how to get access or advice to any parts of the system, as they need it, in a timely way;
- There is a common information system with patient information easily accessible to all staff so that lack of information does not create a barrier to patient care;
- Rehabilitation and reablement programmes will ensure patients are discharged into the community as early as possible and supported to remain there.
Domain 4 - Ensuring that people have a positive experience of care

By 2017:
Gateshead patients’ entire experience of the health system will be positive. They will be treated with compassion, dignity and respect in a clean, safe and well-managed environment’ and involved in decisions about their individual health.

- Patient and client experience will be clear within our priorities and patients will be involved in our decision making and priority setting;
- All care providers will have patient and client experience at the centre of everything they do;
- All commissioned care will be clinically safe, effective, high quality and provide excellent patient experience, delivered by high quality, well trained capable teams;
- All commissioned treatment will be person centred and patients will be treated with respect, honesty, dignity and have their religious and cultural needs met;
- Patients will be cared for and have confidence in a safe and comfortable environment;
- Patients and their carers will be informed and have a say in the care they receive;
- Patients will have choice and access to a range of primary and secondary care providers.

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

By 2017:
- There will be a process for reporting and learning from incidents to improve safety and quality of care which will be endemic in primary and secondary care;
- The move to integrated working and the blurring of the boundaries between care sectors will have been a key enabler;
- The number of incidents reported will have peaked and will now be falling as the culture of reporting, reviewing, learning and celebrating success will be systematically embedded in integrated governance structures and owned by the health community;
- We will be sharing the learning of how we achieved change with other CCG’s;
- We will have a national profile as a health community that has the lowest medication errors;
- The mantra of safety and no avoidable harm will be as familiar as dignity and respect in the way we care for our patients;
- All providers from whom we commission services will aim for the quality standards of the highest quartile in the country.
4.2 Commissioning for Quality

Commissioning for quality is an integral part of Gateshead CCG’s vision and encompasses the three key components of quality: patient safety, clinical effectiveness and patient experience. Gateshead CCG will promote the principles and values of the NHS Constitution and have due regard for people’s rights and NHS pledges in the organisations quality improvement work. Gateshead CCG will drive continuous improvements in quality through provider management and pathway reform and this is a key development area for the Executive Committee in the short term. Gateshead CCG will work within the NHS quality improvement framework using relevant standards and best use of available levers to maximise outcomes for local people.

An example of Gateshead CCG’s rejection of mediocrity and drive towards consistently excellent services the CCG has rolled out the Datix reporting system to all 34 CP practices across Gateshead. This allows all GPs to report incidents and quality issues centrally, where trends and issues can be picked up early and addressed in a consistent manner.

How Gateshead CCG will commission for quality and drive improvement across the region is documented throughout this document and specifically in detail in sections six and seven of this plan.
5. Financial Strategy

5.1 CCG Income Assumptions

Nationally CCG’s do not currently have financial allocations for 2013/14 and the likelihood is it may be late in the 2012/13 financial year before any further information is received. The only exception to this is being the formal notification of the CCG’s “running cost” allowance which has been set at £23.91/head of population as an indicative sum, this equates to £4.9m.

To support the ongoing development of the CCG the Gateshead PCT Board delegated full responsibility for Headquarters and Commissioning budgets that will transferred to the CCG at its March 2012 meeting. This excluded PCT commissioning or central reserves and amounted to a delegated sum of £290m.

To help influence future CCG allocations a mapping of expenditure exercise was undertaken during 2011 and this was repeated in June 2012 with the expectation that the second exercise would increase the level of accuracy of reporting following feedback from the first exercise. Significant effort was put into the mapping exercise to help support the aim of the Department of Health to have a document that clearly mapped existing PCT expenditure/plans across the new NHS architecture that will come into place from April 2013. Following the second exercise which now includes allocation of reserves to successor bodies the CCG element of PCT resources has increased to £296m. However, for planning purposes the start point for 2013/14 is assumed, prudently, as £290m. The CCG is aware that it is proposed to prepare a national consultation document outlining the results of the mapping exercise against allocations based upon a new formula, however this is not expected until the autumn.

It is anticipated that this document will outline the Department of Health’s approach to increasing the funding of under target CCGs whilst at the same time balancing the requirement to maintain a financially sustainable healthcare system.

Given this gap in financial planning, the CCG plan has been initially based upon the PCT plans, although all the information has been reviewed and amended where appropriate to reflect the CCG led process. Given the lack of allocations and national assumptions, the finance plan is driven by assumptions agreed by the North East PCT Cluster Directors of Finance.

The remainder of this section has its roots based upon the Gateshead PCT ISOP which the CCG was actively involved in developing and led in a number of areas.

The collective NHS South of Tyne and Wear Strategic Plan for 2011/12-2014/15 forecast the additional income expected over five years; the impact of unavoidable increases in demand such as growth in the elderly population; and the investments needed to achieve the vision of better health, excellent patient experience and the wise use of money.

5.2 QIPP and Efficiency

The CCG plan builds on the good work commenced by Gateshead PCT to ensure delivery of financial and other targets using savings and efficiency measures as a foundation to success. During the period 2010/11 to 2012/13 £33m has been saved from
tariff/prescribing efficiency and a further £13.9m from QIPP Initiatives. These figures clearly demonstrate a sound track record in delivery of the local QIPP plan in which the CCG has been involved. The CCG also acknowledges that it will need to continue to deliver savings throughout the life of this commissioning plan.

In December 2011, the NHS Operating Framework for 2012/13, PCT allocations for 2012/13 and the 2012/13 rules on tariff were all published. These documents changed:

- The planning assumptions used to determine the size of the financial gap;
- The split of the savings between those required from providers through tariff and those needed to be generated by commissioners through reform.

These documents build upon information published within the national Government Comprehensive Spending Review (CSR) published in October 2010. The CSR gave an insight into the additional funding the NHS is likely to receive in the period through to 2014/15.

5.3 Source and Application of Funds

This Commissioning Plan takes account of all of these documents and from a financial perspective a full five-year Source and Application of funds model has been produced. However, the CCG recognises that as a new organisation, with primarily a secondary care portfolio, it is particularly vulnerable to activity swings. Therefore, in addition to the QIPP initiatives which were part of the PCT plan, the CCG identified a further £4.5m of initiatives to drive further efficiencies from the system in order to create some financial resilience for the CCG. The specific initiatives in the QIPP plan can be seen in appendix 2. For the purpose of planning a prudent view has been adopted and is reflected in the figures included in the Commissioning Plan. For each QIPP initiative a cautious view on prioritisation and deliverability was undertaken as part of the QIPP delivery assessments. In addition the level of contingency within the plan at present is higher than the QIPP initiatives thus allowing further confidence should some initiatives not deliver the expected amounts or are not deliverable within the planned timescales.

The following table is a summary of the headline numbers extracted from the five-year model.
Based upon these financial plans Gateshead CCG will be able to:-

- Meet national requirements described in the Operating Framework for 2012/13, the developing outcomes frameworks and other national policies;
- Complete implementation of existing commitments;
- Meet the costs of implementing the QIPP programme initiatives;
- Provide contingency reserves for future uncertainty given the lack of future years planning guidance and the abolition of PCT’s from the 1st April 2013.

The detailed actions and costs associated with each of these are described in the yellow programme sheets in Appendix 5 of this plan and the costs are summarised in Appendix 2 which details the £26.8m recurrent investment plans for Gateshead.

5.4 Planning Assumptions

A summary of the planning assumptions within the CCG plan are detailed in table 10.
Table 10: Gateshead CCG planning assumptions for the coming five years

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Allocations are expected to increase by circa 2.0% for the first two years of the plan in line with the detail of the current government comprehensive spending review (CSR). However, the current economic downturn will inevitably have an impact on the period commencing 2015/16. Consequently, the CCG has assumed a reduction in growth funding to 1.0% from this point; although it should be recognised that there remain unknowns with regard to funding formulas and pace of change policy that may affect future plans.

The QIPP agenda remains with £63.5m savings assumed from the delivery of tariff/prescribing efficiencies. In addition, further QIPP efficiencies are anticipated to deliver £12.8m.

The need for investments has been calculated at £26.8m over the life of the plan, however given lack of allocations and planning assumptions a cautious approach has been taken and £14.6m remains in reserve.

The refreshed five year target of £12.8m from QIPP initiatives for Gateshead will be delivered through a revised programme of initiatives which are listed in Appendix 3. The schedule includes a number of technical savings (some of which have been previously agreed with providers) together with initiatives that continue to support the reform agenda described in the PCT original Strategic Plan including urgent care, long term conditions and children. Each is supported by a detailed integrated plan which describes actions, milestones, risks and key performance indicators and these are summarised in the relevant yellow programme sheets in Appendix 5.

The commissioning plans for both the CCG and PCT are clearly aligned demonstrating cohesion of strategic objectives and goals. It also demonstrates delivery of our strategic objectives whilst at the same time maintaining recurrent financial balance throughout the life
of the plan given the limitations as outlined at the outset of this section regarding the lack of formal CCG allocations.

The Chief Finance and Operating Officer will have lead director responsibility for the delivery of QIPP, overseen by the Finance and Performance Committee of the CCG but most crucially underpinning the practice plans that will enable performance management and granularity at a practice level.

5.5 Running Costs

As mentioned previously in this section, the CCG has received an indicative running cost allocation of £4.9m. The CCG has fully costed its proposed management structure including services it plans to commission from the North East Commissioning Support organisation and can demonstrate affordability within the target set.

5.6 Financial Risks

The lack of allocations and national planning guidance have been mentioned a number of times within this plan, serving to highlight the need for plans to manage financial risk. In preparing the plan the CCG has adopted prudent scenario in terms of modelling of investments and QIPP initiatives but has assumed worst-case in terms of allocation, i.e. using current delegated budgets £290m rather than the results of the recent expenditure mapping exercise £296m. The difference (£6m) relates primarily to the apportionment of PCT reserves which, if included in the starting position, would create headroom for the CCG of around 2% of turnover. Nevertheless, a prudent approach has been taken for the plan, in particular, planning assumption for the future are limited and investment plans carefully worked through, with available funds not fully committed. The CCG is able to carry levels of contingency in all years of the plan but with a caveat around delivery of QIPP initiatives. As the national and local position becomes clearer the plan will be revisited but given the levels of uncertainty in the system the CCG has chosen a cautious approach for its first financial strategy with the aim of consolidating its position and maximising deliverability of strategic objectives and goals.

The prudent approach adopted by Gateshead CCG to its financial strategy along with the detailed action plans outlined in the ‘yellow programme sheets’ in Appendix 5 and a close performance management framework to monitor progress ensures that Gateshead CCG is on course to deliver against these plans for 2012/13 and beyond.

The financial plans outlined above have, as far as possible, adopted a prudent approach to budgeting, QIPP delivery and contingency provision. However, this alone will not mitigate the significant risks faced by a new organisation and the financial consequences of them. To this end and over the forthcoming months, the CCG will enter discussions with the CCGs in the alliance and wider, providers and partner organisations with regard to possible risk sharing arrangements.

It is expected that the first planning framework for CCGs will provide a permissive environment for formulating risk management arrangements. Key considerations but not limited to, would be:

- on what?
- on what basis?
- with whom?
• over what period?
• advantages and disadvantages for patients.

Early potential areas are:
• high cost patients
• individual funding requests
• continuing healthcare
• transformation schemes
• acute ambulance services
• integration schemes.

The financial position of the CCG will continued to be reassessed and refined using simulation modelling on the significant variables such as income, activity, demographics, etc ahead of the CCG allocations so that a robust upside and downside of the underlying financial position of the CCG can be understood by member practices and the whole health economy.
6. Strategy

6.1 Gateshead CCG Success so far

The Gateshead CCG pathfinder application set out the following priority areas:
- Prescribing
- Maintaining good medical practice
- Urgent Care

Achievements to date against these priorities are highlighted below:

**Prescribing**
- We moved to real practice prescribing budgets from February 2011;
- To reduce variation in prescribing quality across and within practices we provide prescribing information on four key indicators to individual practices through the Business Intelligence Reporting Tool (BIRT) information system;
- We are working with practices and Gateshead Health NHS FT to achieve planned savings in prescribing. We are implementing an action plan with clear and measurable deliverables and are currently projected to over achieve our QIPP target by £170k;
- A joint work plan has been developed to reduce clinical variation for Osteoporosis and chronic non-malignant pain management.

**Maintaining good medical practice**
- We have developed a Combined Predictive model (Risk stratification tool) for use in primary care;
- Practice visits have been held to review activity and identify areas for change. Action plans have been developed with GP practices and further visits arranged for May/June 2012;
- Peer review sessions have been successfully embedded across Gateshead, with peer review being carried out for prescribing, out patient referrals and emergency admissions. An example of the good work is a dramatic improvement in prescribing of Safer Non-steroidal anti-inflammatory drugs (NSAID): ibuprofen & Naproxen with 25 of the 34 practices improving in Q3 2010/2011, moving Gateshead to number One in the country.

**Urgent Care**
- We have implemented a successful nursing home pilot, providing specialist nursing input into nursing homes to improve patient outcomes. We have won an NHS Alliance acorn award for excellence - **winner 2011 for the Gateshead Care Home programme**;
- We have developed a Community IV antibiotics service for patients with cellulitus as an alternative to admission to hospital;
- We are continuing work with the primary care organisation to ensure appropriate primary care response to urgent care problems and improve access to GPs for patients in Gateshead;
- We have agreed a vision for urgent care in Gateshead (patients have universal access to high quality urgent and emergency care services 24/7; whatever the need, whatever the location, people get the best care, from the best person, in the best place at the best time) and are starting to work towards this through implementation of an urgent care hub. Work is well underway to deliver this.
Other successes

- **CVD** - We have supplied all practices with 24 hour ambulatory blood pressure machines to assist with the diagnosis of hypertension and support practices to implement NICE guidelines. This will lead to fewer referrals to secondary care and provide care closer to home;

- **Sexual Health** – We have developed a pathway to introduce mentoring through a sexual health Local Enhanced Service for insertion of mirena coils to manage menorrhagia and we have supported the development of a sexual health LES in Gateshead;

- **Musculoskeletal** - We have developed an Musculoskeletal Clinical Assessment and Treatment service (MSK CATS) service in Gateshead which has been implemented to reduce referrals to secondary care; developed a community based self referral physiotherapy service; reviewed and developed services to manage carpal tunnel. We have won the Northern Health and Social care award for community musculoskeletal services in Gateshead;

- **Other** - We are currently rolling out a successfully piloted community based pulmonary rehabilitation programme for chronic obstructive pulmonary disease patients; have developed a new model of care for an intermediate dermatology service in Gateshead (out to tender to be implemented April 2012); are involved in the procurement and development of the memory protection service for early diagnosis of dementia (due to be implemented April 2012); and are currently redesigning the diabetes pathway in Gateshead together with partners.;

- **GIN** - Gateshead Information Network (GIN) have established a web portal for use by healthcare professionals in Gateshead. This allows up to date clinical and non-clinical information to be stored in one central place, including local guidance, patient pathways, referral forms and contacts. The site reduces the reliance on email and paper based information and enables best practice to be shared with other clinicians.

6.2 Overview of Strategic Objectives and initiatives

To achieve the vision Of Gateshead CCG by 2017, the five key strategies identified in the NHS Outcomes Framework will be used to help achieve Gateshead CCG’s vision and to move Gateshead from where it currently is now, to where it wants to be:

1. Preventing people from dying prematurely;
2. Enhancing quality of life for people with long term conditions;
3. Helping people recover from episodes of ill health or following injury;
4. Ensure people have a positive experience of care;
5. Treat & care for people in a safe environment & protect them from avoidable harm.

In order to deliver the NHS Outcomes Framework, Gateshead CCG has configured its clinical structure and aligned its clinical priorities/objectives to mirror that of the five key strategies of the NHS Outcomes Framework.

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6 The NHS Outcomes Framework 2012/13
(http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131723.pdf)
Figure 10: Gateshead Clinical Structure

- **Gateshead CCG Governing Body**
  - **Gateshead CCG Executive**
    - **Exec. GP Lead Domain 1**
      - Clinical
      - Engage
      - Locality
      - Prevent
      - Obs, Gynae & Sexual Health
      - Cancer & End of Life
      - Child Health
      - Prevention & Screening
    - **Clinical Leads**
      - Diabetes
      - CVD
      - Respiratory
      - Quality of Life for Carers
      - Planned Care 1
      - Planned Care 2
    - **Domain 1**
      - Preventing people from dying

- **Exec. GP Lead Domain 2**
  - Clinical
  - Engage
  - Locality
  - LTC & Planned Care
  - Secondary Care
  - West
  - **Clinical Leads**
    - Urgent Care
    - Re-ablement & Rehab
    - **Domain 2**
      - Enhancing quality of life for people with long term conditions

- **Exec. GP Lead Domain 3**
  - Clinical
  - Engage
  - Locality
  - Urgent
  - Community Urgent
  - Inner West
  - **Clinical Leads**
    - Adult Mental Health
    - Dementia
    - Learning Disabilities
    - **Domain 3**
      - Helping people to recover from episodes of ill-health or following injury

- **Exec. GP Lead Domain 4**
  - Clinical
  - Engage
  - Locality
  - Mental Health
  - Mental Health
  - East
  - **Clinical Leads**
    - Prescribing
    - Reducing Variation
    - Informatics
    - Provider Quality
    - Safeguarding
    - **Domain 4**
      - Ensuring that people have a positive experience of care

- **Exec. GP Lead Domain 5**
  - Clinical
  - Engage
  - Locality
  - Primary Care
  - South
  - **Clinical Leads**
    - **Domain 5**
      - Treating and caring for people in a safe environment and protecting them from avoidable harm
Fig. 10 outlines five clinical Domains, made up of GP clinical leads with special interests that will, together, help deliver the national and local priorities. Each Domain has a GP lead that is also a member of the Gateshead CCG Executive, ensuring clear channels of communication throughout the organisation, facilitating delivery of this plan.

