NHS Newcastle Gateshead CCG Operational plan narrative 2015/16

April 2015

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Introduction

We are pleased to submit to NHS England our operating plan in accordance with the assurance process. The plan is underpinned by two nationally mandated excel templates for activity and finance and a UNIFY submission detailing performance targets and trajectories. A rationale for the planning trajectories has also been submitted.

Waterfall charts accompany the narrative for this final submission, which focus on activity and aim to demonstrate the movement from 2014/15 forecast outturn and the 2015/16 CCG plan.

This document is the narrative element which supports our plan and includes reference to all of the Annexe A Fundamental Elements of Operational Plans, as set out in the planning guidance. Wherever possible we have incorporated specifics from the operational plan assurance checklist (strawman) rather than having a number of separate documents.

For ease of reference we have utilised the operational checklist to signpost the reader to the sections of the narrative where we have provided information on which to assure the plan.

We are cognisant that as we have been in transition to form the merged NHS Newcastle Gateshead CCG the document evidences progress in the three former organisations while articulating how we share ambitions and common approaches to meeting the challenges ahead as one organisation.

The plan was agreed at the final meeting of the Joint Governing Bodies on 31st March 2015.

The narrative describes how we have assessed our current position and the progress being made to implement the two year operational plans in light of the Five Year Forward View and covers progress with the two Better Care Fund (BCF) plans and the Newcastle Gateshead health and care economy five year strategic plan.
It sets out our:

- **Achievement and progress to date**
- **How we meet the fundamental elements of the planning guidance**
- **Our reflections on the Five Year Forward View, our local approach to progressing this and opportunities with new models of care**
- **The challenges ahead**

We have reviewed BCF non-elective targets and agreed revisions with partners, ensured that capacity and demand has been modelled and activity and finance assumptions has been triangulated with providers a well as described our position in agreeing and signing contracts with providers.

1. Background

The Clinical Commissioning Groups (CCGs) within the Newcastle Gateshead Alliance, NHS Newcastle North and East CCG, NHS Newcastle West CCG and NHS Gateshead CCG ceased to exist on 31st March 2015; we became NHS Newcastle Gateshead CCG on 1st April 2015.

The narrative was therefore written during a time of transition and bringing three organisations together each of whom have previously had individual plans.

The CCG will retain a clear locality focus in the Newcastle and Gateshead area units of delivery, with one overarching transformational approach that provides a framework for all strategies including the design and delivery of five year plans.

In developing our narrative we have taken the opportunity offered from the 2015/16 operational planning round to assess our current position and the progress being made to implement the two year operational plans.

This review has been undertaken in light of the Five Year Forward View and covers the two Better Care Fund (BCF) plans and the Newcastle Gateshead health and care economy five year strategic plan.

2. Context

Our two year plans 2014/15 – 2015/16 adopted the strategies described in the NHS Outcomes Framework and provide the basis upon which our planning for Better Care Fund and the Five Year Strategic Plan are founded.

This narrative should therefore be read alongside a number of key documents which we have previously published. The links to these documents can be found below:

- Newcastle and Gateshead health and care economy five year strategic plan 2014/15 – 2018/19 http://www.newcastlenorthandeastccg.nhs.uk/wp-content/uploads/sites/3/2014/02/2014-06-NEC_Alliance_strategic-plan_v10.pdf
- Better Care Fund Plans – Gateshead and Newcastle
  http://www.newcastlenorthandeastccg.nhs.uk/news/better-care-fund/
  http://www.gatesheadccg.nhs.uk/news/better-care-fund-2/
- Newcastle 2 year plan (14/16) on a page
  http://www.newcastlenorthandeastccg.nhs.uk/our-latest-news/publications/
  http://www.newcastlewestccg.nhs.uk/news-and-media/publications-2/
- Gateshead 2 year plan (14/16) on a page
  http://www.gatesheadccg.nhs.uk/our-latest-news/publications/
- Newcastle Gateshead Alliance Commissioner Plan 2015/16
  http://www.gatesheadccg.nhs.uk/our-latest-news/publications

Our plans above describe the key health and care challenges in both Newcastle and Gateshead in a context of higher than average levels of deprivation and significant public health challenges which exist in our area. The plans were co-produced in

conjunction with our health and social care partners, directly influenced by our patients and public whom we continue to actively engage as part of our development processes.

Importantly, the establishment of the Accountable Officer forums in Newcastle and more recently in Gateshead enable strategic level oversight and the alignment of provider and commissioner plans.

Operational alignment of commissioner and provider plans is facilitated through the respective System Resilience Groups that inform current contract negotiations.

Our plans set out our collective ambitions for improving the health and wellbeing of our patients and public across Newcastle and Gateshead, outlining similar transformational themes and strategies aimed at improving service, and are underpinned by the following key principles:

> We have ambitious collective leadership through our Accountable Officers forums in Newcastle and Gateshead

- Prevention and early intervention
- Integrated and coordinated primary, community, secondary and social care services supporting patients, as far as possible, in their own home or community
- Timely access to secondary care services for those requiring hospital admission.

3. Achievements and progress to date

This section describes achievements and progress to date on the areas described below, including risks and mitigating actions.

We identified in 2014/15 a number of key ***strategic objectives*** and ***strategic work programmes*** that will deliver and achieve our collective success for the patients and the public of Newcastle and Gateshead which support the delivery of:

- The NHS Constitution
- The NHS Outcomes Framework as represented by the seven national outcome ambition measures as set out in Everyone Counts: Planning for Patients 2014/15 to 2018/19
- The National and local Quality Premium Outcomes
- The National and local CQUIN
- The National and local Better Care Fund Outcomes

The tables within section 3.1 and 3.2 report the current position of the CCGs in delivering our strategic objectives within the five year strategy and achieving the five domains and seven outcome measures set out in the NHS Outcomes Framework.

3.1 Achievements and progress in the Newcastle unit of delivery

Health and Wellbeing partners across the health and care economy have a clear vision for Newcastle in 2018/19, which is as follows:

'People who live and work or learn in Newcastle equally enjoy positive wellbeing and good health'

Newcastle's unit of delivery's strategic objectives are described as follows:

- **Early Intervention -** Improve long term health outcomes through early intervention
- **Complex Needs** - Develop and implement a high quality, accessible integrated health & social care pathway for children & young people with complex care needs
- **Emotional Health** - Enhance emotional wellbeing of children and young people
- **Improve Community Access** - Management and monitoring of planned care and increasing opportunities for admission avoidance through ambulatory care
- **Pathway Redesign -** Reduce unnecessary hospital attendances and effective implementation of an urgent care pathway which ensures appropriate, accessible and timely care delivery
- **Health Outcomes -** Enhanced recovery and/or support to manage condition and improve QOL through enhanced management of long term condition
- **Quality of Life -** Enable more people with mental health to live their lives to their full potential

- **Improve access to services and support for those living with cancer** - Extend and improve range of services
- **Promote choice & experience of end of life care** - Embed shared decision making within normal working practice to empower people to make choices
- **Enhance care outside of hospital** - Support professionals to deliver high quality services
- **Integrate Services** - Provision of a high quality, safe integrated health and social care pathway
- **Enhance management** - Older people with complex needs outside of hospital

Table 1: Strategic objectives and Strategic Programmes

Strategic Programmes (including objectives)	Key work areas 2014/15	Key work areas 2015/16
Children & Young People Improving long term health & wellbeing of children & young people through a focus on: • ***Early Intervention*** • ***Complex needs*** • ***Emotional wellbeing***	• Early years • Primary & Community Pathways • Looked After Children • Continuing Care	• **Pathways:** Promote children and young people friendly services • **Pathways:** Access to the sick and injured pathway • **Continuing Care:** Formalise sub-regional continuing care delivery model. • **Personal Health Budgets:** Promote the personalisation agenda • **CCNT:** Review and revise to ensure offer fits with personalisation • **Complex Needs:** Develop a responsive and seamless system for children with complex needs including joint transitions framework between NCC and the CCG • **Therapies:** Jointly commission a Speech, Language and Communication delivery model. • **Therapies:** Jointly review and draft options appraisal for occupational therapy services • **Therapies:** Support the commissioning of a regional framework for the Independent Special School market under the leadership of NCC. • **Integration:** Promote integrated commissioning and provision of services across health, social care and education
Planned Care Ensuring appropriate demand and increasing access to high quality, safe out of hospital pathways for planned care through: • ***Improved community access*** • ***Pathway redesign***	• Community Based Assessment, Monitoring & Management • Community Based Elective Care Pathways • Referral Management	• **MSK:** Initiate integrated community MSK services through partnership working with providers. • **Care closer to home:** Review elective care pathways to understand the potential for increasing community based services (e.g. ENT; Ophthalmology) • **Shared care:** Strengthen the safe monitoring of DMARD medication and extend the number of shared care guidelines and service agreements to enable monitoring within the community. • **Nurse led clinics:** Implement recommended actions from initial focus on dermatology and wound care nurse led outpatient clinics. Extend the review to ring pessary and pre-assessment clinics • **Social Prescribing:** Implement the Ways to Wellness Social prescribing service. • **Referral Management:** Evaluate and roll out pilot of computerised system

Strategic Programmes (including objectives)	Key work areas 2014/15	Key work areas 2015/16
		prompts for clinical guidelines. • **Improve Effectiveness & Quality:** Agree and implement procedures to improve productivity and reduce use of procedures of limited clinical value
Mental Health & Learning Disabilities Developing high quality, effective and accessible mental health and learning disability services with a focus on: • ***Health outcomes*** • ***Quality of life*** • ***Early intervention***	• Parity of esteem • Pathway Development • Quality & Safety	• **Specialist Services:** Redesign across Newcastle and Gateshead • **Adult ADHD & Autism:** Develop specialist teams and educate community teams in the diagnosis and care of adults with ADHD and autistic disorders • **IAPT**: Work with current services to ensure a seamless patient pathway and enable improvement of quality and performance • **LD:** Develop a strategy for a community based and inpatient service model for LD • **Family Emotional and Mental Health:** Support the collaborative commissioning of future service model for children young people and their families mental health and wellbeing services across Newcastle and Gateshead • **Dementia services**: Continue implementation of strategic priorities – through review of a complete pathway from diagnosis, post diagnostic care, complex need, care in the acute setting and end of life
Urgent Care Ensuring people with acute care needs can be seen in right place at the right time by the right professional through: • ***Pathway redesign***	• Alternative Dispositions • Primary Care	• **Local Strategy**: Development of a local Urgent Care Strategy, which is able to respond 24/7 to both the physical and mental health urgent care needs of people living in Newcastle. • **Model Development**: Exploratory work to test out urgent care options in relation to, out of hours provision (OOH), walk in centre's and NHS 111 to inform the final urgent care delivery model.

Strategic Programmes (including objectives)	Key work areas 2014/15	Key work areas 2015/16
Long Term Conditions, Cancer and End of Life Promoting self-management. Empowering and supporting people with long term conditions to lead full and active lives with a focus on: • ***Early intervention*** • ***Quality of life*** • ***Community access*** Ensure people living with cancer or approaching end of life regardless of condition are able to easily access clinical expertise and holistic personalised care delivered with human compassion through: • ***Improved access to services and support for those living with cancer*** • ***Promotion of choice and experience of end of life care*** • ***Enhancing care outside of hospital***	• Pathway Development • Quality & Safety • Ways to Wellness • Community based services • End of Life	• **Hypertension:** Implement recommendations from 24 ambulatory blood pressure monitoring review • **Diabetes:** Procure new diabetes education service and review design and capacity of wider community diabetes service to produce an option appraisal including economic assessment of future state service • **COPD**: Implement pulmonary rehabilitation service and work with partners to review and redesign full COPD pathway including development of diagnostic spirometry service • **Heart Failure**: Review current pathway • **Cancer:** Implement cancer priorities including end of life standards of care, support mechanisms for those living with and surviving cancer (commence: breast, colorectal and prostate) and identify opportunities to move cancer treatments into the community / closer to home (commence: PSA) • **End of Life:** Develop end of life pathways for adults and children / young people and continue roll out of North of Tyne End of Life documentation
Older Person Promoting quality of life and independence for individuals, carers and families of the older person with complex health & social	• Case Finding • Intermediate Care • Hospital Care	• **CRRT:** Review service implementation to date and understand potential to move to phase 2 of the programme. • **Care outside of hospital and early intervention:** To explore contracting and currency options for people over 75 • **Care homes:** Continue roll out and increase scope of structured care programme. • **Intermediate Care:** Map current state and agree future need for intermediate care provision

Strategic Programmes (including objectives)	Key work areas 2014/15	Key work areas 2015/16
care needs through: • ***Integration of services*** • ***Enhanced management*** *Health & Social Care Integration and Transformation Programme*		• **Carers:** Identify strategic priorities for carers and re-procure carers support services • **Loan Equipment:** Implement any agreed recommendations from review

Table 2: Achievement in 2014/15 against the national outcome ambition measures

Outcome ambitions	What we said we were going to do in 2014/15	Progress to date	Actions required in 2015/16
Securing additional years of life for the people of England with treatable mental and physical health conditions	3.2% reduction from a baseline of: 2125 (NNE) 2814 (NW)	The latest position (2013) shows the following reductions: 17.5% (NNE) 21% (NW)	Main cause - Smoking related Lung cancer and CVD (AF and hypertension): • Further campaigns to improve screening and cancer awareness • New distributed model of stop smoking service. • PEP programme for prevalence and case finding • Increase the range of community settings through which NHS Health checks
Improving the health related quality of life of the 15 million+ people with one or more long term condition, mental health conditions (4 measures)	Average EQ 5D score: 1% annual improvement from a baseline of: 0.718 (NNE) 0.70 (NW) Improving access to Psychological therapies (achieve 15% by March 2015) Achieve IAPT recovery rate 50% by March 2015 Increase dementia diagnosis rate to 67% by March 2015	The latest position (2013/14) shows: 0.724 (NNE) 0.69 (NW) Projected outturn for 2014/15 YTD: 10% (NNE) 8% (NW) Projected outturn for 2014/15 YTD: 43% (NNE) 43% (NW) Projected outturn for 2014/15 Jan – YTD: 67% (NNE) 60% (NW)	LTCs and Mental health programme boards have a number of work streams that are tackling the care for people with LTCs with both physical and mental health components: • Mental health access to community based care pathways and older people service (e.g. dementia care) • PEP work around dementia diagnosis and prevalence figures across General Practice • Care planning programmes for people at risk of hospital admissions. • Disease specific programmes of work to promote holistic care closer to home (e.g. cardiac and pulmonary rehabilitation) • 3rd sector and voluntary alignment to tackle social isolation and loneliness – social prescribing concept • Adoption of YOC model and patient orientated goal setting

