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

Case for Change
November 2015
Thanks you for taking the time to read this document.

My name is Dr Guy Pilkington, I am a GP in Newcastle and I am also the chair of NHS Newcastle and Gateshead Clinical Commissioning Group (CCG).

A few years ago we created a Mental Health Programme Board (MHPB) to help us ensure that we transform the way people in Gateshead and Newcastle are supported when they, or people close to them, are living with mental health issues.

I am very involved in the work of this board and would like to write about why we have been working on reforming our specialist mental health services and why we feel change is necessary.

Supporting people with mental health issues needs to change. For far too long mental health care has had to play second fiddle to health care for physical complaints. There is no health without mental health. We also know that our current services and ways of supporting people need to improve. Despite the best efforts of skilled and committed care professionals we know that we fail to prevent ill health as much as we should and we rely too much on medicine, when there can be better results from talking therapy, social connections and the human touch. As a result people are getting more ill too often and as a consequence we use admission to hospital more than we should.

We can do better than this. We believe we need to invest more in mental health services in community settings. We need to tap into the strengths of individuals and communities themselves, of voluntary organisations who can support people and help them live fulfilling, independent lives. When people's mental health gets worse we need to have options for them to access more intense help near where they live, whether that is in places they can visit through the day and get help to tackle their problems, or even in community based facilities where they can feel safe and receive support overnight. When people have become seriously unwell we need to help them recover in ways that are more effective than now, helping people to get back to where they want to be.

But to do this we need to spend less on looking after people in hospital. Our inpatient facilities across Newcastle and Gateshead are too numerous, some wards are not up to the standard we nowadays expect and they are too dispersed across the area for us to ensure the highest quality of specialist care possible. We cannot carry on with what we do now. People are missing out on the best care possible.
I recognise that some of you might see these statements as a cause for concern, but the purpose of this document is to set out in detail the changes we need to make and how they will be managed safely.

We will ensure that any changes we do make are done with the aim of improving the support available for people. We will continue to recognise the mental health needs of people. We will continue to have the range of options to care for people that we have now. But we will also make sure we create new, different and better ways of offering support.

In order to do this we need your help. We know that health professionals, social care staff and their organisations can only provide one side of the story. We need to hear from and listen to the thoughts of people who have a different point of view – people who have experience of living with mental health concerns, people who have cared for friends and relatives, people who work in the community in this field and members of the public who do not have experience of mental health problems, but are interested anyway.

So thank you for reading this, thank you for contributing.

With your help we can do better. We can build a better way to offer mental health care in Newcastle and Gateshead. Together, we can think differently about mental health.

Dr Guy Pilkington
GP chair of Newcastle Gateshead CCG
Chair of the Gateshead and Newcastle Mental Health Programme Board and a Newcastle GP
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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 also sets out different scenarios of where inpatient services could be located in future to ensure the provision of sustainable, good quality, safe services.

Section 1, 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 2 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 3, 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 4 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 6 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 forthcoming formal consultation will continue to be used as part of our decision making.

**Section 7, 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 8, Scenarios for Change,** describes different scenarios for future services. Firstly, we set out a potential framework of community services provided by statutory and voluntary organisations, including potential new, redesigned or extended services. The formal consultation will seek views on this. 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 Hopewood 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 9, Funding and Cost Estimates, provides information about the funding available (estimated at £46.6m) and indicative costs of the different scenarios. At this stage, a full financial evaluation is not necessary, or possible, given that detailed aspects of each of the scenarios for consultation have not been worked up, e.g. fully designed construction specifications. The costings do however allow a financial comparison to be made between the scenarios, including the potential to release funding for investment to further improve community services. This indicates that a combination of Scenario T with Scenarios 1 or 2 above (T1 and T2) would release an estimated amount of between £1.1 million to £1.4 million for such investment; Scenarios N1 and N2 would be borderline or neutral in being able to release additional funding; and Scenarios G1 and G2 would result in no additional funding being released for such investment and would require additional savings to be made.

Section 10 sets out the Next Steps to progress these proposals, particularly the arrangements for the forthcoming formal consultation from 12 November 2015 to 12 February 2016 and for a planned final decision by the CCG Governing Body in May 2016. The formal consultation methodologies and the additional information that will be obtained to help inform the final decision are explained. It is planned that the service changes will be implemented by March 2018, although all capital improvements may not be completed until around winter 2018. A detailed Implementation Plan will be agreed, following the selection of the preferred scenario, so that changes are managed a safe and effective way.
1 INTRODUCTION

1.1 Role of the Clinical Commissioning Group

From 1 April 2015 three local clinical commissioning groups\(^1\) 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 Board\(^2\) 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

1.2 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

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\(^1\) 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.

1.3 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 Section 6.
1. **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.

1.1 **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. **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.

The report identified three main workstreams 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.

### 2.2 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.

Financially, in line with national requirements we are expecting NTW to deliver services for the population of Newcastle and Gateshead within a reduction in funding of around 20% over five years (4% each year) if recent efficiency requirements continue. This represents a reduction of £9m in real terms. There will be some scope to offset this by ensuring parity of esteem in terms of share of CCG growth funding to mental health services in line with national guidelines.

2.3 **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 has seen the implementation of new models of care in Sunderland and South Tyneside and this is now being rolled out across other areas in Northumberland, Tyne and Wear. This Case for Change is therefore a key document in taking forward both the CCG’s and NTW’s plans to improve community mental health services in Newcastle and Gateshead, thereby reducing reliance on inpatient services.

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

2.4 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.

2.5 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.
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.

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.
2. **BEST PRACTICE**

This section considers best practice in providing mental health services, based on 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.

3.1 **Peer Review Clinical Advice** Paragraphs 3.1.1 to 3.1.3 below presents the advice from the independent consultant psychiatrist / clinical director.

3.1.1 **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 Cardiometabolic 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.

3.1.2 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 outwith 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.

3.1.3 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)
3.2 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.

The new community pathways in Sunderland and South Tyneside, which commenced in April 2014, are still being embedded and enhanced consultant 7 day working was also introduced. An associated reduction in 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. It is based on activity in a 5 month period from April 2014 when implementation of the new community service model of care commenced and August 2014, which was before the beds were reduced; and a comparison with a similar 5 month period between April to August 2015 i.e. when the new community services had become more embedded and the bed reductions had been made.

