A meeting of NHS North Tyneside Clinical Commissioning Group Governing Body is to be held in Public on Tuesday 21 May 2019, 10:15 – 12:00, in Longsands North, 12 Hedley Court, Orion Business Park, Tyne Tunnel Trading Estate, North Shields NE29 7ST

Members of the public are invited to meet members of the Governing Body informally prior to the meeting, from 10:00-10:15

This meeting will be recorded for minuting purposes as a trial. When you sign to confirm your attendance, you are also agreeing to the proceedings being recorded.

**Agenda**

<table>
<thead>
<tr>
<th>Item No</th>
<th>Item</th>
<th>Lead</th>
<th>Enc/ Verbal</th>
<th>Action Required</th>
<th>Time</th>
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<tbody>
<tr>
<td>1</td>
<td>Welcome and Introductions</td>
<td>Dr Scott</td>
<td>Verbal</td>
<td></td>
<td>10:15</td>
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<tr>
<td>2</td>
<td>Apologies for Absence</td>
<td>Dr Scott</td>
<td>Verbal</td>
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<tr>
<td>3</td>
<td>Confirmation of Quorancy</td>
<td>Dr Scott</td>
<td>Verbal</td>
<td>Confirm</td>
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<tr>
<td>4</td>
<td>Declarations of Interest</td>
<td>Dr Scott</td>
<td>Enclosure</td>
<td>Manage</td>
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<tr>
<td>5</td>
<td>Minutes of the Previous Meeting held on 26 March 2019</td>
<td>Dr Scott</td>
<td>Enclosure</td>
<td>Agree</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Matters Arising from the Previous Meeting held on 26 March 2019</td>
<td>Dr Scott</td>
<td>Verbal</td>
<td>Respond</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Action Log</td>
<td>Dr Scott</td>
<td>Enclosure</td>
<td>Update</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Report from Chair and Chief Officer</td>
<td>Dr Scott/Mr Adams</td>
<td>Verbal</td>
<td>Note</td>
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</tr>
<tr>
<td>9</td>
<td><strong>Provider Assurance</strong></td>
<td>Sir James Mackey</td>
<td>Verbal</td>
<td>Assurance</td>
<td>10:25</td>
</tr>
<tr>
<td>9.1</td>
<td>• Urgent Care</td>
<td>Sir James Mackey</td>
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<td></td>
<td>• Ambulance Delays</td>
<td>Sir James Mackey</td>
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<td></td>
<td>• 4 Hour Waits</td>
<td>Sir James Mackey</td>
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<tr>
<td>9.2</td>
<td>Achievement of the National Cancer Targets</td>
<td>Sir James Mackey</td>
<td>Verbal</td>
<td>Assurance</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td><strong>Quality &amp; Safety</strong></td>
<td>Mr Connolly</td>
<td>To be tabled</td>
<td>Information</td>
<td>11:10</td>
</tr>
<tr>
<td>10.1</td>
<td>Improvement and Assessment Framework (IAF)</td>
<td>Mr Connolly</td>
<td></td>
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<tr>
<td>10.2</td>
<td>Integrated Performance &amp; Quality Report</td>
<td>Mr Connolly/Dr</td>
<td>Enclosure</td>
<td>Assurance</td>
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<tr>
<td>11</td>
<td>Finance &amp; Contracting</td>
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<tr>
<td>11.1</td>
<td>Financial Position Report</td>
<td>Mr Connolly</td>
<td>Verbal</td>
<td>Assurance</td>
<td>11:30</td>
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<tr>
<th>12</th>
<th>Public and Patient Involvement</th>
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<tr>
<td>12.1</td>
<td>Report from the Patient Forum</td>
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<th>13</th>
<th>Strategic &amp; Commissioning</th>
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<tbody>
<tr>
<td>13.1</td>
<td>Final Operating Plan &amp; Commissioning Priority Areas</td>
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<th>14</th>
<th>Governance and Assurance</th>
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<tr>
<td>14.1</td>
<td>Terms of Reference - IM&amp;T Strategy Group</td>
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<tr>
<th>15</th>
<th>Items for Information</th>
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</table>
| 15.1 | Reports/Minutes from Committees of the Governing Body for Assurance:  
\- Quality & Safety Committee: 05.02.19, 02.04.19  
\- Primary Care Committee: 14.02.19  
\- Northern CCG Joint Committee: 07.03.19 | Mrs Walker | Enclosures | Note | 11:55 |

<table>
<thead>
<tr>
<th>16</th>
<th>Date of Next Meeting</th>
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| Tuesday 23 July 2019:  
08:30 – 09:50: Private Governing Body Meeting  
09:50 – 10:00: Members of the Public meet the Governing Body  
10.00 -10:30: Annual General Meeting  
10:30 - 12:00: Governing Body Meeting in Public  
Venue: Longsands North, NTCCG, Hedley Court |
## Published Register of Declarations of Interests by Decision Makers v2-0 issued 25 April 2019

This register lists members of Governing Body; members of Governing Body committees, and as appropriate sub committees; staff grade 8d and above if not already listed; members of new care models joint provider/commissioner groups/committees; members of advisory groups which contributes to direct or delegated decision making on the commissioning or provision of tax payer services.

<p>| Surname | Forename | Current Position(s) held in CCG | Declared Interest (name of organisation and nature of business) | Type of Interest | Non Financial Interests | Non Financial Personal Interests | Is the Interest direct or indirect? | Nature of Interest | From | To | Action taken to mitigate risk |
|---------|----------|---------------------------------|---------------------------------------------------------------|------------------|-----------------------|----------------------------------|----------------------------------|------------------|----------------|--------------------------------|
| Adams   | Mark     | Governing Body member/Committee member | Beverley Park Leisure Ltd | Direct | Director | 2008 | Ongoing | Not relevant to CCG role |
| Adams   | Mark     | Governing Body member/Committee member | GLISKR.com Ltd | Direct | Director | 2015 | Ongoing | Will declare at meetings as appropriate |
| Adams   | Mark     | Governing Body member/Committee member | NHS Newcastle Gateshead Clinical Commissioning Group | Direct | Accountable Officer | 01/12/2016 | Ongoing | Will declare at meetings as appropriate |
| Addy    | Catherine | Entry Closed 28/1/19 as no longer a member of IM&amp;T Committee | Woodlands Park Health Centre | | IM&amp;T Strategy Group | Aug 17 | | I will comply with the Standards of Business Conduct |
| Airey   | Gillian  | NECS Employee supporting NTCCG | None | None | | | | |
| Charlton | Gary     | CCG Employee | Entry suspended 28/1/19 (working abroad) | | Non-financial personal interest | Indirect | relative working within CCG | 13/05/2016 | Ongoing | I will comply with standards of business conduct policy |
| Charlton | Walter   | CCG Employee | Wife is a bio medical science technician at Freeman Hospital | | | Indirect | Wife is a bio medical science technician at Freeman Hospital | Circa 2001 | Ongoing | Will comply with Standards of Business Conduct Policy |
| Charlton | Walter   | CCG Employee | Daughter – in – law is employed as District nurse with Northumbria Healthcare Foundation Trust | | | Indirect | Daughter – in – law is employed as District nurse with Northumbria Healthcare Foundation Trust | Circa 2014 | Ongoing | Will comply with Standards of Business Conduct Policy |
| Charlton | Walter   | CCG Employee | Nephew is employed by North Tyneside CCG as a Primary Care development manager | | | Indirect | Nephew is employed by North Tyneside CCG as a Primary Care development manager | Circa 2013 | Ongoing | Will comply with Standards of Business Conduct Policy |
| Charlton | Walter   | CCG Employee | Non Executive Director at Linckell and North Tyneside Community Development Trust | | | Direct | Non Executive Director | 01/10/2017 | 26/02/2019 | Will comply with Standards of Business Conduct Policy |
| Connolly | Jon      | Governing Body member/Committee member | JM Connolly Limited | Direct | Director (Company inactive) | Sep-14 | | No conflict as company inactive |
| Surname | Forename | Current Position(s) held in CCG i.e. Governing Body member; Committee member; Council of Practices member (Member practice); CCG employee; other | GP Practice (if applicable) | Declared Interest (name of organisation and nature of business) | Financial | Non Financial Professional Interests | Non Financial Personal Interests | Is the interest direct or indirect? | Nature of Interest | From | To | Action taken to mitigate risk |
|---------|----------|-----------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------|----------|---------------------------------|---------------------------------|----------------------------------|-----------------|------|-----------------------------|
| Connolly | Jon      | Governing Body member/ Committee member | NHS Northumberland Clinical Commissioning Group | ✓ | Direct | Chief Finance Officer | 01/03/2019 | I will comply with the Standards of Business Conduct and Declarations of Interest Policy |
| Coyle   | Mary     | Governing Body member/ Committee member | Newcastle University, Trustee Member of Pension Trustee Limited | ✓ | Indirect | There may be a connection between the University and the CCG | 2011 | Ongoing | Not required |
| Coyle   | Mary     | Governing Body member/ Committee member | Forum Member, Northumbrian Water Forum | ✓ | Indirect | Northumbrian Water and CCG may have some connection | 2011 | Ongoing | Not necessary |
| Coyle   | Mary     | Governing Body member/ Committee member | Board Chair, Shared Interest Society and Shared Interest Foundation | ✓ | Indirect | There may be connection between Shared Interest and CCG | 2015 | Ongoing | Not required |
| Craig   | Lynn     | Consultant Future Care | None | | | | | |
| Evans   | Ruth     | Council of Practice member/ Committee Member CCG Employee | The Village Green Surgery | ✓ | Direct | Partner | 2007 | Ongoing | I will comply with the Standards of Business Conduct and Declarations of Interest Policy; I will declare at meetings as required; I will not participate in any CCG business relating to the surgery |
| Evans   | Ruth     | Council of Practice member/ Committee Member CCG Employee | The Village Green Surgery | ✓ | Direct | Practice is shareholder in Tynehealth | 2015 | Ongoing | I will comply with the Standards of Business Conduct and Declarations of Interest Policy; I will declare at meetings as required |
| Evans   | Ruth     | Council of Practice member/ Committee Member CCG Employee | The Village Green Surgery | ✓ | Indirect | | | |
| Evans   | Ruth     | Council of Practice member/ Committee Member CCG Employee | | | | | | |
| Evans   | Ruth     | Council of Practice member/ Committee Member CCG Employee | The Village Green Surgery | | | | | |</p>
<table>
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<tr>
<th>Surname</th>
<th>Forename</th>
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<th>GP Practice (if applicable)</th>
<th>Declared Interest (name of organisation and nature of business)</th>
<th>Financial Non-Personal Interests</th>
<th>Non - Financial Personal Interests</th>
<th>Is the interest direct or indirect?</th>
<th>Nature of interest</th>
<th>From</th>
<th>To</th>
<th>Action taken to mitigate risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goldthorpe</td>
<td>Jeffrey</td>
<td>Head of Finance</td>
<td>Nothing to declare</td>
<td></td>
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<tr>
<td>Grieveson</td>
<td>Maureen</td>
<td>Committee member/ CCG employee</td>
<td>Nothing to declare</td>
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<tr>
<td>Hall</td>
<td>Margaret</td>
<td>Cabinet Member for Health and Wellbeing North Tyneside Council</td>
<td>Cabinet Member for Health (Suzanne Duncan - Daughter, HR Manager North Tyneside Council)</td>
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<tr>
<td>Hayward</td>
<td>Eleanor</td>
<td>CCG Employee - Clinical Director</td>
<td>Suzanne Duncan - Daughter, HR Manager North Tyneside Council</td>
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<tr>
<td>Hemingway</td>
<td>Jan</td>
<td>CCG Employee</td>
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<tr>
<td>Horfield</td>
<td>Philip</td>
<td>Committee member</td>
<td>The Village Green Surgery</td>
<td>NHS England CNTW</td>
<td>Indirect</td>
<td>Daughter is Commissioning Manager for NHS England Health &amp; Social Justice</td>
<td>2017 ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy</td>
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<tr>
<td>Horfield</td>
<td>Philip</td>
<td>Committee member</td>
<td>The Village Green Surgery</td>
<td>The Village Green Surgery</td>
<td>Direct</td>
<td>Partner</td>
<td>2015 ongoing</td>
<td>I will declare at meetings as required</td>
<td>I will not participate in any CCG business relating to the practice or the company which the new business is competitor to</td>
<td></td>
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<tr>
<td>Horfield</td>
<td>Philip</td>
<td>Committee member</td>
<td>The Village Green Surgery</td>
<td>Tynehealth GP Federation</td>
<td>Direct</td>
<td>Practice is shareholder in Tynehealth</td>
<td>2014 ongoing</td>
<td>I will declare at meetings as required</td>
<td></td>
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<tr>
<td>Kent</td>
<td>Alexandra</td>
<td>CCG Employee - Clinical Director</td>
<td>Priory Medical Group</td>
<td></td>
<td>Indirect</td>
<td>Emma Lackey (wife) is a GP employee in member practice (Woodlands Park Health Centre)</td>
<td>08/04/2013 ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy</td>
<td>I will declare at meetings as required</td>
<td></td>
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<tr>
<td>Lackey</td>
<td>Shaun</td>
<td>Committee member/ CCG Employee</td>
<td>Woodlands Park Health Centre - GMS GP</td>
<td></td>
<td>Indirect</td>
<td>Director and shareholder of TRUSTY LTD, a company which provides GP services and consultancy (including website services in the near future)</td>
<td>09/04/2019 ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy</td>
<td>I will declare at meetings as required</td>
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<tr>
<td>Lackey</td>
<td>Shaun</td>
<td>Committee member/ CCG Employee</td>
<td>Director and share holder of TRUSTY LTD</td>
<td></td>
<td>Indirect</td>
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<tr>
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<td>Declared Interest (name of organisation and nature of business)</td>
<td>Financial Non Professional Interests</td>
<td>Non Financial Personal Interests</td>
<td>Is the interest direct or indirect?</td>
<td>Nature of interest</td>
<td>From</td>
<td>To</td>
<td>Action taken to mitigate risk</td>
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<tr>
<td>Martin</td>
<td>James</td>
<td>Committee member/ CCG employee</td>
<td>Northumberland Tyne and Wear NHS Foundation Trust</td>
<td>✓ Indirect</td>
<td>Wife is a Clinical Psychologist working for NTW Mental Health Trust</td>
<td>01/02/2014</td>
<td>Ongoing</td>
<td>Whilst NTW is a provider of services, the wife's role (Clinical Psychologist) is highly unlikely to lead to any conflict of interest. Notwithstanding this the NTCCG Standards of Business Conduct and Declarations of Interest Policy will be followed.</td>
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<tr>
<td>Paradis</td>
<td>Anya</td>
<td>CCG Employee</td>
<td>N/A</td>
<td>Nothing to declare</td>
<td>Direct</td>
<td>Shareholder</td>
<td>2014/15</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy</td>
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<tr>
<td>Rice</td>
<td>Marc</td>
<td>CCG Employee employee</td>
<td>None</td>
<td>Direct</td>
<td>GP Partner</td>
<td>01/05/2008</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy</td>
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<tr>
<td>Richardson</td>
<td>Kirsten</td>
<td>GP Partner &amp; Council</td>
<td>Bewick Medical Centre</td>
<td>✓ Direct</td>
<td>GP Partner</td>
<td>01/05/2008</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy</td>
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<tr>
<td>Richardson</td>
<td>Kirsten</td>
<td>GP Partner &amp; Council</td>
<td>Bewick Medical Centre</td>
<td>✓ Direct</td>
<td>Shareholder</td>
<td>2014/15</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy</td>
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<tr>
<td>Richardson</td>
<td>Kirsten</td>
<td>GP Partner &amp; Council</td>
<td>Bewick Medical Centre</td>
<td>✓ Direct</td>
<td>Member of Local Health</td>
<td>30th March 2015</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy</td>
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<tr>
<td>Richardson</td>
<td>Kirsten</td>
<td>GP Partner &amp; Council</td>
<td>Bewick Medical Centre</td>
<td>✓ Direct</td>
<td>CCG Role</td>
<td>01.04.17</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy</td>
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<tr>
<td>Richardson</td>
<td>Kirsten</td>
<td>GP Partner &amp; Council</td>
<td>Bewick Medical Centre</td>
<td>✓ Indirect</td>
<td>Husband is Group Medical Director for South Locality and Trust Wide. This includes specialist services and neurological services.</td>
<td>Apr-15</td>
<td>Ongoing</td>
<td>I will not participate in any CCG business relating to NTW FT.</td>
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<tr>
<td>Richardson</td>
<td>Kirsten</td>
<td>GP Partner &amp; Council</td>
<td>Bewick Medical Centre</td>
<td>✓ Indirect</td>
<td>Husband is Old Age Psychiatrist</td>
<td>Jan-06</td>
<td>Ongoing</td>
<td>I will not participate in any CCG business relating to this service.</td>
<td></td>
<td></td>
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<tr>
<td>Ross</td>
<td>Rebecca</td>
<td>Council of Practices attendee, Practice</td>
<td>Mallard Medical Practice</td>
<td>✓ Direct</td>
<td>Employee</td>
<td>Sep-11</td>
<td>Present</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy</td>
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<tr>
<td>Rundle</td>
<td>Steve</td>
<td>Committee member/ CCG employee</td>
<td>Sheila Rundle (Spouse)</td>
<td>✓ Indirect</td>
<td>Partner at Craggall and University Medical Group, Durham and GP Constituency Deputy (Durham) at NHS North Durham Clinical Commissioning Group</td>
<td>04/01/2013</td>
<td>Ongoing</td>
<td>Unlikely to lead to any conflict of interest. Notwithstanding this the NTCCG Standards of Business Conduct and Declarations of Interest Policy will be followed</td>
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<tr>
<td>Rundle</td>
<td>Steve</td>
<td>Committee member/ CCG employee</td>
<td>Dr Jan Panke (Brother in Law)</td>
<td>✓ Indirect</td>
<td>Partner at Craggall and University Medical Group, Durham and GP Constituency Deputy (Durham) at NHS North Durham Clinical Commissioning Group</td>
<td>04/01/2013</td>
<td>Ongoing</td>
<td>Unlikely to lead to any conflict of interest. Notwithstanding this the NTCCG Standards of Business Conduct and Declarations of Interest Policy will be followed</td>
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<tr>
<td>Rundle</td>
<td>Steve</td>
<td>Committee member/CCG employee</td>
<td>Or Anna Basu (Sister in Law)</td>
<td>✗ Indirect Clinical Senior Lecturer, Newcastle University. Honorary Consultant Paediatric Neurologist at The Newcastle upon Tyne Hospitals NHS Foundation Trust</td>
<td>Direct GP Partner and GP trainer; member of CCG Council of Practices.</td>
<td>Ongoing 07/01/2013</td>
<td>Unlikely to lead to any conflict of interest. Notwithstanding this the NTCCG Standards of Business Conduct and Declarations of Interest Policy will be followed</td>
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<tr>
<td>Scott</td>
<td>Richard</td>
<td>Clinical Chair of CCG</td>
<td>Marine Avenue Medical Centre</td>
<td>✗ Indirect Dr Anna Basu (Sister in Law)</td>
<td>Direct GP Partner and GP trainer; member of CCG Council of Practices.</td>
<td>2008 present</td>
<td>I will comply with the Standards of Business Conduct &amp; Declarations of Interest Policy</td>
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<tr>
<td>Scott</td>
<td>Richard</td>
<td>Clinical Chair of CCG</td>
<td>Tyne Health (North Tyneside GP Federation)</td>
<td>✗ Indirect Dr Anna Basu (Sister in Law)</td>
<td>Direct Partner in a GP Practice that is a shareholder of Tyne Health Practice Manager is a director of Tyne Health</td>
<td>2013 present</td>
<td>I will comply with the Standards of Business Conduct &amp; Declarations of Interest Policy</td>
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<tr>
<td>Scott</td>
<td>Richard</td>
<td>Clinical Chair of CCG</td>
<td>Northumbria Healthcare FT</td>
<td>✗ Indirect Dr Anna Basu (Sister in Law)</td>
<td>Direct Nurse for Northumbria Healthcare FT</td>
<td>2008 present</td>
<td>I will comply with the Standards of Business Conduct &amp; Declarations of Interest Policy</td>
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<tr>
<td>Shabde</td>
<td>Neela</td>
<td>Governing Body Member</td>
<td>Be Serene Limited - business of keeping health &amp; well</td>
<td>✔ Direct Nurse for Northumbria Healthcare FT</td>
<td>Direct Nurse for Northumbria Healthcare FT</td>
<td>2008 present</td>
<td>No conflict as not trading</td>
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<tr>
<td>Shabde</td>
<td>Neela</td>
<td>Governing Body Member</td>
<td>Krista Associated, UK Ltd - Training &amp; Development Company</td>
<td>✔ Direct Nurse for Northumbria Healthcare FT</td>
<td>Direct Nurse for Northumbria Healthcare FT</td>
<td>2008 present</td>
<td>No conflict as not trading</td>
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<tr>
<td>Shabde</td>
<td>Neela</td>
<td>Governing Body Member</td>
<td>World Health Innovation Summit (Community Interest Company)</td>
<td>✔ Direct Nurse for Northumbria Healthcare FT</td>
<td>Direct Nurse for Northumbria Healthcare FT</td>
<td>2008 present</td>
<td>No conflict as not trading</td>
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<tr>
<td>Shabde</td>
<td>Neela</td>
<td>Governing Body Member</td>
<td>Ishybruce Anxiety &amp; Weight Management, Life coaching &amp; Therapy Services</td>
<td>✗ Indirect Nurse for Northumbria Healthcare FT</td>
<td>Direct Nurse for Northumbria Healthcare FT</td>
<td>2008 present</td>
<td>No conflict as not trading</td>
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<tr>
<td>Southern</td>
<td>Alice</td>
<td>Practice Manager/Committee</td>
<td>Practice Manager at VP Practice - Collingwood Surgery</td>
<td>None None None</td>
<td>None None None</td>
<td>None None None</td>
<td>No direct involvement</td>
<td>2018 ongoing</td>
<td>No conflict</td>
<td></td>
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<tr>
<td>Stephens</td>
<td>Wendy</td>
<td>Primary Care Contract Manager (NHSE)</td>
<td>Practice Manager at VP Practice - Collingwood Surgery</td>
<td>None None None</td>
<td>None None None</td>
<td>None None None</td>
<td>No conflict - other than that which all GPs have who are members of CCGs</td>
<td></td>
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<tr>
<td>Tomson</td>
<td>Dave</td>
<td>GP Partner</td>
<td>Collingwood Surgery</td>
<td>✔ Direct Nurse for Northumbria Healthcare FT</td>
<td>Direct Nurse for Northumbria Healthcare FT</td>
<td>1992 ongoing</td>
<td>I will comply with the standards of Business Conduct and Declarations of Interest Policy</td>
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<tr>
<td>Tomson</td>
<td>Dave</td>
<td>GP Partner</td>
<td>Tyne Health (Provider Organisation)</td>
<td>✔ Direct Nurse for Northumbria Healthcare FT</td>
<td>Direct Nurse for Northumbria Healthcare FT</td>
<td>2011 ongoing</td>
<td>I will comply with the standards of Business Conduct and Declarations of Interest Policy</td>
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<td>Surname</td>
<td>Forename</td>
<td>Current Position(s) held in CCG i.e. Governing Body member; Committee member; Council of Practices member (Member practice); CCG employee; other</td>
<td>GP Practice (if applicable)</td>
<td>Declared Interest (name of organisation and nature of business)</td>
<td>Financial</td>
<td>Non Financial Professional Interests</td>
<td>Non Financial Personal Interests</td>
<td>Is the interest direct or indirect?</td>
<td>Nature of interest</td>
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<td>To</td>
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<td>Tomson</td>
<td>Dave</td>
<td>Locality Director</td>
<td>Collingwood Surgery</td>
<td>CCG</td>
<td>✓</td>
<td>Direct</td>
<td>Paid by CCG</td>
<td>2018</td>
<td>Ongoing</td>
<td>I will comply with the standards of Business conduct and Declarations of interest policy</td>
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<tr>
<td>Tomson</td>
<td>Dave</td>
<td>Locality Director</td>
<td>Collingwood Surgery</td>
<td>CCG</td>
<td>✓</td>
<td>Direct</td>
<td>Freelance educationalist with interests in shared decision making and persistent pain - I sometimes do work for CCG on these areas</td>
<td>2018</td>
<td>Ongoing</td>
<td>I will withdraw from decision making at relevant meetings. I will comply with the standards of Business conduct and Declarations of interest policy</td>
<td></td>
</tr>
<tr>
<td>Walker</td>
<td>Irene</td>
<td>Committee member</td>
<td>East Bedlington Community Centre Trust. Charity.</td>
<td>✓</td>
<td>Direct</td>
<td>East Bedlington Community Centre Trust. This is a charity responsible for developing and managing a local community centre in the Bedlington area.</td>
<td>01/01/2014</td>
<td>Ongoing</td>
<td>This is unlikely to present any conflict of interest. In any event the NTCCG Standards of Business Conduct and Declarations of Interest Policy will be followed.</td>
<td></td>
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<tr>
<td>Westwood</td>
<td>Mark</td>
<td>Council of Practices Representative &amp; GP Partner</td>
<td>The Village Green Surgery</td>
<td>The Village Green Surgery</td>
<td>✓</td>
<td>Direct</td>
<td>Partner</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy I will declare at meetings as required I will not participate in any CCG business relating to the surgery</td>
<td></td>
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<tr>
<td>Westwood</td>
<td>Mark</td>
<td>Council of Practices Representative &amp; GP Partner</td>
<td>The Village Green Surgery</td>
<td>Tynehealth GP Federation</td>
<td>✓</td>
<td>Direct</td>
<td>Practice is shareholder in Tynehealth</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy I will declare at meetings as required I will not participate in any CCG business relating to this organisation</td>
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<td>Westwood</td>
<td>Mark</td>
<td>Council of Practices Representative &amp; GP Partner</td>
<td>The Village Green Surgery</td>
<td>Newcastle upon Tyne Hospital Foundation Trust</td>
<td>✓</td>
<td>Direct</td>
<td>Clinical Assistant Neurology Trial</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy I will declare at meetings as required I will not participate in any CCG business relating to this organisation</td>
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<td>Westwood</td>
<td>Mark</td>
<td>Council of Practices Representative &amp; GP Partner</td>
<td>The Village Green Surgery</td>
<td>Academic Health Science Network</td>
<td>✓</td>
<td>Direct</td>
<td>Primary Care lead for Connected Health Cities (Great North Care Project)</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy I will declare at meetings as required I will not participate in any CCG business relating to this organisation</td>
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<tr>
<td>Westwood</td>
<td>Mark</td>
<td>Council of Practices Representative &amp; GP Partner</td>
<td>The Village Green Surgery</td>
<td>Northumbria Healthcare Foundation Trust (NHCFT)</td>
<td>✓</td>
<td>Indirect</td>
<td>Operational Service Manager</td>
<td>Ongoing</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations of Interest Policy I will declare at meetings as required I will not participate in any CCG business relating to this organisation</td>
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<tr>
<td>Willis</td>
<td>Dave</td>
<td>Governing Body member/ Committee member</td>
<td>No conflict of interests</td>
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<td>Surname</td>
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<td>Current Position(s) held in CCG i.e. Governing Body member; Committee member; Council of Practices member (Member practice), CCG employee; other</td>
<td>GP Practice (if applicable)</td>
<td>Declared Interest (name of organisation and nature of business)</td>
<td>Non Financial Professional Interests</td>
<td>Non Financial Personal Interests</td>
<td>Is the interest direct or indirect?</td>
<td>Nature of interest</td>
<td>From</td>
<td>To</td>
<td>Action taken to mitigate risk</td>
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<tr>
<td>Woollam</td>
<td>Meg</td>
<td>CCG Communication and Engagement Sub-committee</td>
<td>NA</td>
<td>Search Newcastle Services for Older People</td>
<td>Yes</td>
<td>Direct</td>
<td>Trustee</td>
<td>01/04/2016</td>
<td>To date</td>
<td>I will declare at meetings as required</td>
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<td>Woollam</td>
<td>Meg</td>
<td>CCG Communication and Engagement Sub-committee</td>
<td>NA</td>
<td>Healthwatch North Tyneside</td>
<td>Yes</td>
<td>Direct</td>
<td>Employee</td>
<td>01/04/2013</td>
<td>To date</td>
<td>I will declare at meetings as required</td>
<td></td>
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<tr>
<td>Young- Murphy</td>
<td>Lesley</td>
<td>Governing Body member, committee member Primary Care, CE, commissioning.</td>
<td>NA</td>
<td>Professor at Northumbria University</td>
<td>✔</td>
<td>Direct</td>
<td>Professional reputation/ research/development role</td>
<td>01/04/2013</td>
<td>Ongoing</td>
<td>I will comply with the Standards of Business Conduct and Declarations Policy; I will declare at meetings as required</td>
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<tr>
<td>Young- Murphy</td>
<td>Lesley</td>
<td>Governing Body member, committee member Primary Care, CE, commissioning.</td>
<td>NA</td>
<td>HEE/ CRN Lead for NMAHP Research and Chair of HEE/CRN NMAHP Strategy Implementation Group</td>
<td>✔</td>
<td>Direct</td>
<td>Professional reputation/ research/development role</td>
<td>05-Feb-18</td>
<td>Present</td>
<td>I will comply with the Standards of Business Conduct and Declarations Policy; I will declare at meetings as required</td>
<td></td>
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<tr>
<td>Zwanenberg</td>
<td>Linda van</td>
<td>Trustee of Healthwatch North Tyneside (attends Primary Care Committee)</td>
<td>I have no interests to declare.</td>
<td>I have no interests to declare.</td>
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<td>I have no interests to declare.</td>
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Minutes of the North Tyneside CCG Governing Body meeting in Public held on Tuesday 26 March 2019, 10:15 – 11:30, in Hedley Court

Present:
Dr Richard Scott                Clinical Chair (Chair)
Mark Adams                       Chief Officer
Jon Connolly                    Chief Finance Officer
Mary Coyle                      Deputy Lay Chair
Eleanor Hayward                 Lay Member
Dave Willis                     Lay Member
Dr Lesley Young-Murphy          Executive Director of Nursing & Chief Operating Officer
Dr Neela Shabde                 Secondary Care Doctor

In Attendance:
Anya Paradis                    Director of Contracting & Commissioning
Irene Walker                    Head of Governance
Wendy Hume                      PA (Minutes)

Apologies:
Dr Ruth Evans                   Medical Director

NTGB/19/017 Welcome & Introductions (Agenda Item 1)
Dr Scott welcomed members of the public to the North Tyneside CCG Governing Body meeting in Public.

NTGB/19/018 Apologies for Absence (Agenda Item 2)
Apologies were noted as above

NTGB/19/019 Confirmation of Quoracy (Agenda Item 3)
The meeting was confirmed as quorate.

NTGB/19/020 Declarations of Interest (Agenda Item 4)
Dr Scott asked the members:
Are there any declarations on the enclosed register of interests which are relevant to today’s agenda?

Are there any additional declarations of interest, including gifts and hospitality relevant to today’s meeting?

There were no additional declarations.
Minutes of the Previous Meeting held on 21 January 2019

The minutes of the previous meeting were agreed as being accurate.

Matters Arising from the Previous Meeting held on 21 January 2019

There were no matters arising from the previous meeting.

Action Log

NTGB/18/029; Action 1; This item is on the planner.

Report from Chair and Chief Officer

Chair's Report

Dr Scott reported that there had been a Chairs and Non-Executive Directors event in Newcastle on 6 March 2019. Dr Scott had attended with Ms Coyle and Dr Shabde. It was a good opportunity to meet with other Chairs and Non-Executive Directors. There were also inspirational speakers and they spoke about aspects of the Integrated Care System (ICS), the coming together and working at scale with the North East and Cumbria as one collective regional part and what was emerging out of this in relation to the NHS Long Term Plan. Ms Coyle commented that it was a good opportunity to meet with Non-Executive Directors and Clinical Chairs as there is not enough of these events. Ms Coyle also said that it was good value for her time. Dr Shabde commented that it was a useful event, the NHS is always changing but without the changes to legislation.

Dr Scott informed the members that Alan Foster had presented at the Health and Wellbeing Board and at the away day explaining and informing what ICS might look like referencing some of the old SHA. North East and Cumbria are coming together and working at scale. Mrs Burke said that the presentation was interesting but there was no Social Care; and there was no mention of the interface with the North of Tyne combined Authority.

Dr Scott reported that the Council of Practices (CoP) meeting was a good meeting. The meeting discussed the Committee Effectiveness Survey including the free text comments and results were really positive. The CoP also discussed the Primary Care Network (PCN) whereby groups of practices come together and work collectively with a population of 30 – 50 thousand patients. Table top work was completed within the current localities of North West, Wallsend, Whitley Bay and North Shields.

Dr Young-Murphy confirmed that a lot of work is being carried out with stakeholders and the public building on working together. The practices work with the hospitals and the voluntary sector under the banner of Primary Care Home looking at the best approach and the right service delivery models. Dr Young-Murphy also confirmed that the timescales are tight for the practices to
comply with the contractual requirements of the PCN Directed Enhanced Service requirements. However, previous locality work and investment has provided a good context for this. Dr Scott stated that this is an agenda item for the locality meetings and on the agenda for the LMC open meeting that is happening next week.

**Chief Officer’s Report**

Mr Adams reported that ICS discussions are ongoing and the ICS gateway process would not be going ahead in April as planned. NHS England has said that ICS would stay as aspirant for now and there is currently no formal process and ICS will continue on the path of working together.

Mr Adams also reported that as the CCG year end is a busy time of year and the CCG continues to focus on delivering services for the public and patients. The yearly round of contracting is continuing.

**NTGB/19/025  Integrated Performance & Quality Report (Agenda Item 9.1)**

Mr Connolly presented the report that was distributed with the papers.

NHS constitution performance remains good overall but there are persistent issues with ambulance handovers and cancer waiting times.

Based on current performance the CCG will receive no quality premium as the waiting list has increased and the 62 day cancer wait target is not being met.

The CCG continues to work with the main providers to manage the increase in people on the elective waiting list. For the first time in the waiting list has decreased. Newcastle hospitals are working with NHS England to establish local monitoring to reflect Newcastle’s specific position but the national target will be demanding.

In relation to the Quality Premium the CCG is not hitting the gateway target. The CCG is continuing discussions with NHS England about the opening position as there are no more people waiting. Ms Coyle asked Mr Connolly to explain this. Mr Connolly explained that there was a change in focus and increased scrutiny on the incomplete pathway. Rather than focusing on referral to treatment times, the focus is now on the number of people being treated. As this was not a key indicator before the CCG is trying to get recognition from NHS England for the change in focus.

Mrs Hayward said that the A&E waits are doing much better than most and the government is going to abandon the target for A&E. Mrs Hayward asked whether there had been a formal announcement and whether there is anything that the CCG can do formally. Dr Young-Murphy replied that there are no planned performance changes at present.

Ms Coyle queried the referral to treatment case in Devon and the breach by Ramsey Healthcare. Dr Young-Murphy responded that North Devon had failed to close this case off when the patient transferred. Ramsey Healthcare
identified a breach in their standards and Ramsey Healthcare has put an action plan into place. These were 2 separate patients which have now been dealt with appropriately.

Ms Coyle commented that the percentage rate in relation to the 62 day cancer wait is 74.2% in December and this is low for the CCG as the standard is 85% and it is a long way off. Mr Connolly said that this is a level of performance where the CCG is not hitting the target. Dr Young-Murphy commented that all organisations are working collaboratively to improve the services for patients and recognise that the current situation is not good enough. The local action plan is closely monitored against delivery. Mrs Burke said that 3 out of 12 trusts across the North East and Cumbria had achieved the target.

Mr Willis asked in relation to the ambulance handovers whether the report comments were before or after the new divert pathway was put in place. Dr Young-Murphy responded that the report was after the new divert pathway. The ambulance handovers have been discussed in the Quality and Safety meeting and there are different mechanisms and flows in trusts. Some patients are held in the ambulance or in a different place in the hospital. Ambulances’ sitting outside is not necessarily the only indicator as to how busy it is in an A&E department. Just as no ambulances stacked does not mean the A&E department is not busy. Mr Willis stated that there will need to be more focus on this in future meetings if there is no improvement. Dr Young-Murphy confirmed that members of Northumbria Healthcare FT came and discussed this at a development session and this is a regular item on the Quality Surveillance Group and Quality Review Group meetings.

**Action 1:** Invite Northumbria Healthcare FT Chief Executive to attend a future Governing Body meeting (in public) to discuss NSECH and ambulance handovers.

Mrs Hayward asked whether anyone had died due to ambulances stacking. Dr Young-Murphy replied that this would be reported through STEIS and a route cause analysis would be completed and if that was the case the CCG and system partners would know about it.

Mrs Paradis said that in January and February there was a 45% decrease in handovers at NSECH and this is being looked at in the CCG to see if this happened before NSECH opened and if there has been significant changes. The Local Accident and Emergency Delivery Board (LADB) are completing work on this.

Dr Young-Murphy stated that the CCG cannot lose sight of the E.coli action on pages 25 – 27 if the report. Also Northumberland Tyne & Wear FT should be commended on their achievement in relation to their positive safe programme.

**Financial Position Report** (Agenda Item 10.1)

Mr Connolly presented the report that was distributed with the papers.

The main benefit accruals from 2017/18 where the actual cost was less than
expected (£3.5m) and better than expected delivery of savings from CHC and prescribing. There is also the impact of settlement of the S256 dispute with the local authority.

Acute performance is forecast to be over plan as the CCG has reached year-end with their main providers. This takes all risk out of the position, allowing the CCG to deliver their year-end target surplus. The delay in delivering intermediate care changes generates an adverse forecast outturn variance of around £1m. These savings will be delivered in 2019/20.

The adverse variance on primary care reflects the investment the CCG has made in this area.

The £3.9m forecast variance on reserves reflects additional surplus planned and investment of additional surplus in healthcare

Efficiency savings – the CCG is confident that they will deliver the plan. The main adverse variances are around intermediate care and Lucentis/ Avastin. These savings have been removed from the plan but are expected to be delivered in 2019/20.

Risks and mitigations have reduced significantly as the CCG has reached the year-end.

Ms Coyle commented that there were no surprises as Mr Connolly had kept the members informed of what to expect. Dr Scott stated as a CCG he is not aware of any other CCG nationally that have achieved this. Mr Willis reported that the Mazars materiality threshold is 1.5%.

NTGB/19/027 Report from the Patient Forum (Agenda Item 11.1)

Mrs Hayward gave a verbal update:

Key Points
- Steve Rundle, Commissioning Manager attended the last forum and presented the Commissioning Intentions.
- There is more emphasis on self-care
- The forum has been asked to take part in the GP Practices Participation Group.
- The members are keen to do more
- Members would like to look at the role they can play in the PCNs

NTGB/19/028 Review of the Risk Assurance Framework (Agenda Item 12.1)

Mrs Walker presented the report that was distributed with the papers.

Governing Body is asked to:

1. Review and receive the Risk Assurance Framework (RAF) Q4 18/19, with a particular focus on extreme and high risks;
2. To note that Audit Committee provides assurance on the veracity of the RAF; and
3. Confirm that they consider that the RAF accurately reflects the status
of risks, with five risks categorised as extreme (i.e. residual risk scores between 15-25).