Outcome ambitions	What we said we were going to do in 2014/15	Progress to date	Actions required in 2015/16
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community outside hospital	Composite indicator 2% reduction in year 1	The latest position (Nov 2014): NNE Target YTD: 1488.5 Actual YTD: 1615.5 NW Target YTD: 1659.5 Actual YTD: 1787.5	Further implementation of Better Care Fund programmes of work: • Intensive case management (70 years plus) • GP-led patient-centred care (65 years plus, 2 LTCs, less 2 admissions in 12 months) • Integrated prevention, early diagnosis and management system On-going work in our older people strategic programme with all stakeholders and Public health to promote wellness, primary prevention of disease and frailty care. Community service review to focus on closer to home care and alignment of services for older people that enhances rehabilitation, reablement and recuperation
Increase the proportion of older people living independently at home following discharge from hospital	From a baseline of 84.69% increase to 85.5% in year 1	Latest position for Newcastle (Q2 YTD) 88.7%	As above Further implementation of Better Care Fund programmes of work with a specific focus on the: • Intensive case management (70 years plus) • GP-led patient-centred care (65 years plus, 2 LTCs, less 2 admissions in 12 months) On-going work in our older people strategic programme with all stakeholders and Public health to promote wellness, primary prevention of disease and frailty care. Community service review to focus on closer to home care and alignment of services for older people that enhances rehabilitation, reablement and recuperation
Increasing the number of people having a positive experience of hospital care	0.5% annual improvement from a baseline of: 81.7% (NUTH NHS FT)	The latest position shows an increase to: 82.2% (NUTH NHS FT)	On-going work on pathway redesign to encourage improved care within hospital and improve experience. On-going work through our quality programme with our acute Trust to promote a positive experience during hospital

Outcome ambitions	What we said we were going to do in 2014/15	Progress to date	Actions required in 2015/16
			attendances or stays.
Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and community	1% annual improvement from a baseline of: 70.21%	Latest position (2013/14) shows a decrease in reported positive experience to: 66.22%	On-going work on pathway redesign to encourage care closer to home and promote a positive experience with care provision by our providers of community services and General Practice. On-going work through our quality programme with our community provider to improved care out of hospital. PEP programmes with General Practice to improve quality and experience in care provision. Further exploration of patient experience is to be undertaken to ensure that the provider led surveys are representative of patient experience. This could be via existing patient forums. Analysis of General Practice level results of the National GP Patient Survey is to be undertaken to review for outliers.
Making significant progress towards eliminating avoidable deaths in hospital	Improving the reporting of medication errors – minimum 20 incidents to be reported MRSA 0 tolerance Cdiff reduction. Maximum threshold: NNE 43 NW 25	Latest position (Dec 2014) : 73 (NNE) incidents reported 62 (NW) incidents reported NUTH 4 CCG 0 27 (NNE) 42 (NW)	On-going work through our quality programme with our acute Trust to promote quality and reduce avoidable deaths. The Safeguard Incident Reporting and Management System (SIRMS) was implemented across the Alliance CCGs in April 2014, allowing practices to report incidents occurring in primary care or commissioned service providers.

3.2 Achievements and progress in the Gateshead unit of delivery

Health and Wellbeing partners across Gateshead's health and care community has a clear vision for the local system by 2018/19:

'An affordable, locality-based, wider care system that delivers responsive, needs-based, personalised and empowering care'

Gateshead's unit of delivery's strategic objectives are described as follows:

- Coordination and continuity of care
- Delivery across fitness to frailty
- Greater focus on prevention and re-ablement
- More choice, control and independence
- Confidence and trust in a safe health and care system
- Shift from reactive to responsive services
- Less complex, more sustainable system.

Table 3: Strategic objectives and Strategic Programmes

STRATEGIC PROGRAMMES	Key work areas 2014/15	Key work areas 2015/16
Collaboration and Wellness Programme Tackling major health challenges through citywide initiatives that promote economic prosperity, wellness and helps to reduce health inequalities – leadership by public health and overseen by the Health and Wellbeing Board.	VCS review of services Children, Young People and Families Programme board reviewing services across Gateshead and Newcastle Parity of esteem Mental health programme board reviewing mental health provision across Gateshead and Newcastle Introduction of integrated wellness model in Gateshead Roll out of primary prevention strategies (e.g. NHS health Checks etc.)	Implementation of the VCS reviews – alignment of VCS to programmes of work and new models for partnership working. Children, Young People and Families • **SEND** reforms • **Review** Children's Community Nursing in partnership with the LA and clarify support for GP practices • **Implement** Personal Health Budgets • **Ensure** that children are supported as they transition to adult services • **Work with** social care partners to embed a formal continuing care process aligned to EHC Planning/Commissioning processes • **Review** and clarify process for providing paediatric equipment service Mental health programme: • **Specialist Services: redesign** across Newcastle and Gateshead • **Develop** specialist teams and education of community teams in the diagnosis and care of people with adult ADHD and autistic disorders • **IAPT**: work with current services ensuring the patient pathway is seamless, and enabling deliver of all KPI’s • **Develop** a strategy for a community based and inpatient service model for Learning Disabilities • **Support** the collaborative commissioning of future model of Children Young people and their families mental health and wellbeing services across Newcastle and Gateshead • **Dementia services**: continue implementation of the strategic priorities – through review of a complete pathway from diagnosis, post diagnostic care, complex need, care in the acute setting and end of life

STRATEGIC PROGRAMMES	**Key work areas 2014/15**	**Key work areas 2015/16**
Coordination and Personalisation Programme Personal budget approaches for people with LTC. A whole-system integrated model of cares across health and care systems (BCF). Funding solutions will underpin true coordinated care delivery that is designed by patients and the public to meet their health and wellbeing needs.	Development and implementation of the Better Care Fund initiatives	Implementation of the 11 BCF initiatives and monitoring toward achievement of the national BCF measures. For example, some of the initiatives include: • SPOA – opening Feb 2015 • Intermediate care expansion – 24/7 unit opening March 2015 • Care home expansion – all care home covered with OPNS by June 2015 • Urgent Domiciliary support service – new team in place by April 2015 • Palliative care pathway review and strategy implementation • Alignment of health and social care discharge teams.
Closer-to-home, Locality-based care Programme GP practices and wider primary care teams will be working within locality-based units. These teams will provide localism but with an organisational footprint at scale allowing for a greater range of care being provided. There will be a drive towards enhanced care 24 hours a day, 7 days a week.	Review of community services in Gateshead Commenced Primary Care Strategy Programme across Gateshead and Newcastle for completion of the strategy in 2015/16 Improve quality and reduce variation in General Practice through the PCCP programme. Review of diabetes care for future diabetes community-base model in Gateshead Introduced care planning promotion and support across General Practice and self-care review with successful funding to implement YoC in 2015/16	Expansion of locality-based provision within Primary Care and reduce variation across General practice • Develop a Primary Care Strategy and explore implementation across Gateshead • Community service re-procurement continues • Continued work around care delivery on 5-localities • Continued work to promote alignment of managerial tasks across General Practice • Develop Practice Engagement Programme (PEP) based on the PCCP quality programmes over last 2 years Expansion of delivery for LTC within primary care: • Develop an integrated plan for respiratory disease (COPD/asthma), reducing inappropriate admission and providing greater care within Primary Care. • Improve access for effective heart failure services, including use of community-based IV therapies • Develop a self-care model for LTCs and implement YOC model and generic rehabilitation model • Community-based services (DM, heart failure) • Review of Stroke/TIA pathways aiming for a hyper-acute stroke model • Implementation of community-based diabetes model

STRATEGIC PROGRAMMES	Key work areas 2014/15	Key work areas 2015/16
Responsive, needs-based care Programme A transformational shift that is proactive as well as responsive to reduce crisis. The system will be simple to navigate, with the senior decision-making that can facilitate patient flow across a pathway of care.	Alignment of WIC, A&E – opening of new ECC at GHFT Establish Ambulatory care pathways within GHFT and across community Introduce 'care planning' alignment across primary, community and secondary care for people at risk of hospital admission Align DOS and SPN for appropriate navigation across the system	Implementation of the national Urgent and Emergency care review, including: • Develop local Urgent Care Strategy – including a review of the GP OOH model and community service rapid and intermediate care response provision • Develop a faster and consistent same day, every day access model in primary care for people with urgent care needs. • Develop a fully integrated IT infrastructure to enable sharing of information between clinicians to allow effective treatment to be provided, whatever the time or wherever the setting (including roll out of EMIS web and standardised care planning tools) • Review models of care to ensure patients with mental health problems have access to appropriate and timely mental health crisis support and A&E. • Expand the ambulatory care provision, front door and acute physician model within GHFT and alignment of support discharge teams. • Develop an integrated and consistent service model including co-location of primary care at the A&E department and each of the Walk in Centre sites (based on the outcomes of the Walk in Centre review)

STRATEGIC PROGRAMMES	Key work areas 2014/15	Key work areas 2015/16
Effective planned care Programme More elective care will be managed within general practice - enhanced through recognised best practice approaches (e.g. enhanced recovery and shared-decision making concepts). Patients will have access to the care they need in the right place at the right time. Elective care will be developed using the following principles: • Shared decision making • Screen procedures of limited clinical value • Patients not listed until fit for surgery • Procedures close to home • SOS follow up	Introduced shared-decision making across General Practice Completed Independent Funding Requests (IFR) Reviewed nurse–led clinics/C2C policy. Reviewed MSK pathway	Working towards the achievement of improved productivity gain, including • **Care closer to home** – deliver and review outpatient activity, particularly focussing on alternative ways to managing review appointments • **Non - urgent eye care pathways** – review and transform • **Shared care** – review arrangements for DMARDs for rheumatology, dermatology and gastroenterology • **Nurse-led clinics** - continue to review specifically related to pre-operative assessment • **MSK pathways** – to be implemented • **Agree and implement** procedures of LCV

Table 4: Achievement in 2014/15 against the national outcome ambitions measures

Outcome ambitions	What we said we were going to do 2014/15	Progress to date	Actions required in 2015/16
Securing additional years of life for the people of England with treatable mental and physical health conditions	3.2% reduction from a baseline of 2720.6	The latest position (2013) shows following reduction: 20.7%	The priority diseases areas to close the life expectancy gap in Gateshead includes: • Cancer • Cardiovascular • Gastrointestinal mortality • Respiratory conditions Ensure the quality of provision for preventative measures including targeting practices with high smoking prevalence, reducing alcohol consumption by screening and brief intervention, developing an approach to diabetes prevention and developing NHS Health Checks plus programme jointly with the LA. Embed early identification and intervention with a specific focus on those at increased risk including Health checks programmes, cancer profiles for practices and targeting work, Case finding AF and the PEP programmes for disease prevalence as well as a review of the diagnostic pathways
Improving the health related quality of life of the 15 million+ people with one or more long term condition, mental health	Average EQ 5D score: 1% annual improvement from a baseline of: 0.718	The latest position (2013/14) shows a reduction: 0.712	LTCs and Mental health programme boards have a number of work streams that are tackling the care for people with LTCs with both physical and mental health components:

Outcome ambitions	**What we said we were going to do 2014/15**	**Progress to date**	**Actions required in 2015/16**
conditions (4 measures)	Improving access to Psychological therapies (achieve 15% by March 2015) Achieve IAPT recovery rate 50% by March 2015 Increase dementia diagnosis rate to 67% by March 2015	Projected outturn for 2014/15 YTD: 16% Projected outturn for 2014/15 YTD: 54% Projected outturn for 2014/15 Jan – YTD: 68%	• Mental health access to community based care pathways and older people service (e.g. dementia care) • PEP work around dementia diagnosis and LTC prevalence figures across General Practice • Care planning programmes for people at risk of hospital admissions. • Disease specific programmes of work to promote holistic care closer to home (e.g. cardiac and pulmonary rehabilitation) • 3rd sector and voluntary alignment to tackle social isolation and loneliness – social prescribing concept • Adoption of YOC model and patient orientated goal setting. • Development of multi-morbidity clinics in Primary, Secondary and Community Care will be included within the YOC approach.
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community outside hospital	Composite indicator 2% reduction in year 1	The latest position (Nov 2014): Target YTD: 1810.8 Actual YTD: 1905.8	Further implementation of Better Care Fund programmes of work which include sour 11 schemes, especially around: • SPOA • Ambulatory care pathways • Expansion of community beds • Urgent domiciliary support service • Alignment of support discharge teams • Seamless falls service • Frailty programme – locality-based

Outcome ambitions	**What we said we were going to do 2014/15**	**Progress to date**	**Actions required in 2015/16**
			teams Community service review to focus on closer to home care and alignment of services for older people that enhances rehabilitation, reablement and recuperation
Increase the proportion of older people living independently at home following discharge from hospital	From a baseline 86% increase to 87.7% in year 1	Latest position (Q2 YTD) 85.5%	Further implementation of Better Care Fund programmes of work which includes our 11 schemes, especially around: • Expansion of community beds • Urgent domiciliary support service • Alignment of support discharge teams • Seamless falls service • Frailty programme – locality-based teams • Seamless dementia pathway • Seamless palliative care pathway • Ambulatory care pathways Community service review to focus on closer to home care and alignment of services for older people that enhances rehabilitation, reablement and recuperation.
Increasing the number of people having a positive experience of hospital care	0.5% annual improvement from a baseline of: 78.7% (GHNHSFT)	The latest position shows an increase to: 81.5% (GHNHSFT)	On-going work pathway redesign to encourage improved care within hospital and improve experience. On-going work through our quality programme with our acute Trust to promote a positive experience during hospital attendances or stays.

Outcome ambitions	What we said we were going to do 2014/15	Progress to date	Actions required in 2015/16
Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and community	1% annual improvement from a baseline of: 68.5%	Latest position (2013/14) shows a decrease in reported positive experience to: 67.1%	On-going work pathway redesign to encourage care closer to home and promote a positive experience with care provision by our providers of community services and General Practice On-going work through our quality programme with our community provider to improved care out of hospital: PEP programmes with General Practice to improve quality and experience in care provision: Further exploration of patient experience is to be undertaken to ensure that the provider led surveys are representative of patient experience. This could be via existing patient forums. Analysis of General Practice level results of the National GP Patient Survey is to be undertaken to review for outliers and support development of YOC approach..
Making significant progress towards eliminating avoidable deaths in hospital	Improving the reporting of medication errors – minimum 20 incidents to be reported MRSA 0 tolerance Cdiff reduction. Maximum threshold: 62	Latest position (Dec 2014) shows: 182 incidents reported GHNHSFT 0 CCG 2 57	On-going work through our quality programme with our acute Trust to promote quality and reduce avoidable deaths: The Safeguard Incident Reporting and Management System (SIRMS) was implemented across the Alliance CCGs in April 2014, allowing practices to report incidents occurring in primary care or commissioned service providers.