<table>
<thead>
<tr>
<th>Number of admissions by CCG</th>
<th>South Tyneside</th>
<th>Sunderland</th>
</tr>
</thead>
<tbody>
<tr>
<td>April - August 2014</td>
<td>105</td>
<td>200</td>
</tr>
<tr>
<td>April – August 2015</td>
<td>79 (25% reduction)</td>
<td>126 (37% reduction)</td>
</tr>
</tbody>
</table>

The table above shows a significant reduction in the need for admission after the introduction of these changes, which NTW attributes to the effectiveness of the improved initial response and crisis services, including street triage; new 7 day enhanced working by consultants; the embedding of the new community pathways; and new ways of working by staff.
<table>
<thead>
<tr>
<th>% of residents admitted to “local” hospital</th>
<th>South Tyneside</th>
<th>Sunderland</th>
</tr>
</thead>
<tbody>
<tr>
<td>April - August 2014</td>
<td>80% - Bede Wing, South Tyneside</td>
<td>83% - Cherry Knowle, Sunderland</td>
</tr>
<tr>
<td>April – August 2015</td>
<td>81% - new Hopewood Park, Sunderland</td>
<td>86% - new Hopewood Park, Sunderland</td>
</tr>
</tbody>
</table>

The table above indicates that although there was a 34% decrease in beds, people in Sunderland and South Tyneside were still able to be admitted locally, when compared to a similar period before the reduction in beds.

<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>April - August 2015</td>
<td>22.7 days</td>
<td>20.4 days</td>
</tr>
</tbody>
</table>

The table above shows that average lengths of stay for South Tyneside and Sunderland residents, admitted to Hopewood Park for acute assessment and treatment, are in line with the best practice recommendation in paragraph 3.1.3 above of around 21 days.

<table>
<thead>
<tr>
<th>Emergency re-admission rates within 28 days</th>
<th>Sunderland / South Tyneside</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 2014/15</td>
<td>14%</td>
</tr>
<tr>
<td>Quarter 1 2015/16</td>
<td>8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency re-admission rates within 90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 2014/15</td>
</tr>
<tr>
<td>Quarter 2 2015/16</td>
</tr>
</tbody>
</table>

Also as stated in paragraph 3.1.3 above, 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 above shows that there was a reduction in emergency re-admissions, in both the 28 days and 90 days categories, in Sunderland and
South Tyneside when comparing the same quarters before the community service changes started being made and following the community changes and bed reduction. This will however need to continue to be assessed over a longer period.

Taking into account all the data shown above, this indicates that the new model of care introduced in Sunderland and South Tyneside has:

- Reduced the need for hospital admission;
- Therefore reduced the number of beds that are required, supported by having average lengths of stay in line with best practice;
- Has not resulted in any increase in local people having to be admitted to a hospital outside of Sunderland and South Tyneside; and
- Emergency re-admission rates have, so far shown a reduction, which is a good quality indicator.

We will continue to work with NTW to review the implementation of its Transforming Service 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.

3.3 Some 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. 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.

www.rcpsych.ac.uk/pdf/OP79_forweb.pdf
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
4  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.

4.1  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.

4.2  Community Services provided by NTW and MHVCS organisations

4.2.1  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. Some teams work across more than one local area (for example some Gateshead teams are linked to Sunderland services) which can lead, in some cases, to more complex service user pathways. 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 were 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 later in Section 5. The CCG’s Mental Health Programme Board has agreed to the roll out of these developments in Newcastle and Gateshead.

4.2.2 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 scores (and sometimes hundreds) of 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 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;
- and includes services to particular groups such as young people, women, men, black and other ethnic minorities, older people, service users and carers

The CCG funds a Voluntary Sector Mental Health Network, 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 it is increasingly the case that members provide services across the Tyne and sometimes further afield). In August 2015 the CCG asked VOLSAG to look at extending its role more formally into Gateshead. This is in keeping with the recent establishment of one CCG for Newcastle and Gateshead and it also complements the recent decision to form one Voluntary Sector Consortium across the two areas.

**Appendix 5** provides a list of services commissioned by the CCG from the mental health voluntary and community sector.
4.3 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 to the inpatient services covered in this document in 2014/15 is shown in the table below. 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.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Newcastle</th>
<th>Gateshead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Assessment and Treatment</td>
<td>339</td>
<td>242</td>
</tr>
<tr>
<td>Rehabilitation*</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Older People’s services*</td>
<td>71</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.
**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. The main patient environment issue is the lack of en-suite facilities in bedrooms.
- **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)** These 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. (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). The service is fully compliant with CQC standards (inspection July 2013) and both wards have AIMS accreditation with excellence.

There is however some accommodation issues 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 of current inpatient accommodation for these mental health services in Newcastle and Gateshead. When NTW was formed almost 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.
5 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 in the Current Services section (paragraph 4.2.1), 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 focused 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 the CCG’s Mental Health Programme Board, has now started planning 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.

5.1. 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.
5.2 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 NTW premises. In Newcastle and Gateshead a hub and spoke model will be operated with the hub providing the main team base and services for patients; and the spokes also providing services for patients and some staff facilities. Plans are currently being developed with a view to improving the Trust’s existing bases in Newcastle at Silverdale and at the Molineux Street Resource Centre. In Gateshead, the feasibility of using the existing Dryden Road Clinic as a hub with a spoke in west Gateshead is being assessed.
6 Public Engagement and Service User and Carer Involvement

This section describes the methodology that has been used to develop a listening and engagement process; 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.

6.1 Methodology - Developing a robust listening and engagement process

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

The NHS Constitution also gives the following rights and pledges 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 commits to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution
- The NHS commits to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered; and
- You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences

Additionally, CCGs have further duties, which were set out in the revised NHS Operating Framework for 2010-11, and require existing and future reconfiguration proposals to demonstrate:

- Support from GP commissioners
- Strengthened public and patient engagement
• Clarity on the clinical evidence base; and
• Consistency with current and prospective patient choice.

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.

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.

6.2 Implementing the process and key findings

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.

The methods used to engage with the target audience, included:
- Survey (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).

<table>
<thead>
<tr>
<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 one in Newcastle&lt;br&gt;• Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)</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 than 2</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 on community services&lt;br&gt;• ‘Good indoor and outdoor balance’&lt;br&gt;• Like Newcastle and Gateshead being merged into one hospital</td>
</tr>
<tr>
<td><strong>Bundle 4: Cost 39p or 44p with extra rehab unit</strong>&lt;br&gt;• No Gateshead/ Newcastle based adult wards – inpatient services provided at St George’s Park and Hopewood Park&lt;br&gt;• Option to add one dedicated local rehab unit&lt;br&gt;• Existing access to Trust wide specialist services (psychiatric intensive care and high dependency units)</td>
<td>Strong feeling that the locations were unacceptable as not local&lt;br&gt;In particular concerns over:&lt;br&gt;• Access by friends and family for visiting&lt;br&gt;• Impact on travel&lt;br&gt;• Integration with the community</td>
<td>• Some inpatients would like to be out of their locality&lt;br&gt;• Good offer if transport was considered&lt;br&gt;• Good offer if savings can be reinvested in community services</td>
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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 the listening exercise has been used to inform the thinking behind the development of this Case for Change. The methodologies used for engagement, overseen by the Deciding Together Advisory Group, have also informed how the consultation process will be conducted. This is described more fully in Section 10 - Next Steps
7 Summary of the 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.