Fig. 11 gives an overview of the Gateshead CCG strategy; a plan on a page which flows from left to right. It can be seen from this overview that Gateshead CCG’s strategy has been developed in order to address the challenges faced by Gateshead and the Objectives, Outcomes and initiatives have been aligned to the five NHS Outcomes Framework strategic themes and the five Clinical Domains identified in Fig. 12.

To apply the identified strategies and achieve the outcome aspirations, 13 strategic objectives have been identified across the five Domains:

Domain 1
- Work with partners to maximise prevention and reduce excess deaths;
- Maximise GP contribution to prevention;
- Improve end of life care in and out of hospital.

Domain 2
- Shift management of people with long term conditions from reactive to proactive;
- Increase out of hospital capacity;
- Shift appropriate elective care outside of hospital.

Domain 3
- Develop community services to support the shift of care out of hospital;
- Streamline and integrate reactive services.

Domain 4
- Ensuring people have a positive experience of care underpins all of Gateshead CCG’s objectives, outcomes and initiatives
- Shift mental health care outside hospital, including improving access to counselling and mental health crisis services;
- Improve dementia services.

Domain 5
- Safety underpins all objectives;
- Improving the quality and reducing the cost of prescribing.
Figure 11: Gateshead CCG Plan on a Page 2012 – 2017

Challenges
- Poor quality of life
- Excess cancer, CVD & COPD deaths
- Excess hospital activity
- Growing elderly population
- Fragmented services
- Clinical variation
- Need for financial resilience

Mission
- Enhance people's health, live longer and better lives

Operating Model
- Prevention & early intervention
- Improved access to and delivery of care
- Better joined up care
- Sustain and improve clinical effectiveness and efficiency
- Safety and quality

Objectives
- Reduce years of life lost from causes amenable to healthcare increases life expectancy
- Improve cancer survival rates
- Reduce unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Reduce emergency admissions for acute conditions that should not usually require hospital admission
- Reduce risk of repeat emergency admissions within 38 days of discharge
- Reduce number of high-risk.readmission reviewed by consultant before being discharged
- Improve patient reported outcome measures (PROMs) for selected procedures
- Increase % of people with mental health problems who have accessed psychological therapies
- Reduce number of patient admissions "gate kept" by Crim Meds resolution and case management
- Improve patient experience of hospital care
- Reduce adverse incidents involving severe harm or death
- Reduce prescribing costs

Outcomes
- Early detection and identification of cancer
- Advanced care plans & DNR
- Teaching and sharing of cancer standards
- Remote breast screening
- Cancer pathways aligned to NICE guidance
- Redo/redo heat parentage
- Increase OP access to local non-invasive and I&I
- Eliminate outcomes of specialist palliative care
- Reduction of mortality: Falls Care

CCG Initiatives 2012/13
- Early detection and identification of cancer
- Advanced care plans & DNR
- Teaching and sharing of cancer standards
- Remote breast screening
- Cancer pathways aligned to NICE guidance
- Redo/redo heat parentage
- Increase OP access to local non-invasive and I&I
- Eliminate outcomes of specialist palliative care
- Reduction of mortality: Falls Care

2013/14
- Early detection and identification of cancer
- Advanced care plans & DNR
- Teaching and sharing of cancer standards
- Remote breast screening
- Cancer pathways aligned to NICE guidance
- Redo/redo heat parentage
- Increase OP access to local non-invasive and I&I
- Eliminate outcomes of specialist palliative care
- Reduction of mortality: Falls Care
6.3 Initiatives to deliver changes

As part of the development of this Commissioning Plan, Gateshead CCG has played a key role in shaping the detailed changes planned for the NHS in Gateshead in 2012/13, known as commissioning intentions.

The initial list of changes was generated from the PCT legacy strategy but Gateshead CCG has scrutinised and changed this to fit as its own strategy emerges.

2012/13 is a year of transition, as commissioning transfers from PCT to CCG. Gateshead CCG has agreed, delegated responsibility for the priorities set out in the Pathfinder application for 2011/12. Gateshead CCG is currently extending their lead delivery role to a broad range of priorities in 2012/13, on a path to accountability for the full agenda from April 2013. Taking on increasing responsibilities on a phased basis will both assist with the rapid development as an effective decision making body and provide the evidence of delivery required for authorisation.

A structured process has been used to allow the organisation to:

- become familiar with the full agenda to help in determining this 5 year plan;
- influence, shape and change the initiatives planned for 2012/13;
- decide where to focus CCG efforts in 2012/13, in addition to Pathfinder priorities.

Working with PCT strategic leads, the CCG Board, with input from the Gateshead Director for Public Health, identified potential changes with each of the strategic objectives which were considered suitable for the organisation to lead upon, in 2012/13 as noted in Appendix 4.

Gateshead CCG agreed a set of standard prioritisation criteria against which potential changes were reviewed and used a simple scoring system to score each change based on impact and do-ability, informed by local engagement. The simplicity of the scoring helped the discussion but also meant some subtleties of impact and do-ability needed to be reflected in addition to the scores and this was reflected in the outcome of the process.

A key vehicle to help the CCG deliver change is the Practice Clinical Commissioning Project (PCCP). The PCCP is a two way process between CCG and practices and involves every GP practice across Gateshead. Practices take ownership regarding their own activity performance and are supported to develop and implement specific plans to address, sharing good practice across Gateshead wherever possible.

6.4 Programmes of work for 2012/13

Gateshead CCG is currently developing strategic programmes of work to link with clear clinical leadership. These strategic programmes build upon the work commenced by the PCT and are built around the five domains of the NHS Outcomes Framework, which mirrors the five domains of the organisations clinical structure.
These detailed programmes, grouped into the five Domains will link all the changes back to the organisations vision and can be viewed in full in Appendix 5. It describes for each:

- Why is change needed?
- How do we want the future to look?
- What are we doing about it?
- What impact will these actions have?
- How much will this cost or save?
- What capacity and capability is needed to deliver the planned changes?
- What is distinctive about the planned approach?
- How do planned initiatives improve quality, prevention and productivity through innovation?
- How will we know we are doing what we planned and that our actions have the desired impact?

6.5 Contracts agreed and signed off

In accordance with the requirements of the Department of Health deadline of the 31st March 2012, contracts were signed off with all of the major NHS providers with whom Gateshead CCG is the co-ordinating commissioner.

Moving forward Gateshead CCG has arrangements in place to collaborate with neighbouring CCG’s where there is more than one CCG contracting with a provider. Gateshead CCG will be the lead Commissioner for the acute contract with Gateshead Health NHS Foundation Trust and Newcastle upon Tyne Hospitals NHS Foundation Trust. Gateshead CCG will also be an ‘Associate’ to several other acute contracts, the most significant being South Tyneside NHS Foundation Trust. Fig. 12 details the key contracts and their respective value.
### Figure 12: Gateshead CCG key contracts and respective value

<table>
<thead>
<tr>
<th>Provider</th>
<th>Contract Type</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateshead Health NHS Foundation Trust</td>
<td>Lead Commissioner</td>
<td>£123,990,651</td>
</tr>
<tr>
<td>City Hospitals NHS Foundation Trust</td>
<td>Associate Commissioner</td>
<td>£3,244,730</td>
</tr>
<tr>
<td>Northumbria Healthcare NHS Foundation Trust</td>
<td>Associate Commissioner</td>
<td>£1,844,803</td>
</tr>
<tr>
<td>South Tyneside NHS Foundation Trust*</td>
<td>Associate Commissioner</td>
<td>£32,411,739</td>
</tr>
<tr>
<td>Newcastle upon Tyne Hospitals NHS Foundation Trust</td>
<td>Lead Commissioner</td>
<td>£36,482,710</td>
</tr>
<tr>
<td>County Durham and Darlington NHS Foundation Trust</td>
<td>Associate Commissioner</td>
<td>£2,379,618</td>
</tr>
<tr>
<td>North East Ambulance Service</td>
<td>Associate Commissioner</td>
<td>£7,614,622</td>
</tr>
<tr>
<td>Northumberland, Tyne and Wear NHS Foundation Trust</td>
<td>Associate Commissioner</td>
<td>£18,308,316</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>£226,349,189</strong></td>
</tr>
</tbody>
</table>

*Includes community services provision*

### 6.6 Triangulation of activity, workforce and finance

Gateshead CCG has agreed contract levels with its main providers which broadly reflect the actual activity levels in 2011/12. Reflecting the activity over performance, there has been substantial additional investment in 2012/13, particularly in elective activity.

Linking with workforce planning, Gateshead CCG discussions with providers describe a potential reduction in staffing of around 1.5% in 2012/13 across South of Tyne and Wear. Discussions with providers, suggest that the Trusts will be able to make these moderate productivity gains through continued improvements in sickness and absence; greater skill-mixing and more effective use of overtime. It may be possible to find additional paybill savings out of reviewing terms and conditions of employment, pay and incremental progression and looking for efficiency savings out of non-workforce areas, e.g. estates, day case and medicines costs.

Rather than detailed, quantitative assessment of provider-based workforce plans, the main mechanism by which Gateshead CCG will gain assurance that the workforce of its providers is of sufficient capacity and capability to deliver safe, high quality services for the Gateshead population, is the use of the workforce “key lines of enquiry” and the national workforce assurance framework.

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7 Planning and Developing the NHS Workforce: The National Framework  
(http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114866.pdf)
6.7 2013/14 Draft Commissioning Intentions

The 2013/14 Commissioning Intentions for Gateshead CCG will build on the progress achieved in this financial year and also initiate the additional planned changes the organisation wishes to make in realising its longer term vision. The commissioning intentions will also be influenced by the emerging priorities identified in the Gateshead Health and Wellbeing strategy in order to ensure better integrated commissioning.

The process for developing Gateshead CCG’s commissioning intentions includes strong input from the Gateshead community and strong clinical input from its 34 member practices. The process commences with numerous stakeholder events to discuss current health issues and clinical priorities across Gateshead, in order to involve stakeholders in health commissioning decisions for the coming year.

Stakeholder events are hosted at the Local Engagement Board, to involve the public, and are also hosted at TimeIn/TimeOut events to involve primary care. A dedicated engagement event is to be held, bringing together representatives from the local Foundation Trusts, Local Authority, Third Sector and Patient and Carers.

To ensure that this process is clinically led by the 34 member GP practices of Gateshead CCG the Practice Board of Gateshead CCG (made up of one GP from each of the 34 practices of Gateshead) is involved with developing the intentions and has ultimate responsibility in approving the draft intentions prior to contracts being developed and drawn. The Gateshead CCG Practice Board will convene in January 2013 to finalise this process and confirm commissioning intentions for 2013-14. The draft commissioning intentions 2013/14 currently include:
Domain 1

- Early detection and identification of cancer;
- Advanced care & Do Not Attempt Resuscitation;
- Teenager and young adult cancer standards;
- Remodel breast cancer services;
- Cancer pathways aligned to North of England Cancer Network (NECN) model pathways;
- Radiotherapy local provision;
- Increase GP access to non obstetric ultrasound and MRI;
- Deliver outcomes of specialist palliative care with NECN;
- Increase use of Palliative Care Register in practices;
- Initiatives to realise a gold standard delivery of Children’s Services:
  - Implement the recommendations of the Speech, language and communication needs review working in partnership with the Local Authority to ensure the model meets the current and projected needs of the local population;
  - Implement recommendations from the review of Community Children’s Nurses and palliative care for children and young people in line with the SEND pathfinder in Gateshead;
  - Working in partnership with Local Authority support the review of the SEN assessment and statement framework. Explore the potential for changing / revising the existing systems with an assessment process, a single, joined up ‘Education, Health and Care Plan’;
  - Develop mechanisms to implement personal health budgets for children and young people in line with National requirements (implementation from 1st April 2014). Working closely with CCG colleagues in Newcastle to develop a standardised approach;
  - Ensure early intervention and prevention is woven into commissioning arrangements across children and young people’s health care;
  - Monitor implementation of the maternity specification and newly introduced PbR tariff
  - Contribute to ongoing CQC and Ofsted inspections and work in partnership to implement recommendations arising;
  - Develop a review programme of service specifications and their monitoring arrangements for community based children services and maternity against existing evidence base. Identify opportunities to develop innovative practice;
  - Work with key partners to support the implementation of an integrated commissioning model for children and young people working across CCG, LA, PHE and NHS CB.
Domain 2

- Review of nurse led clinics;
- Review Critical Care;
- Review community midwife service;
- Review paediatric neuro rehab;
- Introduce standard referral protocols, indicative costs on referral forms;
- Consultant to consultant referral policy implementation;
- Initiatives to realise gold standard Cardiovascular Disease service:
  - Community arrhythmia;
  - Heart failure service;
  - Community stroke rehab;
  - Heart failure rehabilitation for housebound and for west of Gateshead;
  - Continue heart failure LES;
  - Expand heart failure service to include HFPEF;
  - Review of leg ulcer pathway and associated services;
  - Expand stroke rehab to include acquired brain injury.

- Initiatives to realise gold standard Respiratory Disease service:
  - Develop a commissioning model for Long Term Conditions (Self Care) - review the future commissioning arrangements of self care services & embed self care opportunities into health care core services;
  - Develop a commissioning model for Long Term Conditions (Specialist Rehabilitation) - Commission new models and approaches to specialist rehabilitation;
  - Review the Chronic Obstructive Pulmonary Disease pathway and identify improvements that could be made to improve patient care;
  - Increase the use of risk stratification tools including the combined predictive model across primary community and secondary care;
  - Pilot of ‘case finding’ microspirometry followed by quality assured diagnostic spirometry for those identified;
  - Re-commissioning of Pulmonary Rehabilitation – that is to commission less Hospital PR activity and mo-re Community PR activity.
### Domain 3
- GP led MIU model - Acute Hub on QE site;
- 111 single point access;
- Proactive review of urgent care attendance data, non-elective activity and primary care same day access;
- Improving access to primary care medical notes for community colleagues;
- CPM tool for tier two patient with COPD;
- Introduce Telehealth technology;
- Nursing homes support nurses;
- Palliative care OOH – establishing single point of access;
- Improving/providing respite and PIC beds for patient in Southernwood;
- Seasonal planning + escalation arrangements;
- Ambulatory care pathways avoiding inappropriate admissions.

### Domain 4
- Implement mental health model of care including resource releasing initiatives & Payment by Results (PbR);
- Further development of IAPT;
- Further develop access to mental health services;
- Increase health checks for people with learning disabilities;
- Implement the national dementia strategy;
- Progress joint commissioning arrangements with Local Authorities.
Domain 5

- Savings from prescribing of drugs in secondary care;
- Initiatives to realise a gold standard medicines management services:
  - Develop a comprehensive Medicines Optimisation Strategy which will include a plan to develop links with the Local Professional Network (LPN) to ensure engagement with community pharmacy;
  - To have an action plan in place to improve the quality of prescribing, optimise medicines usage in patients and deliver disinvestment opportunities in Primary Care prescribing and address variation in prescribing in the primary care setting;
  - Work with stakeholders, including secondary care, to develop a health economy approach to prescribing of medicines across pathways of care, including initiatives to improve effectiveness of communication, the transfer of prescribing responsibility, reduction in variation of prescribing and supply of medicines;
  - Work with the CCG to ensure there are robust local mechanisms for funding approval for medicines and implementation of NICE guidance;
  - Ensure collaborative working across community care is maintained in relation to wound management;
  - Work with other clinical leads to address medicines optimisation requirements of the CCG wider commissioning intentions;
  - Work in collaboration with Secondary Care to optimise efficiency through improved management, procurement and monitoring of secondary care medicines and Homecare;
  - Explore options to reduce medicines waste and support to patients in the community which includes implementation of RPS guidance on medicine waste and the recommendations from the Regional Behaviour Change Project;
  - Explore options for alternative provision of gluten free products in primary care with relevant stakeholders;
  - Ensure that robust systems are in place for appropriate advice on the legal, safe and secure handling of medicines including any CCG requirements for the safer management of controlled drugs;
  - Make links with Local Authorities and Health and Wellbeing Boards to ensure, where appropriate, that commissioned medicines services are coherent, linked up across the CCG and wider localities and meet the public health need;
  - Mobilise the contract for provision of medicines management support to individual practices within the CCG, include development and implementation of a COMPACT agreement with those practices.

The number of commissioning intentions for each Domain are reflective of the size of the challenge for both the Domain and the challenge of the individual intention.

The 'plan on a page' (see Fig. 11) provides an overview of how the planned changes for 2013/14 will build on the initiatives implemented to date and link to Gateshead CCG’s strategic objectives and delivery of the long term vision.

These initiatives will be built upon during the commissioning intentions process for 2013/14 which will commence in September 2012.
Key activities and milestones for developing these commissioning intentions are:

- Identification of detailing planned changes for inclusion in 2013/14 contracts;
- Incorporate national requirements and performance standards specified in 2013/14 NHS Operating Framework;
- Delivery of 2nd year of local QIPP programme including next phase of resource releasing initiatives;
- Prioritisation of planned changes in order to ensure balanced financial plan;
- Production of CCG 2013/14 Integrated Strategic and Operational Plan (CCG ISOP);
- Underpinned by ongoing involvement with the Health and Well Being Board together with partners, providers and the public to inform and shape our plans.