Mrs Walker said that there had been effective risk management by directors and committees. There were circa 6 risks red at the start of the year and there are 5 red risks at year end, however 2 of these are new. Mr Willis confirmed that the report had been through the Audit committee and there was a recommendation to reduce the score of 1 risk.

The Governing Body:

1. Reviewed and received the Risk Assurance Framework (RAF) Q4 18/19, with a particular focus on extreme and high risks;
2. Noted that Audit Committee provides assurance on the veracity of the RAF; and
3. Confirmed that they consider that the RAF accurately reflects the status of risks, with five risks categorised as extreme (i.e. residual risk scores between 15-25).

**NTGB/19/029 Comms & Engagement Strategy** (Agenda Item 12.2)

Dr Young-Murphy gave a presentation.

This strategy builds on the CCG’s previous strategy and what the CCG heard people say about how they wanted to work with the CCG to reshape local services and the various ways in which they wanted to be involved and receive communication.

Key Points:
- NHS North Tyneside CCG’s Vision
- The Statement of Principles and the delivery of these principles
- Strategic Priority Themes
- To Involve patients, public and other key stakeholders as part of the commissioning cycle
  - Moving beyond involvement to collaboration and co-production ensures that local people and organisations find solutions to local challenges together.
- Co-production
  - This is part of a range of approaches that includes citizen involvement, participation, engagement and consultation. It is a cornerstone of self-care, of person-centred care and of health-coaching approaches all of which are included in the CCG commissioning and operating plans.
- Delivery & Measuring success
  - Annual work plan
  - All activity benchmarked against NHS England statutory guidance for engaging with patients and the public
  - The CCG will align outcomes and monitor the impact against the 10 principles of participation and against the continuum of inform-co-production
Governance
- NTCCG Governing Body retain overall accountability for the delivery of effective communications and engagement
- The communications and engagement steering group are responsible for monitoring, evaluating and reporting on communications and engagement activity. This group meets on a monthly basis
- Patient forum have a pivotal role in supporting delivery of the strategy

Ms Coyle asked how the CCG knows that they are managing effectiveness and was there a professional view on this. Dr Young-Murphy replied that there has been an independent review completed and the information available needs to be improved. Dr Shabde asked how the CCG is communicating with young people. Dr Young-Murphy said that there is joint work with the Local Authority including established forums and mechanisms. Dr Young-Murphy cited some good examples of work involving the CCG officers, London College and Looked after Children. Wally Charlton and Michelle Douthwaite from the CCG’s Transformation team have also been going into some local schools. Mrs Burke commented that children and young people are the best example and the Local Authority have a young mayor and there could be a better way of linking that up with sound mechanisms.

Dr Scott said that the general public do not usually interact with the CCG as the CCG is invisible to them. Dr Young-Murphy responded that people see the NHS as one NHS and do not realise that there are different organisations or that GPs are independent providers; they see the NHS as one NHS. Good work is being done every day and this is an opportunity to look at things differently together. The CCG does interact with the public on a daily basis in a variety of ways which are different to the way in which the providers interact but if we bring that together which the CCG does with a number of co-production pathway events that can powerful.

The Governing Body endorsed the ratification of the strategy and noted that the operational plan will be monitored via the Communication and Engagement Group.

**NTGB/19/030** Items for Information (Agenda Item 13.1)

The Governing Body received the following minutes of Committees for assurance.
- Quality & Safety Committee: 05.02.19
- Primary Care Committee: 13.12.19
- Patient Forum Notes: 10.01.19
- Northern CCG Joint Committee: 10.01.19

**NTGB/19/031** Any Other Business

There was no other business and the meeting closed at 11:30
NTGB/19/032  Date of Next Meeting (Agenda Item 14)

The next meeting of NHS North Tyneside Clinical Commissioning Group Governing Body is to be held on:

Date:  Tuesday 21 May 2019:
Time:  10:00 - 10:15:  Members of the Public meet the Governing Body
       10:15 – 12:00:  NTCCG Governing Body Meeting in Public
Venue:  Longsands North, NTCCG, Hedley Court
### Quality and Safety Committee Report:
An annual report to be brought to the Quality and Safety Committee (Q&SC) and Governing Body on healthcare acquired infections.

- **Resp. Officer:** Dr Young-Murphy
- **Target Date:** TBC
- **Status:** On Planner

### Integrated Performance & Quality Report:
Invite Northumbria Healthcare FT Chief Executive to attend a future Governing Body meeting (in public) to discuss NSECH and ambulance handovers.

- **Resp. Officer:** Mr Adams
- **Target Date:** May-19
- **Status:** Complete

### Comms & Engagement Strategy
The governing Body endorsed the ratification of the strategy and noted that the operational plan will be monitored via the Communication and Engagement Group.

- **Resp. Officer:** Dr Young-Murphy
Report to: Governing Body

Date: 21 May 2019 | Agenda item: 10.2

Title of report: Integrated Performance and Quality Report

Sponsor: Jon Connolly, Chief Finance Officer and Lesley Young-Murphy, Executive Director of Nursing and Chief Operating Officer
Authors: Teresa Ho, Performance and Monitoring Manager and Gillian Airey, NECS Senior Officer Clinical Quality.

Purpose of the report and action required: To report progress against the CCG performance and quality measures. Members are asked to note the current progress in 2018/19 against the listed measures.

Executive summary: The 2018/19 Integrated Performance and Quality Report shows delivery against the NHS Constitution, CCG Health Outcomes, Quality Premium and other Quality measures. Part A of the report covers the performance indicators and Part B of the report covers the quality indicators. The CCG is held to account for the delivery of these measures by NHS England.

Part A Performance Summary
The performance indicators to note identified in this report are:-

NHS Constitution

• Referral to Treatment – In February the proportion of patients on the waiting list that had been waiting under 18 weeks was below the standard of 92%. This is the first time this standard hasn’t been achieved in over three years. The specialties experiencing the largest proportion of patients waiting over 18 weeks are rheumatology, trauma and orthopaedics, ENT, and ophthalmology. The CCG is working with both Trusts to understand where there is increasing demand and capacity constraints and what actions can be put in place to resolve these.

• A&E
  o Ambulance handovers – Newcastle and Northumbria FT are both experiencing ambulance handover delays in March 2019. The target is that there are no ambulance handovers 30 minutes and above. Newcastle FT in conjunction with NEAS will be installing additional screens in assessment/handover areas to improve real time handover times.
  o Ambulance response times – Ambulance Response times for Category 2 and Category 3 calls are above the national standard. The target for category 2 calls is 18 minutes and 2 hours for category 3 calls. NEAS have put in additional staff within the contact centre and additional third part qualified paramedic crews to improve performance. A Specialist Dispatch Desk has been established to improve the falls referrals process. 70 Paramedics have been recruited so far this year. The vacancy gap has reduced from 86 in August to 42 in November. This has resulted in
improved management and reduction of staff abstractions.

- **Cancer 62 day** – Newcastle FT achieved 68.7% and Northumbria FT achieved 77.3% in February 2019 for percentage of patient’s treated within 62 days of an urgent GP referral for suspected cancer. The CCG achieved 71.7% in January which does not meet the standard. The standard is to achieve 85% of patients treated within 62 days. Newcastle FT has a Cancer Steering Group which has to date: help weekly patient tracking list reviews, undertook tumour specific reviews, updated cancer improvements plans, undertook capacity and demand modelling. Northumbria FT has installed a Cancer Board which has focused on: clearing the backlog of legacy patients, developing clinical systems to interface with each other, establish a multi-disciplinary cancer tracking team and use allocated nurse specialists which stay with the patient throughout the pathway journey, exploring additional out sourcing for testing and reporting of diagnostic tests associated with diagnosis, and introducing a process of diagnostic test first before consultant appointment. This has resulted in the backlog of patients reducing. The Cancer Commissioning Manager is working closely with both FTs and the Cancer Network to monitor performance from a system wide perspective. The CCG has also established a Cancer Improvement Group with Northumberland CCG and Northumbria FT to monitor performance.

**Other Commitments**

- **IAPT:** The Talking Therapies North Tyneside service achieved 14.9% IAPT access rate in February 2019. The January year to date target is 15.8% and the March 2019 target is 19% access rate. The service has indicated that the access rate for March 2019 has been achieved for the month. This means that the access rate for quarter 4 is 4.85% which achieves the required run-rate to achieve the 19% standard for 2018/19. The service has recently appointed to a number of therapists posts, some of which will be dedicated to increasing the access rate. Although the therapists do not start in post still April 2019, it is expected that these posts will be pivotal in achieving the revised standard of 22% access rate by the end of 2020.

**NHS Quality Premium**

- **Incomplete pathways:** The CCG had 16,657 patients on an incomplete pathway in Feb 2019 which is a 5.3% increase from the March 2018 position. The target is for the number of patients on an incomplete pathway not to be higher in March 2019 than in March 2018. The CCG is currently in ongoing discussions with NHSE and NHSI to rebase the CCG March 2018 position to include appointment slot issue patients which were not previously recorded in the March 2018 position. If agreed, this will increase our current recorded March 2018 position of 15,818. Northumbria FT have submitted revised incomplete pathway numbers for 2018/19 which provides a true reflection of the number of incomplete pathways for March 2018. If rebased, then the Feb 2019 position would be a lot closer to this rebased level. As one of the gateway measures for the Quality Premium, this will mean that if the target is achieved for 2018/19, then this could potentially unlock £176,532 Quality Premium funds based on current performance levels.
Part B Quality Summary
The quality indicators to note from this report are:

Safe
- NHCFT had their first MRSA case isolated and apportioned to the Trust in January 2019. The Trust is showing as below standard for this criterion on the NHSE Acute Quality Dashboard (Mar 19).
- NuTHFT remains the highest reporter of MSSA in the region having reported 86 (published) cases since April 2018, but is no longer an outlier on NHSE Acute Quality Dashboard (Mar 19).
- NuTHFT and NHCFT continue to be the second and third highest reporters of E.Coli in the region, with 427 and 400 published cases respectively. NTCCG has 187 published cases exceeding the YTD trajectory of 165.
- NHCFT recorded a figure of 0.6% for falls (with harm) above the national average of 0.5%.
- NHCFT recorded a figure of 45.7% for Venus Thromboembolism (VTE) Risk Assessments and 32.9% for VTE Prophylaxis. Both these measures continue to be below the national average of 55.4% and 43.4% respectively.
- NHCFT reported 2 never events in March 2019 and a further 2 in April 2019. The total number of never events reported in 2018/19 is 4. Of the 4 never events reported in March and April 2019, 3 related to NTCCG patients.
- NTWFT and NEASFT had absence rates of 5.95% and 5.3% respectively in November 2018. The Trusts have implemented workforce initiatives.

Effective, Caring, Responsive & Well Led
- NHCFT continues to be below the England average for Friends and Family Test (FFT) for A&E response rates and recommended score, and inpatient response rates. The Trust has developed a new technical solution to boost response rates.
- NuTHFT continues to be below the standard for FFT for A&E and In-patient response rates. The Trust is participating in the national review of the FFT in order to improve the process and delivery of capturing national data sets.
- NTWFT FFT mental health recommendation rate was 87.0% below the England average of 89.0%. The Trust continues to use the Points of You survey, which incorporates FFT, across the organisation to seek feedback on the experience of service users and carers.
- NTCCG had 2 formal complaints and 2 concerns reported during March 2019.
- NEASFT appraisal compliance rates in February decreased. The action plan created following the Trust’s CQC inspection includes an action about compliance with staff appraisals.
- NHCFT Palliative Care Units triggered red in January 2019 relating to pressure ulcers and falls.

Additional Quality Concerns
- NuTHFT Prevent compliance was 77.26% at the end of March 2019.
- NEASFT had a CQC inspected in October 2018; the Trust was awarded a “Good” rating overall. However two requirement notices were issued for Regulation 12 HSCA 2014 Safe Care and Treatment and Regulation 18 HSCA 2014 Staffing. A plan has been designed to address the actions the Trust MUST and SHOULD comply with.
Governance and Compliance

1. Links to Corporate Objectives

<table>
<thead>
<tr>
<th>2018/19 Corporate Objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>√</td>
</tr>
<tr>
<td>2. Meet the CCG’s financial duties and support delivery of the CCG’s other objectives, on a sustainable basis</td>
<td></td>
</tr>
<tr>
<td>3. Work collaboratively with partners and stakeholders to develop sustainable health and social care in North Tyneside and the wider Cumbria &amp; North East system</td>
<td>√</td>
</tr>
<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>√</td>
</tr>
</tbody>
</table>

2. Consultation and Engagement
Not applicable

3. Resource Implications
Not applicable

4. Risks
For escalated risks, please refer to Risk Assessment Framework

5. Equality Assessment
Not applicable

6. Environment and Sustainability Assessment
There are no environmental or sustainability issues arising from this report.
Performance Report (Part A)

February 2019
### Part A NHS Constitution

#### Performance Area

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
<th>NHCFT</th>
<th>Movement</th>
<th>NuTH</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>% patients waiting for initial treatment on incomplete pathways within 18 weeks</td>
<td>Feb-19</td>
<td>92.0%</td>
<td>91.8%</td>
<td></td>
<td></td>
<td>92.3%</td>
<td></td>
<td>93.0%</td>
<td></td>
</tr>
<tr>
<td>Number of patients waiting more than 52 weeks for treatment</td>
<td>Feb-19</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>% patients waiting less than 6 weeks for the 15 diagnostic tests (including audiology)</td>
<td>Feb-19</td>
<td>&gt;99%</td>
<td>99.5%</td>
<td></td>
<td></td>
<td>99.9%</td>
<td></td>
<td>98.3%</td>
<td></td>
</tr>
<tr>
<td>% patients spending 4 hours or less in A&amp;E or minor injury unit</td>
<td>Mar-19</td>
<td>95.0%</td>
<td>95.5%</td>
<td>95.9%</td>
<td></td>
<td>95.2%</td>
<td></td>
<td>96.2%</td>
<td></td>
</tr>
<tr>
<td>Over 12 hour trolley waits</td>
<td>Mar-19</td>
<td>&lt;0</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ambulance handovers 30 mins - 60 mins</td>
<td>Mar-19</td>
<td>&lt;0</td>
<td></td>
<td></td>
<td></td>
<td>267</td>
<td></td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Ambulance handovers =&gt; 60 mins</td>
<td>Mar-19</td>
<td>&lt;0</td>
<td></td>
<td></td>
<td></td>
<td>29</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Ambulance handovers =&gt;120mins</td>
<td>Mar-19</td>
<td>&lt;0</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% of patients seen within 2 weeks of an urgent GP referral for suspected cancer</td>
<td>Feb-19</td>
<td>93.0%</td>
<td>90.6%</td>
<td>94.9%</td>
<td></td>
<td>88.7%</td>
<td></td>
<td>85.3%</td>
<td></td>
</tr>
<tr>
<td>% of patients treated within 62-days of an urgent GP referral for suspected cancer</td>
<td>Feb-19</td>
<td>85.0%</td>
<td>71.7%</td>
<td>71.4%</td>
<td></td>
<td>77.3%</td>
<td></td>
<td>68.7%</td>
<td></td>
</tr>
<tr>
<td>% of patients treated within 62-days of urgent referral from an NHS Cancer Screening Service</td>
<td>Feb-19</td>
<td>90.0%</td>
<td>84.6%</td>
<td>93.4%</td>
<td></td>
<td>64.3%</td>
<td></td>
<td>83.1%</td>
<td></td>
</tr>
<tr>
<td>% of patients treated for cancer within 62-days of consultant decision to upgrade status</td>
<td>Feb-19</td>
<td>N/A</td>
<td>n/a</td>
<td>64.0%</td>
<td></td>
<td>33.3%</td>
<td></td>
<td>60.0%</td>
<td></td>
</tr>
<tr>
<td>% of patients treated within 31 days of a cancer diagnosis</td>
<td>Feb-19</td>
<td>96.0%</td>
<td>100.0%</td>
<td>97.3%</td>
<td></td>
<td>99.3%</td>
<td></td>
<td>96.0%</td>
<td></td>
</tr>
<tr>
<td>% of patients receiving subsequent treatment for cancer within 31-days - Surgery</td>
<td>Feb-19</td>
<td>94.0%</td>
<td>95.5%</td>
<td>93.5%</td>
<td></td>
<td>100.0%</td>
<td></td>
<td>90.4%</td>
<td></td>
</tr>
<tr>
<td>% of patients receiving subsequent treatment for cancer within 31-days - Drugs</td>
<td>Feb-19</td>
<td>98.0%</td>
<td>100.0%</td>
<td>98.6%</td>
<td></td>
<td>100.0%</td>
<td></td>
<td>98.7%</td>
<td></td>
</tr>
<tr>
<td>% of patients receiving subsequent treatment for cancer within 31-days - Radiotherapy</td>
<td>Feb-19</td>
<td>94.0%</td>
<td>100.0%</td>
<td>99.3%</td>
<td></td>
<td>100.0%</td>
<td></td>
<td>99.7%</td>
<td></td>
</tr>
<tr>
<td>Mixed sex accommodation - number of unjustified breaches</td>
<td>Feb-19</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cancelled operations for non-clinical reasons to be rescheduled within 28 days</td>
<td>Q3 19/19</td>
<td>95.0%</td>
<td></td>
<td></td>
<td></td>
<td>91.2%</td>
<td></td>
<td>95.4%</td>
<td></td>
</tr>
<tr>
<td>Urgent operations cancelled for a 2nd time</td>
<td>Feb-19</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>% people followed up within 7 days of discharge from psychiatric in-patient care</td>
<td>Q3 18/19</td>
<td>95.0%</td>
<td>95.0%</td>
<td>99.1%</td>
<td></td>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>C1 Response Time CCG (Mean time)</td>
<td>Feb-19</td>
<td>00:07:00</td>
<td>00:06:15</td>
<td>00:06:03</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2 Response Time CCG (Mean time)</td>
<td>Feb-19</td>
<td>00:18:00</td>
<td>00:21:29</td>
<td>00:18:28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C3 Response Time CCG (90th centile)</td>
<td>Feb-19</td>
<td>02:00:00</td>
<td>03:32:07</td>
<td>02:45:23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4 Response Time CCG (90th centile)</td>
<td>Feb-19</td>
<td>03:00:00</td>
<td>01:37:32</td>
<td>02:51:29</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### Constitution Measure

<table>
<thead>
<tr>
<th>Constitution measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Timeline</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to Treatment</td>
<td>In the Feb 2019 snapshot of waiting times 91.8% of patients with an incomplete pathway had been waiting less than 18 weeks, this is below the standard of 92%</td>
<td>This is the first time in over 3 years that this measure hasn’t been met by the CCG. Both Newcastle FT and Northumbria FT continue to achieve the standard. Both Trust treat patients in order and don’t differentiate or prioritise patients based on CCG. The specialties with the largest proportions of patients waiting over 18 weeks are rheumatology, trauma and orthopaedics, ENT, and ophthalmology. The CCG is working with both Trusts to understand where there is increasing demand and capacity constraints. A major area of concern flagged by the Trust relates to the change in pension scheme for doctors. This has resulted in a reduced incentive for doctors to volunteer to staff additional sessions or waiting list initiatives. Northumbria FT have flagged achieving the 92% threshold as a risk for 2019/20.</td>
<td>Q1 2019/20</td>
<td>Med</td>
<td>SR</td>
</tr>
<tr>
<td>Referral to Treatment – patients waiting over 52 weeks</td>
<td>One patient has been flagged as waiting more than 52 weeks for treatment in October 2018</td>
<td>North Devon Healthcare Trust identified a patient who has waited over 52 weeks for treatment and allocated against North Tyneside CCG as commissioner. The patient at the time of the referral resided in North Devon. They subsequently moved to Durham and were treated in June 2018 and following that, moved to North Tyneside. This created a validation issue where the patient's clock was not closed off and therefore appeared on North Tyneside CCG’s 52 week waiter list for October 2018. North Devon Healthcare Trust has stopped the patients RTT clock and have confirmed that they have resubmitted the RTT data for this time period which will remove the 52 week waiter from the CCG. This will be reflected when the dataset is next republished Nov 2019.</td>
<td>Completed</td>
<td>Low</td>
<td>SR</td>
</tr>
<tr>
<td>Diagnostic waits</td>
<td>Newcastle FT achieved 98.3% in February 2019 and therefore did not achieve the standard of &gt;99%</td>
<td>In February, although there was a reduction in the number of breaches, there was also less tests undertaken, and while performance improved it was still below the standard. The FT are still experiencing capacity issues within sleep studies and backlog in urodynamics. The FT also saw increased referrals for cancer diagnostics and additionally an increase in referrals associated with adding</td>
<td>Qtr. 4 2018/19</td>
<td>Low</td>
<td>SR</td>
</tr>
</tbody>
</table>
### Part A Issues to Note on Constitution Measures

**Official-Sensitive: Commercial**

<table>
<thead>
<tr>
<th>Constitution measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Timeline</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance Handovers</strong></td>
<td>Newcastle FT had 88 ambulance handovers 30 – 60 mins in Mar 2019 which is an increase from the 97 reported in Feb 2019. Newcastle FT had 6 ambulance handovers =&gt;60 mins in Mar 2019, Northumbria FT had 267 ambulance handovers 30 – 60 mins in Mar 2019 which is a significant decrease on the 369 reported in Feb 2019. Northumbria FT had 29 ambulance handovers =&gt;60 mins in Mar 2019 a decrease on the 48 reported in Feb 2019.</td>
<td>Newcastle FT in conjunction with NEAS will be installing 2 additional screens in assessment/handover areas in Emergency Departments and paediatric locations with a view to improving handover in real time. In addition to this, the FT has undertaken a ‘real time’ audit in the Emergency Department which showed that there were no genuine breaches during the time of the audit, and that the crews were not entering handover PINs at the correct time straight after the official handover. The number of 30 – 60 minute handover delays at Northumbria FT has decreased by 28% in March, compared to February. They did not have any patients wait longer than 2 hours for an ambulance handover. Northumbria FT has raised concerns about the increasing number of ambulance drop offs at NSECH and the potential impact this may have on ambulance handovers. Across the region a work stream has been established to review the compliance by each provider against the current (NEAS-led) Divert Policy. There is also interest in reviewing the Operational Pressures Escalation Levels Framework (OPEL) triggers across the region. The Emergency and Urgent Care Strategic Network Group is leading on these areas of work. The CCG is undertaking some analysis on ambulance handover data, both before NSECH was operational, and up to present day. It is hoped the analysis will show any shift in the number of North Tyneside residents accessing A&amp;E and what base site they were allocated to. If a disproportionate use of base sites is evidenced, then the CCG will seek to address this with relevant providers. The CCG will also want to monitor any in impact following this work to determine whether there has been a noticeable shift towards other more accessible sites for those patients.</td>
<td>Qtr. 4 2018/19</td>
<td>High</td>
<td>TD</td>
</tr>
</tbody>
</table>
### Part A Issues to Note on Constitution Measures

**Official-Sensitive: Commercial**

<table>
<thead>
<tr>
<th>Constitution measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Timeline</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients seen within 2 weeks or an urgent GP referral for suspected cancer</td>
<td>The CCG achieved 90.6% in Feb and therefore did not meet the standard of 93%. The YTD position remains above the standard at 94.9%. Both Newcastle FT (85.3%%) and Northumbria FT (86.7%) failed to meet the standard in Feb.</td>
<td>Newcastle FT had 260 patients breach the two week wait for an urgent GP referral for suspected cancer. The volume of referrals have risen at the Trust but breach numbers have increased significantly. The majority of these are in Colorectal and this is being investigated further. This 2WW service has recently been moved onto e-referral and the potential impact of that move on demand is being reviewed. The Trust has recently had a visit from the Intensive Support Team who continued support to the Trust and has resulted in key actions being undertaken to help improve performance and address increased demand. The CCG year to date position is 94.9% which is above the standard. The CCG will continue to check under performance to ensure that it is not sustained.</td>
<td>Qtr. 4 2018/19</td>
<td>Low</td>
<td>TD</td>
</tr>
<tr>
<td>% of patients seen within 2 weeks or an urgent GP referral for breast symptoms</td>
<td>Newcastle FT achieved 70.6% for Feb 2019 and therefore did not meet the standard of 93%. The CCG achieved 98.6% in Feb 2019 and therefore was well above the standard. The CCG year to date position is also above the standard at 94.9%.</td>
<td>Newcastle FT had 46 patients which were seen outside of the two week target for an urgent GP referral for breast symptoms. Newcastle FT have identified that performance was impacted upon by reduced radiologist capacity at Northumbria FT by causing appointment slot issues at Newcastle FT. The issue has been raised during performance meetings with Northumbria FT who assure the CCG that capacity was reduced temporarily and that they have two additional clinics on at present to increase radiology capacity. The CCG will continue to check under performance to ensure that it is not sustained. The CCG will continue to monitor patient flows within the pathway.</td>
<td>Qtr. 4 2018/19</td>
<td>Low</td>
<td>TD</td>
</tr>
<tr>
<td>% of patients treated within 62 days of an</td>
<td>Newcastle FT achieved 68.7% for Feb 2019 and therefore did not meet the</td>
<td>Newcastle FT had 47 patients delayed with the majority within the urology pathway. The FT has a Cancer Steering Group which meets regularly to discuss performance. The Cancer Steering Group has identified a number of actions to</td>
<td>Qtr. 4 2018/19</td>
<td>High</td>
<td>TD</td>
</tr>
</tbody>
</table>
## Part A Issues to Note on Constitution Measures

**Official-Sensitive: Commercial**

<table>
<thead>
<tr>
<th>Constitution measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>urgent GP referral for suspected cancer</td>
<td>standard of 85%</td>
<td>date: hold weekly patient tracking list review meetings for high risk specialities, undertake a tumour specific review to update the cancer improvement plans, undertake capacity and demand modelling and alignment with the workforce plans in terms of capacity shortfalls.</td>
</tr>
<tr>
<td></td>
<td>Northumbria FT achieved 77.3% for Feb 2019 and therefore did not meet the standard</td>
<td>Northumbria FT has installed a Cancer Board which includes representatives of all tumour site lead clinicians, senior management and performance.</td>
</tr>
<tr>
<td></td>
<td>The CCG achieved 71.7% for Feb 2019 and therefore did not meet the standard</td>
<td>Main actions have focussed on:-</td>
</tr>
<tr>
<td></td>
<td>The YTD position is below the standard at 81.4%.</td>
<td>- Clearing the backlog of legacy patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Working with their clinical system provider (Somerset) to develop an interface with the FT PAS (Patient Appointment System). This will enable cancer teams to track patients through the pathway more effectively.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Establish a multi-disciplinary cancer tracking team that will track cancer patient lists and ensure patient reviews and subsequent decisions are followed up in a timely manner.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Where pathways interface with other FT such as the urology pathway into Newcastle FT, patients will be allocated a specialist nurse who will stay with the patient throughout the pathway journey. This will enable any potential blockages to be minimised, e.g. access to oncology at Newcastle FT.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Extending the number of cancer patient trackers to improve resilience during holiday periods and absence of current staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Exploring additional outsourcing for testing and reporting of diagnostic tests associated with diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Introducing process of diagnostic test first before consultant appointment.</td>
</tr>
</tbody>
</table>

The cancer lead Commissioning Manager is meeting regularly with both FT and working closely with the Cancer Network to monitor performance from a system wide perspective. The CCG has explored feasibility of alternative providers to commission more capacity but due to the national shortage of specialist staff there is no scope for this option.
### Part A Issues to Note on Constitution Measures

#### Official-Sensitive: Commercial

<table>
<thead>
<tr>
<th>Constitution measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Timeline</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
</table>
| Cancer % of patients treated within 62 days or urgent referral from screening service | Newcastle FT achieved 83.1% for Feb 2019 and therefore did not meet the standard of 90%.
Northumbria FT achieved 64.3% and therefore did not meet the standard. | Newcastle FT had 6 patients out of 35.5 treated over 62 days following an urgent referral from an NHS cancer screening service. Northumbria FT had 2.5 patients out of 7 treated.
The low number of patients can have a significant impact on the percentages achieved. This will be monitored as part of the contract meeting with providers to ensure there are no underlying performance issues. | Qtr. 4 2018/19 | Low | TD |
| Cancer % of patients receiving subsequent treatment for cancer within 31 days – surgery | Newcastle FT achieved 90.4% in Feb 2019 and therefore did not achieve the standard of 94%.
The CCG achieved 95.5% for Feb 2019 and therefore achieved the standard. The CCG year to date position of 93.5% is below the standard. | The CCG experienced a large number of breaches during August 2018 which brings the CCG YTD position to below the standard.
Due to the low number of patients involved, this can have a significant impact on the percentages achieved. The CCG will continue to monitor to check under performance is not sustained. | Qtr. 4 2018/19 | Low | TD |
## Part A Issues to Note on Constitution Measures

**Official-Sensitive: Commercial**

<table>
<thead>
<tr>
<th>Constitution measure</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Cancelled operations for non-clinical reasons to be rescheduled within 28 days</td>
<td>Newcastle FT achieved 95.4% and Northumbria FT achieved 91.2% and therefore both Trusts did not meet the standard of 95% for Qtr. 3 2018/19.</td>
<td>Newcastle FT had 7 cancelled operations and Northumbria FT had 3 cancelled operations in Qtr. 3 which is a reduction on Qtr. 2. Newcastle FT is currently undertaking a feasibility study for a National Institute of Health Research (NIHR) cancelled operations research project. This will provide a benchmark and enable the FT to fully understand all cancellation reasons and productivity opportunities. Due to the low number of patients involved, this can have a significant impact on the percentages achieved. The CCG will continue to monitor to check under performance is not sustained.</td>
<td>Qtr. 4 2018/19</td>
<td>Low</td>
<td>SR</td>
</tr>
<tr>
<td>Ambulance Response Times</td>
<td>C2 response times achieved 21 minutes 29 seconds on average in Feb which did not meet the standard of 18 minutes. The CCG YTD position to response for a C2 call is 18 minutes and 28 seconds. C3 response times achieved 3 hours 32 minutes on average in Feb, which did not meet the standard of 2 hours. The CCG YTD position for response for a C3 calls is 2 hours 45 minutes</td>
<td>NEAS are putting in additional staff within the contact centre and additional third party qualified paramedic crews subcontracted to improve performance. A Specialist Dispatch Desk has been established to complete administrative tasks on behalf of crews such as falls referrals. This is aimed at helping to reduce handover to clear time. A new Cleric module is being rolled out within NEAS which will speed up and enhance performance reporting. 70 Paramedics have been recruited so far this year, including over 60 students which graduated September and October which have now been active in post from December 2018. The paramedic vacancy gap has reduced from 86 in August to 43 in November 2018. Work has also been on-going to improve the management of and reduction of staff abstractions, which is currently on track to exceed the year 1 target of 32%. System wide discussions are ongoing between NEAS and Northumbria FT as covered in the handover measure above. Performance continues to be monitored at the monthly contract meetings.</td>
<td>Qtr. 4 2018/19</td>
<td>High</td>
<td>TD</td>
</tr>
</tbody>
</table>
### Part A Other commitments

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Movement to recovery</td>
<td>Feb-19</td>
<td>50.0%</td>
<td>61.6%</td>
<td>53.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IAPT Waiting times - 6 weeks</td>
<td>Feb-19</td>
<td>75.0%</td>
<td>98.0%</td>
<td>94.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IAPT Waiting times - 18 weeks</td>
<td>Feb-19</td>
<td>95.0%</td>
<td>100.0%</td>
<td>99.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IAPT access rate</td>
<td>Feb-19</td>
<td>1.58%</td>
<td>1.62%</td>
<td>14.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waiting times for routine referral to CYP Eating Disorder Services - Within 4 weeks</td>
<td>Jan 2018 - Dec 2018</td>
<td>95.0%</td>
<td>85.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Waiting times for Urgent referrals to CYP Eating Disorder Services - within 1 week</td>
<td>Jan 2018 - Dec 2018</td>
<td>95.0%</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Out of Area Placements</td>
<td>Dec-18</td>
<td>&lt;0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services</td>
<td>2016/17</td>
<td>92.0%</td>
<td>92.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency readmissions within 30 days of discharge from hospital</td>
<td>Jan-19</td>
<td>15.5%</td>
<td>15.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>Feb-19</td>
<td>1,546.0</td>
<td>1,668.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency admissions for children with lower respiratory tract infections</td>
<td>Feb-19</td>
<td>375.7</td>
<td>513.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Children waiting more than 18 weeks for a wheelchair</td>
<td>Q3 18/19</td>
<td>92.0%</td>
<td>95.0%</td>
<td>92.5%</td>
<td></td>
</tr>
</tbody>
</table>

There are 12 indicators under other commitments which warrant monitoring on behalf of the CCG. Currently 5 of the indicators have a red rating and 7 indicators have a green rating.
# Part A Other commitments

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Time-line</th>
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<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT access rate</td>
<td>North Tyneside Talking Therapies YTD actual is 14.9% against a YTD trajectory of 17.4%</td>
<td>The threshold IAPT access rate has increased from 15% in 2017/18 to 19% in 2018/19. The service has indicated that the access rate for March 2019 has been achieved for the month. This means that the access rate for quarter 4 is 4.85% which achieves the required run-rate to achieve the 19% standard for 2018/19. The service recognises that to achieve the new increased access threshold, they will need more people to pass through the service. The service recently appointed a number of additional therapists which will be dedicated to increasing the access rate. Although the Therapists do not start in post till April 2019, it is expected that these posts will be pivotal in achieving the revised standard of 22% access rate by the end of 2020.</td>
<td>Qtr. 4 2018/19</td>
<td>Low</td>
<td>JA</td>
</tr>
<tr>
<td>Waiting times for routine CYP referral for eating disorders – within 4 weeks</td>
<td>The CCG achieved 85.0% and therefore did not achieve the standard of 95% during Qtr. 3</td>
<td>The CCG had three routine patients waiting more than 4 weeks for treatment for an eating disorder out of 20 patients over the last 12 months. The low number of patients involved can have a significant impact on the percentage achieved. The monitoring period is for a full twelve month period, which will include historical breach numbers until enough time has elapsed to not be counted towards performance. The service has investigated both breaches which were due to data recording errors. The Eating Disorder Intensive Community Treatment Service leadership team will undertake awareness raising regarding the importance of accurate recording to address data errors. This did not negatively impact upon the treatment received by the patients. Performance will be monitored at the monthly contract meetings.</td>
<td>Qtr. 4 2018/19</td>
<td>Low</td>
<td>JA</td>
</tr>
<tr>
<td>Emergency readmissions within 30 days of discharge from hospital</td>
<td>Readmission rate of 15.5% for Jan 2019 compared to 15.5% for Jan 2019</td>
<td>As part of winter plan the A&amp;E Delivery Board Northumberland and North Tyneside have agreed a number of preventative initiatives for readmissions: Red Cross commissioned to support patient social needs, shift in resource from front door to support capacity in the system, acute providers identified specific escalation beds, system wide bed management, community reablement service and timely discharges of End of Life patients, including use of End of Life ambulance. The CCG will continue to monitor performance as part of the A&amp;E Delivery Board and contract meetings.</td>
<td>Qtr. 4 2018/19</td>
<td>Low</td>
<td>TD</td>
</tr>
</tbody>
</table>
### Part A Other commitments

#### Official-Sensitive: Commercial

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<tbody>
<tr>
<td>Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>The rate of admissions has increased in comparison to the previous YTD position from 1,668 to 1,546 age standardised rate for 100,000 population</td>
<td>The number of avoidable emergency admissions has increased in comparison to the same period in 2017. The annual trend has shown a decrease overall since 2016/17. Northumbria FT have changed their staffing model in A&amp;E which has resulted in more people being seen in ambulatory care which is coded as admitted activity, contributing to the increase in numbers. Analysis of the avoidable admissions has been undertaken at practice level to identify any trends. Although no clear trends were identified the Performance Manager will undertake a deep dive to assure the CCG that there are no other underlying trends contributing to the measure. This will be monitored as part of the contract meeting with providers.</td>
<td>Qtr. 4 2018/19</td>
<td>Low</td>
<td>TD</td>
</tr>
<tr>
<td>Emergency admissions for children with lower respiratory tract infections</td>
<td>The rate of emergency admissions for children with lower respiratory tract infections is 514 in Jan, which is higher than 376 for the same period last year</td>
<td>Analysis of the emergency admissions has been undertaken at practice level which has not identified any trends. The low number of patients can have a significant impact on the percentages achieved. Although no clear trends were identified the Performance Manager will undertake a deep dive to assure the CCG that there are no other underlying trends contributing to the measure. This will be monitored as part of the contract meeting with providers</td>
<td>Qtr. 4 2018/19</td>
<td>Low</td>
<td>TD</td>
</tr>
</tbody>
</table>
# The Quality Premium Indicators for 2018/19 are made up of 13 national and 1 local indicators.

