

**NEWCASTLE PCT
LOCAL DELIVERY PLAN 2005 – 2008**

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SECTION 1 – PRINCIPLES FOR LOCAL DELIVERY 2005-08

INTRODUCTION

- 1.1 This is the second three year Local Delivery Plan (LDP) produced by Newcastle PCT. It sets out our plans to demonstrate how we will through our role as Commissioner of health services, deliver our share of national NHS targets and our own local priorities.
- 1.2 The LDP is a strategic framework setting out how partners will work together to improve the health and social care of local people and deliver local services. It covers the period 2005 to 2008 and will be a rolling plan which will be updated to reflect progress made towards hitting the national and local targets that we are working towards, and any future changes to Government policy.
- 1.3 The Plan will be used as a working document and will be updated quarterly to reflect our progress towards hitting those targets that we have been set and the local targets we have set ourselves. It will also be updated to reflect policy changes and any local initiatives that develop throughout this three year planning cycle.

OVERALL NHS PERFORMANCE

- 1.4 The population of Newcastle has fallen steadily since the 1960s and the rate of decrease has increased in the last six years. The latest population figure (mid 2003) for all ages is 266,589. Twelve (almost 50%) wards in the city rank in the 10% of the most deprived nationally with increasing concentrations of poverty , linked to joblessness, health inequalities , poor educational achievement, high levels of crime and fear of crime and low aspirations.
- 1.5 However Newcastle is also leading the renaissance of the North East and plays an important part in driving the growth of the regional economy, research and education, and creating cultural assets of international significance. Not surprisingly, the available evidence shows that Newcastle is experiencing a widening gap between areas of affluence and areas with high levels of poverty and social exclusion.
- 1.6 Since the last LDP was produced in 2003, NHS services have changed to deliver improved performance against national targets. For example:
 - 3739 people are waiting for inpatient treatment now compared to 4327 at the end of March 2003;
 - The maximum wait for inpatient treatment is 9 months and only 370 people had been waiting more than 6 months in December 2004;
 - The maximum wait for an outpatient appointment is 17 weeks, and only 174 people had been waiting more than 13 weeks in December 2004;
 - 2396 people have been helped to stop smoking since April 2003;

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- 1007 people are receiving treatment for drug misuse compared to 331 (estimated) in 2002-03;
- In 2003-04 169508 inpatients and 731825 outpatients were treated at NUTHT; and
- 129013 people passed through the A&E department/walk in centre.

1.7 Newcastle PCT:

- provides and commissions services for 274,060 people;
- employs 1128 staff;
- is responsible for the services delivered by 38 GP Practices, 58 General Dental Practices, 59 Local Pharmacies and 40 Opticians;
- manages Health Centres, clinics and other premises; and
- is budgeted to spend £301m on services in 2004-05.

ORGANISATIONAL PERFORMANCE

1.8 Within this overall picture of improvement, organisations working for Newcastle residents have been rated on their own performance. NHS organisations are given star ratings (from 0 up to 3 stars) by the Healthcare Commission as a measure of their overall performance. For 2003/04 (the most recent star ratings available), local organisations were given the following ratings:

- Newcastle PCT – 3 stars;
- Newcastle upon Tyne Hospitals NHS Trust - 3 stars;
- North East Ambulance Service NHS Trust - 3 stars;
- Newcastle, North Tyneside & Northumberland Mental Health NHS Trust - 1 star; and
- Newcastle Social Services Department – 3 stars.

1.9 As the commissioning organisation for NHS services in Newcastle, as well as delivering primary care services, the PCT is responsible for securing services that meet national and local targets and the star rating reflects our performance in achieving this.

PRINCIPLES FOR LOCAL DELIVERY 2005-08

1.10 The principles underpinning the Newcastle LDP for 2005-08 have been agreed by the Trust's PEC and Board following extensive discussions with local stakeholders including Trusts, primary and secondary care clinicians, patients and carers and the local authority. They represent the basis on which decisions will be taken on the way in which services are commissioned for Newcastle people:

- Health and social care services for Newcastle residents will meet national and agreed local targets. The PCT will deliver against the core and developmental

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standards set by the Healthcare Commission, the Commission for Social Care Inspection, and other external assessment organisations;

- Decisions on investment and service modernisation priorities will be evidence-based and focused on providing effective, high quality care in the most appropriate setting;
- Any investment will be channelled through whole system Streams of Care which will be responsible for delivering service change against agreed objectives. These include managing demand for traditional secondary care to achieve national targets for emergency care and, as a minimum, no growth in elective activity during the lifetime of the LDP. We will work to understand health needs and activity trends and ensure that appropriate models of care are in place to deliver these objectives;
- Where possible and appropriate, services will be integrated across organisations and across health and social care at all levels of the system;
- The PCT will maintain recurring financial balance; and
- As commissioner of services we will work with providers, patients/ users, carers and the public to plan service change.

DEVELOPING THE COMMISSIONING OF HEALTH CARE IN NEWCASTLE, NORTH TYNESIDE AND NORTHUMBERLAND

- 1.11 The North of Tyne Commissioning Consortium, responsible for secondary care commissioning on behalf of the North of Tyne PCOs was officially launched in October 2004, although work had progressed where possible from the beginning of the financial year.
- 1.12 Northumberland Care Trust, Newcastle PCT and North Tyneside PCT had agreed in 2003 to develop their commissioning arrangements as a logical transformation for delivering the NHS Plan and the SHA strategic direction in the era of financial flows, choice and foundation status. The case for change and the outline model was set out in the Northumberland Tyne and Wear SHA paper “Developing the Commissioning of Health Care in Newcastle, North Tyneside and Northumberland”.
- 1.13 As all three PCOs north of Tyne have developed their local interpretation of the agreed SHA-wide vision for “Care Streams”, the new commissioning arrangements have been designed to mirror these approaches. There are four overarching ‘whole system’ building blocks which run alongside client group/disease group programmes which will inevitably change and develop over time.
- 1.14 The consortium is led by the Chief Executive of Newcastle PCT supported by 5 directors, with “governance” representation from Northumberland Care Trust and North Tyneside PCT through a Commissioning Consortium Board, which meets monthly to advise the Chief Executive on key Consortium issues and monitor progress against the Consortium High Level Workplan.

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- 1.15 The Chief Executive and Chair of Newcastle PCT meet regularly with their counterparts from North Tyneside and Northumberland to agree the evolving High Level Workplan and ways of working, and ensure PCO commissioning requirements are fully understood by the Consortium. Accountability through statutory bodies and Accountable Officers remains. Performance reports are provided for each PCO Board presented where requested by the link Director. A formal subgroup of the Newcastle Professional Executive Committee, the Commissioning Advisory Group, meets regularly with Consortium Directors to provide commissioning advice. Similar arrangements through a Priorities and Decisions Group operate for Northumberland Care Trust and mechanisms for involvement are developing in North Tyneside.
- 1.16 Each director carries a corporate responsibility, plus the lead role for a combination of streams and programmes. Each stream and programme is led by a Head for Service. The Heads are supported by a number of Service Improvement Managers who deliver time limited pieces of work, for example Choose & Book, Practice Based Commissioning, and an information team, led by the Director for Performance.
- 1.17 The Commissioning Consortium covers:
- Newcastle Hospitals NHS Trust;
 - Northumbria Healthcare NHS Trust;
 - Newcastle, North Tyneside and Northumberland Mental Health NHS Trust;
 - North East Ambulance Service (currently led by Gateshead PCT); and
 - Northgate and Prudhoe NHS Trust (currently led by South Tyneside PCT).
- 1.18 The functions include:
- Analysis of need, outcomes and priorities based on local LDPs and collective considerations;
 - Development of service specifications encompassing for example, external guidelines, access criteria, treatment protocols, standards, NICE appraisals/guidance;
 - Developing a commissioning approach focussed on integrated care pathways in response to the SHA's vision for services in the future;
 - Development of binding contracts including risk sharing arrangements;
 - Performance management of those contracts; and
 - Service review.
- 1.19 The PCT's Directorate of Community Services with an enhanced infrastructure now operates at arms length from the remainder of the organisation, and is directly accountable to the Trust Board through the Chief Executive. It operates in the same way as other provider organisations with a similar relationship to the

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PCT's commissioning function thereby addressing previous relationship concerns.

DELIVERING IMPROVEMENT THROUGH STREAMS OF CARE

- 1.20 The Newcastle PCT approach to local delivery of the Strategic Health Authority-wide agreed vision (*Delivering the NHS Plan in Northumberland and Tyne and Wear – A Vision for Sustainable Quality*) was approved in January 04 by the Professional Executive Committee and Board.
- 1.21 The local vision for the delivery of healthcare services builds on current national and local thinking to develop a model for sustainable high quality and accessible health services which makes best use of available and developing skills, recognises the constraint of the current system and the benefits of emerging technology, and proposes a new balance and enhanced partnership between primary, acute and tertiary care. The principles behind development of the model are:
- The whole system needs to be viewed both vertically and horizontally without traditional boundaries and roles;
 - Evidence should be used where available but its lack should not be used as an excuse not to test alternatives;
 - Staff, patients and users must have the opportunity to contribute to development of the model;
 - Patient care should be journey and pathway based. Continuity is important;
 - Accessibility is key – appropriate care at the appropriate location;
 - The model should reflect community expectations, technology changes and workforce requirements;
 - Development of the model should be through a clear strategic direction with a programme/plan to achieve it; and
 - All resources should be taken into account not just 'the new';
- 1.22 The model replaces the slicing of care into primary, secondary and tertiary services with four care 'streams'. These are:
- **Urgent care** – largely provided from locality based Urgent Care Centres (UCCs) and hospital emergency casualty facilities.
 - **Planned Care** – provided by personal practitioners and from locality based Resource Centres (RCs) filtering to specialist hospital centres.
 - **Episodic Care** – provided by personal practitioners and from locality based Resource Centres, supported by specialist consultants working mainly in the community but 'in-reaching' to hospital as necessary.
 - **Health Maintenance** – in the main provided by personal practitioners.
- 1.23 The "Care Streams" model has been used to develop the Consortium's future commissioning approach to services. The Consortium infrastructure reflects the models through four stream heads; clinical PEC members and other clinical

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advisors take responsibility for providing advice for particular streams. Northumberland Care Trust and more recently North Tyneside PCT arrangements have been reviewed and effort has been made to ensure clinical and managerial linkages in to this infrastructure.

1.24 A key initial piece of work for the Consortium has been to undertake a gap analysis for all services which will inform a programme for modernisation and service review across the north of Tyne. The gap analysis considers for each commissioned service: -

- Existing service model and pathways
- Objectives and targets, and performance against these
- Current activity and financial data
- Outcome measures
- Benchmarking
- Evidence of unmet need
- Gaps in available information to support commissioning
- Gaps in service
- Proposed redesigned model
- Progress with modernisation work to date and supporting infrastructure

1.25 The resulting programme for modernisation arising from this work will inform the High Level Work Plan for the Consortium in 2005-06. Early work to implement the streams approach in Newcastle includes integration of primary urgent care services, development of clinical pathways, and piloting of the approach at Molineux Street with a new venture incorporating two GP practices, a Resource Centre, PCT and mental health services and an Urgent Care Centre all within a new build in the East of the city.

SECTION 2 – PARTNERSHIP WORKING

Health and social care services in the City

- 2.1 Ensuring we have joined up arrangements across organisations to steer the development of the services we need is essential. The planning and provision of health and social care embraces a variety of important agendas and needs to involve a range of partner organisations and contributors in its delivery.
- 2.2 Maintaining the existing services upon which we all depend and achieving progress to improve them means working together with all local partners towards effective planning and service delivery. A great deal of the work done to improve health involves social issues and social care. A very close partnership between Health and Social Services is essential and this LDP reflects that partnership work.

Primary care

- 2.3 There is a good network of primary care services in the City with many practices at the forefront of modern primary care provision. Premises are an area where significant investment is needed and this is being addressed by the PCT. We are one of the first in the country to develop a long-term relationship with a private sector partner to modernise its health centres and clinics. Clinical standards are generally good and there has been significant investment in primary care over recent years. However, there will continue to be a need to expand the capacity of primary care if the ambitious targets in the NHS Plan are to be met.
- 2.4 The PCT is a substantial provider of services in its own right. During 2004-05 the PCT will spend more than £301 million and Social Services more than £150 million on services for local people. We provide community nursing and therapy services and a range of more specialist services such as diabetes, health psychology, community dentistry, family planning and sexual health and GUM. Having these services as an integral part of the PCT offers the potential for the provision of more seamless care across primary and secondary care.

Secondary and specialist health care

- 2.5 The **Newcastle upon Tyne Hospitals Trust (NUTHT)** provides the overwhelming bulk of secondary and specialist health care services (apart from mental health, neuro-disability and learning disabilities). It is a 3-star Trust with an excellent reputation in a wide range of specialties, and provides tertiary services to the whole of the Northeast and sometimes beyond.
- 2.6 The Trust is in the final stages of securing a substantial PFI deal to complete the implementation of the Newcastle Strategic Review. Whilst this will bring substantially improved facilities to the City it also has significant cost implications.

SECTION 2 – PARTNERSHIP WORKING

- 2.7 The **Newcastle, North Tyneside and Northumberland Mental Health Trust (3Ns)** provides specialist mental health services. The Trust has some leading edge services but also areas where performance needs to improve and significant investment is required. Primary care looks after large numbers of people with enduring mental illness but has not seen investment to match this. Significant work has begun to reshape services for people with severe mental illness. The Trust also provides a range of services for older people. It is planned that these will move to the PCT to be incorporated into a single, integrated service for older people from 1 April 2005.
- 2.8 Services for people with learning disabilities are provided by **Northgate and Prudhoe NHS Trust** which also provides services through the neuro-rehabilitation centre at Hunter's Moor Hospital. The latter is due to be reprovided into new facilities in Walkergate by the end of 2006. Northgate and Prudhoe still provide long-stay accommodation for a number of people and active plans are being developed to resettle these people into more appropriate accommodation in the City.

Social care services

- 2.9 The PCT is co-terminus with the City Council and there is strong partnership working between the Council and the NHS. Plans for integration of services have been implemented in some areas, notably mental health, and are well advanced in others for example older people's services. There is ongoing progress towards the objectives set within the established Children's Trust.
- 2.10 Social services face significant pressures with high levels of demand for services, for example nursing home care leading to some financial pressures. Nonetheless the Department provides high quality care and has recently had its 3 star status re-confirmed.

