Agenda item 8 i)

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 22 February 2017

Title and Author of Paper: Contract 2017-19 Update

Executive Lead: Lisa Quinn, Executive Director of Commissioning & Quality Assurance

Paper for Debate, Decision or Information: Information & Debate

Key Points to Note:

The enclosed paper provides an update on 2017-19 contract negotiations. At the date of writing this report NTW have a signed contract with Newcastle Gateshead CCG, North Tyneside CCG, South Tyneside CCG, Sunderland CCG and NHS England which means there are signed contracts for 82% of income which is covered by contracts (i.e. excluding non-contracted activity). The largest unsigned contract is with Northumberland CCG. Attached to this paper are the agreed quality schedules across all our contracts, Service Development improvement plans (SDIPs) and the final agreed CQUIN indicators which are all nationally or NHS England mandated.

Risks Highlighted: Contract penalties as a consequence of underperformance

Does this affect any Board Assurance Framework/Corporate Risks: No

Equal Opportunities, Legal and Other Implications: none

Outcome Required / Recommendations: for information only

Link to Policies and Strategies: 2016-17 NHS Standard Contract, 2017-19 Planning Guidance and standard contract

BOARD OF DIRECTORS

22 February 2017

2017-19 Contract Update

PURPOSE

To provide an update on the 2017-19 contract negotiations.

INTRODUCTION

The planning guidance for 2017-19 was issued late 2016, earlier than in previous planning cycles, to facilitate contract sign off by 23rd December 2016 and allow enhanced planning prior to the start of the new financial year.

Attached to this paper is a series of Appendices:

Appendix 1: Quality Standards and Information requirements (Page 5 – 21)
Appendix 2: Commissioning for Quality and Innovation **(**CQUIN) requirements (Page 22)
Appendix 3: Service Development Improvement Plan (SDIP) requirements (Page 23 - 25)

All CCGs have applied 2.1% uplift, 2% efficiency and 2.5% CQUIN – of which, 1% is to be withheld as a reserve dependent upon STP progress and compliance with agreed control totals.

Five Year Forward View for Mental Health (FYFV): No funding has been given for specific elements of the FYFV, but priorities have been included in the SDIP.

Specific CCG adjustments are shown below:

NEWCASTLE GATESHEAD CCG

We have a signed contract for £61.4m, which includes the following additional investment:

Liaison services £403k

Investments which were made non-recurrently in 16/17 have been made recurring in 17/18 for:

Liaison services £300k
Memory Assessment £150k

The CCG has non-recurrently supported Belsay transitions costs as agreed in the business case.

£390k (from recurring OATS savings) has been reinvested in CYPS community services on a non-recurrent basis

£1.7m has been disinvested from autism services following the closure of Woodside, Ingram & Middlerigg.

NORTHTYNESIDE CCG

We have a signed contract for £19.1m, which includes the following additional investment:

Liaison services £156k
5YFV contingency (non-specific) £47k

The CCG has disinvested in the LD Forensic transitions team following notice given in 16/17.

The CCG has non-recurrently supported Belsay transitions costs as agreed in the business case.

NORTHUMBERLAND CCG

This contract is not yet signed. The Trust is working with the CCG to progress this, however, as yet we have not received a formal offer of a contract value for 17/18. In the absence of an offer and agreed contract the existing contract will roll forward.

SOUTH TYNESIDE CCG

We have a signed contract for £21.6m, which includes the following additional investment:

Liaison services £126k

Investments which were made non recurringly in 16/17 have been made recurring in 17/18 for:

CYPS Community services £330k
Liaison services £187k

The CCG has disinvested in the LD Forensic transitions team following notice given in 16/17.

The CCG has non-recurrently supported Belsay transitions costs as agreed in the business case.

SUNDERLAND CCG

Investments which were made non-recurrently in 16/17 have been made recurring in 17/18 for:

CYPS Community services £461k (funded from recurring OATS savings)

A further non-recurrent amount of £370k has been made available for CYPS community pressures in 17/18.

The CCG has disinvested in Craigavon.

The CCG has non-recurrently supported Belsay transitions costs as agreed in the business case.

NHS ENGLAND

We have a signed contract for £50.5m, plus £1.4m for Health & Justice services and £3.9m for PD services which includes the following additional investment:

Neuro rehab wards 3&4 - £322k for outturn activity

Neuro rehab ward 1 will move to a cost and volume contract based on UKROC activity with an additional £304k investment.

£977k funding for a Secure Outreach Transition team has been funded from the closure of Villa 15 and 4 KDU beds

£120k for KDU therapeutic space

A non-recurrently amount of £100k has been agreed for Villa 15 closure transition.

DURHAM & TEES CCGs

These contracts are cost per case and under £5m. We expect to sign before 31st March.

RECOMMENDATIONS

That the Board of Directors note the information included within this report.