## National

<table>
<thead>
<tr>
<th>Measure</th>
<th>Requirement</th>
<th>Period</th>
<th>Threshold</th>
<th>Actual</th>
<th>Passing/Failing</th>
<th>Weighting</th>
<th>Value</th>
<th>Funding calculation</th>
<th>Linked to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>Total number of type 1 A&amp;E attendances for 2018/19 is no greater than their total planned number of type 1 A&amp;E attendances in 2018/19</td>
<td>Feb 2019 to YTD</td>
<td>66,000</td>
<td>51,493</td>
<td>Passing</td>
<td>18.88%</td>
<td>£207,596</td>
<td>£207,596</td>
<td>£0</td>
</tr>
<tr>
<td>Part A</td>
<td>Total number of actual non-elective admissions with LOS of 0 days in 2018/19 is no greater than their total planned number of non-elective admissions with LOS of 0 days in 2018/19</td>
<td>Feb 2019 to YTD</td>
<td>10,361</td>
<td>10,539</td>
<td>Failing</td>
<td>18.88%</td>
<td>£207,596</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Part B</td>
<td>Actual number of non-elective admissions with LOS of 1 day or more to be no greater than the planned number of non-elective admissions with LOS of 1 day or more</td>
<td>Feb 2019 to YTD</td>
<td>15,717</td>
<td>15,731</td>
<td>Failing</td>
<td>37.17%</td>
<td>£415,192</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

## Quality Indicators (63.75% of funding)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Requirement</th>
<th>Period</th>
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<th>Funding calculation</th>
<th>Linked to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1</td>
<td>Early Cancer Diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(i)</td>
<td>a) Demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour) that were diagnosed at stages 1 and 2 in the 2018 calendar year compared to the 2017 calendar year</td>
<td>Q3 2017/18 12 month rolling</td>
<td>52.0%</td>
<td>53.7%</td>
<td>Failing</td>
<td>4.16%</td>
<td>£45,711</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Part 2</td>
<td>GP Access and Experience</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>(ii)</td>
<td>b) Achieve a 3 percentage point increase from July 2018 publication on the percentage of respondents who said they had a good experience of making an appointment</td>
<td>71.86%</td>
<td>Data not yet available</td>
<td>Data not yet available</td>
<td>Data not yet available</td>
<td>4.16%</td>
<td>£45,711</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

## National

<table>
<thead>
<tr>
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<th>Funding calculation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>To achieve the Quality Premium for this part, CCGs must ensure that in more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility).</td>
<td>Q3 2018/19</td>
<td>80%</td>
<td>86.8%</td>
<td>Passing</td>
<td>4.16%</td>
<td>£22,855</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Part B</td>
<td>To achieve the Quality Premium for this part, CCGs must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting</td>
<td>Q3 2018/19</td>
<td>15%</td>
<td>1.5%</td>
<td>Passing</td>
<td>4.16%</td>
<td>£22,855</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

## Quality Indicators (63.75% of funding)

<table>
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<tr>
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<th>Funding calculation</th>
<th>Linked to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 3</td>
<td>Continuing Healthcare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(ii)</td>
<td>Part a) reducing gram negative bloodstream infections (BSI) across the whole health economy</td>
<td>Feb 2019 to YTD</td>
<td>165</td>
<td>167</td>
<td>Failing</td>
<td>4.16%</td>
<td>£13,713</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

## National

<table>
<thead>
<tr>
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<th>Weighting</th>
<th>Value</th>
<th>Funding calculation</th>
<th>Linked to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 4</td>
<td>Mental Health</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(i)</td>
<td>Part A</td>
<td>50% reduction in growth in prescribed pregabalin or gabapentin (GABA-ergic medicines) for chronic non-cancer pain management.</td>
<td>Jan 19 to 12 month rolling</td>
<td>5,065</td>
<td>3,375</td>
<td>Passing</td>
<td>4.16%</td>
<td>£4,571</td>
<td>£0</td>
</tr>
<tr>
<td>Part C</td>
<td>Additional reduction in items per specialty: Therapeutic group Age-Sex Related Prescribing Unit (STAR-PU) equal to below 0.965 items per STAR-PU</td>
<td>Jan 19 to 12 month rolling</td>
<td>0.965</td>
<td>1.095</td>
<td>Failing</td>
<td>4.16%</td>
<td>£11,428</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

## Local

<table>
<thead>
<tr>
<th>Measure</th>
<th>Requirement</th>
<th>Period</th>
<th>Threshold</th>
<th>Actual</th>
<th>Passing/Failing</th>
<th>Weighting</th>
<th>Value</th>
<th>Funding calculation</th>
<th>Linked to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part B</td>
<td>Musculoskeletal System Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i)</td>
<td>50% reduction in growth in prescribed pregabalin or gabapentin (GABA-ergic medicines) for chronic non-cancer pain management.</td>
<td>Jan 19 to YTD</td>
<td>1,326,240</td>
<td>1,286,456</td>
<td>Passing</td>
<td>4.16%</td>
<td>£45,711</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

### Total Value

- **National**: £1,099,270
- **Quality Indicators**: £353,063
- **Local**: £326,093
- **Total Value**: £1,788,426

## Pre-conditions

<table>
<thead>
<tr>
<th>Measure</th>
<th>Requirement</th>
<th>Period</th>
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<th>Actual</th>
<th>Passing/Failing</th>
<th>Weighting</th>
<th>Value</th>
<th>Funding calculation</th>
<th>Linked to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial plans on target</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Significant quality failure</td>
<td></td>
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</tbody>
</table>

## NHS Constitution measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Requirement</th>
<th>Period</th>
<th>Threshold</th>
<th>Year to date</th>
<th>Passing/Failing</th>
<th>Weighting</th>
<th>Adjustment</th>
<th>Funding calculation</th>
<th>Linked to</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of patients on an incomplete pathway not to be higher in March 2019 than in March 2018 (15,818).</td>
<td>CCG</td>
<td>Feb-19</td>
<td>14,222</td>
<td>16,660</td>
<td>Failing</td>
<td>50%</td>
<td>£116,532</td>
<td>-£31,064</td>
<td>C</td>
</tr>
<tr>
<td>Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
<td>CCG</td>
<td>Feb-19</td>
<td>85.7%</td>
<td>71.7%</td>
<td>Failing</td>
<td>50%</td>
<td>£116,532</td>
<td>-£207,596</td>
<td>C</td>
</tr>
</tbody>
</table>

Adjusted total: £353,063
<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Time-line</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of actual non-elective admissions with LOS=0 days in 2018/19</td>
<td>The CCG had 10,539 non-elective admissions with length of stay of zero days between April 2018 and Feb 2019.</td>
<td>The CCG planned 10,351 non-elective admissions with a zero day length of stay from April 2018 to Feb 2019. The CCG actual number has exceeded the planned figure for the period. Northumbria FT has made changes to their staffing model in A&amp;E, which has resulted in more people being seen in Ambulatory Care, contributing to the increase in numbers. Newcastle FT currently record ambulatory care as outpatient activity. Due to improvements in IT systems providing increased granularity of data, Newcastle FT will be recording ambulatory care as admitted patients, rather than out patients. This will mean that activity figures for 2019/20 will need to reflect an increase in admitted and corresponding decrease in outpatient activity.</td>
<td>Qtr. 4 2017/18</td>
<td>Low</td>
<td>SR</td>
</tr>
<tr>
<td>Total number of non-elective admissions with LOS of 1 day or more</td>
<td>The CCG had 15,731 non-elective admissions with LOS of 1 day or more between April 2018 and Feb 2019</td>
<td>The CCG planned 15,717 non-elective admissions with LOS of 1 day or more from April 2018 to Feb 2019. The CCG actual number has exceeded the planned figure for the period. This is marginally above the planned figure for the period. The CCG will continue to monitor activity numbers as part of the contract management process.</td>
<td>Qtr. 4 2017/18</td>
<td>Low</td>
<td>SR</td>
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</tbody>
</table>
| Early cancer diagnosis | 490 patients out of 943 were diagnosed at stage 1 and 2 from Jan 2017 to Dec 2017. 488 patients out of 915 were diagnosed at stage 1 and 2 from Jan 2016 to Dec 2016 | The CCG has improved the proportion of patients diagnosed at stage 1 and 2 by 2 patients in 2017, compared to the same period in 2016, despite the cohort of patients increasing by 28 patients (3.1%). The CCG has made continuous improvements in the early diagnosis rate and is currently above the England average. The 4 percentage point improvement or 60% achievement for the quality premium is a challenging measure. There are a number of tasks in the CCG Cancer Plan to support early diagnosis:—
- Improve pathway and achieve/consistently maintain minimum standards
- Reduce variability in primary care through strengthening clinical engagement
- Implement optimal cancer pathways
- Improve access to lung cancer diagnostic
- Achieve and consistently maintain minimum standards for screening update
- Improve uptake to bowel programme
- Reduce number of cancer diagnosis as a consequence of an emergency presentation
- Develop robust emergency pathway interfaces | Qtr. 4 2017/18 | High | TD |
| Part 5 – Bloodstream Infections – Part Ai BSI | 187 gram negative BSI for Feb 2019 position which exceeds the 165 reported in the same period 2017 | The CCG started a programme of work in 2017 around a Falls strategy. As part of this, a Falls bundle was developed which increased the number of urines test carried out in nursing and residential homes. Traces of infection may be found when the urine of over 65 year olds were tested, even if the patient is asymptomatic, so testing needed to be more individualised for patients. The CCG is focusing on hydration and delivering this work into the nursing and residential homes. Northumbria FT advised that as more blood cultures have been taken this has identified more cases of e-coli. The FT has completed an audit which did not identify any issues with patient care. Newcastle FT has identified directorates with the highest number of e-coli and developed actions plans. HCAI performance and actions are monitored through the regional HCAI Partnership Group. | March 2019 | Low | MG |
| Part 5 – Bloodstream Infections – Part Cii | Rate of 1.095 against a threshold of 0.965 by for a rolling 12 month period | The rate was 1.168 in April 2018 and continued to reduce month on month. The prescribing engagement scheme (PES) for 2018/19 has specifically included the quality premium targets to further incentivise engagement with prescribers. The NECS Medicine Optimisation team will help drive the changes required to meet the target, investigating ways to support practices analyse prescribing through internal practice bench marking and supporting measures to appropriately reduce antibiotic usage. | Qtr. 4 2018/19 | Low | NF |
| Constitution – Cancer waiting times – patients treated within 62 days of an urgent GP referral | NT CCG achieved 81.4% against a threshold of 85.7% for Feb 2019. | The YTD position for the CCG is 81.4%. Further details of the measure are within the NHS Constitution part of the report. | Qtr. 4 2018/19 | High | TD |
NHS Constitution Measures – incomplete pathway not to be higher in March 2019 than in March 2018

Currently both Newcastle FT and Northumbria FT continue to achieve above the standard for referral to treatment waiting times, achieving 93.0% and 92.3% respectively for Feb 2019. The CCG position is currently showing a 5.3% increase in incomplete pathways from March 2018 to Feb 2019 (15,816 March 2018 to 16,657 Feb 2019).

Newcastle Gateshead CCG has submitted a more realistic baseline and trajectory to NHSE for Newcastle FT for March 2018 onwards. NHSE have agreed to the local monitoring of the target which reflects the ASI issues experienced by Newcastle FT at the beginning of the year and impact of the transfer of the Tyneside Integrated Musculoskeletal Service to Newcastle FT.

Newcastle Gateshead CCG, Northumberland CCG and North Tyneside CCG are in ongoing discussions with NHSE and NHSI to rebase the March 2018 position. Northumbria FT have submitted revised RTT data to Unify for 2018/19 which includes all appointment slot issues and shows a true reflection of the number of incomplete pathways for March 2018. The CCG are awaiting formal confirmation of what the rebased March 2018 position is, which will affect the Quality Premium assessment. If rebased, then the Jan 2019 position would be a lot closer to the rebased position.
Quality Report (Part B)

February 2019
## Part B – Safe

<table>
<thead>
<tr>
<th>Key Performance Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG Actual</th>
<th>YTD Actual</th>
<th>Movement</th>
<th>NHCFT</th>
<th>Movement</th>
<th>NuTH</th>
<th>Movement</th>
<th>NTWFT</th>
<th>Movement</th>
<th>NEAS</th>
<th>Movement</th>
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<tbody>
<tr>
<td><strong>HCAI NT CCG</strong></td>
<td>MRSA Assignment Following PIR Process</td>
<td>Feb-19</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td></td>
<td>C Difficile</td>
<td>Feb-19</td>
<td>7.0</td>
<td>3.0</td>
<td>44.0</td>
<td>0</td>
<td>7</td>
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<td>C Difficile Community Cases</td>
<td>Feb-19</td>
<td>N/A</td>
<td>2.0</td>
<td>31.0</td>
<td>N/A</td>
<td>N/A</td>
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<td>MSSA</td>
<td>Feb-19</td>
<td>N/A</td>
<td>4.0</td>
<td>59.0</td>
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<td>E Coli</td>
<td>Feb-19</td>
<td>15.0</td>
<td>16.0</td>
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<td><strong>NHS Safety Thermometer</strong></td>
<td>Pressure Ulcers (All)</td>
<td>Mar-19</td>
<td>4.6</td>
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<td></td>
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<td>4.01</td>
<td>3.94</td>
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<td>Pressure Ulcers (New)</td>
<td>Mar-19</td>
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<td>0.49</td>
<td>0.86</td>
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<td>Falls (All)</td>
<td>Mar-19</td>
<td>1.5</td>
<td></td>
<td></td>
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<td>1.42</td>
<td>1.01</td>
<td>2.24</td>
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<td>Falls (With harm)</td>
<td>Mar-19</td>
<td>0.5</td>
<td></td>
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<td></td>
<td>0.62</td>
<td>0.25</td>
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<td>Urinary Tract Infections (UTIs) - Catherisation</td>
<td>Mar-19</td>
<td>14.0</td>
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<td>15.00</td>
<td>16.54</td>
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<td>Mar-19</td>
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<td>0.31</td>
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<td>Venus Thromboembolism (VTE) - Risk Assessment</td>
<td>Mar-19</td>
<td>55.4</td>
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<td>45.96</td>
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<td>Venus Thromboembolism (VTE) - Prophylaxis</td>
<td>Mar-19</td>
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<td>Harm free Care - All</td>
<td>Mar-19</td>
<td>93.9</td>
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<td>94.94</td>
<td>94.99</td>
<td>96.41</td>
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<td>Maternity Harm Free Care - All</td>
<td>Mar-19</td>
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<td>77.50</td>
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<td>** Incidents**</td>
<td>Never Events</td>
<td>Mar-19</td>
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<td>2</td>
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<td>0</td>
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<td>Serious Incidents</td>
<td>Mar-19</td>
<td>N/A</td>
<td>10</td>
<td>47</td>
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<td>11</td>
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<td>NHS SI Framework: 2 Day Reporting</td>
<td>Q4 18/19</td>
<td>95%</td>
<td></td>
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<td>100.0%</td>
<td>93.0%</td>
<td>100.0%</td>
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<td>NHS SI Framework: 60 Day Reporting</td>
<td>Q4 18/19</td>
<td>95%</td>
<td></td>
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<td>78.0%</td>
<td>55.0%</td>
<td>61.0%</td>
<td>100.0%</td>
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<td></td>
<td>Safeguard Incident Risk Management (SIRMS)</td>
<td>Mar-19</td>
<td>N/A</td>
<td>23</td>
<td>379</td>
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<td>39</td>
<td>62</td>
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<td></td>
<td>NRLS - Proportion of Incidents that are harmful.</td>
<td>Jan-19</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td>22.1%</td>
<td>29.5%</td>
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<td>NRLS - Potential under-reporting of death/severe harm</td>
<td>Jan-19</td>
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<td></td>
<td></td>
<td></td>
<td>0.2</td>
<td>0.1</td>
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<td>NRLS - Potential under-reporting</td>
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<td>49.0</td>
<td>41.7</td>
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<td></td>
<td>NRLS - Consistency of Reporting</td>
<td>Jan-19</td>
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<td>6</td>
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<td><strong>Staffing</strong></td>
<td>Absence rate</td>
<td>Nov-18</td>
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<td></td>
<td></td>
<td>4.48%</td>
<td></td>
<td>4.57%</td>
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<td>5.35%</td>
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<td><strong>Alerts</strong></td>
<td>Central Alerting System - Patient safety alerts</td>
<td>Mar-19</td>
<td>0</td>
<td></td>
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<td></td>
<td>0</td>
<td>0</td>
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<tr>
<td>Measure</td>
<td>Synopsis of Issue</td>
<td>Actions taken to resolve issue</td>
<td>Timeline</td>
<td>Level of risk</td>
<td>Owner</td>
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<tr>
<td>HCAI – MRSA</td>
<td><strong>NHCFT</strong> had 1 MRSA case isolated and apportioned to the Trust in January 2019. The Trust is showing as below standard for this criterion on the NHSE Acute Quality Dashboard (Mar 19)</td>
<td>This is the only MRSA case to be reported during 2018/19.</td>
<td>Reviewed Monthly</td>
<td>Low</td>
<td>MG</td>
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<tr>
<td>HCAI - C Difficile</td>
<td><strong>NuTHFT</strong> reported 7 (published) cases in February 2019 exceeding their monthly trajectory of 6. YTD the Trust had 71 (published) cases exceeding their YTD trajectory of 70.</td>
<td>The Trust has had 22 successful appeals with a further 5 cases being considered. This brings the Trust within their annual trajectory of no more than 76 cases for the period 2018/19.</td>
<td>Reviewed Monthly</td>
<td>Low</td>
<td>MG</td>
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<tr>
<td>HCAI – MSSA</td>
<td><strong>NuTHFT</strong> has reported 86 (published) cases since April 2018 and continues to be the highest reporter in the region. The Trust is no longer an outlier on the NHSE Acute Quality Dashboard (Mar 19).</td>
<td>The Trust saw a decrease of 4 cases in MSSA Bacteraemia rates in January 2019. A specialist IV Nurse post had been created to continue collaboration with clinical areas, support education and the implementation of improvement strategies for MSSA.</td>
<td>Reviewed Monthly</td>
<td>Medium</td>
<td>MG</td>
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<tr>
<td>HCAI – E.Coli</td>
<td>Since April 2018:</td>
<td>The Trust is continuing with the gram negative bloodstream infections (GNBSI) project.</td>
<td>Reviewed Monthly</td>
<td>Medium</td>
<td>MG</td>
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<tr>
<td>HCAI – E.Coli continued</td>
<td>NuTHFT reported 427 (published) cases and continues to be the second highest reporter in the region. The Trust continues to be outlier against this measure on the NHSE Acute Quality Dashboard (Mar 19).</td>
<td>All directorates have identified GNBSI as an area of work in their specific action plans. The Trust identified that there were 18 cases of E. coli bacteraemia identified post 48 hours of admission in January 2019. The Trust has a number of initiatives, including a local working group to maintain a focused approach to UTI reduction as part of the national GNBSI reduction initiative. <em>(Source: Integrated Quality and Performance Report Jan 19 and Healthcare Associated Infections (HCAI) DIPC Report – Jan 19 Board Papers)</em></td>
<td>Reviewed Monthly</td>
<td>Medium</td>
<td>MG</td>
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<td>NTCCG has 187 (published) cases, exceeding the YTD trajectory of 165</td>
<td>NTCCG continues to focus on hydration, delivering this work into nursing and residential homes. Work is ongoing to develop a consistent approach to urine testing through ‘<em>To Dip or Not to Dip</em>’. The medicines optimisation team continue to focus on antibiotic prescribing.</td>
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<tr>
<td>Safety Thermometer</td>
<td>All elements of the Safety Thermometer continue to be monitored via the Quality Review Groups (QRG) for each provider. Where Trusts are identified as significant outliers, challenge is made at each QRG to obtain assurance of the actions being taken to resolve any issues.</td>
<td>The Trust updated their Safety and Quality Committee on the significant progress made to reduce the number of in-hospital falls in the last 12 months. The committee were given information on falls bundle compliance, new processes associated with investigation and understanding of the underlying causes of falls, more rapid specialist nursing input and a new standardised assessment tool to support enhanced observations. (Source: Excellence in Safety and Quality Report Jan 19)</td>
<td>Reviewed Monthly</td>
<td>Low</td>
<td>MG</td>
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</table>

Exceptions in March 2019:

**NHCFT** recorded a figure of 0.6% for falls (with harm). This is above the national average of 0.5%.

**NHCFT** recorded a figure of 15.9% for patients with a catheter. This is above the national average of 14.0%.

The prevalence of urinary catheters fluctuates each month, but has continued to rise above the national average since August 2018. It should be noted that although catheterisation rates are high, the number of catheter associated UTI’s is at 0.3%, below the national average (0.6%). The Trust is involved in the UTI collaborative.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Timeline</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Thermometer</td>
<td>NHCFT recorded a figure of 45.7% for Venus Thromboembolism (VTE) Risk Assessments and 32.9% for VTE Prophylaxis. Both these measures are below the national average of 55.4% and 43.4% respectively.</td>
<td>The Trust advised the QRG in March 2019 that the lack of compliance with this measure is related to difficulty in gathering data manually from patient records, rather than there being a lack of risk assessments or prophylaxis. The Trust is in the process of implementing the E-Meds system, which will enable more efficient gathering of data and require prescribers to confirm that a risk assessment has been completed and/or prophylaxis administered.</td>
<td>Reviewed Monthly</td>
<td>Low</td>
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<td>NuTHFT recorded a figure of 16.6% for patients with a catheter, above the national average of 14.0%.</td>
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<td>NTWFT recorded a figure of 2.2% for falls (all) and 0.9% for falls (with harm). These are both above the national average of 1.5% and 0.5% respectively.</td>
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<td>The Trust reports consistently above the national average for this criterion. Catheter related urinary tract infections remain consistently below the national average.</td>
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<td>Since October 2017 the Trust has been above the national average for falls (all), except on four occasions. For falls with harm the Trust has been below or matched the national average since July 2018 until March 2019 when they rose above this. These figures should be treated with caution due to the comparatively small number of falls reported. The Trust continues to review all patient falls to determine if there are lessons to be learnt.</td>
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| Never Events  | **NuTHFT** reported no never events in March 2019. The total number of never events reported during 2018/19 is 6. None of the never events related to NTCCG patients.                                                                 | The Trust report that when compared with the Shelford Group they are in the mid-range of reporters for the period April 2018 to December 2018. Never events continue to be discussed and monitored via the QRG.  
(Source: Integrated Quality and Performance Report Jan 19) | Ongoing  | Medium        |       |
|               | **NHCFT** reported 2 never events in March 2019. This brings the total number reported for 2018/19 to 4. The two never events reported in March both involved NTCCG patients.                                                                 | Of the 4 never events reported in 2018/19, two related to wrong site surgery, these have been closed at the relevant CCG’s SI panel pending receipt of a completed action plan.                                                                 |          |               |       |
|               | A further two never events were reported in April 2019; one related to a NTCCG patient.                                                                                                                                                                                      | The never events reported in March and April 2019 related to:  
• Medication - the patient was given insulin drawn from the patient’s Kwik pen resulting in an overdose. The root cause analysis (RCA) report is due in May 2019.  
• Medical Device - oxygen tubing was incorrectly connected to the AIR flow meter instead of the oxygen flow meter. RCA is due in June 2019.  
• Wrong Site Surgery – surgery completed to incorrect finger. RCA is due in July 2019.  
• Medication – transcription error resulted in the patient receiving an overdose of insulin. RCA is due in July 2019. |          |               |       |
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<tr>
<td>NHSI SI Framework: 60 Day Reporting</td>
<td>Compliance in Q4 2018/19 with the target (95%) continues to be an issue.</td>
<td>NECS works closely with the trusts via the regular caseload meetings. SI performance is discussed and managed via the relevant QRG meetings. The Trust requested and was granted a deadline extension for one RCA. This demonstrates an improvement on the previous quarter.</td>
<td>Ongoing</td>
<td>Low</td>
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<td><strong>NHCFT</strong> achieved compliance of 76% (n=16 of a possible 21 SIs). This is an improvement on Q3 performance (38%).</td>
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<td><strong>NuTHFT</strong> achieved compliance of 55% (n=11 of a possible 20 SIs). This is a deterioration on Q3 performance (63%).</td>
<td></td>
<td>No extensions were requested. The Trust routinely provides a report on their SI performance, including the rationale for any delays to the QRG.</td>
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<td><strong>NTWFT</strong> achieved compliance of 61% (n=11 of a possible 18 SIs). This is a deterioration on Q3 performance (85%).</td>
<td></td>
<td>The Trust requested and was granted deadline extensions for six RCAs, of which three were received within the agreed timescale, one was received out of the timescale and two were extended until the end of April 2019. The RCA was received within the required 60 day timescale.</td>
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<td><strong>NEASFT</strong> achieved compliance of 100% (n=1 of 1 SI). This is an improvement on Q3 performance (50%).</td>
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<td>Absence Rate</td>
<td><strong>NTWFT</strong> NHS Sickness Absence Rates for November 2018 gave an overall sickness absence rate as 5.95%. The Trust’s provisional “in month” sickness absence rate was 5.92% for February 2019.</td>
<td>The 12 month rolling average sickness rate increased to 5.79%. As previously reported the Trust has implemented a number of workforce initiatives to support staff.</td>
<td>Ongoing</td>
<td>Low</td>
<td>MG</td>
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<td>(Source: Integrated Commissioning &amp; Quality Assurance Report (Month 11 February 2019)).</td>
<td>(Source: Integrated Commissioning &amp; Quality Assurance Report (Month 11 February 2019)).</td>
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<td>Absence Rate continued</td>
<td><strong>NEASFT</strong> was noted to have an absence rate of 5.3% in November 2018 demonstrating an improvement from previous months. (Source: NHS Sickness Absence Rates Nov 18)</td>
<td>The monthly sickness absence rate for February decreased to 5.88% when compared to the previous monthly absence rate of 6.23%. Long term absence also decreased this month to 3.32% however, short term absence increased by +0.48%. The Trust’s FirstCare Dashboard informs line managers and HR teams on absence monitoring compliance levels. (Sources: Workforce Metrics Report for the period 1st – 28th February 2019)</td>
<td>Ongoing</td>
<td>Low</td>
<td>MG</td>
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<tr>
<td>Staffing Fill Rates</td>
<td><strong>NHCFIT</strong> In January 2019 9 areas reported shift fill rates below 80% on days for registered nurses (RN) and 1 area on nights. (Source: Nursing and Midwifery Assurance Report for the month of Jan 19)</td>
<td>The lower fill rates were due to vacancies, reduced patient dependence levels, short term sickness and staff moves to support other wards or departments following the Matrons daily staffing assessments and allocation of staff across all sites. The Chief Matrons for Medicine and Surgery have confirmed there were no safety concerns regarding the lower fill rates. (Source: Nursing and Midwifery Assurance Report for the month of Jan 19)</td>
<td>Ongoing</td>
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<td>Staff Vacancy</td>
<td><strong>NHCFT</strong> The Trust Nursing Assistant (NA) vacancy rate remains at 12%, specifically within medicine and surgery. The Trust vacancy position for RNs overall is 3%. <em>(Source: Nursing and Midwifery Assurance Report for the month of Jan 19)</em></td>
<td>The Director of Nursing for Delivery holds recruitment meetings every two weeks with the workforce team and business units. The Trust’s first cohort of Trainee Nursing Associates (TNAs) is due to register with the NMC in April 2019 and all interviews for the sixteen TNAs have now been completed. Within community services most vacancies have been filled with start dates awaited. The internal Aspire programme has facilitated staff to move within the organisation and services are filling some vacancies more efficiently. Recruitment is continuing and short term staff moves have helped to cover some more difficult to recruit vacancies. A review of team structures and skill mix has resulted in some teams merging to provide more resilience in the workforce particularly where sickness is a factor on top of vacancies. Midwifery recruitment continued in January 2019 due to a small outstanding vacancy. Start dates have been arranged for new recruitments. Maternity Services continue to report challenges with sickness absence, staffing levels are closely monitored and included in the matron’s daily staffing plans. <em>(Source: Nursing and Midwifery Assurance Report for the month of Jan 19)</em></td>
<td>Ongoing</td>
<td>Low</td>
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<td>Staff Vacancy continued</td>
<td><strong>NuTHFT</strong> Total nursing vacancy factor is 8.71%, with Band 5 vacancies at 8.55%. <em>(Source: Nursing, Midwifery And Allied Health Professional Staffing Trust Board – 31.01.2019)</em></td>
<td>The Trust has 138 Band 5 registered nurses (RN)/operating department practitioners in the recruitment process, 119 of which are external which will improve the overall Trust vacancy position. Some areas have a higher than average vacancy position for RNs, including the Directorate of Medicine, in particular Older Peoples Medicine, Surgical Services, Community District Nursing and Peri-Operative Scrub. <em>(Source: Nursing, Midwifery And Allied Health Professional Staffing Trust Board – 31.01.2019)</em></td>
<td>Ongoing</td>
<td>Low</td>
<td>MG</td>
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## Part B – Effective, Caring, Responsive & Well Led

### Key Performance Area

#### Mortality
- **Summary Hospital-level Mortality Indicator (SHMI)**
  - Period: Sep-18
  - Threshold: N/A
  - CCG Actual: 101.5%
  - Movement: 98.5%

#### VTE
- **VTE Risk Assessment**
  - Period: Q3 18/19
  - Threshold: 95%
  - CCG Actual: 96.4%
  - Movement: 97.2%

### Caring Quality Indicators Overview

#### Key Performance Area

#### Patient Experience of GP Services - Satisfaction with the overall care received at the surgery
- **Aug-18 publication**
  - CCG Actual: 84.0%
  - Movement: 87.0%

#### Overall experience of making an appointment
- **Aug-18 publication**
  - CCG Actual: 69.0%
  - Movement: 72.0%

#### Patient experience of GP out of hours services
- **Aug-18 publication**
  - CCG Actual: 69.0%
  - Movement: 73.0%

### Responsive and Well-Led Quality Indicators Overview

#### Key Performance Area

#### Responsive
- **Formal Complaint**
  - Period: Mar-19
  - Threshold: N/A
  - CCG Actual: 2.0
  - Movement: 17.0

#### Concern/Advice/Other
  - Period: Mar-19
  - Threshold: N/A
  - CCG Actual: 2.0
  - Movement: 17.0

#### Freedom of Information Requests
  - Period: Mar-19
  - Threshold: N/A
  - CCG Actual: 16.0
  - Movement: 220.0

#### Well-Led
- **CQUIN - NHCFT**
  - Period: Q3
  - Achievement: 100.0%

- **CQUIN - NuTHFT Acute**
  - Period: Q3
  - Achievement: 100.0%

- **CQUIN - NuTHFT Community**
  - Period: Q3
  - Achievement: 100.0%

- **CQUIN - NTWFT**
  - Period: Q3
  - Achievement: 100.0%

- **CQUIN - Ramsay Healthcare**
  - Period: Q3
  - Achievement: 100.0%
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<tbody>
<tr>
<td>Friends &amp; Family Test (FFT)/Patient Experience</td>
<td><strong>NHCFT</strong> rates continue to be below the England averages for:</td>
<td>The Trust’s:</td>
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<td>• A&amp;E response rate 7.6% (England average 12.2%)</td>
<td>• FFT response rates for all areas have remained low and need further development. PosterVote is being tested in high frequented departments and wards; the Trust hopes to see an improvement in response rates.</td>
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<td>• A&amp;E recommendation rate 83% (England average 85%)</td>
<td>• Patient Perspective results for 2018 demonstrated that 98% of inpatients, 98% of day-case patients, and 99% of outpatients would rate their experience as good, very good or excellent.</td>
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<td>• Inpatient response rate 15.6% (England average 24.6%)</td>
<td>• Real Time 2018 data capture of in-patient experience reveals consistent and high performance, although three domains warrant further scrutiny. The Trust will continue to monitor variation over time and use the information to underpin improvement.</td>
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<td>• National Maternity Survey 2018 - the Trust performed statistically better for Care in hospital when compared with other Trusts and no significant changes in performance when compared with the previous year’s survey.</td>
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<td>Friends &amp; Family Test (FFT)/Patient Experience continued</td>
<td>NHCFT continued</td>
<td>• Staff Experience results from the first real time survey has been widely shared across the organisation and improvement continues. Initial feedback is very positive. Picker will provide the Trust with an independent baseline evaluation report in the summer. The Trust’s next schedule of surveys is being conducted in partnership with iOpener – a research team in Oxford. In April 2019 all staff will be invited to take part in a happiness at work survey with an individual benchmarked report being available for each respondent.</td>
<td>Reviewed Monthly</td>
<td>Low</td>
<td>MG</td>
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<td>NuTHFT rates continue to be below the England averages for:</td>
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<td>• A&amp;E response rate 1.3% (England average 12.2%)</td>
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<td></td>
<td></td>
<td>• Inpatient response rate 11.4% (England average 24.6%)</td>
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<td>The response rate in the Emergency Department remains challenging and the directorate is exploring ways to improve this. FFT continues to be the largest source of patient feedback. The Trust is participating in the national review of the FFT in order to improve the process and delivery of capturing national data sets. The final report from NHSE is expected early spring.</td>
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<td>(Source: Executive Chief Nurse Report – Dec 18)</td>
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<td>Friends &amp; Family Test (FFT)/Patient Experience continued</td>
<td>NTWFT rate for the mental health recommendation rate was 87.0% below the England average of 89.0%.</td>
<td>The Trust continues to use the Points of You survey, which incorporates FFT, across the organisation to seek feedback on the experience of service users and carers. There remains a large number of services with very low or no responses, and work is ongoing to increase engagement with the points of you process in these teams. <em>(Source: Service User and Carer Experience Summary Report - Quarter 3 2018/19)</em></td>
<td>Reviewed Monthly</td>
<td>Low</td>
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<td>CQUIN</td>
<td>NuTHFT Q3 community CQUIN had three indicators that were not met.</td>
<td>For the Acute contract the Trust met all the required milestones and full reconciliation has been agreed by the CCG executive team. For the community contract the Trust did not achieve three of the indicators; tobacco brief advice, alcohol screening and alcohol brief advice.</td>
<td>Ongoing</td>
<td>Low</td>
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| Formal Complaints                            | NTCCG received 2 formal complaints during March 2019. A further 3 formal complaints were received for other providers. These relate to: CCG Formal Complaints:  
  - Request to review the decision to stop NHS physiotherapy.  
  - Enquiry about reimbursing of private health costs by the CCG. | Original complaint reopened. As the CCG had previously responded the patient was advised that there was nothing further to add. Patient directed to the Parliamentary and Health Services Ombudsman should they remain dissatisfied. Status: Closed Complaint withdrawn. Status: Closed | Ongoing  | Low          | MG     |
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| Formal Complaints continued | Provider Formal Complaints:  
• Access to GP appointments.  
• A provider who allegedly failed to meet the terms and conditions of a continuous care funding contract.  
Status: Awaiting consent to pass to provider. | Ongoing | Low | MG |
| Concern/Advice/Other | NTCCG received 2 concerns during March 2019. These relate to:  
• Withdrawal of personal budget.  
• NHSE requested assistance with a gender reassignment query. | CCG advised that they will deal with the complaint in conjunction with the Local Authority. Status: Closed  
Assistance requested from Provider Management Team. Status: Ongoing | Ongoing | Low | MG |
| Freedom of Information Requests | NTCCG received 16 requests in March 2019. | All were acknowledged within 2 working days.  
15 were responded to within the statutory 20 working days, with an average response time of 12 working days.  
1 is outstanding with a response date in April. | Ongoing | Low | MG |
### Additional Quality Concerns

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<tr>
<td>Safeguarding Training</td>
<td><strong>NHCFT</strong> current compliance for WRAP is 75.1%. Level 3 training is 77.8%.</td>
<td>The Trust is confident that they will have reached the NHSE compliance of 85% for Prevent by the end of March 2019 through targeted intervention. At the March 2019 QRG the low percentage for level 3 training was noted. The Trust’s safeguarding team and business units have a plan to target individual staff (and their managers) who have not completed mandatory training.</td>
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(Source: Safeguarding Children and Adults at Risk Quarterly Report Q3 18-19) | Bi-monthly | Medium | MG |
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| Safeguarding Training       | **NuTHFT** Prevent compliance was 77.26% at the end of March 2019 with 11,013 staff trained across all staff groups. This is an estimated figure as this still includes staff on long term sickness and the Trust is waiting for this to be updated via ESR.  
(Source: Prevent Training Compliance Update – April 2019 QRG) | Compliance is reported weekly at senior managers ‘stand ups’ and monthly via the integrated quality report to the Board. Additional face to face sessions continue to be delivered. Monthly reports are sent to directorate managers detailing compliance and identifying individual staff who need to be trained. All training is advertised weekly in Trust In Brief bulletin.  
There are challenges in clinical staff being released to attend training or complete e-learning. Also staff such as domestics, porters and catering staff have limited IT access and often cannot be released from work at peak times to complete face to face training.  
(Source: Prevent Training Compliance Update – April 2019 QRG) | Bi-monthly | Medium        | MG    |
| Appraisal Compliance        | **NEASFT** compliance rate in February 2019 decreased slightly on the previous month and is now 65.36%.  
(Source: Workforce Metrics Report for the period 1st – 28th February 2019) | The Trust identified that this decrease was due to the holiday period. The action plan created following the Trust’s CQC inspection includes compliance with staff appraisals.  
## Glossary of Terms

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<tr>
<th>Term</th>
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<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>ASI</td>
<td>Appointment Slot Issue</td>
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<td>BCF</td>
<td>Better Care Fund</td>
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<td>CAS</td>
<td>Central Alerting System</td>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>Cdiff</td>
<td>Clostridium Difficile</td>
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<tr>
<td>CHC</td>
<td>Continuing Health Care</td>
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<td>CYP</td>
<td>Children Young People</td>
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<td>DTOC</td>
<td>Delayed Transfers of Care</td>
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<td>E.Coli</td>
<td>Escherichia coli</td>
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<tr>
<td>ECIP</td>
<td>Emergency Care Improvement Plan</td>
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<td>ENT</td>
<td>Ear, Nose and Throat</td>
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<td>FFT</td>
<td>Friends Family Test</td>
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<td>FT</td>
<td>Foundation Trust</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HCAI</td>
<td>Healthcare Associated Infections</td>
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<td>HSMR</td>
<td>Hospital Standardised Mortality Ratio</td>
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<td>IAF</td>
<td>Improvement and Assessment Framework</td>
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<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>LADB</td>
<td>Local Accident and Emergency Delivery Board</td>
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<td>LocSSIPS</td>
<td>Local Safety Standards for Invasive Procedures</td>
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<td>LOS</td>
<td>Length of stay</td>
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<td>MRSA</td>
<td>Meticillin-resistant Staphylococcus aureus</td>
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<td>MSK</td>
<td>Musculoskeletal</td>
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<tr>
<td>MSSA</td>
<td>Methicillin-sensitive Staphylococcus aureus</td>
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<td>NEAS FT</td>
<td>North East Ambulance Service Foundation Trust</td>
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<td>NECS</td>
<td>North of England Commissioning Support Unit</td>
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<td>NHCFT</td>
<td>Northumbria Healthcare Foundation Trust</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NHSE</td>
<td>National Health Service England</td>
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<td>National Health Service Improvement</td>
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<td>National Reporting and Learning System</td>
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<td>NSECH</td>
<td>Northumbria Specialist Emergency Care Hospital</td>
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<td>NTCCG</td>
<td>North Tyneside Clinical Commissioning Group</td>
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<td>NTW FT</td>
<td>Northumberland Tyne and Wear Foundation Trust</td>
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<td>NuTH FT</td>
<td>Newcastle upon Tyne Hospitals Foundation Trust</td>
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<td>OAP</td>
<td>Out of Area Placements</td>
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<td>PIR</td>
<td>Post Incident Review</td>
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<td>PTL</td>
<td>Patient Tracking List</td>
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<td>QP</td>
<td>Quality Premium</td>
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<td>QRG</td>
<td>Quality Review Groups</td>
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<td>RCA</td>
<td>Root Cause Analysis</td>
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<td>RTT</td>
<td>Referral to treatment time</td>
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<td>SHMI</td>
<td>Summary Hospital-level Mortality Indicator</td>
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<td>SI</td>
<td>Serious Incident</td>
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<td>SIRMS</td>
<td>Safeguard Incident Risk Management System</td>
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<td>STAR-PU</td>
<td>Specific therapeutic group age-sex prescribing unit</td>
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<td>Urgent Treatment Centre</td>
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<td>UTIs</td>
<td>Urinary Tract Infections</td>
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<td>VTE</td>
<td>Venous thrombosis</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>YTD</td>
<td>Year To Date</td>
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### Report to: Governing Body

**Date:** 21 May 2019  
**Agenda item:** 13.1

<table>
<thead>
<tr>
<th><strong>Title of report:</strong></th>
<th>2019/20 Operating Plan and Commissioning Intentions</th>
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<tr>
<td><strong>Sponsor:</strong></td>
<td>Anya Paradis, Director of Contracting &amp; Commissioning</td>
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<tr>
<td><strong>Author:</strong></td>
<td>Steve Rundle, Head of Planning &amp; Commissioning, NTCCG</td>
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**Purpose of the report and action required:**
This report is for information.

**Executive summary:**
A draft of the North Tyneside CCG 2019/20 Commissioning Intentions was received by Governing Body at its February 2019 meeting. Also, an early draft of the North Tyneside CCG 2019/20 Operating Plan was received by Governing Body at its March 2019 meeting.

The Operating Plan, CCG Finance Plan and associated Excel workbooks covering activity, performance and finance were submitted successfully to NHS England on 4 April 2019, in time for the national deadline.

Because of the national deadline and the date of Governing Body, retrospective approval was sought for the Operating Plan. This was provided by the Governing Body at its meeting on 23 April 2019.