7.1 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.

- Best practice guidance and peer review identifies key elements that should be in place in an effective system to provide good community support, reduce the need for hospital admission, reduce unnecessary long stays and promote 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.

7.2 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. Views on these services will be sought as part of the formal public consultation.
• 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

• 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.

• We have been listening to your views about current services and improvements that you 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.

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.
8. SCENARIOS FOR CHANGE

Following on from making the case for change, this section describes (a) how the community service changes described in Section 5 could be further improved through the potential development of other new, re-designed or extended community services as part of a community support framework and (b) the development and shortlisting of scenarios for the future provision of inpatient services.

8.1 Development of other potential new, re-designed or extended community services

8.1.1 In Section 5, we described the improvements that have already been agreed with NTW to improve their community care pathways and ways of working. These improvements will increase the capacity of NTW’s service and help to reduce the reliance of inpatient services. In addition to this, the CCG, the Mental Health Voluntary and Community Sector and NTW have been working closely together to ensure that the community model going forward has a balanced approach, including alternative provision to statutory services, and innovative practice. As explained in Section 6 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 and 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
- 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
8.1.2 The resulting community support framework is shown on the following page and describes:

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

Several potential service developments to improve the framework of services are being explored. Some of these additional (or in some cases redesigned or extended) services present ideal opportunities for MHVCS and/or peer and service user led models of service delivery. The possible new, re-designed or extended services are described more fully below.

**Multi-agency initial response system**
Developing a multi-agency initial response system is one of the key workstreams of the CCG's Mental Health Programme Board. 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 defines their need as urgent then they need an urgent response, although this response may not need a high level service: The system 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.
- Demonstrate “Parity of Esteem”
Improving our Community Mental Health Support Framework

**Access Points**

Access to mental health services, advice and support will be clear and consistent. A multi-agency initial response system will provide a listening ear and rapid help to those in crisis. Potential access points include:

- GPs
- Police
- Local Authority Social Services
- Accident & Emergency Departments
- Housing
- Voluntary Sector and Community Organisations
- Urgent Care and Crisis Services, including Street Triage
- Psychological Therapies
- NHS Choices & 111

**Managing the Change**

We will continue to re-design community support at the same time as re-modelling inpatient services.

The precise nature and range of new, re-designed or extended community support for mental health and wellbeing will be shaped by the **Deciding Together** consultation process.

Funding will be used as innovatively as possible to meet the financial challenges in health and social care and still provide excellent and improved services.

**New, Re-Designed or Extended Services**

- A multi-agency initial response system
- Revised community mental health teams and specialist teams
- Community based residential rehabilitation
- Commissioned alternatives to hospital admission eg: crisis beds, crisis house, step up and step down facilities
- Improved and increased housing with support

Each part of our framework will be based on important principles. You told us you wanted to see how we will do this in a Service Charter. This includes:

- Using local intelligence
- Early intervention
- Good physical health
- Stigma-free
- Citizenship, social networks and communities
- Safeguarding and risk
- Sensitive coordination of care and brokerage
- Peer support

Increased focus on social inclusion, arts and creativity, personalisation and direct payments

- Community Wellbeing Hub
- Recovery College
- Increased access to vocational pathways (volunteering, education and employment)

Access at all stages, quick in quick response, quick out

- Properly person and family centred
- Culturally sensitive
Redesigned community mental health teams and specialist teams
These have been fully described in Section 5 above

Community based residential rehabilitation, step up/step down facilities and supported housing
There is already a range of housing 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. Extending / developing the range of accommodation that is available to include step up and step down facilities (short term, non-crisis, 24 hour staffed units) would reduce the need for and / or shorten the length of hospital admission. The overall range of options that is available and the level of support that is offered would need careful review 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). Developing this service could include less clinical and / or non-clinical approaches to community based rehabilitation and longer term accommodation based support.

Urgent response / care - crisis beds
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. Service user satisfaction with such services has been found to be high (e.g. research undertaken by Rethink). There could be options to provide this as a shared resource across Newcastle/Gateshead, or have one in each locality.

Urgent response/care - crisis support without beds
This would provide a short term safe place / sanctuary in a crisis. It would not be an overnight service, but could for example provide a 9.00am to 9.00pm or a 2.00pm to 2.00am service. 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. It could be peer-led (noting that the higher the level and presence of clinical staff the higher the cost would be). There could be options to provide this as a shared resource across Newcastle/Gateshead or have one in each locality.
**Community Based Recovery College**

The existing Ivy Centre for Recovery College is run by NTW and is based at St. Nicholas Hospital. It utilises NTW’s own peer support workers to deliver non-clinical mental health courses, self-management sessions and personal and skills development. It adheres to a social model and aspires to be user-driven. This recent development coincided with the development of a Mental Health Collective among those voluntary and community sector organisations working in mental health and related fields, which themselves employ peer support workers and have a long history of innovative community based work. Together, the Ivy Centre and the Collective are looking to develop a community base e.g. at Broadacre House in Newcastle, where there are already many potential cross-over activities, while maintaining an in-reach service into the service at St. Nicholas Hospital. This would be a shared, collaborative enterprise that brings together the statutory and MHVCS organisations to pool expertise, resources and good practice. It would provide a key interface between NTW specialist mental health services, MHVCS and wider community resources. The existing base at St. Nicholas Hospital attracts some use by Gateshead residents (20%) - this will increase with the move to Broadacre House in Newcastle City Centre but an outreach service into Gateshead or an annexe in Gateshead is actively being pursued.

**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. It would provide a peer co-ordinated educational and personal development programme and the Recovery College above could form a natural focus for this development.

As explained in the “Our Innovative Community Support” diagram, views will be sought through the forthcoming Deciding Together formal consultation process on the provision of these types of services.

**8.2 Inpatient Services**

**8.2.1 Acute Assessment and Treatment Bed Numbers** We have shown 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, its 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. Since then, the most recent national benchmarking data, for 2013/14, shows that NTW has a significantly higher level of acute beds compared with most other Trusts, with 27 beds per 100,000 population compared to a median of 21 - the 5th highest out of 57 mental health trusts benchmarked.