The Local Strategic Partnership

- 2.11 The Newcastle Partnership is the local strategic partnership (LSP) for Newcastle. Under the Local Government Act 2000, Newcastle City Council has to produce a Community Strategy to promote the social, economic and environmental wellbeing of the city. It does this in partnership with other public sector agencies, and private, community and voluntary sector groups. The PCT plays a key part in the LSP and in nine themed groups which include Health and Social Care, and the Children and Young People's Strategic Partnership. The PCT's Chair is Chair of the Health and Social Care group (the Health Partnership).
- 2.12 Targets and actions in the Newcastle Plan are closely linked to those of the national NHS agenda. Key aims of the targets set within the LSP are to achieve better health for everyone, less inequality in health and high-quality, accessible health and social care services. Actions agreed jointly with the LSP include:

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- Support disadvantaged people and communities suffering from health inequalities;
- Promote sexual health;
- Promote positive mental health and stress reduction;
- Inform people about the risks of smoking, alcohol and obesity, and the benefits of exercise;
- Support vulnerable people to live in their own homes wherever possible;
- Support carers in their caring role; and
- Support families and protect children and adults from abuse and neglect.

2.13 Targets set by the LSP relating to the health of the Newcastle population include:

- 25,000 homes will be better insulated and warmer by March 2007;
- 30% of people in the city will take regular exercise;
- In 2006-7, 50% more people with problems linked to their use of drugs will access treatment services;
- Newcastle will continue to have one of the highest proportions of vulnerable adults and older people cared for in their own homes, compared with other English cities;
- We will see an improvement in patients' views about access to information and services, choice and waiting times;
- By 2007 we will see a downturn in our teenage pregnancy rate;
- By 2007 there will be a city centre-based walk-in sexual health centre incorporating contraception, sexual health and GUM services;
- Kenton, Brunton Park and Walker will have new health and community facilities by the end of 2005; and
- At least five public spaces will be smoke-free by the end of 2007.

The Newcastle Children and Young Peoples Strategic Partnership

2.14 Newcastle Children and Young People's Strategic Partnership (C&YPSP) aims to be inclusive while providing robust partnership arrangements that add value to single agency functions. To ensure that the requirements of the Children Act 2004 are met and that the outcomes for children identified within Every Child Matters and the Children's NSF are met, an executive group of commissioning agencies, including voluntary sector representatives, led by the (acting) Director of Children's Services, was established in January 2005.

2.15 Responsibilities include governance and information sharing, mapping and needs analysis, integrated commissioning and strategic planning, development of the Newcastle Children and Young Peoples Plan (for 2006) and implementation of the Participation Strategy with children and young people. Commissioning responsibility for specific functions is delegated where appropriate e.g. Children and Young Peoples DAT, Teenage Pregnancy, Children's Trust Pathfinder. Quarterly outcome sessions which focus on cross agency delivery of key

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outcomes will be held from March 2005 with relevant partners, voluntary and community sectors, parents, carers and children and young people.

- 2.16 An annual stakeholder conference aims to raise issues that need to be addressed in future plans and review progress against the Children and Young people's Plan. The second annual conference will be held in February 2005. Underpinning this process is work based on the Investing in Children Model which ensures active involvement of children and young people across the children's services agenda.
- 2.17 The five outcomes described in the Strategy for Children and Young People have been accepted by all partners. Outcome based accountability is the process that will be used to determine the effectiveness of services in terms of improving outcomes for children and young people.
- 2.18 A range of resources are provided by the PCT to support this process including dedicated director and lead officer time and a jointly funded disabilities manager. In addition, the PCT are key partners in the development of the Children's Trust Pathfinder (with a dedicated senior manager) , the associated FAME/LinkIT development which has been recognised nationally as an example of excellent practice, and the Gateshead/Newcastle ISA trailblazer. Significant financial contribution is also made to support the work of the current ACPC, the C&YPSP and implementation of the participation strategy.

Voluntary Sector Partners

- 2.19 The Voluntary Sector is an important partner in the delivery of local services. Both the NHS and the Local Authority commission a range of services from Voluntary Sector Providers. During 2004 these arrangements were strengthened through the development of a Local Compact between the statutory and voluntary sector. Work is commencing to understand the contribution to key targets of voluntary sector organisations, for both PCT and non-PCT funded bodies.

Involving Patients, Carers and the Public

- 2.20 Most people are either a patient or a carer at some time or another and everyone has an interest in how his or her healthcare is provided. Working more closely with the public so that patients, service users and carers can influence developments is a key theme in modernisation and an important aspect of the Local Delivery Plan. Since the implementation of the Health and Social Care Act 2001 the NHS now has a duty to involve and consult with patients and the public and we are increasingly working to develop effective ways of doing this.
- 2.21 The well established HIMP and other multi-stakeholder modernisation groups have continued to use a variety of methods to ensure appropriate user and public

SECTION 2 – PARTNERSHIP WORKING

involvement in their work, with the Chair of each group charged with ensuring and reporting on compliance with Section 11 requirements. The work of these groups has provided the basis for prioritisation in each service/client group area which has informed the development of the business cases considered.

- 2.22 An exercise has been undertaken with members of the Newcastle Patient and Public Involvement Forum, exploring the PCT approach through PBMA to prioritisation, and engaging members in the scoring system and weighting process used. It is intended that as the PBMA process develops that the PPIF will be actively involved in ongoing prioritisation decisions affecting Newcastle residents.
- 2.23 Discussion is taking place with Community Action on Health as to the priorities for their work over the next year. Of particular note is their involvement in the delivery of the new independent contracts and engagement in ensuring appropriate implementation of Choose and Book policy.
- 2.24 As the Consortium embeds and other organisational changes are established North of Tyne, the supporting structures to ensure appropriate clinician and public engagement in Consortium business will be continually reviewed. This will include discussion with partner PCOs as to how existing mechanisms may best be used to inform the commissioning process.

Communication with stakeholders

- 2.25 The LDP has been developed in discussion with NHS Trusts, other PCOs and partner agencies through existing fora which also have individual mechanisms for public engagement. More recently specific discussions have taken place as the LDP has come close to being finalised and this has included ongoing involvement of the PEC and the Newcastle Clinical Advisory Group. Progress toward implementation of the LDP will continue to be monitored through these groups, as will further refinement of commissioning priorities in future years. The Scrutiny Committee and Patients Forum will also be kept engaged with the ongoing process. Further patch-wide plans for stakeholder communication will be taken forward through the PCT's Communications lead.

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES

3.1 The current agenda facing the NHS is huge. It includes:

- National Programme for Information Technology;
- Choice of provider at point of Referral;
- Modelling to achieve the 18 week target;
- Independent Sector Provision;
- The Public Health White Paper;
- Practice Based Commissioning;
- New contracts for Dentists, Pharmacists and Ophthalmologists; and
- Quality Outcomes Framework.

3.2 The following pages set out a short commentary on each of these initiatives and what actions we are taking locally to deliver them.

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES

NPFIT - NATIONAL PROGRAMME FOR THE NHS

- 3.3.1 The National Programme for IT (NPfIT) is without doubt one of the biggest implementations of change that the NHS has ever attempted. The concept is to move away from a number of separate information systems based primarily around organisational structures and with which health and social care professionals interact, to a situation in which professionals are provided with an Integrated Care Records Service.
- 3.3.2 As part of the implementation, GP Practices will migrate their existing data into the new application. Because Data Migration is linked to application development and deployment this work has been restricted.
- 3.3.3 Overall the Primary Care project has a number of problems. Problems and possible actions have been reviewed by the North of Tyne Projects Board on the 7th December 2004. The Board decided that the 5 practices should be given the following options considering the issues they have faced: -
- Continue with the National Programme and wait until the P1R1b application is available. This could be April 2005 but this has not been confirmed.
 - Procure and Implement a standalone system : either Torex Synergy or Phoenix Primary Care. NPfIT will meet all costs due to failure to deliver. The Practices will then move towards the National Application at a later stage.
- 3.3.4 Early discussions suggest that practices will take option (b) and deploy Torex locally.

Single Assessment Process (SAP)

- 3.3.5 In response to the National Service Framework requirement for Older people having a joint assessment between health and social care professionals, Northumberland Care Trust, North Tyneside PCT and Newcastle PCT are implementing an NPfIT Single Assessment System called "Liquid Logic". This will be the first NPfIT system to be deployed across multiple organisations.
- 3.3.6 There are a number of Health and Social Care Professionals and Teams involved in the delivery of older person services North of Tyne. In the first phase of the SAP Project, teams within North Tyneside, Northumberland and Newcastle would access the new system and create joint assessments and make electronic referrals.
- 3.3.7 Within North of Tyne key users have been the first nationally to gain access to the Liquid Logic application. A number of assessments and referrals have been made and there is a partial user base. Deployment and connectivity is still on going in Newcastle and only once all users are active will the project fully 'GO-

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NPFIT - NATIONAL PROGRAMME FOR THE NHS

LIVE'. There have been a number of lessons learned about the process and contract issues. This will support future projects.

Helpdesk

- 3.3.8 A North of Tyne interim helpdesk has been implemented providing a 24x7 service to users of NPfIT systems, and hosted by Northumbria Health Care Trust. A working group which consists of a nominated representative from each of the organisations North of Tyne has been set up with the objective of establishing a more final solution.
- 3.3.9 The main users of NPfIT to date are users of the SAP system. An aide memoire has been distributed for these staff to assist them in the following areas:
- Logging into the system;
 - Loss of Smart Card;
 - Resetting smart card password; and
 - Reporting a problem to the helpdesk.

Registration Authority

- 3.3.10 The "Registration Authority" is the process of checking the identity of individuals who will access NPfIT systems, assigning a role to these individuals, and allocating electronic security smart cards to these individuals. These cards will then be used to gain secure access to NPfIT systems via swipe-card readers attached to PC keyboards.
- 3.3.11 Work has been slower than anticipated on Registration Authority due to issues with the release of staff and the unreliability of the Card Management Service. The technical problems with the Card Management Service have now been resolved by NPfIT.

Issues for North of Tyne

- 3.3.12 The North of Tyne Programme will impact on a number of organisations. There is a need to work together to support services that are designed around the patient not organisations. Early Adopter work in SAP and Primary care has highlighted the need for a Central Deployment Team that can support organisations during their implementations. The central deployment team will complement existing resources and provide common roles across numerous projects. This will allow North of Tyne to recruit key staff on longer contracts, providing consistency and stability to the overall programme, while ensuring that North of Tyne keep key skills and experience that are developed during implementations. Organisational Resources are limited and it is difficult for them

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES

NPfIT - NATIONAL PROGRAMME FOR THE NHS

to support multi-organisational deployments as well as support their existing workloads. In addition:

- A North of Tyne Helpdesk is needed to support NPfIT application user. This needs to be a 24/7-service facility. This service will clearly need to link very closely with existing helpdesk provision;
- A North of Tyne Registration Authority needs to be created that can support the creation of Smart Cards and allocation of roles. This needs to be a joint approach so Organisational staff can use any facility for registration or to get replacement cards. This needs to be linked to the North of Tyne Helpdesk;
- A North of Tyne NPfIT Programme Manager has been appointed to review current arrangements and create and define an effective implementation model that can be used to ensure that the NPfIT Programme is achieved North of Tyne; and
- In order to deliver a single record across both health and social care it is important to form an 'NPfIT Partnership Approach'. The concept of a Care Record Service is to provide integrated clinical and social information systems across the whole care continuum.

3.3.13 The North of Tyne Programme will introduce through project delivery a number of benefits. Benefits management provides the North of Tyne organisations with a target and means of monitoring achievements against that target on a regular basis. Projects should be aimed at benefits delivery and positive outcomes, it should not be about the technology being deployed.

3.3.14 Information measured against the benefits will show whether the programme is a success North of Tyne. It is important that benefits management is a core activity and a continuous management process that each organisation has at the centre of its project delivery arrangements. In practices users understand benefits more than the technology that will be deployed, and this can be a very effective way of gaining buy-in and support.

3.3.15 A key requirement of organisations Local Development Plan is for North of Tyne to create a benefits plan for benefits management. These arrangements will cover:

- How North of Tyne will define the expected benefits from the programme;
- How benefits will be achieved and measured;
- Allocation and responsibility for successful delivery of benefits; and
- Monitoring the achievement of benefits using a clear well defined process.

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES

CHOICE OF PROVIDER AT POINT OF REFERRAL

- 3.5.1 This major organisational change introduces a number of challenges for the health community. From December 2005 Elective Patients can expect:
- To be offered a choice of four or five hospitals or suitable alternative providers;
 - To be able to book their appointment with their preferred provider;
 - Information to be available locally to inform their choice;
 - To be supported in making their choice by their GP or PCP; and
 - Aftercare/rehabilitation provided locally following any hospital treatment.
- 3.5.2 PCTs are responsible for implementing Choice and the necessary systems. Secondary Care will be responsible for ensuring appointment bookings are honoured. This means development of clinical governance and service provision arrangements. The policy identifies a number of benefits:
- For patients: improvements to patients' experience and influence leading to a more personalised health service plus greater convenience and certainty which will reduce the stress of the referral process;
 - For GPs and PCTs: a reduction in enquiries regarding appointments and a reduction in bureaucracy in the existing referral processes; and
 - For Secondary care: a reduction in DNAs and cancellations, a reduction in administration of the existing process and a more consistent approach to the format of referral letters.
- 3.5.3 Patients will choose a provider for the whole of their elective care episode. This will include an initial outpatient appointment and any subsequent treatment. However aftercare and rehabilitation services should normally be delivered locally, providing greater convenience for patients. PCTs will be expected to provide information to enable patients to make an informed choice. Key factors include waiting times, location and convenience of the hospital, patient experience and clinical quality.
- 3.5.4 Waiting Times introduce the dynamic element of commissioning. Patients can expect to be offered a choice of Providers able to provide appointments within maximum waiting time targets. Providers should provide appointments up to 13 weeks in advance. PCTs will need to monitor referrals to ensure patients are able to choose appointments within maximum waiting times. Trusts that prove more popular and receive additional referrals may be able to increase activity to enable them to treat the additional patients within the maximum waiting time. PCTs should support this. Patients currently eligible for free transport will continue to be eligible for free transport to any of the hospitals on their PCT's choice menu.

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES

CHOICE OF PROVIDER AT POINT OF REFERRAL

3.5.5 There are some exceptions:

- For some treatments with real capacity constraints, it may not be possible to offer the full range of 4-5 choices. PCTs will need to seek SHA agreement to offering reduced menus for such treatments;
- Services where speed of access to diagnosis and treatment are particularly important: e.g. emergency attendances/admissions, Rapid Access Chest Pain Clinics, Cancer 2 week waits; and
- Some limits on choice may also be appropriate for paediatric services where it may not be possible to offer choice for all referrals, particularly for referrals requiring more specialist interventions.