The CCG’s Commissioning Intentions document does not form part of the national submission. However, it has been agreed by the Clinical Commissioning & Contracts Committee at its April 2019 meeting and approved by the Governing Body at its meeting on 23 April 2019.

Both documents are published on the CCG’s web-site.
Governance and Compliance

1. **Links to corporate objectives**

<table>
<thead>
<tr>
<th>2019/20 corporate objectives</th>
<th>Item links to objectives</th>
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<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution.</td>
<td>✓</td>
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<tr>
<td>2. Meet the CCG’s financial duties and support delivery of the CCG’s other objectives, on a sustainable basis.</td>
<td>✓</td>
</tr>
<tr>
<td>3. Work collaboratively with partners and stakeholders to develop sustainable health and social care in North Tyneside and the wider Cumbria &amp; North East system.</td>
<td>✓</td>
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<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture.</td>
<td>✓</td>
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2. **Consultation and engagement**
Commissioning Intentions have been subject to wide engagement including Council of Practices, Patient Forum, Practice Manager Forum, Practice Nurse Forum, Healthwatch North Tyneside, VODA, Health and Wellbeing Board, Clinical Commissioning & Contracts Committee and Governing Body.

3. **Resource implications**
These documents describe how the resources available to the CCG during 2019/20 will be deployed.

4. **Risks**
There are no risks associated with this report.

5. **Equality assessment**
An equality impact assessment has not yet been carried out.

6. **Environment and sustainability assessment**
There are no environmental or sustainability risks.
## Contents

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Section 1

NHS North Tyneside CCG Introduction and Vision
NHS North Tyneside CCG
Introduction and Vision

We continue to deliver our local health and care economy vision but within the context of the region’s aspirant Integrated Care System (ICS) programme, and North Integrated Care Partnership (ICP) vision.

The CCG work is consistent with the ICS ambitions for prevention, health & wellbeing, out of hospital care, mental health and broader acute hospital collaboration, with the ICS Priority Workstreams agreed as:

- Population Health & Prevention
- Optimising Health Services
- Digital Transformation
- Workforce Transformation
- Mental Health
- Learning Disabilities

Our collaborative work to date has positively informed and contributed to development of our strategic plans across our health and care economy in the Operating Plan for 2019/20.

North Tyneside CCG works with its partners for its population on many different geographies including at place in local neighbourhoods and communities.

Our vision is “Working together to maximise the health and wellbeing of North Tyneside communities by making the best use of resources”.

We strive to find and implement new ways of working which will mean that care will be closer to home and people will only be in hospital when it is really needed. Our strategic priority themes for changing the health care system are:

- Keeping healthy, self-care
- Caring for people locally
- Hospital when it is appropriate

Our strategic vision is supported by ambitious plans to change the way that care is delivered. The figure below gives a pictorial representation of the CCG’s commissioning priorities which echoes our vision.
Recognising the pre-eminence of place based working, we are proceeding on the principle that work that we might wish to undertake at an ICP or ICS level will be driven from our individual CCG place based agendas, making best use of the all-inclusive stakeholder partnerships already established to inform the development of these plans.

Our local system is transforming and many of the traditional boundaries between providers and commissioners are already being removed in response to integrated care approaches.

Work is beginning in the three CCGs within the North ICP to understand how they will work more closely together. Collectively they are identifying a number of key priority areas:

- Aspiring towards shared management arrangements
- Developing joint Governance structures and Committees in common
- Developing a meaningful Primary Care Strategy for implementation within the next 12 months across the three CCGs
- Working arrangements to support Primary Care Networks – supporting place based working and across the ICP
- Adopting a joint approach to contract management and planning
- Identifying opportunities for standard ways of working e.g. GP Career Starts
- Moving towards A&E delivery boards in common

Noting that the three CCGs are exploring ways of working more closely together, we are clear that place based working in partnership with our local authorities and provider organisations underpinned by emerging Primary Care Networks remains our most important point of focus to deliver improved outcomes for the people we serve.
However, regardless of the changing landscape that we continue to work within, at NHS North Tyneside Clinical Commissioning Group (NTCCG), we remain focused on improving the quality of care for patients and maintaining financial balance, whilst working in partnership to strengthen the sustainability of services for the future.

Mark Adams
Chief Officer
Section 2

North East and North Cumbria Integrated Care System (NENC ICS) / Integrated Care Partnerships (ICPs)
NENC ICS Introduction and Vision

The long term ambition for the people of the North East and North Cumbria (NENC is to transform health outcomes and help them to live longer, healthier and wealthier lives.

A separate document titled ‘North East and North Cumbria, ICS Vision, Strategy and Framework for System Working’ details the vision and longer term priorities as well as the mechanism for system working.

A draft NENC System Operating Plan (aggregated plan) has been developed to provide a supportive narrative to articulate how NENC ICS will deliver the requirements of the NHS Operational Planning and Contracting Guidance. It has been built up from Place level discussion, where there is active engagement with local government and community and voluntary sector partners, through to ICP level plans and active collaboration with NENC wide priority programmes including Health Education England. These 2019/20 planning submissions align with, and support delivery of, NENC’s longer term priorities.

There are four ICPs within the NENC ICS. The map below illustrates the formation of the four ICPs.
North ICP Vision /
Introduction

The North ICP is the largest of the four ICPs in the North East and North Cumbria aspirant ICS. The footprint covers a population of 1.025m and comprises of the statutory organisations shown.

The North ICP is building on a long history of partnership working across health and social care, and through this collaboration the results have been positive and greater than any individual organisation could have achieved alone.

As a footprint we are growing and developing as the North ICP system, and are starting to understand what working together as a system might offer in facing the challenges ahead, and delivering much more for the people who we serve.

Through our active involvement in the regional system development of the North East and North Cumbria aspirant ICS (Aspirant programme), we have developed and refined our ICP approach to system delivery, taking into consideration the learning from the following key areas:

- Population health management approaches
- Strategic and tactical commissioning
- Working with local government
- Strengthening Primary Care
- System wide approach to managing resources collectively

There is support at ICP level for an emerging focus on frailty and further development of children’s services at place based level.
Section 3

NHS North Tyneside CCG Operating Plan Narrative
NHS North Tyneside CCG
place based working

NHS North Tyneside CCG has played a full and active role supporting the development of ICP and ICS system planning, ensuring there is alignment with our organisational plan and alignment with the planning guidance:

“For 2019/20, every NHS trust, NHS foundation trust and clinical commissioning group (CCG), will need to agree organisation-level operational plans which combine to form a coherent system-level operating plan. This will provide the start point for every Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) to develop five-year Long Term Plan implementation plans, covering the period to 2023/24.”

Noting the need now, we need to understand at what level we will take various elements of our work forward.

In the next section we describe how the CCG is working at place and neighbourhood level in North Tyneside.
NTCCG position within the NENC ICS

There are demonstrable synergies to working as a single ICS, but the vast majority of services will continue to be commissioned, planned and delivered locally. The ICS is constructed across four levels of scale as outlined below, with the 2019/20 deliverables also addressed at these different levels. This diagram highlights where NTCCG plays its part in the NENC system.

**Neighbourhoods** - meaning populations of c30,000-50,000 people in natural geographical areas, built around groups of Primary Care Networks, with a strong emphasis on integration of General Practice, Community Services, Social Care and the voluntary sector.

NTCCG has an established system of four localities, and plans for Primary Care Networks are being developed.

**Integrated Care Partnerships** - meaning populations of circa one million (with the exception of North Cumbria, due to its unique geographic and demographic features), focussed on acute collaboration across multiple NHS Trusts to ensure sustainable services.

In order to inform identification of ICP level working priorities the North Forum completed a joint work mapping exercise to identify the wide range of work already being undertaken between partners.

**Place** – meaning populations of c150,000 to 500,000 people as the main focus for partnership working between the NHS and Local Government.

There is much to celebrate and share from the work happening at place in North Tyneside.

**Integrated Care System** – meaning across the population of circa 3.3 million people, focused on ‘at scale’ functions that deliver added value.

Across NENC ICS this includes the work stream areas being delivered.
We have described the CCG’s vision on pages 4 and 5.

Our Strategic Principles are:

- High quality care that is safe, effective and focused on patient experience
- Services coordinated around the needs and preferences of our patients, carers and their families
- Transformation in the delivery of health and wellbeing services provided jointly with the local authority, other public sector organisations and the private and voluntary sector
- Best value for taxpayers’ money and using resources responsibly and fairly
- Right services in the right place delivering the right outcomes

The CCG is committed to developing an improved way of working with the voluntary sector, including considering any potential commissioning opportunities. It is also keen to work more closely with other CCGs, Healthwatch (e.g. around mental health crisis pathways) and North Tyneside Council.

The CCG also has quality of patient provision at its heart and constantly seeks to ensure that, through the work with our partners, we continue to improve the quality of services for the patients in North Tyneside. Considering the CCG’s vision and principles that we have described in this document, we strive to find and implement new ways of working which will mean that care will be closer to home and people will only be in hospital when it is really needed.
Financial position

The CCG’s financial objectives are to meet its financial duties and support the delivery of its other corporate objectives.

Over the last four years, CCG has successfully implemented its financial recovery plan, delivering savings of around £45m. This work has put the CCG in recurrent financial balance and it is making good progress in repaying the deficit it accumulated. The deficit peaked at £19.3m and is expected to be around £6.1m at the start of 2019/20.

The CCG’s 2019/20 financial plan demonstrates that it will deliver the £3.5m control total set by NHS England, along with the other key business rules, including the Mental Health Investment Standard, investing in primary care networks and holding a 0.5% contingency. The plan is based on prudent assumptions, including increases to fund growth in A&E and non-elective activity and to tackle increases in waiting lists. By the end of 2019/20, the CCG expects to have repaid its accumulated deficit.

In terms of efficiency savings, the CCG’s target is again much lower in 2019/20 than in previous years. The success of previous years has reduced the opportunity for savings but has also put the CCG in a strong position where high levels of savings are not required. A robust plan to deliver around £6.5m (1.7%) savings is in place. Medicines Optimisation, changes to the delivery of intermediate care and ensuring packages of care are proportionate are key areas within the plan. There are risks to this delivery but there is mitigation set aside to cover this risk.

Much of our success in turning around the financial position is as a result of the financial governance arrangements we have in place. This includes a strong Programme Management Office. We will maintain these arrangements.

Delivery of the CCG’s financial targets is only important because it will allow the CCG to commission high quality care for patients on a sustainable basis. The financial plan supports providers and the key Future Care development. The CCG has improved its underlying financial position and this is strengthened further by the overall 5.1% increase in allocation. The improved financial position allows the CCG to begin implementation of the long term plan.

Key to the sustainability of our plans is collaboration with our partner organisations. We are and will continue to work with fellow commissioners, our providers and the local authority to make the money work both within North Tyneside and on the larger footprints of our Integrated Care Partnership across North Tyneside, Northumberland and Newcastle and Gateshead and our Cumbria and North East Integrated Care System.
Reducing health inequalities

Inequalities in health outcomes in the North East are related to the ‘wider determinants’ of health rather than healthcare experience. Many of these wider determinants are factors and are an integral part of the place (work, housing, environment, etc.) and are largely the responsibility of local government however the CCG is working closely with partners to identify opportunities to support the reduction in health inequalities.

Overview

North Tyneside is one of the least deprived boroughs in the region and there is generally an improving picture of health and wellbeing.
Life expectancy has been increasing at all ages across the borough, which is very good news. The reasons are changes in infant mortality, improvements in medical treatments, improved standards of living such as good nutrition, cleaner air, fewer people smoking and generally better public health. However life expectancy at birth for men and women has plateaued over the last five years (2012-2016).

Healthy life expectancy has not increased at the same rate as life expectancy, leaving large numbers of people living the later stages of their lives in poor health, often with multiple long term conditions.

A woman can expect to live 62.1 years in good health at birth in North Tyneside (2014/16). This is similar to the England average (63.9 years), and higher than the North East average (60.6 years). Full life expectancy at birth in North Tyneside for women is 82.4 years (2014/16).

A man can expect to live 61.9 years in good health at birth in North Tyneside (2014/19). This is similar to the England average (63.3 years) and higher than the North East average (59.7 years). Full life expectancy at birth in North Tyneside for men is 77.9 years (2014/16).
Relative deprivation in North Tyneside is improving; in the 2010 IMD North Tyneside was ranked 113 out of 326 authorities (higher is better). In the 2015 IMD, North Tyneside was ranked 130. However there are wide inequalities across the borough, with persistent pockets of deprivation particularly in the wards of Riverside and Chirton.

The gap in life expectancy between the most and least deprived areas within the borough is 11 years, and this gap has remained static during the last decade. Men in our most deprived wards live on average 11.7 years less than those residing in our least deprived wards and for women the corresponding figure is 10.6 years less.

Premature mortality

Cancer, cardiovascular disease (CVD) and respiratory disease are the leading causes of premature death in North Tyneside. Age standardised mortality rates for all three diseases are higher than the England rate:

- Cancer remains the most significant cause of premature mortality in North Tyneside with 888 deaths in 2015-17
- Although CVD mortality has declined faster than cancer; there were still 461 premature deaths in 2015-17
• COPD is one of the major respiratory diseases and smoking is a major cause of COPD. There were 214 deaths in 2015-17
• People are also dying from liver disease at a younger age compared to the national average. Deaths due to liver disease are heavily influenced by both alcohol and obesity. In North Tyneside there were 135 deaths in 2015-17

Social factors, lifestyle choices and late presentation, diagnosis and treatment contribute to the premature mortality, however much of this premature mortality is preventable. The figure below highlights that there were 1,432 deaths in North Tyneside that were considered as preventable.

Lifestyle and behaviour

Major risk factors for poor health include unhealthy diets, smoking, drinking too much alcohol and physical inactivity:

• Just under two thirds (62.2%) of adults in North Tyneside are overweight or obese (2016/17)
• There are increasing numbers of people who have type 2 diabetes there are 12,848 individuals in North Tyneside with type 2 diabetes (7.2%) and there is a further 2,147 (1.4%) individuals who have not been diagnosed
• It is estimated that 11.6% of adults have non-diabetic hyperglycaemia and thus represent an opportunity to prevent from developing type 2 diabetes
• The numbers of adults smoking in North Tyneside has significantly declined over the last decade to an all-time low of 16.5% (2017). However there is variation in North Tyneside: 30% of adults in the most deprived areas of North Tyneside smoke compared to only 8% in our least deprived areas.
• Alcohol related admissions to hospital are higher in North Tyneside compared to the national average. In 2016/17 there were over 1,700 people admitted to hospital for specific alcohol reasons.
• 23.5% of the population is drinking at levels that risk damaging health
• 27.2% of adults are doing less than 30 minutes of exercise per week (2016/17)

Children and young people
• 17% of children are living in poverty. There is a persistent gap in educational attainment between disadvantaged children and other children in the borough.
• The rate of obese children doubles between five year olds and 10 year olds. One in 10 children are obese aged 4-5, and one in five by aged 10. There is a clear relationship between deprivation and obesity.
• 10.5% of 15 year olds are regular smokers (this is similar to the England average)

An ageing population
• North Tyneside’s population is getting older.
• There are growing numbers of people with multiple long term conditions and frailty.
• More than one in 10 of the adult population has a caring responsibility.
• An estimated 14% of people over 65 years old are caring for someone.
• There are just under 15,000 older people over the age of 65 who live alone.
• The number of people aged over 75 living alone is predicted to rise by 41.9% by 2030.

Health inequalities

We have regard to the need to reduce inequalities between patients in accessing health services for our local population.

We understand our local population and local health needs, through the use of joint strategic needs assessments (JSNAs) and we collate additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.

The average life expectancy for the people of North Tyneside is 77.9 years (2014/16) for men and 82.4 years for women (2014/16). Life expectancy is 11.7 years lower for men and 10.9 years lower for women in the most deprived areas of North Tyneside than in the least deprived areas.

The principal cause of premature death in North Tyneside is cancer, followed by cardiovascular disease (CVD). Smoking is the major cause of preventable death, with alcohol misuse the second biggest lifestyle health risk factor.
In summary, the challenges within North Tyneside include:

- Ageing population with increasing needs
- Health inequalities between localities
- Increasing over reliance on hospital-based services
- Increasing high cost drugs and cost of new medical technologies
- Minimal growth in financial allocations and funding shift to social and primary care

We work in partnership with local NHS trusts, as well as local voluntary sector organisations and community groups to identify the needs of the diverse local community we serve to improve health and healthcare for the local population.

We seek the views of patients, carers and the public through individual feedback/input, consultations, working with other organisations and community groups, attendance at community events and engagement activity including patient surveys, focus groups and Healthwatch.

As the local commissioners of health services, we seek to ensure that the services that are purchased on behalf of our local population reflect their needs. We appreciate that to deliver this requires meaningful consultation and involvement of all our stakeholders.

We aim to ensure that comments and feedback from our local communities are captured and, where possible, giving local people the opportunity to influence local health services and enable people to have their say using a variety of communication methods enabling them to influence the way NHS health services are commissioned.

Through our Commissioning Support Unit, we have continued to work closely with other local NHS organisations to support the regional working that has been a legacy of the Equality, Diversity and Human Rights Regional Leads Meetings. Also nationally they have been awarded E&D Partner status for 2016/17 and have continued to work closely with partners as part of the alumni programme for 2017/18.

We continue to monitor the health profiles and data available which detail the health challenges of our population including the Joint Strategic Needs Analysis (JSNA) and Public Health Profiles.

Further information can be found at:

- PHE Local Authority Health Profiles: [www.healthprofiles.info](http://www.healthprofiles.info)
- Public Health England – Local Health: [www.localhealth.org.uk](http://www.localhealth.org.uk)
NHS RightCare and population health

NHS RightCare packs are used by the CCG to support service reviews and service development; they are designed to help reduce health inequalities and improve health outcomes for the local population of North Tyneside.

By using NHS RightCare alongside the local intelligence such as the JSNA the CCG is able to ensure our plans focus on the opportunities which have the potential to provide the biggest improvements in health outcomes and reductions in health inequalities.

The National Big Picture

Socioeconomic Status
People living in deprived areas on average have poorer health and shorter lives. Research shows that socioeconomic inequalities result in increased morbidity and decreased life expectancy. The UCL Institute of Health Equity estimates 1.3 to 2.5 million potential years of life lost annually due to inequalities.10

Protected Characteristics
These are individuals' characteristics protected by the Equality Act of 2010. Understanding these different characteristics can improve patient care in terms of health outcomes, access and experiences. There are 9 protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

- The under 75 mortality rate from Cardiovascular Disease (CVD) is almost five times higher in the most deprived compared to the least deprived areas
- People with learning disabilities are 4 times as likely to die of preventable causes
- South Asians are up to 6 times more likely to develop type 2 diabetes
- Africans, Caribbean and Asian females over 65 have a higher risk of cervical cancer
- Suicide is currently the biggest killer of men under 35 in the UK
- Lesbian and bisexual women are twice as likely to have never had a cervical smear test, compared with women in general
- It is becoming more common for children to develop type 2 diabetes
- Older people report receiving poorer levels of care than younger people with the same conditions
- Muslim people report worse health on average compared to other religious groups
Future Care

Future Care is North Tyneside’s transformation programme which includes:

- Delivering Population Health and Wellbeing
- Delivering high quality, coordinated care
- Improving quality of life and experience of services
- Supporting and empowering staff
- Providing effective stewardship of resources

A central component of Future Care is development of a new model of community and primary care provision to support a move in resources from acute to primary and community services, as well as working in four localities across North Tyneside to support local delivery where appropriate. Future Care requires all of the partners in the health and social care system to come together to make the identified changes.

The multiagency Future Care Board involves all of the NHS Foundation Trusts working in North Tyneside, the Ambulance service, TyneHealth GP Federation, North Tyneside Local Authority, Public Health, GP practice representatives, VODA, HealthWatch, patient representatives, the independent sector and the CCG itself. This group provides oversight and governance to this programme and was established during 2018/19.

The programme of work has the following themed work streams which will focus on achievement of agreed outcomes:

- Primary Care Home
- Urgent and Emergency Care
- Planned Care, Long Term Condition Management and NHS RightCare
- Children and Young People

There are a number of prioritised projects under each work stream as well as a number of system cross cutting enablers/ risks (each with their own work plan) which include:

- IT
- Workforce
- Communication and Engagement
- Parity of Esteem
- Safeguarding
- Better Care Fund

The schematic below provides details of the services that fall within the Future Care banner and how the governance structure around Future Care operates.
Partnership working

In addition to the Future Care Executive and Programme Board, the CCG is a key partner in a range of strategic fora. These include the North Tyneside Strategic Partnership and the Health and Wellbeing Board, and also many themed partnership boards including those focused on mental health, learning disabilities, carers and children and young people.
National requirements

The next sections of the operating plan outline the CCG’s plans in the following key areas, including how it will deliver on national requirements:

- Urgent and Emergency Care
- Referral to Treatment Times (RTT)
- Cancer Treatment
- Mental Health
- Learning Disabilities and Autism
- Primary Care and Community Health Services
- Workforce
- Data and Technology
- Personal Health Budgets
- Longer Term Deliverables
Urgent and Emergency Care

The national requirements for urgent and emergency care are:

- The existing NHS Constitution standards remain in force until new clinical standards for urgent and emergency care are set out in the Clinical Standards Review, to be published in spring 2019, tested in the first half of the year, and implemented from October 2019.
- Ambulance services should ensure they meet ambulance response time constitutional standards as set out below:
  - Category 1: 7 minutes (mean), 15 minutes (90th centile)
  - Category 2: 18 minutes (mean), 40 minutes (90th centile)
  - Category 3: 120 minutes (90th centile)
  - Category 4: 180 minutes (90th centile)
- No one arriving by ambulance should wait more than 30 minutes from arrival to hospital handover.
- Every acute hospital with a type 1 A&E department will deliver a comprehensive model of Same Day Emergency Care (SDEC) at least 12 hours per day, seven days a week, by September 2019.
- There will be a focus on reducing long hospital stays for patients and Delayed Transfers of Care (DTOCs).

Why change?

- Increased demand on Urgent and Emergency Care services along with changing patient behaviours and expectations;
- Fragmented service provision and gaps in workforce;
- Patients being confused about where to go for help;
- Poor co-ordination and integration between health, community and social care affecting the ability to provide effective and timely healthcare;
- Multiple access routes.

What are we going to do?

We will continue to work with North East Ambulance Service NHS Foundation Trust (NEAS) to ensure:
  - Response standards are maintained for access, unscheduled care and scheduled care
  - That services provided by NEAS are adequately resourced
  - That NEAS deals with fluctuations in demand during periods of high demand, e.g. winter.

We will continue to work with NEAS and Northumbria Healthcare NHS Foundation Trust to reduce delays in ambulance handovers by ensuring fluidity in the admissions process.
We will work with Northumbria Healthcare NHS Foundation Trust (Northumbria Specialist Emergency Care Hospital) and The Newcastle-upon-Tyne Hospitals NHS Foundation Trust (Royal Victoria Infirmary) to deliver Same Day Emergency Care by September 2019.

We have a number of processes to support patient flow and reduce the risks of delayed transfers of care. These include: discharge to assess, nursing care assessment team monitoring, provision of intermediate care beds in the community and the ability to block purchase nursing beds.
Referral to Treatment Times (RTT)

The national requirements for RTT are:

- Building on the expectation that providers will deliver March 2019 waiting lists at the March 2018 level, all providers to reduce their waiting list during 2019/20
- No patient will wait more than 52 weeks for treatment
- Every patient waiting 6 months or longer to be contacted and offered the option of care at an alternative provider
- Implement agreed standards as set out in the Clinical Standards Review to be published in spring 2019.
- No more than 1% of patients should wait six weeks or more for a diagnostic test.
- Ensure patients will have direct access to MSK First Contact Practitioners

Why change?

- Managing demand for elective services more efficiently
- Meeting waiting list targets
- Delivery of Referral to Treatment Times (RTT)
- Implementing clinical best practice and improving quality
- NHS RightCare data and methodology still shows large amounts of unwarranted or unexplained variation, regionally and between providers and GP Practices.

What are we going to do?

Details of the CCG’s current and planned performance against the national requirements are provided in the Technical Narrative on page 77.

CCGs and providers in the North ICP are working to redesign outpatients to ensure right professional, right place, right time, delivering high quality pathways across primary and secondary care and adding value to people’s lives.

The case for change includes:

- Increasing demand e.g. activity and complexity
- Frustration with duplication and variation from both clinicians across primary and secondary care and patients.
- Workforce challenges
- Estates
- Technological advances

Northumbria Healthcare NHS Foundation Trust, NHS North Tyneside CCG and NHS Northumberland CCG are working together on the Outpatients Project aiming to:
• Deliver improved patient experience, improved patient safety and improved efficiency
• Reduce outpatient follow-ups in identified specialties (including Rheumatology, Orthopaedics, Gynaecology, Colorectal, Cardiology and CAMHS) including implementation of patient-initiated follow-up (PIFU) where appropriate
• Promote innovative and alternative models of care including uses of digital technology, learning from the implementation of the teledermatology pilot in selected practices in Northumberland
• Implement SystmOne to facilitate effective communication within outpatients pathways
• Work with NHS Improvement to trial new payment models to support these changes

The outcome measures for the project are:

• To improve rapid (maximum one week) outpatient access by 20% by March 2020
• To reduce outpatient follow up by 20% in identified specialties by March 2020
• To reduce outpatient estate utilisation by 30% at Northumbria Healthcare by March 2020
• To improve patients and staff experience scores for outpatients

We will also use intelligence from NHS RightCare to flag further areas for consideration.

We will continue to pilot MSK First Contact Practitioners in the North Shields locality, and potentially roll out further across the CCG.

We will continue to review the operation of our newly-commissioned Advice & Guidance (A&G) and Rapid Specialist Opinion services and make changes as necessary, and potentially expand A&G to more specialties.

We will continue to work with local CCGs and providers to explore the options for implementing the Combined Physical and Psychological Programme as part of the National Back Pain Pathway.
Cancer Treatment

The national requirements for cancer are:

- At least 93% of patients who receive an urgent GP (GMP, GDP or Optometrist) referral for suspected cancer should have their first outpatient attendance within a maximum of two weeks.
- At least 93% of patients with breast symptoms who receive an urgent GP referral for suspected cancer should have their first hospital assessment within a maximum of two weeks.
- At least 96% of patients should wait no more than one month (31 days) for their first definitive treatment, from the date a decision to treat is made, for all cancers.
- At least 94% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is surgery.
- At least 98% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is drug treatment.
- At least 94% of patients should wait no more than one month (31 days) for subsequent treatment, from the date a decision to treat is made, where the treatment is radiotherapy.
- At least 85% of patients receiving an urgent GP (GMP, GDP or Optometrist) referral for suspected cancer should wait no more than two months (62 days) for their first definitive treatment, for all cancers.
- At least 90% of patients with an urgent referral from an NHS cancer screening programme should wait no more than two months (62 days) for their first definitive treatment.
- Implement human papillomavirus (HPV) primary screening for cervical cancer across England by 2020

Why change?

- Cancer is the leading cause of premature death in North Tyneside, with the age standardised mortality rate higher than the England rate
- Nearly one quarter of the North Tyneside population is drinking at levels that risk damaging health
- Significant variation in smoking levels across North Tyneside
- Pressure on services meaning the CCG is not meeting all eight constitutional standards

What are we going to do?

Details of the CCG’s current and planned performance against the national requirements are provided in the Technical Narrative on pages 78-80.
The CCG has developed in partnership with local providers a three year strategic plan to make the changes necessary to ensure that people identified and diagnosed with cancer receive the highest level of care possible and maximise life expectancy.

The Strategic plan focusses on six priorities areas:

2. Achieve earlier diagnosis using evidence based clinical pathways to achieving faster diagnosis.
3. Improve patient experience
4. Delivery of Living with and Beyond Cancer Survivorship Pathways in breast, colorectal and prostate.
5. Make necessary investments to deliver a modern high quality service.
6. Ensure commissioning of local services is aligned to region based integrated systems where necessary.

Key actions identified for 2019/20 include:

- Improving access to stop smoking services and increase smoking quit rates.
- Continue community based approaches to target populations at greater risk of cancer and design and deliver interventions which:
  a) Inform people about what action to take in response to cancer signs, symptoms and screening invitations
  b) Provide targeted support to help people manage their weight, reduce their levels of alcohol and or smoking intake.
- Roll out national “Optimal colorectal pathway”
- Develop systems and process in preparation and readiness for the 28 day pathway on referral to diagnosis which comes into effect in 2020.
- Establish a Patient experience cancer group to advise, inform and challenge commissioners and providers on those aspects of cancer care can be greatly improved in terms of quality based outcomes.
- Encourage primary care participation in the National Cancer Audit
- Implement a Lung Cancer Case finding pilot.
- Consolidate the successful roll out of the Living With and Beyond Breast Cancer pathway
- Roll out the Living with and Beyond Colorectal Cancer pathway.
- Ensure all patients diagnosed with cancer have a full holistic needs assessment.
- Implement Faecal Immunochemical Testing (FIT) for low risk, symptomatic patients.
- Support the implementation of FIT for bowel screening.
Mental Health

The national requirements for mental health are:

- By March 2020 IAPT services should be providing timely access to treatment for at least 22% of those who could benefit (people with anxiety disorders and depression).
- At least 50% of people who complete IAPT treatment should recover.
- At least two thirds (66.7%) of people with dementia, aged 65 and over, should receive a formal diagnosis.
- At least 75% of people referred to the IAPT programme should begin treatment within six weeks of referral.
- At least 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.
- At least 56% of people aged 14-65 experiencing their first episode of psychosis should start treatment within two weeks.
- At least 34% of children and young people with a diagnosable mental health condition should receive treatment from an NHS-funded community mental health service, representing an additional 63,000 receiving treatment each year.
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within one week of an urgent referral.
- By March 2021, at least 95% of children and young people with an eating disorder should be seen within four weeks of a routine referral.
- Continued reduction in out of area placements for acute mental health care for adults, in line with agreed trajectories.
- At least 60% people with a severe mental illness should receive a full annual physical health check.
- Nationally, 3,000 mental health therapists should be co-located in primary care by 2020/21 to support two thirds of the increase in access to be delivered through IAPT-Long Term Conditions services
- Nationally, 4,500 additional mental health therapists should be recruited and trained by 2020/21.
- The further deliverables for mental health outlined in the technical annex must also be delivered during 2019/20, most notably for: perinatal mental health; all age crisis and liaison services; 50% of early intervention in psychosis services graded at level 3; and reducing suicides.

Why change?

- Performance against 5 Year Forward View and Long Term Plan
- Parity between mental health and physical health
- Taking a Marmot view to mental health with focus on early life interventions through perinatal mental health provision and improvements for children and young people mental health provision
- Reducing health inequalities providing equal access to mental health interventions
• Emphasis on prevention and early intervention thus reducing pressure on higher level services

What are we going to do?

Details of the CCG’s current and planned performance against the national requirements are provided in the Technical Narrative on pages 80-83.

Implementation of Mental Health Forward View

We are committed to delivering the Mental Health Five Year Forward View.

The Mental Health Boards which include Public Health, North Tyneside Local Authority, NTWFT, NHCFT, voluntary sector organisations, patient and carer representatives as well as the CCG, continue to meet regularly. Three strategy documents have been produced mirroring the Boards:

• Children & Young People's Mental Health & Emotional Well-Being Strategy, incorporating the CAMHS Transformation Plan
• Adult Mental Health Strategy
• Older Peoples Mental Health Strategy

In relation to children and young people’s mental health provision, we implemented new pathways during 2018/19 to enable school headteachers and SENCOs to refer directly into the CAMHS service. Additionally, there is now access for schools to urgent appointments and professional telephone advice. The CCG also funded, along with the Wellcome Trust, an innovative project called MI:2K. The MI:2K project was a year-long engagement programme, run by national charity Involve and Leaders Unlocked. A team recruited and trained young people in our area, including at-risk groups, on how local mental health prevention, support and services can be most effective and supported them to conduct a research project resulting in key recommendations to be taken up by the CYP MHEWB Strategic Group for action.

CAMHS provision remains a priority for the CCG in 2019/20. The CAMHS Local Transformation Plan is a five year Plan and is now entering its fourth year. The current, 2017/18 Plan is available on the CCG’s website. During 2018/19, mental health in education and improved involvement and engagement were the two key priorities. Building on the success of the Emotionally Healthy Schools Resource Pack which was launched in May 2017, we worked with the Local Authority, the Anna Freud National Centre for Children and Families and the Department for Education as part of the Schools Link Programme 2017-18 to strengthen communication and joint working arrangements between schools and mental health professionals.
During 2019/20, the CCG will:

- Form a strategic alliance with Barnardo’s and the local authority, in relation to children’s and young people’s emotional health and wellbeing. The focus will be on early intervention and prevention. The purpose is to identify challenges, examine service delivery and service design. The process will begin with workshops to identify what is working and where there are challenges. A school survey regarding children and young people’s mental health will be undertaken and the New Forest Parenting training programme will be rolled out across social care and health.
- Review existing CAMHS Tier 2 & 3 provision to identify areas of efficiency and improved pathways
- Review the outcomes from the Mi:2K project to inform and influence service design and development for CAMHS
- Work with partners to continue to work with schools to implement some of the improvements identified in the Schools Link Programme workshops during the coming year which will include establishing a termly Mental Health School Mental Health Leads Network where school staff would come together with CAMHS, Educational Psychology and School Improvement staff.
- Fund additional resource into the CAMHS neurodevelopmental pathway where we have already identified specific issues with the current pathway and waiting times for assessment
- Develop CAMHS services in preparation for implementation of the requirements of the Children & Young People Mental Health Green Paper, focusing on mental health provision in schools and improved access times.
- Review, with the Local Authority, the pilot of the Kooth online counselling service to determine how it may be commissioned in the future.
- The CCG continues its involvement in the regional work on the national New Care Models programme, whereby secondary mental health providers are given the opportunity to take responsibility for tertiary commissioning budgets for children and adolescent mental health services (CAMHS) Tier 4 inpatient services, adult secure and adult eating disorders services. The aim of New Care Models is to innovate and transform services in the best interests of service users and their families and to provide care as near to home as possible.

For working age adults’ services, the CCG will provide additional funding to enable the expansion of IAPT services for people with Long Term Condition and to also improve waiting times for access to Step 3 therapy.

We will also work with VODA to re-establish the North Tyneside Recovery College, offering a range of courses and workshops related to mental health and wellbeing.

The CCG is also working with provider partners to implement closer ways of working between services and organisations, minimising multi-referrals between services for individual patients and rejection of referrals.

We are also working at a Locality level to develop mental health nursing posts, based in GP Practices, who will be able to assist patients, signpost and provide education and training for GPs on mental health issues. This project will initially be
based in the North Shields and Wallsend locality areas and may be considered for future cross-Borough roll-out.

We will continue to fund both the national Core 24 model of liaison psychiatry, based at the A&E department of The Northumbria Hospital and the older people’s liaison psychiatry services, based in inpatient and rehabilitation wards at North Tyneside General Hospital. We are closely monitoring the impact of these services and will evaluate their outcomes.

Community based mental health services

Northumberland, Tyne and Wear NHS Foundation Trust (NTWFT) implemented new pathways and structures for community based mental health services in North Tyneside during 2016/17.

Since then, a review was undertaken of some of these new pathways, focusing specifically on the pathway for people experiencing a mental health crisis aiming to ensure that people receive timely access to appropriate services to manage their needs. The review was undertaken in partnership with Healthwatch to gain patient and carer input into the pathways work and to help inform future commissioning decisions.

As a result of this work and the subsequent Healthwatch published report, the CCG will, during 2019/20:

- Commission a low level crisis support service for people who feel they are experiencing a crisis but do not meet the threshold for the Crisis Resolution and Home treatment Team
- Review the availability of carer support to ensure that their support needs are identified. The CCG already funds one mental health carer support worker and will identify how further support can be provided
- Continue to work with GP Practices to increase mental health awareness, knowledge of services available and referral mechanisms

This work will be monitored at the bi-monthly North Tyneside Mental Health Crisis Concordat Strategy Group and will be reported to the appropriate Mental Health Board and, ultimately, the Health and Wellbeing Board.

Maintaining a High Level of dementia diagnosis and good quality care for people with dementia

The CCG currently has an early dementia diagnosis rate which exceeds the national target of at least two-thirds of the estimated number of people with dementia.

The CCG continues to review the national information to ensure that it continues to meet this target. The CCG is also working with GP Localities to ensure that patients who have been diagnosed with dementia have their care plan reviewed annually. This is audited nationally and the CCG aims to improve its rating in this area.
During 2017/18, the CCG agreed to fund an Admiral Nurse post with Age UK North Tyneside, aiming to improve post diagnostic support for people with dementia and their carers. The CCG has worked with Age UK North Tyneside to review the impact of this post and the CCG has agreed to continue funding this post on a recurrent basis.

Development of a single model of mental health care for older people across North Tyneside

We will secure a more consistent service experience across North Tyneside for older people with mental health problems, working with both current older people mental health providers to effect this.

This will involve:

- Data gathering
- Pathway mapping
- Benchmarking

The aim will be to develop, agree and implement a service specification with both mental health providers providing older peoples mental health services to people in North Tyneside.

We have also finalised a joint strategy with North Tyneside Council on mental health services for older people, including dementia. Following this, a joint action plan will be developed and presented to the Health & Wellbeing Board for approval. Progress against the actions will be monitored by the Health & Wellbeing Board.

We will also review and implement new pathways for older people who are experiencing a mental health crisis. This work will be undertaken via the appropriate Mental Health Board.
Learning Disabilities and Autism

The national requirements for transforming care for people with learning disabilities:

- Reduction in reliance on inpatient care for people with a learning disability and/or autism (CCG-funded) to 18.5 inpatients per million adult population by March 2020.
- Reduction in reliance on inpatient care for people with a learning disability and/or autism (NHS-England funded) to 18.5 inpatients per million adult population by March 2020.
- At least 75% of people on the learning disability register should have had an annual health check.
- CCGs are a member of a Learning from Deaths report (LeDeR) steering group and have a named person with lead responsibility.
- There is a robust CCG plan in place to ensure that LeDeR reviews are undertaken within 6 months of the notification of death to the local area.
- CCGs have systems in place to analyse and address the themes and recommendations from completed LeDeR reviews.
- An annual report is submitted to the appropriate board/committee for all statutory partners, demonstrating action taken and outcomes from LeDeR reviews.

Why change?

- To reduce health inequalities and improve life expectancy for those with learning disabilities and or autism through health checks, medication reviews, learning lessons from mortality review
- To reducing the number of inappropriate admissions to inpatient facilities through improved community provision

What are we going to do?

Details of the CCG’s current and planned performance against the national requirements are provided in the Technical Narrative on pages 83-84.

The Local Authority and North Tyneside CCG have established joint processes to enhance and/or integrate services that underpin living well in the community.

The North Tyneside Implementation plan for people with learning disabilities and/or autism takes into account regional planning assumptions and the CCG will continue to work as part of the regional Transformational Board on developing system-wide out of hospital care and allow people with complex learning disabilities to be appropriately and safely supported closer to home.

In line with the Transforming Care agenda, North Tyneside will work with other CCGs and Local Authority Commissioners as part of the North Region
Implementation Group to develop a complex case framework that will ensure community based pathways are robust, fit for purpose with clear ‘step up and step down’ processes to ensure the delivery of community-based care for the people with the most challenging and complex behaviours is of a high quality and meeting the assessed needs of individuals. Alongside this development a review of assessment and treatment beds will be undertaken across the North Region.

