Board of Directors Meeting (PUBLIC)

27 June 2018, 13:30 to 15:30
The Large Training Room, Hopewood Park, Ryhope, Sunderland, SR2 0NB.

Agenda

1. Service User/Carer Experience

Information

2. Apologies

Information

Chair

3. Declarations of Interest

Information

Chair

4. Minutes of the previous meeting: Wednesday 23 May 2018

Decision

Chair

Item 4 - Meeting Minutes Board of Directors 23 May 2018.pdf (7 pages)

5. Action list and matters arising not included on the agenda

Discussion

Chair

Item 5 - Action List.pdf (2 pages)

6. Chair's Remarks

Information

Chair

7. Chief Executive's Report

Information

Chief Executive

- Item 7 - CE Report June 2018.pdf (6 pages)
- Item 7a - Appendix 1. NHS Providers OTDB 201718 Q4 Finances and Performance.pdf (6 pages)
- Item 7b -Appendix 2. NHS Providers OTDB.pdf (10 pages)
- Item 7c -Appendix 3. NHS Providers OTDB.pdf (8 pages)
- Item 7d -Appendix 4. HSC OTDB 11 June 2018.pdf (6 pages)

Quality, Clinical and Patient Issues

8. Integrated Commissioning and Quality Assurance Report (April Month 2)

Discussion

Executive Director of Commissioning and Quality Assurance

- Item 8 - Intergrated Commissioning and Quality Assurance Report (Month 2).pdf (43 pages)

Strategy and Partnerships

9. Announcement from NHS Improvement and NHS England

Information

Chief Executive

- Item 9 - Announcement from NHS Improvement and NHS England.pdf (20 pages)

10. Integrated Care System (ICS) Bid (formerly STP) Integrated Secure Site

Discussion

Deputy Chief Executive/ Executive Director of Finance

- Item 10 - Integrated Care System (ICS) Bid (formerly STP) Integrated Secure Site.docx.pdf (29 pages)
- Item 10b - STP Capital VFM template (NTW) (130618 Submission File).pdf (15 pages)

11. Interim Accommodation for Newcastle and Gateshead Adult In-Patient Services

Decision

Executive Director of Nursing and Chief Operating Officer

Item 11 - Interim Accommodation for Newcastle and Gateshead Adult In-Patient Services.docx.pdf (16 pages)

Regulatory

12. Board Self Certification to NHS Improvement – Governors Training

Decision

Executive Director of Commissioning and Quality Assurance

Item 12 - Board self Certification - Governors Training.doc.pdf (3 pages)

Minutes/Papers for Information

13. Committee updates

Information

Non-Executive Directors

14. Council of Governors' Issues

Information

Chair

15. Questions from the Public

Discussion

Chair

Date, time and place of next meeting:

16. Wednesday 25 July 2018, 13:30 to 15:30, Kiff Kaff, St Georges Park, Morpeth, NE61 2NU

Information

Chair

Board of Directors 23 May 2018 (PUBLIC)

23 May 2018, 13:30 to 15:30
The Board Room, St Nicholas Hospital, NE3 3XT

NHS Northumberland, Tyne and Wear NHS Foundation Trust

Attendees

Board member group

Ken Jarrold (Chair) , John Lawlor (Chief Executive) , Alexis Cleveland (Non-Executive Director) , Dr Leslie Boobis (Non-Executive Director) , Miriam Harte (Non-Executive Director) , Dr Rajesh Nadkarni (Executive Medical Director) , Gary O'Hare (Executive Director of Nursing and Chief Operating Officer) , Lisa Quinn (Executive Director of Commissioning and Quality Assurance) , Peter Studd (Non-Executive Director) , James Duncan (Executive Director of Finance and Deputy Chief Executive) , Lisa Crichton-Jones (Executive Director of Workforce and Organisational Development) , Ruth Thompson (Non-Executive Director) , Martin Cocker (Non-Executive Director)

In Attendance

Lynne Shaw (Deputy Director of Workforce and Organisational Development) , Jennifer Cribbes (Corporate Affairs Manager) , Tony Gray (Head of Safety and Security)

Meeting minutes

1. Service User/Carer Experience

Joanne Peacock and Sue Barrow delivered a verbal presentation to share their personal experiences of using NTW services.

The Board thanked Joanne and Sue for sharing their experiences which were said to be very powerful, inspiring and provided a valuable insight on services.

In response to a question raised by John Lawlor, Sue and Joanne agreed that they would be willing to speak to Trust staff for development and improvement purposes.

Ken Jarrold summed up the key messages gained from the presentation. It was clear that Joanne and Sue felt that the recovery college provided people with another opportunity, allowed them to be themselves and that everyone is accepted for who they are.

2. Welcome and Apologies

Chair

Ken Jarrold opened the meeting and welcomed attendees.

There were no apologies recieved.

3. Declarations of interest

Chair

There were no further interests declared.