6.7.1 Outcomes for Gateshead by 2014/15

By implementing this plan and by confirming and delivering the 2013/14 commissioning intentions, Gateshead CCG aims to deliver the following improvements across Gateshead by 2014/15:

- Increased life expectancy;
- Improved Cancer survival rates;
- Reduced unplanned hospitalisation for chronic ambulatory care sensitive conditions;
- Reduced emergency admissions for acute conditions that should not usually require hospital admission;
- Reduced emergency readmissions within 30 days of discharge;
- Reduced number of high risk re-attenders reviewed by consultant before being discharged;
- Improved patient reported outcome measures (PROMs) for elective procedures;
- Increased percentage of people with anxiety disorders and depression who access psychological therapies;
- Increased number of inpatient admissions ‘gate kept’ by crisis resolution and home treatment teams;
- Improved patient experience of hospital care;
- Reduced safety incidents involving severe harm or death;
- Reduced prescribing costs.

These outcomes relate to the long term plan for Gateshead and will be built upon for the coming years commissioning intentions. As part of this process the level of expected improvement for each of these points will be quantified.
Impact of the strategy on the market

6.7.2 Impact on Gateshead CCGs plan on acute services

Why is change needed?

- Levels of hospital activity exceed current contract levels;
- Financial context (reduced growth in NHS funding) including the national changes in 2012/13 tariff and the local requirement to generate savings to fund health improvement programmes;
- Fragmentation and lack of integration of current services across acute, community and primary care services.

What will the acute sector look like in the future?

- Safe, high quality care which is consistently delivered and routinely evidenced through commissioning mechanisms;
- Reduced admissions as more care available closer to patients homes; with routine treatment increasingly provided in primary and community settings;
- Greater internal efficiency achieved through reduction in overheads to cope with changes in tariff, impact of local resource releasing initiatives and better integration and streamlining across care pathways.

How will we ensure this happens?

- Services commissioned based on best clinical evidence available; in line with NHS Quality improvement framework using relevant standards and best use of available levers to maximise outcomes for local people;
- Use of incentives implemented via CQUIN and agreed NE wide penalties in contracts;
- Additional reablement funding targeted at preventing admissions and speeding up discharge.
6.7.3 Impact of Gateshead CCG’s plan on the mental health and learning disabilities sector

**Why is change needed?**

- Ageing population will increase numbers of people with dementia;
- Variable access to adult and children’s mental health services;
- Complicated care pathways restrict appropriate access to relevant, timely interventions.

**What will the acute sector look like in the future?**

- New model of care with integrated pathways across sectors with all partners working in collaboration will deliver personalised holistic care for patients and their carers and drive increased productivity and efficiency through greater integration and streamlining;
- Re-provision of Gateshead inpatient services will provide highly specialist care only;
- Strengthened community teams able to provide breadth of early interventions and services to patients in the community.

**How will we ensure this happens?**

- Building effective partnerships as model of care addresses 'whole-system' in particular interface issues between sectors and organisations;
- Improved information systems and data collection and data sharing across pathways and sectors;
- Joint collaborative commissioning arrangements with partners will ensure new model is implemented to planned timetable;
- Inclusion in contract specifications of meaningful personalised outcome measures for service-users.
6.7.4 Impact of Gateshead CCG’s plan on primary and community care

Why is change needed?

- Need capacity and capability to respond to increasing elderly population and shift of activity out of hospital;
- Variation in quality, outcomes, patient experience and type of care offered;
- Major health problems and stark health inequalities across Gateshead.

What will the acute sector look like in the future?

- Standardisation of provision;
- Increased identification of people with risk factors in early stages of disease;
- Optimum treatment pathways with standardised care consistently provided by all GP Practices.

How will we ensure this happens?

- Ensuring a multi disciplinary approach where appropriate to enable a holistic approach to care planning;
- Consistent standard application of optimum pathways in primary care resulting in a reduction in clinical variation;
- Procurement / contracting to drive up quality through CQUIN and incentivising preventative schemes;
- Commission specialist community services to provide urgent and planned care at home or in the community.
7. Delivery and Transition

7.1 Organisational Development

Organisational development is a planned and systematic approach to enabling sustained organisational performance through the involvement of its people; it is often termed as the “oil that keeps the engine going”.

Gateshead CCG has fully embraced the philosophy and concept of Organisational Development (OD) and agree this strategic approach to development is of critical importance at a time when the NHS operating system is undergoing such significant and fundamental change.

The key OD aim of Gateshead CCG is to be a:

‘Clinically led and managerially enabled organisation’

Gateshead CCGs organisational Development (OD) Strategy 2012 - 2014 has been developed in order to:

- Support the delivery of this Commissioning plan;
- Enable the Board to mature and expand its skill and knowledge base on our journey towards authorisation and beyond;
- Achieve authorisation by December 2012;
- Ensure that the actions taken in the shorter term support delivery of the organisation’s longer term objectives;
- Ensure that the organisational enablers for delivery are in place and being progressed; and
- Be refreshed regularly as different needs are identified within the Board and as requirements change.

As a clinically led organisation, Gateshead CCG will add value and build upon the current NHS South of Tyne and Wear Integrated and Strategic Operational Plan (ISOP). Gateshead CCG is working closely with the PCT to ensure effective knowledge transfer and management of legacy prior to and beyond April 2013.

A key milestone for Gateshead CCGs development is to achieve authorisation by the end of 2012. The Department of Health self-assessment diagnostic tool was utilised to assess the organisations current state against the 6 domains for effective clinically led commissioning organisations.

Members of the Board completed the diagnostic tool, followed by whole Board dialogue to test assumptions, challenge perceptions and agree the current state of organisational health and the key areas for development.
Following completion of the authorisation diagnostic tool in October 2011 Gateshead CCG identified a number of actions under each of the domains outlined within this tool. These actions were grouped into key themes, which are detailed below:

- Communication & Engagement
- Finance
- Governance
- Leadership & People Development
- Practice Involvement
- Structure & Support
- The Clinical Commissioning Cycle

A Board link was identified for each theme and milestones with key timelines agreed for implementation. As a result a critical path for development was established with nominated Board leads. This OD action plan has been continually updated as the organisation progresses towards Authorisation and can be viewed in full in the Gateshead CCG OD strategy (2012-14)

7.2 Structure and Support

Gateshead CCG identified the creation of an effective organisational structure as critical in both the pursuit of becoming a clinically lead and managerially enable organisation and in the successful delivery of its strategic objectives. This structure will provide the appropriate framework for decision making to be clinically led, to engage and communicate with key stakeholders, and to promote effective leadership at every level of the organisation.

7.2.1 Clinical Leadership Structure

Work on management structures has followed debate and agreement on the appropriate structures for clinical leadership. The proposed management arrangements are aimed at providing maximum support for clinical leaders. There are a number of different dimensions Gateshead CCG has sought to incorporate into their clinical leadership structure. These include:

- All clinical programme areas, and importantly all Gateshead CCG’s priority areas, have been mapped to the five Domains of the NHS Operating Framework\(^8\);
- There is an executive GP Lead for each of the five Domains ensuring clear GP leadership;
- All clinical leads will work in Domain groups defined by the Outcomes Framework to ensure cross cover, peer review and mentoring support;
- This structure allows clarity of communication and decision making between Clinical Leads and the Gateshead Executive;

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\(^8\) The Operating Framework for the NHS in England 2012-13
• Executive GP Domain Leads will also have responsibility for one of the five localities within Gateshead and will be the nominated point of contact for each member practice in that locality. This ensures a direct link between all Gateshead member practices and the Gateshead Executive;
• As a commissioning body contracting, and all its associated activities, will form a large part of what Gateshead CCG does. Each Executive GP leader with responsibility for an Outcomes Framework domain will also have responsibility for a section of the CCG’s contracting portfolio.

To illustrate this proposed way of working, the clinical leadership arrangements for Gateshead are shown in fig. 10. Very similar models are taking shape in Newcastle NE and Newcastle West.

The clinical structure, based around the NHS Outcomes Framework (see fig. 10) ensures that clinical views and clinical input is central to the decision making and to the delivery of this commissioning plan. The result is quality is a high priority across all five clinical Domains and Domain 5 is dedicated to Quality, underpinning this approach.

7.2.2 Management Support Structures

The approach of achieving efficiencies in scale and scope through appointment of shared posts and functions across the Gateshead-Newcastle alliance is continued in the management support structure.

There are two elements to the proposed management structure, a shared central team and local delivery team. All will need to work effectively together to ensure that each CCG and the CCG alliance collectively succeed.

In addition, where appropriate, specialist functions will be outsourced to the clinical support service. It is essential that strong working relations are developed quickly both across the alliance management teams and between the commissioning support service.

7.2.3 Gateshead CCG Governing Body and Executive

In keeping with the philosophy of a clinically led, managerially enabled organisation both the Gateshead CCG Governing Body and Executive have strong clinical representation being in the majority on both body. In addition there are strong lines of accountability back to the 34 GP members that constitute Gateshead CCG via the Gateshead CCG Practice Board.

7.2.4 Primary Care involvement

Gateshead CCG recognises that harnessing the added value clinicians can bring to commissioning is a key factor to successfully improving quality, stimulating innovation and ensuring value for money. Engagement with practices and the wider clinical community has always been a key priority for the organisation. A key focus of activity is to ensure clinical engagement across all health sectors and effective engagement with practices.
As well strong clinical representation at all levels within the organisation, Gateshead CCG plans to build upon work to date in engaging with clinicians on the following 3 levels:

**Practice level**
- Each practice recognises itself as having commissioning responsibilities which are owned, delegated and delivered from the Governing Body;
- *TimeIn/TimeOut* (TITO) sessions are held 6 times a year and are attended by all Gateshead GP member practices. In excess of 250 people attend every TITO;
- Practices are grouped into localities which reflect the 5 LA areas with an Executive GP Domain Lead and Practice Manager Domain Lead aligned to each;
- Regular locality meetings which involve peer review and sharing and learning from each other are held at alternate TITO events;
- The Gateshead Information Network (GIN) is a valued tool that is used by practices and partners to share clinical reference material such as standard referral forms, guidelines and links to other useful sites;
- Produce and circulate a weekly bulletin and monthly newsletter which includes information on local and national issues, updates from all clinical leads and partner organisations on ongoing work and new developments;
- Each practice has signed a practice engagement plan and constitution which will be reviewed to align with national requirements;
- Undertake practice supportive visits to further enhance the relationship between the board and its constituent practices;
- Incentive Scheme – the annual incentive scheme enables practices to formally support the implementation of the commissioning plan;
- Practices can engage in service redesign through completion of audits, peer review and data collection. Outcomes are collated to inform redesign activities and improve pathways as well as change referral behaviours amongst clinicians.

**Clinical lead**
- Clinical leads have been aligned to one of the five Clinical Domains for Gateshead ensuring they form an integral part of the commissioning intentions process and can easily see where there work fits with the overall delivery of the organisations vision;
- The Clinical leads chair local improvement groups that bring together clinicians across the health economy together with management support for priority clinical areas.

This means that views elicited from patients in GP practices, either from patient forums or gained in direct consultation can be fed back to the central CCG team in a variety of ways to inform future planning and decision making.

**Secondary and tertiary clinical engagement**
- The Gateshead joint clinical forum brings together both primary and secondary care clinicians on a regular basis to discuss and agree joint approaches to areas of mutual interest;
- Newcastle clinicians have been invited to the Gateshead joint clinical forum to further improve relationships and foster collaborative working;
- Gateshead CCG now attends the Newcastle “better together” meetings in order to influence developments in clinical pathways;
- Actively engaged with Clinical networks such as cancer and Cardio Vascular Disease;
- Well established Nurses Forum in Gateshead.

7.3 Working with Partners and Stakeholders

7.3.1 Patients and public involvement

Gateshead CCG’s approach to patient and public involvement and engagement is represented in Fig. 13 below. The diagram shows how the CCG needs to work with local people and patients to ensure that their views are heard at all stages of the commissioning process.

Figure 13: Definition for patient and public involvement and engagement

Patient experience captures direct feedback from patients, service users, carers and wider communities through involvement and engagement activity

(Adapted from Health and Social Care Bill (2012), Patient and Public Engagement Toolkit for World Class Commissioning (2011) and (Helping the NHS put patients at the heart of care (2009))

Broadly, involvement and engagement will be carried out across four levels:

1. Corporate
2. Clinical Services
3. GP Practice
4. Community Involvement and Engagement
Corporate
A Lay member will be appointed to the governing body of the CCG board to lead and champion patient and public involvement and engagement. The Lay member will work closely with the CCG Involvement and Engagement Manager to ensure patient and public involvement and engagement is embedded and is central to the commissioning process.

The Local Engagement Board (LEB) has been refocused and is now being driven by the CCG with continued support from the Gateshead CCG chair to engage patients and the public. LEBs are central to working with the public to support the development of more patient involvement structures. The CCG is leading the four meetings planned throughout the year giving presentations to update and inform local people about CCG services and developments. The agenda is aligned to the commissioning cycle to ensure PPI throughout the commissioning process is visible and transparent and effective in involving people at the highest levels.

The Gateshead Patient User Carer Public Involvement Group (PUCPI) is an established group with in excess of 80 members including the voluntary and statutory sector. The agenda is driven by members of the group. In monthly meetings this active group has contributed to the development of strategic plans, participated in national and local consultations and worked on local grass roots issues. The meetings are chaired by the CCG involvement and engagement manager and the PPI the board lead attends each meeting. An issues and action log has been developed by the group, the log is presented to both the Executive and Governing Body for information and action as standing agenda items.

Clinical Services
Clinical Leads will continue to ensure appropriate involvement and engagement mechanisms are in place to involve patients in the reviewing of current services and the development of new services. It is recognised that patients' views and experience of services lead to more efficient and effective pathways and is a pre-requisite in any change to services. This area of involvement is viewed as an area of strength for the CCG as patients have successfully been involved in the development of new services including dermatology and the review of a range of existing services including diabetes, muscular skeletal services and audiology.

GP Practice
As providers GP’s are being encouraged to establish patient forums to elicit views from patients on the services they receive.

Currently, any insights relating to patient choice and broader health needs gained in practice consultations or practice engagement can be feedback to the central CCG team in a number of ways to inform future planning and decision making.

Community Involvement and Engagement
The CCG has demonstrated its commitment to community involvement and engagement by signing up to the ‘Gateshead Community Together Strategy’, \(^9\) which brings together the CCG,

\(^9\) Gateshead Communities Together Strategy 2012 -2115 ?This document is currently being refreshed
Public Health, Local Authority and the third sector to make best use of resources and help address the wider determinants of health. Community involvement will be delivered through a range of mechanisms including:

- Five local authority neighbourhood management teams
- Promoting Health Engagement Team – Public Health
- Community Networks
- Community Volunteers
- Health Champions
- Community Groups
- LINk (Health Watch from 2013)

The themes identified will be fed into commissioners through the Health and Well Being Board.

7.3.2 Working with partners and stakeholders

Gateshead CCG has a well-established history of partnership working and actively pursues the development of productive relationships with key stakeholders across Gateshead. The CCG plans to continue to build upon existing communication mechanisms already put in place as detailed below:

**Providers**

- Communicate the vision for more integrated community and primary care services to prevent unnecessary hospital admissions to South Tyneside Foundation Trust, provider of Community Services;
- Regular meetings are held with the Executive Officers of Gateshead Health NHS FT as part of a joint strategy for urgent care services and the objective for an integrated urgent care hub on the acute site;
- Regular meetings are held with the Medical Director and Director of Business development at Newcastle hospitals;
- Streamlining Care events have been organised in conjunction with the Local Authority and Gateshead Health NHS FT to remodel pathways around the urgent care agenda.

**Local Authority**

- Continue to engage with the local authority in delivering health improvement in Gateshead;
- The Director of Public Health for Gateshead is a member of the Gateshead CCG Board;
- Continue to engage with the Local Authority in a variety of ways, including informal discussions with the Chief Executive and Leader, formal representation at the Shadow Health and Wellbeing Board, Health Transition Reform Group and Health and Social Care Partnership;
- Continue to be a member of the JSNA Steering Group, where Gateshead CCG clinical expertise can be utilised in the shaping of the JSNA for Gateshead;
- Continued representation on the Local Area Forums across Gateshead.
- All councillors in Gateshead with interests in health have been met and are piloting health seminars for members where local GP’s can present topical areas of strategic importance for discussion.
Members of Parliament

- The three members of parliament that represent Gateshead regularly meet with the GP Chair of Gateshead CCG. Relationships are established and continue to be developed with future meetings and events scheduled.

Health and Well Being Board

The Health and Wellbeing Board (HWB) is chaired by the leader of Gateshead Local Authority and Gateshead CCG has formal membership on this board. Clear communication channels have been established between the HWB and the Gateshead CCG Governing Body with HWB minutes formally received by the Governing Body.

The Health and Wellbeing board has the following priorities which Gateshead CCG is participating in:

- To ensure a focus on the wider determinants of health, including deprivation, employment, education and environment;
- To join up the ongoing programmes of disease management and lifestyle work with tackling the wider determinants of health;
- To develop a prototype strategy 'Big Shift Plus' which includes an input from Gateshead CCG on early detection, secondary prevention and treatment, alongside Local Authority led work to tackle healthy lifestyles, engage with communities;
- Contributing to 'Active and Healthy' a key idea within The Sustainable Communities Strategy Vision 2030[10].

Gateshead CCG has worked to ensure these priorities are reflected in the organisations Commissioning plan (Integrated Plan). In addition, Gateshead CCG is inputting to the development of the Gateshead HWB strategy and will ensure its own commissioning intentions and plans reflect this.