The North Tyneside Disability Integration Board will be focussing on the following in 19/20:

- Developing an autism strategy for North Tyneside, informed by the submitted Self-Assessment Framework.
- Revisit the STOMP (Stopping Over-Medication of People with a Learning Disability, Autism or Both) baseline practice audit as a benchmark for developing a robust clinical pathway for the review of psychotropic medication prescribed to people with learning disability. The CCG continues to work with NTW NHS FT and Northumbria Healthcare NHS FT on a medicines optimisation programme to ensure patients and carers are involved in decision making about medication, its use and review.
- Developing an assurance framework for physical health screening and exploring how this offer can be extended to people with a diagnosis of just autism.
- Together with our various stakeholders in community and acute services, continue to carry out Mortality Reviews for people who are known to services as having a learning disability, who have died.
- Undertake a pathway mapping exercise in relation to community service provision, (which incorporates New Care Models) ensuring that the local offer is inclusive of a wrap-around service, including crisis provision.

A joint review with regional CCGs of adult ADHD and autism services concluded during 2017/18 From this review, a new pathway was implemented by the Northumberland, Tyne and Wear NHS Foundation Trust, aiming to reduce waiting lists and waiting times for assessment as it had grown at a significant rate. The aim was to develop a service which involves:

- Specialist assessment
- Community focus for ongoing management of people diagnosed with ADHD/Autism

A model of delivery and implementation plan was agreed between the Trust and CCGs.

During 2019/20, the CCG will work in partnership with other CCGs to review this new model of delivery to determine if it has achieved its aims and reduced waiting lists and times.

The CCG will also work with local partners in North Tyneside to develop a system-wide strategy for ADHD and autism in North Tyneside. This strategy will include benchmark information of other services around the country, highlighting areas of good practice and will provide an analysis of potential areas for development.
Primary Care and Community Health Services

The national requirement for primary care and community health services is to commit a recurrent £1.50 per head of population to develop and maintain primary care networks so that 100% coverage is achieved as soon as possible and by 30 June 2019 at the latest.

Why change?

- General practice is facing major challenges, not least workforce and workload. The Primary Care Network (PCN) investment, workforce initiatives and integrated working aim to alleviate this
- PCNs build on the core of current general practice while also increasing resilience of practices. They enable greater provision of proactive, personalised, coordinated care by working together with health and social care and community and voluntary sector
- They offer the opportunity to really work together to meet patients’ needs in a more effective efficient way
- Need to develop the “out of hospital” care model
- Confusion amongst patients and practitioners as to where to go for help
- Fragmented service provision and gaps in workforce
- Inconsistent access to community service provision

What are we going to do?

Primary Care Strategy and GP Forward View

We will implement the North Tyneside Primary Care Strategy and the GP Forward View in conjunction with the local GP Federation, TyneHealth, and Newcastle & North Tyneside Local Medical Committee. There are four components to our Strategy:

1. Redesigning Access to Primary Care
2. Extended Primary Care Team (EPCT)
3. Integrating Specialist Support
4. Prevention and Self care

Through 2018/19 the CCG and TyneHealth GP Federation have been engaging with member practices to develop and support delivery of projects to deliver this strategy including but not limited to:

- additional recurrent investment to each GP practice to use to improve access, improve patient experience, and improve staff experience
• additional non-recurrent investment to each GP practice to support practice improvements
• the provision of extended access to GP services in evenings and on weekends for all practices in North Tyneside
• completion of a gap analysis and support to practices to implement the 10 high impact changes identified in Releasing Time to Care
• ongoing support to local practices to develop the role of Care Navigators
• the piloting of new technology such as online consultation software
• the training of clerical coders within general practice
• the pilot of a peripatetic care home team
• the pilot of a Physio First model to allow faster access to specialist MSK support
• the pilot of a respiratory hub including specialist spirometry, FeNO testing and treatment
• implementation of a GP career start programme
• initiation of a nurse career start programme

In 2019/20 we will continue to support GP practices to implement these projects, and make the changes identified to increase resilience and make general practice more sustainable. These projects include:

• the further development of locality groups / primary care networks to support the delivery of Primary Care Home
• development of a workforce strategy for primary care
• development of a general practice estates strategy
• development of a support package for practices that are looking to work more collaboratively
• development of a home visiting service
• provision of additional pharmacist support into localities to provide home based medication reviews
• pilot of integrated mental health workers into general practice in 2 localities
• increase roll out of new technology such as online consultation software to additional practices
• increased coordination of the care navigator role
• additional training of clerical coders within general practice
• continued implementation of the 10 high impact changes identified in Releasing Time to Care

**Review and Reconfiguration of Community Services**

Improving how community services\(^1\) proactively and reactively work with patients is critical to making the NHS more effective, efficient and therefore sustainable. It is well rehearsed that the majority of NHS contacts happen in the community, the majority of which come through Primary Care. “Transforming Community Services”

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\(^1\) In this context “community services” refers to services delivered in the community and include the current community contracts with FT’s, primary care, independent contractors, voluntary organisations who deliver care for the population of North Tyneside
resulted in the community contract transferring into acute hospitals in North Tyneside and Newcastle. At the time it was envisaged that the opportunity for pathway enhancement, transformation and improvement of community based care would be enhanced by this vertical integration. It was envisaged that proactive care in the community aligned with Primary Care would be realised, resulting in more patients being cared for at home and people attending hospital by exception with the expertise and staff being made available in a community setting.

However, community services as a whole are not well coordinated with other services, causing patients to receive care that is fragmented and of variable quality and value for money. It could be argued that this is currently the case in North Tyneside with the community contract last being reviewed in 2011. The primary care strategy sets out the direction of travel for primary care in response to the NHS ‘Five Year Forward View’\(^2\) which envisions new models of care that break down the traditional divides between primary care, community services and hospitals. The aim is for patients to receive personalised and coordinated care from different types of services with clinicians working together.

North Tyneside Clinical Commissioning Group is a level 3 commissioner in relation to Primary Care, which adds another opportunity to commission fit for purpose “community services” in order to ensure sustainability in response to the demographic and system challenges in North Tyneside previously detailed.

NHS North Tyneside CCG now has an important opportunity to commission community services in a way that will support this shift to more coordinated care for patients closer to home. The community services contracts put in place three to five years ago are no longer fit for purpose, giving us an opportunity to:

- Move to new ways of working or new models of care that are better for patients with a focus on outcome delivery.
- Test which providers are most likely to achieve the changes that commissioners want for patients to embrace a new “community services” delivery model
- Move to new contracts that provide greater transparency and accountability for wider community services provision, as well as greater incentives for providers to improve services for patients.
- Focus upon the population where the greatest need lies and provide a system approach to care delivery whilst maintaining universal services for other patients rather than a piecemeal approach to services\(^3\).

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\(^3\) Kings Fund (2014) *The Reconfiguration of Clinical Services*
Workforce

We recognise that our staff are our greatest asset and therefore strive to ensure their health and wellbeing is paramount; we support flexible working and encourage positive workforce practices.

We are committed to a ‘whole system’ approach to workforce development to ensure that it is fit for the future. There are three areas of focus: CCG staff, primary care and the staff working within the provider organisations that we commission services from. The CCG continues to monitor Safe Staffing information through the QRGs and during assurance visits.

The future sustainable delivery of high quality care is dependent upon an agile, adaptive workforce that can respond to the changing context of care delivery. In order for providers to work effectively with Health Education North East (HENE), the CCG will work in collaboration to ensure that future commissioning priority areas and large scale change are identified. This will enable the projected workforce changes to be made for undergraduate, post graduate and continuing professional development programmes.

We will continue to work in partnership with HENE and the North East Leadership Academy to maximise the opportunities to influence workforce development now and in the future.

We will work with member practices to identify future workforce needs in response to the changing landscape of primary care. As commissioners we will ensure that we have robust succession and talent management systems in place for our own CCG workforce. We are committed to help grow the next generation of clinical leaders and will work with key stakeholders to turn this commitment into a reality.

Further detail is provided in the Technical Narrative on pages 68-69.
Data and technology

In recent years, the CCG has made considerable progress towards improving informatics. For example, phase one of Patient Online was implemented across all 27 GP practices – this gives citizens access to their online GP records and the availability of online appointments. Patient Online was also introduced into a care home as a pilot project and has been successful with a plan to roll this out across all of our 31 Care and Nursing homes. The implementation of Patient Online phase two will create a significant increase in patient access to their health records. This functionality will allow patients to access detailed coded information held within their record.

We are continuing our aim to have a minimum of 24% of the patient population within North Tyneside actively accessing primary care services online through the development of apps and improved website functionality allowing patients to book appointments and other services online, by the end of 2018/19. This will include EPS, online appointments and access to detailed information within their GP record. This process will have an assigned project lead and planning group to deliver the project.

We are also, in partnership with NHSE in the process of delivering the nhsapp which will be live in practices for patient to use by July 2019.

SNOMED CT implementation for Primary Care - currently there are two versions of clinical codes (Read v2 and CTV3) in existence within general practice, so not all GP systems use the same coding system and they do not provide the sophisticated features now expected from a clinical terminology, browser or system. The NHS needs a single clinical terminology (SNOMED CT) in order for clinical data to be exchanged accurately and consistently across all care settings; this will enable better patient care and improve the analysis and reporting of clinical data.

2018/19 will also see the implementation of Black Pear software across primary care services which will help support the development of the national interoperability programme.

We have been implementing an informatics programme during 2018/19 to continue to improve the patient experience and be as efficient as possible. We have developed an electronic Patient Forum newsletter which is sent to all Patient Forum members and to all of our 27 member practices. We continue to develop GP TeamNet which is our corporate communication tool for GP practices.

We have also purchased and are in the process of implementing a system called Sensemaker which will allow patients to tell their story of their care within the health system.

We have released a self-care app for Android and iOS which is free to access. The app offers advice and guidance, contact numbers, patient signposting and “how to” videos. A further GP practice application was released in 2017 bringing the total number of GP practices with mobile applications in North Tyneside to 10.
We are working very hard to continue the development of rolling out nhs.net in care homes which is in conjunction with the national strategy for improving health in care homes. This will allow patient information to flow securely across the health system creating safer and more efficient pathways.

We have also updated the vast majority of our member practice web sites which will create easier access for patients when booking appointments, ordering prescriptions and seeking advice without making a GP appointment. We have also introduced patient information screens across our member practices.

To improve quality and patient experience we have implemented remote working across all of our GP practices which allows clinicians to access their clinical system when in care homes and patients’ homes. This has been a very positive experience for both clinicians and patients.

In 2018/19 we have digitised all current GP hard copy patient records which will improve efficiency and create space within GP practices by the development of treatment/multi use rooms. This project will meet the NHSE Personalised Health and Care strategy 2020.

Electronic discharge summaries are now being used by GP practices across North Tyneside. We are continuing to develop electronic referrals between GP practices and other services to create a fully interoperable digital record. This work has led to the development and implementation of the Medical Interoperability Gateway (MIG) in collaboration with acute and primary care services and organisations. The introduction of the MIG has allowed acute and primary care services access to full medical records with agreed data sharing agreements in place. This will give clinicians the ability to treat patients in a more efficient way and will be accessed at the point of contact with patient approval. This work continues to develop and the evolution of the Great North Care record has continued to develop in 2018/19.

We continue to develop a collaborative care data initiative with hospitals, GP practices admin and audit to support quality improvement.

All GP practices will complete the IG toolkit creating robust data security standards. This process will be supported by the continuous governance arrangements we have in place with our system supplier which has completed all the national data security standards through the GP National Framework and GP SoC.

The continued development of the Local Digital Roadmap with our partners and service providers across North Tyneside and Northumberland will result in a more sustainable and efficient pathway when sharing information across the health and social care economy.

We will continue to support and lead on the Forward View into Action through the development, delivery and completion of the Digital Maturity Self-Assessment (The Digital Road Map) in collaboration with Northumbria Healthcare NHS FT, Northumberland, Tyne and Wear NHS FT, North Tyneside Council, Northumberland CCG and The Newcastle-upon-Tyne Hospitals NHS FT. The roadmap will have an
effective, clear and consistent baseline against which local partners can demonstrate how far they have progressed towards the goal of being paper-free at the point of care. A collaborative working group has been developed which includes all the relevant partners to support the delivery of the project.

We are currently finalising our digital strategy which will help us identify our informatics plan and IM&T strategy for the next three years.

We have identified a number of outcomes and impacts in relation to our work on informatics:

- Quality improvement through improved collaboration on care data between hospitals and GP Practices;
- Improved access for patients to their GP records and online appointment booking;
- Improved patient treatment through access to full medical records;
- Improved information governance;
- Significant progress towards being paper-free at the point of care;
- Creating an interoperability programme.
Personal health budgets

The national requirement for personal health budgets (PHBs) is that by March 2021, 50,000 to 100,000 people should have a PHB.

Why change?

Personalised care means people have choice and control over the way their care is planned and delivered.

What are we going to do?

The CCG has written to all patients receiving Continuing Health Care (CHC) who are being cared for at home to offer them the opportunity to either self-manage their personal health budget or allow the CCG to continue to case manage on their behalf. In 2019/20, all patients eligible for CHC will receive a personal health budget and given the opportunity to self-manage the budget or leave the case management to the CCG. The CCG is forecast to achieve the standard for 2019/20.
Longer term deliverables

The NHS Long Term Plan sets out expectations for the years beyond 2019/20. Specifically CCGs are asked to set the ground work for coming years in the areas in the table below:

<table>
<thead>
<tr>
<th>Area</th>
<th>Requirement from Planning Guidance</th>
<th>North Tyneside CCG Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>System architecture</strong></td>
<td>Work towards every area of the country being part of an ICS by April 2021</td>
<td>North Tyneside CCG is part of the emerging ICS in the North East and North Cumbria.</td>
</tr>
<tr>
<td><strong>Health inequalities</strong></td>
<td>All local health systems will be expected to set out during 2019 how they will specifically reduce health inequalities by 2023/24 and 2028/29, including clearly setting out how those CCGs benefiting from the health inequalities adjustment are targeting that funding to improve the equity of access and outcomes</td>
<td>See pages 15-20</td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td>Start to implement an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies</td>
<td>North Tyneside CCG is part of a region wide partnership to implement requirements regarding maternity.</td>
</tr>
<tr>
<td></td>
<td>Offer all women who smoke during their pregnancy, specialist smoking cessation support to help them quit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support work to achieve a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025</td>
<td></td>
</tr>
<tr>
<td></td>
<td>By spring 2019, every trust in England with a maternity and neonatal service will be part of the National Maternal and Neonatal Health Safety Collaborative, supported by Local Learning Systems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roll out the Saving Babies Lives Care Bundle during 2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maternity digital care records are being offered to 20,000 eligible women in 20 accelerator sites across England, rising to 100,000 by October 2019</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue to work with midwives, mothers and their families to implement continuity of carer so that, by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All maternity services that do not deliver an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative, will begin the accreditation process in 2019/20</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>By 2020/21, the NHS will ensure that at least 280,000 people living with severe mental health problems have their physical health needs met</td>
<td>See pages 32-36 and 80-83</td>
</tr>
<tr>
<td></td>
<td>Begin roll out of Mental Health Support Teams working in schools and colleges in trailblazer areas to cover one fifth to a quarter of the country by the end of 2023</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue to expand access to IAPT services for adults and older adults with common mental health problems, with a focus on those with long term conditions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue to progress delivery of standards for early intervention in psychosis, IAPT and services for young people with eating disorders by 2021</td>
<td></td>
</tr>
<tr>
<td><strong>Learning disability and autism</strong></td>
<td>Delivering against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21</td>
<td>See pages 37-38 and 83-84</td>
</tr>
<tr>
<td></td>
<td>Continue to reduce the number of people with a learning disability, autism or both by 2023/24</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td>From September 2019, all boys aged 12 and 13 will be offered vaccination against HPV-related diseases, such as oral, throat and anal cancer</td>
<td>See pages 30-31 and 78-80</td>
</tr>
<tr>
<td></td>
<td>Extend lung health checks (already piloted in Manchester and Liverpool)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>From 2019, we will start the rollout of new Rapid Diagnostic Centres (RDCs) across the country</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Implement a stratified approach for follow up for breast cancer in 2019 and prostate and colorectal cancers in 2020 (expanding to all cancers which are clinically appropriate in 2023). From 2019, we will begin to introduce an innovative quality of life metric – the first on this scale in the world – to track and respond to the long-term impact of cancer</td>
<td></td>
</tr>
</tbody>
</table>
North Tyneside CCG aims to address the changes needed in the way in which carers’ health and wellbeing needs are identified, addressed and supported. We will work with our providers to develop an integrated approach to identifying and meeting carers' health and wellbeing needs (of all ages).

This will be achieved by promoting positive practice in supporting carers, with particular focus on carers from vulnerable communities or at key transition points in order to reduce health inequalities.

The CCG will lead on the development of a three year action plan for carers and this will be overseen by a multi-agency Carers Partnership Board. Key priorities include:

- Support the identification and recognition of carers in primary care, working directly with ‘Care Navigators’ in improving the registration and assessments process of carers including young carers.
- Work with all providers to ensure carers are supported in the choices they make about their caring role and access appropriate services and support for them and the person they care for.
- Improve access to support for those caring for people with a diagnosis of a mental health condition.
- Improve the carers’ experience in secondary care by:
  - Raising the profile of carers amongst staff through raising awareness of carers needs.
  - Promote a holistic approach from initial diagnosis, improved care-coordination, discharge planning and;
  - Ensuring the carer is provided with information and/or referring early for support and in doing so, reduce the risk of a crisis situation or breakdown in the carer’s health.
- Increase capacity in the Young Carers and families support service.
Quality

Overview

In order to commission high quality care successfully, we actively promote engagement, transparency and successful relationships between all key stakeholders involved in the delivery of health and care services. This is in order to realise our vision of a health system shaped by patient and citizen participation and is designed with improved outcomes and patient experience at its heart.

Quality Systems and Processes

Quality Review Groups (QRGs) are in place for all Foundation Trusts and local private hospital providers. They focus on assurance relating to the clinical quality of commissioned services across the domains of clinical quality; patient safety, patient experience and clinical effectiveness. This includes triangulation of data from a range of sources including mortality indices, patient experience programmes including the Friends and Family Test, staff surveys, patient surveys, serious incidents, complaints, soft intelligence and the internal processes in place within providers to ensure the robust management of these issues.

During 2018/19 the CCG has continued to receive specific assurance in areas such as safe staffing levels, incident reporting, management and learning processes, falls management and harm minimisation, compliance with NICE guidance, action on mortality and sepsis and the avoidable harms outlined in the NHS Safety Thermometer. Assurance relating to national reports is also sought including gap analysis and action taken to address any issues.

The QRGs also oversee the assurance process for provider cost improvement plans, maintaining a constructive dialogue with providers throughout the year ensuring that plans are quality impact assessed for any potential quality or safety issues.

The CCG member practices continue to play a key role in the identification and reporting of clinical quality intelligence about our providers. The Safeguard Incident and Risk Management System (SIRMS) enables practices to report data on incidents, experiences and issues that they and their patients have with various providers within the local healthcare system. Reporting rates are declining across North Tyneside practices, 100% of practices have access to SIRMS and it is expected that incidents reported during 2018/19 will be in excess of 380. Where quality issues are identified, they are discussed collaboratively with providers and feedback/learning is requested for identified themes, trends and significant individual patient safety issues.
The CCG has in place a robust process for the assurance, management and closure of serious incidents reported by commissioned services. The serious incident closure panel ensures that serious incidents are only closed when the CCG has evidence that lessons have been learned and all actions have been taken to prevent re-occurrence. The CCG received ‘Substantial Assurance’ from internal audit that the serious incident closure process within the CCG is robust.

The CCG is an active member of the local Quality Surveillance Group at which information and intelligence on Providers is shared between NHS England and the local CCGs and other agencies. This is then communicated to our Quality and Safety Committee and Governing Body as part of the assurance process.

We have continued to work in collaboration with the Care Quality Commission (CQC), sharing review information and provider action plans when there has been any concern regarding quality issues. During 2018/19 we have continued with a schedule of quality assurance visits in partnership with the Local Authority to all Independent Nursing Homes. In addition we attend quarterly information sharing meetings with each Nursing Home provider in partnership with the Local Authority. We have also continued to undertake assurance visits with our acute trusts and independent hospital providers. Regular meetings continue with Healthwatch North Tyneside as part of a strong and collaborative working relationship, which includes membership of the CCG Patient Forum, Health and Social Care Integration Partnership working groups and the Health and Wellbeing Board.

The CCG places a high priority on sepsis awareness raising and education on the use of the National Early Warning Score (NEWS), and this will be included in service specifications and in any local incentive schemes funded by the CCG.

**Better Care Fund**

The North Tyneside Better Care Fund plan will take the North Tyneside health and care system closer to the goal of health and social care integration through a range of services aiming to maintain people in their own homes and avoiding hospital admission when possible. This includes integration of reablement, immediate response and overnight home care services; intermediate care services; improving the coordination of mental and physical healthcare services and 24/7 crisis support.

**Patient Experience**

Robust complaints processes ensure that we are notified of all complaints relating to our patients as soon as they are recorded. Provider complaints are managed under the provider’s complaints procedures and reported to us through their board level Patient Experience report, which is shared at Quality Review Group meetings. We continue to work with member practices and the NHS England Team to develop and assure quality and safety in primary care.
Safeguarding

The Governing Body has delegated responsibility for monitoring and assuring safeguarding to the Quality and Safety Committee and this is explicit in the CCG Constitution and the Quality and Safety Committee terms of reference. The Executive Director of Nursing and Chief Operating Officer is the lead officer for safeguarding, supported by the CCG employed Head of Safeguarding: Designated Nurse Safeguarding Children, the Designated Nurse Safeguarding Adults, the Designated Nurse Looked After Children, the Designated Doctor Safeguarding Children, the Designated Doctor Looked After Children and the Named GP Safeguarding Children and Adults.

In addition to regular and detailed reports to the Quality and Safety Committee, reports are provided to the CCG Governing Body at a private session at every meeting. The CCG also works closely with providers to ensure that safeguarding remains part of regular discussions at the QRGs, receiving regular reports outlining the internal assurance process and activity around adults and children at risk.

The Governing Body members and CCG staff receive safeguarding adults and children training and are clear about their respective roles and responsibilities. The CCG is an active member of the Safeguarding Adults Board and the Local Safeguarding Children Board.

Safeguarding of children is an important element of contract monitoring with providers, and assurance is sought through regular meetings, quality review groups and Section 11 provider audit reports to the Local Safeguarding Children Board. Quarterly monitoring is also in place using a safeguarding children performance dashboard. During 2018/19 the CCG received significant assurance from NHS England when benchmarked against the regional safeguarding audit tool.

In relation to adults, the CCG has robust information sharing mechanisms in place with the CQC and North Tyneside Council. The Local Authority and the CCG have joint monitoring arrangements in place for nursing homes, which have identified opportunities for improvement across a range of areas.

Currently the CCG receives a safeguarding performance dashboard from the following providers:

- Northumbria Healthcare NHS Foundation Trust (NHCFT) in relation to children, including Looked After Children and adults.
- Northumberland, Tyne and Wear NHS Foundation Trust (NTW) in relation to children and adults.
- North East Ambulance Service (NEAS) in relation to children and adults.

In addition to the dashboards, the CCG receives information and assurance from a variety of other sources for example:
• North Tyneside Safeguarding Children Board – the CCG is represented on the Board and all of the sub-groups
• Quality Review Groups – safeguarding is a standing agenda item
• North of Tyne Child Death Overview Panel

**PREVENT**

The Counter-Terrorism and Security Act 2015, places a duty on certain bodies in the exercise of their functions to have “due regard to the need to prevent people from being drawn into terrorism”. Those bodies are referred to “specified authorities” and include NHS Trusts.

The statutory guidance: ‘Prevent Duty Guidance’ was published in 2015 and clarifies that all specified authorities subject to the duty will need to ensure they provide appropriate training for staff involved in the implementation of this duty. The CCG monitors implementation of the PREVENT agenda through the QRGs. The PREVENT strategy is part of the Governments overall counter-terrorism strategy called CONTEST. The aim of the PREVENT strategy is to reduce the threat to the UK from terrorism by safeguarding and supporting those individuals vulnerable to radicalization, and so prevents them becoming terrorists or supporting terrorism.

In health, training is delivered in partnership between NHS England, CCGs and health providers.

In line with statutory requirements North Tyneside Clinical Commissioning Group (NTCCG) has a PREVENT lead who in conjunction with provider leads is responsible for driving the strategy forward in North Tyneside and providing support and advice. The PREVENT lead role includes training and education, monitoring and reporting locally, regionally and if required nationally. The lead also attends and receives updates from the North of England PREVENT forum and ensures this information is disseminated to relevant agencies.

NTCCG’s health providers report on training compliance with PREVENT via the PREVENT national reporting system and is also monitored via the NHS Standard Contract. It is also monitored through the QRGs and have developed action plans to enable them to meet the compliance targets set by NHS England.

NTCCG has been delivering PREVENT basic awareness sessions to its staff since 2014 to ensure CCG staff have the required a knowledge and skills to fulfil their role. At the present time, the CCG is compliant with regard to prevent training.

NTCCG Safeguarding Team has delivered WRAP (level 3) training to all North Tyneside GP practices. WRAP is a higher level of training which is a requirement for all clinical staff working with adults, children and young people who could potentially
contribute to assessing, planning, intervening and evaluating care where there are safeguarding concerns.

Primary care staff can now access national e-learning that meets the requirements of both the basic PREVENT awareness and WRAP training. The CCG safeguarding team continues to deliver face to face WRAP sessions for CCG and primary care staff via a scheduled programme.

NHS England’s *Mental Capacity Act 2005 A Guide for Clinical Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance* sets out our duty to ensure that the legislation, guidance and policy relating to the Mental Capacity Act (MCA) are delivered by service providers thereby assuring CCGs and NHS England that the rights of patients are being recognised and protected; in North Tyneside we use the framework for tendering, contracting and monitoring and ongoing assurance. The CCG has an appointed Lead Nurse for MCA and Deprivation of Liberty Safeguards (DoLS) to strengthen the clinical team, providing training and advice.

**Patient and Public Engagement**

Our public engagement and communications strategy meets the requirements set out in the ‘transforming participation’ guidance and national planning guidance. We are an active Health and Wellbeing Board member, driving the integration agenda in order to support the ambitions of the borough which is underpinned by patient and community participation to ensure high quality sustainable responsive services for local people.

We have a proactive patient and public engagement approach ensuring that patients and local communities help to shape our commissioning priority areas and the future of care delivery for the residents of North Tyneside. Working with our key partners, we ensure that the patient and public voice is heard and actively engage them in service transformation and development programmes.

Adopting systematic approaches such as *My NHS*, which is a sophisticated customer management tool, also allows us to recruit patient and community members aligned with their own particular areas of interest. We actively seek ongoing feedback on NHS-commissioned services and have a proactive approach to ensure that local voices and residents, who are historically hard to reach, are heard. This then informs ongoing service and system improvement.

The vibrant patient forum, and its six working groups, is made up of members of the GP practice participation groups as well as the Community and Health Care Forum. The working groups are topic specific; mental health, end of life care, future care, primary care, self-care and communications. Building capacity to promote self-care is an ongoing area of priority and builds on the successful work so far including the ‘Keep Calm’ winter campaign developed by this group. In addition there are back pain drop in sessions for the community to seek advice from clinicians to self-
manage their condition. Members have taken an active role in the production of falls prevention materials in partnership with the CCG. A quarterly patient forum newsletter is published by members.

Ensuring the delivery of person centred care is a core feature of ongoing developments across primary and secondary care. Working with the patient forum and community members will raise the awareness of the importance of shared decision making and help local people to get the most from their contacts with health professionals.
Section 4

NHS North Tyneside CCG
Technical Narrative
In the following sections we provide our local technical narrative for activity and performance, with detail for NHSE to be able to assure NTCCG plans.

During the planning process the CCG has worked with our providers to ensure effective alignment between our plans, with the work with system partners at place based level in North Tyneside and the weekly Directors of Finance meetings resulting in agreement for Directors to work together to manage delivery of individual and ICP control totals a major contributing factor.

The technical narrative provides the rationale for the trajectories submitted within the CCG MAOR template including Constitution standards, Activity, Primary Care, Mental Health and other areas such as personal health budgets.

We have answered the key lines of enquiry as follows:

1. Alignment of CCG and provider activity and growth assumptions which are in line with national assumptions (or reason for variation)
2. Assumptions based on YTD and FOT activity
3. Alignment of specialised commissioning assumptions
4. Activity assumptions are profiled
5. The capacity requirements needed to deliver the activity have been identified, including a preliminary gap analysis?
6. Workforce plans are reflective of activity plans/capacity requirements
7. That any quality issues arising from activity and capacity plans have been addressed in the provider’s quality plan
8. Delivery of NHS constitution standards and the ask on elective waiting lists
9. Plans reflect the delivery of control totals by CCGs and providers
10. CCG plans demonstrate that Mental Health Investment Standard will be met
11. CCG plans demonstrate that funding for primary and community health services is growing faster than the overall NHS revenue settlement (3.6%) and that plans meet the recurrent primary care funding ask
12. There is clarity on the areas of focus for the achievement of any necessary efficiencies, associated with planning assumptions
13. Each CCG to set out its plan to deliver a 20% reduction against their 2017/18 running costs by 2020/21 including a description of initial changes in 2019/20.
1. Alignment of CCG and provider activity and growth assumptions which are in line with national assumptions (or reason for variation)

2. Assumptions based on YTD and FOT activity

3. Alignment of specialised commissioning assumptions

4. Activity assumptions are profiled

In this section we describe our assumptions in relation to baseline activity levels, projected outturns and what modelling has been used to underpin the activity numbers submitted.

The activity demand has been built using the following methodology:

**Activity lines**

**18/19 Forecast Outturn (FOT)**

The methodology for projecting the forecast outturn was to use a three year seasonal model. Activity theoretically happens in a similar volume at the same time each year, therefore adopting this type of model allows us to apportion expected activity to the remaining months of the year, based on what happened in previous years.

We have compared our FOT position to those provided by NHS England. In all instances the forecast outturn variance at a POD level was within 5% of the NHSE figure and we have therefore defaulted to the NHSE position in the first instance.

Adjustments have also been made to activity to reflect agreed forecast outturn assumptions with local providers. The most significant adjustment has been made to Other A&E Attendances to reflect the opening of the new Urgent Care centre on 1 October 2018.

The Financial outturn has been constructed using demand planning activity information based on the period 1 October 2017 to 30 September 2018 adjusted to reflect the forecast outturn position. Demographic growth based on ONS data has been included along with a growth factor to reflect an increase in cancer prevalence. An adjustment for working days has also been made.

The CCG has actively worked with providers to reconcile activity to ensure consistency of activity and finance assumptions across the ICP.
19/20 Projections

Activity for 19/20 is based on the 18/19 FOT outlined above, adjusted for growth based on the assumptions below:

Growth Assumptions

In the absence of national figures, growth assumptions have been discussed locally in order to attempt to align submissions with local providers. Demographic uplifts have been applied based on ONS growth and non-demographic based on local indicators.

Monthly Profiling

The 19/20 monthly positions are profiled using the previous three completed financial years (at CCG & POD level) to apply an appropriate seasonal phasing to the monthly plans.

Constitutional indicators

When calculating the 19/20 plans for the constitutional indicators, we have again used the three year seasonal model and used this to forecast the position for the remainder of the year.

For the numerators, we have looked at the latest performance of that indicator and if the latest performance is above the national threshold, then we have projected that this position will be maintained. If it is currently performing below the national threshold for that indicator, the CCG has tried to forecast when the standard will be achieved.

For some of the indicators where there are low numbers we have projected a higher performance than the latest position, this is due to the submissions requiring whole numbers. To achieve this, numbers have been rounded up rather than down. For some indicators this would lead to some months projecting 90-100% on indicators where the threshold is lower than that, this is simply so it will meet the validation criteria of the submission templates, without dropping below the performance target.

For the RTT 52 week waits, all of the CCGs have a very small number of these historically, so we have forecast zero in 19/20 based on this.

As always, there is the expectation that this position will be triangulated, and delivery agreed with the providers to ensure that achievement of this metric is attainable.
Data sources

The Activity data has been sourced from the National Commissioning Data Repository (NCDR) and the criteria applied in line with the NHSE/I Technical guidance.

The Constitutional Indicators have been sourced, where possible, from national data sources. Where this hasn’t been possible, provisions via the CCG/Providers have been made accordingly.

Specialised commissioning assumptions

Work continues to align with specialised services commissioning through a number of fora, e.g. various Learning Disabilities groups including Transforming Care Board, Transforming Care Steering Group and North Regional Implementation Group (NORIG). Commissioners and providers are represented at these meetings and groups. Alongside this CCGs CFOs meet in the Strategic Finance LD group.

Adjustments arising from the specialised commissioning IR and PEL exercises have been reflected where available in demand plans.
Finance and Activity POD Level Reconciliation

This section provides a technical narrative for each Point of Delivery (POD) describing the increase/decrease in activity from 18/19 to 19/20. It also explains the differences between movements in activity and movements within the Financial Plan.

First Outpatient Attendances

<table>
<thead>
<tr>
<th>2018/19 Forecast outturn</th>
<th>79,954</th>
<th>Brief description of assumption/scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic growth</td>
<td>661</td>
<td>Demographic growth based on ONS figures</td>
</tr>
<tr>
<td>Non demographic growth</td>
<td>843</td>
<td>Non-demographic growth (as discussed with main Providers)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2019/20 Planned Activity</th>
<th>75,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019/20 Planned Growth</td>
<td>-5.2%</td>
</tr>
</tbody>
</table>

Movement from 18/19 to 19/20

The reduction in outpatients from 2018/19 to 2019/20 of 5.2% relates predominantly to the change in coding of ambulatory care activity from outpatient activity to non-elective activity.

Reconciliation of Finance and Activity

The ambulatory care activity reduction will not result in a corresponding reduction in first outpatient cost as the current costs sit within ‘other’ within the financial plan.
Follow Up Outpatients

Movement from 18/19 to 19/20

The increase in outpatients of 1.1% is due to an increase in non-demographic growth of 0.7% and an increase in population of 1% offset by a reduction in activity due to ambulatory care coding changes.

Reconciliation of Finance and Activity

The ambulatory care activity reduction will not result in a corresponding reduction in outpatient follow up cost as the current costs sit within ‘other’ within the financial plan.
## Elective Admissions - Day Cases

<table>
<thead>
<tr>
<th>2018/19 Forecast outturn</th>
<th>32,521</th>
<th>Brief description of assumption/scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coding changes</td>
<td>2,101</td>
<td>Change in Ambulatory Care coding at Northumbria FT and NuTH FT (costs within ‘Other’ category within Finance Plan)</td>
</tr>
<tr>
<td>Demographic growth</td>
<td>347</td>
<td>Demographic growth based on ONS figures</td>
</tr>
<tr>
<td>Non demographic growth</td>
<td>366</td>
<td>Non-demographic growth (as discussed with main Providers)</td>
</tr>
</tbody>
</table>

### Movement from 18/19 to 19/20

The increase of 8.7% is made up of an increase in demographic growth of 1.1%, non-demographic growth of 1.1% and coding changes due to ambulatory care of 6.5%.

### Reconciliation of Finance and Activity

The ambulatory care activity reduction will not result in a corresponding reduction in outpatient follow up cost as the current costs sit within ‘other’ within the financial plan.
### Elective Admissions – Ordinary

#### Movement from 18/19 to 19/20

Elective admissions will remain constant with a 0.2% increase planned during the year. There are currently no QIPP schemes included which plan to reduce elective activity.
## Non Elective Admissions Zero Length of Stay

<table>
<thead>
<tr>
<th>2018/19 Forecast outturn</th>
<th>11,368</th>
<th>Brief description of assumption/scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coding changes</td>
<td>4,626</td>
<td>Change in Ambulatory Care coding at Northumbria FT and NuTH FT (costs within ‘Other’ category within Finance Plan)</td>
</tr>
<tr>
<td>Demographic growth</td>
<td>159</td>
<td>Demographic growth based on ONS figures</td>
</tr>
<tr>
<td>Non demographic growth</td>
<td>199</td>
<td>Non-demographic growth (as discussed with main Providers)</td>
</tr>
<tr>
<td><strong>After Growth Assumptions</strong></td>
<td><strong>16,352</strong></td>
<td></td>
</tr>
</tbody>
</table>

| 2019/20 Planned Activity | 16,352 |
| 2019/20 Planned Growth   | 43.8%  |

### Movement from 18/19 to 19/20

The 43.8% increase can be explained due to a change in ambulatory care coding. Excluding the coding changes an increase of 3.1% is planned due to demographic and non-demographic growth.

### Reconciliation of Finance and Activity

The ambulatory care activity reduction will not result in a corresponding reduction in outpatient follow up cost as the current costs sit within ‘other’ within the financial plan. As per national Readmission and MRET guidance a financial adjustment has been made to the non-elective POD without a corresponding activity adjustment.
Non Elective Admissions – 1 or more days

<table>
<thead>
<tr>
<th>2018/19 Forecast outturn</th>
<th>17,550</th>
<th>Brief description of assumption/scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic growth</td>
<td>174</td>
<td>Demographic growth based on ONS figures</td>
</tr>
<tr>
<td>Non demographic growth</td>
<td>297</td>
<td>Non-demographic growth (as discussed with main Providers)</td>
</tr>
</tbody>
</table>

Movement from 18/19 to 19/20

The CCG is planning an increase of 2.7% on Non-elective admissions for with a stay of one day or more. This is due to demographic and non-demographic growth.

Reconciliation of Finance and Activity

As per national Readmission and MRET guidance a financial adjustment has been made to the non-elective POD without a corresponding activity adjustment.
A & E Attendances

<table>
<thead>
<tr>
<th>2018/19 Forecast outturn</th>
<th>115,619</th>
<th>Brief description of assumption/scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent activity</td>
<td>10,577</td>
<td>FYE of Urgent Care Centre (opened 01/10/18)</td>
</tr>
<tr>
<td>Demographic growth</td>
<td>838</td>
<td>Demographic growth based on ONS figures</td>
</tr>
<tr>
<td>Non demographic growth</td>
<td>4,599</td>
<td>Non-demographic growth (as discussed with main Providers)</td>
</tr>
<tr>
<td>After Growth Assumptions</td>
<td>131,633</td>
<td></td>
</tr>
</tbody>
</table>

Movement from 18/19 to 19/20

The 13.9% increase can be explained by the full year effect of the Urgent Care Centre which opened on 1 October 2018 resulting in an increase in Type 3 activity which had previously been accounted for within a block contract and not accounted for as Type 3 activity. In addition the CCG has planned for a 4.7% increase in activity as a result of demographic and non-demographic growth.

Reconciliation of Finance and Activity

The increase in A & E activity is not matched by a corresponding increase in the financial plan. A negative financial adjustment has been applied to the plan as cost shift from A & E to ‘Other’ Healthcare as this is now a block contract.
5. The capacity requirements needed to deliver the activity have been identified, including a preliminary gap analysis?

