Meeting of the Newcastle Gateshead CCG Governing Body

To be held on Tuesday 24 May 2016 at 2.15 – 4.15pm

Grainger Suite, The Centre for Life, Times Square,
Newcastle upon Tyne, NE1 4EP

Agenda

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Newcastle Gateshead Clinical Commissioning Group
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|   | Strategic Items |
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|   | Items for Information |
| 13. | Committee Minutes/Reports to be received for information |
|     | a) Joint CCG Executive Committee minutes 16 February and 15 March 2016 |
|     | b) Audit, Finance & Performance Committee minutes 20 January 2016 |
|     | c) Quality, Safety & Risk Committee minutes 7 January and 17 March 2016 |
|     | d) Primary Care Joint Committee minutes 26 January and 22 March 2016 |
|     | e) Gateshead Health & Wellbeing Board agenda 22 April 2016 |
|     | f) Newcastle Wellbeing for Life Board agenda 21 April 2016 |
| Questions from the public | Enclosure  
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|                           | Enclosure  
|                           | Enclosure  
|                           | Enclosure  
|    | Date of the next CCG Governing Body Meeting |
|   | Tuesday 24th May 2016, Gateshead Civic Centre. |
Minutes of the CCG Governing Bodies Meeting held on
To be held on Tuesday 22 March 2016 at 1.45 – 4.00pm

Armstrong/Stephenson Room, Newcastle Civic Centre,
Newcastle upon Tyne, NE1 8QH

Present:
Dr Guy Pilkington Chair
Dr Mark Dorna Assistant Clinical Chair
Mark Adams Chief Officer
Joe Corrigan Chief Finance Officer/Chief Operating Officer
Chris Piercy Executive Director of Nursing, Patient Safety & Quality
Dr Neil Morris Medical Director
Bill Cunliffe Secondary Care Clinician
Jeff Hurst Lay Member
Tim Morgan Lay Member
Mandy Taylor Lay Member
Michael Burke Lay Member
Paul Gertig Lay Member
Jackie Cairns Director of Delivery & Transformation
Jane Mulholland Director of Delivery & Transformation
Dr Alison Smith Member Practice Representative

In Attendance:
Professor Eugene Director of Public Health, Newcastle
Milne
Carole Wood Director of Public Health, Gateshead
Jeffrey Pearson Head of Corporate Affairs
Louise McAndrew Minute Taker

2016/03/01 Welcome and Introductions
Dr Guy Pilkington, Chair, welcomed the members of the Governing Body and the members of the public who were attending the meeting.

Guy Pilkington reminded those present that ‘Questions from the public relating to the agenda’ will be taken after every section of the agenda.

2016/03/02 Apologies for absence:
Oliver Wood Lay Member
Julia Young Director of Quality Development
Dr Peter Ward Member Practice Representative
Sheinaz Stansfield Member Practice Representative
2016/03/03 Declarations of Interest
There were no declarations of interest regarding any of the items on the agenda except that all GPs may have interests which they must declare.

It was noted that Bill Cunliffe, Secondary Care Clinician, works for the Care Quality Commission (CQC) but not in the North East.

2016/03/04 Quoracy
Jeffrey Pearson, Head of Corporate Affairs, confirmed that the meeting was quorate.

2016/03/05 Minutes of previous meeting held on 26 January 2016
The minutes were agreed as an accurate record.

2016/03/06 Matters arising from the Minutes
There were no matters arising that were not on the agenda.

2016/03/07 Report from Chief Officer
Mark Adams, Chief Officer, updated the meeting:

Strategic Transformational Plan (STP) Process
There are now 44 STP footprints across the country with Newcastle Gateshead a part of the Northumberland, Tyne & Wear (NTW) plan, which also includes Northumberland/North Tyneside and South Tyneside/Sunderland. The other plans in the region are Cumbria and Tees/Durham. Nationally there is a lead for each STP and Mark Adams is the lead for NTW.

It was described that in previous years we have been used to planning in the CCG footprint but we are now starting to plan much wider and as organisations we will need to work more closely with each other.

The plans will be agreed by both NHS England and NHS Improvement.

Tim Morgan, Lay Member, queried if there are financial implications – will the money move towards the better plans? Mark confirmed that there will be a transformation amount of money but there are no details as yet as how that will be distributed.

Gateshead QE Care Quality Commission (CQC) Assessment
It was noted that following the CQC inspection at the Gateshead QE Hospital they had been rated ‘good’ very close to outstanding. They are now in the top 5 in the country.

It was noted that the Newcastle Hospitals Trust have had their CQC inspection and are awaiting the report and the Northumberland, Tyne & Wear (NTW) Mental Health Trust will have their inspection in May.
Devolution Agenda

The Health & Social Care (H&SC) Committee has started to meet and the CCG will be involved as well as our local authority partners.

It was clarified that within the STPs Durham input into the south of the region whereas with devolution they input into the north.

2016/03/08 Patient and Public Involvement Updates

8.1 CCG PPIE Update

Paul Gertig, Lay Member, presented the joint report which briefly summarised progress on Patient, Carer, Public Involvement and Engagement work across the CCG and includes locality specific engagement and involvement.

Paul added that the CCG is demonstrating real commitment to engaging with patients and the public.

Paul reported that the Gateshead Voluntary Organisations Council (GVOC) is working towards closing down in April this year which will affect the voluntary sector more than the patients and public and the CCG is working with GVOC regarding this.

The CCG Governing Body noted the contents of the report.

Dr Steve Kirk, Dr Rachel Cooper and Sam Hood gave a presentation regarding Long Term Conditions (LTCs). It looked at:

- The aims of the programme
- The national picture for LTCs
- Local context
- The challenges and how they will be addressed
- What we have done so far
- Identification and support
- The Year of Care
- Cancer and end of life care
- What is included in the 2016/17 commissioning plan
- How we are taking LTCs forward

Neil Morris, Medical Director, commented that it is impressive to see how much there is going on and the progress being made. Steve Kirk added that there is a comprehensive outcomes framework which has a wide range of indicators which he offered to circulate if required.

Tim Morgan commented that there has been no heavy industry in the area for 30 years so at what point does this stop featuring in patients with LTCs and it was discussed that the main areas are around chest problems, deprivation/healthy lifestyles.
Self-care and mutual support was also discussed as being a universal approach as the more people that are enabled the better as there is never enough capacity in primary care. Steve Kirk confirmed that they are working with charities to set up peer support groups.

Jeff Hurst, Lay Member, queried how is the CCG working with secondary care to help patients who have numerous appointments with different departments and can anything be done through contracting to make this better for patients. Steve explained that through the Year of Care work they are looking at primary care in year 1 and secondary care in year 2 and a working group has been put in place which will start with specialist nurses in secondary care. As yet they have not considered the contracting route but it is something to look into.

Joe Corrigan praised the very powerful patient story within the presentation and Paul Gertig added that all the strategy groups could use that as a powerful tool.

A member of the public commented that the patient story was very good but how typical was it of the majority of patients and how much fine tuning of the strategy would there have to be to deal with the wide range and complexity of patients and have we understood what is important to them? It was clarified that during the research there had been 1:1 interviews, group sessions, forums and questionnaires used to gain views from patients and the public.

Steve Kirk thanked Rachel Cooper for her help and work in this area as she is standing down from her post in the CCG.

2016/03/09 Quality, Finance & Performance

9.1 Quality, Finance & Performance Report
Joe Corrigan and Neil Morris presented the report which appraised members of the high level themes from all aspects of quality and patient safety whilst linking with performance and finance.

The report provides context as to the reasons for pressures and actions being taken to mitigate their impact in relation to key quality, performance, contract and finance issues.

The data in this report relates to the reporting period December 2015 except where stated. KPIs of note are:

1. Quality and Safety page 3
   • 3 Never Events NuTHFT 1 reported May 2015 and 2 February 2016
   • 5 MRSA cases NuTHFT reported November ytd 2015
   • 1 MRSA case NGCCG reported October 2015

2. Key performance indicators page 14
   • 67 Green (within target)  33 Red (beyond target)  5 indicators have no in year data/target so not rag rated
   • RTT – Orthopaedics
Cancer waiting times CCG
Diagnostics NUTH
Avoidable Emergency admissions
CDiff – CCG and GHFT
NEAS Response times
A&E

Quality Premium page 17
- NHS Constitution - Cat A Red 1 Ambulance Response times off track – 20% reduction in QP payment
- A&E CCG off track – 30% reduction in QP
- Patients with SMI who smoke on track

Better Care Fund
- Permanent admissions of older people 65+ to residential and nursing care homes
- Non elective pressures apparent at GHNHSFT and NuTHFT

Strategic Plan: Outcome Ambitions
- OA3 – Avoidable Emergency admissions
- HCAI

3. Contract Activity page 24
- GHNHSFT – Elective activity is exceeding planned levels at month 9 (£1,333k)
- NuTHFT – Drugs and Devices are over performing by £1,313k at month 9

4. Finance page 31
- Month 10 reports a surplus of £10,019 or 1.4% of budget
- NuTHFT - year-end position is currently forecast to be a £6,232 over performance at month 10
- CHC/FNC – year-end position is currently forecast at £6,114k over budget at month 10

Michael Burke noted that there has been a lot of discussion focused on non-electives but the figures show that the electives have gone up. Joe Corrigan clarified that this has been affordable and has also meant that we have achieved the targets but procedures are being looked at.

The CCG Governing Body noted the contents of the report.

2016/03/10 Public Health Items

Director of Public Health Updates

Gateshead
Carole Wood, Director of Public Health, gave a verbal update to the meeting, key points:
In Newcastle and Gateshead there has been a major reduction in smoking at the time of delivery – the figures cannot be split into Newcastle/Gateshead. Also seeing the benefits of the baby clear initiative.

The budget proposals have been agreed bar 3:
- The contract with Gateshead carers with substance misuse – subject to review of all carer services.
- Oaktrees is an intense programme for people mainly with alcohol problems.
- Live Well programme – cuts not taken in full.

0-19 health visitor and school nursing programme – this has been delayed as they are going to revise the specification.

Asset based workshop – there has been a lot of focus on this and there was a mixed reaction to the Cormack session. There are conversations going on at the local authority but they are going to take step back and produce a clearer plan with an area focusing on community, building activities and connecting with communities and will share when available.

Newcastle
Professor Eugene Milne, Director of Public Health in Newcastle, gave a verbal update to the meeting, key points:
- Smoking – it would be helpful to have a breakdown of the figures discussed above to a local level. Bill Cunliffe queried if there has been a rebound in the smoking figures after birth – there is no follow up data as yet.
- The quit rates have also gone up in the third quarter and they are now rolling out the programme through pharmacies.
- There will be a new national tobacco strategy and expecting the focus to be on smoking in pregnancy and long term conditions.
- Standardised packaging is being introduced.
- Still waiting to see the impact of E-cigarettes.
- Through a range of concerted activities across different agencies there has been a 60% fall in legal high incidents in February with a number of outlets being closed down, starting to see a level of control but do recognise that it could be driven underground or to the use of other substances.
- The Annual Report is going to the April council meeting with the portfolio report.
- Welcomes the legislation regarding the sugar tax on fizzy drinks.
- Disappointed that the diabetes prevention programme was not in the first wave but it does give more time to develop it.
- The call for evidence regarding Health & Social Care integration has been received – Duncan Selbie is keen to steer in the direction of prevention. MD commented that there are a number of different ways we could give feedback:
  - By organisation.
  - Locally.
  - Regionally.
  - Joined up system response.

A member of the public queried if there is anything planned regarding salt reduction in foods? Eugene answered that there was not as this forms part of general healthy eating – a reduction in the blood pressure figures could be an indication of this.
2016/03/11 Strategic Items

(1) Strategic Planning 2016/17
Joe Corrigan presented the report which provided a further update on progress made so far in the planning process for 2016/17 including how we have addressed the key requirements set out in the NHS England Planning Guidance.

The guidance set out a clear list of national priorities for the NHS 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules.

The paper therefore updates the current position in relation to
1. the one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP including the Commissioner plan (commissioning intentions)
2. the five year Sustainability and Transformational Plan (STP) place-based, driving the Five Year Forward View
3. the Better Care Fund Plan.

Next steps include:
- Publication of the Commissioning Plan for 2016/17 by the end March 2016;
- Submission of the final operational plan to NHS England on 11th April 2016;
- Further work with senior partners across the system to develop the STP;
- Engagement event with stakeholders to support the development of the STP;
- Submission of final STP in June 2016.

The Governing Body noted the requirements outlined in the guidance and the progress made in terms of the planning process for 2016/17.

2016/03/12 Assurance, Risk & Governance items

(1) Revised Terms of Reference for the Remuneration Committee
Jeffrey Pearson presented the paper which looked to seek approval from the Governing Body to implement and publish the revised Terms of Reference for the Remuneration Committee.

The meeting of the Remuneration Committee held on 23 February 2016 considered the performance and effectiveness of the committee, and as part of this, reviewed its terms of reference which were considered to be relevant to the work of the committee, with only one recommendation for amendment, that being increasing the quoracy from two members to three members.

This recommendation requires formal approval from the Governing Body before it can be implemented.

Section 8.2.2 was queried as a potential conflict of interests but it was clarified that in the past the decision made by the Governing Body was ratified by NHS England. It was agreed that this should be included in the Terms of Reference.
Action: Jeffrey Pearson to amend the Terms of Reference and bring back to the May meeting.

The Governing Body noted the content and issues of the report and approved the Terms of Reference pending the amendment to section 8.2.2.

(2) Approval of the Amended Standards of Business Conduct and Declarations of Interest Policy

Jeffrey Pearson presented the paper the purpose of which was to seek approval from the governing body to implement and publish the amended Standards of Business Conduct and Declarations of Interest Policy.

The policy has been amended to remove the sections and references to Anti-Fraud, Bribery and Corruption, following the implementation of the revised Anti-fraud, Bribery and Corruption Policy.

The policy remains essential to the CCG in order to ensure that the organisation maintains a high standard of integrity in its functions and relationships with partners and stakeholders.

The CCG Governing Body noted the content and issues of the report and approved the policy.

2016/03/13 Committee Minutes/Reports to be received for information

13.1(a) Minutes of the Joint CCG Executive Committee meeting held on 19 January 2019

The CCG Governing Body RECEIVED the minutes.

(b) Minutes from the Audit, Finance & Performance Committees held on 18 November 2015

The CCG Governing Body RECEIVED the minutes.

(c) Minutes from the Primary Care Joint Committee held on 13 October and 24 November 2015

The CCG Governing Body RECEIVED the minutes.

(d) Agenda for the Gateshead Health & Wellbeing Board Meeting 26 February 2016

The CCG Governing Body RECEIVED the agenda.

Guy Pilkington gave a short presentation on his reflections of the first year of Newcastle Gateshead CCG and his year as Chair before handing over to Dr Mark Dornan for 2016/17.

2016/03/14 Date of Next Meeting

The next meeting will be held on Tuesday 24 May 2016.
### CCG PPIE Update

This report summarises progress to date by NHS Gateshead and Newcastle CCGs in developing its involvement and engagement strategy.

For further details please contact the appropriate Lead:
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- Alisonthompson4@nhs.net
- norahstevens@nhs.net
- lindsay.gibbins@nhs.net
- steven.bramwell@nhs.net

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**Lead Director**

Jane Mulholland, Director of Delivery and Transformation  
Chris Piercy, Executive Director of Nursing, Patient Safety and Quality

**Report Author**

Christanne Ormston, Norah Stevens, Lindsay Gibbins  
PPI & Community Development Leads

Alison Thompson  
Patient Experience Lead

Steven Bramwell  
Health Champion Lead

**Classification**

NHS Unclassified

**Purpose** (click one box only)

- Approval 
- Decision 
- To note 
- Information  

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<th>Benefits to patients &amp; the public</th>
<th>The CCG approach to PPI is championed and led by the PPI Lay Representatives and Executive Practice Managers, supported by the Directors of Commissioning. Effective engagement and involvement of patients in commissioning decisions and actions is integral to the business of the CCG.</th>
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<td>Enhancing quality and safety of services</td>
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<td>Identified risks &amp; risk management actions</td>
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<td>Legal implications &amp; equality and diversity assessment</td>
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<td>Sustainability implications</td>
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<td>NHS Constitution</td>
<td>Reflects Principle 4 of the NHS Constitution – involving and consulting, reflecting needs and preferences.</td>
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<td>Next steps</td>
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1. **Introduction**
   This paper briefly summarises progress on Patient, Carer, Public Involvement and Engagement work across the alliance and includes locality specific engagement and involvement.

   The following sets out progress to date.

2. **Mental Health and Learning Disabilities**
   2.1 **Deciding Together – a new future for adult specialist mental health services**
   The CCG were due to make the decision on 24 May on Deciding Together. It has now been agreed to postpone making the decision until 28 June 2016 – and not at the May meeting as previously envisaged.

   The reason for this is to ensure the governing body has additional time to take into consideration all the issues that have been raised during the consultation process and in particular those most recently raised from Newcastle and Gateshead health overview and scrutiny committees and individual carers.

   A dedicated extraordinary governing body meeting is being arranged for the afternoon of the 28 June 2016 – venue to be confirmed – and Deciding Together will be the only item on the agenda.

   We recognise the high level of public interest in this issue and that it is an extremely important decision to ensure they get right for the best interests of local people. As such, more time is needed to review all the evidence and feedback gained before a decision on which scenario from the consultation would be taken forward could be made by the governing body.

   When the venue for the meeting in June meeting is confirmed, we will issue a notice out to stakeholders and the public who are welcome to attend to observe the meeting.

3. **Children and Young People**
   3.1 **Expanding Minds, Improving Lives – motivating and working together to transform mental health services for children and young people**
   The pre-consultation and listening phase has now concluded, and a summary report has been produced. The work is now entering a 'design phase', to develop a new model of emotional and wellbeing care and support. This will involve working together with providers, stakeholders and young commissioners to build on the views shared in the listening phase, to design a new approach.

   As part of this phase of work, a provider workshop was held on 12 April to explore what a new approach would look like. Following this event, six public workshops will also be held in May to help develop this new model.
3.2 Children and Young People - 0-5 Booklet
CCG wide engagement is being undertaken in May to test the appearance, content and impact of a new pilot booklet to inform parents of poorly younger children, aged 0-5 years, on information about certain common conditions, how to look after their child, and if necessary, information on which services to access.

The objective of this work is to improve services and educational support in the sick and injured Children and Young People’s Pathway, and reduce inappropriate admissions to A and E.

This work intends to ensure that each child gets the most appropriate advice and treatment in the right place, at the right time, and which enables NHS resources to be used appropriately.

Once engagement is concluded at the end of May, it is intended to follow up this work at 6 and 12 months to evaluate the impact of the booklet on parents’ behaviour.

4. Long Term Conditions including Cancer and EOL (Gateshead)
4.1 Long Term Condition (LTC) Patient Reference Group
The Gateshead LTC Patient Reference Group met on 11th April. The main focus of the meeting was around the implementation of the Year of Care in Gateshead Practices. A Gateshead Year of Care Trainer who is also a local practice nurse, gave the group an overview of the Year of Care and there was a useful discussion on how this works in practice. Patient’s felt that the recall system for annual LTC reviews where they receive their recall letter in their birthday month works very well for patients and is easy for them to remember when their review is due. Generally the group feel the Year of Care approach to LTC care is very positive for patients.

The group have also been closely involved in working with the CCG to develop a general information leaflet for patients that can be used by practices now implementing the Year of Care to promote the approach to their patients.

5. Long Term Conditions including Cancer and EOL (Newcastle)
5.1 End of Life Strategy and Action plan
The Steering Group met on 19 April to discuss the scope of the proposed engagement work.

The engagement will look to establish ‘the good principles of end of life care’, and will seek to involve and engage patients, public and carers in a conversation about good end of life care in order to develop a strategy and action plan for end of life.

The group agreed that the engagement will be targeted, talking to people from seldom heard groups across Newcastle, and will include BME communities, Deaf and hard of hearing, homeless people and those who are blind and visually impaired. This is because there is little evidence that people from these communities have been asked about their expectations, experiences and views on end of life care.

Other, ongoing and previous engagement will also feed into this work. This includes ongoing work with COPD/Dementia patients, previous engagement work with those with
learning disabilities and dementia carers and work by colleagues at Macmillan who have regular contact with patients who are on the palliative care register.

The group also approved the Call for Evidence report that had been produced by Involve North East, detailing previous engagement work on end of life care that had been completed by partners.,

The next stage will be for the questions to be formalised and agreed. These will be drafted by the Clinical Lead, the CCG and NECS colleagues, with input from partners Deaflink, HAREF and Macmillan. The questions and process will then be approved by the Steering Group at their meeting in June.

6. **Voluntary and Third Sector Services (Gateshead and Newcastle)**

6.1 **Connected people, connected communities**

Targeted invitations have now been sent out for the Connected People, Connected Communities event taking place on 7 June, at the Banqueting Suite, Newcastle Civic Centre. Invitees include representatives from Newcastle and Gateshead local authorities, voluntary and community sector leads, NTW, NUTH, clinical leads, practice nurses, and practice managers from across Newcastle and Gateshead.

Alongside this, partnership organisations across a broad range of networks have been asked to contribute to ‘pre-work’ prior to the event to consider what more can be done to make Newcastle and Gateshead into places where people make and maintain good quality relationships. Organisations have been encouraged to submit posters which focus on what good social relationships mean and how they can be fostered.

It is intended that these posters will be put on display at the event and be used to inform discussions on the day.

In addition to this ‘pre work’, ongoing plans for the event programme are continuing to be progressed.

7. **Voluntary and Third Sector Services (Newcastle)**

7.1 **Community Forum**

The Community Forum met on 11 May 2016 and included discussion on suicide prevention training, domestic abuse support, information on porcine-based vaccinations, Connected People, Connected Communities, and an update from the Haref network.

The next meeting of the Community Forum will take place on 6 September.

7.2 **Involvement Forum**

No meeting since previous update. The next meeting of the Involvement Forum will take place on 26 July
8. **Informatics**

8.1 **Information Technology Integration**

The aim of the Information Technology Systems Integration work is to collaborate with partners to identify and understand the challenges for the next phase in working toward achieving a shared information technology system.

It also aims to guide the development of a local digital roadmap to full health and social care system IT integration, with the production of the roadmap being a requirement set by NHS England for each locality to produce during the 2016-17 year.

Following the Interoperability Event held on 1st and 2 December, a number of next steps were agreed, including the setting up of a Newcastle Informatics Network to take this work forward, which would also include patient, and voluntary and community sector representation, and the development of a clear communication and engagement plan for patients and stakeholders.

Approaches are currently being made to potentially suitable patient and VCS representatives to attend Newcastle Informatics Network meetings, and work is to be developed via this network on approaches to engagement.

9. **Patient Safety and Quality – Patient Experience**

9.1 **Patient centred outcome measure for Children's Asthma (PCOM)**

Testing of the newly developed tool is complete and the final report is being prepared by ELC (experience led care). They will present the report and recommendations to CCG Clinical Leads and NECS on 2 June.

9.2 **Personal Health Budgets**

The local offer for personal health budgets has been agreed. The offer details the additional groups the CCG will support to provide personal health budgets.

This means that the CCG can now offer personal health budgets to:

- Adults who receive NHS continuing healthcare support.
- Children and young people who receive NHS continuing healthcare support.
- Adults and Children with learning disabilities and/or autism who have complex health needs.
- A child who has special education needs and disabilities as part of their education, health and care plan.

Following approval by the Executive, the local offer will now be published on the CCG website and a general leaflet produced to share with healthcare teams who currently work with these specialist patients and families. Information on the expanded offer will also be shared with our GP practices through the weekly bulletins and on GP teamnet and with our community and voluntary sector networks.

9.3 **Commissioner Visits for 2016/17**

The CCG carries out a rolling programme of commissioner visits to seek assurances that quality services remain high, that they are being delivered in a safe way and that our patients have a positive experience of care and good outcome.
The dates for the Commissioner Visits for this year are being finalised and will again see our patient representatives be part of the visiting team.

In 2015, we carried out 12 visits in total to services provided at Gateshead Health NHS Foundation Trust, Newcastle Upon Tyne NHS Foundation Trust and Newcastle Tyne and Wear NHS Foundation Trust.

Having a patient representative as part of the visiting team ensures that services are seen through the eyes of patients and services users, gives the opportunity to talk to patients and families about the care they are receiving and help capture what good quality care looks, sounds and feels like.

9.4 Health Champions
Health Champions work is happening in 7 new practices all based within Gateshead, and as yet no new practices in Newcastle. Conversations continue re practice engagement in Newcastle, and in order to create parity across the CCG conversations are continuing to explore options in Newcastle.

The 7 new practices are joining the existing 3 Gateshead practices and 2 Newcastle practices (previously funded via Big Lottery) mean that 12 practices have been worked with this approach. While both Newcastle practices are still keen to support the Health Champions approach both practices have had a reduction in champions and the work has significantly reduced or stopped. However, Health Champions is just one social prescribing approach amongst many.

In Gateshead three different approaches have been designed and will be evaluated by Involve North East to establish which approach is the most suitable to expand and develop further, while also being mindful of meaningful outcomes. This approach evolved naturally but gives a good evaluation of the work locally.

1. Cluster model approach. One practice having worked with health champions for 2+ yrs and will link with 2 other practices to develop health champions across all practices. This removes the “silo approach” and supports practices co-creating. This has benefits in that champion activities will be more community based and open for all, but has disadvantages such as all practices needing to agree – however, this so far hasn’t been an issue.

29th April 2016 will be the “Welcome Event” for new champions and so far 10 patients have signed up to attend this session.

2. Care navigator approach. Working in care navigators in four practices they recruited patients to become health champions. This approach has a strength that Care Navigators skills make them ideal and ideally placed in a practice to meaningfully recruit. The “Welcome Event” for this took place on 13th April with a good number of patients (champions) and care navigators attending. This event was packed with energy and ideas.

3. LTC approach. Working with one practice to only recruit patients who are diabetic. This approach has a strength that champions have something in common and will perhaps build connections quicker and agree what they want
to do quicker, but has a weakness in that at the early recruitment stage can exclude some people who may be interested. While champions are being recruited from patients who have diabetes any activity they do will be open to any patient or member of the community.

The “Welcome Event” for this practice will take place on 26th May.

Advantages and disadvantages of the three approaches will be looked at and evaluated by Health Champion lead and Involve NE who potentially will speak to others such as practice staff and champions, however, the papers aim is to highlight which approach is the most sensible to continue with, and use as a model within future practices. Due to the length of time this work has the paper will be complete by mid-June, while this does only give new practices a matter of weeks to evaluate, this isn’t a concern as many evaluations are available for the long-term impact of the work. This paper is to assess the best foundations for the Health Champions work.

10. Communications and Engagement

10.1 Patient and Community Fora – Newcastle
ACORN patient participation group (North and East)
The next meeting of the group will be held in June, which will be the AGM.

Items on the agenda include:
- ACORN summary of the year from the Chair
- CCG summary of the year
- Discussion with Chris Piercy, Executive Director of Nursing, Patient Safety and Quality on the current and possible future arrangements for ACORN, other existing PPGs and the involvement agenda in general.

The next meeting will be held in September.

Newcastle West Patient Forum
The Newcastle West Patient Forum met on 5 May and focused on the theme of ‘Connected People, Connected Communities’. The group undertook a workshop to develop a poster as part of the pre-work for the Connected People, Connected Communities event taking place on 7 June.

A discussion was also held on the Newcastle Innovation Fund and patients explored what could be done to encourage take up of the opportunities offered. The next meeting of the Newcastle West Patient Forum is to be held on 15 September.

10.2 Patient User Carer Public Involvement (PUCPI) Group - Gateshead

The PUCPI Group met on 3 May, and focused on the theme of ‘Connected People, Connected Communities’, undertaking a workshop to complete a poster for the event on 7 June. The meeting also covered matters arising, issue and action log, and updates from the group.
10.3 Gateshead Local Engagement Board (LEB)
There is no update since the previous meeting. The next meeting of the LEB is on 16 June.

10.4 Healthwatch Newcastle Annual Conference
We attended the annual Healthwatch Conference and hosted a workshop on GP appointments and urgent care.

Following an update on the urgent care review, Dr Steve Summers, Marc Hopkinson and Julia Young facilitated table discussions that asked:

- What does the term ‘urgent’ mean to people?
- How do we ensure that the public know about and understand the role of the NHS 111 service?
- How do we make calling NHS 111 a good experience?
- What would an ideal ‘urgent access to primary care’ service to look like?

Feedback from the sessions will be included in the report from the day which we will use as we develop our urgent care work.

11. Older People (Gateshead)
The Self-Care participation Programme has now successfully recruited all 16 volunteers and a reserve list is now being held to capture further interest. The programme will be delivered by North of England Mental Health Development Unit and will commence 27th May, running over five consecutive Friday’s.

This project will provide a core group of volunteers with the skills and knowledge necessary not just to better manage their own care, but to engage with the wider population of Gateshead on behalf of the vanguard programme. Co-designing the volunteer-led participation workshops offers the vanguard programme an opportunity to talk to patients and residents in a focused and topic-related way. These workshops offer the opportunity for wider public engagement in both the Care Pathway and Outcomes work streams.

As part of the Innovation and Involvement Project, consultation has now finished and reports are due to be submitted by May 10th from the following organisations:

- Jewish Community Council
- Gateshead and South Tyneside Sight Service
- Community Links
- Age UK Gateshead

A focus group was held as part of the consultation process with older people living with visual impairments via Gateshead and South Tyneside Sight Service. This session was very successful and informative. The key challenges raised were around raising awareness with carers and care homes.

There are useful aids and adaptations which are available to help someone live well and independently with a visual impairment which all require greater promotion.
The next Engagement and Communications Working Group will be held Tuesday 3\textsuperscript{rd} May where older people are encouraged to attend and influence health and social care for older people.
# Newcastle Gateshead CCG Governing Body Meeting

**Meeting Title:** Newcastle Gateshead CCG Governing Body Meeting  
**Date:** 24/05/16  
**Agenda Item:** 9.1

## Report Title
Newcastle Gateshead CCG Integrated Delivery Report

## Synopsis
The Integrated Delivery Report presented to the Governing Body, brings together high level themes from all aspects of quality and patient safety whilst linking with performance and finance, so that none of the components are seen in isolation.

Each report provides context as to the reasons for pressures and actions being taken to mitigate their impact in relation to key quality, performance, contract and finance issues.

## Implications and Risks
The report provides context as to the reasons for pressures and actions being taken to mitigate their impact in relation to key quality, performance, contract and finance issues.

## Recommendation
The Governing Body is asked to note the content of this report.

## Report history
The Integrated Delivery Report has been considered at the CCG Executive Committee meeting held on 17th May 2016.

## Lead Director & Report Author
**Director:** Joe Corrigan  
**Title:** Chief Finance Officer and Operating Officer  
**Author:** Jill McGrath, Colin Smith, Claire Dovell, Neil McKnight  
**Title:** Provider Management Team

## Classification
Official

## Purpose (click one box only)
Decision ☐  
Information ☒
<table>
<thead>
<tr>
<th><strong>Benefits to patients &amp; the public</strong></th>
<th>The Integrated Delivery report provides an update and assurance in relation to a range of contractual related issues and specifically provides an update on key quality issues as they impact on patient care.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Links to Strategic objectives</strong></td>
<td>To embrace the principles of cost effectiveness and improving value for money, in order to ensure we deliver and overall balanced budget. To improve the quality of services we offer our patients.</td>
</tr>
<tr>
<td><strong>Identified risks &amp; risk management actions</strong></td>
<td>This paper provides an update on risks relating to quality, performance and finance and identifies mitigating actions where applicable.</td>
</tr>
<tr>
<td><strong>Resource implications</strong></td>
<td>Not applicable. This report provides a general update on key quality, performance and finance issues.</td>
</tr>
<tr>
<td><strong>Legal implications &amp; equality and diversity assessment</strong></td>
<td>To comply with the legal requirements of the Health and Social Care Act 2012. There are no implications for the nine protected characteristics.</td>
</tr>
<tr>
<td><strong>Sustainability implications</strong></td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>NHS Constitution</strong></td>
<td>Principle 6: The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.</td>
</tr>
<tr>
<td><strong>Next steps</strong></td>
<td>Actions being undertaken are as outlined in the individual CCG reports attached as appendices to this report and progress updates will be provided at the next meeting of the Governing Body.</td>
</tr>
<tr>
<td><strong>Appendices</strong></td>
<td></td>
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Newcastle Gateshead CCG
Executive Integrated Delivery Report
17th May 2016
Newcastle Gateshead CCG – 17 May 2016
Executive Summary

The data in this report relates to the reporting period February 2016 except where stated. KPIs of note are:

1. Quality and Safety page 3
   - 3 Never Events NuTHFT 1 reported May 2015 and 2 February 2016 – page 7.
   - 5 MRSA cases NuTHFT reported November ytd 2015 – page 8.
   - 3 MRSA case NGCCG reported 1 Oct 2015 & 2 Jan 2016 – page 8.
   - 1 MRSA case GHFT reported January 2015 – page 8.

2. Key performance indicators page 15
   - ▶️ 67 Green (within target) ▼️ 34 Red (beyond target) ⃣ 5 indicators have no in year data/target so not rag rated
   - Cancer waiting times CCG – page 19.
   - Diagnostics NUTH – page 21.
   - CDiff – CCG and GHFT – page 22.
   - NEAS Response times – page 23.
   - A&E – page 23.

Quality Premium page 18
- NHS Constitution - Cat A Red 1 Ambulance Response times off track – 20% reduction in QP payment – page 23.
- Patients with SMI who smoke on track – page 22.

Better Care Fund
- Permanent admissions of older people 65+ to residential and nursing care homes – page 22.
- Non elective pressures apparent at GHNHSFT and NuTHFT - page 22.

Strategic Plan: Outcome Ambitions
- HCAI – page 22.

3. Contract Activity page 25
- GHNHSFT – Elective activity is exceeding planned levels at month 11 (£1,518k) page 26.
- NuTHFT – Drugs and Devices are over performing by £1,465k at month 11 page 27.

4. Finance page 32
- Month 12 reports a surplus of £10,275k or 1.45% of budget.
- NuTHFT - year-end position is currently forecast to be a £5,635k over performance at month 12.
- CHC/FNC – year-end position is currently forecast at £7,760k over budget at month 12.
Quality and Safety
1. Quality and Safety

This report links quality and patient safety alongside finance and performance so that neither component is seen purely in isolation. The quality elements of this report provide a more detailed analysis of quality issues and are in addition to the Alliance Joint Quality, Safety and Risk Committee and the Area Teams Quality Surveillance group. The data used in this section has been sourced from published data sources.

1.1 Quality and Safety – Serious Incidents by Provider and Category

All serious incidents are formally reviewed and closed by Newcastle Gateshead CCG or other relevant SI Panels. The trends of incidents are also monitored.

Between 01/03/2015 and 31/03/2016 there have been 170 recorded SIs involving Newcastle Gateshead CCG registered patients for the providers detailed above.

The graphs overleaf demonstrate SIs reported between March 2015 and March 2016, which involved Newcastle Gateshead CCG registered patients, by provider. These graphs do not represent the total number of SIs reported by the providers in the timeframe.
1.1 Quality and Safety – Serious Incidents by Provider and Category continued

### Types of SIs - Gateshead Health NHS Foundation Trust

- **Number of SIs:**
  - Mar-15: 4
  - Apr-15: 2
  - May-15: 2
  - Jun-15: 1
  - Jul-15: 1
  - Aug-15: 2
  - Sep-15: 1
  - Oct-15: 2
  - Nov-15: 1
  - Dec-15: 2
  - Jan-16: 4
  - Feb-16: 1
  - Mar-16: 3

### Types of SIs - Newcastle upon Tyne Hospitals NHS Foundation Trust

- **Number of SIs:**
  - Mar-15: 1
  - Apr-15: 3
  - May-15: 1
  - Jun-15: 1
  - Jul-15: 1
  - Aug-15: 4
  - Sep-15: 1
  - Oct-15: 1
  - Nov-15: 1
  - Dec-15: 1
  - Jan-16: 5
  - Feb-16: 4
  - Mar-16: 5
1.1 Quality and Safety – Serious Incidents by Provider and Category continued

Types of SIs - Northumberland Tyne & Wear NHS Foundation Trust

Types of SIs - North East Ambulance Service NHS Foundation Trust

Executive Summary ➔ Quality ➔ Performance ➔ Contracting ➔ Finance
1.2 Quality and Safety – Never Events

<table>
<thead>
<tr>
<th>Reference</th>
<th>Reported Date</th>
<th>Incident Date</th>
<th>Type of SI</th>
<th>Organisation</th>
<th>Status</th>
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<td>12/02/2016</td>
<td>22/01/2016</td>
<td>Surgical/invasive Procedure - wrong site surgery</td>
<td>NuTHFT</td>
<td>Awaiting 60 Day Report</td>
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<td>25/02/2016</td>
<td>23/02/2016</td>
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<td>NuTHFT</td>
<td>Awaiting 60 Day Report</td>
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<tr>
<td>2016/8901</td>
<td>01/04/2016</td>
<td>29/03/2016</td>
<td>Surgical/invasive Procedure - wrong site nerve block</td>
<td>GHFT</td>
<td>Awaiting 60 Day Report</td>
</tr>
</tbody>
</table>

1.3 Quality and Safety – Health Care Acquired Infection (HCAI)

The HCAI Reduction Partnership continues to closely monitor trends and to develop action plans in conjunction with commissioner and provider organisations.

- Newcastle Gateshead CCG is above trajectory for the whole year, reporting 199 against a trajectory of 142
- 119 community cases in the year
- Trends and themes continue to be monitored by HCAI Partnership – includes RCAs around incidence of community cases
Acute Hospitals CDi
- Newcastle upon Tyne Hospitals FT has exceeded the trajectory of 77 cases for the year, reporting 94 cases.
- Gateshead Health FT has exceeded the trajectory of 19 cases for the year, reporting 47 cases

MRSA February ytd
- 5 cases of MRSA have been reported by NUTFT.
- 1 case of MRSA reported by GHFT – identified as a contaminant.
- 3 cases of MRSA reported by CCG.
1.5 Quality and Safety – Complaints

The following complaints and concerns have been handled by the NECS Complaints Team on behalf of the CCG in the year 2015/16.

All cases, by grade

All cases, by lead organisation

CCG cases, by category
1.6 Quality and Safety – Mortality Rates

- South Tyneside NHS Foundation Trust (STNFT) has been identified as “higher than expected” in both Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Index (SHMI). STNFT is responsible for the community contract for Gateshead patients until October 2016.
- Newcastle Hospitals has been identified as having higher than expected weekend HSMR. This is currently being investigated by the Trust and will be reported back at the next Quality Review Group.

1.7 Quality and Safety – Transforming Care - Learning Disabilities

- There are no risks currently identified as Red in Gateshead or Newcastle.
- All other risks will continue to be monitored and managed by the Newcastle Gateshead working group.
Newcastle Gateshead CCG practices reported 409 incidents in March 2016. The graphs below detail the type of incidents reported in March 2016 and the reporting rates from March 2015 to March 2016.

- Themes and trends continue to be raised directly with the Trust and at Quality Review Group meetings.
The Friends and Family Test now features within all provider contracts.

The following actions have been taken:

- Friends and Family Test response rates and scores continued to be monitored via respective contract monitoring meetings and Quality Review Groups.
- Both Trusts remain above national average of 95.0% for Inpatient recommendation.
- Both Trusts above national average of 85.0% for A&E recommendation
- NuTH A&E response rate remains very low (2.2%) in February (national average = 13.3%)
1.10 Quality and Safety – Monitor Rating

- South Tyneside NHS Foundation Trust investigated by Monitor for continuity of services risk (level 2) due to concerns relating to financial stability (level 1 highest risk, level 4 lowest)
- Risk to be monitored through QRG and contracting routes.

1.11 Serious Incidents

- Newcastle upon Tyne Hospitals FT reporting to the National Patient Safety Agency a higher proportion of patient safety incidents that are harmful.
- This is monitored via the Serious Incident panel of the CCG.

1.12 Latest CQC Inspections

- Gateshead Hospitals rated as “Good”.
- South Tyneside rated as “Needs Improvement”.

1.13 Quality and Safety – NTW FT Restraint Information

- NHS Benchmarking Network latest data collection (August 2015) has highlighted that NTWFT is 3rd highest overall user of restraint with an average of 7.6 instances per 10 beds compared with the national average of 2.8.
- The highest reported incidences of restraint within the Trust are primarily from within Learning Disability and Child Adolescent Mental Health Services.
- The Trust has commissioned an independent investigator to review the restraint data and will present a formal update on their findings at the next QRG in May 2016. The CCG’s have also asked the Trust to provide written assurance prior to this of the work they are undertaking in respect of restraint.
1.14 Cost Improvement Plans

Cost Improvement Plans (CIP): All Trusts are required to identify schemes to increase efficiency or reduce expenditure and these can include both recurrent (year on year) and non-recurrent (one-off) savings. These are based on long-term plans to transform clinical and non-clinical services which not only result in a permanent cost saving but also improve patient care, satisfaction and safety. The potential risks that cost saving schemes can have on the quality of services must be assessed by each provider and plans put in place to mitigate any risks. It is important that CIPs do not impact on patient care and therefore Trusts undertake a quality impact assessment which is approved by their Board prior to implementation.

GHFT, NuTHFT and NTWFT provide assurance to NGCCG via the Quality Review Group that their CIPs take safety and quality into account. Where there are any exceptions or issues of note the Trust raise these at the QRG and any actions agreed are documented in the minutes.

1.15 Quality Team Deliverables and Achievements

- Medicines Optimisation Team shortlisted for national HSJ award at Clinical Pharmacy Congress
- Patient Experience Team engaging with 40 families in the child asthma programme
- Unborn child protection audit undertaken for Maternity Department at QE by the CCG’s Quality Team – results shared with local authority and used to inform social care practice.
- Independent Domestic Violence Advocate pilot underway in Newcastle Gateshead GP practices
- Two thirds of Newcastle Gateshead practices signed up to deliver local Vanguard programme
- Basket of Care project group initiated
- Safeguarding and Looked After Children (SLAC) action plan for CQC nearing completion
- Process to recruit Health Champions underway
Performance
### Performance Table

This table details performance against key performance measures for Newcastle Gateshead CCG.

