Deciding Together: Developing new specialist mental health services for Newcastle and Gateshead

Case for Change
June 2016
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1. FOREWORD

My name is Dr Guy Pilkington and I am Chair of the Mental Health Programme Board for NHS Newcastle Gateshead Clinical commissioning Group. For over two years the Board has been overseeing the work of Deciding Together. The Governing Body of the CCG is soon to complete its deliberations on how to reconfigure specialised mental health services for adults of working age living in Newcastle and Gateshead, as well as services provided by Northumberland, Tyne and Wear NHS Foundation Trust (NTW) for older people living in Newcastle.

In order to make the very best decisions we have worked hard to gather evidence from as wide a range of interested parties as possible. We have engaged clinical expertise from outside our area to advise us. We have heard from doctors and nurses currently working in mental health services with NTW. Our local GPs have been involved in telling us what is important for their patients and from their point of view. The Clinical Senate for the North of England has visited and advised us, and NHS England is assuring the overall process.

NHS North of England Commissioning Support has been helping the CCG with all this work. Their contribution has been invaluable.

Above all, however, we have heard from over 1000 local people who have shared with us their opinions, experiences and views. This has ranged from 18 in-depth interviews with users of specialist mental health services to approximately 800 people who took part in surveys on the streets of Gateshead and Newcastle. We have heard from users, carers, voluntary sector organisations, colleagues in partner organisations and local elected members.

The task for the Governing Body is to weigh up and consider all that we have heard and decide the best way forward. Whatever is decided we commit to the following:

1. The changes we make will improve the quality, safety and effectiveness of specialist mental health care for our population.
2. The environment in which people are cared for in hospital settings will improve.
3. We will invest more in supporting people in community settings. We will do this in new and innovative ways.
4. The changes we make will be done in safe and sustainable ways.
5. We will continue to work closely with our communities and our partners over the coming years to transform care and support for people’s mental health and wellbeing.
Thank you for your interest, thank you for your contribution.

Together, we can think differently about mental health.

Dr Guy Pilkington
Assistant GP Chair of Newcastle Gateshead CCG
Chair of the Newcastle and Gateshead Mental Health Programme Board and a Newcastle GP
2. EXECUTIVE SUMMARY

This Case for Change sets out the need to develop new specialist mental health pathways for Newcastle and Gateshead by improving the provision of specialist community mental health services and, by doing so, reducing the reliance on adult acute assessment and treatment inpatient services and the number of beds required. It sets out different scenarios of where inpatient services could be located in future to ensure the provision of sustainable, good quality, safe services.

Section 3, the Introduction, describes the role of the Clinical Commissioning Group (CCG). It also explains that the scope of this Case for Change focuses on community mental health services and acute, rehabilitation and older people’s inpatient services provided by Northumberland, Tyne and Wear NHS Foundation Trust (NTW). Although mental health services provided by the community and voluntary sector are not part of the formal consultation, depending on the outcome, these services could be extended or enhanced. This section also sets out the aims that we want to achieve in making these changes and briefly describes how the CCG has engaged with its partners in taking this forward.

Section 4 which summarises national, CCG, NTW and mental health voluntary and community services (MHVCS) strategic plans shows that there is a very strong alignment between those organisations’ plans to improve and extend community mental health services, to provide alternatives to inpatient admission and to reduce the reliance on inpatient beds. The CCG’s strategic objectives include:

- “Increase the number of people with mental and physical health conditions having a positive experience of care outside hospital....”; and
- Reduce the amount of time people spend unavoidably in hospital through better and more integrated care in the community...."

NTW’s Transforming Services Programme has similar aims and the Trust has developed new community care pathways, developed in partnership with service user and carer partner organisations, to improve and increase the capacity of its community services. We have agreed to roll out this new model of care in Newcastle and Gateshead. We also want to look at other ways of preventing admissions to inpatient services. And the MHVCS is looking ahead to take on new or increased roles in prevention, in providing alternatives to hospital admissions and helping people recover.
This section also summarises local population and public health data, including mental health prevalence, which indicates a higher need in Newcastle and Gateshead, compared with other areas of the country, for effective and resourced community provision, particularly focused on the recovery of service users.

Section 5, building upon these common strategic objectives, looks at best practice in the provision of community and inpatient services. Expert advice was obtained from an independent consultant psychiatrist / clinical director and this was subsequently used by the CCGs Mental Health Programme Board to inform the development of different high level scenarios for the future provision of our local services. We have also considered evidence from the recent implementation of changes by NTW in Sunderland and South Tyneside as part of its Transforming Services Programme. Although this evidence can only be based so far on a short period of time it indicates that this new model of care:

- Is reducing the need for hospital admission;
- Has, together with inpatient lengths of stay in line with best practice, enabled a reduction in the number of beds that are required;
- Is managing local demand for inpatient care – there has not been any increase in the numbers of local people in Sunderland and South Tyneside being admitted to a hospital outside of that area; and that
- A reduction in the emergency re-admission rates to hospital, indicates that patients are generally not being discharged too quickly and that community services are supporting people without the need for re-admission

Section 6 considers the current services. For community services, it describes various features of NTW’s existing community services which the Trust itself identified as requiring improvements. NTW subsequently undertook a fundamental review with service user and carers’ organisations’, which has resulted in the development of new community pathways and ways of working. We have agreed to the roll out of these pathways in Newcastle and Gateshead and look forward to these being implemented and then fully embedded by March 2017. This section also describes the range of services carried out by mental health voluntary and community sector organisations’ and those services which we commission.

The inpatient services for acute assessment, complex care and moving on rehabilitation, and older people’s services are all fully compliant with Care Quality Commission standards. The acute and older people’s wards have also been assessed through the Royal College of Psychiatrist’s AIMS accreditation process, with five of the seven accredited with excellence. However, the building environments for these services make it more difficult for the staff to deliver and improve upon the quality of care for
patients and Care Quality Commission Mental Health Act inspections have consistently reported upon these accommodation shortcomings. The patient environment difficulties are described and NTW has estimated that it would cost in the region of £4 million to address some of these issues, if the services remained in their current accommodation. Both the CCG and NTW recognise and agree that a capital investment priority is to significantly improve the accommodation for these services, within any future changes.

Section 7 on public engagement and service user and carer involvement describes how the CCG has already listened and engaged with people and organisations as it is imperative that we listen and engage with those using mental health services and their carers in helping to change and improve the way services are provided. A range of different methods were used to obtain people's views on issues such as access into mental health care; treatment in the community; inpatient care; transport and travel; rehabilitation; and services for older people. We also used innovative participatory budgeting events (the mental health £) to enable people to collaborate in how to allocate a finite financial resource. The findings, which are fully described in this section and in Appendix 8, were then used to help develop some high level scenarios for future services. And the findings, along with views obtained through the formal consultation have been used as part of our decision making.

Section 8, the Case for Change, summarises the previous sections. There are strong strategic and operational reasons why we need to improve community mental health services for the people of Newcastle and Gateshead, reduce the reliance and number of inpatient beds, and improve ward environments for inpatients and staff.

Section 9, Scenarios for Change, describes different scenarios for future services. Firstly, we set out some thinking around potential frameworks of community services provided by statutory and voluntary organisations, including potential new, redesigned or extended services. Secondly for inpatient services, this section explains how, in line with best practice in both community and inpatient care, we can work towards reducing the number of adult acute assessment and treatment wards for Newcastle and Gateshead residents from five wards to three. Thirdly, we describe how we developed different scenarios for the location of the different services being considered and how these were shortlisted to select those for formal consultation. The shortlisted scenarios for acute and rehabilitation services are:

- Scenario T - acute services provided at St. George’s Park, Morpeth and Hopwood Park, Sunderland; complex care rehabilitation provided at St. George’s Park; and moving on rehabilitation provided in Gateshead
• Scenario N – acute services provided at St. Nicholas Hospital, Newcastle; complex care rehabilitation provided at St. Nicholas Hospital; and moving on rehabilitation provided in Gateshead;
• Scenario G – acute services provided in Gateshead; and complex care rehabilitation and moving on rehabilitation provided in Gateshead

Older people’s services are applicable to Newcastle residents only as the Gateshead older people’s mental health service, which is provided by Gateshead Health NHS Foundation, is not affected by these changes. There are two shortlisted scenarios for older people’s services for Newcastle residents:
• Scenario 1 - services provided at St. Nicholas Hospital, Newcastle
• Scenario 2 - services provided at St. George’s Hospital, Morpeth

Some advantages and disadvantages of the scenarios are described to help inform consideration of the scenarios.

Section 10 describes the formal public consultation methodology and summarises the responses received. It also summarises the independent travel impact report which provided more information about how the different scenarios would impact on travel times and costs.

Section 11 describes the non-financial option appraisal process that was followed in considering the inpatient locations. Non-financial benefit criteria were agreed and used to evaluate the scenarios. The Governing Body is asked to consider this information when identifying a preferred scenario on 28th June.

Section 12, Funding and Cost Estimates, Further Financial analysis and assessment being worked on and will be presented to Governing Body as part of Business Case and discussion on 28th June Governing Body meeting.

Section 13 sets out the Next Steps to progress this work following the decision on the preferred scenario by the Governing Body on the 28th June. The formal consultation methodologies and the additional information obtained to help inform the final decision are explained. It is planned that the service changes will be implemented sometime in 2018, although all capital improvements may
not be completed until the latter part of 2018. An Implementation Plan will be agreed, following the selection of the preferred scenario in June (so that changes are managed a safe and effective way) and presented to the Governing body in July 2016.
3. INTRODUCTION

3.1. Role of the Clinical Commissioning Group

From 1 April 2015 three local clinical commissioning groups¹ merged to become Newcastle Gateshead Clinical Commissioning Group (CCG). The role of the CCG includes:

- Choosing, planning and buying (commissioning) the majority of healthcare for the people of Gateshead and Newcastle
- Leading the Mental Health Programme Board² including wider stakeholders and partners, NHS providers and other providers from the community and voluntary sector. The Mental Health Programme Board’s role is to oversee the development and implementation of a local mental health strategy with the purpose of improving the emotional wellbeing and mental health of people in Gateshead and Newcastle.
- Considering both adult and older people’s mental health services in developing mental health pathways

3.2. Scope of the Review

The CCG has therefore been leading on work with its partners, including Northumberland, Tyne and Wear NHS Foundation Trust (NTW) and other providers from the community and voluntary sector to develop new specialist mental health pathways for people living in Newcastle and Gateshead. The scope of this Case for Change focuses on the following services provided by NTW, which we have described as “specialist” services to distinguish them from primary care services provided by GPs and others. Similarly it does not cover very “specialised” services such as forensic psychiatry.

- Community mental health services for working age adults living in Newcastle and Gateshead provided by NTW
- Community mental health services for older people living in Newcastle provided by NTW
- Inpatient mental health services for working age adults living in Newcastle and Gateshead provided by NTW – this covers acute care and rehabilitation inpatient services;
- Inpatient mental health services for older people living in Newcastle provided by NTW

¹ Gateshead, Newcastle North & East and Newcastle West
² This is a multi-agency and multi-professional group that is leading the development and provision of mental health services in Newcastle and Gateshead. It includes statutory and voluntary sector service providers, as well as service user and carer representatives.
Based on what service users have told us, our aim is to develop specialist mental health pathways covering the above services, which:

- Make sure that specialist community services support people very well and early on in their care, so that people don’t get worse and don’t need to be admitted to hospital;
- Make sure that all our services are focused on helping people to recover sooner and get back to having the best opportunities and life they can;
- Make sure that hospital based services are able to support people with very complex needs in a safe and person centred way; and
- To ensure that the services are financially sustainable.

It is also important to note the services below, which are outside the scope of this project:

- Mental health services provided by GPs, primary care counsellors and therapists, including IAPT services (Improving Access to Psychological Services);
- Community and inpatient mental health services for older people in Gateshead provided by Gateshead Health NHS Foundation Trust;
- Other specialist inpatient mental health services (such as psychiatric intensive care, forensic psychiatry etc.)
- Children and young people’s mental health services
- Mental health services provided by the community and voluntary sector – although not part of the formal consultation, depending on the outcome, these services could be extended or enhanced.
- Mental health services provided or commissioned by Newcastle and Gateshead local authorities.

Governance Arrangements and Engagement with Partner Organisations

The work has been progressed under the governance arrangements as illustrated in Appendix 1

The Clinical Commissioning Group Executive oversees the work under delegated powers from the CCG Governing Body.

The multi-agency, multi-professional Mental Health Programme Board, in its role of overseeing the development and implementation of a local mental health strategy, has received regular reports on progress and contributes and advises on the development of the work.
The **Deciding Together Advisory Group** oversees the engagement process and is chaired by the Chairperson and Coordinator of VOLSAG, Newcastle’s Mental Health Voluntary & Community Sector (VCS) Network. The Advisory Group also includes representatives from the CCG, the North East Commissioning Support Unit, NTW, Healthwatch and service user and carer representatives.

**A Project Co-ordinating Group** led by the CCG’s Executive Director of Nursing co-ordinates the project and the different strands of work.

Regular, monthly meetings (Joint Executives meetings) have also taken place with partner organisations including NTW, Newcastle and Gateshead Local Authorities and the mental health community and voluntary sector representatives.

More information about engagement with the wider community is provided in Sections 7 and 10.
4. STRATEGIC CONTEXT

This section describes national and local strategies and plans which are relevant to these services. It shows in particular that there is an alignment between the strategic plans of the Clinical Commissioning Group, Northumberland, Tyne and Wear NHS Foundation Trust and the Mental Health Voluntary and Community Sector to improve and extend community mental health services, providing alternatives to inpatient admission and reducing the reliance on inpatient beds. Summary population and public health data also provides a context for mental health prevalence and those who access mental health services.

4.1. National Strategies and Context

The most recent and key strategic document for the NHS in recent years – The NHS 5 Year Forward View - is significant in that it reiterates the focus on parity of esteem, whereby mental health is valued equally to physical health, and an ambition to achieve this by 2020. The Five Year Forward for Mental Health sets out a change in mind-set focusing upon 7 day NHS, Integrated mental and physical health approach and promoting good mental health and preventing poor mental health. Appendix 2 provides more details on a number of other relevant, key mental health strategies and reports.

There are a number of strategies relating to specific areas of mental health provision but the key over-arching strategic direction is described in No health without mental health (H.M. Government 2011) which sets out a strategy to mainstream mental health across Government, establish parity of esteem, improve the mental health and wellbeing of the population and get better outcomes for people with mental health problems. It identified four main ways of increasing value for money in mental health services:

- Improving the quality and efficiency of current services;
- Radically changing the way that current services are delivered so as to improve quality and reduce costs;
- Shifting the focus of services towards promotion of mental health, prevention of mental illness and early identification and intervention as soon as mental illness arises; and
- Broadening the approach taken to tackle the wider social determinants and consequences of mental health problems.

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3 The Five Year Forward View for Mental Health – A report of the independent Mental Health Taskforce to NHS in England February 2016
The report identified three main work streams to improve the quality and efficiency of current services, the most relevant to this document being the “acute care pathway”, focusing on avoiding hospital admissions through effective joined-up community care and ensuring that hospital inpatient care itself is effective and that unnecessarily long stays are avoided. The report also recommends that local commissioners and providers should consider joining together with non-clinical agencies such as employment or housing support services in delivering services.

Nationally, the NHS is facing growing demands and increased costs. Funding is unlikely to increase, therefore as recognised above in No health without mental health, the NHS needs to change the way that services are delivered to both improve quality and reduce costs. For CCGs this means that we have to review where we spend our money and what outcomes are achieved in order to ensure that we are getting best quality and value for our patients. As part of this, there is a national requirement that providers of NHS services make savings every year, which in turn enables the CCG to fund demands for new services.

### 4.2. Newcastle Gateshead Clinical Commissioning Group

Our strategic plan for all the services that we commission sets out how, as a health and care economy, we want to develop and deliver health care services across Newcastle and Gateshead for the next five years. This is in the context of some significant local and national challenges particularly in relation to the future financial climate. In order to meet these challenges, we will continue to ensure we work closely with our patients and public, provider and local authority colleagues, all of whom have been actively involved in the production of our strategic plan. We will continue to actively develop these relationships to ensure alignment of plans and resources.

The CCG’s strategic plan includes objectives, which apply equally to mental health and physical health, to:

- Increase the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and in the community; and to
- Reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

The CCG’s vision for the model of mental health service provision in 2018/19 will ensure that it will be as equally focussed on improving mental health as it is on physical health and that patients, young or old with mental health problems, do not suffer inequalities. In order to ensure parity of esteem for mental health we aim to address the 25 areas identified in ‘Closing the Gap: priorities for essential change in mental health’, DoH, January 2014.
In delivering our commissioning objectives we will ensure that mental health services benefit from equal priority and are subject to the principle of parity of esteem; it is a golden thread that runs across and within all commissioning areas. Our mental health commissioning agenda is focussed on:

- Health outcomes ensuring patients move to recovery quickly and are supported to manage their condition,
- Quality of life, enabling more people to live their lives to their full potential
- Early intervention, improving health and wellbeing through prevention and early intervention

Whilst we expect these overarching work programmes to support the delivery of the reduction in the 20 year gap in life expectancy for people with serious mental illness we will consider how we can adopt the following models and strategies to help achieve the reduction:

- A fully integrated model of mental health care
- Robust whole population emotional health and wellbeing strategies
- Comprehensive primary care services
- Redesigned specialist services
- Reprovision of inpatient services; and
- Implementation of the national dementia strategy.

4.3. Northumberland, Tyne and Wear NHS Foundation Trust

NTW’s Integrated Business Plan for 2012-17 sets out the Trust’s strategic objectives and how it intends to take these forward. The Trust has seven strategic objectives, the most relevant to this Case for Change being:

- Modernising and reforming services in line with local and national strategies and the needs of individuals and communities; providing first class care in first class environments; and
- Being a sustainable and consistently high performing organisation

One of NTW’s priorities in delivering its strategic objectives over this period is to progress its Service Transformation Programme by:

- Developing new care pathways to improve the quality of care for all of those that use the Trust's community services;
• Working with their staff who support people in the community, to help them to free up more of their clinical time through the use of mobile technology and new ways of working; and
• Reviewing the use and the reliance on inpatient services for adults who require mental health and learning disability services in the light of the provision of improved community, access and initial response services.

Phase 1 of NTW’s Service Transformation Programme saw the implementation of new models of care in Sunderland and South Tyneside and this is now being rolled out across Northumberland, North Tyneside, Newcastle and Gateshead. The Deciding Together proposals, encompassing improvements to community services and a reduced reliance on inpatient services, are therefore an integral part of both the CCG’s and NTW’s strategic plans.

NTW has re-affirmed the importance of completing its service transformation programme, with specific reference to implementing the outcome of the Deciding Together proposals, in its 2016/17 Operational Plan recently submitted to NHS Improvement (formerly Monitor) for approval. It sets out the Trust’s integrated service, workforce and financial plans, including the requirement for capital funding, to achieve its 2016/17 objectives.

The implementation of NTW’s Service Transformation Programme is also seen as a key factor in helping the Trust to achieve its strategic objective of being a sustainable and consistently high performing organisation

4.4. The Mental Health Voluntary and Community Sector

In Newcastle and Gateshead, voluntary sector and community organisations provide a wide range of advocacy, advice and support (including specialist services and nursing care) to people with mental health problems. This includes creative, educational, vocational and therapeutic activities as well as help with housing and homelessness. It also includes services to particular groups including young people, women, men, black and other ethnic minorities, older people, service users and carers.

The sector’s service provision is based on the following principles:
• Greater emphasis on the value of expertise resulting from lived experience, peer support, and carer support
• Services that embody equality, diversity, choice, control, hope and recovery
• Services that demonstrate service user and carer focused outcomes
• Services that reduce stigma and negative discrimination
• Increasing the focus on social inclusion; and
• Increasing the use of personal budgets, personal health budgets and social prescribing

Locally the strategic direction of the sector is informed by a number of factors:
• Information that has emerged from the listening and engagement phase of the Deciding Together process
• Ongoing intelligence gathered from beneficiaries, local communities and partners
• The ongoing work of the Mental Health Programme Board
• National policy and guidance

These factors make it possible to identify a number of key themes for the strategic development of specialist and universal mental health services provided by the sector. The following list illustrates the kind of areas (not exhaustive) where the sector considers that it can take on a new or increased role:
• Alternatives to hospital admission e.g. crisis beds and crisis houses (i.e. non-residential) and rehabilitation
• Improved and increased housing and support (including adult fostering)
• Input to a multi-agency initial response system
• Increased access to vocational pathways including volunteering, training, education and employment
• Greater range of arts, creativity and cultural activities
• Increased access to link workers, signposting and service navigators who can quickly guide and connect people to the information, advice, help and resources they need

In common with the wider voluntary sector the Mental Health Voluntary Sector (MHVCS), is currently experiencing a significant increase in demand whilst at the same time funding and contracting opportunities are reducing.

4.5. Population and Public Health Information

Some summary information on population and mental health related public health in Newcastle and Gateshead is provided below. More detailed information is provided in Appendix 3.
The data indicates a higher level of mental health need in Newcastle and Gateshead, compared with many other areas of the country. There is no formula which translates this information into a specific recommended level of community and inpatient provision but it does indicate a need for effective and resourced community provision, particularly focused on the recovery of service users.

4.5.1. Population Summary

There are differing population structures across Newcastle and Gateshead which need to be taken into consideration in the provision of healthcare:

- Combined population of nearly 500,000 residents, alongside those that work and visit the city
- Gender split is in line with the England average of 50:50 male : female
- There are a greater proportion of under-25 year olds in Newcastle (37%) compared to Gateshead (29%) which is largely influenced by the much greater numbers in the 20-24 year age group reflecting a larger student population
- Gateshead has an older population with 17.6% of the population over-65 years old compared to Newcastle at 13.8%
- 67% of the Newcastle / Gateshead population is made up of those who are working age (16-64 years)
- There is a greater BME population in Newcastle; 85.5% identifying as White and 9.7% as Asian / Asian British. Within Gateshead 96.3% identify as White, followed by 1.9% as Asian / Asian British. This doesn’t account for specific communities such as the Orthodox Jewish community (3000) in Gateshead and Muslim community in Newcastle (17,040).
- Both populations are projected to increase over the next 10 years by 1.5% in Newcastle and 3% in Gateshead. Specific groups such as males, the over-65s and the 0-19 year olds will see the largest increases.

Risk Factors

- Deprivation is higher than average in both Newcastle and Gateshead, and a quarter to a third of children respectively live in poverty. Life expectancy for both men and women is below the England average
- Women (1 in 4) are more likely to be treated for depression compared to men (1 in 10), and also have higher levels of anxiety. Men are more likely than women to have a drug or alcohol problem and five times more likely to be diagnosed with antisocial personality disorder
- Rates of mental health problems are thought to be higher in minority ethnic groups compared to the White population in the UK, however they are much less likely to have their mental health problems identified or diagnosed
75% of those who die due to suicide are men and this is the most common cause of death for men under 35 years old

Social deprivation and its links with lower educational attainment, single person families, unstable housing and employment all have associations with higher levels of presentation and treatment in primary and secondary care

Common Mental Health Prevalence

Approximately 20% of the population are estimated to experience a common mental health problem (including anxiety, depression, phobias etc.). This would equate to around 70,000 people living in Newcastle and 48,678 living in Gateshead.

There were 26,627 (6.5%) adults with depression who were known to GPs across Newcastle & Gateshead during 2013/14

During the same period there were 3,937 new diagnoses of depression.

Significant difference in those known to services and overall prevalence estimates – who without appropriate early intervention may develop more significant problems

Serious Mental Illness Prevalence

The Serious Mental Illness register, a Public Health England profiling tool, includes adults diagnosed with schizophrenia, bipolar disorder or other psychoses or on lithium therapy known to GPs. Data shows there were 4,814 persons on this register across Newcastle / Gateshead, which equates to 0.96% of the overall population during 2013/14; significantly higher than the England average of 0.86%.

Estimated prevalence of psychotic disorder 1,897 adults across Newcastle / Gateshead, which equates to 0.48% of the overall population

4.5.2. Morbidity and Mortality

Links to long term conditions, physical ill health, substance abuse and risk taking behaviours such as smoking (e.g. 64% prevalence compared to the general population at 22%)

Life expectancy for people with serious mental illness can be 10 – 15 years lower than the national average

Excess mortality rate for mental health services users with serious mental illness was 3.2 times higher than the general population across Newcastle / Gateshead

Patients with severe mental illness are more likely to die from specific conditions such as cancer, cardiovascular disease, liver and respiratory disease, compared to the general population.
5. BEST PRACTICE

This section considers best practice in providing mental health services, with reference to two recent national reports and a peer review which the CCG commissioned from an independent consultant psychiatrist / clinical director. Within this section we have also included evidence to date on the implementation of a new model of community care that has been introduced by NTW and the Clinical Commissioning Groups in Sunderland and South Tyneside along with an associated reduction in bed numbers; and some key best practice publications.

5.1. Best Practice in National Reports

The Deciding Together proposals reflect several of the recommendations and examples of best practice described in the reports from the Independent Mental Health Taskforce and the Independent Commission on Acute Adult Psychiatric Care set up by the Royal College of Psychiatrists. We believe that our proposals are contributing to the Mental Health Taskforce’s Recommendation 23 that there should be “a programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible”. Our proposals also include the need to increase the provision of community based services such as residential rehabilitation and supported housing, as identified in the report’s recommendation.

The Independent Commission on Adult Acute Psychiatric Care undertook a wide review of care provision across the country identifying several areas of good practice. NTW was highlighted in the following areas:

- Commission members were “extremely impressed” by the physical environment of Hopewood Park in Sunderland, which is relevant to the quality of in-patient accommodation that we want to provide;
- The Urgent Access model introduced to cover the Trust’s South of Tyne area which we want to develop and build upon; and
- Its “value based” recruitment of staff

Other examples of good practice that were identified in the independent Commissions report we want to develop are:

- Redesigning community care pathways
• Developing Recovery Colleges; and
• Better access to a mix of supported housing, including respite and crisis care

We are also very conscious of the recommendation that the practice in some areas nationally of sending acutely ill patients long distances for non-specialist treatment is phased out nationally by October 2017 and that commissioners and providers should work together with patients’ and carers groups locally to agree what constitutes an out of area transfer in their locality within the national framework and definitions provided by NHS England and NHS Improvement.

5.2. Peer Review Clinical Advice

Paragraphs 5.2.1 to 5.2.3 below present the advice from the independent consultant psychiatrist/clinical director.

5.2.1. Community and Inpatient Model of Care

Best practice indicates that in providing effective services, the number of beds per head of population in an area is not nearly as important as the model of care, skill mix and staffing numbers. In addition, it is critical to have a relationship between the acute bed system and other aspects of the clinical system. In essence, if there is an aim to reduce the need for hospital admission then there needs to be good alternatives to admission and a range of discharge options, including stable placements in the community as well as rehabilitation provision.

Therefore, before planning acute bed provision there needs to be:

• Rehabilitation options which most importantly can cope with complex co-morbidity between psychosis, substance misuse and other complexities such as autistic spectrum, adult ADHD etc.
• Alternatives to hospital admission such as crisis and home treatment options which may include other community provisions such as adult foster placements supported by the Crisis Team etc.
• Assertive in-reach from addiction services.
• Good and cooperative relationships with other services such as learning disability and forensics for patients that are showing other complexities.
• A wide range of peer, community and volunteer sector resources to support statutory resources and provide alternatives to them.

Within inpatient environments, to provide good quality care and minimise the length of time someone stays in hospital and therefore the number of beds required, the following aspects are highly desirable:

• Daily decision making (minimally 5 days/week, but ideally 7 days/week). This needs to be multidisciplinary and led by senior clinicians to facilitate rapid assessment, treatment planning and discharge to maintain throughput in acute units. (The smaller the units and the more pressure on those beds, the more it becomes essential to maintain support services through weekends and Bank Holidays, otherwise a differential service is provided, which leads to front loading of pressure at the beginning of the week).