4. Minutes of previous meeting held on 25 April 2018

Decision
Chair

Item 50/18 Integrated Commissioning and Quality Assurance Report
Amendment to the paragraph regarding system changes in South Tyneside to specify that waiting times for Children and Young Peoples' services may be difficult to understand due to service charges.

The minutes of the meeting held on 25 April 2018, as amended, were agreed as a true and correct record.

Item 4 - Public Board of Directors minutes.pdf

4.1. Action list and matters arising not included on the agenda

Discussion
Chair

Action List

Action's 50/18 responsible person to be amended to DR (Damian Robinson)

Matters arising
There were no matters arising.

Item 5 - Action List.pdf

5. Chair's Remarks

Information
Chair

Ken Jarrold provided a verbal update and made the Board aware that the Council of Governors, at their meeting on the 17 May 2018, approved the Nominations Committees recommendation to re-appoint Les Boobis, Non-Executive Director and Alexis Cleveland, Non-Executive Director and Deputy Chair for another three year term. The Board congratulated Les and Alexis on their re-appointments.

The Board were also made aware that the CQC had observed the Governors meeting on the 17 May 2018.

In relation to the ongoing Chair and Governor one to one meetings, Ken advised that he had met with eight governors so far which had been invaluable in terms of understanding their skills and life experience. Ken advised that he has dates in the diary to meet a further nine Governors.

Finally Ken advised that work was commencing to prepare for Governors elections at the end of the year.

6. Chief Executive's Report

Information
Chief Executive

John Lawlor spoke to the enclosed Chief Executive's report to update the Board on key areas.

John advised the Board that the Collective Leadership Programme; Joint Operational and Corporate Services Sharing and Learning Event, took place on the 10th May which had been a very large event and feedback gained had been very positive.

James Duncan advised that the Gateshead System Partnership was in development and the workshop was due to take place in the next two weeks.

John referred to the section containing the North East Staff Survey Results and highlighted that although NTW had scored best in the region it is important that the Trust does not become complacent.

In relation to the Workforce Race Equality Standard, John advised that a group of regional leaders had met and spoken about particular issues and work to improve in this area. John highlighted that further work can be done to improve and the CQC had been right to indicate to the Trust the need to continue to focus on this area.

Gary O'Hare spoke to the section relating to 'report into deaths amongst people with learning disability' and explained that a more robust approach to investigate deaths for those with learning disabilities was being introduced Nationally.

The Board received the Chief Executive's report for information.

Item 7 - CE Report May 2018.pdf

Quality, Clinical and Patient issues:

7. Safer Staffing Levels (Quarter 4)

Discussion
Executive Director Of Nursing And Chief Operating Officer

Gary O'Hare spoke to the enclosed safer staffing report which included exception data and analysis of all ward staffing against safer staffing levels for Quarter 4.

The Board were made aware that some wards were outside of the agreed staffing levels during the quarter and that the report focused on exception reporting for those ward groups. Gary referred to the Bank and Agency staff rates on page 3 of the report and explained that the increase in use of agency staff during the last quarter was, in part, a result of staff using up left over annual leave. It was explained that work was being undertaken to schedule leave entitlements across the year to prevent this situation occurring in the future.

Gary advised that future reports would include a brief narrative/exception report that will map vacancies, incidents and percentage of sickness against wards in line with the new guidance. Data for each ward on care hours per patient day would also be included which would be valuable information.

Gary confirmed there had been no incidents relating to staffing levels in the quarter.

Discussion took place relating to the work being conducted on retention of staff and understanding the Trust's turnover levels for qualified staff.

The Board of Directors noted the contents of the report.

Item 8i - Safer Staffing Q4 report.pdf

8. Annual Security Management Report

Information
Executive Director Of Nursing And Chief Operating Officer

Tony Gray spoke to the annual Security Management report to update the Board on the security arrangements currently in place within the Trust.

It was explained that the report now includes Lone Working, Physical Assaults on Staff and Security Management, which have previously been presented in separate reports.

Ruth Thompson left the meeting at 14:29.

A significant discussion took place in relation to the use of lone working devices. Martin Cocker requested that the Board receive assurance that lone working devices are being used properly. Ken Jarrold and Alexis Cleveland further requested that the Board keep lone working devices under review.

John Lawlor referred to the aggression and violence statistics on page 17 of the report and requested the number to be checked as the number of incidents have doubled from those previously reported. Tony advised that it may be result of a change in the way the data has been coded. It was agreed that the data would be checked and an explanation would be provided.

Lisa Crichton-Jones raised that people were still smoking on site and requested that the Board keep smoking under review.

Ken Jarrold summed up the item as discussed and requested that;
1. The issues, as discussed, relating to lone working and staff turning on devices be kept under review by the Board this included receiving progress reports.
2. An explanation be provided in relation to the aggression and violence statistics.
3. The Board keep smoking issues under review.

Tony Grey left the meeting at 14:43

The Board of Directors noted the contents of the report.