3.3 So what difference are we making for our public and patients?

We have made excellent progress on setting the foundations for our future local health and care economy, for delivering more care in or closer to people's homes, joining up health and social care and agreeing a way forward for local hospital service. Our achievements to date (as shown in the previous tables) mean that the public and patients of Newcastle and Gateshead will have a greater choice and access to services that provide high quality, safe care as well as feel empowered to self-care and supported to achieve wellbeing. Therefore, what has changed for patients is:

- More people having access to wellness programmes and preventative services (e.g. smoking, weight management)
- More people having preventative health checks than ever before within Primary Care.
- More people being identified with an underlying Long Term Condition and receiving appropriate care
- More people accessing IAPT services for mental health problems
- More people at risk to hospital have a care plan which is shared across the whole system
- More people with Long Term Conditions (e.g. diabetes, complex needs) are being managed closer to home
- Less older people from care homes are going into hospital (inappropriately) and being managed within the community
- More people being diagnosed with dementia early and receiving appropriate care
- More acutely unwell children receiving care in a centre of excellence
- More recording and management of quality and safety concerns across the system.

Table 5: Gives a high level overview of the risks and mitigating actions in achieving delivery

Risks	Mitigating Actions
The plan and supporting initiatives do not enable resources to be redirected towards redesign of care pathways towards closer-to-home care	Our plans are designed for the best interest of patient and the public to make a sustainable local health and care economy. Pathways have an evidence base, are best practice concepts and are what works locally. These 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.
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 through BCF (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. We have robust resilience plans in place that has been successful over the last few years, which we will continue to focus on, adapt and consider implications of increasing pressures. 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.
Relationship challenges – commissioner and providers	Our local system has good working relationships in place across the local health and care sector. Our 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. We will aim to develop a concordant/compact between commissioners and providers on ways of working and sign up to this common approach for the local health and care economy
IT infrastructure/sharing arrangements are not	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. The IT programme board has a clear strategy with outcomes

Risks	Mitigating Actions
fit for purpose to support plan delivery.	that have been worked through from all providers and are working towards an aligned system that allows a whole–system approach to care delivery.
Cultural changes required and change to working behaviours/skills not adequately addressed.	Work will be undertaken with stakeholders and employees across the sector to address this requirement, with input from Health Education North East as required who have been invited to discuss this issue at our HWB.
There is a disconnect between commissioner and provider plans	Our plans for 2015/16 have been developed in the context of a whole system view consistent with our HWB strategies. 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. Providers are core and key to all service changes and are actively co-producing the system transformation and how delivery will be implemented The BCF Strategy Group and System Integration Programme Board will have a focus on planning for long term sustainability.

3.4 CQUIN

During the past year, in collaboration with providers, the Alliance has begun a process of developing clinically-led 2 year CQUINs. This is in order to enable stability of services in transition to new ways of working and to embed changes over a longer time period.

Key improvements in CQUINS developed under this new process, and the benefits they have brought, include:

- Both major acute providers have developed and are implementing a protocol for discharging frail elderly patients from hospital. Planning for the patient going home begins as soon as possible after they are admitted and involves multi-disciplinary approach involving the patient, their relatives or carers, clinical teams and social care. Evidence suggests that a collaborative approach to discharge from hospital for frail patients helps to reduce the risk of re-admission.

- All nursing and clinical staff delivering end of life care are being trained in the new care arrangements following the withdrawal of the Liverpool Care Pathway. This ensures that appropriate support for patients and families at end of life is in place when needed.

- 85% of all outpatient letters are now sent electronically to GPs within 14 days of an outpatient appointment. This allows GPs to ensure that any changes to medications, or required clinical follow-up, are in place in a timely manner.

- Over 90% of patients aged over 75 admitted to hospital as an emergency are now assessed for signs of dementia. Of those patients that are identified as potentially having dementia.

3.5 Quality Premium

The Quality Premium is intended to reward CCGs for improvements in the quality of services that they commission along with associated improvements in health outcomes and reducing inequalities for patients and the public. The Quality Premium comprises a set of national and local indicators, set against the 5 domains of the outcomes framework, against which CCGs are assessed.

Current progress for Newcastle and Gateshead CCGs in 2014/15 demonstrates achievements in some of these areas, and NHS Newcastle Gateshead CCG is currently assessing the newly published guidance for 2015/16 with a view to making further quality improvements going forward.

3.6 Better Care Fund (BCF)

Our BCF plans (Newcastle and Gateshead) promote closer collaboration between health and social care, and are a catalyst for the integration of services. The plans in each of the units of delivery describe how the local single pooled budget will be developed to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

The BCF plans are critical components of our five year strategic plan and are designed to produce year on year quantitative improvement in patient health and wellbeing outcomes across a number of demographic and public health areas.

Section 75 of the 2006 Act, gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

Section 75 agreements are now in place for both Newcastle and Gateshead units of delivery setting out the terms on which the partners, have agreed to transact the BCF

Significant analysis of health need and the system challenges has been undertaken in each unit of delivery in partnership with public health to support the development of improvement trajectories that will be delivered through our integration and transformation proposals.

Within each of our BCF plans we have identified a defined set of metrics, which compliment other success and patient outcome measures.

3.6.1 Reducing non elective admissions

Demand profiles have been shared with providers as part of the 2015/16 contract negotiations. Whilst our net demographic pressures have been assessed at 0.8%, non-elective activity growth in the current year is not consistent with this.

Table six, details a comparison of the year on year non elective activity up to, and including December 2014. It tends to indicate that non elective activity admissions excluding ambulatory care, of patients in Gateshead has reduced 3.2%, conversely for Newcastle patients non elective activity has increased 2.2% (being the composite of 2.6% increase in Newcastle North and East CCG and 1.6% increase in Newcastle West CCG).

Table 6: details a comparison of the year on year non elective activity

Number of Non-Elective Admissions										
Admission Method	Gateshead			Newcastle North and East			Newcastle West			Aggregate variance
	2013/14	2014/15	Var	2013/14	2014/15	Var	2013/14	2014/15	Var	
Ambulatory care	36	2,378	6505.6%	1	7	600.0%	2	9	350.0%	6038.5%
General and Acute										
A&E	11,988	12,607	5.2%	5,583	6,254	12.0%	6,160	6,946	12.8%	8.7%
Bed bureau	144	140	-2.8%	2,356	2,054	-12.8%	2,619	2,096	-20.0%	-16.2%
Consultant Clinic	877	788	-10.1%	860	817	-5.0%	905	903	-0.2%	-5.1%
GP	4,137	2,988	-27.8%	809	805	-0.5%	865	772	-10.8%	-21.4%
Hospital Transfer	237	268	13.1%	99	27	-72.7%	114	22	-80.7%	-29.6%
Maternity	749	764	2.0%	677	589	-13.0%	707	715	1.1%	-3.0%
Other	573	567	-1.0%	682	805	18.0%	785	923	17.6%	12.5%
General and Acute Total	***18,705***	***18,122***	***-3.1%***	***11,066***	***11,351***	***2.6%***	***12,155***	***12,377***	***1.8%***	***-0.2%***

In accordance with planning guidance we have worked with our system partners through the Health and Wellbeing Boards to review our BCF non elective reductions in light of these changes and ongoing winter surge activity. As part of this work we have also undertaken comparative analysis, including amongst other issues additional winter beds and surge capacity compared to previous years.

We have concluded at the time of writing that a 3.0% reduction in Gateshead non-elective admissions remains challenging but achievable, however in respect of the Newcastle BCF we now believe a non-elective reduction of 1.8% on baseline is more appropriate and forms part of our updated planning assumptions.

The changes to the non elective reductions in Newcastle were approved by the Chair of Newcastle Wellbeing for Life Board in accordance with the agreed process.

Due to scheduling issues for the Gateshead Health and Wellbeing Board the non elective reductions will be agreed at the April board, but were agreed with all system partners at the Gateshead System Resilience Group in February 2015.

3.6.2 Progress to date

We continue to use the opportunities afforded by the BCF pooled budget to work with partners in clearly articulating a number of transformation schemes for the integration of care, which will provide better support at home and earlier treatment in the community to prevent the need for emergency care or care home admission.

Within each unit of delivery strategic partnership groups have been established to oversee the implementation of the BCF initiatives and programmes with progress measured on an agreed basis.

All initiatives and programmes are integrated into the CCG Commissioner Plan for 2015/16.

Our strong transformation programme governance provides a forum for discussion beyond the specific areas of focus contained within the BCF, creating a catalyst for the broader integration that we aim for. As articulated in our five year strategic plans key interdependencies such as workforce planning, funding alignment, contract review and partnership development is being addressed in relation to the BCF programme.

> Colleagues from the CCGs and LAs continue to make best use of the BCF (KPMG) support such as Virtual clinics and coaching support to gather insight and good practice to help us overcome the barriers to successful implementation of BCF plans

Throughout this process we focus on public participation and engagement, as we understand their critical role in the development of our new 'care model'.

Within Newcastle unit of delivery the BCF has seen work towards:

- Enhancing and expanding the functionality of the existing integrated Community Rapid Response Team
- Introduction of a programme of proactive geriatric assessment and community follow up
- Expansion of the care homes programme
- Establishment of a link geriatrician role to allow older people with sever frailty to be managed in their own home
- Development of a whole system integrated pathway for chronic heart failure management
- Enhancing capacity and capability within palliative and community nursing to support people to die in their place of choice

Within Gateshead unit of delivery the BCF has seen work towards:

- Establishment of a Single Point of Access for all intermediate and health care urgent needs
- Expansion of the care home programme
- Establishment of a care home of excellence - 24/7 nursing, expanded IC bed provision
- Nurse consultant post for 'frailty care'
- Alignment of all discharge teams across health and social care
- Establishment of community-based MDT (for care home provision)
- Community-based palliative care provision

3.7 Meeting the fundamental elements

This section describes in detail how we are meeting the fundamental requirements set out within the national planning guidance. Key areas of the fundamentals are also referenced in earlier sections of this narrative.

Outcomes

3.7.1 Delivery across the five domains

See section 3.

3.7.2 Improving health

Commissioning for Value-packs

In the Five Year Strategic Plan we articulated where the commissioning for value opportunities were within Newcastle and Gateshead and these were used to develop the two year operational plan 2014/15 – 2015/16.

Many of these opportunities are helping to address health inequalities and our aim to close the life expectancy gap. We are now developing our programmes of transformation utilising the Commissioning for Value: Pathways on a Page. We will continue to assess progress and outcomes related to these pathway improvements.

The table below summarises the key value opportunities identified for each CCG.

Table 7: Summary: Commissioning for Value

Value opportunities	Newcastle North and East CCG	Newcastle West CCG	Gateshead CCG
Quality and Outcomes	Cancer & Tumours Circulation Problems (CVD) Mental Health Problems Respiratory System Problems	Cancer & Tumours Respiratory System Problems Circulation Problems (CVD) Trauma & Injuries Gastrointestinal	Circulation Problems (CVD) Endocrine, Nutritional and Metabolic Problems Mental Health Problems Respiratory System Problems Trauma & Injuries
Acute and prescribing spend	Gastrointestinal Cancer & Tumours Respiratory System Problems Circulation Problems (CVD) Neurological System Problems	Gastrointestinal Cancer & Tumours Neurological System Problems Respiratory System Problems Circulation Problems (CVD)	Cancer & Tumours Circulation Problems (CVD) Gastrointestinal Musculoskeletal System Problems Respiratory System Problems
Spend and Quality / Outcomes	Cancer & Tumours Circulation Problems (CVD) Respiratory System Problems Mental Health Problems	Cancer & Tumours Respiratory System Problems Circulation Problems (CVD) Trauma & Injuries Gastrointestinal	Cancer & Tumours Circulation Problems (CVD) Gastrointestinal Respiratory System Problems Trauma & Injuries

3.7.3 Improving health and reducing health inequalities

We have reviewed and amended the following sections in light of the valuable feedback received from public health colleagues as part of the assurance meeting with NHS England.

We are aware of the estimate that 15-20% of the life expectancy gap can be directly influenced by healthcare interventions. A number of evidence-based high impact interventions have been shown to work in tackling health inequalities and reducing the gap in life expectancy. These include:

- Increased prescribing of drugs to control blood pressure;
- Increased prescribing of drugs to reduce cholesterol;
- Increase smoking cessation services;
- Increased anticoagulant therapy in atrial fibrillation;
- Improved blood sugar control in diabetes;

3.7.4 Newcastle unit of delivery – reducing health inequalities

> Our approach to diabetes prevention remains a key priority for us and we look forward to the development of the new national programme to enhance our services locally.

The population of Newcastle is approximately 282,000 and is projected to rise over the next few years as a consequence of demographic shift, changes in social structure and migration. The City's population profile reflects its very large student population, and the changing nature of the population is reflected in a much increased ethnic minority element in recent years. Around 30% of primary school intake is now from BEM groups.

Life expectancy has risen in Newcastle, as in the rest of the North East. The pace of this rise has exceeded national averages, particularly for men, but the degree of that excess is small and would take many decades to reach national mean or best rates.

As elsewhere, the fastest growing elements of the population will be in older age groups, and the city places great emphasis on becoming age-friendly. Claims made elsewhere that life expectancy rises have slowed or reversed in older people (which have been attributed to austerity) are not apparent in Newcastle.

Inequalities between socio-economic groups are wide, and internal analysis suggests that this is very largely related to absolute levels of poverty and disadvantage in the lower deciles of the socioeconomic scale.

Information detailing the position of Newcastle on a range of indicators is available in the Newcastle Future Needs Assessment - NFNA (the JSNA equivalent) which can be accessed at:

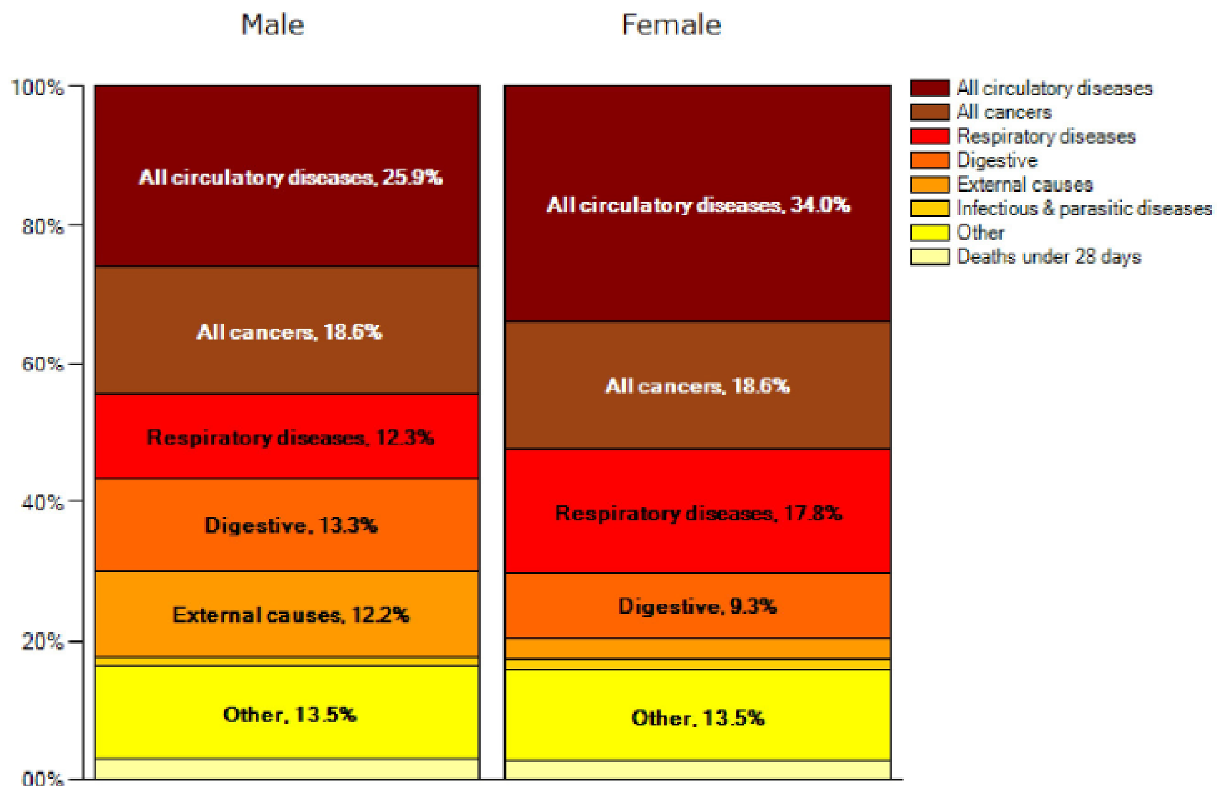
http://www.wellbeingforlife.org.uk/newcastle-future-needs-assessment

The NFNA has been developed under the auspices of the Wellbeing for Life (Health and Wellbeing equivalent) Board with the full engagement of all partners.