We referred earlier in the Best Practice section, paragraph 3.4, to the implementation of a new model of community and inpatient mental health care that is being implemented in Sunderland and South Tyneside, which included a reduction in acute admission beds from 82 to 54, equivalent to a 34% reduction. Indicators suggest that, to date, the reduced number of beds within the new model of care is sufficient to meet local demand, there being no increase in the number of Sunderland and South Tyneside residents being admitted to hospitals outside of that area. Also, the Sunderland / South Tyneside decrease to date in emergency readmission rates is a positive indicator that the model of care is working effectively. As we will be implementing the same 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. 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>
<thead>
<tr>
<th>Admission rates per 100,000 population by CCG</th>
<th>Newcastle</th>
<th>Gateshead</th>
<th>South Tyneside*</th>
<th>Sunderland*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>189</td>
<td>196</td>
<td>208</td>
<td>176</td>
</tr>
</tbody>
</table>

*South Tyneside and Sunderland admission rates are based on April to August 2015 admissions, extrapolated for a full year

Sunderland and South Tyneside admission rates reduced to the levels shown in the above table following the implementation of the new model of care. It is expected that the new community support framework in Newcastle and Gateshead will impact significantly on its admission rate and actual numbers of admissions, although as Newcastle and Gateshead starts from a lower admission rate, it is possible that that this rate and the number of actual admissions may not reduce by the same level as experienced in Sunderland and South Tyneside where a 37% and 25% reduction respectively in admissions was recorded.
Average length of stay for CCG residents in local hospitals

<table>
<thead>
<tr>
<th></th>
<th>Newcastle</th>
<th>Gateshead</th>
<th>South Tyneside*</th>
<th>Sunderland*</th>
<th>National Median by Trust 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>38.0 days</td>
<td>24.4 days</td>
<td>22.7 days</td>
<td>20.4 days</td>
<td>31.0 days</td>
</tr>
</tbody>
</table>

*South Tyneside and Sunderland admission rates are based on April to August 2015 admissions, extrapolated for a full year

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 a considerably longer average length of stay for Newcastle residents admitted to acute wards in Newcastle compared to the other areas. South Tyneside and Sunderland average lengths of stay for their residents using Hopewood Park are more in line with the best practice average length of stay of 21 days. This indicates that there is scope to reduce lengths of stay for Newcastle and Gateshead residents, for example by improving community services to facilitate earlier discharge from hospital, and thereby reduce the need for beds.

<table>
<thead>
<tr>
<th>Emergency re-admission rates within 28 days</th>
<th>Newcastle / Gateshead</th>
<th>Sunderland / South Tyneside</th>
<th>National Median (by Trust) for 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 2015/16</td>
<td>9%</td>
<td>8%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency re-admission rates within 90 days</th>
<th>Newcastle / Gateshead</th>
<th>Sunderland / South Tyneside</th>
<th>National Median (by Trust) for 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 2015/16</td>
<td>17%</td>
<td>17%</td>
<td>Benchmarking data not available</td>
</tr>
</tbody>
</table>

Readmissions can occur when a patient is discharged without an adequate care package; or with an insufficient level of community support; or when discharge occurs too early. The table above indicates that Q1 re-admission rates within 28 days in Newcastle/Gateshead and Sunderland / South Tyneside are currently very close to the national median rate across the country, assuming that there has been no significant change in the national rate (which has not changed much since 2011/12).

In further analysing future inpatient requirements for Newcastle and Gateshead residents, we have taken into account best practice recommendations and patient activity information to date resulting from the implementation of the new model of care in Sunderland.
and South Tyneside. Based on this, we have modelled a range of future possible changes to admission rates and lengths of stay to help identify the number of wards needed for Newcastle and Gateshead residents in the future. The model, shown below, is based on the Royal College of Psychiatrists’ best practice guidance that an acute ward should have no more than 18 beds. With regard to bed occupancy, the Royal College recommends an optimal bed occupancy rate of 85%, excluding patients on leave. However, this is difficult to achieve, as shown by the national benchmarked median bed occupancy rate for 2013/14 of 93%, with a lower quartile below 88%. NTW’s bed occupancy in 2013/14 was near this optimal figure at 87% and more recent 2014/15 figures for the Newcastle Gateshead acute wards is also showing an average bed occupancy of 87%. Taking this into account we have used an 87% bed occupancy rate for the model.

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Average Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>32</td>
</tr>
<tr>
<td>581</td>
<td>5</td>
</tr>
<tr>
<td>552</td>
<td>4</td>
</tr>
<tr>
<td>523</td>
<td>4</td>
</tr>
<tr>
<td>494</td>
<td>4</td>
</tr>
<tr>
<td>465</td>
<td>4</td>
</tr>
<tr>
<td>436</td>
<td>3</td>
</tr>
<tr>
<td>407</td>
<td>3</td>
</tr>
</tbody>
</table>

The top left hand corner cell represents the current position of 5 wards in Newcastle / Gateshead, receiving 581 Newcastle and Gateshead admissions a year at an average length of stay of 32 days. The vertical axis shows a projected reduction in admissions from 5% to 30%, resulting from our planned improvements in community services. The horizontal axis shows a scaled reduction in lengths of stay from the current Newcastle / Gateshead average of 32 days to the best practice recommended level of 21 days. The intersection of the vertical and horizontal co-ordinates shows the number of wards that would be required for that number of admissions and that average length of stay. Our planning assumption is that although admissions should decrease, they may not decrease at the same level as being experienced in Sunderland and South Tyneside, as Newcastle and Gateshead already has a lower admission rate. However, there appears to be significant scope to achieve a reduction in average lengths of stay for Newcastle and Gateshead residents when looking at best practice, comparative lengths of stay elsewhere, and our aim of improving local community services to help reduce the need for admission to hospital and also facilitate discharge from hospital.
The model above shows a wide range of variables where 3 wards would be required and we and NTW are confident that this can be achieved.

It should be noted that this review has not considered any changes in the number of wards for Newcastle older people’s services or for complex care and moving on rehabilitation services. As a CCG we do review bed numbers and demand on an ongoing basis with our provider organisations.

8.2.2 Long List and Shortlisting of Scenarios / sub options. In April and May 2015, the Mental Health Programme Board developed and agreed an initial set of six different scenarios, including a no-change scenario. All the scenarios were based on the provision of:-

- 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. (As previously stated, the older people’s service for Gateshead is not included in this consultation)

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).

8.2.3 The shortlisted scenarios  The shortlisted scenarios to be taken forward for formal consultation are described below and illustrated on pages 64 and 65. It was acknowledged that the variation of locations for adult acute, rehabilitation and older people’s services was confusing and therefore it would be easier for the public to understand if these were split into different parts:

- Three possible locations for adult acute assessment and treatment and rehabilitation services; and
- 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
- 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 (1):**
- The older people’s service being provided from St. Nicholas Hospital, Newcastle

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

## Adult Acute and Rehabilitation Services

### Current Locations

<table>
<thead>
<tr>
<th>Location</th>
<th>Services Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newcastle</td>
<td>Rehabilitation, Adult Acute Assessment and Treatment</td>
</tr>
<tr>
<td>Gateshead</td>
<td>Rehabilitation - Complex Care, Rehabilitation - Moving On</td>
</tr>
<tr>
<td>Other NTW hospital sites</td>
<td>SGP, HWP, SGP</td>
</tr>
</tbody>
</table>