3.5.6 The delivery of Choose and Book will fundamentally change the way in which services are planned and provided, and radically redesign patient pathways. A group has been established North of Tyne to take forward Choose and Book, led by the Consortium, representation from each PCO. There are a number of key issues to consider North of the Tyne in term of patient and clinical engagement, and governance arrangements to implement the programme.

3.5.7 Choose and Book will have a major impact on commissioning and introduces the need for much more flexible contracts, greater monitoring and, coupled with Payment by Results, introduces risks for both PCTs and Providers. It necessitates radical redesign of existing processes and patient pathways. Additionally the programme is dependent on Ebooking – a major project in itself with some key dependencies on the NPfIT.

3.5.8 Implementation is phased and this has been built into our plans

- From **January 2005**, cataract surgery patients;
- From **April 2005**, patients who need a heart operation; and
- By **December 2005**, all patients.

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES

MODELLING TO ACHIEVE THE 18 WEEK TARGET

- 3.5.1 The Government has set a target that no-one should wait for more than 18 weeks from diagnosis to treatment by March 2008. It has therefore been necessary to prepare a capacity plan to determine how much additional activity will be required to be delivered in order to hit this target by the required date.
- 3.5.2 Meeting the 18 week target will require new patient pathways and ways of accessing services that differ from the historic route of GP referral – out patient attendance – diagnostics - in patient treatment. These will be designed and commissioned through the Consortium's Care Stream model which is outlined on page 8.
- 3.5.3 The three PCTs across the Consortium approached the capacity planning exercise on a partnership basis to determine the activity we would require from our two main providers – Newcastle upon Tyne Hospitals Trust and Northumbria Healthcare Trust. This has been supported by the two acute Trusts as part of their support to Consortium working. The assumptions and modelling underpin the LDP process in line with national guidance.
- 3.5.4 A number of models were jointly developed using varied growth assumptions based upon national guidance and local trends, and the final model selected on which to base our future commissioning plans represents the upper limit of demand. The model used differential local variations to reflect the nature of activity patterns at the two main acute provider Trusts:
- NUTHT is a major tertiary centre with a higher level of non-elective admissions – e.g. as a result of care pathways across Trusts, followed by tertiary treatment. Therefore the model uses the national assumptions; and
 - NHCT covers a wide geographical area across several sites, and analysis of its recent years' activity suggests growth rates well in excess of the national model. Whilst it is assumed that these growth rates will not continue at present rates (as issues of demand management and service modernisation are addressed), it would seem prudent to use growth rates of 5% for both in patients and out patients.
- 3.5.5 A productivity gain of 1% per annum was assumed and reflected in each year's capability in line with the national model. The model should therefore be viewed as setting the upper level of expected growth and is supported by the acute Trust organisations as appropriate for planning assumptions.
- 3.5.6 There are a number of other factors that may have local impact upon capacity and access. For example:

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES MODELLING TO ACHIEVE THE 18 WEEK TARGET

- The nGMS focus upon chronic disease management may improve patient stability, reduce acute and chronic exacerbations and the requirement for secondary care intervention;
- Enhanced services may support the transfer of activity from secondary to primary care and offer an opportunity to better manage demand and reduce activity in secondary care (e.g. MAST scheme);
- PCO-commissioned primary care out of hours services may reduce non-elective admissions;
- Improved urgent care arrangements and chronic disease management may further restrict non-elective demand; and
- All PCOs are developing case management programmes for those with chronic diseases currently resulting in multiple admissions.

3.5.7 These factors will militate against projections for future activity requirements but it is difficult at this stage to quantify the extent of their impact. There are also opportunities to look at capacity across the two acute Trusts. The increased capacity assumptions in the schedules have been based on two key points:

- It is assumed current SLA activity levels will be delivered; and
- acute Trusts will achieve a 1% p.a. productivity gain in line with the NHS Improvement Plan.

3.5.8 Diagnostics will be a key element of achieving the 18 week target and is already subject to independent sector provision. The Consortium will look to develop care pathways to accommodate diagnostics and utilise IS provision where needed, if capacity cannot be delivered by local organisations. In addition we propose increased direct access from GPs to diagnostic tests through Primary Care Commissioning, and protocol driven pathway management could reduce secondary care service demand. There is a commitment to minimise diagnostic waits in all provider areas and this is to be achieved through a combination of commissioning and service modernisation and redesign. Modernisation of the diagnostics pathway will be further supported through the development of robust and accurate data collection and there is a commitment to working in partnership to develop this area.

3.5.9 As a result of this work, the forecast demand and capacity shortfall shows an estimated increase in capacity required of 21,449 inpatient episodes and 17,858 outpatient episodes across the North of Tyne patch, broken down as follows:

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES MODELLING TO ACHIEVE THE 18 WEEK TARGET

	Current Capability 2004-05	Forecast Demand 2007- 08	NHS Capacity 2007-08 Incl. 1% pa productivity	Capacity Shortfall 2007-08
OP first attendances	214,949	239,320	221,462	17,858
Elective Ord FCEs	31,858	35,311	32,823	2,488
Day Case FCEs	86,290	96,478	88,905	7,573
Non-elective FCEs	115,838	130,736	119,348	11,388

3.5.10 Given the track record of local Trusts and PCTs it is assumed that this capacity gap can be met locally via a variety of solutions such as:

- Modernisation of services;
- Service reconfiguration;
- Sweating the Assets; and
- Additional activity.

3.5.11 It is therefore assumed that the additional requirement will be delivered locally with little recourse over and above that already committed to the independent sector.

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES INDEPENDENT SECTOR PROVISION

National procurement of elective activity

- 3.6.1 Considerable work has been undertaken to address DH requirements to provide 15% of elective activity in the Independent Sector. Following an announcement by the Prime Minister, a further investment of £500m nationally will be made in the Independent Sector to increase capacity, reduce waiting lists and to add further elements of choice into the NHS.
- 3.6.2 The initial SHA capacity return to DH identified that additional capacity could be delivered through efficiency savings, service modernisation and additional commissioned NHS activity. No requirement for Independent Sector activity was identified above that already committed. The NTW track record and current excellent performance on waiting times were acknowledged, but DH remain concerned that the capacity plan excludes additional Independent Sector requirement. Additional guidance on how this process will proceed is awaited.
- 3.6.3 There is ongoing debate regarding the approach to diagnostics. The SHA plan to increase MRI provision is understandable, however we are also considering provision of a whole Radiology Service in the Independent Sector and members will be updated on progress in this area. Again, additional guidance on how this process will proceed is awaited.
- 3.6.4 A number of issues remain regarding how this additional activity can be afforded and the Consortium has made the position clear that we cannot invest in the Gateshead Treatment Centre as well as investing in the Independent Sector. The SHA need to resolve this issue before the national procurement process commences.
- 3.6.5 Issues in terms of public and clinical involvement and PCO duties in relation to section 11 are still outstanding. This has been raised with DH and a response is anticipated from the National Implementation Team. PCOs will need to develop a local communications strategy and there will be a number of sensitivities that will need to be handled. These issues have also been flagged with the SHA and PCOs will need to consider the overall approach.

Provision of Day Case Surgery by the Independent Sector

- 3.6.6 A national contract has recently been signed with Capio Healthcare UK to provide elective surgery, in eight different locations, (known as Gaps), as part of the DH's ISTC Programme. PCT Chief Executives in Northumberland Tyne and Wear signed a Project Agreement for this scheme in April 2004. The scheme across the patch involves the commissioning of 2,016 day case procedures in each of five years commencing 2005-06. There is some flexibility in the casemix

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES INDEPENDENT SECTOR PROVISION

in years two to five of the contract. The activity has been divided equally across the six PCTs and Newcastle PCT there has access to 336 day cases in 2005-06.

- 3.6.7 The costs to local PCOs will be £1.32m in total in 2005-06, rising to £1.74m in the final year - this equates to £220k- £290k per year for each PCO over the five year period. As part of the terms of the contract, PCOs will have to pay Capiro irrespective of whether the slots are filled.
- 3.6.8 Capiro is constructing a facility on Cobalt Business Park in North Tyneside which will have two theatres, and an annual capacity of approximately 4,000 day cases. Capiro will staff and run the centre. Referral protocols are currently being developed with stakeholders and a communications plan led by the SHA has been developed. The facility is scheduled to open on 1 June 2005.

Cataract Choice and Provision of Surgery by the Independent Sector

- 3.6.9 From 31st January 2005 PCTs are expected to offer Choice of at least two providers for cataract surgery, increasing to up to five providers by December 2005 in line with roll out of the national Choose and Book Policy. Cataract choice is the first step to achieving the milestones for full booking and choice at point of referral set within the Choose and Book Framework.
- 3.6.10 Across the SHA there are only two providers available to us at present - Newcastle Upon Tyne Hospitals and City Hospitals Sunderland. Both Trusts have relatively short waiting times and as experience of choice at six months has shown us patients only choose an alternative to their local provider if it will benefit their waiting time we anticipate few patients will choose the alternative to their local Trust. That said we do recognise that where patients live on geographical boundaries there may be convenience factors for them in choosing where they are referred. Local referral and communications systems are being put in place to support this initiative and the system will be live in order that the 31 January 2005 deadline is met.
- 3.6.11 As part of the national initiative to increase capacity so that waiting time targets can be achieved, independent sector providers have been introduced by the DH to provide capacity for cataract surgery. NTW SHA area was included in the national procurement which has resulted in an independent provider – NetCare – being awarded a contract for five years to deliver cataract surgery. This will commence in NTW in January 2006, with 2,000 cases across the six PCTs being delivered by March 2008. As part of the terms of the contract, PCOs will have to pay NetCare irrespective of whether the slots are filled.

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES PUBLIC HEALTH WHITE PAPER

- 3.7.1 The White Paper details the strategic direction for improving health and preventing disease. A more detailed delivery plan is expected in early 2005. The key principles underpinning the paper are:
- Informed choice – leading to increased motivation and willingness to change;
 - Ensuing that those at disadvantage have opportunities to improve their health;
 - Protecting people’s health from the actions of others;
 - Recognising the specific needs of children and young people;
 - Providing collective support to create a health-promoting environment;
 - Empowerment and support;
 - Personalisation; and
 - Partnership.
- 3.7.2 Most aspects of this legislation will impact on the PCT in one way or another, and we already have plans to address a number of the key areas. These are set out in detail on page 46 in Section 5.

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES PRACTICE BASED COMMISSIONING

- 3.8.1 Practice Based Commissioning (PBC) is seen by the PCT as an important tool to enable better engagement with general practices. Not only can PBC engage referrers in the management of scarce secondary care resource but it can also ensure that the expertise and knowledge of primary care clinicians can be harnessed to develop and design services which best meet the needs of patients delivered wherever possible from community settings, in line with our vision for integrated services in Streams of Care.
- 3.8.2 There are a number of risks relating to injudicious implementation of PBC guidance which potentially might jeopardise the delivery of capacity plans, destabilise organisations and increase health inequalities and 'post-code rationing', and the PCT has worked closely with clinical members of the Professional Executive Committee and our other GP advisors to ensure the fullest understanding of our objectives and anticipated benefits as well as inherent risks. A set of principles have been agreed within which our approach to PBC can develop which seek to maximise the benefits and minimise risk.
- 3.8.3 A number of meetings have been held to discuss the approach with GPs, community nurses and other stakeholders. A project manager has been identified, and work is underway to gather the activity and financial information necessary to support PBC and to identify those areas where greatest benefit can be achieved from the approach. The PCT and clinical advisors are mindful that PBC is one of many tools available to us to achieve our objectives and that this work must not be seen in isolation from these, and from work to deliver on other key policy areas such as Patient Choice.
- 3.8.4 It is anticipated that PBC will be undertaken within a common PCT framework through our localities, with clear linkages to the LDP and will initially concentrate on a small number of areas, evolving over time to enable greater coverage of commissioned services.

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES NEW CONTRACTS FOR PRACTITIONERS

Dentistry contract

- 3.9.1 The Health and Social Care Act has given the Primary Care Trust powers to secure provision of Primary Care Dental Services allowing the introduction of open access appointment for emergency care. Recent instructions from the Department of Health have moved the full implementation date of the general dental contract to April 2006. Work will therefore continue to encourage practices to use the Primary Dental Care Services (PDS) route to access the benefits proposed for the new contract.
- 3.9.2 Excellent progress has been made on the move of practices to PDS and a programme is in place to convert a high proportion of practices to PDS prior to the implementation of the general dental contract. Establishment of a working group with involvement from LDC members is helping move this agenda forward. Involvement of commissioners in the working group will allow the transition to a commissioned service in 2008. The change in service delivery is also having a positive impact on the Community Dental Service allowing a more cohesive approach to the provision of dental care across the city.
- 3.9.3 The new contract offers opportunities to consider provision of other services e.g., Dentists seeing themselves ideally place to provide a smoking cessation service. Guidance is awaited to inform the process for the transfer of Orthodontics to PDS status.

Pharmacy contract

- 3.9.4 The new Pharmacy Contract will open up new ways of service delivery for the Primary Care Trust to consider, which are likely to have very positive impacts on the new GMS contract, choice, public health and chronic disease management. The new Pharmacy Contract framework comprises:
- Essential services which will form the core of the contract and will include:
 - Dispensing
 - Repeat dispensing
 - Disposal of medicines
 - Promotion of healthy life styles
 - Promotion of self care for patients with minor ailments
 - Signposting for patients to other healthcare providers.
 - Advanced services (previously known as enhanced). It is anticipated these services will be provided from most pharmacies once appropriate training and accreditation are in place. The initial service will be medicine use reviews and prescription intervention services.

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES NEW CONTRACTS FOR PRACTITIONERS

3.9.5 Enhanced services will be commissioned locally by PCTs depending on local patient need and priorities. It is expected service specification, benchmarking and pricing will be developed nationally, and examples include:

- Minor ailments scheme;
- Smoking cessation;
- Services to support chronic disease management packages; and
- Development of Out of Hours Services.

3.9.6 Newcastle PCT is currently undertaking a pharmaceutical needs assessment to inform the process. Despite the implementation of the new contract target being 1st April 2005, PCT's are still awaiting the guidance from the Department of Health. Due to this lack of guidance it is presently impossible to predict any cost pressures.

Optometry contract

3.9.7 The *'Choose and Book – Patient's Choice of Hospital and Booked Appointment'* policy guidance states that "PCTs are expected to offer a choice of at least two providers for cataract surgery from January 2005 increasing to a choice of 4-5 providers by December 2005". Details of our overall approach to choice at point of referral have already been outlined on page 19.