Some headline indicators of success include the continued rise in breastfeeding rates in the city and the continued, dramatic fall in teenage conceptions that has been in progress since 2007. Measures of obesity in school age children show signs of a curtailed rise or even of a slight fall, though they remain high and require much further attention.

Less satisfactory figures include a continued very low rate of drug and alcohol treatment completions and a small reversal of the previous downward trend in smoking prevalence in the last two years.

The principal drivers of mortality inequalities in Newcastle are illustrated in these scarf diagrams as comparisons with averages for England:



These drivers of mortality, together with the outstanding causes of morbidity in our community (mental health conditions and musculoskeletal disorders) inform the Wellbeing for Life Strategy, which is jointly owned by the constituent members of the Wellbeing for Life Board.

http://www.wellbeingforlife.org.uk/our-strategy

Evidence suggests that 10-20% of the overall life expectancy gap can be directly influenced by healthcare interventions. A number of evidence-based high impact interventions have been shown to be of use in tackling health inequalities and reducing the gap in life expectancy. These include:

- Increased prescribing of drugs to control blood pressure;
- Increased prescribing of drugs to reduce cholesterol;
- Increase smoking cessation services;
- Increased anticoagulant therapy in atrial fibrillation;
- Improved blood sugar control in diabetes;

In truth, the potential of smoking cessation services to reduce inequalities is limited by the very small impact that such services have on overall prevalence of smoking, despite being highly cost-effective interventions to assist individuals in quitting. All of the substantial influences on smoking prevalence and inequalities tend to lie in the areas of broader tobacco control and prevention rather than in smoking cessation per se.

The last few years have seen a national move away from Stop Smoking Services (SSS) as a route for quit attempts. It appears increasingly likely that this has been

driven by individuals opting for self-directed quit attempts using e-cigarettes. Nationally, this trend appears to have been associated with a more rapid fall in smoking prevalence. However, to date in Newcastle, we have seen a fall in SSS demand but no concomitant fall in prevalence.

Review of the throughput of SSS in Newcastle in recent years shows much poorer performance and value for money than services elsewhere within the region, with an excessive focus on specialist provision. As a consequence, it is proposed that the Newcastle City Council will tender the service during 2015 to secure a better value for money and more effective provision.

We are also looking to collaboration across sectors to increase smoking cessation among those with a chronic disease – notably for COPD. This will be a proposed quality measure for General Practice in 2015-16.

As smoking during pregnancy has been identified as probably the number one cause of adverse outcomes for babies we have worked closely with Newcastle Hospitals NHS Foundation Trust to implement Babyclear. This has seen a positive impact on smoking at time of delivery statistics in recent months. Our Health visiting service also plays a key role in supporting women and their families to stop smoking during the antenatal period with discussions as relevant at every visit.

The Newcastle Health Check programme was established originally to run exclusively through general practice, and paid a fee per completed check that was among the highest in the country. This resulted neither in markedly higher throughput nor in better targeting to deprived areas. As a consequence, the programme is being substantially overhauled. In future it will pay a fee in keeping with the national average and checks will be available through a variety of sources including voluntary and community organisation health trainers, healthy living pharmacies and participating general practices. Checks will be targeted to areas of greatest need to make best use of case-finding opportunities.

Newcastle City Council is looking to establish a clearer public health 'offer' for priority wards – that is, the wards with the greatest degree of deprivation and its consequences. The aim is that, in future years, achievement of change in a range of key indicators for these areas will form the basis of the local target for the Health Premium.

We continue to work collaboratively as commissioners and providers to ensure seamless pathways of care for example across the obesity pathway. The Northern CCG Forum has identified the commissioning of integrated weight management pathways across the tiers as an area to explore further.

Joint working with all key partners has taken place to support the new procurement of the drug and alcohol services in Newcastle. Work is ongoing to develop a shared care model in General Practice as a core element of the overarching model of treatment, care coordination and recovery. The Newcastle Drug and Alcohol group continues to be supported by a lead GP.

Through Newcastle's Strategic programmes (e.g. Long Term Condition) we are implementing the five most cost effective high impact interventions as outlined by the National Audit Office.

Summary of achievement

Implementation of the five most cost effective interventions:

- ***Prescribing of drugs to control blood pressure*** – although prescribing trends over a three year period are relatively stable for anti-hypertensive medication across Newcastle we are proactively case finding through the NHS Healthcheck programme (including some community pharmacies) and we have identified opportunistic blood pressure monitoring at all GP surgeries.
- ***Prescribing of drugs to reduce cholesterol*** – again prescribing trends over a three year period are relatively stable there has been an increase in prescribing of statins during 2014 as a result of changes to NICE guidance. The NHS Healthcheck programme has supported casefinding for individuals with high cholesterol levels or high cardiovascular risk.
- ***Anticoagulant therapy in atrial fibrillation*** – we are actively casefinding using the GRASP AF tool within General Practice which has resulted in a significant increase in our prescribing levels for Anticoagulants. As a result of changes to the NICE guidance a programme of switching from Aspirin to Anticoagulants is underway.
- ***Blood sugar control in diabetes*** – through ongoing work within General Practice we have seen an increase in the percentage of patients whose blood sugar is controlled from the period 2012/13 to 2013/14.

	Financial Year	
Intervention	**2013/14**	**2014/15**
Smoking cessation services	1179 of whom 614 were successful	Not yet available (expected to fall)
Smoking prevalence	23.7%	Not yet available (predicted to fall)

3.7.5 Reducing health inequalities – Gateshead unit of delivery

The population of Gateshead (around 200,000 people) experiences wide variations in health outcomes across different groups and communities. Overall life expectancy continues to improve, but men and women are more likely than the average England population to suffer a life limiting illness before reaching retirement age. The number of older people (aged 65+) in Gateshead is set to rise by 39.3% by 2037.

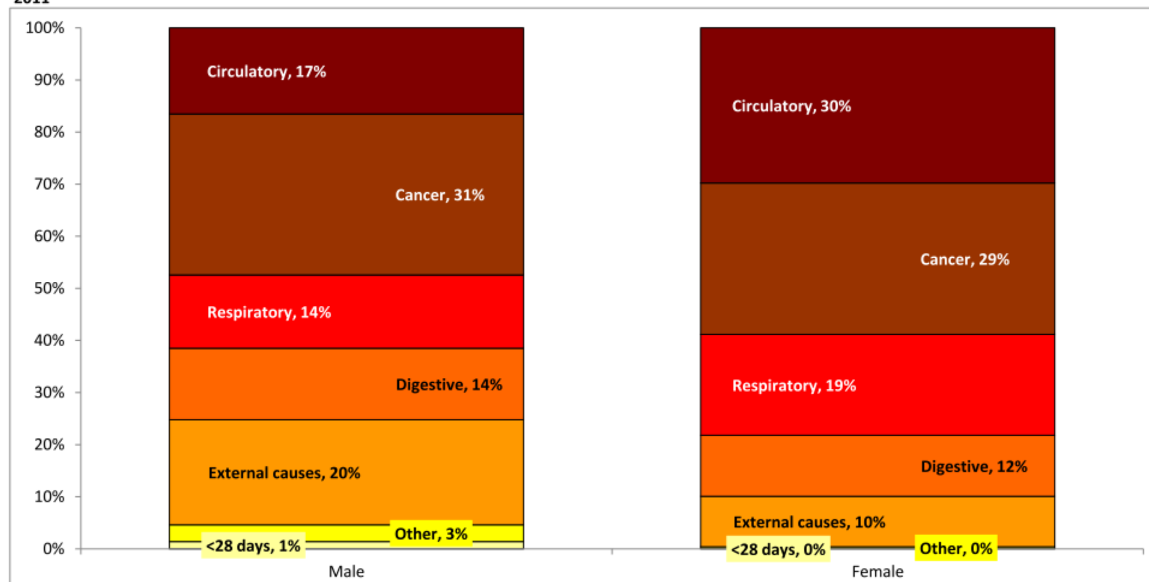
In the past year, health indicators did not show overall significant change from the previous year. However, a number of indicators relating to children's health are showing improvement: breastfeeding, reception year obesity levels and smoking in pregnancy, and progressively lowering rates of teenage pregnancies.

Information available in the Joint Strategic Needs Assessment (JSNA) and other public health published data has been used to inform the commissioning intentions and pathway improvement priorities for the CCG.

Working in partnership with our Public Health colleagues we have identified the groups of people that have a worse outcome and experience of care. This information highlights the variation in life expectancy between the most deprived and the least deprived quintile in Gateshead and indicates the four major causes of inequality for the population:

- Cancer
- Cardiovascular
- Gastrointestinal mortality
- Respiratory conditions

Chart 1: Scarf chart showing the breakdown of the life expectancy gap between Gateshead as a whole and England as a whole, by cause of death, 2009-2011



We have identified a number of key priorities which will support us to close the gap in health inequalities for the groups identified above. These priorities are outlined within the Health and Well Being Strategy and are reflected within the Newcastle Gateshead Alliance Commissioner Plan 2015/16. They include:

- Tackle the major causes of ill health and early death, ensuring a focus on prevention and high quality treatment
- The CCG have established locality working arrangements based on the five areas which the council operates – to facilitate a robust approach to understanding and addressing health inequalities on a smaller scale. A named Public Health Lead has been identified for each of the five localities to support the locality approach.
- Implementation of the Live Well Gateshead programme which aims to reduce lifestyle risks (e.g. smoking, obesity, alcohol consumption) in communities with greatest disadvantage.
- Working collaboratively as commissioners and providers to ensure seamless pathways of care for example across the obesity pathway. The Northern CCG

Forum has identified the commissioning of integrated weight management pathways across the tiers as an area to explore further.

- Reduce alcohol consumption by ensuring the quality of screening and brief intervention within Primary Care
- Ensure effective population cancer screening including increasing the uptake of cancer screening programmes
- Implementation of the newly commissioned Drug and Alcohol treatment service. The model includes s shared care arrangement between 21 GP practices across Gateshead, providing substitute prescribing and the specialist service. This model ensures that this particularly vulnerable group also have good access to primary care.
- The CCG have been involved in recent the review of the local Substance Misuse Strategy (Drugs and Alcohol). A new strategy is currently in development under both the Health and Wellbeing Board and the Community Safety Board.
- Pilot the Early Identification and Risk Assessment tool which has been shared with practices and focuses specifically on 5 Cancers.
- Development of a long term conditions strategy which:

    - Promotes a patient centred approach where multi-morbidities are considered in one appointment, reducing the number of appointments patients need whilst providing a more holistic approach.
    - Includes a House of Care pilot of NHS Health Checks Plus to identify people at greatest risk of developing CVD earlier, this will be piloted in the areas of highest deprivation.
    - Includes the development of practice level profiles for LTCs (cancer, COPD, CDV, mental health) to help share good practice, identify practice variation and encourage use of other services e.g. Live Well Gateshead to help tackle behaviour change.

Through Gateshead's Wellness and Collaboration strategy programme and Long Term Condition and Prevention strategies we are implementing these high impact interventions:

- **Managing blood pressure**, reducing cholesterol and case finding for atrial fibrillation are all being tackled through our improving quality programme with General Practice
- **Improving diabetes sugar control** is also being tackled through our Quality programme, together with the new diabetes work that's sees a community based focus to care and the implementation of a component of the current local enhanced service that encourage care around Impaired Glucose Regulation (IGR), education and training for staff in diabetes care. Work to date has resulted in Gateshead performing well against national benchmarks for the number of patients receiving the full bundle of care for diabetes.
- **Reducing smoking prevalence** through ensuring the quality of smoking cessation provision within primary care and including a specific focus on addressing the prevalence of smoking with those on a disease register through our Quality programme. Working collaboratively with partners Gateshead implemented a new model of stop smoking services. This model has encouraged a range of stop smoking providers into the market in order to increase the reach and provide support to specific groups such as pregnant

mothers and their families. During the past year the numbers into the stop smoking service have dropped but not as much as other local areas or the national trend. The new stop smoking services model compliments and is a core component of the new integrated wellness model that aims to support people with multiple lifestyle risks.

This new integrated wellness approach responds to the evidence around inequalities in that those in the more deprived communities are more likely to be participating in three or more risk behaviours (smoking, drinking too much alcohol, not taking enough physical activity and poor nutrition).

Summary of achievement

Implementation of the five most cost effective interventions:

- ***Prescribing of drugs to control blood pressure*** – although prescribing trends over a three year period are relatively stable for anti-hypertensive medication across Gateshead we are proactively case finding through the NHS Healthcheck programme (including some community pharmacies) and we have identified opportunistic blood pressure monitoring at all GP surgeries.
- ***Prescribing of drugs to reduce cholesterol*** – again prescribing trends over a three year period are relatively stable there has been an increase in prescribing of statins during 2014 as a result of changes to NICE guidance. The NHS Healthcheck programme has supported casefinding for individuals with high cholesterol levels or high cardiovascular risk.
- ***Anticoagulant therapy in atrial fibrillation*** – we are actively casefinding using the GRASP AF tool within General Practice which has resulted in a significant increase in our prescribing levels for Anticoagulants. Gateshead are a higher prescriber of Anticoagulant therapy due to the previous commissioned service to undertake pulse checks during the annual flu vaccine campaign. As a result of changes to the NICE guidance a programme of switching from Aspirin to Anticoagulants is underway.
- ***Blood sugar control in diabetes*** **–** through ongoing work within General Practice we have seen an increase in the percentage of patients whose blood sugar is controlled from the period 2012/13 to 2013/14.