<table>
<thead>
<tr>
<th>Ref:</th>
<th>Newcastle Gateshead CCG - Performance Indicators</th>
<th>Source</th>
<th>Latest Data Period</th>
<th>Month Actual</th>
<th>Actual to Date</th>
<th>Target to Date</th>
<th>2015/16 Target</th>
<th>Risk to Year End</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT 18 weeks for admitted pathways - NGCCG</td>
<td></td>
<td>C, OP</td>
<td>Feb-16</td>
<td>87.9%</td>
<td>93.7%</td>
<td>90.0%</td>
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<tr>
<td>RTT 18 weeks for admitted pathways - GHFT</td>
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<td>C</td>
<td>Feb-16</td>
<td>81.6%</td>
<td>86.9%</td>
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<td>RTT 18 weeks for non-admitted pathways - NUTH</td>
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<td>C</td>
<td>Feb-16</td>
<td>91.0%</td>
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<td>RTT incomplete pathways within 18 weeks - NGCCG</td>
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<td>&gt; 6 weeks for the 15 diagnostics tests - NGCCG</td>
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<td>Feb-16</td>
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<td>Over 12 hour trolley waits - GH</td>
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<td>62 days NHS Cancer Screening Service - NGCCG</td>
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<td>Feb-16</td>
<td>75.0%</td>
<td>93.5%</td>
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<tr>
<td>62 days NHS Cancer Screening Service - NUTH</td>
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<td>97.7%</td>
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<td>Subsequent treatment for cancer within 31 days - radiotherapy - NUTH</td>
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<tr>
<td>Category A (Red 1) 8 minute - NEAS</td>
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<td>Category A 19 minutes - NGCCG</td>
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<td>Ambulance handover &lt;=30 mins - NUTH</td>
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<td>Mar-16</td>
<td>5</td>
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<td>0</td>
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<tr>
<td>Mixed Sex accommodation - NGCCG</td>
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<td>C</td>
<td>Mar-16</td>
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<td>Mixed Sex accommodation - GHFT</td>
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<td>Mar-16</td>
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<td>Mixed Sex accommodation - NUTH</td>
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<tr>
<td>Cancellations operations rescheduled within 28 days - GHFT</td>
<td></td>
<td>C</td>
<td>Q3 2015/16</td>
<td>98.2%</td>
<td>98.4%</td>
<td>100%</td>
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<tr>
<td>Cancellations operations rescheduled within 28 days - NUTH</td>
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<td>Q32015/16</td>
<td>95.3%</td>
<td>94.8%</td>
<td>100%</td>
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| PYLL | | | | | | | | | | Preventable Years of Life Lost (PYLL) OA1; OP
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<th>Ref:</th>
<th>Newcastle Gateshead CCG - Performance Indicators</th>
<th>Source</th>
<th>Latest Data Period</th>
<th>Month Actual</th>
<th>Actual to Date</th>
<th>Target to Date</th>
<th>2015/16 Target</th>
<th>Risk to Year End</th>
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<tr>
<td>% follow up within 7 days of discharge from psychiatric inpatient care</td>
<td>C</td>
<td>Q3 2015/16</td>
<td>95.6%</td>
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<td>95.0%</td>
<td>95.0%</td>
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<tr>
<td>% people who access psychological therapies (IAPT)</td>
<td>OA2</td>
<td>Feb-16</td>
<td>1.72%</td>
<td>16.5%</td>
<td>13.75%</td>
<td>15.0%</td>
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<td>People accessing IAPT moving to recovery</td>
<td>OA2</td>
<td>Feb-16</td>
<td>44.3%</td>
<td>46.8%</td>
<td>60.0%</td>
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<td>IAPT &gt;6 weeks treatment - NGCCG</td>
<td>C</td>
<td>Dec-15</td>
<td>97.3%</td>
<td>97.3%</td>
<td>75%</td>
<td>75%</td>
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<tr>
<td>IAPT &gt;6 weeks treatment - STFT</td>
<td>C</td>
<td>Dec-15</td>
<td>100.0%</td>
<td>100.0%</td>
<td>75%</td>
<td>75%</td>
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<tr>
<td>IAPT &gt;6 weeks treatment - NUTFT</td>
<td>C</td>
<td>Dec-15</td>
<td>94.0%</td>
<td>94.0%</td>
<td>75%</td>
<td>75%</td>
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<tr>
<td>IAPT &gt;6 weeks treatment - NT</td>
<td>C</td>
<td>Dec-15</td>
<td>100.0%</td>
<td>100.0%</td>
<td>75%</td>
<td>75%</td>
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<tr>
<td>% first episode of psychosis within two weeks of referral - NGCCG</td>
<td>C</td>
<td>Mar 2016 ytd</td>
<td>454.1%</td>
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<tr>
<td>% first episode of psychosis within two weeks of referral - STFT</td>
<td>C</td>
<td>Mar 2016 ytd</td>
<td>100.0%</td>
<td></td>
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<td></td>
<td></td>
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<td>67.0%</td>
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<tr>
<td>% first episode of psychosis within two weeks of referral - NUTFT</td>
<td>C</td>
<td>Mar 2016 ytd</td>
<td>100.0%</td>
<td></td>
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<tr>
<td>% first episode of psychosis within two weeks of referral - NT</td>
<td>C</td>
<td>Mar 2016 ytd</td>
<td>100.0%</td>
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<td>67.0%</td>
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<tr>
<td>% of acute trusts with an effective model of liaison psychiatry - STFT</td>
<td>C</td>
<td>Mar 2016 ytd</td>
<td>Indicator in development</td>
<td></td>
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<tr>
<td>% of acute trusts with an effective model of liaison psychiatry - NUTFT</td>
<td>C</td>
<td>Mar 2016 ytd</td>
<td>Indicator in development</td>
<td></td>
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<tr>
<td>% of acute trusts with an effective model of liaison psychiatry - NT</td>
<td>C</td>
<td>Mar 2016 ytd</td>
<td>Indicator in development</td>
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<td>Diagnosis rate for people with dementia</td>
<td>OA2</td>
<td>Mar 2016</td>
<td>41.1%</td>
<td>41.1%</td>
<td>42.0%</td>
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<td>Number of people with severe mental illness who are smokers</td>
<td>QP</td>
<td>Jan-16</td>
<td>1.2</td>
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<td>Antibiotic Prescribing</td>
<td>QP</td>
<td>Jan-16</td>
<td>7.9</td>
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<td>Avoidable Admissions</td>
<td>BCF,OA3</td>
<td>Feb-16</td>
<td>63.4</td>
<td>958.6</td>
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<td>Availabe Admissions</td>
<td>BCF,OA3</td>
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<td>Unplanned hospitalisation for chronic ambulatory care sensitive conditions.</td>
<td>BCF,OA1</td>
<td>Feb-16</td>
<td>115.3</td>
<td>1507.8</td>
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<td>Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s)</td>
<td>BCF,OA3</td>
<td>Feb-16</td>
<td>35.1</td>
<td>454.1</td>
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<td>Unplanned admissions for conditions not usually requiring hospital admission</td>
<td>BCF,OA3</td>
<td>Feb-16</td>
<td>9,04</td>
<td>77</td>
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<td>Emergency admissions for children with lower respiratory tract infections (LRTI).</td>
<td>BCF,OA3</td>
<td>Feb-16</td>
<td>97.3%</td>
<td>97.3%</td>
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<td>Patient experience of hospital care GHFT</td>
<td>OA5</td>
<td>2014/15</td>
<td>8.4</td>
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<td>10.0</td>
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<td>8.5</td>
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<td>Patient experience of GP QOF services</td>
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<td>Sep-15</td>
<td>86.6%</td>
<td>86.6%</td>
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<td>Patient satisfaction with the quality of consultation at the GP practice</td>
<td>OA5</td>
<td>Sep-15</td>
<td>442.27</td>
<td>447.27</td>
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<td>Satisfaction with the overall care received at the surgery</td>
<td>OA5</td>
<td>Sep-15</td>
<td>87.2%</td>
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<td>Satisfaction with accessing primary care</td>
<td>OA5</td>
<td>Sep-15</td>
<td>75.2%</td>
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<td>Average score (in the GP patient Survey) for people with Long Term Condition</td>
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<td>2014/15</td>
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<td>Delayed Transfers</td>
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<td>Mar-16</td>
<td>642</td>
<td>6,161</td>
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<td>Delayed transfers of care from hospital NHS only NGCCG</td>
<td>OA7</td>
<td>Feb-16</td>
<td>0</td>
<td>0</td>
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<tr>
<td>MRSA NGCCG</td>
<td>OA7</td>
<td>Feb-16</td>
<td>0</td>
<td>0</td>
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<td>MRSA GHFT</td>
<td>OA7</td>
<td>Feb-16</td>
<td>0</td>
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<td>MRSA NUTH</td>
<td>OA7</td>
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<td>15</td>
<td>109</td>
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<td>Clostridium Difficile NGCCG</td>
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<td>2</td>
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<td>19</td>
<td>19</td>
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<td>Clostridium Difficile NUTH</td>
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<td>2</td>
<td>47</td>
<td>19</td>
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<td>Flu Vaccs</td>
<td>Sept - Dec 15</td>
<td>72.4%</td>
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<td>Flu vaccination uptake under 65 years at risk groups, including pregnant women</td>
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<td>48.0%</td>
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</tr>
<tr>
<td>Elective FFCEs</td>
<td>Feb-16</td>
<td>6,226</td>
<td>71,187</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Elective FFCEs</td>
<td>Feb-16</td>
<td>4,712</td>
<td>52,350</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Outpatient Attendances</td>
<td>Feb-16</td>
<td>12,018</td>
<td>131,701</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E Attendances</td>
<td>Feb-16</td>
<td>20,593</td>
<td>222,084</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% children and young people (age 5 – 18 yrs) on the asthma disease register who have had a personal asthma action plan (PAAP) created or reviewed as part of their annual review in the last 12 months</td>
<td>OA2</td>
<td>Mar 2016 ytd</td>
<td>6.5%</td>
<td>65.8%</td>
<td>7%</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification of young carers (aged under 18 years) to ensure that they receive appropriate support and onward referral.</td>
<td>OA2</td>
<td>Mar 2016 ytd</td>
<td>79</td>
<td>409</td>
<td>45</td>
<td>45</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Better care Fund - Gateshead**

<table>
<thead>
<tr>
<th>Ref:</th>
<th>Newcastle Gateshead CCG - Performance Indicators</th>
<th>Source</th>
<th>Latest Data Period</th>
<th>Month Actual</th>
<th>Actual to Date</th>
<th>Target to Date</th>
<th>2015/16 Target</th>
<th>Risk to Year End</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>% people who were still at home 91 days after discharge from hospital into rehabilitation/ rehabilitation service</td>
<td>BCF,OA4</td>
<td>Q3 14/15</td>
<td>85.3%</td>
<td>85.3%</td>
<td>88.7%</td>
<td>88.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent admissions of older people aged 65+ to residential and nursing care homes per 100,000</td>
<td>BCF</td>
<td>Q3 14/15</td>
<td>666</td>
<td>666</td>
<td>817.2</td>
<td>817.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent admissions of older people aged 65+ to residential and nursing care homes per 100,000</td>
<td>BCF</td>
<td>Jan - Sep 14</td>
<td>40.0%</td>
<td>40.0%</td>
<td>43.0%</td>
<td>43.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total non-elective admissions (general &amp; acute), all-age</td>
<td>BCF</td>
<td>Q3 14/15</td>
<td>6495</td>
<td>6495</td>
<td>6,727</td>
<td>5,663</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Better care Fund - Newcastle**

<table>
<thead>
<tr>
<th>Ref:</th>
<th>Newcastle Gateshead CCG - Performance Indicators</th>
<th>Source</th>
<th>Latest Data Period</th>
<th>Month Actual</th>
<th>Actual to Date</th>
<th>Target to Date</th>
<th>2015/16 Target</th>
<th>Risk to Year End</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>% people who were still at home 91 days after discharge from hospital into rehabilitation/ rehabilitation service</td>
<td>BCF,OA4</td>
<td>Q2 14/15</td>
<td>78.9%</td>
<td>78.9%</td>
<td>84.7%</td>
<td>84.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent admissions of older people aged 65+ to residential and nursing care homes per 100,000</td>
<td>BCF</td>
<td>Q2 14/15</td>
<td>912</td>
<td>912</td>
<td>745</td>
<td>745</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delayed transfers of care from hospital (NHS)</td>
<td>BCF</td>
<td>Q3 14/15</td>
<td>1,576</td>
<td>1,576</td>
<td>1,306</td>
<td>1,306</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delayed transfers of care from hospital NHS &amp; Social Care Newcastle LA</td>
<td>BCF</td>
<td>Q2 14/15</td>
<td>1,288</td>
<td>1,288</td>
<td>2,089</td>
<td>2,089</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injuries due to falls</td>
<td>BCF</td>
<td>Q2 14/15</td>
<td>2,428</td>
<td>2,428</td>
<td>2,194</td>
<td>2,194</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total non-elective admissions (general &amp; acute), all-age</td>
<td>BCF</td>
<td>Q3 14/15</td>
<td>7,659</td>
<td>7,659</td>
<td>8,249</td>
<td>31,691</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C - NHS Constitution Indicator
OA – Outcome Ambition Indicator
QP – Quality Premium Indicator
BCF – Better Care Fund Indicator
## 1. Quality Premium

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage of Quality Premium</th>
<th>Value for CCG</th>
<th>Threshold</th>
<th>Latest data</th>
<th>Risk rating</th>
<th>Eligible QP Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in Preventable Years of Life lost from causes amenable to healthcare</td>
<td>10%</td>
<td>£239,112</td>
<td>Reduction in 2015 compared to 2014</td>
<td>Annual data collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduction in delayed transfers of care</td>
<td>30%</td>
<td>£717,336</td>
<td>Reduction in 2015/16 compared to 2014/15</td>
<td>Mar YTD 6,161</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health - Reduce the number of patients with SMI who smoke</td>
<td>30%</td>
<td>£717,336</td>
<td>Reduction in 2015/16 compared to 2014/15 42%</td>
<td>Mar 2016 YTD 41.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic prescribing Improved antibiotic prescribing in primary and secondary care</td>
<td>30%</td>
<td>£717,336</td>
<td>Reduction in 2015/16 compared to 2014/15 42%</td>
<td>Jan 2015/16 Part A 1.2 Part B 7.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood asthma</td>
<td>10%</td>
<td>£239,112</td>
<td>10% increase on Q1 2015/16 baseline 7%</td>
<td>Mar 2016 YTD 65.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young carers</td>
<td>10%</td>
<td>£239,112</td>
<td>50% increase on 2014/15 baseline 45</td>
<td>Mar 2016 YTD 409</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>£2,391,120</strong></td>
<td></td>
<td></td>
<td></td>
<td>£0</td>
</tr>
</tbody>
</table>

### NHS Constitution
- **RTT Incomplete pathways (92%)**
  - Adjustment: 30%
  - YTD: 94.0% Feb
- **A&E Waitings <4 hrs (95%)**
  - Adjustment: 30%
  - YTD: 94.1% Feb ytd
- **Cat A ambulance (NEAS) 75%**
  - Adjustment: 20%
  - YTD: 68.0% Mar ytd
- **Cancer Waiting times 2 wwp (93%)**
  - Adjustment: 20%
  - YTD: 94.5% Feb ytd
The following table provides additional detail for KPIs which are beyond their target or where there is a risk to year end performance.

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Issues Risks and Key Actions</th>
</tr>
</thead>
</table>
| **Referral to Treatment (RTT)** | • RTT standards at NUTHFT remain on track; CCG and Gateshead Health have fallen below the admitted and non-admitted standards in February, this is due to validation of pathways at Gateshead Health who concentrate validation on incomplete pathways given the removal of admitted and non-admitted standards from the standard contract. Incomplete standard is being met by CCG and both FTs. Gateshead Health FT is initiating a piece of work around RTT validation.  
• The incompletes target is being met overall at a Trust aggregate level at GH (93.6%); all specialties are now meeting or exceeding the 92% incompletes standard.  
• Orthopaedics performance at NUTHFT has dropped since the improvement seen in July 2015. Improvements are expected to be seen in March when various initiatives are in place. In February performance is 83.2%.  
• The National Guidance has been amended and where spinal patients had been included in the “other” specialty for 2 years, they are now to be included within Orthopaedics, which will have a significant impact on overall performance within this specialty. |
| **Cancer Waiting Times** | • 62 day standard  
Of NUTHs 62 day activity, only 40-45% is for NGCCG, hence the CCG is off track Q4 YTD Feb.  
• Gateshead Health has recovered the Q1 position and the Trust met Q2 and Q3 and Q4 to date  
• Newcastle Hospitals failed to meet the August position and subsequently failed Q2 (83.6%), although have since met the standard. Areas that continue to be a cause for concern are endoscopy, radiology and elements of the pathology service. Tumour groups where performance is consistently below standard are Lung, Upper GI, Urology and Colorectal. Late referrals continue to be an issue for NUTH.  
• NHSE and NHSI published the National Cancer Breach Allocation Guidance which uses day 38 as a clear single target date by which handover from referring trusts to |

- 92% standard - incompletes  
Non-achievement of the RTT waiting time standard for incomplete pathways will reduce the Quality premium payment by 30% in 2015/16.  
- 62 day (85% standard) - NGCCG at risk  
  - NUTH on track Feb YTD 86.8%  
  - GH on track Feb YTD 86%  
  - NGCCG off track marginally Feb YTD 84.7%
<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Issues Risks and Key Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2 week wait (93% standard) – all cancers</strong></td>
<td>treating trusts should take place. The CCG and Trusts are to work collaboratively with the network to implement this. Other actions are as follows:</td>
</tr>
<tr>
<td>- Gateshead Health failed this standard for 3 consecutive quarters however Q3 has been met and 93.6% Feb YTD.</td>
<td></td>
</tr>
<tr>
<td>- NUTH on track – met standard Q2 and Q3 Feb YTD at 95.8%.</td>
<td></td>
</tr>
<tr>
<td>- NGCCG - met standard Q2 and Q3 and are 94.5% at Feb YTD.</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic &gt; 6 week waiters</strong></td>
<td></td>
</tr>
<tr>
<td>NHS Constitution requirement 99% standard</td>
<td>- Gateshead Health FT failed to meet the Diagnostic waiting times target from January 2015, largely due to the impact of long waits arising in echocardiography, and from July long waits arising in Non-Obstetric Ultrasound.</td>
</tr>
<tr>
<td>- GH back on track Nov 2015 - March 2016</td>
<td></td>
</tr>
<tr>
<td>- NUTH failed Dec -Jan 2016 on track February, March 2016</td>
<td></td>
</tr>
<tr>
<td>- NGCCG remain on track Nov 2015 – March 2016</td>
<td></td>
</tr>
<tr>
<td>- Significant work in conjunction with the FT and CCG has seen the FT and subsequently the CCG position recovered in November – March 2016.</td>
<td></td>
</tr>
</tbody>
</table>
| - The Trust has developed an action plan to help sustain the improved performance and 2 radiologists have now been appointed. | }

Pressures at NUTH include MRI, sleep studies, urodynamic and echocardiography. The Trust currently outsources to Nuffield, in Dec staffing difficulties resulted in this resource being withdrawn and as a result the FT failed the 1% diagnostics standard for the first time. Due to minimal breaches at GH, the CCG remained on track Dec to Feb 2016. The NUTH target has not been met for January 2016, and despite the trust meeting the standard in February and March, an action plan is in development for sustained recovery by Q2 2016/17.
<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Issues Risks and Key Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avoidable emergency admissions</strong>&lt;br&gt;Quality Premium for 2014/15 reduction in previous yr.&lt;br&gt;Outcome Ambition 2014/15 – 2018/19</td>
<td>• This is a composite indicator comprising 4 targets relating to avoidable emergency admissions where the CCG must achieve a staged reduction by 2018/19 compared to 2013/14.&lt;br&gt;• The introduction of ambulatory care pathways in Gateshead in 2014/15 has led to a reduction in the number of non-elective admissions which would previously have been categorised as avoidable. However as per the national definition, these patients are included within this data and in year proxy data indicates that this overall indicator has not been achieved in Gateshead or Newcastle for 2014/15.&lt;br&gt;• Practice level analysis and frequent fliers info collated and reviewed&lt;br&gt;• Actions linked to BCF and the overall requirement of the payment for performance metric to reduce non-elective admissions.</td>
</tr>
<tr>
<td><strong>Mental Health</strong>&lt;br&gt;IAPT - Outcome Ambition 2014/15 - 2015/16 to maintain a 15% access rate and 50% recovery rate&lt;br&gt;Waiting times standards of 75% seen in 18 weeks and 95% in 18 weeks are to be achieved by Q4 2015/16</td>
<td><strong>IAPT 2015/16</strong>&lt;br&gt;NGCCG has been successfully bid for £196,476 matched national IAPT funding to reduce waiting lists. A MOU has been completed by the CCG and the payment is to be in 2 halves, the first immediately and the 2nd on performance. Bi-monthly monitoring meetings are in place with providers.&lt;br&gt;• Current performance for NGCCG on track against the 6 week and 18 week waiting time standards.&lt;br&gt;• Pressures at NUTH but improving.&lt;br&gt;• STFT waits exist between 1st and 2nd appointment.&lt;br&gt;• Newcastle Gateshead CCG are currently achieving the access standard February YTD 2015/16 (16.5% YTD compared to 13.75% YTD target).&lt;br&gt;• NGCCG remain below the 50% requirement for patients to move to recovery at 46.8% (February YTD). The current Newcastle co-development model has been in a pilot phase and it is expected that significant improvements will be made to the recovery rate from March and April when the current pilot goes live.</td>
</tr>
<tr>
<td><strong>Quality Premium Local measures 2015/16</strong>&lt;br&gt;Reduction in patients with SMI who smoke worth 30% QP (£717, 316)</td>
<td>• This metric has now been achieved - Mental Health patients who smoke is 41.1% in March YTD, below the baseline of 42.0%.</td>
</tr>
<tr>
<td><strong>BCF metrics</strong></td>
<td>• A separate report is reviewed and actions considered at the BCF programme Board (Gateshead) and the Integrated System Programme Board (Newcastle).&lt;br&gt;• Older people who were still at home 91 days after discharge - The year end position</td>
</tr>
<tr>
<td>Performance Area</td>
<td>Issues Risks and Key Actions</td>
</tr>
<tr>
<td>------------------</td>
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<tr>
<td></td>
<td>was 2.6% lower than at the end of December, possibly due to a high number of deaths in Q3 (35) compared to Q1 (14) and Q2 (29) (Newcastle).</td>
</tr>
<tr>
<td></td>
<td>• Admissions to care homes – (Newcastle) The proportion of admissions that were residential (that panel approve) fell from 71.3% of the total to 64%, while the proportion of admissions that were for nursing care (which don't go through a panel process) has increased from 28.7% to 36%. This 7.3% increase is the equivalent to an additional 9 admissions to nursing care.</td>
</tr>
<tr>
<td></td>
<td>• Contract activity information at both GHNHSFT and NuTH suggests significant pressures are already apparent against non-elective activity, a key performance target for the BCF. See pages 26, 27 and 28.</td>
</tr>
<tr>
<td></td>
<td>• Newcastle Gateshead CCG has breached the year-end target of 142 for CDiff reporting 199 YTD in March.</td>
</tr>
<tr>
<td></td>
<td>• See Quality section.</td>
</tr>
<tr>
<td>HCAI</td>
<td></td>
</tr>
<tr>
<td>Outcome ambition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NEAS Cat A Red 1 Response times Non-achievement of the NEAS Cat A R1 waiting time standard will reduce the Quality premium payment by 20% in 2015/16.</td>
</tr>
<tr>
<td>Handover delays</td>
<td>Performance at the end of 2015/16 is below target at 68.0% ytd and the CCGs Quality Premium will now be reduced by 20%. A number of actions and additional schemes were implemented by the provider to improve the position. A senior clinical meeting was held in November, with CCG and NEAS representatives to discuss current issues and make some rapid decisions about what NEAS should, or should not be doing, to ensure that performance improves.</td>
</tr>
<tr>
<td></td>
<td>An action plan was produced. Key actions agreed included:</td>
</tr>
<tr>
<td></td>
<td>• NEAS to seek additional third party support to increase capacity.</td>
</tr>
<tr>
<td></td>
<td>• NEAS to address meal break issue. NEAS suggest this will have a material impact on performance.</td>
</tr>
<tr>
<td></td>
<td>• Regionally both NUTH and GH are good performers in terms of handover delays; however pressures at GH in relation to beds resulted in an increase in October, November and January handover delays.</td>
</tr>
<tr>
<td>A&amp;E 4 hour Waits</td>
<td></td>
</tr>
<tr>
<td>Reduction of QP by 30% for non-achievement at CCG level</td>
<td>NUTH actions</td>
</tr>
<tr>
<td></td>
<td>• Closer working with LA to proactively manage flow</td>
</tr>
<tr>
<td></td>
<td>• Funded CHC co-ordinator to manage patient pathway for those seeking long term placements</td>
</tr>
<tr>
<td></td>
<td>• Patient Service Co-ordinators and Discharge Team are actively trying to free up beds by expediting discharges.</td>
</tr>
<tr>
<td>Performance Area</td>
<td>Issues Risks and Key Actions</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>NGCCG performance Feb YTD is currently under performing at 94.1%</td>
<td>• The GP in A&amp;E pilot has been extended until March with the additional primary care funding used to deliver additional staffing sessions - covering both adults and paediatrics.</td>
</tr>
<tr>
<td>Gateshead FT 93.4% 15/16 outturn</td>
<td>• This funding has also been used to provide additional capacity to the OOH services and directly to primary care.</td>
</tr>
<tr>
<td>NUTH FT 93.7% 15/16 outturn</td>
<td>• A Minor ailments scheme is now also in place with all pharmacies.</td>
</tr>
<tr>
<td>GH FT achieved April - September monthly A&amp;E 4 hour wait targets but has failed October - March 2015/16.</td>
<td>• The ‘Perfect Week’ pilot was undertaken in November 2015 to test improved ways of working within the Acute Medicine and Elderly Care Directorate – priority now is to identify and sustain the key elements of success.</td>
</tr>
<tr>
<td>NUTH failed Nov – March 2015/16</td>
<td>• The pilot also highlighted that not all pressures in ED related to flow and beds. Separate ED “perfect week” is to be undertaken in February and a Paediatric exercise expected to follow in March 2016.</td>
</tr>
<tr>
<td>GH actions</td>
<td>• Specific focus on children in A&amp;E and use of education and technology to support parents and families.</td>
</tr>
<tr>
<td>• The Trust held a 2 day multi-disciplinary accelerated discharge event in early January with the following key areas for development identified:</td>
<td>• Specific communication message to use services wisely and promote use of primary care</td>
</tr>
<tr>
<td>• Surge/ Escalation Planning must cover all parts of the hospital</td>
<td>• Funded CHC co-ordinator to manage patient pathway for those seeking long term placements</td>
</tr>
<tr>
<td>• ‘Discharge to Assess’ model being implemented.</td>
<td>• Improved GP access through the Prime Ministers Challenge Fund is being delivered in and out of hours</td>
</tr>
<tr>
<td>• Senior review of the care plan and its delivery, for every patient, in every bed, seven days a week.</td>
<td>• Increased capacity is available to enable patients to access a GP - whilst the Emergency Care Centre and Blaydon WiC have a GP working as part of the team 8am - 10 pm.</td>
</tr>
<tr>
<td>• Specific cohorts of patients must be assertively managed e.g. frail, older people</td>
<td></td>
</tr>
</tbody>
</table>
Contracting
3. General Contract Update

This section of the report updates on the current position relating to key contractual issues the Provider Management Team are addressing with our major providers:

2015/16 Contracts

A year end settlement was agreed with Newcastle Hospitals.

Given the nature of the block contract agreement with GHNHSFT, variances reported below do not present a financial risk to the CCG. Shadow monitoring indicates that orthopaedic activity is contributing most significantly to the indicative over performance.

Areas of over performance within acute contracts have been consistent throughout the year with pressures being experienced in a range of areas including non-elective activity, drugs and devices. With regard to non-electives it should be noted that planned activity levels were reduced by 3.5% in both contracts to reflect the BCF ambitions and whilst the GHNHSFT contract reflects an overall financial envelope, an agreement is in place to fund NEL over performance up to the value of the 3.5% reduction.

2016/17 Contracts

Contract negotiations with all of our major providers have now been concluded. Main points to note are as follows:

- Individual provider activity plans reflect adjustments for prevalence, demographics and changes in demand.
- Contract agreements with NuTH and GHNHSFT reflect an adjustment for QIPP
- With effect from 1st April 2016, the GHNHSFT acute contract has moved from an overall cash envelope arrangement to a traditional PbR approach.

A number of specific issues arising from the 2016/17 negotiation process will not be progressed with individual providers. These include the following:

- Review of the spinal pathway to address waiting time pressures with NuTH.
- Progress the disaggregation of the excluded drugs block with NuTH, associates and NHSE
- Review of pathology, INR, nurse led and audiology tariffs with GHNHSFT
3.1 Contract Activity – Gateshead Health overview

<table>
<thead>
<tr>
<th>POD Summary</th>
<th>Plan</th>
<th>Activity (YTD)</th>
<th>Variance</th>
<th>Plan</th>
<th>£000s (YTD)</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>AandE</td>
<td>86,392</td>
<td>85,475</td>
<td>(917)</td>
<td>5,959</td>
<td>5,230</td>
<td>(729)</td>
</tr>
<tr>
<td>Critical Care</td>
<td>3,183</td>
<td>3,348</td>
<td>165</td>
<td>4,542</td>
<td>4,778</td>
<td>236</td>
</tr>
<tr>
<td>Drugs and Devices</td>
<td>2,656</td>
<td>3,328</td>
<td>(672)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>18,469</td>
<td>20,932</td>
<td>2,463</td>
<td>18,347</td>
<td>19,865</td>
<td>1,518</td>
</tr>
<tr>
<td>Emergency Readmissions</td>
<td>3,854</td>
<td>3,963</td>
<td>(109)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Pathways</td>
<td>4,608</td>
<td>4,465</td>
<td>(143)</td>
<td>4,245</td>
<td>4,000</td>
<td>(245)</td>
</tr>
<tr>
<td>Non Elective</td>
<td>21,360</td>
<td>20,932</td>
<td>(438)</td>
<td>18,347</td>
<td>19,865</td>
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<td>Excess Beddays</td>
<td>18,469</td>
<td>20,932</td>
<td>2,463</td>
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<td>Outpatient Diagnostics</td>
<td>4,465</td>
<td>3,963</td>
<td>(492)</td>
<td>4,245</td>
<td>4,000</td>
<td>(245)</td>
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<td>Outpatient First</td>
<td>37,741</td>
<td>39,591</td>
<td>(1,850)</td>
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<tr>
<td>Outpatient Follow Up</td>
<td>94,062</td>
<td>93,186</td>
<td>(876)</td>
<td>8,340</td>
<td>8,372</td>
<td>32</td>
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<tr>
<td>Outpatient Procedures</td>
<td>12,877</td>
<td>10,515</td>
<td>(2,362)</td>
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<tr>
<td>Sub Total</td>
<td>109,432</td>
<td>112,219</td>
<td>2,787</td>
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<tr>
<td>CQUIN</td>
<td>2,588</td>
<td>2,588</td>
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<td></td>
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<tr>
<td>Penalties</td>
<td>0</td>
<td>(704)</td>
<td>(704)</td>
<td></td>
<td></td>
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<td>Challenges</td>
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<td>(58)</td>
<td>(58)</td>
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<tr>
<td>Block Adjustment</td>
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<td>(2,025)</td>
<td>(2,025)</td>
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<td></td>
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<tr>
<td>Total</td>
<td>112,020</td>
<td>112,020</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Contract Update**
- This contract is a block contract; however shadow monitored based on full PbR principles where over/underperformance will be a pressure/benefit to the CCG’s financial position.
- The contract has been agreed and signed.

**Data Issues**
- A monthly Data Quality Improvement group meet as a matter of course to review issues.
- A sub set of the DQIG group met in August to confirm the Business rules which have now been agreed.

**Financial Performance**
- The current contract for the Gateshead element of the CCG is block and therefore there is no financial risk; however when shadow monitored against PbR the contract would be over performing by £2,025k.
- Elective admissions are over-performing by £1,518k, the main HRG Sub Chapters where is occurring are HB Orthopaedic Non-Trauma Procedures, HR Orthopaedic Reconstruction Procedures, FZ Digestive System and QZ Vascular Procedures & Disorders and SA Haematological Disorders.
- Non-Elective admissions are over-performing by £609k. The main HRG Sub Chapters where this over performance is occurring are VA Multiple Trauma, FZ Digestive System Procedures, WD Mental Health and LA Renal Procedures and Disorders.
- Outpatient Diagnostics is under performing by £357k, the main HRGs where this is occurring are RA60C Simple Echocardiogram 5 years & under, RA01C Magnetic Resonance Imaging Scan, one area, no contrast, 5 years and under, RA08C Computerised Tomography Scan, one area, no contrast, 5 years and under and RA09C Computerised Tomography Scan, one area, with post contrast only, 5 years and under
- Drugs and Devices are over performing by £672k.
3.2 Contract Activity – Newcastle upon Tyne Hospitals overview

### Contract Update
- This contract is based on full PbR principles and as such any over/underperformance will be a pressure/benefit to the CCG’s financial position;
- The contract has now been agreed and signed.

### Data Issues
- There is a monthly Information and Data Group which analyses all data to ensure consistency in the treatment of PbR Guidance and rules.
- NuTH are now submitting ACM data files, the Information and Data Group meet monthly and review all data submitted to give CCGs assurance that activity is charged to the correct responsible commissioner.

### Financial Performance
- Non Elective is over performing by £1,528k, the main area for this over performance is the 3.5% non elective reduction built into the contract to aid the Better Care Fund (£1,994k).
- Unbundled Diagnostics is over performing by £512k, the main HRGs where this over performance is occurring are RA68Z Cardiac CT Scans, RA03Z Magnetic Resonance Imaging Scan, one area, pre and post contrast and RA23Z Ultrasounds.
- Outpatient First Attendance is over performing by £1,544k, the main specialities where this is occurring are 320 Cardiology, 650 Physiotherapy, 420 Paediatrics and 304 Clinical Physiology. There is a contract cap for Physiotherapy as when the contract was negotiated the total activity for was not fully identifiable.
- Outpatient Procedures is over performing by £1,223k, the main HRG Sub chapter where this is occurring is JC Skin Surgery and in particular HRG JC29Z Phototherapy.
- Drugs and Devices are over performing by £1,596k, of which £1,228k relates to Drugs and £368k over performance on Devices.
3.3 Contract Activity – Other acute contracts overview

<table>
<thead>
<tr>
<th>POD Summary</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>6,904</td>
<td>11,927</td>
<td>5,023</td>
<td>699</td>
<td>1,113</td>
<td>414</td>
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<tr>
<td>Critical Care</td>
<td>146</td>
<td>231</td>
<td>85</td>
<td>173</td>
<td>189</td>
<td>17</td>
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<tr>
<td>Drugs and Devices</td>
<td>482</td>
<td>5,180</td>
<td>359</td>
<td>5,543</td>
<td>6,405</td>
<td>862</td>
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<tr>
<td>Elective</td>
<td>0</td>
<td>455</td>
<td>500</td>
<td>550</td>
<td>560</td>
<td>106</td>
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<tr>
<td>Emergency Readmissions</td>
<td>0</td>
<td>(151)</td>
<td>(121)</td>
<td>30</td>
<td>30</td>
<td></td>
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<tr>
<td>Excess Bedays</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Maternity Pathways</td>
<td>1,016</td>
<td>815</td>
<td>(201)</td>
<td>220</td>
<td>179</td>
<td>(40)</td>
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<tr>
<td>Non Elective</td>
<td>426</td>
<td>441</td>
<td>15</td>
<td>320</td>
<td>320</td>
<td>10</td>
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<tr>
<td>Other Services</td>
<td>2,024</td>
<td>2,526</td>
<td>502</td>
<td>2,364</td>
<td>3,280</td>
<td>916</td>
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<tr>
<td>Outpatient Diagnostics</td>
<td>17,978</td>
<td>5,359</td>
<td>(12,619)</td>
<td>3,942</td>
<td>5,019</td>
<td>1,078</td>
</tr>
<tr>
<td>Outpatient First</td>
<td>1,488</td>
<td>1,769</td>
<td>282</td>
<td>213</td>
<td>223</td>
<td>10</td>
</tr>
<tr>
<td>Outpatient Follow Up</td>
<td>7,672</td>
<td>8,918</td>
<td>1,246</td>
<td>977</td>
<td>1,054</td>
<td>77</td>
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<tr>
<td>Outpatient Procedures</td>
<td>17,025</td>
<td>19,768</td>
<td>2,743</td>
<td>1,166</td>
<td>1,385</td>
<td>219</td>
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<tr>
<td>Penalties</td>
<td>1,663</td>
<td>2,116</td>
<td>453</td>
<td>245</td>
<td>328</td>
<td>83</td>
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<td>Quality Payments</td>
<td>0</td>
<td>274</td>
<td>303</td>
<td>28</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16,439</td>
<td>20,238</td>
<td>3,798</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>British Pregnancy Advisory Service</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>128</td>
<td>195</td>
<td>67</td>
</tr>
<tr>
<td>City Hospitals Sunderland NHS FT</td>
<td>10,967</td>
<td>11,842</td>
<td>875</td>
<td>2,920</td>
<td>3,360</td>
<td>429</td>
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<tr>
<td>Connect Physical Ltd</td>
<td>13,408</td>
<td>0</td>
<td>(13,408)</td>
<td>1,071</td>
<td>968</td>
<td>(104)</td>
</tr>
<tr>
<td>County Durham and Darlington NHS I</td>
<td>7,818</td>
<td>7,028</td>
<td>(790)</td>
<td>1,862</td>
<td>1,804</td>
<td>(58)</td>
</tr>
<tr>
<td>Newgene</td>
<td>16</td>
<td>0</td>
<td>(16)</td>
<td>13</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>North East Podiatry Ltd</td>
<td>0</td>
<td>1,556</td>
<td>1,566</td>
<td>21</td>
<td>170</td>
<td>150</td>
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<tr>
<td>Northumbria Healthcare NHS FT</td>
<td>14,743</td>
<td>14,678</td>
<td>(65)</td>
<td>4,579</td>
<td>4,518</td>
<td>(61)</td>
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<tr>
<td>Nuffield Health</td>
<td>2,608</td>
<td>2,002</td>
<td>(606)</td>
<td>927</td>
<td>952</td>
<td>24</td>
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<tr>
<td>Ramsay Health Care</td>
<td>2,573</td>
<td>2,665</td>
<td>92</td>
<td>688</td>
<td>774</td>
<td>86</td>
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<tr>
<td>South Tyneside NHS FT</td>
<td>1,500</td>
<td>2,325</td>
<td>825</td>
<td>454</td>
<td>530</td>
<td>76</td>
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<tr>
<td>Spire Healthcare</td>
<td>2,027</td>
<td>2,913</td>
<td>886</td>
<td>795</td>
<td>1,187</td>
<td>392</td>
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<tr>
<td>The Grove Medical Group</td>
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<td>593</td>
<td>346</td>
<td>37</td>
<td>41</td>
<td>3</td>
</tr>
<tr>
<td>Tyneside Surgical Services</td>
<td>3,903</td>
<td>3,260</td>
<td>(643)</td>
<td>1,126</td>
<td>1,028</td>
<td>(99)</td>
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<tr>
<td>Other</td>
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<td>4,695</td>
<td>2,888</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16,439</td>
<td>20,238</td>
<td>3,798</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Cost Trend for Other Acute Services

Financial Performance

- South Tyneside NHS FT are over performing at month 11 by £76k. This is mainly on their Emville Unit.
- Spire Healthcare are over performing by £392k at month 11. The main areas of over performance are in day cases & electives specifically in HRG Chapter H - Orthopaedics.
- City Hospitals Sunderland NHS FT are over performing at month 11 by £429k. The main area for this over performance is Elective admissions and mainly HRG Sub Chapter BZ Eyes and Periorbita Procedures and Disorders and Other Services in particular High Cost Drugs and Medical Devices.
- Ramsay Healthcare are over performing by £86k at month 11. The main area where this is occurring is day cases and particularly HRG FZ61Z - upper GI endoscopy with biopsy.
3.4 Northumberland Tyne and Wear NHS FT overview

**Contract Update**
- This contract is based on a mixture of Block, Cost per Case and Cost & Volume services and as such any over/underperformance will be a pressure/benefit to the CCG’s financial position.

**Data Issues**
- NTW has been requested to supply data so that Gateshead and Newcastle activity can be accurately identified.

**Financial Performance**
- The contract is currently showing an under performance of £77k.
- The main area where the contract has underperformed is in Tyne Villa 19 (£107k), Alnwick Villa 14 (£105k) and Affective Disorders (£99k), offset by over performance in CBT Centre £141k and Head Injuries Team £131k.

---

<table>
<thead>
<tr>
<th>POD Summary</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walkergate Park Outpatients - Botulinum Dyst</td>
<td>363</td>
<td>352</td>
<td>(11)</td>
</tr>
<tr>
<td>CBT Centre</td>
<td>233</td>
<td>374</td>
<td>141</td>
</tr>
<tr>
<td>Alnwick - Villa 14 OBD</td>
<td>433</td>
<td>328</td>
<td>(105)</td>
</tr>
<tr>
<td>Tyne - Villa 19</td>
<td>426</td>
<td>319</td>
<td>(107)</td>
</tr>
<tr>
<td>Deliberate Self Harm - Newcastle &amp; North Tyn</td>
<td>214</td>
<td>187</td>
<td>(27)</td>
</tr>
<tr>
<td>Northumberland Head Injuries Team</td>
<td>0</td>
<td>131</td>
<td>131</td>
</tr>
<tr>
<td>Affective Disorders - Inpatients</td>
<td>249</td>
<td>150</td>
<td>(99)</td>
</tr>
<tr>
<td>Middlerigg</td>
<td>234</td>
<td>247</td>
<td>13</td>
</tr>
<tr>
<td>Woodside - Villa 16</td>
<td>799</td>
<td>786</td>
<td>(13)</td>
</tr>
<tr>
<td>Other</td>
<td>52,238</td>
<td>52,240</td>
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<tr>
<td>CQUIN</td>
<td>1,380</td>
<td>1,378</td>
<td>(2)</td>
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<tr>
<td><strong>Total</strong></td>
<td>56,569</td>
<td>56,492</td>
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3.5 Contract Activity – North East Ambulance FT overview

<table>
<thead>
<tr>
<th>POD Summary</th>
<th>Activity (YTD)</th>
<th>£000s (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>999 Service</td>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td>111</td>
<td>112</td>
<td>112</td>
</tr>
<tr>
<td>Additional Non Recurrent Investments</td>
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<td></td>
</tr>
<tr>
<td>Cross Boundary Flows Adjustment</td>
<td>(742)</td>
<td>(742)</td>
</tr>
<tr>
<td>NEAS Hear and Treat Contract Adjustment</td>
<td>175</td>
<td>175</td>
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<tr>
<td>NEAS MERIT Contract Adjustment</td>
<td>80</td>
<td>80</td>
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<tr>
<td>NEAS Emergency Planning</td>
<td>66</td>
<td>66</td>
</tr>
<tr>
<td>NEAS HART</td>
<td>561</td>
<td>561</td>
</tr>
<tr>
<td>NEAS Intensive Care Bed Information Service</td>
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</tr>
<tr>
<td>NEAS 999</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>NEAS - Hear and Treat / Refer</td>
<td>4,335</td>
<td>4,124</td>
</tr>
<tr>
<td>NEAS - Other</td>
<td>231</td>
<td>189</td>
</tr>
<tr>
<td>NEAS - See, Treat and Convey</td>
<td>55,295</td>
<td>54,911</td>
</tr>
<tr>
<td>NEAS - Urgent and Emergency Care</td>
<td>99,243</td>
<td>101,643</td>
</tr>
<tr>
<td>Winter pressures CCG funded</td>
<td>103</td>
<td>103</td>
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<tr>
<td>Divert Incentive Penalties</td>
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</tr>
<tr>
<td>Penalties/reinvestment of penalties</td>
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<td>0</td>
</tr>
<tr>
<td>CQUIN Scheme</td>
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<td>350</td>
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<td>Sub Total 999 Service</td>
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<td>13,761</td>
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<tr>
<td>Patient Transport Service</td>
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</tr>
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<td>PTS Contract</td>
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<td>PTS 7 Day Services</td>
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<td>PTS Call Centre</td>
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<td>71</td>
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<td>PTS Dedicated Vehicle</td>
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<td>35</td>
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<tr>
<td>CQUIN</td>
<td>74</td>
<td>74</td>
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<td>Sub Total PTS Service</td>
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<td>Renal Transport Service</td>
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</tr>
<tr>
<td>Renal Transport Service</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>CQUIN</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sub Total Renal Transport Service</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>111 Service</td>
<td></td>
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<tr>
<td>111 Service</td>
<td>1,373</td>
<td>1,373</td>
</tr>
<tr>
<td>Penalties</td>
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<td>(36)</td>
</tr>
<tr>
<td>Sub Total 111 Service</td>
<td>1,373</td>
<td>1,337</td>
</tr>
<tr>
<td>Total NEAS Ambulance Service</td>
<td>18,162</td>
<td>18,149</td>
</tr>
</tbody>
</table>

**Contract Update**
- 2015/16 contract is a block contract and therefore no financial risk to CCGs.

**Data Issues**
- There are currently no data issues.

**Financial Performance**
- The main NEAS contract is now a block and therefore no financial risk to the CCG. There is however a slight over performance which relates to the new divert incentive policy.
Finance
4. Finance

The section reports on the financial position of the CCG for the period to March 2016, highlighting any areas of pressure.

4.1. CCG Financial Position and Risks - narrative

<table>
<thead>
<tr>
<th>Issue and risk</th>
<th>Key Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>NuTH: The reported NuTH overspend at Month 12 is £5,635k.</td>
<td>The NuTH reported overspend reflects the agreed year end position with NuTH based on latest information. The main increase in this position from Month 11 relates to the Work in Progress adjustment required as part of year end closedown process at £230k.</td>
</tr>
<tr>
<td></td>
<td>The most significant pressures in contract performance relate to “other services” as outlined earlier in this report. A significant proportion of this over performance relates to drugs, ITU and devices, services which are difficult to influence in terms of active contract management. Work is routinely undertaken to assure the CCG that drugs and devices are being charged to the appropriate commissioner given that NHSE are also responsible for commissioning a significant amount of excluded drugs and devices. The internal Finance and Activity review Group continues to meet regularly to review performance pressures with a view to seeking practice intelligence to inform future contract management discussions.</td>
</tr>
<tr>
<td></td>
<td>Non elective pressures are the subject of a separate action plan which is being reviewed in the context of the Sustainability and Transformation Plan in the context of 2016/17 contract discussions.</td>
</tr>
<tr>
<td></td>
<td>As stated earlier, it should be noted that planned non elective contract activity levels were reduced by 3.5% in anticipation of the impact of Better Care Fund schemes.</td>
</tr>
<tr>
<td>Gateshead Healthcare FT: the reported overspend at Month 12 is £575k.</td>
<td>The GHFT forecast at Month 12 is reduced from Month 11 due to an improvement of £196k in the Work in Progress adjustment required to be included in year end positions. Other than this change the remaining overspend is due to the agreement to fund additional non-recurrent support for winter over and above the agreed block contract in 15/16. All other reported financial variances on the remainder of the block contract do not present a risk to the CCG. Non elective activity is currently over performing against a baseline which was reduced by 3.5% to reflect the anticipated impact of the Better Care Fund. Non elective over performance will be funded in accordance with the BCF defund and reasons for over performance have been reviewed. Elective over performance is partly due to the provider changing ambulatory care activity recording from outpatient to elective activity. Following agreement on the ambulatory care pathway charging and recording arrangements, it is expected that this issue will be resolved. Pressures in remaining elective specialties will be reviewed by the Finance and Activity Review Group. Shadow monitoring of the 2015/16 contract indicated that the actual value only exceeded plan by circa £90k, however it should be noted that this position includes an adjustment for some elements such as the BCF non elective reserve or the impact of the emergency threshold which mitigate the activity overperformance.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Continuing Healthcare (CHC)/Funded Nursing Care (FNC): reported overspend of £7,760k at Month 12.</td>
<td>The forecast overspend is largely the result of increased recharges from local authorities in Newcastle and Gateshead. This relates to packages of care which the councils contract on behalf of the CCG. The reported position has increased from Month 11 by a further £1,474k due to further detailed costings from local authorities undergoing validation.</td>
</tr>
<tr>
<td>Non Contracted Activity &amp; Individual Funding Requests reported overspend of £659k at Month 12.</td>
<td>Analysis of charges received to date has resulted in an increase to the forecast position by £2k in Month 12. The inherently random nature of</td>
</tr>
</tbody>
</table>
Non Contracted Activity and out of area charging means that this position will be closely monitored throughout the year.