Lisa Quinn
Executive Director of Commissioning & Quality Assurance
22 February 2017

Appendix 1: Quality Standards and Information requirements

A. Standard Contract Quality Standards 2017-19

Services are expected to comply with a range of contract requirements. National quality standards with financial penalties are:

Ref	Operational Standards	Threshold	Consequence of breach
E.B.3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	Operating standard of 92% at specialty level (as reported on Unify)	Where the number of Service Users waiting more than 18 weeks at the end of the month exceeds the tolerance permitted by the threshold, £300 in respect of each such Service User above that threshold
E.B.S.1	Mixed sex accommodation breach*	>0	£250 per day per Service User affected
	Duty of candour	Each failure to notify the Relevant Person of a suspected or actual Notifiable Safety Incident in accordance with Regulation 20 of the 2014 Regulations	Recovery of the cost of the episode of care, or £10,000 if the cost of the episode of care is unknown or indeterminate
	Completion of a valid NHS Number field	99%	Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £10 in respect of each excess breach above that threshold
	Completion of Mental Health Services Data Set ethnicity coding	Operating standard of 90%	Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £10 in respect of each excess breach above that threshold

Local NHS England Quality Requirements:

No.	Quality Requirement	Threshold	Method of Measurement	Applicable Service Specification
LQ1	Demonstrate use of HoNOSca and CGAS as effective tools for improving outcomes.	95%	95% of all patients will be assessed on admission and discharge using HoNOSca & CGAS to determine their health and social functioning.	CAMHS Tier 4
LQ2	Assuring the appropriateness of unplanned admissions.	95%	A multi-agency review of all unplanned admissions to general adolescent Tier 4 CAMHS within 5 working days of admission.	CAMHS Tier 4
LQ3	To systematically collect outcome measures for individuals receiving inpatient care at admission and discharge.	95%	To provide a report of all discharges during the quarter, detailing on admission and discharge: - EDEQ - BMI - Length of stay Also including a qualitative narrative of any significant factors impacting on patient's outcomes.	Adult Eating Disorders

No.	Quality Requirement	Threshold	Method of Measurement	Applicable Service Specification
LQ4	HCR 20 and HONOS Secure Assessment. (Version 3).	95%	Percentage of Low and Medium Secure patients with a HCR 20 complete within 3 months of admission.	Adult Low and Medium Secure
		95%	Percentage of Low and Medium Secure patients with a length of stay >9 months who have had an HCR 20 and HONOS Secure Assessment within previous 6 months.	Adult Low and Medium Secure
		N/A	Demonstrate improvement/reduction in score or evidence for reasons of no change.	Adult Low and Medium Secure
LQ5	All patients have co-produced recovery outcomes focused CPA progress plan	95%	1. Total number of patients on CPA. 2. Total number of patients on CPA with an outcomes recovery CPA progress plan covering points listed. 3. Total number of CPAs with an outcome recovery plan signed by the patient. 4. Total number of CPAs co-produced with the patient	All MH services – except Gender.
LQ6	Discharge planning clearly evidenced in CPA with consideration given to possible discharge destinations.	100%	% patients with clear discharge planning evidenced in CPA plan	All MH Services – Except Gender
LQ7	All patients offered 25 hours per week recovery focused meaningful activity.	100%	% patients undertaking recovery focused meaningful activity for a minimum of 25 hours per week	All Low and Medium Secure
LQ8	Physical Health Improvement	100%	Number of patients in service at quarter end Number of patients in service at quarter end with a physical health care plan in place Number of physical healthcare plans that record the status in respect of access to National Screening Programmes Number of physical health care plans that have identified patients in service who have a long term condition.	All MH Services
LQ9	Access to Dentistry	>70%	Total number of inpatients who have had a routine dental check-up/ examination within the last 12 months.	All Inpatient MH Services
LQ10	The provider will demonstrate, annual service improvement/s identified through the use of Patient Reported Outcome Measure.	N/A	Adult Secure Service providers are required to utilise outcomes from PROM to inform the strategy as described in the Discharge and Resettlement CQUIN. Principles stated in guidance should also be applied to non secure services.	All Inpatient MH Services

Note that specialised services quality dashboards are also submitted quarterly.

The services are also required to report on a range of local Key Performance Indicators as set out below:

Description	**Perinatal**	**Secure Services**	**CAMHs**	**Mental Health & Deafness**	**Gender Dysphoria**	**Eating Disorders Services**
Percentage of inpatients with an initial care plan within 72 hours of admission	Y	Y	Y	N	N	Y
Percentage of inpatients who have had a risk assessment (other than HCR -20) completed within one month of admission	Y	Y	N	N	N	N
Number of episodes of seclusion within the reporting period	N	Y	Y	N	N	N
Number of patients on observation	Y	Y	Y	N	N	N
Number of hours of observation 2:1	Y	Y	Y	N	N	N
Number of patients in reporting period who have been secluded for more than 12 hours	N	Y	Y	N	N	N
Number of 'urgent ' gatekeeping assessments undertaken breaching agreed timescales as per national average	N	Y	N	N	N	N
Number of routine gatekeeping assessments undertaken breaching agreed timescales as per national guidance	N	Y	N	N	N	N
Number of stepdown gatekeeping assessments undertaken breaching agreed timescales as per national guidance	N	Y	N	N	N	N
Number of incidents where patients have sustained injury requiring medical attention as a consequence of violence	Y	Y	Y	N	N	N
Number of sickness absences (days) as a consequence of injury following a violent incident	Y	Y	Y	N	N	N
Number of prison transfers which exceeded 14 calendar days	N	Y	N	N	N	N
Number of inpatients transferred back to prison in reporting period	N	Y	N	N	N	N
Number of patients referred to high secure by the trust	N	Y	N	N	N	N
Percentage of young people with a formal risk assessment completed within 1 week of admission	N	N	Y	N	N	N
Proportion of new patients seen in the quarter who have had their first definitive treatment (first assessment visit) within 18 weeks	N	N	N	N	Y	N
Number of patients due their 6 monthly review in the quarter who have been reviewed	N	N	N	N	Y	N

Description	Perinatal	Secure Services	CAMHs	Mental Health & Deafness	Gender Dysphoria	Eating Disorders Services
Number of patients with a first contact within reporting period	N	N	N	N	Y	N
Number of patients with a follow - up contact within reporting period	N	N	N	N	Y	N
Numbers of patients within the service at >3 years at the end of the quarter	N	N	N	N	Y	N
Number of patients referred for surgery within quarter	N	N	N	N	Y	N
Number of patients referred for hair removal within the reporting period	N	N	N	N	Y	N
Number of patients referred for second opinion	N	N	N	N	Y	N
Percentage of patients who have had a psychological assessment within the previous 6 months	N	N	N	N	N	Y
Of the patients who have had a psychological assessment in the previous six months, the percentage who have received formal psychological intervention as described in the national specification	N	N	N	N	N	Y

Alongside the quality requirements are a range of datasets and other data items provided as part of the NHS England contract.

Liaison and Diversion Service
The National Minimum Data Set ("MDS") for each individual using the Services as set out in Annex 1 of this Schedule 6B.
The Provider will collate and maintain the following: • a Risk Register; • Issues Log; • Lessons learned; and • Innovations Record
The Provider will submit an Incident Report and Workforce Report.
The Provider will review all referrals on a monthly.
The Provider will notify all complaints to the Commissioner.
[If fitness to detain/fitness to interview is undertaken by the Provider, the Provider will submit the following information to the Commissioner: • when the request was made; • by whom; • result of assessment; • whether police called on Forensic Medical Examiner (FME) subsequent to the L&D determination regarding Fitness to detain/fitness to interview; • the time taken for arrival of FME; and • whether the FME's findings matched those of the L&D practitioner.]
[If the fitness to detain/fitness to interview is not undertaken by the Provider, as per the National Operating Model, the Provider will submit the following information to the Commissioner: • any requests by police personnel for such assessments; • when; • by whom; • the time taken for arrival of FME; and • the subsequent result of the FME examination.]

CYPS Inpatient Services are required to be part of the Quality network for Inpatient CAMHS and to comply with the quality standards outlined below as well as to meet the standards for accreditation.

Number	**QNCC standard**
6.3	Young people who require inpatient care are referred to units that meet their individual needs with effective continuing care.
6.3.2	Young people are referred to a unit that is as accessible as possible so that contact with home and family is maintained.
6.3.5	If inpatient care is required the key worker or equivalent contacts the inpatient soon after admission and attends review meetings during the inpatient.
6.6	Staff work closely with the young person's locality CAMHS team or inpatient service to arrange effective handover and joined up provision of continuing care after the community based intensive intervention.
Number	**QNIC standard**
3.3	There is equity of access to inpatient units in relation to location of residence.
3.5	Families are involved throughout assessment.
3.6	Before discharge decisions are made about meeting any continuing care needs
4.6	Young people can continue with their education whilst admitted.
4.6.7	Educational and unit staff supports the young person to reintegrate back to their local educational facility.