3.9.8 Cataract choice is an opportunity to test and adopt new ways of working and delivering services to patients rather than fitting choice into existing systems. The PCT established a local Eye Health Development Group early 2004. The group covers the RVI catchment area of Newcastle, Northumberland, North Tyneside and Gateshead. The remit of the group is to:

- create a local 'Eye Health' clinical governance network and promote effective communication and co-operation within the network;
- promote the creation and development of inter-professional clinical care pathways;
- stimulate the development of inter-professional support between relevant organisations; and
- establish mechanisms to ensure the creation of robust clinical governance systems across primary and secondary care.

3.9.9 Work areas for continuation and further development in 2005-06 include:

- Development of guidelines to support good practice e.g. ARMD and red eye;
- Potential pathways to support enhanced care in the community by optometrists e.g. for cataract and glaucoma. These proposals build on the recommendations of the National Eye Care Services Steering Group. Both

SECTION 3 - DELIVERY OF NATIONAL INITIATIVES NEW CONTRACTS FOR PRACTITIONERS

nationally and locally it is recognised that this will require additional funding as part of Local Delivery Plan proposals; and

- Reviewing the provision of low vision services proposing an appropriate shift in responsibility for from secondary to community care.

Quality Outcomes Framework (QOF)

- 3.9.10 The PCT views the QOF as the central plank for quality improvement/clinical governance for our general practices and we are delighted with the excellent achievement to date. We seek to build on the incentives provided through the QOF and prescribing schemes through the introduction of practice based commissioning to extend quality improvement into aspects of secondary care (and other) resource utilisation.
- 3.9.11 The QOF visiting process has been viewed as facilitative and productive by practices, who have been able to learn from each other and share good practice. During next year we hope to be able to focus the visits further and potentially encompass other aspects of quality building on the learning of the joint visits undertaken by Community Action on Health and the Community Health Council in recent years. We will monitor the overall performance for the PCT in the various domains, benchmarking our results and setting ourselves targets for 2005-06 based on our end of year performance for 2004-05.
- 3.9.12 The investment in enhanced services for 2005-06 has increased as a result of additional investment in some mental health support services and pharmacist support and is well over our required financial floor. Over the next 12 months we will be reviewing the overall provision of these enhanced services to consider how these can be best used to assist in demand management and provide a comprehensive infrastructure to support community based provision. In particular services to support refugees and asylum seekers will be comprehensively reviewed in order to ensure access to all parts of the city from nurse led provision.

SECTION 4 – NATIONAL AND LOCAL TARGETS

4.1 This Plan sets out planned service improvements in health and social care for the local population across Newcastle for 2005 to 2008 in which:

- standards are the main driver for continuous improvement in quality;
- there are fewer national targets;
- there is greater scope for addressing local priorities;
- incentives are in place to support the system; and
- all organisations locally play their part in service modernisation.

4.2 The National Planning Framework confirms that the responsibility for assessing and reporting on the performance of PCTs, Trusts and Foundation Trusts rests with the Strategic Health Authority, and the independent Healthcare Commission which published its assessment criteria in November 2004. The PCT has therefore undertaken a risk assessment exercise against current levels of local compliance/achievement against existing targets and the new standards. The list of targets has been split between those related to Primary Care and local authority colleagues, and those for which the Consortium will take the lead although, in many cases, actions are interlinked.

The targets are split into two areas:

- Existing targets which we are required to meet in 2004-05 and maintain in future years; and
- New targets set out in the Department of Health's (DH) paper "*National Standards, Local Action*".

4.3 The main areas of risk to the PCT are:

- **IM&T targets** relating to delivering broadband access to NHS net (target R15), implementation of the electronic booking (target R16) and implementation of the National Prescriptions Service (target R17). Hitting each of these targets is dependent on the successful and timely implementation of the National Programme for IT (NPfIT) which is already subject to considerable slippage. Dependences on an external supplier are flagged as a major concern, and we still require confirmation of timescales. We therefore consider hitting each of these targets to be an area of high risk;
- Mental Health target (T16) relating to **Early Intervention in Psychosis**. We have set out on page 39 of this plan our investment proposals in this area;
- Achieve agreed **local teenage conception reduction targets** while reducing the gap in rates between the worst fifth of wards and the average by at least a quarter in line with national targets. The teenage conception rate in Newcastle is not yet falling in order to meet the national target. A newly formed strategic partnership and a reconfigured strategy will refocus the work, provide a more robust evaluation mechanism and drive forward a range of initiatives. We are currently examining what these will deliver in

SECTION 4 – NATIONAL AND LOCAL TARGETS

terms of reductions in conception rates, but at present consider this target to be high risk; and

- **Suicide rates** - Newcastle has completed significant work in relation to the reduction of suicide contained in the suicide strategy this includes 3 year training programme, comprehensive suicide audit, multi agency suicide forum, NICE prescribing protocols for anti-depressants, risk assessment protocols, media articles, and currently the local authority is planning plaques for the bridges over the Tyne with contact details for the Samaritans. Despite this work which is recognised regionally there is no evidence of a significant trend in the reduction in suicide rates. Data available is for 2002/2003 and this may not fully reflect the impact of the above actions. More audit will be undertaken on suicide outcomes to see if any further progress can be made.

4.4 Annex A shows the trajectories for each of the targets together with a short commentary. Each trajectory will be updated quarterly in order to inform progress towards hitting target deadlines, and enable us to identify any pressure points.

Local Authority targets

4.5 There are four indicators we share with the local authority:

- Delayed discharge
- Community loan equipment
- Emergency admissions
- Older people supported to live at home

4.6 There are two targets for which the local authority is responsible but the PCT's actions impact on their delivery. These are:

- Health of children looked after
- Adults helped to live at home (three separate indicators)

4.7 In addition there are four targets whose responsibility rests with the PCT, but where the actions of the local authority make a significant contribution:

- Drug misusers
- Teen conceptions
- Childhood obesity
- No growth in readmissions

4.8 As already outlined there is strong partnership working between the Council and the PCT and we will work together to ensure that these interdependent targets are met.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

5.1 This section sets out

- how we approached prioritisation of the finite financial resources available to us; and
- a commentary of each of those areas we have identified for investment.

PBMA PRIORITISATION EXERCISE

5.2 The “Vision” documents of both the PCT and the SHA outline a whole system approach to commissioning and service delivery which incorporates notions of:

- value for money;
- cost-effective solutions;
- having to make significant investments which imply ‘efficiencies’ and, perhaps, reductions in some services; and
- treating all proposed developments and reductions fairly.

5.3 This requires a commissioning prioritisation framework which:

- recognises that resources are scarce and not all health care needs can be met;
- will lead to an efficient and integrated system through better use of existing resources; and
- have the flexibility to engage clinicians and incorporate public views and political considerations.

5.4 Programme Budgeting and Marginal Analysis (PBMA) offers such a framework. Implementation of the PBMA process enables:

- decision-makers to direct resources in order that the impact of health care on the health needs of the local population is maximised within existing budgets;
- identification of which services to fund, and which services to re-design to release resources, by explicitly comparing alternative uses of the limited resources available;
- a hands-on approach that does not take place in isolation from other managerial activities and processes; and
- other information to be used to aid decision making, e.g. needs assessment, examination of published evidence (including of relevant literature; research projects), the input of local data, the views of the public and local knowledge and expert opinion of managers and clinicians.

5.5 The methodology is very different to the traditional way that the PCT has approached prioritising its finite financial resources in previous years. Our approach has been to:

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

- develop and agree a set of weighted criteria for assessing options for service change;
- identify the information requirements for undertaking a macro-level PBMA and producing a PBMA 'Fact Pack';
- develop a process for generating, assessing, and ranking business case options for resource investment, resource release, and resource neutral service re-design;
- prioritise options for investment in services to meet national and local PCT targets; and
- Use the above to inform the development of the LDP and SLAs for 2005-06.

5.6 The prioritisation exercise was conducted in partnership with colleagues from the two other PCTs in the North of Tyne Commissioning Consortium, and two lists of investments – one for Consortium-wide developments and one for Newcastle PCT – were drawn up and scored by both PCT colleagues and members of each PCTs' PEC. The output from the scoring has produced a cost:benefit ratio for each proposal.

5.7 For Newcastle PCT, the outputs from this exercise highlighted the following areas in which we propose to invest funding over the next three years:

- Elective access to secondary care
- Mental Health Services
- Older People's Services
- Learning Disabilities resettlement
- Tobacco Control
- Public Health White Paper initiatives
- Child and Adolescent Mental Health Services (CAMHS)
- Non-elective pressures/Out of Hours service
- Looked after Children
- Specialist Weight Management Service;
- Digital Hearing Aids;
- Diabetic Retinopathy Screening; and
- Provision of Locality based services.

5.8 A short commentary on each of these areas is set out on the following pages:.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

ELECTIVE ACCESS TO SECONDARY CARE

- 5.8.1 Whilst the PBMA exercise has shown that there is a need for investment into access it is clear from modelling work undertaken that in 2005-06 the PCT has an opportunity to consolidate the current progress and begin to work through the modernisation and redesign opportunities.
- 5.8.2 Significant progress has already been made in terms of movement towards the NHS plan targets and by the end of March 2005 it is expected that maximum 6 month IP/DC and 13 week OP waiting times will be achieved for Newcastle PCT.
- 5.8.3 Whilst we are optimistic that this is achievable some risks in relation to this have been identified in advance and steps taken to ensure at risk specialties are supported towards the targets stated. Some specialties continue to provide challenges in terms of capacity and demand management and actions have been taken to address these:
- **Trauma and Orthopaedics:** Additional activity has been commissioned for this specialty through GSUP 1 and through Access Incentive Funding. This additional activity combined with the Trusts commitment to delivery against baseline activity targets will ensure this specialty is able to achieve the desired waiting times;
 - **ENT:** A partnership arrangement between NHS providers and independent sector surgical teams (CAPIO) has been established and this again combined with delivery against activity contracts will have a significant impact on the current waiting time position for ENT;
 - **General Surgery:** At end of November the specialty was underperforming against contract and modelling of waiting lists has shown that should this position be reversed to delivery against contract then the 6 month/13 week target is easily attainable; and
 - **Urology, Plastic Surgery and Neurosurgery:** The numbers of over 6 month waiters in the above specialties are very small and there is no indication that the numbers will significantly increase . Management to contract should ensure that they are able to meet a maximum waiting times stipulated.
- 5.8.4 Across all other specialties it is expected that the provider organisations are able to pro actively manage waiting lists to ensure that the year end PCT position can be sustained through 2005-06 without any additional activity needing to be commissioned.

The way forward

- 5.8.5 The NHS Improvement Plan, Putting People at the Heart of Public Services outlines very clearly the driving forces for elective service delivery and the standards NHS bodies are tasked to achieve over the coming years. By

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

ELECTIVE ACCESS TO SECONDARY CARE

December 2005 patients will wait no longer than 13 weeks for a first out patient appointment and 6 months for in patient surgery – a total wait of 39 weeks.

- 5.8.6 By 2008 patients will be admitted within a maximum of 18 weeks from referral by their GP and clearly health service organisations must begin planning and investing now if they are to achieve this demanding timeframe. In addition patients will be given a much greater say in where and how their care is delivered and this can only be achieved via flexible working and a partnership approach between primary and secondary care providers.
- 5.8.7 Capacity modelling work undertaken has shown that within elective surgical services across the North of Tyne Consortium there is a capacity gap which requires filling to allow these challenging targets to be met. The trajectory positions assume consistent reductions in waiting times to inform commissioning decisions. These trajectories further assume that the overall 18 week waiting time excludes diagnostic work up as this will be undertaken in primary care via GP or Clinical Assessment Services prior to referral. This is a significant change from current provision but is consistent with current thinking on Independent Sector provision.
- 5.8.8 Partnership working across NHS and non- NHS will also prove key to the maintenance of target waiting times and consideration should be given to the DH's plans for growth in independent sector activity. From a commissioning perspective this needs careful consideration in terms of relationships with Provider Trusts but does not significantly change the levels of activity to be provided just who the activity is provided by.
- 5.8.9 The commentary on pages 21-23 sets out the capacity planning work that has been undertaken to meet the 2008 waiting time targets. Additional activity will need to be undertaken within the following specialities:
- General surgery;
 - ENT;
 - Urology; and
 - Orthopaedics.
- 5.8.10 A proportion of the additional activity undertaken to meet waiting time targets has related to additional activity commissioned through independent sector providers. In 2005-06 there is an expectation that for some specialties this additional activity will continue to be needed and plans are in places for the following

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

ELECTIVE ACCESS TO SECONDARY CARE

GSUP 2

- 5.8.11 There is a plan in place that has been drawn together in partnership with provider organisations to roll forward GSUP 1 with the same provider and baseline activity numbers. To provide service flexibility the case mix has been adjusted and GSUP 2 is expected to have a more flexible approach. This will enhance relationships with the provider and ensure patients are afforded greater choice in terms of service
- 5.8.12 GSUP 2 will primarily focus on orthopaedic services giving the commissioners and providers the opportunity to work on delivery of a modernised patient pathway that can deliver reductions in waiting times commencing 2006-07.

ACCESS INCENTIVE FUNDING

- 5.8.13 Modernisation of the patient pathway is the key to achieving a better service for patients. In line with the NHS plan this should encompass a secondary to primary care shift to release secondary care capacity and continued appropriate investment in infrastructure to support attainment of performance targets. A full review of the patient journey will be needed and the Planned Care Steering Group will lead this work across the North of Tyne patch. This will include a review of:
- Out patient referrals;
 - Conversion rates;
 - Day case rates;
 - Length of Stay;
 - Referral protocols;
 - New to Review ratios;
 - Theatre Capacity and utilisation;
 - Opportunities for transfer of Minor Ops into primary care settings; and
 - Delivery of out patient review in primary care.
- 5.8.14 Utilisation of GPwSI and professionals allied to medicine in specialist roles will enable patient care delivery in a more convenient and user friendly location for patients and will free capacity within secondary care which in turn will allow attainment of key performance indicators.

RAPID ACCESS DIAGNOSTICS

- 5.8.15 Within the current patient pathway access to diagnostic services is a hidden waiting time for patients. As we move towards the 18 week pathway it must be considered and a move towards greater direct access for GPs and protocol driven assessment within CAS will be essential. Full shift of diagnostic work up of

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

ELECTIVE ACCESS TO SECONDARY CARE

patients to primary care is the preferred option for this as this will allow streamlining of the patient pathway and improve local access in line with modernisation aims.