<table>
<thead>
<tr>
<th>Prescribing at month 12 reporting an overspend of £1,063k.</th>
<th>The Prescribing position increased from month 11 by £907k due to the latest expenditure data being applied to the PPA forecast model.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for Over 75's reporting £1,397k underspend at Month 12.</td>
<td>The forecast on Services for Over 75s is due to slippage in the start dates of the £5 per head schemes in 15/16.</td>
</tr>
<tr>
<td>The final surplus reported at Month 12 is £10,275k.</td>
<td>This final reported position is in line with the control total agreed with NHS England and is subject to external audit currently.</td>
</tr>
</tbody>
</table>
4.1.1 CCG Financial Position and risks - Table

<table>
<thead>
<tr>
<th>Funding:</th>
<th>Annual Budget £'000</th>
<th>Year to Date Budget £'000</th>
<th>Year to Date Actual £'000</th>
<th>Year to Date Variance £'000</th>
<th>Forecast Outturn £'000</th>
<th>Forecast Variance £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16 Initial Commissioning Allocation</td>
<td>664,611</td>
<td>664,611</td>
<td>664,611</td>
<td>0</td>
<td>664,611</td>
<td>0</td>
</tr>
<tr>
<td>2015/16 Running Costs Allowance</td>
<td>10,716</td>
<td>10,716</td>
<td>10,716</td>
<td>0</td>
<td>10,716</td>
<td>0</td>
</tr>
<tr>
<td>Additional Allocations</td>
<td>31,661</td>
<td>31,661</td>
<td>31,661</td>
<td>0</td>
<td>31,661</td>
<td>0</td>
</tr>
<tr>
<td>Anticipated Allocations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>706,988</strong></td>
<td><strong>706,988</strong></td>
<td><strong>706,988</strong></td>
<td>0</td>
<td><strong>706,988</strong></td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Running Costs:</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CCG Running Costs</td>
<td>11,646</td>
<td>11,646</td>
<td>9,966</td>
<td>(1,680)</td>
<td>9,966</td>
<td>(1,680)</td>
</tr>
</tbody>
</table>

| Commissioning Expenditure Budgets:             |                      |                           |                           |                             |                       |                         |
| City Hospitals Sunderland NHSFT                | Acute                | 3,222                    | 3,222                    | 3,665                       | 443                   | 3,665                   |
| Co Durham & Darlington NHSFT                   | Acute                | 2,033                    | 2,033                    | 2,144                       | 111                   | 2,144                   |
| Gateshead Hospitals NHSFT                      | Acute                | 123,477                  | 123,477                  | 124,052                     | 575                   | 124,052                 |
| Northumbria Healthcare NHSFT                   | Acute                | 4,994                    | 4,994                    | 4,734                       | (260)                 | 4,734                   |
| South Tyneside NHSFT                           | Acute                | 707                      | 707                      | 975                         | 268                   | 975                     |
| Non NHS Acute                                  | Acute                | 5,529                    | 5,529                    | 6,152                       | 623                   | 6,152                   |
| Non Contracted Activity & Individual Funding Requests | Acute | 3,641                    | 3,641                    | 4,300                       | 659                   | 4,300                   |
| North East Ambulance Service                   | Amb                  | 18,370                   | 18,370                   | 18,468                      | 98                   | 18,468                  |
| Northumberland Tyne & Wear NHSFT               | MH/LD                | 62,435                   | 62,434                   | 62,431                      | (3)                   | 62,431                  |
| Newcastle upon Tyne Hospitals NHSFT            | MH/LD                | 2,901                    | 2,901                    | 2,709                       | (192)                 | 2,709                   |
| South Tyneside NHSFT                           | Community            | 29,178                   | 29,178                   | 29,218                      | 40                   | 29,218                  |
| South Tyneside NHSFT                           | Community            | 23,037                   | 23,037                   | 23,158                      | 121                   | 23,158                  |
| Non NHS Community                              | Community            | 5,356                    | 5,356                    | 5,428                       | 72                   | 5,428                   |
| Local Authority Services                       | Community            | 743                      | 743                      | 737                         | (545)                 | 737                     |
| Continuing Healthcare/Funded Nursing Care      | CHC                  | 57,445                   | 57,445                   | 65,209                      | 7,760                 | 65,209                  |
| Prescribing                                    | Prim Care            | 84,517                   | 84,517                   | 85,580                      | 1,063                 | 85,580                  |
| Commissioned Services & Out of Hours           | Prim Care            | 7,911                    | 7,911                    | 8,421                       | 510                   | 8,421                   |
| Services for Over 75's                         | Prim Care            | 2,500                    | 2,500                    | 1,103                       | (1,397)               | 1,103                   |
| Programme Costs                                | Prog                 | 4,681                    | 4,681                    | 6,738                       | 2,057                 | 6,738                   |
| Better Care Fund                               | Prog                 | 16,953                   | 16,953                   | 15,278                      | (1,146)               | 15,278                  |
| **Total Commissioning Expenditure Budgets**    | **670,088**          | **670,088**              | **686,176**              | **16,088**                  | **686,176**           | **16,088**              |

| Reserves:                                      |                      |                           |                           |                             |                       |                         |
| Earmarked Reserves                             | Reserve              | 19,736                   | 19,736                   | 570                         | (19,165)             | 570                     |
| Contingency                                    | Reserve              | 0                        | 0                        | 0                           | (5,518)              | 0                       |
| **Total Commissioning Reserves**               | **25,254**           | **25,254**                | **570**                  | (24,683)                    | **570**               | (24,683)                |

| Total Commissioning Expenditure                | **695,342**          | **695,342**              | **686,747**              | (8,595)                     | **686,747**           | (8,595)                 |

| Total Expenditure (Running costs & commissioning) | 706,988              | 706,988                  | 696,713                  | (10,275)                    | 696,713               | (10,275)                |

(Surplus) / Deficit on Total Budget             0     0     (10,275) / (10,275) / (10,275) / (10,275) / (10,275)
### 4.2 CCG Statement of Financial Position - table

#### STATEMENT OF FINANCIAL POSITION - March

<table>
<thead>
<tr>
<th></th>
<th>March £000’s</th>
<th>February £000’s</th>
<th>Movement £000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>0</td>
<td>2</td>
<td>(2)</td>
</tr>
<tr>
<td>Intangible Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Financial Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Non Current Assets</strong></td>
<td>0</td>
<td>2</td>
<td>(2)</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other Receivables</td>
<td>2,390</td>
<td>692</td>
<td>1,698</td>
</tr>
<tr>
<td>Prepayments and Accrued Income</td>
<td>2,533</td>
<td>2,526</td>
<td>7</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>260</td>
<td>341</td>
<td>(81)</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>5,183</td>
<td>3,559</td>
<td>1,624</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>5,183</td>
<td>3,561</td>
<td>1,622</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(13,732)</td>
<td>(11,431)</td>
<td>(2,301)</td>
</tr>
<tr>
<td>Accruals</td>
<td>(34,350)</td>
<td>(55,086)</td>
<td>20,736</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Borrowings</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>(48,082)</td>
<td>(66,517)</td>
<td>18,435</td>
</tr>
<tr>
<td><strong>Non-Current Assets plus/less Net Current Assets/Liabilities</strong></td>
<td>(42,899)</td>
<td>(62,956)</td>
<td>20,057</td>
</tr>
<tr>
<td><strong>Non-Current liabilities</strong></td>
<td>(42,899)</td>
<td>(62,956)</td>
<td>20,057</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Borrowings</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Non-Current Liabilities</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
<td>(42,899)</td>
<td>(62,956)</td>
<td>20,057</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers Equity</strong></td>
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<td></td>
</tr>
<tr>
<td>Capital &amp; Reserves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Fund</td>
<td>(42,899)</td>
<td>(62,956)</td>
<td>20,057</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Other reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL TAXPAYERS EQUITY</strong></td>
<td>(42,899)</td>
<td>(62,956)</td>
<td>20,057</td>
</tr>
</tbody>
</table>
### 4.2.1 CCG Statement of Financial Position - narrative

#### Cash Balance:
The cash balance for March is reported at £260k a reduction from £341k in February.

#### Key Actions
- On-going management of cash balances via the Accounting team within NECS.

### 4.3 In year allocations March 2016

#### NHS ENGLAND IN YEAR ALLOCATIONS - NEWCASTLE GATESHEAD CCG - March

<table>
<thead>
<tr>
<th>Recurrent</th>
<th>Non Recurrent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000's</td>
<td>£000's</td>
<td>£000's</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>664,611</td>
<td>10,716</td>
<td>10,484</td>
<td>12,073</td>
<td>910</td>
<td>600</td>
<td>150</td>
<td>1,298</td>
<td>411</td>
<td>22</td>
<td>288</td>
<td>289</td>
<td>1,068</td>
<td>788</td>
<td>121</td>
<td>113</td>
<td>720</td>
<td>925</td>
<td>121</td>
<td>113</td>
<td>98</td>
<td>460</td>
<td>256</td>
<td>214</td>
<td>150</td>
<td>(761)</td>
<td>254</td>
</tr>
<tr>
<td>Total</td>
<td>690,166</td>
<td>16,822</td>
<td>706,988</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Cash Flow Forecast - March 2016

#### Income

<table>
<thead>
<tr>
<th>April £000's</th>
<th>May £000's</th>
<th>June £000's</th>
<th>July £000's</th>
<th>August £000's</th>
<th>September £000's</th>
<th>October £000's</th>
<th>November £000's</th>
<th>December £000's</th>
<th>January £000's</th>
<th>February £000's</th>
<th>March £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance brought forward</td>
<td>360</td>
<td>3,786</td>
<td>322</td>
<td>538</td>
<td>124</td>
<td>615</td>
<td>556</td>
<td>499</td>
<td>444</td>
<td>77</td>
<td>117</td>
</tr>
<tr>
<td>Department of Health Income</td>
<td>52,200</td>
<td>46,000</td>
<td>43,300</td>
<td>48,800</td>
<td>53,000</td>
<td>49,500</td>
<td>48,200</td>
<td>44,100</td>
<td>47,500</td>
<td>50,500</td>
<td>51,900</td>
</tr>
<tr>
<td>Prescribing and Home Oxygen Therapy Charge to Cash Limit</td>
<td>6,427</td>
<td>6,925</td>
<td>6,679</td>
<td>6,622</td>
<td>7,026</td>
<td>7,067</td>
<td>6,504</td>
<td>6,880</td>
<td>7,183</td>
<td>6,803</td>
<td>7,485</td>
</tr>
<tr>
<td>CHC Risk Pool Contribution</td>
<td>0</td>
<td>0</td>
<td>2,092</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Income</td>
<td>2,090</td>
<td>1,289</td>
<td>1,252</td>
<td>778</td>
<td>677</td>
<td>207</td>
<td>67</td>
<td>921</td>
<td>884</td>
<td>324</td>
<td>429</td>
</tr>
<tr>
<td>Total Income</td>
<td>61,077</td>
<td>58,000</td>
<td>53,845</td>
<td>56,738</td>
<td>60,827</td>
<td>57,409</td>
<td>55,327</td>
<td>52,400</td>
<td>56,011</td>
<td>57,714</td>
<td>59,941</td>
</tr>
</tbody>
</table>

#### Expenditure

<table>
<thead>
<tr>
<th>April £000's</th>
<th>May £000's</th>
<th>June £000's</th>
<th>July £000's</th>
<th>August £000's</th>
<th>September £000's</th>
<th>October £000's</th>
<th>November £000's</th>
<th>December £000's</th>
<th>January £000's</th>
<th>February £000's</th>
<th>March £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Payments including contracts</td>
<td>(44,670)</td>
<td>(38,609)</td>
<td>(35,074)</td>
<td>(38,749)</td>
<td>(43,595)</td>
<td>(41,414)</td>
<td>(39,247)</td>
<td>(37,732)</td>
<td>(39,935)</td>
<td>(39,918)</td>
<td>(40,286)</td>
</tr>
<tr>
<td>Other Payments - BACS/CHAPS/Payable orders</td>
<td>(5,702)</td>
<td>(10,036)</td>
<td>(5,894)</td>
<td>(9,259)</td>
<td>(6,338)</td>
<td>(6,403)</td>
<td>(7,121)</td>
<td>(4,980)</td>
<td>(6,863)</td>
<td>(8,910)</td>
<td>(9,852)</td>
</tr>
<tr>
<td>Better Care Fund Payments</td>
<td>(968)</td>
<td>(2,620)</td>
<td>(1,196)</td>
<td>(1,196)</td>
<td>(1,196)</td>
<td>(1,196)</td>
<td>(1,196)</td>
<td>(1,196)</td>
<td>(1,196)</td>
<td>(1,196)</td>
<td>(1,196)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>(6,427)</td>
<td>(6,925)</td>
<td>(6,879)</td>
<td>(6,622)</td>
<td>(7,026)</td>
<td>(7,067)</td>
<td>(6,504)</td>
<td>(6,880)</td>
<td>(7,183)</td>
<td>(6,803)</td>
<td>(7,485)</td>
</tr>
<tr>
<td>CHC Risk Pool Contribution</td>
<td>0</td>
<td>0</td>
<td>2,092</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>(790)</td>
<td>(395)</td>
<td>(395)</td>
<td>(1,693)</td>
<td>(395)</td>
<td>(395)</td>
<td>(797)</td>
<td>(374)</td>
<td>(374)</td>
<td>(374)</td>
</tr>
</tbody>
</table>

**Balance Carried Forward**: 3,786 322 538 124 615 556 499 444 77 117 341 260
The Better Payment Practice Code requires that all valid invoices should be paid by their due date or within 30 days of receipt, whichever is later.

Gateshead CCG compliance is shown in the table below.

### BETTER PAYMENT PRACTICE CODE - March

<table>
<thead>
<tr>
<th>Better Payment Practice Code - 30 Days</th>
<th>NUMBER</th>
<th>£000's</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-NHS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices Paid in the Year</td>
<td>12,686</td>
<td>135,554</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices Paid Within 30 Day Target</td>
<td>12,193</td>
<td>133,384</td>
</tr>
<tr>
<td><strong>Percentage of Non-NHS Trade Invoices Paid Within 30 Day Target</strong></td>
<td>96.11%</td>
<td>98.40%</td>
</tr>
<tr>
<td><strong>NHS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>3,545</td>
<td>487,486</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid Within 30 Day Target</td>
<td>3,446</td>
<td>485,925</td>
</tr>
<tr>
<td><strong>Percentage of NHS Trade Invoices Paid Within 30 Day Target</strong></td>
<td>97.21%</td>
<td>99.68%</td>
</tr>
</tbody>
</table>
**Meeting Title**

Newcastle Gateshead CCG Governing Body Report

**Report Title**

Looked after Children Report – Newcastle & Gateshead

**Synopsis**

This report will provide members with the current looked after children activity in Newcastle & Gateshead. Key themes will focus on key statistical activity, inspection feedback, quality assurance, as well as training and development, identified risks and future developments.

**Implications and Risks**

---

**Recommendation**

---

**Report history**

This is the 1st report tabled this financial year April 2016

**Lead Director & Report Author**

Director: Chris Piercy  
Title: Executive Director of Nursing  

Author: Linda Hubbucks  
Title: Designated Nurse Looked After Children

**Classification**

NHS Confidential

**Purpose** (click one box only)

[ ] Decision  [x] Information
<table>
<thead>
<tr>
<th>Benefits to patients &amp; the public</th>
<th>This report provides an update on Looked After Children activity across Newcastle &amp; Gateshead CCG including the LAC Quality Assurance work for Newcastle &amp; Gateshead. This report will outline progress to date in meeting statutory requirements and achieving identified performance indicators and recommendations from Inspections.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Links to Strategic objectives</td>
<td>Under the Children Act 1989, CCGs and NHS England have a duty to comply with the requests from a local authority to help them provide support and services to LAC. Local Authorities, CCGs and NHS England can only carry out their responsibilities to promote the health and welfare of LAC if they cooperate. They are required to do so under section 10 of the Children Act 2004 As commissioners of health services the CCG should have appropriate arrangements and resources in place to meet the physical and mental health of LAC. (Promoting the Health and Wellbeing of Looked After Children DfE/DoH 2015)</td>
</tr>
<tr>
<td>Identified risks &amp; risk management actions</td>
<td></td>
</tr>
<tr>
<td>Resource implications</td>
<td></td>
</tr>
<tr>
<td>Legal implications &amp; equality and diversity assessment</td>
<td>None applicable</td>
</tr>
<tr>
<td>Sustainability implications</td>
<td>None applicable</td>
</tr>
<tr>
<td>NHS Constitution</td>
<td>Principle Three: The NHS aspires to the highest standards of excellence and professionalism.</td>
</tr>
<tr>
<td>Next steps</td>
<td>The contents of this report should be noted</td>
</tr>
<tr>
<td>Appendices</td>
<td></td>
</tr>
</tbody>
</table>
1. Introduction

This report highlights the work undertaken by the designated professionals on behalf of Newcastle Gateshead CCG to ensure looked after children continue to be protected from abuse and neglect and have their health needs identified and met, across the health community in Newcastle and Gateshead localities.

2. Newcastle & Gateshead CCG Priorities:

Newcastle Gateshead CCG with NHS England has a duty to cooperate with requests from local authorities to undertake health assessments and help them ensure support and services are provided to looked after children (and by extension to care leavers) without delay. Services commissioned should contribute to the care planning cycle for looked after children and systems should be in place to assure the quality of service delivery, supported by training and supervision and monitored by effective audit processes. Looked After Children is a priority area for NHS England.


- Prepare for future joint Ofsted/CQC inspections. Review the findings and implement the recommendations following CQC or Joint Inspections 2015-16 that have taken place sharing learning and cascading areas of best practice across Gateshead and Newcastle.
### 2.2 Statistical Analysis: Table 1 Newcastle Gateshead

#### Table 1 Overview 2014-15:

<table>
<thead>
<tr>
<th></th>
<th>England</th>
<th>North East</th>
<th>Gateshead</th>
<th>Newcastle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio</td>
<td>60:10,000</td>
<td>82:10,000</td>
<td>85:10,000</td>
<td>90:10,000</td>
</tr>
<tr>
<td>Placed within council boundary</td>
<td>60%</td>
<td>62%</td>
<td>61%</td>
<td>38%</td>
</tr>
<tr>
<td>In foster placements</td>
<td>75%</td>
<td>80%</td>
<td>87%</td>
<td>76%</td>
</tr>
<tr>
<td>Initial health assessments in timeframe (14-15)</td>
<td>This is a standard within the Promoting Health Statutory Guidance but is not reported nationally or regionally. <strong>Local statistic</strong></td>
<td>finden sich in der angegebenen Quelle. <strong>Regional statistik</strong></td>
<td>51.2%</td>
<td>93%</td>
</tr>
<tr>
<td>Children looked after for more than 1 year as of 31.03.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health assessment</td>
<td>90%</td>
<td>95%</td>
<td>96%</td>
<td>88%</td>
</tr>
<tr>
<td>Dental appointment</td>
<td>86%</td>
<td>87.5%</td>
<td>94%</td>
<td>71%</td>
</tr>
<tr>
<td>Immunisations up to date</td>
<td>88%</td>
<td>93%</td>
<td>96%</td>
<td>87%</td>
</tr>
<tr>
<td>Developmental checks up to date</td>
<td>89%</td>
<td>91%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Overall SDQ score</td>
<td>13.9</td>
<td>14</td>
<td>12.7</td>
<td>13.3</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

#### 2. Serious Cases

There are currently no serious case reviews for looked after children in Newcastle or Gateshead. There is a scoping exercise underway in relation to a care leaver aged 18.

#### 4. Unannounced CQC Inspection (Safeguarding and Looked After Children)

**Gateshead**

- Gateshead Borough Council were subject to a Single Agency Inspection on 27th October 2015. The Report was published on 11.3.16. Children’s Services in Gateshead was identified as good. Gateshead LSCB have made significant progress in implementing the recommendations for this report.
Within the report was a recommendation that ‘care leavers are supported to understand their health histories more thoroughly’ and that ‘they have regular and timely access to mental health services’. The LAC health team is making progress strengthening the process of providing care leavers with their health histories and are developing this area of work with care leavers and social care staff who provide support.

**Newcastle**

- NUTH CQC inspection was completed in Jan/Feb 2016, the report is pending.

5. **New Developments / key achievements Newcastle Gateshead CCG**

   **Joint CCG Issues**
   The Designated Nurse Looked After Children has been appointed and commenced her role in the CCG on 4th April 2016.

   **Gateshead**
   The looked after health team for Gateshead has additional resources of 1 x full time additional nurse post and 1 x 0.5 additional administrative post.

   **Newcastle**
   The looked after health team for Newcastle has additional resources of 1 x 0.5 additional administrative posts.

6. **Quality Assurance Issue for the CCG**

   **Newcastle and Gateshead**
   - This strategic leadership role for Looked After Children will be determined by a number of key priority areas.
   - Ensure that Looked After Children Health provision is a priority area for the CCG as outlined by NHS England
   - Building new and strengthening existing professional relationships both at local, regional and national level.
   - Review of current arrangements for looked after children across the CCG.
   - Review local policies, standards and processes in line with new NICE guidelines.
   - Embed the responsible commissioner arrangements and strengthen the existing payment by results/tariff arrangements in the CCG.
   - Implement the findings from the recent LAC benchmarking assurance visit and monitor the respective actions and commissioning arrangements following this.
7. Risks:

- Designated Doctors LAC planned departure in November 2016 in both areas will require succession planning.
- Changes to provider organisation (Gateshead): transfer requires effective planning to avoid disruption to service delivery.
- Long term absence in permanent team members (Newcastle). The impact on capacity will need to be monitored closely.
- Implications surrounding the Government plans for wider dispersal of unaccompanied asylum seeking children may impact on all services providing social and health care, specifically relating to the health and wellbeing of Looked After Children.

8. Action Plan

- Ensure that the health needs of looked after children and care leavers are identified, profiled and reported on supported by the development of a robust data base.
- Review systems and processes to improve initial health assessment timeframes (Gateshead)
- Review systems and processes to improve annual return of health data (Newcastle)

9. Recommendations:

- Note the content of the report.

10 Author and lead director

Author: Linda Hubbucks
Title: Designated Nurse Looked After Children

Director: Chris Piercy
Title: Executive Director of Nursing, Patient Safety and Quality.
Date: 06.05.16
### Strategic Planning 2016 - 17


The Planning Guidance indicated that NHS organisations were required to produce two separate but connected plans:

- a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
- a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP
- update the Better Care Fund Plan.

### Implications and Risks

Risks to delivery of a small number of the ‘9 Must dos’ outlined in the guidance have been identified, specifically in relation to achievement of the access standards for A&E and ambulance waits. There are also issues in Newcastle which may impact our ability to achieve the IAPT and dementia diagnosis rate standards. Access to additional transformation funding from April 2017 is linked to the most compelling and credible STP.

### Recommendation

The Governing Body is asked to note the requirements outlined in the guidance and to sign off both the Commissioner and Operational plans, and note the progress to date in developing the STP and BCF Plan.

### Report history

This is the second paper in this planning round to be brought to the Governing Body.
Benefits to patients & the public | Delivery of the Vision set out in the Five year Forward View will ensure better preventative measures are in place to stop people getting sick, when people do need health services, they will gain far greater control of their own care along with seamless care across all services. The planning guidance for 2016/17 outlines specific requirements to continue to lay the foundations to achieve this vision.

Links to Strategic objectives | The planning guidance for 2016/17 continues to focus on delivery of the vision set out in the Five Year Forward View and so our strategic objectives are aligned with this.

Identified risks & risk management actions | We need to prioritise effectively to ensure there is sufficient resource to deliver.

Resource implications | Sufficient resource is in place to develop both the operational plan and longer term Sustainability and Transformation Plan.

Legal implications & equality and diversity assessment | NHS England is legally required to seek to achieve the objectives set out in the Mandate. In turn, CCG’s are required to play their part in delivering the Mandate.

Sustainability implications | In order to ensure the sustainability of the local health and care system moving forward, it is imperative that we develop a robust joint plan, across all agencies, outlining the transformative changes which will be made to the system by 2020.

NHS Constitution | The guidance outlines the need to continue to deliver the standards set out in the NHS Constitution.

Next steps | We will receive feedback from NHS England regarding the Operational and BCF Plan. Work will continue to progress on the development of the sustainability and transformation plan with the June submission document being brought to the Governing Body in July.

Appendices | Appendix 1 Operational Plan 2016/17
Appendix 2 Better Care Fund
Appendix 3 Commissioner Plan
2016/17 NHS England Planning Guidance

1. NHS England Planning Framework

1.2 NHS England’s short to medium term planning for the service is covered by a framework of interdependent plans:

- Operational Plans for 2016/17
- The Five Year Local health system Sustainability and Transformation Plan (STP)
- Better Care Fund Plan 2016/17
- Commissioner Plan 2016/17

1.3 Operational Plans for 2016/17

The Operational Plan (Appendix 1) was submitted to NHS England on 18th April 2016 in accordance with the planning timetable.

Members will recall our plan detailed our actions in respect of the nine national must do’s for 2016/17. It also identified how we expect to achieve targets and identified risk areas, whilst describing our overarching transformational approach to the emerging STP.

1.4 The Five Year Local health system Sustainability and Transformation Plan (STP)

Work continues on a single Sustainability and Transformation plan for the Northumberland Tyne & Wear region (NTW STP) consisting of three local health economies (LHE’s), Newcastle Gateshead, North Tyneside and Northumberland, and Sunderland and South Tyneside.

This plan will describe our shared local vision for 2021 regarding care both inside and outside our hospitals underpinned by better integration with local authority services in respect of prevention, early intervention and social care.

STPs will cover the five period to 2021, and will be subject to formal assessment in July 2016 following submission on 30th June 2016. The STP will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards.

The Planning Guidance provides the detailed list of ‘national challenges’ to help us set out ambitions for our populations focusing on reducing the “3 Gaps” below in respect of:

- Health and Wellbeing;
- Care and Quality;
- Finance and efficiency.
1.5 Better Care Fund (BCF plan) (Appendix 2)

The BCF planning process required the CCG and Local Authorities to agree joint plans to continue to deliver the requirements of the Better Care Fund (BCF) in 2016/17, building on the 2015/16 BCF plan, and taking account of what has worked well in meeting the objectives of the fund, and what has not.

BCF funding is targeted to support reductions in unplanned admissions and hospital delayed transfers of care.

The BCF plan narrative and template were submitted to NHS England on 3rd May, following approval by the respective Health and Wellbeing/Wellbeing for Life Boards.

An assessment will be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Agency, Monitor and local government.

These judgements on ‘plan quality’ and ‘risks to delivery’ will contribute to the placing of plans into three categories – ‘Approved’, ‘Approved with support’, ‘Not approved’.

1.6 Commissioner Plan (Appendix 3)

Commissioning intentions were subject to a robust prioritisation process taking into account the national requirements outlined in the guidance, how they support the achievement of our transformational changes as well as the development of an achievable QIPP plan.

The commissioning intentions outlined in this document are not a complete list of all the initiatives, projects and service transformation areas that are either already underway or are in the pipeline, but instead:

- Outline the key priorities for the year ahead which will improve the quality of service and/or improved value for money;
- Provide the context for commissioning changes;
- Provide an indication to current and potential providers of how, working with our partners we intend to shape the delivery of health services for our population.

The Commissioner Plan was agreed by all member practices in March 2016.

2. Recommendations

The Governing Body is asked to:

- note the BCF and STP planning process
- approve the final commissioner and operational plans
NHS Newcastle Gateshead CCG
Commissioner Plan 2016/17
Version 2.0
# Contents

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1. Introduction

NHS England published the Five Year Forward View on 23rd October 2014. The Forward View sets out a clear vision for the future of the NHS based around new models of care.

In December 2015, NHS England published the NHS Shared planning guidance which outlines a clear list of national priorities for 2016/17 as well as longer term challenges for local systems. Each local health and care system has also been asked to come together to create their own local blueprint for accelerating implementation of the Forward View.

All NHS Organisations have been asked to produce two separate but interconnected plans:

- A local Northumberland Tyne & Wear health & care system ‘Sustainability & Transformation Plan’ covering the period from October 2016 to March 2021
- A plan by organisation for 2016/17. This will need to reflect the emerging Sustainability and Transformation Plan. This document describes the NHS Newcastle Gateshead CCG commissioning plan for 2016/17.

We are currently in the process of working with partners, stakeholders, the clinical community, patients and the public to develop our long term ‘Sustainability & Transformation plan’ and it is imperative that in 2016/17 we focus on key areas of transformational work to address our greatest challenges (long term sustainability and current pressures).

To date the following areas have been identified as priorities to ensure the sustainability of our local health economy:

**Population Focus**
- Older People
- Children, young people and families

**System Focus**
- Collaborative hospital working
- Intermediate care system
- Sustainable primary care

**System Approach**
- Prevention & Early intervention
- Individual and community resilience
In order to ensure our priorities for 2016/17 are aligned with this emerging thinking, we have linked each of our priorities to these key areas of focus.

The commissioning intentions outlined in this document are not a complete list of all the initiatives, projects and service transformation areas that are either already underway or are in the pipeline, but instead:

- Outline the key priorities for the year ahead which will improve the quality of service and/or improved value for money;
- Provide the context for commissioning changes;
- Provide an indication to current and potential providers of how, working with our partners we intend to shape the delivery of health services for our population.

2. Background and context

We have made significant progress towards achieving our local health and care economy vision and continue to accelerate our programme of transformation working closely with partners utilising opportunities outlined within the NHS Five year Forward View.

Moving forward, there will be a single Sustainability and Transformation plan for the Northumberland Tyne & Wear region which will be made up of three local footprints, namely Newcastle Gateshead, North Tyneside Northumberland & Sunderland South Tyneside. This plan will describe our shared local vision for 2021 regarding care both inside and outside our hospitals underpinned by better integration with local authority services in respect of prevention and social care.
2.1 Case for Change

*The challenges for Clinical Commissioners*

We know the NHS is facing a period of unprecedented challenges which are not unique to NHS Newcastle Gateshead CCG. These challenges are driven by the following:

| An ageing population                                                                 | • Anticipated significant growth in over 85 year olds  
|                                                                                     | • Currently more than 40% of people admitted to hospital are over 65 years  
|                                                                                     | • Unplanned admissions for people over 65 years account for more than 70% of hospital emergency bed days  
|                                                                                     | • When they are admitted to hospital, older people generally stay longer and are more likely to be re-admitted  
| Increasing costs                                                                   | • 80% of deaths in England are from major diseases (i.e. Cancer) many of which are attributable to lifestyle risk factors i.e. excess alcohol, smoking, poor diet  
|                                                                                     | • 46% of men and 40% of women will be obese by 2035  
| Budgetary constraints                                                              | • Although NHS budgets are protected in real terms, current forecasts point to a £30bn gap in funding by 2020/21.  
| Increasing long term conditions                                                    | • It is predicted that there will be 550,000 additional cases of diabetes and 400,000 additional cases of stroke and heart disease nationally  
|                                                                                     | • 25% of the 15 million people in England with a long term condition currently utilise 50% of GP appointments and 70% of the total health and care spend in England.  
| Public expectations                                                                | • Patients and the public rightly have the high expectations for the standards of care they receive. There are increasing demands for access to latest therapies, greater information requirements and more involvement in decisions about their care.  

In response to the challenges set out above our collective ambition is to maintain high quality and sustainable health and care services for our public and patients which we will achieve through:

- Ensuring our citizens are fully engaged
- Wider primary care provided at scale
- A modern model of integrated care
- Access to highest quality urgent and emergency care
- A step change in the productivity of elective care
- Specialised services concentrated in centres of excellence.

**Population demographics and health profile**

The health of people in Newcastle and Gateshead is generally worse than the England average, with life expectancy for both men and women lower than the England average. The 2013 Health profiles and demographics provide us with the following overview of our population:
There are significant health inequalities in Newcastle and Gateshead, despite the progress made in improving the health of the population over the last few years. These inequalities are described in detail in the reports of the Director of Public Health and the Joint Strategic Needs Assessment.

We are committed to promoting opportunities for health for all people in Newcastle and Gateshead through partnership working and efforts to prevent illness, protect from harm or threat to health and wellbeing and reduce unfair and avoidable health inequalities. To support the achievement of these goals we will continue to implement the evidence based practice utilising frameworks such as the Commissioning for Prevention 5 step framework as outlined within the NHS England Call to Action.
3. Commissioning plan 2016/17

This document outlines our current thinking in relation to key areas of focus for 2016/17.

We know there are underlying challenges in our health economy that must be addressed to successfully build a sustainable care model. These include:

- Managing increased demand for services from our frail elderly population;
- Delivering robust and effective community services, bringing care closer to home;
- Working together to develop new models of delivery which ensure sustainability and affordability.

Our process for developing these key areas of focus has been set clearly in the context in which the organisation operates, responding to (in no particular order):

- National requirements outlined within the Five Year Forward view;
- What our patients and the public are telling us;
- What the Quality Review process highlighted;
- What our stakeholders and partners are telling us;
- The CCG’s vision and values;
- Local population need, as described by the Joint Strategic Needs Assessment (JSNA/NFNA);
- Utilising the evidence base for example NICE, Commissioning for Value and Right Care;
- Intelligence from in-year contract performance monitoring;
- Assurance requirements, including the DH Operating Framework/Outcomes Framework and NHS England requirements;
- QIPP (Quality, Innovation, Productivity & Prevention) delivery;
- Transformational change requirements to ensure a sustainable health economy;
- Funding and efficiency requirements.
Nationally, NHS England has prescribed the following must do’s which must be achieved in 2016/17:

<table>
<thead>
<tr>
<th>National Must Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Development of STP</td>
</tr>
<tr>
<td>2. Aggregate financial balance</td>
</tr>
<tr>
<td>3. Sustainability and quality of general practice</td>
</tr>
<tr>
<td>4. Achievement of access standards for A&amp;E and ambulance waits</td>
</tr>
<tr>
<td>5. Achievement of NHS Constitution referral to treatment standards</td>
</tr>
<tr>
<td>6. Achievement of NHS Constitution cancer standards and one year survival</td>
</tr>
<tr>
<td>7. Achievement of new mental health standards</td>
</tr>
<tr>
<td>8. Transform care for people with learning disabilities</td>
</tr>
</tbody>
</table>

These requirements have been considered through our planning process to ensure we achieve these as well as accelerating transformation in 2016/17.
4. Our vision

Our Vision is to transform lives together by prioritising:

- **Involvement** - of people in our communities and providers to get the best understanding of issues and opportunities.
- **Experience** - people centred services that are some of the best in the country.
- **Outcome** - focusing on preventing illness and reducing inequalities.

The diagram below summarises our vision and is surrounded with the core NHS values to show our local work is always in the context of being a consistent National Health Service.
5. Areas of Focus in 2016/17

In 2016/17 we will focus on key areas of transformation to address our greatest challenges (long term sustainability and current pressures). Our key areas of focus moving forward will be:

**Population Focus**
- Older People
- Children, young people and families

**System Focus**
- Collaborative hospital working
- Intermediate care system
- Sustainable primary care

**System Approach**
- Prevention & Early intervention
- Individual and community resilience

We continue to progress with the development of the new care models described within the Five year forward view, and in line with this, our major areas of transformation for 2016/17 continue to be:

- Mental Health Services;
- Urgent Care Vanguard;
- Care Homes Vanguard in Gateshead;
- Proof of concept model of care in Newcastle;
- Re-procurement of community services in Gateshead;
- Implementation of the General Practice Strategy.

The full list of our priorities for 2016/17 can be found at Appendix 1:
6. Measuring success

We will continue our work on the development of an Outcomes Based Commissioning (OBC) framework. This framework will focus on Providers delivering services that focus on outcomes for patients and their carers. The focus will also be on patient centred goals and overall service improvement.

Nationally, our performance will be assessed against the following measures in 2016/17:

<table>
<thead>
<tr>
<th>NHS Constitution Standards</th>
<th>Standard</th>
<th>Monthly/Quarterly/Annual Total</th>
<th>Technical Guidance</th>
<th>Planning Trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E waits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E Waiting Times – Total time in the A&amp;E department</td>
<td>95%</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cat A Ambulance Calls</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance clinical quality – Category A (Red 1) 8 minute response time</td>
<td>75%</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulance clinical quality – Category A (Red 2) 8 minute response time</td>
<td>75%</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulance clinical quality – Category A 19 minute transportation time</td>
<td>95%</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Referral To Treatment waiting times for non-urgent consultant-led treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral</td>
<td>92%</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Diagnostic Test Waiting Times</td>
<td>1%</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cancer Two Week Wait</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All cancer two week wait</td>
<td>93%</td>
<td>Monthly/Quarterly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Two week wait for breast symptoms (where cancer was not initially suspected)</td>
<td>93%</td>
<td>Monthly/Quarterly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cancer Waits - 31 Days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from ‘date of decision to treat’)</td>
<td>96%</td>
<td>Monthly/Quarterly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>31-day standard for subsequent cancer treatments-surgery</td>
<td>94%</td>
<td>Monthly/Quarterly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cancer Waits - 62 Days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.</td>
<td>85%</td>
<td>Monthly/Quarterly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service</td>
<td>90%</td>
<td>Monthly/Quarterly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.</td>
<td>n/a</td>
<td>Monthly/Quarterly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS Constitution Supporting Standards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One-year survival from all cancers</td>
<td>N/A</td>
<td>Annual</td>
<td>Yes</td>
<td>See note 1</td>
</tr>
<tr>
<td>Infection</td>
<td>Monthly/Quarterly/Annual Total</td>
<td>Technical Guidance</td>
<td>Planning Trajectory</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------</td>
<td>--------------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>Healthcare acquired infections (HCAI) measure (Clostridium Difficile Infections)</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Monthly/Quarterly/Annual Total</th>
<th>Technical Guidance</th>
<th>Planning Trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total referrals (All specialities)</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Consultant led 1st Outpatient attendances</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Consultant led Follow up outpatient attendances</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Total elective admissions (spells)</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Total non-elective admissions (spells)</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Total A&amp;E attendances</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Total Endoscopy tests*</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Total Diagnostics tests (excluding Endoscopy)*</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>RTT admitted activity</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>RTT non-admitted activity</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Expectation</th>
<th>Monthly/Quarterly/Annual Total</th>
<th>Technical Guidance</th>
<th>Planning Trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT Roll-Out</td>
<td>15%</td>
<td>Quarterly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Estimated diagnosis rate for people with dementia</td>
<td>66.7%</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IAPT Recovery Rate</td>
<td>50%</td>
<td>Quarterly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

| IAPT Waiting Times - The proportion of people that wait six weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.* | 75% | Quarterly | Yes | Yes |
| IAPT Waiting Times - The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.* | 90% | Quarterly | Yes | Yes |
| Percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral | 50% | Quarterly | Yes | See note 1 |

<table>
<thead>
<tr>
<th>Better Care Fund</th>
<th>Expectation</th>
<th>Monthly/Quarterly/Annual Total</th>
<th>Technical Guidance</th>
<th>Planning Trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services</td>
<td>N/A</td>
<td>Annual</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Delayed Transfers of care per 100,000 population (attributable to NHS, social care or both)</td>
<td>N/A</td>
<td>Monthly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population</td>
<td>N/A</td>
<td>Annual</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The financial plan for 2016/17 has been developed in parallel with the wider planning requirements.

Following release of the CCG’s allocation for 2016/17 (and expectations for the following four years) in January 2016 it has become clear that there will be increased financial pressure on the CCG in 2016/17 and future years.

The CCG’s programme cost allocation for 2016/17 has increased by 3.05% which equates to £20.7m, giving total funding for services of £721m for the year.

Financial plans have been developed in line with national financial planning assumptions for the year including:
- Inflation and efficiency adjustments to contracts based on national tariff guidance
- CQUIN to remain at 2.5% of contract value
- Provision of funding for mental health services, including child and adolescent mental health services (CAMHS) and general practice information technology (GPIT), some of which was provided via national non recurrent funding in 2015/16.
- Compliance with national business planning requirements to provide contingency and non-recurrent funds
- Planned achievement of surplus in as agreed with NHS England.

### Table: Transforming Care

<table>
<thead>
<tr>
<th>Transforming Care</th>
<th>Expectation</th>
<th>Monthly/Quarterly/Annual Total</th>
<th>Technical Guidance</th>
<th>Planning Trajectory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliance on inpatient care for people with a learning disability and/or autism*</td>
<td>An overall reduction in the number of inpatients who have either a learning disability and/or an autistic spectrum disorder (including Asperger’s syndrome) throughout 2016/17.</td>
<td>Quarterly</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* Added for 2016/17 Planning Round

**Note 1:** Trajectory for this indicator must be reflected in CCG plans, although it will not be formally collected in UNIFY. It will be monitored in-year, and CCGs will be held to account for their performance against this indicator.
Given the significant calls on the funding allocation for 2016/17, new plans for spending on commissioning of services outside of the demand planning and performance requirements within major contracts has been minimal.

A key focus of the financial plan is in developing and implementing the CCG’s Quality, Innovation, Prevention and Productivity (QIPP) savings plans for 2016/17 and future years. The plans total £14m for 16/17 and are reflected across the full range of services commissioned by the CCG. The CCG will look to work closely with service providers to explore opportunities to ensure all parties achieve best value for the funding available, including utilising focused work on Right Care opportunities. This will be supported by the application of consistent objectives across the range of commissioning tools, for example CQUIN schemes with providers and engagements programmes with general practice.

Even within the current balanced financial plan significant risks remain, and alongside them the need to continue with QIPP and wider transformation schemes which will support the local health economy to achieve sustainability in future years.

**8. Contract implications**

Where appropriate, detailed financial and activity schedules reflecting modelled activity requirements will be issued for discussion with our providers. In circumstances where commissioning intentions are expected to have a material impact on 2016/17 provider activity levels, the activity impact will be included in the proposed activity and financial schedule.

Commissioners and providers are required to jointly agree activity profiles and consequently the assumptions underlying our activity estimates will be shared with providers for discussion and agreement as part of the contract negotiation process.
9. Equality and Diversity

As public sector organisations, the NHS Newcastle Gateshead CCG Alliance are statutorily required to ensure that equality, diversity and human rights are embedded into all our functions and activities as per the Equality Act 2010, the Human Rights Act 1998 and the NHS Constitution.

In the exercise of our functions we will ensure that we:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Human Rights Act.
- Provide equality of opportunity and ensure good relationships for people who are protected by the Equality Act 2010.

This means that we should:

- Work towards ensuring that people protected by the Equality Act are not disadvantaged.
- Take steps to meet the needs of people from protected groups.
- Encourage people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Our aim is to uphold these objectives and to close the gap in health inequalities.

Our equality strategies are available on our website.

10. Summary

The purpose of this document is to raise awareness of the transformation initiatives and schemes NHS Newcastle Gateshead CCG intends to implement during 2016/17. As plans are developed and implemented, the impact on individual contracts will be discussed with providers.
We will **transform lives together** by prioritising:
- **Involvement** - of people in our communities and Providers to get the best understanding of issues and opportunities.
- **Experience** - people-centred services that are some of the best in the country.
- **Outcome** - focusing on preventing illness and reducing inequalities.

**Whole Person Centered Care Pathways**

**Mental Health & LD**
- Emotional Wellbeing
- EIP for adults
- IAPT single model
- Psychological therapies spec
- CTR for LD
- LD Transformation
- Deciding together (including crisis beds)

**Older People**
- Dementia Services
- Falls prevention
- CHC Case management and appeals capacity
- ONS Service Newcastle
- Care Homes Vanguard
- Intermediate Care

**Children, Young People & Families**
- Primary care access / services
- Sick and injured child pathway
- Maternity
- LD Autism
- SEND Reforms
- CAMHS (Enhancing minds, improving lives)

**LTC**
- Stroke
- Hypoglycaemia pathway
- Respiratory
- Year of Care
- Diabetes Prevention
- Diabetes Education

**Care Settings - New Care Models**

**Cancer**
- Implementation of Cancer strategy
- End of Life care inc: review of hospice contract
- Hospices contract drugs supply

**Involving End of Life care**

**Planned Care**
- MSK
- Variation programme (Right Care)
- Basket of Care

**Urgent Care**
- Urgent care strategy (24/7 Primary Care)
- Urgent Care Vanguard (Regional)
- CRP Testing

**Transformation Led by Partners**
- Social Prescribing
- SOS Outpatient Follow Up
- Respiratory Ambulatory Care LOS
- Heart Failure
- Urgent Care Vanguard

**Enablers**
- Digital Care programme & LDR Plan
- Workforce
- Estates
- Primary care strategy
- Involvement & Engagement
NHS Newcastle Gateshead CCG
Operational Plan
2016/17
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1. Introduction

We are pleased to share our operating plan for 2016/17. In accordance with the requirements, outlined in the national guidance ‘Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21’, our plan covers the following areas.

- how we will reconcile finance with activity;
- our planned contribution to the efficiency savings;
- our plans to deliver the nine key must-dos;
- how quality and safety will be maintained and improved for patients;
- how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
- how we have linked our operational plan with the emerging Northumberland Tyne and Wear Sustainability and Transformation Plan (NTW STP).

Using our assessment framework, the operational plan demonstrates that sufficient activity has been planned for the nine must do’s and the NHS constitution standards to be delivered, and how we have fully met the financial business rules.

The plan also demonstrates alignment with the Northumberland Tyne & Wear Sustainability and Transformation Plan and our plans for transformation, in this first year of the Sustainability and Transformation Plan implementation.
2. Our Vision

Our 5 year Health and Social care system vision requires new Models of Care delivery across Care Settings underpinned by sustainable, value-based, Person-centred Co-ordinated Care pathways. Achievement of such will support the triple integration agenda and help narrow the 3 gaps within our local Health and Social Care system.

We will transform lives together by prioritising:

**Involvement** - of our communities and providers to get the best understanding of issues and opportunities;

**Experience** – people centred services that are some of the best in the country;

**Outcome** – focusing on preventing illness and reducing inequalities to help people live happier, healthier lives.
3. The Nine National Must Do’s

We have assessed our current position in respect of the nine national must do's, outlined by NHS England for 2016/17, identified how we expect to achieve targets and identified risk areas, whilst describing our overarching transformational approach to the emerging STP.

9 National Must Do’s

<table>
<thead>
<tr>
<th>National Must Do</th>
<th>CCG Plan in place</th>
<th>Risk to Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Development of STP</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>2. Aggregate financial balance</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>3. Sustainability and quality of general practice</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>4. Achievement of access standards for A&amp;E and ambulance waits</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>5. Achievement of NHS Constitution referral to treatment standards</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>6. Achievement of NHS Constitution cancer standards and one year survival</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>7. Achievement of new mental health standards</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>8. Transform care for people with learning disabilities</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
4. National Must Do 1 - Development of the Northumberland Tyne and Wear Sustainability and Transformation Plan (NTW STP)

The following section describes the process we have undertaken to date in developing the Newcastle Gateshead Local Health Economy (LHE) contribution to the overarching Northumberland Tyne and Wear Sustainability and Transformation Plan (NTW STP).

Why are we working together?

Accountable Officers (AO) across Newcastle Gateshead recognise that our local system will only remain viable and/or succeed if we act ‘together’ across all Health, Local Authority and public partnerships.

Many of the organisations in our LHE and care system face significant financial challenges, consequently there is recognition that we need to move towards a more ‘Collaborative Accountable System’.

How are we going to work together?

Although, we have built the foundations for excellent working across Newcastle Gateshead, we know that the pace and scale of change that is required to establish a ‘sustainable Health and Care system’ is considerable. Therefore, a radical and accelerated shift towards ‘shared accountability, leadership and responsibility’ is crucial. As a system we need to embed principles of ‘place-based’ systems. In doing so, we are focused on the following approach:

- **Understanding challenges and outcome ambition** – health profile, cultural expectations, quality, safety, financial pressures and barriers to service delivery (enablers)
- **Shifting current challenges into enablers** – Workforce, Estates, IT/Technology and Communication.
- **Focusing on areas of system redesign** – Prevention and Early Intervention and Care and Support
- **Using transformation methodologies** that encompass analytical rigor (Right Care), cross sector and organisational collaboration (Integration Taskforce) and public involvement, rapid evaluation, learning and roll out (Proof of Concept)
- **Determine together ‘in action’** what the future Health and Care system needs to look like
Across the Newcastle Gateshead health and social care system we have commissioned external support to help us in exploring a Collaborative Accountable System.

To date, the external work has developed an interim report to understand:

- Principles of partners working together
- Roles, responsibilities and commitment of partners
- Governance and leadership arrangements

What are we working together on?

Currently we know ‘what that system should look like’ through engagement with our Public and Patients, but work continues in partnership with our stakeholders.

Like many areas we have numerous existing transformational programmes underway to redesign services. We have prioritised our redesign to drive sustainable change across a person’s life course by preventing of ill-health, early intervention of disease and supportive care based on need. In doing so, we will embed health improvements in all contacts giving more control to the citizens and increase individual and community resilience.

Areas of focus include:

- Collaborative hospital working across pathways – Stroke, ENT, Vascular, Pathology, Diagnostics and back office functions
- Redesigning the Out of Hospital system:
  o A sustainable intermediate care system
  o A sustainable primary care
- Transforming care for people with Mental Health and/or Learning Disability
- Prevention at Scale – Smoking, Obesity, Dementia, Diabetes

We are in no doubt that these priority areas of focus in 2016/17, year one of the five year STP, will be a significant first step in delivering our sustainability and transformation programme.

What approach are we taking?

Working together as an accountable health and care system will allow us to build upon transformation, to shape services based on need and opportunity and to reduce organisational silos and barriers.
Involvement will be a population/place based approach using ‘Proof of Concept’ methodology to involve communities and professionals working with communities in analysis, shaping and testing out new models for health and care (e.g. use the People and Communities Principles).

Our approach will be ‘outcome focused’; with key enablers to change (e.g. Workforce, contract and payments) acting as the platform to sustainable change.

**Diagram A.** An overview of Newcastle Gateshead approach to a future sustainable Health and Care system

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**Workforce transformation**

Workforce transformation is a significant lever for change and key to ensuring we are able to meet changing needs and expectations of service users.

We recognise the requirement to challenge without destabilising how we currently use our health and care workforce in order to be able to maximise people’s
independence and ‘reduce, prevent, delay’ requirement for acute hospital intervention or residential care.

In order to improve out of hospital care response and to create individual and community resilience we will work with provider and academic partners and HENE to:

- Influence professional bodies and universities to ensure core training equips professionals with knowledge and skills required to meet the changing demographic needs and to ensure numbers admitted to programmes responds to local demand
- Extend professional scope of practice to allow our workforce to work between acute and community settings according to patient flow
- Shift from discipline defined to competency based roles
- Introduce non-traditional roles including the voluntary sector and volunteers
- Improve professional ability and confidence to work across the health and care system
- Ensure greater collaboration and/or integration to reduce handoff between professionals and organisations
- Understand international best practice and to consider how such approaches and models of care might be implemented within Newcastle and Gateshead

In respect of short term workforce deficit we are cognisant of the need to avoid shifting workforce without managing any potential negative consequences to other parts of the system and we will look at how we:

- Attract and retain new people to work in Newcastle and Gateshead
- Develop duality of roles
- Introduce more junior roles to improve succession planning and to allow more experienced members of our workforce to extend their scope of practice

There is however, a huge opportunity to attract the future workforce to live and train in Newcastle and Gateshead especially given the excellent reputation of our hospitals, to the extent that the area is seen as a training centre of excellence.

As a CCG we recognise that the empowerment of people and communities is a crucial part of a sustainable future workforce and recognise the need to address the 6 principles articulated below (New Care Models: empowering patients and communities: A call to action for a directory of support. NHS England).

- Care and support is person centred: personalised and empowering
- Services which are created in partnership with citizens and communities
- Focus is on equality and narrowing health inequalities
- Carers are identified, supported and involved
• Voluntary, community, social enterprise and housing sectors as key partners and enablers
• Volunteering and social action are recognised as key enablers.

The CCG has excellent relationships and working practices with HENE and non-health focused organisations supporting workforce issues (e.g. Skills for Care, Tyne and Wear Care Alliance, local universities etc.).

We will continue to build on these relationships and explore new relationships as we redesign the Health and Care system (across ‘footprints’ - locally and regionally) for example continuing our work to date with HENE:

• on a regional workforce approach, providing information to support workforce planning to inform education and training investment
• to provide whenever possible intelligence to inform the process of planning for service transformation and workforce modernisation which supports delivery of the five year forward view
• supporting the delivery of Primary Care at scale through the Workforce Task and Finish group to include the following areas
  – Role of Bands 1-4 workforce
  – Development of GPs with additional interests, particularly re care of the elderly
  – Practice nurse development
  – Development of a career start scheme for GPs
  – Training for bands 1-4 staff (or equivalent) working in practices
  – Better use of expected opportunities to be realised from the changes to CPD/CWD

Workforce availability and transferability from hospital to out of hospital care settings will be one of the major challenges we will face in delivering the STP for Newcastle Gateshead LHE, alongside the need for recruitment, retention and redesign of the General Practice workforce

For example we know that the GP and practice nurse age profile in our area has caused disequilibrium in supply and demand which may not be addressed sufficiently through national recruitment targets.

We are therefore seeking to develop our own CCG GP Fellowship Programme, and have already established our own Career Start programme for Practice nurses in Newcastle to address this.
System leadership

As system leaders we will be required to challenge ourselves across key enabling areas to understand and prioritise the actions necessary to achieve system accountability.

Leadership will be a key enabler to our change programmes, we will review our opportunities for Leadership development as follows:

- By defining and engaging with system leadership programmes to develop a culture of leadership across all levels of Health and Care system.
- By establishing appropriate governance that supports robust and accountable decision making within a new system. For example, Joint Accountable Officer and Integrated Care Programme Board across Newcastle and Gateshead.

Although the NTW STP footprint is a new construct which will enable us to plan and work together across organisational boundaries and a larger geography, in order to maximise opportunities for closing the three gaps in each LHE, we will have Mark Adams, Newcastle Gateshead CCG Chief Officer in the STP leadership role.

Mark has been very much involved in the development of the Accountable Officers work to date, which strengthens the opportunity for successful delivery of the STP.

5. National Must Do 2 - Aggregate financial balance

5.1 Finance Overview

During this shared open book operational planning process for 2016/17, we have welcomed the opportunity to respond to queries raised from NHS England as iterations of the plan have been developed, discussed and amended.

As outlined in draft annual accounts, Newcastle Gateshead CCG will report delivery of a surplus outturn position for 2015/16 in line with plan and above the 1% national requirement. This continues the strong performance of the three former CCGs across Newcastle and Gateshead. The main pressures were increased costs for continuing healthcare packages and those for S117 patients following discharge from hospital. There was also growth beyond plan in acute contracts. The first priority in financial planning for 2016/17 has been to ensure recurrent funding is in place to cover these pressures.
The financial position for 2016/17 and future years is likely to be increasingly challenging with financial risks again focused in CHC/packages of care and in demand pressures for acute care.