• A full range of multidisciplinary professionals who will include senior medical staff supported by adequate junior doctor support, enough nurses to ensure not only the basic care on the ward, but interventions and also facilitation of leave. Pharmacy, occupational therapy and psychology presence needs to be strong, (without the full multidisciplinary assessment, rapid treatment plans and discharge plans with complex patients cannot be done in a timely manner). The increased awareness and importance of trauma informed services and specifically an awareness of the association of the mechanisms complicating psychotic presentations, means it is significantly important to have a psychologist to help lead formulations and upskill the nursing staff in psychological interventions.

• Services need to have a recovery focus.

• There needs to be a strong emphasis on good physical healthcare and the attention needs to be given to either increased medical support to ensure that physical healthcare and monitoring is being done adequately, covering the Lester Cardio metabolic assessment as well as attending to smoking cessation and thromboembolic risk, high dose antipsychotics and all monitoring requirements etc. Consideration should be given to physical care nurse specialists at practitioner level to augment the training of medical staff.

5.2.2. National Trends – Inpatient Services
There are also a number of factors which have been affecting the client base which are admitted to hospital. Firstly, the overall national trend to reduce beds and reduce reliance on inpatient care whilst expanding home treatment options has led to two effects.

- Increased intensity of illness in hospital and shortening length of stay. This puts inpatient services under pressure and at a premium and requires inpatient staff to have a style of working which is comfortable with the pace of decision making and risk and to be expert at multidisciplinary working. It also requires rapid response in-reach from services that may not be used to coming into hospital so quickly to review patients. Conflict resolution needs to be engaged with and decision making primacy held by the inpatient team.

- Drug and alcohol abuse, particularly legal highs and alcohol. This means that inpatient teams have to be much more expert at the assessment or treatment of alcohol and drug withdrawal, in particular when this is in association with self-harm or suicidal risk. It is unhelpful when working with addiction services that are commissioned only to deal with patients in the community, when it is critically important to pick these patients up and engage them in services whilst they are in hospital prior to discharge.

- Crisis Concordat and the interface with the Police and Section136 usage. There is a national drive to keep mentally ill people out of custody where at all possible, but this may have the unintended effect of having people who are more aggressive coming into hospital as the emphasis moves to treating the disorder, rather than processing the offence legally. This, in combination with the use of legal highs and alcohol means that inpatient services are facing the increased likelihood of managing challenging behaviour out with the PICU environment and this has implications for both. The inpatient units need to have particular expertise in terms of rapid tranquillisation and control and restraint and this will also impact upon some rehabilitation services when managing dual diagnosis patients.

5.2.3. Outcome measures to assess best practice

Best practice advice is that lengths of stay in acute assessment and treatment wards would be expected to be around 3 weeks. If units are running consistently below 20 days this would suggest a level of inappropriate admissions; and a length of stay consistently above 28 days may suggest issues with conservative practice or outflow problems such as poorly resourced community teams or lack of placements.
Readmission rates are also an important quality measure, but need to be carefully analysed as to whether the problem is due to inpatient services not performing well or the relationship with the community services not keeping people well.

In general, the patient group that tends to impact the most upon bed occupancy are in hospital beyond 2 or 3 months. Usually not enough effort is made to address this group of patients which can be a small number, but have a significant effect on the total bed pool as opposed to the large number of people who are admitted for a short period of time. In essence, putting more effort into the longer stay population will have a greater effect on the bed base, than a large amount of effort trying to prevent inappropriate people coming into hospital. (Note: this is being addressed by NTW with the introduction of Transitions Teams)

5.3. NTW’s Transforming Services Programme

Phase 1 of NTW’s Transforming Services Programme has seen the implementation of new community care pathways in Sunderland and South Tyneside, along with a reduction in inpatient beds, as agreed with the respective Clinical Commissioning Groups for these areas. We have therefore assessed evidence from NTW of how this has been working, including the ability of the reduced number of beds to cope with demand.

New community pathways in Sunderland and South Tyneside were introduced in April 2014. An improved Initial Response Service had already been established in early 2013; a new street triage system in co-operation with the police introduced in September 2014; and enhanced consultant 7 day working introduced in October 2014. An associated reduction in acute admission bed numbers from 82 to 54 (34%) was completed in September 2014, when Cherry Knowle Hospital in Sunderland and the Bede Wing in South Tyneside both closed and the new Hopewood Park hospital opened in Sunderland.

NTW’s evidence is summarised in the tables below. The November 2015 Case for Change data has been updated, including comparing admissions and lengths of stay between the calendar year 2013 (before the new community pathways had been implemented) and the calendar year 2015 when the new community services described above and the reduced bed numbers were in place. We have included data for 2014, although it should be noted that community and inpatient services were in transition during that year.
Admissions

The table below shows a significant reduction in admissions to adult acute assessment and treatment wards from Sunderland and South Tyneside after the introduction of these changes.

<table>
<thead>
<tr>
<th>Number of admissions by CCG to any NTW acute admission unit</th>
<th>South Tyneside</th>
<th>Sunderland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>265</td>
<td>506</td>
</tr>
<tr>
<td>2014</td>
<td>238</td>
<td>458</td>
</tr>
<tr>
<td>2015</td>
<td>183 (31% reduction from 2013)</td>
<td>309 (39% reduction from 2013)</td>
</tr>
</tbody>
</table>

The reduction in local bed numbers in Sunderland / South Tyneside would, in itself, be a major factor in reducing admissions so the table below, considers if these changes caused more Sunderland and South Tyneside residents to be admitted to other NTW acute admission wards elsewhere. The data shows that this has not been the case; rather it shows that although there was a 34% reduction in beds, there is an increase in the percentage of people in Sunderland and South Tyneside who are being admitted locally, to the new Hopewood Park hospital in Sunderland.

<table>
<thead>
<tr>
<th>% of residents admitted to “local” hospital</th>
<th>South Tyneside</th>
<th>Sunderland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>63%</td>
<td>71%</td>
</tr>
<tr>
<td>2014</td>
<td>66%</td>
<td>78%</td>
</tr>
<tr>
<td>2015</td>
<td>70% (7% increase from 2013)</td>
<td>72% (1% increase from 2013)</td>
</tr>
</tbody>
</table>
Emergency re-admissions

As stated earlier in this section by the independent clinical advisor, emergency re-admission rates are an important quality measure which can indicate how well inpatient services are performing and / or how community services are performing in keeping people well. The table below shows a reduced emergency re-admission rate, in both the 28 days and 90 days categories, in Sunderland and South Tyneside, when comparing 14/15 data with 15/16 data. National benchmarking data from the 2015 Mental Health Benchmarking Report shows that the Sunderland / South Tyneside 28 days emergency re-admission rate of 9.4% is close to the national median of 9.2%; the report does not include national benchmarking for the 90 days re-admission rate.

<table>
<thead>
<tr>
<th>Emergency re-admission rates within 28 days</th>
<th>Sunderland / South Tyneside</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months to end February 2014</td>
<td>15.3%</td>
</tr>
<tr>
<td>12 months to end February 2015</td>
<td>12.2%</td>
</tr>
<tr>
<td>12 months to end February 2016</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency re-admission rates within 90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months to end February 2014</td>
</tr>
<tr>
<td>12 months to end February 2015</td>
</tr>
<tr>
<td>12 months to end February 2016</td>
</tr>
</tbody>
</table>

Lengths of stay

The table below compares average lengths of stay for South Tyneside and Sunderland residents, admitted locally, in 2013 and 2015. It shows that from a wide disparity between South Tyneside and Sunderland in 2013, the average lengths of stay have converged following the opening of Hopewood Park in autumn 2014.

<table>
<thead>
<tr>
<th>Comparison of average length of stay for CCG residents in local hospitals</th>
<th>South Tyneside</th>
<th>Sunderland</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>38.9 days</td>
<td>20.9 days</td>
</tr>
<tr>
<td>2014</td>
<td>28.5</td>
<td>20.0</td>
</tr>
</tbody>
</table>
The combined average length of stay in 2015, for Sunderland and South Tyneside residents’ in Hopewood Park was 30.5 days. This is lower than the most recent national benchmarking data for 2014/15 which shows a mean average nationally of 32.3 days and is identical to the national median value of 30.5 days. Although the time period used in the above table is not exactly the same as in the national benchmarking report, the national report states that the national average length of stay figure has remained relatively constant in recent years. The report also states that “there are many factors which may influence this metric, but an important one is the sustained reduction [nationally] in adult acute beds, which may result in higher thresholds for admission and a more acutely unwell case mix than in previous years when more beds were available.” This accords with clinicians’ recent experience in Sunderland and South Tyneside where some people who would previously have had a short length of stay now no longer need to be admitted, leading to an upward pressure on average lengths of stay.

Taking into account all the data shown above, despite a recent increase in average lengths of stay (attributable to fewer patients now having to be admitted for short lengths of stay and therefore a generally increased level of acuity) it indicates that the new model of community and inpatient care introduced in Sunderland and South Tyneside:

- has reduced the number of people who need to be admitted to hospital;
- has not resulted in any increase in local people having to be admitted to a hospital outside of Sunderland and South Tyneside (indeed it shows a small increase in the percentage admission of local people locally); and
- has reduced emergency re-admission rates, which is a good quality indicator.

NTW attributes the reduction in admissions and the improvements in the service to the effectiveness of the enhanced initial response service that was introduced, including a street triage service operated in partnership with the police service; new 7 day enhanced working by inpatient consultants; and the embedding of the new community pathways. These multi-factorial reasons, introduced around the same time, make it difficult to evaluate the effectiveness of any single development.

We will continue to work with NTW to review the implementation of its Transformation Programme in Sunderland and South Tyneside to help inform and further develop our own plans to meet the needs of local people in Newcastle and Gateshead.

5.4. Key Best Practice Publications
There are many publications providing best practice advice – some key ones are referenced below.

“Do the right thing: how to judge a good ward" from the Royal College of Psychiatrists, suggests a bed occupancy rate of 85% is optimal as it enables patients to be admitted in a timely fashion, reducing the risk of deterioration which may occur if a patient has to wait for a bed to become available. This level of occupancy also allows flexibility for patients to take leave without the risk of losing a place in the same ward should that be needed.

It also recommends that general adult wards should not have more than 18 beds (from Royal College of Psychiatrists “Not Just Bricks and Mortar, 1998). Larger wards can seem institutional and can contribute to patients feeling less safe. Integral to effective treatment and recovery is a good relationship between the patient and the staff, coupled with a tailored approach to the individual’s needs and careful planning of their care pathway. This can be more difficult to build and sustain with greater numbers of patients on wards. Smaller wards also permit a more personal and comfortable environment.

Joint Commissioning Panel for Mental Health: Guidance for commissioners of acute care – inpatient and crisis home treatment provides a range of advice on the commissioning of acute mental health care

Rethink - The Commission to review the provision of acute inpatient psychiatric care for adults in England and Northern Ireland, is a briefing paper by this independent commission identifying key issues in the provision of such care to inform the commission’s work

AIMS Accreditation for inpatient Mental Health Services by the Royal College of Psychiatrists sets out a range of standards to achieve covering general matters, timely and purposeful admission, safety, environment and facilities, and therapies and activities for wards to work to and achieve accreditation
http://www.rcpsych.ac.uk/PDF/AIMS-WA%20Standards%205th%20Ed.pdf
6. CURRENT SERVICES

This section describes the community mental health services provided by NTW and MHVCS organisations; and the inpatient services provided by NTW. For community services, it highlights that NTW has previously identified the need to improve the ways in which these services are delivered and plans for doing this have been progressed in conjunction with the CCG. For inpatient services, there is full compliance with Care Quality Commission standards and the acute and older people's service wards are all accredited by the Royal College of Psychiatrists, most with excellence. However, there are patient environment / quality of accommodation issues which NTW and the CCG acknowledge need to be addressed to improve patient environments and quality of care.

6.1. Context

Over the last 30 years, service users and their advocates have worked with the NHS and other partners to make sure that people with mental health problems are no longer expected to live in hospitals or other institutions. In the early 1990’s services were encouraged to place mental health wards on general hospital sites, alongside physical health services as was the case in Newcastle and Gateshead. This was an attempt to reduce stigma and move away from institutions. Now, there are much smaller numbers of people who need to be admitted to hospital. Those who do need to be admitted have very high levels of need, require much more intensive support, are likely to be detained under the Mental Health Act and to be in hospital for a shorter time.

6.2. Community Services provided by NTW and MHVCS organisations

NTW Community Services.

NTW provide a number of different mental health teams which work across Gateshead and Newcastle. These include community treatment teams, supporting the non-psychosis and psychosis pathways, the older person’s pathway (Newcastle), assertive outreach teams, early intervention in psychosis teams, community rehabilitation teams, crisis and home treatment teams, and initial response team (Gateshead). Most community teams work from 9am – 5pm, Monday to Friday and close at the weekends and in the evenings. Maps showing the types of services provided and their locations are shown in Appendix 4. There are almost 5,000 adult working age people receiving community care services, relevant to this document, across Newcastle and Gateshead and about 1,300 older people in Newcastle.
NTW recognised a few years ago that there needed to be changes in the ways in which community services were provided. Their analysis of the provision of community services across the NTW area, undertaken in late 2012, suggested that 30-40% of inpatients experienced a hospital stay because of a lack of the community and social provision that would keep them out of hospital. The analysis demonstrated the following features:

- Patients were unable to always quickly and simply access the right service and pathway for their needs;
- Pathways of care were not always clear and coherent for the patient journey;
- Detailed formulation following assessment was not always evident which could result in ineffective care being delivered and a potential risk to patient safety;
- Current pathways did not provide the effective, evidence-based interventions capable of delivering the best outcome for patients. Service Users often stayed in the service for a long time with relatively little contact with staff;
- Pathways were not designed around the patient, nor were they particularly efficient in their delivery;
- Pathways often generated considerable waits for patients;
- Patients were often unable to achieve timely discharge from the community service;
- Clinical staff was only able to spend approximately 25% of their time deployed in direct contact with patients.

Many of these themes were also identified in the feedback received during the recent Listening and Engagement phase of the CCG’s Deciding Together process.

To address these issues, NTW initiated a Transforming Services Programme to develop new community pathways and new ways of working, as described in paragraph 6.4. The CCG’s Mental Health Programme Board has agreed to the roll out of these developments in Newcastle and Gateshead.

Mental Health Voluntary and Community Sector Organisations’ Services.

MHVCS organisations in Newcastle and Gateshead vary in size from those which exist because of the dedicated efforts of a few volunteers, to regional and national charities employing many staff. They are usually funded in three main ways - they are commissioned by the local authority; or by the CCG; or they receive grant funding from charitable trusts like the Big Lottery, Comic Relief or other sources. Sometimes organisations receive a mix of income from more than one of these sources. Local fundraising
can also play a part. Also, many voluntary sector organisations (for example Citizen’s Advice and the Volunteer Centre) work with high levels of people with mental health needs despite the fact that they do not see themselves as mental health organisations as such. These organisations provide a wide range of care and support to people with mental health problems, as well as advocacy, advice and creative, educational and therapeutic activities. This includes:

- Specialist community mental health services
- Accommodation with nursing and other support
- Floating support packages
- Vocational opportunities in work, education and volunteering,
- provision of supported housing and services to homeless people
- Signposting and linking to mainstream community resources;
- Services to particular groups e.g. young people, women, men, black and other ethnic minorities, older people, service users and carers

The CCG funds a Voluntary Sector Mental Health Advisory Group, VOLSAG, which aims to improve the lives of people who have mental health problems, by building and supporting an alliance of ‘not for profit’ organisations and groups that provide mental health and emotional wellbeing services. It promotes the unique role of the sector in the overall provision of mental health services and provides a robust and formally recognised forum for dialogue and discussion between the MHVCS, public sector partners, and others who deliver services to people who have mental health problems, their families and carers. VOLSAG has historically been a Newcastle network (although members provide services across the Tyne and sometimes further afield). In April 2016, at the request of the CCG and following consultation with the relevant agencies, it was agreed that VOLSAG would extend its role to include membership and representation of the MH VCS in Gateshead as well. This is in keeping with the establishment of one CCG for Newcastle and Gateshead (in April 2015) and the formal launch of the Bluestone Voluntary Sector Consortium across the two localities (in February 2016).

Appendix 5 provides a list of services commissioned by the CCG from the mental health voluntary and community sector.
6.3. **Inpatient services provided by NTW**

People only need to be admitted to hospital when home or community treatment is not possible or appropriate due to the risk to either themselves or to other people around them. The majority of inpatients are detained in hospital under the Mental Health Act 1983. The inpatient service locations referred to in this document are shown in Appendix 6.

The number of admissions of Newcastle and Gateshead residents in the 12 months to end February 2016 is shown in the table below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Newcastle</th>
<th>Gateshead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Assessment and Treatment</td>
<td>355</td>
<td>233</td>
</tr>
<tr>
<td>Rehabilitation*</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Older People’s services**</td>
<td>73</td>
<td>0</td>
</tr>
</tbody>
</table>

*Rehabilitation – direct admission only (other admissions are transfers from other wards)

**Older People’s services – the service in Gateshead is not provided by NTW.

The following diagram illustrates where these residents were admitted as inpatients i.e. into wards based in Newcastle, in Gateshead, or into other Trust wards outside of Newcastle and Gateshead. Not all CCG residents are admitted to a bed within their CCG of residence. This may be due to patient choice, clinical need or because a bed was not available locally at the time of admission. The “Other” box in the diagram refers to admissions to other NTW wards either at Hopewood Park, Sunderland or St. George’s Park, Morpeth. The diagram shows for example that for adult acute admissions from Gateshead 12.5% were admitted to wards in Newcastle and 29% to Hopewood Park or St. George’s Park. For Newcastle, 17% were admitted to wards in Gateshead and 30% to Hopewood Park or St. George’s Park.
Current State - Inpatient Flow (NTW)

Newcastle:
- Older People: 71
- Rehabilitation: 1
- Acute: 338

Gateshead:
- Older People: 0
- Rehabilitation: 1
- Acute: 242

Flow Directions:
- Older People: 30, Rehabilitation: 1, Acute: 169
- Acute: 95
- Rehabilitation: 5
- Other: 192
- Acute: 45
Acute assessment and treatment service

This service provides intensive 24 hour support for adults with very serious acute mental health problems such as severe depression, schizophrenia, and psychosis.

The Tranwell Unit on the Queen Elizabeth Hospital site in Gateshead includes two wards in a two storey building - Fellside is a 20 bed acute admission ward for men and Lamesley is an 18 bed acute admission ward for women. The general hospital site is managed by the Gateshead Health NHS Foundation Trust. The services are fully compliant with CQC standards (inspection in July 2013) and both wards are AIMS accredited, Lamesley ward being with excellence. AIMS is a quality assurance accreditation from the Royal College of Psychiatrists which identifies and acknowledges wards which have high standards of organisation and patient care and supports and enables others to achieve these.

However, as identified by NTW, the environment for this service makes it more difficult for staff to deliver and improve upon the quality of care provided. There are no en-suite facilities on the wards, compounded by a low number of communal bathroom facilities, and it is not possible to introduce these facilities without reducing the wards to 9 beds each and significant disruption to services. This level of bed reduction would make the running costs of the wards prohibitive. Also, the current external space is not safe and secure so service users have to be escorted by staff to a shared male and female central courtyard, which significantly increases staff costs. Both of these environmental shortfalls are routinely raised by Care Quality Commission, Mental Health Act inspections.

There are also problems with:

- Window safety;
- Poor control of internal temperatures; and
- Inadequate CCTV coverage.

Environmental issues are outside the direct control of NTW, as it is not the owner of the building. NTW estimate that it would require capital investment of about £1.4 million to improve upon those environmental issues that are able to be resolved.

The Hadrian Clinic on the Campus for Ageing and Vitality site in Newcastle (formerly Newcastle General Hospital) has three wards in a three storey building - Gainsborough and Collingwood are 16 bed acute admission wards for men and Lowry is a 16 bed acute admission ward for women. The site is managed by the Newcastle Hospitals NHS Foundation Trust. The services are fully compliant with CQC standards (inspection in July 2013). All three wards are AIMS accredited, Lowry and Gainsborough with excellence.
As with the Tranwell Unit, there are environmental issues in Hadrian Clinic which compromise the ability of the staff to provide good quality care. Many of these issues are similar to those at the Tranwell Unit – there are no en-suite facilities in the Hadrian Clinic wards and these could only be introduced by reducing the capacity of the wards to nine beds. And as with the Tranwell Unit remedial works are required on window safety, control of indoor temperatures, external space security measures and CCTV improvements. Additionally, NTW has identified a need to improve general patient facilities such as exercise therapy provision and staff facilities e.g. there is no staff changing or staff shower facilities. NTW estimate that it would require about £1.3 million capital investment to address those issues which could be resolved - staff facility improvements could not easily be rectified and there would remain difficulties with two wards being on upper floors.

As the Tranwell Unit and The Hadrian Clinic are both small units on larger hospital sites which are owned by other NHS Trusts, these units are relatively isolated, with no surrounding mental health wards. This means that there are no additional clinical or support staff who can support patients and staff to stay safe in situations when a patient might become more challenging. Clinical observation of patients can be difficult due to the design of some wards and this can mean that patients are more restricted in their activities than they would be in a more modern ward. Also some rooms have ‘blind spots’ which are addressed by mirrors, but this is not ideal, and increases risk. We also know it is increasingly difficult to recruit and retain clinical staff to work in these poorer environments. These issues mean that some patients who are assessed as being more challenging are unable to be safely cared for in these locations, so are admitted to NTW beds elsewhere – at St. George’s Park in Morpeth or Hopewood Park in Sunderland. Inspections by Care Quality Commission through Mental Health Act visits have highlighted that these two buildings are not up to the standards required for modern care and this view is shared by both the CCG and NTW.

Rehabilitation Services

These services comprise:

- Willow View, a 16 bed ward at St. Nicholas Hospital, Newcastle for men and women with complex needs who require intensive rehabilitation over the short to medium term. It is fully compliant with CQC standards (inspection July 2013). It has not gone through the AIMS accreditation yet as the service is relatively new, having amalgamated from two former wards.
- Elm House in Gateshead, which is a community, based rehabilitation service with 14 beds for individuals with complex mental health needs requiring longer term rehabilitation. This is termed a “moving on” rehabilitation ward in this document. It is fully compliant with CQC standards (inspection July 2013)
Older People’s mental health services (Newcastle only)

The services comprise of two wards, within the Centre for the Health of the Elderly on the Campus for Ageing and Vitality site in Newcastle. Castleside is a mixed sex 20 bed ward providing assessment treatment and rehabilitation for older people with mental health problems arising from organic disorders such as dementia. Akenside is an 18 bed mixed sex ward providing assessment, treatment and rehabilitation for older people with mental health problems arising from functional disorders such as depression. Although the wards can accommodate 20 and 18 patients respectively, both have been operating on low occupancy rates. The service is fully compliant with CQC standards (inspection July 2013) and both wards have AIMS accreditation with excellence. (Note that the Gateshead older people’s mental service is provided by the Gateshead Health NHS Foundation Trust and is outside the scope of this document).

There is however some accommodation issues in the Centre for the Health of the Elderly which compromise the ability of the staff to provide good quality care:

- None of the bedroom areas have en-suite facilities and the design of the wards present a challenge in meeting single sex accommodation standards in terms of access to bathroom and shower facilities for both men and women. The provision of single en-suite bedrooms throughout the two wards would involve the wards being decanted to alternative accommodation whilst capital works of around £1 million was undertaken; and this would reduce bed numbers on the refitted wards by about 50%.
- The wards are on two floors, so patients on the upper floor have to be escorted to the ground floor so they do not have ease of access to an external area and this also places a pressure on ward staffing resources.
- There is poor control of internal temperatures and although air conditioning could be installed this would only partially address this issue.

NTW estimate that it would require capital investment of around £1.1 million to rectify those issues which could be addressed.

In summary, there are now significant issues relating to the quality of accommodation for current inpatient accommodation for adult acute services in Newcastle and Gateshead and older people’s services in Newcastle. When NTW was formed just over 10 years ago it inherited a very poor quality of estate around Northumberland, Tyne and Wear and has been implementing an extensive capital programme to address this, giving priority to environments which were in a poorer state than those described above. NTW
and the CCG recognise and agree that there is now a need for investment to significantly improve the facilities for these particular services and to consider how this might be done to deliver the best value in service improvements.

6.4. Agreed planned improvements to NTW Community services

This section describes work that is already underway to improve community services by developing NTW’s new community pathways and new ways of working.

As explained earlier NTW has been progressing work on community pathways with the intention of improving the way staff work; enabling them to spend more time with patients whilst also focusing on evidence based practice to get more effective treatments; and ensuring a recovery focussed approach that wastes as little patient time as possible. It has been implementing these new ways of working in the Sunderland and South Tyneside area and, as agreed with Newcastle Gateshead CCG’s Mental Health Programme Board, NTW has now started to roll out this programme in Newcastle and Gateshead, with the intention of having new ways of working fully embedded by March 2017. The implementation of these new community pathways does not require formal, public consultation but a detailed description of how they will work is included in this section as they will be a very important element in the future network of community support services, on which we are seeking people’s views.

The “Patient Journey”

The patient journey for all service users is described below. The new community pathways have been designed based on new ways of working that will increase the time NTW staff spend providing patient care, through the introduction of new technologies such as digital dictation and through new job roles, skill-mix and team structures, enabling the new pathways to be implemented within existing community services resource limits. The four main stages encompass:

ACCESS → ASSESSMENT AND FORMULATION → TREATMENT → DISCHARGE FROM NTW SERVICES

Single Point of Access for NTW Services
It is planned to introduce a single point of contact for enquiries, which will be accessible 24/7. This single point will manage all requests for help, including:

- Urgent and non-urgent referrals, including self-referrals, as soon as a clinical need is identified, will be passed to a clinician;
- Booking and re-booking appointments, including sending service users an ‘Introduction to Me’ document (designed by service users and carers) to help them prepare for their assessment appointment
- Providing advice and information, including signposting to other services
- Following up service users who do not attend for appointments
- Gathering together all relevant information and documentation in preparation for assessment appointment

This single point of contact will:

- Make it much easier for service users, carers and partners (such as GPs, primary care, social services and independent and third sector providers) to access the help and support they need
- Reach people who need our help earlier and quicker
- Free up time spent by community teams chasing information and completing paperwork

Assessment & Formulation

Where the full extent of service user need cannot be met on the Trust community pathway, then other appropriate people, services, skills and knowledge will be brought to the service user so that all their needs can be met, or will be used to support staff using their expertise and knowledge. If their needs would be better met on another pathway then that transition will be smooth and seamless for them. The service user is never ‘bounced’ around the system.

Following the first assessment, as much of the Mental Health Clustering Tool will be completed as possible. The Mental Health Clustering Tool is a standardised way of rating the type, complexity and severity of a service user’s needs across a broad range of issues in order to ensure a more consistent, needs-led service response. This will lead to a working formulation, which is a shared understanding of biological, social and psychological factors to help identify the service user’s needs and strengths and help staff and the service user to develop a Treatment Plan. Once this has been developed, the need for further assessments will be considered, as well as the need for additional input from other services, external or internal to NTW. Where specialist assessments
are needed, these will be undertaken alongside a basic physical health assessment. Once the results of all assessments have been received, the formulation is further developed to determine the most appropriate clinical pathway for the service user. A face to face discussion will be held with the service user (and carer if appropriate) to discuss the outputs of the assessment and potential treatment plan, a copy of which will be given to the service user and their carer where appropriate, in a timely fashion.

Treatment

The agreement of the treatment plan will be a collaborative process, taking account of the needs and wishes of the service user, and carer where appropriate. The service user (or carer) will be able to book their agreed treatment appointments by a range of methods, that include over the phone, in person at their appointment, or potentially online. Once agreed, these will then be shared with their GP and relevant partners.

New evidence-based treatment packages will be available for service users to ensure that they benefit as quickly as possible and outcomes are maximised. Staff will continue to be trained and clinically supervised and supported to deliver the agreed treatment packages. Staff will be able to access expert clinical advice and support from other specialist areas to reduce the need for transitions between services. The proposed pathways have sought to design out as many transitions for service users as possible. A crucial outcome is ensuring our services provide a recovery focused culture. Decisions around care and treatment will be made collaboratively with service users and their carers. Service users will be educated and supported where possible to self-manage their condition with clear plans for staying well, including at discharge.