	Financial Year	
Intervention	**2013/14**	**2014/15**
Smoking cessation services	2200 of whom 1037 were successful (Q2 2013/14)	1220 of whom 558.4 were successful (Q2 2014/15)
Smoking prevalence	22.9%	Not yet available (predicted to fall)

3.7.6 Implementing Equality Delivery Standard 2 (EDS2)

The NHS Newcastle Gateshead CCG will be migrating to EDS2 in April once the single statutory organisation is established. At that stage we will review progress made against the previous objectives and develop an action plan which will include identified leads for each of the 18 outcomes outlined in the EDS.

3.7.7 NHS Workforce Race Equality Standard (WRES)

The metrics have been defined for the WRES however we are currently awaiting further detailed guidance from NHS England outlining expectations for implementation from April 2015.

3.7.8 Parity of esteem

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.

Our vision for the model of service provision in 2018/19 will ensure that we are as equally focussed on improving mental health as we are on physical health and that patients, young or old with mental health problems do not suffer inequalities.

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 currently 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, improve 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 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
- re provision of inpatient services
- implementation of the national dementia strategy.

Parity of esteem is also at the forefront of our transformation and all programmes of work will have a mental health parity running through them. A&E and community access for mental health crisis will be overseen by our mental health programme

board, but also aligned to our urgent Care, primary care and older people programmes of work.

The CCG leads a collaborative commissioning group which includes local authority partners in Newcastle and Gateshead. The group is reviewing how it can identify and support young people with mental health problems in a more joined up way. This work will focus on providing services which are more child focused, putting the child very much at the centre, with a whole family approach. This will be a multi-agency partnership including community and voluntary services.

For 2015/16 the CCG financial plan includes investment in Mental Health that equals a 1.9% increase in line with the CCG allocation increase excluding seasonal resilience funding. An element of the seasonal resilience funding will also need to be invested within Mental Health services as part of wider planning in this area.

Linking to the financial plan, this includes:

I. An allocation of additional funding for Early Intervention Psychosis (estimated at £213k).
II. No investment as yet for IAPT on the basis that the additional funding identified in planning guidance is not within the current CCG allocation.
III. Additional investment has also been noted for Liaison Psychiatry, although this may be reviewed in the final plan following further discussions with mental health commissioning leads.
IV. CAMHS services are a further area of planned investment but a figure has not been included within the draft plan as review work is still underway.

In many instances the areas of investment are still in development, with no decision on provider.

3.7.9 Mental health targets for EIP Access, IAPT, Liaison Psychiatry and Dementia

We are working together with NHS Northumberland Tyne and Wear Foundation Trust (NTW) to put in place arrangements to ensure that all people referred to an EIP service are receiving treatment in line with NICE guidance, with 50% within the access target of two weeks. New guidance was published on 12th February and local plans against this guidance are under discussion for inclusion within the 2015/16 contract.

IAPT is currently provided by South Tyneside Foundation Trust (STFT) for Gateshead and by Newcastle Talking Therapies (NTT) and NHS Newcastle upon Tyne Hospitals Foundation Trust (NuTH) for Newcastle. The CCG is currently working with all providers to ensure delivery against the new access targets for IAPT by the end of March 2016 in line with new guidance.

In Newcastle we have started to work jointly with both Newcastle Talking Therapies (NTT) and NHS Newcastle upon Tyne Hospitals Foundation Trust (NuTH) to see the development of a single delivery model for primary care mental health services

incorporating IAPT over the next year. All parties are committed to ensuring the planning and implementation of any new model will also see the achievement of national KPIs for IAPT.

Significant work has been undertaken in 2014/15 to improve and maximise the dementia diagnosis rates for Newcastle and Gateshead practices. Practices have been encouraged to use the nationally issued dementia toolkit and the CCG locality teams continue to support the practices with this work.

The Newcastle Gateshead Mental Health Programme Board has a work stream that is dedicated to the planning of urgent care services across the two units of delivery and working alongside the local Crisis Concordat Agreement. Working with key stakeholders they will be further developing plans to have established liaison services in line with the recently published guidance.

3.7.10 Learning Disabilities

Our commitment to improve the system of care for people with learning disabilities through collaboration with our partners is recognised through the development of a joint agreement in both Newcastle and Gateshead. The joint agreements support the transformation of care and support for individuals with learning disabilities.

A key priority within Newcastle is to develop new ways of jointly commissioning services with our partners with a focus on discharge planning and improving section 117 agreements to support a reduction in readmissions.

In Gateshead the transformation of community services agenda includes the transformation of learning disability services. Work is ongoing to establish the interface between community and inpatient service whilst developing opportunities linked to new models of care.

Access

3.7.11 Convenient access for everyone

Access to services, especially those out-of-hospital services for minor groups is being considered and implemented in all strategic programmes of work (e.g. Primary care, Urgent care, Long Term Conditions).

Supplying services for an increasing demand of people who can access care and redesigning pathways and using innovative approaches for people who struggle to access care is a core part of our transformation agenda.

The older population are being given opportunities to access services via telehealth and pathway redesign (e.g. proactive home visiting, MDT care planning), while the younger population groups will enjoy access via online and mobile technology.

As we explore and start to introduce and expand on 7 days services within primary care (General Practice and community services), access will be tailored to demand and convenience. However, continuity of care will remain a core component of any

system redesign (both professional contact and information sharing) in order to create a sustainable health and social care system that provides value-based services.

Providing wider access to health and social care services requires careful consideration, it is important not to create a supply-demand environment that is not affordable nor improves quality for patients *(Meeting Need or Fuelling Demand. Improved access to primary care and supply-induced demand. Nuffield Trust, June 2014).*

To ensure convenient access during the recent periods of significant pressure on the healthcare system we have demonstrated our ability to flex resources to meet demand for example GPs supporting colleagues in secondary care and Walk in Centres.

Our cancer strategic and End of Life strategic programmes are working on pathways of care and services that will improve early diagnosis for cancer and overall 1 year survival rates. Initiatives include:

- Promoting the use of support mechanism and self-care for those living with cancer – initial focus on breast, colon and prostate
- Cancer practice profiles – early identification and diagnosis of cancer

3.7.12 Meeting the NHS Constitution standards

Contract activity requirements have been modelled to ensure that NHS constitution standards will be met on an ongoing basis. Modelling has reflected both elective and non elective requirements over the twelve month period to ensure contracts are underpinned by elective activity levels which account for the impact of winter pressures. On an ongoing basis, local System Resilience Groups will oversee the impact of winter on elective activity and associated targets.

The CCG is currently undertaking a baseline assessment of the current performance position relating to the new mental health access standards. This will support discussions with providers aimed at ensuring appropriate levels of investment into contract baselines in order to deliver these targets.

We expect to meet our constitutional requirements in relation to offering choice of mental health provider. In line with national guidance we will provide support and information to increase accessibility and choice. We will work with providers and primary care to promote choice in accordance with national expectations.

The CCG is committed to driving continuous improvements in quality across the local healthcare economy within our sectors of influence and control

Quality

We are directing quality improvements in a number of key areas including the following:

- ***Primary Care*** via the Practice Engagement Programme in each CCG which includes three mandatory and three optional quality indicators
- ***Care homes*** through the care home project in which practices are aligned to care homes to enable weekly ward rounds which allows triangulation with the local authority quality framework to identify any quality issues
- ***Community services*** through CQUIN and regular quality review group (QRG) meetings

3.7.13 Response to Francis, Berwick and Winterbourne View

The CCG maintains and manages a single action plan which maps our responsibilities, actions and requirements against the recommendations of Francis, Berwick and Winterbourne. The plan is owned and monitored by the Quality, Safety and Risk Committee. All actions are now green and recommendations embedded within everyday working arrangements.

Led by the CCG, we have an inter-agency Winterbourne Task Group which is responsible for oversight and direction of planning and actions to ensure progress against all Winterbourne recommendations.

This group will be responsible for overseeing reduction in the number of inpatients for people with a learning disability and ensuring robust community services are in place.

> Our practices are the highest users of SIRMS across the North East, we were the first CCG to have all our practices signed up to using it

3.7.14 Patient safety

The merger of the CCGs in the Alliance has enabled us to review director roles and responsibilities. Recognising the growing portfolio of the Quality and Patient Safety team, a Director of Quality Development is now in post to work with the Executive Director of Nursing, Patient Safety, and Quality, the Medical Director and the Secondary Care Clinician, providing further clinical leadership and advice.

A Band 7 patient experience officer will work within the quality and patient safety team to provide credible, effective and visible leadership for patient experience programmes. The roles described will support the CCG in ensuring the patient and carer voice has an increasing involvement in patient safety improvement.

All practices in Newcastle and Gateshead have had training in and access to SIRMS in order to report incidents and raise concerns about the healthcare services with which their patients interact. Practices are encouraged to report incidents occurring externally and internally and each internal incident recorded has an action plan and lessons learnt section, which the practice can choose to be shared with other practices and CCG.

Serious Incidents (SIs) relating to secondary care Newcastle and Gateshead patients are reported by providers and are reviewed, monitored and signed-off by the CCG's SI Panel.

These reporting structures and procedures are an integral part of the CCGs assurance process, giving us knowledge and intelligence of when those providers and the systems, processes and pathways to which our patients are exposed fail to operate in a safe or effective manner. This evidence is triangulated via commissioner led visits and discussions at QRG meetings to provide assurance.

A standing agenda item at the QRG meeting is progress against sign up to safety campaigns.

Sepsis and Acute Kidney Injury are included in the National CQUINs for 2015/16 and will be agenda items at QRG meetings with providers where we will monitor progress on a quarterly basis.

The CCG hosts an active Healthcare Acquired Infection (HCAI) Partnership, which shares good practice on antibiotic prescribing across acute, community and primary care. Root cause analysis of all MRSA and C Diff reports is undertaken across primary and secondary care and peer review analysis.

The prescribing incentive scheme in primary care addresses antibiotic prescribing and monitoring for the scheme enables the CCG and Prescribing Support to work with practices identified as antibiotic prescribing outliers to reduce their rates.

3.7.15 Patient experience

We assess the quality of care experienced by patients across Newcastle and Gateshead through many routes. This includes an assessment of the quality of care experienced by vulnerable groups of patients.

Patient experience is reported widely across the Alliance, in monthly Executive reports, bi-monthly Governing body reports and stakeholder bulletins. Work is also reported in partner bulletins (e.g. Information Now, CVS news bulletin, HAREF stakeholder bulletin. By capturing patient experience we are able to influence and improve current and future services in order to make the patient experience better for all patients including vulnerable groups.

We have strong relationships with Healthwatch, HAREF, Deaflink and voluntary organisations which enable patients from all communities the opportunity to share experiences. Targeted engagement work (e.g. Deciding Together) captures patient

experience to influence current and future services including work with those harder to reach groups.

A team of Health Quality Checkers work with the Newcastle GP practices to make sure that patients with learning disabilities don't face any inequalities or barriers when accessing health services or information.

The uniqueness and value of the checks is that they are carried out by people who themselves have learning disabilities, therefore are best placed to know what problems or barriers people may face.

We have a number of processes in place to gather patient experience feedback, Friends and Family Test (FFT) and complaints to ensure action is taken to support improvements:

> The CCG is also exploring the opportunity to become a "Community Care Maker" as a way of bringing commissioners and providers together to ensure quality patient care across the local healthcare economy by supporting the changing face of the NHS services.

- We have a CQUIN target for the response rate for (FFT) with responses monitored and reported at provider QRGs, any issues highlighted are discussed and an action plan implemented.

- The Commissioner Visit Programme whereby the visiting team which includes Lay Members ask patients about their experience in:
  - Privacy and dignity
  - Practical help and support
  - Involvement in Care
  - Facilities and Environment

  Reports from the visits detail recommendations for providers to address and any subsequent action plans are monitored at the QRG.

- SIRMS reporting from GP practices provides us with soft intelligence which is used to identify emerging themes which are then triangulated with operational performance data. Practices are also encouraged to use SIRMS for reporting patient experience of their services which can be used as a learning tool and an audit trail for CQC.

- We monitor responses from the National GP practice survey, and the Healthcare Practitioner Performance Triage group also review responses and work with practices on any issues or concern. The CCG will work with the Area Team to achieve an annual improvement in 2015/16 in the satisfaction levels of patients specifically for the quality of consultation at a GP practice, satisfaction with the overall care received at the surgery, and satisfaction with accessing primary care, as measured by the GP survey. In comparison to the national and local picture, NHS Newcastle Gateshead CCG compare favourably. Newcastle are amongst the top performing nationally.

- Quality Review Groups – meet bi-monthly with providers. Patient Experience is a standard agenda item. CLIPPER report is discussed from the NHS Foundation

Trusts, part of which is patient experience and any issues highlighted are discussed.

- Ensuring good handling of complaints is one way in which we as commissioners can help to improve quality for our patients and public. Learning from complaints helps us to continually improve the services we provide and the experience for patients such as 'you said, we did' which demonstrates the actions we have carried out as a result of patient experience in work such as Deciding Together, MSK, COPD and Diabetes work in 2014/15. There are also plans to develop a 'you said, we did' area on the CCG website.

- At QRGs providers share thematic presentations around for example never events with focus on lessons learnt.

- Practice patient groups and local engagement boards are another mechanism in which we can gather intelligence.

The NHS Constitution and Caldicott review are embedded and committed to by CCG practices and all NHS providers. We demonstrate throughout this document that we monitor and review how our providers meet the NHS Constitution patient rights and commitments, for example in quality of care and environment, involvement and choice, and complaints.

3.7.16 Compassion in practice

We will utilise the opportunity to triangulate the evidence gathered across all of the above areas against the 6C's of Compassion in practice, to ensure provider plans are delivering against each of the areas and monitor how the 6Cs are continuing to be rolled out with all staff groups.

Monitoring and review of provider's development plans and strategies in meeting Compassion in practice is addressed at QRG meetings.

3.7.17 Staff satisfaction

The NHS Employers report Staff Experience and Patient Outcomes: What Do We Know provides us with evidence that the experience of staff in healthcare organisations is linked to the quality of care provided to patients.

Similarly the report from the NHS National Quality Board (NQB) highlights the role of leadership, management and an engaged, committed workforce as critical to building a positive experience of care. Evidence shows that organisations which deliver good experiences of care have workforces with higher levels of wellbeing as well as more satisfied patients and service users.

We have considered this research and recommendations from a number of sources as part of understanding the factors affecting staff satisfaction in the Newcastle Gateshead health economy and how staff satisfaction locally benchmarks against others.