The financial plan is focused on delivery of the required business rules including:

- Surplus of £8.8m which includes drawdown of £1.5m in 2016/17
- Provision of 0.5% contingency (£3.6m)
- Provision of 1.0% non-recurrent requirement (£7m)

Drawdown for 2016/17 has been included at £1.5m in line with the agreed sum.

The BCF schedule has been updated and reflects new allocation information which details the changed health to social care allocations.

Risks and mitigations are shown on the appropriate schedule in the finance plan and are largely focused on CHC/S117 and acute pressures. There is also some risk in under-delivery of QIPP plans which has also been assessed. While the 1% non-recurrent is not included as a mitigation, the CCG will need ongoing review of emerging evidence of risks throughout the year against the sources of mitigation currently identified in the finance plan to understand whether they can be fully covered.

There is alignment between the activity and finance assumptions within the CCG’s plans and contract activity and finance schedules which have been agreed with providers. It remains the case that delivery of activity and finance within planned levels will be challenging but the plan and contracts which support it represents a balance between growth to meet demographic and performance requirements, together with reductions to contribute to the QIPP programme.

The updated finance plan has been completed and submitted in line with required timescales. Further supporting information has been submitted to NHSE in the form of the 2016/17 Budget Report to the Governing Body, together with an updated QIPP plan based on further discussions since this was presented in March. A copy of the latest, fully identified, QIPP plan is shown below:
Risks and mitigations have been reviewed and amended where appropriate but will continue to be assessed in year. While the 1% non-recurrent is not included as a mitigation the CCG will need ongoing review of emerging evidence of risks throughout the year against the sources of mitigation currently identified in the schedule to understand whether they can be fully covered.
5.2 Activity Analysis

The planning development process was focussed on the creation of ever stronger and more robust relationships between all the main commissioning and provider organisations across Newcastle and Gateshead, including Social Care.

Part of the joint development process has been to ensure collective ownership of our plans and to identify cross organisational responsibilities for delivery. In this way we are seeking to ensure that we have identified the required capacity to take our plans forward, with whom the Accountable Officers covering the Newcastle and Gateshead area have a clear understanding of the deliverables and for which their individual teams are accountable to the system.

CCG Demand plans have been developed using the following principles and process:

**Principles**

- Fundamentally, activity plans have been developed to reflect a reasonable level of activity which takes into account 2015/16 actual activity as well as previous year’s activity trends. They have been developed in such a way as to ensure compliance with key NHS constitution requirements (i.e. RTT, cancer and A&E performance targets) while reflecting the impact of service transformation and pathway changes (i.e. ambulatory care). In line with previous years, contracts have been agreed with a number of independent sector providers for the provision of activity including specialities which have historically been the subject of waiting list pressures, most particularly elective orthopaedics.

- The CCG adopted an open book approach to demand planning with providers and, as part of the contract negotiations, ensured that the respective organisational demand plans were reviewed in detail in order to reach a consensus on an appropriate activity plan which both parties could sign off.

- As required by national guidance, NGCCG has agreed activity plans with providers which are able to be triangulated at the centre to ensure that all parties are working to an agreed plan throughout the year.
Process

NGCCG demand plans have been modelled to adjust for:

- Demographics - Population growth has been applied using 2013 ONS data

- Prevalence - Prevalence adjustments using various sources have been applied with specific emphasis on COPD, CHD, Stroke, Hypertension, Diabetes and Cancer

- Waiting list pressures - Waiting List Stock adjustment for admitted and non-admitted activity was applied comparing the current Sept 2015 waiting list to the same point last year

- Changes in GP referrals

- 12% growth in cancer related activity has been factored into selected service lines in 2016/17 to reflect the anticipated growth in referrals and associated activity impact arising from the new NICE cancer referral guidance

Where appropriate, GP clinical advice was sought regarding potential activity adjustments based on clinical pathway revisions.

Transformational change

At present we know ‘what that system should look like’ through engagement with our Public and Patients, but are yet to determine a future 'system form'. Like many areas we have numerous existing transformational programmes underway, but we have prioritised ‘key areas’ of focus in our redesign to drive sustainable change as well as support current challenges.

We discuss this in more detail in the section relating to our Sustainability and Transformation Plan.

The CCG’s own transformational programmes continue to develop a range of initiatives to deliver transformation with BCF schemes being a significant contribution to our QIPP plan.
5.3 Triangulating Finance and Activity

As noted above our activity plans are sensitive to demographic and non-demographic demand assumptions, which in turn mirror those used to derive the consequential finance plan thereby ensuring alignment between the two interdependencies.

While the basis for all elements of the plan submission and contract development is the same, contract agreements with individual providers reflect where appropriate the financial impact of QIPP. The activity impact of these schemes at an individual provider level are still being assessed and clarified with providers.

From a planning perspective the local activity waterfall charts show the transformational impact of QIPP at a POD level, although the finance waterfall charts show QIPP at a provider level in line with agreed contracts.

Phasing of QIPP developments within the finance plan reflects some degree of continued work-up in the early months of 2016/17, with most plans currently expected to deliver from Q2 onwards.

5.4 Sustainable Delivery

Contract negotiations with providers have been undertaken in the context of the new planning guidance and the collective responsibility to deliver transformation as outlined in the Operational Plan and in the Sustainability and Transformation Plan.

The need for individual organisations to own and contribute to the delivery of the QIPP challenge has been emphasised in these meetings in the context of discussions taking place at AO level.

The CCG has undertaken a review of current commissioning intentions and their fit with the key themes outlined in the draft Operational Plan and ‘key areas’ of focus for early acceleration as part of our Sustainability and Transformation Plan (for example, a specific population and system focus). These can be found at Appendix 1: CCG Plan on a Page.

Two major system focus areas have emerged in relation to out of hospital care and intermediate care. These themes fitted with discussions which have taken place with provider colleagues and are also opportune given the community services procurement in Gateshead and the possibilities this presents.
Following further internal meetings of CCG urgent care, finance and provider management leads supported by NECS business intelligence, the CCG developed a number of proposals which are aimed at addressing the QIPP challenge in relation to urgent care.

In the last twelve months a significant focus of work in order to address this issue has been the BCF schemes. Whilst these will continue and will need to make a contribution to delivery, there are also significant opportunities arising from more effective engagement with primary care in order to reduce emergency admissions.

While developing the BCF plan for 2016/17 we have taken the opportunity to review the current schemes and align them with emerging new models of care e.g. Care Homes Vanguard, Urgent Emergency Care Vanguard and Other Emerging Models of Care such as redesign of community health services, primary care, out-of-hospital care, prevention, assertive early intervention and enablement services. We now view the BCF as part of our wider delivery proposals rather than as a separate project.

We have also assessed the effectiveness of the schemes overall achievements, what has worked well, challenges, what has not worked so well and what are the key next steps to progress and re-focus work, mindful of how this will support reductions in unplanned admissions and hospital delayed transfers of care.

As outlined elsewhere in this paper it has been estimated that there is an opportunity to reduce emergency admissions by 37 per practice annually, which would make a material impact on Non Elective admission expenditure. This equates to less than one admission per practice per week. This therefore provides some context as to the materiality of the challenge at practice level which, if delivered, would make a significant contribution to our QIPP target.

As part of the ongoing planning discussions, analysis has been undertaken in relation to individual practice variation in relation to emergency admissions.

This has revealed significant variation across practices in Newcastle Gateshead in relation to the rate of emergency admissions in the 0-4, 5-17, 18 -75 and 75+ cohorts.

This analysis provides an assessment of the activity and financial impact of reducing admissions for all practices to the level of what might be considered the best performing practices. This information is being used by the CCG in developing and refining our approach to working with primary care in order to reduce emergency admissions and deliver QIPP.
Direct engagement with practices will be required in order to meet this challenge. A key lever to supporting this initiative is the proposed 2016/17 Primary Care Engagement Programme the overall aim of which is to ensure that no patient should have to use urgent and emergency care services because they have been unable to access primary care support.

In particular practices will be supported to:

- Offer a range of options for patients to access same-day care. These may include telephone consultations, e-consultations and walk-in clinics, as well as face-to-face appointments.
- Provide the appropriate number of urgent, same day appointments per day (which is informed by demand and takes into account seasonal variation) ensuring that these are available each day.

Specific demand management initiatives will be aimed at practices:

- Responding early to the small number of requests for an urgent home visit facilitating early intervention by community services to avoid admission.
- Providing appropriate access to early morning and late afternoon same day consultations and/or appointments for children.
- Publicising and enabling patients to access the ‘Think Pharmacy First’ Minor ailments scheme.
- Multi-disciplinary working (at practice, at locality-cluster level) to deliver robust care and support planning for older people to manage Long Term Conditions, multi-morbidity and frailty.

Specific focus is also being given within the PEP to the children’s pathway and LTC care with practices being incentivised to:

- Identify a designated GP from each practice to be identified as the practice Child Health Lead.
- Ensure that the practice team has the right basic skills and competencies in place to deal with common paediatric presentation.
- Ensure relevant practice representation at specific Time Out workshops focusing on embedding best practice across the CCG.
- ‘Care and Support’ planning for people with LTCs.
NGCCG has reviewed the Right Care data for our three former CCGs and identified the areas with the greatest opportunity for saving as Gastrointestinal, Respiratory, MSK and Cancer care. Overall the biggest opportunities appear to be in non-elective care, but the analysis is also being used to inform the work of our Planned Care Programme Board as part of wider work on QIPP and the implementation of commissioning intentions for 2016/17 and future years.

As part of implementation, assurance will be provided that no unintended consequences arise in terms of service delivery and in particular quality is assured both in terms of direct patient care and in relation to compliance with key NHS Constitution standards.
6 National Must Do 3 - Sustainability and quality of general practice

The transformation to a sustainable General Practice requires our work to focus on:

- Alternative service models that improve productivity and reduce the demand burden.
- Recruitment, retention and redesign of workforce that ensures healthy and capable individuals and teams.
- Enhanced use of technology to assist communication and information sharing, to manage access and demand and to support self-care.
- Estate solutions that enable collaboration and integration of ‘out of hospital’ teams.

Our current baseline position

We believe our baseline for General Practice is largely effective, where 41 of our 66 practices in NGCCG have been assessed.

- 3 have been graded as outstanding under the new CQC inspection regime,
- 35 as good,
- 3 requiring improvement and 0 as inadequate.
- 2 practices previously rated as inadequate have now been regarded as good.
- 25 await inspection or published report.

There is a higher ratio of GP’s per 100,000 of population to that of both the North East and England figures

What will we doing in 2016/17 in our journey to a future sustainable General Practice for Newcastle Gateshead?

In 2016/17 we will focus on the following key issues that we see are pivotal first steps:

- **Delegated functions of Co-commissioning** – CCG will be exploring Level 3 commissioning and through transformational programmes (Proof Of Concept and Transformation) we will look at new care models of delivery that supports working at scale, closer-to-home provision, 7 day services and cluster/locality-based provision (implementation of the General practice strategy).
- **Leadership** - Partnership with Federation(s) and alignment to joint AO forum, system governance, through CCG medical Director. Implementation of leadership programmes and incentivising the development of leadership skills in General Practice through local work (Practice Engagement Programme)
Workforce - 2 key strands in the general practice strategy include workforce and estates. We have established a career start programme for primary care nursing, practice manager’s leadership development, and are exploring GP fellowship. Also learning from the Prime Ministers Challenge Fund (PMCF) – 7/7, locality-based provision aided through mobile EMIS technology within Gateshead.

Estate mapping exercise is underway to understand ‘one public estate’ and prepare to closer-to-home delivery at scale.

Technology - Embedding Digital Care programme and LDR with roll out of EMIS Web, interoperability solutions around SCR/MIG. Tele-health programme as part of General practice strategy and Transformational programme

Implement the Great North Care Record to facilitate sharing of patient level clinical information and enable seamless pathways of care that reduce unnecessary reassessment and admission. Develop Local Digital Roadmaps to support delivery of ‘Personalised Health and Care 2020’

Payments + Contracts - Incentivisation of improving quality and reducing variation through PEP, exploring ‘basket of services’. Simplification and equity across NGCCG. Exploring the new GP contract

Engagement + Involvement - Continue existing work around active participation and involvement of General practice through the PEP programme, communication via newsletters, GIN/TEAMNET, General practice development forum and Time In Time Out programme.

What levers will we be using to implement redesign?

- Co-commissioning – shift to level 3 delegation
- Practice Engagement Programme – a programme that promotes ‘best practice’, care at home and aims to reduce variation of practice.
- General Practice strategy - implementation

What are the risks to achieving a sustainable General Practice?

- Capacity, capability of current workforce
- Growing demand in Out-of-Hospital provision
- Primary Care transformation team - Developing General Practice at scale aligned to General Practice strategy focusing on workforce, estate and transformation funding.
7 National Must Dos 4, 5, 6 & 7 – Achieving National Standards

Our performance against NHS constitutional standards continues to be strong; however there are performance issues of note that will need to be addressed in 2016/17 in order to further improve service standards to our patients.

The table which can be found in Appendix 2 outlines our current performance against the following national standards:

- Access standards for A&E and ambulance waits;
- NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice;
- NHS Constitution 62 day cancer waiting standard;
- The two new mental health access standards including continuing to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

The table also identifies planned 2016/17 performance, actions to, where appropriate, recover or sustain current performance together with expected timescales and a risk assessment.
8 National Must Do 8 - Transform care for people with learning disabilities

Our approach to "Building the Right Support" remains as a collegiate Transforming Care Partnership (TCP) of CCGs in CNE. The Cumbria and North East TCP rate currently stands at 49.79 inpatients per million capita.

End of year target:
Currently 14 inpatients beds have been closed within the TCP and we remain on target to deliver the fast track trajectory agreed in August 2015.

How will we achieve this in 2016/17?

Adopting NHSE’s model for transformational change we see the following issues key enablers to the change programme in 2016/17:

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Commissioning / Provision</td>
<td>Sustained implementation from the strategic transformational care group which is a sub group of the mental health programme board comprising a partnership between statutory, non-statutory, thirds sector and patient representatives.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Continued executive director leadership from the Executive Director of Nursing as lead and responsible director.</td>
</tr>
<tr>
<td>Workforce / estates</td>
<td>Enhancement of community services to enable greater support of people with learning difficulties in our communities Reduction in the number of inpatient beds and rationalisation of inpatient to community based estate stock through the independent sector.</td>
</tr>
<tr>
<td>Technology / Informatics</td>
<td>Benefit realization of technology and informatics opportunities that may exist specifically to support this client group. Telehealth for people in community.</td>
</tr>
<tr>
<td><strong>Payment / contracts</strong></td>
<td>Explore joint contract arrangements for social care and health to facilitate earlier re-provision and new support services in community settings including personal health budgets where appropriate.</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Outcomes /metrics</strong></td>
<td>National targets.</td>
</tr>
<tr>
<td><strong>Communication / Engagement</strong></td>
<td>Continue the current engagement that is in place through stakeholder meetings.</td>
</tr>
<tr>
<td><strong>Empowerment people / communities</strong></td>
<td>Working with people with learning disabilities to enable them to live and contribute within communities supported where appropriate by a personal health budget</td>
</tr>
<tr>
<td><strong>High value pathways / innovation</strong></td>
<td>Out of institutions into non institution environments. Assisted living.</td>
</tr>
</tbody>
</table>
9 National Must Do 9 – Development & implementation of an affordable plan to make improvements in quality

Quality is everyone’s business, we have robust senior level leadership to this important agenda, supporting this golden thread throughout the organisation and through matrix working with all staff groupings.

As part of the contractual process with providers, quality review group (QRG) meetings continue to be held with each acute and mental health provider organisation, and these meetings are chaired by CCG executive leads. QRGs are also held with the ambulance service and independent providers.

The focus of QRG meetings is on quality assurance and provides the CCG with the opportunity to review and monitor areas for improvement, highlight good practice and allows for challenge if areas of concern arise. QRGs are fundamental in maintaining the positive relationships that have been developed with providers since establishment of the CCG and ensures that quality is reported on in an honest and transparent way.

2015/16 Quality Premium quality indicators currently progressing towards local and national targets.

End of year target:
To achieve CQUIN and Quality Premium national and locally set requirements

2016 – 21 Ongoing transformational delivery

• Primary Care Transformation Team – Developing General Practice at scale aligned to the General Practice strategy focusing on workforce, estate and transformation funding;
• Prime Ministers Challenge Fund (PMCF) – 7/7, locality-based provision aided through mobile EMIS technology based on a nationally funded model;
• Digital Care Programme (regional) – 5 areas of focus encompassing work streams of patient online, standardisation, governance, access/operability, communication aligned to local IT strategy (Local Digital Record LDR plan);
• Technology - Implement the Great North Care Record to facilitate sharing of patient level clinical information and enable seamless pathways of care that
reduce unnecessary reassessment and admission. Develop *Local Digital Roadmaps* to support delivery of ‘Personalised Health and Care 2020’

- **Proof of Concept (POC)** – exploring accountable care in Newcastle. List-based approach. 2 out of 5 localities co-designing future working relationships with creation of design laboratories linked with Northumbria University through local task force;
- **Care Home Vanguard** – National programme redesigning care pathways for over 65 year population with new outcome-based contractual and payment models;
- **Urgent Care Vanguard (regional)** – National programme redesigning Urgent and Emergency Care in the region focusing on Clinical Hub (SPOA), Flight deck navigation, governance and payment/contracts aligned to local Urgent Care strategy and delivery of National Road map.
- **Acute Trust Transformation** – High value pathways (unplanned and planned care) with partnership alliances (e.g. hyperacute Stroke Care with NuTH) and out-of-hospital shift (e.g. Diabetes).
- **Deciding Together** - Inpatient and community based service redesign and provision for adults + older people. Core pathways are around Urgent Care, Primary Care, older people [dementia].
- **Expanding Minds** - CAMHS + IAPT services through Transforming Care Partnerships
- **Learning Disabilities** – Programme to improve community offer which particular focus on maternity service (Transforming Care programme fast track plan).

**7 day services**

- Extend opportunities for 7 day discharge (perfect week, MADE)
- Learning from PMCF in Gateshead to explore extended access in Primary Care
- Prevent unnecessary non-elective admissions, through re-designed community provision (BCF)
- Think Pharmacy First Scheme – reducing demand in GP and A&E

**Risks**

- Workforce - Capacity and Capacity (Out of Hospital + In hospital)
- Siloed working
- Social Care Funding reduction
- Delayed IT integration / communication (e.g. 111, GP OOH)
## 10 Risks and Mitigation

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relationship challenges – commissioner and providers</strong></td>
<td>Our local system has good working relationships in place across the local health and care sector.</td>
</tr>
<tr>
<td></td>
<td>Our Joint Accountable Officers Group and Health and Wellbeing boards are further developing working relationships allowing for appropriate and timely escalation of issues that need resolving but also allow for alliances and relationships to be strengthened.</td>
</tr>
<tr>
<td><strong>Cultural changes required and change to working behaviours/skills not adequately addressed.</strong></td>
<td>Work will need to be undertaken with all stakeholders and employees across the sector to address this requirement which is key to successful transformational change.</td>
</tr>
<tr>
<td><strong>IT infrastructure/sharing arrangements are not fit for purpose to support plan delivery.</strong></td>
<td>We have a robust IT programmes with multi-stakeholder arrangements. Funding is being released to invest in solutions that allow benefits across the system not only for the public but address the national requirements but also benefits providers.</td>
</tr>
<tr>
<td></td>
<td>The IT programme board has a clear strategy with outcomes that have been worked through from all providers and are working towards an aligned system that allows a whole–system approach to care delivery.</td>
</tr>
<tr>
<td><strong>There is a disconnect between commissioner and provider plans</strong></td>
<td>Our plans for 2016/17 have been developed in the context of a whole system view consistent with our Health and Wellbeing and wellbeing for Life strategies.</td>
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<tr>
<td></td>
<td>Consideration has and continues to be given to the impact on providers with a view to jointly defining our direction of travel on health and care integration and transformation.</td>
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<td></td>
<td>Providers are core and key to all service changes and are actively co-producing the system transformation and how delivery will be implemented</td>
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<tr>
<td></td>
<td>Joint Integration Programme Board will have a focus on planning for long term sustainability that links with</td>
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<tr>
<td>Financial risks</td>
<td>A number of risks remain within the financial planning assumptions, namely:</td>
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<tr>
<td></td>
<td>• Over performance of contracts</td>
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<td></td>
<td>• Prescribing costs – current budget plans assume an uplift of 2% on budget</td>
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<td></td>
<td>• Continuing healthcare costs – impact of trend to cost growth, particularly in the context of both increased numbers of cases and potential inflation in costs of current packages (living wage etc.)</td>
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<td></td>
<td>• Under-delivery on QIPP/Resource releasing initiatives – the CCG has recognised that there are opportunities highlighted by Right Care, but also the challenges in driving these through for impact in 2016/17.</td>
</tr>
<tr>
<td>Mitigating actions are detailed within the financial plan and are primarily related to deployment of contingency funds, cost avoidance measures and deferment of discretionary spend.</td>
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<table>
<thead>
<tr>
<th>The plan and supporting initiatives do not enable resources to be redirected towards redesign of care pathways towards closer-to-home care</th>
<th>Our plans are designed for the best interest of patients and the public to make a sustainable local health and care economy.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pathways have an evidence base, are best practice concepts and are what works locally.</td>
</tr>
<tr>
<td></td>
<td>Changes are being considered in relation to whole-system transformation and new funding/payment systems (e.g. new models of care) that will allow risk sharing arrangements with providers, new service configurations (e.g. alliance networks) and focus on rewarding value-based outcomes across health the social care economy.</td>
</tr>
</tbody>
</table>
| Pressures on the acute sector are not reduced and demand continues to grow across the system with significant and continued financial consequences | Our transformational plans have a strong focus on prevention, wellness and are adopting alternative pathways of care with investment into the out-of-hospital sector.

Aligning health and social care efforts with a big push towards wellness we hopefully start to see a reducing in ‘needs’ and an expansion in wellness. Focusing on the high demand cohorts for the acute sector (e.g. older people) and the children, young people and families programme will hopefully start to reduce activity as alternative pathways of care start to come on line.

Through our most senior forum e.g. Accountable Officers Group we will manage system and service resilience whether through pressures such as surge, financial or through transformation. |
| --- | --- |
| Delivery of STP | Key risks which may affect our ability to develop and deliver our STP:

- Misaligned incentives in the NHS reimbursement system
- Capacity and capability to drive system transformation to deliver new care models whilst sustaining quality, safety and productivity |
11 In Summary

We believe our plan and approach will take us closer to achievement of our vision, achieve the 2016/17 deliverables and National Must Do’s as well as achieve sustainability in these areas through our transformational ‘enabling framework’.

Our plan clearly defines the activity modelling undertaken with our partners, and sets out a financial framework to achieve aggregate financial balance.

We will continue to develop stronger relationships and define the necessary governance arrangements across the Newcastle Gateshead system to explore models of a ‘Collaborative Accountable System’; as well as the potential risks/mitigating actions and areas of transformational focus in 2016/17.
Appendix 1: CCG Plan on a Page 2016/17

NHS Newcastle Gateshead CCG – Plan on a Page 2016/17

We will **transform lives together** by prioritising:
- **Involvement** - of people in our communities and Providers to get the best understanding of issues and opportunities.
- **Experience** – people-centred services that are some of the best in the country.
- **Outcome** - focusing on preventing illness and reducing inequalities.

**Whole Person Centered Care Pathways**

<table>
<thead>
<tr>
<th>Mental Health &amp; LD</th>
<th>Older People</th>
<th>Children, Young People &amp; Families</th>
<th>LTC</th>
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<tbody>
<tr>
<td>Emotional Wellbeing</td>
<td>Dementia Services</td>
<td>Primary care access / services</td>
<td>Stroke</td>
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<tr>
<td>EIP for adults</td>
<td>Falls prevention</td>
<td>Sick and injured child pathway</td>
<td>Hypoglycaemia pathway</td>
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<tr>
<td>IAPT single model</td>
<td>CHC Case management and appeals capacity</td>
<td>Maternity</td>
<td>Respiratory</td>
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<tr>
<td>Psychological therapies spec</td>
<td>ONS Service Newcastle</td>
<td>LD Autism</td>
<td>Year of care</td>
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<td>CTR for LD</td>
<td>Care Homes Vanguard</td>
<td>SEND Reforms</td>
<td>Diabetes Prevention</td>
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<td>Intermediate Care</td>
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<td>LD Transformation</td>
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<td>Deciding together (including crisis beds)</td>
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<tr>
<td><strong>Cancer Including End of Life care</strong></td>
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<tr>
<td>Implementation of Cancer strategy</td>
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<tr>
<td>End of Life care inc: review of hospice contract</td>
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<tr>
<td>Hospices contract drugs supply</td>
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<tr>
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<tr>
<td><strong>Planned Care</strong></td>
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<tr>
<td>MSK</td>
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<tr>
<td>Variation programme (Right Care)</td>
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<tr>
<td>Basket of Care</td>
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<tr>
<th>Care Settings - New Care Models</th>
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<tbody>
<tr>
<td><strong>Urgent Care</strong></td>
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<tr>
<td>Urgent care strategy (24/7 Primary Care)</td>
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<tr>
<td>Urgent Care Vanguard (Regional)</td>
</tr>
<tr>
<td>CRP Testing</td>
</tr>
</tbody>
</table>

**Transformation Led by Partners**
- Social Prescribing
- SOS Outpatient Follow Up
- Respiratory Ambulatory Care LOS
- Heart Failure
- Urgent Care Vanguard

**Enablers**
- Digital Care programme & LDR Plan
- Workforce
- Estates
- Primary care strategy
- Involvement & Engagement
### Appendix 2: Performance against National Standards

<table>
<thead>
<tr>
<th>Target</th>
<th>Current Performance</th>
<th>Planned Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT 92%</td>
<td>NGCCG: 93.4% Jan YTD</td>
<td>CCG aggregate trajectory position using the provider NHSI recovery trajectories has been calculated in excess of 93%. The aggregate monthly trajectory for Gateshead Health and NUTH has been profiled as the NGCCG trajectory. Historical performance has been strong for both NUTH, Gateshead Health and NGCCG, and an ambitious trajectory reflective of this can be evidenced.</td>
</tr>
</tbody>
</table>
|              | GHFT: 92.7% Jan YTD         | Overall compliance in 15/16 Dec YTD 93%  
Recovery trajectory is based on 15/16 activity with level of over 18 week waiters. Forecast for February and March is based on the January 16 position, trajectory demonstrates compliance throughout 16/17 |
|              | NUTH: 93.7% Jan YTD         | Predicted 2015/16 outturn above standard 94.1%  
Overall compliance throughout 15/16, trajectory ranges from 93.4% to 94.7% to demonstrate compliance throughout 16/17. |
| A&E GHFT 95% | Q1:95.3%; Q2:95.8%; Q3: 93.3%;Q4: 90.5% April 2016 to date 98.2% | 2015/16 outturn 93.7%  
NHSI trajectory submitted.  
Monthly compliance anticipated Q1 – Q3 2016/17. Underperformance anticipated in Q4 2016/17, however, a minimum 3% increase on 15/16 monthly actual is expected Jan – March.  
Monitor recovery actions submitted. |
| A&E NUTH 95% | Q1: 95%; Q2: 95.7%; Q3 94%; Q4: 91.47% | 2015/16 outturn – 93.9%  
Compliance expected from Q2 2016/17  
Recovery action plan submitted to Monitor  
Recovery plan reflects the significant increase in attendances April-Dec 15/16 compared to 14/15. Increased ED conversion rates reflect the acuity of patients attending ED. This growth has been exacerbated by the opening of the new Cramlington Specialist Emergency Care Hospital in June 2015. |
<table>
<thead>
<tr>
<th>Target</th>
<th>Current Performance</th>
<th>Planned Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer 62 day 85%</strong></td>
<td>NGCCG: 84.7% Feb YTD; Q1 85.1%; Q2 80.4%; Q3 86.6%; Q4 88.2%</td>
<td>Trajectory for 2016/16 reflects an aggregate position of both NUTH and GH although this is scaled down slightly to allow for the percentage of NUTH patients which are not responsible to NGCCG. Approximately 40% of NUTH activity is not NGCCG activity, as reflected in the 62 day CWT activity breakdown tool, which would explain why NUTH and GH could meet the standard whereas NGCCG may not, depending on how the breaches are allocated.</td>
</tr>
<tr>
<td></td>
<td>GHFT: 86% Feb YTD Q1:83.5%;Q2: 86%; Q3: 87.9%; Q4 86.4%</td>
<td>NHSI recovery trajectory 16/17 86%, Quarterly compliance planned with in-month risks due to small numbers, to reflect historical performance</td>
</tr>
<tr>
<td></td>
<td>NUTH: 86.8% Feb YTD Q1 87.6%; Q2 83.6%; Q3 88.5%; Q4: 88%</td>
<td>Predicted 15/16 outturn in excess of 88%, quarterly compliance planned for 16/17 through NHSI improvement trajectories</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pressures continue to exist in Lung, Upper GI and HPB. Areas that continue to be a cause for concern are endoscopy, radiology and elements of the pathology service.</td>
</tr>
<tr>
<td><strong>Cancer 2ww 93%</strong></td>
<td>NGCCG 94.3% Jan YTD</td>
<td>Plan to sustain performance through 2016/17. The closure of the breast service at Sunderland significantly impacted on performance at Gateshead Health early 2015. Through patch wide meetings facilitated by NGCCG, the issues have been resolved and performance recovered.</td>
</tr>
<tr>
<td><strong>Diagnostics 99%</strong></td>
<td>NGCCG: 0.47% Feb</td>
<td>Compliance throughout 2016/17 planned, trajectory reflects the NUTH and GH aggregate. GH compliant and NUTH compliant from Q2 following implementation and development of recovery action plan.</td>
</tr>
<tr>
<td></td>
<td>GH:0.1% Feb</td>
<td>2016/17 compliance planned on monthly basis through NHSI recovery trajectory Performance recovered from Nov 2015 following FT implementation and recovery actions implemented in echocardiography and USS</td>
</tr>
<tr>
<td></td>
<td>NUTH: 0.9% Feb</td>
<td>Trust failed target Dec-Jan, compliant Feb but NHSI recovery trajectory plans for sustainable compliance from Q2 2016/17 due to current pressures.</td>
</tr>
<tr>
<td>Target</td>
<td>Current Performance</td>
<td>Planned Performance</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>NEAS response times 75% standard</td>
<td>68.6% Feb YTD NEAS performance</td>
<td>Recovery trajectories demonstrate compliance at 31st March 2017. Trajectories reflect anticipated seasonal pressures and individual months of non-compliance.</td>
</tr>
<tr>
<td>Dementia diagnosis 66.7% standard</td>
<td>74% as at February 2016</td>
<td>Good historical performance has been reflected in a trajectory in excess of the 66.7% national standard where the CCG is projecting to sustain a diagnosis rate of 70% through 2016/17, Improvement has been significant but has plateaued at marginally above the national standard.</td>
</tr>
<tr>
<td>IAPT access 15% standard</td>
<td>Projected outturn Jan 16.56%</td>
<td>Historically good performance for Newcastle Gateshead CCG. The plan is to sustain performance through 2016/17 at the national required level. The CCG is monitoring the transition to a co-development arrangement for IAPT services in Newcastle which has gone live from April, and work continues with the providers to understand the sustainability of the early successes under this new model of delivery.</td>
</tr>
<tr>
<td>IAPT recovery 50% standard</td>
<td>NGCCG: 46.6% Performance is measured through 3 providers, STFT for Gateshead patients and in Newcastle the CCG is currently overseeing a transition to a co-development arrangement for IAPT services between NTT and NUTH. Currently STFT is performing above the required standard and averaging a recovery rate of 53% per month where</td>
<td>A recovery plan is currently being implemented with a view to being compliant with the 50% requirement from April 2016.</td>
</tr>
<tr>
<td>Target</td>
<td>Current Performance</td>
<td>Planned Performance</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td></td>
<td>as currently Newcastle performance is below the requirement.</td>
<td></td>
</tr>
<tr>
<td>IAPT Waiting times</td>
<td>&lt;6 wks 97.7%; &lt;18 wks 100%;</td>
<td>Monthly Contract and Performance oversight meetings led by the CCG Director of Clinical Quality and Nursing to ensure performance is maintained.</td>
</tr>
<tr>
<td>95% &lt;18 wks</td>
<td>75% &lt;6 wks</td>
<td></td>
</tr>
<tr>
<td>HCAI</td>
<td>186 cases of Cdiff Feb YTD compared to a year end trajectory of 142</td>
<td>Given the increase in C Diff infections over 2015/16 the nationally derived thresholds have been carried over into 2016/17. NGCCG plans to work to the nationally set threshold of a maximum of 142 cases in 2016/17.</td>
</tr>
<tr>
<td>142 max Cdiff CCG</td>
<td>0 MRSA</td>
<td>5 cases MRSA at NUTH and 1 at GH Jan YTD</td>
</tr>
</tbody>
</table>
Gateshead Better Care Fund (BCF)

Narrative Submission

3rd May 2016

Joe Corrigan, Chief Finance and Operating Officer, NHS Newcastle Gateshead CCG

Alison Elliott, Interim Strategic Director, Care, Wellbeing and Learning, Gateshead Council
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1. Our Vision for Health and Social Care Services – Next Steps towards Delivery

Our vision for health and social care was articulated within our original BCF submission (Part 1, section 2). It has subsequently informed the development of our strategic plans across our health and care economy and most recently Operational Plans for 2016/17 and the Newcastle Gateshead chapter of an emerging Sustainability & Transformation Plan for Northumberland Tyne and Wear (2016/17 to 2020/21).

At the heart of this vision is a recognition that our Health and Social care system requires new models of care delivery across care settings. This, in turn, needs to be underpinned by sustainable, person-centred co-ordinated care. In this way, we can work to narrow the three gaps within our local health and social care system:

- **The health and wellbeing gap** – closed by earlier identification / management of long terms conditions, greater personalisation of care and investment in prevention and public health.

- **Care and Quality Gap** – delivered by introducing new models of care.

- **Finance and Efficiency Gap** – addressed through annual efficiencies and making the most of available resources together.
New Care Models are being developed spanning organisational and service boundaries, with new approaches to commissioning and paying for care and a focus on early intervention and prevention, improving population health and wellbeing.

Early thinking towards a step change in shifting to ‘place-base’ systems means that Newcastle Gateshead in their whole system redesign will focus on the following ‘key areas’ based on needs (individual and population).

This work will include aligning BCF with whole-system integration beyond simply programme management.

In building upon our BCF submission for the period 2014/15 to 2015/16 and working towards our longer term aspirations, 2016/17 will represent a transition year where our 11 BCF schemes are aligned with the emerging new models of care (see illustration below).
BCF schemes aligned with the emerging new models of care

In this way, the BCF will be closely aligned to our transformational programmes, with an enabling framework (e.g. workforce, payments and contracts) being applied to transform care for people over 65 years:

- Wellbeing, self-care and isolation
- Care and support planning, intermediate care,
- Case management, dementia, care homes

2. An Evidence Base Supporting the Case for Change

We know the challenges we face across our health and care economy – poor health-related outcomes, high levels of deprivation, excess hospital use, fragmented service provision, a growing elderly population and significant financial challenges.

Our original BCF submission (Part 1, sections 2c and 7d) identified the BCF population as being predominantly elderly although the determining factors identified were:
- people who are at risk of admission to hospital and/or care home, thereby requiring particular health and care support (people at very high risk and high risk of admission);
- people whose progression along the risk ladder can be halted or delayed through proactive preventative support (people at moderate risk of admission).

Our approach to risk stratification was informed by a combined predictive model risk-profiling tool which was used to segregate the population into 4 tiers, according to an individual's probability of using secondary care services. It was agreed that our population for the BCF would include all people in tiers 1 and 2 (very high and high) and have a particular focus (although not an exclusive focus) on people aged 65 years and over within tiers 3 and 4 (medium and low risk). Overall, this represented an approximate BCF population of 38,000 (19%).

In developing our BCF plan for 2016/17 we have taken the opportunity to review the current schemes (see attached BCF Scheme Review template Appendix 4) in order to reflect on key achievements/what has worked well, key challenges/what has not worked so well and what the key next steps are to progress and re-focus work. In doing so we have been mindful of how this will support reductions in unplanned admissions and hospital delayed transfers of care.

The schemes have then been aligned with new models of care relating to Care Homes Vanguard, Urgent Emergency Care Vanguard and other emerging models of care such as the redesign of community health services, primary care, out-of-hospital care, prevention, assertive early intervention & enablement services etc.

3. A Co-ordinated and Integrated Plan of Action for Delivering the Change

In developing the BCF Plan as part of broader system change planning, a balance has been sought between organisational autonomy and accountability with shared system responsibility.

In 2016/17, we will continue to explore what a collaborative accountable system could look like for Newcastle Gateshead:
- Communities empowered to promote health and wellbeing, especially for those with the poorest health;
- A care system with Health and Social care working together;
- Patients receiving the majority of their care in the community which is easily accessible and coordinated (less fragmented and wasteful) based on their choice (and control) and need of populations;
- Hospital care will be for unavoidable admissions and essential planned care;
- Primary and social care services delivered around wider GP practices footprints with a workforce (and new roles) capable of managing people needs;
- Our local DGH will deliver secondary care services and support primary care in the delivery of care out of hospital;
Digital technology will allow secure and safe information flows that enables care delivery, self-care and allows people to only tell their story once.

In 2016/17, we will also be exploring system leadership as part of what a collaborative accountable system could look like by establishing appropriate governance that supports robust and accountable decision making within a new system e.g. a Joint Accountable Officer and Integrated Care Programme Board across Newcastle and Gateshead.

We recognise that we are not at the beginning of a journey as there are already examples of collaborative working across our system. However, we need to do more, faster. Towards this end, we will:

- Continue to involve our local communities in taking this work forward and reshape the accountability arrangements;
- As leaders, continue to come together through our Health and Wellbeing Board and Integrated Care Programme Board to provide direction and steer the implementation of our plans;
- Explore areas for transformation to design and develop new models of care;
- Use an ‘Enabling Framework’ as a vehicle to drive interconnectivity between transformational programmes (e.g. workforce, leadership, IT, involvement).
The enabling framework will focus on system redesign across Gateshead looking at health and care in and out-of-hospital.

**Key milestones**

Key milestones identified in delivering our plan in 2016/17 can be summarised as follows:

- Align our 11 BCF schemes with new models of care spanning organisational and service boundaries;
- Use our enabling framework (leadership, workforce, IT, payments/contracts, involvement etc.) to drive interconnectivity between our programmes of work and transform care for our BCF population;
- Develop a collaborative accountable system for our local health economy;
- Embed existing governance arrangements into future governance that supports system accountable decision making;
- Meet the requirements of national BCF conditions and, in particular, the new national conditions set:
  - develop a standardised intermediate care model to ensure that patients are able to be discharged from hospital when medically fit and be able to be cared for out of the acute sector (national condition ‘agreement to invest in NHS commissioned out-of-hospital services’);
  - implement DTOC action plan (national condition ‘agreement on a local action plan to reduce DTOC’);
- Monitor performance against national and local BCF metrics, taking mitigation action to address the risks identified as required;
- Continue to involve our local communities in taking our programme of work forward.

### 4. Communications & Engagement

In 2016/17 we will work with service users, their carers, local communities, the VCS and independent sector to co-design ongoing work and move to transiting our BCF schemes into our wider transformation programmes of work.

Our approach necessitates an ‘us’ discussion around providing health and care support in its broadest sense to understand from people’s perspective:

- What health and wellbeing means to them and the outcomes they would wish to achieve for themselves and the community.
- What they feel may be barriers in the current health and care system to achieving good health and wellbeing.
- How the health and care system could be developed to help prevent, reduce and support those experiencing poor health and wellbeing in order to achieve the desired outcomes.
- How the health and care system can work with other public system partners (as an example education and housing) to support individuals and communities where they feel it is appropriate and desirable to increase their independence and resilience.
We appreciate the importance of culture and relationships in the process which allows us the best chance of ensuring successful change – embracing ‘normative integration’. Our approach sets out to prove that by identifying the problems and solutions together and in working together in a new way we can:

- Improve support to people, meet needs in better ways, increase their ability to look after themselves (confident and connected).
- Build on community assets, grow involvement.
- Build strong community teams.
- Create more effective and efficient ways for public services to work together and be delivered (remove obstacles, reduce waste, help stretch the budget)
- Focus more of our effort on better prevention.
- Support attainment of healthier people, healthier communities and a healthier workforce.

5. Financial Information

5.i Funding Contributions

A summary of the financial contributions to the Better Care Fund in 2016/17 is shown below as compared to the contributions in 2015/16:

<table>
<thead>
<tr>
<th>Better Care Fund Allocations</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nationally</td>
<td>Ghead £m</td>
</tr>
<tr>
<td>Local Authority Allocations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled Facilities Grant</td>
<td>0.2</td>
<td>0.905</td>
</tr>
<tr>
<td>Social Care Capital Grant</td>
<td>0.1</td>
<td>0.631</td>
</tr>
<tr>
<td>Care Act</td>
<td>0.1</td>
<td>0.614</td>
</tr>
<tr>
<td>NHS Social Care - NHS England transfer to social care</td>
<td>0.9</td>
<td>4.100</td>
</tr>
<tr>
<td>Addl Social Care Allocation in 16-15</td>
<td>0.2</td>
<td>1.094</td>
</tr>
<tr>
<td>Reablement funding</td>
<td>0.3</td>
<td>1.320</td>
</tr>
<tr>
<td>Carer’s breaks funding</td>
<td>0.1</td>
<td>0.370</td>
</tr>
<tr>
<td>CCG Allocations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payment for Performance on total emergency admissions</td>
<td>0.3</td>
<td>1.336</td>
</tr>
<tr>
<td>Core CCG funding</td>
<td>0.7</td>
<td>2.830</td>
</tr>
<tr>
<td>NHS Commissioned Out of Hospital Services</td>
<td>*approx</td>
<td>0.9</td>
</tr>
<tr>
<td>Remaining CCG Contr *approx</td>
<td>0.9</td>
<td>4.014</td>
</tr>
<tr>
<td>TOTAL BCF</td>
<td>3.854</td>
<td>17.214</td>
</tr>
<tr>
<td>Change in Total Pool</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9
The overall BCF pool in 2016/17 (£16.5m) is circa £0.726m lower than in 2015/16 (£17.2m) due to a number of factors:

- The minimum required CCG contribution to the Better Care Fund in Gateshead reduced in 2016/17 by circa £0.670m compared to 2015/16 due to recalculation nationally of expected contributions.
- Local Authority contribution reduced by circa £0.056m due to the Social Care capital grant being merged with the Disabled Facilities Grant.

Within the minimum CCG contribution however, the value of the NHS to Social Care transfer increased by circa £0.09m in 2016/17.

5.ii Impact of changes on schemes and services
The impact on Local Authority commissioned schemes of these funding changes can be managed, as despite the removal of the Social Care Capital Grant in 2016/17 the Disabled Facilities Grant has increased by a comparable amount.

Much of the Social Care capital grant was used to fund DFG schemes in 2015/16 and therefore the increase to the DFG allocation more accurately reflects historic and continuing spend in this area.

The extra £0.090m included in the NHS to Social care transfer for 2016/17 will be deployed in the protection of Social Care services, based on a review of current schemes and through mutual agreement at the BCF Programme Board.

Whilst the CCG minimum contribution requirement has decreased in Gateshead by £0.670m the delivery of BCF schemes has been unaffected. As the minimum requirement is not linked to changes in CCG allocations the boundaries of the health contribution have been reviewed, and the level of current acute spend on Non Elective activity included in the BCF pool has been adjusted.

Therefore the overall reduction in the pool is merely a technical change in terms of the boundaries of the BCF programme rather than a reduction in individual scheme funding.
In developing the expenditure plan for 2016/17 the schemes funded in 2015/16 were reviewed in light of the replacement of the payment for performance fund with the new national requirement around NHS commissioned out-of-hospital services. The full minimum contribution is allocated to schemes for 2016/17, and the local spending target around commissioned out-of-hospital services is being achieved in Gateshead plans.

Many of the changes to scheme values above are within the Local Authority led schemes and align to the Adult Social Care Service remodelling. Specifically in relation to the palliative care service, the funding identified was for a specific social worker, due to the remodelling of services there will no longer be a dedicated worker and work will be incorporated into teams. The new model includes a buyers function which in essence replaces brokerage and is included in the review of existing service portfolio. The funding previously identified as a contingency is funding carers commissioned services and is also included in the review of existing service portfolio.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Scheme Name</th>
<th>Commissioner</th>
<th>Pool</th>
<th>16/17 Budgeted Scheme Value £</th>
<th>15/16 Budgeted Scheme Value £</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Single point of access</td>
<td>LA</td>
<td>X</td>
<td>350,000</td>
<td>260,000</td>
<td>90,000</td>
</tr>
<tr>
<td>2</td>
<td>Alignment of District Nursing, Community Matrons, and Older People Nurse Specialists and RICC nurses + GP frailty register</td>
<td>CCG</td>
<td>Y</td>
<td>96,000</td>
<td>96,000</td>
<td>-</td>
</tr>
<tr>
<td>3</td>
<td>Elderly care coordinator / Alignment of frailty teams</td>
<td>CCG</td>
<td>Y</td>
<td>1,028,000</td>
<td>1,028,000</td>
<td>-</td>
</tr>
<tr>
<td>4</td>
<td>Enhance a seamless dementia pathway across Gateshead</td>
<td>LA</td>
<td>X</td>
<td>190,000</td>
<td>290,000</td>
<td>-100,000</td>
</tr>
<tr>
<td>5</td>
<td>Expansion of Ambulatory Emergency Conditions (AEC) pathways</td>
<td>CCG</td>
<td>Y</td>
<td>200,000</td>
<td>200,000</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>Establish a seamless palliative care service</td>
<td>LA</td>
<td>X</td>
<td>-</td>
<td>46,000</td>
<td>-46,000</td>
</tr>
<tr>
<td>7</td>
<td>Establish an urgent domiciliary support service</td>
<td>CCG</td>
<td>Y</td>
<td>351,000</td>
<td>351,000</td>
<td>-</td>
</tr>
<tr>
<td>8</td>
<td>Alignment of discharge support teams and coordination officers</td>
<td>CCG</td>
<td>Y</td>
<td>880,000</td>
<td>960,000</td>
<td>-80,000</td>
</tr>
<tr>
<td>9</td>
<td>Expansion of intermediate care services</td>
<td>LA</td>
<td>X</td>
<td>1,734,000</td>
<td>1,658,000</td>
<td>76,000</td>
</tr>
<tr>
<td>10</td>
<td>Expansion of the Gateshead Care Homes initiative</td>
<td>CCG</td>
<td>Y</td>
<td>246,000</td>
<td>246,000</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td>Establish a seamless falls service</td>
<td>LA</td>
<td>X</td>
<td>1,600,000</td>
<td>1,539,000</td>
<td>61,000</td>
</tr>
<tr>
<td>12</td>
<td>Carers</td>
<td>CCG</td>
<td>Y</td>
<td>504,000</td>
<td>504,000</td>
<td>-</td>
</tr>
<tr>
<td>13</td>
<td>Review Existing Service Portfolio Incl remaining Non Elective Activity</td>
<td>CCG</td>
<td>Y</td>
<td>3,750,159</td>
<td>4,510,000</td>
<td>-759,841</td>
</tr>
<tr>
<td>14</td>
<td>Care Act</td>
<td>LA</td>
<td>X</td>
<td>-</td>
<td>450,000</td>
<td>-450,000</td>
</tr>
<tr>
<td>15</td>
<td>Post to support Data Integration and performance Analysis</td>
<td>LA</td>
<td>X</td>
<td>614,000</td>
<td>614,000</td>
<td>-</td>
</tr>
<tr>
<td>16</td>
<td>Brokerage</td>
<td>LA</td>
<td>X</td>
<td>-</td>
<td>30,000</td>
<td>-30,000</td>
</tr>
<tr>
<td>17</td>
<td>Contract Management</td>
<td>LA</td>
<td>X</td>
<td>-</td>
<td>81,000</td>
<td>-81,000</td>
</tr>
<tr>
<td>18</td>
<td>Contingency</td>
<td>CCG</td>
<td>Y</td>
<td>523,000</td>
<td>523,000</td>
<td>-</td>
</tr>
<tr>
<td>19</td>
<td>ASC Capital Grants</td>
<td>LA</td>
<td>X</td>
<td>-</td>
<td>631,000</td>
<td>-631,000</td>
</tr>
<tr>
<td>20</td>
<td>Disabled Facilities Grant</td>
<td>LA</td>
<td>X</td>
<td>1,479,687</td>
<td>905,000</td>
<td>574,687</td>
</tr>
</tbody>
</table>

**TOTAL BCF FUND**

| SUBTOTAL POOL X | LA | 7,377,687 | 7,344,000 | 33,687 |
| SUBTOTAL POOL Y | CCG | 9,110,159 | 9,870,000 | -759,841 |
5.iv Financial Risk Sharing

In 2015/16, the Section 75 for the Gateshead BCF included an agreement around risk sharing of overspends in relation to the pooled funds (attached as Appendix 1).