SUSTAINING HEALTH IN THE COMMUNITY

5.8.16 In collaboration with the stream for Health maintenance it is essential that consideration be given to sustaining health in the community for patients and their families/carers. Anticipated Beneficiaries are:

- **Out patient referrals** – a reduction in primary to secondary care referral rate of 10% per annum could benefit up to 2,200 out patients per annum and would create capacity within secondary care to focus on attainment of significantly lower out patient waits;
- **Day case rates** – an increase in rates of day case procedures from current position to Audit Commission 95%ile could allow an additional 10-15% of patients to benefit from a day case episode in place of an in patient episode. In number terms this equates to between 600 and 800 patients per annum. This will have the added advantage of freeing acute beds giving potential to refocus these on other pressure areas;
- **Length of Stay** – a reduction in pre operative length of stay resulting 20% fewer patients being admitted 1 day or more pre operatively could benefit 5,000 patients per annum;
- **Secondary to primary care activity shifts** – it is difficult to measure without further analysis the numbers of patients that may benefit from this modernisation of pathway management. Areas of good practice from include the use of primary care for routine endoscopy work and within Newcastle a pilot site is currently assessing the potential for roll out of this practice; and
- Historically **endoscopic procedures** can account for 30% or more of surgical day case activity. Assuming this figure in the activity for North of Tyne an estimated 5,000 patients could be treated in primary care.

5.8.17 Whilst we can assume that the above modernisation work will increase available capacity and assist in the management of demand this is difficult to quantify accurately and it is likely that some additional activity will be needed to deal with the sump of additional activity that is needed to meet target trajectories. Given affordability constraints Waiting List Initiative work will need to be undertaken on a specialty basis if the risk of over commissioning is to be avoided.

5.8.18 The changes proposed are likely to result in investment shifts but buy in to these will only be achieved if the modernisation work does not destabilise financially the organisations involved.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 MENTAL HEALTH SERVICES

- 5.9.1 There are two specific areas of mental health services where we propose to invest funding in 2005-06:

EARLY INTERVENTION IN PSYCHOSIS

- 5.9.2 The development of Early Intervention in Psychosis is a core target of DH priorities and planning. Psychosis, predominantly schizophrenia and bipolar disorder, affects many aspects of sufferer's life – education, employment, relationships and overall social functioning.
- 5.9.3 This service is intended to offer health and social care interventions for people between 14 and 35 years of age with a first presentation of psychotic symptoms and for a maximum period of 3 years. It is based upon existing clinical evidence and best practice from both a national and international perspective. The evidence suggests that early intervention is crucial as in the early years of psychosis people may present with the highest risk of serious physical, social and legal harm. 1 in 10 people with psychosis commit suicide and two thirds of these deaths occur within the first 5 years of the illness.
- 5.9.4 The service is designed to reduce untreated psychosis and wherever possible promote recovery during the early course of the illness. This in turn should assist in the prevention of inappropriate use of secondary care services.
- 5.9.5 Our investment in the EIP service will enable us to add to the expansion of local teams delivering services aimed at reducing the duration of untreated psychosis to less than 6 months for these individuals. The team will also assertively manage a cohort of approximately 120 new cases per year which will genuinely improve levels of functioning, reduce the need for hospitalisation, improve prognosis and through a recovery model reduce the burden on the wider health economy through raising the level of opportunity for enjoying a fulfilling life.
- 5.9.6 It is envisaged as this service develops, work will need to be done by way of a remodelling or reengineering of existing services. EIP Services receive referrals from a number of sources: primary care, education, CAMHS, general adult services, YOTs, amongst others. Most notably, we would need to consider the impact of EIP developments on existing mental health services; crisis service, acute inpatient service and CAMHS. As yet a body of evidence has yet to be identified which would indicate the long-term impact on existing services. The Trust however, would be keen to work with our commissioning partners to examine this further.
- 5.9.7 Early intervention has been proven to have positive effects on long-term outcomes. Through preventing delays in uptake of treatment, prompt and active management plans working in partnership with a wide range of stakeholders

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 MENTAL HEALTH SERVICES

offers the opportunity to reduce levels of disability, reduce relapse rates and improve the quality of life of sufferers of psychosis.

- 5.9.8 The agreed way forward will be to continue a phased development approach. This allows for the gradual uptake of cases that would be manageable in light of perceived recruitment problems were there to be a major investment. It also allows for reflection on any recommendations and future planning emanating from the HASCAS review, following which we are contemplating a radical redesign of adult mental health services. Phased development will also help us gauge local need for service and plan service around local people rather than national targets. In the short term existing national targets will not be met neither will expected local need.

PRIMARY CARE MENTAL HEALTH

- 5.9.9 This is a pre-commitment from the 2004-05 LDP. Improving the quality of and access to effective mental health services is a strategic priority for the NHS. One in four GP consultations is with people with mental health problems. The World Health Organisation anticipates that depression will be the second most debilitating disease by 2020 and it is already the third most common reason for consultation in UK general practice.
- 5.9.10 Currently adult mental health services across Northumberland, Tyne and Wear are being reviewed through the Chief Executive Horizontal Working Group. The need to embed mental health in primary care is an emerging theme of the review. Newcastle Mental Health Partnership (MHP) have prioritised the development of primary care services in the overall strategy recognising that without effective primary care services it will not be possible to provide good access to specialist mental health services to people with complex needs. Currently there is very limited mental health capacity in primary care.
- 5.9.11 Current services in primary care include:
- Counselling (commissioned on a sessional basis);
 - Primary care mental health workers (employed by the PCT); and
 - Psychology.
- 5.9.12 At the present time these services are not integrated and function as separate teams. This needs to be reviewed and there is general agreement that some integration of services is necessary to ensure effective use of resources and access to services for people with mental health problems. The proposed service developments aim to increase capacity and capability of PHCTs to identify people with mental health problems, provide treatment and support to manage their illness.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 MENTAL HEALTH SERVICES

- 5.9.13 Our plans are to progress the direct employment of counsellors by the PCT, restructuring current resources to provide an integrated service with a single management structure, protocols etc is developed to maximise access to services. The service developments will include direct employment of counsellors, fund appointments to psychology already made but no further increases in 2005/2006 and to increase the primary care mental health workers as the core of the service within the financial commitment.
- 5.9.14 This will further support the development of specialist CMHTs where it is agreed this cannot be completed until there is an increase in the number of primary care mental health workers. This will increase sessions available for all GP practices of the primary care mental health workers.
- 5.9.15 We are not suggesting that there should be no future investment in primary care psychology, but that this is a sequencing issue, and that for the development of capacity in practices and for the implementation of the specialist community mental health teams that the increase in primary care mental health workers should be the next phase in developing a comprehensive primary care mental health service.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 OLDER PEOPLE’S SERVICES

- 5.10.1 Commitment to integrating older people’s services remains a priority for the PCT and the transfer is planned to take place on 1 April 2005. The integration plans support: the achievement of key modernisation and improvement targets; the implementation the local rehabilitation and intermediate care strategy; the implementation of the local continuing care strategy; the introduction of a single assessment process; and improvement in mental health services for older people.
- 5.10.2 This is a major project which has 3 strands to it:
- The integration of specialist services for older people currently provided by the PCT, Social Services and 3Ns (Newcastle Integrated Older People’s Services or NIOPS). The PCT will become the provider of these services. 3Ns staff will TUPE across whilst Social Services staff will be managed by the PCT but remain employed by the City Council;
 - The setting up of integrated commissioning arrangements with SSD being the lead commissioner; and
 - Strengthened partnership arrangements.
- 5.10.3 A joint PCT/Social Services commissioning manager for older people has been appointed whose role is to commission services on behalf of both health and social care.
- 5.10.4 Current partnership arrangements for older people’s services in general are led by the Older People’s Strategic Planning and Implementation Group. This comprises representatives of a wide range of organisations involved in the commissioning and delivery of services as well as older people themselves, and is chaired by Steven Louw who is a Clinic Director at NUTHT.

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LEARNING DISABILITIES RESETTLEMENT

- 5.11.1 Delivering the targets in the White Paper 'Valuing People' has been adopted as a local priority by the PCT, along with all the other PCOs within the SHA boundaries. Valuing People dictates that the outcomes of services delivered to people with a learning disability should meet four basic principles which are to give the individual:
- Full access to civil and legal rights and treatment which respects their dignity;
 - Support to be independent;
 - Choice in what they do with their life; and
 - Inclusion in mainstream community services and activities.
- 5.11.2 Valuing People lays down eleven objectives relating to these principles that are to be delivered by the members of the Learning Disability Partnership Board, and eight of these have to be achieved locally. These are that all people with a learning disability will:
- have an identified healthcare facilitator by spring 2003 ;
 - be registered with a GP by June 2004;
 - be offered a health action plan to all service users by June 2005;
 - have services in mainstream hospitals made available to them;
 - have access to local specialist services for people with severe challenging behaviours if they need it;
 - receive benefit from the mental health NSF, if they have a mental health problem;
 - have the services of a specialist learning disabilities team whose role has been redefined and whose mode of operation changed to make the most effective use of their skills and delivers evidence based services; and
 - action will be taken to challenge discrimination against people with a learning disability from minority ethnic communities.
- 5.11.3 A substantial amount of work has already taken place within the PCT to meet these targets, with the health community in Newcastle working collaboratively to achieve these.
- 5.11.4 We are working towards a target of ensuring that all people currently in NHS long-stay hospitals will move into more appropriate accommodation by March 2006. This work is being led by the PCT because of the need to release resources from hospital to contribute to the long term funding of the moves, to develop the healthcare infrastructure in the community to support people once they have left hospital and to intervene in a timely and competent manner to prevent other people in the community needing to have a healthcare intervention which requires a hospital admission. Closure of the long stay beds in learning disability hospitals is the PCT's highest priority for learning disability services. There are 29 patients that require resettlement by the target date.

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LEARNING DISABILITIES RESETTLEMENT

- 5.11.5 An earmarked capital allocation from the 2002-03 Learning Disability Development Fund of £300,000 is available to the PCT for use in 2005-06 to support the development of community accommodation that the patients will rent from registered social landlords. These funds will be used to contribute to the capital costs of purchase or construction to ensure that the rent levels charged are viable for the patient and conform to the Housing Corporation's recently revised rent setting regime. In addition to this, the PCT will need to access a further sum of £975,000 in 2005-06 from the earmarked SHA non-recurring revenue provision. This sum is over and above the £795,000 which will be drawn from this provision in 2004-05.
- 5.11.6 The whole process will require the shifting of funding of some £2.38m from Northgate and Prudhoe NHS Trust and the investment of £1.63m of PCT funds into local services. From this £4.01m, £3.29m will be used to support Newcastle City Council's delivery of social care and the remaining £0.72m is required to deliver enhanced community health services by the Trust and the PCT.
- 5.11.7 Northgate and Prudhoe NHS Trust will require a measure of non-recurring service bridging over the three years of this plan whilst it reconfigures its business. The preliminary estimates of Trust's bridging costs in the most onerous year is £1.96m but further discussion with commissioners is required before the final level of bridging can be agreed.
- 5.11.8 This would require the PCT to set aside non-recurring sums of £1.43m in 2005-06, £1.96m in 2006-07 and £1.59m in 2007-08 to cover service bridging.
- 5.11.9 **Key risks** to delivery by the target date are failure to:
- provide robust evidence of person centred plans for individuals (timing risk);
 - find suitable community accommodation and manage the new RSL rent regimes (funding risk);
 - deliver significant reductions in the proposed non-productive costs which the Northgate and Prudhoe NHS Trust plans to have absorbed by purchasers (funding risk);
 - achieve the necessary complements of suitably skilled and competent care staff in the community provision to meet the timetable (the age and mobility profile of current Northgate care staff indicates that large scale redeployment may not be an option); and
 - deal quickly with any challenges to the process of reprovision by patients wishing to remain on site (timing risk).

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 TOBACCO CONTROL

- 5.12.1 Tobacco control is a key part of the Public Health White Paper. Reducing passive smoking / exposure to second hand smoke, has widespread health impacts – and will contribute to the reduction of deaths from CHD and cancers, as well as reducing morbidity from respiratory diseases in both adults and children and reducing risks of cot deaths. Tobacco control measures have also been shown to reduce the prevalence of smoking.
- 5.12.2 There are widespread inequalities in exposure to second hand smoke – both in terms of occupational exposure – current legislation does not protect workers in traditionally lower paid jobs in the hospitality industry, and in terms of overall smoking prevalence which is higher in more deprived areas. Tobacco control measures will therefore play an important role in reducing health inequalities.
- 5.12.3 Regionally plans are already underway to develop a Regional Office for Tobacco control, which will coordinate activity across the region, taking on the more political roles of lobbying and media activity, as well as developing legislative approaches and working on region –wide activity such as custom and excise, enforcement etc.
- 5.12.4 Reducing smoking prevalence and tobacco control - the implementation of smoke free public places - is one of the highest profile proposals in the White paper. This is one of the key LSP targets agreed, as already outlined on page 11. From 2005-06, the Health Care Commission will examine local action on smoking, staffing levels, action on tobacco control and progress towards smoke-free environment, and the PCT has set aside specific funding in this LDP for tobacco control.
- 5.12.5 We have adopted the North East target of 21% prevalence by 2010. However we also intend to analyse variation in smoking prevalence across Newcastle using QOF data. We will then set local targets for reducing the observed variation in prevalence between practices.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

PUBLIC HEALTH WHITE PAPER INITIATIVES

5.13.1 The White Paper details the strategic direction for improving health and preventing disease. A more detailed delivery plan is expected in early 2005. The key principles underpinning the paper are:

- Informed choice – leading to increased motivation and willingness to change;
- Ensuring that those at disadvantage have opportunities to improve their health;
- Protecting people's health from the actions of others;
- Recognising the specific needs of children and young people;
- Providing collective support to create a health-promoting environment;
- Empowerment and support;
- Personalisation; and
- Partnership.