As part of this work Gateshead CCG jointly commissions services with Gateshead Council in a number of areas. These include section 75 and section 256 agreements in the following areas:

- Community Equipment Service;
- Mental Capacity Act co-ordinator;
- Continuing Healthcare.

The Head of Commissioning Development for Gateshead CCG is a member of the HWB and the framework for a draft strategy has now been produced and agreed by this group. The draft HWB strategy will be taken through a full public consultation between August and October 2012 before being taken back to the Shadow HBW on 26th October 2012. Following this a final

version will be produced and taken to the HWB in February 2013 in preparation for when the board assumes its formal responsibilities in April 2013.

Gateshead CCG recognises there are many other stakeholders and partners with whom the organisation needs to engage over time and in a variety of ways. A stakeholder mapping exercise undertaken as part of the diagnostic tool kit has been developed into the Gateshead CCG Communications and Engagement Strategy (2012 - 2014) to underpin how this work is taken forward, building on reflections of work done to date.

### 7.3.3 Working with other CCGs

Gateshead CCG is committed to working closely with both Newcastle CCGs to realise a number of significant common opportunities as commissioners:

- Patient flows to Newcastle Hospitals, Gateshead Hospital, South Tyneside Community Services, Northumberland Tyne and Wear and North East Ambulance Services NHS Foundation Trusts;
- Two local authorities, Newcastle City Council, and Gateshead Council, who work closely together;
- Similar population cultures and issues;
- Critical mass in size to ensure longer term stability;
- Ability to attract high calibre people to work with the CCG’s;
- Greater influence over providers.

This is realised in the shared management structure, the three Governing Bodies meeting simultaneously and shared Quality, Safety & Risk committee and shared, Finance & Performance committee. Specific activities where Gateshead CCG is collaborating and working jointly together across the Gateshead-Newcastle alliance include:

- Delivery of QIPP initiatives;
- Operation of lead and associate CCG commissioner model with local trusts;
- Development of national and regional networks;
- Developing joint risk arrangements;
- Agreement to jointly procure and share commissioning support across the alliance to complement local in house support and services procured from the commissioning support service;
- Participating the identification and disaggregation of the NE Specialised Commissioning Contract, which is currently hosted by NHS North of Tyne, and will transfer to the NHS Commissioning Board in 2013/14.

### 7.4 Delivery of safe high quality care

Gateshead CCG success will be measured by the NHS Commissioning Board against the Commissioning Outcomes Framework which reflects the priorities set out in the NHS Outcomes Framework. The five domains of the outcomes framework are derived from the three part definition of quality:
• Effectiveness of care;
• Patient experience;
• Patient safety.

Gateshead CCG is committed to delivering quality improvement across these three areas of quality. The organisation will ensure truly clinically led commissioning, ensuring quality and outcomes drive everything.

7.4.1 Safety

Healthcare acquired infections
Gateshead CCG will lead an approach for all relevant providers of NHS care that aims to monitor progress against infection control targets such as MRSA, C difficle, MSSA and eColi across the health community and most importantly to facilitate the sharing of learning and best practice to improve outcomes for patients.

Safeguarding
Gateshead CCG will work in partnership with the Local Authority and other relevant organisations to ensure that statutory duties regarding the health and well-being of looked after children are met. The organisation will lead on safeguarding adults and interpret and implement emerging statutory responsibilities across the health economy.

Safety systems
Gateshead CCG will maintain systems to manage serious incidents and incidents as appropriate and identify themes and trends to inform quality improvements. Incident reporting in Primary Care is being actively promoted.

7.4.2 Clinical effectiveness

Gateshead CCG will establish a systematic process to review published guidance and ensure these are used in pathway or service reform or reviews. Analysis of published audits and data will be used to secure assurance identifying and addressing unwarranted clinical variation.

7.4.3 Patient experience

Gateshead CCG will review published patient experience information and locally collated patient experience information to provide assurance and identify areas for quality improvement. The organisation will feedback to patients and the public how the information has been used and the improvements made as a result.

7.4.4 Quality assurance and improvement in commissioned services

Gateshead CCG will:
• develop and maintain relationships with providers to ensure continuous dialogue on quality;
• secure and use quality assurance information from a broad range of sources both external and local;
• identify areas for improvement, respond to areas of concern in relation to quality and monitor accordingly;
• maximise use of contractual levers to secure quality improvement e.g. use of quality indicators and Commissioning for Quality and Innovation (CQUIN) schemes;
• promote the implementation of national guidance and standards with all providers;
• work with associate/lead commissioners, including local authority, to maximise quality assurance/improvement in commissioned services;
• summarise quality assurance reports to CCG Board as the accountable body.

The diagram in Fig. 14 highlights the range of activities which collectively provide assurance of the quality of commissioned services. This approach to planning and commissioning of health services ensures that the three pillars of quality - Effectiveness of care; Patient experience; and Patient safety are fully incorporated into the planning and commissioning process for Gateshead CCG.
7.5 Enablers of delivery

7.5.1 Workforce

Developing and remodelling the workforce is critical to the delivery of this Plan to ensure that Gateshead CCG has a workforce that is fit for purpose, working flexibly across boundaries in integrated pathways in order to provide patient centred quality care. In developing the objectives and initiatives, a number of generic workforce requirements have been identified, including the need to:
Gateshead CCG will work with the Local Education and Training Board (LETB) to address these generic workforce requirements, and ensure that appropriate planning and commissioning of education is in place to respond to future commissioning needs.

7.5.2 Workforce changes and assurance

With regards to workforce, local FT’s are identifying areas where paybill savings can be achieved to improve productivity including:

- Reductions in mean sickness absence rate;
- Reduction in temporary staffing, agency costs and reduction in the use of overtime;
- Reviewing skill mixing and re-profiling vacant posts;
- Reviewing terms and conditions of employment, pay and incremental progression;
- Efficiency savings out of none workforce areas, e.g. estates, day case and medicines costs.

For Gateshead CCG to assure itself of Quality and Safety in provider workforce plans to deliver this change in workforce, the PCT have integrated the 9 national assurance Key Lines

- Build capacity and capability to provide the skills to improve health and deliver the new types of services required;
- Enable the effective transfer of services from acute to primary / community settings through development of skills to support integrated care delivery within pathways and across organisational boundaries;
- Develop a broader skills base in all sectors of the generic workforce to deliver health improvement messages routinely within care delivery i.e. every contact is health improvement opportunity;
- Develop robust and meaningful workforce productivity and assurance measures (including the 9 national assurance key lines of enquiry) with early emphasis on community services;
- Support recruitment in specific disciplines, including health visitors, through reform of the existing shape of the workforce, given that the current age profile indicates that a proportion of staff will be retiring in the next five years.
of Enquiry (KLOEs) into formal contracts with the Foundation Trust providers and have received a completed self-assessment for each organisation.

As part of the workforce assurance process, Gateshead CCG has encouraged providers to engage in the collaborative use of the Workforce Assurance Framework (WAF) to support discussions relating to concerns or queries with changes in workforce, finance and activity as part of the Contract and Quality Review meetings. This process will enable the organisation to better understand the emerging pressures throughout the year and the knock on effects on quality, safety and performance.

7.5.3 Informatics

Health Informatics can be defined as the knowledge, skills and tools which enable information to be collected, managed, used and shared to support the delivery of healthcare and to promote health.

Informatics will be a key factor in supporting the delivery of our plan. The three key dimensions are as follows:

1. Gateshead Local Health Community
2. Commissioning
3. Organisational

Gateshead Local Health Community
A roadmap across the health and social care community will be developed, describing the present and future state of information systems and flows. This strategic picture will allow Gateshead CCG to co-ordinate programmes of work across the local health community where there are opportunities to improve the flow of information across organisational boundaries. A joint vision will be sought across all health and social care organisations operating in Gateshead and a strategic network established to deliver this, chaired by the CCG informatics lead. Organisational plans to deliver change across the local health community will be underpinned by local informatics plans that enable, support and are achievable.

Multi organisational programmes will be initiated, planned and delivered, with information governance assurance and confirmation that the strategies of partner organisations will meet local informatics requirements. These include:

- Rolling out Healthlinxx - a common network infrastructure for the Local Health Community (LHC), enabling greater cooperation and collaboration between health professionals for the benefit of patients;
- Development of health portal (Gateshead Information Network) for local health professionals;
- GP integrated working across Minor Injury Units
- Electronic discharge communications, – information flows between primary and secondary care;
• Telehealth – exploitation of technology available to support self care for patients with long term conditions, enabling more integrated care pathways across providers and social care, increasing patient confidence in their ability to manage their condition;
• Risk stratification tools including the combined predictive model across primary, community and secondary care to identify people at high risk of suffering conditions in order to provide preventive intervention.

A data quality framework within primary care will be developed to improve the quality of data held on GP clinical systems, involving cleansing practice lists, as practice data forms the nucleus of clinical records.

**National informatics perspective**
Projects relating to the roll out of national informatics priorities such as 111, GP out of hours, Choose & Book, Electronic Prescription Service release 2, GP2GP record transfer, Summary Care Record, NHS Number and GP Systems of Choice will be initiated, planned and delivered, with risk escalation and assurance that the strategies of partner organisations will meet national informatics expectations. New ways of working will be supported using the standards defined within the national Interoperability Toolkit.

**Commissioning**
When commissioning or re-commissioning services, and when reviewing pathways, consideration of informatics requirements and information flows will be built into the design of service specifications so that providers are clear on what they are to deliver and how, and to maximise opportunities to drive forward improvements and efficiencies in patient care through the use of technology.

Examples of services / pathways identified for focus in 2012/13 include:-
• Review of diabetes service;
• Re-provision of inpatient, outpatient and community services;
• Provision of integrated care services to support nursing homes;
• Review of Urgent Care Nursing Services;
• Review gynaecology pathways;
• Commissioning new models of specialist rehabilitation for long term conditions;
• Health economy approach to the prescribing and management of medicines;

The best service delivery providers will be selected and assurance secured over their ability to deliver with appropriate informatics in place, working within the Information Governance legislation framework. A key focus will be assurance from commissioned service providers that a minimum of level 2 compliance in the Information Governance Toolkit has been achieved and is sustainable, or plans are in place to address non-compliance areas.

Assessment of proposed locations for health service delivery will include analysis from an informatics perspective to ensure capabilities for appropriate physical infrastructure to enable fast, secure and efficient information sharing and communication channels.
National informatics perspective

National standards for information sharing and requirements for data on local service delivery will be understood and incorporated into all points of the commissioning cycle, ensuring the availability of data in a compatible format for business intelligence, analysis and interpretation purposes, building a picture for future commissioning priorities.

Organisation

Gateshead CCG will put in place the required informatics provision in order to operate as an organisation, which will depend upon variables such as:

- Information flows into, out of and around the CCG and between members;
- Functions performed in-house or externally;
- Collaborative work arrangements;
- Fixed, mobile and agile workers.

Informatics considerations will also be borne in mind with the assessment of suitability of any new sites proposed to ensure that locations selected will be able to provide the correct physical infrastructure to be able to enable fast, secure and efficient information sharing and communication channels.

Gateshead CCG will consider the informatics expertise and knowledge required to ensure delivery the three above informatics dimensions and oversee the governance responsibilities across the health community.

7.6 Commissioning Support Service

The shared operating model has made clear that Clinical Commissioning Groups should be centrally involved in the development of the commissioning support that will help them to achieve their objectives. Commissioning support will need to help CCGs to achieve their objectives and give the CCGs the information and support they need to take effective commissioning decisions and then make them into a reality.

Gateshead CCG is currently considering the issue of Do, Buy or Share i.e. what functions the organisation wants to provide itself or across the Gateshead-Newcastle CCG alliance; what functions the organisation wants to buy from a Commissioning Support Service and what functions the organisation wants to deliver in collaboration with a commissioning support Service. It is expected that this process will be completed in September/October 2012.

Gateshead CCG will continue to help shape the commissioning support through ongoing local discussion and as part of regional discussions on the plans to develop one commissioning support organisation for the North East but with a local presence in South of Tyne and Wear.

Gateshead CCG will look to the commissioning support to be customer focused and designed around the needs and requirements of the CCG. Gateshead CCG will require a high quality, responsive and flexible business support solution that will enable the Executive to take responsibility for commissioning local healthcare successfully.
7.7 Proactive Management of Risks

The risks to delivery of the Plan have been systematically identified and quantified for all of the investment and disinvestment initiatives as part of the planning process, using an assessment of likelihood and impact. A moderation exercise then reviewed the risks to ensure comparability and validity. This is an ongoing and evolving process which will be regularly reviewed and updated as both sets of initiatives are implemented and evaluated and also as new evidence becomes available.

From the detailed analysis underpinning these high level risks, a number of cross-cutting risks to delivery have been identified, which predominately reflect the impact of undertaking system wide transformational change in the short to medium term. These have been assessed for impact and likelihood and are plotted on the following chart.

Assessment of cross cutting risks

- IMPACT
  - Financial control
  - Delivery of objectives
  - Transition to CCG
  - Authorisation
The risk log below outlines mitigating actions to reduce impact and likelihood for each of the cross cutting risks and is ranked by severity.

**RISK LOG**

<table>
<thead>
<tr>
<th>Failure to meet control total and deliver financial balance and QIIPP savings as part of the of pathfinder delegated authority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact</strong> – High, <strong>Likelihood</strong> – Medium/High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delivery risks</th>
<th>Mitigating actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Comprehensive Spending Review (CSR) confirms NHS funding through to 2014/15 with allocations only for 2012/13, consequently future plans based on assumptions derived from CSR</td>
<td>▪ Clear and Credible Plans incorporate financial plans based upon an agreed funding scenario for the period 2012/13 – 2014/15</td>
</tr>
<tr>
<td>▪ 40% management cost reduction over three years</td>
<td>▪ Detailed financial planning identifies range of risks and contingencies</td>
</tr>
<tr>
<td>▪ Tight control totals reduce flexibility</td>
<td>▪ Legally binding contracts include levers to manage activity</td>
</tr>
<tr>
<td>▪ Ability to manage/control secondary care demand and financial impact</td>
<td>▪ Additional funding for reablement services to help prevent admission and speed up discharge</td>
</tr>
<tr>
<td>▪ Reduced level of resource arising from penalties within new tariff regime ?</td>
<td>▪ Extend QIIPP initiatives to generate further schemes to release efficiencies</td>
</tr>
<tr>
<td>▪ Under delivery of savings required from inherited and new CCG QIIPP schemes to deliver financial balance</td>
<td>▪ 2012/13 Integrated plans for each strategic programme include the RRI initiatives with savings to be delivered - signed off by either each Programme Board / Director</td>
</tr>
<tr>
<td></td>
<td>▪ Progress against the financial savings is tracked through the integrated performance and planning system, reported to each CCG Pathfinder Committee ; note recent internal audit report on internal control confirmed that significant assurance could be given</td>
</tr>
<tr>
<td></td>
<td>▪ Grip on delivery is managed via a number of internal forums including individual Programme Boards, Accelerated Bigger Picture Board (includes Chief Executives from NHS SoTW and Foundation Trusts), Collaborative Commissioning Team (involves CCG Pathfinder Committee Chairs)</td>
</tr>
<tr>
<td>Failure to deliver strategic objectives and associated performance targets as part of pathfinder delegated authority</td>
<td></td>
</tr>
<tr>
<td>High Impact – High, Likelihood – Medium/High</td>
<td></td>
</tr>
</tbody>
</table>

### Delivery risk
- Underperformance against specific objectives during 2012/13 where CCG is the identified agreed lead
- Unable to control demand for activity
- Lack of clinical capacity within CCG to support deliver objectives

### Mitigating action
- Integrated plans identified for delivery of specific initiatives supported by robust performance management framework including assessment of risks and mitigating actions
  - 2011/12 Integrated plans for each strategic programme include all the health improvement and performance requirements together with milestones, risks and mitigation actions - signed off by either each Programme Board or Director
  - Locally as part of Pathfinder Bid, undertaking review of outpatient referrals as part of the reduction in clinical variation and also considering alternatives to contribute to the on-going work to reduce activity levels
  - Menu of actions agreed with practices for better identification and management of high risk patients, referral standard and work with nursing homes
  - Progress against planned milestones is reported directly via Performance Update Report to Clinical Commissioning Pathfinder Committees
  - Activity over performance is in escalation across all 4 PCT clusters with recovery actions and rigorous review of impact
  - Grip on delivery is reviewed via a number of internal forums including monthly review of performance by Clinical Commissioning Pathfinder Committee, update at individual Programme Boards, visibility wall updates, specific escalation meetings, review at Collaborative Commissioning Team which involves CCG Pathfinder Committee Chairs
### Transition to Clinical Commissioning Arrangements

**Impact – High, Likelihood - Medium/High**

<table>
<thead>
<tr>
<th>Delivery risk</th>
<th>Mitigating action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of clarity, capacity and capability to enable CCG Board to undertake commissioning role</td>
<td>Production of Organisational Development Plan includes timeline of actions to enhance CCG commissioning knowledge, skills and expertise including joint working with practices, stakeholders, patients and the public</td>
</tr>
<tr>
<td>PCT capacity to support transitional arrangements</td>
<td>Terms of Reference, Ways of Working and Scheme of Delegation agreed with Constitution for each CCG in development</td>
</tr>
<tr>
<td>Viability of CCG going forward (applicable to South Tyneside only - to be undertaken by SHA Cluster and will focus on sign up of member practices, size of CCG and geographical area of CCG, resulting in RAG rating).</td>
<td>CCG supported by Commissioning Development Unit with Head of Commissioning Development. PCT Executive Director aligned to each CCG</td>
</tr>
<tr>
<td></td>
<td>Detailed Transition Plan and Programme for Commissioning Development mapped to DoH Shared Operating Model for PCT Cluster, with supporting risk register</td>
</tr>
</tbody>
</table>

### Failure to achieve Authorisation by local agreed date October 2012

**Impact – High, Likelihood – Medium/High**

<table>
<thead>
<tr>
<th>Delivery risk</th>
<th>Mitigating action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear and credible plan is not signed off by North of England SHA</td>
<td>Project plan in place to develop Plan including dedicated CCG Board development sessions</td>
</tr>
<tr>
<td>Capability and capability gaps within the CCG Board</td>
<td>Ensure alignment of PCT ‘s ISOPs with Clear and credible Plan with regard to Finance, Performance and QIPP</td>
</tr>
<tr>
<td>Lack of support by partners including local Health and Well Being Board</td>
<td>Additional capacity with PCT to support development of the Plan (South Tyneside text includes together with dedicated input from Price Waterhouse Cooper)</td>
</tr>
<tr>
<td>Failure by Commissioning Support Organisation to achieve Authorisation within timescales</td>
<td>Production of Organisational Development Plan includes timeline of actions to enhance CCG commissioning knowledge, skills and expertise</td>
</tr>
<tr>
<td></td>
<td>Proactive input in the development and implementation of the Health and Well Being Board – key link being DPH who is joint PCT / LA appointment on Health and Well Being Board and</td>
</tr>
</tbody>
</table>
is also a member of CCG Board

- Developing a comprehensive engagement strategy including stakeholders, patients and the public
- Development of CSO build upon identification of CCG customer requirements with full engagement throughout the production of initial prospectus through to full business plan

7.7.1 Performance Management

Gateshead CCG has set in place a framework and structure to ensure that all of the components of this Commissioning Plan are efficiently and effectively implemented including a comprehensive performance management regime and a governance framework to routinely advise the CCG Board (to be known as the Governing Body post Authorisation) on progress.