In the context of the removal of the payment for performance fund in the 2016/17 BCF, there are currently no funds in the plans that are deemed at risk for 2016/17, however the risk sharing agreement included in 2015/16 that has been subject to audit will essentially be rolled forward and amended where necessary.

Please see the risk log for non financial risks associated with not meeting BCF targets in 2016/17.

6. How our BCF Plan will address the National Conditions

6.i Plans to be jointly agreed:

The Gateshead BCF plan for 2016/17 was considered by the Gateshead BCF Programme Board on 29 March. It was approved by Gateshead's Health & Wellbeing Board on 22 April, prior to submission to NHS England.

The BCF Plan is being developed in tandem with Operational Plans for 2016/17 and the Sustainability & Transformation Plan for the local health and care economy. Therefore, this narrative should be read in conjunction with a number of following documents:

The links to these documents can be found below:

- Newcastle Gateshead CCG Operational plan 2016/17 (to follow)
- Newcastle Gateshead CCG Commissioner Plan 2016/17 [link]
- Newcastle Gateshead CCG General Practice Strategy 2016/17 (Attached)
- Newcastle and Gateshead health and care economy five year strategic plan 2014/15 – 2018/19 [link]
- Better Care Fund Plans – Gateshead and Newcastle [link]
- Newcastle 2 year plan (14/15) on a page [link]
- Gateshead 2 year plan (14/15) on a page [link]
- Newcastle Gateshead Alliance Commissioner Plan 2015/16 [link]
6.ii Maintain provision of social care services:

Social care services will be protected as we:
- Reshape assessment and care management to strengthen single point of contact
- Focus on prevention and early intervention enabling individuals to live independently for longer
- Strengthen commissioning to shape and improve the care market to ensure its sustainability
- Meet needs of individuals as set out in the Care Act 2014
- Meet new responsibilities under the Care Act to give advice and information to enhance choice and address demand and to work with self-funders and carers
- Invest in 7 day services

6.iii Agreement on the delivery of 7 Day Services:

Arrangements for the delivery of 7 Day Services include:
- Access to social care services 7 days via contact centre (adult social care direct) and Care call out-of-hours service.
- Emergency duty team response with social work support.
- Access to rapid response domiciliary care services and reablement to prevent admissions and facilitate discharge.
- On site social work cover at QE hospital, extended to weekend cover to meet the needs of winter pressures. Access to senior management support out-of-hours via the emergency duty team.
- Access to promoting independence centres and short stay facilities in Council and independent sector settings.
- Agreement that if urgent placement is needed, funding will be agreed retrospectively rather than have any delay to funding panels/formal agreements.

Current community services that are 24/7 include:
- RICC team – intermediate home based care team
- Urgent Care Team – rapid response team
- District Nursing – general nursing cover
- Palliative Care – aligned team to cover 24/7

The development of 7 day working will be a key focus for the CCG and its partner organisations both to effectively utilise resources as well as to provide patient centred, convenient services routinely at weekends, involving the entire team in service delivery.

Plans have been developed, which will be further enhanced based on the recommendations of the UEC Review/ 8 High Impact Actions to ensure that multi-agency, multi-disciplinary care is available 7 days a week. See also the DTOC action plan (Action DT6 – Seven Day Services).
How we will achieve this in 2016/17

- Extend opportunities for 7 day discharge (perfect week, MADE).
- Learning from Prime Minister’s Challenge Fund in Gateshead to explore extended access in Primary Care.
- Prevent unnecessary non-elective admissions through enhanced community provision (BCF) Think Pharmacy First Scheme – reducing demand in GP and A&E.

6.iv Better data sharing between health and social care, based on the NHS number:

The CCG chairs a multi-stakeholder group known as the Gateshead Interoperability Network (GIN) that meets monthly with our local Acute and Mental Health Trusts, the Local Authority, Primary Care Federation representatives, the Local Pharmacy representatives and NECS IT Project Managers.

The group discusses all aspects of information and data sharing across the health and social care remit but recently has moved to having every second meeting dedicated to the Interoperability agenda (the Gateshead Interoperability Board).

Recent focus of this group has concentrated on the requirement to develop a Local Digital Roadmap that outlines the steps, activities and timelines to meet the ‘Paperless by 2018’ and ‘Fully interoperable records by 2020’ targets. The LDR asks health and social care partners to plan for the next 2 years in detail and the next 5 years at a strategic level.

The full guidance for the LDRs has recently been updated and the group is actively working on identifying baseline evidence for monitoring and identifying the ambitions and milestones that will be used to measure performance of the 10 identified Universal Capabilities.

Already in operation is the use of the Medical Interoperability Gateway (MIG) software which acts as a viewer into GP records when explicit consent is given by a patient. This is already enabling consultants at our local Mental Health Trust, to look at a subset of the GP held records when meeting with patients. The aim is to roll the use of the MIG out into social care settings, once all the information Governance and data sharing agreements have been completed and the appropriate data sets collated.

As part of this project, patient communications about sharing of data via the MIG have been created. Working with the regional communication group within the Urgent and Emergency Care Vanguard Team, it is hoped to develop an engagement and communication schedule that can be used in other areas.

Information governance controls: Current arrangements for information sharing are compliant with Caldicott principles and guidelines.
Interoperable APIs: It is envisaged that Application Programming Interfaces (APIs) with the necessary security and controls will be met through the new Platform for Care that is planned to be available in 2016/17. The LA systems supplier is aware of this requirement.

How these changes will impact upon the integration of services: These changes will enable us to connect existing services to reduce duplication and improve the experience of service users/patients.

In 2016/17 we will continue to:
- Work with co-located health and care teams as part of our Intermediate Care System to understand requirements for and barriers to data sharing and to test out how we address any system and mode of operation issues.
- Develop a clear digital roadmap for information sharing.
- Use technology to support reduction of unnecessary NELs, 7 day working, out of hospital services, and timely discharge.
- Engage our local population on data use, access and legal rights.

6.v A joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional:

All funding for integrated packages of care are jointly agreed between CCG and LA leads. There are well established ‘panel’ arrangements in place to ensure that there is a joint approach to assessments and care planning and appropriate funding allocated. Ongoing reviews of eligibility and care packages are also jointly agreed. There are clear accountable professionals identified in both the LA & CCG.

Community matrons are also key to the development of integrated packages of care; this is of particular significance in the management of long term conditions and where there is a dominance of complex specialist health care needs.

BCF schemes 1 (Single Point of Access) and IT development work further support joint care planning arrangements, as will the redesign of community services.

The proportion of the local population that will be receiving care and support planning and named care co-ordinator support (e.g. a community matron or district nurse) will be 2% (4,000) to 4% (8,000) of the local population (section 7d of original BCF submission, Part 1 refers).

As identified within our original BCF submission (Part 1, Annex 1, Scheme 4), there are a range of services within health and social care and across NHS and voluntary providers that support patients with dementia. We are continuing to work with providers to align patient referral pathways around consistent service delivery.

Local work has also been undertaken to support General Practices to identify and manage patients with dementia (e.g. care planning training). Dementia is a specific
workstream of the Gateshead Newcastle Care Homes Vanguard and a service review is underway within old age psychiatry in Gateshead Health NHS FT aiming to enhance pathways in conjunction with primary care.

6.vi Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans:

Newcastle Gateshead has well established governance arrangements supporting ‘Better Care’. There is joint ownership across both Health and LA commissioners and providers to lead on the development and implementation of the plans.

Ongoing discussions around service redesign with a shift in ‘closer to home’ provision are transparent and as such implications for acute and non-acute providers both in Health and Care are understood. A shift in the ‘national conditions’ to explicit funding to support community health (including social care) underpins the ethos to Better Care, coupled with ring-fenced investment.

The current governance arrangements in ‘Better Care’ and wider system contractual and planning discussions (STP development) have enabled us to collectively understand the consequential impact on providers of our strategic plans and sign off is undertaken in the Accountable Officers Forum; this being a meeting of all of the NHS and LA Chief Executives in the health and social care economy.

6.vii Agreement to invest in NHS commissioned out of hospital services:

A priority will be given to developing out of hospital services to ensure that effective care can be provided to patients in their own home or as close to home as possible. Community teams will be integrated to effectively fulfil their role as the first point of access for patient care.

This work in 2016/17 will focus on the development of a standardised intermediate care model to ensure patients are able to be discharged from hospital when medically fit and be able to be cared for out of the acute sector. A plan of action will be developed between key stakeholders which clearly specifies the services which will have a specific focus.

As referenced above in the section on the expenditure plan for 2016/17 the schemes funded in 2015/16 were reviewed in light of the replacement of the payment for performance fund with the new national requirement around NHS commissioned out-of-hospital services.

The full minimum contribution is allocated to schemes for 2016/17, and the local spending target around commissioned out-of-hospital services is being achieved in Gateshead plans. Expenditure on out of hospital services is clearly marked in the template submission under “Community Setting”.

In the context of the removal of the payment for performance fund in the 2016/17
BCF, there are currently no funds in the plans that are deemed at risk for 2016/17, however the risk sharing agreement included in 2015/16 that has been subject to audit will essentially be rolled forward and amended where necessary.

In reviewing the requirement for a risk sharing arrangement we have included an analysis of previous performance and a realistic assessment of impact of BCF initiatives (see BCF review template).

As no payment for performance funding was released to the BCF pool in 2015/16, schemes in 2016/17 continue to be funded broadly in line with 2015/16 as part of the transition to new models of care. For further detail on scheme expenditure, please see the Financial Information section.

6.viii Agreement on a local action plan to reduce DTOC:

Work has been undertaken with key partners to understand bed utilisation and the barriers to discharging patients once medically fit. A joint local plan of action has been developed which has been influenced by the need to implement 7 days working and the 8 High Impact Actions (along with the other recommendations of the UEC Review). Discussions will take place across the Gateshead footprint to ensure a standardised approach in order to reduce the number of delayed discharges.

See attached DTOC Plan Appendix 2.

7. National Metrics

In agreeing the targets for the following metrics we have identified the process followed, which has included analysis of previous performance and a realistic assessment of the impact of BCF initiatives.

7.i Non-elective admissions:

In terms of overall performance, cumulative non-elective admissions are still above plan year to date; however an improved position for Q2 and Q3 of 2015/16 has brought the level of over performance against plan down significantly. This paired with accurate recording of Ambulatory Care activity is expected to bring activity in line with plan by the end of the year.

NHS Newcastle Gateshead CCG opened a dialogue with the national team around the apportionment of the Non Elective admission plan between Health and Wellbeing Boards. Due to the merger of the three former Newcastle Gateshead CCGs, moving to the national apportionment formula for the combined CCG significantly changes the apportionment of the NEL admissions plan.

This results in a NEL plan that is materially different to the way in which activity has been apportioned and reported throughout 2015/16.
The outcome of these discussions is that the national formula must be upheld and therefore reporting on non elective admissions activity by Health and Wellbeing board in 2015/16 will be re stated using the new formula to allow for prior year comparators.

The target for Non Elective admissions included in the BCF planning document is directly linked to the activity demand plans for 2016/17 submitted as part of the wider CCG planning round.

NGCCG demand plans were modelled to adjust for:

- Demographics - Population growth has been applied using 2013 ONS data
- Prevalence - Prevalence adjustments using various sources have been applied with specific emphasis on COPD, CHD, Stroke, Hypertension, Diabetes and Cancer
- Waiting list pressures - Waiting List Stock adjustment for admitted and non-admitted activity was applied comparing the current Sept 2015 waiting list to the same point last year
- Changes in GP referrals
- 12% growth in cancer related activity has been factored into selected service lines in 2016/17 to reflect the anticipated growth in referrals and associated activity impact arising from the new NICE cancer referral guidance

Draft activity plans are reviewed and sense checked, which involved comparing the proposed 2016/17 estimated demand with projected outturn and actual outturn from previous years.

By comparing to outturn in this way any changes in activity trends that have occurred due to impact of BCF schemes can be built into the demand plan for 2016/17. The demand plan was then adjusted by CCG staff to amend areas of significant, unexplained variance using local knowledge including the impact of known pathway changes and an assessment of the impact of changes in the number of planned working days in 2016/17.

7.ii Admissions to residential homes and care homes:

The admissions data for 2015/16 (based on April to February) shows that 55% of all new admissions (208 out of 377) were for people 85 and over. 46% of all new admissions were for people with dementia. The 2015/16 outturn has been forecast as being 408 admissions - 1061.9 per 100,000 population (based on ONS 2012 population projections) -which is higher than the 2015/16 plan.

Planned performance for 2015/16 (314 admissions) was based on the previous ASCOF definition. The revised definition, which was published after submission of
the original BCF plan, increases figures considerably due to the inclusion of self-funders who are care managed.

The plan for 2016/17 has been set at 388 admissions (998.9 per 100,000 population). We have identified the reduction in the number of admissions which is achievable based on the emerging new models of care, also having regard to our ageing population profile.

The Council has reviewed the sources and reasons for residential referrals and is focusing its resources upon extra care and reablement solutions as well as more efficient deployment of adaptations, including the deployment at every opportunity of Assistive Technology to maintain independence in the community.

It is anticipated that BCF scheme 7 (Urgent Response Service) will prove to be successful in deflecting potential hospital and residential admissions and, working closely with BCF scheme 9 (Expansion of Intermediate Care facilities), will secure a reduction in demand during the 2016/17 transition year as the schemes are aligned with emerging new models of care (see illustration on page 5).

A panel has been re-introduced as a gatekeeper to all residential placements to ensure continuity and rigour for the application of alternatives to residential placements and to also review the referral pathway to determine whether BCF initiatives had been or could have been deployed.

**7.iii Effectiveness of reablement:**

Performance for 2015/16 is forecast to be under plan for (85.1% against a planned 88.7%). Performance is based on those that were discharged from hospital during October to December, and followed up 91 days later during January, February and March. The forecast outcome for 2015/16, however, shows an improvement on 2014/15 levels.

The planned outturn for 2016/17 has been reached by examining the last 13 months of data and applying a linear trend projection. The projected outturn of 85.1% for 2015/16 shows that performance is traveling in the right direction. Considering this positive trend in performance, along with the anticipated improvements the new model of care will bring, the planned outturn has been set at 87.5% for 2016/17, which maintains the upward trend in performance.

Adult social care has developed a new enablement focused model which significantly increases the reablement capacity at a Single Point of Access and provides multi-disciplinary interventions to clients entering into the system. The new and extended model recognises the need for both home based and bed based services to develop and maintain independence.

The model has been established through the repositioning of long term domiciliary care services from being delivered by in-house services to being delivered by the independent sector and diverting released resource to focus upon prevention, intervention and rehabilitation.
The new model of care for early intervention and enablement services (see illustration on page 3) will come into effect from the 1st June 2016, which will include a multi-disciplinary front door and an enhanced enablement service to deflect demand and offer solutions through early intervention. The enhanced enablement function is multi-disciplinary and reflects an investment of a further £600,000 on the existing 2015/16 budget for this service.

7.iv DTOC:

See attached DTOC plan with trajectory Appendix 3.

8. Risks and Mitigation

Key risks and associated mitigating measures reflect the direction of travel being taken by our local system and the role of our BCF plan for 2016/17 in facilitating the transition to new care models and broader transformational change.

<table>
<thead>
<tr>
<th>Risks</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship challenges – commissioner and providers</td>
<td>Our local system has good working relationships in place across the local health and care sector. Our Health and Wellbeing board and Joint Accountable Officers Group are further developing working relationships allowing for appropriate and timely escalation of issues that need resolving but also allow for alliances and relationships to be strengthened.</td>
</tr>
<tr>
<td>Cultural changes required and change to working behaviours/skills not adequately addressed.</td>
<td>Work will need to be undertaken with all stakeholders and employees across the sector to address this requirement which is key to successful transformational change.</td>
</tr>
<tr>
<td>IT infrastructure/sharing arrangements are not fit for purpose to support plan delivery.</td>
<td>Robust IT programmes are in place with multi-stakeholder arrangements. The IT programme board has a clear strategy with outcomes that have been worked through from all providers and are working towards an aligned system that allows a whole–system approach to care delivery.</td>
</tr>
<tr>
<td>There is a disconnect between commissioner and provider plans</td>
<td>Our plans for 2016/17 have been developed in the context of a whole system view consistent with our Health and Wellbeing Strategy. Consideration has and continues to be given to the impact on providers with a view to jointly defining our direction of travel on health and care integration and transformation.</td>
</tr>
<tr>
<td>Risks</td>
<td>Mitigation</td>
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<tr>
<td>Providers are core and key to all service changes and are actively co-producing the system transformation and how delivery will be implemented.</td>
<td></td>
</tr>
<tr>
<td>JJoint Integration Programme Board will have a focus on planning for long term sustainability that links with joint AO group and our Health &amp; Wellbeing Board.</td>
<td></td>
</tr>
<tr>
<td>Financial risks</td>
<td>A number of risks remain within the financial planning assumptions, some of which will become clearer as contract negotiations are concluded during March.</td>
</tr>
<tr>
<td></td>
<td>In mitigation of financial risks, the CCGs have set aside 1.5% of baseline for non-recurrent and risk mitigation purposes.</td>
</tr>
<tr>
<td>The plan and supporting initiatives do not enable resources to be redirected towards redesign of care pathways towards closer-to-home care</td>
<td>Our plans are designed for the best interest of patients and the public to make a sustainable local health and care economy.</td>
</tr>
<tr>
<td></td>
<td>Pathways have an evidence base, are best practice concepts and are what works locally.</td>
</tr>
<tr>
<td></td>
<td>Changes are being considered in relation to whole-system transformation and new funding/payment systems (e.g. new models of care) that will allow risk sharing arrangements with providers, new service configurations (e.g. alliance networks) and focus on rewarding value-based outcomes across health the social care economy.</td>
</tr>
<tr>
<td>Pressures on the acute sector are not reduced and demand continues to grow across the system with significant and continued financial consequences</td>
<td>Our transformational plans have a strong focus on prevention, wellness and are adopting alternative pathways of care with investment into the out-of-hospital sector.</td>
</tr>
<tr>
<td></td>
<td>Aligning health and social care efforts with a big push towards wellness we hopefully start to see a reduction in ‘needs’ and an expansion in wellness. Focusing on the high demand cohorts for the acute sector (e.g. older people) will hopefully start to reduce activity as alternative pathways of care start to come on line.</td>
</tr>
<tr>
<td></td>
<td>Through our most senior forum e.g. Accountable Officers Group we will manage system and service resilience whether through pressures such as surge, financial or through transformation.</td>
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APPENDIX 1

Risk Share Agreement from 2015/16 Section 75

RISK SHARE, OVERSPENDS AND UNDERSPENDS

1 To the extent that the pay for performance element of the Better Care fund is not available to the Pooled fund the partners have agreed:

that the CCG will manage this risk within its pooled fund, Pool Y. Performance Fund shortfalls may be deducted from the indicative scheme contributions from Pool Y in the Service Schedule.

2 The Partners agree that Overspends shall be apportioned in accordance with this Schedule 3.

Pooled Fund Management

3 For the avoidance of doubt, the Partners shall be responsible for expenditure of funds within the Pooled Fund hosted by them without reference, save for the reporting obligations of this Agreement, to the Better Care Fund Programme Board and may vire funds between Individual Schemes within that Pooled Fund, provided the total amount of that Pooled Fund is not exceeded without the prior approval of the Better Care Fund Programme Board.

4 It shall be a general principle that the treatment of any Overspend will be determined by the Better Care Fund Programme Board in an equitable manner. If the Better Care Fund Programme Board identifies poor management by a Lead Commissioner as a contributing factor to an Overspend it will give due consideration to that poor performance and the extent of the contribution of it to the overspend when determining the division of the Overspend.

In relation to the division of Overspends, the Better Care Fund Programme Board may:

▪ determine that the Partners should agree an action plan to reduce expenditure;

▪ identify underspends that can be vired from any other Fund maintained under this agreement or outside of this agreement and recommend their virement

▪ ask for more money from the Partners; and

▪ if no more money is available agree a plan of action, which may include decommissioning all or any part of the Individual Service to which the Overspend relates.

Overspend

5 The Better Care Fund Programme Board shall consider what action to take in respect of any actual or potential Overspends.

6 The Better Care Fund Programme Board shall, acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and
any agreed outcomes and any other budgetary constraints, agree appropriate action in relation to Overspends which may include (but is not limited to) the following:

6.1 any action that can be taken in order to contain expenditure;

6.2 the viring of any underspends that can be vired from any other fund maintained under this Agreement;

6.3 the apportionment of any Overspend between the Partners, such apportionment to be just and equitable taking into consideration all relevant factors.

6.3.1 In apportioning any Overspend between the partners the Better Care Fund Programme Board shall consider:

(a) first, whether it is just and equitable for the Overspend to be borne entirely by the Partner with Lead Commissioning responsibilities in respect of the Individual Scheme;

(b) second, whether it is just and equitable for the Overspend to be allocated between the Partners in proportion to their contributions to the Individual Scheme;

(c) third, whether some other apportionment of the Overspend is just and equitable.

5.3.2. In the absence of agreement of the Better Care Fund Programme Board as to the apportionment of any Overspend between the Partners, the Overspend shall be apportioned between the Partners in accordance with the commissioning responsibilities of each Partner in respect of the relevant Individual Scheme such that responsibility for Overspend (or part or parts thereof) will fall to the Partner or Partners with commissioning responsibility for the Service or Services to which the Overspend relates. For the avoidance of doubt, the Council will manage any Overspend in relation to Pool X and the CCG will manage any Overspend in relation to Pool Y.

7 The Partners agree to co-operate fully in order to establish an agreed position in relation to any Overspends.

8 Where there is an Overspend in a Non Pooled Fund at the end of the Financial Year or at termination of the Agreement or the Individual Scheme, such Overspend shall be met by the Partner whose financial contributions to the relevant Non Pooled Fund were intended to meet the expenditure to which the Overspend relates save to the extent that such Overspend is the fault of the other Partner.

9 Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service or Individual Scheme where the Scheme Specification provides for such termination and where the Service does not form part of the Better Care Fund Plan.

Underspend

10 The Better Care Fund Programme Board shall consider what action to take in respect of any actual or potential Underspends.

11 The Better Care Fund Programme Board shall, acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints, agree appropriate action in relation to Underspends which may include (but is not limited to) the following:

11.1 the viring of the Underspends to any other fund maintained under this Agreement;
11.2 the carrying forward of the Underspend into the next financial year in respect of the relevant Individual Scheme or its successor scheme or the carrying forward of the Underspend into the next financial year in respect of a different Individual Scheme;

11.3 the apportionment of any Underspend between the Partners, such apportionment to be just and equitable taking into consideration all relevant factors.

11.3.1 In apportioning any Underspend between the partners the Better Care Fund Programme Board shall consider:

(a) first, whether it is just and equitable for the Underspend to be allocated entirely to the Partner with Lead Commissioning responsibilities in respect of the Individual Scheme;

(b) second, whether it is just and equitable for the Underspend to be allocated between the Partners in proportion to their contributions to the Individual Scheme;

(c) third, whether some other apportionment of the Underspend is just and equitable.

11.3.2 In the absence of agreement of the Better Care Fund Programme Board as to the apportionment of any Underspend between the Partners, the Underspend shall be apportioned between the Partners in accordance with the commissioning responsibilities of each Partner in respect of the relevant Individual Scheme such that the benefit of the Underspend (or part or parts thereof) will fall to the Partner or Partners with commissioning responsibility for the Service or Services to which the Underspend relates. For the avoidance of doubt, the Council will manage any Underspend in relation to Pool X and the CCG will manage any Underspend in relation to Pool Y.
Newcastle health and care Better Care Fund (BCF) Narrative Submission

3rd May 2016
## Authorisation and sign off

<table>
<thead>
<tr>
<th>Signed on behalf of the Clinical Commissioning Group</th>
<th>[Signature]</th>
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<tbody>
<tr>
<td>Joe Corrigan Chief Finance and Operating Officer</td>
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<th>Signed on behalf of the Council</th>
<th>[Signature]</th>
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<tr>
<td>Ewen Weir Director of Wellbeing Care and Learning</td>
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<tr>
<td>Newcastle City Council</td>
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1. Vision for health and social care services

Our BCF Plan is a key component of the transformational work taking place in the Newcastle Health and Care economy and has provided the catalyst for us in developing new models of integrated delivery and commissioning based on the needs of communities.

Since writing our BCF plan in 2014 we have continued to build collaborative relationships and refined our shared vision with the community and partners.

Our vision for Newcastle is a fully integrated health and care system designed to meet people’s needs in a sustainable way.

Our BCF plan 2016/17 will continue to move us towards the outcome ambitions detailed in previous planning documents and therefore this narrative should be read in conjunction with a number of others. The links to these documents can be found below:

- Newcastle Gateshead CCG Operational plan 2016/17 (to follow)
- Newcastle Gateshead CCG General Practice Strategy 2016/117 (Attached)

The key attributes of and outcomes from our remodelled system as detailed within the BCF Plan 2014 remain central to our plans and we are confident that they reflect and respond to the Five Year Forward View. These attributes and our collaborative work to date have positively informed and contributed to development of our 2016/17 CCG Operational Plan and the Newcastle Gateshead Local Health Economy (LHE) contribution to the Northumberland Tyne & Wear Sustainability and Transformation plan (NTWSTP).

At the heart of our vision is recognition that our Health and Social Care System requires new models of care delivery that enable collaboration across care settings.
This in turn needs to be underpinned by sustainable, person centred co-ordinated care. It is only through system redesign and collaboration of both providers and commissioners that we can hope to achieve the success we desire, specifically in narrowing the three gaps within our local health and care system:

**Health and wellbeing gap:** Focus upon prevention, earlier identification and intervention for people with long term conditions using personalisation and population health approaches.

**Care and quality gap:** Delivered through the development of our Newcastle Model of Care.

**Finance and efficiency gap:** Addressed through annual efficiencies and ensuring best use of resource within the redesign of care provision.

We are clear that our BCF plan for 2016 is a central and connective part of a suite of plans all of which align to ensure that the people of Newcastle can expect:

- **Primary care underpinned by innovative models, bringing together GP practices to work at scale and utilising these strong partnerships to deliver an increased range and scope of services which enable more pro-active care to be delivered outside of hospital.**
- **Communities fully engaged in shaping services, sharing ownership of the health challenges they face.**
- **People adapting to the conditions they live with – confident and connected.**
- **Individual and community assets valued and fostered.**
- **Voluntary and community service sector fully engaged in the planning and, where appropriate, the provision of services to our patients and public.**
- **Integrated working across primary, secondary, tertiary, community, voluntary and social care providers.**
- **High quality secondary care services for those who need to access them.**
- **World renowned specialist services locally accessible to our patients.**
- **Health and social care without walls, organisations without barriers.**

These attributes have formed the basis of and approach to the work we have undertaken to date.

Building and sustaining trust is recognised as essential to our success in establishing a Newcastle Model of Care. We have spent time building a strong partnership foundation resulting positively in joint sign up of Accountable Officers and dedicated support at a senior level from each organisation/sector.

Following endorsement of our intended approach by the Wellbeing for Life Board we have created a System Integration Taskforce made up of representatives from Health and Care Statutory Organisations, General Practice, the Voluntary Sector and Healthwatch. This team provides dedicated capacity and works in a non-traditional and informal way coming together each week to generate ideas and to drive forward whole system transformational change.
Our work on developing new models of care in order to achieve sustainability and to deliver the outcome ambitions detailed in the BCF Plan 2014 and the CCG two-year plan 2014/16, involves front line practitioners working together with members of the community to design and test new ways of working in 2 localities in the city, known as “Proof of Concept” sites.

In addition to acting as test sites for designing and delivering integrated health and social care, the Proof of Concept site work is exploring approaches to prevention and early intervention, connecting with and building on the assets within our communities and exploring the needs of people who are socially marginalised.

**Public Involvement and Engagement**

Using a ‘proof of concept’ methodology to remodel our system changes the relationship we have with our communities. It necessitates an ‘us’ discussion in which we work with communities and the organisations and professionals providing health and care support in its broadest sense to understand from their perspective:

- What health and wellbeing means to them and the outcomes they would wish to achieve for themselves and the community
- What they feel may be barriers in the current health and care system to achieving good health and wellbeing
- How the health and care system could be developed to help prevent, reduce and support those experiencing poor health and wellbeing in order to achieve the desired outcomes
- How the health and care system can work with other public system partners (as an example education and housing) to support individuals and communities where they feel it is appropriate and desirable to increase their independence and resilience

Approaching change using a proof of concept site recognises that this is an adaptive rather than technical change programme. It appreciates the importance of culture and relationships in the process and allows us the best chance of ensuring that Newcastle is within the 6% of successful transformation programmes (Statistics supplied by Stephen Singleton).

In essence our approach sets out to prove that by identifying the problems and solutions together and in working together in a new way we can:

- Improve support to people, meet needs in better ways, increase their ability to look after themselves (confident and connected)
- Build on community assets, grow involvement
- Build strong community teams
- Create more effective and efficient ways for public services to work together and be delivered (remove obstacles, reduce waste, help stretch the budget)
- Focus more of our effort on better prevention
• Support attainment of healthier people, healthier communities, healthier workforce
2. 2016/17 Priorities and Case for Change

As stated in the 2014 BCF Plan partners in Newcastle use a single policy approach called the Newcastle Future Needs Assessment to take an holistic approach to the assessment of need.

In preparation for our 16/17 BCF plan we have reviewed progress on implementation of our 2014 BCF Plan to understand how/if the schemes are contributing positively to both sustainability and transformational requirements.

We are assured that the three strategic schemes and their component parts have collectively helped us to improve the care and outcomes for individuals and to address system demand.

The schemes adopted and/or adapted over the two year period of BCF implementation have all contributed positively, for example, expansion of extra care sheltered accommodation has helped to reduce use of residential care.

Nevertheless, whilst there has been some improvement in outcomes and performance, the case for change and the financial challenge remain largely unaltered. We still have areas where quality, productivity and experience within our health and care system can be enhanced in order to ensure we are able to achieve our vision for health and care in Newcastle.
In Newcastle despite excellent health services we still have poor health outcomes. We have pockets of significant deprivation, excessive hospital use, an increasing older population many of whom have multiple health and care needs, which are difficult to support within a fragmented health and care landscape.

We have considered the areas within the health and care system where there is evidence of significant pressure and/or where we are not maximising ‘the system’ response to best effect in supporting people with mental, physical or social care needs and identified four priority areas of focus in 2016/17:

**Priority areas of focus in 2016/17:**

<table>
<thead>
<tr>
<th>Focus 2016/17</th>
<th>Sustainability Programmes</th>
<th>Transformation Programmes</th>
<th>Proof of Concept Programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Care</td>
<td>Out of hospital bed capacity</td>
<td>Redesign of Intermediate care system across Newcastle Gateshead</td>
<td>Safe Discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Personalised Care</td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>Improving productivity and appropriateness of falls prevention services Care homes programme Fire service risk assessment in people’s own homes</td>
<td>Development of multi-component approach to falls prevention across Newcastle Gateshead</td>
<td>Learn to Prevent</td>
</tr>
<tr>
<td>Social Prescribing</td>
<td>Implementation of ‘Ways to Wellness’</td>
<td>Enhancing asset base and resilience of individuals and communities</td>
<td>Compass Connecting Communities</td>
</tr>
<tr>
<td>Children, Young People and Families</td>
<td>Sick children’s pathway</td>
<td>Enhancing prevention, early intervention and emotional wellbeing</td>
<td>Amazing Start</td>
</tr>
</tbody>
</table>

It is envisaged that dedicated focus on collaboration and/or integration across these four areas will result in improvement in current system performance and in the longer term offer a sustainable model of care that continues to enhance the quality and productivity of health and care services.
It is important to note that Better Care is only a part of the wider transformational work in the city to improve the way the system works for people. The totality of which is focused upon delivering the same outcomes and improvement in performance. As such it is difficult to disaggregate or apportion success at the level of a single intervention. However significant work has been done to determine ‘indicators of success’ which alongside qualitative assessment have enabled us to sense check progress.

**Indicators of success**

### A Integrated Turnaround and Intensive Case Management

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reablement/Discharge to Assess (CRRT)</td>
<td>Proportion of people re-admitted to hospital from reablement</td>
</tr>
<tr>
<td>Single Point of Access</td>
<td>Proportion of contacts to Social Care Direct and Community Health which result in NFA (no further action) or Info &amp; Advice given</td>
</tr>
<tr>
<td>Reablement / Intermediate Care</td>
<td>Proportion of people completing reablement with no ongoing care needs</td>
</tr>
<tr>
<td></td>
<td>Proportion of reablement service users referred to Therapy Team for assessment</td>
</tr>
<tr>
<td></td>
<td>Proportion of reablement service users showing improvement following therapy team input</td>
</tr>
<tr>
<td>A&amp;E and Assessment Suite Interface Team (CRRT)</td>
<td></td>
</tr>
<tr>
<td>A&amp;E Psychiatric Liaison (Local RAID)</td>
<td></td>
</tr>
<tr>
<td>Palliative Care Specialist Team and Community Nursing</td>
<td>No. of Admissions Avoided</td>
</tr>
<tr>
<td>Intensive Case Management, Care Coordination and Reablement</td>
<td></td>
</tr>
</tbody>
</table>

### B Person Centred Community Integrated Care

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource Centre Dementia</td>
<td>No of people accessing emergency residential placements at Byker Lodge (and broken down by referral source - hospital or community)</td>
</tr>
<tr>
<td></td>
<td>No of people discharged from emergency residential placements at Byker Lodge (broken down by destination)</td>
</tr>
<tr>
<td></td>
<td>Number of carers for people with dementia accessing support through carers Support Pilot (impact evaluation metrics to be developed)</td>
</tr>
<tr>
<td>Community Response Social Work</td>
<td>Proportion of people completing reablement with no ongoing care needs</td>
</tr>
<tr>
<td>Mental Health Recovery Support Team</td>
<td>Number of new people accessing support at Scrogg Road</td>
</tr>
<tr>
<td></td>
<td>Proportion of people discharged from residential support at Scrogg Road (broken down by destination)</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>No. of Attendances</td>
</tr>
<tr>
<td></td>
<td>% Admitted</td>
</tr>
<tr>
<td>Care Homes Specialist Nursing</td>
<td>People aged 65 or over admitted on a permanent basis in the year to residential or nursing home (LA funded) per 100,000 population:</td>
</tr>
<tr>
<td></td>
<td>As above but shows actual number of admissions</td>
</tr>
</tbody>
</table>
### Ways to Wellness

**Outcome Star**

| Number of people aged 65+ admitted to nursing care (and as a proportion of overall admissions to residential and nursing care) |
| Average age at admission to residential / nursing care for people aged 65+ |
| Average duration of stay in residential & nursing care for people aged 65+ |

### C Integrated Prevention, Early Intervention and Management

| Home & Specialist Housing for Older People | Number of people aged 65+ eligible for council funded support living in extra care housing |
| Prevention Social Work | Proportion of new requests for support which resulted in low level support, signposting to information and advice or NFA |
| | Number of people using the reablement service (broken down by route of access) |
| | Number of people completed reablement with no ongoing care needs out of all service ends |

### Supporting People with Long Term Conditions

| Carer Support & Wellbeing | Number / proportion of carers self directing their own support |
| | Number of carers accessing support through Newcastle Carers Centre |
| | Proportion of carers responding that the support they receive has sustained them in their caring role |
| | Numbers of carers accessing the emergency carers scheme |
| | Number of carers accessing support through Barnardo’s |

### Heart Failure

#### 3. Key successes in 2015/16:

Our approach is to enhance and strengthen system response rather than to ‘reinvent the wheel’ and as such many of the contributing interventions already benefit from a degree of integrated working. A key success indicator despite a backdrop of rising demand and reducing finance has been the multiplier effect of bringing teams from health and social care together and enabling professionals to work out for themselves where and how to integrate and collaborate to improve service response and outcomes. This positive relationship is illustrated by the constructive approach teams have taken in their response to challenges such as reduction in adult social care budgets and consequential impact on services. Concern for people in receipt of services has been the top priority.

Particular success in 2015/16 includes but is not restricted to:

- Implementation of our at scale approach to social prescribing ‘Ways to Wellness’ to support people’s health and care needs using non-medical interventions
- Local authority and CCG jointly commissioning services for carers
- Appointment of a community geriatrician to support proactive care for older people
• Development of additional Extra Care Sheltered Accommodation which has resulted in a reduction in people requiring residential care.
• Improvement in facilitating hospital discharge
• Intermediate care services well used with good outcomes from bed based services
• Establishment of an interagency Informatics and technology group to take forward the intra-operability and data sharing requirements

4. Challenges and Risk to Delivery in 2016/17:

• Continued reliance and increasing demand on hospital services
• Insufficient availability of bed based Intermediate Care. Temporary funding has been agreed to preserve existing capacity in order to enable us to undertake robust analysis, modelling and redesign of our intermediate care system.
• Reduction in adult social care funding and consequential impact on health service provision.
• Reduction in social workers and anticipated impact upon the hospital discharge process. Operational and clinical managers from health and social care are exploring opportunities to streamline the system to mitigate any risk. A proof of concept team is also exploring this from a patient and community perspective to seek improvements in the way the system currently works.
• Maintaining parity of esteem requiring realignment of resource in 16/17 to preserve recovery services for adults with mental health problems.
• Availability of financial and human resource to drive transformational change
• Workforce capacity and capability
• Pressure on the domiciliary care market due to the changes in living wage. The contract is currently being retendered
• Measuring success in respect of outcomes and process metrics. We have secured support from the BCF team to support us to continue to refine and improve our performance and outcome framework
• Data sharing (Governance and Intra-operability) – both for immediate care requirements and to enable analysis of performance across organisational boundaries. A strategic priority for us in 16/17 is to develop an approach to consent to data sharing as a key enabler for the future. Temporary fixes will be sought as a short term measure in order to preserve confidentiality but enable system learning

Review of all of our schemes has been done with commissioners and providers being cognisant of the activity, outcomes and positioning in pathways of care.
5. Co-ordinated and integrated plan of action for delivering change

As described above leadership of our work to collaborate and integrate across health and social care is lead through our Accountable Officer Forum with responsibility for development and delivery delegated to the Integration Task Force.

Governance

6. Reporting:

As previously described the Integration Task Force is responsible for implementation and management of the BCF plan, reporting monthly to the Integrated Care Programme Board and providing regular update reports at the monthly Accountable Officer Forum.

In addition finance and performance leads work collaboratively and meet monthly to oversee and prepare monitoring reports to be received at the Integrated Programme Board.

Discussion at programme board is practical and solution focused with relevant partners taking performance issues directly back to service managers to discuss, understand and seek to resolve promptly at the point of delivery. This iterative process has ensured we are clear about the priority areas for focus in 2016/17.
7. Funding and Risk Sharing Arrangements:

7.i Funding Contributions:

A summary of the financial contributions to the Better Care Fund in 2016/17 is shown below as compared to the contributions in 2015/16:

<table>
<thead>
<tr>
<th>Better Care Fund Allocations</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nationally</td>
<td>Newc</td>
</tr>
<tr>
<td>Disabled Facilities Grant</td>
<td>0.2</td>
<td>1.029</td>
</tr>
<tr>
<td>Social Care Capital Grant</td>
<td>0.1</td>
<td>0.836</td>
</tr>
<tr>
<td>Care Act</td>
<td>0.1</td>
<td>0.840</td>
</tr>
<tr>
<td>NHS Social Care - NHS England transfer to care</td>
<td>0.9</td>
<td>5.628</td>
</tr>
<tr>
<td>Addtl Social Care Alloc in 14-15</td>
<td>0.2</td>
<td>1.251</td>
</tr>
<tr>
<td>Reablement funding</td>
<td>0.3</td>
<td>1.696</td>
</tr>
<tr>
<td>Carer's breaks funding</td>
<td>0.1</td>
<td>0.520</td>
</tr>
</tbody>
</table>

The overall BCF pool in 2016/17 (£22.9m) is circa £1,129k higher than in 2015/16 (£21.8m) due to a number of factors:

- The minimum required CCG contribution to the Better Care Fund in Newcastle increased in 2016/17 by circa £1,127k compared to 2015/16 due to recalculation nationally of expected contributions.
- Local Authority contribution increased by circa £2k due to the Social Care capital grant being merged with the Disabled Facilities Grant.

Within the minimum CCG contribution the value of the NHS to Social Care transfer increased by circa £119k in 2016/17.

7.ii Impact of changes on schemes and services

The impact on Local Authority commissioned schemes of these funding changes is minimal, as despite the removal of the Social Care Capital Grant in 2016/17 the Disabled facilities grant has increased by a comparable amount.

The extra £119k included in the NHS to Social care transfer for 16/17 will be deployed in the protection of Social Care services, based on a review of current schemes and through mutual agreement at the BCF programme board.
As the CCG minimum contribution requirement has increased in Newcastle by £1,127k the delivery of existing BCF schemes has been largely unaffected. However as the minimum requirement is not linked to changes in CCG allocations the boundaries of the health contribution have been reviewed, and the level of current acute spend on Ambulatory Care, as well as spend on Community schemes included in the BCF pool has been adjusted.

Therefore the overall increase in the pool is merely a technical change in terms of the boundaries of the BCF programme rather than an increase in individual scheme funding.

7.iii Expenditure Plan

The expenditure plan for 2016/17, as compared to 2015/16, is included below:

<table>
<thead>
<tr>
<th>Project</th>
<th>Commissioner</th>
<th>16/17 Budgeted Scheme Value £</th>
<th>15/16 Budgeted Scheme Value £</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1.1 Integrated Turn around and intensive case management system</td>
<td>Reablement/discharge to assess</td>
<td>Local Authority</td>
<td>£1,950,000</td>
<td>£1,950,000</td>
</tr>
<tr>
<td>A1.2 Single point of access</td>
<td>Local Authority</td>
<td>£250,000</td>
<td>£250,000</td>
<td>0</td>
</tr>
<tr>
<td>A1.3 Reablement/intermediate care – older people S256</td>
<td>Local Authority</td>
<td>£2,501,000</td>
<td>£1,751,000</td>
<td>£750,000</td>
</tr>
<tr>
<td>A1.4 A&amp;E interface</td>
<td>CCG</td>
<td>£305,900</td>
<td>£300,000</td>
<td>£5,900</td>
</tr>
<tr>
<td>A1.5 RAD</td>
<td>CCG</td>
<td>£234,000</td>
<td>£234,000</td>
<td>0</td>
</tr>
<tr>
<td>A1.6 Palliative Care Nursing</td>
<td>CCG</td>
<td>£229,400</td>
<td>£225,000</td>
<td>£4,400</td>
</tr>
<tr>
<td>A1.7 CRRT Service</td>
<td>CCG</td>
<td>£3,583,000</td>
<td>£3,654,000</td>
<td>-£71,000</td>
</tr>
<tr>
<td>A1.8 Non elective admissions</td>
<td>CCG</td>
<td>£1,032,000</td>
<td>£1,032,000</td>
<td>0</td>
</tr>
<tr>
<td>A2 Person Centred Community integrated care and support system</td>
<td>Resource Centre Dementia</td>
<td>Local Authority</td>
<td>£119,000</td>
<td>£750,000</td>
</tr>
<tr>
<td>A2.2 Community response social work</td>
<td>Local Authority</td>
<td>£350,000</td>
<td>£350,000</td>
<td>0</td>
</tr>
<tr>
<td>A2.3 Mental health recovery support team</td>
<td>Local Authority</td>
<td>£799,000</td>
<td>£799,000</td>
<td>0</td>
</tr>
<tr>
<td>A2.4 Ambulatory Care</td>
<td>CCG</td>
<td>£1,334,224</td>
<td>£1,334,224</td>
<td>0</td>
</tr>
<tr>
<td>A2.5 Care homes specialist nursing</td>
<td>CCG</td>
<td>£527,900</td>
<td>£415,000</td>
<td>£112,900</td>
</tr>
<tr>
<td>A2.6 Ways to wellness</td>
<td>CCG</td>
<td>£168,000</td>
<td>£168,000</td>
<td>0</td>
</tr>
<tr>
<td>A2.7 Non elective admissions</td>
<td>CCG</td>
<td>£2,315,000</td>
<td>£2,315,000</td>
<td>0</td>
</tr>
<tr>
<td>A2.8 Community Matrons</td>
<td>CCG</td>
<td>£250,000</td>
<td>£250,000</td>
<td>0</td>
</tr>
<tr>
<td>A3 Integrated prevention, early intervention and management system</td>
<td>Home &amp; specialist housing for older people</td>
<td>Local Authority</td>
<td>£300,000</td>
<td>£300,000</td>
</tr>
<tr>
<td>A3.2 Prevention social work</td>
<td>Local Authority</td>
<td>£207,000</td>
<td>£207,000</td>
<td>0</td>
</tr>
<tr>
<td>A3.3 Supporting people with long term conditions</td>
<td>Local Authority</td>
<td>£2,118,000</td>
<td>£2,118,000</td>
<td>0</td>
</tr>
<tr>
<td>A3.4 Carers</td>
<td>CCG</td>
<td>£520,000</td>
<td>£520,000</td>
<td>0</td>
</tr>
<tr>
<td>A3.5 Heart Failure</td>
<td>LA</td>
<td>£204,000</td>
<td>£204,000</td>
<td>0</td>
</tr>
<tr>
<td>A3.6 Non Elective admissions</td>
<td>CCG</td>
<td>£312,400</td>
<td>£312,400</td>
<td>0</td>
</tr>
<tr>
<td>B1 Respond to requirements of health and care policy and legislation</td>
<td>Local Authority</td>
<td>£840,000</td>
<td>£840,000</td>
<td>0</td>
</tr>
<tr>
<td>B2 Facilitate data sharing and use of technology to engage patients and service users</td>
<td>Local Authority</td>
<td>£135,000</td>
<td>£200,000</td>
<td>£65,000</td>
</tr>
<tr>
<td>B3 Joint Working arrangements</td>
<td>Local Authority</td>
<td>£150,000</td>
<td>£150,000</td>
<td>0</td>
</tr>
<tr>
<td>C1 Disabled Facilities Grant</td>
<td>Local Authority</td>
<td>£1,867,086</td>
<td>£1,029,000</td>
<td>£838,086</td>
</tr>
<tr>
<td>C2 Social Care Capital Grant</td>
<td>Local Authority</td>
<td>£0</td>
<td>£0</td>
<td>0</td>
</tr>
<tr>
<td>Capital</td>
<td>£6,787,101</td>
<td>£6,787,101</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>£22,921,313</td>
<td>£21,792,000</td>
<td>£1,129,313</td>
<td></td>
</tr>
<tr>
<td>Total Local Authority</td>
<td>£11,456,086</td>
<td>£11,335,000</td>
<td>£121,086</td>
<td></td>
</tr>
<tr>
<td>Total CCG</td>
<td>£11,465,227</td>
<td>£10,457,000</td>
<td>£1,008,227</td>
<td></td>
</tr>
</tbody>
</table>

In developing the expenditure plan for 2016/17 the schemes funded in 2015/16 were reviewed in light of the replacement of the payment for performance fund with the new national requirement around NHS commissioned out-of-hospital services.
The full minimum contribution is allocated to schemes for 2016/17, and the local spending target around commissioned out-of-hospital services is being achieved in Newcastle plans.

Many of the changes to scheme values above are within the Local Authority led schemes, however these changes are on the whole reallocation of resource between schemes, as the overall LA contribution is increased in 16/17.

Changes to the CCG led schemes are to bring 16/17 budgeted expenditure in line with plans for 16/17, and increase the overall contribution to comply with guidance around minimum funding levels. Much of the increased funding is utilised to expand the inclusion of schemes A2.4 and A2.5 within the BCF, and the inclusion of the Community Matrons service (A2.8) within the BCF pool.

7.iv Risk Sharing and Contingency:

In 2015/16, the Section 75 for the Newcastle BCF included an agreement around risk sharing of overspends in relation to the pooled funds.