5.13.2 Most aspects of the legislation will impact on the PCT in one way or another, and we already have plans to address a number of the key areas. In particular:

- Integrated planning and delivery of services through **Children's Trusts** and Children's Centres. Newcastle City Council is in the process of setting up a Children's Trust, and more details of this are provided on page 71;
- **Children's nutrition**, with a particular focus on food in schools' catering services and access to food / cookery skills, with support for development of breakfast clubs, healthy tuck shops etc. This work was previously developed in schools across the city through the Newcastle Schools Food Initiative. Joint funding with the local authority has been explored in the past, and we will pursue these further;
- **Childhood obesity/physical activity** and sport at school. There is a joint DH/DfES PSA target to halt the rise in childhood obesity. The PCT has received funding from Active England for two physical activity coordinators to tackle childhood obesity, but there is need for more coordinated approach to prevention across the city. We will therefore explore joint working on this with the local authority linking to education, leisure services, transport, and planning. We understand that DfES/DCMS will announce further funding in 2006/7 and 2007/8 to support school sport and the national strategy. We will ensure that the PCT is involved in any developments;
- **Teenage pregnancy** - support will be given to implementation of a Teenage Pregnancy strategy, particularly through actions in neighbourhoods with high teenage conception rates. It is not clear what this support will be, but we have already highlighted on page 31 that this is a key issue to be addressed;
- **Reducing smoking prevalence and tobacco control** - the PCT has set aside specific funding in this LDP for tobacco control;
- All services in the NHS should plan and deliver effective action to **tackle inequalities** and improve health. Details on our plans in these areas are set out on the following page;

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

PUBLIC HEALTH WHITE PAPER INITIATIVES

- **Tackling obesity** - definitive guidance from NICE on prevention, identification and management of obesity is expected in 2007. This will include care pathways and development of tools for NHS staff. Each PCT will need a specialist weight management service, and should look to develop innovative models in partnership with local organisations including the independent sector. Details of our proposed investment in this service are set out on page 54; and
- **Alcohol harm reduction** – there will be an audit of treatment service, and guidance on models of care. There will also be guidance for health care professionals and pilot sites for screening / brief interventions. The merging of the Newcastle Drugs Action Team with the Community Safety Partnership to form the Newcastle Criminal Justice Improvement Partnership (CJIP), and the development of the next three-year workplan of that partnership will be a key driver for taking this work forward. As a Responsible Authority on the CJIP, the PCT will be fully involved.

Health Inequalities

5.13.3 Our ongoing work in this area particularly builds on the partnership working that has been highlighted in this Plan, and links to topics that have either been highlighted in recent DH and other Government publication, or are topics that feature strongly in the public health white paper. In setting local targets there needs to be a clear link made between health improvement and reducing inequalities and other areas of work, particularly:

- Action on chronic disease management;
- Control and demand for hospital admission; and
- Financial viability over the coming years (fully engaged scenario – Wanless report).

5.13.4 Many of the determinants of health are outside the influence of the NHS. However, to the extent that access to health care impacts on health inequalities, Newcastle PCT will ensure that the principle of equal access to health services for equal need is reflected in everything that the NHS does and is an important consideration in any service improvement or health promotion strategy.

5.13.5 Essential areas for investment that we have identified are:

- Smoking reduction and tobacco control;
- Action to improve health, education and prospects of children and young people
- Action to support vulnerable groups
- Action on sexual and reproductive health

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

PUBLIC HEALTH WHITE PAPER INITIATIVES

- Actions to ensure specialist services for obesity management continue in the context of an emerging obesity strategy.

5.13.6 These areas correspond to the performance criteria for LSPs agreed with GONE.

5.13.7 In **National Standards: Local Action**, there is a clear statement that “*PCTs with the largest burden of heart disease and cancer are expected to set and achieve particularly stretching local targets*”. This statement applies to all PCOs within the SHA area. Local targets we have drawn up include:

- Life expectancy
- Influenza immunisation - we have set a locally agreed influenza immunization target of 77%
- Infant mortality
- Cardiovascular and cancer targets
- Smoking prevalence:
 - Working with the Strategic Health Authority to establish an office for tobacco control.
 - Evaluating the effectiveness of the smoking cessation service
- Sexually Transmitted Infections:
 - Reducing teenage pregnancy through a reinvigorated strategy that builds on epidemiology evidence of need capitalizes on evidence of effectiveness both locally and nationally and draws together the collective resources of all agencies through a newly established Strategic Partnership Board.
 - Providing opportunistic Chlamydia screening as part of the national roll out programme (through central funding once secured)
 - Tackling the syphilis situation in Newcastle – where there is a very high prevalence through a combination of prevention and treatment services.
 - Further developing the HIV pathway to ensure the most effective and efficient journey through services for patients
- Local obesity:
 - Monitoring and reducing obesity levels in the population:
 - Practice-based registers for BMI >30 by March 2006
 - Diet and nutrition work will link to obesity strategy
 - Implementing findings of 5-a-day pilots
 - Free fruit in schools
 - Physical activity: Move towards a tariff-based system for commissioning physical activity and rehabilitation services
 - Quantified provision to support collaborative working with local education and leisure services to deliver obesity targets for children
 - Providing appropriate services for those with obesity

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

PUBLIC HEALTH WHITE PAPER INITIATIVES

- Providing infrastructure to conform to NICE technology appraisals for anti-obesity interventions. Further guidance on the management of obesity due out in 2006;
- Systematic treatment regimes for patients with BMI >30 by March 2006
- Planning for requirement for obesity surgery – will need planning for capacity in acute and primary care, and development of models of care / management.

5.13.8 Additional targets that we are currently working through include:

- Smoke-free public places
- Access to food
- Development of full-service schools
- Availability of healthy school coordinators
- Comprehensiveness of school meals / breakfast clubs
- Linkage between employment and education
- Comprehensiveness of affordable warmth – tackling fuel poverty
- Extent of benefits maximisation
- Expansion of mental health early interventions
- Extent of employment of local people
- Programme budgets for expenditure on key areas of health improvement – e.g. increase spending on exercise, rehabilitation etc.
- Availability of community transport

5.13.9 The PCT is currently reviewing available data sources with a view to developing measures of inequality of access to, and provision of, key health services in relation to measures of need. This analysis will be undertaken on a small area basis, i.e. GP practice or ward. An indicator set is being developed for each service within the four main streams of care. This profiling will allow the PCT to commission services that are better designed and configured to reduce the mismatch between access/provision and need across Newcastle.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 CAMHS

- 5.14.1 The joint strategy for CAMHS 2000-01 to 2005-06 identified the necessity to continue to develop the workforce to meet the high level of need within the population. Improvement Expansion and Reform requires that CAMHS must provide a comprehensive service including health promotion and early intervention by 2006 and requires an increased capacity of at least 10% year on year.
- 5.14.2 Resources identified within the plan will ensure the PCT meets a major national policy objective for increased investment and brings key local targets for providing a comprehensive CAMHS significantly closer.
- 5.14.3 The multi agency CAMHS commissioning group in Newcastle have worked with providers to determine priorities for investment across the health, social care, education systems and voluntary sector providers. This process has been informed by:
- A review of the needs assessment within the five year CAMHS strategy;
 - The DH's matrix/traffic light tool (SHA wide exercise);
 - Internal review of CAMHS in 3N and consideration of the impact of providing regional tier 4 services in the city; and
 - Involvement in the national CAMHS mapping exercise.
- 5.14.4 Our plans for additional investment in CAMHS are in line with the NSF for Children (2004) and National Standards, Local Action (2004). Investment in tiers 2 and 3 will ensure increased capacity in the specialised CAMHS workforce to more effectively meet the needs of children and their families and carers:
- Improve access for young people with moderate/severe mental health needs
 - Develop services for high care, special needs or excluded children which cross health providers and education services
 - Deliver a wider range of evidence based specialist treatments
 - Provide a wider range of advice, consultation and care within community, primary care and local authority settings
 - Provide a consultation service for other professionals (e.g. teachers, primary care workers, SureStart and Children's Centre staff, foster carers)
 - Introduce holistic care plans for LAC and link to the development of the Common Assessment framework for Children
 - Provide an enhanced programme of training and supervision for professionals working at tier 1 and tiers 1-2, to increase capacity across the whole system for prevention and early intervention, minimising the need for tier 3 or 4 intervention, and potentially reduce the need for out of area placements

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

NON-ELECTIVE PRESSURES/OOH SERVICE

NON-ELECTIVE PRESSURES

- 5.15.1 Northumbria Healthcare Trust and Newcastle Upon Tyne Hospitals are both forecasting activity for non-elective admissions in 2004-05 in excess of the levels commissioned. Under payment by results the same activity will cost considerably more than current contract. The main areas of additional activity relate to cardiology, vascular surgery and haematology, with the majority being in cardiology. A&E attendances have also increased in 2004-05.
- 5.15.2 Newcastle PCT is assuming no increase in non elective activity (including A&E) in 2005-06. Work is being undertaken to further strengthen and integrate out of hours primary care provision, chronic disease management and community based support to ensure demand can be effectively managed to avoid emergency admissions and A&E attendance. Some of these measures will also impact on non elective bed days which are to be reduced by over 1.9% on the 2003-4 baseline in 2005-6 and by 6.9% by 2008, but it should be noted that achievement of this target is anticipated to relate more to length of stay than patient episodes.
- 5.15.3 Work is also being undertaken to look at altering current response to Category C ambulance calls, diverting primary care work where possible from A&E to the Urgent Care Centres, developing the approach to case management (especially focusing on those 'frequent fliers') and integrating and strengthening intermediate care provision (see also Chronic Disease Management).
- 5.15.4 Further investment in urgent care activity is proposed in Years 2 &3 but this will be in locality centres rather than in hospital based provision. There will therefore be a need to continue to invest in community provision and the more active management of chronic disease. Careful modelling is being undertaken to ensure appropriate forecasting for shifts in activity.
- 5.15.5 Additional funding in 05/06 of £500k has been identified for further integration of urgent care including further development of the nurse practitioner role, provision of day time GP provision in the Walk in Centre and development of additional services to prevent A&E attendances and non-elective admissions through enhanced community support particularly with regard to work on long term conditions.
- 5.15.6 The Newcastle Urgent Care Network is well established with good representation from all the relevant organisations. A detailed workplan has been produced since completion of the emergency care checklist. The group is currently prioritising the objectives, many of which cross organisational boundaries.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 NON-ELECTIVE PRESSURES/OOH SERVICE

OUT OF HOURS SERVICE

- 5.15.7 Pressures relating to higher than anticipated costs of medical staffing require additional investment in the Out of Hours Service in 2005-06. Integration plans with the Walk In Centre/Minor Injuries Unit and delivery of the vision for Urgent Care will be implemented over the coming 12 months, and may result in longer term savings once double running/training support for nurse practitioners is complete and medical staffing can be reduced. Plans will focus on moving from discrete services to a combined service for primary urgent care provision, operating from urgent care centres which will be nurse led, supported by other staff including GPs and which integrates clearly with Accident and Emergency. Attention will be paid to integration of the anticipated Commuter Walk In Centre with local plans for primary and urgent care provision.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 LOOKED AFTER CHILDREN

- 5.16.1 Newcastle is one of 35 trailblazer sites for the development of a Children's Trust. One of the key objectives for the trust is to develop a Section 31 Agreement between the PCT and the Local Authority to jointly fund packages of care for vulnerable children whose needs are so great that they cannot be met within routine provision.
- 5.16.2 In 1999/2000 the Child Health Commissioning Group, agreed that where a 3 way funded package was required to meet a child's health, social and educational needs, the package would be funded using a previously agreed formula. This formula was developed and agreed based on actual funding from 1998/1999. The split was 3% health, 57% education and 40% social services. Since this time, the level of need for a small number of children and the cost of the packages have increased substantially. It has been suggested that the agreed split is no longer valid.
- 5.16.3 Detailed work has been undertaken on behalf of the multi agency Child Health Commissioning Group to determine overall budget, eligibility criteria and appropriate percentage split. The PCT is intending to invest an additional amount to enable the PCT to increase its percentage contribution to three-way packages to 5%.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

SPECIALIST WEIGHT MANAGEMENT SERVICE

- 5.17.1 The Public Health White Paper prioritises obesity reduction and outlines the responsibilities of health promoting NHS which will include:
- NICE guidance on prevention, management and treatment of obesity (2007);
 - A national partnership for obesity – a source of information and research evidence;
 - Funding for obesity work base on National Occupational Standards; and
 - A comprehensive care pathway for obesity (prevention and treatment).
- 5.17.2 The increasing public awareness of obesity, coupled with the introduction of national targets for its reduction are the drivers for providing a city wide obesity strategy (or rather diet and exercise) that embraces:
- Health living – good diet and exercise (implicitly obesity prevention)
 - Weight management – specialist provision for overweight and obese people
- 5.17.3 The Specialist Weight Management Service (SWiMS) was established in 2001 with Neighbourhood Renewal Funding (NRF) for three years. Subject to the demonstration of a successful evaluation, the PCT was committed to pick the revenue consequences in April 2004. In the absence of an evaluation date the PCT did not pick up the funding and the service has continued with NRF (slippage) - which has now run out.
- 5.17.4 The University of Northumbria has produced an interim evaluation report (final report: Summer 2005) which shows:
- The SWiMS service is based on evidence of effectiveness in that diet and behavioural interventions form the most effective approach to obesity reduction;
 - The first 100 morbidly obese patients to go through the service showed statistically significant weight loss; and
 - Qualitative data from semi-structured patient interviews is very positive.
- 5.17.5 We propose to expand the SWiMS service to a city wide provision with explicit activity targets. The model of service delivery is currently being reviewed to provide a more streamlined patient journey and to capitalise on the opportunities available in related services including diabetes and cardiology. SWiMS will expand its geographical boundaries to provide an equitable city wide service, with three levels of work.
- Primary Care Support: advice, training and support for primary care as the first point of contact with patients (including support of patients on anti obesity drugs). This service complements and works in partnership with Newcastle Nutrition and includes input to the community kitchen;

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

SPECIALIST WEIGHT MANAGEMENT SERVICE

- Group work: eight week, community programmes to tackle obesity and physical inactivity (BMI>25). Using the skills of the multi disciplinary team (nurse/dietician/exercise instructor) patients are followed up at 3 and 6 months. Peer support training is being developed to encourage sustainable weight loss once the programme has ended; and
- One to one service: morbidly obese patients (BMI>40) are offered the chance to attend a group – or they can be seen on a 1-1 basis. Individuals seen at home will often have a co-existing health or social problem, which means they are unable or unwilling to attend a clinic. The service acts as a gatekeeper for anti-obesity surgery.

5.17.6 Targets will be set for:

- Primary care support: number of training/advice episodes to primary care; sessions in community kitchen
- Group work: number of groups per year – with target numbers for group membership and drop out rates. Success criteria will be established
- One to one work: number of individuals offered support – again with success criteria attached.
- Audit: building in requirements for audit will ensure continual evaluation of SWiMS.