Activity growth assumptions have been tested with providers during the 2019/20 contract negotiation process. As part of the development of demand plans, provider colleagues reviewed activity requirements with directorates to establish the reasonableness and deliverability of proposed volumes. Based on the growth assumptions outlined above, neither of the CCG’s major acute providers have raised capacity concerns, other than issues with hitting the cancer 62 day and breast cancer 2 week wait targets.
6. Workforce plans are reflective of activity plans/capacity requirements

Workforce is both the issue and the solution to many of the current challenges facing the health and social care system, supported by technology and working environments which are fit for purpose.

People are living longer with complexity of care needs which means that if we continue to do what we have always done by 2030 we would need an additional 15,000 staff at a cost of £550m across the North East and North Cumbria Integrated Care System (ICS). This is compounded by an aging workforce with nearly 20% over 55 and 50% over the age of 45, many of whom are concerned that pension and tax changes implicate negatively on their working lives.

Workforce shortages are a recognised risk across health economy – all partners in the NENC ICS are working together to develop an integrated workforce plan.

Activity plans are seasonally profiled, with detailed winter planning carried out by Trusts and overseen by LAEDB.

Limited inclusion of additional seasonal workforce in plans is because of limited availability, but providers deploy existing workforce in response to known variations in demand.

Workforce Priorities have been identified at ICP level, with many reflected in CCG and local providers’ plans; the CCG will work with national and regional workforce leaders and arms-length bodies to take forward immediate priorities including:

- Increase domiciliary workforce supply through proactive marketing of health and social care careers within schools programmes
- Facilitate agile working across organisations and sectors to sustain the system ‘right skills, right place’ through streamlining of policies and clinical passporting
- Move to competency based roles which remove boundaries but value unique professional contribution
- International Recruitment including general practitioners, hospital nurses and other shortage occupation groups
- Enhancement of retention strategies including cross sector fellowships and flexible working options
- Portfolio career opportunities across health sectors, research, leadership and academia
- Increasing multidisciplinary pre and post registration placement opportunities for learners in primary care
- Nursing Associate Programmes in acute, care home, general practice and third sector organisations, supporting development across sectors
- Development of apprenticeship pathways that encourage ‘earn and learn’ from career entry to advanced level professional for the clinical and non-clinical workforce
- Development of career entry apprenticeship roles that work across health and social care
• Career start programmes for medical, nursing, care support and business administrator roles that support career entry and transition from acute to primary care settings

• Increasing capacity and diversity of primary and community teams to include enhanced patient facing roles such:
  – Clinical Pharmacist
  – Advanced Clinical Practitioners
  – Physician Associates
  – Community Paramedics
  – Social Prescribers
  – Mental Health Therapists

• Enhancing opportunities for workforce collaboration across Primary Care Networks and at Place including role development with third and voluntary sector organisations.
7. That any quality issues arising from activity and capacity plans have been addressed in the provider’s quality plan

Providers demand and capacity planning continues to be based on robust activity modelling taking into account a realistic forecast outturn position, underlying activity changes, resilience planning, key operational deliverables and transformation / service redesign. Providers and commissioners have worked together to compare and align 2019/20 activity plans.

Trusts continue to progress their transformation programmes as a means to ensure the delivery of high quality and safe clinical services, whilst enabling financial viability and sustainability. A number of transformation work streams are currently ongoing to improve patient flow, reduce lengths of stay (with a focus on stranded and super stranded patients and pre-op length of stays) and increase the proportion of day case admissions.

In the NTCCG system NHS providers are all recognised as providing high quality care (overall CQC Outstanding), with many examples of excellent practice in place, for example in NuTH the Trust is compliant with all four priority standards for seven day services and this is demonstrated through the new 7DS board assurance framework.

Providers place a strong emphasis on education, training, multidisciplinary root cause analysis and reviews as well as sharing good practice to ensure the delivery of safe, high quality patient care.

Productivity – existing high benchmarked productivity of providers, low use of agency staff and premium staffing.

Increasingly, CIPs are being developed and assessed on a system-wide basis, which allows for system-wide quality impact assessment to enable true impact of changes on patients – commitment by partners to further develop this approach in next year.

The CCG has a standardised quality impact assessment policy and process in place, in order to assess and analyse the impact of commissioning decisions, QIPP plans, organisational cost improvement plans, business cases and any other plans for change including large scale transformation projects. The QIA identifies any potential impacts - positive, negative or neutral, on quality on any proposed transformational changes to the way services are commissioned or delivered. Where potential impacts upon equality/ equity of services, or impacts upon privacy or data processing are identified, a more detailed assessment of these specific issues is undertaken.
8. Delivery of NHS constitution standards and the ask on elective waiting lists

The CCG plans to deliver all NHS constitution standards, however a number of risks to achievement are highlighted. These include 52 week waiters, incomplete pathways and cancer 62 day targets.

During 2018/19 the CCG was attributed one patient who was an out of area 52 week waiter, who subsequently moved to the North Tyneside area. The patient’s clock start was not closed off from the original trust, but they were treated within the 52 week target. The CCG is assured that our local providers have robust processes in place to monitor and manage long waiters effectively. Where long waiters are identified after the threshold has been breached, the CCG is unable to manage the risk. With new national NHSE guidance on managing long waiters at an earlier stage in 2019/20, the CCG classifies this as low risk.

With regard to RTT, the number of incomplete pathways in March 2018, which is used as the baseline figure for the measure, is under reporting the real number of patients waiting for treatment. Since the baseline was set, both Northumbria FT and Newcastle FT have changed the way they calculate the incomplete pathway numbers following the implementation of the electronic referral management system and counting of appointment slot issues in 2018/19. Following ongoing discussions between NHSE, NHSI, Northumbria FT, Newcastle FT, Newcastle Gateshead CCG and Northumberland CCG, NHSE have now confirmed that the CCG March 2018 position will be rebased to reflect the change in counting. The CCG’s activity plans and trajectories have been developed to reflect the planning guidance requirements and are expected to meet the target.

The CCG is currently forecast below the national standard of 85% for 2018/19 for Cancer 62 day wait. Both FTs have increasing patient numbers for cancer pathways and have undertaken work to address any gaps and this work will continue into 2019/20. The CCG expects to achieve the standard in 2019/20 and classifies the risk as medium.
9. Plans reflect the delivery of control totals by CCGs and providers

A fortnightly Directors of Finance meeting has been established in the North ICP. The group has met to discuss planning requirements, using the opportunity to share and discuss at system level activity and finance, and identify risks and mitigations. The group has agreed that the Directors will work together to manage delivery of individual and ICP control totals. Underpinning principles for managing ICP finances are currently being agreed. Further discussions will also consider the role of commissioning support services in system working and reducing transactional work.

Suggested principles for system working:

- A single control total for the ICP.
- Open book approach with transparency from all partners.
- As much money out to service providers from the outset acknowledging this will mean:
  - no comeback for more funds once deployed;
  - collective oversight of the 0.5% CCG contingency funds;
  - minimum ask for service developments/delivery to provide maximum system flexibility.
- Collective identification of residual risk and development of a strategy as to how best they could be managed on a system basis.
- No cost shifts.
- The pick-up of a service collapse either within the ICP or wider ICS is not one organisation’s problem/challenge. There needs to be an ICP or wider ICS response as appropriate.
- Focus on real cost and activity reductions that are clinically led.
- Collective ICP approach to monitoring going forward.
- There needs to be a collective approach to managing cash to avoid interest payments on cash borrowings.

NTCCG has its control total set by NHSE of a £3.5m surplus. In respect of its providers, NHSI control totals have been set as follows:

- The Newcastle upon Tyne Hospitals FT: £12.2m surplus
- Northumberland, Tyne and Wear FT: £2.6m surplus
- Northumbria Healthcare FT: £24.4m surplus
- North East Ambulance Service FT: £75k surplus
10. CCG plans demonstrate that Mental Health Investment Standard will be met

The CCG financial plan demonstrates that funding has been earmarked for investment in mental health.

A 5.85% increase is required to meet the standard, and the CCG has made provision for this.
11. CCG plans demonstrate that funding for primary and community health services is growing faster than the overall NHS revenue settlement (3.6%) and that plans meet the recurrent primary care funding ask

The Long Term Plan commits to increase investment in primary and community health service as a share of the total national NHS revenue spend across 5 years 2019/20–2023/24 (i.e. spending on these services will be at least £4.5bn higher in five years).

This is on a 2018/19 baseline made up of:

- Funding for general practice and primary medical services from CCGs and national programmes funded by NHS England;
- Commissioned expenditure on community services (excluding mental health) and continuing healthcare.

The CCG can confirm the financial plan includes achievement of this requirement; this includes provision of £1.50 per head of population to support Primary Care Networks.
12. There is clarity on the areas of focus for the achievement of any necessary efficiencies, associated with planning assumptions

The CCG efficiency savings schemes for 2019/20 total £6.5m, which equates to 1.7% of the CCG’s allocation. The schemes are:

- Prescribing £1,965k
- Drugs and Devices £1,748k
- Intermediate Care £1,091k
- Continuing Care £734k
- Urgent Care £561k
- Running Costs £200k
- MH Perinatal £178k

The schemes have no direct impact on secondary care activity.

The CCG will continue to develop further efficiency schemes during 2019/20.
13. Each CCG to set out its plan to deliver a 20% reduction against their 2017/18 running costs by 2020/21 including a description of initial changes in 2019/20.

The CCG will be required to contain running costs within a reduced envelope of £4,144k in 2020/21.

Initial actions already underway include a joint review of costs recharged by NECS, our Commissioning Support Unit, and a review of CCG non-pay and pay costs incurred during 2018/19.

The CCG expects to achieve the requirement by 2020/21.
Performance Measures

NHS Constitution

E.B.3 - Incomplete RTT pathways performance

The CCG has experienced significant increases in waiting list numbers during the latter part of 2017/18 and during 2018/19. This was due to the unintended consequences of the implementation of the electronic referral system at Newcastle Hospitals and a change in counting due to Appointment Slot Issues (ASI) at Northumbria Healthcare. These issues combined appeared as ‘growth’ in the number of incomplete pathways which was actually a historically under reported position. Both main providers are now reporting a true reflection of all incomplete pathways during the latter part of 2018/19. Northumbria Healthcare FT will resubmit historical incomplete pathway data which will rebase North Tyneside CCG’s March 2018 baseline figure. It is anticipated that the CCG will achieve the proposed March 2018 target for incomplete pathways once the rebasing has been undertaken.

Both FTs and the CCG are currently achieving the percentage of patients waiting for initial treatment on incomplete pathways within 18 weeks. The CCG expects to meet the standard in 2019/20 and the trajectory has been set at that level.

E.B.18 - 52 week waits

The CCG had one 52 week waiter breach during 2018/19 to date which was a data validation error by North Devon Healthcare trust. The patient’s clock start was not closed off when they moved out of the area and subsequently treated within the target 52 weeks.

The CCG works with both providers to monitor and effectively manage long waiters, reviewing waiting lists regularly and identifying services to support expedited treatment where possible.

The CCG does not expect to have any 52 week waiters in 2019/20.
E.B.4 - Diagnostic test waiting times

Newcastle FT has long standing workforce shortages in radiology which significantly impact upon diagnostic tests and reporting and have continued to outsource activity. The FT is currently developing a short, intermediate and long term plan to sustain delivery.

The CCG is currently forecast below the national standard of 99% for 2018/19. The CCG expects to achieve the standard in 2019/20.

E.B.6 - Cancer 2 week waits

The number of patients being seen within 2 weeks of an urgent GP referral for suspected cancer has increased during 2018/19. Pressures within breast radiology across the region present a risk to breast cancer services with a potential risk to all cancer standards.

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

E.B.7 - Cancer two week waits Breast Symptomatic

Pressures within breast radiology across the region present a risk to breast cancer services. The Cancer Alliance is reviewing breast services across the region to assess potential risks.

The CCG is currently forecast below the national standard of 93% for 2018/19. The CCG expects to achieve the standard in 2019/20.

E.B.8 - Cancer 31 day waits first treatment

The CCG is currently not meeting the Cancer 31 day cancer diagnosis standard. Directorate Managers are reviewing their patient tracking list processes with a view to mandating best practice to improve performance.
The CCG is currently forecast below the national standard of 96% for 2018/19. The CCG expects to achieve the standard in 2019/20.

**E.B.9 - Cancer 31 day waits – Surgery**

The CCG and Newcastle Hospitals Foundation Trust are currently not meeting the Cancer 31 day wait – surgery standard. Directorate Managers are reviewing their patient tracking list processes with a view to mandating best practice to improve performance. The low number of patients for the measure can have a significant impact upon performance which is being monitored by the respective FT Cancer Steering Group/Board.

The CCG anticipates achieving the standard for 2018/19 and 2019/20.

**E.B.10 - Cancer 31 day waits – Drugs**

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.B.11 - Cancer 31 day waits – Radiotherapy**

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.B.12 - Cancer 62 day GP referral**

Newcastle FT reports cancer waiting times to their Executive Team. The Trust has installed a Steering Group to oversee and deliver an improvement plan. This includes improves in access to radiology with more straight to tests, improved tracking data of patients through the whole pathway journey, and addressing capacity and workforce issues. They have experienced a number of breaches, the majority of which are within the urology pathway. As the Trust has tertiary status, they receive many patients well into their 62 day journey. The Cancer Steering Group review patient tracking lists on a weekly basis and have undertaken tumour specific reviews to update cancer plans. They have also undertaken capacity and
demand modelling and alignment with the workforce plans to identify capacity shortfalls.

Northumbria FT has installed a Cancer Board which includes representatives of all tumour site lead clinicians, senior management and performance. The Cancer Board oversees both the long term strategic and operational plan to ensure delivery of targets. Key focus has been around the high risk specialties which are lung, colorectal and urology.

The CCG is currently forecast below the national standard of 85% for 2018/19. The CCG expects to achieve the standard in 2019/20.

**E.B.13 - Cancer 62 day waits – Screening**

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer waits</td>
<td>% of patients treated within 62-days of urgent referral from an NHS Cancer Screening Service</td>
<td>Jan-19</td>
<td>90.0%</td>
<td>100.0%</td>
<td>94.9%</td>
<td></td>
</tr>
</tbody>
</table>

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.B.14 - Cancer 62 day upgrade**

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer waits</td>
<td>% of patients treated for cancer within 62-days of consultant decision to upgrade status</td>
<td>Jan-19</td>
<td>N/A</td>
<td>100.0%</td>
<td>64.0%</td>
<td></td>
</tr>
</tbody>
</table>

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**Mental Health**

**E.A.S.1 - Estimated diagnosis rate for people with dementia**

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Estimated diagnosis rate for people with dementia</td>
<td>Jan-19</td>
<td>68.7%</td>
<td>76%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.A.3 - IAPT roll-out**

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>IAPT access rate</td>
<td>N/A</td>
<td>1.6%</td>
<td>13.3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The IAPT roll-out target is based upon achievement of 19% by March 2019. The CCG has performed over the standard for quarter 4 and is therefore currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.A.S.2 - IAPT Recovery Rate**

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Recovery Rate</td>
<td>Jan-19</td>
<td>50.0%</td>
<td>54.4%</td>
<td>52.90%</td>
<td></td>
</tr>
</tbody>
</table>

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.H.1_A1 - IAPT waiting times – 6 weeks**

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>IAPT Waiting times - 6 weeks</td>
<td>Jan-19</td>
<td>75.0%</td>
<td>97.0%</td>
<td>97.30%</td>
<td></td>
</tr>
</tbody>
</table>

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.H.1_A2 - IAPT waiting times – 18 weeks**

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>IAPT Waiting times - 18 weeks</td>
<td>Jan-19</td>
<td>95.0%</td>
<td>100.0%</td>
<td>99.90%</td>
<td></td>
</tr>
</tbody>
</table>

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.H.4 - Psychosis treated with a NICE approved care package within two weeks of referral**

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>Psychosis treated within 2 weeks of referral</td>
<td>Qtr 3 2018/19</td>
<td>56.0%</td>
<td>62%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.H.9 Improve Access to Children and Young People`s Mental Health Services**

Problems with the national data collection for the measure via MHSDS have led to under reporting for North Tyneside CCG. Local data collection clearly demonstrates that the CCG has achieved the standard for 2018/19. The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.
E.H.10 - waiting times for Routine Referrals to Children and Young People Eating Disorder Services – 4 weeks

The CCG is currently not achieving the standard for routine referrals to CYP Eating Disorder Services up to quarter 2 2018/19. This underperformance was due to two breaches, which upon investigation were due to data recording errors by the Trust. The Trust has improved data recording procedures and monitor patient pathways closely to ensure no further breaches occur. The CCG is forecast to meet the standard for 2018/19 and expects to achieve the standard for 2019/20.

E.H.11 - waiting times for Urgent Referrals to Children and Young People Eating Disorder Services – 1 week

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

E.H.13 - People with a severe mental illness receiving a full annual physical health check and follow-up interventions

The CCG is in discussions with providers to incentivise the undertaking of full annual physical health checks and follow up interventions with people with a severe mental illness. It is expected an incentivised scheme will increase the cohort of people undertaking the physical health check.

The CCG plans to achieve the target of 60% in 2019/20.

E.H.14a - IAPT Trainees

The IAPT provider for North Tyneside CCG (Talking Therapies North Tyneside) has employed a number of therapists to increase the access rate for IAPT services from April 2019 onwards. This includes fully qualified and trainee staff which will be fully qualified through the year.

It is anticipated that the CCG will achieve the agreed trajectories for 2019/20.

E.H.14b - Therapists co-located in primary care

It is anticipated that the CCG will achieve the agreed trajectories for 2019/20.
**E.H.12 - Out of Area Placements**

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**Primary Care**

**E.D.16 - Proportion of the population with access to online consultations**

The CCG has piloted online consultations across four practices within North Tyneside in 2018/19.

The CCG has a roll out programme for online consultations in 2019/20 with September and March being key milestones for implementation. The CCG expects to achieve the standard by March 2020.

**E.D.17 - Extended access Appointment Utilisation**

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.D.18 - Extended access (evening and weekends) at GP services**

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**LD Patient Projections**

**E.K.1a - Reliance on inpatient Care for People with LD or Autism – Care Commissioned by CCGs**

During the latter part of 2019/20 it is anticipated that a number of patients will step down from care commissioned by NHS England into a CCG commissioned bed. The transfer of patients into a lower secure facility does increase patient numbers overall for CCG commissioned beds, but is in line with the principles of transforming care.

**E.K.1b - Reliance on inpatient Care for People with LD or Autism – Care Commissioned by NHS England**

During the latter part of 2019/20 it is anticipated that a number of patients will step down from care commissioned by NHS England into a CCG commissioned bed. One patient is subject to approval by the Ministry of Justice to step down. This does
reduce inappropriate hospitalisation of people with a learning disability, autism or both to meet the target.

**Other commitments**

**E.N.1 - Personal Health Budgets**

The CCG has written to all patients receiving Continuing Health Care who are being cared for at home to offer them the opportunity to either self-manage their personal health budget or allow the CCG to continue to case manage on their behalf. In 2019/20, all patients eligible for CHC will receive a personal health budget and given the opportunity to self-manage the budget or leave the case management to the CCG. The CCG is forecast to achieve the standard for 2019/20.

**E.O.1 - Percentage of children waiting more than 18 weeks for a wheelchair**

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG</th>
<th>YTD</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Children waiting more than 18 weeks for a wheelchair</td>
<td>Q3 18/19</td>
<td>92.0%</td>
<td>95.0%</td>
<td>92.5%</td>
<td></td>
</tr>
</tbody>
</table>

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.

**E.K.3 - AHCs delivered by GPs for patients on the Learning Disability Register**

The CCG is currently achieving the standard and expects to continue to achieve the standard for 2019/20.
NHS North Tyneside CCG
Commissioning Intentions 2019/20
Introduction

This document describes our Commissioning Intentions for 2019/20, which both build on the progress we have made to date in previous years and also how we will fulfil our commissioning obligations as detailed in the national planning guidance for 2019/20, and within the context of the region’s aspirant Integrated Care System (ICS) programme, and North Integrated Care Partnership (ICP) vision.

When developing our Commissioning Intentions, the CCG has taken into account its local commissioning priorities in the challenging context of an increasingly elderly population and health inequalities.

This is necessarily a high-level document, and each commissioning intention has more detail supporting it. It is important to note that the document does not include all the CCG’s commissioning activity planned for 2019/20 – rather, it seeks to describe new plans, as opposed to the significant amount of “business as usual” (e.g. commissioning secondary care, primary care, etc.) which continues year to year. It sits alongside the NHS North Tyneside CCG 2019/20 Operating Plan, which provides more context, including detail on health inequalities.

NHS North Tyneside CCG works with its partners for its population on many different geographies including at place in local neighbourhoods and communities.

Our vision is “Working together to maximise the health and wellbeing of North Tyneside communities by making the best use of resources”.

We strive to find and implement new ways of working which will mean that care will be closer to home and people will only be in hospital when it is really needed. Our strategic priority themes for changing the health care system are:

- Keeping healthy, self-care
- Caring for people locally
- Hospital when it is appropriate

Our strategic vision is supported by ambitious plans to change the way that care is delivered. The figure below gives a pictorial representation of the CCG’s commissioning priorities which echoes our vision.
The CCG is committed to developing an improved way of working with the voluntary sector, including any considering any potential commissioning opportunities. It is also keen to work more closely with other CCGs, Healthwatch (e.g. around mental health crisis pathways) and North Tyneside Council.

The CCG also has quality of patient provision at its heart and constantly seeks to ensure that, through the work with our partners, we continue to improve the quality of services for the patients in North Tyneside. Considering the CCG’s vision and principles that we have described in this document, we strive to find and implement new ways of working which will mean that care will be closer to home and people will only be in hospital when it is really needed.
The CCG's financial objectives are to meet its financial duties and support the delivery of its other corporate objectives.

Over the last four years, CCG has successfully implemented its financial recovery plan, delivering savings of around £45m. This work has put the CCG in recurrent financial balance and it is making good progress in repaying the deficit it accumulated. The deficit peaked at £19.3m and is expected to be around £6.1m at the start of 2019/20.

The CCG's 2019/20 financial plan demonstrates that it will deliver the £3.5m control total set by NHS England, along with the other key business rules, including the Mental Health Investment Standard, investing in primary care networks and holding a 0.5% contingency. The plan is based on prudent assumptions, including increases to fund growth in A&E and non-elective activity and to tackle increases in waiting lists. By the end of 2019/20, the CCG expects to have repaid its accumulated deficit.

In terms of efficiency savings, the CCG's target is again much lower in 2019/20 than in previous years. The success of previous years has reduced the opportunity for savings but has also put the CCG in a strong position where high levels of savings are not required. A robust plan to deliver around £6.5m (1.7%) savings is in place. Medicines Optimisation, changes to the delivery of intermediate care and ensuring packages of care are proportionate are key areas within the plan. There are risks to this delivery but there is mitigation set aside to cover this risk.

Much of our success in turning around the financial position is as a result of the financial governance arrangements we have in place. This includes a strong Programme Management Office. We will maintain these arrangements.

Delivery of the CCG’s financial targets is only important because it will allow the CCG to commission high quality care for patients on a sustainable basis. The financial plan supports providers and the key Future Care development. The CCG has improved its underlying financial position and this is strengthened further by the overall 5.1% increase in allocation. The improved financial position allows the CCG to begin implementation of the long term plan.

Key to the sustainability of our plans is collaboration with our partner organisations. We are and will continue to work with fellow commissioners, our providers and the local authority to make the money work both within North Tyneside and on the larger footprints of our Integrated Care Partnership across North Tyneside, Northumberland and Newcastle and Gateshead and our Cumbria and North East Integrated Care System.
Future Care

Future Care is North Tyneside’s transformation programme which includes:

- Delivering Population Health and Wellbeing
- Delivering high quality, coordinated care
- Improving quality of life and experience of services
- Supporting and empowering staff
- Providing effective stewardship of resources.

A central component of Future Care is development of a new model of community and primary care provision to support a move in resources from acute to primary and community services, as well as working in four localities across North Tyneside to support local delivery where appropriate. Future Care requires all of the partners in the health and social care system to come together to make the identified changes.

The multiagency Future Care Board involves all of the NHS Foundation Trusts working in North Tyneside, the Ambulance service, TyneHealth GP Federation, North Tyneside Local Authority, Public Health, GP practice representatives, VODA, HealthWatch, patient representatives, the independent sector and the CCG itself. This group provides oversight and governance to this programme and was established during 2018/19.

The programme of work has the following themed work streams which will focus on achievement of agreed outcomes:

- Primary Care Home
- Urgent and Emergency Care
- Planned Care, Long Term Condition Management and RightCare
- Children and Young People

There are a number of prioritised projects under each work stream as well as a number of system cross cutting enablers/ risks (each with their own work plan) which include:

- IT
- Workforce
- Communication and Engagement
- Parity of Esteem
- Safeguarding
- Better Care Fund

The schematic below provides details of the services that fall within the Future Care banner and how the governance structure around Future Care operates.
Detailed Commissioning Intentions

The following table details the CCG’s commissioning intentions for 2019/20. They are grouped into the three strategic priority themes shown on the schematic on page 3:

- Keeping healthy, self care
- Caring for people locally
- Hospital when it’s appropriate

The purple shading indicates where a CCG commissioning intention fits with a Health and Wellbeing Board Work Plan 2018-2020 Objective, clearly demonstrating the close synergy between the two sets of priorities. The Health and Wellbeing Board Work Plan 2018-2020 was co-produced, following a refresh of the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment.

The CCG will play its part in supporting all areas of the Health and Wellbeing Board Work Plan, even if it has no explicit CCG commissioning intention identified as yet for that area – two examples are childhood accidents, and the cultural offer.

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<th>Commissioning Intentions</th>
<th>Initiative Summary</th>
<th>Impact &amp; Outcomes</th>
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<tr>
<td><strong>Strategic Priority Themes - Keeping healthy, self care</strong></td>
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<tr>
<td>High quality affordable health care</td>
<td>Reduce smoking prevalence rates</td>
<td>We will continue to work with our partners across health and social care and the third sector to improve access to a number of initiatives to enable more smokers to quit smoking. Evidence suggests that the provision of local stop smoking services offers the best chance of success and is four times more effective than no help or over the counter nicotine</td>
<td>Reduce smoking prevalence rates to 12% by 2022</td>
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<td>7500 less smokers in North Tyneside by 2022</td>
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<td>Commissioning Intentions</td>
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<td>replacements. The CCG has developed with partners a stop smoking plan that aims to promote good health and reduce the harm and impact of smoking. Key elements of the plan include:</td>
<td>Regional target of 5% by 2025 (19,500 fewer smokers)</td>
<td>Improved health and wellbeing at a population level</td>
<td>Improved outcomes following elective surgery. Reduced bed day usage &amp; readmissions</td>
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<tr>
<td>• Embedding ‘Very Brief Advice’ and ‘Making Every Contact Count’ within all commissioned health services.</td>
<td></td>
<td>Reduced smoking related mortality and morbidity</td>
<td>Potential to make savings on reduced demand on inhalers (short term) and costs associated with treating cancer (longer term)</td>
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<tr>
<td>• Improving clinical outcomes for smokers and reducing the demand placed on health and social care as a burden of disease caused by addiction to tobacco through use of preventative campaigns, and targeted support to areas in North Tyneside where smoking rates are significantly higher than the national average.</td>
<td></td>
<td>Lower demand on primary and secondary care</td>
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<td>• Working with Public Health to ensure appropriately designed Stop Smoking Services/interventions within the following settings:</td>
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<td>o Drug and Alcohol Services</td>
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<td>o Community Mental Health Services</td>
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<tr>
<td>o Community settings in areas of high prevalence</td>
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<td>o Maternity Services and early years (0-19)</td>
<td></td>
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<tr>
<td>• Implementing ‘stop before your op’ for all elective procedures</td>
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<tr>
<td>• Building on the achievements of Northumbria Healthcare NHS Foundation Trust’s ‘Smoke</td>
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<tr>
<td>Free NHS’ policy and improving the pathway flow into community and primary care based interventions following discharge from hospital.</td>
<td>High quality affordable health care</td>
<td>NHS North Tyneside CCG is the lead for the Wave 3 National Diabetes Prevention Programme (NDPP). The aim is to:</td>
<td>Increased identification of patients with a high risk of developing type 2 diabetes</td>
<td>Strategic priority</td>
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|                          | Diabetes Prevention         | • Provide evidence based interventions that will support those at high risk of developing type 2 diabetes in reducing their level of risk e.g. weight management and physical activity programmes.  
• Use the NHS health checks programme as an effective way to identify those at risk of developing type 2 diabetes and develop local systems to refer patients into the NDPP.  
Delivery of the NDPP will continue during 2019/20 and will continue to be monitored by the regional NDPP Steering Group. | Lower type 2 diabetes prevalence as a result of providing appropriate and timely interventions to reduce the risk of developing type 2 diabetes (Public Health England estimates 26% reduction compared to usual care).  
Lower level of adult obesity in North Tyneside  
Reduction in demand on primary and secondary care associated with the |
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| High quality affordable health care | Alcohol | In line with the Sustainability and Transformation Plan, we will begin to implement the following initiatives to tackle alcohol-related issues within NHS settings:  
- Develop and deliver systematic approaches to alcohol identification and brief advice (IBA) using the “Have a Word” approach and AUDIT C tool across all NHS settings including primary and secondary care.  
- Support alcohol hospital teams and ensure a well-resourced, clinician-led alcohol liaison team/service is available.  
- Amplify and embed Balance alcohol harm reduction campaigns in NHS settings, including primary care by utilising existing NHS communication channels.  
- Contribute to treating treatment-resistant drinkers in NHS settings and participate in the North Tyneside multi-agency blue light initiative via MEAM to move the most frequent attendees into more appropriate, supported, community environments. | Reduction in the number of alcohol attributable admissions  
Reduction in alcohol related harm | Strategic priority |
| High quality affordable health care | Health At Work | Promote the Better Health at Work programme:  
The CCG has recently achieved the Better Health at  
Healthy, productive workforce with reduce sickness absence | Strategic priority |
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<td>Work Silver Award, and is now working towards the Gold Award.</td>
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<td>Reduce NHS Trusts sickness absence rates to 3.8% by 2021</td>
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<td>• As part of the gold award we will be promoting healthy eating, healthy mind and healthy body. We invite and encourage the GP practices and other partner organisations to join us whenever they can.</td>
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<td>Supporting the long term health of staff by ensuring that they have mechanisms in place to stay fit and healthy both physically and mentally.</td>
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<td>• We will be providing opportunities for staff to engage in new activities that they may have not tried before, these will include, cycling, running, Pilates, yoga and some crafting.</td>
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<td>• We will be encouraging staff to sign up for dry January and promoting lots of ways to ensure we mentally stay fit and well.</td>
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<td>• Some staff from the CCG and GP practices will be completing the Mental Health First Aid course.</td>
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<tr>
<td>High quality affordable health care</td>
<td>Up-Scaling Prevention</td>
<td>Key actions for 2019/20 include working with the Integrated Care System (ICS) prevention work stream and Public Health to implement the priorities within the agreed plan into the delivery of health care in North Tyneside. To date, this plan includes:</td>
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<td></td>
<td>• Smoking (which has already been identified separately)</td>
<td>A regional approach that places prevention within every aspect of the health and social care infrastructure.</td>
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<td></td>
<td></td>
<td>• Alcohol (which has already been identified separately)</td>
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<td></td>
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<td>• Embed Very Brief Advice (smoking, alcohol</td>
<td>A health and social care delivery model that prevents the known causes of mortality and morbidity.</td>
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<td>Strategic priority</td>
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<td>and weight management) in Primary Care.</td>
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<td>• Giving every child the best start in life</td>
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<td>• Reducing the prevalence of excess weight in adults and children through the application of evidence based programmes that involve physical activity and interventions to improve diet</td>
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<td></td>
<td></td>
<td>• Health at work (which has already been identified separately)</td>
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<td>• Increasing flu immunisation rates amongst specific groups including staff in primary and secondary care, staff in residential/care homes and amongst at risk groups.</td>
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<td></td>
<td>• Increase screening uptake rates and reduce the health inequality gaps in uptake at a practice level.</td>
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<td>• Increase of preventive spending across the health and care system</td>
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<td>• Development of community centred and asset based approaches to enhance self-care, increase independence, self-esteem and self-efficacy</td>
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<td></td>
<td></td>
<td>• Mandatory training for NHS staff in Making Every Contact Count</td>
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<td>• Develop a targeted prevention programme that includes tobacco and cancer awareness and deliver this in primary care.</td>
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| High quality affordable health care | Commitment to Carers | North Tyneside CCG aims to address the changes needed in the way in which carers’ health and wellbeing needs are identified, addressed and supported. We will work with our providers to develop an integrated approach to identifying and meeting carers’ health and wellbeing needs (of all ages).

This will be achieved by promoting positive practice in supporting carers, with particular focus on carers from vulnerable communities or at key transition points in order to reduce health inequalities.

The CCG will lead on the development of a three year action plan for carers and this will be overseen by a multi-agency Carers Partnership Board. Key Priorities include:

- Support the identification and recognition of carers in primary care, working directly with ‘Care Navigators’ in improving the registration and assessments process of carers including young carers.
- Work with all providers to ensure carers are supported in the choices they make about their caring role and access appropriate services and support for them and the person they care for.
- Improve access to support for those caring for people with a diagnosis of a mental health | • Improve access to support for Young Carers.
• Aim to achieve a 2% increase in the numbers on the GP carers register.
• Increase numbers of carers receiving a carer’s assessment. | Strategic priority |
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<tr>
<td>High quality affordable health care</td>
<td>Diabetes Structured Education</td>
<td>Structured education for patients with diabetes has been proven to prolong the period of time that patients stay well and do not require medication. National Institute Clinical Excellence (NICE) Technology Appraisal 60 states: “structured education is made available to all people with diabetes at the time of initial diagnosis and then as required on an ongoing basis, based on a formal, regular assessment of need.” The NHS Five Year Forward View also described the need to develop evidence based diabetes prevention programmes. The Sustainability &amp; Transformation Plan (STP) for North Tyneside also stated a requirement for more structured education availability.</td>
<td>• More structured education availability in North Tyneside  • Improved self-management opportunities for patients with diabetes  • Reduced reliance on hospital care</td>
<td>Strategic priority</td>
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<td>Northumberland Tyne and Wear and North Durham commits to rolling out the diabetes prevention programme, which includes the provision of education services around type 2 diabetes. The CCG increased the number of places available on its structured education programme for patients with type 2 diabetes during 2018/19. It has also improved access to training by introducing direct booking and self-referral. In 2019/20 the CCG will continue to focus on maintaining high fill-rates for its commissioned structured education programmes and working with practices to increase the number of referrals.</td>
<td>Development of partnership framework between health, social care and the Voluntary and Community Sector.</td>
<td>Strategic priority</td>
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<tr>
<td>High quality affordable health care</td>
<td>Asset-based approaches</td>
<td>We will put greater focus on supporting the reorientation of care towards place based whole population approach and encouraging greater participation from the Voluntary and Community Sector to work in partnership across health and social care to effectively promote self-care and wellbeing and reduce loneliness.</td>
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| **Strategic Priority - Caring for people locally** | Care for older people | Continuing healthcare (CHC) - quality and value | There are a number of strands of work already in place to meet demographic changes in North Tyneside. These include implementation of the revised Continuing Health Care (CHC) framework (October 2018), focussing on meeting national timeframes from check list to decision making, quality and value for money, and providing the opportunity for Personal Health Budgets (PHBs). Other work strands include:  
  - Assessing, monitoring and reviewing fast track packages of care in an appropriate time frame and ensuring support is proportionate to needs  
  - Ensuring all reviews are up to date, prioritising high cost cases  
  - Ongoing review of all shared care cases  
  - Joint monitoring and quality reviews in nursing homes in partnership with the Local Authority  
  - Commissioning domiciliary services from the joint provider framework  
  - Further develop the Broadcare IT system to ensure accurate reporting  
  - Ensure all CHC patients living in their own homes are offered PHBs | Commissioned packages of care will respond to assessed needs, taking patient preferences into consideration in line with CCG Policy and transparency and equality in relation to the care packages will be achieved as well as quality and value for money.  
In relation to quality of service provision, the initiatives will:  
  - Provide ongoing assurance in relation to CHC assessment toolkit recommendations in order to promote equity  
  - Ensure providers meet the quality standards | Strategic priority |
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<td>Key Performance Indicators</td>
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<td>• Ensure commitment to working with the Local Authority in an integrated way so that the care needs of people in North Tyneside are met and transition into CHC is a seamless process</td>
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<td>• Ensure existing commissioned providers understand their contribution to care packages</td>
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<td>• Ensure that activity data is accurate and accessible</td>
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<td>• PHBs will offer patients flexible opportunities to meet their care needs</td>
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<tr>
<td>Care for Older People</td>
<td>Maintaining a High Level of dementia diagnosis and good quality care for people with dementia</td>
<td>The CCG currently has an early dementia diagnosis rate which exceeds the national target of at least two-thirds of the estimated number of people with dementia. The CCG continues to review the national information to ensure that it continues to meet this target. The CCG is also working with GP Localities to ensure that patients who have been diagnosed with dementia have their care plan reviewed annually. This is audited nationally and the CCG aims to improve its rating in this area. During 2017/18, the CCG agreed to fund an Admiral Nurse post with Age UK North Tyneside, aiming to improve post diagnostic support for people with dementia and their carers. The CCG has worked with Age UK North Tyneside to review the impact of this post and the CCG has agreed to continue funding this post on a recurrent basis</td>
<td>Identification of service improvement areas with joint responsibility established and a relevant Action Plan developed</td>
<td>Strategic priority</td>
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<tr>
<td>Care for older people</td>
<td>Development of a single model of mental health care for older people across North Tyneside</td>
<td>We will secure a more consistent service experience across North Tyneside for older people with mental health problems, working with both current older people mental health providers to effect this. This will involve: - Data gathering - Pathway mapping</td>
<td>- Deliver service outputs, waiting times and patient outcomes to ensure that all older people with mental health have timely and appropriate access to mental health</td>
<td>Strategic priority</td>
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</tbody>
</table>
The aim will be to develop, agree and implement a service specification with both mental health providers providing older peoples mental health services to people in North Tyneside.

We have also finalised a joint strategy with North Tyneside Council on mental health services for older people, including dementia. Following this, a joint action plan will be developed and presented to the Health & Wellbeing Board for approval. Progress against the actions will be monitored by the Health & Wellbeing Board.

We will also review and implement new pathways for older people who are experiencing a mental health crisis. This work will be undertaken via the appropriate Mental Health Board.