Both scheduled and un-scheduled review meetings will be co-ordinated to ensure that the number of meetings required is minimised and administrative support will be increased to support the organisation of meetings.

Discharge from Trust Services

Discharge planning will be considered and discussed throughout the assessment and treatment phases of the pathway. This will ensure that appropriate goals are set and service users are encouraged to aim for improved quality of life, independence and self-management where appropriate.

Services users will leave with a co-ordinated discharge plan that will include information on:
- What the triggers for relapse are and how to recognise the early warning signs for relapse;
- A 'staying well' plan, including what help and support is available in the community;
- Where to go for help, including how to re-access Trust services.
New Community Pathways

There are two new community pathways being introduced relevant to these services, as described below.

Psychosis and Non-Psychosis Pathways
The psychosis pathway is primarily for people who experience psychosis, where a person has thoughts and experiences that are out of touch with reality, and who may experience symptoms such as delusions or hallucinations.

The non-psychosis pathway is primarily for people who do not experience a psychosis, but who may experience changes in the way they think, feel or behave.

These pathways are needs led. It is envisaged that physically healthy older people and those with a mild learning disability with a functional mental health problem will be managed within it, supported by staff from the Cognitive and Functionally Frail pathway (see below) and the Learning Disability pathway.

Support will also be obtained from other specialist staff as required to meet the service user’s need.

The psychosis and non-psychosis pathways will have sub-specialisms within them. Staff working within these clinical areas will have specialist knowledge, experience and skills in working with service users with psychosis and non-psychosis, though it is expected that staff will also continue to maintain a broader skill base and have some variety in their caseload.

A Step Up function will form an essential part of this pathway by:

- Protecting planned work within the community team from being disrupted by urgent request
- Creating a resource that can be rapidly pulled to a service user showing early signs of relapse. This is particularly crucial in psychosis where relapses are difficult to manage in the later stages
- Managing the care of people who require intensive care packages, who have previously been managed by Assertive Outreach Teams;
- Having a ‘ward facing’ remit to ‘pull’ people out of Stepped Care and Urgent Care beds when inpatient care is not required
- Monitoring and reviewing out of area placements and facilitating early returns to the local area.

Currently these functions are provided by different services (Community Treatment Team, Assertive Outreach Team, and Community Rehabilitation Service). The new model will offer a more robust service out of hours and will be integrated into the
psychosis pathway, creating a more seamless pathway. The increased integration will enable service users to move through the pathway easier and with less change.

The non-psychosis pathway will have a Personality Disorder sub-specialism within it, where staff will have specialist knowledge, experience and skills in working with service users with a personality disorder. Whilst staff will have particular focus on working with service users with a specific personality diagnosis as personality disorder is a pervasive issue in the non-psychosis pathway it is important that wider team members also develop skills in working with personality disorders.

Cognitive and Functional Frail Pathway for Newcastle
As already stated, NTW does not provide older people’s community health services in Gateshead. This pathway will support people of all ages with a cognitive impairment (the ability to think, learn and remember) and also people with a psychosis or non-psychosis presentation whose physical health impacts on their mental health, resulting in increasing complexity of their needs. The pathway will consist of the following key elements:

- A Memory Service to provide high volume early diagnosis of dementia. This function will expand its current role to incorporate ongoing management of some patients with low intensity needs, particularly around medication management and mood.
- Community Teams to manage those service users who require treatment and ongoing management due to their complexity. These teams will co-ordinate people’s care across the Trust’s pathway and in conjunction with other partners. The Younger People with Dementia specialists and Nursing Home Liaison posts will be based within these teams.
- Day Hospital and Step Up services will support the Community Teams to provide a responsive and intensive support function, which are key functions in delivering this pathway. Extended hours of delivery will support the development of a crisis response for this pathway.
- Challenging Behaviour will operate on a hub and spoke model. It is envisaged that challenging behaviour will be managed across the pathway but where a person requires a different approach the Challenging Behaviour Team will provide an enhanced intervention.

All of the community teams within the pathway will need to work closely with each other and with the in-patient wards to avoid admission and facilitate timely discharge. Pathway Managers will facilitate the smooth journey of patients who need to transition across the pathway. As with other pathways, close working with partners including primary care, social services, and independent and third sector providers will be essential to provide a co-ordinated care package for service users.
Service Locations

Part of NTW’s programme to implement these new pathways involves improving premises so that they are appropriately located, have better service user facilities and enable more effective and efficient ways of working for staff. People will continue to be seen in a range of places in their locality including in their own home and primary care premises and also in other local NTW premises. In Newcastle design plans are currently being developed with a view to improving the Trust’s existing bases in Silverdale in west Newcastle and at the Molineux Street Resource Centre in east Newcastle. In Gateshead the feasibility of using the existing Dryden Road Clinic as a hub, with a spoke in west Gateshead e.g. Blaydon is being assessed.
7. PRE-CONSULTATION ENGAGEMENT AND LISTENING

This section describes the key policy context for engagement and consultation required from the NHS; the methodology that has been used to develop a listening and engagement processes; how this was implemented and the key findings which emerged from the process; and how the key findings were used to inform the further planning of improved services. It also describes how clinicians have been engaged and involved in this process. The formal consultation process is described later in Section 10.

7.1. NHS Consultation policy requirements

Any reconfiguration of services requires a robust and comprehensive staff and community engagement and consultation process in order ensure plans are well informed, that public and stakeholders are aware of the issues and changes required and the risks of challenge and risk to reputation is minimised.
NHS organisations are required to ensure that local people, stakeholder and partners are informed, involved and have an opportunity to influence any changes.
The process for involving people requires a clear strategy, action plan and audit trail, including evidence of how the public and key stakeholders have influenced decisions at every stage of the process and the engagement mechanisms used. It must also take into account the key sections of statute, policy and NHS Constitution.

NHS England assurance framework⁴

The NHS England assurance framework sets out the required assurance process commissioners follow when conducting service reconfiguration. Its purpose is to provide support and assurance to ensure reconfiguration can progress, with due consideration for the four tests of service change which the government mandate requires NHS England to test against.

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⁴[Link to NHS England assurance Framework](#)
It also covers the agreed levels of assurance and decision making required for significant service change which the NHS England board ratified in May 2015 key themes of service reconfiguration and the assurance process.

This is a key document as it sets out the requirements that must be met and highlights main themes of clinical leadership, public engagement and stakeholder management.

The NHS legal duties Section 242 of the NHS Act 2006 (as included in the Health and Social Care Act 2012) sets out the statutory requirement for NHS organisations to involve and consult patients and the public in:

- The planning and provision of services.
- The development and consideration of proposals for changes in the way services are provided.
- Decisions to be made by NHS organisations that affect the operation of services.

Section 244 of the NHS Act 2006 requires NHS organisations to consult relevant Overview and Scrutiny Committees (OSC) on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

Section 2a of the NHS Constitution gives the following right to patients:

“You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.”

**The NHS Mandate ‘Nicholson tests’**

Additionally, CCGs have further duties which have been set out through the NHS Mandate 2013 - 15, which sets out the ‘4 tests’ to be met in services reconfiguration (known as the Nicholson tests). These tests feature significantly in the NHS England assurance framework.

<table>
<thead>
<tr>
<th>Support from GP Commissioners</th>
<th>Engagement with GPs, particularly with practices whose patients might be significantly affected by proposed service changes</th>
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<tbody>
<tr>
<td>Clear clinical evidence base</td>
<td>The strength of the clinical evidence to be reviewed, along with support from senior clinicians from services where changes are proposed, against clinical best practice and current and future</td>
</tr>
</tbody>
</table>
needs of patients

| **Strengthened patient and public engagement** | Ensure that the public, patients, staff, Healthwatch and Health Overview and Scrutiny Committees are engaged and consulted on the proposed changes |
| **Supporting patient choice** | Central principle underpinning service reconfigurations is that patients should have access to the right treatment, at the right place and the right time. There should be a strong case for the quality of proposed service and improvements in the patient experience |

**The Gunning Principles**

Before 1985 there was little consideration given to consultations until a landmark case of Regina v London Borough of Brent ex parte Gunning. This case sparked the need for change in the process of consultations when Stephen Sedley QC proposed a set of principles that were then adopted by the presiding judge. These principles, known as Gunning or Sedley, were later confirmed by the Court of Appeal in 2001 (Coughlan case) and are now applicable to all public consultations that take place in the UK.

The principles are:

1. **Consultation must take place when proposals are still at a formative stage**
   - Consultation should be at a stage when the results of the consultation can influence the decision-making (and Gunning 4).

2. **Sufficient reasons must be put forward for the proposals to allow for intelligent consideration**
   - A preferred option may be included and this must be made obvious to those being consulted. Information and reasons for the proposals must be made available to allow for consultees to understand why they are being consulted as well as all the options available and what these mean.

3. **Adequate time must be given for consideration and response**
   - There is no set timeframe recommended but reasonable steps must be taken to ensure that those consulted are aware of the exercise and are given sufficient time to respond.
4. **The outcome of the consultation must be conscientiously taken into account**

Decision-makers must be able to show they have taken the outcome of the consultation into account – they should be able to demonstrate good reasons and evidence for their decision. This does not mean that the decision-makers have to agree with the majority response, but they should be able to set out why the majority view was not followed.

The risk of not following these procedures could result in a Judicial Review. A number of public bodies across the UK have been taken to Judicial Review and deemed to have acted unlawfully in the Public Sector Equality Duty – usually linked to the four Gunning Principles.

It should be noted that there is also ever changing case law that should be taken into account when planning public consultation.

As well as documented evidence of GP support, any case for change will need to:

- Be led by clinicians
- State clearly the benefits for patients, quality and finance.
- Demonstrate that the clinical case conforms to national best practice.
- Be aligned to commissioners’ strategic plans.
- Be aligned with the recommendations of *Healthy Ambitions*.
- Have clear details of option appraisals.
- Provide an analysis of macro impact.
- Be aligned with QIPP work streams.

The Independent Reconfiguration Panel (IRP), whose role is to advise ministers on controversial reconfigurations, recommends that those considering proposals for significant health service changes should:

- Make sure the needs of patients and the quality of patient care are central to the proposal.
- Consider the role of flexible working in the proposals – this may involve developing new approaches to working and redesigning roles.
- Assess the effect of the proposal on other services in the area.
- Give early consideration to transport and site access issues.
• Allow time for public engagement and a discussion phase before the formal consultation – people want to understand the issues, so involving them early on will help when it comes to the formal stage.
• Obtain independent validation of the responses to the consultation.

They have also identified a range of common themes:

• Inadequate community and stakeholder engagement in the early stages of planning change
• The clinical case has not been convincingly described or promoted
• Clinical integration across sites and a broader vision of integration into the whole community has been weak
• Proposals that emphasise what cannot be done and underplay the benefits of change and plans for additional services
• Important content missing from the reconfiguration plans and limited methods of conveying them
• Health agencies caught on the back foot about the three issues most likely to excite local opinion - money, transport and emergency care.
• Inadequate attention given to responses during and after the consultation.

Consultations should influence final proposals and it is important to be able to show that they have. Clearly, not all these recommendations will be applicable to all engagement and consultation exercises, but the basic principles of early involvement, and being able to demonstrate that responses have influenced the final outcome, are.

NHS organisations should also consider how their engagement and consultation activity impacts upon a wide range of service users including those protected groups identified within the Equality Act 2010.

7.2. Developing a robust listening and engagement process

To develop and manage the public engagement and service user and carer involvement for these proposed changes, we commissioned the NHS North of England Commissioning Support (NECS), which working on our behalf brought together a range of public sector and third sector organisations and formed an advisory group to oversee the listening process and provide a forum which allowed for two way communications, discussions and agreement between commissioners, NECS, Northumberland, Tyne and Wear NHS Foundation Trust and key third sector and scrutiny partners including HealthWatch.
Called the Deciding Together Communications and Engagement Advisory Group, it was responsible for developing and coordinating communications and engagement activity around all stages of the Deciding Together public engagement listening process and future consultation processes. The terms of reference are provided at Appendix 7. It was agreed to call the process ‘Deciding together’ as the CCG’s mission statement is ‘Transforming Lives Together’, and there was very much a will from the advisory group to do this.

A communications and engagement strategy was developed, including stakeholder mapping, key messages, tactics, and evaluation and equality analysis. The Advisory Group reviewed and inputted into the strategy development and supported aspects for delivery.

To further ensure independence and robustness, the engagement work is also being reviewed by Consultation Institute and the feedback from the listening and engagement activities was analysed independently by an external company, Kenyon Fraser, to provide an objective and independent review.

This process was carried out in three phases:
- Early listening phase: June to August 2014
- Pre-engagement ‘Deciding together’ listening exercise: November 2014 to February 2015
- Formal public consultation: November 2015 to February 2016

Each phase had engagement activity and output reports which have been presented to the mental health programme board, CCG and NTW executives, and the deciding together project team and has helped develop the case for change thinking since summer 2014.

A dedicated website section has been developed and all documents have been published on the site: 

The Deciding Together listening and engagement process sought the views and shared experiences of specialist mental health services from people who:
- Receive or have received care;
- Care for someone who uses or has used the services; or
• Have a special interest in this area of service delivery.

A summary of the timeline of the three phases is below:
12th February 2016

Consultation period ends (13 weeks)

15th February 2016

Analysis of feedback starts by an independent organisation - not the NHS.

21st March 2016 to 11th April 2016

Publication of the feedback report from the consultation to public on the website www.newcastlegatesheadccg.nhs.uk
Two public feedback sessions to be arranged and promoted to the public.

9th May 2016

Complete full case for change document

24th May 2016

CCG Governing Body Meeting held in public – decision made

24th May 2016

Decision communicated to stakeholders and the public
7.3. **Early listening phase: June to September 2014**

After hearing concerns from service users and carers, the first stage of early listening began with a meeting for service users and carers in Newcastle Carers Centre on 9 July which was attended by 27 service users, carers and representatives from community and voluntary organisations. This was followed by a series of listening events planned by the deciding together advisory communications and engagement group.

Four events were held to gather patient experiences and views in a more structured way and were held on:

- Tuesday 16 September – St James Park, Newcastle
- Friday 26 September – Thistle Hotel, Newcastle
- Tuesday 14 October – Thistle Hotel, Newcastle.

In total, just short of 100 people attended all four events, with the majority of people attending the event on 26 September. This figure includes carers, service users, patients or members of the voluntary and community sector and not NHS staff or other partners who were supporting the running and facilitation of the events.

Eight themes emerged from the case studies and the priorities for future services. These were:

- **Whole person approach**
  - Mental health problems don’t happen in isolation. Treat the person first, not the illness.
  - Patients are the experts in their own care – involve and empower them to make joint decisions with their healthcare professionals and their families.
  - Understand and treat the whole person – the mental health issue is just one part of the person - e.g. do they need practical advice to support them that would help alleviate issues (finance advice, housing support etc.)
  - Services should follow the patient, not the other way around.
  - Treatment should be a continuous cycle from accessing services, treatment, through to discharge and aftercare – have ongoing support and consider a ‘buddy’ system.
  - Improve in-patient discharge planning.
  - Some people don’t have a home or a community or a safe house to go to – what happens to these people? They also need a personal approach.
Meaningful choice for people with specific needs (e.g. hard of hearing, sight impairments etc. with a whole person approach should mean when a specialist clinician recommends a therapist for someone with specific needs, the therapist is able to meet their needs. For example, working with a BSL interpreter is not necessarily the most appropriate way for some deaf people.

- Deaf people have missed vital information and there are gaps in education. A deaf person needs more time and information explained to them about their condition.

**Support for carers and families**
- Carer and family support, both in one to one and group settings are key to the treatment and recovery of the patient (links back to whole person approach).
- Support everyone in the family to prevent others being affected.
- Mental health, just like other illnesses, affects everyone in the patients’ life.
- Couples counselling is important but this should be widened to include families.
- Transport is important for families, carers and the patient for ongoing treatment. If you rely on public transport, visiting can take several hours and be expensive.

**Access to treatment**
- The role of the GP as most people’s first port of call is important – need GPs trained in mental health issues. The initial response a patient gets shapes their experience through the system.
- Access to services should be fast, quick and simple.
- Access to services for the deaf community is compromised by the lack of support and complicated information that’s given to people on appointments etc. This information is overly complicated which in a lot of cases, discourages deaf people to attend appointments or access services. More awareness of how to communicate with deaf people is needed across the NHS.
- Easy, accessible medical assessment in a crisis
- Effective crisis prevention and quick initial response and diagnosis.
- Need to have one place; one contact number for people to have for when things happen.
- Access to a safe place if something happens - ‘a mental health casualty’.
- Services should be as close to home as possible with some available at home.
- There should be good care for all but cultural difference need to be rigorously observed.
- Criteria of who can access services needs to be revised.
- Make information available to everyone on where services are and for patients already in the system, clear information about who to contact if they are in crisis.
o Clear, easily understandable information should be widely available to everyone which will support prevention and reduce stigma.
o Use of community and voluntary organisations and teams and alternative therapies to provide services and support for people reduce stigma. This needs to be made more ‘formal’ and part of the treatment plan.
o People need different types of beds and support.
o Ensure CATS team early discharge co-ordinator post remains.
o Expand acute day services.
o Decrease waiting times for cognitive behavioral therapy.
o Keep all inpatient beds within Newcastle.

- **Good environments**
o Wherever people are treated, environments need to be friendly, homely and positive but with that suitable for individual needs.
o The places people receive treatment should not be called ‘asylum’ as this gives negative messages to the patient and their family.
o Access to a safe place, at whatever time of day is important.
o Best environment isn’t always a clinical setting.
o Having all mental health service users together isn’t always beneficial to recovery.
o Important to get location of treatment right, not everyone wants to be close to home – what’s right for them?
o In-patient care should be locally accessible – patients’ needs their families around them to help recovery and treatment.
o All information on conditions, support etc. should be available in BSL.

- **Co-ordinated services**
o Joined up compassionate services between agencies – it shouldn’t be the patient’s responsibility to make sure everyone knows their situation.
o Fill the gap between primary and secondary care.
o Fill the gap for people who need help, but are not yet ‘in crisis’
o Open conversations between service providers that include the patient.
o Out-patient services need to be more joined up with in hospital care and what’s available in the community – e.g. Sunderland IRT model.
o Use expertise in the community and voluntary sector to support patients before crisis, after discharge and provide aftercare.
o Consider a ‘Case Manager’ concept to ensure consistency of care.
Make the patient and the family aware of what services are out there.
There should be a menu of services for patients and carers which is kept up to date.
Ensure support groups etc. are accessible by everyone – these are not accessible by the deaf community and therefore can increase isolation for people after discharge.
Work with the community and voluntary sector to provide a holistic approach to mental health.
Common and shared knowledge and understanding of how mental health services function to avoid false, incorrect information being given.
Clear signposting for patients so they know who to contact when.
More Innovative approach on working together by different agencies – not competing

Quality
Service equality for everyone – a lot of work is required to provide high quality services to BME and deaf communities and those with visual impairments.
Respectful and focused on recovery and outcomes, delivered by well trained staff.
Agreed and consistent quality and standard of care agreed across all organisations that they sign up to.
Open and honest monitoring of services.
Education and training for the deaf community is poor. Staff in all areas of the NHS including CCGs should have deaf awareness training – this basic training is needed.
Maintain and aim to improve standards but be aware that change can be unsettling for patients.

Be bold
Think outside the box – look at what works in other areas and try it here.
Consider new approaches to care which include widening who and what patients can have access to as a matter of course.
Work together to reduce the stigma of mental health.
Look at the language that used – this can increase the stigma of how other people perceive people with mental health issues. Also consider language that patients hear – ‘crisis’, ‘intervention’ are negative words and need redefining – change to ‘here to help’, ‘safe place’, 'supporting you'. Crisis means different things to different people.
Reduce the stigma of mental health by having clear messages to make people question their own behaviour. This will help people identify when they have a mental health issue but not be scared to seek help. This should include advertising campaigns similar to stop smoking and exercise.

Investment
Be open and honest about the increasing need for mental health services. Invest in education programmes in general.
Invest in the right number and quality of clinical staff who understand mental health services.
Prevention agenda is hugely important.
Access to properly trained and professional staff who receive ongoing training – also important that all staff are aware of mental health issues – e.g. admitted to hospital for another condition and how this can affect someone.
Sufficient resources to respond to individual need.
Training more GPs in mental health services.


7.4. Pre-engagement ‘Deciding together’ listening exercise: November 2014 to February 2015

In November 2014 we published a discussion document which described the challenges and issues under consideration to improve specialist mental health in Newcastle and Gateshead. The listening phase discussion document can be found at:


The methods used to engage with the target audience, included:

- Survey – paper and on-line (total sample size: 103)
- Market place events (6 events were held in public locations, with a total of 60 individuals attending the events)
- Focus groups; MHVCS groups in Newcastle and Gateshead were encouraged to convene and moderate focus groups (10 focus groups were conducted, with a total of 90 individuals taking part)
- Participatory budgeting events (2 sessions were held, one with providers and the other with members of the public. A total of 45 individuals attended the sessions)
- Seven individual submissions were also received in the form of letters from organisations and groups

The key findings from the survey, market place events and focus groups are described below. Appendix 8 is the independent Kenyon Fraser’s summary of the Deciding Together listening exercise. The full feedback report, along with reports on all the engagement activity that was undertaken, is on the CCG website below:
In terms of access to services, people want:

- Discussion on mental health issues to address the stigma
- Help to address cultural issues
- Personal contact with one primary healthcare professional
- To know who they can talk to and to be able to do this easily within their local community
- To talk to the people that can help in a way they feel comfortable and familiar
- A crisis team that responds, simply and consistently
- Clear and effective pathways for referrals and access
- Responsive mechanisms to meet people's needs; 87% of survey participants want to be able to speak to someone quickly and 88% want to be able to make an appointment straight away
- A service that is easily accessible and provides out-of-hours support; 71% of survey participants want a single phone number available 24/7, whilst over half indicated that they would occasionally/sometimes access services during evening or weekend opening hours (53%).

In terms of treatment in the community, it was felt that:

- The role of carers in the wellbeing of individuals receiving care needs to be recognised more widely, as well as the role of the third sector
- Carers are able to provide better care with better information
- Good practice is often ignored or not known about, and needs to be recognised
- Individuals are frustrated with the lack of clarity that exists.

For those survey participants who had experience of receiving treatment in the community, it was found that:

- 50% of service users felt involved in the planning of their care, whilst 35% didn’t
- 61% of service users were not offered any choice of therapy, whilst 44% were only offered one choice and for 40% no therapy was available
Just under half felt satisfied with the quality of care received (49%) whilst 35% rated their care as excellent or good.

In terms of their care plan; 37% felt involved in their plan and treatment, 41% understood it, 28% were able to contact their care plan coordinator and 46% felt they had enough information about their care and treatment options.

Dissatisfaction among service users related to individuals being turned away by the crisis team although they genuinely needed/wanted support, staff shortages leading to a lack of consistency in care and frequent changes, a lack of cohesion between services, patients and carers and lack of specialist support available for specific conditions.

It was suggested there should be reduced caseloads and more clarity with regards to roles and responsibilities of different health professionals.

In terms of the **transition from children’s to adults’ services**, it was found that:

- There is a gap in the provision of mental health support to young people aged 16-18 which needs addressing.
- Individuals were confused as to how young people make the transition to support under adult services due to the number of barriers that exist and the inflexibility in the system.
- Very few survey participants had experience of the transition.
- Suggestions to improve the transition included more support for young people (i.e. in the places where young people go to) and better liaison between children’s and adult’s services.

In terms of **inpatient care**, it was found that:

- Service quality was perceived to be more important than infrastructure - although having good facilities was important, people want a service that responds flexibly to the needs of all.
- Patient safety was considered paramount.
- The home/community environment was preferred to hospital care, where possible. Methods suggested to support individuals to stay out of hospital included more frequent community care, halfway houses and immediate post-discharge support.
- Moving services outside of the immediate area was perceived to be a backwards step, reasons for this included:
  - Travel is a major issue for families and carers.
  - People need to feel part of their community to support recovery.
  - Family support is very important for treatment and recovery.
- Of those survey participants who had experience of inpatient care 53% were satisfied with the care received and 57% rated their experience as good or very good.
In terms of transport and travel, it was found that:

- The main modes of transport used by patients and their families to access inpatient services were their own car (29%), public transport (25%) or a friend or families’ car (20%)
- The majority favoured only travelling short distances to receive care; 75% of survey participants stated that it was perfectly acceptable or acceptable to travel 0-7 miles and 40% 8-15 miles, however ratings of acceptability for longer distances improved when offered transport by the NHS
- Those who had experience of travelling long distances to receive inpatient care or to visit a relative/friend indicated that it was stressful, costly and time-consuming and therefore made it difficult for family and friends to visit their loved ones, especially for those on a low income or those without a car
- Suggestions to help mitigate transportation issues included financial support for regulars (i.e. reimbursements for travel & parking), free shuttle bus, mental health ambulance and taxis for inpatient transport.

In terms of Section 136 place of safety, it was found that:

- The Section 136 Suite was perceived to be vital, however it was felt that it could work better to help people in crisis to feel safe
- 79% of survey participants agreed that mental health services and the police should work more closely together. However, it was felt imperative to ensure that police officials have an awareness and appreciation of different mental health conditions to ensure that individuals are treated appropriately.

In terms of Specialist Mental Health Care Services, it was found that:

- Having moving on and rehabilitation units located in the communities where people live was perceived to be very important, so support can be provided to the patient by family and carers
- It was felt that valuable learning, experience and different approaches as well as reach into marginalised communities needs to be recognised more widely
- A small proportion of survey participants had experience of psychiatric intensive care services (17%), of these approximately half were satisfied with the care received and rated their experience as good or very good.
- Very few survey participants had experience of rehabilitation services for people with complex mental health needs (11 participants), seven of which were satisfied with the care received and half rating their experience as very good or good.

In terms of services for older people, including memory services (Newcastle only), it was found that:
- People want a simple system of support, in which people benefit from:
  - Having a single key person to help navigate through the care system who is able to provide frequent updates to the family
  - Supporting dietary needs particularly in cases of a diagnosis of Alzheimer’s
  - Having more dementia experience amongst the staff in hospitals
- A small number of survey respondents stated that they had experience of older people’s services in Newcastle, just over half of which were satisfied with their experience, describing their experience as very good or good.

The key findings from the participatory budgeting events are also described below. Participatory budgeting is a structured process that enables citizens to collaborate in decision making around the allocation of financial resources. Participants were asked to debate and agree how they would spend their ‘mental health £ (pound)’. This is the amount of money which is currently spent on mental health services with NTW by the CCG and calculations were made which proportionately reduced this sum to £1. The hope was that participants could relate more easily to a proportion of £1 rather than working on the true costs which were millions of pounds.

Participants were provided with indicative costs of a range of inpatient and community services. For inpatient services, the choices were based around four ‘bundles’ of services, with different costs recognising that wards would cost different amounts depending on the infrastructure wrapped around them and whether new or refurbished buildings would be used. Groups were asked to reach a consensus on which inpatient ‘bundle’ they would buy, and this would give them a remaining amount from their £ to spend on community services. On day one all groups selected bundle 3 and on day two the majority of service users selected bundle 3, whilst two groups selected bundle 4. Although most groups agreed on bundle 3, it was often a compromised position. The table below shows the rationale for decisions as well as further points for consideration for bundles 3 and 4 (feedback for bundle 1 and 2 is available in the full report available on our website).