### Scenarios

#### T
- Newcastle: Rehabilitation, Adult Acute Assessment and Treatment
- Gateshead: Rehabilitation - Complex Care, Rehabilitation - Moving On
- Other NTW hospital sites: SGP, HWP, SGP

#### N
- Newcastle: Rehabilitation, Adult Acute Assessment and Treatment
- Gateshead: Rehabilitation - Complex Care, Rehabilitation - Moving On
- Other NTW hospital sites: SGP, HWP, SGP

#### G
- Newcastle: Rehabilitation, Adult Acute Assessment and Treatment
- Gateshead: Rehabilitation - Complex Care, Rehabilitation - Moving On
- Other NTW hospital sites: SGP, HWP, SGP

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### Key

- **Rehabilitation**: General rehabilitation services
- **Adult Acute Assessment and Treatment**: Services for acute care
- **Rehabilitation - Complex Care**: Complex care rehabilitation services
- **Rehabilitation - Moving On**: Rehabilitation services for moving on
- **SGP**: St. George’s Park, Morpeth
- **HWP**: Hopwood Park, Sunderland
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
There are different advantages and disadvantages to consider relating to the different scenarios, for example the quality of clinical care, the quality of accommodation, travel considerations, and the balance of funding between community and inpatient care. The formal consultation will ask people to consider these, as well as any other perceived advantages and disadvantages, and the CCG will take all these factors into account in making its decisions.

**Quality of Clinical Care**  Best practice advice 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. This co-location:

- helps staff to work together in a more flexible way to reduce the need for patients to be transferred between wards, reducing risks e.g. patient and staff safety and minimising disruption to patients;
- means that there are more staff on site to be able to respond quickly to psychiatric emergencies, helping to reduce patient and staff safety risks;
- makes it more sustainable to provide 7 day a week working by consultant psychiatrists which, evidence shows, delivers better outcomes for patients; and
- helps to provide, in a more cost-effective way, a range of important clinical support services for patients such as physiotherapy, exercise therapy, occupational therapy, carers’ support and other social and recreational activities – these are significant in the context of the increasing emphasis being given to the physical health of people with mental health problems and that many more of those people who are now in hospital are detained under the Mental Health Act restricting their ability to access social and recreational activities outside of hospital.

The scenario which is most in line with this advice is 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 crisis services and the specialist psychiatric intensive care and high dependency rehabilitation services being located on other NTW sites. Paragraph 8.3 below also provides an assessment of the proposed community and inpatient scenarios by the independent consultant clinician who provided the evidence of best practice described in Section 3. Discussions around Scenario G, a new build unit in Gateshead, also considered possible increased patient and staff safety risks as this would be a smaller site with less staff than would be the case on the other scenarios.
Quality of Accommodation. All the scenarios would see significant overall improvements in patient accommodation, including new buildings or major conversions of existing wards. As explained in Section 9, there are options to enhance the specification of some of the accommodation which, if supported by the detailed design work, could increase the revenue costs for each scenario by £0.2m to £0.3m. This applies to the scenarios where older people’s services would be provided at St. Nicholas Hospital, where this enhancement of capital and revenue funding may be required to provide en-suite facilities (scenarios T1, N1 and G1).

Location and Travel. We heard a clear view from local people that they are worried if they have to travel longer distances to visit relatives and friends who may need to be admitted to hospital. In particular they are concerned about the cost of travel, the time this would take if using public transport and how people will keep in touch with their local communities. All the scenarios would impact on people’s travel arrangements in different ways – with those where the services are located outside of the Newcastle / Gateshead locality likely to involve longer travel times overall. To understand the implications more clearly, an independent travel impact survey is being commissioned to consider all the scenarios. A commitment has also been made by the CCG and NTW that the impact of travel on service users, and the people who support them, will be considered as part of every individual's care plan. This will include access to taxis and mini bus transport where that is required. We do not want service users and visitors to struggle to get to hospital; and we have made an absolute commitment to support travel in any scenarios where inpatient services are further away from local communities.

Scope to Develop Community Services. The inpatient scenarios have different costs, which impacts upon the amount of funding which could then be released to further improve community services. These indicative amounts for each scenario are shown in the table below - the less funding that is available, the fewer of the new, re-designed or extended forms of community services (as described in paragraph 8.1) would be able to be provided, or they would have to be provided at a lower level. This, in turn, would potentially impact on the ability of the community services framework to reduce hospital admissions and facilitate discharge from inpatient care to the levels desired. These indicative amounts are shown below and also in the following Funding and Cost Estimates section.

These considerations are summarised in the table below and will be the type of factors which the CCG will take into account, along with the feedback from the formal consultation, in making a decision on the future location of these inpatient services.
<table>
<thead>
<tr>
<th>Scenario T1</th>
<th>Scenario T2</th>
<th>Scenario N1</th>
<th>Scenario N2</th>
<th>Scenario G1</th>
<th>Scenario G2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Clinical Care</td>
<td>Most consistent with best clinical practice</td>
<td>Most consistent with best clinical practice</td>
<td>Less consistent with best clinical practice</td>
<td>Less consistent with best clinical practice</td>
<td>Less consistent with best clinical practice</td>
</tr>
<tr>
<td>Quality of Accommodation</td>
<td>Acceptable, depending on ability to fund provision of en-suite facilities for older people</td>
<td>Acceptable</td>
<td>Acceptable, depending on ability to fund provision of en-suite facilities for older people</td>
<td>Acceptable</td>
<td>Acceptable, depending on ability to fund provision of en-suite facilities for older people</td>
</tr>
<tr>
<td>Location and Travel</td>
<td>Acute and complex care rehabilitation services located outside of Newcastle and Gateshead. A travel impact study is being commissioned and support will be provided</td>
<td>Acute, complex care rehabilitation and older people’s services located outside of Newcastle and Gateshead. A travel impact study is being commissioned and support will be provided</td>
<td>All services located within Newcastle and Gateshead. A travel impact study is being commissioned and support will be provided</td>
<td>All services, with the exception of the Older People’s service located within Newcastle and Gateshead. A travel impact study is being commissioned and support will be provided</td>
<td>All services located within Newcastle and Gateshead. A travel impact study is being commissioned and support will be provided</td>
</tr>
<tr>
<td>Location and Travel</td>
<td>Acute and complex care rehabilitation services located outside of Newcastle and Gateshead. A travel impact study is being commissioned and support will be provided</td>
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<td>All services, with the exception of the Older People’s service located within Newcastle and Gateshead. A travel impact study is being commissioned and support will be provided</td>
<td>All services, with the exception of the Older People’s service located within Newcastle and Gateshead. A travel impact study is being commissioned and support will be provided</td>
</tr>
<tr>
<td>Potential for release of funding for investment in community services</td>
<td>£1.4 million</td>
<td>£1.1 million</td>
<td>- £0.2 million</td>
<td>£0 million</td>
<td>- £2.1 million</td>
</tr>
</tbody>
</table>
8.3  **Peer Review**

8.3.1. Section 3 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 in paragraph 8.3.2 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. Our Clinical Senate will provide advice on the scenarios during the consultation period and we will take its advice into account in making our decision.