5.17.7 The service will provide for 600 patients per year – in either group or individual work. This represents a significant expansion of activity, within existing resources, based on a new model of practice that capitalises on the varied skills in the team and brings in the skills of staff in neighbouring services (including cardiology and diabetes)

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 DIGITAL HEARING AIDS

- 5.18.1 In February 2003 the Secretary of State for Health announced that by March 2005 all hearing aids services would provide digital rather than analogue hearing aids as part of the "Modernising Hearing Aid Services" programme. Central monies would be allocated to cover the majority of the additional costs and the national programme of implementation would be managed by the Royal National Institute for Deaf People (RNID). The implementation of the national programme followed the piloting of digital hearing aid services at 66 sites.
- 5.18.2 In recognition of both the financial consequences of implementation and the substantial operational problems to be overcome it was agreed locally that digital hearing aid services for Newcastle, North Tyneside, and Northumberland should be introduced in 2004-05.
- 5.18.3 In March 2003 The Newcastle upon Tyne Hospitals Trust submitted an application, following formal expressions of support from the primary care organisations and educational authorities concerned, to join the programme in 2004/2005. A local planning group was established in July 2003 to formulate a plan for the implementation of digital hearing aid services. The group included representation from the three PCOs, two trusts, and a local education authority along with a patient and clinician representatives.
- 5.18.4 In September 2004 the digital aid hearing service commenced covering the populations of Newcastle, North Tyneside, and Northumberland. The service covers both adults and children. Services are provided in a number of locations in order to make it as accessible as is practicable given the need to install and maintain high specification audiology equipment and facilities.
- 5.18.5 Funding for service to date has been provided in part through ring-fenced allocation and in part from PCT baseline budgets. Our investment in 2005-06 will enable the digital hearing aid service for North of Tyne to continue in line with the original proposals.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 CANCER

- 5.19.1 Cancer services are planned across two structures for Newcastle. For specialist cancer services, Newcastle is a member of the Northern Cancer Network. For specialist services investment priorities are agreed within the Network and recommended to the individual PCT's. The Northern Cancer Network provides strategic, managerial and clinical leadership for cancer services across the SHA area. Services are co-ordinated taking a whole systems approach, with agreed care pathways across the whole system to maximise the utilisation of resources and improve services for patients
- 5.19.2 There is also a Newcastle Cancer HIMP with local membership for the planning of local cancer services in Newcastle. This group has a wide membership of stakeholders including the Voluntary sector, Users and Carers. To ensure a whole systems approach to planning there is cross membership of the network and HIMP groups. The PCT clinical lead is also involved in service planning groups with NCCT.
- 5.19.3 Investments included in the LDP for cancer services include:
- Continued working towards meeting the 2005 waiting time standards;
 - Developing the provision of evidence based treatments in line with NICE guidance;
 - Supporting people with smoking cessation services within primary care;
 - Further development of health promotion and screening services; and
 - Continue to meet and further improve on local and national waiting time targets for cancer.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 SPECIALISED SERVICES

- 5.20.1 Specialised services are nationally defined, mainly tertiary, health care services that require collaborative commissioning (service planning, procurement, performance monitoring) to meet the requirements of local populations exceeding one million people.
- 5.20.2 Within the North East and North Cumbria, the 19 PCTs responsible for commissioning healthcare have appointed the Northern Specialised Commissioning Group (NSCG), formerly known as the Northern Commissioning Specialised Services Group, as the collaborative commissioning body to undertake specialised service commissioning on their behalf.
- 5.20.3 A central commissioning team (known as NORSCORE) is hosted and located at North Tyneside Primary Care Trust. It came into effective operation at the end of March 2004. The NORSCORE team implement the planning, procurement and performance monitoring requirements relating to specialised services, although ultimately responsibility for delivery of the specialised service agenda continues to rest with individual PCTs through the NSCG.
- 5.20.4 Collaborative investments for 2005-06 have been in a number of areas for 2005 onwards including:
- Neurosciences – Neurophysiology;
 - HIV/AIDS Infrastructure;
 - Downs Screening - Quadruple Testing;
 - Gender Dysphoria;
 - Neonatal Intensive Care;
 - Paediatric Oncology Strategy;
 - Paediatric Neurodisability; and
 - Fetal & Maternal Medicine.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

DIABETIC RETINOPATHY SCREENING

- 5.21.1 The NSF for Diabetes outlines the targets and standards NHS bodies are tasked to achieve by 2013. Primary Care Trusts are required to stage delivery over the coming years. The immediate targets are:
- Minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy, within a systematic programme which meets national quality standards, by 2006; and 100% by 2007; and
 - In primary care update practice-based registers so that patients with CHD and Diabetes continue to receive appropriate advice and treatment in line with NSF Standards, by March 2005.
- 5.21.2 The NHS Plan sets out a sustained programme of investment and reform designed on delivering faster, better quality and more patient centred care. The NSF takes the NHS Plan's principles and applies them to Diabetes Services. In practice this should mean that everyone has better access to good services, and information on diabetes; services are focused on people; key groups get the resources and developments they need.
- 5.21.3 NICE evidence-based guidelines have also been issued for implementation in relation to Type 1 Diabetes in Adults and also in Children and Young People. PCTs are being audited on a year by year basis on implementation of both NSF targets/standards and NICE recommendations.
- 5.21.4 The numbers of people being diagnosed in Newcastle as diabetic is increasing by 15% year on year. The Newcastle Diabetes Retinal Screening Service, based in the Newcastle Diabetes Centre, Newcastle General Hospital, provides a screening programme for the early detection, and treatment, if needed, of diabetic retinopathy. This is offered to all Newcastle patients with diabetes whether in primary care or at the Diabetes Centre i.e. both Type 1 and Type 2.
- 5.21.5 Currently 3.8% of the population of Newcastle are diabetic i.e. 9,000 patients. This is projected to rise to 10% by 2010. The service is now struggling to cope with the ever-rising workload. There are currently over 200 GP patients waiting three months for an initial screen and the annual review for retinal screening is now over 13 months. New Diabetes Centre patients are waiting up to six weeks.
- 5.21.6 In order to reduce the considerable pressure on staff and meet the increased demand on the service additional staffing is required. This will enable the service to:
- ensure waiting times are kept within national guidance, despite the year on year increase of numbers of people with diabetes;
 - continue to offer a service to 100% of people with diabetes in Newcastle;

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 DIABETIC RETINOPATHY SCREENING

- retain quality assurance within the service and meet national quality standards; and
- provide cover for leave (annual, study, sick-leave).

5.21.7 The additional support will also help to ensure that waiting times are in line with the requirements of the GMS Contract for GPs.

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

PROVISION OF LOCALITY BASED SERVICES

MOLINEUX STREET URGENT CARE AND RESOURCE CENTRE

- 5.22.1 Key elements of the Streams of Care model that we are introducing are the separation of urgent from non-urgent care in both secondary and primary care, and the development of multidisciplinary interface teams to support planned care delivery, chronic disease management and health maintenance activities.
- 5.22.2 With the focus on locality care as the central theme for first patient contact and using the “personal practitioner” as the life-journey “health friend” for each member of the community, a balance must be struck between local access and economies of scale. It is considered that two or possibly three resource centres/urgent care centres will be required for the city. Whilst there are advantages to co-location the two need to be functionally separated acting as discrete elements within the building with, for example, separate waiting areas.
- 5.22.3 The significant change of role for the “general practitioner” means that the concept of small neighbourhood practices is probably increasingly outdated over time albeit that the move to a more ‘grouped’ environment may take time. A grouped environment not only makes best use of physical space and human resource but facilitates aspects of clinical governance. Ultimately ‘personal practitioner centres’ may well be the preferred model, providing state-of-the-art premises, staffed by multi-disciplinary teams including mental health and local authority services, with some sited adjacent to the locality Resource Centre.
- 5.22.4 Our plan is to implement two or three strategically located dedicated centres across the city incorporating urgent care facilities, diagnostic services, a resource centre for elective/planned care provision within a locality facility which also includes a range of primary care services including GP services, optometry, dental and pharmacy services. The PCT plans to utilise the opportunity presented by the original GP-only Molineux Street development and build upon these plans and incorporate these wider services to develop the first of these Centres in 2005-06. The PCT has sought and received approval from the SHA for £5m worth of capital funding to support the scheme. GP services will be provided from the centre which will be the base for two existing GP practices.
- 5.22.5 The PCT plans to ultimately provide 24/7 services for minor illness, injuries, treatment and assessment using Extended Nurse Practitioners (ENPs) supported by a range of other health professionals including GPs.
- 5.22.6 The resource centre service will be staffed by consultants, GPs with special interests, ENPs and other health professionals providing a range of services including chronic disease management in areas such as diabetes and COPD services. In addition planned care and clinical assessment services can be

SECTION 5 – LOCAL PRIORITIES FOR 2005-08

PROVISION OF LOCALITY BASED SERVICES

provided as outreach. To support both the urgent care and the resource centre, diagnostic services will be provided.

- 5.22.7 There is an expectation that there will be some initial double running and pump priming costs but that a proportion of service provision will be through bookable, outreach sessions from existing service providers, (although the nature of the workforce and service delivery will change over time). In addition it is anticipated that the impact of additional input to health maintenance and CDM work will enable the significant reduction in non-elective activity. The PCT will also provide other services from the centre such as physiotherapy which will be a re-location of existing services.

LOCAL IMPROVEMENT FINANCE TRUST (LIFT) INITIATIVE

- 5.22.8 LIFT is a variation on the traditional PFI schemes approach and allows the private and public sectors to enter into legal contracts to establish a joint company to deliver long term estate solutions. It was formally introduced through the NHS Plan and required a change to primarily legislation to allow NHS bodies to become partners in companies. Newcastle and North Tyneside PCTs and Councils were successful in bidding for first wave status, becoming the only first wave project to incorporate Local Authority participations. The LIFT company was formally established in May 2004, and is currently delivering four schemes on behalf of the four partners.

- 5.22.9 Both as part of the legal agreement and as a key deliverable of the NHS Plan around improving the quality of NHS estate there is a requirement to deliver on-going schemes over a number of years. The next phase is primarily Local Authority driven, with one scheme (Benwell) being a joint development between the Local Authority and Newcastle PCT. The Local Authority has received confirmation of funding from the ODPM. To access the funds the scheme must be completed by March 2007.

- 5.22.10 The PCT has been undertaking a review of service needs within the West of the city including the impact on provision of services from the Benwell site. This links with the wider strategic vision to develop Urgent Care centres/Resource centres in a number of key locations across the city already outlined. This development would provide the second one of these schemes for the PCT. The intention is to consolidate services into a more appropriate and 'fit for purpose' location, incorporating amongst others, the following services:

- GP services: 3 practices, plus the Asylum Seekers PMS service;
- Community Nursing;
- Podiatry;
- Physiotherapy;

SECTION 5 – LOCAL PRIORITIES FOR 2005-08 PROVISION OF LOCALITY BASED SERVICES

- Community Dental;
- CAMHS;
- Community Cardiology; and
- Urgent Care & Resource Centre.

SECTION 6 – FINANCIAL COMMENTARY AND RISK ASSESSMENT

- 6.1 The financial context in which we are trying to develop services and support the staff delivering them remains challenging, but a great deal of work has taken place in the last year to address this and to plan for a future that can deliver quality services within financial balance.

FINANCIAL OVERVIEW

- 6.2 This section of the LDP outlines anticipated growth funding, proposed deployment of these sums and an analysis of key financial assumptions and risks.
- 6.3 Firm PCT growth funding figures are known for 2005-06 (as part of three year allocations for the period April 2003 to March 2006), and for 2006-07 and 2007-08 as recently notified by the Department of Health. Annex B summarises growth funding and proposed deployment for each of the three years 2005-06 to 2007-08.

2005-06 FINANCIAL YEAR

- 6.4 Newcastle PCT's recurrent general growth funding for 2005-06 is £25,986,000. In addition the PCT will receive £271,000 further earmarked funding for Child and Adolescent Mental Health Services and some specific inflation uplifts, giving total growth of £26,257,000. After taking account of the PCT's anticipated recurring deficit carried forward from 2004-05 (£3,159,000) there is a balance of £23,098,000 uncommitted funding.
- 6.5 Annex B summarises the proposed deployment of this funding. The analysis reflects the requirement to provide a level of funding to meet the costs of inflation and pressures, to meet a range of national targets and to deliver some local priorities. It also takes account of the outcome of the Programme Budgeting and Marginal Analysis (PBMA) work which has been used to help in the process of prioritisation.
- 6.6 A total of £18,226,000 (Lines i to v on Annex B) has been provided to meet the costs of pay and price inflation and some pressures. This figure has been determined by a combination of national directions (national tariff rates and other specific initiatives such as Agenda for Change and Consultants' Contract) and a local assessment of what might be included in Service Agreements for non tariff services, which are currently being negotiated. There is an underlying assumption of a cost improvement saving of 1.7%.
- 6.7 At this stage of the development of the Local Delivery Plan there is a recurrent deficit of £4,035,000. (Equivalent to approximately 1.1% of total revenue budget)

SECTION 6 – FINANCIAL COMMENTARY AND RISK ASSESSMENT

2006/07 AND 2007/08 FINANCIAL YEARS

- 6.8 The Department of Health has advised PCOs of their 2006-07 and 2007-08 Initial Revenue Resource Limits. Growth has been allocated to PCTs on a differential basis related to Distance from Capitation target and (for the first time) population projections have been used. For Newcastle PCT the growth funding is as follows:

	<u>£m</u>	<u>%</u>	<u>(National Av %)</u>
2006/07	30.0	8.4	9.2
2007/08	31.0	8.0	9.4

The national ranges of growth funding for PCTs is between 8.1% and 15.7% for 2006-07 and 8.0% and 14.3% for 2007/08. The uplifts for Newcastle PCT are below national average levels as the PCT's baseline funding is above capitation target and also because the city's population is projected to decline over the course of the next few years. On the basis of the allocations notified the PCT will still be £6.7m (1.6%) above capitation target by March 2008. However, the figures which have been used by the Department of Health do not include the funding implications of the Payment by Results financial regime. For 2005-06 (at least) PbR funding will be issued on a non-recurrent basis.

- 6.9 The PCT's additional funding for 2006-07 is £30,033,000 (including £1,948,000 for Choosing Health White Paper initiatives) and for 2007/08 is £30,974,000 (including £397,000 for Choosing Health White Paper initiatives). After taking account of the recurrent deficit brought forward from previous years this leaves recurrent funding available of £25,998,000 and £28,887,000 in 2006-07 and 2007-08 respectively. Annex B provides an initial estimate of the proposed deployment of this funding and shows a prospective recurrent surplus of £877,000 at the end of 2007-08. Clearly at this stage these figures must be viewed as work in progress and will be developed during the course of 2005/06.