Offender PD – Oswin/IIRMs		
QUALITY REQUIREMENTS	**Threshold**	**Method of Measurement**
1. Appropriate offenders are identified against the criteria for the service	No target	1c. Total number of live cases that you are managing in your service
	100%	1d. Number and percentage of referrals received in the previous quarter that have been reviewed against the criteria for the service, and a decision made within 3 months of receipt of the referral.
2. Offenders have appropriate and timely i) case consultation ii) case formulation (where appropriate) iii) pathway/sentence plan or treatment plan	**OPD Community:** 90% Level 1 or higher **Treatment Services**: 90% Level 2 or higher **Progression:** No target	**2b. OPD Community:** Number and percentage of cases in the OPD Pathway with a case formulation recorded **2b. Treatment Services**: Number and percentage of cases in the OPD Pathway with a case formulation recorded **2b. Progression Services:** (for information only) Number and percentage of cases in the OPD Pathway with a case formulation recorded
	OPD Community: No target **Progression Services**: No target **Treatment Services**: 100% of those engaged in treatment	**2c. OPD Community:** Number and percentage of cases in the OPD Pathway that are considered 'ready for services' that have had a recommendation or a referral made or a referral accepted as part of their OPD Pathway Plan. **2c. Treatment and Progression Services:** Number and percentage of cases in the OPD Pathway with a Pathway/Sentence Plan or a Treatment Plan
4. An offender's progress against their treatment objectives is reviewed at least annually	Information only (baseline to be established in 2015/16)	4a. Number and percentage of cases in OPD Services with a review of the Treatment Plan within the last 6 months (dependent on model)
5. Offenders access and complete services that are identified in their Pathway Plan	No target	5b. Number of offenders that have moved from the assessment phase of the service to the core treatment phase, where a separate assessment unit/ process is in place in the service
	No target	5c. Number of offenders leaving the service, including reasons for non-completion/dis-engagement from both assessment and core treatment elements of the service (where applicable)
	No target	5d. For those who have left the service in the previous year, record i) the average length of time spent participating in the treatment phase of the service (excluding time spent waiting for referral out and not actively participating) and ii) the average length of time on the unit/ in the service (all services)

Offender PD – Oswin/IIRMs		
QUALITY REQUIREMENTS	**Threshold**	**Method of Measurement**
6. Plans are in place for each offender to make a progressive move along their Pathway/Sentence Plan post-participation in a service	Information only (baseline to be established in 2015/16)	6a. Number and percentage of cases who have left the service with a recorded planned move
7. Plans are in place to enable appropriate follow-up of offenders who both complete and disengage with services, regardless of move-on location	Information only (baseline to be established in 2015/16)	7a. Number of cases that the service has had contact with following departure; broken down by completers and non-completers
8. There is a sustained focus on staff training and reflective practice appropriate to the specialist nature of the service and staff's individual roles and responsibilities	Written Report (no target)	8a. A staff training plan, which identifies all training needs and gaps relevant to the OPD Pathway, is completed for the service and updated yearly, including gender specific training needs where appropriate
	90%	8b. Number of OPD pathway specific training activities delivered to staff, and shown as a percentage against total OPD training activities recommended in the training plan
	No target	8c. Number of OPD pathway staff attending planned training activities, and shown against the target number that should attend
9. The service has processes in place to give staff ongoing support in the form of supervision	OPD Community: no target Treatment and Progression Services = 90%	**9a. OPD Community:** Number of staff involved in the OPD Pathway who are offered (individual or group) clinical supervision once in the previous quarter **9a. OPD Treatment and Progression**: Number and percentage of staff involved in the OPD Pathway who are offered (individual or group) clinical supervision once in the previous quarter / or once monthly (dependent on service type)
	No target	9b. Number and percentage of OPD pathway staff attending planned clinical supervision sessions
10. Offenders are offered psycho-social and psycho-educational interventions that are responsive to their needs	Information only (baseline to be established in 2015/16)	10a. Number of activities delivered compared to activities planned to be delivered (activities/ intervention types reported to be agreed locally with commissioners)
	No target	10b. Number and percentage of offenders that complete/ do not complete key components of the treatment service; where applicable (e.g. Chromis, CBT
11. Offenders are offered constructive, pro-social activities	No target	11a. Number and type of pro-social activities of daily living offered on the unit
12. The service has a clear purpose, a well-defined model and a coherent philosophy of	Written Report (no target)	12a. The purpose of the service, service model and philosophy of care is documented and shared with staff and offenders

Offender PD – Oswin/IIRMs		
QUALITY REQUIREMENTS	**Threshold**	**Method of Measurement**
care, that is documented, provided to and understood by staff and offenders	Written Report (no target)	12b. Summary report of events that have been held with direct care staff / frontline delivery staff (e.g. OMs) and offenders to inform them about, and gather feedback on, the ongoing development of the OPD service
	Written Report (no target)	12c. Evidence that offender and staff suggestions / requests are recorded and actioned where appropriate
13. The service operates in a safe and respectful environment and provides experience of reliable relational support, which is consistent and continuous over time	Written Report (no target)	13a. The service is recording changes in the social climate of the environment using an appropriate tool (e.g. Enabling Environments portfolio, EssenCES, MOOS, bespoke questionnaire where others not appropriate)
	Written Report (no target)	13b. Report on progress made by the service in working towards establishing an Enabling Environment (applicable services only)
14. The service is able to provide the conditions for a sustained and consistent therapeutic operation; evidenced by a formal 'enabling' agreement between the 'host' organisation and the joint OPD Pathway service.	Written Report (no target)	14a. A formal partnership arrangement between providers delivering the service and host organisations is in place and updated annually
15. There are explicit governance arrangements covering effective collaborative working agreements and operational arrangements between the partners delivering the service and the wider operational requirements in the organisation	Written Report (no target)	15a. Joint report between the OPD Service and host organisation on how the OPD Pathway impacts on leadership, management and the delivery of seamless operations
16. Services provide a framework for meaningful involvement of both staff and service users. This should address individual treatment, as well as service level and pathway level issues.	Written Report (no target)	16a. Annual service user involvement strategy, with targets and commentary on how well these targets were met
17. The service will aim to keep at a minimum occupancy unless prior agreement not to do so has been obtained from the co-commissioners of the service.	Target agreed locally with commissioners	Occupancy (attendance) level reported as an average over the quarter
18. Data is collected and submitted in the required format	100%	18a. Agreed data collection schedules are submitted
	90%	18b. Number and percentage of cases with a HCR 20 (or other agreed risk measure) completed annually.