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<td>- Benchmarking</td>
<td>* Reduce variability in service provision and access to services*</td>
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<td>The aim will be to develop, agree and implement a service specification with both mental health providers providing older peoples mental health services to people in North Tyneside.</td>
<td>* Access to the most appropriate service to meet the specific needs to older people experiencing a mental health crisis*</td>
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<td></td>
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<td>We have also finalised a joint strategy with North Tyneside Council on mental health services for older people, including dementia. Following this, a joint action plan will be developed and presented to the Health &amp; Wellbeing Board for approval. Progress against the actions will be monitored by the Health &amp; Wellbeing Board.</td>
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<td></td>
<td>We will also review and implement new pathways for older people who are experiencing a mental health crisis. This work will be undertaken via the appropriate Mental Health Board.</td>
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</table>
| Care for Older people    | Intermediate Care | We will continue to extend the range of services and level of provision for Intermediate Care. Key features to include:  
  * an increase in community bed based rehabilitation provision for people stepping down from hospital based care  
  * strengthening peripatetic resource supporting rehabilitation at home  
  * an increase in ‘step up’ support for patients  | More community provision will be available, enabling people to return to their own homes appropriately and timely.                                                                                               |
<p>|                          |              |                                                                                                                                                                                                          | Strategic priority                                                                                                                                                                                                  |</p>
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<td>Care for Older People</td>
<td>Falls Minimisation</td>
<td>who are at risk of a hospital admission.</td>
<td>100% of patients seen in the falls clinic within 3 months of first fall</td>
<td>Strategic priority</td>
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<td></td>
<td></td>
<td>Aim</td>
<td>Reduce the number of inpatient falls</td>
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<td>Objectives</td>
<td>Reduction in the number of admissions for falls in patients aged &gt;65</td>
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<td>Reduction in % of patients aged &gt;75 sustaining a fracture</td>
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<td>Increase in % of patients returning to usual place of residence after fracture</td>
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<td>Care for Older People</td>
<td>Community frailty services</td>
<td>Care Plus provides specialist multi-disciplinary input to support Practices, to see patients in surgery or in their own home. It also delivers dedicated specialist clinics with members of the team to support patients, e.g. Geriatrician clinic, Physio clinic etc. The team works with frail patients who are able to engage with and likely to benefit from input from the multidisciplinary team.</td>
<td>The first iteration of the model showed: admissions (a count of both elective and non-elective spells) reduced by 20% for the patients within</td>
<td>Strategic priority</td>
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<td>Examples of patients who may benefit:</td>
<td>the service over the same period in the previous year</td>
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<td>• Rockwood frailty score – 4 to 6 are the most likely group to benefit from interventions as those with higher scores are often too frail and ill to engage, or are approaching end of life.</td>
<td>• length of hospital stay has reduced by 36% for the patients within the service over the same period the previous year</td>
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<td>• EFI score indicating moderate frailty</td>
<td>• A&amp;E attendances have reduced by 15% for the patients within the service over the same period in the previous year</td>
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<td></td>
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<td>• Falls</td>
<td>• an average of 5.8 per patient appointments have been dealt with by the Care Plus service. This equates to circa 1100 appointments being saved in primary care.</td>
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<td>• Frequent GP appointments</td>
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<td>• Recent hospital admissions</td>
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<td></td>
<td></td>
<td>• Multiple comorbidities</td>
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<td>• Under multiple hospital specialities</td>
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<td></td>
<td></td>
<td>• Polypharmacy</td>
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<td></td>
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<td>• Socially isolated</td>
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<td></td>
<td>• Confidence problems</td>
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<td>Care Plus provides a specialist assessment and MDT review of patients within 2 weeks of referral, and often sooner. Following the MDT review it works with the patient to set goals with regular review dates, aimed at minimising the impact of their frailty, and improving their quality of life.</td>
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<td>During 2019/20 the CCG will review the role of Care Plus with a view to increasing its role in the provision of home-based care for more severely frail patients. This could include changing the pathways from the specialist acute frailty service so that Care Plus can be used as a community-based ‘step-down’ option</td>
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| Care for Older people    | Enhanced Health in Care Homes | The Enhanced Health in Care Homes Framework lays out a clear vision for working with care homes to provide joined up primary, community and secondary, social care to residents of care and nursing homes, via a range of in-reach services.  
  - Enhanced primary care support  
  - MDT in-reach support  
  - Reablement and rehabilitation to promote independence  
  - High quality end of life care and dementia care  
  - Joined-up commissioning and collaboration between health and social care  
  - Workforce development  
  - Harnessing data and technology | Deliver framework objectives | Strategic priority |
| High quality affordable health care | Community based mental health services | Northumberland, Tyne and Wear NHS Foundation Trust (NTWFT) implemented new pathways and structures for community based mental health services in North Tyneside during 2016/17.  
Since then, a review was undertaken of some of these new pathways, focusing specifically on the pathway for people experiencing a mental health crisis aiming to ensure that people receive timely access to appropriate services to manage their | Strategic priority |
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<td>needs. The review was undertaken in partnership with Healthwatch to gain patient and carer input into the pathways work and to help inform future commissioning decisions.</td>
<td></td>
<td>Increase the proportion of people who are assisted with a non-clinical urgent mental health need</td>
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<td>As a result of this work and the subsequent Healthwatch published report, the CCG will, during 2019/20:</td>
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<td>Reduce demand on statutory urgent care resources</td>
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<td>• Commission a low level crisis support service for people who feel they are experiencing a crisis but do not meet the threshold for the Crisis Resolution and Home treatment Team</td>
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<td>Support the service user to make use of appropriate relevant resources which could include peer-support, community, third sector or</td>
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<td>• Review the availability of carer support to ensure that their support needs are identified. The CCG already funds one mental health carer support worker and will identify how further support can be provided</td>
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<td>• Continue to work with GP Practices to increase mental health awareness, knowledge of services available and referral mechanisms</td>
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<td>This work will be monitored at the bi-monthly North Tyneside Mental Health Crisis Concordat Strategy Group and will be reported to the appropriate Mental Health Board and, ultimately, the Health and Wellbeing Board.</td>
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<td>High quality affordable Health Care</td>
<td>Implementation of Mental Health Forward View</td>
<td>We are committed to delivering the Mental Health Five Year Forward View. The Mental Health Boards which include Public Health, North Tyneside Local Authority, NTWFT, NHCFT, voluntary sector organisations, patient and carer representatives as well as the CCG, continue to meet regularly. Three strategy documents have been produced which focus on the area of implementation and have a strong focus on the development of services and ensuring people are able to access services.</td>
<td>People who require access and treatment for those identified mental health services should be able to do so within national timescales.</td>
<td>Strategic priority</td>
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<td>been produced mirroring the Boards:</td>
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<td>• Children &amp; Young People’s Mental Health &amp; Emotional Well-Being Strategy, incorporating the CAMHS Transformation Plan</td>
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<td>• Adult Mental Health Strategy</td>
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<td>• Older Peoples Mental Health Strategy</td>
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<td>In relation to children and young people’s mental health provision, we implemented new pathways during 2018/19 to enable school headteachers and SENCOs to refer directly into the CAMHS service. Additionally, there is now access for schools to urgent appointments and professional telephone advice. The CCG also funded, along with the Wellcome Trust, an innovative project called MI:2K. The MI:2K project was a year-long engagement programme, run by national charity Involve and Leaders Unlocked. A team recruited and trained young people in our area, including at-risk groups, on how local mental health prevention, support and services can be most effective and supported them to conduct a research project resulting in key recommendations to be taken up by the CYP MHEWB Strategic Group for action.</td>
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<td>CAMHS provision remains a priority for the CCG in 2019/20. The CAMHS Local Transformation Plan is a five year Plan and is now entering its fourth year. The current, 2017/18 Plan is available on the CCG’s</td>
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<td>website. During 2018/19, mental health in education and improved involvement and engagement were the two key priorities. Building on the success of the Emotionally Healthy Schools Resource Pack which was launched in May 2017, we worked with the Local Authority, the Anna Freud National Centre for Children and Families and the Department for Education as part of the Schools Link Programme 2017-18 to strengthen communication and joint working arrangements between schools and mental health professionals. During 2019/20, the CCG will:</td>
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<td>• Form a strategic alliance with Barnardo’s and the local authority, in relation to childrens and young people’s emotional health and wellbeing. The focus will be on early intervention and prevention. The purpose is to identify challenges, examine service delivery and service design. The process will begin with workshops to identify what is working and where there are challenges. A school survey regarding children and young people’s mental health will be undertaken and the New Forest Parenting training programme will be rolled out across social care and health.</td>
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<td>• Review existing CAMHS Tier 2 &amp; 3 provision to identify areas of efficiency and improved pathways</td>
<td>• Development of an early intervention and prevention strategy, ensuring that children and young people and their families have access to the right support at the right time.</td>
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<td>• Improved and quicker access to CAMHS specialist services for schools</td>
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<td>• Review the outcomes from the MI:2K project to inform and influence service design and development for CAMHS</td>
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<td>• Children &amp; Young People will have a voice in how services are designed so they better meet needs.</td>
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<td>• Work with partners to continue to work with schools to implement some of the improvements identified in the Schools Link Programme workshops during the coming year which will include establishing a termly Mental Health School Mental Health Leads Network where school staff would come together with CAMHS, Educational Psychology and School Improvement staff.</td>
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<td>• Improved access to support and therapies for children and young people</td>
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<td>• Fund additional resource into the CAMHS neurodevelopmental pathway where we have already identified specific issues with the current pathway and waiting times for assessment</td>
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<td>• Timely access for children and young people to specialist services</td>
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<td>• Develop CAMHS services in preparation for implementation of the requirements of the Children &amp; Young People Mental Health Green Paper, focusing on mental health provision in schools and improved access times.</td>
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<td>• Provision of community based services closer to people’s homes</td>
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<td>• Review, with the Local Authority, the pilot of the Kooth online counselling service to determine how it may be commissioned in the future.</td>
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<td>• The CCG continues its involvement in the regional work on the national New Care Models programme, whereby secondary mental health providers are given the opportunity to take responsibility for tertiary commissioning budgets for children and adolescent mental health services</td>
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<td>(CAMHS) Tier 4 inpatient services, adult secure and adult eating disorders services. The aim of New Care Models is to innovate and transform services in the best interests of service users and their families and to provide care as near to home as possible. For working age adults services, the CCG will provide additional funding to enable to expansion of IAPT services for people with Long Term Condition and to also improve waiting times for access to Step 3 therapy. We will also work with VODA to re-establish the North Tyneside Recovery College, offering a range of courses and workshops related to mental health and wellbeing. The CCG is also working with provider partners to implement closer ways of working between services and organisations, minimising multi-referrals between services for individual patients and</td>
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<td>Increased number of trained IAPT staff in the area</td>
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<td>Increased access to IAPT services</td>
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<td>Reduction in mental health assessment waiting times</td>
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<td>Increased opportunity for people with mental health needs to receive appropriate low level support</td>
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<td>A wider range and type of services will be available</td>
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<td>Smoother transitions between services</td>
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<td>Prevention of</td>
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### Commissioning Intentions

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<td>ADHD &amp; Autism</td>
<td>A joint review with regional CCGs of adult ADHD and autism services concluded during 2017/18 From this review, a new pathway was implemented by the Northumberland, Tyne &amp; Wear NHS Trust, aiming to improve transition pathway, eradicating delays and waits in the service most appropriate to their needs</td>
<td>• Improved transition pathway, eradicating delays and waits in the service most appropriate to their needs, ensuring model(s) of provision will meet patients’ needs and will be based on evaluation of the existing services</td>
<td>Strategic priority</td>
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- Rejection of referrals.

- We are also working at a Locality level to develop mental health nursing posts, based in GP Practices, who will be able to assist patients, signpost and provide education and training for GPs on mental health issues. This project will initially be based in the North Shields and Wallsend locality areas and may be considered for future cross-Borough roll-out.

- We will continue to fund both the national Core 24 model of liaison psychiatry, based at the A&E department of The Northumbria Hospital and the older people’s liaison psychiatry services, based in inpatient and rehabilitation wards at North Tyneside General Hospital. We are closely monitoring the impact of these services and will evaluate their outcomes.

#### High quality, affordable Health Care

- Improved access to mental health support in GP Practices
- Improved education and awareness of mental health issues in GP Practices
- Reduction of admissions
- Will ensure model(s) of provision will meet patients’ needs and will be based on evaluation of the existing services.
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| reduce waiting lists and waiting times for assessment as it had grown at a significant rate. The aim was to develop a service which involves:  
- Specialist assessment  
- Community focus for ongoing management of people diagnosed with ADHD/Autism  

A model of delivery and implementation plan was agreed between the Trust and CCGs.  

During 2019/20, the CCG will work in partnership with other CCGs to review this new model of delivery to determine if it has achieved its aims and reduced waiting lists and times.  

The CCG will also work with local partners in North Tyneside to develop a system-wide strategy for ADHD and autism in North Tyneside. This strategy will include benchmark information of other services around the country, highlighting areas of good practice and will provide an analysis of potential areas for development. | system  
- Improved adult ADHD and autism services, based in the community  
- Provision of specialist assessment hub with community input for ongoing support and management | Strategic priority |
| High quality affordable Health Care | Learning Disabilities Services | The Local Authority and North Tyneside CCG have established joint processes to enhance and/or integrate services that underpin living well in the community.  

The North Tyneside Implementation plan for people |  
- Appropriate use of hospital beds  
- Greater focus on early intervention  
- Greater focus on crisis prevention |  

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<td>with learning disabilities and/or autism takes into account the STP planning assumptions and the CCG will continue to work as part of the regional Transformational Board on developing system-wide out of hospital care and allow people with complex learning disabilities to be appropriately and safely supported closer to home.</td>
<td>• Delivery of a sustainable, integrated outcome focused community model, which is of high quality, affordable and safe to use.</td>
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<td>In line with the Transforming Care agenda, North Tyneside will work with other CCGs and Local Authority Commissioners as part of the North Region Implementation Group to develop a complex case framework that will ensure community based pathways are robust, fit for purpose with clear ‘step up and step down’ processes to ensure the delivery of community-based care for the people with the most challenging and complex behaviours is of a high quality and meeting the assessed needs of individuals. Alongside this development a review of assessment and treatment beds will be undertaken across the North Region.</td>
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<td>The North Tyneside Disability Integration Board will be focussing on the following in 19/20:</td>
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<td>• Developing an autism strategy for North Tyneside, informed by the submitted Self-Assessment Framework.</td>
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<td>• Revisit the STOMP (Stopping Over-Medication of People with a Learning Disability, Autism or Both) baseline practice</td>
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<td>Audit as a benchmark for developing a robust clinical pathway for the review of psychotropic medication prescribed to people with learning disability. The CCG continues to work with NTW NHS FT and Northumbria Healthcare NHS FT on a medicines optimisation programme to ensure patients and carers are involved in decision making about medication, its use and review.</td>
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<td>• Developing an assurance framework for physical health screening and exploring how this offer can be extended to people with a diagnosis of just autism.</td>
<td>Development of a data sharing agreement between health and social care.</td>
<td>QIPP plan</td>
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<td>• Together with our various stakeholders in community and acute services, continue to carry out Mortality Reviews for people who are known to services as having a learning disability, who have died.</td>
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<td>• Undertake a pathway mapping exercise in relation to community service provision,(which incorporates New Care Models) ensuring that the local offer is inclusive of a wrap-around service, including crisis provision.</td>
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<td>High quality affordable Health Care</td>
<td>Better Care Fund</td>
<td>The Better Care Fund remains an important vehicle for driving forward the integration agenda across Health and Social Care in North Tyneside.</td>
<td>Development of a data sharing agreement between health and social care.</td>
<td>QIPP plan</td>
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<td>In our Better Care Fund Plan we are developing our aspiration to collectively design a North Tyneside Better Care Fund Plan.</td>
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<td>system to address the broader determinants of health that affect people's lives, enabling change through joint commissioning, system redesign and joining up workforce capacity and capability to deliver against shared goals and ambitions.</td>
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<td>Following a recent review of all initiatives included in the Better Care Fund, three key areas of improvement have been identified for 19/20:</td>
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<td>1. Remodelling of those schemes within the BCF from individual silo initiatives bringing them together towards a more cohesive model with a focus on supporting the fragility agenda.</td>
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<td>2. Align BCF schemes more closely with the Future Care Programme.</td>
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<td>3. Scaling up the use of reliable evidence based information across the whole health and social care system that will help to inform future development of schemes.</td>
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| High quality affordable Health Care | Medicines Optimisation & Prescribing | Medicines Optimisation continues to be an important feature of the CCG’s commissioning intentions for 2019/20, as it has been in previous years. We will:  
- Implement interventions to support optimal medicine-taking to enhance the quality of life and experience of care for people with long term conditions. For example, we will deliver medicine optimisation solutions for patients who are less visible to healthcare services but who are becoming frailer, with a reducing ability to cope, helping to maintain their independence whilst minimising the risk of harm and supporting more adherent medicine taking behaviour  
- Continue to reduce waste within the overall system through increasing use of electronic prescribing and repeats systems, and systems to manage products that can be provided by more value adding processes  
- Work closely with care homes to optimise medicines and medicine processes to minimise avoidable waste.  
- Support judicious use of antibiotics to appropriately manage infections and minimise the risk of the development of healthcare-acquired infections  
- Support prescribers to prescribe | Ensure efficient and effective use of the CCG’s prescribing budget, enabling people to manage their own health, reduce the need for acute intervention, maintain independence, support improved medicine-taking behaviour, reduce variation and improve outcomes. | QIPP plan, Practice Activity Scheme and Prescribing Engagement Scheme |
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| High Quality Affordable Healthcare | Primary Care Strategy and GP Forward View | We will implement the North Tyneside Primary Care Strategy and the GP Forward View in conjunction with the local GP Federation, TyneHealth, and Newcastle & North Tyneside Local Medical Committee. There are four components to our Strategy:  
1. Redesigning Access to Primary Care  
2. Extended Primary Care Team (EPCT)  
3. Integrating Specialist Support  
4. Prevention and Self care  
Through 2018/19 the CCG and TyneHealth GP Federation have been engaging with member practices to develop and support delivery of projects to deliver this strategy including but not limited to: | • Improve sustainability and quality in General Practice.  
• Improve access to General Practice  
• Ensure that resources match patients’ needs and in the right location | Strategic priority |
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<td>• additional recurrent investment to each GP practice to use to improve access, improve patient experience, and improve staff experience&lt;br&gt;• additional non-recurrent investment to each GP practice to support practice improvements&lt;br&gt;• the provision of extended access to GP services in evenings and on weekends for all practices in North Tyneside&lt;br&gt;• completion of a gap analysis and support to practices to implement the 10 high impact changes identified in Releasing Time to Care&lt;br&gt;• ongoing support to local practices to develop the role of Care Navigators&lt;br&gt;• the piloting of new technology such as online consultation software&lt;br&gt;• the training of clerical coders within general practice&lt;br&gt;• the pilot of a peripatetic care home team&lt;br&gt;• the pilot of a Physio First model to allow faster access to specialist MSK support&lt;br&gt;• the pilot of a respiratory hub including specialist spirometry, FeNO testing and treatment&lt;br&gt;• implementation of a GP career start programme&lt;br&gt;• initiation of a nurse career start programme</td>
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<td>In 2019/20 we will continue to support GP practices</td>
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<td>to implement these projects, and make the changes identified to increase resilience and make general practice more sustainable. These projects include:</td>
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<td>• the further development of locality groups / primary care networks to support the delivery of Primary Care Home</td>
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<td>• development of a workforce strategy for primary care</td>
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<td>• development of a general practice estates strategy</td>
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<td>• development of a support package for practices that are looking to work more collaboratively</td>
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<td>• development of a home visiting service</td>
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<td>• provision of additional pharmacist support into localities to provide home based medication reviews</td>
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<td>• pilot of integrated mental health workers into general practice in 2 localities</td>
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<td>• increase roll out of new technology such as online consultation software to additional practices</td>
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<td>• increased coordination of the care navigator role</td>
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<td>• additional training of clerical coders within general practice</td>
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<td>• continued implementation of the 10 high impact changes identified in Releasing Time</td>
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General practice is a fundamental part of the NHS, playing a pivotal role in coordinating patient care and seeing millions of patient interactions every week. The challenge of achieving high quality care in the face of growing demand, changing patient needs and rising expectations can only be met if we harness the power of innovative digital technology, as highlighted in the General Practice Forward View. To operate within known financial constraints, we must ensure that every pound spent on IT improves patient care, reduces bureaucracy for practitioners and drives efficiencies across the health and care system.

NTCCG will maximise the opportunity that technology can bring to deliver its vision for North Tyneside communities. NTCCG GPIT strategy consists of the following core areas:

- Integrated Digital Care Records
- Patients and Clinicians working together to Maximise Health
- GP Clinical Systems
- CCG Corporate and Business Development

These core areas have a number of priorities which must be aligned to them, they are as follows:

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| GP Information Technology | GP Information Technology | General practice is a fundamental part of the NHS, playing a pivotal role in coordinating patient care and seeing millions of patient interactions every week. The challenge of achieving high quality care in the face of growing demand, changing patient needs and rising expectations can only be met if we harness the power of innovative digital technology, as highlighted in the General Practice Forward View. To operate within known financial constraints, we must ensure that every pound spent on IT improves patient care, reduces bureaucracy for practitioners and drives efficiencies across the health and care system. NTCCG will maximise the opportunity that technology can bring to deliver its vision for North Tyneside communities. NTCCG GPIT strategy consists of the following core areas:  
- Integrated Digital Care Records  
- Patients and Clinicians working together to Maximise Health  
- GP Clinical Systems  
- CCG Corporate and Business Development  
These core areas have a number of priorities which must be aligned to them, they are as follows; | To improve General Practice IT to enable more effective and efficient care delivery | Strategic Priority |
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|                          |            | • Digitisation of GP records  
|                          |            | • The continued development of the medical interoperability programme (Great North Care record)  
|                          |            | • The implementation of Black Pear across practice systems resulting in the sharing of live patient information.  
|                          |            | • Hardware replacement programme  
|                          |            | • The implementation of remote access for GP practices  
|                          |            | • GP2GP – NHS Digital process for transferring patient records between practices  
|                          |            | • The implementation of a digital system across the North Tyneside health estate  
|                          |            | • Continued development and implementation of data quality, governance and security  
|                          |            | • Asset management registers and the secure disposal of hardware  
|                          |            | • The continued development of GP practice web sites  
|                          |            | • The implementation of nationally mandated systems  
| High quality affordable health care | Cancer | North Tyneside CCG will continue to lead a system wide approach working directly with local services and those people directly impacted by cancer on delivering better outcomes for those patients at risk of cancer and those living with cancer. In addition, we will work closely with the North East and Cumbria | • Increased numbers of smoking quitters  
|                          |            | • 85% target for 62 urgent GP referral for | Strategic priority |
Cancer Alliance Team to ensure the commissioning, provision and accountability processes are fit for purpose and aligned with integrated care systems.

The CCG has developed in partnership with local providers a three year strategic plan to make the changes necessary to ensure that people identified and diagnosed with cancer receive the highest level of care possible and maximise life expectancy.

The Strategic plan focusses on six priorities areas:

2. Achieve earlier diagnosis using evidence based clinical pathways to achieving faster diagnosis.
3. Improve patient experience
4. Delivery of Living with and Beyond Cancer Survivorship Pathways in breast, colorectal and prostate.
5. Make necessary investments to deliver a modern high quality service.
6. Ensure commissioning of local services is aligned to region based integrated systems where necessary.

Key actions identified for 2019/20 include:

- Improving access to stop smoking services and increase smoking quit rates.
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<td>• Continue community based approaches to target populations at greater risk of cancer and design and deliver interventions which: a) Inform people about what action to take in response to cancer signs, symptoms and screening invitations b) Provide targeted support to help people manage their weight, reduce their levels of alcohol and or smoking intake.</td>
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<td>• Roll out national “Optimal colorectal pathway”</td>
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<td>• Develop systems and process in preparation and readiness for the 28 day pathway on referral to diagnosis which comes into effect in 2020.</td>
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<td>• Establish a Patient experience cancer group to advise, inform and challenge commissioners and providers on those aspects of cancer care can be greatly improved in terms of quality based outcomes.</td>
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<td>• Encourage primary care participation in the National Cancer Audit</td>
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<td>• Implement a Lung Cancer Case finding pilot.</td>
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<td>• Consolidate the successful roll out of the Living With and Beyond Breast Cancer pathway</td>
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<td>• Roll out the Living with and Beyond Colorectal Cancer pathway.</td>
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| High Quality Affordable Healthcare | End of Life Care | NHS North Tyneside CCG has successfully commissioned a number of community based specialist palliative care and End of Life services that have demonstrably improved out of hospital services. The hospice at home service (RAPID) and the nursing home palliative care service are now well established and embedded within the End of Life pathway, providing necessary specialist nursing support for those people living in their place of residence who are at risk of a hospital admission. We will continue to work with leaders of local health and care systems to develop a plan for delivering good quality, equitable end of life care for everyone and in doing so, maximise good out of hospital care. In 2019/20 NHS North Tyneside CCG will continue to develop a whole systems approach that focuses on the current range of commissioned services across the care pathway and to identify further opportunities to maximise their effectiveness in the following ways:  
- Improve the facilitation of discharge from acute settings e.g. planned discharge from hospital for a person who requires palliative care and end of life support and reduce the risk of people dying in hospital when their | • Continued improvement of responsive and expert support and care for people with complex, advanced terminal illness and their families | Strategic priority |

• Ensure all patients diagnosed with cancer have a full holistic needs assessment.
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<td>preferred place of death is their own place of residence, and reduce the risk of unplanned discharges.</td>
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<td>• Improve the coordination of Advanced Care Planning processes across specialty conditions such as respiratory and cardiovascular disease.</td>
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<td>• Deliver shareable e-records across the healthcare system for people on the End of Life register.</td>
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<td>• Work with GPs and support practices to increase the percentage of North Tyneside practice patients on the palliative care register to meet the national target.</td>
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<td>• To achieve equality of access, provision and responsiveness for those populations where inequalities in access to palliative and end of life care currently exist e.g. BAME communities, LGBTQ, the homeless and travellers.</td>
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<td>• Increase the uptake of Emergency Healthcare plans for palliative care patients.</td>
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<td>• Develop a joined up bereavement policy applicable across health and social care which is inclusive and supports the provision of services available.</td>
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<td>High quality affordable health care</td>
<td>Review and Reconfiguration of Community Services</td>
<td>Improving how community services proactively and reactively work with patients is critical to making the NHS more effective, efficient and therefore sustainable. It is well rehearsed that the majority of NHS contacts happen in the community, the majority of which come through Primary Care. “Transforming Community Services” resulted in the community contract transferring into acute hospitals in North Tyneside and Newcastle. At the time it was envisaged that the opportunity for pathway enhancement, transformation and improvement of community based care would be enhanced by this vertical integration. It was envisaged that proactive care in the community aligned with Primary Care would be realised, resulting in more patients being cared for at home and people attending hospital by exception with the expertise and staff being made available in a community setting. However, community services as a whole are not well coordinated with other services, causing patients to receive care that is fragmented and of variable quality and value for money. It could be argued that this is currently the case in North Tyneside with the community contract last being reviewed in 2011. The primary care strategy sets</td>
<td>As part of Future Care, development of locality working under the ‘banner’ of Primary Care Home which focusses on locality working with the following principles: - Locality working – c.50k population - Innovation / transformation - Agile workforce - Shift from Acute to Primary / Community - Care closer to patients home - Support new models of care - Patient at centre of decision making - Managing</td>
<td>Strategic priority</td>
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1 In this context “community services” refers to services delivered in the community and include the current community contracts with FT’s, primary care, independent contractors, voluntary organisations who deliver care for the population of North Tyneside.
out the direction of travel for primary care in response to the NHS ‘Five Year Forward View’\(^2\) which envisions new models of care that break down the traditional divides between primary care, community services and hospitals. The aim is for patients to receive personalised and coordinated care from different types of services with clinicians working together.

North Tyneside Clinical Commissioning Group is a level 3 commissioner in relation to Primary Care, which adds another opportunity to commission fit for purpose “community services” in order to ensure sustainability in response to the demographic and system challenges in North Tyneside previously detailed.

NHS North Tyneside CCG now has an important opportunity to commission community services in a way that will support this shift to more coordinated care for patients closer to home. The community services contracts put in place three to five years ago are no longer fit for purpose, giving us an opportunity to:

- Move to new ways of working or new models of care that are better for patients with a focus on outcome delivery.

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<td>out the direction of travel for primary care in response to the NHS ‘Five Year Forward View’(^2) which envisions new models of care that break down the traditional divides between primary care, community services and hospitals. The aim is for patients to receive personalised and coordinated care from different types of services with clinicians working together. North Tyneside Clinical Commissioning Group is a level 3 commissioner in relation to Primary Care, which adds another opportunity to commission fit for purpose “community services” in order to ensure sustainability in response to the demographic and system challenges in North Tyneside previously detailed. NHS North Tyneside CCG now has an important opportunity to commission community services in a way that will support this shift to more coordinated care for patients closer to home. The community services contracts put in place three to five years ago are no longer fit for purpose, giving us an opportunity to:</td>
<td>resources efficiently and effectively • Right care, right place, right person, right time</td>
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| • Test which providers are most likely to achieve the changes that commissioners want for patients to embrace a new “community services” delivery model  
• Move to new contracts that provide greater transparency and accountability for wider community services provision, as well as greater incentives for providers to improve services for patients.  
• Focus upon the population where the greatest need lies and provide a system approach to care delivery whilst maintaining universal services for other patients rather than a piecemeal approach to services3. | Long Term Conditions | Better management of long term conditions is a key priority of North Tyneside CCG. There remains a strong case for taking further actions to improve the outcomes for people, remain relatively stable, be confident in self-management and enjoy a quality of life free from frequent crisis or frequent and often unnecessary hospital visits.  
North Tyneside CCG recognises that we need to work collectively with our providers in primary care, community and secondary care in changing our approach in how interventions are appropriately | • Improved patient experience  
• Preventing people from dying prematurely  
• Reduced reliance on hospital care  
• Improved accuracy in diagnosis of | Strategic priority |

3 Kings Fund (2014) The Reconfiguration of Clinical Services
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|                          |            | targeted. This will require a whole system approach and to be more proactive with greater emphasis on prevention and achieving diagnosis and developing interventions that can help slow deterioration at the earliest stage possible. Greater priority will be to support patients to manage their condition more effectively and reduce the need for specialist interventions and hospital based care. Opportunities to design those specialist services in respiratory, diabetes and CVD to have a more community focussed approach will be explored. To achieve this, North Tyneside CCG will set out a vision that covers all aspects of the health and care system including public health, social care and the voluntary and community sector and will set out best practice in order to achieve improved outcomes and improve the quality of life. Key outcomes to be achieved: • Work with our partners in Public Health to commission an in depth Long Term Conditions needs assessment for the adult population of North Tyneside to understand the level of present and future needs on the health and social care system over the next three years. The assessment will focus will be on conditions with the highest prevalence: o Respiratory Disease, specifically COPD and asthma | COPD  
• Improved management of asthma |        |
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<td>o Cardiovascular Disease</td>
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<td>o Diabetes</td>
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<td>o Chronic Kidney Disease</td>
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<td>• Identify opportunities to prevent onset long term conditions and identify opportunities to manage</td>
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<td>• Improve the well-being of all communities and minimise the inequalities that currently exist in North Tyneside with COPD and asthma being significantly more prominent in our poorest communities.</td>
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<td>• Reduce the number of people with co-morbidities who die prematurely through a proactive approach to early identification using risk stratification tools, multi-disciplinary working and proactive care management, greater use in technology and targeting of high areas of prevalence.</td>
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<td>• Develop a programme of delivery projects within 2019/20 which can deliver improvements in the <em>respiratory pathways</em> including:</td>
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<td>o Expansion of the Hospital at Home service and supported discharge service</td>
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<td>o Full delivery of a community based pulmonary rehab programme for patients with an MRC score of 2 and above.</td>
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<td>o Roll out of self-management tools such</td>
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| High quality affordable health care | Enhanced care for long term conditions – diabetes | The priorities for commissioning diabetes services in 2019/20 are:  
- Implement a revised care planning LES for primary care. The LES contract has been co-produced with NHS Year of Care and will ensure that North Tyneside residents with type 1 and type 2 diabetes receive a care planning process which is consistent with nationally-recognised standards of best practice.  
- Commission a ground-breaking diabetes remission service for patients with type 2 diabetes. North Tyneside CCG is the first CCG in the country to commission a service based on the weight control programme developed | The aim will be to deliver high quality cost effective care, by shifting care outside of hospital. We will have quicker access to structured education for patients who have been newly diagnosed with diabetes (additional 500 places per annum compared to 2017/18). | Strategic priority |
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<td>during the DiRECT programme pilot in Scotland. We have commissioned 270 places on the programme this year and will evaluate the outcomes with a view to informing our commissioning intentions for 2020/21. - Exploring the possibility of developing community-based specialist diabetes clinics as part of our emerging Primary Care Home / Networks. This could include provision of community-based insulin and GLP1 clinics, as well as the delivery of more community-based diabetic foot checks and foot care.</td>
<td>We will also target access to structured education for patients who have been diagnosed as having diabetes but who have not yet had an opportunity to access diabetes structured education We will have improved pathways to access the specialised Diabetic Resource Centre and diabetic podiatry.</td>
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| Strategic Priority - Hospital when it's appropriate | Urgent care Reforming local urgent care services | • Continue to embed the recently established integrated urgent care pathway and improve the quality of the patient experience in all urgent care pathways demonstrating flexibility and supporting patients to make the right decision.  
• Continue to promote the Integrated 111 service to ensure those with an urgent care need can be booked in to the most appropriate service or/and receive the most appropriate advice on how to manage their own care.  
• Achieve and sustain the 4 hour A&E target by reducing avoidable attendances at NSECH through the development of alternative pathways and initiatives that support patients to be treated in an alternative setting where clinically appropriate.  
• Work with NuTH and Northumbria Healthcare to ensure a comprehensive model of Same Day Emergency Care, at least 12 hours per day, seven days a week, by September 2019. | • Improved patient outcomes and experience  
• Increase in the number of patients accessing booked appointments with urgent care services via NHS 111  
• A financially sustainable urgent care system which is more cost effective to run and reduces discretionary demand for Type 1 A&E services.  
• A sustainably resourced urgent care | Strategic priority |
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<td>- Develop a ‘No Place like Home’ communications strategy.</td>
<td>- Compliance with national commissioning standards</td>
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<td>- Deliver in partnership with the Local A&amp;E Delivery Board a demand and capacity plan to ensure continued delivery during the next winter and period of high demand on reducing lengths of stay with specific focus on stranded and super stranded patients who have been in hospital for over 7 and 21 days respectively.</td>
<td>- Reduction in number of patients presenting at A&amp;E / UTCs and associated cost.</td>
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<td>- Work with the Local A&amp;E Delivery Board to develop a new Urgent and Emergency Care Strategy.</td>
<td>- Increase in the proportion of 111 calls being passed to a clinician for consultation and completion.</td>
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<td>- Work with North East Ambulance Service NHS Foundation Trust (NEAS) to ensure:</td>
<td>- High fill-rates for appointments with the extended access hubs.</td>
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<td>o Response standards are maintained for access, unscheduled care and scheduled care</td>
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<td>o That services provided by NEAS are adequately resourced</td>
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<td>o That NEAS deals with fluctuations in demand during periods of high demand, e.g. winter.</td>
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<td>- Work with NEAS and Northumbria Healthcare NHS Foundation Trust to reduce delays in system.</td>
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<td>ambulance handovers by ensuring fluidity in the admissions process.</td>
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<td></td>
<td></td>
<td>• Undertake a review of the North Tyneside provision of the Consultant Connect service, taking into account user experience, and identify opportunities for improvement.</td>
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<tr>
<td>High quality affordable health care</td>
<td>Remodelling of the Pain Management Service</td>
<td>During 2019/20, the CCG will work with Northumbria Healthcare NHS Foundation Trust to complete and implement the remodelling of the pain management service, into a Living Well With Pain service, moving from a medical to a biopsychosocial model of care. The CCG will also build on the education provided to GPs during 2018 to enable them to be supported in having better conversations with patients about their pain.</td>
<td>• Increased ability of people to live well with their pain • Reduction in use of opioid medications</td>
<td>Service redesign and strategic priority</td>
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<tr>
<td>High quality affordable health care</td>
<td>Rapid Specialist Opinion / Advice &amp; Guidance</td>
<td>The CCG will continue to monitor the impact of the Rapid Specialist Opinion service which was commissioned from October 2018. The CCG will continue to monitor the impact of the Advice &amp; Guidance services commissioned during January to March 2019, and review whether there is a need for further Advice &amp; Guidance services.</td>
<td>• To ensure appropriateness of secondary care referrals • To provide GPs with an alternative to referral where they are unsure whether this is</td>
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<tr>
<td>Commissioning Intentions</td>
<td>Initiative</td>
<td>Summary</td>
<td>Impact &amp; Outcomes</td>
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| High Quality Affordable Healthcare | System-wide Pathways Reviews | NHS RightCare is a system which uses data to identify areas of variation in clinical services across the country. It is an enabler for CCGs to look at those areas of variation and, using national and local data, to understand the reasons for the variation. Using this information, it can be used to identify opportunities to use robust clinical leadership to deliver sustainable service transformation and drive clinical change. We will continue to use RightCare methodology to identify areas of variation in North Tyneside and have developed a programme of review on those service areas which are identified as priority areas for North Tyneside. We have prioritised the following areas for improvement:  
  - Musculoskeletal  
  - Respiratory  
  - Circulation  
  - Gastrointestinal  
  - Cancer  
  - Trauma and Injuries  
These priority areas have been incorporated into five RightCare Delivery Plans which are aligned to savings within our QIPP plan. The plans are: | Quality improvements to identified services  
Potential financial savings | QIPP plan                  |
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<tr>
<th>Commissioning Intentions</th>
<th>Initiative</th>
<th>Summary</th>
<th>Impact &amp; Outcomes</th>
<th>Status</th>
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<tr>
<td></td>
<td>Medicines Optimisation</td>
<td>• We are working collaboratively with NHS Northumberland CCG and Northumbria Healthcare NHS FT to continue to develop and implement change programmes, and ensuring that we use national support effectively to gain the maximum outcomes.</td>
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<td>Respiratory</td>
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<td>Gastrointestinal</td>
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<td>Trauma and Injuries</td>
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<td>Complex Patients</td>
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<td></td>
<td>Referral to Treatment Times (RTT)</td>
<td>• The CCG will continue to work with providers to redesign outpatients to ensure right professional, right place, right time, delivering high quality pathways across primary and secondary care and adding value to people’s lives.</td>
<td>• Improve rapid outpatient access</td>
<td>Strategic priority</td>
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<td>• Reduce outpatient follow-up</td>
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<td>• Improve patient experience</td>
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High Quality Affordable Healthcare
Report to: Governing Body

Date: 21 May 2019  
Agenda item: 14.1

Title of report: Terms of reference

Sponsor: Dr Lesley-Young Murphy, Executive Director of Nursing & Chief Operating Officer

Author: Irene Walker, Head of Governance NTCCG

Purpose of the report and action required:
Governing Body is asked to approve the terms of reference for IM&T Strategy Group

Executive summary:

IM&T Sub Committee
Parent committees approve their sub-committee terms of reference. The exception to this is where a sub-committee has delegated decision making. In these cases Governing Body must approve the terms of reference.

The terms of reference for the IM&T subcommittee has been reviewed and agreed by the Primary Care Committee. There are no changes to these terms of reference.

Primary Care Committee recommends that Governing Body approves the terms of reference for the IM&T sub-committee.

Governance and Compliance

1. Links to corporate objectives

<table>
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<tr>
<th>2019/20 corporate objectives</th>
<th>Item links to objectives</th>
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<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution.</td>
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<td>2. Meet the CCG’s financial duties and support delivery of the CCG’s other objectives, on a sustainable basis.</td>
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<td>3. Work collaboratively with partners and stakeholders to develop sustainable health and social care in North Tyneside and the wider Cumbria &amp; North East system.</td>
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<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture.</td>
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</table>
2. Consultation and engagement
IM&T Strategy Group and Primary Care Committee have been consulted on the IM&T Strategy Group terms of reference and no changes are suggested to the existing terms of reference.