In the context of the removal of the payment for performance fund in the 2016/17 BCF, there are currently no funds in the plans that are deemed at risk for 2016/17, however the risk sharing agreement included in 2015/16 that has been subject to audit will essentially be rolled forward and amended where necessary.

Please see the risk log for non-financial risks associated with not meeting BCF targets in 2016-17.
8. Responding to National Conditions:
(Details also included in planning template)

8i. Plans to be jointly agreed
The BCF plan for 2016/17 has been jointly developed with partners from provider and commissioner organisations and reviewed at the March Integrated Programme Board and changes agreed and documented.

This final plan has been signed off as per the agreed process by the Wellbeing for Life Board, and by the lead officers from both CCG and LA.

The BCF Plan is being developed in tandem with Operational Plans for 2016/17 and the Sustainability & Transformation Plan 2016-2021 therefore, this narrative should be read in conjunction with a number of documents listed on page one.

8.ii. Maintaining the provision of social care services:
Our plan ensures that the level of protection agreed in 15/16 is maintained in 16/17 in line with guidance requirements. In addition non-recurrent funds which sit outside of the BCF are being applied to support social care while we undertake a review and redesign of our Intermediate Care System.

All mandatory funding contributions are being made to support social care including funding contributions in respect of DFGs, Care Act 2014 monies, former Carers Break funding and Reablement.

Despite this the reality of reducing funding for social care overall, due to pressure on councils, constitutes a significant risk to the delivery of an efficient and effective health and social care system. The BCF contribution although welcome, is insufficient to ameliorate this pressure and partners continue to work together intensively to deploy resources to gain maximum value for the system and the people who need care and treatment.

Against this backdrop of financial pressure social care is

- Reshaping assessment and care management to strengthen single point of contact
- Focusing on prevention and early intervention enabling individuals to live independently for longer
- Strengthening commissioning to shape and improve the care market to ensure its sustainability
- Meeting needs of individuals as set out in the Care Act 2014
- Meeting new responsibilities under the Care Act to give advice and information to enhance choice and address demand and to work with self-funders and carers
8.iii. Seven Day Services:
The development of 7 day working will continue to be a key focus for the CCG and its partner organisations in order to ensure patient centred, convenient services that effectively utilise multidisciplinary and multiagency teams in service delivery.

Intermediate Care: A range of intermediate care services already operate on a 7 day a week basis:
- Bed based intermediate care services are already able to respond at weekends to both step up and step down requests.
- Social care reablement can respond to urgent new community requests but can only do so for discharge if pre planned. This will be reviewed as part of our wider system review of intermediate care.
- The current out of hours model of social work which ensures 7 day cover has the potential to be enhanced as funds become available. This will enable discharge to be routinely available at weekends as part of anticipated overall system change.

In 2016/17 a key principle for our remodelled Intermediate Care System and Falls Prevention Programme will be access to the right professional and support in the right place 7 days per week.

Urgent Care: Plans have been developed to respond to the recommendations of the UEC Review/ 8 High Impact Actions.

In 2016/17 we will improve the percentage of Newcastle Gateshead residents receiving 4/10 clinical standards in Acute Trusts from 25% to 50% and maintain 20% population having enhanced primary care access (PM Challenge Fund).

We will:
- Enhance our ability to discharge people from hospital seven days a week (Perfect Week, MADE)
- Explore need and opportunity to further extend access in Primary Care across a wider footprint in order to maintain 20% threshold (learning from Prime Ministers Challenge Fund in Gateshead)
- Support prevention of admission through initiatives such as Think Pharmacy First.

Early Implementer: Newcastle Hospitals has been identified as one of the early implementer sites for the 7 Day Service Programme. With support from the Trust’s Medical Director and Director of Nursing and Patient Services, a Steering Group has been established to develop an action plan to facilitate delivery of the 4 key standards identified nationally as requiring immediate focus by March 2017 and the 10 clinical standards by 2020. Whilst much of the focus for the initial standards is on activities specific to the hospital, there are ongoing discussions via various multiagency groups to determine the actions needed to achieve all of the standards. This includes those around shared decision making; integrated management plans; psychiatric liaison; and streamlining care pathways.
Proof of Concept: Accountable Officers and Wellbeing for Life Board agreed that we should pursue a “bottom up” approach, enabling teams on the ground to work together with representatives of their local communities to design and put in place new approaches and pathways, designed around the needs of the local population.

In developing this approach the Integration Taskforce approached Northumbria University Design School to assist. Through this collaboration a series of Design Labs were planned to enable us to think differently about how to tackle longstanding problems. The focus of the labs is on people, not on organisations, professions or services.

The initial aim was to identify those groups of people that we struggle to support well on a 24/7 basis, who have a poor experience of care, or where poor collective management of their overall health and wellbeing leads to repeated crisis and poor life experience. We have recently held the third Design Lab giving teams the opportunity to look at the problems in different ways using design principles, tools and techniques. These teams are now active, using the design lab as a springboard to start working on further understanding the issues, looking at design solutions, and thinking about how they might be implemented.

8.iv Data sharing between health and social care, based on the NHS number
We have established a Newcastle Information Network (NIN), comprising representatives from key health and social care organisations across Newcastle, and tasked with progressing interoperable systems and lawful interagency data sharing. The group has initiated research into role-based access consent models in place in other localities, and has identified a number of service settings as ‘quick win’ opportunities for task and finish work. This is includes a current service base, where community health and social care staff are co-located and provide a single point of access for community health and social care support.

An Information Sharing Agreement has been developed to facilitate data matching using the NHS number and GP practice codes between 5 GPs practices identified as Proof of Concept sites, and the local authority. This will support transformation work and allow the profiling of social care activity and spend for registered patients, facilitating joint planning across health and social care, including targeting of resource at areas of greatest need.

In simplest of terms Proof of Concept offers us a defined community in which to ‘test out’ new ideas about how we might develop our whole approach to health, care and healthy communities to achieve our vision of a ‘fully integrated health and care system designed to meet people’s needs in a sustainable way’.

Using the NHS number: In Newcastle we are using the NHS number as the consistent identifier for health and social care services, 90% of adult and children social care records have the NHS number recorded in case files. We maintain our high match rate through a 4 weekly batch transfer to the Demographic Batch Service (DBS).
**Interoperable APIs:** APIs and connectors for core systems are in place across health and social care systems which will enable us to integrate systems and share data. Discussions are underway to use the Medical Interoperability Gateway (MIG) as the middleware which connects to GP systems, EMIS and System One.

Social Care have Care Connect in place to enable link up to the MIG and are progressing the procurement of a multi agency viewing tool which would enable social workers to access linked records and pre-agreed sharable datasets.

Newcastle City Council were recently awarded grant funding from the LGA Care and Health Improvement Programme (CHIP) to enable GPs and Social Care practitioners to access real-time service user/patient information from the GP systems and the social care system in use in Newcastle.

**Information governance controls:** Current arrangements for information sharing are compliant with Caldicott principles and guidelines. Opportunities identified through Proof of Concept and work led by the NIN is enabling us to create a legal basis for sharing information to integrate care and improve population outcomes are progressing in line with the IGA toolkit and guidance.

We ensure that local people have clarity about how data about them is being used, through our representatives from patient and user forums who are invited to take part in the Newcastle Information Network, and are involved in discussions to progress a role-based consent model across Newcastle.

**How these changes will impact upon the integration of services:** These changes will enable us to connect existing services to reduce duplication and improve the experience of service users/patients.

In 2016/17 we will continue to:

- Work with co-located health and care teams as part of our Intermediate Care System to understand requirements for and barriers to data sharing and to test out how we address any system and mode of operation issues.
- Use learning from Gateshead to make available and test out use of the MIG Portal with our local Mental Health provider. This will allow a direct link between mental health care and GP records established at the point of direct care with the patient.
- Work with Health Care Gateway (MIG supplier) and the Social Care system supplier (OLM Systems) on an integration piece with the aim of presenting Social Care practitioners with GP record information via an agreed dataset (Dataset) and conversely, GPs with Social Care record information.
- Develop a clear digital roadmap for information sharing.
- Use technology to support reduction of unnecessary NELs, 7 day working, out of hospital services, and timely discharge.
- Engage our local population on data use, access and legal rights.
8.v Joint approach to assessments and care planning:
All funding for integrated packages of care are jointly agreed between CCG and LA leads, with ongoing reviews of eligibility and care packages also jointly agreed. Where packages of care are jointly funded, social workers act as the case managers to ensure a single lead professional is identified.

We know there is further work to be done in 2016/17 to enhance our “joint approach” and this remains a central principle within the redesign of our Intermediate Care System and our overarching Newcastle Model of Care. Our approach will be tested and refined working with communities and professionals within our ‘Proof of Concept’ sites.

Work is already underway on exploring models of integrated assessment in hospitals. At present this is done on a small scale within A&E and the Assessment Unit. Visits have been planned to learn from others who have adopted an integrated assessment.

8.vi Agreement on the consequential impact of changes on providers:
Newcastle Gateshead has well established governance arrangements supporting ‘Better Care’. There is joint ownership across both Health and LA commissioners and providers to lead on the development and implementation of the plans.

Ongoing discussion around service redesign with a shift in ‘closer to home’ provision is transparent and as such implications in principle for acute and non-acute providers both in Health and Care are understood although further work is required.

A shift in the ‘national conditions’ to explicit funding to support community health (including social care) underpins the ethos to Better Care, coupled with ring-fenced investment.

The current governance arrangements in ‘Better Care’ and wider system contractual and planning discussions (STP development) have enabled us to collectively understand the consequential impact on providers on our strategic plans and sign off is undertaken in the Accountable Officers Forum; this being a meeting of all of the NHS and LA Chief Executives in the health and social care economy.

8.vii Agreement to invest in NHS commissioned out of hospital services:
Priority will be given to developing out of hospital services to ensure that effective care can be provided to patients in their own home or as close to home as possible.

This work in 16/17 will focus on the development of a standardised integrated intermediate care model to ensure patients are able to be discharged from hospital when medically fit and be able to be cared for out of the acute sector.

A plan of action will be developed between key stakeholders which, clearly specifies the services involved within the remodelling of our Intermediate Care System.”
Given that the BCF plan demonstrates that the ring fence for out of hospital commissioned services has been met (see above) no pay for performance element is anticipated in 2016/17.

8.viii Action plan to reduce DTOC and improve patient flow:
Work has been undertaken with key partners to understand bed utilisation and the barriers to discharging patients once medically fit (see attached Appendix 1 DTOC Action Plan).

The rate of delayed transfers as a % of occupied bed days at NUTH is routinely below the 2.5% nationally recommended limit. The projected number of delayed days in Newcastle in 2015/16 is 20.6% lower than the 2015/16 plan.

Given this is above expectations we intend to maintain this level for 2016/17 which would equate to a 29% relative reduction in 2016/17 compared to 2014/15.

A joint local plan of action is being developed with partners as part of our System Resilience and Intermediate Care System remodelling work.

This plan will focus upon the immediate actions required as well as building in 7 day working and the 8 High Impact Actions from the Urgent and Emergency Care review into our longer term sustainability and transformation plans.

<table>
<thead>
<tr>
<th>BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share</th>
<th>Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local share of ring-fenced funding</td>
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<tr>
<td>Total value of NHS commissioned out of hospital services spend from minimum pool</td>
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<tr>
<td>Total value of funding held as contingency as part of local risk share to ensure value to the NHS</td>
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<tr>
<td>Balance (+/-)</td>
<td>£200,989</td>
</tr>
</tbody>
</table>
9. National metrics:
In agreeing the targets for the following metrics we have identified the process followed, which has included analysis of previous performance and a realistic assessment of impact of BCF initiatives.

9.i Non-elective admissions:
NHS Newcastle Gateshead CCG opened a dialogue with the national team around the apportionment of the Non Elective admission plan between Health and Wellbeing Boards. Due to the merger of the three former Newcastle Gateshead CCGs, moving to the national apportionment formula for the combined CCG significantly changes the apportionment of the NEL admissions plan.

This results in a NEL plan that is materially different to the way in which activity has been apportioned and reported throughout 2015/16.

The outcome of these discussions is that the national formula must be upheld and therefore reporting on non elective admissions activity by Wellbeing for Life Board (HWB) in 15/16 will be re stated using the new formula to allow for prior year comparators.

Over the 2015 calendar year the number of non-elective admissions for Newcastle residents were 2% below trajectory and 3.8% lower than 2014. In particular performance against Payment for Performance improved in the second half of the year.

Partners in Newcastle have been working together for some time via the BCF and other fora to try to develop system wide solutions to ensure a reduction in non-elective admissions and support timely discharge of patients. Whilst the number of non-elective admissions for Newcastle residents is below trajectory for 2015, the overall demand, and continued over-reliance, on hospital services continues to be a concern. Attention remains on the continued demand for hospital services. We have used ‘Perfect Week’ methodologies to observe and monitor patient flows across the system and priorities for BCF plan in 2016/17 alongside those within the CCG 2016/17 Operational plan are intended to support further reduction in this key metric.

The Non Elective admissions target included in this plan is also directly linked to the activity demand plans for 2016/17 submitted as part of the wider CCG planning round.

NGCCG demand plans were modelled to adjust for:

- Demographics - Population growth has been applied using 2013 ONS data;
- Prevalence - Prevalence adjustments using various sources have been applied with specific emphasis on COPD, CHD, Stroke, Hypertension, Diabetes and Cancer;
• Waiting list pressures - Waiting List Stock adjustment for admitted and non-admitted activity was applied comparing the current Sept 2015 waiting list to the same point last year;

• Changes in GP referrals;

• 12% growth in cancer related activity has been factored into selected service lines in 2016/17 to reflect the anticipated growth in referrals and associated activity impact arising from the new NICE cancer referral guidance.

9.ii Admission to residential care:
This remains a challenging target although the age on admission suggests that people are living independently for longer. Additional extra care facilities are contributing positively to reducing requirement for admission. We will also aim to strengthen our Intermediate Care System in order to be able to deliver the wrap around care required to support independent living.

Previously prescribed target expectations were set at a ‘statistically significant’ reduction of 12% in council funded admissions to residential and nursing care over 2 years, from a baseline position of 348 admissions (calculated by taking an average of the previous 3 years admissions).

We have achieved a 5.74% reduction between 2014/15 and 2015/16, which has been particularly challenging as a) the population of people aged 85 and over has risen by 1.8% over the period (85 years old being the average age at admission), and b) some unanticipated delays to the opening of extra care housing schemes in the city.

Further extra care capacity is planned to come on stream in 2016/17, and this, along with BCF schemes designed to support people to maintain community independence for longer, mean that we will maintain the same level of ambition, i.e. a 6.4% reduction between 2015/16 and 2016/17, which equates to 12% reduction, but over the 3 year period.

9.iii Effectiveness of Reablement:
We have reviewed our reablement provision and are already seeing improvement in outcomes. We are working with partners across the health and care system to better understand and respond to system wide issues concerning increased levels of demand, the complexity of needs being referred and the capacity and skills required. We anticipate that this will enable us to ensure the better targeting of services so that the right service can be provided at the right time to most effectively meet the needs.

The emerging work on hospital discharge within our locality “proof of concept” site will add to our understanding of discharge from a primary care perspective and will enable a rapid approach to the redesign and testing of how services can best support people to return home safely.
On the basis of the work already planned we propose a target of 83%. This would represent a 4.1% improvement over the 3 year period.

Previously prescribed target expectations were set at a ‘statistically significant’ improvement of 6% between 2014/15 – 2015/16. We have achieved a 1.9% improvement between 2014/15 and 2015/16 from our baseline position of 78.9%. From our provisional 2015/16 outturn position of 80%, we have set an ambitious target to achieve a 3% improvement in 2016/17

   a) Our BCF schemes will drive improvement,
   b) We feel this to be a more realistic target than maintaining the original level of ambition of 6% improvement and
   c) Historical analysis shows that we achieved 84.6% in 2013/14

We therefore feel a target of 83% to be challenging but achievable

9.iv Delayed Transfers of care:
This is discussed in more detail in the DTOC plan and trajectory (Appendix 2).
### 10. Risk Log:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient availability of bed based Intermediate Care.</td>
<td>Temporary funding has been agreed to preserve existing capacity in order to enable us to undertake robust analysis, modelling and redesign of our intermediate care system.</td>
</tr>
<tr>
<td>Reduction in adult social care funding and consequential impact on service provision.</td>
<td></td>
</tr>
<tr>
<td>Reduction in social workers and anticipated impact upon the hospital discharge process.</td>
<td>Operational and clinical managers from health and social care are exploring opportunities to streamline the system to mitigate any risk. A proof of concept team is also exploring this from a patient and community perspective to seek improvements in the way the system currently works.</td>
</tr>
<tr>
<td>Maintaining parity of esteem</td>
<td>Realignment of resource in 16/17 to preserve recovery services for adults with mental health problems.</td>
</tr>
<tr>
<td>Availability of financial and human resource to drive transformational change</td>
<td>Work underway led by the Integration Task Force with Accountable Officers to understand and address resource requirements</td>
</tr>
<tr>
<td>Workforce capacity and capability</td>
<td></td>
</tr>
<tr>
<td>Pressure on the domiciliary care market due to the changes in living wage.</td>
<td>The contract is currently being retendered</td>
</tr>
<tr>
<td>Measuring success in respect of outcomes and process metrics.</td>
<td>We have secured support from the BCF team to support us to continue to refine and improve our performance and outcome framework</td>
</tr>
<tr>
<td>Data sharing (Governance and Intra-operability) – both for immediate care requirements and to enable analysis of performance across organisational</td>
<td>A strategic priority for us in 16/17 is to develop an approach to consent to data sharing as a key enabler for the future. Temporary fixes will be sought as a short</td>
</tr>
<tr>
<td>boundaries.</td>
<td>term measure in order to preserve confidentiality but enable system learning</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Continued reliance and increasing demand on hospital services</td>
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# Cover Sheet

<table>
<thead>
<tr>
<th>Meeting Title</th>
<th>Newcastle Gateshead CCG Governing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>24 May 2016</td>
</tr>
<tr>
<td>Agenda Item</td>
<td>11.2</td>
</tr>
<tr>
<td>Report Title</td>
<td>Proposed Budgets for 2016/17</td>
</tr>
<tr>
<td>Synopsis</td>
<td>This report outlines the proposed financial plan for 2016/17 together with the business rules and planning assumptions on which it is based.</td>
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<tr>
<td>Implications and Risks</td>
<td>As disclosed</td>
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<tr>
<td>Recommendation</td>
<td>The CCG Governing Body is asked to approve the proposed budget for NHS Newcastle Gateshead CCG in 2016/17</td>
</tr>
<tr>
<td>Report history</td>
<td>2015/16 Annual Budget Report to May 2016 Governing Body meeting</td>
</tr>
</tbody>
</table>
| Lead Director & Report Author | Director: Joe Corrigan  
Title: Chief Finance & Operating Officer  
Author: Jill McGrath  
Title: Head of Finance |
| Classification | Official / Official-Sensitive: Commercial / Official-Sensitive: Personal |
| Purpose (click one box only) | Decision X  
Information □ |
| **Benefits to patients & the public** | Outlines the financial plans to support sustainably commissioning plans for health services |
| **Links to Strategic objectives** | Achievement of financial balance and commissioning of services within planned surplus |
| **Identified risks & risk management actions** | As disclosed in report |
| **Resource implications** | Total application of CCG revenue budgets |
| **Legal implications & equality and diversity assessment** | N/A |
| **Sustainability implications** | N/A |
| **NHS Constitution** | |
| **Next steps** | Reporting against approved budget will be provided throughout the year |
| **Appendices** | Appendix 1: Funding Allocation including "place based" allocations for Newcastle Gateshead CCG  
Appendix 2: Summary of Source and Application of Funding 2016/17  
Appendix 3: Medium Term Financial Outlook |
Proposed Annual Budgets for 2016/17 and Medium Term Financial Plan

1 INTRODUCTION

Clinical Commissioning Groups are required to develop and approve a balanced budget, outlining the allocated resources across its main areas of spend in advance of the new financial year. This paper details the final 2016/17 opening operating budget proposals for approval by the Governing Body following contract settlements.

Information on initial budget plans has been used to inform financial plans (18th April) to NHS England as part of wider reporting of plans for 2016/17.

The planning guidance “Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21” published in December 2015 highlights the business rules and high level financial assumptions which need to be reflected in financial and service plans for 2016/17. These have been followed to establish the proposed financial plan for the CCG.

The proposed budgets outlined in this report will be subject to amendment as some minor contracts for 2016/17 are yet to be agreed and therefore represent an opening budget position.

2 FINANCIAL PLANNING ASSUMPTIONS

CCG Funding:

Detailed financial allocations were published on 11th January by NHS England and the Governing Body received a report in this regard at its January meeting. For ease of reference members are reminded of the CCG’s allocation for the five year period, together with those of other commissioning funding streams, in Appendix 1.

Planning Guidance and 2016/17 Business Rules:

The NHS England document “Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21” outlined the national financial planning assumptions for the year which were:

- Estimated provider cost inflation for 2016/17 of 3.1%,
- Offset by provider efficiency requirement of 2%
- Resulting in a net increase to be applied to contracts of 1.1%
- Individual acute tariff prices have also been adjusted for the impact of CNST (Clinical negligence scheme for trusts), expected to increase the average impact to a net increase of 1.8% on acute services
- CQUIN to remain at 2.5% of contract value
• Requirement for all commissioning organisations to set aside 1% of recurrent funding for non-recurrent expenditure. In 2016/17 CCGs are required to produce financial plans with no commitments against this funding.

• Clinical commissioning groups are asked to hold a contingency of at least 0.5% of revenue within their plans.

• Each commissioning organisation should plan to make a cumulative surplus at the end of 2016/17 of at least 1% of revenue. A higher figure may be required based on actual surplus for 2015/16, unless drawdown has been agreed with NHS England. For Newcastle Gateshead drawdown of £1.5m has been agreed with NHS England, which means a planned surplus of £8.8m (£1.5m less than the outturn reported for 15/16) but still above the 1% minimum required surplus.

Further analysis has highlighted that some significant funding which was provided to the CCG on an additional, non-recurring basis in 2015/16 is included within the programme allocation growth (3.05%) for 2016/17. These include funds for GPIT and for developing Child and Adolescent Mental Health Services (CAMHS).

2016/17 Budget

The budget plans for 2016/17 are detailed by major spending head in Appendix 2. Recurrent budgets from 2015/16 have been taken to outturn levels (column C), with some significant pressures in acute care and CHC being funded within this adjustment.

A number of adjustments have been applied to these base budgets (columns E to L) in respect of the following:

• Column E for the change to recurrent allocation for the CCG in 16/17 and includes an increase in the Programme allocation of £20m.

• Column F for the technical efficiency to be delivered via tariff rule changes to provider contracts (-2%) which totals a benefit of £10m to the CCG.

• Column G for the impact of provider inflation uplift (which ranges 3.1% to 3.9% depending on where CNST has impacted on national tariffs) with a total cost to the CCG of £18m.

• Column H for the estimated costs of demographic growth pressures and is focused on the impact of disease prevalence on acute tariff based contracts.

• Column I for other non-demographic growth and includes further technical changes to national tariff, for example the change in business rules for the emergency threshold. It also includes an uplift to the CHC/S117 budget of £5m (which equates to 8% based on month 9 forecast) and £1.7m for prescribing (2%).

• Column J for other recurrent cost pressures. This includes the provision of £1m under Non NHS MH/LD (line 29) for CAMHS/Mental Health Parity of Esteem investment. Detailed plans for spending this sum are currently being
completed and it may be deployed in other areas of mental health spend. In addition £1.4m has been set aside to fund GPIT costs which was previously funded via separate non recurring allocation in year. Within reserves (line 44) the 1% non recurrent has been restated and totals £7m for 16/17.

- Column K for QIPP/financial sustainability plans for 2016/17 based on current plans, with the overall total requirement for 2016/17 being £14m.
- Column L for further areas of investment, in particular £1.1m for activity to support the achievement of waiting times and cancer targets in secondary care.
- Column M included further final transfers to match agreed contract values. The main movements are:
  - £1.1m from Other Acute (line 25) to Gateshead FT acute contract (line 20) for seasonal resilience agreed as part of contract baseline
  - On the Gateshead FT acute contract (line 20) this is offset by a reduction of £839k transferred to the Gateshead Community Services (line 32). This reflects the revised specification for Community Services following procurement and is a part year effect.
  - £515k moved from Earmarked Reserves (line 43) to the Newcastle Hospitals Community Contract, (line 31) which is linked to the specialist care homes readmissions project becoming recurrent within the community contract.
- Column N shows the total recurrent budget in balance for the year.
- Columns O to Q detail additional non recurrent sources and application of funds. The source of funding is the return of surplus from 2015/16, reported in draft annual accounts at £10.3m. Of this £837k has been applied to fund the national CHC risk share for 2016/17 and £8.8m remains uncommitted to provide the planned surplus for the year.

3 FINANCIAL SUSTAINABILITY PLANS/QIPP

The delivery of efficiency across the health sector continues to be a priority, with significant savings built into national planning assumptions.

The resource release/efficiency delivery continues to be demonstrated both via “technical” changes i.e. the efficiencies incorporated into the national tariffs and additional changes which relate to plans for resource releases at a local level.

The requirement for delivery of additional cost savings via QIPP programmes has increased in 2016/17 as a result of a range of factors including:

- Cost pressures from 15/16
- 1% Non-Recurrent requirement to remain uncommitted
- Reduced provider sector efficiency requirement
• Requirement to provide for specifics from growth eg GPIT
• Costs of demand plans in acute sector, including triangulation of activity estimates and provision for performance targets eg activity to meet waiting times requirements

This has resulted in a requirement for QIPP saving plans to deliver a £14m cost reduction in 2016/17 to ensure that the CCG achieves its planned surplus of £8.8m. Plans targeted to date are outlined below

*Table 3: Financial Sustainability Plans/QIPP*

<table>
<thead>
<tr>
<th></th>
<th>Final Plan £m</th>
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</thead>
<tbody>
<tr>
<td>Right Care Programmes (tackling variation)</td>
<td>6.0</td>
</tr>
<tr>
<td>Best Value Programmes</td>
<td>3.0</td>
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<tr>
<td>Out of Area costs</td>
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<tr>
<td>Prescribing</td>
<td>1.5</td>
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<tr>
<td>Review of non NHS contracts</td>
<td>1.2</td>
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<tr>
<td>Review of urgent care out of hospital</td>
<td>1.2</td>
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<tr>
<td>Running costs (NR)</td>
<td>0.3</td>
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<tr>
<td>Earmarked funds and reserves</td>
<td>10.5</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>14.0</strong></td>
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</table>

Governance arrangements for the delivery of these plans have been agreed, with some key roles identified to support lead directors in implementation of the plans. The refinement of Financial Sustainability plans continues and is being led by the CCG’s directors. This includes a strong focus on the intelligence available to date from the Right Care initiative which aims to support CCGs to identify opportunities to reduce cost and improve value/quality in the services they commission.

4 **RISKS AND MITIGATION**

A number of risks remain within the financial planning assumptions, namely:

• Delivery of activity based contract outturn costs within the contract values which have been agreed. The main acute contract values include an expectation of delivery on planned and urgent care targets, but given that these are activity based, payment by results contracts, the CCG will be required to pay for the costs of actual activity throughout the year.

• Prescribing costs – current budget plans assume an uplift of 2%, and a £1.5m contribution to QIPP based on estimated outturn for the current year. Regional horizon scanning information suggested an uplift of 4% was recommended which represents a risk to delivery.

• Continuing healthcare costs – impact of trend to cost growth, particularly in the context of the introduction of the national living wage which may
increase the local authority rates which are used as the basis for CHC costs.

- Under-delivery on QIPP/Financial sustainability plans. The increased QIPP plan for 2016/17 represents a significant increased risk of under-delivery. Work is already underway to look at developing projects beyond the initial £14m requirement identified to ensure that alternatives are in place if any initial plans cannot be realised. The CCG has developed internal stretch targets for each project, but will also need to consider other mitigation where full year impact is not achieved.

- Premises costs – Changes in the operating model for NHS Property Services caused increased uncertainty in 2015/16. In addition the provider plans to change the basis of charging for 2016/17 and future years leaving risk for the CCG in the charges it receives.

In mitigation of these risks the CCGs are required to set aside 0.5% of baseline for risk mitigation purposes.

The CCG also holds a budget for 1% non-recurring costs. However, planning guidance for 2016/17 indicates that this should not be planned for use on any commitments.

5 MEDIUM TERM FINANCIAL OUTLOOK

A Medium Term Financial Outlook covering the following four years, 2017/18 – 2020/21 has been developed and is included at Appendix 3.

This is based on the allocations published for the CCG over these years, and a number of assumptions as follows:

a) Net tariff impact of zero in the three years 2017/18 to 2019/20, moving to a net 1% uplift in 2020/21

b) Acute demographic growth (reflecting disease prevalence etc) of 0.9% over each of the four years

c) Cost pressure of 5% on CHC/S117 and related packages of care over each of the four years

d) Cost pressure/inflation of 3% in Prescribing costs over each of the four years

e) QIPP requirement of 1.5% in each year from 2017/18 to 2020/21.

The outlook continues to show break even on recurring funds in each year, reflecting the expectation that the surplus generated in the previous year will be re-provided to the CCG the following year and that this forms the source of funds for a continued 1% surplus. However, this position is contingent upon the service continuing to deliver efficiencies and the ability to manage rising demand through transformational change.
6 SUMMARY AND RECOMMENDATIONS

This paper outlines the proposed 2016/17 budgets for NHS Newcastle Gateshead CCG. Negotiations are still ongoing across many of the key contracts for each CCG for the new financial year. Based on current assumptions regarding likely outcomes the Governing Body of the CCG is asked to:

1. Note the planning assumptions which underlie the financial plans for 2016/17.
2. Note the risks and mitigation outlined in this report.
3. Approve the initial budgets outlined as the opening position for the CCG in 2016/17.
4. Note the outline Medium Term Financial Plan for the CCG over the coming years.

Joe Corrigan
Chief Finance Officer and Chief Operating Officer
May 2016
## NHS Newcastle Gateshead CCG - 13T

### CCG Name
- NHS Newcastle Gateshead CCG

### CCG Code
- 13T

### NHS England Region
- North

### NHS England Local Geography
- Cumbria and North East

<table>
<thead>
<tr>
<th></th>
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<tbody>
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<td>Allocation £k</td>
<td>679,450</td>
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<td>1.443</td>
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<td>Growth</td>
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<tr>
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### Primary Medical

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### Specialised

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### Total

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## Population

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### MEDIUM TERM FINANCIAL OUTLOOK: Source and Application of Funds

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#### Source of Funds

**Programme Allocations:**
- City Hospitals Sunderland: £3,491
- Durham & Darlington FT: £1,964
- Gateshead Hospitals FT: £124,773
- Newcastle upon Tyne Hospitals FT (acute): £207,069
- Northumbria Healthcare FT: £4,940
- South Tyneside NHSFT (acute): £1,023
- Non NHS Acute: £6,050
- Other Acute: £2,402
- Non Contractual Activity: £3,711
- Festival: £18,391
- Northumberland Tyne & Wear MHFT: £62,696
- Non NHS MH/LD: £9,656
- Packages of Care MH/LD: £2,660
- South Tyneside NHSFT (community): £30,285
- Newcastle upon Tyne Hospitals FT (community): £24,060
- Non NHS Community: £5,561
- Local Authority Services: £756
- Continuing Healthcare/Funded Nursing Care: £62,130
- Prescribing: £85,061
- Primary Care Services & Out of Hours: £7,893
- Over 75’s: £2,500
- Better Care Fund: £15,817
- Programme Costs: £3,239

**Total Allocations:** £721,074

#### Application of Funds

**Running Costs Budgets:**
- Running Costs: £10,634
- Total Running Costs Budgets: £10,634

**Programme Costs Budgets:**
- City Hospitals Sunderland: £3,491
- Durham & Darlington FT: £1,964
- Gateshead Hospitals FT: £124,773
- Newcastle upon Tyne Hospitals FT (acute): £207,069
- Northumbria Healthcare FT: £4,940
- South Tyneside NHSFT (acute): £1,023
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- Prescribing: £85,061
- Primary Care Services & Out of Hours: £7,893
- Over 75’s: £2,500
- Better Care Fund: £15,817
- Programme Costs: £3,239

**Total Commissioned Services:** £686,128

**Total Commissioning Expenditure:** £701,661

**Total Earmarked Funds:** £15,533

**Total Commissioning Surplus:** £70,559

**Total Overall Expenditure:** £712,295

**Planned Surplus:** £8,779
# Cover Sheet

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<thead>
<tr>
<th>Meeting Title</th>
<th>Newcastle Gateshead CCG Governing Body Meeting</th>
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<tr>
<td>Date</td>
<td>24/05/May</td>
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<tr>
<td>Agenda Item</td>
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<tr>
<td>Report Title</td>
<td>Deciding Together - Case for Change – Acute mental health inpatient provision</td>
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<tr>
<td>Synopsis</td>
<td>Discussion by the Governing Body on the most up to date version (9) of the Case for Change (previous version presented to the Governing Body in April.)</td>
</tr>
<tr>
<td>Implications and Risks</td>
<td>Financial, reputational, strategic management, achievement of CCG objectives and national Five Year Forward View – ensuring parity of esteem between mental and physical health care.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>The Deciding Together Case for Change is being presented for information and to support decision making at the meeting of the Governing Body on the 28th May.</td>
</tr>
<tr>
<td>Report history</td>
<td>The Case for Change has been to the April meeting of the Governing Body. This provided an update on the work to date including the output from the Mental Health Programme Board non-financial appraisal.</td>
</tr>
<tr>
<td>Lead Director &amp; Report Author</td>
<td></td>
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</table>
Director: Chris Piercy  
Title: Executive Director of Nursing, Patient Safety and Quality.  
Author: Bruce Dickie on behalf of Deciding Together Co-ordinating Group  
Title: Senior Commissioner |
<p>| Classification        | Official / Official-Sensitive: Commercial |
| Purpose (click one box only) | Decision ☐ Information ☒ |</p>
<table>
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<tr>
<th>Benefits to patients &amp; the public</th>
<th>There has been service user and carer involvement from the initiation of this work in 2014. The outcome of this Case for Change will provide patients with clearer inpatient pathways and improved and some new accommodation.</th>
</tr>
</thead>
</table>
| Links to Strategic objectives | The CCGs strategic objectives apply to mental and physical health:  
- Increase the number of people with mental and physical health conditions having a positive experience of care outside 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 hospital |
| Identified risks & risk management actions | See Case for Change |
| Resource implications | Further financial analysis and assessment is being worked on and will be presented to the Governing Body as part of the Business Case to consider Inpatient bed provision. The Case for Change outlines a range of possible community support options. Their implementation will be dependent on the wider funding available following the decision on Inpatient beds. |
| Legal implications & equality and diversity assessment | An Equality Impact assessment has been undertaken as part of this work. |
| Sustainability implications | New Patient environments will be established as part of these scenarios and provide accommodation more relevant to the care of people with acute psychiatric conditions. New and refurbished buildings will provide inpatient care improving the poor fabric and design of current buildings. |
| NHS Constitution | Principle 1 - The NHS provides a comprehensive service available to all  
Principle 3 - The NHS aspires to the highest standards of excellence and professionalism  
Principle 4 - The patient will be at the heart of everything the NHS does  
Principle 5 - The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.  
Principle 6 - The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.  
Principle 7 - The NHS is accountable to the public, communities and patients that it serves. |
| Next steps | A decision by the Governing Body will be taken on the 28th June for a recommended scenario. |
| Appendices | No additional appendices to the Case for Change are attached. |
Deciding Together: Developing new specialist mental health services for Newcastle and Gateshead

Case for Change V9

17th May 2016
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1. FOREWORD

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

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

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

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

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

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

Together, we can think differently about mental health.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Scenario T - acute services provided at St. George’s Park, Morpeth and 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 10 describes the formal public consultation methodology and summarises the responses received. It also summarises the independent travel impact report which provided more information about how the different scenarios would impact on travel times and costs.

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

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

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

3.1. Role of the Clinical Commissioning Group

From 1 April 2015 three local clinical commissioning 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

3.2. Scope of the Review

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

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

\(^1\) Gateshead, Newcastle North & East and Newcastle West

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

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

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

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

Governance Arrangements and Engagement with Partner Organisations

The work has been progressed under the governance arrangements as illustrated in Appendix 1
The Clinical Commissioning Group Executive oversees the work under delegated powers from the CCG Governing Body. The multi-agency, multi-professional Mental Health Programme Board, in its role of overseeing the development and implementation of a local mental health strategy, has received regular reports on progress and contributes and advises on the development of the work.
The Deciding Together Advisory Group oversees the engagement process and is chaired by the Chairperson and Coordinator of VOLSAG, Newcastle’s Mental Health Voluntary & Community Sector (VCS) Network. The Advisory Group also includes representatives from the CCG, the North East Commissioning Support Unit, NTW, Healthwatch and service user and carer representatives.

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

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

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

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

4.1. National Strategies and Context

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

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

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

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

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

4.2. Newcastle Gateshead Clinical Commissioning Group

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

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

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

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

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

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

4.3. Northumberland, Tyne and Wear NHS Foundation Trust

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

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

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

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

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

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

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

4.4. The Mental Health Voluntary and Community Sector

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

*The sector’s service provision is based on the following principles:*

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

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

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

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

4.5. Population and Public Health Information

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

4.5.1. Population Summary

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

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

Risk Factors

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

Common Mental Health Prevalence
• Approximately 20% of the population are estimated to experience a common mental health problem (including anxiety, depression, phobias etc.). This would equate to around 70,000 people living in Newcastle and 48,678 living in Gateshead.
• There were 26,627 (6.5%) adults with depression who were known to GPs across Newcastle & Gateshead during 2013/14
• During the same period there were 3,937 new diagnoses of depression.
• Significant difference in those known to services and overall prevalence estimates – who without appropriate early intervention may develop more significant problems

Serious Mental Illness Prevalence
• The Serious Mental Illness register, a Public Health England profiling tool, includes adults diagnosed with schizophrenia, bipolar disorder or other psychoses or on lithium therapy known to GPs. Data shows there were 4,814 persons on this register across Newcastle / Gateshead, which equates to 0.96% of the overall population during 2013/14; significantly higher than the England average of 0.86%
• Estimated prevalence of psychotic disorder 1,897 adults across Newcastle / Gateshead, which equates to 0.48% of the overall population

4.5.2. Morbidity and Mortality
• Links to long term conditions, physical ill health, substance abuse and risk taking behaviours such as smoking (e.g. 64% prevalence compared to the general population at 22%)
• Life expectancy for people with serious mental illness can be 10 – 15 years lower than the national average
• Excess mortality rate for mental health services users with serious mental illness was 3.2 times higher than the general population across Newcastle / Gateshead
• Patients with severe mental illness are more likely to die from specific conditions such as cancer, cardiovascular disease, liver and respiratory disease, compared to the general population.
5. BEST PRACTICE

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

5.1. Best Practice in National Reports

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

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

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

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

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

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

5.2.  Peer Review Clinical Advice

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

5.2.1. Community and Inpatient Model of Care

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

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

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

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

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

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

• Services need to have a recovery focus.

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

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

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

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

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

5.2.3. Outcome measures to assess best practice

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

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

5.3. NTW’s Transforming Services Programme

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

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

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

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

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

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

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

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

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

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

Lengths of stay

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

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

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

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

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

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

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

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

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

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
6. CURRENT SERVICES

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

6.1. Context

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

6.2. Community Services provided by NTW and MHVCS organisations

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

- Patients were unable to always quickly and simply access the right service and pathway for their needs;
- Pathways of care were not always clear and coherent for the patient journey;
- Detailed formulation following assessment was not always evident which could result in ineffective care being delivered and a potential risk to patient safety;
- Current pathways did not provide the effective, evidence-based interventions capable of delivering the best outcome for patients. Service Users often stayed in the service for a long time with relatively little contact with staff;
- Pathways were not designed around the patient, nor were they particularly efficient in their delivery;
- Pathways often generated considerable waits for patients;
- Patients were often unable to achieve timely discharge from the community service;
- Clinical staff 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 in paragraph 6.4. The CCG’s Mental Health Programme Board has agreed to the roll out of these developments in Newcastle and Gateshead.

**Mental Health Voluntary and Community Sector Organisations’ Services.**

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

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

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

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

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

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

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

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

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

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

Newcastle
- Older People: 71
- Rehabilitation: 1
- Acute: 339

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

Flow:
- Older People: 95
- Rehabilitation: 5
- Acute: 45

Deviations:
- Older People Inpatient
- Rehabilitation
- Acute
- Other
Acute assessment and treatment service

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

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

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

There are also problems with:

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

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

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

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

Rehabilitation Services
These services comprise:

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

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

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

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

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

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

6.4. **Agreed planned improvements to NTW Community services**

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

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

The “Patient Journey”

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

- **ACCESS**
- **ASSESSMENT AND FORMULATION**
- **TREATMENT**
- **DISCHARGE FROM NTW SERVICES**

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

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

This single point of contact will:

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

Assessment & Formulation

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

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

Treatment

The agreement of the treatment plan will be a collaborative process, taking account of the needs and wishes of the service user, and carer where appropriate. The service user (or carer) will be able to book their agreed treatment appointments by a range of methods, that include over the phone, in person at their appointment, or potentially online. Once agreed, these will then be shared with their GP and relevant partners. New evidence-based treatment packages will be available for service users to ensure that they benefit as quickly as possible and outcomes are maximised. Staff will continue to be trained and clinically supervised and supported to deliver the agreed treatment packages. Staff will be able to access expert clinical advice and support from other specialist areas to reduce the need for transitions between services. The proposed pathways have sought to design out as many transitions for service users as possible. A crucial outcome is ensuring our services provide a recovery focused culture. Decisions around care and treatment will be made collaboratively with service users and their carers. Service users will be educated and supported where possible to self-manage their condition with clear plans for staying well, including at discharge. Both scheduled and un-scheduled review meetings will be co-ordinated to ensure that the number of meetings required is minimised and administrative support will be increased to support the organisation of meetings.

Discharge from Trust Services

Discharge planning will be considered and discussed throughout the assessment and treatment phases of the pathway. This will ensure that appropriate goals are set and service users are encouraged to aim for improved quality of life, independence and self-management where appropriate. Services users will leave with a co-ordinated discharge plan that will include information on:

- What the triggers for relapse are and how to recognise the early warning signs for relapse;
- A 'staying well' plan, including what help and support is available in the community;
- Where to go for help, including how to re-access Trust services.
New Community Pathways

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

Psychosis and Non-Psychosis Pathways
The psychosis pathway is primarily for people who experience psychosis, where a person has thoughts and experiences that are out of touch with reality, and who may experience symptoms such as delusions or hallucinations. The non-psychosis pathway is primarily for people who do not experience a psychosis, but who may experience changes in the way they think, feel or behave.

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

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

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

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

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

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

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

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

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

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

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

7.1. NHS Consultation policy requirements

Any reconfiguration of services requires a robust and comprehensive staff and community engagement and consultation process in order ensure plans are well informed, that public and stakeholders are aware of the issues and changes required and the risks of challenge and risk to reputation is minimised.

NHS organisations are required to ensure that local people, stakeholder and partners are informed, involved and have an opportunity to influence any changes.

The process for involving people requires a clear strategy, action plan and audit trail, including evidence of how the public and key stakeholders have influenced decisions at every stage of the process and the engagement mechanisms used. It must also take into account the key sections of statute, policy and NHS Constitution.

NHS England assurance framework

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

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NHS England assurance Framework

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4
It also covers the agreed levels of assurance and decision making required for significant service change which the NHS England board ratified in May 2015 key themes of service reconfiguration and the assurance process.

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

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

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

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

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

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

**The NHS Mandate ‘Nicholson tests’**

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

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

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

### The Gunning Principles

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

The principles are:

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

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

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

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

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

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

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

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

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

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

Obtain independent validation of the responses to the consultation.

They have also identified a range of common themes:

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

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

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

### 7.2. Developing a robust listening and engagement process

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

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

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

This process was carried out in three phases:

- Early listening phase: June to August 2014
- Pre-engagement ‘Deciding together’ listening exercise: November 2014 to February 2015
- Formal public consultation: November 2015 to February 2016

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

A dedicated website section has been developed and all documents have been published on the site: http://www.newcastlegatesheadccg.nhs.uk/get-involved/mental-health/deciding-together-2/

The Deciding Together listening and engagement process sought the views and shared experiences of specialist mental health services from people who:

- Receive or have received care;
- Care for someone who uses or has used the services; or
- Have a special interest in this area of service delivery.

A summary of the timeline of the three phases is below:
Consultation period ends (13 weeks)

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

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

Complete full case for change document

CCG Governing Body Meeting held in public – decision made

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

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

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

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

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

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

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

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

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

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

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

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

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

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

• Investment
• Be open and honest about the increasing need for mental health services. Invest in education programmes in general.
Invest in the right number and quality of clinical staff who understand mental health services.

Prevention agenda is hugely important.

Access to properly trained and professional staff who receive ongoing training – also important that all staff are aware of mental health issues – e.g. admitted to hospital for another condition and how this can affect someone.

Sufficient resources to respond to individual need.

Training more GPs in mental health services.


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

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


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

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

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

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

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

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

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

- 50% of service users felt involved in the planning of their care, whilst 35% didn’t
- 61% of service users were not offered any choice of therapy, whilst 44% were only offered one choice and for 40% no therapy was available
- Just under half felt satisfied with the quality of care received (49%) whilst 35% rated their care as excellent or good.
- In terms of their care plan; 37% felt involved in their plan and treatment, 41% understood it, 28% were able to contact their care plan coordinator and 46% felt they had enough information about their care and treatment options.
- Dissatisfaction among service users related to individuals being turned away by the crisis team although they genuinely needed/wanted support, staff shortages leading to a lack of consistency in care and frequent changes, a lack of cohesion between services, patients and carers and lack of specialist support available for specific conditions.
- It was suggested there should be reduced caseloads and more clarity with regards to roles and responsibilities of different health professionals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In addition, the following caveats to selections were provided:

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

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

7.5. **Clinical engagement**

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

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

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

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

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

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

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

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

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

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

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

8.1. At a strategic level:

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

8.2. At an operational level:

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

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

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

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

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

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

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

9. SCENARIOS FOR CHANGE
Following on from making the Case for Change, this section describes

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

9.1. Community services

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

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

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

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

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

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

9.1.1. Multi-Agency initial response service

Developing a multi-agency initial response system is a key work stream of the CCG's Mental Health Programme Board (MHPB) and a project group consisting of statutory sector, VCS and service user colleagues is being led by one of the CCG GP mental health leads. This service development is being designed in parallel with the Deciding Together Consultation, given the clear need for improvement demonstrated by:
the listening and engagement work already undertaken
- the Crisis Care Concordat, the Urgent Care Vanguard and
- the recommendations of policy such as the *Five Year Forward View for Mental Health*, which states that urgent access to mental health care 7 days a week and 24 hours a day is a key priority.
- Locally the introduction of a related model as part of the NTW Transformation Programme in South Tyneside and Sunderland contributed to a 34% decrease in beds.
- the MHPB is aware of the Collaborative approach that is part of the successful *Living Well in Lambeth* model, which is another example of how redesign and improvement in urgent response can release resources elsewhere in the system

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

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

It could offer an immediate bio-psycho-social triage, with enhanced access to urgent care mental health services and the ability to ‘warm transfer’ to other services. The model could include a detailed ‘whole person’ social triage and link work including case coordination, peer-support, system navigation and wellbeing & resilience interventions. The service will recognise that an urgent mental health need may require a variety of responses including a crisis response, but also preventative and early interventions delivered by a variety of people and agencies. A key aim is to de-escalate urgent need at an early stage and intervene at the right time to achieve better long term outcomes for people.
There could be an urgent care hub with a core team of multiagency workers and there is a proposed phased approach for developing the model further to include functions such as mental health liaison. The core multiagency workers could include health and social care workers who will work within the hub to enhance the social, housing and other LA input. The model also includes the development of new 'solidarity in crisis workers' alongside system brokers and peer support workers and volunteers.

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

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

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

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

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

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

9.1.3. Urgent response / care - crisis accommodation

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

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

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

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

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

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

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

9.1.4. Community based recovery college

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

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

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

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

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

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

9.1.6. Community Resilience and Wellbeing Hub

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

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

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

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

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

9.2. INPATIENT SERVICES

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

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

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

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

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

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

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

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<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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<tbody>
<tr>
<td>Newcastle</td>
<td>52.4</td>
<td>56.4</td>
<td>40.9</td>
</tr>
<tr>
<td>Gateshead</td>
<td>43.3</td>
<td>29.1</td>
<td>30.0</td>
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</table>
Average length of stay is a key indicator, which can measure efficiency but is also used to assess whether patients are being appropriately admitted for acute inpatient care. A number of factors influence length of stay including the capacity and range of community services to which patients can be discharged; the acuity of patients; the number of patients experiencing delayed transfer of care and length of these delays; and the number of beds available.