Offender PD – Oswin/IIRMs		
QUALITY REQUIREMENTS	**Threshold**	**Method of Measurement**
	90%	**Male ex-DSPD Services only:** 18c. Number and percentage cases with a VRS (or other agreed risk measure) completed at least three points during time with the service
	90%	18d. Percentage cases with a CORE-OM assessment (or other health measure as agreed with commissioners) completed at least three points during time with the service
19. An integrated multi-disciplinary team is in place to meet the needs of offenders who are accessing the services	Target agreed locally with commissioners	19a. The provision of staff contracted to deliver the OPD Service is at the required level throughout programme delivery, with vacancies reported
	Target agreed locally with commissioners	19b. Number of staff contracted to deliver the OPD Service leaving in each quarter, and as a percentage of total staff group
	Target agreed locally with commissioners	19c. Percentage of days lost to staff sickness as a percentage of total staff sickness days

B. Clinical Commissioning Groups

Operational Standards	Threshold 2017/ 18	Consequence of breach	Applicable CCGs
Percentage of Service Users on incomplete RTT pathways waiting no more than 18 weeks from referral	Operating standard of 92% at specialty level	£300 in respect of each Service User above threshold	All
Mixed sex accommodation breach*	>0	£250 per day per Service User affected	All
Care Programme Approach (CPA): The percentage of Service Users on CPA who were followed up within 7 days of discharge from psychiatric in-patient care	Operating standard of 95%	£200 in respect of each such Service User above threshold	All
National Quality Requirement	**Threshold 2017/ 18**	**Consequence of breach**	**Applicable CCGs**
Zero tolerance RTT waits over 52 weeks for incomplete pathways	>0	£5,000 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	All
Duty of candour	Each failure to notify the Relevant Person of a suspected or actual Reportable Patient Safety Incident	Recovery of the cost of the episode of care, or £10,000 if the cost of the episode of care is unknown or indeterminate	All
Completion of a valid NHS Number field	99%	£10 in respect of each excess breach above threshold	All
Completion of Mental Health Minimum Data Set ethnicity	Operating standard of 90%	£10 in respect of each excess breach above threshold	All
Completion of IAPT Minimum Data Set outcome data	Operating standard of 90%	£10 in respect of each excess breach above threshold	Sunderland CCG
Early Intervention in Psychosis programmes: % experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral	For the period 1 April 2017 to 31 March 2018 operating standard of 50%. From 1 April 2018 operating standard of 53%	Issue of Contract Performance Notice and subsequent process in accordance with GC9	All
Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users who are treated within six weeks of referral	Operating standard of 75%	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Sunderland CCG
Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users who are treated within 18 weeks of referral	Operating standard of 95%	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Sunderland CCG
Improving Access to Psychological Therapies (IAPT)	Access Target 2017/18 - 17%	N/A	Sunderland CCG
Improving Access to Psychological Therapies (IAPT)	Access Target 2018/19 - 16%	N/A	Sunderland CCG

Local Quality Requirements	Threshold 2015 / 16	Consequence of Breach	Applicable CCGs
Delayed Transfers Of Care (Monitor Definition)	7.50%	N/A	All
The proportion of users on CPA with a crisis plan	95%	N/A	All
The proportion of users on CPA who have had a review within the last 12 months	95%	N/A	All
Percentage of Children's eating disorders patients being seen within the 1 weeks and 4 week timescales as per the access & waiting times requirements	Data only	N/A	All Local commissioners except - North Tyneside
EMERGENCY RE-ADMISSIONS WITHIN **30** DAYS -	Data only	N/A	All
EMERGENCY RE-ADMISSIONS WITHIN 90 DAYS (LD SERVICES	Data only	N/A	All
NUMBER OF SERVICE USERS ON CPA IN EMPLOYMENT	Data only	N/A	All
NUMBER OF SERVICE USERS AGED 18 TO 69 ON CPA WITH EMPLOYMENT STATUS RECORDED IN THE LAST 12 MONTHS	Data only	N/A	All
Local CPP Metrics	**Threshold 2015 / 16**	**Consequence of Breach**	**Applicable CCGs**
The proportion of users with a crisis plan in place, limited to those on Care Programme Approach	95%	N/A	All
The proportion of users on CPA who have had a review within the last 12 months	95%	N/A	All
The completeness of ethnicity recording	90%	N/A	All
The accommodation status of all users (as measured by an indicator of settled status)	Data Only	N/A	All
The proportion of users in each cluster who are on CPA	Data Only	N/A	All
Proportion of in scope patients assigned to a cluster	Data Only	N/A	All
Proportion of initial cluster allocations adhering to red rules	Data Only	N/A	All