We have reviewed the recent staff survey results for our main providers to understand how they benchmark against other providers locally regionally and nationally. Key findings from this review are outlined in the table below:

Table 8: Demonstrates local provider trusts staff survey results

	Average median for acute trusts	NUTH FT		GHFT		Average median for mental health trusts	NTW FT	
		2014	2013	2014	2013		2014	2013
Care of patients / service users in my organisation is a top priority	70%	**83 %**	83%	**75%**	74%	63%	**72%**	68%
My organisation acts on concerns raised by patients / service users	71%	**82%**	83%	**78%**	80%	71%	**76%**	81%
I would recommend my organisation as a place to work	58%	**69%**	72%	**65%**	65%	53%	**53%**	55%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	64%	**85%**	87%	**75%**	70%	59%	**61%**	63%

The table demonstrates that our main providers compare favourably with the national averages in both categories of care and place to work.

As an associate commissioner for the North East Ambulance Service (NEAS) contract we are represented at the QRG meetings. We are aware of the deterioration in the staff survey results for 2014 and will be working with fellow commissioner colleagues and NEAS to review the subsequent actions NEAS will be taking to improve the ratings.

Staff satisfaction is discussed at all provider QRG meetings to provide assurance that they are proactively acting on the results of the staff surveys**.**

3.7.18 Staff Friends and family test data

Reassuringly, the findings from the Staff Friends and Family test data reflect the results outlined in table eight above. To validate and triangulate QRG information and survey results from our providers the CCG randomly ask staff the ‘Care’ and ‘Work’ question at the provider quality visits.

3.7.19 NHS Newcastle Gateshead CCG

In 2014 the CCGs in the Newcastle Gateshead Alliance applied to NHS England to merge into a single organisation, feedback from them during the merger process identified that we had the potential to move from being a good to being a great commissioning organisation.

The CCG does not participate in the national staff survey however we undertook a local survey with staff to understand how we could further improve. We were delighted with the feedback received from staff and we are working with staff through our organisation development strategy to ensure we achieve the improvements they identified.

> As an organisation we have lower than average sickness, absence and vacancy rates which we believe is a good indication of staff satisfaction and well being

Much of this work, especially around culture has helped during our transition period as we move from three CCGs into a single organisation and ensures we will not lose the best of the past and what has worked well for us.

3.7.20 Seven day services

Providers are either in the process of undertaking a self-assessment against compliance with the ten standards or have submitted this to the Alliance. Work is ongoing to confirm which five of the ten standards will be included in the contract Service Development and Improvement plan for in year implementation.

Guided by Sir Bruce Keogh's Urgent and Emergency Care findings and published framework, the CCG has fully utilised this evidence as well as its own local assessment of need to inform plans at both strategic and operational levels to continue to develop consistent, high quality Urgent and Emergency care services across the CCG's two units of delivery.

Operationally the System Resilience Group's (SRG) action plans also include a number of Keogh priorities for implementation both at a system and provider level, tp ensure we have a high quality emergency and urgent care system with services that are timely, trusted, easy to understand and comprehensive in their function and coverage.

3.7.21 System resilience

In order to review the impact of the schemes which were funded from System Resilience Funding and implemented during the winter period 2014/15, a 'wash up' event was held by each SRG to:

- Understand how the challenges of the winter period were met whilst sustaining service delivery.
- Evaluate the effectiveness of planning and briefing mechanisms.
- Identify areas for improvement and highlight best practice.

This enabled an evidenced based, robust Risk and Resilience Plan to start to be developed by each SRG to ensure adequate year round capacity is available to effectively manage surge/pressures; the significant challenge for the Alliance is that local providers are now experiencing regular pressures across the system, rather than predicted surges during winter.

Importantly, this approach allowed schemes which were identified as being appropriate for mainstreaming, more substantive funding or even roll out across the whole system to be interplayed or even included as part of more strategic discussions such as the Better Care Fund and annual contracting discussions with providers to ensure delivery within the resources available.

Non-recurrent funding for system resilience totalling £4.8m was received by the 3 CCGs across Newcastle and Gateshead for 2014/15 and utilised to support schemes across acute, mental health, local authorities and other providers. For 2015/16 an allocation of £3.5m has been included within the recurrent baseline of the new NHS Newcastle Gateshead CCG.

While this funding has been ring fenced in finance plans for spending in 2015/16 resilience plans, it nonetheless is less than the total funding available in 2014/15. Expectations from the local health and social care systems will also be high, particularly as this funding has primarily supported secondary care providers and there is a need to support the whole of the system including primary care and the voluntary sector.

3.7.22 Safeguarding

As major commissioners of local health services we need to assure ourselves that the organisations from who we commission have effective safeguarding arrangements in place.

We have a Safeguarding Strategy and work plan in place which has no gaps identified. Our designated professionals seek assurance from provider organisations and exception reports are provided through the Alliance Strategic Safeguarding Committee to the Executive Committee and Joint Governing bodies.

The Named GPs, designated professionals and safeguarding team provide training with regards to Safeguarding Children and Adults, Domestic Violence and Abuse, Mental Capacity Act and Prevent agendas to Primary care teams. They are full members of local safeguarding boards and work closely at a strategic level with partner agencies.

This gives us the assurance that critical services are in place to respond to children and adults who are at risk or who have been harmed, and we are able to deliver improved outcomes and life chances for the most vulnerable.

In regard to the CCG duty to ensure provider services are delivered in accordance with Mental Capacity Act, a comprehensive programme is in place to promote understanding and embed practice in provider organisations. To further this agenda,

we are one of few CCGs who employ an MCA development worker who works into provider organisations to provide bespoke training packages.

In order to meet the standards in the prevent agenda our Safeguarding staff are delivering WRAP 3 training into Primary care and also supporting Primary care in any referrals to Channel procedures.

Assurance from Provider organisations is gathered via an assurance dashboard.

Innovation

3.7.23 Research and innovation

There is strong interconnectivity and cross representation in the North East and North Cumbria to ensure support for research and innovation. All CCGs in the area are represented by two CCG Accountable Officers on the Academic Health Sciences Network (AHSN) North East and North Cumbria Board (NE & NC). The Clinical Director of the local research clinical network for NE&NC is also a member of the AHSN board and the CCGs have two Accountable Officers on the AHSN board on behalf of all CCGs

In addition North of England Commissioning Support Unit on behalf of CCGs are embedded in AHSN activity to support and promote research and innovation. A number of AHSN funded programmes are supported by and running in CCGs http://www.ahsn-nenc.org.uk to accelerate adoption of evidence.

We shared the Gateshead Vanguard submission with the AHSN who said '*It seems to fit very well with the AHSN priority area of elder care (http://www.ahsn-nenc.org.uk/project_type/elderly-care/) and would be suitable for submission to the Bright Ideas in Health Awards either under the service innovation or the primary care category*'.

This response reinforces the quality of the Vanguard submission in particular the transformation of services resulting in significant improvements for patients. The successful Vanguard bid enhancing healthcare in care homes has therefore been submitted to the *Bright Ideas in Health Awards* under the primary care category

Delivering Value

3.7.24 Financial resilience

The finance and activity plan brings together the commissioning plans of the CCG with the delivery of national business rules/planning guidance, and the expected contract activity and costs for 2015/16, whilst maintaining the financial obligation of the CCG.

Key assumptions within the plan meet the national business rules and include:

I. provision of 0.5% contingency, totalling £3.5m
II. provision of 1% headroom for non-recurrent spend, totalling £6.6m

III. A control total of £8.4m surplus
IV. Net acute tariff reduction of 0.9%
V. Overall non acute tariff reduction of 0.6%. This is a combination of the application of differential tariff impacts to elements of the non-acute services
VI. Anticipated QIPP plans at 0.7% of the total CCG revenue resource limit

The contract schedules within the plan are based on finance and activity projections for acute contracts as shared with providers in our latest contract proposals. As such, they should triangulate with our main providers understanding of our commissioning plans and represent our expectation of the contracts to be agreed.

Our assessment is based on a 12 month sample, October 2013 – September 2014, adjusted for expected 2014/15 outturn and with further adjustments for ONS population changes, disease prevalence, waiting list changes and known developments or service redesign. These elements are demonstrated in the waterfall charts below. (Section 3.7.24i)

We continue to finalise 2015/16 contract agreements in light of the tariff options exercised by our providers on 4th March 2015, when our providers indicated their preferred tariff option for 2015/16.

Newcastle Hospitals have opted for the Default Tariff Rollover (DTR) which rolls forward the 2014/15 tariff prices but excludes access to CQUIN. Negotiations have progressed on this basis, but the CCG recognises that there remains a risk of additional cost if a revised tariff is agreed nationally in year. All other providers have opted for the Enhanced Tariff Option (ETO), with a reduced efficiency requirement which will remain in place throughout 2015/16. The CCG has been notified of additional non recurring funds totalling £600k for 2015/16 and this has been built into financial plans, offsetting the majority of the cost of the ETO this year.

The CCG recognises a specific risk of financial deficit in relation to Gateshead Healthcare NHS Foundation Trust which was recently highlighted to Monitor. We are working closely with the Trust to understand the nature of, and potential impact of current financial issues. This underscores the importance of taking forward our wider transformation agenda with the Trust whilst continuing the provision of quality and safe services for patients.

Our Executive to Executive monthly bilateral meetings provides the opportunity for top team overview and assurance between the commissioner and provider that joint strategic and recovery support plans are being implemented. Furthermore, the Accountable Officers group in Gateshead which includes the Local Authority provides the opportunity for wider system oversight.

Budgeted commissioning spend has been adjusted for demographic growth where appropriate as well as the impact of planned investments and QIPP. Plans have been developed to include the required investment to deliver local objectives and national initiatives such as the required investment into Mental Health services. For 2015/16 the CCG financial plan includes investment in Mental Health that equals a

1.9% increase in line with the CCG allocation increase, excluding seasonal resilience funding.

Our QIPP plans total £4.7m, which represents 0.7% of the total CCG revenue resource limit. They include a range of specific schemes, including £1m led by medicines management to reduce costs in primary care prescribing, although it is recognised that there will be growth in other aspects of prescribing, which is covered by provision of growth funding at 4%.

Other QIPP savings are anticipated from a range of interventions, to shift activity from secondary to primary care which, combined with benefits from initiatives negotiated within contracts, are expected to deliver circa £2m . Further contributions are planned from working with providers to manage further demographic pressures within current costs, reducing the costs of high cost out of area placements, and transformation work in Continuing Healthcare and related systems.

In this way we are confident that we can demonstrate our plans are clear and credible and meet the efficiency challenge in 2015/16, and provide the basis for further medium term efficiency savings.

Moving forward we are developing our ambitions for future evidence based planning, with work led by the Clinical Director of Transformation and utilising information from a range of benchmarking sources including Commissioning for Value as referenced earlier in section 3.5.

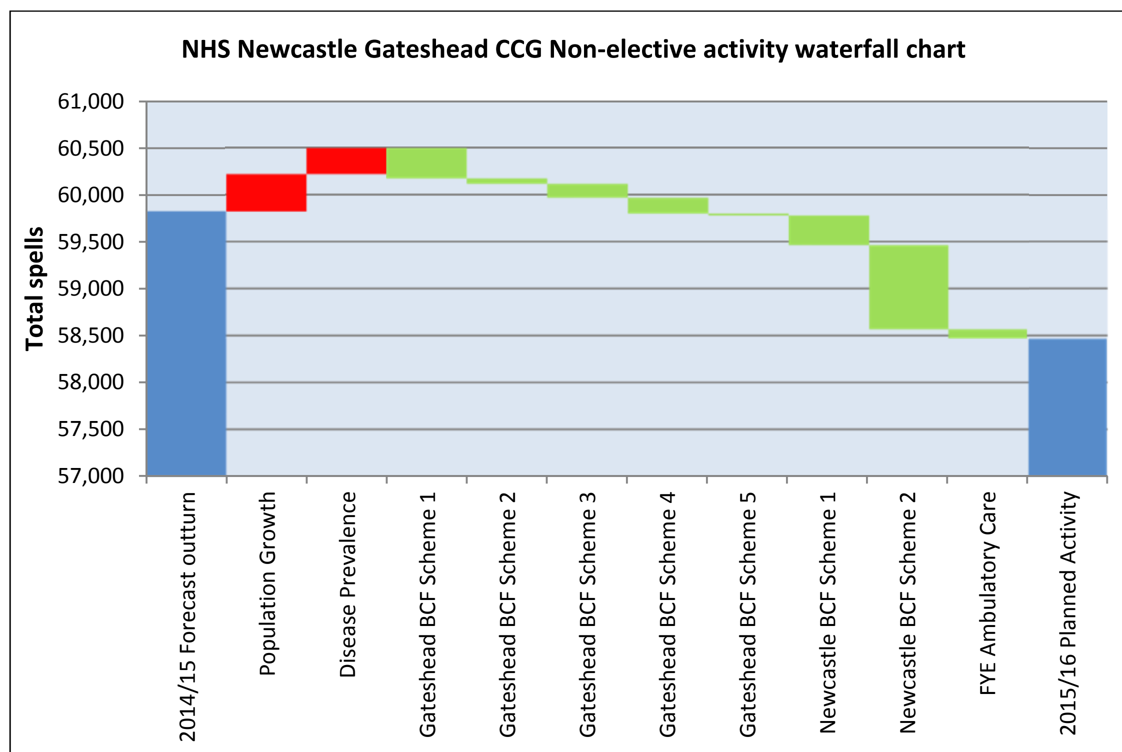
As well as developing QIPP plans to demonstrate delivery of value for money for taxpayers and patients, we also ensure that all service development plans are underpinned by robust review to ensure appropriate procurement options are considered as an integral part of commissioning.

Unit of delivery commissioning plans are designed with value for money, alongside quality and other measures, as a focus for any change. Business cases and internal governance processes are utilised to support robust implementation. This is supported by well-developed practice engagement led by the two delivery teams, and by contracting, performance and finance staff.

3.7.24i Waterfall charts:

The "Waterfall charts" in this section of the narrative demonstrate the movement in activity from 2014/15 forecast outturn to 2015/16 contracted levels for the CCG. As referenced above, the activity modelling period used for contract development was October 2013 to September 2014, and this basis has been shared with our providers, with some amendments made for expected changes in the full 2014/15 outturn.