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<th>Bundle</th>
<th>Considerations for rejecting</th>
<th>Considerations for including</th>
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<tr>
<td><strong>Bundle 3: Cost 48p</strong>&lt;br&gt;• Single site in Newcastle or Gateshead area with less wards (using an existing site e.g. St Nicholas Hospital), (3 acute admission wards)&lt;br&gt;• 2 rehab wards – one in Gateshead and</td>
<td>• Don’t want to see a reduction in beds&lt;br&gt;• Like it but does not attract a generous enough investment&lt;br&gt;• Concern about the need to spread staff across 3 hospital sites rather</td>
<td>• Only realistic option&lt;br&gt;• Site is huge with massive grounds and great access&lt;br&gt;• Change the name&lt;br&gt;• Best thing we already have&lt;br&gt;• Still leaves some money to spend</td>
</tr>
</tbody>
</table>
one in Newcastle
• Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)

than 2

on community services
• ‘Good indoor and outdoor balance’
• Like Newcastle and Gateshead being merged into one hospital

Bundle 4: Cost 39p or 44p with extra rehab unit
• No Gateshead/ Newcastle based adult wards – inpatient services provided at St George’s Park and Hopewood Park
• Option to add one dedicated local rehab unit
• Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)

Strong feeling that the locations were unacceptable as not local
In particular concerns over:
• Access by friends and family for visiting
• Impact on travel
• Integration with the community

• Some inpatients would like to be out of their locality
• Good offer if transport was considered
• Good offer if savings can be reinvested in community services

In addition, the following caveats to selections were provided:

• Transport solutions to be offered which meet the needs of people in a range of locations
• The unit operates a 7 day discharge process
• A crisis house is offered in an alternative locality to address inequality of access when only having one site
• Strong support for community teams to assist carers
• 7 day working, not just discharge
• Request costings for a 3 ward option
• Get the community services right
• No reduction in beds:
  - Mental health is increasing across society
  - More people are presented with mental health issues
  - There is more demand and less opportunity to access services
  - Beds are not available when needed
All the information gathered from this listening exercise phase was presented back to the public and stakeholders in March and April 2015 in order to ensure nothing had been missed during the listening exercise.

These findings were presented to the mental health programme board in April 2015, and also were key in the two scenario development days where mental health programme board members participated in developing scenarios for change that would subsequently be consulted upon (see section 10).

7.5. Clinical engagement

The CCG has engaged with its member practices throughout the Deciding Together process. Ongoing engagement and information has been shared since September 2014 via weekly GP bulletins as well as information being shared on the intranet, GP Teamnet. The CCG has also regularly attended existing meetings throughout 2015, including the GP Commissioning Fora and GP Time In, Time Out sessions. Through these sessions and presentations given, comments and views were encouraged on the process, the work taking place/progress so far, for members to get involved and share information with GP staff.

Deciding Together also has a monthly slot on the agenda for the Mental Health Programme Board, which is Chaired by the CCG Chair (a GP) and members include the Executive Director of Nursing, Quality and Patient Safety (Nurse) and the Clinical Leads for Mental Health (also GPs) and two consultants from NTW. This allows the MHPB to receive updates and comment and challenge on the work of the programme. The Board membership also includes the Chair of the Deciding Together Planning Group, who is also Chair of the Voluntary Sector Advisory Group, as well as other members of the planning group. They represent a range of other Voluntary and community sector bodies across Newcastle and Gateshead. This embeds in the process the input and challenge from a range of voluntary, community sector and clinical views.

Details of these meetings and bulletin information can be accessed via the Newcastle Gateshead CCG website.

Within NTW, there has been very strong clinical involvement and engagement in developing these proposals, going back to 2010, and subsequently throughout the process.

- A clinician led Service Model Review started in 2010, chaired by a Consultant Clinical Psychologist. This brought together expert clinicians from across the Trust to help develop the Trust's vision for the future delivery of services, ensuring that
services are designed around patients’ needs. This work involved a whole system review, within a context of looking to increase quality while significantly reducing cost. The review further developed the Trust’s thinking around whole system management, and the need to further significantly reduce demand on in-patient beds, through improving first line interventions; provide better support and maintenance, allowing people to be cared for in the least restrictive environment for them; and managing effective discharge and step-down.

- The Service Model Review recommendations led to the establishment of a Trust-wide Transforming Services Programme. Relevant parts of this programme to the proposals in this are:-

  o Transforming Community Services – clinician led development of new community pathways, involving (multi-disciplinary staff groups. There was also active involvement of service user and carer representatives in the development of the pathways. New pathways have been implemented in Sunderland and South Tyneside and are about to be rolled out across the remaining NTW area, including Newcastle and Gateshead

  o Transforming Inpatient Services – strong clinician engagement and involvement by senior medical staff, nurses and associated health professionals in developing a future bed model for adult, older people and learning disability services. This programme was initiated in June 2013 with a series of four well-attended internal workshops across July and August 2013 to fully explore options and encourage debate. These workshops set the direction of the programme and proposals received subsequent support from the Trust’s Board. Further, wider engagement events took place up to January 2014. The resulting bed model was used to help the CCG’s Mental Health Programme Board develop an initial set of scenarios for the location of inpatient services. NTW has two consultant psychiatrists on the Mental Health Programme Board.

- Clinicians were involved in providing information to those involved in the pre-consultation Listening Exercise and also engaged in the participatory budgeting events (spend the mental health £) one of which was held with providers of services. These took place between November 2014 and February 2015

NTW clinicians have continued to be engaged during and after the consultation period e.g. participating in question and answer session at consultation launch and attending local authority overview and scrutiny committee meetings.
8. SUMMARY CASE FOR CHANGE

This section summarises the preceding sections, highlighting the strategic drivers and the need for improvements that have been identified at a local level to improve the quality of care and service users’ experience. It summarises what action has been taken to address the issues that were identified but also what further changes we want to consult on.

8.1. At a strategic level:

- There is a strong alignment between the strategic plans of the Clinical Commissioning Group, Northumberland, Tyne and Wear NHS Foundation Trust and the Mental Health Voluntary and Community Sector to improve and extend community mental health services, providing alternatives to inpatient admission and reducing the reliance on inpatient beds. The CCG’s Mental Health Programme Board, representing a wide range of stakeholders, supports this strategic direction.
- The two recent national reports focusing on best practice and peer review of mental health services identify key elements that should be in place to deliver an effective system which provides good community support; reduces the need for hospital admission; reduces unnecessary long stays; and promotes recovery. It is considered that the services which provide alternatives to hospital admission and help to promote recovery need to be strengthened in Newcastle and Gateshead.

8.2. At an operational level:

- We have a relatively high number of beds compared with other areas of the country and an analysis by NTW indicated that 30 - 40% of inpatients were experiencing a hospital stay because of a lack of community health and social support. The analysis identified a number of problems in the ways in which community care systems were working and similar themes were also subsequently expressed in the listening and engagement process with service users, carers and others. NTW has been addressing this through its Transforming Services Programme and new community care pathways and new ways of working in the community will soon be rolled out in the Newcastle Gateshead area.
In addition to the above, in order to improve community services and reduce the need for inpatient care, we want to provide some other new, re-designed or extended community support services. Some of these types of services are highlighted in the recent national report by the Independent Commission on Adult Acute Psychiatric Care.

There is local evidence in the North East on implementing improved community services, and being able to reduce the need for hospital admission and the number of beds required.

Existing inpatient accommodation in Newcastle and Gateshead for those services being considered does not meet the standards which the CCG and NTW wish to provide; and Care Quality Commission Mental Health Act inspections have consistently reported shortcomings in these facilities.

We have listened to people’s views about current services and improvements that they would like to see – so we want to take action to respond to these.

If we do not implement changes in the way these services are provided, in view of the national requirement for providers of NHS services to make savings, there would still have to be a significant reduction in the current funding of existing services, both community and inpatient services. We think it is important that community services are not reduced to make savings, for the reasons set out in our strategic objectives.

In aiming to reduce the number of beds required and make sure that hospital based services are able to support people with very complex needs in safe and therapeutic environments, we need to consider where these inpatient services should be provided.

Therefore there is a very strong case to improve community services and reduce the reliance on hospital admissions. The next section considers ways in which this could be done.
9. SCENARIOS FOR CHANGE

Following on from making the Case for Change, this section describes

- How the community service changes described previously could be further improved through potential revision and amendment to existing services or development and re-design leading to new services
- How extended community services could be developed as part of a comprehensive community support framework and support increased activity in the community and a reduction of inpatient admissions and/or length of hospital stay.
- The development and shortlisting of scenarios for the future provision of inpatient services.

9.1. Community services

Previously we described the improvements that have already been agreed with NTW NHS FT to improve their community care pathways and ways of working. These improvements will increase the capacity of the Trust’s service and help to reduce the reliance of inpatient services. In addition to this, the CCG, Mental Health Voluntary and Community Sector and NTW NHS FT have been working closely together to ensure that the community model going forward has a balanced approach, including alternative and adjunctive provision to statutory services, all supporting innovative practice.

As explained earlier we also engaged with service users and carers along with professional staff to seek views on the provision of community services. The outputs from these engagement events were then used in Mental Health Programme Board workshop sessions and meetings to develop an initial future community support scenario. This was further developed and refined by CCG, MHVCS and NTW representatives and reviewed by the Mental Health Programme Board and at Joint Executives meetings. Current thinking is that there needs to be a very strong framework of support in the community building on future community care pathways provided by NTW NHS FT, local authority and MHVCS services. This innovative community framework should contain a number of important features:

- Improved access to help, advice and support when in a crisis, including alternatives to admission to hospital
- Increased availability of step up and step down accommodation, rehabilitation resources, and housing with support
• Greater access to vocational opportunities, such as supported volunteering, education, training and employment support
• Increased availability of peer support
• Increased involvement of and support for carers
• Increased access to navigation and link workers
• Greater use of social prescribing, direct payments and personalisation
• Development of alternative models like adult fostering

The resulting community support framework is described on the following pages, showing

• The principles that we want our community support framework to be based upon
• A range of access points into the community support framework
• The principles that we want our community support framework to be based upon
• Re-designed or extended community support services which we are implementing, such as revised community mental health teams and specialist teams, and other new or revised services which we consider would further improve the framework of support
• How we will manage these changes

Several potential service developments to improve the current framework are being explored. Some of these additional (or in some cases redesigned or extended existing services) present ideal opportunities for MHVCS and/or peer and service user led models of service delivery. It is important to stress that the community services framework set out below describes a set of complementary and interdependent resources and services. These are all therefore equally critical and integral to ensuring there is a range of supports in place that will help to prevent, reduce and minimise the need for in-patient treatment. The possible new, re-designed or extended services are described more fully below.

9.1.1. Multi-Agency initial response service

Developing a multi-agency initial response system is a key work stream of the CCG's Mental Health Programme Board (MHPB) and a project group consisting of statutory sector, VCS and service user colleagues is being led by one of the CCG GP mental
health leads. This service development is being designed in parallel with the Deciding Together Consultation, given the clear need for improvement demonstrated by:

- the listening and engagement work already undertaken
- the Crisis Care Concordat, the Urgent Care Vanguard and
- the recommendations of policy such as the Five Year Forward View for Mental Health, which states that urgent access to mental health care 7 days a week and 24 hours a day is a key priority.
- Locally the introduction of a related model as part of the NTW Transformation Programme in South Tyneside and Sunderland contributed to a 34% decrease in beds.
- the MHPB is aware of the Collaborative approach that is part of the successful Living Well in Lambeth model, which is another example of how redesign and improvement in urgent response can release resources elsewhere in the system

The initial response system model being developed states that an urgent care need is a patient defined need, which may subjectively be viewed in a variety of ways and which may require a variety of responses - in order that this need is met and escalation is avoided. It is important to recognise that if a person (or their carer or a third party such as a VCS worker) defines their need as urgent then they need an urgent response, although this response may not necessarily need a high level clinical intervention. The service would:

- Have whole system responsibility –elements of which include transfer of responsibility and duty of care principles
- Have excellent communication between services / providers and with service users and carers
- Have enhanced, easy and quick access to urgent care services 24 hours a day with flexible services that recognise times of high demand
- Ensure that urgent care needs are assessed in the context of a service users’ culture and community
- Be a proactive model which aims to prevent future crises by care planning and fast track access to services
- Be a model which enables outcomes to be monitored and service design changed in response to need

It could offer an immediate bio-psycho-social triage, with enhanced access to urgent care mental health services and the ability to ‘warm transfer’ to other services. The model could include a detailed ‘whole person’ social triage and link work including case co-ordination, peer-support, system navigation and wellbeing & resilience interventions. The service will recognise that an urgent mental health need may require a variety of responses including a crisis response, but also preventative and early interventions
delivered by a variety of people and agencies. A key aim is to de-escalate urgent need at an early stage and intervene at the right time to achieve better long term outcomes for people.

There could be an urgent care hub with a core team of multiagency workers and there is a proposed phased approach for developing the model further to include functions such as mental health liaison. The core multiagency workers could include health and social care workers who will work within the hub to enhance the social, housing and other LA input. The model also includes the development of new ‘solidarity in crisis workers’ alongside system brokers and peer support workers and volunteers.

The outcomes of the new model will positively impact on the wider system in which it operates and include:

- Reduction in presentations to multiple agencies such as A&E, 111, Primary Care, Police, NEAS
- Reduction in patients being bounced around the system and duplication of contacts
- Reduction in inpatient admissions and length of patient stay in hospital
- Reduction in mental health prevalence as need is actioned at an earlier stage
- More efficient use of available specialist resources
- Improved service user, carer and stakeholder outcomes and satisfaction
- Improved access to other service such as housing, drug & alcohol, voluntary sector.

The aim is to develop a pilot starting in 2016 in Newcastle, with a view for it to be ‘rolled out’ to Gateshead and other areas of the North East. The implementation will be phased in line with service evaluation. It is envisaged that the fully comprehensive service will be introduced as a number of phases and this staging also requires further planning.
Old Problems New Solutions: Improving acute psychiatric care for adults in England (Final Report of The Commission to review the provision of acute inpatient psychiatric care for adults, February 2016) recommends that ‘There is better access to a mix of types of
housing – and greater flexibility in its use – to provide for short-term use in crises, reduce delayed discharges from inpatient services and offer long-term accommodation’ (pp.51).

An inpatient survey undertaken for the same report found that

- 'On average, 16% of patients per ward could have been treated in an alternative setting. The most common alternative settings named were crisis houses, rehabilitation services and personality disorder services.
- On average, 16% of patients per ward were identified as delayed discharges. The most common causes of delayed discharges were issues with housing, issues transferring patients to rehabilitation services and community team capacity/resources' (pp.25)

There is already a range of housing and care provided by the voluntary and community sector and local authorities in Newcastle and Gateshead that offers support to vulnerable people, those with housing problems, and those with mental health needs. These vary from offering a few hours face to face support a week to units that have staff (social care or nursing) available on site 24 hours. We recognise however that there is a need to:

- Extend / develop the range of accommodation that is available to include step up and step down facilities (short term, non-crisis, and 24 hour staffed units) and alternative crisis facilities.
- review the overall range of options that is available and the level of support that is offered to ensure that people get the right level of support, that housing is used as efficiently and effectively as possible, and that there are easily accessible pathways to independent living (with or without ongoing support).
- Developments could include less clinical and / or non-clinical approaches to community based rehabilitation and longer term accommodation based support would reduce the need for and / or shorten the length of hospital admission

9.1.3. Urgent response / care - crisis accommodation

The Newcastle & Gateshead Mental Health Programme Board have identified that mental health ‘crisis house’ provision may be a valid and useful part of an urgent care pathway. The national evidence base for the effectiveness of crisis bed provision is growing (see for example JCPMH, NICE evidence database, and evidence published on outcomes and user satisfaction by Rethink). Overall the evidence base is currently immature and locally, there is little experience and therefore little evidence of the effectiveness or otherwise for these types of services. But we have an good opportunity to pilot clinically supported crisis provision, by utilising existing services before system wide changes are made, and to gather evidence for the effectiveness & need for Crisis
Housing provision in Newcastle & Gateshead. This will enable the CCG and other partners to develop a sound basis upon which to make commissioning decisions locally.

This service would be a short term residential facility offering an alternative to, and a step down from, traditional mental health hospital inpatient admission. It would have a 24 hour clinical staff presence; be voluntary and community service led; have mental health professionals employed by the MHVCS sector; and employ peer workers. There would be shared pathways with statutory community and inpatient teams, and the service would be registered with the Care Quality Commission. There could be options to provide this as a shared resource across Newcastle/Gateshead, or have one in each locality.

Initial work has been undertaken on the pilot via a partnership between existing relevant VCS and NTW NHS FT. Scoping work has included analysis of admissions data (e.g. discharges within 7 days) and identified characteristics of a cohort of inpatients whose needs could alternatively be met by access to a bed in a community based crisis house setting providing a safe but non-clinical homely environment, (not ligature free, for instance) with:

- ‘just enough’ clinical intervention,
- rapid access,
- 24 hour clinical / nursing support & supervision,
- peer-support available from people with lived experience
- a stable basis for recovery to support independence/community ‘survival’
- established ‘shared care’ arrangements with support agencies involved with person

A crisis accommodation pilot would test out such a model and mitigate risks by using an existing commissioned service/accommodation, and would also allow for thorough evaluation of costs and benefits, demand, impact, target client group and so on.

An urgent response/care service (without beds) would provide a short term safe place / sanctuary in a crisis. It would not necessarily be an overnight service, but could for example provide a 9.00am to 9.00pm or a 2.00pm to 2.00am service. Discussions at Deciding Together consultations and focus groups have shown that there is a lot of interest in this kind of model from service users, and a variety of opinions about what the hours of opening should be. It would offer de-escalation, access to immediate emotional and psychological support and practical assistance, listening, advice and signposting to other services. It could deliver
some functions that are currently provided by the Partial Hospitalisation service at the Hadrian Clinic, Newcastle. There could be options to provide this as a shared resource across Newcastle/Gateshead or have one in each locality.

It could be peer-led (noting that the higher the level and presence of clinical staff the higher the cost would be). Examples that exist elsewhere tend to be designed very much around local circumstances e.g. Dial House in Leeds (peer led) and Drayton Park Women's Crisis House and Resource Centre as featured in Old Problems New Solutions: Improving acute psychiatric care for adults in England (Final Report of The Commission to review the provision of acute inpatient psychiatric care for adults, February 2016).

9.1.4. Community based recovery college

The Tyneside Recovery College is run by peer workers employed by NTW NHS FT. With interim financial support from the CCG and NTW FT it has recently moved into a community base at Broadacre House in the centre of Newcastle. Peer support workers, clinicians, volunteers and workers from the third sector deliver a wide range of mental health courses, self-management and emotional resilience sessions, personal skills development, and creative expressive activities. The College adheres to a social model and is user-driven. The previous base at St. Nicholas Hospital was accessed by some Gateshead residents (approximately 20%) - this will increase with the new location being much closer to Gateshead. In addition the College runs courses at Gateshead venues such as the Clubhouse and Bill Quay Community Farm, and provides some courses to St Nicholas Hospital site for learners whose movements are restricted by the Mental Health Act.

Like the Recovery College, a growing number of VCS organisations now have a base at Broadacre House and there are many potential cross-over activities. This has led to early thinking about the concept of a Mental Health Collective, with voluntary agencies and community groups working in mental health and related fields, who employ peer support workers and have a long history of innovative community based work, coming together to explore partnership opportunities. This has the potential to bring together statutory and MH VCS organisations to pool expertise, resources and good practice. It would provide a key interface between NTW NHS FT specialist mental health services, the MH VCS, and wider community resources.

Basic Recovery College costs are currently covered by NTW NHS FT with the service charge for the new venue covered by NTW NHS FT and Newcastle and Gateshead CCG for the first year. Going forward, the Recovery College may need additional workers to provide increased capacity/meet demand. A steering group has been formed to develop the concept of Collective and to help the
College to become sustainable and independent. A detailed Position Statement with an options appraisal for future costs and sustainability is being produced for consideration by the various partners in 2016.

9.1.5. Increased focus on the arts, social inclusion and educational approaches

A steering group has been set up between MH VCS groups, MH statutory sector, and senior colleagues from the Art and Design School at Northumbria University, to look at piloting the Converge model in Newcastle and Gateshead. Converge is a collaboration in York where the main focus is to support local people who use/have used mental health services to access courses at St John University, using an educational model. Higher Education students act as buddies and sometimes tutors on a range of courses e.g. creative and performance arts, psychology, sports, life coaching and business start-up. Converge is designed to meet a ‘convergence of needs’ across different aspects of the public sector and there is interest nationally in the model. In Newcastle and Gateshead this kind of programme would provide another step in a recovery pathway for those whose confidence in learning has grown as a result of attending MH VCS and Recovery College courses and groups.

The model relies heavily on partners (especially Northumbria University) providing key resources in kind, but requires coordination, administration and evaluation. Plans to set up a pilot in late 2016 early/2017 are progressing. Following the pilot a business case for further funds will be made.

9.1.6. Community Resilience and Wellbeing Hub

Including increased access to vocational pathways, social inclusion etc. This would develop a multi-agency hub that enables speedy linking, navigating and signposting to existing provision in Newcastle and Gateshead including MHVCS services; service user and carer networks; advocacy; primary care and specialist mental health services; adult social care and wider / mainstream community resources; social and leisure activities; health trainers; Ways to Wellness; Chain Reaction; Live Well Gateshead; and information about debt, benefits, housing, relationships, work, volunteering and education and training.

9.1.7. Adult Fostering
This is a model already established for people with Learning Disabilities but less so in mental health (7% of current placements). Shared Lives schemes (Adult Placement) are run by Local Authorities and can vary in cost for long term carer support, usually with additional payments e.g. holidays, Christmas etc. Typically

- Individuals or families take in one or more a vulnerable adults
- There is payment to cover accommodation, care/support and living expenses
- Already available for people with LD locally see here (Newcastle) and here (Gateshead)
- In Control have produced a Costing and Pricing Tool
- 'Live in buddies' and 'Home share' are alternative models
- SharedLivesPlus is the UK network for family-based and small-scale ways of supporting adults
- Evidence - Investing in Shared Lives calculates lower costs for long term mental health care, compared to traditional care (much higher for people with physical/LD needs). Further work on costs will be undertaken.

Other local models NightStop De Paul Trust - emergency accommodation for homeless young people http://www.depaulnightstopuk.org/what-we-do/nightstop-services/.

Further work on developing the overall community framework will be undertaken, including more detailed assessment of these services and their costs as part of developing the Implementation Plan for the future development of community provision linking in to existing and potential for redesigned and new services.

9.2. INPATIENT SERVICES

9.2.1. Acute Assessment and Treatment Bed Numbers

We have stated earlier in the document that reducing avoidable stays in hospital and therefore reducing the reliance on beds is a common strategic objective for the CCG and its partners. We have therefore worked in conjunction with NTW to review future bed needs, taking into account the improved community services described in Section 5 above, that we have already agreed to implement.
When NTW commenced its Transforming Services Programme a few years ago, its clinician-led analysis of inpatient care suggested 30-40% of inpatients were experiencing an avoidable stay in hospital due to a lack of community and social provision that would otherwise have kept them out of hospital. Subsequently, national benchmarking data, for 2013/14, showed that NTW had a significantly higher number of acute beds compared with most other Trusts - 27 beds per 100,000 weighted population compared to a median of 21 beds. This bed level was the 5th highest out of 57 mental health trusts benchmarked. NTW has subsequently been able to reduce its bed numbers, for example by introducing the new model of care in Sunderland and South Tyneside, referred to in Section 3. In the most recent national benchmarking data, for 2014/15, it had 20.7 beds per weighted population of 100,000. This is a little higher than the national mean of 19.5 beds and the national median of 19.9 beds. Clinicians continued to be central within NTW’s Transforming Services Programme in developing a future bed model for the Trust with a reduced number of beds, and identifying different scenarios for the locations of those beds. This work was subsequently progressed through the CCG’s multi-agency, multi-professional Mental Health Programme Board.

As described in the Best Practice section, implementation of a new model of community and inpatient mental health care implemented in Sunderland and South Tyneside included a reduction in acute admission beds from 82 to 54, equivalent to a 34% reduction. Indicators are showing that the reduced number of beds has not resulted in any more patients being admitted to other NTW acute admission wards, outside of the Sunderland / South Tyneside area – indeed there has been a small increase in the number of Sunderland and South Tyneside residents being admitted to the local hospital, Hopewood Park. Also, the Sunderland / South Tyneside reduction in emergency readmission rates is a positive indicator that the model of care is working effectively. As we will be implementing similar new community pathways and ways of working by community staff, it is useful and appropriate to use these indicators to inform and model the number of beds required for Newcastle and Gateshead. It should also be noted that the Newcastle / Gateshead proposals include the development of a range of additional community services that were not part of the Sunderland / South Tyneside model of care changes.

The tables below show comparative indicators between the current Newcastle / Gateshead model of care and the new model of care for Sunderland / South Tyneside.

<table>
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<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>% change</th>
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<tbody>
<tr>
<td>Newcastle</td>
<td>322</td>
<td>343</td>
<td>347</td>
<td>+8%</td>
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Sunderland and South Tyneside admissions reduced to the levels shown in the above table following the implementation of the new model of care. The reduction in admissions in Gateshead is at least partly attributable to the enhanced Initial Response Service covering Gateshead which was introduced during this period. This indicates that with the introduction of:

- similar community pathways in Newcastle and Gateshead to those that are now operational in Sunderland and South Tyneside;
- an improved multi-agency Initial Response Service in partnership with the mental health voluntary and community sector; plus
- other new, redesigned or extended community services (as described earlier in this section) which were not part of the changes introduced in Sunderland and South Tyneside

It is reasonable to expect a significant reduction in the number of Newcastle residents needing to be admitted to hospital and a smaller reduction in the number of Gateshead residents being admitted (given that Gateshead has already benefitted from an improved Initial Response Service).

Average length of stay (days) for CCG residents in local wards

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<tr>
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<th>2013</th>
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<tr>
<td>Newcastle</td>
<td>52.4</td>
<td>56.4</td>
<td>40.9</td>
</tr>
<tr>
<td>Gateshead</td>
<td>43.3</td>
<td>29.1</td>
<td>30.0</td>
</tr>
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</table>
Average length of stay is a key indicator, which can measure efficiency but is also used to assess whether patients are being appropriately admitted for acute inpatient care. A number of factors influence length of stay including the capacity and range of community services to which patients can be discharged; the acuity of patients; the number of patients experiencing delayed transfer of care and length of these delays; and the number of beds available.

The table above shows that in 2015 the average length of stay for a Newcastle resident in an acute admission ward in Newcastle was almost 41 days, considerably above comparable figures for Gateshead, Sunderland and South Tyneside. Averaging the Newcastle and Gateshead data, the average length of stay of a Newcastle or Gateshead resident in an acute admission ward in Newcastle or Gateshead was 34.5 days, which is higher than the average lengths of stay in Sunderland / South Tyneside and higher than the 2014/15 national benchmarking data which showed a mean of 32.3 days and a median Trust value of 30.5 days. (Note that although the Royal College of Psychiatrists recommend an optimum length of stay of 21 days, very few Trusts achieve this as an average length of stay for all patients. The lower quartile in the national mental health Benchmarking Report is 26.3 days).

The table above also shows an increase in average lengths of stay for Sunderland and South Tyneside residents admitted to Hopewood Park, comparing 2015 with 2014. This is attributable to a smaller number of people now being admitted who have short lengths of stay. This is positive as it is an indicator that the new community / inpatient model of care in Sunderland / South Tyneside is having an impact in reducing the need for people to be admitted to hospital, albeit that this has a consequence of increasing the average length of stay of those patients who need to be admitted.

The average length of stay for Newcastle residents in a ward in Newcastle has been reducing significantly over recent years and continues to do so, facilitated by work undertaken by NTW with a specialist consultancy organisation. Taking into account this work and the lower average lengths of stay for the other localities in the table above, NTW consider that there is further scope to reduce the average length of stay for Newcastle residents admitted to wards in Newcastle, particularly by enabling the quicker discharge of those patients with very long lengths of stay.