Proportion of patients within cluster review periods	Data Only	N/A	All
PREMS	Data Only	N/A	All
CROMS	Data Only	N/A	All

National Requirements reported Centrally	**Applicable CCGs**
As specified in the list of omnibus, secure electronic file transfer data collections and BAAS schedule of approved collections published on the HSCIC website to be found at **https://rocrsubmissions.ic.nhs.uk/Pages/search.aspx?k=R*** where mandated for and as applicable to the Provider and the Services	All
Patient Reported Outcome Measures (PROMS) **http://www.hscic.gov.uk/proms**	All
National Requirements reported locally	
Activity & Finance Report	All
Service Quality Performance Report, detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour, including, without limitation: **a.** details of any thresholds that have been breached and any Never Events and breaches in respect of the duty of candour that have occurred; **b.** details of all requirements satisfied; **c**. details of, and reasons for, any failure to meet requirements	All
CQUIN Performance Report	All
NHS Safety Thermometer Report, detailing and analysing: **a.** data collected in relation to each relevant NHS Safety Thermometer; b. trends and progress; **c.** actions to be taken to improve performance.	All
Complaints monitoring report, setting out numbers of complaints received and including analysis of key themes in content of complaints	All
Report against performance of Service Development & Improvement Plan (SDIP)	All
Summary report of all incidents requiring reporting	All
Data Quality Improvement Plan: report of progress against milestones	All
Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (Staff)	All
Report on compliance with National Workforce Race Equality Standard	All
Local requirements reported locally	
External Reports (including Monitor, CQC, staff and patient and others)	All

Delayed Transfers Of Care (all ages)	All
Memory Protection Service MDS & MAMs	All
CYPS data set	All Local commissioners except North Tyneside
CYPS Narrative Report	All Local commissioners except - North Tyneside
CPP Data set	All
CCG Summary Activity Report / Dashboard	All
Emergency Readmissions report	All
Waiting times data	All
Surveys	**Applicable CCGs**
Friends and Family Test (where required in accordance with FFT Guidance)	All
Service User Survey	All
Staff Survey (appropriate NHS staff surveys where required by Staff Survey Guidance)	All
Carer Survey	All

CYPS Community Service Performance Management Framework 2017/18

Alongside the new waiting time bands CYPS community report quarterly on a number of key performance indicators as set out below.

Community CYPS Performance Management Framework 2017/18	
	Overview of key issues
1	Patient flow analysis – to remain as this year but with additional information to show the breakdown into the 3 secondary groups – mental health, LD challenging behaviour, Neurodevelopmental.
2	Breakdown of caseload by CCG
3 4	Children's Global Assessment Scale – 80% of patients have score at initial appointment and on discharge
5	Quarterly analysis of CGAS data to be provided
6	HONOSCA - 80% of patients who have 3 attended treatment appointments will have a score at initial appointment and on discharge
7	80% of C&YP who have completed a course of treatment in each quarter will demonstrate a statistically significant medium or higher level improvement (HONOSCA),
8	Goal based outcomes – 80% of patients who have 3 attended treatment appointments will have a score at initial appointment and on discharge – new KPI
9	Quarterly analysis of Goal based outcomes data to be provided – new KPI. Looking to achieve 3 point improvement on goals
10	Information and analysis of Points of You returns from children, young people and their families to be provided on a quarterly basis and to include a description of how the service has responded to feedback – new KPI to replace ESQ.
11	The service will demonstrate how it engages with stakeholders and how it reacts to feedback to make service improvements – annual report
12	IAPT - Quarterly templates submitted to the IAPT collaborative to be embedded in here rather than previous narrative description on progress to minimise duplication
13	Source of referral, including self-referral