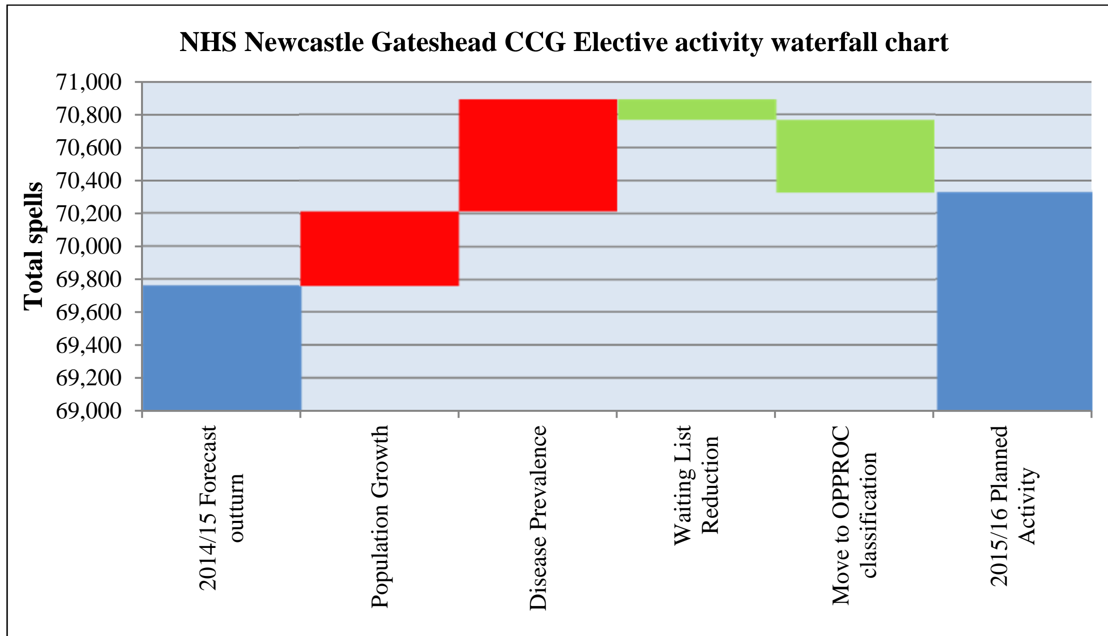
Non - elective activity waterfall chart



The overall position shows a planned 2.3% reduction in non-elective activity across Newcastle Gateshead CCG during 2015/16. This reflects the 1.8% (Newcastle) and 3.0% (Gateshead) reduction detailed in each of our Better Care Fund plans.

Increased activity can be seen for population growth and prevalence, while this is offset by the expected activity reductions from BCF interventions. Nuances in the two units of planning can be seen, with five schemes planned to deliver a total of 819 reduction in non-elective admissions in Gateshead, while for Newcastle two overarching schemes are planned to deliver a reduction of 1209 admissions.

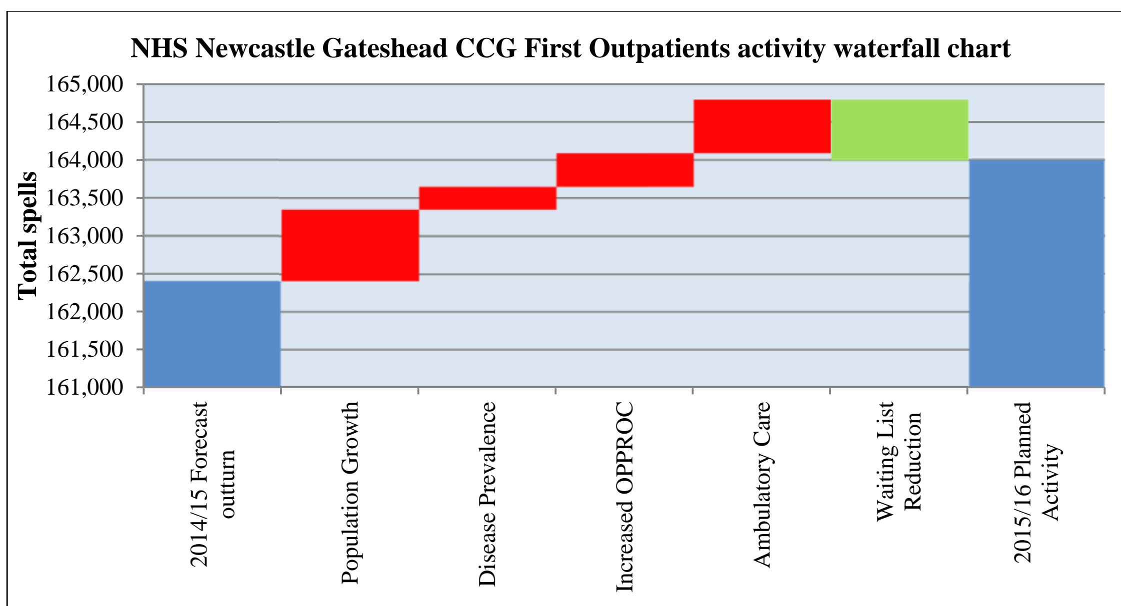
Elective activity waterfall chart



The elective activity waterfall chart includes an adjustment for specific waiting list initiatives commenced in July 2014, and which inflated outturn beyond normal levels.

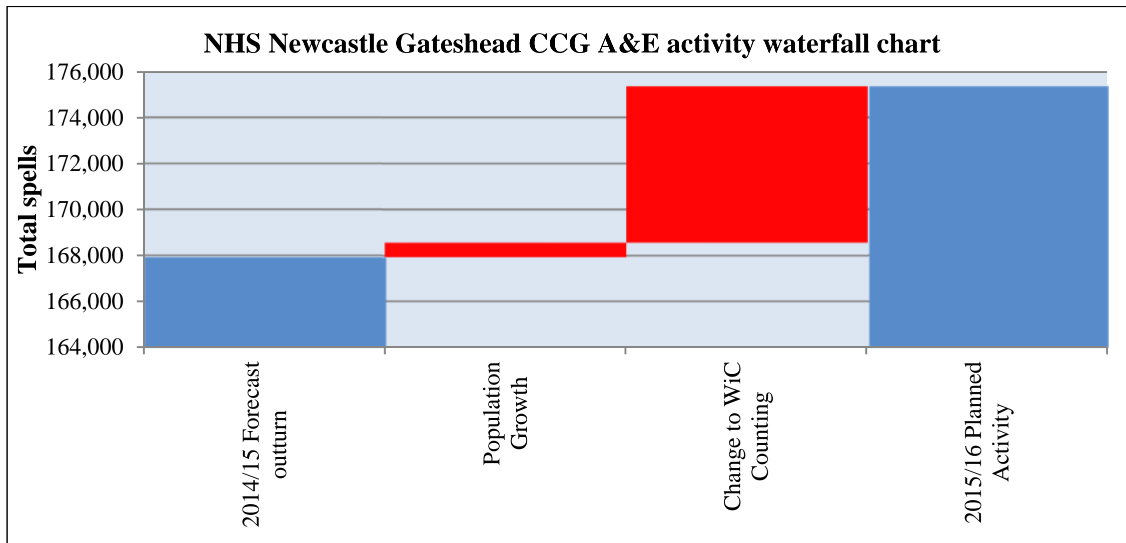
Activity has been adjusted for population growth and disease prevalence thereby ensuring sufficient commissioned capacity to maintain compliance against key performance targets. Reductions have also been modelled to reflect continued productivity gains arising from Daycase to Outpatient Procedure setting. The net position is a 0.8% increase in activity during 2015/16.

First Outpatients activity waterfall chart



A net increase of 1% is anticipated for first outpatient activity, with growth due to population prevalence and for continued compliance against RTT performance targets. In addition, increased utilisation of the Ambulatory Care pathway in line with Better Care Fund plans have been modelled into Outpatient activity, which is partially offset by the waiting list reduction due to the 2014 RTT initiatives.

A&E activity waterfall chart



The A&E activity chart shows a total growth of 4.4% in attendances, which principally is due to a change in counting of previous walk in centre activity at Gateshead Hospitals. This has been discussed within contract meetings in some detail and is not expected to result in a cost pressure to the CCG.

4. The Five Year Forward

The NHS Five Year Forward View sets out how the health service needs to change, a vision of a better NHS, the steps that we as a CCG should take and how we need to work with our partners to deliver the vision.

4.1 Reflections

The national planning guidance Everyone Counts: Planning for Patients 2014/15 to 2018/19 articulated 6 service patterns that would create a sustainable health and social care system. Work to date in our strategic programmes has encouraged development of new pathways of care to underpin the foundations of these 6 service patterns. As described in our 5-year plan, the following key features and changes were considered within each service pattern:

Service patterns	Key features	Key changes
Empowered Citizens	Communities looking after communities Shared decision making Citizens feeling part of the community	Information at fingertips Flexibility in the system to manage risk Forget who is going to deliver it Technology abled-solutions Encourage self-care
Wider primary care, provided at scale	Flexible provision in local areas Continuity of care Shared information Single voice Back-office coordination	Expert generalists Single system coordination Family key worker Remote hands-off system In-hours and OOH alignment Diagnostic support Wrapped-round services
A modern model of integrated care	Patient explain once Patient voice Central point of access I still don't understand this Generalist and specialist alignment	Care planning at scale/consistent Competency framework Low cost solutions (VCS) Shared budgets Core teams Key workers
Access to the highest quality urgent and emergency care	Respond to need Reablement /rehabilitation Named professional Crisis care Warning markers Single point of access	Triaged – tiered care Remote management Individual plans 111 potential Specialist navigators Community paramedics
A step-change in the productivity of elective care	Streamline pathways Enhanced recovery programmes Out patient referrals systems Shared decisions making Productive wards	Enhance community provision Confidence in hand-over/interfaces Whole –system pathways Pre-post care arrangements
Specialised services concentrated in centres of excellence (as relevant to the locality)	Patient choice-localism Patient safety/experience Leadership Step-down care provision	Population-based analysis Safe services Integrated step-down IT coordination

4.2 Our local approach to progressing the Five Year Forward View

The NHS Five Year Forward View clearly sets out how the health service needs to change, a vision of a better NHS, the steps that we as a CCG should take and how we need to work with our partners to deliver the vision.

It represents a shared view of the NHS and is intended both to prompt thinking in the NHS and to prompt a public and political debate about the challenges we face and the scale of change we need to implement to address the widening gaps in the health of the population, quality of care and the funding of services.

In December we held a strategic workshop within the Alliance to map our Five Year Strategic Plan against the NHS Five Year Forward View and identify any implications. We asked ourselves the following questions:

- To what extent will our strategic aims deliver the Five Year Forward View?
- Will we do anything differently as a result of the Five Year Forward View (i.e. are there any identified gaps)?
- Is there anything we should stop doing?
- What conversations should we have with our partners and the public about the Five Year Forward View?

From these discussions it was acknowledged that the NHS Five Year Forward View provides "how" we will deliver the broad strategic aims previously identified in our Five Year Strategic Plan. There was agreement that the key strategic vision and aims of each unit of delivery align to the vision within the Five Year Forward View.

We identified four key areas for development which will be considered in future planning, which also fit well with our local Health and Wellbeing, Wellbeing for Life Strategy and the more detailed work in the Better Care Fund Plans:

1. Strengthening Public Health with a key focus on reducing health inequalities and variation
2. Strengthening Primary Care Development
3. Developing 'models of care' which focus on the patient and the patient journey
4. Utilising new 'models of delivery' to facilitate improvements

This work has been shared with all stakeholders and partners in the health and social care system, including the Foundation Trusts and the Local Authority, patients and the public. We are working collaboratively with our partners to further develop ideas about new models of commissioning and delivering of services, and establishing clear views on the approach, future shape of health and care services and plans to transform.

An executive paper outlining this work was shared with Gateshead Health and Well Being Board on 16th January 2015 and at the Well Being for Life Board in Newcastle on the 11th February 2015 as part of a wider discussion about strategic development of primary care, new models of care and primary care co commissioning.

4.3 Opportunities

To support our five year vision and transformation agenda we have identified a number of key opportunities outlined within the Five Year Forward View.

4.3.1 Place based Clinical commissioning

The four key areas for development identified from the strategic workshop are all components of our plans to move towards place based clinical commissioning so that we are able to review our investment decisions against local needs and aspirations.

Through enhanced joint commissioning arrangements and primary care co-commissioning, different commissioners will come together to jointly agree commissioning strategies and plans, using pooled funds, for services for a local population.

- **Strengthening Public Health with a key focus on reducing health inequalities and variation**

We await the guidance from NHS England on their approaches to improving health and wellbeing as these will inform our plans to strengthen our work with public health partners.

However, work is in progress with the Directors of Public Health to establish outcome ambitions for the new NHS Newcastle Gateshead CCG, and to set and share in 2015/16 quantifiable levels of ambition to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing.

These will be supported by agreed actions to achieve these, such as specifying behavioural interventions for patients and staff, in line with NICE guidance, with respect to smoking, alcohol and obesity, with appropriate metrics for monitoring progress.

- **Strengthening Primary Care development – Primary Care at scale**

    - **Primary Care Strategy**

We are progressing well with the development of the strategy for Primary Care for the next 3 - 5 years in the changing health and social care landscape in Newcastle and Gateshead.

Our vision is to maximise the quality, capacity, capability and resilience of General Practice for patients focussed on quality and sustainability.

The strategy is being developed in the context of BCF, ambitions of the CCG and as a response to challenges articulated in the NHS Five Year Forward View.

We have four sub groups who are progressing the areas identified from initial planning work:

- New models of care – general practice at scale
- Workforce
- IM&T
- Estates

This work is providing direction and will support the development of service sectors to be able to respond to the challenges of providing high quality care outside of hospital to an older population with increasing complexity of health care need.

Engagement events with our member practices, stakeholders and patients and public on the requirement for, and focus of a Newcastle Gateshead Primary Care Strategy highlighted consensus that the challenges facing primary care are unprecedented, and that whilst quality and standards were generally good there was an immediate need to support and develop this part of the system in order for it to achieve its full potential and to be at the forefront of the required NHS transformation.

➢ Primary Care Co-commissioning

Our overall aim for primary care co-commissioning is to create a joined up, clinically-led commissioning system which delivers seamless, integrated out-of-hospital services based around local population needs.

It is a key enabler for out of hospital care and integration of health and care services, and provides the catalyst and platform from which general practice, community health, mental health and social care can be commissioned and developed more cohesively to deliver the outcome ambitions of our Operational, Better Care Fund and Five Year Strategic Plans.

We consulted with Newcastle Gateshead Alliance member practices who voted overwhelmingly (82%) in favour of a level 2, joint commissioning application.

Key objectives of our co-commissioning proposal are to positively unite ambition and align effort and leverage of commissioners to:

- Respond more effectively and holistically to people's needs
- Improve health and wellbeing of residents of Gateshead and Newcastle
- Promote a vibrant and responsive primary care sector
- Enable transformation and integration of our health and care delivery system

We believe primary care co-commissioning will offer leverage and opportunity to create the right model of care through joint decision making with the Area Team about form and function of general practice which is a key element of any new model that we design.

In designing new models of care we will be reviewing options such as multispecialty community providers and primary and acute care systems in order to have better alignment of outcome measures and incentives across primary and community services.

➢ Developing and utilising ‘models of care’ which focus on the patient and the patient journey

The Gateshead unit of delivery has been successful in two National programmes that will allow accelerated learning on service transformation to support delivery of Newcastle and Gateshead health and care economy five year strategic plan:

Over the next year the CCG will focus attention on developing the foundations of a collaborative provider landscape to underpin the transformation of service delivery.

➢ Prime Minister's Challenge Fund

The successful bid worth £ 2.1 million has been granted to Gateshead CBC provider organisation. The bid will deliver extended access to General Practice through locality-based units and home visiting supported by an integrated IT system allowing for interconnectivity between practices and mobile services.