Emergency Re-admission rates
Readmissions can occur when a patient’s health deteriorates unavoidably. However this may also be because a patient is discharged without an adequate care package; with an insufficient level of community support; or when discharge occurs too early. The table above indicates that re-admission rates for the 12 month period to the end of February 2016 are very similar in Newcastle / Gateshead to Sunderland / South Tyneside. These rates are also very close to the national median rate across the country of 9.2% (although the national benchmarking figure relates to 2014/15, the report notes that there has been no significant change in this national rate since 2011/12). Section 3 showed that the emergency re-admission rate has recently reduced in Sunderland and South Tyneside. The introduction of the new community pathways and other community services in Newcastle and Gateshead may help to reduce the Newcastle / Gateshead emergency re-admission rate, but this is not assumed in assessing future bed needs below.

In analysing future inpatient adult acute admission bed requirements for Newcastle and Gateshead residents, based on the evidence above, the bed model below shows:

- on the vertical axis, a range of admission numbers is shown from 588 (the number in the 12 months to the end of February 2016) reducing by 5% gradations to a 30% reduction (as evidenced in Sunderland and South Tyneside where there were reductions of 39% and 31% respectively following the implementation of the new model of care).

- on the horizontal axis, a range of average length of stay values for Newcastle and Gateshead residents in local wards, from 34.5 days in 2015, reducing towards the Royal College of Psychiatry’s optimum length of stay of 21 days.

- a bed occupancy rate of 85% has been applied, which is the Royal College of Psychiatrist’s recommended optimal bed occupancy rate, excluding patients on leave. It should be noted however that nationally, Trusts are finding this difficult to
achieve, as shown by the national benchmark report occupancy rate for 2014/15 of a mean of 91.1%, a median of 94.1%, and a lower quartile of 87%.

- wards will have 18 beds, in line with the Royal College of Psychiatrist’s best practice guidance (“Not Just Bricks and Mortar” 1998).

In the model below the intersection of the vertical and the horizontal co-ordinates indicates the number of wards that would be required for a given number of admissions and a given average length of stay. As an example, the top left hand corner cell indicates that at a current rate of 588 admissions; at the current average length of stay of almost 35 days; and a bed occupancy rate of 85%; there is a requirement for 4 wards. This reflects current NTW experience that, at the time of writing, there is spare capacity within its existing 5 acute admission wards. It should be noted that the model assumes that all patients stay for the given average length of stay - a larger range of length of stays produces a higher bed requirement.

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Average Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35</td>
</tr>
<tr>
<td>588</td>
<td>4</td>
</tr>
<tr>
<td>559</td>
<td>4</td>
</tr>
<tr>
<td>529</td>
<td>4</td>
</tr>
<tr>
<td>500</td>
<td>4</td>
</tr>
<tr>
<td>470</td>
<td>3</td>
</tr>
<tr>
<td>441</td>
<td>3</td>
</tr>
<tr>
<td>412</td>
<td>3</td>
</tr>
</tbody>
</table>

In Sunderland and South Tyneside there were reductions of 39% and 31% respectively in admissions, with no increase in the number of local people admitted to an NTW ward outside of the Sunderland and South Tyneside area. However it is noted that for a similar population size, Sunderland had a much higher number of admissions in 2013 compared to Newcastle and therefore we
would not foresee a reduction of as much as 39% in Newcastle. However, we believe that with the introduction of similar new community pathways and ways of working in Newcastle and Gateshead, plus the range of additional new or extended community services that are described in these proposals, a reduction in the number of admissions of at least 10%, to 529 admissions, is achievable.

In considering average lengths of stay, when comparing the Newcastle figure of 40.9 days with those for other localities in NTW and nationally, there remains significant scope to continue to reduce this figure, through both the work that NTW is currently undertaking and by improving community services to facilitate earlier discharge from hospital. For example the new community pathways will facilitate much earlier involvement of the community teams in discharge planning. A reduction in the average length of stay for Newcastle and Gateshead residents to 31 days, which would be in line with both the 2014/15 national benchmarking data and the 2015 data for Sunderland and South Tyneside, is considered achievable by NTW as the new community services begin to be implemented and become embedded. Such a reduction, along with a reduction in admissions of at least 10%, would indicate a requirement for three wards in the model above.

The bed model demonstrates a wide range of variable reductions in admissions and average length of stay which would result in a requirement for three wards. Operationally, we will work closely with NTW in pro-actively monitoring patient flow in the whole system, including the community and inpatient service, ensuring that planned bed reductions are managed in a phased and safe way from 5 wards to 4 wards; and from 4 wards to 3 wards when and if this is possible. This will include an aim of avoiding out of area referrals (i.e. outside the NTW area\(^5\)) unless clinically necessary and monitoring bed occupancy and emergency re-admission rates.

9.2.2. Long List and Shortlisting of Scenarios / sub options.

NTW clinicians were central in developing the work within NTW to develop a possible future bed model and to identify different scenarios for the location of services. This work was then taken forward through the CCG’s Mental Health Programme Board and included in the listening and engagement processes described in Section 6. In April and May 2015, the Mental Health Programme Board, including clinician and service user and carer representatives then developed and agreed an initial set of six high level scenarios for the Case for Change, including a no-change scenario. All the scenarios were based on the provision of:-

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\(^5\) Deciding Together co-ordinating group assumes out of area referral relates to referral out with the NTW footprint. This is in the absence of a national definition.
- Three acute assessment and treatment wards, in line with the aim of reducing reliance on inpatient beds
- Either one or two rehabilitation wards, with a complex care rehabilitation ward to be co-located on the same site as the acute wards
- Older people’s wards for Newcastle residents.

These high level scenarios required further development by CCG, NTW and MHVCS officers and included:

- More consideration of the number and possible locations for the older people’s mental health wards, serving Newcastle residents. The scenarios were further developed based upon retaining the existing two wards; and
- Different levels of indicative capital investment for each scenario being identified

This resulted in the six high level scenarios being developed into 12 more detailed scenarios showing variations of where services could be located. Sub-options were then identified relating to lower and higher levels of indicative capital investment (for all but the no change scenario) making 23 sub options in total. The scenarios and the shortlisting process are shown in more detail in Appendix 9. The CCG then went through a shortlisting process in three stages which reduced the scenarios in number.

First sifting - some of the 12 scenarios included one rehabilitation unit and the others included two units. In further considering this at a meeting of joint executives of the CCG, NTW, local authorities and MHVCS representatives on 20 August 2015, it was agreed that two rehabilitation units were required, one being a hospital based complex care rehabilitation ward and the other being a “moving on” community based rehabilitation unit. This resulted in the rejection of the 5 scenarios (10 sub options) which included only one rehabilitation unit, leaving 7 remaining scenarios, comprising of 13 sub options, for further consideration. At this meeting, the joint executives also confirmed that they supported these scenarios being further developed and analysed for a decision by the CCG Executive on which scenarios should be taken forward for formal consultation.

These 7 scenarios were also reported back to the Mental Health Programme Board on 10th September 2015, where it was agreed that they provided a good range of possible scenarios for further development and analysis.
Second sifting - following further development of these scenarios, including costs, the CCG Executive at its meeting on 15 September assessed them against the following broad criteria, which are commonly used in shortlisting options in business cases, whereby a scenario / option can be rejected if:

- It is not practical or not feasible
- It does not meet the principal objectives or benefit criteria desired
- It is clearly unaffordable
- A scenario / option, when compared with another, can be identified as inferior. Inferiority is demonstrated if fewer benefits would be delivered at a higher or equivalent cost; or the same level of benefits would be delivered at a higher cost; or
- Where there is a group of scenarios / options which are similar, providing comparable benefits by the same method, a single representative scenario / option can be chosen for further evaluation.

At this second sifting stage, the CCG Executive rejected the do nothing option on the basis that it would not meet the principal objectives desired and it would clearly be unaffordable. This left a shortlist of 6 scenarios, with 12 sub options based on a lower and higher revenue cost for each scenario, the differences between these being due to differing revenue consequences arising from the lower and higher indicative capital costs within each scenario. Following the second sifting, members of the CCG Governing Body were reminded about the background of how the different scenarios had been developed at their meeting on 29 September.

Third sifting - in undertaking further financial analysis of the indicative capital costs it was decided that for the purposes of comparing the scenarios at this stage it was reasonable to take the average of the lower and higher capital costs for each scenario, leaving 6 shortlisted scenarios for consideration (with no sub options).

9.2.3. The shortlisted scenarios

The shortlisted scenarios which were taken forward for formal consultation are describe and illustrated below. For ease of understanding in the public consultation these were presented as;

1. Three possible locations for adult acute assessment and treatment and rehabilitation services; and
2. Two possible locations for older people services
For acute assessment and treatment and rehabilitation services they are:

**NTW trust - wide based scenario (T):**

- The adult acute assessment and treatment service for Newcastle and Gateshead residents being provided from NTW’s hospital at St. George’s Park, Morpeth (two additional wards to be provided there) and from NTW’s hospital at Hopewood Park, Sunderland (one additional ward to be provided there)
- The rehabilitation service currently at St. Nicholas Hospital, Newcastle being provided from St. George’s Park; Elm House in Gateshead would be retained as a moving on rehabilitation unit

**Newcastle based scenario (N):**

- The adult acute assessment and treatment service (three wards) for Newcastle and Gateshead residents being provided from St. Nicholas Hospital, Newcastle
- The rehabilitation ward at St. Nicholas Hospital, Newcastle would provide complex care and Elm House in Gateshead would be retained as a moving on rehabilitation unit

**Gateshead based scenario (G):**

- The adult acute assessment and treatment service (three wards) for Newcastle and Gateshead residents being provided from a location to be identified in Gateshead. As part of the ongoing consultation with Gateshead Local Authority the CCG were subsequently offered, following the public consultation period, the potential for a brown-field site in Gateshead (St Cuthbert’s village site). Further detailed consideration would need to be given by professional estates staff to the suitability of this site, if it was identified as part of the preferred scenario. It is also noted that Gateshead Local Authority state that their cabinet would need to agree to the site being offered at no cost and that this may also require a referral to the Secretary of State for Communities and Local Government.

- A complex care rehabilitation ward would also be provided at the same location as above. Elm House in Gateshead would be retained as a moving on rehabilitation unit.
For older people’s mental health services, for Newcastle residents, the two scenarios are:

Older people services in Newcastle (Scenario 1):
- The older people’s service being provided from St. Nicholas Hospital, Newcastle

Older people services in Morpeth (Scenario 2):
- The older people’s service being provided from St. George’s Park, Morpeth.
Proposed Inpatient Locations

**Current Locations**

- **Newcastle**
- **Gateshead**
- **Other NTW hospital sites**

**Scenario 1**

**Scenario 2**

**Key**

- Older Peoples Services (only applicable for Newcastle residents)
- SGP: St. George’s Park, Morpeth
9.2.4. Alignment with other Clinical Services

Whichever preferred scenario is selected, they will require to be aligned with all other clinical services.

Inpatient services, as at present, need to be aligned with other clinical services such as primary care, general practice, community mental health services, other mental health inpatient services and acute medical inpatient services. The inpatient model identified will not significantly change these current relationships, but our considerations of this are outlined.

- Primary care services, including general practice - The Primary Care work stream of the Mental Health Programme Board works on interface issues e.g. between community and inpatient, primary and secondary care. This work would continue and would include communication, discharge planning and development of shared care plans with clear areas of accountability.

- Forensic psychiatry services, there is considered to be no significant risk that a reduction in acute admission and treatment beds will impact on the number of forensic psychiatry in-patient admissions. NTW has not experienced any such risk occurring as part of recent acute admission and treatment bed reductions in other parts of its area i.e. Sunderland, South Tyneside, North Tyneside and Northumberland. This will however be monitored as part of the Implementation Plan to ensure that bed reductions are implemented safely.

There is also a Forensic Community Mental Health Team in place, whose role is to manage the transition from secure placements to community and continually monitor and manage risk. The new NTW Community Pathways that are to be implemented are also designed to improve liaison and support between the psychosis and non-psychosis pathways and other specialist staff, such as forensic services. And the non-psychosis pathway (as described in Section 5) will also have a Personality Disorder sub specialism within it, where staff will have specialist knowledge, experience and skills in working with service users with a personality disorder.

Specific accommodation and community resources are in place for those forensic psychiatry patients who require Ministry Of Justice approval prior to discharge – Westbridge Hostel which has been operational since 2003, takes many individuals discharged from secure placements and has successfully managed their re-integration into the community. This is not an issue for the acute admission and treatment service.
• Older people’s services, there are no significant service alignment issues arising from a different NHS Trusts providing this service for Gateshead residents. There is currently good liaison between the adult acute admission service at the Tranwell Unit in Gateshead and the older people’s mental health service on the same site, managed by the Gateshead Hospitals NHS FT. There is also a clinician from the Gateshead older people’s mental health service on the CCG’s Mental Health Programme Board, where the future effective alignment of the whole system is, and will continue to be monitored.

• Alignment between older people’s mental health and acute medical services, the important thing is to have good communication and collaborative working between the mental health and the medical service. In Newcastle, a senior RGN nurse practitioner provides in reach expertise into the older people’s wards, acting as a link between NTW services and the acute medical wards. NTW’s Self Harm and Liaison Psychiatry Team at the Royal Victoria Infirmary also provide liaison when a patient is transferred there for acute medical care. In cases where an older person has to be transferred from an NTW ward to an acute ward in an emergency, the 999 ambulance service is used. These liaison arrangements would continue if the older people’s wards transfer to St. Nicholas Hospital.

Similarly at St. George’s Park, a nurse practitioner provides medical expertise into the older people mental health wards and the NTW Northumberland Integrated Liaison Psychiatry Team looks after the mental health of patients in medical wards. Such liaison and collaborative arrangements would continue if the older people’s mental health inpatient service was transferred to St. George’s Park, and an older person was transferred to an acute medical ward in either Newcastle or Northumberland.

• Alignment between adult services and acute medical services, as with any member of the public, timely access to acute emergency services is of paramount importance. All adult mental health wards access emergency services via a blue light ambulance call. NTW does not operate any crash/emergency response systems for acute medical care. Routine physical health care e.g. dentistry and primary care screening is provided via a broad range of service level agreements with other local NHS Providers. A range of initiatives are also being undertaken by NTW as part of the recent national drive to improve the physical health of people with mental health problems and learning difficulties. The expectation is that patients are not penalised in terms of access by being in receipt of NHS mental health services. These proposals in this document do not impact on these arrangements.

• Liaison psychiatry services, there are services located in Newcastle and Gateshead A&E departments but it is recognised that these will need to be enhanced. We and NTW want to develop a robust liaison model with the intention of it being a 24
hour service. There will be clear arrangements put in place for the transfer of patients from these A&E departments to acute mental health admission wards, wherever these are located.

10. FORMAL PUBLIC CONSULTATION AND TRAVEL IMPACT REPORT

This section describes the formal public consultation methodology and summarises the responses received. It also summarises the independent travel impact report which provided more information about how the different scenarios would impact on travel times and costs.

10.1. Formal public consultation

The formal public consultation period took place between November 2015 to February 2016, and the engagement methods included:

- Focus groups led by the CVS
- An online survey (and paper based equivalent)
- A street survey with a representative sample of the public
- Letters, emails and other written submissions, including feedback from meetings with voluntary and community sector service providers
- Public consultation events

• Results independently analysed and reported by Kenyon Fraser
  - In-depth interviews – carried out by Northumbria University peer researchers

A total of 1,249 people have contributed to these results.

- A minimum of 147 people attended 13 focus groups (not all evaluations were completed)
- 165 people responded to the online and paper survey
- 797 people responded to the street survey
- 26 written submissions were received from individuals and organisations
- 18 in-depth interviews with service users and carers - and
- 114 people attended public consultation events.
All reports are available on the Newcastle Gateshead CCG website.

Focus Groups

Voluntary and community sector partners to hold Focus Groups for service users, carers and service providers. These groups were run against a standard discussion guide, supported by guidance notes, which was co-produced by representatives of the sector and the CCG.

**Overall preferences:**

- **Community services:**
  - No clear preferences for any scenario
  - Felt it important all were in place and combined with inpatient care
- **Inpatient care:**
  - No clear winner between Scenarios N and G (dependent on location of the group)
  - Unanimously not in favour of Scenario T
- **Older peoples services:** Newcastle based scenario for all, based on:
  - Maintaining links to the local community; and
  - Reduction of the demands of travel on friends, relatives and carers.

On-line and paper survey

Respondents were asked to rank their preferred option for community services developments. The following were the order of preference.

- Community based Recovery College.
- Multi-agency initial response system.
- Community resilience and wellbeing hub, offering increased vocational and social inclusion.
- Urgent response and care - residential crisis support.
- Community based residential rehabilitation.
• Redesigned community mental health teams and specialist teams.
• Urgent response and care - crisis support without beds.

Preferred option Inpatient Care was Scenario N: Newcastle based

More people responded from Newcastle than Gateshead so taking this into account – preferences are more equal following the focus group pattern

There was a more even response when asked if each scenario would meet their needs:
  • Scenario T is 51% likely to slightly or fully meet needs;
  • Scenario N is 51% likely to slightly or fully meet needs; and
  • Scenario G is 57% likely to slightly or fully meet needs;

In terms of Older People people’s services preference was Newcastle (St. Nicholas). Respondents said that avoiding inpatient care for older people through access enhanced community provision and people were less concerned with the ability of the scenario to generate additional resources to invest in new community services

Representative street survey

The sample representative of the Newcastle and Gateshead population of 797 people:
  • Newcastle 400
  • Gateshead 397
All were interviewed in-street during the consultation period.
94% felt it was important for people’s overall wellbeing that they should experience good mental health with near equal importance given to the inpatient and community care:
  – 95% believe inpatient care is important when needed
  – 91% believe care and support in the community people are familiar with when needed

General views on mental health included:
“…do you feel somebody who has a serious mental health problem could hold a responsible job?”
The majority (51%) felt that this was not possible for a person with a serious mental health to hold a responsible job
  • 23% felt that it was possible.

Reasons given for rating inpatient care as important varied:
  • Can get specialised treatment in hospital / medication / monitored / 24-hour care:
    “I think that they will get better care in hospital, they would be monitored better.”
    “It’s more supportive, there’s always someone on hand to help them live, a mentor.”
  • The patients are sometimes dangerous to themselves / others / general public:
    “I don’t think that they ever fully recover and can’t cope on their own, they are a danger to themselves and others.”
    “Someone with this level of mental health issues should be hospitalised not just for their own safety but that of the public also.”
    “They are better off in hospital”
    “Not sure people with mental problems should be in the community.”
    “Don’t think people with special need can be in the community. They need a lot of care”

“(the)...CCG’s proposals focus on using money saved by avoiding hospital admissions wherever possible to allow investment in improved specialist mental health services in the community.”
Agree 62%  (Newcastle 71%, Gateshead 54%)
Neutral 13%  (Newcastle 17%, Gateshead 9%)
Disagree 10%  (Newcastle 8%, Gateshead 13%)

Inpatient care preferences:
  • The NTW trust wide scenario (T) is rated as the most important (40% overall)
  • The Gateshead scenario (G) was second with 30% ranking it most important, and
  • The Newcastle scenario (N) was marginally less attractive than Gateshead (29%), but both came out significantly less important than the NTW proposal.

Older people’s services:
• 89% Newcastle
• 12% Morpeth

Reasons for preference:
• Reducing travel for service users, relatives and carers
• Maintaining links with their community
• Problems with transport to Morpeth/too far away

Letters and submissions
The CCG presented the proposals to two Newcastle and Gateshead joint Overview and Scrutiny panel meetings, as well as other meetings with the OSC’s separately. Gateshead OSC have reserved the right to refer to the Secretary of State of scenario T is chosen.

There were 26 written submissions were received from individuals and organisations. Issues include:
Support for the consultation process:
• Current situation is unsustainable
• Observable and robust wide and deep consultation
Specific comments on the consultation process:
• Very well presented documents – lacking in specific detail to make informed choice
• Apparent lack of engagement with people living with dementia or their carers
• Specific technical issue with policy publication during the consultation
• Concerns the consultation events were too structured preventing fullest comment and question

Consultation events

114 people attended 4 formal public consultation events.
General concerns and comments
• Concerns around the future provision of specialist mental health services in Newcastle and Gateshead:
• More clarity wanted on the community scenarios
• Transport and travel issues
• Stigma needs to be front of mind

Community health service scenarios
• Improved community service seen as a good and wanted change,
• Better multi agency working and innovation requested
• The appropriateness of assessment, including in primary care settings/GPs was raised as a concern
• Support for better/more voluntary and community sector provision

Inpatient mental health service scenarios
• There were concerns raised about a potential reduced capacity for crisis care - could action be taken quickly enough and would the necessary provision be available?
• In general and where expressed, Scenario N was preferred over Scenario T.

Older peoples services scenarios
• There was no feedback recorded from these sessions on this area of the consultation

In-depth interviews

Northumbria University conducted in-depth interviews with 11 service users and 7 carers and the intent was to capture their lived experience. Service users and carers importantly designed the tools, conducted the interviews and contributed to the analysis and the interviews took place in January and February of 2016 during the consultation period.
The participants ages ranged from 25 years to 70 plus and their length of time in service ranged from 1 to 15+ years. 11 participants had been in services for 15+ years.
The themes generated from the transcripts fitted into having the right support in the right place at the right time with the right values.

Right support

• Participants wanted better facilities in inpatient settings, including en-suite toilets and private areas for service users and carers to meet
• They wanted inpatient settings where activities reflected the diversity of their needs including reading, art, games and opportunities to be outdoors
• The availability of quality information particularly around transition points such as moving in and out of services or between children and adult services was reported as important
• Targeted support over maintaining quality housing was also stressed by participants. This would help avoid service users being discharged from hospital into unsuitable housing arrangements or becoming homeless.
• Ongoing conversations over mental health ‘recovery’ were reported as important in developing hope for both carers and service users.

Right place

• When considering the three presented scenarios the general theme from this qualitative data indicates that the option of services being delivered from Morpeth received little support and that participants generally wanted to have services delivered close to their place of residence.
• Participants overall wanted an increase in investment in community mental health services. Where this worked well intervention was ‘recovery’ orientated.
• A recognition is needed of the time and cost implications for travelling to and from services. This was seen as having a direct effect on the frequency and length of visits that carers could make to service users.

Right time

• Continuity of care and the benefit of having one professional who steers people through the service was important to achieving joined up services.
• The importance of having a good GP particularly from the outset of becoming unwell was also stressed.
• At transition points such as moving between children and adult services extra support and information was valued.

Right values

• One of the biggest concerns of both service users and carers was not being listened to by services.
• The different mental health teams and inpatient services need to communicate effectively with each other. Participants reported different services not informing each other of changes to service users’ care and even services being in conflict.
• Continuity of care provided by both staff and services was also important to participants.
• The values of staff were seen as key, in particular clearly articulated respect and empathy.

10.2. Summary of public feedback from the consultation phase

There is a need for solid reassurance that future commissioning decisions which lead to changes will deliver the right care at the right time, as well as location and travel: “...I’d rather go to shabby premises than have to travel for hours…”.

There was no discernible difference between the views of carers and service users to those of professionals in terms of preferences for both the both in-patient scenarios and community proposals in the online/paper based survey and Focus Groups.

The most important basis of preference for all methods apart from the public survey was around reducing the impact of travelling and maintaining close links with the community that patients are established within. For example, respondents to the consultation recognise the benefits of better accommodation for inpatients in Morpeth and Sunderland, but extra funds in the system is not a major persuader – minimising travel and maintaining links into the local community are more important.

The provision of in-patient services in Newcastle appears to be favoured by respondents overall. However, responses through the online and paper surveys suggested that all three in-patient scenarios were favoured similarly in terms of respondents’ perceptions of a scenario’s ability to fully or partially meet their needs.

A preference for provision of older peoples’ services from Newcastle was given by a significant and large majority of respondents to this question.

The need for reassurances about staffing emerged - familiar faces and relationships are valued above the premises - and the lack of reference to this in the consultation documents was commented on.

New information published

Since the formal consultation started, new information has become available through the publication of reports into mental health.

These are:

A commission to review the provision of acute inpatient and psychiatric care for adults has published findings and recommendations for England. The full report and summary here: http://www.caapc.info/
NHS England has also published a special task force into mental health – The Five Year Forward View for Mental Health


10.3. Travel impact

The public consultation recognised that all the scenarios would impact on people’s travel arrangements in different ways – with those scenarios involving services being located outside of Newcastle and Gateshead likely to involve longer travel times overall. The consultation document promised that the impact of travel on service users, families and carers would be considered and addressed as part of every individual’s care plan. It stated “We do not want service users and visitors to struggle to get to hospital and we make a very clear and absolute commitment to support travel in any scenarios where inpatient services are further away from local communities.” The consultation stated that support would include access to taxis and minibus transport.

An independent travel analysis carried out by North East Quality Observatory (NEQOS) www.negos.nhs.uk

Travel Times

Table A: Gateshead residents. Single journey travel times for adult acute services (median* in minutes), by private and public transport

<table>
<thead>
<tr>
<th></th>
<th>Current to QE Tranwell Unit or CAV</th>
<th>Scenario T Hopewood Park</th>
<th>Scenario N St Nicholas Hospital</th>
<th>Scenario G Bridges (proxy**)</th>
<th>Scenario G QE Hospital (proxy**)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Transport</td>
<td>8</td>
<td>28</td>
<td>18</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Public</td>
<td>24</td>
<td>75</td>
<td>50</td>
<td>23</td>
<td>23</td>
</tr>
</tbody>
</table>
The median is the value “in the middle” of all the values so that as many travel times are below that value as are above it. It is a better measure of average than the “mean” as the mean is very easily distorted by extreme values. The median is a better reflection of the typical time taken.

**As a possible site in Gateshead has not been identified yet for Scenario G, the Bridges area and the QE Hospital have been used as proxy locations to represent a central and outer location in Gateshead town.**

Table B: Newcastle residents. Single journey travel times for adult acute services (median in minutes), by private and public transport

<table>
<thead>
<tr>
<th></th>
<th>Current to QE Tranwell Unit or CAV</th>
<th>Scenario T St George’s Park</th>
<th>Scenario N St Nicholas Hospital</th>
<th>Scenario G Bridges (proxy location)</th>
<th>Scenario G QE Hospital (proxy location)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Transport</td>
<td>13</td>
<td>30</td>
<td>14</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Public Transport</td>
<td>29</td>
<td>72</td>
<td>36</td>
<td>31</td>
<td>46</td>
</tr>
</tbody>
</table>

Table C: Newcastle residents. Single journey travel times for older people’s services (median in minutes), by private and public transport

<table>
<thead>
<tr>
<th></th>
<th>Current : to Campus for Ageing and Vitality</th>
<th>Scenario 1 St Nicholas Hospital</th>
<th>Scenario 2 St George’s Park</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>14</td>
<td>14</td>
<td>28</td>
</tr>
</tbody>
</table>
Table D: *Gateshead residents* – *estimated number of journeys for patients and carers by private and public transport per annum – adult acute services*

<table>
<thead>
<tr>
<th></th>
<th>Current (single journeys)</th>
<th>Future estimate (single)</th>
<th>By private transport (single)</th>
<th>By public transport (single)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>756</td>
<td>634</td>
<td>364 (57%)</td>
<td>270 (43%)</td>
</tr>
<tr>
<td>Carers</td>
<td>8,182 (est.)</td>
<td>5,606</td>
<td>3,290 (59%)</td>
<td>2,316 (41%)</td>
</tr>
</tbody>
</table>

Table E: *Newcastle residents* – *estimated number of journeys for patients and carers by private and public transport per annum – adult acute services*

<table>
<thead>
<tr>
<th></th>
<th>Current (single journeys)</th>
<th>Future estimate (single)</th>
<th>By private transport (single)</th>
<th>By public transport (single)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>958</td>
<td>810</td>
<td>388 (48%)</td>
<td>422 (52%)</td>
</tr>
<tr>
<td>Carers</td>
<td>11,672 (est.)</td>
<td>7,960</td>
<td>3,761 (47%)</td>
<td>4,199 (53%)</td>
</tr>
</tbody>
</table>

Table F: *Newcastle residents* – *estimated number of return journeys for patients and carers by private and public transport per annum – older people’s services*

<table>
<thead>
<tr>
<th></th>
<th>Current (single journeys)</th>
<th>Future estimate (single)</th>
<th>Private transport (single)</th>
<th>Public transport (single)</th>
</tr>
</thead>
</table>
Patients | 300 | 300 | 300 (100%) | N/A
---|---|---|---|---
Carers | 8,620 | 8,620 | 5,175 (60%) | 3,445 (40%)

Costs

Costs by Private Transport

The following tables indicate the median travel costs of a return journey for the new scenarios, by private transport.