ASSESSMENT OF FINANCIAL RISK

- 6.10 The key financial risks which impact on this LDP are as follows:
- that the PCT is unable to negotiate service agreements within the level of inflation/pressures funding which has been provided;
 - inflation and pressures funding for the PCT's own services (in particular prescribing and the Directorate of Community Services) exceed the funding provided;
 - the implications of the Payment by Results (PbR) financial regime in terms of its application in 2005-06 (approximately £0.5m under funded) and future years, and also the financial consequences of in year patient activity levels;

SECTION 6 – FINANCIAL COMMENTARY AND RISK ASSESSMENT

- the implications of the introduction of Practice Based Commissioning;
- the new GMS contract and Quality Outcomes Framework payments;
- the financial implications of the new Dental Services Contract;
- the consequences of the Learning Disabilities resettlement programme and, in particular, the financial rebasing exercise at Northgate and Prudhoe Hospital;
- the integration of Older Peoples services;
- the implications of the Patients' Choice initiative and the requirement to place patient care contracts with the Independent Sector;
- the implications of prospective Foundation Trust status for Newcastle University Hospitals NHS Trust;
- that it may not be possible to significantly reduce the current 2005/06 financial gap (£4.0m)
- growth funding for Newcastle PCT is substantially below national average levels for 2006-07 and 2007-08 (2.2% in total, equivalent to approximately £8m recurrent funding).

RISK MANAGEMENT - OVERALL ASSESSMENT

6.11 At this stage there are still risks that the PCT will not deliver national targets in a small number of areas and these have been outlined in paragraph 6.12. There are a number of underlying risk factors that potentially affect a range of targets. The main ones include:

- Slippage in the NPfIT programme – the delivery of a number of targets is dependent on this programme being successfully implemented on time;
- Affordability issues regarding the delivery of the overall agenda

Modernisation agenda

6.12 Whilst there has been some modernisation of services locally, there is considerably more that needs to be done. The PCT will seek to strengthen local capacity to take forward modernisation by a number of initiatives, including:

- Reviewing the role and remit of all HIMP groups to ensure that modernisation forms a key part of their work plans;
- Ensuring continued participation in SHA and other modernisation networks; and
- Seeking to build a local network of people with experience of modernisation across local organisations in the NHS and beyond (for example the Local Authority).

SECTION 6 – FINANCIAL COMMENTARY AND RISK ASSESSMENT

Workforce issues

- 6.13 There are a number of risks associated with the workforce. Primarily these are around recruitment, development and retention.
- 6.14 Recruitment - It is key to our ability to support the national and local drivers for expanding the workforce for use to be able to recruit. Within the Workforce Development Confederation area we have committed to work collaboratively to prevent poaching from neighbours. We are also looking to recruit from those retiring from the armed forces medical services and be proactive in the modernisation of roles and responsibilities.
- 6.15 Development - To achieve a modernised workforce with strong leadership skills there is an increasing demand on staff development. This requires time and money. We are therefore looking at training local facilitators, multi media training opportunities, and via the effective use of PDPs linked to the Learning and Development Strategy targeted and priorities development opportunities thus reducing waste and managing expectations.
- 6.16 Retention - Community staff tend to be more mature due to the length of training and previous entry requirements. The PCT has a skewed working population clumped at the older end of the age range. We are proactively managing this through flexible working opportunity and in particular flexible retirement options.

PERFORMANCE AND RISK MANAGEMENT

- 6.17 The PCT has put in place rigorous performance and risk management strategies that will assist in ensuring overall risks are managed. We undertake a number of tasks on a monthly basis including:
- Detailed review of monthly monitoring returns submitted to the SHADH;
 - Submission of monthly performance reports to the Board covering - activity, waiting lists, cancer waits, CHD waits, access to A&E and delayed discharges;
 - Formal monthly meetings with providers about their performance; and
 - Submission of the Annual Accountability Return information to the SHA on a quarterly basis.
- 6.18 The PCT's overall risk management strategy provides a robust framework for identifying the risks it faces and ensuring these are subject to the most robust controls that the PCT can apply. All risks are routinely fed into the Risk Register which is a key tool in monitoring the PCT's exposure to risk. The register itself is based on the PCT's objectives, the risks of not meeting them and the adequacy

SECTION 6 – FINANCIAL COMMENTARY AND RISK ASSESSMENT

of the controls the PCT can apply to each risk. Risks arising from the LDP will contribute to the PCT's risk agenda and consequently be subject to regular monitoring and scrutiny by the Risk Management Group and ultimately the Board.

SECTION 7 – FUTURE DEVELOPMENTS

7.1 As already outlined in this Plan, the NHS agenda is huge and there are a number of national and local initiatives which we will need to develop as policy and guidance emerges. Across our Care Streams these include:

- Ongoing Care - Chronic Disease Management;
- Children and Families - Children's Trusts;
- Public Health - Spearhead PCTs;
- Urgent Care - Commuter Walk-in Centre;
- Infrastructure Medicines Management; and Newcastle Strategic Review.

7.2 A short commentary on each of these areas is set out in the following paragraphs. These will be updated as further guidance is received.

CHRONIC DISEASE MANAGEMENT

7.3 Chronic disease represents a significant and exciting challenge for the NHS. Good chronic disease management offers real opportunities for improvements in patient care and service quality, and reductions in costs. Chronic diseases include diabetes, asthma, arthritis, heart failure, chronic obstructive pulmonary disease, dementia and a range of disabling neurological conditions.

7.4 Chronic diseases constitute the major demand on the health care system:

- Around 80% of general practitioners (GP) consultations relate to chronic disease
- Patients with a chronic disease or complications use over 60% of hospital bed days
- People with three or more chronic conditions make much higher use of health care - 15% of people account for almost 30% of inpatient days
- For patients with more than one condition costs are six times higher than those with only one
- Some people are highly intensive users of health care (10% of inpatients account for 55% of inpatient days) or very high intensive users (5% of inpatients account for 40% of inpatient days)
- Treatment costs are far higher than the costs of elective surgical procedures in England.

7.5 In the UK around six in ten adults report some form of chronic disease and by 2030 the incidence of chronic disease in the over 65s is expected to double. 45% of those with chronic disease suffer from more than one condition. The Government has published a new model of care for people with long term conditions in advance of the NSF for long term conditions due out later on 05/06 and the PCT will be working closely with our partners in particular the Local Authority in taking immediate action to implement this model.

Central to the model are three levels of delivery of services:

SECTION 7 – FUTURE DEVELOPMENTS

- Case management by community matrons or equivalent for those with the most complex conditions
- Disease specific care management for people with complex single need or multiple conditions, and
- Supported self-care for the 70-80% of those with long term conditions

7.6 Our work in the coming months will ensure that the Newcastle health economy develops a strategy for the management of chronic diseases to ensure that emergency admissions to hospital are kept to the essential minimum. This strategy will link up with ongoing work in Northumberland and North Tyneside around chronic disease to co-ordinate the development of a North of Tyne approach. The essential six components of a full disease management program are:

- Population identification processes;
- Evidence-based practice guidelines;
- Collaborative practice models to include physician and support-service providers;
- Patient self-management education (may include primary prevention, behaviour modification programs, and compliance/surveillance) ;
- Processes and outcomes measurement, evaluation, and management; and
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling)

7.7 Other existing and developing national initiatives that will help to deliver good CDM include:

- Existing National Service Frameworks (NSFs);
- New GMS and associated Quality & Outcomes Framework;
- Use of other new independent contracts
- Practice based commissioning
- Pooled budget arrangements between health and social care
- Developments in IT (ICRS/NPfiT);
- Introduction of choice at point of GP referral;
- New roles and new ways of working are emerging for all professionals;
- The Expert Patient Programme; and
- The National Primary Care Collaborative; The Healthy Communities Challenge.

7.8 Several PCTs in the UK have launched the implementation of US models of CDM with the help of the DH and which have informed the recent policy paper. A review commissioned by the modernisation agency to identify the transferable learning from the experience of these sites, suggests that PCTs should evaluate themselves using indicators of effective CDM and identify the aspects of various

SECTION 7 – FUTURE DEVELOPMENTS

approaches to CDM that are locally relevant. Involvement of stakeholders, particularly acute trusts and social services was highlighted.

7.9 Identifying a cohort of patients to initiate this change is the first step to implementing a chronic disease management strategy. We need to be able to demonstrate that using the components previously listed it is possible to improve the care to patients and use less resource in secondary care. Work already underway includes:

- reviewing work in progress locally around diabetes and mapping of this model;
- revisiting the Shield Court respiratory rehabilitation project (nurse –led);
- looking in more detail at the patients who were admitted 4 times in 2003 /2004 with respiratory disorders as their primary diagnosis;
- establishment of an initial steering group to develop a local strategy; and
- mapping of all the self –care, patient education programmes available across primary, secondary and the voluntary sectors in Newcastle.

The PCT will be considering the DH model of care recommendations and requirements in line with Streams of Care and be prioritising the progression of this work over the coming months.

CHILDREN’S TRUSTS

7.10 Newcastle Children's Trust is one of 35 pilot programmes, and is managed jointly between the PCT and the Local Authority Social Services and Education Directorates. Responsibility will lie with the Director of Children’s Services once appointed.

7.11 The Trust is taking a developmental approach to providing integrated services, starting with two distinct but overlapping groups of children and young people - children with disabilities and complex health needs, and looked after children with high care needs who have to leave Newcastle to receive services that meet their specific, complex health needs.

7.12 The main thrust of the Trust has been to develop a shared electronic referral, assessment and planning process across the Local Authority and Health Services, which will support the co-ordination of care for individual children and provide information for strategic planning. The system is half way through a pilot and will be "rolled out" during the next 6 months. In addition a model has been developed to ensure the early identification of children with high care needs, to monitor the shared care plan and where possible to develop services to meet their needs within the city, on an individual and strategic level. In line with government directives, we are in the final stages of agreeing a Section 31 agreement to share the funding of care packages for children with high care needs.

SECTION 7 – FUTURE DEVELOPMENTS

7.13 While there is still a great deal of work to be completed before children with disabilities and their families benefit directly from the Children's Trust, bearing in mind the long lead time to implement complex cross agency developments, the Children and Young People's Strategic Partnership have agreed the next steps in the trust's development. All Looked After Children and children with challenging behaviour will be the next focus for the Children's Trust. During 2005-06 the trust will consult with children, young people, their families, staff and manager, to develop an action plan to improve services to these specific groups based on integrated working.

SPEARHEAD PCTS

7.14 The DH has recently announced that PCTs in the most deprived areas of England will be designated "Spearhead" PCTs. They were identified using information on deprivation, mortality from cancer and heart disease as well as life expectancy to determine the areas that face the greatest health challenges.

7.15 Newcastle PCT is one of 88 of these, and will be the first to pilot initiatives such as health trainers and enhanced Stop Smoking Services set out in the recently published White Paper on Public Health. The goal is to improve health in the most disadvantaged communities, and it is recognised that severe health inequalities often occur with other forms of disadvantage, such as high unemployment, high crime and poor housing.

7.16 Further announcements are expected on this initiative including whether additional funding will be made available.

COMMUTER WALK-IN CENTRE

7.17 The DH has commissioned the development of seven NHS Walk in Centres located at rail stations, scheduled to open in 2005. One of these will be located in Newcastle, and will offer commuters the chance to see a doctor on their way to or from work. It is estimated that over 30,000 patients per year will benefit from treatment at each of the seven new centres.

7.18 The new centres will offer the same range of high quality services patients traditionally receive from a GP practice, but without the need for an appointment and in a more convenient location for commuters. The centres will also be open to local residents. The new NHS Walk in Centres for commuters will offer:

- services tailored to patients' needs, such as physiotherapy and monitoring of long term conditions through blood pressure checks;
- treatment for minor injuries;
- prescriptions and pharmacy services; and
- access from 7am-7pm without having to book an appointment.

SECTION 7 – FUTURE DEVELOPMENTS

7.19 The PCT will continue to work with SHA and DH colleagues to ensure integration of the service with other local provision for primary and urgent care and maximise the potential of this new service. This section will be updated as further information is made available.

MEDICINES MANAGEMENT/PRESCRIBING

7.20 Newcastle PCT will continue to invest significantly in pharmacy advice which is clearly demonstrating the delivery of high quality and cost effective prescribing and prescribing systems. Medicines Management plans for the PCT and regular reports to the PEC and Board on progress tightly monitor and control prescribing issues. Cost growth is currently estimated at 7% for 2005-06 and 6% in 2006-07 and 2007-08, although issues such as changes in central policy, introduction of new drugs and generic changes will heavily influence prescribing costs and alter projections. The PCT will continue to participate in collaborative work across Northumberland Tyne and Wear.

7.21 Of particular note is the establishment within 2004-05 of a Medicines Management Group with Newcastle Hospitals, chaired by Newcastle PCT PEC chair which seeks to develop a detailed understanding of drug expenditure and to facilitate a shared approach to medicines management particularly tackling issues such as the introduction of new and expensive drugs.

NEWCASTLE STRATEGIC REVIEW

7.22 Newcastle Upon Tyne Hospitals NHS Trust has produced a Full Business Case (FBC) for the Newcastle Strategic Review (NSR). It sets out the strategic direction of the NSR, the assumptions about capacity and activity, the content of the building schemes and an indication of the present position of the Private Finance Initiative (PFI) Unitary Payment and the overall revenue impact of the project.

7.23 The NSR was originally approved by commissioners in December 1993, reviewed and re-approved in 1998 and an Outline Business Case approved in June 2001. The overall strategy is designed to:

- Consolidate acute healthcare facilities in Newcastle from 3 to 2 sites, in purpose built accommodation for the transferring services;
- To eliminate a substantial proportion of outdated, clinically inappropriate and difficult to maintain estate;
- Improve significantly the integration and thus safety and effectiveness of clinical services;
- Improve the infrastructure available for teaching and research.

SECTION 7 – FUTURE DEVELOPMENTS

- 7.24 The major features of the NSR are the move of all acute services off the Newcastle General Hospital site, new build cancer and renal centres on the Freeman Hospital site and new build on the RVI site for A&E/trauma, neurosciences, critical care, children and infectious diseases. During the PFI process an option (known as option B) was developed which included an enhanced capital scheme at the RVI allowing for the complete integration of paediatrics into the new build, better overall integration and the removal of remaining Edwardian accommodation (other than listed buildings).
- 7.25 The scheme will be paid for by commissioners under the Payment by Results (PbR) financial regime. Funding will flow to NHS service providers on a basis determined by patient activity levels. For services covered by national PbR tariffs, the tariff (or charge) will be fixed centrally by the Department of Health (effectively a national average) and for other services a charge will be locally agreed between providers and commissioners. The Trust is working to a financial close date of end of March 2005, although there are risks of achieving this, particularly around the timing of a general election.

ANNEX A – TARGETS AND TRAJECTORIES

ANNEX B – FINANCIAL PROJECTIONS