➢ Vanguard programme - enhancing healthcare in care homes

The successful bid will see the accelerated developed of a Provider Alliance Network (PAN) to delivery services to patients within community beds and receiving home-based intermediate care services. The contractual arrangements will focus on cycles of care and be value-based with capitation and outcome-focused payments.

The Vanguard submission supported and is aligned to the five year vision as set out within our Five Year Strategic Plan.

The application has been reviewed with the Academic Health Science Network (AHSN) and fits with the priority area of elder care and submitted to the Bright Ideas in Health Awards under the primary care category.

➢ Integrated Personal Commissioning

Although Newcastle and Gateshead CCGs did not submit an Integrated Personal Commissioning application both areas are further developing Personal Health Budgets work which includes:

- The development of an options paper outlining potential funding streams for non-funded Continuing Health Care patients
- Exploration of opportunities associated with Prepayment cards
- Draft proposed Contract developed with Legal services for advice reference Direct Payments and CCG’s
- Development of a standard operating procedure to meet MHA requirement for PHB and Direct Payment as required from the 1st April 2015

Social prescribing

The NHS Five Year Forward Review talks about a new relationship with patients and communities and the need for more support for people to manage their own health, and about stronger partnerships with charitable and voluntary sector organisations.

These are all key objectives for social prescribing and the Ways to Wellness and Live Well projects described below.

> Our Ways to Wellness programme for Newcastle West is truly ground breaking. We believe the Social Impact Bond model is the first at such scale in the country.

‘Ways to Wellness’ – Newcastle’s approach to social prescribing

We know that over 15 million people in England suffer from LTCs, they:

- experience poorer health outcomes and reduced quality of life as a result
- are proportionately higher users of health services (GP appointments, prescription drugs, outpatient services and in-patient hospital bed days)
- and 55 % of GP appointments are with patients with one or more LTCs.

Newcastle West includes some of the most deprived wards in England. It is estimated that some 30,000–40,000 people living in Newcastle West suffer with one or more LTCs.

Evidence from community health interventions, both locally and nationally, has shown that a contributory factor to health and wellbeing is being linked into a local community and reduced social isolation. Social prescribing is used to achieve sustained healthy behaviour change and improved self-care, supplementing the support a patient gets from their health care professional.

Our Ways to Wellness programme pushes the boundaries of providing social prescribing at scale with 5,000 patients per annum with one or more long term condition being supported by the programme.

It secures £3.0m Big Lottery and Cabinet Office funding coupled with a further £1.6m Social Impact Bonds. These are new innovative outcome based funding models.

Contracts with the Voluntary Sector have now been signed, the voluntary sector being the main service provider, again leading the way in the voluntary sector being a part of a new community services workforce indicated in the Forward View.

‘Live well’ – Gateshead’s approach to social prescribing

The Public Health team has reviewed the way that Health Improvement services have historically been provided. Evidence emerging through this work suggests that current services are not adequately meeting the needs of people from more deprived communities, who are less likely to access the services as they are currently offered.

This issue is compounded in light of the fact that people in more deprived communities are more likely to engage with more than one risk behaviour.

As a result of the review, a new approach to commissioning public health services is being developed. During 2014/15, a new model of integrated wellness has been commissioned and implemented. This service will offer a streamlined single point of contact for a wider range of lifestyle risks. Assessment of need will take a holistic approach considering the physical, occupational, emotional, spiritual and intellectual aspects of wellness. Alongside this single point of contact, a robust approach to community health development and capacity building will be commissioned. The intention of this element is to support communities in identifying their own needs as well as assets and potential solutions.

The Integrated Wellness Model will develop clear pathways to ensure a seamless pathway between prevention services and the wider social issues which contribute to poorer health outcomes which will be addressed through the model in Gateshead.

- **Engaging communities - Working with our voluntary and community sector**

We will maximise opportunities for the voluntary and community sector to work alongside statutory services to provide proactive and responsive care.

Our focus going forward is to implement recommendations of the Voluntary and Community Sector review completed in 2014. We will explore different models of partnership working across Newcastle and Gateshead which will contribute to a vibrant and sustainable voluntary and community sector that can support delivery of our health and social care community ambitions.

- **Transforming health and care services in the community - care closer to home**

Transforming services in the community brings together health and social services and looks at the needs of patients as a complete picture reducing the number of fragmented interventions and 'handovers' between services to improve patient experience.

By integrating pathways of care, Newcastle and Gateshead patients will have better access to the right care, close to home, from the most appropriately skilled professional at their time of need.

Whilst many individual services are already providing high quality care, community services are sometimes still fragmented and complex resulting in duplication and gaps in provision. This transformation will ensure a co-ordinated service for patients that is easier to understand and to navigate.

This whole system approach will see patients at the centre of planning, commissioning, delivery and support which will result in a greater focus on ill health prevention, provide proactive and responsive care when it is needed and maintain the patient's independence for as long as possible.

Simply creating shifts in community care delivery by location or with individual organisations is not enough to produce the required scale of change to coordinate care for patients and achieve the desired improvements in outcomes. Our plans include establishing evolutionary partnerships to redesign community services, where all stakeholders can see the true benefits of working together is required.

In Gateshead we believe that procurement will provide the best opportunity to deliver significant services changes that are needed to completely transform the way community healthcare services are arranged, and deliver the changes needed to improve healthcare and health services for the people of Gateshead.

In Newcastle we will work in partnership with our local authority to agree a new blueprint for health and care for Newcastle that will meet the needs of our future population.

We work with high achieving, top performing providers, NUTH achieved a CQC level 5 rating and GHFT a level 6 rating

- **Specialised services concentrated in centres of excellence**

The Area Team and CCGs will work collectively with the providers as NHS England begins to undertake service reviews in 2015, to understand and manage the impact of any changes.

Newcastle upon Tyne Hospitals NHS Foundation Trust is a renowned provider of tertiary services. While it is recognised that it is currently difficult to quantify the impact of the national strategy, it is clear that specialised service provision will continue to constitute a significant element of the Trust portfolio in the future.

This is equally the case in the field of mental health through services delivered by Northumberland Tyne & Wear NHS Foundation Trust.

- **Accountable doctor**

As part of the 2014/15 GMS contract GP practices are to provide an ‘Accountable GP’ for all patients 75 years and over. The ‘Accountable GP’ will provide increasing continuity of care for this patient cohort, overseeing care delivery and coordination of care between health and social care professionals. In order to support this GMS requirement the CCG has and will continue to support ‘care planning’. Work-based learning and training within Primary Care, new funding streams and service redesign of community services and General Practice will enable and help implement 24/7 ‘accountable’ care provision by a named doctor for cohorts of patients.

5. Enablers

There are a number of strategic enablers which we have identified to support our strategic ambitions.

5.1 Workforce

As identified within our Five Year Strategic Plan we recognise our staff as our greatest asset. We also recognise the implementation and success of our plans will require significant workforce change.

Within the last twelve months the CCG has become an active member of the newly formed Workforce and Commissioning Forum. This provides us with the opportunity to discuss with Health Education North East (HENE) key workforce issues, risks, challenges and developments through the agreed terms of reference.

Through the forum we are assured that the commissioner voice and any issues are escalated via the Partnership Council to the Health Education North East Governing Body.

The forum is providing the CCG with the support required to achieve our ambitions set out within respective plans. This includes the development of a flexible workforce able to work across acute and community boundaries, and to ensure workforce plans are affordable and support our local strategies for transformation.

Through the forum and associated task and finish groups we are exploring:

- Support for GPs and practice nurses in preparing high quality care plans - critical to the implementation of our BCF proposals
- Further practice nurse development – enhancing the role of practice nurses (asthma, CVD, COPD, diabetes, immunisation and family planning)
- Further development of the career start scheme for GPs
- Access to clinical leadership programmes for GPs – review clinical leadership programmes for capacity and additional training requirements
- Training for bands 1- 4 staff (or equivalent) working in practices – (HENE currently supports a range of training at apprentice \ foundation degree level) possibility to extended to develop the primary care workforce
- Progress dementia training for practice staff
- Exploring links with HENE regarding their Care home work project

We will be an early implementer for the General Practice Workforce Planning tool so that we can understand the current Primary Care workforce structure and challenges to ensure that there will be enough people to deliver services tomorrow, next year and 5 years after.

This will help us to better understand how we can develop our existing workforce and as a result improve quality of care. Primary Care data collection is an opportunity to improve healthcare services so that we can invest in the right workforce. This work is a key enabler for our Primary Care Strategy.

5.2 Information Technology

Integrated working is a huge priority for the new models of care, in order to deliver this, patients require health and social care providers to work together; good communication is therefore essential. We are aiming for as near to real time documentation in the practice held records so that there is a single place where everything is held.

Currently this is being delivered in Gateshead with EMIS web (the system now used by all Gateshead practices), and is being rolled out to community nursing teams and some of the hospital teams such as the diabetes service and more parts of the urgent care system. We hope by the end of this year that multiple parts of the local NHS will access the primary care record and be able to input to it leading to vastly more joined up care reducing the current delays and errors in handovers.

This will be a key part of delivering our CCG vision. Clearly it will improve experience and outcomes but by better clarity of patients wishes and systems patients use, we also hope this will enable people to me more involved in their care

We are very excited that in 2015 the patients and public of Newcastle and Gateshead will see a number of important information technology projects come to fruition, which will help people use care services less and support healthier lives.

5.2.1 NHS Number

Work is being undertaken as part of the 2015/16 contract negotiation round to address this issue. Baseline assessments indicate that our two major acute providers already perform very well in relation to the use of the NHS number, both exceeding 99% coverage for both inpatient and outpatient related activity. Compliance against A&E correspondence exceeds 96% for both providers. We will continually monitor performance and work with all of our providers to ensure delivery of this standard.

5.2.2 Progressing the use of assistive technologies and digital records

- **Easy-to-use electronic prescription service**.
  The Electronic Prescription Service (release 2) will be implemented in all practices in Newcastle and Gateshead by the end of the summer 2015.

- **Electronic discharge summaries**
  Significant progress has already been made in this area, for example Gateshead Health NHS Foundation Trust are already sending around 80% of their discharge summaries electronically to all Gateshead practices. Newcastle Hospitals NHS Foundation Trust also transmit many of their discharge summaries in an electronic format, to both Newcastle and Gateshead practices. Further work is ongoing to expand this to all departments within the trusts.

Work continues to improve quality of the summaries and to ensure that all practices in the CCG are supportive of receiving discharge information electronically (only one practice is not currently doing so).

- **Extending online access to medical records and the availability of online appointments**
  The CCG is working with GP practices to enable them to enable online access to medical records, online appointment booking and online ordering of prescriptions. This will be available in most, if not all practices by the end of March 2015. The CCG will continue to work with practices to expand these facilities and ensure they are utilised by practices and patients.

- **Electronic referrals**
  Work is being undertaken as part of the 2015/16 contract negotiation round to address this issue. Our most recent analysis indicates that both The Newcastle Hospitals NHSFT and Gateshead NHSFT are exceeding the 80% target at 88% and 82% respectively. Compliance will be continually reviewed as part of the contract monitoring process.

5.2.3 National Information Board framework for Personalised Health and Care 2020

We are aware of the requirement to develop a roadmap for the introduction of fully interoperable digital records, including for specialised and primary care and have started to raise this at out information network meetings in Newcastle and Gateshead. More detailed work will be progressed as guidance on those roadmaps becomes available in June 2015.

6. The challenges ahead

In this section we want to convey the challenges we face across the healthcare system in Newcastle and Gateshead. We have reflected on these challenges when assessing our position in completing the 3x3 matrix as part of the assurance submission.

6.1 Resources and funding

With an increasingly challenging climate of a reducing funds and resources, the opportunity offered on placed-based commissioning such as co- commissioning of primary care requires careful consideration of capacity requirements and support resources to deliver and successfully implement operational activities.

6.2 Competition and provider development

Although we have started the journey on new models of care for patients, the development and implementation will be challenging. Aligning systems with multiple providers across health and social is not without its complexity. Traditionally the provider landscape is dominant and influencing change to meet the needs of a whole population together with the redistribution of funds outside of the acute provider is not without its obstacles. For example, redirecting funds directly influences the financial stability of acute providers and can hinder genuine co-production which is fundamental for system transformation.

The complicated payment structure in health and social care means support and time will need to be spent on understanding and gaining traction on the potential for new commissioning and financial methodology arrangements. It will be a challenge to align contractual processes with new levers and enablers around care transformation.

6.3 Demand and expectation

Providing valued-based services for all is our goal, but delivering services to meet the growing needs of a whole population is a challenge. As people's expectations increase around a 24/7 culture and instance access we have to understand the implications for workforce and cost. Simply creating more services will result in a supply-demand environment that it is unsustainable. Therefore, the challenge is to create a system to meet people's needs, but also embeds personal responsibility and wellness at its core and look towards neighbourhood and communities to improve overall health and wellbeing.

Redirecting funding towards prevention is crucial for a sustainable local system. However, wider challenges around national austerity are having a detrimental effect on the wider determinants of health and these factors are difficult for us to influence, especially if conditions continue to deteriorate. Only by robust partnership working and visioning with our health and social care colleagues can these external factors be addressed and accounted for.

6.4 Pace of change and monitoring

We are signed up to whole system transformation and coordination of service provision. Unfortunately, multi organisational commissioning makes placed-based commissioning a real challenge in the near future. Additionally, changes to political policy of any future government may impact on both pace and direction.

Further changes to the commissioning landscape could result in more instability and making long term planning and transformation difficult to implement.

A further challenge we face is trying to deliver on transformation while still being required to demonstrate improvement using short term transactional process measures. Large scale change and normative integration requires robust longer term goals that encourage transformation not hinder.

However, despite these challenges we do consider that within NHS Newcastle CCG we can demonstrate many of the conditions for transformation required in order to successfully deliver the Five Year Forward View.

- Stable and ambitious collective leadership
- Commissioners, providers, councils, LETBs, HWBs and partners work collaboratively within a defined local health economy
- High levels of patient and community engagement
- Strong clinical leadership and engagement
- Current service quality, experience and outcomes are satisfactory, or better, with plans for improvement
- Sound financial position
- Strong primary care and out of hours system, including people with long term conditions
- Plans to invest in some workforce areas
- Shared vision between partners on estates and capital, procurement and information technology
- Development of interoperable information and technology system

7. Summary

The purpose of this narrative document is twofold, it will provide assurance to NHS England that our plans are credible, deliverable and meet the NHS Constitution supported by agreed contracts with providers.

But, more than that it will tell the story to the reader of where we are as an organisation, our patients and public will recognize us for our achievements and where we have made improvements in outcomes for them.

Through a process of sharing with all staff and relevant stakeholders the narrative will be owned and used in a wide ranging arena.

We believe our ambition as outlined within our plan is relatively high, however we recognise the complex financial environment in which we are working and this impacts upon our confidence to deliver as many of these complexities are out with our control. Where they are within our control we have a high degree of confidence.