8.3.2. “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.
9  FUNDING AND COST ESTIMATES

9.1  Financial Context

The service changes under consultation and outlined within this document will need to be implemented in the context of continued financial constraint within both NHS service providers and clinical commissioning groups.

Continued national tariff efficiencies are expected to be delivered by providers each year and this requires them to engage with commissioners in an ongoing process to ensure that cost reductions can be achieved without impacting on the quality of services.

In terms of the wider medium term financial planning, Newcastle Gateshead CCG is currently 3.72% above its target allocation of funds and is unlikely to have access to significant new funding for investment. The CCG recognises the policy commitment set out in parity of esteem and affordable investment in this regard will have to be made within allocated resources.

Therefore, in financial terms the CCG will need to recognise the relative costs of each of the scenarios, alongside wider clinical quality and public engagement indicators in making future decisions. This includes an assessment of the scope for future flexibility, recognising that financial pressures are likely to continue beyond 2017/18 (financial working assumption for completion of changes resulting from this consultation). At this stage in the development of options, costings have been modelled at a high level, taking into account:

- Current costs of services,
- Estimated capital costs for new, altered or re-furbished buildings,
- Estimated savings from moving out of existing facilities
- Additional revenue costs related to service shifts (e.g. medical cover)

9.2  Capital Costs of Scenarios

As previously stated in Section 5, we have already agreed to the implementation of NTW’s new community pathways. This involves an estimated capital cost for NTW of about £3m to improve service users' experiences and to facilitate new ways of working by staff to increase their capacity. We have included the revenue implications of this in the costing of all of the scenarios.
With regard to inpatient services, we want to ensure that all accommodation is provided to an acceptable standard. As the scenarios differ in the amount of new build development and/or the level of conversion works that would be required to deliver acceptable standards, they have different estimated capital costs. These indicative capital costs, shown in the table below, are based on a mid-range specification estimate. There are options to enhance the specification of buildings provided for these services, which if supported by the detailed design work could increase the revenue costs for each scenario by £0.2m to £0.3m.

Table: Estimated Capital Costs

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Capital Cost £m</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1</td>
<td>15.1</td>
<td>- Major conversion of 2 wards for acute care at St. George’s Park; Improvements for complex care rehabilitation accommodation at St. George’s Park; minor improvements to Elm House</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Major improvements of accommodation for older people’s services at St. Nicholas Hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Major improvements for NTW community services accommodation</td>
</tr>
<tr>
<td>T2</td>
<td>19.7</td>
<td>- two new build wards for acute care at St. George’s Park</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- one new build complex care rehabilitation ward at St. George’s Park; minor improvements to Elm House</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Improvements for older people’s services at St. George’s Park.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Major improvements for NTW community services accommodation</td>
</tr>
<tr>
<td>N1</td>
<td>24.6</td>
<td>- Major conversion of 3 wards for acute care at St. Nicholas Hospital; Improvements for complex care rehabilitation ward at St. Nicholas Hospital; minor improvements to Elm House</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Major conversion / improvements of accommodation for older people’s services at St. Nicholas Hospital.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Major improvements for NTW community services accommodation</td>
</tr>
</tbody>
</table>
### N2

20.5

- Major conversion of 3 wards for acute care at St. Nicholas Hospital;
- Improvements for complex care rehabilitation ward at St. Nicholas Hospital; minor improvements to Elm House
- Improvement of accommodation for older people’s services at St. George’s Park
- Major improvements for NTW community services accommodation

### G1

34.3

- New build acute wards in Gateshead
- One new build complex care rehabilitation ward in Gateshead; minor improvements to Elm House
- Major conversion / improvements of accommodation for older people’s services at St. Nicholas Hospital.
- Major improvements for NTW community services accommodation

### G2

31.3

- Three new build acute wards in Gateshead
- One new build complex care rehabilitation ward in Gateshead; minor improvements to Elm House
- Improvement of accommodation for older people’s services at St. George’s Park
- Major improvements for NTW community services accommodation

### 9.3 Revenue Costs of Scenarios

Real terms funding available is estimated at £46.6m for the range of services within the scope of this Case for Change. The revenue cost of doing nothing would be £51.1m, which is one of the reasons why the “current state” scenario was rejected.

At this stage in the development of the scenarios, the costings, shown in the table below, have been modelled at a high level, taking into account:

- Current costs of services,
- Estimated capital costs for new, converted or re-furbished buildings,
- Estimated savings from moving out of existing facilities
- Additional revenue costs related to service shifts (e.g. medical cover)
Note that for costing purposes the acute and rehabilitation scenarios and the older people’s scenarios have been combined in the tables below.

**Table: Estimated annual revenue costs following implementation of each scenario:**

<table>
<thead>
<tr>
<th>Do Nothing</th>
<th>T1</th>
<th>T2</th>
<th>N1</th>
<th>N2</th>
<th>G1</th>
<th>G2</th>
</tr>
</thead>
<tbody>
<tr>
<td>£51.1m</td>
<td>£45.2m</td>
<td>£45.5m</td>
<td>£46.8m</td>
<td>£46.6m</td>
<td>£48.7m</td>
<td>£48.6m</td>
</tr>
</tbody>
</table>

Using the above costs, in comparison with the estimated funding available of £46.6m following the implementation of these changes, the table below indicates the balance which could be re-invested in improving community services.

**Table: Potential for release of funding for investment in community services**

<table>
<thead>
<tr>
<th>Do Nothing</th>
<th>T1</th>
<th>T2</th>
<th>N1</th>
<th>N2</th>
<th>G1</th>
<th>G2</th>
</tr>
</thead>
<tbody>
<tr>
<td>No investment available</td>
<td>Investment available</td>
<td>Investment available</td>
<td>No investment available</td>
<td>No investment available</td>
<td>No investment available</td>
<td>No investment available</td>
</tr>
<tr>
<td>-£4.5m</td>
<td>£1.4m</td>
<td>£1.1m</td>
<td>-£0.2m</td>
<td>£0m</td>
<td>-£2.1m</td>
<td>-£2.0m</td>
</tr>
</tbody>
</table>

As can be seen from the above table:

- Options T1 and T2 result in estimated investment for release into new community mental health services
- Options N1 and N2 result in a borderline/neutral result
- Options G1 and G2 would result in less investment in community services within the £46.6m funding

As referred to in paragraph 8.2, the less funding that is available for community services, in turn, potentially impacts on the ability of the community services framework to reduce hospital admissions and facilitate discharge from inpatient care to the levels desired, which presents a risk to the delivery of this best practice model of care.
# 10 NEXT STEPS

This section sets out the schedule for the next stages of formal consultation and decision making by the CCG on the way forward. Following this, the timescale for the implementing the preferred scenarios for community and inpatient services is outlined.