Performance is reviewed on a monthly basis by the CCG Pathfinder Committee and covers delivery against our integrated plans (including national targets), contracting position at each of our providers and delivery against our QIPP programme. The report documents, for each of the key performance indicators, the actual position against plan, trend month on month, an assessment of risk to year end delivery and key actions to recover any underperformance. The reporting regime is also supplemented by specific high risk key measures being monitored more frequently e.g. A&E 4 hour standard and HCAI cases. The report also includes an external monthly assessment produced by the NE SHA of seven key performance indicators comparing the performance of individual commissioners and providers.

A key part of performance framework is the systematic review of the risks associated with the delivery of each aspect of performance, and if circumstances change, the risk management plan is amended to reflect the latest context. Where key risks have been identified, routine reporting is supplemented by escalation, exception reporting, development and close tracking of performance time limited recovery plans, focused on root causes of the problems and remedial action including, where appropriate, the use of contractual interventions to ensure delivery and sustainability of improvement. Initiatives and targets ranked as high risk are closely scrutinised to ensure performance remains on track, and any deviation from plan is quickly identified so that appropriate action can be taken.

Understanding of provider contributions to overall delivery is critical and commissioned providers have agreed information schedules including both national and local requirements with required submission dates. Performance targets are detailed in contracts across a broad range of key performance domains such as activity, access, health improvement, safety and quality. Internal monitoring supports the performance improvement discussions which form a key part of monthly contract review mechanisms.
7.8 Governance

In accordance with the requirements of the Health and Social Care Act 2012 (the Act), subsequent regulation, and guidance from the Department of Health, Gateshead CCG has put in place effective and robust governance arrangements. As part of this process the organisation has produced and adopted a Constitution which includes:

- arrangements for delegation of the CCG’s functions and duties;
- arrangements for the effective governance of the CCG including adopting the Nolan Principles and managing conflicts of interest;
- details the membership and roles of the Governing Body and any committees of the CCG with delegated authority;
- a detailed Scheme of Delegation, including those matters reserved to the membership and exercised through their representative body;
- details of the reciprocal responsibilities of Member Practices, Practice Representatives and the CCG.

The governance arrangements reflect the alliance Gateshead CCG has formed with NHS Newcastle North and East CCG and NHS Newcastle West CCG. Collectively these organisations will be collaborating in taking forward their commissioning functions.

It is a requirement of the Act for the CCG to prepare and publish annually a commissioning plan setting out how it proposes to exercise its functions. This requirement is reflected in the Constitution in relation to the arrangements for discharging the organisations functions to promote a comprehensive health service, reduce inequalities and promote integration together with the general financial duties.

Gateshead CCG’s constitution, through its scheme of delegation, sets out those functions and duties of the CCG which have been retained by the Members of the CCG and those which have been delegated to the Governing Body. As part of its role the Governing Body is charged with developing the CCG’s commissioning plan, after having engaged interested stakeholders. In order to ensure that the plan is clinically focussed and led the Governing Body of the CCG consists of a minimum of two Primary Care representatives and on establishment will have a GP Chair. In keeping with the Act and regulations other key appointments on the Governing Body include a secondary care doctor, a nurse advisor who is a registered nurse, and two lay members. Within their constitution Gateshead CCG have also made it a requirement, as part of the CCGs duty to obtain appropriate advice from persons who have a broad range of professional expertise in healthcare and public health, to seek advice from the Director of Public Health and such external bodies as the Clinical Senate and Public Health England.

Production of the commissioning plan is supported by the CCGs close working with the Director of Public Health and the Health and Wellbeing Board with whom the CCG also jointly develops the joint strategic needs assessment. Member practices and other important key stakeholders are involved in the development of the commissioning plan.

To ensure that the CCG and its Governing Body are delivering on its strategic intentions, a committee structure has been developed to provide assurance on the key aspects of the
organisation’s strategic plans. This committee structure includes an Audit Committee, Remuneration Committee, Quality, Safety & Risk Committee and a Finance and Performance Committee. They are supported in their work by an Executive Committee comprising elected GPs and Practice Managers, together with senior managers within the CCG.

The Quality, Safety & Risk Committee will be combined across the three CCGs of Gateshead-Newcastle. This will ensure strong clinical representation including primary care representatives from each CCG, the Medical Director and Governing Body registered Nurse. In addition there will also be three lay members and the Accountable officer sitting on this committee. This high priority to quality and ensuring clinical views are foremost, extends beyond Gateshead CCG’s Governing Body to the Executive and the entire clinical structure of the organisation. The Executive is made up of a clinical majority and has a GP and registered nurse responsible for Quality at the Exec level.

Importantly, the Audit Committee will ensure that the CCG has effective internal controls and risk management arrangements in place to ensure that risks to delivery of the commissioning plan are identified and mitigated through effective action at an early stage. The CCGs Assurance Framework which the Audit Committee will oversee will play an important role in this. The Finance and Performance Committee will assist the Governing Body in providing additional scrutiny delivery and performance against plan of the QIPP programme including resource releasing initiatives, implementation of which will be managed by the Executive Committee. The Executive Committee will be supported by the relevant Strategic Care Groups in delivery of Integrated Plans for which they have been assigned lead responsibility including delivery of specific resource releasing initiatives. The Quality, Patient Safety & Risk Committee will provide assurance that for those services which the CCG commission as part of the commissioning plan are of high quality and safe for the patient and that risks are being effectively controlled with mitigating action put in place.

Underpinning all of the CCGs work is its commitment to the Nolan principles of openness, accountability and transparency; with these principles in mind the CCG will adopt a Standards of Business Conduct and Declaration of Interests Policy in keeping with the NHS Commissioning Board’s guidance. All members of the governing body, its committees, member practices and senior employees of the CCG are required to adhere to the policy, including registering of their interests and arrangements are set out as to how such conflicts of interest will be managed.

7.9 Equality Impact Analysis (Assessment)

In accordance with Gateshead CCG’s equality duties, an Equality Impact Assessment was carried out on the PCT five year Strategic Plan and the supporting integrated plans. As a result of the Equality Act 2010 Gateshead CCG has updated this by undertaking an Equality Impact Analysis on this CCG Commissioning plan. There is no evidence to suggest that the plan has an adverse impact in relation to race, disability, gender, age, gender reassignment, marriage and civil partnership, pregnancy and maternity, sexual orientation, religion and belief or infringe individuals’ human rights. The plan is accessible to everyone regardless of age, disability, race, gender, gender reassignment, marriage and civil partnership, pregnancy and
maternity, sexual orientation, religion/belief or any other factor which may result in unfair treatment or inequalities in health.

Throughout the development of the plan, Gateshead CCG has sought to promote equality, human rights and tackle health inequalities. This has been through carrying out health needs assessments, life-style surveys, publication of the Single Equality Scheme, equality impact assessments and analysis and involving partners, stakeholders and local communities in the design, planning and development of services. In addition stakeholder events were held in order to agree the CCG’s gradings of the Equality Delivery System and identify the equality development objectives, published by 31 March 2012. Full Equality Impact Analysis scoping will continue to take place on each programme of work to ensure that the needs of all local communities are fully reflected in the design, planning, implementation and evaluation of services.
### Appendix 1 – Performance recovery action plans

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>2012/13 Recovery actions going forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateshead Health FT A&amp;E Quality</td>
<td>In April 2012 Gateshead Health FT was failing 4 out of 5 A&amp;E Quality indicators; which means they are no longer achieving the national standard. To achieve the national standard the trust must achieve one target in each of the 2 baskets of indicators. The trust is currently not achieving the following indicators:</td>
</tr>
<tr>
<td></td>
<td>Unplanned re-attendance rates</td>
</tr>
<tr>
<td></td>
<td>Time spent in A&amp;E</td>
</tr>
<tr>
<td></td>
<td>Time to initial assessment</td>
</tr>
<tr>
<td></td>
<td>Time to treatment</td>
</tr>
<tr>
<td></td>
<td>The drop in performance is to be addressed at the next contract meeting between the PCT contracting team and the FT.</td>
</tr>
<tr>
<td>Activity including Outpatient and day-case hospital activity</td>
<td>Activity trajectories set for 12/13 are significantly more robust than those set in 11/12 addressing the following:</td>
</tr>
<tr>
<td></td>
<td>• Out turn was forecast for 2011/12;</td>
</tr>
<tr>
<td></td>
<td>• Changes expected as a result of population, technological and other unavoidable changes were forecast using the SOTW PCT predictive model;</td>
</tr>
<tr>
<td></td>
<td>• Adjustments were made for:</td>
</tr>
<tr>
<td></td>
<td>o Known changes in counting, coding and payment rules;</td>
</tr>
<tr>
<td></td>
<td>o Known changes in service configuration or capacity;</td>
</tr>
<tr>
<td></td>
<td>o The expected impact of investment and disinvestment initiatives detailed in this plan.</td>
</tr>
<tr>
<td></td>
<td>Gateshead CCG have in place a Practice Clinical Commissioning project with the 34 Member practices. The Project focuses on the following areas:</td>
</tr>
<tr>
<td></td>
<td>• GP Referral rates for Outpatient appointments in the three highest specialties, Orthopaedics, General Surgery and Gynaecology</td>
</tr>
<tr>
<td></td>
<td>• Regular review of activity at practice level using BIRT and local data.</td>
</tr>
<tr>
<td>Clostridium difficile infections</td>
<td>Detailed joint action plans have been developed between the CCG Clinical Lead, PCT, foundation Trusts and Community Infection control team which include:</td>
</tr>
<tr>
<td></td>
<td>• The multi-agency HCAI reduction group is focusing on clostridium difficile across the health economy, encouraging peer support from the group to identify any additional interventions;</td>
</tr>
<tr>
<td></td>
<td>• The Community Health Services team continue to carry out Root Cause Analysis on all cases, each case is discussed at a weekly meeting and</td>
</tr>
<tr>
<td></td>
<td>• findings and lessons learnt are shared with GP’s, hospital infection</td>
</tr>
</tbody>
</table>
- control teams, with medicines management where appropriate, and the
- Health Protection Agency so that a joint approach is maintained;
- Development of strategies in primary care to prevent clostridium difficile infection in the community, e.g. antimicrobial prescribing,
- identification of high risk patients;
- GP awareness of appropriate management of CDI linked to QIPP medicines management action plan target re appropriate use of laxatives;
- Educational sessions with primary care to raise awareness of CDI, risk factors and management of CDI in the community including awareness of the CDI primary care guidance.
### Appendix 2 - New Investments

<table>
<thead>
<tr>
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</thead>
<tbody>
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<td>LONG TERM CONDITIONS / SELF CARE MANAGEMENT</td>
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<tr>
<td>OXYGEN ASSESSMENT &amp; REVIEW TENDER</td>
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<td>CONTINUING CARE</td>
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<td>CARERS STRATEGY / RESPIRE BREAKS</td>
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</thead>
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<td>BALANCE OF INVESTMENT TO DELIVER M.H. STRATEGY</td>
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<td>MENTAL HEALTH REBASING</td>
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<td>£0</td>
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</thead>
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<td>ACUTE ACCESS - OTHER</td>
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<td>£4,000,000</td>
<td>£4,000,000</td>
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<tr>
<td>ACUTE ACCESS - SPECIFIC CONTRACT ISSUES</td>
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<td>£0</td>
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<tr>
<td>LOCAL CANCER DRUGS @ £300k p.a. + NATIONAL CANCER PLAN</td>
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<td>£390,000</td>
<td>£250,000</td>
<td>£250,000</td>
<td>£250,000</td>
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</thead>
<tbody>
<tr>
<td>NEAS OVER-PERFORMANCE + HART 12/13 @ £330k plus £200k p.a. re Conseq of Acute Activity</td>
<td>£100,000</td>
<td>£100,000</td>
<td>£50,000</td>
<td>£50,000</td>
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<td>111 RECURRENT CONSEQUENCES</td>
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<tr>
<td>IM&amp;T ADD RUNNING COSTS</td>
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<td>£0</td>
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<td>£0</td>
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**Total** | **£6,820,370** | **£5,580,000** | **£4,800,000** | **£4,800,000** | **£4,800,000** |
Appendix 3 – QIPP Savings 2013-18

<table>
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<tr>
<td><strong>LONG TERM CONDITIONS</strong></td>
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<tr>
<td>ACS ADMISSIONS--RE-Admission tariff rule</td>
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<td>EXCESS BED DAYS</td>
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<tr>
<td><strong>MENTAL HEALTH</strong></td>
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<td>OPMH GATESHEAD</td>
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<td><strong>PLANNED CARE</strong></td>
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<td>O.P. 1st ATT'S</td>
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<td>5% FEWER DEATHS IN HOSPITAL THROUGH IMPROVED END OF LIFE CARE</td>
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<td>REVIEW NURSE LED CLINICS</td>
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<td>-£190,000</td>
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<td>£0</td>
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<td>ADDITIONAL QIPP CHOOSE&amp;BOOK/CONS TO CONS STANDADISE REFERRAL PROTOCOLS</td>
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<td>REVIEW PAEDIATRIC REHAB SPECIFICATION</td>
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<td><strong>URGENT CARE</strong></td>
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<td>READMISSIONS 11/12 = REABLEMENT // 12/13 ONWARDS = EMERGENCY TRAJECTORY</td>
<td>-£250,000</td>
<td>-£595,000</td>
<td>£1,500,000</td>
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<td>REVIEW LOCAL CRITICAL CARE COSTS</td>
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<td>DECOMMISSION OOH/UC/CROP - REPROCURE</td>
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<td><strong>MEDICINES MANAGEMENT</strong></td>
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<td>PRESCRIBING DRUGS IN SECONDARY CARE</td>
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<td>-£300,000</td>
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<td><strong>SUPPORT FUNCTIONS</strong></td>
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<td>MANAGEMENT COSTS STFT COMMUNITY HEALTH SERVICES</td>
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<td>£0</td>
<td>£0</td>
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<tr>
<td>REVIEW/RATIONALISE OR DECOMMISSION/REPROCURE COMMUNITY MIDWIFERY SERVICES</td>
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<td>-£200,000</td>
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<td><strong>Total</strong></td>
<td>£2,689,000</td>
<td>£3,026,000</td>
<td>£2,450,000</td>
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### Appendix 4: Prioritisation Exercise

<table>
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<tr>
<th>CRITERIA</th>
<th>Impact of change</th>
<th>Do-ability of change</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improves health</td>
<td>Reduces inequalities</td>
<td>Safer / more effective</td>
</tr>
<tr>
<td>Early detection and identification of cancer</td>
<td>2 2</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Review urology pathways</td>
<td>1.5 1.5</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Advanced care plans and DNAR</td>
<td>1 1.5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Review outpatient attendances</td>
<td>0 0.5</td>
<td>0.5</td>
<td>1</td>
</tr>
<tr>
<td>Review nurse led clinics</td>
<td>0 0.5</td>
<td>0.5</td>
<td>1</td>
</tr>
<tr>
<td>Compliance of Consultant to Consultant referral policy</td>
<td>0 1.5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Review pain pathway pilot</td>
<td>1.5 1.5</td>
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<td>1.5</td>
</tr>
<tr>
<td>Review acute gynae pathways inc. ring pessaries</td>
<td>0.5 1</td>
<td>0.5</td>
<td>1</td>
</tr>
<tr>
<td>Integrated support for nursing homes</td>
<td>1.5 1.5</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Integrated intermediate care services for LTCs &amp; frail elderly</td>
<td>1 1</td>
<td>1.5</td>
<td>1</td>
</tr>
<tr>
<td>Review specialist Community Nursing and Community matron</td>
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<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Long term conditions specialist rehab</td>
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<td>1</td>
<td>1</td>
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<tr>
<td><strong>Urgent care agreed whole urgent care agenda was a GATESHEAD CCG priority</strong></td>
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<td></td>
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<tr>
<td>Health checks for Learning disabilities</td>
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<td>1.5</td>
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<tr>
<td>Primary care mental Health Services</td>
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<tr>
<td>Continue implementation of the Mental health Model of Care</td>
<td>2 1.5</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Improve quality of prescribing, optimise medicines use, disinvestment properties in PC prescribing</td>
<td>0.5 1</td>
<td>1.5</td>
<td>1</td>
</tr>
<tr>
<td>Health economy approach to prescribing</td>
<td>1 1.5</td>
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<tr>
<td>Mechanisms for medicines Funding approval</td>
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Appendix 5: ‘Yellow’ Programme Sheets

Domain 1: Care of sick and injured children

Why is change needed?
- Changing nature of childhood illness, fewer children need inpatient stay
- High proportion of zero length of stay (approximately 60%)
- Underutilisation of paediatric inpatient capacity
- Workforce issues linked to availability of middle grade medical cover

Objective
Reform services for **acutely sick & injured children**, moving to integrated, high quality, 24/7 services, with increased emphasis on care outside hospital working with viable inpatient units

How do we want the future to look and what are the transitional issues?
- Streamlined, integrated 24/7 services for sick & injured children, increased emphasis on care outside hospital
- Reconfigured paediatric services to provide high quality, well utilised inpatient facilities and locally accessible consultant led assessment and short stay facilities; enhanced children’s community nursing teams
- Continued good access to high quality tertiary paediatric services

What are we doing about it?