Community CYPS Performance Management Framework 2017/18	
14	Number of urgent referrals and outcome following triage. To understand the number of urgent referrals and outcome of those referrals, how many are then not seen as urgent and reasons for this.
15	Provide number of referrals to ICTS in the quarter, open cases at the quarter start, open cases at the quarter end, cases discharged in the quarter, total cases open in the quarter
16	Number of referrals with a suspected eating disorder who are classed as either routine or urgent and are seen in the nationally mandated timeframes with reasons for exceptions to this.
17	Provide number of referrals to the eating disorder teams in the quarter, open cases at the quarter start, open cases at the quarter end, cases discharged in the quarter, total cases open in the quarter
18	Age range including under 5's, 6-13yrs, 14-16yrs, 16-18yrs and over 18's
19	Caseload analysis by C&YP in special circumstances including young carers
20	Newcastle T2 only – The service will provide information on the range of non-direct work that it carries out demonstrating how it develops capacity and capability in other parts of the children's mental health pathway. Remain until work on local transformation is complete and then review.
21	Report the number of training sessions and number of attendees by recipient organisation (e.g. school, general practice, multi-disciplinary, cross agency) by CCG
22	CQUIN – Quarterly CQUIN update to be provided. CYPS transitions CQUIN to apply to CCG commissioned services only.
23	16% DNA first appointment each quarter with analysis and action plan to meet the target
24	16% DNA subsequent appointments with analysis and action plan to meet the target

C. CCG Commissioned – Outside Main Contract

Community Acquired Brain Injury Service (CABIS)

Quality Requirement
Baseline of patient re-engagement in community activities (without / reduced dependency on services). Patient experience and social outcome measure before injury and after.
Training provided to other agencies/teams to help them manage patients with ABI in the community
Partnership arrangements that achieve local solutions and community engagement supporting a spectrum of needs. Demonstrate sustainable social outcomes for patients and their families.
1. Seamless transition between secondary or tertiary care and CABIS. Use of partnership agencies in this role.
2. Patients accessing generic community rehabilitation services as part of wider community support i.e. Intermediate Care, Fall Team. Demonstrate sustainability of rehab and ensure patients with ABI plus other morbidities / needs are collectively met. Referrals will be submitted via patient level dataset.
3. Signposting and take up of community support services in order to demonstrate appropriateness of referrals and community services supported to enable people with an acquired brain injury
4. Services that CABIS have supported to manage people in local services in order to demonstrate appropriateness of referrals and community services supported to enable people with an acquired brain injury.
5. Use of Telehealth / Telecare by clients in order to predict future need, potential benefits and cost implications. Monitoring of seizure falls / wandering to be led by specialist nurse.
6. Professional alignment with best practice via publication / presentation of audits / papers within credible ABI networks. The service will be open to peer challenge and professional accountability of the service. Promote learning and shift of professional expertise from tertiary settings to community.
7. Survey of Professional Groups (agencies/teams) supported by CABIS

D. OTHER

Addictions
Addictions Services have a range of quality and performance frameworks bespoke to the Local Authority where the service is provided. These are reported via a separate system and reviewed in contract meetings quarterly.

National Services Division (NSD)
Where we have a contract in place to provide services to patients from Scotland we are required to provide a Bi annual patient update and to provide an annual Quality narrative report. This contains a range of information in relation to safeguarding, incidents, quality of care and record keeping.

Rotherham CCG Contract
We are currently contracted to provide a bespoke package of care to a patient from Rotherham CCG. This was organised via a tender process and contains within it a quality framework. This is provided and reviewed quarterly.

Appendix 2: CQUIN requirements

A. NHSE Specialised Commissioned CQUINs 2017-19

MH2 Recovery Colleges for Medium and Low Secure Patients	Goal: The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services.
MH3 Reducing Restrictive Practices within Adult Low & Medium Secure Services	Goal: The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, to improve patient experience whilst maintaining safe services.
MH4 Discharge and Resettlement	Goal: To find initiatives to remove hold-ups in discharge when patients are clinically ready to be resettled into the community. To include implementation of CUR for MH at pilot sites.
MH5 CAMHS Inpatient Transitions	Goal: To improve transition or discharge for young people reaching adulthood to achieve continuity of care through systematic client-centred robust and timely multi-agency planning and co-ordination.
Health & Justice – Patient Experience	Goal: NHS England has a national priority and focus on patient experience in order to improve the quality of services.

B. CCG Mandated CQUINs 2017-19

Improving Staff Health & Wellbeing	Goal: Improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well.
Improving physical healthcare to reduce premature mortality in people with serious mental illness(PSMI)	Goal: Assessment and early interventions offered on lifestyle factors for people admitted with serious mental illness (SMI).
Improving services for people with mental health needs who present to A&E	Goal: Ensuring that people presenting at A&E with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at A&E.
Transitions out of Children and Young People's Community Mental Health Services	Goal: To improve the experience and outcomes for young people as they transition out of Children and Young People's Community Mental Health Services.
Preventing ill health by risky behaviours – alcohol and tobacco	Goal: To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.