## 10.1. Schedule from Formal Consultation to Decision Making

The schedule for formal consultation is provided below, with key dates being the formal consultation from 12th November 2015 to 12th February 2016 and a decision by the CCG Governing Body scheduled for 24th May 2016.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>12th November 2015</td>
<td>Formal consultation begins. Formal launch event – Centre for Life, Newcastle</td>
</tr>
<tr>
<td>18th November 2015</td>
<td>Public Event: Brunswick Methodist Church</td>
</tr>
<tr>
<td>3rd December 2016</td>
<td>Public Event: Newcastle City Library</td>
</tr>
<tr>
<td>16th December 2015</td>
<td>Mid-term review with The Consultation Institute – Quality Assurance to review activity so far to ensure ongoing best practice</td>
</tr>
<tr>
<td>13th January 2016</td>
<td>Public Event: Gateshead Civic Centre</td>
</tr>
<tr>
<td>6th February 2016</td>
<td>Public Event: Community Art Space, St. Edmunds Chapel, Gateshead</td>
</tr>
<tr>
<td>12th February 2016</td>
<td>Consultation period ends (13 weeks)</td>
</tr>
<tr>
<td>15th February 2016</td>
<td>Analysis of feedback commences</td>
</tr>
<tr>
<td>7th March 2016</td>
<td>Draft report of analysis of consultation feedback received</td>
</tr>
<tr>
<td>14th March 2016</td>
<td>Final report of analysis of consultation feedback agreed for publication</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>21 March 2016 to 11th April 2016</td>
<td>Consultation analysis – feedback to public. Two public feedback sessions to be arranged</td>
</tr>
<tr>
<td>26th April 2016</td>
<td>CCG Governing Body Development Session to consider preferred scenarios for acute / rehabilitation services and older people’s services</td>
</tr>
<tr>
<td>9th May 2016</td>
<td>Complete full Case for Change document</td>
</tr>
<tr>
<td>24th May 2016</td>
<td>CCG Governing Body Meeting – decision.</td>
</tr>
<tr>
<td>Post 24th May 2016</td>
<td>Decision communicated to stakeholders and the public</td>
</tr>
</tbody>
</table>

Within the above schedule, these proposals will be considered at meetings of the respective Newcastle and Gateshead Local Authority Overview and Scrutiny Committees.

10.2 **Formal Consultation Methodology**

The objective is to provide a range of engagement activity that allows different stakeholders and groups to get involved in the way that is most suitable to them. All methods ensure that feedback and dialogue is captured, which will be then be analysed and included in a final feedback report. All methods will include data monitoring of the key characteristics of participants to ensure the CCG is hearing from key groups and that equality monitoring can take place. This is not only best practice, but will also ensure that the NHS meets its equality duties as well as its statutory duties to involve and consult. They are in line with the principles of ‘Transforming Participation’ and the rights and pledges set out in the NHS Constitution.

There will be a detailed communications plan to ensure appropriate publicity to promote the launch of the consultation and attendance at events and take up of the survey, focus groups etc. The engagement methodologies include:
Formal CCG led public events
As part of the consultation process, formal public events should take place across the Newcastle Gateshead area. There will be four in total – one consultation launch event and three consultation discussion events. While efforts will be made to specifically target services users, carers and people with a specific interest, it is important that efforts are made to involve the wider public.

Consultation launch event
The launch event will take place on the first day of the consultation period and will provide an opportunity to gain publicity for the consultation issues, and encourage people to take part. The format is: Cabaret style two hour event.
- Presentation introduction led by CCG clinical leader to explain the background to the process and outline each of the scenarios
- Expert panel question time, independently chaired, cross section of experts to field questions and comment
- Notes taken of comments people make and report written
- Promotion of other ways to get involved to feedback views

Consultation discussion events
There should be a formal consultation discussion event every month during the consultation period – three events in total. The objective is to present information about the consultation, the scenarios and gain dialogue and feedback on scenarios for change being put forward. The format is: Cabaret style two hour event.
- Presentation introduction led by CCG clinical leader to explain the background to the process and outline each of the scenarios
- Facilitated table discussions on scenarios using a structured discussion guide in-line with other engagement methods, notes captured on flip chart so visible to participants and report written for each event
- Roving experts for points of clarification
- Promotion of other ways to get involved to feedback views

CCG led survey
A survey provides an easily accessible way for people to give their views. It will be available in both paper form and on-line. Paper versions will include a pre-paid envelope for ease of return. Support will be offered to those who may need to help to complete the survey.
As recommended by the Deciding Together Advisory Group, the survey will take account of the following groups:

- Service users
- Carers
- Professionals/mental health providers
- Members of the public

An independent organisation with expertise in complex survey design will support the survey development. The survey will be tested via the deciding together group. This is also to provide assurance that questions will not be leading. The survey will have its own output report of findings. The same organisation will conduct the full analysis of all the feedback gained from all the methods in this paper for a final consultation feedback report.

**CCG developed focus group pack for MHVCS use**

An offer will be made to interested voluntary and community sector organisations to recruit and run a focus group and submit a report. In return reasonable expenses will be covered and a payment of £100 per group made. This was a successful method used in the listening period and is endorsed by the Deciding Together group. Responses from key groups would be encouraged. It would be desirable to have a group with current in-patients – and while this may be difficult the Deciding Together group would like this to be pursued.

A focus group pack will include both a discussion guide (the open ended questions to pose) plus a facilitation guide (guidance for the person running the focus group) and a data monitoring form. The focus group pack and discussion guide will be co-produced with VCS organisations who will be invited to a development session in November. The discussion guide will be structured in-line with the survey, and will allow a more deliberative qualitative discussion to take place. Using a structured discussion guide means that more depth can be added to the survey responses which are usually more qualitative than quantitative. Data monitoring must be requested from all participants.

**CCG commissioned in-depth interviews**

Northumbria University will carry out 25 in depth interviews with service users and their carers. This will be done by peer researchers who have experience of mental health services. A discussion guide will be structured in line with the survey and focus group guides. In-depth interviews are carried out on a one to one basis and allow the opportunity for much more detailed and personal experience to be gained. Close data monitoring will take place to ensure the right balance of interviews across the areas.
of services and care involved in the scenarios. Northumbria will provide an output report to be included in the final consultation feedback report.

**CCG commissioned events from the voluntary and community sector**

The Deciding Together group has recommended that dedicated events could be commissioned by the CCG from specific interest groups of the voluntary and community sector. The offer would be for groups to organise and run their own events, using a structured template guide in line with the other engagement methods, which could be tailored for their interest group. In return a payment of £300 plus running and operational costs, e.g. room hire, would be covered by the CCG. It is anticipated that Involve North East will support the co-ordination of these groups.