<table>
<thead>
<tr>
<th>Project Gantt Chart</th>
<th>2012/13</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
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</tbody>
</table>

- Enhance services provided by Children’s Community Nursing Teams to include care of acutely sick and injured children and with extended hours (evenings and weekend working). Evaluate the ongoing testing of the revised Children’s Community Nursing Teams model in South Tyneside and use the evaluation to inform future development of services.
- Subject to public consultation, implement the agreed paediatric emergency pathway, including children’s assessment and short stay services.
- Implement a contract variation to extend the role of Walk-in-centres and Minor Injury Units to include assessment and treatment of children under two years of age.

* +£k = Investment; -£k = Disinvestment

What Key Performance Indicators will we use to monitor progress?

- Headline Measures
- Supporting Measures
- Local Measures
  - Emergency hospital admissions for deliberate and unintentional injuries to children and young people, per 100,000 population

Implications, Risks and Mitigating Actions

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working with providers for development of services</td>
<td>Having clear communication with both commissioners and providers regarding appropriate levels of service</td>
</tr>
<tr>
<td>Public engagement</td>
<td>Development of comprehensive, accurate and easily accessible information widely available so that public can make informed view. Clinicians will be at forefront of public consultation</td>
</tr>
</tbody>
</table>

Communications Implications
- Ongoing communication with parents and young people accessing services
- Communication in relation to public consultation re paediatric emergency pathway
- Effective collaboration with all stakeholders to ensure continued delivery of high quality and safe urgent care services across the three health localities.

Informatics Implications
- Sharing information re referral pathways to all agencies / health professionals for child health
- Data capture of public consultation re paediatric emergency pathway
- Evaluation of any pathway changes using identified set of measures

Estates Implications
- Potential changes to paediatric emergency pathway; including children’s assessment and short stay services
- Minor Injuries Unit and Walk In Centres offering services to all ages

Workforce Implications
- Implications following review of Children’s Community Nurses
- Increased skills and training for all front line staff
- European working time directive will impact on sustainability of medical cover

82
Domain 1: Childrens and Maternity

- **Why is change needed?**
  - Child health is significant predictor of life expectancy & health in later life
  - Higher numbers of unnecessary hospital admission
  - The integration agenda requires a review of therapy services – remodelling to meet need

- **Objective**
  - Provide high quality integrated child health and maternity services

---

**How do we want the future to look and what are the transitional issues?**

- All children to receive regular health checks with appropriate referral to services as required
- Therapy services available to all children who require them
- Process in place for identification & management of high risk women
- Work across Children’s services requires development to ensure early identification is effective within the broad range of children’s services. This approach is reliant on integrated and coordinated pathways of care for children and families with additional needs

---

**What are we doing about it?**

<table>
<thead>
<tr>
<th>Project Gantt Chart</th>
<th>2012/13</th>
<th>Ek</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review Child Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review Children’s Community Nurses (CCNs) and palliative care for children in line with requirements set out in Aiming High for Disabled Children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review school nursing services to ensure all key elements of the Healthy Child Programme 5-19 years are delivered and key outcomes are achieved.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure compliance with NHS SOTW strategy, policies and procedures for Safeguarding Adults and Children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review occupational therapy and physiotherapy services for children and young people and consider future commissioning intentions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure increased focus on short breaks for young carers and parents of children with disabilities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review the implications for new national tariff for children’s diabetes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review pathways for families with additional needs with a view to develop an integrated pathway with children’s services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As part of the programme to develop integrated pathways of care for high risk women; To implement a restricted pilot to measure the impact of an additional home visits from community midwifery team at 16 weeks gestation, to undertake a comprehensive family needs assessment and review the outcome. To consider future commissioning intentions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review newborn screening pathways including assessment of Any Qualified Provider impact on audiology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* +Ek = Investment; -Ek = Disinvestment

---

**What Key Performance Indicators will we use to monitor progress?**

- Prevalence of breastfeeding at birth
- Coverage of breastfeeding at 6-8 weeks
- Under 18 conception rates
- Childhood immunisation rates aged 5 (DTaP/IPV) Diphtheria, Tetanus, Pertussis (whooping cough), polio  and Haemophilus influenzae type b, (MMR) measles, mumps and rubella
- Childhood immunisation rates aged 6 (DTaP/IPV) Diphtheria, Tetanus, Pertussis (whooping cough), polio and Haemophilus influenzae type b, Meningococcal group C meningitis , (MMR) measles, mumps and rubella
- Childhood immunisation rates aged 12-13 years (HPV) human papilloma virus
- Childhood obesity rates – reception and year 6
- Childhood immunisation rates aged 1 (DTaP/IPV/Hib) Diphtheria, Tetanus, Pertussis whooping cough, polio (with Inactivated Polio Vaccine) and Haemophilus Influenzae type b
- Childhood immunisation rates aged 2 (PCV) passive cranium ventilation, (Hib/MenC) Haemophilus influenzae type b Meningococcal group C meningitis , (MMR) measles, mumps and rubella
- Childhood immunisation rates aged 13-18 years (DTaP booster) diphtheria, tetanus, and pertussis
- Childhood obesity rates – reception and year 6
- Percentage of children living in poverty (age <16 years) (Local Authority measure)

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**Implications, Risks and Mitigating Actions**

- **Risks**
  - Work with partners to review Special Educational Needs assessment and statement framework and replace existing system
  - Ensure providers deliver in accordance with ‘You’re Welcome’ standards
  - Changes to child health service provision across the borough (preventative services) may result in adverse impact on medium to long term outcome
  - Provider IT system not able to report outcome measures required to demonstrate performance against healthy child programme.

- **Mitigating Actions**
  - Implement the risk and resilience model, reviewing service provision to ensure services are targeted appropriately across the four levels of need
  - Having clear communication with both commissioners and providers regarding appropriate way forward for sexual health services
  - Discussions with children’s leads x 3 and respective Local Authority to determine the impact of the Comprehensive Spending Review in relation to child health services and identify opportunities for joint commissioning
  - Development of comprehensive, accurate and easily accessible information widely available so that public can make informed view. Clinicians will be at forefront of public consultation

---

**Communications Implications**

- No specific implications have been identify

**Estate Implications**

- Potential changes to occupational therapy and physiotherapy services for children and young people

**Supporting Measures**

- 12 week maternity appointments
- Prevalence of breastfeeding at 6-8 weeks
- Coverage of breastfeeding at 6-8 weeks

**Informatics Implications**

- Monitor compliance with NHS SOTW Safeguarding Adults and Children strategy, policies and procedures
- Define minimum data sets for new community child health contracts
- Clarifying information re referral pathways to all agencies / health professionals for child health
- Effects of pathway redesign in relation to high risk behaviours and lifestyle issues

**Workforce Implications**

- No specific implications have been identify

**Local Measures**

- Breastfeeding initiation rates
- Smoking during pregnancy rates
- Maternal obesity rates

---

83
Domain 1: Cancer

Why is change needed?
- Significantly higher than average early deaths from cancer
- 30% of all deaths across Gateshead are due to cancer
- Evidence shows earlier identification of cancer would have most significant impact on life expectancy

How do we want the future to look and what are the transitional issues?
- Increased uptake of cancer screening
- Earlier diagnosis & treatment of cancer
- Improved survival rates
- Reduced cancer mortality

Objective
- Earlier diagnosis and treatment of cancer to reduce mortality and improve survival.
- To improve access to appropriate treatments

What are we doing about it?

<table>
<thead>
<tr>
<th>Project Gantt Chart</th>
<th>2012/13</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review urology pathways to increase the proportion of men managed in primary care particularly looking at LUTS (Lower urinary tract systems) and follow up of men with prostate cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the early detection and identification of cancer by reducing variation in General Practitioner profiles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local cancer drugs @£100k pa and National Cancer Plan</td>
<td>NA</td>
<td>700</td>
</tr>
<tr>
<td>Continue to implement the Improving Outcomes Strategy for Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remodel Breast Cancer Services across NHS SoTW (excluding screening services) in order to implement a sustainable service model.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure cancer pathways for Foundation Trusts are in line with North East Cancer Network model pathways. Awaiting standards for Brain and sarcoma services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with Foundation Trusts to ensure processes are in place to recoup funding through Patient Access Schemes for High Cost Cancer Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase uptake of Bowel Cancer Screening by raising awareness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify sufficient endoscopy capacity to meet demand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction of Human Papilloma Virus (HPV) testing for Cervical Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deliver outcomes of teenager and young adult cancer standards in collaboration with North of England Cancer Network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What Key Performance Indicators will we use to monitor progress?

<table>
<thead>
<tr>
<th>Operating Framework Measures</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2 week wait (aggregate measures for urgent and breast referrals)</td>
<td>31 day – diagnosis to treatment</td>
</tr>
<tr>
<td>62 day wait (urgent referral from General Practitioner and consultant)</td>
<td>31 day – diagnosis to treatment (surgery)</td>
</tr>
<tr>
<td>62 day wait (referral from national screening service)</td>
<td>31 day – diagnosis to treatment (anti cancer drug regime)</td>
</tr>
<tr>
<td>2 week wait – urgent referral to 1st aptt</td>
<td>31 day – diagnosis to treatment (radiotherapy)</td>
</tr>
<tr>
<td>2 week wait (breast symptoms)</td>
<td>Extension of breast screening to 47-49 and 71-73</td>
</tr>
<tr>
<td>62 day – urgent referral to treatment</td>
<td>Extension of bowel screening to men and women 70-75</td>
</tr>
<tr>
<td>62 day – urgent referral from screening service</td>
<td></td>
</tr>
<tr>
<td>62 day – urgent referral from screening service upgrade</td>
<td></td>
</tr>
</tbody>
</table>

Implications, Risks and Mitigating Actions

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure of remodelling Breast Cancer Services will result in lack of workforce for future</td>
<td>Hub and spoke model for Breast Cancer Services being developed.</td>
</tr>
<tr>
<td>Delayed access to diagnosis following changes to the cancer pathways and awaiting publication of standards.</td>
<td>Close working with all providers led through cancer locality group to support alignment of cancer pathways.</td>
</tr>
<tr>
<td>Risk that patient access schemes may cease nationally i.e. there will be no schemes which require reimbursement.</td>
<td>Link in with North of England Cancer Drug Approval Group (NECDAG) to monitor national trends for patient access schemes to ensure that the contract for the risk share element is only viable whilst patient access schemes exist.</td>
</tr>
<tr>
<td>Failure to secure patient uptake of Bowel Cancer Screening.</td>
<td>Dedicated health promotion specialist working within the field of Bowel Cancer Screening.</td>
</tr>
<tr>
<td>Develop endoscopy capacity and fail to increase demand through awareness campaign.</td>
<td>Work with cancer network to ensure early knowledge of economic model for endoscopy.</td>
</tr>
<tr>
<td>Hitting the 14 day turnaround time for HPV testing for Cervical Screening as two tests on same sample will be undertaken within same timescale.</td>
<td>All cervical screening services working together to ensure pathway implementation within timescale. Will be closely monitored by Primary Care Trust.</td>
</tr>
<tr>
<td>Failure to understand and meet demand of early detection and identification of cancer.</td>
<td>Working collaboratively with providers across North East Cancer Network as this agenda develops.</td>
</tr>
<tr>
<td>Failure to secure Urology Network Site Specific Groups agreement to proceed on basis of risk of not identifying cancers and establishing early treatment.</td>
<td>Lead will be taken from Network Site Specific Groups. If agreement to proceed robust governance infrastructure will be in place for review of urology pathways.</td>
</tr>
</tbody>
</table>

Communications Implications
- Communications strategy for GPs in relation to the remodelling of Breast Cancer Services.
- National endoscopy strategy and awareness campaign commencing January 2012.
- General Practitioner cancer leads working with identified practices for the early detection and identification of cancer.
- Any changes in urology pathway would need to be shared with General Practitioners and Urology Network Site Specific Groups at North East Cancer Network to ensure successful implementation.

Informatics Implications
- None

Estates Implications
- May require additional capacity to run endoscopy clinics in the community.

Workforce Implications
- Require more clinical oncology in local Multi Disciplinary Teams for Radiotherapy Services.
- Requirement to grow workforce to meet anticipated demand for endoscopy.
- Potential requirement for colposcopists, awaiting impact of HPV testing for cervical screening.
Domain 1: End of Life Care

Why is change needed?

- Increased number of deaths forecast in next 5-10 years, many occur in hospital
- People say they want choice of place of death
- Inconsistent standards of end of life care in different settings
- Bed days in hospital for people who die after 14 days or more have increased

Objective

Ensure all people entering the end of life have their needs, priorities and preferences identified and met, with the same standards of care in all settings

How do we want the future to look and what are the transitional issues?

- All people in Gateshead towards the End of Life will have their needs, priorities and preferences for End of Life Care, including care after death, identified and met, throughout the last phase of life and bereavement
- People can choose their place of death
- 5% reduction in numbers of people dying in hospital

What are we doing about it?

<table>
<thead>
<tr>
<th>Project Gantt Chart</th>
<th>2012/13</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
</tr>
<tr>
<td>To have advanced care plans and Do Not Attempt Resuscitation in place for all appropriate patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To ensure end of life care packages are co-ordinated and available 24/7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deliver outcomes of specialist palliative care standards in collaboration with NECN</td>
<td>Need timelines</td>
<td>500</td>
</tr>
</tbody>
</table>

* +£ = Investment; -£ = Disinvestment

What Key Performance Indicators will we use to monitor progress?

**Operating Framework Measures**

- Proportion of Deaths at Home (Reduce hospital deaths by 5%)
- Total length of stay in last year of life
- Reduction in total admissions
- Number of patients with DNAR in place
- Number of patients on palliative care register

**Implications, Risks and Mitigating Actions**

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay in establishing contract in April 2012 to ensure end of life care packages are co-ordinated and available 24/7.</td>
<td>Lead in time built into contract.</td>
</tr>
<tr>
<td>Failure to secure buy in from non palliative care specialists to have advanced care plans and Do Not Attempt Resuscitation (DNAR) in place.</td>
<td>Communications strategy on Do Not Attempt Resuscitation and integrated model of care.</td>
</tr>
</tbody>
</table>

**Communications Implications**

- End of life care packages subject to communications strategy.
- Communications are being led by North of England Cancer Network supported by Primary Care Trust for advanced care plans and Do Not Attempt Resuscitation.

**Informatics Implications**

- No additional informatics implications for end of life care packages

**Estates Implications**

- Local access to palliative care beds for advanced care plans and Do Not Attempt Resuscitation

**Workforce Implications**

- Educational element to ensure end of life is everyone’s business. Assessment of care home training requirements will help inform educational agenda for 12/13.
**Domain 2: Long Term Conditions**

### Why is change needed?
- Higher than average emergency admissions and emergency re-admissions to hospital compared to England.
- Significantly higher rates of admissions for long term conditions compared to England.
- More people living with long term conditions.
- An ageing population – if current hospital use continues the system becomes unaffordable in 10 years.

### Objective
Develop a generic Commissioning Model for Long Term Conditions which will deliver high quality, out-of-hospital support for people with chronic conditions, and eliminate unnecessary hospital admissions and shorten necessary admissions. Pilot with Cardiovascular Disease, diabetes and Chronic Obstructive Pulmonary Disease then rollout to all Long Term Conditions. Develop rehabilitation model with specialist and generic support across acute and community care, longer term support and self management.

### How do we want the future to look and what are the transitional issues?
- People with Long Term Conditions are confident in managing their condition and are clear about the care they need and when.
- When conditions worsen there are easily accessible services to help and patients feel these are ‘joined up’.
- Most interventions are available outside hospital.