*Table G: Median travel costs* of a return journey by private transport – adult acute services

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Scenario T Hopewood Park / St George’s Park</th>
<th>Scenario N St Nicholas Hospital</th>
<th>Scenario G Bridges</th>
<th>Scenario G QE Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gateshead residents</td>
<td>£1.34</td>
<td>£9.41</td>
<td>£3.95</td>
<td>£1.79</td>
<td>£1.23</td>
</tr>
<tr>
<td>Newcastle residents</td>
<td>£2.24</td>
<td>£9.86</td>
<td>£2.24</td>
<td>£2.35</td>
<td>£3.08</td>
</tr>
</tbody>
</table>

* for comparative purposes, based on mileages and Trust mileage rate for private vehicle use

*Table H: Median travel costs of a return journey by private transport – older people’s services

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Scenario 1 St Nicholas Hospital</th>
<th>Scenario 2 St George’s Park</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle residents</td>
<td>£2.24</td>
<td>£2.24</td>
<td>£9.55</td>
</tr>
</tbody>
</table>

Costs by Public Transport

NEQOS were not asked to consider public transport costs because (a) there is already Trust guidance on financial support for service users and carers travelling to and from a hospital and (b) the commitment provided as part of the public consultation to support travel in any scenarios where inpatient services are further away from local communities, including access to taxis and
minibus transport. For example, as part of the relocation of acute admission beds from South Tyneside to Hopewood Park, Sunderland in 2014, NTW continues to provide a free transport service two times a day (afternoon and evening), seven days a week between its former Bede Unit in South Tyneside and Hopewood Park. In these circumstances it is difficult to model future public transport costs for the number of people affected or determine a median value. However, based on the estimated number of future journeys by service users and carers using public transport, estimated costs for the provision of a free transport service between local communities (i.e. Newcastle, Gateshead, Morpeth and Sunderland) will be included in the financial analysis of the scenarios which have been consulted upon.

It should also be noted there is already existing support arrangements in place though a national scheme and local NTW Guidance on supporting patients, carers and relatives with travelling:

1. The **Hospital Travel Costs Scheme** places a legal requirement on NHS Trusts to pay NHS travel expenses of eligible patients. It is part of the NHS Low Income Scheme set up to provide financial assistance to those patients who do not have a medical need for ambulance transport, but require assistance with their travel costs. Under the Scheme, patients on low incomes or are in receipt of specific qualifying benefits or allowances are reimbursed in part or in full costs incurred in travelling to receive certain NHS services, where their journey meets certain criteria. When deemed medically necessary by a health care professional involved in the patient’s care the travelling expenses of an escort may also be claimed.

2. **NTW Guidelines for facilitating and supporting carer and relative travel to visit Inpatients**

   The HTCS does not include carers / relatives travel costs to visit hospital in-patients, however, the Trust has recognised this is an integral requirement in order to achieve the outcomes of the service users care plan. If visits cannot be facilitated due to travel difficulties this can widen health inequalities and potentially have serious consequences for the health of the patient. Therefore the Trust is committed to supporting patient and carer / relative’s travel as part of an overall package of care.

   Where the service user does not identify a carer, carers may come forward themselves for advice and support. In such cases it is important to establish that the link between patient and carer exists.

   In some cases family members will not recognise themselves as carers or understand the term carer so, if this is the case, it is important to inform friends and family that the term carer does apply to them.
If a patient's care plan indicates that it would be beneficial for their carer or relative to visit them and/or facilitate leave, the Trust should support this to happen. This should always be considered on admission to a hospital ward and within the 72 hour review. The Ward Manager will work with patient and main carers to agree the benefits of ward attendance by the broader family members. It would not be expected that broader family members would be offered transport solutions unless it was clearly identified that this would have significant benefits to the service users.

The travel needs of carers should be explored with carers as part of the ‘Getting to Know You’ (GTKY) process within 72 hours of an inpatient admission. In doing so, ward managers and named nurses should be mindful of the individual needs and requirements of carers/relatives.

Travel solutions (see below) should always be offered to carer/relatives in any of the following circumstances:

- When the carer/relative is not able to use a car to visit;
- When the public transport journey is longer than 45 minutes (door to door) or the complexity of the travel arrangements mean that the time spent on travelling is longer than 45 minutes;
- When carer/relative have individual access requirement which make their journey more difficult (e.g. elderly carers/relatives, young carers/relative, those with disabilities or health difficulties, those with young children);
- Where the patient is located in comparison to carers/relatives home address.

The following solutions/options are available and agreement should be made via the GTKY process:

- Travel planning and support to access public transport and community transport;
- Use of the ward car to collect/drop off at a convenient bus stop/metro station etc.;
- Car sharing where appropriate;
- Taxi - The use of taxis will not be prohibited solely on the grounds of the expense to the Trust, there may be a valid reason and requests should be reviewed on an individual basis to take into account of the reason for the request and the carer/relative’s personal circumstances.
- Purchase of train tickets;
• Reimbursement of Parking fees – if charged.

Where arrangements are made to support carers/relative’s travel to visit patients in receipt of care, arrangements should be recorded in the carers action plan in ‘Getting to know You’ (located in the e record).

Carer’s champions (supported by ward managers or named nurses) are able to support carers and their families by providing information about local public transport links. Staff on the ward should be signposting patients and their carers to their carer’s champion and Carer Support Services.

There will be no Car Parking charges applied to visitors on NTW Trust sites. Local arrangements e.g. the use of a disc will be made available to carers and patient visitors. Unfortunately, NTW cannot offer the same arrangement for non-Trust owned sites, where the Trust delivers a service. This includes, for example, the Tranwell Unit and Royal Victoria Infirmary (RVI).
11. INPATIENT SCENARIOS – OPTION APPRAISAL

This section describes the option appraisal process that was followed in considering the inpatient locations. Non-financial benefit criteria were agreed and used to evaluate the scenarios and a financial analysis has been produced and included in this case for change. On the basis of this and other information described in this section, including responses from the public consultation, the CCG Governing Body is asked to consider this information in identifying a preferred scenario.

11.1 Option Appraisal Methodology

The “Treasury Green Book” and the supplementary “Public Sector Business Cases – Using the Five Case Model (2015)” provide guidance on delivering public value from spending decisions, including the appraisal of options as part of a Business Case. This has been used to guide our inpatient option appraisal methodology, taking into account the Treasury advice that the approach taken should be scalable and proportionate.

11.2 Non-Financial Benefit Criteria

The Treasury guidance advises that the benefits criteria to be used in assessing options should be developed by the parties most directly affected by the proposal, usually the main stakeholders. To do this we used our Mental Health Programme Board, which was instrumental in developing the scenarios, and is a multi-agency and multi-professional group including commissioners, providers (NTW and MHCVS representatives), local authorities and service user and carer organisations.

A set of benefit criteria were agreed which were derived from:

- the national and local strategic objectives to improve mental health services, as described in the November 2015 Case for Change;
- the need to address the shortcomings in the existing inpatient service, also described in the Case for Change; and
- the different advantages and disadvantages that we asked people to think about in the public consultation – quality of care, quality of accommodation and environment; travel considerations and the opportunity to develop new services.
The criteria, including issues to be considered as part of each criterion, are shown in the Table below. Following the methodology recommended in the Treasury guidance, the Mental Health Programme Board then agreed the relative importance of the criteria by sharing a weighting of 100 between them. Patient and Carer experience was allocated 30%, split between quality of accommodation and access to services.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Weighting</th>
<th>Issues to Consider</th>
</tr>
</thead>
</table>
| Quality of care, clinical effectiveness and patient and staff safety | 35%       | • Inpatient co-location benefits, including patient and staff safety  
• Best practice advice from the independent consultant psychiatrist / clinical director (in the Case for Change)  
• Clinical Senate advice  
• Consultation feedback e.g. ensuring effective integration of inpatient and community services |
| Patient and carer experience: quality of accommodation and environment | 15%       | • Professional estates advice on the quality of accommodation based on the comparative amount of new build; part new build / part major refurbishment of existing wards; and major refurbishment only within each of the scenarios, taking the level of new build in each scenario as providing a higher benefit  
• Any shortcomings in accommodation aimed to be provided  
• Provision of a therapeutic environment for patients  
• Consultation feedback e.g. meeting the needs of carers |
| Patient and carer experience: access to services              | 15%       | • Travel impact  
• Patient choice  
• Equality impact assessment  
• Consultation feedback e.g. stigma |
The Programme Board was then split into three balanced groups so that each group included a cross-representation of stakeholders, enabling all members to be more engaged in scoring each scenario (from 1 to 10) for how well it would deliver each of the benefits. The scores and weights in each group were then multiplied together and aggregated to provide a total weighted score for each scenario. The current state (“do nothing” scenario) was also scored to provide a baseline value. Written information was also provided to each group on the accommodation that would be provided in each scenario; a summary of the travel impact analysis; and the equality impact summary. The scores from each group were totalled.

Further information on these considerations is summarised below, followed by the scoring of the scenarios. The adult acute and rehabilitation scenarios were assessed separately from the older people’s scenarios.

**Quality of Care, Clinical Effectiveness and Patient and Staff Safety**

Best practice advice (as identified by the independent clinical adviser and by the independent Clinical Senate Report to the CCG and referenced later in this section) is to provide a range of adult mental health services on the same site. This includes crisis services, adult acute assessment and treatment wards, psychiatric intensive care and complex care and high dependency rehabilitation wards. The co-location of these types of wards provides a range of benefits, described below, which combine to enable the delivery of a high quality, safe, effective and efficient service.

Clinically, the co-location of complex care rehabilitation wards with acute wards has advantages in enabling the cross sharing of staff and the transfer of patients as early as possible from acute to rehabilitation care. It strengthens the clinical team in caring for
patients with more challenging or unsettled behaviour by facilitating better partnership working across the wards. It also provides the complex care rehabilitation team with reassurance that the skills of an acute team are at hand on the same site. Where a patient is able to be transferred more quickly to a rehabilitation ward this should improve the patient’s experience. Further co-locating these wards with high dependency rehabilitation provision reduces the need for transfers between hospital sites at times when patients are acutely unwell.

There are also advantages to co-location from a safety perspective. The more co-ordinated joint working of acute and rehabilitation teams should help to reduce patient and staff safety risks. And having more clinical staff on one site should improve the response to psychiatric emergencies.

Co-location also has benefits for the effectiveness and efficiency of the service model and one of the prime objectives of these proposals which is to reduce the amount of time that people spend avoidably in hospital. For example, the ability to transfer a patient earlier from an acute ward to a rehabilitation ward, where this is required, should assist in reducing average lengths of stay on acute admission wards enabling the whole community / inpatient service model to work more effectively and efficiently and help to reduce average lengths of stay to the Royal College of Psychiatrist’s recommended 21 days. Co-location also helps to create a critical mass of services, such as at NTW’s Hopwood Park site where the number of consultants available led to the implementation of innovative 7 day consultant cover on the wards, contributing to the delivery of an improved service model (as described earlier). The number of available consultants makes the use of a shift system more achievable and practical to extend consultant presence into the evenings and weekends, without unduly reducing the presence of consultant staff during the standard working day.

The Peer Review of the scenarios referred to below also refers to some design flexibility benefits from co-location of acute wards whereby swing bed zones can be created between wards to help to manage variance in demand between male and females or to provide an area where a patient can be managed rather than using seclusion or referring to another specialist service elsewhere.

Finally, co-location of a larger cluster of wards better facilitates the provision of a range of important clinical support services such as physiotherapy, exercise therapy, carers support and other social and recreational activities. Where wards are more geographically disperse the input from such additional services is greatly reduced and / or becomes more expensive to provide and the patient experience significantly reduced.
The scenario which the option appraisal considered could deliver the highest level of care for adult services was Scenario T, which would provide a range of these different services on two sites at St. George’s Park and Hopewood Park. Scenarios N or G would provide a more dispersed range of adult working age services, with the specialist psychiatric intensive care and high dependency rehabilitation services being located on other NTW sites. In considering patient and staff safety risks, it was felt that Scenario G, a new build unit in Gateshead, would pose a higher patient and staff safety risk, as the services would be provided on a smaller site with less staff support for emergency responses than would be the case in the other scenarios.

For older people’s services it was considered that Scenario 1 (the provision of services in Newcastle) would deliver better quality care.

Patient and Carer Experience - Quality of Accommodation and Environment

The November 2015 Case for Change described various shortcomings with existing inpatient accommodation and the need for substantial improvements. In the proposed scenarios, all accommodation would address these shortcomings and be at least to a good standard; compliant with legislation; meet NTW accommodation standards e.g. en suite bedrooms; and be functionally suitable for the client group e.g. including ground floor accommodation for all services that would be relocated. The scenarios include different levels of new build; part new build/part major refurbishment of existing buildings; or major refurbishment. New build gives the greatest opportunity to deliver the best accommodation for patients. Major refurbishments will also provide good quality accommodation, but generally involves some compromise, e.g. internal courtyards may not be as big compared to a new build. Professional estates advice was provided showing the comparative amount of new build and refurbishment in each scenario and consideration was also given by Mental Health Programme members to the quality of the overall environment at the different hospital sites.

For adult services, the Mental Health Programme Board assessed that Scenario G would deliver the best quality accommodation, followed by Scenario T then Scenario N. For older people’s services, it was assessed that Scenario 1 would deliver a slightly higher level of quality accommodation than Scenario 2.

Patient and Carer Experience - Access to Services

The November 2015 Case for Change and the Public Consultation document acknowledged a clear view from local people in pre-consultation engagement that they were worried if they have to travel longer distances to visit relatives and friends who need to be
admitted to hospital and the cost of travel. The documents therefore included a commitment from the CCG and NTW that the impact of travel on service users, families and carers will be considered and addressed as part of every individual’s care plan and that this would include access to taxis and minibus transport. The Public Consultation document stated that “We do not want service users and visitors to struggle to get to hospital and we make a very clear and absolute commitment to support travel in any scenarios where inpatient services are further away from local communities”.

The NEQOS\(^6\) travel impact report referenced earlier quantified the impact showing:

- for adult acute and rehabilitation services, Scenario G would have a minimal travel impact in terms of increased travel times and costs; Scenario N would involve some increase, mostly for Gateshead residents; and Scenario T would have the biggest increase

- for older people’s services, Scenario 2 would involve a much bigger increase in travel time and costs than Scenario 1.

The Equality Impact Assessment (accessed from the Newcastle Gateshead CCG website) also refers to the travel impact of the different scenarios and highlights as it key conclusion:

“The Equality Impact Assessment for the in-patient facilities has revealed that the key equality issue for the decision in principle is travel time and costs for carers. Therefore the mitigating actions required need to be developed alongside the plans for delivery of the selected scenario. Further consultation and equality impact assessment will be required on the proposals for redesigned community services when they develop in the next phase”.

In assessing this information, for adult services, the Mental Health Programme Board assessed Scenarios N and G equally highly, and Scenario T scoring least, having the biggest adverse impact on access to inpatient services. For older people’s services, the shortcomings of the current site environment at the Campus for Ageing were recognised and Scenario 1 scored significantly higher than Scenario 2 for better access to services.

**Delivery of Strategic Objectives: co-dependencies with development of community services framework**

\(^6\) [www.neqos.nhs.uk](http://www.neqos.nhs.uk)
This criterion was identified to reflect how each scenario would compare in contributing to the strategic objective of the Deciding Together programme to reduce the amount of time people spend unavoidably in hospital through better and more integrated care in the community. It recognises that for the whole-system to work effectively and sustainably it requires improvements in community services in order to both reduce the number of admission to inpatient care and facilitate discharge from inpatient care, thereby reducing average lengths of stay. The November 2015 Case for Change and the Public Consultation document asked people to consider this as each different inpatient scenario has a different cost and this therefore has a direct impact on the amount of funding which can be released over time to further improve community services. Mental Health Programme Board members also took into account consultation feedback about the integration of local community teams and inpatient services in the different scenarios.

In assessing this criterion for adult services, the Mental Health Programme Board considered that Scenario N delivered the greatest benefits, followed by Scenario T then G. For older people’s services, Scenario 1 scored more highly than Scenario 2.

Table: Non-financial option appraisal scores – Adult Acute and Rehabilitation Services

<table>
<thead>
<tr>
<th></th>
<th>Weight</th>
<th>Do Nothing</th>
<th>Scenario T</th>
<th>Scenario N</th>
<th>Scenario G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of care, clinical effectiveness and patient and staff safety</td>
<td>35%</td>
<td>385</td>
<td>840</td>
<td>770</td>
<td>560</td>
</tr>
<tr>
<td>Patient and carer experience</td>
<td>30%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of accommodation &amp; environment</td>
<td>15%</td>
<td>120</td>
<td>330</td>
<td>285</td>
<td>360</td>
</tr>
<tr>
<td>Access to services</td>
<td>15%</td>
<td>315</td>
<td>165</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td>Delivery of Strategic Objectives: co-dependencies with development of</td>
<td>35%</td>
<td>315</td>
<td>665</td>
<td>735</td>
<td>630</td>
</tr>
</tbody>
</table>
Scenario T scored highest for quality of care, Scenario G scored highest for quality of accommodation; the do-nothing scenario scored highest for access to services; and Scenario N scored highest for delivery of strategic objectives and co-dependency with the development of the community services framework. Overall, Scenario N scored highest.

Table: *Non-financial option appraisal scores – Older People’s Services*

<table>
<thead>
<tr>
<th></th>
<th>Weight</th>
<th>Do Nothing</th>
<th>Scenario 1 (SNH)</th>
<th>Scenario 2 (SGP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care, effectiveness and patient and staff safety</td>
<td>35%</td>
<td>420</td>
<td>770</td>
<td>630</td>
</tr>
<tr>
<td>Patient and carer experience</td>
<td>30%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of accommodation &amp; environment</td>
<td>15%</td>
<td>150</td>
<td>345</td>
<td>300</td>
</tr>
<tr>
<td>Access to services</td>
<td>15%</td>
<td>240</td>
<td>345</td>
<td>105</td>
</tr>
<tr>
<td>Delivery of Strategic Objectives: co-dependencies with community services framework</td>
<td>35%</td>
<td>490</td>
<td>770</td>
<td>560</td>
</tr>
<tr>
<td><strong>Total Weighted Score</strong></td>
<td></td>
<td><strong>1300</strong></td>
<td><strong>2230</strong></td>
<td><strong>1595</strong></td>
</tr>
</tbody>
</table>
For older people’s services, Scenario 1 scored higher than Scenario 2 in all criteria and significantly higher overall.

**SENSITIVITY ANALYSIS**

The robustness of non-financial option appraisals should be tested by varying the weightings of the benefit criteria and the scoring of the options, to an extent considered reasonable as part of the option appraisal process. This is demonstrated below, to determine if potential variations would have a material impact on the conclusions reached.

1. **Testing the Criteria Weighting**

The criteria weightings were varied to reflect discussion by the Mental Health Programme Board in agreeing the weightings to be used. The tables below show the effect of increasing the Quality of Care criteria from 35 to 40% and the Access to Services criteria from 15% to 20% for both the adult acute and rehabilitation services and the older people’s service.

<table>
<thead>
<tr>
<th>Acute / Rehabilitation Services</th>
<th>Original Weighting</th>
<th>Sensitivity Weighting</th>
<th>Do Nothing</th>
<th>Scenario T</th>
<th>Scenario N</th>
<th>Scenario G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care, Effectiveness and Safety</td>
<td>35%</td>
<td>40%</td>
<td>440</td>
<td>960</td>
<td>880</td>
<td>640</td>
</tr>
<tr>
<td>Patient Carer Experience: Accommodation &amp; Environment</td>
<td>15%</td>
<td>12%</td>
<td>96</td>
<td>264</td>
<td>228</td>
<td>288</td>
</tr>
<tr>
<td>Patient Carer Experience: Access to Services</td>
<td>15%</td>
<td>20%</td>
<td>420</td>
<td>220</td>
<td>400</td>
<td>400</td>
</tr>
<tr>
<td>Delivery of Strategic Objectives: Co-dependencies with community services developments</td>
<td>35%</td>
<td>28%</td>
<td>252</td>
<td>532</td>
<td>588</td>
<td>504</td>
</tr>
<tr>
<td>Rank</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Older People’s Services | |
|-------------------------| |
In both the above tables the application of revised weighting criteria does not change the ranking of the scenarios as assessed in the Mental Health Programme Board’s option appraisal. In addition to the above, sensitivity analyses were undertaken to test changes in the quality of care weighting and the access to services weighting separately. In both these analyses, there was no change in the ranking of the scenarios.

2. Testing the Scoring

The Mental Health Programme Board groups were asked to report where there was a significant difference of opinion in agreeing the scoring of the options. There were no such differences reported in scoring the older people’s service scenarios. There were only a few differences for the adult acute and rehabilitation service and these are shown in bold italics in the table below. For quality of care, one group considered a higher score and another group considered a lower score for scenario N. However, these changes balanced out so the score of 770 remains unchanged. There is a small reduction in accommodation and environment score for scenario T and a small increase in the access to services criteria for scenario G. However these changes do not alter the ranking of the scenarios.
### Delivery of Strategic Objectives: Co-dependencies with community services developments

<table>
<thead>
<tr>
<th></th>
<th>35%</th>
<th>315</th>
<th>665</th>
<th>735</th>
<th>630</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1135</td>
<td>1985</td>
<td>2105</td>
<td>1865</td>
<td></td>
</tr>
<tr>
<td>Rank</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

#### 3. Testing the Weighting and the Scoring

In this sensitivity test, the changes in both the weighting and the scoring are applied together. This produces the scores shown in the tables below for adult acute and rehabilitation services and older people’s services.

### Adult Acute and Rehabilitation Services

<table>
<thead>
<tr>
<th></th>
<th>Weight</th>
<th>Do Nothing</th>
<th>Scenario T</th>
<th>Scenario N</th>
<th>Scenario G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care, Effectiveness and safety</td>
<td>40%</td>
<td>440</td>
<td>960</td>
<td>880</td>
<td>640</td>
</tr>
<tr>
<td>Patient Carer Experience; Accommodation &amp; Environment</td>
<td>12%</td>
<td>96</td>
<td>252</td>
<td>240</td>
<td>288</td>
</tr>
<tr>
<td>Patient Carer Experience; Access to Services</td>
<td>20%</td>
<td>420</td>
<td>220</td>
<td>400</td>
<td>420</td>
</tr>
<tr>
<td>Delivery of Strategic Objectives: Co-dependencies with community services developments</td>
<td>28%</td>
<td>252</td>
<td>532</td>
<td>588</td>
<td>504</td>
</tr>
<tr>
<td></td>
<td>1208</td>
<td>1964</td>
<td>2108</td>
<td>1852</td>
<td></td>
</tr>
<tr>
<td>Rank</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

### Older People’s Services

<table>
<thead>
<tr>
<th></th>
<th>Weighting</th>
<th>Do Nothing</th>
<th>Scenario 1 (SNH)</th>
<th>Scenario 2 (SGP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care, Effectiveness and safety</td>
<td>40%</td>
<td>480</td>
<td>880</td>
<td>720</td>
</tr>
<tr>
<td>Patient Carer Experience; Accommodation &amp; Environment</td>
<td>12%</td>
<td>120</td>
<td>276</td>
<td>240</td>
</tr>
<tr>
<td>Patient Carer Experience; Access to Services</td>
<td>20%</td>
<td>320</td>
<td>460</td>
<td>140</td>
</tr>
<tr>
<td>Delivery of Strategic Objectives: Co-dependencies with community services developments</td>
<td>28%</td>
<td>392</td>
<td>616</td>
<td>448</td>
</tr>
<tr>
<td></td>
<td>1312</td>
<td>2232</td>
<td>1548</td>
<td></td>
</tr>
<tr>
<td>Rank</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
In summary, the non-financial sensitivity testing shows no changes in the ranking of the scenarios for adult acute and rehabilitation services or for older people’s services when changes in the weighting and scoring of the criteria are applied.

11.3 Peer Review

The Best Practice section of this document referred to the best practice advice received from an independent clinician on key elements of an effective community and inpatient mental health model of care. We also asked the independent clinician to review our shortlisted scenarios for assurance or otherwise that these scenarios reflected best practice and this is provided below. Clinical Senates have also been established by NHS England to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent. The Clinical Senate findings are also summarised below.

11.3.1 Independent Clinician Review

“Regardless of inpatient configuration, again the most important thing is the community care model which underpins inpatient services as the overall principle should be to treat people at or near home wherever possible and avoid hospital admission. Largely, you would expect to see a reduction in admission rates as community service models become more robust and therefore the patients that are in hospital are going to be more challenging and more ill and so the detail around bed configuration and flexibility and staffing levels and access to high dependency or PICU facilities is critical. As the bed base does reduce, then throughput into all forms of rehabilitation needs to be robust and robustly managed. More specifically for individual services:

Community Services

- These principles look excellent, in particular the commissioned alternatives to hospital admission and the improved and increased housing with support are probably the two most important issues to support any modelling of inpatient services.
The next thing which is very interesting is the revision of the community mental health teams and specialist teams: the detail of this will be really important in terms of working with patients to keep them well and at the highest possible level of recovery. I wonder whether you are thinking of retaining any generalist teams. In urban areas there are of course greater advantages in specialising your community teams with regard to treatment of psychosis, affective disorder and personality disorder (the latter two are often very closely co-morbid in secondary care services).

I wonder whether you will be specifying a particular service wide training and skill set, in this regard. I am becoming increasingly convinced that trauma informed services are critical across the board as the majority of secondary care mental health patients have experienced a marked degree of trauma and this has historically been ignored and/or inappropriately medicated due to lack of psychological skills.

Complex Care Rehabilitation

I think it is excellent that in every one of the scenarios you have co-located the complex care rehabilitation unit with the acute units. This has numerous clinical advantages, but the most particular one being the potential cross sharing of staff, the facilitation of moving patients as early as possible into rehabilitation and the strengthening of the clinical team in being able to handle more challenging behaviours or unsettled behaviours by the reassurance of being co-located within an acute team. If a complex care rehabilitation unit is standalone or isolated from other acute units this reduces its ability to handle more challenging behaviour and thus the clinical and utility to beds is reduced.

Moving On Rehabilitation

The location of this type of service is not as critical due to the very nature of these units. Therefore it could be regarded that these could be located in wherever is the best area without any consideration of being located with the acute wards.

Acute Wards
• As a general principle stand-alone wards are extremely inefficient, particularly these days when talking about single gender units. This is because there can be marked variance of demand between the genders and it becomes very inefficient if you only have standalone units (empty beds in one gender ward when you have a huge pressure on the other gender). Our largest hospital is flexible because male wards link with female wards with a swing bed section between the two of them. This enables us to flex the bed configuration in the hospital according to demand.

• The other issue about co-locating wards enabling them to be linked to each other is that if you have a swing bed configuration design then this also creates flexible space in which to treat and nurse more challenging patients in segregated areas, rather than using seclusion or referring outside the Trust into specialist services. Accordingly, there are huge clinical advantages to connecting your male and female wards with a swing zone between them and therefore the scenarios that have all the wards in the same place would be favoured by me.

(Note: At this stage the CCG and NTW are not considering the design of the acute units in the scenarios e.g. incorporating swing zones, but this will be considered when design development of the preferred scenario takes place).

Older People’s Wards

• my main comment is that there is less value with co-location with adult acute wards as there is not a frequent transfer of patients from one to the other. When this occurs it is usually a manic patient in good physical health that is considered to be a threat to their more frail peers or a very sexually disinhibited, physically well patient and they get taken temporarily into an adult ward. A consideration with old age wards is the transfer of patients to and from acute general hospital wards as the degree of comorbid and physical illness and frailty of these patients necessitates a high use of medical assessment. However your clinical models can reflect or account for this, i.e. if the service is co-located with a general hospital the expectation is that you will manage people in much earlier phases of recovery from physical illness or even co-work with the general hospital and manage people who are physically ill on an older people’s mental health ward, whereas if the distance is greater, then clinical models would dictate that patients have to be at a higher level of physical wellbeing to come to be on the older people’s mental health ward. Ideally, though old age services would usually prefer to be closely located to general hospital acute services.