Appendix 3

Service Development and Improvement Plans (SDIP)

A. NHSE Specialised Commissioned Services Contract Service Development and Improvement Plan

	Milestones
Review Mental Health Secure Outreach Team against service specification called Forensic Outreach and Liaison Service	Ensure service meets the national specification Develop action plan to meet service specification with clear timescales Reach a clear understanding of the types of contacts and activity levels by professionals within the team
Gender Dysphoria Service	NTW to work with NHS England to develop a clear description of the types of contacts within the service and how they are recorded NHS England to review the service against the new specification which is out to consultation NTW will work with NHSE to complete the national reporting template when implemented
Mental Health and Deaf Team	NTW to work with NHS England to develop a clear description of the types of contacts within the service and how they are recorded
Peri-natal outreach	If funding is agreed nationally, implement development of peri -natal outreach service in line with agreed business case
Peri natal service	To ensure that the service meet the new specification when published
CAMHS Tier 4 National Service Review	NTW and NHS England to work together to implement recommendations from the national service review
Adult Secure National Service Review	NTW and NHS England to work together to implement recommendations from the national service review
Secure Outreach and Transitions Team	**If approved and agreed by NHS England** Develop Secure Outreach and Transitions Team as per agreed business case
Adult Medium and Low Secure services	To ensure that the services meet the new specifications when published
CAMHs Tier 4 services	To ensure that the services meet the new specifications when published
Neuropsychiatry	The current service specification is in draft. NTW will work with NHSE to ensure that the service meets the specification when finalised.
CNDS	NTW to work with NHS England to develop a clear description of the types of contacts within the service and how they are recorded

B. Clinical Commissioning Groups Service Development and Improvement Plan

Description
Children & Young Peoples Mental Health (Community CYPS) Joint working between CCGs, NTW and other relevant providers to review the Local Transformation Plans for Children & Young Peoples Mental Health (submitted by CCGs) and to jointly develop plans in order to meet the required trajectories and the new access & waiting times standards. This will incorporate reviewing: • Access & Waiting Times • CYPS IAPT • Evidence based interventions
Children & Young Peoples Mental Health (Community CYPS) Joint working between CCGs and NTW to review the Local Transformation Plans developed prior to April 1st 2017 for Children & Young Peoples Mental Health (submitted by CCGs) and to jointly develop plans in order to meet the required trajectories and the new access & waiting times standards. Specifically for NTW in Sunderland this will entail: • Full pathway review to deliver provision within agreed 16/17 financial envelopes or as jointly agreed. • Any efficiencies realised to be re-invested to manage requirements of 5YFV for CYPs.
EDICT (All) Following the completion of the review of EDICT by CCGS in 2016/17 and based on the outcomes from this NTW & Commissioners will: explore best practice; improve early identification and establish robust data monitoring around eating disorder services.
Perinatal Mental Health CCGs, NTW and relevant stakeholders will work together to ensure implementation / roll out of newly funded community perinatal service across all CCGs, in line with CCG caveats given in support of the NTW bid Review of M&B services during 2018/19 (once service embedded) to ensure compliance against NICE standards
Adult Mental Health: EIP NTW & Commissioners will work together to ensure that sufficient staff of the requisite skill-mix are employed and appropriately trained to ensure compliance with the improvements identified within Waiting Time Self-Assessment and actions required to deliver 53% waiting time standard in 2018/19 and NICE compliance.
Adult Mental Health: Liaison Teams During 2017/18 - CCGs (in conjunction with NTW and relevant stakeholders) to review current Liaison services.

Adult Mental Health: common mental Health problems (IAPT)

NTW to work with CCG & Partner agencies to develop and implement a project plan in line with the national early implementer requirements.

NTW to work with CCG and partner agencies to develop plan to deliver 25% access target and business case for recurring funding.

Adult Mental Health: Crisis Teams

NTW, CCG and other relevant stakeholders to review urgent and crisis services and plan for the best model for our local area

Adult Mental Health: Community Services

NTW working with CCGs and other stakeholders to review community services

Adult Mental Health: Access to psychological therapies

Following the outcome of the review of Psychotherapy and CBT by CCGS in 2016/17 NTW and the commissioners will work together to develop a plan to address any recommendations that result.

Suicide prevention

NTW to support the CCG in the development of local multi-agency prevention plans and to engage with the work required to achieve this. This plan to cover all age groups

ADHD and Autism (All)

To continue with the work developing the plans for the Adult ADHD and Autism Diagnostic service following on from the 2016/17 discussions / agreements.

Review of Clinical Pathways for the Over 65's (North Tyneside only)

The CCG and NTW will work together, with relevant stakeholders, to review and develop services for older people.

LD Transformation

NTW is fully committed to work collaboratively with CCGs to meet the requirements of the Transforming Care agenda, and any emerging guidance, policy or requirements.

LD Assessment & Treatment Beds

The CCGs (all who commission beds at Rose Lodge) and NTW will work together to review the current provision of assessment and treatment beds at Rose Lodge and agree any next steps required

Outcomes

NTW and CCGs to work jointly in moving towards an outcome based commissioning model and responding to the national requirements in relation to this