### What are we doing about it?

<table>
<thead>
<tr>
<th>Project Gantt Chart</th>
<th>2012/13</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a commissioning model for Long Term Conditions (Self Care) - review the future commissioning arrangements of self care services &amp; embed self care opportunities into health care services</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Develop a commissioning model for Long Term Conditions (Specialist Rehabilitation) - Commission new models and approaches to specialist rehabilitation</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>Develop and commission an integrated model of intermediate care services (including rehabilitation and re-appointment)</td>
<td></td>
<td>111</td>
</tr>
<tr>
<td>Review existing rapid access community nursing teams - intention is to improve access and clarity of role</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Review provision, role and effectiveness of Community Matrons - develop appropriate models of case management</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>Implement revised service specification of the district nursing service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop sustainable and successful reablement/readmission schemes</td>
<td></td>
<td>90</td>
</tr>
<tr>
<td>Improve provision of heart failure services across primary community and secondary care</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Review the Chronic Obstructive Pulmonary Disease pathway and identify improvements that could be made to improve patient care.</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Improve discharge processes (including documentation) and opportunities for early supported discharge.</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Implement an Any Qualified Provider procurement for community based INR services</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Implement single-site model for weekend Transient ischemic Attack clinics.</td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>Develop a revised service model for the provision of diabetes services across primary community and acute.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop recommendations for future commissioning following the pilot of the community arrhythmia service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement standard service specification for community stroke rehabilitation services with a focus on early appointed discharge.</td>
<td></td>
<td>63</td>
</tr>
<tr>
<td>Implement the procure diabetic retinol screening programme management service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commission a home oxygen assessment service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the use of risk stratification tools including the combined predictive model across primary community and secondary care</td>
<td></td>
<td>35</td>
</tr>
</tbody>
</table>

* £k = Investment; -£k = Disinvestment * Gateshead CCG Prioritised projects

### What Key Performance Indicators will we use to monitor progress?

- **Operating Framework Measures**
  - Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
  - Unplanned hospitalisation for asthma, diabetes and epilepsy <19s

- **Local Measures**
  - Emergency admissions for Long Term Conditions
  - Readmissions within 30 days
  - Delayed transfers of care
  - Proportion of people spending 90% of their time on a stroke ward
  - Proportion of Transient Ischemic Attacks treated within 24 hrs

  - Diabetic retinopathy screening
  - All-age all cause mortality (Males)
  - All-age all cause morality (Females)
  - Proportion of individuals admitted to Care Homes
  - People supported to live independently

### Implications, Risks and Mitigating Actions

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity for CCG and PCT to develop a whole new approach to commissioning LTCs and complexity of projects</td>
<td>Identified lead for SoTW. Working collaboratively with GP Consortia Clinical Leads, Local Authority, Public Health and Social Care partners. work with stakeholders to develop investment plans for 2012/13</td>
</tr>
<tr>
<td>Competing agendas</td>
<td>Clinical engagement with CCGs to determine prioritisation.</td>
</tr>
<tr>
<td>Long Term Conditions Model with focus on this rather than individual pathways</td>
<td>Develop Commissioning Model and focus on Workforce strategy</td>
</tr>
<tr>
<td>Unable to reduce emergency admissions/readmissions</td>
<td>Align strategies. Targeted interventions. Cross cutting reform issues e.g. Long Term Conditions and Urgent Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communications Implications</th>
<th>Estates Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and implement joined up social marketing approach to support self management of Long Term Conditions across all programme linking into national campaigns.</td>
<td>Group space in all Primary Care Centres and many health centres.</td>
</tr>
<tr>
<td>Development of Integrated Teams</td>
<td>Community ECHO facilities within Primary Care Centres.</td>
</tr>
<tr>
<td>Effects of review of Community Nursing</td>
<td>Consider community based services for Atrial Fibrillation, Diabetes and Heart Failure within Primary Care Centres.</td>
</tr>
<tr>
<td>Review of specialist inpatient and community neurological rehabilitation services</td>
<td>Consider opportunity to co-locate community teams and facilitate team working and integration</td>
</tr>
<tr>
<td>Increase capacity and training health professionals to manage range of conditions in primary/community care.</td>
<td>Informatics Implications</td>
</tr>
<tr>
<td>Up skilling community and primary care staff.</td>
<td>Standard sets of information/data sets (recurring).</td>
</tr>
<tr>
<td>Training/culture change to encourage and promote self-care.</td>
<td>Real time data – monitoring.</td>
</tr>
<tr>
<td></td>
<td>Introduce a minimum data set and outcome measures and ensure that all eligible patients are included for rehabilitation. This will have an impact on hospital re-admissions.</td>
</tr>
</tbody>
</table>
Domain 2: Planned Care

**Why is change needed?**
- Unsustainable levels of hospital activity if admissions cannot be reduced
- Not all patients are being seen at the right time, in the right place
- Disjointed planned care services
- Care often not close to home

**How do we want the future to look and what are the transitional issues?**
- Planned, Streamlined, high quality, patient centred, care close to home
- Shift of planned activity out of hospital into primary and community settings
- Reduced patient travel, waste and duplication
- Right care, first time, right place

**Objective**
- Streamline & integrate reactive services
- Shift elective care outside of hospital
- Increase out of hospital capacity
- Increase access to diagnostics

**What are we doing about it?**

<table>
<thead>
<tr>
<th>Operating Framework Measures</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce outpatient first and follow up attendances. Specialties for focus include Ophthalmology, Urology, Ear Nose and Throat, gynaecology i.e: ring pessary &amp; osteoporosis service</td>
<td>£k</td>
</tr>
<tr>
<td>The Clinical Commissioning Groups expect that intra specialty referrals will be made in accordance with the Consultant to Consultant Referral Policy. Compliance against this policy will be monitored with a view to funding only those referrals which are in accordance with this policy.</td>
<td></td>
</tr>
<tr>
<td>Implement the revised pathway for patients with carpal tunnel syndrome</td>
<td></td>
</tr>
<tr>
<td>Implement new dermatology pathway</td>
<td></td>
</tr>
<tr>
<td>Review Adult Hearing Services with an aim to improving access, choice and quality of care (Any Qualified Provider).</td>
<td></td>
</tr>
<tr>
<td>Review podiatry services with an aim to improving access, choice and quality of care (Any Qualified Provider).</td>
<td></td>
</tr>
<tr>
<td>Specialist commissioning developments / issues</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project Gantt Chart</th>
<th>2012/13</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reduction in outpatient activities.</strong> Specialties for focus include Ophthalmology, Urology, Ear Nose and Throat, gynaecology i.e: ring pessary &amp; osteoporosis service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Following scope of nurse led clinics in terms of continued viability and cost, agree clinics to “decommission” or change to ensure added value to patient pathways</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Clinical Commissioning Groups expect that intra specialty referrals will be made in accordance with the Consultant to Consultant Referral Policy. Compliance against this policy will be monitored with a view to funding only those referrals which are in accordance with this policy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement the revised pathway for patients with carpal tunnel syndrome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explore feasibility to increase General Practitioner access to diagnostic tests for non obstetric ultrasound and MRI (magnetic resonance imaging) for dementia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement new dermatology pathway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review Adult Hearing Services with an aim to improving access, choice and quality of care (Any Qualified Provider).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review podiatry services with an aim to improving access, choice and quality of care (Any Qualified Provider).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist commissioning developments / issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* +£ = Investment  -£ = Disinvestment  * Gateshead CCG prioritised projects

**What KPIs will we use to monitor progress?**

- Proportion of General Practitioner referrals to 1st op appointments booked using Choose & Book
- Trend in value/volume of patients being treated at non NHS hospitals

**Local Measures**
- Length of stay (acute)
- Daycase rate
- Patient Reported Outcome Measures Scores
- Low value procedures

**Contractual Measures**
- Cancelled elective operations for non clinical reasons
- Choose and Book – direct booking
- Choose and Book – slot issues
- MRSA (meticillin-resistant staphylococcus aureus) Screening

**Implications, Risks and Mitigating Actions**

<table>
<thead>
<tr>
<th>Implications, Risks and Mitigating Actions</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued over performance on elective and outpatient activity contracts</td>
<td>Action plan developed and agreed by Clinical Commissioning Groups</td>
</tr>
<tr>
<td>Failure to engage all parties in pilot of carpal tunnel pathway.</td>
<td>Negotiations with Gateshead Foundation Trust underway re: pilot of carpal tunnel pathway.</td>
</tr>
<tr>
<td>Acute sector engagement to increase General Practitioner access to diagnostic tests</td>
<td>Development of pathway with all stakeholders</td>
</tr>
<tr>
<td>Overperformance on contract i.e: failure to realise reduction in outpatient activity or dermatology pathway is underutilised.</td>
<td>Clinical Lead to work with General Practitioner’s and contract team to monitor activity with providers</td>
</tr>
<tr>
<td>Capacity to manage contracts with large number of new providers for Adult Hearing Services and Podiatry Services using ‘Any qualified provider’</td>
<td>Address through design of Commissioning Support Organisation</td>
</tr>
<tr>
<td>Consultant to Consultant Referral Policy is not clear and mechanism to review referrals is not robust.</td>
<td>Clarity around Consultant to Consultant Referral Policy identified.</td>
</tr>
</tbody>
</table>

**Communications Implications**
- Communications re revised carpal tunnel pathways dependent on procurement method.
- Liaison with provider re communications for the review of osteoporosis clinics.
- Stakeholder engagement required for the review of Adult Hearing Services and Podiatry Services.

**Informatics Implications**
- Implications of move to ‘Any qualified provider’.

**Estates Implications**
- Explore Primary Care Centre facilities to increase General Practitioner access to diagnostic tests.

**Workforce Implications**
- May be training and educational needs within Primary care in relation to ring pessary.
Under the NHS Constitution, patients have the right to access services within maximum waiting times. There is still scope to improve the choice of services for patients, including having more services closer to patients’ homes. There is an ongoing need to manage waiting lists in a way which prioritises the clinical need of patients while maximising the use of resources.

Objective
Ensure that patients have an informed choice of services and appointments when they are referred to hospital for planned care and are seen as quickly as their condition requires, within the maximum waiting times in the NHS Constitution. The choice of services should include an appropriate range of hospital and out-of-hospital care.

How do we want the future to look and what are the transitional issues?

- Patients will get the right care, first time, in the first place they go to.
- Patients will be able to use the Choose and Book system for planned treatments.
- Patients will have more information to allow them to make informed choices.
- Patients will continue to be seen on the basis of clinical need.
- Patients will have more information to allow them to make informed choices.

What are we doing about it?

<table>
<thead>
<tr>
<th>Activity</th>
<th>2012/13</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree contracts with acute hospitals to meet the increased demand seen in 2011/12 and projected demand for 2012/13, then manage those contracts</td>
<td>Q1</td>
<td>5520</td>
</tr>
<tr>
<td>Q2</td>
<td>80</td>
<td></td>
</tr>
</tbody>
</table>

*Walling times from referral to treatment*
Joint PCT / hospital “Access & Choice Task & Finish Group” to review waiting lists and times (including planned waiting lists) to identify issues and actions and share good practice. The Group will oversee delivery of the following:

- Ensure systems in place to manage waiting lists effectively
- Review of waiting lists for all specialties and diagnostic services to ensure that safety and standards of care are not compromised
- Ensure 90% of admitted patients and 95% of non-admitted patients are seen within 18 weeks for all specialties in all months
- Ensure 92% of patients who are still waiting will be seen within 18 weeks
- Ensure all patients waiting longer than 18 weeks & where this is not due to patient choice or is in the patients clinical best interests a plan is in place to manage the patient
- Ensure that patients have the information they need to choose a different provider when they have waited over 18 weeks
- Ensure no more than 1% of patients wait more than 6 weeks for a diagnostic test

*Choice*

- Patients will be offered the choice of using “Any Qualified Provider” in three services by September 2012, using outcome-based specifications
- Continue to develop the Choose and Book service and increase use:
  - Include the “Any Qualified Provider” services and communicating this
  - Improve engagement with GPs to encourage use of Choose and Book
  - Include all community Allied Health Professional services on Choose and Book
  - Work with providers to reduce Slot Issues
  - Work with GP practices towards them making 90% of referrals using Choose and Book
  - Evaluate and roll out pilots under which hospitals offer advice and guidance to GPs to avoid inappropriate referrals

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**What KPIs will we use to monitor progress?**

- Proportion of General Practitioner referrals to 1st op appointments booked using Choose & Book
- Trend in value/volume of patients being treated at non NHS hospitals
- Length of stay (acute)
- Daycase rate
- Patient Reported Outcome Measures Scores
- Low value procedures

**Operating Framework Measures**

- Referral to Treatment times (admitted 90%, non admitted 95%, incomplete 92%)
- Numbers waiting on incomplete Referral to Treatment pathway
- Patient experience survey
- Venous Thromboembolism risk assessment
- General Practitioner written referrals to hospital
- 6 week waiting time for 15 key diagnostic tests
- Diagnostic Activity – Endoscopy based tests
- Diagnostic Activity – Non endoscopy based tests
- Bed Capacity – General and Acute
- Other referrals for a 1st outpatient appointment
- 1st outpatient attendances following General Practitioner referral
- All 1st outpatient attendances
- Elective First Finished Consultant Episode
- Bookings to services where named consultant led team available

**Local Measures**

- Efficiency of planning and resource allocations
- Bed occupancy

**Contractual Measures**

- Total number of patients treated
- Total number of elective procedures
- Total number of patients referred
- Total number of patients treated
- Total number of patients treated

---

**Implications, Risks and Mitigating Actions**

**Risks**

- Continued over performance on elective and outpatient activity contracts
- Unplanned increases in demand – financial pressures
- Increased numbers of providers & associated demands on contract requirements & capacity

**Mitigating Actions**

- Refer to Planned Care Action plan developed and agreed to manage demand into secondary care
- Provider management – 12/13 contract negotiations/use of contract and contract review groups to mitigate supplier driven demand
- Effective commissioning business processes to ensure AQP used as the most appropriate procurement option; risk analysis & proportionate approach to contract management
- Efficiently embedded within health provider contracts
- Strong engagement at all levels
- Ongoing discussions at Strategic level and Contract level with Acute Trusts.

**Informatics Implications**

- Support for activity management, Any Qualified Provider, and Choose & Book

**Communications Implications**

- Communication Strategy to support waiting times, Any Qualified Provider and choice

**Estates Implications**

- Understand implications of Any Qualified Provider for estate capacity

**Workforce Implications**

- Understand implications of Any Qualified Provider on workforce in providers, (e.g. TUPE); and the capacity & skills in the PCT to implement
Domain 3: Urgent Care

**Why is change needed?**
- Higher than average emergency admissions and re-admissions to hospital compared to England
- High rates of hospital emergency admissions for 0 and 1 day length of stay and for emergency admissions for long term conditions
- Improved intermediate care and reduced admissions from care homes

**Objective**
Ensure integrated 24/7 urgent care systems across all sectors which delivers quality care in appropriate settings. Providing for increased need yet constraining costs within

**What are we doing about it?**

### Project Gantt Chart

<table>
<thead>
<tr>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Implement the 111 single point of access for urgent care to signpost patients with an urgent care requirement to the most appropriate service to meet their needs.</td>
<td></td>
</tr>
<tr>
<td>Develop an urgent care transport strategy to support the implementation of 111.</td>
<td></td>
</tr>
<tr>
<td>Standard model of General Practitioner integrated working will be implemented across all Minor Injury Units. Establish Gateshead acute Hub on the Queen Elizabeth site.</td>
<td></td>
</tr>
<tr>
<td>Commission activity to reflect the expected impact of the introduction of Trauma Centres and locally the potential re-classification of our local Foundation Trusts as Trauma Units.</td>
<td></td>
</tr>
<tr>
<td>Review Urgent Care Nursing Services to understand the impact to develop a future state.</td>
<td></td>
</tr>
<tr>
<td>Primary care foundation work to improve access to practices and enable more minor illness to be managed in primary care</td>
<td></td>
</tr>
<tr>
<td>Commission the overall strategy to support nursing homes in Gateshead with the vision to provide integrated care by coordinating a set of service specifications and Service Level Agreements.</td>
<td></td>
</tr>
<tr>
<td>Develop safe and appropriate pathways for patients with ambulatory care conditions to enable assessment and treatment in hospital without the need to be admitted or to be discharged earlier.</td>
<td></td>
</tr>
<tr>
<td>Improve local Accident &amp; Emergency &amp; Medical Assessment Unit Discharge letters to enable all practices to be informed by the next working day. Work towards more integrated IT records so the right information is available at the right time. Move to more integrated directories of services on Gateshead Information Network.</td>
<td></td>
</tr>
<tr>
<td>Introduce Telehealth technology for patients with long term conditions under a joint initiative across NHS SoTW with Local Authority colleagues in each locality.</td>
<td></td>
</tr>
<tr>
<td>Annual 'Choose Well' public information campaign to publicise the range of services, points of access, hours of operation &amp; areas of exclusion.</td>
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<tr>
<td>North East Ambulance Service contract over performance and funding for Ambulance Hazardous Area Response Team</td>
<td></td>
</tr>
</tbody>
</table>

* +£k = Investment; -£k = Disinvestment *Gateshead CCG Prioritised projects

**What Key Performance Indicators will we use to monitor progress?**

### Operating Framework Measures

- Ambulance quality - Cat A response times
- Emergency admissions for acute conditions that should not normally require hospital admission
- Accident & Emergency quality indicators (all other measures)
- Ambulance quality indicators (all other measures)
- Accident & Emergency Quality Indicators (5 measures)

### Local Measures

- Emergency Readmissions
- Urgent care metrics
- MRSA (meticillin-resistant staphylococcus aureus) Screening (contractual measure)
- Non elective First Finished Consultant Episodes
- Accident & Emergency Attendances
- Ambulance Urgent & Emergency Journeys

### Implications, Risks and Mitigating Actions

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateshead Acute Hub on the Queen Elizabeth site being procured by April 2014</td>
<td>Urgent care strategic group and network and work with OSC, LEB and others</td>
</tr>
<tr>
<td>Working with providers for development of services</td>
<td>Partnership to promote integration in the above groups and joint clinical forum, with performance metrics</td>
</tr>
<tr>
<td>Provider engagement</td>
<td>Clinical engagement sessions and pathway kaizen events, Rapid Process Improvement Workshop</td>
</tr>
<tr>
<td>Financial pressures</td>
<td>Close contract monitoring</td>
</tr>
<tr>
<td>Agreement to collaborative model</td>
<td>Learning from best practice</td>
</tr>
<tr>
<td>Workforce and infrastructure</td>
<td></td>
</tr>
<tr>
<td>Payment by Result tariff changes (emergency admissions)</td>
<td></td>
</tr>
<tr>
<td>Pace of change required to deliver initiatives</td>
<td></td>
</tr>
</tbody>
</table>

### Communications Implications

- Improve local Accident & Emergency and Medical Assessment Unit Discharge letters to enable all practices to be informed by the next working day.
- Arranging an annual ‘Choose Well’ public information campaign
- Introduction of single point of access services (111)
- Information around accessing appropriate urgent care services
- Effective collaboration with all stakeholders to ensure continued delivery of high quality and safe urgent care services across the three health localities.
- Communication in relation to the introduction of Trauma Centres and locally the potential re-classification of our local FTs as Trauma Units.