Overall, this looks an excellent beginning and I will watch the developments with great interest”.
We are assured that the clinical peer review is very supportive of the possible scenarios and has not identified any causes of concern. Where observations have been made, for example about operational working between older people’s mental health and physical illness services, we will follow this up with the relevant NHS organisations.

11.3.2 Clinical Senate feedback

The initial feedback from the visit of the Clinical Senate was reported to the Mental Health Programme Board in undertaking the non-financial appraisal and an interim report was provided to the Governing Body in April. The final Clinical Senate report has now been received and is available on the CCG website. The report was positive about the work to date by the Deciding Together process and the progress of the development of the scenarios and involvement from the start of the clinical teams and service users and carers. They summarised their findings in the 4 conclusions stated below. There are actions and suggestions within the report for the CCG and they will be working on these over the coming months as part of the further development of this work.

Conclusion 1 - The Review Team were impressed by the Deciding Together programme approach.

Conclusion 2 – The appropriate clinical interdependencies and risks have been identified, considered and mitigated.

Conclusion 3 – The programme is right to reduce the number of inpatient settings and rebalance the service with greater community provision closer to patient’s homes.

Conclusion 4 – The ultimate success of this programme will rely on the development and continued investment in services and sectors that are “out-of-scope” of this review.

**Safe Workforce**

NTW has experience of implementing similar workforce changes in Sunderland and South Tyneside as part of its Transforming Services Programme.

**Community Services**
NTW has been undertaking a Transformation Programme for Access and Community Mental Health Teams across all care pathways. Future skill mixes to support these pathways have been agreed and the Trust is working towards implementing these across Newcastle and Gateshead in the financial year 2017-2018.

This lead in period allows for effective workforce planning to enable the achievement of the future skill mixes and ongoing review, whilst also ensure continuity of services at a time of change.

It is envisaged that because of this incremental approach, there will be a limited requirement for staff to be displaced. Where this happens staff will be supported by the Trust’s Transitional Employment and Development approach (TED). This approach has been operating for some years as an integral part of the Trust’s Transforming Services Programme. Workforce planning for the new community pathways has included a skills audit for all teams; identification of the skills gaps, based upon NICE recommended treatments for different mental health cluster groups (patient diagnoses); and the roll out of an associated training programme. NTW is progressing its community pathways development within an agreed cost envelope of £27.5m for community services, as set out in the financial analysis.

In developing the proposed new community services framework, we are aware of a national shortage of Band 6 nursing staff. This has been recognised as a risk (within risk 2.2 in the risk log) and will be monitored as part of these developments. There are no TUPE implications for community services as we are not proposing any changes in provider.

Inpatient Services
For inpatient services, the reduction in wards will see a reduction in the number of inpatient staff required. The proposed phased reduction in acute admission wards from five to three will assist in workforce planning. Staff who are displaced will also be supported by NTW’s TED approach, providing opportunities for training and the development of new skills for new jobs. No significant recruitment issues are envisaged in implementing the proposed inpatient changes. There are no TUPE implications in these proposals.

With regard to workforce capability, inpatient multi-disciplinary teams are comprised of highly skilled nurses, medical staff, psychologists and allied health professionals. NTW is very aware of the trend of increasing patient complexity on acute wards and believes that its ongoing training and development programme will continue to provide staff with the necessary skills and experience to meet this challenge.
With regard to workforce capacity, detailed staffing levels are included in the financial analysis. In summary, these provide for:

- On 18 bed adult acute admission wards - 15 qualified nurses, 11 unqualified nurses. 1.2 medical staff and other allied health professionals including psychology, occupational therapy, physiotherapy, exercise therapy and speech and language therapy staff
- On the 18 and 14 bed adult rehabilitation wards - 11 qualified nurses, 12 unqualified nurses, 1.2 medical staff and other allied health professional staff
- On older people’s wards, based on smaller ward bed numbers, there would be 6.5 qualified nurses; 8 unqualified nurses on the functional ward and 11 on the organic ward; 0.6 medical staff; and allied health professionals as above.

The staff numbers have been agreed with NTW to provide safe staffing levels.
12. FUNDING AND COST ESTIMATES

Further Financial analysis and assessment being worked on and will be presented to Governing Body as part of Decision Making Business Case and discussion on 28th June Governing Body meeting.

12.1. Financial Context

12.2. Capital Costs of Scenarios

12.3. Revenue Costs of Scenarios
13. NEXT STEPS

This section sets out the outline schedule for the next stages of development and the way forward.

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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</thead>
</table>
| 24 May             | Governing Body – to meet and discuss (latest) updated Case for Change document.  
                      Note: Governing Body met and discussed Case for Change – no issues identified.        |
| 14 June            | CCG Corporate Management team to consider Decision Making Business Case and identify a recommended scenario to present to the Executive Committee on 21 June. |
| 21 June            | CCG Executive Committee to consider Decision Making Business Case, Decision making framework.                                                |
| 28 June            | Governing Body – to meet and consider Decision Making Business Case document, Decision making framework and to make decision on preferred scenario. |
| Post 28 June 2016  | Decision communicated to stakeholders and the public.                                                                                         |
| July 2016 onwards  | Initiate implementation of preferred scenario and further development of overall mental health planning.  
                      Develop high-level project plan and timelines for the next stage of the Deciding Together project. |

Implementation and Next Steps

We referred previously to the agreement to progress implementation of the new NTW community pathways and that these are planned to be fully embedded in 2017.

With regard to the proposed accommodation improvements associated with the scenarios, these require the development of full design plans; planning permission where necessary; and then construction. For NTW services, these will also require capital investment business cases to be approved by their Board of Directors for their governance purposes.

A full Implementation Plan will be developed and agreed following the decisions to be made in June 2016, to help ensure that the changes will be made in a phased and safe way. Further development work will be undertaken on the community models, urgent care provision and liaison psychiatry as part of the further development of the mental health plan for Newcastle Gateshead CCG.
Benefits Realisation Plan

Clinical Outcome and Patient Experience Indicators
A range of clinical outcome and patient experience measures will be incorporated into a full Benefits Realisation Plan following the identification of the preferred scenario. This will include various measures to assess the effectiveness of the new clinical model.

NTW Community Services
NTW is further developing its community pathways dashboard of metrics which it is using in its Sunderland and South Tyneside locality where the new community pathways are in operation. These will also be used in the roll-out of the pathways in Newcastle and Gateshead. The dashboard includes the following measures.

<table>
<thead>
<tr>
<th>Caring – in collaboration with families, carers and partnership organisations so that you can gain / re-gain independence as far as possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Friends and Family Test</td>
</tr>
<tr>
<td>• “Were you happy with the service you received today” survey</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safe – to get the right care, safely and easily from our flexible and skilled workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bank, agency and overtime costs</td>
</tr>
<tr>
<td>• Incidents of harm and SUIs</td>
</tr>
<tr>
<td>• Staff sickness</td>
</tr>
<tr>
<td>• Staff vacancies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response – you can reach us simply and quickly, the earlier the better</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Wait from referral to 1st appointment</td>
</tr>
<tr>
<td>• Wait from referral to treatment</td>
</tr>
<tr>
<td>• Wait from assessment to treatment</td>
</tr>
<tr>
<td>• Complaints</td>
</tr>
</tbody>
</table>

| Effective – to get the right care, safely and early (integrated with inpatient care) |
- Inpatient admissions and discharges
- Inpatient days
- Staff time – including time spent on direct patient contact
- Re-referrals – 3 months and 6 months
- HONOS scores

Transformation Implementation – a RAG rating covering:
- Staffing
- Information Technology
- Standard Work
- Accommodation
- Pathways Function
- Clinical Pathways / Interventions

Capacity
- Referrals, Discharges and Flow

NTW Inpatient Services
For inpatient services, patient experience and clinical outcome measures will include:
- Admission levels, including ward location compared to area of residence
- Average lengths of stay
- Bed occupancy
- Emergency re-admission rates
- In-patient safety data – incidents of harm and SUIs
- Patient Experience metrics including:
  - The Friends & Family Test (FFT) – the FFT is nationally mandated single question survey that asks patients to rate the likelihood they would recommend the service they have received to family or friends.
- Point of You (POY) – this is an NTW feedback tool which enables Service users and carers to report feedback on various qualitative and quantitative questions, as developed and agreed by the Trust. POY is operational within NTW on a rolling monthly basis.

- NTW is also rolling out “patient IT networks” across inpatient services, giving patients greater access to the internet and associated systems. This will provide greater opportunity to obtain real time feedback from patients. Another example is working with service users and their representatives to develop an exit questionnaire concept, via text, which will be piloted within a small number of their acute wards.

- Patient Outcomes – the Short Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS). The SWEMBW survey enables the measurement of mental well-being, covering subjective well-being and psychological functioning.

- Clinical Outcomes - HoNOS (4 factor) is recommended for routine use in the UK as a clinical-rated outcome measure for mental health, including symptomology and social functioning.

Risks

The Deciding Together Co-ordinating group will continue to manage the risk process and as part of this continue to manage and mitigate risks for this project. The table below highlights the key risks as at May 2016. These will be reviewed and managed on a regular basis.

<table>
<thead>
<tr>
<th>Key identified risk</th>
<th>Key mitigating actions</th>
</tr>
</thead>
</table>
| That proposal is referred for Judicial review and/or to the Secretary of State’s Independent Reconfiguration Panel, requiring reworking of proposals and delay to implementation | Case for Change / Business Case to follow NHS England guidance, including adherence to “4 tests”  
Clinical Senate report  
Review of process by Consultation institute |
| That new NTW Community Pathways and ways of working do not deliver planned targets and benefits to help reduce reliance on inpatient beds and planned reduction from 5 to 3 adult acute admission wards | • NTW to implement new pathways using lessons learned from Phase 1 implementation in Sunderland and South Tyneside  
• NTW to monitor delivery of service and effectiveness using community pathways dashboard metrics  
• CCG Mental Health Programme Board to review whole system effectiveness |
|---|---|
| That other proposed community framework service developments will not be effective in helping to reducing reliance on inpatient beds and planned reduction from 5 to 3 adult acute admission wards | • New community developments to include this objective in their service brief  
• Service providers to monitor delivery of service and effectiveness  
• CCG Mental Health Programme Board to monitor and review whole system effectiveness |
| That the reduction in acute admission bed numbers results in undue pressure on beds, including high bed occupancy rates; increasing referrals to other NTW adult acute admission wards; out of area referrals | • Indicators to be monitored by CCG / NTW as part of managing a phased reduction of beds – reducing beds / wards only when deemed safe to do so.  
• Pro-active monitoring of whole system patient flow by NTW, to help identify any future inpatient pressures  
• Current contingency plans to be reviewed and developed |
| That NTW is unable to secure a capital funding loan for inpatient accommodation improvements | • NTW Annual Plan submitted to Monitor for approval, including estimated capital requirement  
• NTW / CCG review of accommodation priorities / capital expenditure, if required |
| That there is limited funding to develop community services in order to facilitate the reduction in bed numbers | • To plan implementation of new developments over a longer period, prioritising those developments identified as having most impact in reducing bed numbers |
14. APPENDICES

1. Deciding Together – governance organisational chart
2. National strategies
3. Population and public health information
4. Maps – community services provided by NTW
5. Services commissioned by the CCG from the mental health voluntary and community sector
6. Map – Inpatient Services provided by NTW
7. Deciding Together Communications and Engagement Advisory Group – Terms of Reference
8. Listening Exercise – summary feedback report
9. Inpatient Scenarios and shortlisting process
10. Abbreviations
14.1. APPENDIX 1
DECIDING TOGETHER – GOVERNANCE ORGANISATIONAL CHART

CCG Governing Body

CCG Executive (Delegated Powers)

CCG – Mental Health Programme Board

Project Co-ordinating Group

Deciding Together - Communications and Engagement Advisory Group

CCG / NTW/ LAs / MHVCS Joint Executives Meeting
14.2. APPENDIX 2
NATIONAL STRATEGIES


With respect to mental health services it identifies 5 key priority areas (*these mirror the 5 domains of the NHS Outcomes framework*\(^8\)):

* **Preventing people from dying prematurely** – within mental health there is a need to address the high mortality rate of people with severe and enduring mental illness and to improve life expectancy of those with physical & mental health.

* **Enhancing the quality of life for people with long term conditions** – all those with a mental health problem should have a personalised care plan with services focusing upon support to enable people to achieve personal recovery and supporting people to achieve employment.

* **Helping people to recover from episodes of ill health or following injury** – helping people to get back to their everyday lives. Parity of Esteem is the phrase most oft quoted widely from the Mandate. In essence there is a need to shine a light on unacceptable practices, unequal provision and to learn from the best. To receive the same level of quality and provision as for physical healthcare (some of whom will have co-morbid issues).

* **Ensuring that people have a positive experience of care** – those accessing and receiving care should do so with the same levels of waiting times and access to care as the rest of the NHS.

* **Treating and caring for people in a safe environment and protecting them from avoidable harm** – patient safety including a focus upon incidents of self-harm and suicide, including within prisons, police custody, young offenders institutes and

The Crisis Concordat\(^9\) identified 4 key areas:

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\(^7\) 2013 NHS Mandate, NHS England
\(^8\) 2013 NHS Outcomes Framework, Department of Health, www.gov.uk/dh
\(^9\) 2014 The Mental Health Crisis Care Concordat – improving outcomes for people experiencing mental health crisis, DOH.
Access to support before crisis – the need for services to intervene early to prevent distress and escalation into crisis

Urgent and emergency access to crisis care – when access is needed then treatment of mental health emergency receives the same urgency as a physical health emergency (parity of esteem as identified within the NHS Mandate).

Quality and treatment of care when in crisis – local ‘crisis’ mental health services should meet the patients’ needs at all times. (Quality of treatment as identified within the NHS Mandate)

Recovery and staying well & preventing future crisis – through integrated multi-agency recovery focused post crisis support (in other words, agencies working together for the patient) with patients being offered a crisis plan.

NHS England’s recently published 5 Year Forward View\(^{10}\) sets out how health services need to change arguing for a more engaged relationship with patients, carers and citizens to promote wellbeing and prevent ill-health. It defines the framework about how the NHS needs to change over the next 5 years. It highlights areas of disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services and consistent leadership across the health and care system.

Mental health undoubtedly falls within many of these areas but it is also separately identified linking in to sickness absence and that mental health account for more than twice the number of Employment & Support Allowance and incapacity benefit claims than do musculoskeletal (e.g. bad backs). The employment rate of people with a severe and enduring mental health problem is the lowest of all disability groups at just over 7%. The government backed Fit to Work scheme starts in 2015.

These examples are helpful in highlighting the profile that mental health and mental illness is now receiving. The 5 year forward view also notes:

- The need for new care models - urgent and emergency care networks
- Proper funding and integration of mental health crisis services, including liaison psychiatry.
- Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams,
- Mental illness is the single largest cause of disability in the UK - the cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS.

\(^{10}\) NHS England The NHS 5 Year Forward View, October 2014.
Physical and mental health are closely linked - people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England.

Only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.

The review sets out 5 year ambitions for mental health:

- Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together.
- Access to Psychological Therapies Programme – continue this programme
- Next year, for the first time, there will be waiting standards for mental health.
- Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards
- Better case management and early intervention.

The much wider ambition is to achieve genuine parity of esteem between physical and mental health by 2020.

Mental Health therefore has been given an integrated profile within this 5 year vision. There is no separate section for mental health; it is integrated within this ‘view’ of the NHS over the next 5 years. This is not accidental. It is a feature of the approach being taken that mental illness and health are not to be treated separately.

It is therefore important to be aware of this aspect in our development and planning of all mental health provision but specifically with regard to this paper in the development of urgent care provision.

The transition and relations for mental health are numerous - between primary and secondary care; health and social care; health and criminal justice; children/adolescent and adult care; health and voluntary/independent sectors.

There are therefore a number of other policy and guidance documents that we must be aware of and which require more consideration than the brief list below.
Community Safety Partnerships¹¹ (locally called Safe Newcastle - They work out how to deal with local issues like antisocial behaviour, drug or alcohol misuse and reoffending. They annually assess local crime priorities and consult partners and the local community about how to deal with them.

**Five Year Forward View – Mental Health**¹² - Five Year Forward View officially sets out the governments key NHS deliverables to CCGs, including a range of mental health KPIs. However FYFVMH clearly goes well beyond that set out in FYFV. **It is not yet clear what the status of these additional ambitions from the Mental Health Taskforce is. Their position is these recommendations should be reflected in the local Sustainability and Transformation Plans.** They also identify there is a funding shortfall of £1 billion pound in services, but it is not clear where or how this gap will be filled other than efficiencies gained from early intervention and transformation of current services. The taskforce believe that with chronic underinvestment in mental health care then reinvestment (via efficiencies made through better value for money) should be made to meet the significant unmet mental health need. The key areas for focus identified are:

- 7 day NHS
- Integrated mental and physical health approach
- Promoting Good mental health and preventing poor mental health

**MIND ‘listening to experience’**¹³ commissioned an independent panel to carry out an inquiry into acute and crisis mental health care. There was a call for evidence, hearings were held and services visited. The report asked that mental health services are responsive, effective, and appropriate and promote recovery. In doing this 4 key areas were identified:

**Humanity** – to be treated in a warm, caring respective way irrespective of the circumstances

**Commissioning for people’s needs** – not assume one-model fit and be aware of rural/urban variations and that encouragement of flexibility and creativity in providing personalised and community-specific solutions should form part of the commissioners objectives.

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¹¹ Established under the Crime & Disorder Act 1998 (sections 5-7)
¹² *The Five Year Forward View for Mental Health – A report of the independent Mental Health Taskforce to NHS in England February 2016*
¹³ MIND 2011 Listening to experience (an independent enquiry into acute and crisis mental health care)
Choice & Control – biggest issue was for those in crisis and those who could anticipate the need for more intensive support to help prevent a crisis. They needed more direct access options, with the ability to self-refer and explicit acknowledgement that individuals knew what they need. People were told they did not meet (or over-met) criteria to access services. People wanted their own definition of being in crisis respected and more ability to exercise choice and control.

Reducing the medical emphasis within acute care – people described their needs as care, safety, someone to listen to, something to do. Some people emphasised trained professional support many would prefer more peer support from those who have experienced mental health problems and those with good listening

Commissioners were specifically requested to:

- Review how far acute services are meeting local people’s requirements, and consult with black and minority ethnic communities.
- Set clear standards for values-based services in the procurement or planning process and hold providers to account using measures that include service user/carer satisfaction.
- Expand the range of options to meet different needs; for example, crisis houses, host families and services provided by people with experience of mental health problems, and self-referral options.

The MIND report reflects some of the issues identified in the Urgent Care work stream planning days around how services may be developed and commissioned to meet local need.

Criminal use of Police cells 14 - The police have powers under section 136 of the Mental Health Act 1983 to take individuals who are suffering from mental health issues in a public place to a ‘place of safety’ for their protection, and so they can be medically assessed. Identifying appropriate capacity and ensuring that there are enough AMHP (Approved mental health professionals)

No Health without Mental Health 15 - published in 2011, but still very relevant as an outcomes strategy document. It identified good mental health as everybody’s business and a more holistic approach to good mental health and resilience being fundamental to our physical health, relationships, education, training and working towards our potential. In doing so challenging inequalities and intervening early to help build resilience and improve quality of care.

14 A Criminal Use of Police Cells? The use of police custody as a place of safety for people with mental health needs
15 No Health without Mental Health, HM Government, 2011 A cross Government Mental health outcomes strategy for people of all ages
Six shared objectives were identified:

1. More people will have good mental health
2. People with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and experience

The Public Health outcomes framework\textsuperscript{16} are relevant to mental health and the Adult Social Care outcomes framework\textsuperscript{17} also have relevance to the achievement of outcomes in mental health and in doing so emphasises multi-agency working that has to take place to achieve any gain for people with a mental health problem who need the care and support of all organisations to support their recovery and help intervene early.


14.3. APPENDIX 3
POPULATION AND PUBLIC HEALTH INFORMATION

Population

Newcastle Gateshead Clinical Commissioning Group covers the cities of Newcastle upon Tyne and Gateshead, with a combined population of nearly 500,000 residents, alongside those that work and visit the city. Newcastle has a population of 284,000 and Gateshead 200,000 (ONS Mid 2012 estimates). The two population pyramids below show the age and gender structure of these populations, with clear differences visible.

Source: Office for National Statistics
Across the two populations the population split by sex is 50:50 in Newcastle and 49:51 male: female in Gateshead, in line with the England average. The age structure of the population differs, and as highlighted in the Newcastle population pyramid, there is a greater proportion of under-25 years in Newcastle (37%) compared to Gateshead (28.6). This is largely influenced by the much greater numbers in the 20-24 year group in Newcastle (12.9%) compared to Gateshead (6%). Gateshead however has an older population, with 17.6% over 65 years, compared to Newcastle at 13.8%. The working age population (age 16-64 years) accounts for 69% of the Newcastle population and 65% of the Gateshead population. There are a greater proportion of BME within Newcastle, compared to Gateshead, with 85.5% of the population identifying as White and 9.7% as Asian / Asian British. Within Gateshead 96.3% identify as White, followed by 1.9% as Asian / Asian British. This doesn’t include however, the Orthodox Jewish community; over 3000 people state their religion as Jewish in Gateshead, and 6% of the Newcastle population are Muslim.

The population is projected to increase by 1.5% in Newcastle and 3% in Gateshead by the year 2023. Despite these overall changes to the population, there are particular groups that are affected. For example the population of males is projected to increase in both localities, by 2.8% and 4% respectively. In looking at particular age groups, there is an aging population, with projected increases in the over-65 population of 15.1% and 12.9% respectively. The 0-19 year’s groups are set to increase again in both localities by 2.5% and 1.1%, whereas the working age population (15-64 years) is projected to decrease by 2.9% and 0.6%.

Prevalence of Mental Health Conditions

Mental health problems are amongst the most common health conditions, and are one of the main causes of disability worldwide. Around a quarter of the population will be affected in any one year. Depression and anxiety are the most widespread conditions, accounting for 9% of diagnoses in the UK, while only a small percentage of people experience more severe mental illness. Nationally 1 in 4 people are likely to have a mental health problem in any given year, and 1 in 6 people are likely to have a mental health problem at any given time. Within Newcastle, around 20% of the population are estimated to experience a common mental health problem (including anxiety, depression, phobias etc.). This would equate to around 70,000 people living in Newcastle and 48,678 living in Gateshead.

In 2013/14, there were 14,046 patients recorded on the depression register across the two clinical commissioning groups covering Newcastle, which gives a prevalence rate of 5.7% (North and East CCG) and 6.0% (West CCG). This is below the North of England average of 7.2%, and the England average of 6.5%, however all have seen increases in prevalence compared to 2012/13. For Gateshead, in 2012/13 there were 11,391 patients on the register, equating to a prevalence of 6.84%.

In the same period, there were 2,858 patients recorded on the Severe Mental Illness register with schizophrenia, bipolar disorder or other psychoses, which gives an overall prevalence rate of 0.96% within in Newcastle. In Gateshead, there were a total of 1,956
patients on the SMI register, giving an overall prevalence rate of 0.95%. Both are above the North of England (0.89%) and England (0.86%) average.

Rates of emergency admissions for self-harm are above the national average in both Newcastle (221.3 per 100,000) and Gateshead (266.6 per 100,000), compared to the national average of 188.0 per 100,000. Young person (aged 10-24) admissions for self-harm are 334.9 per 100,000 in Newcastle and 517.6 per 100,000 in Gateshead.

The most recent local data available shows that between 2011 and 2013 there were 81 suicides in Newcastle and 40 suicides in Gateshead for those aged 15+ years (3 yearly Suicide Audit 2015). This is a suicide rate in Newcastle is 10.2 per 100,000 and 6.5 per 100,000 in Gateshead. Both are considered similar to the England average according to Public Health England.

Whilst mental illness does not discriminate in those it affects, there are some key factors which can play a role in the potential to experience mental ill health. As identified in the literature, it is known that women are much more likely to be treated for a mental
health problem than men. For example depression is more common in women than men; 1 in 4 women will require treatment compared to 1 in 10 men and women are twice as likely to experience anxiety compared to men. Men are more likely than women to have an alcohol dependency (80%) or drug problem (69%) and are also five times more likely to be diagnosed with an anti-social personality disorder. Rates of mental health problems are thought to be higher in minority ethnic groups compared to the White population in the UK, however they are much less likely to have their mental health problems identified or diagnosed by a GP. Older people are less likely to have a common mental health problem, other than depression, than the rest of the population. An estimated 70% of new cases of depression in older people are related to poor physical health. About 75% of those who die due to suicide are men, and this has been the case for over a decade. Suicide is the most common cause of death in men under the age of 35. Social deprivation and its links with lower educational attainment, single person families, unstable housing and employment all have associations with higher levels of presentation and treatment in primary and secondary care in socially deprived areas and inner city.

**Deprivation** is higher than average in both Newcastle and Gateshead, and a quarter to a third of children respectively live in poverty. Life expectancy for both men and women is below the England average.

**Wider determinants**

**Dual diagnosis** substance misuse: Mental health problems are common among those needing treatment for drug and alcohol misuse, and substance misuse is common amongst those with a mental health problem. A direct indicator of dual diagnosis is currently unavailable; however a measure of indicative dual diagnosis to assess levels of co-existing mental health problems is available. This measure however is likely to be an underestimation, as it only captures whether a person is receiving mental health treatment at a given point in time during an assessment. Nonetheless the measure shows the proportion of people with concurrent contact with mental health services and substance misuse services for drug misuse: 23.6% Newcastle, 22.2% Gateshead, compared to 17.5% England average; concurrent contact with mental health services and substance misuse services for alcohol misuse: 28.7% Newcastle, 32.2% Gateshead, 21.2% England average.

**Accommodation** can play a key role in supporting and aiding recovery for those with mental illness. A range of accommodation types are available and an individual’s requirements may change over time depending on the levels of support they may require. This could include hospital stays, supported accommodation through to independent living. Of those who are in contact with secondary mental health services on a Care Programme Approach 42.4% in Newcastle and 51% in Gateshead were recorded as being in settled accommodation compared to 58.5% nationally.

**Employment** – 1 in 4 unemployed people have a common mental health problem. People with a common mental health problem aged 16 – 74 are more likely to be economically inactive (39% compared to 28%) and less likely to be employed (58% compared to 69%) compared to the general population. Less than a quarter of people with long term mental health problems are employed - the
lowest rate for any group of disabled people. Unemployment is more prevalent amongst people receiving secondary mental health care; only 1 in 10 has a job. People with mental health problems are at more than twice the risk of losing their jobs compared to the general population. Stress, anxiety and depression account for a third of sick days in the UK, translating to a cost of £4.1 billion. Locally the employment rate within the North East has typically been lower than that nationally, with higher rates of unemployment. Unemployment rates are beginning to decline but are still higher than the national average. Both Newcastle (9.2%) and Gateshead (8.1%) have a higher unemployment rate than England (6.2%) during 2014. Rates of for those who are economically inactive as a result of long-term sickness are also higher, at 25.2% and 33.5% respectively compared to England (20.7%). Looking at employment rates of those with Mental illness, and taking into account the rates of employment in the general population, there is a considerable gap between the two. For example in quarter 4 2014, 27.5% of the population with mental illness were in employment compared to 65.7% of the overall population in Newcastle (note – complete Gateshead employment data unavailable). When looking at those with more severe mental illness, rates of employment are lower still. Of those on a Care Programme Approach, 7.0% in Newcastle and 7.4% in Gateshead were employed compared to 8.8% nationally.

Source: Health and Social Care Information Centre
Morbidity

The National Psychiatric Morbidity Survey in England found that 16 per cent of people with schizophrenia were drinking over the recommended limits of 21 units of alcohol for men and 14 units or alcohol for women a week.