3. Resource implications
N/A

4. Risks
N/A

5. Equality assessment
N/A

6. Environment and sustainability assessment
N/A
IM&T Strategy Group
Terms of Reference

1. Introduction

The IM&T Strategy Group (the Group) is established as a sub-committee of the North Tyneside CCG Primary Care Committee, in accordance with constitution, standing orders and scheme of delegation.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of The Group.

2. Principal Function

The IM&T Strategy Group is responsible for ensuring that robust systems and processes are in place to commission, monitor and ensure the delivery of the North Tyneside CCG IM&T Strategy as part of commissioned services.

The Group will provide oversight and scrutiny of the strategy in relation to securing continuous improvement and financial balance across the CCG and GP practices.

3. Accountability

The IM&T Strategy Group is a sub-committee of the Primary Care Committee.

4. Membership

Membership of The Group is:

- Executive Director of Nursing: Chief Operating Officer - (Chair)
- GP IT lead
- Head of Improvement & Development
- Improvement and Development Manager
- Practice Manager representation (x2)
- NTCCG Finance
- Head of Governance

The following are invited to attend all meetings of the Group but are not members:

- Medical Director (or designee)
- NECS IM&T representative (senior level)
- NECs Finance
The Chair has the responsibility to ensure that the Group obtains appropriate advice in the exercise of its functions.

Officers, employees, and practice representatives of the CCGs and other appropriate individuals may be invited to attend all or part of meetings of the Group to provide advice or support particular discussion from time to time. This may include, for example, representatives from the Commissioning Support service.

5. Authority

5.1 The Group has the authority to pursue any activity within these Terms of Reference including to:

(i) Seek any information it requires from CCG employees, in line with its responsibility

(ii) Require all CCG employees to co-operate with any reasonable request made by The Group

(iii) Review and investigate any matter, with due regard to the Information Governance Policies of the CCG, regarding personal health information and the CCG’s duty of care to its employees when exercising its authority.

6. Roles and responsibilities

6.1 To monitor and review the IM&T strategy and any associated budgets.

6.2 To receive reports on the IM&T strategy, budgets and project delivery and monitor progress in implementing recommendations and action plans.

6.4 To oversee development of the North Tyneside CCG IM&T strategy and commit expenditure, as approved by the Governing Body or as secured from successful IM&T bids, subject to compliance with the SFIs and scheme of financial delegation and SFIs.

6.5 To ensure that all plans meet the business objectives of the CCG.

6.8 To seek assurance on progress with the development and implementation of plans.

6.9 To provide assurance on the IM&T Strategy to the Primary Care Committee.

7. Administration

Meeting minutes will be taken and appropriate admin support provided to the group.
8. **Quorum**  
The quorum shall be 3 members of the Group.

9. **Decision Making**  
Generally it is expected that decisions will be reached by consensus. Should this not be possible then a view of members will be required. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting) will have a second, and casting vote.

10. **Frequency and notice of meetings**  
Meetings will be held at such interval as the Chair shall judge necessary to discharge the responsibilities of the Group, but shall be at least 4 times per year.

11. **Attendance at meetings**  
11.1 The members of the Group are required to provide information to progress and inform the agreed agenda items.

11.2 The Group members are required to attend each meeting or if apologies are made any information they are expected to contribute must be supported either through a deputy or in writing to the Chair.

12. **Reporting Arrangements**  
The minutes of the meetings shall be formally recorded and submitted to the Primary Care Committee, which this committee reports to.

The IM&T Strategy Group will prepare an annual report for the Primary Care Committee, its parent committee.

13. **Conduct of the Group**  
All members of the Group and participants in its meetings will comply with the Standards of Business Conduct for NHS Staff, the NHS Code of Conduct and the CCG’s Policy on Standards of Business Conduct and Declarations of Interest which incorporate the Nolan Principles.

14. **Date of Review**  
The Group will review its performance, membership and these Terms of Reference at least once per financial year.
No changes to these Terms of Reference will be effective unless and until they are agreed by the Primary Care Committee, which this committee reports to and approved by Governing Body.

Date agreed at IM&T Strategy Group - 12 December 2016
Date approved at Primary Care Committee – 11 May 2017
Date agreed at Primary Care Committee – 10 May 2018
Date approved at Governing Body - 22 May 2018
Date agreed at IM&T Strategy Group – 29 April 2019
Date agreed at Primary Care Committee – 2 May 2019
Date approved at Governing Body - 21 May 2019 TBC
Quality and Safety Committee

Minutes of the Quality and Safety Committee Meeting held on Tuesday
5 March 2019, 10:20 – 11:30, at Hedley Court

Present:
Mary Coyle CCG Deputy Lay Chair (Chair)
Dr Lesley Young-Murphy Executive Director of Nursing & Chief Operating Officer
Maureen Grieveson Deputy Director of Nursing, Quality and Patient Safety
Dr Neela Shabde Secondary Care Doctor
Jan Hemingway Head of Safeguarding
Irene Walker Head of Governance, North Tyneside CCG
Dr Riaan Swanepoel GP Safeguarding Lead

In Attendance:
Wendy Hume PA, North Tyneside CCG (Notes)
Trish Grant Lead Nurse Safeguarding Children and Adults
Gillian Airey Senior Clinical Quality Officer
Phil Crozier Operational Lead for CHC
Teresa Ho Performance & Monitoring Manager

Apologies:
Dr Ruth Evans Medical Director
Steve Rundle Head of Planning & Commissioning

NTQS/19/0013 Agenda Item 1 – Welcome and apologies for absence
Mary Coyle welcomed all to the Quality & Safety Committee and apologies were noted as above.

NTQS/19/014 Agenda Item 2 – Declarations of Interest
Mary Coyle reminded the committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of North Tyneside CCG. Along with any gifts or hospitality received relating to the committee.

Declarations declared by members of the Quality & Safety Committee are listed on the CCG’s register of interest and attached to the committee papers.

Declarations of interest from sub committees
Not applicable.

Declarations of interest from today’s meeting (Including gifts and hospitality)
Nothing to declare

NTQS/19/015 Agenda Item 3 – Minutes of the previous meeting: 05.02.2019
The minutes were reviewed and agreed to be a true record.
NTQS/19/016  Agenda item 4 – Matters arising from previous meeting: 05.02.2019
There were no matters arising.

Action Log:
All actions were completed.

NTQS/19/017  Agenda Item 5 – North Tyneside CCG Safeguard Incident and Risk Management System (SIRMS) Incident Report Q3

Maureen Grieveson gave an overview of the report highlighting the poor discharge information going to GPs from Vocare. The consultation pages are blank that GPs are receiving. There has also been a 38% increase which is a significant increase on previous quarters.

Tom Dunkerton is currently dealing with this through the contracting route and raising this with Northumbria Healthcare FT (NHCFT).

NTQS/19/018  Agenda Item 6 – Integrated Performance and Quality report.

Maureen Grieveson presented the integrated performance and quality report to the committee advising that part A of the report covers the performance indicators and part B covers the quality indicators.

The report detailed the following;

Part A Summary

- **IAPT:** The Talking Therapies North Tyneside service achieved 11.6% IAPT access rate in December 2018. The target for December 2018 is 15%. The service has recently appointed to a number of therapists posts, some of which will be dedicated to increasing the access rate. Although the therapists do not start in post still April 2019, it is expected that these posts will be pivotal in achieving the revised standard of 22% access rate by the end of 2020.

- **Cancer 62 day** – Newcastle FT achieved 78.3% and Northumbria FT achieved 79.1% in December 2018 for percentage of patient’s treated within 62 days of an urgent GP referral for suspected cancer. The CCG achieved 74.2% in December which does not meet the standard. The standard is to achieve 85% of patients treated within 62 days. Newcastle FT has a Cancer Steering Group which has to date: help weekly patient tracking list reviews, undertook tumour specific reviews, updated cancer improvements plans, undertook capacity and demand modelling. Northumbria FT has installed a Cancer Board which has focused on: clearing the backlog of legacy patients, developing clinical systems to interface with each other, establish a multi-disciplinary cancer tracking team and use allocated nurse specialists which stay with the patient throughout the pathway journey. This has resulted in the backlog of patients reducing. The Cancer Commissioning Manager is working closely with both FTs and the Cancer Network to monitor performance from a system wide
perspective.

- **Incomplete pathways:** The CCG had 16,887 patients on an incomplete pathway for Dec 2018 which is a 6.8% increase from the March 2018 position. Currently both Newcastle FT and Northumbria FT continue to perform above the standard for referral to treatment times, achieving 93.3% and 92.7% respectively for Nov 2018.

  Teresa Ho informed the members that the Incomplete pathways were to be rebased for March 2018 as it was incorrect.

- **Ambulance handovers** – Newcastle and Northumbria FT are both experiencing ambulance handover delays in January 2019. The target is that there are no ambulance handovers 30 minutes and above. Newcastle FT in conjunction with NEAS will be installing additional screens in assessment/handover areas to improve real time handover times.

  Maureen Grieveson said there was a difference in handover times between NHCFT and NuTH and wondered if the fact that NuTH admit direct to wards whereas with NHCFT everyone has to go through A&E, makes a difference. Lesley Young-Murphy commented that NHCFT are in the process of streamlining ambulatory care. Tom Dunkerton and Dr Shaun Lackey are going to visit both trusts to see the difference with handovers.

  Irene Walker asked if a breakdown of the breached 62 day wait could be completed to show the reasons for not hitting the target.

  **Action 1** = Teresa Ho to bring the breakdown to the June 2019 Quality & Safety Committee Meeting.

  Riaan Swanepoel stated that if a patient cannot do the date for a 2 week cancer referral the GP is asked to follow a different pathway. Lesley Young-Murphy said for non 2 week referrals, negotiations have started with Ramsey Healthcare for endoscopies.

  Neela Shabde enquired about the 2 patients waiting over 18 weeks for a wheelchair. Lesley Young-Murphy confirmed that these were bespoke wheelchairs and took longer than normal. Lesley Young-Murphy gave assurance that everyone has access to a wheelchair.

**Part B Summary**

There is a positive report from Northumberland Tyne & Wear FT (NTW) in relation to the Safe Care Programme and the use of restraints.

Ramsey Healthcare have breached the 52 week wait for one patient who was lost to follow up and will be penalised, this is a Newcastle Gateshead CCG patient. Ramsey healthcare have developed an action plan to prevent this happening again.

Neela Shabde enquired about the Never Events as NuTH has increased by 6 and NHCFT by 2, how is this being dealt with. Maureen Grieveson replied
that the majority of Never Events for NuTH are in relation to dental where freeze was applied to the wrong side and resulted in low or no harm. However, despite all of the checks that have been put in place the Never Events continue often due to human error. Therefore, NHS England are organising a regional learning event to look at Never Events.

NTQS/19/019 Agenda Item 7 – Annual Assessment Outcomes for 2018/19 and Specialised Services Comprehensive Peer Reviews Visit Programme.

Maureen Greiveson presented the report for information stating that the outcomes for Foundation Trusts following the quality surveillance annual assessment process for 2018/19 for all specialised services had been completed.

The outcomes will be used by regional commissioning teams to monitor quality of service delivery and compliance with NHS England’s service specifications.

NTQS/19/011 Agenda Item 8 – Any other business
None

NTQS/19/012 Agenda Item 9 – Date and time of the next meeting
Tuesday 2 April 2019, 10.30-11.30am
Hedley Court
Quality and Safety Committee

Minutes of the Quality and Safety Committee Meeting held on Tuesday
2nd April 2019, 10.30am – 11.30am, at Hedley Court

Present:
Dr Neela Shabde Secondary Care Doctor (Chair)
Dr Lesley Young-Murphy Executive Director of Nursing & Chief Operating Officer
Maureen Grieveson Deputy Director of Nursing, Quality and Patient Safety
Irene Walker Head of Governance, North Tyneside CCG
Dr Riaan Swanepoel GP Safeguarding Lead

In Attendance:
Teresa Ho Planning and Performance
Trish Grant Lead Nurse Safeguarding Children and Adults
Alice Southern Practice Manager
Gillian Airey Senior Clinical Quality Officer
Sarah Turner PA, North Tyneside CCG (Notes)

Apologies:
Mary Coyle CCG Deputy Lay Chair
Dr Ruth Evans Medical Director
Jan Hemingway Head of Safeguarding
Steve Rundle Head of Planning & Commissioning

NTQS/19/021 Agenda Item 1 – Welcome and apologies for absence
Neela Shabde welcomed all to the Quality & Safety Committee and apologies were noted as above.

NTQS/19/022 Agenda Item 2 – Confirmation of Quoracy
The committee was confirmed to be quorate.

NTQS/19/023 Agenda Item 3 – Declarations of Interest
Neela Shabde reminded the committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of North Tyneside CCG, along with any gifts or hospitality received relating to the committee.

Declarations declared by members of the Quality & Safety Committee are listed on the CCG’s register of interest and attached to the committee papers.

Declarations of interest from sub committees
Not applicable.

Declarations of interest from today’s meeting (Including gifts and hospitality)
Nothing to declare

NTQS/19/024 Agenda Item 4 – Minutes of the previous meeting: 05.03.2019
The minutes were reviewed and agreed to be a true record with the following
amendments;

- Teresa Ho to be added as in attendance
- Steve Rundle to be added under apologies

**NTQS/19/025 Agenda item 5 – Matters arising from previous meeting: 05.03.2019**

All actions were agreed to be complete with the following comments / exceptions:

- NTQS/19/018 – 1 – Teresa Ho to bring a breakdown of the cancer breaches to the June 2019 Quality and Safety committee meeting. This action is ongoing and not due until June.

**NTQS/19/026 Agenda Item 6 – Integrated Performance and Quality report**

Teresa Ho presented the integrated performance and quality report to the committee advising of the following:

- 4 hour waits
  Neither trust achieved the 95% target with Northumbria Healthcare achieving 93.6% and Newcastle Hospitals 92.9%.

- Ambulance Handovers –
  Both trusts have experienced handover delays in February 2019. Teresa Ho advised that Tom Dunkerton is currently carrying out a piece of work to look at handover delays pre and post NSECH with a view to results coming back to the June meeting. Lesley Young-Murphy advised the committee that both of the trusts deal with ambulance handovers differently, Newcastle Hospitals take patients into the hospital to release the ambulance even if this means patients waiting in corridors, whereas Northumbria Healthcare will make the patient wait in the ambulance until a bed is available.

- Ambulance response times –
  Response times for category 2 and 3 calls are above the national standard of 18 minutes and 2 hours respectively. To deal with this NEAS have recruited to the contact centre along with an additional third part qualified paramedic crews, closing the vacancy gap from 86 in August to 42 in November. This has also been aided by the reduction in sickness absence.

- Cancer 62 day –
  Both trusts failed to achieve the 85% standard with Northumbria Healthcare achieving 80.2% and Newcastle Hospitals achieving 75.2%. Both trusts have groups established to look at these areas however regionally the trusts are struggling due to key staff retiring causing a backlog in the system. Newcastle Hospitals have tried to mitigate this by recruiting staff from Italy. This was discussed at length and it was agreed that a consistent approach is required across the trust in how they use other providers of diagnostics and reporting to free up capacity to treat these patients
within 62 days.

**Action 1** = A consistent approach to be looked at with regard to how 62 day cancer waits are managed to ensure that the targets are met.

- **IAPT** –
  
The service has achieved the quarter four target and it was identified that the appointment of a number of therapists starting in April 2019 will be pivotal in achieving the revised standard of 22% access rate by the end of 2020.

- **Quality Premium** –
  
  Teresa Ho advised that the target is based on the number of patients on an incomplete pathway in March 2019 to not exceed the number of patients on an incomplete pathway in March 2018. At present the figures are 16,482 against the previous year of 15,818. The CCG are currently in discussion with NHS England around rebasing the March 2018 figures to include appointment slot issue patients, this would allow the CCG to achieve the target.

Maureen Grieveson presented the quality summary of the report advising the committee of the following:

**Newcastle Hospitals**

- Highest reporter of MSSA in the region
- Second highest reporter of E.Coli in the region
- Continue to the below the standard for friends and family test in relation to A&E and inpatient response rates
- Did not achieve the quarter 3 community CQUIN
- PREVENT compliance increased to 72.73% at the end of January 2019

**Northumbria Healthcare**

- Third highest reporter of E.Coli in the region
- Falls figure is 1.7% above the national average of 1.6%
- Recorded below average figures for VTE risk assessments and VTE Prophylaxis
- Reported two never events in March 2019 bringing the year to date total to 4. The two events in March relate to North Tyneside patients and the trust have confirmed that an action plan is in place
- Compliance with the 60 day reporting timescale for serious incident RCA’s is declining and was raised at the March 2019 QRG
- A lead has been nominated for Patient Safety Alert NHS/PSA/D/2019/001 and the trust are confident they will comply with this alert.
- Continue to be below the average for friends and family test for A&E. The trust has developed a new technical solution to boost response rates.
- Compliance for WRAP is 75.1% and level 3 training is 77.8% with the
trust confident they will achieve the 85% target by the end of March 2019.

Maureen Grieveson confirmed that the non-compliance for the level 3 safeguarding children training is raised continually at the QRG meetings and included within the action plan however not addressed. Lesley Young-Murphy advised that the director of nursing in both trusts need to be notified of any outstanding areas.

Neela Shabde queried the poor performance rate for the family and friends test in Northumbria Healthcare and whether this needed to be addressed. Maureen Grieveson provided assurance that although the performance rate is low for family and friends the trust carries out other patient experience measures that are more meaningful.

**NTQS/19/027 Agenda Item 7 – Health and Safety Annual Report 2018/19.**

Irene Walker presented the Health and Safety Annual Report for 2018/19 advising the committee of the following;

- An audit was conducted at Hedley Court on 4th March 2019 resulting in 100% compliance and a 4 star rating. The key item was that the fire drill resulted in an evacuation time of 1 minute and 50 seconds.

- A second audit was undertaken at Youth Village on 27th February 2019 resulting in 94% compliance and a 4 star rating with the key items to note being;
  - Training scheduled for two first aiders in March 2019
  - First Aider signage to be displayed once training complete
  - Only one DSE outstanding

Irene Walker confirmed that this provides assurance for 12 months.

**NTQS/19/028 Agenda Item 8 – Any other business**

Gilian Airey advised the committee that NECS produce a SIRMs thematic report which they then have difficulty disseminating to practise through GP team net.

NECS have queried whether or not the CCG would be happy for these reports to be uploaded to SIRMS, however this would allow all with SIRMs access to be able to view the reports.

The proposal was discussed at length and it was agreed that this is not appropriate, a subsequent solution was agreed, that a one page flyer would be produced by NECS identifying key areas to note that can be disseminated with the CCG bulletin.

**NTQS/19/029 Agenda Item 9 – Date and time of the next meeting.**

Tuesday 7th May 2019
10.30-11.30am
Hedley Court
Minutes of the Primary Care Committee Meeting held on Thursday 14 February 2019, 2.05pm-3.30pm, Longsands North, Hedley Court

Present:
Mary Coyle (MC) Chair, NTCCG
Jon Connolly (JC) Chief Finance Officer, NTCCG
Lesley Young-Murphy (LYM) Executive Nurse and Chief Operating Officer, NTCCG

In Attendance:
James Martin (JM) Commissioning & Performance Manager, NTCCG
Cllr Margaret Hall (MH) Chair, Health & Wellbeing Board
Linda van Zwanenberg (LvZ) Board Member, Healthwatch
Dianne Effard PA, NTCCG

Agenda Item, Discussion & Agreed Actions

NTPCC/18/070 Welcome & Apologies for Absence: Agenda Item 01
Mrs Mary Coyle (MC) welcomed all to the meeting and Margaret Hall and Linda van Zwanenberg introduced themselves to the Committee.

Apologies were noted from Ruth Evans, Irene Walker, Philip Horsfield, Wendy Thompson and Keith Davidson.

NTPCC/18/071 Confirmation of Quoracy: Agenda Item 02
The meeting was confirmed as being quorate.

NTPCC/18/072 Declarations of Interest: Agenda Item 03
The register of interest is included with the agenda for the meeting. The Chair asked:
Are there any declarations on the enclosed register of interests which are relevant to today's agenda?
- Jon Connolly (JC) declared he now has a dual role as Director of Finance with Northumberland CCG, as well as with North Tyneside CCG. It was agreed there is no conflict with anything on today's agenda.
- Margaret Hall declared an interest as her daughter, Kathryn Hall, is a GP at Collingwood Surgery and is involved in work with the CCG. It was agreed there is no conflict with anything on today's agenda.

Are there any additional declarations of interest, including gifts and hospitality, relevant to today's agenda?
There were none.

Action 1: Irene Walker (IW) to send conflict of interest form to Cllr Margaret Hall for completion.
NTPCC/18/073  Minutes of the Previous Meeting: Agenda Item 04

The minutes of the meeting held on 13 December 2018 were agreed to be accurate.

NTPCC/18/074  Action Log: Agenda Item 05

NTPCC/18/046, Action 1: Welcome & Apologies for Absence
LYM to have a conversation with the Chair of HWB about who will attend meetings of this committee.

Update:
Revised terms of reference for the Primary Care Committee is on today’s agenda.
Complete

NTPCC/18/075  Operational Update: Agenda Item 06

James Martin (JM) presented the report for the Committee to note the recent decisions that have been made outside of the Primary Care Committee held in public. As the meeting in public is held every two months, sometimes it is necessary to have a private meeting to consider business. Information is then presented to the next meeting in public.

An application had been received from Forest Hall Medical Group (FHMG) and Garden Park White Swan Practice (GPWSP) to merge practices, which has been approved by the private meeting. The rationale for the merger is the sustainability of one of the practices. This also meets the national requirement for practices to work together in larger practices. Consultation was undertaken which was very positive with no major objections. There will be no impact on patients.

Margaret Hall (MH) advised that this had been brought to the attention of local Council members and no issues were raised.

Lesley Young-Murphy (LYM) advised that the CCG will develop a toolkit locally on mergers for practices to make it easier for them if they are considering a merger. There are national toolkits available but are complex and can put practices off considering a merger.

MC noted an error in the report.
Under Operational Update, end of first sentence referred to “three items” and should read “one item”.

Action 2: JM to change the error in the report and ensure it is changed on the website.

NTPCC/18/076  Wallsend Health Centre PID: Agenda Item 07

JM presented the Project Initiation Document (PID) regarding the proposed relocation of Portugal Place Health Centre (PPHC) and Park Road Medical Practice (PRMC) in Wallsend, and apologised for the fact it had been sent out late. There was a query about whether this proposal should be considered in the private meeting, but it was agreed
it should come to the public meeting. If the Committee agrees the PID is reasonable, then a full business case will be worked up for full engagement and consultation.

The proposal is for both practices to move to one single hub in a new build, located near the Forum in Wallsend. Northumbria Healthcare NHS FT (NHC) will also have space within the hub for community service provision but that element of the development doesn’t form part of this PID. The building will also be able to be used for locality work and across a number of practices. The aim is to future proof practices going forward.

The CCG previously received a PID from these two practices for this development as application for the Estates and Technology Transformation Fund and it was approved. The funding implications for that proposal were different as they included a significant investment of NHS capital funding. That funding is now not available resulting in the submission of a revised PID.

Both existing practice buildings are old and have large levels of backlog maintenance. There is no opportunity to expand for either site and there are car parking issues. The proposed new facility has significant advantages outlined in the PID including long term practice security.

There is a possible proposed merge of the practices signalled in the PID, and the building will be set out to enable the practices to work closely together even if a merger doesn’t materialise.

The size of building is calculated in the PID at 1,530 sqm. This is around one third bigger than the premises maxima guidelines suggests for the practice list size. Another tool used to gauge space required is the PID space estimator, which is more advanced. It considers population, how many contacts per patient per year and how many used consulting rooms and treatment rooms. The building size in the PID is in line with the space estimator submitted with the PID. There are a number of queries in relation to the figures entered into this tool however that if changed would reduce the size that comes out. The Local Strategic Estates Advisor feedback is he feels that the proposed space is larger than necessary.

The existing rent reimbursement is £96,000 per year. Based on figures in the PID, including VAT, the new rent will be £316,140 per year. The proposed estimated rent assumption has been requested from the District Valuer but has not yet been received. The CCG would only reimburse rent based on the District Valuer’s valuation. The cost for the new build was considered to be high at £19.77 per sqm. A previous application by Forest Hall was around £13-14, excluding VAT.

Having reviewed all of the information the Committee could see the issues with the current premises and the benefits of a move to the proposed building but the application was turned down on the basis of value for money. Feedback to the practices and the developer on the discussion should be provided along with an indication around what
changes might make the PID acceptable. Practices can then sit down with developer and consider whether it is feasible and what size the building would be.

The CCG supports developing the GP estate, and it will take some years to get all practices up to a good standard. Moving out of old style houses is top priority, and new premises will cost more. We have to balance need and ensure value for money. Moving practices out of old type houses has also been discussed by North Tyneside Council.

It is important to understand that the CCG doesn’t get any more money to do this. Investment is outwith the CCG’s current primary care budget and will have to come out of the overall CCG budget.

**Action 3:** JM to feedback information to practices, so they can meet with the developer to see if there is a viable way to continue with their plans.

**NTPCC/18/077 Primary Care Policies and Procedures:** Agenda Item 08

JM presented the report for information and members were asked to note the listed policies and procedures.

Some of the policies and procedures are important for practices and have been sent to them.

The Committee noted the policies and procedures.

**NTPCC/18/078 Finance Update:** Agenda Item 09

Jon Connolly (JC) presented the report to update members on the current and forecast financial position with regard to Primary Care budgets.

It was noted the report stated the Financial Summary is for the period ended 31 October 2018, which is incorrect, and should be December 2018.

The overall position shows we are forecasting a small underspend of £49k on the overall budget. We are managing the position within the tight budget and there are no unmanageable risks.

There are two variances to note: APMS reconciliation shows favourable movement as numbers have been more certain, rather than estimates. Premises costs show we have an overspend against budget. There is still a lot of uncertainty around Property Services numbers. We continue to work with them to try to get their processes to work well, which affects everyone not just us. We are in a sound position for this year.

Ms Coyle noted it is encouraging to see we are in this position and understand things could go differently. The report explains the position well without being baffling with too much information.
Errors in the report were identified:
Pg 3: Enhanced Services, last sentence: “A number have declined to deliver the all services.”
Pg 4: Other GP Services, third sentence: “As no new entrants to the scheme are not allowed there has been a reduction in the number of GPs qualifying for seniority payments.

The Committee noted the content of the report.

NTPCC/18/079 Committee Effectiveness Results and Work Plans 2019/20: Agenda Item 10

The report was presented to the Committee, who were asked to:
• receive and discuss the results of the committee’s effectiveness survey
• agree an action plan for improvement
• agree the committee’s work plan for 2019/20

The survey is sent out to members every year. This year, six responses have been received. The report states the number of returns is small, but there are only eight members on the committee.

Members were asked whether the survey results provide any useful information and if not, what would be more useful? It was felt that the results tell us there are no burning issues to be addressed. The results reflect well on the committee, and that is useful to know. Committee is well embedded and there is nothing more that can be done to improve it.

It was noted there was one “partly agree” response to questions 2, 3, 4 and 5.

Two questions were highlighted:
5: “All members of the Primary Care Committee follow through on commitments they have made”: Everything is included in the action log to track items.
6: “The Sub-Committees of the Primary Care Committee follow through on commitments they have made” – two “partly agree” responses: The sub-committees are Primary Care Strategy & Delivery Group, Medicines Optimisation Sub-Committee and IM&T Strategy Group.

It was suggested that when surveys are sent out members should be advised that if they are unsure about any question and what it means they should speak to Irene Walker (IW). Also, the survey should go to external attendees to the Committee and not just to internal CCG members and attendees.

Action 4: IW to be asked to look at sending future Committee Effectiveness Surveys to external attendees as well as internal members and attendees.

The Work Plan is included for members to note, which shows what the Committee will report on. These are items the Committee knows it needs to consider, but anything important will be also brought to the
Linda van Zwanenberg (LVZ) advised that Healthwatch have some work going to the Health & Wellbeing Board regarding access to GPs, and suggested the CCG could feed into that, and also on communications and engagement. She also suggested Healthwatch could give a presentation to the Primary Care Committee in November 2019.

NTPCC/18/080  Terms of Reference: Agenda Item 11

LYM presented the amended Terms of Reference to the Committee who were asked to:

- approve the Primary Care Strategy & Delivery Group (PCSDG) Terms of Reference (ToT)
- agree the Primary Care Committee (PCC) Terms of Reference (ToR) (before presentation to Governing Body for approval).

ToR are reviewed and amended on a regular basis and some changes have been identified by IW.

PCSDG: Primary Care Home sits under Future Care Programme Board between health and social care and the voluntary sector. The amendments give a steer to the sub-group. The Primary Care Home Delivery Group (PCHDG) is not yet fully established. LYM explained what the Integrated Care Partnership (ICP) is and what it covers. The change to Remit and Responsibilities reflects support to the PCHDG. Members approved the amended ToR.

PCC: Two practices have been removed from the list. Members agreed the change, and the amended ToR will now go to Governing Body for approval.

Any Other Business: Agenda Item 12

NTPCC/18/081  Dr Ruth Evans

LYM advised the Committee that Dr Evans is absence at the committee is due to being off work on sick leave. She was not absent because of any other reason, and the CCG is in regular contact with her. LYM reassured the Committee that whilst there is no GP on the Committee, JC, LYM and JM will engage with GPs before papers are presented to this Committee. While not a voting member of the Committee, they will be part of the Committee for GP representation. Responding to a query, LYM advised that it would not be appropriate for TyneHealth to have a representative on this Committee as they are a provider organisation which would be a conflict of interest.

NTPCC/18/082  Date and Time of the Next Meeting: Agenda Item 13

Thursday 2 May 2019, 10.00am-11.30am
Longsands North, Hedley Court
Southern CCG Joint Committee
7 March 2019 / 2.00 – 3.00pm / The Durham Centre

Part 1 - Meeting held in public

Present

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<tr>
<td>Mark Adams</td>
<td>MA</td>
<td>NHS Newcastle Gateshead CCG and NHS North Tyneside CCG</td>
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<tr>
<td>Nicola Bailey</td>
<td>NB</td>
<td>NHS Darlington CCG, NHS Hartlepool and Stockton on Tees CCG, NHS North Durham CCG, NHS Durham Dales, Easington and Sedgefield CCG, NHS South Tees CCG</td>
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<tr>
<td>Vanessa Bainbridge</td>
<td>VB</td>
<td>NHS Northumberland CCG</td>
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<tr>
<td>Amanda Bloor</td>
<td>AB</td>
<td>NHS Hambleton, Richmond and Whitby CCG</td>
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<tr>
<td>Mark Dornan</td>
<td>MD</td>
<td>NHS Newcastle Gateshead CCG</td>
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<tr>
<td>David Gallagher</td>
<td>DG</td>
<td>NHS Sunderland CCG</td>
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<td>David Hambleton</td>
<td>DH</td>
<td>NHS South Tyneside</td>
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<tr>
<td>Neil O’Brien</td>
<td>NO’B</td>
<td>NHS Darlington CCG, NHS Hartlepool and Stockton on Tees CCG, NHS North Durham CCG, NHS Durham Dales, Easington and Sedgefield CCG, NHS South Tees CCG</td>
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<tr>
<td>Jon Rush (Chair)</td>
<td>JR</td>
<td>NHS North Cumbria CCG</td>
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<tr>
<td>Richard Scott</td>
<td>RS</td>
<td>NHS North Tyneside CCG</td>
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<tr>
<td>Jonathan Smith</td>
<td>JS</td>
<td>NHS Durham Dales, Easington and Sedgefield CCG</td>
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<tr>
<td>Janet Walker</td>
<td>JW</td>
<td>NHS South Tees CCG</td>
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Lay members (non-voting)
Ken Readshaw | KR |

In attendance
Dan Jackson | DJ | NHS Sunderland CCG |
Amanda Hume | AH | Executive Lead for System Transformation and Strategic Commissioning Development North East and North Cumbria |
Michelle McGuigan | MMcG | North of England Commissioning Support (NECS) |
Gavin Mankin (item 04) | GM | Northern Treatment Advisory Group (NTAG) |
Gillian Stanger | GS | North of England Commissioning Support (NECS) |

Members of the public
A Bailey | Ranbaxy |
C Gordon | Pfizer |

Minutes
<table>
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<td>01 Welcome, apologies and declarations of conflicts of interest in relation to the agenda</td>
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The Chair welcomed everyone to the meeting and introduced Amanda Bloor, Accountable Officer for the three North Yorkshire CCGs.

Apologies were received from Stephen Childs (North of England Commissioning Support), Jon Connolly (North Tyneside CCG), Stewart Findlay (NHS Darlington, NHS Hartlepool and Stockton on Tees, NHS North Durham, NHS Durham Dales, Easington and Sedgefield and
NHS South Tees CCGs), Feisal Jassat (Lay member), Charles Parker (NHS Hambleton, Richmondshire and Whitby CCG), Ian Pattison (NHS Sunderland CCG), Boleslaw Posymyk (NHS Hartlepool and Stockton and Darlington CCGs), David Rogers (NHS North Cumbria CCG), David Shovlin (NHS Northumberland CCG).

The Committee's register of Interests was received.

### 02 Minutes and action log of previous meeting (10 January 2019)

The minutes of the meeting held on 10 January 2019 were accepted as an accurate record.

The action log was updated.

### 03 Matters arising from the previous meeting (and action log)

#### 03.1 Specialised Services Place Based Commissioning

It was noted that discussions were on-going and the action notes from a recent meeting would be circulated to members.

#### 03.2 Collaboration with the Academic Health Science Network (AHSN) North East North Cumbria

MD noted the AHSN had advised that the vacant places on its Board were for CCG members only; they had therefore not accepted the nomination for a NECS representative to become a member.

**Decision:** David Gallagher volunteered to be a member of the Board, alongside Janet Walker who had been nominated at the last meeting and this was agreed.

### 04 Review of Northern Treatment Advisory Group (NTAG) Terms of Reference / receive Annual Report

Gavin Mankin (GM) introduced the report and highlighted the proposed changes to the NTAG Terms of Reference. NTAG was also seeking confirmation and clarity on its accountability arrangements in the light of changing NHS structures and accountability/decision making processes within the region; whether there was still a place and role for NTAG in light of the creation of Regional Medicines Optimisation Committees and, if so, some clarity on the remit of NTAG.

MA asked whether, as NTAG was increasingly being asked to issue recommendations on prescribable devices, there might be the opportunity to review patient representation on the group. The difficulties in supporting patient representatives on clinical groups were recognised and the gap existed as there was no longer a Healthwatch representative on NTAG.

**Action:** GM would contact Heathwatch to see if a replacement could be identified

However, it was noted that information and patient views on relevant items were obtained in advance of meetings. RS noted patient representatives could also be recruited from existing GP Practice and CCG patient participation groups.

**Decisions:**
- Confirmed there was still a place and role for NTAG in light of changing NHS structures and accountability/decision making processes within the region
- Confirmed that NTAG would continue to be accountable to the Northern CCG Joint Committee
- Approved the updated NTAG Terms of Reference
- Received the NTAG Annual Report 2018
## Governance update – remit of the Joint Committee

The Chair noted a small group had met on 11/2/19 and 29/2/19 to consider the proposed matrix and flowchart which could potentially expand from medical pathways to policies and procedures. Albeit, whilst the group accepted the need for pathways, there had not been the appetite to progress the proposed matrix to policies and procedures proposal.

The Committee discussed its remit which covered learning from elsewhere. AB expanded on the remit of the West Yorkshire and Harrogate ICS Joint CCG Committee, the decision-making process, infrastructure and workplan, and noted that decisions were now starting to be made across the patch.

The Committee then discussed the potential flowchart to identify ICS-level commissioning issues in the North East and North Cumbria, together with the associated scoring criteria, and noted the following points:

- Whether the potential flowchart might be used to set the annual workplan
- A point of clarity on the flowchart which DJ would correct and to change the work ‘issues’ to ‘decisions’
- ‘servant and place’ model – starting with ‘can this be done at place?’ and only progressing to the pyramid model (shown in the presentation) where this would add value
- On what grounds should the question ‘is this an area of service vulnerability that affects more than one ICP?’ be answered
- Taking account of the work done as a system pre-ICS (STP workstreams)
- Noting the areas which the ICS is progressing e.g. urgent and emergency care, learning disabilities
- The use of the matrix for policy work e.g. taking account of the work already underway to align contracts

The proposed governance flowchart for issues delegated to ICS-level was also considered. AB noted in West Yorkshire and Humber, the Joint Committee developed its work programme as commissioners (endorsed by Governing Bodies/Council of Members) and did not engage with providers (who have their own work programme) on this. This differed to the Joint Committee’s remit which would only consider items referred to it by the Health Strategy Group (HSG) with more focus on partnership working.

There was general agreement for the proposed approach which could now be built into the Committee’s Terms of Reference which would also be reviewed and would reflect primacy of ‘place’ and desire to work as a system.

**Decision: to utilise the matrix, with small amendments, as the basis for the topics/areas that the Committee would consider and build this into the revised Terms of Reference.**

However, this did not provide the Committee with an annual work programme and it would therefore meet bi-monthly when there was a decision to be made (recognising that the work previously undertaken by the Northern CCG Forum was now being picked up by the ICPs and Health Strategy Group).

### Feedback from ‘Integrated governance regional meeting’

The Chair noted that the event had been hosted by Sir John Burn, Chair of Newcastle Hospitals, who provided an update for Chairs, CCG lay members and Foundation Trust non-executive directors on progress within the system, and Alan Foster, ICS Executive Lead, North East and North Cumbria ICS. The keynote address was from The Rt Hon Alan Milburn who noted that dealing with ambiguity made it hard to turn that into execution. He highlighted things to change – mindset and behaviours’ legislation won’t be until 2022, new capabilities – sharing of data analytics; tacking health inequalities; changing relationships with citizens, advising and supporting them to be active and take care of themselves. A legal update was provided by Robert McGough.

There followed a governance discussion which noted the need to set up a Partnership Board for
the ICS. The Chair would be working with Neil Mundy of South Tyneside Foundation Trust and others to develop some proposals around this. This ‘board’ could be more of an assembly as it would have no statutory powers.

Brendan Foster closed the event, highlighting the use of ‘Great North’ as brand to be used going forward and his vision to get citizens more active.

### 07 Questions from members of the public relating to specific items on the agenda

A member of the public asked how the Committee might share some of the complex discussions which took place with the public. He noted a meeting of Sunderland CCG which had been live-streamed on Facebook. DG noted that there had been a lot of public interest in that particular meeting; some analysis of number of viewings had been undertaken but not in detail. It was noted that a number of local authorities also live-streamed their public meetings, as did NHS England.

**Action:** DG to circulate basic details of Livestream costs/logistics to Committee members

### 08 Any Other Business

There was no other business.

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Representatives of the press and other members of the public were excluded from part 2 of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1 (2)) Public Bodies (Admission to Meetings) Act 1960

**Date and time of next meeting:**

**Thursday 2 May 2019**

**2.00pm**

The Durham Centre