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

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

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

Emergency Re-admission rates
Readmissions can occur when a patient’s health deteriorates unavoidably. However this may also be because a patient is discharged without an adequate care package; with an insufficient level of community support; or when discharge occurs too early.

The table above indicates that re-admission rates for the 12 month period to the end of February 2016 are very similar in Newcastle / Gateshead to Sunderland / South Tyneside. These rates are also very close to the national median rate across the country of 9.2% (although the national benchmarking figure relates to 2014/15, the report notes that there has been no significant change in this national rate since 2011/12). Section 3 showed that the emergency re-admission rate has recently reduced in Sunderland and South Tyneside. The introduction of the new community pathways and other community services in Newcastle and Gateshead may help to reduce the Newcastle / Gateshead emergency re-admission rate, but this is not assumed in assessing future bed needs below.

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

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

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

- a bed occupancy rate of 85% has been applied, which is the Royal College of Psychiatrist’s recommended optimal bed occupancy rate, excluding patients on leave. It should be noted however that nationally, Trusts are finding this difficult to

<table>
<thead>
<tr>
<th>Emergency re-admission rates within 28 days</th>
<th>Newcastle / Gateshead</th>
<th>Sunderland / South Tyneside</th>
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</thead>
<tbody>
<tr>
<td>12 months to end Feb 2016</td>
<td>9.4%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Emergency re-admission rates within 90 days</th>
<th>Newcastle / Gateshead</th>
<th>Sunderland / South Tyneside</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months to end Feb 2016</td>
<td>17.0%</td>
<td>17.5%</td>
</tr>
</tbody>
</table>
achieve, as shown by the national benchmark report occupancy rate for 2014/15 of a mean of 91.1%, a median of 94.1%, and a lower quartile of 87%.

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

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

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Average Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>35  33  31  29  27  25  23  21</td>
</tr>
<tr>
<td>588</td>
<td>4   4   4   4   3   3   3   3</td>
</tr>
<tr>
<td>559</td>
<td>4   4   4   3   3   3   3   3</td>
</tr>
<tr>
<td>529</td>
<td>4   4   3   3   3   3   3   2</td>
</tr>
<tr>
<td>500</td>
<td>4   3   3   3   3   3   3   2</td>
</tr>
<tr>
<td>470</td>
<td>3   3   3   3   3   3   2   2</td>
</tr>
<tr>
<td>441</td>
<td>3   3   3   3   3   2   2   2</td>
</tr>
<tr>
<td>412</td>
<td>3   3   3   3   2   2   2   2</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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

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

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

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

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

At this second sifting stage, the CCG Executive rejected the do nothing option on the basis that it would not meet the principal objectives desired and it would clearly be unaffordable. This left a shortlist of 6 scenarios, with 12 sub options based on a lower and higher revenue cost for each scenario, the differences between these being due to differing revenue consequences arising from the lower and higher indicative capital costs within each scenario.

Following the second sifting, members of the CCG Governing Body were reminded about the background of how the different scenarios had been developed at their meeting on 29 September.

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

9.2.3. The shortlisted scenarios

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

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

NTW trust - wide based scenario (T):

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

Newcastle based scenario (N):

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

Gateshead based scenario (G):

- The adult acute assessment and treatment service (three wards) for Newcastle and Gateshead residents being provided from a location to be identified in Gateshead. As part of the ongoing consultation with Gateshead Local Authority the CCG were subsequently offered, following the public consultation period, the potential for a brown-field site in Gateshead (St Cuthbert’s village site). Further detailed consideration would need to be given by professional estates staff to the suitability of this site, if it was identified as part of the preferred scenario. It is also noted that Gateshead Local Authority state that their cabinet would need to agree to the site being offered at no cost and that this may also require a referral to the Secretary of State for Communities and Local Government.
  - A complex care rehabilitation ward would also be provided at the same location as above. Elm House in Gateshead would be retained as a moving on rehabilitation unit.
For older people’s mental health services, for Newcastle residents, the two scenarios are:

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

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

CURRENT LOCATIONS

Newcastle

Gateshead

Other NTW hospital sites

Key

- Rehabilitation
- Rehabilitation - Complex Care
- Rehabilitation - Moving On
- Adult Acute Assessment and Treatment
- SGP: St. George’s Park, Morpeth
- HWP: Hopwood Park, Sunderland
Proposed Inpatient Locations

CURRENT LOCATIONS

Newcastle

Gateshead

Other NTW hospital sites

Key

 Older Peoples Services (only applicable for Newcastle residents)
 SGP: St. George's Park, Morpeth

Older Peoples Services

SCENARIO 1

SCENARIO 2

SGP
9.2.4. Alignment with other Clinical Services

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

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

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

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

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

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

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

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

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

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

10. FORMAL PUBLIC CONSULTATION AND TRAVEL IMPACT REPORT

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

10.1. Formal public consultation

The formal public consultation period took place between November 2015 to February 2016, and the engagement methods included:
- Focus groups led by the CVS
- An online survey (and paper based equivalent)
- A street survey with a representative sample of the public
- Letters, emails and other written submissions, including feedback from meetings with voluntary and community sector service providers
- Public consultation events
- Results independently analysed and reported by Kenyon Fraser
  - In-depth interviews – carried out by Northumbria University peer researchers

A total of 1,249 people have contributed to these results.
- A minimum of 147 people attended 13 focus groups (not all evaluations were completed)
- 165 people responded to the online and paper survey
- 797 people responded to the street survey
- 26 written submissions were received from individuals and organisations
- 18 in-depth interviews with service users and carers - and
- 114 people attended public consultation events.
All reports are available on the Newcastle Gateshead CCG website.

Focus Groups

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

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

On-line and paper survey

Respondents were asked to rank their preferred option for community services developments. The following were the order of preference.
- Community based Recovery College.
- Multi-agency initial response system.
- Community resilience and wellbeing hub, offering increased vocational and social inclusion.
- Urgent response and care - residential crisis support.
- Community based residential rehabilitation.
• Redesigned community mental health teams and specialist teams.
• Urgent response and care - crisis support without beds.

Preferred option Inpatient Care was Scenario N: Newcastle based

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

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

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

Representative street survey

The sample representative of the Newcastle and Gateshead population of 797 people:
• Newcastle 400
• Gateshead 397

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

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

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

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

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

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

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

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

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

Consultation events

114 people attended 4 formal public consultation events.

General concerns and comments
• Concerns around the future provision of specialist mental health services in Newcastle and Gateshead:
• More clarity wanted on the community scenarios
• Transport and travel issues
• Stigma needs to be front of mind

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

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

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

In-depth interviews

Northumbria University conducted in-depth interviews with 11 service users and 7 carers and the intent was to capture their lived experience. Service users and carers importantly designed the tools, conducted the interviews and contributed to the analysis and the interviews took place in January and February of 2016 during the consultation period.

The participants ages ranged from 25 years to 70 plus and their length of time in service ranged from 1 to 15+ years. 11 participants had been in services for 15+ years.

The themes generated from the transcripts fitted into having the **right support** in the **right place** at the right time with the right values.

**Right support**

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

Right place

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

Right time

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

Right values

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

10.2. Summary of public feedback from the consultation phase

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

There was no discernible difference between the views of carers and service users to those of professionals in terms of preferences for both the both in-patient scenarios and community proposals in the online/paper based survey and Focus Groups. The most important basis of preference for all methods apart from the public survey was around reducing the impact of travelling and maintaining close links with the community that patients are established within. For example, respondents to the consultation recognise the benefits of better accommodation for inpatients in Morpeth and Sunderland, but extra funds in the system is not a major persuader – minimising travel and maintaining links into the local community are more important.

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

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

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

New information published

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

These are:

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

10.3. Travel impact

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

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

Travel Times

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Transport</th>
<th>Current : to Campus for Ageing and Vitality</th>
<th>Scenario 1 St Nicholas Hospital</th>
<th>Scenario 2 St George’s Park</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>14</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Transport</td>
<td>Current (single journeys)</td>
<td>Future estimate (single)</td>
<td>By private transport (single)</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------</td>
<td>--------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Public Transport</td>
<td>30</td>
<td>35</td>
<td>76</td>
</tr>
</tbody>
</table>

Number of journeys

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

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

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

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

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

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

Costs

Costs by Private Transport

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

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

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

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

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

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

Costs by Public Transport

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.1 Option Appraisal Methodology

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

11.2 Non-Financial Benefit Criteria

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

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

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

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Weighting</th>
<th>Issues to Consider</th>
</tr>
</thead>
</table>
| Quality of care, clinical effectiveness and patient and staff safety | 35%       | • Inpatient co-location benefits, including patient and staff safety  
• Best practice advice from the independent consultant psychiatrist / clinical director (in the Case for Change)  
• Clinical Senate advice  
• Consultation feedback e.g. ensuring effective integration of inpatient and community services |
| Patient and carer experience: quality of accommodation and environment | 15%       | • Professional estates advice on the quality of accommodation based on the comparative amount of new build; part new build / part major refurbishment of existing wards; and major refurbishment only within each of the scenarios, taking the level of new build in each scenario as providing a higher benefit  
• Any shortcomings in accommodation aimed to be provided  
• Provision of a therapeutic environment for patients  
• Consultation feedback e.g. meeting the needs of carers |
| Patient and carer experience: access to services      | 15%       | • Travel impact  
• Patient choice  
• Equality impact assessment  
• Consultation feedback e.g. stigma |


Delivery of strategic objectives: co-dependencies with development of the community services framework

| 35% | - Long term sustainability of the “whole system” service model – scope to be able to continue to develop community services to help reduce hospital admissions and reduce the amount of time people spend avoidably in hospital
- Consultation feedback |

The Programme Board was then split into three balanced groups so that each group included a cross-representation of stakeholders, enabling all members to be more engaged in scoring each scenario (from 1 to 10) for how well it would deliver each of the benefits. The scores and weights in each group were then multiplied together and aggregated to provide a total weighted score for each scenario. The current state (“do nothing” scenario) was also scored to provide a baseline value. Written information was also provided to each group on the accommodation that would be provided in each scenario; a summary of the travel impact analysis; and the equality impact summary. The scores from each group were totalled.

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

Quality of Care, Clinical Effectiveness and Patient and Staff Safety

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

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

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

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

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

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

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

Patient and Carer Experience - Quality of Accommodation and Environment

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

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

Patient and Carer Experience - Access to Services

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

The NEQOS⁶ travel impact report referenced earlier quantified the impact showing:

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

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

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

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

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

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

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

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

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

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

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

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

For older people’s services, Scenario 1 scored higher than Scenario 2 in all criteria and significantly higher overall.

### 11.3 Peer Review

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

#### 11.3.1 Independent Clinician Review

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

- These principles look excellent, in particular the commissioned alternatives to hospital admission and the improved and increased housing with support are probably the two most important issues to support any modelling of inpatient services.

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

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

Complex Care Rehabilitation

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

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

Acute Wards

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

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

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

Older People’s Wards

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

Overall, this looks an excellent beginning and I will watch the developments with great interest”.

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

11.3.2 Clinical Senate feedback

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

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

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

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

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

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

12.1. Financial Context

12.2. Capital Costs of Scenarios

12.3. Revenue Costs of Scenarios
13. NEXT STEPS

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24th May</td>
<td>Governing Body – to meet and discuss (latest) updated Case for Change document.</td>
</tr>
<tr>
<td>28th June</td>
<td>Governing Body – to meet and consider Case for Change document and make decision on preferred scenario</td>
</tr>
<tr>
<td>Post 28th June 2016</td>
<td>Decision communicated to stakeholders and the public</td>
</tr>
<tr>
<td>28th June - August</td>
<td>Full Business case developed by Deciding Together Co-ordinating Group and presented to Governing Body of CCG in July.</td>
</tr>
<tr>
<td>August 2016 onwards</td>
<td>Initiate implementation of preferred scenario and further development of overall mental health planning.</td>
</tr>
</tbody>
</table>

Implementation and Next Steps

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

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

A full Implementation Plan will be developed and agreed following the decisions to be made in June 2016, to help ensure that the changes will be made in a phased and safe way. Further development work will be undertaken on the community models, urgent care provision and liaison psychiatry as part of the further development of the mental health plan for Newcastle Gateshead CCG.
A full Benefits Realisation Plan will be developed following the identification of the preferred scenario. This will include various measures to assess the effectiveness of the new clinical model, timescales for assessment and lead responsibilities. NTW is also working with service users and their representatives to develop innovative approaches to capturing clinical wellbeing and outcome measures. For example, a recent initiative involves the adoption of an exit questionnaire concept, via text, which will be piloted within a small number of their acute wards.

A range of clinical outcome and patient experience measures will be incorporated into the Benefits Realisation Plan following the identification of the preferred scenario.

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

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

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

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

CCG Governing Body

CCG Executive (Delegated Powers)

CCG – Mental Health Programme Board

Project Co-ordinating Group

Deciding Together - Communications and Engagement Advisory Group

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


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

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

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

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

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

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

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

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\(^1\) 2013 NHS Mandate, NHS England
\(^3\) 2014 The Mental Health Crisis Care Concordat – improving outcomes for people experiencing mental health crisis, DOH.
**Access to support before crisis** – the need for services to intervene early to prevent distress and escalation into crisis

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

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

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

**NHS England’s recently published 5 Year Forward View**\(^9\) 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.

\(^9\) NHS England The NHS 5 Year Forward View, October 2014.
• Physical and mental health are closely linked - people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England.
• Only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.

The review sets out 5 year ambitions for mental health:

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

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

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

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

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

There are therefore a number of other policy and guidance documents that we must be aware of and which require more consideration than the brief list below.
Community Safety Partnerships\(^{11}\) (locally called Safe Newcastle - They work out how to deal with local issues like antisocial behaviour, drug or alcohol misuse and reoffending. They annually assess local crime priorities and consult partners and the local community about how to deal with them.

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

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

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

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

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

\(^{11}\) Established under the Crime & Disorder Act 1998 (sections 5-7)

\(^{12}\) The Five Year Forward View for Mental Health – A report of the independent Mental Health Taskforce to NHS in England February 2016

\(^{13}\) MIND 2011 Listening to experience (an independent enquiry into acute and crisis mental health care)
Choice & Control – biggest issue was for those in crisis and those who could anticipate the need for more intensive support to help prevent a crisis. They needed more direct access options, with the ability to self-refer and explicit acknowledgement that individuals knew what they need. People were told they did not meet (or over-met) criteria to access services. People wanted their own definition of being in crisis respected and more ability to exercise choice and control.

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

Commissioners were specifically requested to:

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

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

Criminal use of Police cells¹⁴ - 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 Health¹⁵ - published in 2011, but still very relevant as an outcomes strategy document. It identified good mental health as everybody’s business and a more holistic approach to good mental health and resilience being fundamental to our physical health, relationships, education, training and working towards our potential. In doing so challenging inequalities and intervening early to help build resilience and improve quality of care.

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

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

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


APPENDIX 3
POPULATION AND PUBLIC HEALTH INFORMATION

Population

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

Source: Office for National Statistics
Across the two populations the population split by sex is 50:50 in Newcastle and 49:51 male: female in Gateshead, in line with the England average. The age structure of the population differs, and as highlighted in the Newcastle population pyramid, there 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.

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.

Source: Health and Social Care Information Centre
Morbidity

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

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

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

Mortality

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


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

Source: Health and Social Care Information Centre

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

### Excess under 75 mortality rate in adults with serious mental illness: Condition Type (2012/13)

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

Source: Health and Social Care Information Centre
14.4. APPENDIX 4 - COMMUNITY SERVICES LOCATION MAPS
### 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>Momentum Skills North East</td>
<td>Vocational Rehabilitation for patients with acquired brain injury</td>
</tr>
<tr>
<td><strong>Newcastle Talking Therapies</strong></td>
<td>Mental Health and Learning Disability Services</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>North East Counselling Service (NECS)</strong></td>
<td>Counselling service for family and carers of people with mental health problems &amp; veterans mental health counselling.</td>
</tr>
<tr>
<td><strong>Path Head Watermill</strong></td>
<td>Skills and employability development for referred patients.</td>
</tr>
<tr>
<td><strong>Rape Crisis Tyneside and Northumberland (RCTN)</strong></td>
<td>RCTN provides professional counselling, helpline support &amp; information to women 16+ who have experienced sexual violence &amp; have poor mental and/or physical health. Also raises awareness about rape &amp; sexual abuse via education, training and outreach.</td>
</tr>
<tr>
<td><strong>Tyneside and Northumberland Mind</strong></td>
<td>Tyneside Mind provides brief solution focused counselling interventions, on a locality basis within Gateshead. Interventions are usually assessment + 6 sessions, however some clients may require more depending on individual needs.</td>
</tr>
<tr>
<td><strong>Tyneside Women’s Health (TWH)</strong></td>
<td>TWH enables women to reach personal potential by improving mental health and emotional wellbeing.</td>
</tr>
<tr>
<td><strong>Under The Bridge - Joseph Cowen</strong></td>
<td>General practice, needle exchange and outreach service specialising in homeless people. Also includes cleaning and clinical waste.</td>
</tr>
</tbody>
</table>

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

Terms of Reference

Purpose of the group

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

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

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

Governance arrangements and key relationships

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

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

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

Membership

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

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

Review date for terms of reference
6 months
Introduction

Deciding Together Listening Exercise: Analysis of Findings
Executive Summary
March 2015

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

Kenyon Fraser is an independent marketing, communications and PR agency based in Liverpool. Following a competitive bid process the team was commissioned by NHS North of England Commissioning Support Team to undertake an objective and independent review of the feedback from the public “Deciding Together: Developing a new vision for mental health services for Gateshead and Newcastle” pre-consultation listening exercise conducted between November 2014 to February 2015. The exercise was focussed on discussions around specialist mental health services. The definition given throughout the exercise was:

The sort of services you might get from a community psychiatric nurse (CPN) treating you at home, through to the more serious, but thankfully, much rarer cases when people might need to spend time in hospital.

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

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

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

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

The Kenyon Fraser team was provided with the materials for review from the following sources:
The “Deciding Together” survey;
Focus group discussions convened and moderated by Community, Faith and Voluntary (Third) Sector partners;
Market stalls, held in convenient public locations, providing the opportunity for drop in comment;
Participant feedback from all events.
The Mental Health Pound exercise and the in-depth consultations by Northumbria University are stand-alone reports, produced by independent organisations and as such are outside the scope of consideration of this report.
The listening exercise sought views around a structured set of questions or key lines of enquiry, which were:
Access to services and getting care urgently
Specialist community health services (services outside of hospital)
Adult inpatient units in Gateshead and Newcastle
Ensuring a place of safety – section 136 suites
Services for people with especially complex mental health needs
Services for older people including memory services (Newcastle only)
Transport and travel.
There was also a specific interest in the issues surrounding:
The transition from children’s to adult services.
Overseeing the Listening Exercise
(Governance and Accountability)
The listening and wider ‘deciding together’ exercise is directed by an advisory group, which is a partnership made up of:
HealthWatch Newcastle
HealthWatch Gateshead
Service user, carer, MHVCS representatives from Gateshead and Newcastle
CCG mental health commissioning lead
CCG patient, public and carer involvement officer
NECS mental health provider manager
NECS senior communications and engagement manager
NECS senior communications officer
NTW deputy director of partnerships
Other key partners invited to join the group as indicated by the
group’s work. This is known as the “Deciding Together Communications and Engagement Advisory Group” providing advice,
guidance and intelligence on the engagement activity and insights gained to the Mental Health Programme Board.
The advisory group is responsible for developing and co-ordinating communications and engagement activity around all stages of
the deciding together public engagement consultation process. The overall objectives of the group are to:
Ensure a co-productive consultation process;
Provide a forum which allows two way communications and discussions between commissioners, NTW FT and key third sector and
scrutiny partners; and
Ensure in particular the process is carried out in a positive and non-stigmatising way, which reflects the social model of disability.

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

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

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

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

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

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

Treatment in the Community

The focus groups and market stall responses tell us that you feel:
It is important to be confident that you will get support through psychological therapies in time
There is frustration with the lack of clarity around
More support is needed, as is confidence in the process from the people providing psychological therapies
The third sector has an important role to play
The role of carers in the wellbeing of people receiving care needs to be recognised more widely
Carers provide better care with better information
Recognised good practice is often ignored or not known about.

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

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

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

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

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

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

Transition from Children’s to Adults’ Services

The focus groups and market stall responses tell us that you:
Find the current service confusing and struggle to see how young people make the transition to support under adult services
Feel all the people involved can work together more effectively to support the transition
Feel the service is based on barriers and inflexibility
Feel there needs to be more support available
Feel there is a need to support the places young people go to, to help them in the transition
Overall, you feel there is a gap in the provision of mental health support to young people, aged 16-18, which needs addressing in the future. The responses from the survey tell us that you think:
Only a small minority of participants had experience of moving from children’s to adults’ mental health services (six participants)
The experiences encountered by these individuals were mixed; while three participants felt involved in decisions about their transition, only two indicated that they felt supported
Improvements to the transition were felt imperative with suggestions focusing upon better liaison between the children’s and young person’s service (CYPS) and adult services with regards to facilitating a smoother, more gradual transition and by addressing the ‘age-gap barrier’ for those aged between 16-18 years.
Inpatient Care
The focus groups and market stall responses tell us that you:
Think people need to feel part of their community to support recovery
Feel travelling is a major issue for families and carers
Think that moving services outside of the immediate area is a backwards step
Feel distance will impact on service
Feel it should be service quality before building
Want to know that the people are safe
Want to know that if inpatient service is the best course of action that it will be a pleasant place to stay
Want to see great facilities and services that respond flexibly to the needs of all
Overall, you prefer the home/community environment preferred over hospital care where possible.
The responses from the survey tell us that you think:
34% of participants indicated that they had experience of inpatient mental health care, approximately half of which were satisfied with the service received (53%) and rated their experience as very good or good (57%)
The majority received their inpatient treatment at The Hadrian Clinic, Newcastle or at The Tranwell Unit, Queen Elizabeth Hospital (48% and 36% respectively), with 64% rating the physical environment and surroundings as fair or poor. (77% of these experiences occurred two years ago or more)
Having bedroom facilities with privacy, having access to visiting areas for relatives and friends and having access to fresh air were perceived to be the most important environmental aspects of inpatient care (83%, 82% and 80% rating these as extremely or very important respectively)
The majority agreed on the importance of being able to keep in contact with family whilst in hospital, that they would like to spend the shortest possible time in hospital and that the physical environment is very important to them (93%, 86% and 86% strongly agreeing or agreeing to these statements respectively)
To help patients to stay out of hospital or to be discharged sooner, a number of suggestions were put forth including frequent community care follow-ups, medication reviews and prompts, ‘half-way’ houses/day centres, a support line for individuals to speak
to someone when they feel they need to and most importantly ensuring that an adequate level of support is in place immediately following discharge whether this be from family, support workers or carers
Suggested improvements to inpatient services included more peer-led groups and male/female orientated activities, reducing the workload of staff to enable them to spend more quality time with patients, whilst also having time to update relatives, improving patient safety and providing a variety of food options for service users
A number of participants repeatedly expressed strong objections to the proposals to relocate and reduce the number of inpatient beds in terms of the detrimental effect it will have on the individual as well as friends and family who will have to travel further to see their loved one.

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

Section 136 Place of Safety
The focus groups and market stall responses tell us that you feel:
The section 136 suite is vital but it could work better and most importantly people in crisis need to feel safe
The section 136 suite is only part of the process and the support that “wraps around” it is as important, if not more important, in making people in crisis feel safe.
The responses from the survey tell us that you think:
Only a small minority of participants had experience of using the Section 136 suite in Gateshead or Newcastle
Suggestions to improve the service, offered by a health professional, included securing funding for a specific vehicle to transport individuals when issued with a section 136, improving accessibility of the suites and expanding the ‘street triage’ process to enable the ambulance service to specifically request the specialised mental health vehicle
79% agreed that mental health services and the police should work more closely together. However, it was felt imperative to ensure that police officials have an awareness and appreciation of different mental health conditions to ensure that individuals are treated appropriately.
Specialist Mental Health Care Services
The focus groups and market stall responses tell us that you:
Feel the moving on and rehabilitation units should be in the communities where people live
Want to see support for family and carers
Think the valuable learning, experience and different approaches, as well as reach into marginalised communities, needs to be recognised more widely.
The responses from the survey tell us that you think:
17% of participants indicated that they had experience of psychiatric intensive care services, approximately half of which were satisfied with the care received and described their experience as very good or good. The majority of these experiences had occurred two years ago or more
The small number of suggestions to improve this service related to providing more opportunities to patients to be taken off the ward, more structured activities for service users and giving relatives/carers more opportunities to input upon the patient’s care, by encouraging them to take part in review meetings
A small number stated that they had experience of rehabilitation services for people with complex mental health needs (11 participants), seven of which were satisfied with the care received and half rating their experience as very good or good. The majority of these experiences had occurred two years ago or more.

It was suggested that it would be more effective if rehabilitation services were offered in community settings, whilst also giving service users the opportunity to leave the ward together.

Services for Older People Including Memory Services (Newcastle Only)

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

There is a need for a simple system of support and older people’s 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.
14.9. **APPENDIX 9 INPATIENT SCENARIOS AND SHORTLISTING**

First sifting – 20 August Joint Executives Meeting of CCG, Local Authorities, NTW and MHVCS
Second sifting – CCG Executive meeting – 15 September 2015
Third sifting – agreed by CCG and NTW to provide an average cost between the lower and higher sub options, for comparative purposes at this stage

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>DESCRIPTION</th>
<th>CAPITAL INVESTMENT LEVEL</th>
<th>SHORTLISTING</th>
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<tr>
<td>Old Ref.</td>
<td>New Ref.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Current State – “Do Nothing”</td>
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<td>Rejected – second sifting on grounds of not achieving principal objectives and being clearly unaffordable</td>
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<tr>
<td>2</td>
<td>Acute – SNH Rehabilitation Complex Care – SNH Older People – SNH</td>
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<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
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<td>Lower</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
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<td>2a</td>
<td>Acute - SNH Rehabilitation Complex Care – SNH Older People – SGP</td>
<td>Higher</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Lower</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
<tr>
<td>3</td>
<td>Acute – Gateshead Rehabilitation Complex Care – Gateshead Older People – SNH</td>
<td>Higher</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lower</td>
<td>Rejected – first sifting following confirmation that two rehabilitation units required</td>
</tr>
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<td>3a</td>
<td>Acute - Gateshead Rehabilitation Complex Care – Gateshead Older People – SGP</td>
<td>Higher</td>
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<tr>
<td></td>
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<td>Lower</td>
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<td>4</td>
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<td>Acute – SGP and HWP Rehabilitation Complex Care – SGP Older People – SGP</td>
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<td>5b</td>
<td>N2</td>
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**14.10. APPENDIX - ABBREVIATIONS - LIST OF ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>Attention deficit hyperactivity disorder</td>
</tr>
<tr>
<td>AIMs</td>
<td>Accreditation for Inpatient Mental Health Services</td>
</tr>
<tr>
<td>AMHP</td>
<td>Approved mental health professional</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CCTV</td>
<td>Closed circuit television</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>EIP</td>
<td>Early intervention in psychosis</td>
</tr>
<tr>
<td>HWP</td>
<td>Hopewood Park (hospital) Sunderland</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological therapies</td>
</tr>
<tr>
<td>LAs</td>
<td>Local Authorities</td>
</tr>
<tr>
<td>MHVCS</td>
<td>Mental health voluntary and community sector</td>
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<tr>
<td>NECS</td>
<td>NHS North of England Commissioning Support Unit</td>
</tr>
<tr>
<td>NTW</td>
<td>Northumberland, Tyne and Wear NHS Foundation Trust</td>
</tr>
<tr>
<td>ONS</td>
<td>Office of National Statistics</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>SGP</td>
<td>St. George's Park (hospital) Morpeth</td>
</tr>
<tr>
<td>SMI Register</td>
<td>Serious Mental Illness register</td>
</tr>
<tr>
<td>SNH</td>
<td>St. Nicholas Hospital, Newcastle</td>
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<tr>
<td>VCS</td>
<td>Voluntary and community sector</td>
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<td>VOLSAG</td>
<td>Voluntary Sector Advisory Group</td>
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<tr>
<td>Meeting Title</td>
<td>Newcastle Gateshead CCG Governing Body Meeting</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Date</td>
<td>24/05/16</td>
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<tr>
<td>Agenda Item</td>
<td>12.1</td>
</tr>
<tr>
<td>Report Title</td>
<td>Revised Terms of Reference for the Remuneration Committee</td>
</tr>
<tr>
<td>Synopsis</td>
<td>The purpose of this paper is to seek approval from the governing body to implement and publish the revised Terms of Reference for the Remuneration Committee.</td>
</tr>
<tr>
<td>Implications and Risks</td>
<td>The meeting of the Governing Body held on 22 March 2016 considered an amended version of the Remuneration Committee Terms of Reference, and agreed the change to the quoracy for the committee. During the review of the terms of reference it was considered that section 8.2ii presented a conflict of interest, as it stated that the committee could make recommendation to the CCG’s governing body on the appropriate remuneration for the role of Vice/Deputy Chair and the remuneration and terms of appointment of any lay members. Decisions on the remuneration of the Deputy Chair and other Lay Members will be the responsibility of the Governing Body. The decision from the Governing Body was to request a further review of the terms of reference with a view to removing this section. The members of the Remuneration Committee have agreed that this section of the terms of reference should be removed, and this is reflected in the revised document at Appendix 1.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>The meeting of the Governing Body is asked to:</td>
</tr>
<tr>
<td></td>
<td>• Note the content and issues of the report.</td>
</tr>
<tr>
<td></td>
<td>• Consider the approval of the terms of reference for the Remuneration Committee as appropriate.</td>
</tr>
<tr>
<td>Lead Director &amp; Author</td>
<td>Director: Mark Adams</td>
</tr>
</tbody>
</table>
**Benefits to patients & the public**
Approval of the Terms of Reference for the Remuneration Committee will ensure that the committee continues to provide assurance on issues of remuneration, fees and other allowances for employees.

**Links to Strategic objectives**
Create and maintain strong governance assuring that the CCG complies with the legal requirements of the Health and Social Care Act 2012, and the CCG constitution.

**Identified risks & risk management actions**
No specific risks have been identified with the approval of the terms of reference.

**Resource implications**
No resource implications have been identified.

**Legal implications & equality and diversity assessment**
The Terms of Reference for the Remuneration Committee are required to enable the committee to be constituted and functional. This paper presents no implications for any of the nine protected equality characteristics.

**Sustainability implications**
No specific implications identified.

**NHS Constitution**
Principle Three: The NHS aspires to the highest standards of excellence and professionalism.

**Next steps**
Publication of the Amended Terms of Reference on the CCG website.

**Appendices**
Appendix 1: Terms of Reference for the Remuneration Committee v2
NHS Newcastle Gateshead Clinical Commissioning Group
Remuneration Committee
Terms of Reference

1. Introduction

The Remuneration Committee (the committee) is established as a committee of the Governing Body of the Clinical Commissioning Group, in accordance with constitution, standing orders and scheme of delegation.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the CCG constitution and standing orders.

2. Principal Function

The remuneration committee is an advisory committee which makes recommendations to the governing body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme.

In addition, the group or the governing body has conferred or delegated the following functions, connected with the governing body’s main function, to its remuneration committee:

i). Approving severance payments of the accountable officer, the chief finance officer and of other staff, and

ii). to fulfil the role associated with that of an appointments committee to oversee and where relevant lead the process for governing body appointments, ensure the governing body has the balance of skills and expertise to discharge its duties and responsibilities and ensure succession planning for members of the governing body.
3. **Membership**

The membership of the committee will consist of,

i). All of the Lay members of the Clinical Commissioning Group

The committee will be chaired by a Lay Member. The Chair has the responsibility to ensure that the Committee obtains appropriate advice in the exercise of its functions.

The Accountable Officer will be the lead officer for the committee and will be invited to attend all meetings; he or she will withdraw for discussions relating to his or her own remuneration.

Other officers, employees, and practice representatives of the CCG may be invited to attend all or part of meetings of the committee to provide advice or support particular discussion from time to time. They will not be in attendance for discussions about their own remuneration or terms of service.

Those invited to attend will not be entitled to vote.

4. **Secretarial support**

The Head of Corporate Affairs shall be Secretary to the Committee and shall ensure that a minute of the meeting is taken and provide appropriate support to the Chair and Committee members.

5. **Quorum and Decision Making**

The quorum will be three members.

Generally it is expected that decisions will be reached by consensus. Should this not be possible then a vote of members will be required. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting) will have a second, and casting vote.

6. **Frequency of meetings**

Meetings will be held as and when required, but not less than once per financial year. There will be no more than 15 months between meetings.

Members will be expected to attend each meeting.

In exceptional circumstances and where agreed in advance by the chair, members of the committee or others invited to attend may participate in meetings by telephone, by the use of video conferencing facilities and/or webcam where such facilities are available. Participation in a meeting in any of these manners shall be deemed to constitute presence in person at the meeting.

7. **Agendas and papers**

The agenda for meetings of the committee will be set by the chair.
The agenda and papers for meetings of the committee will be distributed 5 working
days in advance of the meeting. Items for the agenda should be notified to the chair 10
days in advance of each meeting. The setting of agendas for, and minutes of, each
meeting should identify where discussion should rightly be recorded as being of a
confidential or commercially sensitive nature.

8. Remit and responsibilities of the committee

The committee will:

8.1 Make recommendations to the Governing Body on the approach to pay
and remuneration for employees of the CCG and people who provide
services to the CCG and allowances under any pension scheme it might
establish as an alternative to the NHS pension scheme

8.2 Specifically, the duties and functions of the Committee are as follows;

i). to provide advice and make recommendation to the CCG’s governing body on the
appropriate remuneration and terms and conditions for the Accountable
Officer/Chief Officer and other senior managers paid through the Very Senior
Managers Pay Framework including:

   a. all aspects of salary including any performance-related elements;
   b. provisions for other benefits
   c. arrangements for termination of employment and other contractual terms.

ii). to advise and make recommendation to the CCG’s governing body on the
appropriate remuneration for the role of Vice/Deputy Chair and the remuneration
and terms of appointment of any lay members.

iii). to ensure that there is proper calculation and scrutiny of termination payments
taking account of such national guidance as appropriate, seeking HM Treasury
approval as appropriate in accordance with the guidance ‘Managing Public
Money’ available on the HM Treasury.gov.uk website

8.3 The Committee will also fulfil the role associated with that of an
appointments committee to oversee and where relevant lead the process for
governing body appointments, ensure the governing body has the balance of
skills and expertise to discharge its duties and responsibilities, and ensure
succession planning for members of the governing body

9. Reporting arrangements

The committee reports to the CCG Governing Body. The committee will provide a
report to the next meeting of the Governing Body and the Governing Body will hold the
committee to account for the delivery of its remit and responsibilities.

10. Policy and best practice

The committee will apply best practice in its decision making, and in particular it will:
i). comply with current disclosure requirements for remuneration;

ii). seek independent advice about remuneration for individuals where appropriate to ensure equity and fairness;

iii). ensure that decisions are based on clear and transparent criteria

iv). comply with the CCG’s policy and procedures for the declaration of interests

The committee will have full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

11. Conduct of the committee

All members of the committee and participants in its meetings will comply with the Standards of Business Conduct for NHS Staff, the NHS Code of Conduct, and the CCG’s Policy on Standards of Business Conduct and Declarations of Interest which incorporate the Nolan Principles.

12. Date of review

The committee will review its performance, membership and these Terms of Reference at least once per financial year. It will make recommendations for any resulting changes to these Terms of Reference to the Governing Body for approval.

No changes to these Terms of Reference will be effective unless and until they are agreed by the Governing Body.

Approval Date:

Review Date:
The purpose of this paper is to provide the governing body with feedback from the governing body self-assessment, undertaken by members undertaken during March 2016.

The Governing Body is required to undergo an assessment of its performance, carried out by the membership, on an annual basis.

A self-assessment questionnaire was developed using Survey Monkey and members and attendees of the governing body were asked to complete this during March 2016.

Of the 21 possible respondents, 17 completed the questionnaire and a breakdown of the answers given, along with comments offered for each question, can be found at appendix 1.

The meeting of the Governing Body is asked to:

- Note the content and issues of the report.
- Consider the feedback provided by the governing body self-assessment.
<table>
<thead>
<tr>
<th>Benefits to patients &amp; the public</th>
<th>Ensuring that the governing body performs to the highest possible standard will provide patients and the public with confidence in the overall management of the CCG.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Links to Strategic objectives</td>
<td>Create and maintain strong governance assuring that the CCG complies with the legal requirements of the Health and Social Care Act 2012, and the CCG constitution.</td>
</tr>
<tr>
<td>Identified risks &amp; risk management actions</td>
<td>No specific risks have been identified with the approval of the terms of reference.</td>
</tr>
<tr>
<td>Resource implications</td>
<td>No resource implications have been identified.</td>
</tr>
<tr>
<td>Legal implications &amp; equality and diversity assessment</td>
<td>An evaluation of the performance of the governing body is required to be completed annually. This paper presents no implications for any of the nine protected equality characteristics.</td>
</tr>
<tr>
<td>Sustainability implications</td>
<td>No specific implications identified.</td>
</tr>
<tr>
<td>NHS Constitution</td>
<td>Principle Three: The NHS aspires to the highest standards of excellence and professionalism.</td>
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| Next steps                         | |
| Appendices                         | Appendix 1: Feedback from the Governing Body Self-assessment |
Feedback from the Governing Body Self-assessment

During March 2016, governing body members and attendees were requested to undertake a self-assessment questionnaire, which was completed through Survey monkey.

The table below shows the number of respondents and the associated percentage for each question. It should be noted that 17 of the 21 possible respondents completed the questionnaire, and within that number, one respondent did not complete question 14.

Below the table are the comments which were received for each question. These comments have been reproduced verbatim from the Survey Monkey questionnaire.

There are comments which are both positive and challenging relating to most of the questions, and the governing body may wish to use these in a future development session to explore any enhancements to the way in which it functions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes Responses</th>
<th>%</th>
<th>No Responses</th>
<th>%</th>
<th>Don't know Responses</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Are you clear about what the Governing Body is trying to do, and its terms of reference?</td>
<td>17</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Q2 Are you clear about the roles and responsibilities of members of the Governing Body?</td>
<td>17</td>
<td>100%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>Q3 Does the Chair display leadership of the Governing Body, to support it being effective in all aspects of its role? Are there any ideas on how this could be better (this will be treated confidentially).</td>
<td>16</td>
<td>94%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>6%</td>
</tr>
<tr>
<td>Q4 Do all members have clearly set out objectives and mechanisms in place for appraisal/ annual review?</td>
<td>5</td>
<td>29%</td>
<td>1</td>
<td>6%</td>
<td>11</td>
<td>65%</td>
</tr>
<tr>
<td>Q5 Has the Governing Body received assurance on the development process for the OD strategy?</td>
<td>10</td>
<td>59%</td>
<td>0</td>
<td>0%</td>
<td>7</td>
<td>41%</td>
</tr>
<tr>
<td>Q6 Are we covering the right material at the governing body? Are there irrelevant bits; is there anything else we should be discussing?</td>
<td>6</td>
<td>32%</td>
<td>6</td>
<td>32%</td>
<td>7</td>
<td>36%</td>
</tr>
<tr>
<td>Q7 Is the Governing Body supplied with information and support in a timely manner, in a form and of a quality appropriate to enable it to discharge its duties?</td>
<td>14</td>
<td>82%</td>
<td>0</td>
<td>0%</td>
<td>3</td>
<td>18%</td>
</tr>
<tr>
<td>Q8 Are there ways the Governing Body Lay Members could better provide constructive challenge and help develop proposals on strategy?</td>
<td>7</td>
<td>41%</td>
<td>5</td>
<td>29.5%</td>
<td>5</td>
<td>29.5%</td>
</tr>
<tr>
<td>Q9 Is the Governing Body development programme helpful – Can you suggest ways to improve it?</td>
<td>16</td>
<td>94%</td>
<td>1</td>
<td>6%</td>
<td>0</td>
<td>0%</td>
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</table>
Q10 Does the Governing Body make a difference in the management of the CCGs? How can it be better?

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<tbody>
<tr>
<td>12</td>
<td>70.5%</td>
<td>0</td>
<td>0%</td>
<td>5</td>
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</tbody>
</table>

Q11 Do you understand what the CCG is doing and how could we do it better?

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<tbody>
<tr>
<td>16</td>
<td>94%</td>
<td>0</td>
<td>0%</td>
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Q12 The papers and information the Governing Body receives are accessible but comprehensive enough to provide assurance. How can they be improved?

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<tbody>
<tr>
<td>12</td>
<td>70.5%</td>
<td>0</td>
<td>0%</td>
<td>5</td>
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Q13 Is there a formal and transparent procedure on staff remuneration?

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</thead>
<tbody>
<tr>
<td>14</td>
<td>82%</td>
<td>0</td>
<td>0%</td>
<td>3</td>
</tr>
</tbody>
</table>

Q14 Is the governing body assured with progress on the communication and engagement strategy implementation?

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</thead>
<tbody>
<tr>
<td>10</td>
<td>62.5%</td>
<td>2</td>
<td>12.5%</td>
<td>4</td>
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</tbody>
</table>

Q15 Does the Governing Body make the most constructive use of its AGM? How could it be better?

<p>| | | | | |</p>
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<tbody>
<tr>
<td>10</td>
<td>62.5%</td>
<td>2</td>
<td>12.5%</td>
<td>4</td>
</tr>
</tbody>
</table>

Comments:

Question 4

I don't know how the appraisal process works for others. For myself, the process could be better in that it seemed to be to fulfil higher NHS requirements rather than about my personal development. I have never yet seen an appraisal policy which works well but it is worth doing well.

The appraisal policy and process applies to all members of CCG staff, including governing body members, so in theory this should be the case.

I'm not aware of all members re this process but mine were clearly set out etc.

No appraisal /annual review carried out.

Question 5:

This should be a matter of fact from the Board minutes.

The OD strategy was approved in September 2015.

This is management speak, uncertain what it means.

Question 6:

Addition of detailed item each time with a presentation has been a good innovation.

I think there are specific areas that have to form part of the meetings proceedings. Sometimes a bit more discussion would be welcome to make things more interesting - but that has to be balanced with the formal business that has to be achieved.

Need more people stories to illustrate the papers that come to the governing body as agreed by the governing body.
Clinical risk and quality are at the top of the agenda.

Less procedure, more scrutiny of policy/documents.

**Question 7:**
The majority of the attendees appear to be fully conversant with the information for the meetings.

Several hundred pages of dry material, days before the meeting and no protected time to carry out the reading.

**Question 8:**
By being consulted at the outset rather than commenting on work completed at the Governing Body meeting, thus being able to have constructive discussion rather than just challenge something that's almost complete.

Still seems to be a lack of clarity around the contribution expected from the PPI Lay members.

I am not sure how they feel about this and if additional briefing sessions would be helpful.

They do a good job, but there is always more that can be done.

While Audit Committee lay members do receive insight into the CCG's workings, the Patient lay members are often not up to speed with what is happening.

Suggestions: 1. All lay members should have the opportunity to attend any CCG committees as observers 2. Lay members should have a regular meeting together to be briefed by officers on latest developments.

The Lay Members could be involved at an earlier stage during the development of strategic documents.

Could be involved earlier on in the formation of some strategies. However this might need time expansion for the lay reps.

It's an iterative process and I believe that our lay participants are not shy in interjecting!

Lay member provide constructive challenge and are encouraged to do so.

**Question 9:**
Excellent programme. Some of the Board's best work is done there because a full, open open exchange can take place.
More feedback and follow up from the areas discussed.

There is normally something for everyone. However attendance might seem to indicate that people find it hard to commit to.

**Question 10:**
I think the Exec has worked really hard over the last year to obtain challenge and feedback from the "non-execs".

Longer private sections.

Yes and no. Sometimes there is not enough time to digest information and some changes are not always apparent especially if you do not deal with it day to day. This may be hard to overcome.

It holds the CCG to account through this process (and of course the audit committee).

I suspect it is easy to view as a rubber stamping body. Rejecting papers occasionally may mean it's taking more seriously (A bit like the Ho Lords).

**Question 11:**
Being braver.

Does well for the resources it has.

Best stick with one question at a time on these questionnaire things. Can't answer two questions with one yes/no answer.

**Question 12:**
Always good to have some sense of trends where possible. We could still do more on this but overall papers are very good.

I am not sure - they seem well set out and comprehensive to me, the combined performance/quality and financial report provides excellent overview for assurance.

We have already improved the monthly Performance Quality and Finance report into a useful document.

Although there is a defined process and timeline for submission of papers, they aren't always submitted in a timely way which potentially reduces reading time.

Have greatly improved. Good to try and cut out initials, but has done fairly well.
I think that at times they are too comprehensive.

Mostly by paid protected time to properly read the papers, about 2w ahead of a meeting. But is it possible?

**Question 13:**
I can only recall this being discussed once.

The remuneration committee reports to the governing body and provides recommendations on staff remuneration.

It is explicitly documented and open to all.

**Question 14:**
Seems ok - but not always a lot of challenge.

Do not feel this is always the case.

I haven't seen a progress report?

Uncertain what 'assured' means in this question.

**Question 15:**
In the past it has been a place for member practices to lob bombs at the CCG leadership and Senior managers. We don't celebrate the success enough, we produce a list of things we need to do better or more of Schools would say that 55% of pupils getting 5 GCSE at A*-C grade is a success because it's the national average. We would say that 45% didn't achieve the target!

I've said "no" but given the constituency and the huge agenda I think it's difficult to make this a better event (as for example a simpler, stakeholder-driven organisation can do).

Two AGMs have now been held. Both provided a platform for presenting the Annual Report to the public, with the second being a much better event having learned from the first.

Some people who have used services giving their good and bad stories perhaps.

It is open and transparent.

I don't remember having one.
Newcastle Gateshead CCG

Quality, Safety and Risk Committee
Thursday 7 January 2016, 2.00 – 4.00pm
CCG Boardroom, Riverside House, Newburn

Attendees:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Gertig</td>
<td>Chair</td>
<td>NG CCG – Gateshead locality</td>
</tr>
<tr>
<td>Mandy Taylor</td>
<td>Lay Member</td>
<td>NG CCG – Newcastle locality</td>
</tr>
<tr>
<td>Chris Piercy</td>
<td>Exec Director of Nursing</td>
<td>Newcastle Gateshead CCG</td>
</tr>
<tr>
<td>Dr Neil Morris</td>
<td>Medical Director</td>
<td>Newcastle Gateshead CCG</td>
</tr>
<tr>
<td>Dr Phil Taylor</td>
<td>GP</td>
<td>Newcastle Gateshead CCG</td>
</tr>
<tr>
<td>Jeff Pearson</td>
<td>Head of Corporate Affairs</td>
<td>Newcastle Gateshead CCG</td>
</tr>
<tr>
<td>Neil Macknight</td>
<td>Head of Quality &amp; Patient Safety</td>
<td>Newcastle Gateshead CCG</td>
</tr>
</tbody>
</table>

In attendance: Ann Garside/PA Support
Ruth Marshall (RM), Senior Clinical Quality Officer/NECS

Item Action

1. Welcome and Introductions
   In the absence of Oliver Wood Paul Gertig chaired the meeting. Paul welcomed everyone and members introduced themselves.

2. Apologies for absence
   Oliver Wood, Kirstie Atkinson (NECS), Julia Young, Bill Cunliffe

3. Quoracy
   The meeting was declared to be quorate.

4. Declarations of Interest
   There were no declarations of interest to note.

5. Notes of previous meeting held 05.11.15
   The notes were agreed as a true and accurate record.

   Matters Arising;
   Low attendance at QSR was mentioned. Issue previously raised at Governing Body but agreed this should now be raised at CMT.

5.1 Action Log:

   Item 1 NG CCG Exceptions Dashboard - Some narrative required in report and brief detail as to how issues being addressed.
   Narrative shown on today’s report. Action Complete

   Item 2 Terms of Reference for PTG to be updated and brought back to QSR for approval.
   Revised document on agenda today. Action complete
6. **Integrated Quality, Safety & Risk Reports**

6.1 **NG CCG exceptions dashboard**

Neil Macknight gave an update to the committee around the activity dashboard and advised some narrative had now been included but changes to the report format were still being explored. Feedback welcome.

Reporting done by exception and the indicators currently RAG rated red shown in the table. December data will be available by the end of January 2016.

Gateshead FT breached the 18 weeks admitted target in October. Actions taken by the Trust have brought this back on target.