The commissioned MHVCS events would fall into the following categories:

- **Wider VCS events in Newcastle and Gateshead (two events)** An offer to be made to NCVS for Newcastle and GVOC for Gateshead to run an event in each area as the nature of the interest in the consultation issues are likely to be geographically based.
- **Mental health VCS (one event)** An offer to be made via VOLSAG to run a mental health VCS event across both Newcastle and Gateshead.
- **Carer events (two events)** There are three different carers organisations, two in Gateshead and one in Newcastle. Individual events should be commissioned as the nature of the interest in the consultation issues are likely to be geographically based.
- **Service user organisations (two events)** Service user events should be commissioned and an approach to Launch Pad and Mental Health Matters groups should be made to find out if they would come together for an event or prefer to run their own.
- **Current service users** Current service users will be targeted with information and invited to the consultation events.
- **Protected characteristic groups** The Health and Race Equality Forum (HAREF) and Deaflink are CCG involvement partners and will be asked to run focus groups or events as above.

**Attendance at relevant existing meetings, groups and networks**

These have been mapped through to March 2016 and requests will be made for the consultation to be highlighted and appear as an agenda item.

**Submissions received from groups, teams and individuals**

All of the above does not preclude the right of groups, individuals and groups to make their own submission.
The Deciding Together group and the CCG recognised that not everyone will confine their comments to the structured groups and the survey. Any submissions received will be incorporate into the feedback report.

10.3 Full Case For Change

Following the formal consultation a Full Case for Change will be prepared so that a decision on the preferred scenario can be made by the CCG’s Governing Body. The Full Case for Change will consider the formal consultation responses, along with other information below which will be received or developed, in order to make its decision:

- The independent travel impact survey
- An Equality Impact Assessment
- The review of the scenarios by our NHS England Clinical Senate.
- A consideration of risks relating to each of the scenarios and how risks relating to the preferred scenario will be managed

A Benefits Realisation Plan will also be developed with our partners to be used to monitor and review whether the changes are delivering the benefits set out in this Case for Change. This will include measures of clinical care and service user experience.

10.4 Implementation

We referred previously in Section 5 to the agreement to progress implementation of the new NTW community pathways and that these are planned to be fully embedded by March 2017. Timescales relating to the potential implementation of other types of new or extended community services will depend partly on the decisions that will be made but it is envisaged that these and the proposed reduction in inpatient wards would be in place by March 2018.

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. In all the scenarios, it is likely to be around winter 2018 before all the accommodation improvements are completed, although some elements of the scenarios may be able to be completed earlier.

A full Implementation Plan will be developed and agreed following the decisions to be made in May 2016, to help ensure that the changes will be made in a phased and safe way.
APPENDICES

1. Deciding Together – governance organisation 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
DECIDING TOGETHER – GOVERNANCE ORGANISATIONAL CHART

CCG Governing Body

CCG Executive (Delegated Powers)

CCG – Mental Health Programme Board

Project Co-ordinating Group

CCG / NTW / LAs / MHVCS Joint Executives Meeting

Deciding Together - Communications and Engagement Advisory Group
NATIONAL STRATEGIES


With respect to mental health services it identifies 5 key priority areas (\textit{these mirror the 5 domains of the NHS Outcomes framework}\textsuperscript{4}):

\textbf{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.

\textbf{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.

\textbf{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).

\textbf{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.

\textbf{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\textsuperscript{5} identified 4 key areas:

\textbf{Access to support before crisis} – the need for services to intervene early to prevent distress and escalation into crisis

\textbf{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).

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\textsuperscript{3} 2013 NHS Mandate, NHS England
\textsuperscript{4} 2013 NHS Outcomes Framework, Department of Health, www.gov.uk/dh
\textsuperscript{5} 2014 The Mental Health Crisis Care Concordat – improving outcomes for people experiencing mental health crisis, DOH.
**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** 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.
- 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

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* NHS England The NHS 5 Year Forward View, October 2014.
- 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 Partnerships7 (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.

MIND ‘listening to experience’8 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

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7 Established under the Crime & Disorder Act 1998 (sections 5-7)
8 MIND 2011 Listening to experience (an independent enquiry into acute and crisis mental health care)
**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.

**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**⁹ - 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**¹⁰ - 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.

Six shared objectives were identified:

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⁹ A Criminal Use of Police Cells? The use of police custody as a place of safety for people with mental health needs

A joint review by Her Majesty’s Inspectorate of Constabulary, Her Majesty’s Inspectorate of Prisons, the Care Quality Commission and Healthcare Inspectorate Wales

¹⁰ No Health without Mental Health, HM Government, 2011 A cross Government Mental health outcomes strategy for people of all ages
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\(^\text{11}\) are relevant to mental health and the Adult Social Care outcomes framework\(^\text{12}\) 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.

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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 are 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.

![Emergency Hospital admissions for Self Harm (number): 2010/11 to 2012/13, North East Upper Tier Local Authorities](image)

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 indictor 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 and 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.

![Employment Rate of those with Mental Illness](image)

*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\(^\text{13}\). 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\(^\text{14}\).

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).


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
## 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: 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>Organization</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Momentum Skills North East</td>
<td>Vocational Rehabilitation for patients with acquired brain injury</td>
</tr>
<tr>
<td>Newcastle Talking Therapies</td>
<td>Mental Health and Learning Disability Services</td>
</tr>
<tr>
<td>North East Counselling Service (NECS)</td>
<td>Counselling service for family and carers of people with mental health problems &amp; veterans mental health counselling.</td>
</tr>
<tr>
<td>Path Head Watermill</td>
<td>Skills and employability development for referred patients.</td>
</tr>
<tr>
<td>Rape Crisis Tyneside and Northumberland (RCTN)</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>Tyneside and Northumberland Mind</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>Tyneside Women’s Health (TWH)</td>
<td>TWH enables women to reach personal potential by improving mental health and emotional wellbeing.</td>
</tr>
<tr>
<td>Under The Bridge - Joseph Cowen</td>
<td>General practice, needle exchange and outreach service specialising in homeless people. Also includes cleaning and clinical waste.</td>
</tr>
</tbody>
</table>
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
Deciding Together Listening Exercise: Analysis of Findings

Executive Summary

March 2015
1 Introduction

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.

1.1 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.

### 1.2 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.
1.3 References

A copy of the information sources and feedback notes can be found on the following webpage:
www.newcastlegatesheadccgalliance.nhs.uk

The details of the listening exercise are included in “Deciding Together. Developing a new vision for mental health services for Gateshead and Newcastle” published by the NHS Newcastle and Gateshead CCG in November 2014, available to view at:

2 Summary of Findings

2.1 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.

2.2 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.

### 2.3 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.

2.4 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.

### 2.5 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.

### 2.6 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.

### 2.7 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.

2.8 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.
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>
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