Smoking – there is an overall adult smoking prevalence of 23.7% in Newcastle and 22.8% in Gateshead. However it is known that smoking prevalence amongst patients with a mental health condition is almost three times higher than the general population. A Public Health England survey estimates that 64% of mental health patients are addicted to tobacco. Tackling the rates of smoking amongst those with mental health issues can reduce health inequalities, reduce the gap in life expectancy and improve physical health\(^{18}\). Locally, GP practice records shows smoking prevalence ranges between 12 – 65% of patients with a mental health flag across Newcastle and Gateshead.

Physical health problems and long-term conditions can go hand in hand with mental ill health. It is difficult to estimate robustly the proportion of people who go on to experience episodes of depression or anxiety, as many may go undiagnosed, however the Census looks at those who report the impact of ill health on their day to lives. Within Newcastle, 18.8% and 22.2% in Gateshead feel their day-to-day activities are limited by their health or disability.

Mortality

Research has shown that life expectancy for people with serious mental illness can be 10 – 15 years lower than the national average. Compared to national figures, conditions including schizophrenia, serious depression, bipolar disorder and substance misuse were all associated with a substantially lower life expectancy; 8.0 – 14.6 years lost for men and 9.8 – 17.5 years lost for women. Researchers believe a combination of factors including higher risk lifestyles, long-term drug use and social disadvantage can be linked\(^{19}\).


Nationally the excess mortality rate for mental health services users with serious mental illness was 3.4 times higher than the general population in 2012/13. Within Newcastle this was 3.0 times higher and Gateshead 3.4 times higher. (See below chart).

| Excess under 75 mortality rate in adults with serious mental illness - Newcastle |
|---------------------------------|------------------|
| General Population               | Severe Mental Illness |
| 2009/10                          | 1546.3            | 432.0 |
| 2010/11                          | 1557.3            | 408.8 |
| 2011/12                          | 1589.4            | 401.1 |
| 2012/13                          | 1122.1            | 365.2 |

| Excess under 75 mortality rate in adults with serious mental illness - Gateshead |
|---------------------------------|------------------|
| General Population               | Severe Mental Illness |
| 2009/10                          | 1194.4            | 493.0 |
| 2010/11                          | 1562.8            | 497.2 |
| 2011/12                          | 1662.5            | 514.9 |
| 2012/13                          | 1670.2            | 495.3 |

Source: Health and Social Care Information Centre

At a national level, the data shows the excess mortality rates the mortality rate for female mental health service users with serious mental illness is 3.4 times higher than the general population, and 3.5 times higher for male service users compared to the general population. Differences are also highlighted when looking at the age profile of the general population compared to service users with serious mental illness as shown in the chart below.
Disease level mortality data show a similar picture, with patients with severe mental illness more likely to die from specific conditions compared to the general population. The table below shows mortality rates for both the general population and those with severe mental illness for particular conditions.

<table>
<thead>
<tr>
<th>Condition Type</th>
<th>General population (DSR per 100,000)</th>
<th>Severe Mental Illness population (DSR per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>163.6</td>
<td>282.4</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>88.1</td>
<td>279.1</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>20.9</td>
<td>95.4</td>
</tr>
<tr>
<td>Respiratory Disease</td>
<td>37.2</td>
<td>172.2</td>
</tr>
</tbody>
</table>

Source: Health and Social Care Information Centre
14.4.  APPENDIX 4 - COMMUNITY SERVICES LOCATION MAPS
14.5. APPENDIX 5
SERVICES COMMISSIONED BY THE CCG FROM THE MENTAL HEALTH VOLUNTARY AND COMMUNITY SECTOR

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy Centre (Newcastle CVS)</td>
<td>Advocacy North is a specialist provider of advocacy services:</td>
</tr>
<tr>
<td></td>
<td>BME Case Advocacy; Mental Health Case Advocacy; Citizen Advocacy</td>
</tr>
<tr>
<td>Newcastle Carers' Trust</td>
<td>Mental Health Carer Service - Take a break</td>
</tr>
<tr>
<td>Newcastle Carers' Trust</td>
<td>Mental Health Carer Service - Involvement care support worker</td>
</tr>
<tr>
<td>Cruse Bereavement Counselling</td>
<td>Tyneside Cruse provides essential local bereavement support. It also promotes the well-being of bereaved people to enable anyone suffering from bereavement to understand their grief, cope with their loss and adjust to a new way of living.</td>
</tr>
<tr>
<td>Mental Health Concern</td>
<td>Dementia Care Service</td>
</tr>
<tr>
<td>Mental Health Concern</td>
<td>Rehabilitation and Recovery Services. Supportive Rehabilitation Nursing Service and Rehabilitation and Recovery Service</td>
</tr>
<tr>
<td>Mental Health Concern</td>
<td>Jubilee Mews / McGovern Court; EIP supported housing; Launchpad Moving forward service; VOLSAG project lead</td>
</tr>
<tr>
<td>Mental Health Concern</td>
<td>Moving Forward Service</td>
</tr>
<tr>
<td>Mental Health Matters</td>
<td>Gateshead pathways advocacy service.</td>
</tr>
<tr>
<td>Mental Health Matters</td>
<td>Gateshead Mental Health User Forum.</td>
</tr>
<tr>
<td>Momentum Skills North East</td>
<td>Vocational Rehabilitation for patients with acquired brain injury</td>
</tr>
<tr>
<td><strong>Newcastle Talking Therapies</strong></td>
<td>Mental Health and Learning Disability Services</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>North East Counselling Service (NECS)</strong></td>
<td>Counselling service for family and carers of people with mental health problems &amp; veterans mental health counselling.</td>
</tr>
<tr>
<td><strong>Path Head Watermill</strong></td>
<td>Skills and employability development for referred patients.</td>
</tr>
<tr>
<td><strong>Rape Crisis Tyneside and Northumberland (RCTN)</strong></td>
<td>RCTN provides professional counselling, helpline support &amp; information to women 16+ who have experienced sexual violence &amp; have poor mental and/or physical health. Also raises awareness about rape &amp; sexual abuse via education, training and outreach.</td>
</tr>
<tr>
<td><strong>Tyneside and Northumberland Mind</strong></td>
<td>Tyneside Mind provides brief solution focused counselling interventions, on a locality basis within Gateshead. Interventions are usually assessment + 6 sessions, however some clients may require more depending on individual needs.</td>
</tr>
<tr>
<td><strong>Tyneside Women's Health (TWH)</strong></td>
<td>TWH enables women to reach personal potential by improving mental health and emotional wellbeing.</td>
</tr>
<tr>
<td><strong>Under The Bridge - Joseph Cowen</strong></td>
<td>General practice, needle exchange and outreach service specialising in homeless people. Also includes cleaning and clinical waste.</td>
</tr>
</tbody>
</table>

14.6. Appendix 6 map of relevant services
Deciding Together - communications and engagement advisory group

Terms of Reference

Purpose of the group

The Deciding Together communications and engagement advisory group will be responsible for developing and coordinating communications and engagement activity around all stages of the Deciding Together public engagement consultation process.

The objective is to ensure a co-productive consultation process and provide a forum which allows two way communications and discussions between commissioners, NTW FT and key third sector and scrutiny partners.

In particular to ensure the process is carried out in a positive and non-stigmatising way which reflects the social model of disability. It should also ensure that views expressed outside of the Deciding Together process are captured and fed into appropriate organisations for quality and general service improvement purpose.

Governance arrangements and key relationships

The Deciding Together group provides advice, guidance and intelligence on the engagement activity and insights gained to the Mental Health Programme Board.
The advisory group will ensure the Mental Health Programme Board's principles are at the heart of the Deciding Together activity. These are outlined below:

- Be bold, brave and creative
- Right person, right time, right place
- Improve quality and experience, safety and effectiveness
- Carer and user focused outcomes
- Engagement and involvement
- Equality and diversity
- Hope, meaningful choice and control, and recovery orientated
Key related documents

- CCG’s communications and public engagement strategy
- Section 242 NHS Act 2006 – the legal duty to involve current and potential service users or their representatives in everything to do with planning, provision and delivery of NHS services.
- Equality Act 2010 – that all protected groups are considered and that the Equality Delivery System is used appropriately in the context of communications and engagement.
- Domain 2 of the CCG authorisation process – “meaningful engagement with patients, carers and communities”. This means showing how the CCG ensures inclusion of patients, carers, public, communities of interest and geography, health and wellbeing boards and local authorities and how the views of individual patients and practice populations are translated into commissioning intelligence and shared decision-making.
- The CCG’s Constitution
- The NHS constitution
- The CCG’s commissioning intentions

Membership

- HealthWatch Newcastle
- HealthWatch Gateshead – NB HealthWatch retain their scrutiny role
- Service user, carer, MHVCS representatives from Gateshead and Newcastle
- CCG mental health commissioning lead
- CCG Patient, public and carer involvement officer
- NECS mental health provider manager
- NECS senior communications and engagement manager
- NECS senior communications officer
- NTW deputy director of partnerships
- Other key partners will be invited to join the group as indicated by the group’s work.

Frequency of meetings
Every month – the first Thursday of every month
Secretariat
NECS communications and engagement service will provide admin, minute taking and meeting arrangements.

Review date for terms of reference
6 months
14.8. APPENDIX 8 – Analysis of Findings

NHS Newcastle and Gateshead CCG

Introduction

Deciding Together Listening Exercise: Analysis of Findings

Executive Summary

March 2015

This short report provides a summary of the findings of the listening exercise.

Kenyon Fraser is an independent marketing, communications and PR agency based in Liverpool. Following a competitive bid process the team was commissioned by NHS North of England Commissioning Support Team to undertake an objective and independent review of the feedback from the public “Deciding Together: Developing a new vision for mental health services for Gateshead and Newcastle” pre-consultation listening exercise conducted between November 2014 to February 2015. The exercise was focussed on discussions around specialist mental health services. The definition given throughout the exercise was: The sort of services you might get from a community psychiatric nurse (CPN) treating you at home, through to the more serious, but thankfully, much rarer cases when people might need to spend time in hospital.

It’s really important to remember that we are not talking about the sort of mental health problems for which you get care from your GP or primary care counsellor or therapist. These are more common mental health issues, such as anxiety or depression, and they are well treated by your GP with talking therapies and sometimes medication.

The specialist services that we are talking about in this document are the much more complex mental health issues like severe depression, schizophrenia, psychosis and personality disorders.

This exercise sought the views and shared experiences of specialist mental health services from people who:

Receive or have received care;

Care for someone who uses or has used the services; or
Have a special interest in this area of service delivery. The overall objective of this exercise is to collate the feedback gathered into a cohesive set of emerging themes and observations, which will then be used to help inform the development of a set of scenarios for the future of specialist mental health services.

These scenarios - alongside other data - will then be tested in a rigorous formal consultation, which will build on the lessons learnt in the pre-consultation listening exercise.

The Kenyon Fraser team was provided with the materials for review from the following sources:
The “Deciding Together” survey; Focus group discussions convened and moderated by Community, Faith and Voluntary (Third) Sector partners; Market stalls, held in convenient public locations, providing the opportunity for drop in comment; Participant feedback from all events.
The Mental Health Pound exercise and the in-depth consultations by Northumbria University are stand-alone reports, produced by independent organisations and as such are outside the scope of consideration of this report.
The listening exercise sought views around a structured set of questions or key lines of enquiry, which were:
Access to services and getting care urgently
Specialist community health services (services outside of hospital) Adult inpatient units in Gateshead and Newcastle
Ensuring a place of safety – section 136 suites Services for people with especially complex mental health needs
Services for older people including memory services (Newcastle only) Transport and travel.

There was also a specific interest in the issues surrounding:
The transition from children’s to adult services.

Overseeing the Listening Exercise (Governance and Accountability)
The listening and wider ‘deciding together’ exercise is directed by an advisory group, which is a partnership made up of:
HealthWatch Newcastle
HealthWatch Gateshead
Service user, carer, MHVCS representatives from Gateshead and Newcastle
CCG mental health commissioning lead
CCG patient, public and carer involvement officer
NECS mental health provider manager
NECS senior communications and engagement manager
NECS senior communications officer
NTW deputy director of partnerships
Other key partners invited to join the group as indicated by the
group’s work. This is known as the “Deciding Together Communications and Engagement Advisory Group” providing advice,
guidance and intelligence on the engagement activity and insights gained to the Mental Health Programme Board.
The advisory group is responsible for developing and co-ordinating communications and engagement activity around all stages of
the deciding together public engagement consultation process. The overall objectives of the group are to:
Ensure a co-productive consultation process;
Provide a forum which allows two way communications and discussions between commissioners, NTW FT and key third sector and
scrutiny partners; and
Ensure in particular the process is carried out in a positive and non-stigmatising way, which reflects the social model of disability.

It should also ensure that views expressed outside of the deciding together process are captured and fed into appropriate
organisations for quality and general service improvement purpose.

Responses to the Listening Exercise
The listening exercise gathered opinion from 164 people through either attendance at a focus group/market stall event or
completing the survey.
A total of ten focus groups were conducted community and voluntary sector organisations.
In total, 61 participants attended the focus groups and market stalls. Seven organisations and individuals provided their response
by letter. For anonymity, the names of these organisations have not been provided.
A total of 103 respondents completed the survey, however not all respondents completed every question.
Summary of Findings

Accessing Services

The focus groups and market stall responses tell us that you feel:

The mechanisms in place to respond to people’s needs should be changed
The healthcare professionals we see to access support need to understand issues around mental health and to know the services that are available
We want support to discuss mental health issues and address the stigma
We need help to address cultural issues
We want personal contact with a primary healthcare professional who can help us access the services we need
We want to know who we can talk to and we want help to do this in our local community
We want to talk to the people that can help us in a way we are comfortable and familiar with
We want a crisis team that responds to us, simply and consistently. We need appropriate support at the time we know we are having a crisis.

The responses from the survey tell us that you think:

The most important aspects of contacting local specialist mental health services identified by participants was ‘being able to speak to someone quickly’ and ‘being able to make an appointment straight away’ (87% and 88% rating these as extremely or very important respectively)
A larger proportion of participants felt it was important that there was a single phone available 24/7 for individuals to contact the service, as opposed to a phone number only available during office hours (71% and 50% rating these as extremely or very important respectively). However, a quarter felt having multiple points of entry across different providers was extremely important (25%), and a further 31% as very important.

The need for the service to be more responsive to patient needs was repeatedly emphasised, as well as the importance of having clear and effective pathways for referrals and access, to ensure that both health professionals and individuals are able to access the service quickly and easily.

The majority of participants indicated that they would access mental health services occasionally/sometimes during evening or weekend opening hours (53%). However, a quarter indicated that they would frequently access services during these hours, and a further 11% stating that almost all of their service access would be during these hours.

Treatment in the Community
The focus groups and market stall responses tell us that you feel:
- It is important to be confident that you will get support through psychological therapies in time
- There is frustration with the lack of clarity around

More support is needed, as is confidence in the process from the people providing psychological therapies.

The third sector has an important role to play
The role of carers in the wellbeing of people receiving care needs to be recognised more widely
Carers provide better care with better information

Recognised good practice is often ignored or not known about.

The responses from the survey tell us that:

Among those who had received treatment from the CMHT (approximately 41 participants), there was a mixed agreement as to whether participants felt they had been involved in the planning of their care and treatment (50% agreed, 35% disagreed).
Over half of these participants indicated that they had not been offered a choice of psychological therapies (61%).

Similar levels of agreement and disagreement was found in terms of whether participants had only been offered one choice of psychological therapy (44% agree and 47% disagreed) and whether participants had, or had not, experienced a situation in which there were no psychological therapies available after being told that they would benefit from receiving one (40% agreed, 43% disagreed).

Half of participants indicated that they were satisfied with the quality of care they have received (49%), with a quarter rating their experience as very good or excellent (35%).

Dis-satisfaction among service users related to individuals being turned away by the crisis team although they genuinely needed/wanted support, staff shortages leading to a lack of consistency in care and frequent changes, a lack of cohesion between services, patients and carers and lack of specialist support available for specific conditions (e.g. treatment for eating and compulsive disorders).

Respondents gave mixed feedback with regard to their involvement in and understanding of their care plans (37% felt involved in their care plan and treatment whilst 41% stated that they understood their care plan) as well as the ease at which they are able to contact their care co-ordinator or somebody else if their care co-ordinator was not available (28% and 29% agreeing to these statements respectively). Half of respondents were satisfied with the amount of information they had been given about their care and treatment options (46%), however fewer respondents felt that this information enabled them to make better and more informed decisions about their care and treatment (33%). Participants suggested that more detailed up-to-date information about the service should be made available to patients, as well as information about community activities, projects and volunteering opportunities, and fact sheets with different drug and therapy options.

Half of respondents felt that the people in their care team have a good level of understanding with regard to their recovery (51%), whilst 44% felt that they received help to achieve their recovery goals.
In terms of how the service can improve the support offered to patients it was emphasised that services need to be more responsive to patients’ needs, GPs should be more aware of how the CMHT operates so that they can signpost accordingly, as well as developing peer support programmes to facilitate service users and ex-service users to share experiences. A variety of suggestions for improvements to specialist mental health services were made. These included more staff and reduced caseloads, offering interim support whilst individuals are waiting for their first appointment, better communication and administration, clarity in the role and responsibilities of CPNs and other health professionals, better connections with the community sector and more support for family and carers. A number of healthcare professionals provided suggestions which specifically related to the service reconfiguration: ensuring that staff are empowered in the process of service re-design to improve morale, ensuring better connections are made with the police and ambulance service via schemes such as ‘street triage’ and ensuring that there is an adequate provision of individualised, integrative formulation-based psychological therapies.

Transition from Children’s to Adults’ Services

The focus groups and market stall responses tell us that you:
- Find the current service confusing and struggle to see how young people make the transition to support under adult services.
- Feel all the people involved can work together more effectively to support the transition.
- Feel the service is based on barriers and inflexibility.
- Feel there needs to be more support available.
- Feel there is a need to support the places young people go to, to help them in the transition.

Overall, you feel there is a gap in the provision of mental health support to young people, aged 16-18, which needs addressing in the future. The responses from the survey tell us that you think:
- Only a small minority of participants had experience of moving from children’s to adults’ mental health services (six participants).
- The experiences encountered by these individuals were mixed; while three participants felt involved in decisions about their transition, only two indicated that they felt supported.
- Improvements to the transition were felt imperative with suggestions focusing upon better liaison between the children’s and young person’s service (CYPS) and adult services with regards to facilitating a smoother, more gradual transition and by addressing the ‘age-gap barrier’ for those aged between 16-18 years.
Inpatient Care
The focus groups and market stall responses tell us that you:
Think people need to feel part of their community to support recovery
Feel travelling is a major issue for families and carers

Think that moving services outside of the immediate area is a backwards step

Feel distance will impact on service
Feel it should be service quality before building
Want to know that the people are safe
Want to know that if inpatient service is the best course of action that it will be a pleasant place to stay
Want to see great facilities and services that respond flexibly to the needs of all
Overall, you prefer the home/community environment preferred over hospital care where possible.

The responses from the survey tell us that you think:
34% of participants indicated that they had experience of inpatient mental health care, approximately half of which were satisfied with the service received (53%) and rated their experience as very good or good (57%)
The majority received their inpatient treatment at The Hadrian Clinic, Newcastle or at The Tranwell Unit, Queen Elizabeth Hospital (48% and 36% respectively), with 64% rating the physical environment and surroundings as fair or poor. (77% of these experiences occurred two years ago or more)
Having bedroom facilities with privacy, having access to visiting areas for relatives and friends and having access to fresh air were perceived to be the most important environmental aspects of inpatient care (83%, 82% and 80% rating these as extremely or very important respectively)
The majority agreed on the importance of being able to keep in contact with family whilst in hospital, that they would like to spend the shortest possible time in hospital and that the physical environment is very important to them (93%, 86% and 86% strongly agreeing or agreeing to these statements respectively)
To help patients to stay out of hospital or to be discharged sooner, a number of suggestions were put forth including frequent community care follow-ups, medication reviews and prompts, ‘half-way’ houses/day centres, a support line for individuals to speak
to someone when they feel they need to and most importantly ensuring that an adequate level of support is in place immediately following discharge whether this be from family, support workers or carers
Suggested improvements to inpatient services included more peer-led groups and male/female orientated activities, reducing the workload of staff to enable them to spend more quality time with patients, whilst also having time to update relatives, improving patient safety and providing a variety of food options for service users
A number of participants repeatedly expressed strong objections to the proposals to relocate and reduce the number of inpatient beds in terms of the detrimental effect it will have on the individual as well as friends and family who will have to travel further to see their loved one.

Transport and Travel
The focus groups and market stall responses tell us that you feel:
We feel travel and transport is mostly a negative experience
We feel the NHS could help us with travel and transport to enhance the patient experience and recovery
The responses from the survey tell us that you think:
The main modes of transport used by patients and their families to travel to inpatient services was their own car (29%), public transport (25%) or a friend or relative’s car (20%)
The majority favoured only travelling short distances to receive care (75% stated that it was perfectly acceptable or acceptable to travel 0-7 miles and 40% 8-15 miles). However, ratings of acceptability for longer distances improved when offered transport by the NHS. While 34% had found it totally unacceptable to travel 16-24 miles and 55% to travel more than 25 miles by their own means, this figure decreased to 22% for 16-24 miles and 33% if provided with NHS transport
Those who had experience of travelling long distances to receive inpatient care or to visit a relative/friend indicated that it was stressful, costly and time-consuming and therefore made it difficult for family and friends to visit their loved ones, especially for those on a low income or those without a car. A small number of relatives stated that they have had to reduce the frequency with which they visit their loved one due to the cost of travelling
To help mitigate transportation issues, respondents suggested that some form of funding, re-imbursement, or free transport provision, such as a shuttle bus, should be put in place. It was also deemed essential to ensure that there were good transport links in place. Other suggestions included a mental-health ambulance to provide secure and discrete transport for patients or using taxis to transport low risk patients, reducing the demand on A&E ambulances.

Section 136 Place of Safety
The focus groups and market stall responses tell us that you feel:
The section 136 suite is vital but it could work better and most importantly people in crisis need to feel safe
The section 136 suite is only part of the process and the support that “wraps around” it is as important, if not more important, in making people in crisis feel safe.
The responses from the survey tell us that you think:
Only a small minority of participants had experience of using the Section 136 suite in Gateshead or Newcastle
Suggestions to improve the service, offered by a health professional, included securing funding for a specific vehicle to transport individuals when issued with a section 136, improving accessibility of the suites and expanding the ‘street triage’ process to enable the ambulance service to specifically request the specialised mental health vehicle
79% agreed that mental health services and the police should work more closely together. However, it was felt imperative to ensure that police officials have an awareness and appreciation of different mental health conditions to ensure that individuals are treated appropriately.

Specialist Mental Health Care Services
The focus groups and market stall responses tell us that you:

Feel the moving on and rehabilitation units should be in the communities where people live
Want to see support for family and carers
Think the valuable learning, experience and different approaches, as well as reach into marginalised communities, needs to be recognised more widely.

The responses from the survey tell us that you think:
17% of participants indicated that they had experience of psychiatric intensive care services, approximately half of which were satisfied with the care received and described their experience as very good or good. The majority of these experiences had occurred two years ago or more
The small number of suggestions to improve this service related to providing more opportunities to patients to be taken off the ward, more structured activities for service users and giving relatives/carers more opportunities to input upon the patient’s care, by encouraging them to take part in review meetings
A small number stated that they had experience of rehabilitation services for people with complex mental health needs (11 participants), seven of which were satisfied with the care received and half rating their experience as very good or good. The majority of these experiences had occurred two years ago or more. It was suggested that it would be more effective if rehabilitation services were offered in community settings, whilst also giving service users the opportunity to leave the ward together.

Services for Older People Including Memory Services (Newcastle Only)

The focus groups and market stall responses tell us that you feel:

There is a need for a simple system of support and older peoples’ services will benefit from:

- Having a single key person to help navigate through the care system who is able to provide frequent updates to the family;
- Supporting dietary needs particularly in cases of a diagnosis of Alzheimer’s; and
- Having more dementia experience amongst the staff in hospitals.

The survey tells us that:

A small number of respondents stated that they had experience of older people’s services in Newcastle, just over half of which were satisfied with their experience, describing their experience as very good or good. It would be beneficial for patients and their families if there were more leaflets to explain how the service operates, whilst relatives requested a preference to be kept more up-to-date about the patient’s prognosis and possible treatments.
### APPENDIX 9 INPATIENT SCENARIOS AND SHORTLISTING

First sifting – 20 August Joint Executives Meeting of CCG, Local Authorities, NTW and MHVCS

Second sifting – CCG Executive meeting – 15 September 2015

Third sifting – agreed by CCG and NTW to provide an average cost between the lower and higher sub options, for comparative purposes at this stage

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>DESCRIPTION</th>
<th>CAPITAL INVESTMENT LEVEL</th>
<th>SHORTLISTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Current State – “Do Nothing”</td>
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<td>Rejected – second sifting on grounds of not achieving principal objectives and being clearly unaffordable</td>
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<tr>
<td>2</td>
<td>Acute – SNH Rehabilitation Complex Care – SNH Older People – SNH</td>
<td>Higher</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lower</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
<tr>
<td>2a</td>
<td>Acute - SNH Rehabilitation Complex Care – SNH Older People – SGP</td>
<td>Higher</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lower</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
<tr>
<td>3</td>
<td>Acute – Gateshead Rehabilitation Complex Care - Gateshead Older People – SNH</td>
<td>Higher</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lower</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
<tr>
<td>3a</td>
<td>Acute - Gateshead Rehabilitation Complex Care – Gateshead Older People – SGP</td>
<td>Higher</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lower</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
<tr>
<td>No.</td>
<td>Code</td>
<td>Description</td>
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<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Acute – SGP and HWP Rehabilitation Complex Care – SGP Older People – SGP</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>4a</td>
<td>T2</td>
<td>Acute – SGP and HWP Rehabilitation complex care - SGP &amp; moving on - Gateshead Older People – SGP</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4b</td>
<td>T1</td>
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<tr>
<td>5a</td>
<td>N1</td>
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<tr>
<td>5b</td>
<td>N2</td>
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<td>G1</td>
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<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>6b</td>
<td>G2</td>
<td>Acute – Gateshead</td>
<td>Higher</td>
</tr>
<tr>
<td>Rehabilitation complex care – Gateshead &amp; moving on Gateshead Older People – SGP</td>
<td>Lower</td>
<td>SHORTLISTED – midpoint of higher / lower capital investment</td>
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### 14.10. APPENDIX - ABBREVIATIONS - LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADHD</td>
<td>Attention deficit hyperactivity disorder</td>
</tr>
<tr>
<td>AIMs</td>
<td>Accreditation for Inpatient Mental Health Services</td>
</tr>
<tr>
<td>AMHP</td>
<td>Approved mental health professional</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CCTV</td>
<td>Closed circuit television</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>EIP</td>
<td>Early intervention in psychosis</td>
</tr>
<tr>
<td>HWP</td>
<td>Hopewood Park (hospital) Sunderland</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological therapies</td>
</tr>
<tr>
<td>LAs</td>
<td>Local Authorities</td>
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<tr>
<td>MHVCS</td>
<td>Mental health voluntary and community sector</td>
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<tr>
<td>NECS</td>
<td>NHS North of England Commissioning Support Unit</td>
</tr>
<tr>
<td>NTW</td>
<td>Northumberland, Tyne and Wear NHS Foundation Trust</td>
</tr>
<tr>
<td>ONS</td>
<td>Office of National Statistics</td>
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<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>SGP</td>
<td>St. George’s Park (hospital) Morpeth</td>
</tr>
<tr>
<td>SMI Register</td>
<td>Serious Mental Illness register</td>
</tr>
<tr>
<td>SNH</td>
<td>St. Nicholas Hospital, Newcastle</td>
</tr>
<tr>
<td>VCS</td>
<td>Voluntary and community sector</td>
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<tr>
<td>VOLSAG</td>
<td>Voluntary Sector Advisory Group</td>
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