52 week waiters relating to Tyneside Surgical Services showing a breach. Confirmed as a data error and now corrected.

4 hour A&E wait target breached by both NuTH FT and Gateshead FT in November. Issue being monitored closely.

Query raised as to whether the problems in Durham area had improved. Noted 10% increase in demand and delayed discharge has had an effect. Advised Urgent Care Vanguard now in place which should improve situation in this Winter period. Discussions taking place with Accountable Officers and NHSE Area Team.

Six weeks diagnostic indicator shows Gateshead FT still breaching the 1% threshold. A lot of work undertaken and back within trajectory in November.

62 day cancer waiting time target breached by Gateshead FT in Q1 and NuTH FT in Q2. Recent data confirms both now within target for Q3.

HCAI infections (MRSA and CDiff)

NuTH FT showing 7 cases of MRSA with 6 now verified. Issue raised with Director of Nursing and Infection Control team.

No cases at Gateshead FT. Reasons for differences in the Trusts being explored.

CP noted every case of MRSA has a Post Infection Review carried out and results notified to NHS England.

**Action – NMAC to include narrative to update in the future**

Ambulance performance indicators continue to exceed national targets. NEAS experiencing huge pressure and still some problems around recruitment of paramedics.

CP advised that this area was under scrutiny at NEAS QRG. Recruitment taking place and training being undertaken nationally. Call outs for Mental Health patients of huge concern. Also some patients from 111 service being referred to A&E unnecessarily.

CP to send paper to NM which is going to NEAS QRG on Monday.

**Action – Concerns around Urgent Care and 111 to be escalated as a cause for concern to Julia Young.**

CP
Non-elective admissions discharged at weekends across the CCG stand at 17.7% against a target of 30%. Some problems could be attributed to social care cover at home etc.

A&E coding of episodes presently standing at 78.1% against target of 90%.

Currently 85.5% of Mental Health patients attending A&E are seen within 4 hours against the national target of 95%. Noted gradual improving trend in the target.

In answer to a question raised as to what contingencies were in place for the forthcoming Junior Doctors strike, NM advised that Andy Welch (Medical Director at NuTH) had confirmed satisfactory emergency cover would be in place. Outpatients and elective care appointments cancelled but patients had been advised to attend for treatment if strike called off. Gateshead Hospitals yet to confirm arrangements.

### 6.2 NG CCG Clinical Quality Exception Report

In the absence of Kirstie Atkinson, Ruth Marshall/NECS attended to give an update on the Clinical Quality and Exceptions Report and she ran through details of the Executive Summary.

SIRMS incidents. 531 incidents reported by NG CCG member practices. They continue to be the highest reporters across all CCG areas in the North East & Cumbria.

#### Gateshead FT

- Flagged as an outlier in three areas - Central Alert System compliance, Monitor continuity of services and Monitor governance risk ratings. The Trust is below standard on cancer 62 day waits and diagnostics over 6 week waits. Issues continue to be monitored via the QRG and contract monitoring meetings.

- NHS Safety Thermometer data shows Trust’s score for harm free care slightly below national average.

- Since April 2015 Trust has reported 27 Cdiff cases, taking it above annual trajectory of 19. A number of appeals pending. Monitored through QRG and HCAI Reduction Partnership.

- Friends & Family Test response rates remain below national average but A&E response rates significantly higher than the national average.

- CQC inspection took place in September 2015. Verbal update received and Final feedback should be received on the 8 January.

#### Newcastle upon Tyne Hospitals FT

- Quality Dashboard shows that the Trust is below standard on two areas, A&E 4 hour waits and MRSA. Monitored via QRG and Contract Monitoring meetings.
Since July 2015 numbers of Cdiff cases above monthly trajectories. MRSA total 7 cases for year to date. To be raised at QRG and HCAI Partnership.

Friends & Family Test response rates still significantly below the national average. Gateshead FT response rates good so NuTH FT to liaise with Gateshead FT for advice. QRG continue to monitor.

**NTW Foundation Trust**

- Trust continues to be above the national average for falls with harm. Issue raised at QRG and Trust closely monitoring to ensure no further issues or trends emerging.

- Noted independent providers represented in Contracting Review meeting so information available on any emerging problems. CP noted approved notes could be shared if thought to be useful.

**Safeguarding**

- Noted Trust has seen a significant increase in workload around Deprivation of Liberty.

- New Head of Safeguarding appointed and CP noted LD mortality review being undertaken led by Claire Scarlett.

- Safeguarding training rated as amber at present time

---

### 7.1 Assurance Framework & Risk Registers Update

Jeff Pearson updated the committee on the monthly exception report and advised there was little change in relation to the three larger high level red risks.

**Risk 298 CHC funding high activity and costs**

Risk unchanged

**Risk 1420 4 hour A&E targets in Newcastle and Gateshead**

Potential risk that increasing demand will prevent the 4 hour A&E target being achieved. Being managed through Business Continuity Plan and monitored through daily SITREPS.

**Risk 1156/298 relating to CHC funding and Lack of contracts in place for CHC domiciliary care**

Level of risk not reducing at present but not getting worse. Hoping to downgrade rating in next few weeks. CP advised weekly meeting taking place with staff from NECS.

**Three risks reported as Amber because of gaps in controls;**

**Risk 892 Potential loss of clinical leadership in the CCG**

No change in risk. Work still underway to fill posts and ensure no gaps.
**Risk 1094 Potential compensation payment around DoLs**
Huge backlog of assessments to be undertaken.
Two of the three band 7 Managers now recruited.

**Risk 1393 Completion of previously unassessed periods of care (PUPoC)**
Potential risk of being unable to recruit staff with appropriate skills to deliver a robust process.
Noted NHS England has not given agreement to the Business Case they have advised that CCG will be severely penalised if work not delivered in time.
**Action JP will liaise with CP to escalate risk to red at the present time.**

It was queried whether the Green rating around Risk 1125 relating to the implementation of the Better Care Fund should be increased.
Confirmed that no additional risk had been recorded and the risk would be reviewed when gaps in efficiency were agreed at the Local Authority.

**Risk 1295 – relating to health inequalities**
Being reported as Amber and confirmed as a monitoring risk as there are no gaps in controls.

PG noted that the graph shown in Appendix 3 of the report was really useful.
JP confirmed this was produced by Governance in NECS and thanks would be passed on to Kate Watson.

**7.2 Amended Terms of Reference for PTG**
JP confirmed Terms of Reference now in Corporate format being used by all committees and sub committees of the Governing Body.
PTG will be a sub-committee of QSR.
Terms of Reference recommended for approval.
**Action Members agreed and accepted Terms of Reference as produced. Final version to be distributed to members of PTG.**

In answer to a query we to whether a lay member should sit on the PTG committee, it was confirmed that existing membership was well balanced and would not require attendance by a lay member.

**7.3 Updated Information Governance policies**
JP reported that six Information Governance policies had undergone some minor amendments but assurance on policies was unchanged;

- CCG IG01 Confidentiality & Data Protection Policy v2
- CCG IG02 Data Quality Policy v2
- CCG IG03 Information Governance and Information Risk Policy v3
- CCG IG04 Information Access Policy v3
- CCG IG05 Information Security Policy v3
- CCG IG06 Records Management Policy & Strategy v3

**Action : Members approved policies for continued use**
8. **SIRMS Reports**

Ruth Marshall/NECS updated members and advised that this information was a reflection of information shown in the main Integrated Quality, Safety & Risk Reports. These Quarter 2 reports had been provided for information purposes and highlight the main issues reported by GP practices. Confirmed SIRMS reports are shared with providers as well as other CCG's.

A process had commenced to set up quarterly thematic reports

Following a query as to where the reports were published for GP’s, it was confirmed that documents were on the website and would be taken to the Practice Managers meeting.

Members confirmed GP TeamNet shows figures but no narrative.

9. **Notes from other Committees for information**

Members received notes for information and a couple of small queries answered.

10. **Any Other Business**

There were no other specific items of business to raise but NMAC advised the committee that Ruth Marshall was leaving NECS as she had a new post as Quality Manager with North Tyneside CCG.

Thanks were given to Ruth for her input to QSR and members wished her well in her new role.

11. **Date and Time of Next Meeting**

Thursday 17 March 2016, 2 – 4pm, CCG Boardroom
Newcastle Gateshead CCG

Enclosure 13.1 (c)2

Quality, Safety and Risk Committee
Thursday 17 March 2016, 2.00 – 4.00pm
CCG Boardroom, Riverside House, Newburn

Attendees;

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
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<tr>
<td>Paul Gertig (Chair)</td>
<td>Lay Member</td>
<td>NG CCG – Gateshead locality</td>
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<tr>
<td>Chris Piercy (CP)</td>
<td>Exec Director of Nursing</td>
<td>Newcastle Gateshead CCG</td>
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<tr>
<td>Dr Neil Morris (NM)</td>
<td>Medical Director</td>
<td>Newcastle Gateshead CCG</td>
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<tr>
<td>Dr Phil Taylor (PT)</td>
<td>GP</td>
<td>Newcastle Gateshead CCG</td>
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<tr>
<td>Jeff Pearson (JP)</td>
<td>Head of Corporate Affairs</td>
<td>Newcastle Gateshead CCG</td>
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<tr>
<td>Kirstie Atkinson (KA)</td>
<td>Clinical Quality Manager</td>
<td>NECS</td>
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<tr>
<td>Neil Macknight (NMAC)</td>
<td>Head of Quality &amp; Patient Safety</td>
<td>Newcastle Gateshead CCG</td>
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<tr>
<td>Anne-Marie Bailey (AMB)</td>
<td>Senior Meds Optimisation Pharmacist</td>
<td>Newcastle Gateshead CCG</td>
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In attendance:  Ann Garside/PA Support

<table>
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<tbody>
<tr>
<td>1. Welcome and Introductions</td>
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<tr>
<td>In the absence of Oliver Wood Paul Gertig chaired the meeting and welcomed everyone.</td>
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| 2. Apologies for absence    |        |
| Oliver Wood, Bill Cunliffe, Jackie Cairns & Julia Young |

| 3. Quoracy                  |        |
| The meeting was declared to be quorate. |

| Oliver Wood is leaving at the end of March and the Chair asked for thanks to be extended to Oliver for his contribution to QSR and his role as chair. |

| Jeff Pearson advised of his impending retirement and extended thanks to everyone in the committee for their support over the last few years. Thanks were similarly extended to Jeff for his help and valuable contribution to QSR. |

| 4. Declarations of Interest|        |
| There were no declarations of interest to note. |

| CP suggested the wording of this item should read “Declarations of Conflict of Interest” as this was more descriptive. Members agreed for future meetings. |

| 5. Notes of previous meeting held 07.01.15 |        |
| The notes were agreed as a true and accurate record. |
| There were no matters arising. |
### 5.1 Action Log:

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<tr>
<td>1</td>
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<tr>
<td>2</td>
<td>Action complete</td>
<td>Remove from Log</td>
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**Item 3**  Concerns re Urgent Care and 111 to be escalated to Julia Young  
Julia reported via Chris Piercy that detailed discussions had taken place at North East Urgent Care and Emergency Care Network and actions were being addressed through the 111 process. Further information to follow.  
**Action:** It was agreed to circulate the Network newsletter to QSR members for information.

CP advised concerns around NEAS were being addressed by the Quality Review Group (QRG) and regional/local Quality Surveillance Groups (QSG). A lack of A&E systems posing a problem, as well as ambulance transport requests being incorrectly categorised. It was suggested that some general advice for GPs would be useful to ensure the use of the correct category of transport.

### 6. Integrated Quality, Safety & Risk Reports

#### 6.1 NG CCG exceptions dashboard

Neil Macknight gave an update to the committee around the activity dashboard and advised that there was not a great deal of change in the indicators.

Gateshead FT 18 week referral to treatment indicators shown as red status largely due to a lack of data. Trust expected to be back within target by the end of the financial year.

Newcastle and Gateshead FTs noted as having breached the 52 week referral to treatment target. Attributable to a data error which will be corrected.

Newcastle and Gateshead FTs have breached the 4 hour wait for A&E. Noted that the Status Year to Date shows position over the year and Status Actual is the current position. Some breaches attributable to patient flows across the North East, with diverts and deflects mostly from Durham and Darlington. A query was raised as to how the effect of diverts to Newcastle Hospitals from North Tyneside and also from Durham was measured.  
**Action:** NMAC to obtain information to investigate

Newcastle & Gateshead back within trajectory for 62 day cancer waiting time.

HCAI infections. Both acute providers over trajectory for the year.

MRSA infections. Total of 8 cases but not all allocated to Newcastle FT. Gateshead FT has no cases. CP confirmed a meeting was to be held with the clinicians at Newcastle FT and the Infection Control team to discuss but there were no apparent consistent issues. Results will be reported through HCAI Reduction Partnership.

Ambulance performance indicators reflect the regional position for NEAS and continue to exceed national targets.
Non-elective admissions discharged at weekends across the CCG stand at 17.1% against a target of 30%. Noted that Gateshead FT has a locum consultant on duty at weekends. Query raised as to the success of this and whether Newcastle FT would be doing something similar. Take to NuTH QRG after results from Gateshead known.

**Action:** NMAC to check on data. KA to put issue on Gateshead FT QRG agenda.

A&E coding target improving.
It was reported that 77% of mental health patients attending A&E were seen within four hours, against the national target of 95%. Noted there is a Mental Health Liaison Team in both Newcastle and Gateshead.

### 6.2 NG CCG Clinical Quality Exception Report

Kirstie Atkinson updated the committee on the Clinical Quality Exception Report.

**SIRMS incidents**

496 incidents reported by NG CCG member practices in December 2015 and January 2016. Detailed analysis provided in the SIRMS thematic reports.

**Gateshead Health NHS Foundation Trust (GHFT)**

In February 2016 the Care Quality Commission (CQC) published a comprehensive report into the services provided by GHFT with an overall rating of “Good”.

Improvement shown in GHFT Serious Incident performance for two day reporting and submission of investigation reports within 60 days. General discussion on SI reporting and how Trusts struggling to meet reporting requirements.

**Action** – KA to add performance against SI Framework to QRG’s

Since April 2015 Trust has reported 32 cases of Cdiff, taking it above annual trajectory of 19. One case of MRSA reported in January 2016. Monitored through QRG and HCAI Reduction Partnership.

Friends & Family Test response rates remain below national average but A&E response rates are significantly higher than the national average.

**Newcastle upon Tyne NHS Foundation Trust (NuTHFT)**

Improvement shown in the Trust’s performance for the reporting of Serious Incidents within two working days but submission of investigation reports within 60 days remains very poor. Improvement required in both areas to enable the Trust to achieve 100% compliance against targets.

Since April 2015 Trust has reported 84 cases of Cdiff, taking it above annual trajectory of 77. Two new cases of MRSA reported in January 2016, bringing total for year to date to seven. CP reported CCG is facilitating a Deep Dive into MRSA cases to identify any common themes or trends.
Friends & Family Test inpatient and A&E response rates significantly below national average. A&E response rates significantly higher than the national average. QRG will continue to monitor.

**Northumberland Tyne & Wear NHS Foundation Trust**

Friends & Family Test recommendation scores continue to be below national average. Trust to provide an update at next QRG.

NHS Benchmarking Network data shows Trust is the third highest overall user of restraint with an average of 7.6 instances per ten beds, compared with the national average of 2.8. The Trust has commissioned an independent investigator to review the data and will provide an update at the next QRG.

**Action : NMAC to get an update from Ian Nicholson**

**North East Ambulance Service (NEAS)**

Some slight improvement shown in the Trust’s Serious Incident performance for two day reporting but submission of investigation reports within 60 days remains very poor. Improvement required in both areas in order for the Trust to achieve 100% compliance against targets.

Hospital handover delays continue to impact on NEAS.

Sickness absence rates increased. Trust consistently been above target since November 2013.

Call answer performance levels maintained for both 999 and 111. Noted that NEAS was the only Trust nationally to achieve call answer rates over the Christmas period.

**Community Services – South Tyneside NHS Foundation Trust (STFT)**

STFT provides community services to Gateshead patients but KA advised it is impossible to distinguish data between acute and community services at QRG. Noted that the CCG Executive Director of Nursing meets regularly with STFT Director of Nursing.

**Independent Providers**

Named CCG quality lead aligned to each independent provider and regular quarterly meetings take place. During December 2015 and January 2016 there were no exceptions to report.

In answer to a query raised around SIRMS reporting system, KA advised work was ongoing to improve the system and make it easier to use. Update expected by the end of March 2016.

**7. 7.1 Assurance Framework & Risk Registers Update**

Jeff Pearson updated the committee on the monthly exception report. JP advised there were no significant changes to the Assurance Framework but this would be reviewed again in the next few weeks. Revised Assurance Framework will go to Audit, QSR and Governing Body.
Three larger high level red risks to report as follows;

Risk 298 CHC funding high activity and costs
Risk reviewed but this still remains a red risk. Audit Committee received the same report this week and members felt this provided a good opportunity to look at controls and processes for the risk.

Action : JP to speak to CP

Risk 1393 Completion of previously unassessed periods of care (PUPoC)
Risk rating increased from Amber to Red. Target date moved by NHS England from March 2017 to September 2016, with significant penalties being applied if the CCG fails to complete the process for all identified individuals. Some delays experienced in getting Business Case approved and implemented.

Risk 1420 4 hour A&E targets in Newcastle and Gateshead
Potential risk that increasing demand will prevent the 4 hour A&E target being achieved. Being managed through Business Continuity Plan and monitored through daily SITREPS.

There is one risk area recorded as Amber and reported due to gaps in controls;

Risk 892 Potential loss of clinical leadership in the CCG
No major issues but additional demands on GPs means it could well become a future problem. Work still underway to fill posts and ensure no gaps.

Two risks reduced to Green rating;

Risk 1094 re the lowering of the threshold for Deprivation of Liberty Safeguards (DOLS).
Two Band 7 posts now in post and backlog of assessments being addressed. As a result this risk has reduced to a Green rating.

Risk 1156 relating to CHC funding and lack of contracts in place for CHC domiciliary care
Backlog of cases being addressed so risk reduced to a Green rating.

JP reported that the next report would include a risk in relation to Care Homes Vanguard in view of the fact that the CCG as an organisation cannot hold patient identifiable information for anything other than Safeguarding. This is a risk to the Vanguard project.

7.2 Updated C002 Complaints Policy for approval
JP reported some small amendments had been made to this policy and members were asked to approve for use within the CCG.

7.3 Updated CO14 risk Management Policy for approval
JP reported some superficial changes had been made to this policy with the most significant being a change in the way the policy works. Members were asked to approve for use within the CCG.

Action : Members approved both policies for continued use within the CCG
8. **SIRMS Reports Quarter 3**

A selection of four SIRMS incident reports were distributed to members, comprising a CCG report and a thematic report for each of the providers, covering Quarter 3, October – December 2015. Members agreed reports contain useful information to share with practices. Noted reports will continue to evolve and improve.

KA confirmed information uploaded to NRLS in association with NHS England.

**Action:** Members received the reports for information

9. **Updated Terms of Reference for information;**

**9.1 Serious Incident Panel Terms of Reference**

Some slight amendments and membership updated. Members agreed it was an accurate reflection of the membership.

**9.2 Quality, Safety & Risk Committee**

Membership updated with titles of Directors shown. Updated version to be circulated to members with any comments back to Jeff to agree. Query as to whether we need AO or CFO to be a member of QSR.

**Action:** CP and NM to discuss with AO

**Action:** Members received revised Terms of Reference for both Committees

10. **Notes from other Committees for information**

Members received notes for information.

NM suggested it would be useful to discuss two sets of notes in more detail at each meeting and for a rolling annual programme to be drawn up. Representative to attend to present notes to the Committee for discussion. QRG notes to continue to come to QSR for information as usual.

11. **Any Other Business**

NMAC advised that the CQUIN issue is paused at the present time. Attempt being made to align CQUIN with Quality Premium, PEP and QIPP. Feedback to be provided at the next meeting.

PG noted a Chair will need to be appointed at the next meeting.

JP confirmed advert had gone out for lay members.

12. **Date and Time of Next Meeting**

Thursday 5 May 2016, 2 – 4pm, CCG Boardroom
**Executive Committee**  
**Tuesday 16th February 2016, 13:30 – 16:00**  
**CCG Boardroom, Riverside House, Newburn**

**MINUTES**

<table>
<thead>
<tr>
<th>Chair</th>
<th>Dr Mark Dornan</th>
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<tr>
<td>Present</td>
<td>Jackie Cairns, Dr Guy Pilkington, Jane Mulholland, Neil Morris</td>
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<td>Dr Steve Summers, Joe Corrigan, Chris Piercy</td>
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<tr>
<td>Apologies</td>
<td>Dr Guy Pilkington, Bill Cunliffe, Dr Steve Kirk, Mark Adams, Julia Young</td>
</tr>
<tr>
<td>In attendance</td>
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<tr>
<td>PA support</td>
<td>Carol Kalkavoosi</td>
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- Gateshead Department of Public Health Annual Report – Carole Wood, Director of Public Health, Gateshead LA
- Workstream update – Informatics – M Dornan

**Quality, Performance & Finance Visibility Wall**

**Integrated Delivery Report Summary (for challenge and information)**

**Quality Key Issues – C Piercy**

Safeguarding Team supporting the local Child Death Overview Panel (CDOP) review – collaborative piece of work being undertaken with Local Authorities and South Tyneside, Gateshead, Newcastle, Northumberland and North Tyneside CCG’s to develop learning opportunities and minimise child deaths, next review meeting to take place in May 2016.

Deciding Together Mental Health public consultation - closed 12th February – Next phase 2 public sessions arranged March and April, then review of information to go a Governing Bodies development session and then sign off is due at the public Governing Bodies meeting 24.05.16.

PUPOC trajectory challenges facing NHS Newcastle Gateshead CCG - 340 outstanding cases, trajectory with NHS England to agree all cases by September 2016.

MRSA positive cases identified – to date 8 cases in Newcastle – this can effect quality payments to the Trust, all cases to be looked at individually to look for common themes.

**Performance Key Issues – C Dovell**

Gateshead Health Diagnostics 6 week waiting times – GH Health and CCG on track, pressures felt in NuTH around MRI and sleep studies.

Cancer waiting times - 62 day (85% standard) - NUTH and NGCCG – on track but pressures remain, working with clinical networks to streamline specific problem areas

A & E – performance continues to deteriorate - significant system wide pressures remain.

NEAS Cat A response times – standard will not be met by the end of the year

**Quality Premium Indicators** – 6 patients with an SMI who smoke needed to
reach target. Several successes have been reached in a number of practices.

**IAPT NCCCG** – Success so far with waiting list initiative, however pressures remain moving to recovery in Newcastle, action plan is in place to mitigate this risk.

**Contract Month Update 8 – C Smith**

**NuTH** – Application of business rules with regard to emergency threshold and penalties – NuTH would like to suspend some of these national rules – this remains an issue.

**GHNHSFT** – Block contract in place this year. £700k additional funding has been to support the FT through the winter surge to help with additional beds

**NTW** – Finance in-line with expectation.

**NEAS** – Continuing underperforming remains an issue. 2016/17 block contract work ongoing.

**Finance Update – P Argent**

Non Elective performance for BCF

**Gateshead Health & Wellbeing Board** - Latest position above plan by 1.1% to December 15/16

**Newcastle Health & Wellbeing Board** - Latest reported position below plan by 2% to December 15/16

Overall finance Q4 - The surplus reported in January is increased to £10,019k, due to change of national rules around application and financial sanctions as of 1\textsuperscript{st} January CCGs are not allowed to apply financial sanctions.

Year end – main pressures remain around NuTH and increasing expenditure on continuing healthcare

**ACTION: P Argent to give an overview on planning for 2016/17 at March Executive Visibility Wall.**

Welcome

Dr Mark Dornan (Chair) welcomed everyone to the meeting

1.1 **Quoracy**

The meeting was declared to be quorate.

1.2 **Declaration of interest**

None

1.3 **Minutes of the previous meeting held 19\textsuperscript{th} January 2016**

Agreed

1.4 **Matters arising from the previous minutes / review of action log**

Action log updated

2 **Patient and Public Engagement** - J Cairns / J Mulholland

Approved and noted for all the continued extensive work undertaken.

Responsible Director going forward will be C Piercy.

3 **Commissioning and Contracting**

**Newcastle/Gateshead**

3.1 **Primary Care Estates Meeting – J Corrigan**

Feedback from the PC Estates meeting – updated on action log

3.2 **Acute CQUIN Reconciliation Statement: Q1 and Q2 2015/16**

**Gateshead Health NHS Foundation Trust – C Piercy**

The paper presented outlined the progress towards, and achievement of, the agreed CQUIN scheme in Q1 and Q2 and makes a recommendation for
| 3 | Payment or non-payment for each CQUIN indicator  
**ACTION:** Recommendations agreed and signed retrospectively by the Executive Committee |
| 4 | **Governance**  
4.1 Review of Executive Committee Terms of Reference – J Corrigan  
J Corrigan proposed that responses regarding effectiveness and performance of the Executive Committee be done via email.  
**ACTION:** Agreed by the Executive Committee to send responses to J Corrigan via email as soon as possible.  
**Membership of the Executive Committee**  
Executive Committee agreed in principal with the proposed Terms of Reference but it was also acknowledged and noted that the right clinical input at the right level is needed.  
**ACTION:** J Corrigan to revise the wording and clarity of Executive Committee functions, membership and membership titles.  
**Joint Delivery Group**  
Clarification of membership is needed to ensure each function is represented.  
**ACTION:** J Mulholland taking forward  
4.2 Confidentiality Audit Procedure – J Corrigan  
**ACTION:** J Corrigan – Further work and revision of wording to be undertaken on document, to revisit when this has been completed. |
| 5 | **Operational issues for discussion**  
None noted |
| 6 | **Organisational Development**  
None noted |
| 7 | **Transparency – Does any of the discussion need cascading elsewhere**  
None noted |
| 8 | **Items for Information**  
None noted |
| 9 | **Any other Business**  
None Noted |
| **Next Meeting** | **Tuesday 15th March 2016 13:15 – 16:00, CCG Boardroom.** |
# Executive Committee

**Tuesday 15\textsuperscript{th} March 2016, 13:30 – 16:00**

**CCG Boardroom, Riverside House, Newburn**

## MINUTES

**Chair**
Dr Mark Dornan  
**Present**
Dr Guy Pilkington, Jackie Cairns, Dr Guy Pilkington, Jane Mulholland, Neil Morris, Dr Steve Summers, Joe Corrigan, Chris Piercy, Dr Steve Kirk, Mark Adams, Julia Young  
**Apologies**
Bill Cunliffe  
**In attendance**
Helen Berry (GP Registrar) Shona Haining (NECS) Helen Riding (NECS)  
Tom Schatzberger (Research Lead Newcastle Gateshead)  
**PA support**
Carol Kaikavoosi

<table>
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<tr>
<th>Workstream update – Organisational Development – given by H Bellwood and Helen Berry</th>
<th>Action</th>
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<tr>
<td><strong>Quality, Performance &amp; Finance Visibility Wall</strong></td>
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*Integrated Delivery Report Summary (for challenge and information)* |
| **Quality Key Issues – C Piercy** |  
**MRSA** – All of the Trusts root cause analysis has been collected for the 8 MRSA cases. Findings to be shared with NHS England.  
**Gateshead Health FT** – CQC Inspection overall rating good, Clinical Summit takes place 18.3.16 from the CQC inspection no areas needed improvement for GHFT.  
Gateshead Council Ofsted review of Children’s Services and LSCB – overall rating good, issues reported around children leaving care and moving into supported living accommodation, 4\textsuperscript{th} April a Designated Nurse to look after children is joining the Safeguarding Team which will help with transitional issues. |
| **Performance Key risks – C Doveill** |  
**Gateshead Health Diagnostics 6 week waiting times** – Position sustained performance on track. Two new radiologists appointed.  
**NuTH** – Significant pressures remain, MRI & sleep studies - action plan in place.  
**NGCCG** – Remains on track  
**Cancer waiting times - 62 day (85% standard)**  
**NuTH** - Positive performance  
**NGCCG** – Improved position – Q4 standard on track to be met.  
**A & E 4 hour waits** – 30% reduction in QP for non-achievement, action plans in place with both trusts to alleviate key issues around flow and discharge.  
**NEAS Cat A response times** - 20% reduction in QP for non-achievement  
**IAPT NCCC** – Outcomes moving to recovery remains a risk. Recovery action plan for this standard is in place. |
| **2015/16 Contract Update - J McGrath** |  
Continued over performance at NuTH of £4.1m, drugs & devices £1.3m, Non electives £1.2m |
**Newcastle Gateshead Clinical Commissioning Group**

| NuTH: Emergency threshold/readmissions/resilience, QIPP (£3M), spinal penalties |
| GHNHSFT: QIPP (£2.5M), pathology activity pressures, CROP and nurse led tariffs |
| NTW: £2.2m financial gap relating to children and young people’s services, NTW schedule received 11.03.16 further meeting scheduled on 17.3.16 to work this up. |
| NEAS: CCG offer rejected by provider. |

All contracts to be agreed by 31.03.16

**Finance Update – J McGrath**

Still on track to achieve planned surplus. Focus now on financial plan 2016/17.

Increased focus nationally and locally with NHS England on the opportunities in Rightcare to make savings, a suggestion that all CCGs should be looking at 2-3% of their total allocations of QIPP target.

**Visibility Wall Presentation**

| Welcome |
| Dr Mark Dornan (Chair) welcomed everyone to the meeting |

1.1 **Quoracy**
The meeting was declared to be quorate.

1.2 **Declaration of interest**
None

1.3 **Minutes of the previous meeting held 16th February 2016**
Agreed

1.4 **Matters arising from the previous minutes / review of action log**
Action log updated

2 **Patient and Public Engagement – C Piercy**

CP has now met with the Quality/PPI team to look at taking work forward, engaging with other parts of the organisation, looking how to work further with Involve North East and the additional resources within that team.

Engagement Strategy when complete to come to the Executive Committee for ratification and agreement.

The Executive Committee suggested that the “financials” be added to the PPI report in future to show what is being spent and where across Newcastle Gateshead.

3 **Commissioning and Contracting**

3.1 **Newcastle/Gateshead**

Update brought to the Executive Committee to give assurance and highlight work undertaken, what has been achieved and future plans:-

- Newcastle Gateshead CCG KPI’S - Quarter 3 have all been met.
- A great deal of research activity for CCG has taken place.
- 2016/17 - big projects already in place, quarterly reports to the Executive Committee to include update on any variation of excess treatment costs.
- Continued joint working to ensure research strategy and action plan are taken forward for Newcastle Gateshead CCG
- Newcastle Hospitals have decided not to award the contract to NECS
to provide the Primary Care Delivery component – lot of challenging discussions have taken place. R & G going forward will cover everything accept delivery.

**ACTION:** S Haining to send N Morris a summary to be put into the CCG Practice Newsletter regarding the decision made by NuTH

- The Executive Committee were asked if it would be beneficial to have a named person leading this agenda to deliver the strategy across the CCG this would be different than the Clinical Leadership support?
- H Riding and team will move to NuTH but will feed through information to providers.
- Research capability funding is available.

**ACTION:** Any feedback on Strategy document to go to S Haining

**Newcastle**
No agenda items

**Gateshead**
No agenda item

### 4 Governance

- **4.1 Policy for the development and approval of policies**
  **ACTION:** Approved by the Executive Committee
- **4.2 Intellectual Property Management and Revenue Sharing**
  **ACTION:** Approved by the Executive Committee
- **4.3 Confidentiality Audit Procedure**
  **ACTION:** Approved by the Executive Committee
- **4.4 Revised Terms of Reference for Estates Steering Group**
  **ACTION:** Approved by the Executive Committee

### 5 Operational issues for discussion

None noted

### 6 Organisational Development

None noted

### 7 Transparency – Does any of the discussion need cascading elsewhere

Review of Research strategy and Planning - Update on year of research and Funding

### 8 Any other Business

None Noted

**Next Meeting**

*Tuesday 19th April 2016 13:15 – 16:00 CCG Boardroom.*
Minutes of the Primary Care Joint Committee Meeting
held on Tuesday 26 January 2016 at 4.30 – 5.30pm

Lamseley Room, Gateshead Civic Centre, Regent Street,
Gateshead, NE1 8QH

Present:
Jeff Hurst Chair
Christine Keen NHS England

In Attendance:
Mandy Taylor Vice Chair, CCG
John Costello Representative from Gateshead Health & Wellbeing Board
Professor Eugene Milne Representative from Newcastle Wellbeing for Life Board
Jane Mulholland CCG
Rachel Head HealthWatch Newcastle
Marc Hopkinson CCG
Louise McAndrew Minute Taker, CCG

2016/01/01 Welcome and Introductions
Jeff Hurst, Chair, welcomed everyone to the meeting.

2016/01/02 Apologies for absence:
Neil Morris Medical Director, CCG
Jackie Cairns CCG
Steph Edusei HealthWatch Newcastle
Douglas Ball HealthWatch Gateshead
Andrew Moore HealthWatch Gateshead

2016/01/03 Declarations of Interest
There were no specific declarations of interest in relation to the agenda.

2016/01/04 Quoracy
It was confirmed that the meeting was quorate.
2016/01/05 Minutes of previous meeting 24 November 2015
The minutes were agreed as an accurate record.

2016/01/06 Matters arising from the Minutes

See Action Log.

Grange Road Surgery
Christine Keen, NHS England, updated that the situation at the practice is settling and they now have 2 wte GPs and are only using locums for holidays and sickness. They has also appointed a:
- Nurse practitioner
- Practice nurse
- Healthcare assistant.

2016/01/07 Primary Care Transformation Funding Process
Jane Mulholland, CCG, presented the paper which provided the Joint Commissioning Committee with the practice briefing and Expression of Interest and Bid forms for practices. The documents were for information only as they had already received CCG Executive Committee approval to enable timely dissemination to member practices.

The Primary Care Transformation Funding (which replaces the The Primary Care Infrastructure Fund), is a four year £1billion investment programme to support the transformation in primary care through improvements in premises and technology.

Responsibility for the fund rests with NHS England. CCGs have been asked by NHS England to submit proposals for the Primary Care Transformation Fund in their areas.

The CCG now needs to enable practices to submit bids for their premises needs. The CCG will then need to assess bids against the CCG Estates Strategy and PCTF criteria for inclusion in the CCS overall proposal.

A process and information was expected from NHS England in December however, as this has not yet been received, an interim process has been established to ensure the CCG can support practices to be part of the process.

It was discussed that the schemes should come to this committee for approval to make sure that assurance is given and look at why and how the decisions were made before they go forward as it was noted that there could be conflicts of interest as there will be GPs are considering GP bids.

Action: Agenda for the February meeting
Action: Jeff Hurst to speak to Jeffrey Pearson regarding the conflict of interest issue.
2016/01/08 Practice Engagement Programme Proposal (PEP)
Jane Mulholland presented the paper which asked the Joint Commissioning Committee to support the approach taken along with the recommendations agreed at JDG and approved at Executive Committee that;

- The proposed priorities areas are;
  - Planned care particularly around management of patients in primary care
  - Long term conditions building on the Year of Care/House of Care and efficient care pathways
  - Urgent care including promoting the management of children and young people in primary care.
  - Medicines optimisation aligning to the clinical priorities

- Medicines optimisation initiatives align with the clinical areas as far as possible
- The ways of working proposal be adopted
- The delivery team establishes an implementation plan and implement the PEP as in previous years
- Must be targeted, measurable and achievable
- The clinical and management leads in the priority areas take forward the development of specifications ensuring;
  - The PEP is feasible for practices to deliver
  - Reduced requirements
  - A focus on realistic expectations, measurable outcomes and innovation
  - Practice engagement in development
  - There is no duplication with the QOF and basket of care
  - Medicines optimisation initiatives are fully aligned

Due to the limited time, specifications will be developed by the delivery team once the Executive Committee agree the above.

An update on specification development will be provided to JDG by the delivery team in February with the final detailed PEP scheme submitted to JDG and Executive Committee in March.

Jane Mulholland reported that there is no difference to what we have spent in the past and that the Newcastle and Gateshead schemes are now the same.

Any comments/queries please contact Jane Mulholland directly.

2016/01/09 Notification of Proposed Partnership or Practice Changes
Jane Mulholland reported that the Elverston practice in Gateshead have taken on another partner.

2016/01/10 Primary Care Winter Monies
Marc Hopkinson, CCG, joined the meeting for this item and presented the paper which explained that early in December 2015, NHS England had offered Clinical Commissioning Groups (CCGs) the opportunity to submit proposals for additional funding to enhance primary care service provision for patients over the winter period (up until March 2016).
A bid was subsequently developed and submitted by Newcastle Gateshead CCG, following discussions between Clinical Leads and CCG staff. The bid was intended to increase capacity within existing pilot/action research models and schemes that are being implemented by the CCG, assist primary care with the outcomes/learning being used to help inform the final delivery model for urgent primary care across both Newcastle and Gateshead. A total of £925,000 was requested to support two key areas:

1. **Around GP - Increasing capacity in our current initiatives that primarily work in admission avoidance.** Total cost £600,000:
   - Continuing and expanding the Newcastle GP in A&E Scheme with this model being rolled out to the Walk in Centre sites across Newcastle to further ensure access to primary care (£200k). (This is already in place in Gateshead and has worked well)
   - Increasing capacity in the OOHs period - NDUC and GATDOC (£300k).
   - GP’s to support the short stay bed model for patients discharged from hospital (£100k). (Also working with care homes where patients are discharged to).

2. **Within GP - Implementation of locality-based General Practice.** Total cost £325k:
   - Local practices to provide additional evening and weekend sessions for their registered patients in order to meet the demand for urgent, same day patient requests.

Confirmation was received on Friday 8th December in a letter from Christine Keen, Director of Commissioning Strategy that the CCG had been awarded the full £925,000.

Jeff Hurst asked if a report could be brought back showing a qualitative piece of work from practices, quantitative data showing the number of sessions and patients and an evaluation including other CCGs – a full system overview. Jane Mulholland raised a concern that so much has gone into winter that it will be difficult to evaluate directly.

Christine Keen queried if it was possible to get appointments onto 111 and Marc updated that this is not possible in Gateshead at the moment but will be in place by February/March.

Marc Hopkinson added that it would be better to get details of the funding earlier to be able to get practices organised sooner. There are plans to look at the under 5’s as this is a growing key group. Work is also going on with the care home Vanguard to look at the over 75’s.

Mandy Taylor queried that £1 million had been used with no procurement process when other services had had to go through procurement. Christine Keen explained that this is money in the primary care budget for GP services that has not been spent during the year so there was no time to go out to procurement. Jeff Hurst queried if other services/organisations, who could provide this service, could challenge it e.g. NDUC?
John Costello queried the rationale for using the money for just urgent appointments? This is for patients who need to be seen on the same day so they do not go to A&E.

It was noted that there had not been enough time to arrange a media campaign and that everything put in place has been based on reviews completed in previous years.

Jeff Hurst requested that the review goes to the Audit Committee and this Committee.

2016/01/11 Support for Vulnerable Practices
Jane Mulholland presented the paper.

In June this year the Secretary of State for Health announced NHS England would work to develop a £10m programme of support for practices identified in difficulty. The letter sets out how the programme will be delivered and will test how best to identify and support the most vulnerable GP practices. A number of options have been considered, working with NHS Clinical Commissioners and other key stakeholders. Local NHS England teams will be responsible for leading delivery and implementation working in very close collaboration with CCGs. They are looking to secure improvements in vulnerable GP practices to help build resilience in primary care and to support delivery of new models of care. This will provide support to practices under pressure ensuring patients have continued access to high quality care.

It was noted that Newcastle Gateshead does have practices who could access the funds but practices need to match the funding given 50/50. Using the criteria given, to show vulnerable practices, a letter has been sent to practices who were shown to be vulnerable to let them know that they could be eligible for the funding if they want the support but some cannot match the funding. Following this contact with the practices NHS England will have more detailed discussions.

Jeff Hurst queried if these ‘vulnerable’ practices should be added to the CCG risk register but it was reported that they have had their CQC visits and have been rated as good.

2016/01/12 Date & time of next meeting
Tuesday 23rd February 2016
Minutes of the Primary Care Joint Committee Meeting
held on Tuesday 22 March 2016 at 4.30 – 5.30pm

Armstrong Stephenson Rooms, Newcastle Civic Centre,
Newcastle upon Tyne, NE1 8QH

Present:
Jeff Hurst Chair
Neil Morris Medical Director, CCG
Matt Brown NHS England

In Attendance:
John Costello Representative from Gateshead Health & Wellbeing Board
Professor Eugene Milne Representative from Newcastle Wellbeing for Life Board
Jane Mulholland CCG
Lyndsay Yarde HealthWatch Newcastle
Douglas Ball HealthWatch Gateshead
Katharine McHugh CCG
Douglas Ball HealthWatch Gateshead
Louise McAndrew Minute Taker, CCG

2016/03/01 Welcome and Introductions
Jeff Hurst, Chair, welcomed everyone to the meeting.

2016/03/02 Apologies for absence:
Christine Keen NHS England
Mandy Taylor Vice Chair, CCG
Jackie Cairns CCG
Steph Edusei HealthWatch Newcastle
Andrew Moore HealthWatch Gateshead

2016/03/03 Declarations of Interest
There were no specific declarations of interest in relation to the agenda.

2016/03/04 Quoracy
It was confirmed that the meeting was quorate.
2016/01/05 Minutes of previous meeting 26 January 2016
The minutes were agreed as an accurate record.

2016/03/06 Matters arising from the Minutes

See Action Log.

2016/03/07 Newcastle Gateshead Annual Cycle of Business
Matt Brown, NHS England, presented the table which was a start to show the committee when, during the next few months, items may need to come to the committee. He explained that most things can be planned for but there will always be somethings that are unexpected.

Jane Mulholland, CCG, queried where had the evidence come from to go out to procurement for Ponteland Road. Matt clarified that the evidence had been gathered at engagement events that had been arranged by the North of England Commissioning Support Unit (NECS).

It was discussed that the role of the committee would be to give assurance and make sure that due diligence had been observed and the correct process had been followed.

Action: Jeff Hurst asked Matt Brown if the business plan could be worked into the committee’s schedule of meetings.

2016/03/08 Blaydon Practice Consultation End
Matt Brown informed the committee that consultation has now ended and NHS England are about to write out to the patients to inform them.

2016/03/09 CQC Inspection Process Update
This had been circulated for information.
Action: Matt Brown to send Louise McAndrew an electronic copy of the document.

2016/03/10 Primary Care Transformation Update
Neil Morris spoke to the letter which had been circulated which was an update of the process followed and guidance from NHS England regarding the primary care transformation fund for estates and technology.

Jeff Hurst raised concerns that GPs could be submitting bids and then screening bids which would be a conflict of interests but it was explained that all GPs must declare any interests they have and then they would be excluded from the screening process so the people screening would not be bidding. The bids will then go to NHS England who will go through their own process.
Jeff Hurst added that he will be attending the Executive Committee Meeting in April where the bids will be discussed.

2016/03/11 PCC Terms of Reference Review
These will be discussed at a future meeting.

2016/03/12 Healthwatch Newcastle – GP Appointments
Lyndsay Yarde, Healthwatch Newcastle, explained that this was a piece of work that Healthwatch have carried out with Northumbria University looking at what people want when they book appointments. The participants were given scenarios to see what they preferred:
- Speed of appointment
- Who they saw
- Time of appointment.
It showed people were prepared to wait around 5 days to see a GP of their choice or to get a particular time. Older people and women would rather see their preferred GP while young people and men were more concerned about the time of their appointment. The results were also broken down into demographics.

The consultation ended on Friday and the final report is being prepared. It was noted that has been a similar study carried out in Gateshead.

2016/03/13 West 1
Neil Morris, CCG Medical Director, shared an update with the committee regarding the West 1 development noting that in July 2015 representatives from NHS England and Newcastle Gateshead CCG reported that the West One scheme as it was originally conceived could not be progressed in view of the fact that the original proposed tenants had not confirmed their ongoing commitment to the development.

It has now been confirmed that the West One scheme as outlined in the original conception will not proceed and confirmation has been given to NHS Property Services that NHS England has no further proposed use for the land set aside for this development.

Discussions are ongoing with senior representatives from Newcastle City Council and the CCG to review the estate in the west of Newcastle with the intention that any future health premises provision is developed and located in line with a jointly agreed estates strategy which supports the objectives of both organisations in relation to the future provision of health and social care in the area.

Neil added that originally the idea was for a number of practices to come together but views have changed and there is no obvious way to take this forward though something still needs to be done as the premises are not fit for purpose but it is not being discussed currently but the funding may still be available.
Jeff Hurst raised concerns that there does not seem to be a very joined up view as there are some individual practices bidding for improvement funding. Jane Mulholland commented that they are trying to bring everything together. Katharine McHugh informed the Committee that they are liaising with NHS England to bring this into one process and there is to be an Estates Workshop on 20\textsuperscript{th} April to which all practices have been invited as well as the trusts and local authorities.

It was discussed that austerity will also be an issue in the coming years also health and social care integration will need to be taken into consideration. It was also queried where does strategic transformation planning (STP) fit into all of this?

Jeff Hurst queried how not moving forward with the West 1 project leave practices and patients in the West of Newcastle? Micheal Foster, Practice Manager Holmeside, expressed surprise that the scheme had been shelved as the practices have signed a lease. Matt Brown acknowledged that NHS England need to liaise with the relevant stakeholders and that the Strategy Group needs to put a process in place to stop this happening in future as it obviously causes costs to practices.

**Action:** Jeff Hurst asked Matt Brown if this could be brought back to a future meeting as a case study showing the feedback on why the project has been halted

**Action:** Jeff Hurst to have a conversation with Joe Corrigan, CCG Chief Finance and Operating Officer, regarding the planning process.

**2016/03/14 CCG Assurance Framework Delegated Functions**
This paper was for information and it was noted that it had been to the Audit Committee to assure them and this committee that any conflicts of interest that have arisen have been handled correctly.

**2016/01/12 Date & time of next meeting**
Tuesday 26\textsuperscript{th} April 2016
HEALTH AND WELLBEING BOARD AGENDA

Friday, 22 April 2016 at 10.00 am in the Whickham Room - Civic Centre

From the Chief Executive, Jane Robinson

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<td>Apologies for Absence</td>
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<td>2.</td>
<td>Minutes (Pages 3 - 12)</td>
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<td>Minutes of meeting held on 26 February and Action List are attached for approval.</td>
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<td>3.</td>
<td>Declarations of Interest</td>
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<td>Members of the Board to declare an interest in any particular agenda item.</td>
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<td>4.</td>
<td>Items for Discussion</td>
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<td>5.</td>
<td>Newcastle Gateshead CCG Operational and Commissioning Plans 2016/17 (Pages 13 - 30)</td>
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<td>Better Care Fund Submission 2016/17 (Pages 31 - 34)</td>
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<td>7.</td>
<td>Social Prescribing in Gateshead - Update and Next Steps (Pages 35 - 44)</td>
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<td>Report presented by Alice Wiseman</td>
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<td>8.</td>
<td>Personal Health Budgets: Progress Update (Pages 45 - 52)</td>
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<td>Report presented by Julia Young</td>
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<td>Health and Wellbeing Strategy Regional Seminar</td>
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<td>Verbal Update by John Costello</td>
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<td>Items for Information</td>
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<td>11.</td>
<td>Updates From Board Members</td>
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<td>Board members to update on any items for information</td>
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<td>12.</td>
<td>Any Other Business</td>
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<td>13.</td>
<td>Date and Time of Next Meeting</td>
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<td>Friday 10 June 2016 at 10.00 am</td>
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Contact: Sonia Stewart; email: soniastewart@gateshead.gov.uk, Tel: 0191 433 3045, Date: Thursday, 14 April 2016
AGENDA

1. Welcome and Introductions

2. Declarations of Interest

   Please remember to declare any personal interest where appropriate both verbally and by recording it on the relevant form (to be handed to the Democratic Services Officer). Please also remember to leave the meeting where any personal interest requires this.

3. Apologies for Absence

Business Items


   Report by Joe Corrigan, Chief Finance & Operating Officer, NHS Newcastle Gateshead CCG.

An induction loop system is available on request for meetings in the Committee Suit the Civic Centre. Anyone wishing to use this facility should ring the Contact Officer...
5. LGA "Health & Wellbeing Board" peer challenge follow-up

Report by Andrew Lewis, Assistant Chief Executive, Newcastle City Council.

6. Minutes of meeting held on 9 December 2015.

7. Date and Time of Future Meeting

Thursday 7 July 2016 at 4.30 pm, Mansion House, Fernwood Road, Jesmond, Newcastle upon Tyne.