### Workforce Implications

- Providing support to align General Practitioner practices to nursing homes to provide integrated care and supporting existing services provided by the urgent care team and community matrons
- Develop Intravenous therapy provision in the community
- Single point of access & associated transport for all health and social care require additional training in use of new standard clinical protocols
- Integration of Accident & Emergency, Minor Injuries Units and Gtdoc
- Staffing in relation to the introduction of Trauma Centres and locally the potential re-classification of our local Foundation Trusts as Trauma Units.
- Training for Telehealth service

### Informatics Implications

- Work towards more integrated IT records so the right information is available at the right time which will include expanding the single GP electronic record.
- Move to more integrated directories of services on Gateshead Information Network.
- Production of performance data (activity and outcome) from Walk In Centre and Minor Injuries Unit
- Implementation of the single point of access (111): Capacity Management System hosted by North East Ambulance Service / Connecting for Health
- Evaluation of ‘Choose Well’ initiative
- Introduction of Telehealth technology for patients with long term conditions
- Effects of the introduction of Trauma Centres and locally the potential re-classification of our local Foundation Trusts as Trauma Units.
- Introduction of Telehealth service

### Estates Implications

- Development of an urgent care transport strategy to support the implementation of 111
- Introduction of Trauma Centres and locally the potential re-classification of our local Foundation Trusts as Trauma Units.
- Expansion of telehealth initiatives could reduce demand for space over time
Enhance governance & quality arrangements with independent sector providers.
Continue to implement the Carers strategy and local action plans in each locality.
Implement preferred option for CHC (Continuing Health Care), FNC (Free Nursing Care) & s117 (Section 117)
Implementation of robust joint strategic function arrangements with Gateshead Local Authority through the use of Health Act flexibilities.
Continue the process of repatriating high cost out of area placements to locally provided services.
Develop and agree an adult attention deficit & hyperactivity disorder assessment, diagnosis and treatment service.
Lead the implementation of Care Pathways & Packages Project (Payment by Result for mental health) in shadow form across contracts
Work with Northumberland Tyne and Wear to support the implementation of the new facilities in Ryhope & Monkwearmouth.
Continue work with Northumberland Tyne & Wear to realise efficiencies in resource releasing initiatives and support service development.
Consider existing commissioning arrangements moving to Any Qualified Provider for psychological therapies in Primary Care
Re-provide Black and Minority Ethnic and Lesbian Gay Bisexual Transgender wellbeing programmes.
Implement the emotional health & wellbeing plan.
Re-provide workplace health programme with improved service offer for organisations not pursuing North East Better Health at Work Award.
Implement recommendations arising from report on outcomes of physical health improvement programme for people with severe mental illness.
Consider existing commissioning arrangements moving to Any Qualified Provider for psychological therapies in Primary Care
Continue work with Northumberland Tyne & Wear to realise efficiencies in resource releasing initiatives and support service development.
Work with Northumberland Tyne & Wear to support the implementation of the new facilities in Ryhope & Monkwearmouth.
Lead the implementation of Care Pathways & Packages Project (Payment by Result for mental health) in shadow form across contracts
Develop and agree an adult attention deficit & hyperactivity disorder assessment, diagnosis and treatment service.
Continue the process of repatriating high cost out of area placements to locally provided services.
Joint Commissioning arrangements with Local Authorities (including CHC)
Implementation of robust joint strategic function arrangements with Gateshead Local Authority through the use of Health Act flexibilities.
Implement preferred option for CHC (Continuing Health Care), FNC (Free Nursing Care) & s117 (Section 117)
Continue to implement the Carers strategy and local action plans in each locality.
Enhance governance & quality arrangements with independent sector providers.
Re-provision of in patient, out patient & community services at Ryhope & Monkwearmouth
Domain 4: CAMHS, Learning Difficulties and Complex Needs

**Why is change needed?**
- One in ten children and young people between 5 and 16 years has a mental health problem which significantly impacts on health, education and social outcomes, with half of those with lifetime mental health problems experiencing symptoms by the age of 14.
- Fragmented mental health and learning disability service provision for children and young people.
- Lack of clarity about pathways and provision for children with complex needs and children and young people with multiple problems.

**Objective**
Establish integrated models of care that deliver personalised, holistic and outcome focused services to children, young people and their families with mental health, learning difficulties, disabilities and multiple and complex needs.

**How do we want the future to look and what are the transitional issues?**
- Improved access to talking therapies (Improving Access to Psychological Therapies) for children and young people as part of the development of Tier 2 Child and Adolescent Mental Health Services.
- Improved access to effective Child and Adolescent Mental Health Services and Learning Disabilities for all children and young people including those in special circumstances; with acute mental health needs and with complex behavioural mental health and social care needs through the establishment of specialist community Child & Adolescent Mental Health and Learning Disability.
- Reduction in the number of children and young people requiring out of area treatment.
- Clearly defined pathways of care for children and young people with neuro-developmental disorders.
- Clearly defined pathways and effective provision of service for children and young people requiring individual packages of care including implementation of the continuing care framework.
- Improved support for children, young people and their families with disabilities including implementation of Aiming High.
- Improved health outcomes for children and young people in special circumstances including Looked After Children and Children and Young People involved in the Youth Justice System.

**What are we doing about it?**

<table>
<thead>
<tr>
<th>Project Gantt Chart</th>
<th>2012/13</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of Tier 2 Child &amp; Adolescent Mental Health service provision including improved access to talking therapies in line with evidence base. To increase the capacity of universal service providers to promote mental health for children and young people, recognise problems early in their development, intervene and refer as appropriate. Provide direct services to Children, young people and their families with moderate mental health needs, including grouping work and talking therapies. Expansion of existing service in Gateshead.</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Establishment of new model of specialist community Child &amp; Adolescent Mental Health / Learning Disability service provision with a particular focus of integrated pathways of care for children, young people and their families.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-alignment of resources / changes in service provision for children and young people with Autistic Spectrum Disorder based on outcomes of the review.</td>
<td></td>
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</tr>
<tr>
<td>In partnership with the Local Authority, develop services for Children and Young people with Disabilities.</td>
<td></td>
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</tr>
<tr>
<td>Working in partnership with Local Authority support the review of Special Educational Needs assessment and statement framework.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of the review of services for Looked After Children</td>
<td></td>
<td></td>
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<tr>
<td>Implementation of result of review of Child protection service specification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of outcomes of review of services for children and young people involved in youth justice system.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* +£ = Investment; -£ = Disinvestment

**What Key Performance Indicators will we use to monitor progress?**

**Local Measures**
- Improved access to psychological therapies (IAPT).
- Commissioning comprehensive Child & Adolescent Mental Health service.

**Implications, Risks and Mitigating Actions**

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differences in configuration of services in different localities;</td>
<td>Clearly defined level of resource for children and young people to support the development of talking therapies as part of development of Tier 2 Services</td>
</tr>
<tr>
<td>Resources not available to meet requirement to improve access to psychological therapies and reduction of resource available to Local Authorities as a result of Comprehensive spending review and availability of area based grant.</td>
<td>Alignment with developing health and well being board / children’s Local Strategic Partnership arrangements</td>
</tr>
<tr>
<td>Transition between current and new service provision; Transfer of Undertakings Regulations implications; transfer of care, transfer of records implications</td>
<td>Ensure involvement of local Child &amp; Adolescent Mental Health Service and Learning Disabilities &amp; Difficulties partnerships, Foundation Trust, community and Child &amp; Adolescent Mental Health Service commissioners in process</td>
</tr>
<tr>
<td>Lack of clarity in relation to future commissioning arrangements for tier 2 Child &amp; Adolescent Mental Health Service</td>
<td></td>
</tr>
<tr>
<td>New service fails to deliver required changes</td>
<td></td>
</tr>
</tbody>
</table>

**Communications Implications**
- Engagement and communications plan for the development of Tier 2 Child & Adolescent Mental Health service.

**Estates Implications**
- Re-alignment of service provision for children and young people with Autistic Spectrum Disorder (specifically specialist community provision).

**Informatics Implications**
- Information systems – Primary Care Trust and provider system to be developed to support collection of performance information.

**Workforce Implications**
- Employment and workforce remodelling to support re-alignment of service provision.

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Domain 5: Maintaining Good Medical Practice

Why is change needed?
Gateshead practices provide high quality care; however it is believed there scope to reduce clinical variation and inefficiencies from the system. This provides huge potential to improve patient care whilst reducing expenditure.

Objective
To improve Clinical Performance of all practices within the Gateshead CCG consortia through engagement with practices, providers and commissioners.

How do we want the future to look and what are the transitional issues?
- Working with practices to help them get used to reviewing their own data. Using Gateshead Information Network and the clinical dashboard to help clinicians practice to a high common standard e.g. around referrals;
- Regular meetings with key commissioner partners to review and understand the dashboard findings. Using these meetings to decide how to support clinicians/practices where variation is a concern and there is a chance of improving, using clinicians to provide peer support to practices.
- Practices to take ownership and start to address issues of unacceptable variation
- To work with the primary care services agency where underperformance arises

What are we doing about it?

<table>
<thead>
<tr>
<th>Project Gantt Chart</th>
<th>2012/13</th>
<th>£k</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Develop Clinical Dashboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engage with GP practices through the Practice Clinical Commissioning project</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid Process Improvement Workshop on the Clinical Performance to develop standard work for clinical dashboard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop local benchmarking criteria for practices with review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognise good practice and consider how to share with other practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Building on time outs, align education with developing standard work in clinical practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understand the key problems through analysis of dashboard data and communicate that to practices.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider and prioritise possible interventions and roll out to practices.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Align identified needs with the education programme.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* +£ = Investment; -£ = Disinvestment

What Key Performance Indicators will we use to monitor progress?

Operating Framework Measures

Local Measures
- Development of a good medical practice group with scheduled meetings
- Reduce variation in referral rates as monitored by our primary care dashboard group
- Reduce variation in prescribing as monitored by our primary care dashboard group
- Implementation of the Practice Clinical Commissioning project

Implications, Risks and Mitigating Actions

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced management resource may mean the work is not supported</td>
<td>Clarity on resource available</td>
</tr>
<tr>
<td>Practices unwilling to engage and change practise</td>
<td>Use of Practice Based Commissioning Local Improvement Scheme to incentivise engagement, peer pressure, practice visits, publishing data</td>
</tr>
<tr>
<td>Inability of IT/Information to supply information in a timely and usable form</td>
<td>Dedicated resource to develop the dashboard</td>
</tr>
</tbody>
</table>

Communications Implications
- Communication programme with constituent practices regarding standard work in relation to benchmarking of indicators for long-term conditions

Informatics Implications
- Development of the Clinical Dashboard

Estates Implications
- Minimal

Workforce Implications
- Training requirement for staff using clinical dashboard
Domain 5: Medicines Management

Why is change needed?
Medicines are associated with significant cost to the NHS in terms of mortality, morbidity and financial impact. Effective management of medicines can improve patient outcomes and yield cost efficiencies through a reduction in expenditure and hospital admissions due to inappropriate prescribing. Throughout this period of restructuring the local NHS needs to ensure priority is given to the safe, legal and effective use of medicines and medicines management is actively integrated into new commissioning structures.

Objective
To ensure safe, legal and effective use of medicines within commissioned services and supporting patients to take their medicines in an optimal way.

How do we want the future to look and what are the transitional issues?
- Ensure Primary Care Trust statutory obligations with respect to medicines use continue to be met.
- Ensure emergent General Practitioner commissioning consortia develop appropriate governance infrastructure to effectively manage the medicines agenda.
- Ensure prescribing costs are managed within the agreed budgetary envelope and identified cost efficiencies are achieved.

What are we doing about it?

### Project Gantt Chart

<table>
<thead>
<tr>
<th>Project Gantt Chart</th>
<th>2012/13</th>
<th><em>£k</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>To have an action plan in place to improve the quality of prescribing, optimise medicines usage in patients and delivery disinvestment opportunities in Primary care prescribing.</td>
<td>Q1</td>
<td>+£</td>
</tr>
<tr>
<td>Work with stakeholders, including secondary care, to develop a health economy approach to prescribing of medicines across pathways of care, including initiatives to improve effectiveness of communication, the transfer of prescribing responsibility, supply of medicines and address variation in prescribing in primary and acute settings via the Prescribing Committees.</td>
<td>Q2</td>
<td>+£</td>
</tr>
<tr>
<td>Work with emerging Clinical Commissioning Group to ensure there are robust local mechanisms for funding approval for medicines.</td>
<td>Q3</td>
<td>+£</td>
</tr>
<tr>
<td>Ensure collaborative working across community care is maintained in relation to wound management and incontinence products.</td>
<td>Q4</td>
<td>+£</td>
</tr>
<tr>
<td>Work with Substance misuse providers to ensure safe and effective prescribing, to reduce the risk of drug related deaths and support the move from the maintenance to recovery agenda.</td>
<td>Q1</td>
<td>-£</td>
</tr>
<tr>
<td>Explore options to develop services to improve medicines management in care homes in order to reduce the number of emergency admissions and reduce medicines wastage.</td>
<td>Q2</td>
<td>-£</td>
</tr>
<tr>
<td>Explore options for collaborative working across primary and secondary care in relation to the provision of oral nutritional products.</td>
<td>Q3</td>
<td>-£</td>
</tr>
<tr>
<td>Improve the systems for high impact / cost drug exclusions to include a consistent approach across the locality / region and effective implementation of the decisions.</td>
<td>Q4</td>
<td>-£</td>
</tr>
<tr>
<td>Work with local community pharmacists to optimise services available within the community pharmacy contract to support patients taking their medicines including improving rates of repeat dispensing. New medicines service and targeted use of medicines usage reviews.</td>
<td>Q1</td>
<td>+£</td>
</tr>
<tr>
<td>Review the contract for provision of medicines management support to individual practices within the Clinical Commissioning Groups.</td>
<td>Q2</td>
<td>+£</td>
</tr>
</tbody>
</table>

*+£ = Investment; -£ = Disinvestment

*Projects that Gateshead CCG will be responsible for*

### What Key Performance Indicators will we use to monitor progress?

**Operating Framework Measures**

- Prescribing Cost growth
- Prescribing cost per Asto-Astro-Pu (age, sex & temporary resident originated prescribing unit)
- Percentage of prescribed items as repeat dispensing
- All practices to achieve a target of 2 ADQ (average daily quantity) per STAR-PU (Specific Therapeutic group Age-sex weightings Related Prescribing Units) or reduce prescribing of benzodiazepines by 5%
- Simvastatin and Pravastatin as a percentage of all statins. (cardiovascular)
- ACE inhibitors as a proportion of all Renin-Angiotensin-System (RAS) drugs (cardiovascular)
- Total respiratory cost per patient on the Asthma and COPD (Chronic Obstructive Pulmonary Disease) register (Asthma and COPD)(Chronic Obstructive Pulmonary Disease)
- Volume of antibiotics (Rolling 12 month data) – items/STAR-PU (specific therapeutic group age-sex weightings related prescribing units)

**Gateshead CCG Measures**

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### Implications, Risks and Mitigating Actions

#### Risks

- Lack of medicines management resource to deliver objectives; lack of engagement from General Practitioners and secondary care clinicians; transfer of responsibility for Quality Innovation Productivity & Prevention to emergent General Practitioners commissioning consortia; drug tariff price fluctuations.
- Lack of investment in financial resource to support project plan.
- Lack of support / access to procurement expertise; challenge to proposed model from local community pharmacy representatives, possible legal challenge.
- Lack of regional agreement to drug approvals, engagement of emergent General Practitioners consortia, engagement of secondary care.

#### Mitigating Actions

- Requirements for medicines management resource highlighted at senior level. Programme of engagement with key stakeholders.
- Monitoring arrangements in place for primary care medicines expenditure.
- Review of contracts for the provision of medicines management.
- Funding identified for regional procurement expertise; programme of engagement with local pharmaceutical committees.
- Plan for regional collaboration on drug approvals process.
- Identification of opportunities for disinvestment.

#### Communications Implications

- Communication strategy required with all key stakeholders
- Improve the effectiveness of communication by working with both secondary and primary care to develop a health economy approach to prescribing of medicines

#### Workforce Implications

- Limited medicines management resource to deliver objectives
- Additional resource required to deliver new services

#### Estates Implications

- Minimal

#### Informatics Implications

- Limited action plans with local Clinical Commissioning Groups