Item 8ii - Security Management Annual Report - Board of Directors -23 May 2018.pdf

9. Integrated Commissioning and Quality Assurance Report (April Month 1)

Discussion
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed Integrated Commissioning and Quality Assurance Report for April 2018 (month 1) to update the Board on issues arising in the month and progress against quality standards.

Lisa advised that the CQC well-led inspection had taken place last week and the Trust is now awaiting a report on the outcome of the inspection and results of the visits to core services.

In response to a question raised by Les Boobis, Lisa explained that staff are required to complete tranquilisation training every three years so the position as stated in the report is correct. Lisa further explained that the business units had identified actions to redress training shortfalls and subsequently an improvement in the figures should be seen by the end of quarter 1.

James Duncan spoke to the finance section of the report and highlighted the position in relation to bank and agency staff. James explained that this was due to staff using up annual leave and Easter falling early this year. However, early indication shows that bank and agency usage had declined during month 2.

Peter Studd referred to page 6 of the report and questioned the costs associated with the Trust's payroll function. James advised that he had picked up the issues at a consortium level and that he will discuss the issue with the Finance Director at Northumbria.

Les Boobis questioned the legal costs of the Trust. John Lawlor advised that work had been done to reduce legal costs.

Ken Jarrold summed up the item as discussed and requested that the Board receive further updates in relation to;
1. Use of agency and bank staff
2. The outcome of the discussion relating to Payroll costs; and
3. Legal costs

The Board received the integrated commissioning and Quality Assurance report.

Item 8iii - BoD Monthly Commissioning Quality Assurance Report 18-19 month 1.pdf

Workforce

10. Workforce Directorate Quarterly update

Information
Acting Executive Director Of Workforce And Organisational Development

Lynne Shaw spoke to the enclosed quarterly Workforce report to update the Board on the key work and developments across the Trust.

The Board were advised that work had commenced in relation to the implementation of the Workforce Disability Equality Standard (WDES) in preparation of its first publication in 2019.

Rajesh Nadkarni spoke to the sponsorship section of the report and reminded the Board of the ongoing work to gain GMC fellowship status for international doctors. The Board were made aware that the Trust had been granted a licence to host five international psychiatry students on a three year training programme each year.

Lynne Shaw spoke to the Medical Visa section of the report that related to issues another Trust had experienced due to a large number of visas being refused for doctors they had recruited. Lynne advised that at the time the report had been written, NTW had not been affected with this. However, a visa for a speciality doctor had recently been declined. Lynne explained that the reason it had been declined would be explored and medical visas would remain to be under review.

Finally Lynne advised that NTW have been shortlisted for a CIPD award for its Organisational Development work relating to collective leadership. The Board were advised that if NTW are successful at the regional awards, they will then automatically become a contender for a National award.

Ken Jarrold commended the work that had been completed and congratulated Lynne and all involved in the Organisational Development work.

Peter Studd referred to the Tax Treatment of Termination Payments section of the report and questioned the changes in relation to Payment in Lieu of Notice (PILON). Lynne explained that all PILONs are now subject to income tax and National Insurance Contribution deductions.

The Board received and noted the Workforce Directorate quarterly update.

Item 9i - Workforce Quarterly report - May 2018.pdf

11. Whistleblowing/Raising Concerns update

Discussion
Executive Director Of Workforce And Organisational Development

Lynne Shaw spoke to the enclosed Whistleblowing/concerns raised report to update the Board on issues raised and logged by the workforce team between October 2017 and March 2018.

The Board were made aware that 21 cases had been raised over the period which is consistent with previous reporting periods. However, there had been an increase in cases being raised with the Trust's Freedom to Speak up Guardian.

Miriam Harte expressed concerns in relation to the case where a member of staff had raised an issue with the behaviour of an individual from another Trust. Lynne confirmed that it was an unusual case and it was the first time an incident had been raised relating to another Trust.

Les Boobis advised the Board that a summary of statutory and legal requirements relating to Freedom to Speak Up Guardians and Board of Directors involvement had been published. It was agreed that the summary would be circulated to the Board members.

The Board received the whistleblowing/raising concerns update.

Item 9ii - Whistleblowing and Raising Concerns Update - May 2018.pdf

Strategy and Partnerships

12. CEDAR update

Decision
Alexis Cleveland (Chair) And Executive Director Of Finance/ Deputy Chief Executive

James Duncan spoke to the enclosed CEDAR Programme Proposal to update the Board in relation to the programmes long term ambitions, enabler plans, access to STP capital funding and proposed timescales.

The Board were made aware of a number of interim business cases in development that would be presented to the Board in June. James referred to the timescales set out within the enclosed report.

Ken Jarrold commented on the scale of the work involved when moving services. James advised that staff engagement was going well and that some of the proposals had been adapted as a result of the conversations with staff.

Lisa Crichton-Jones expressed the importance of early engagement with staff when considering an organisational change. James assured that a lot of work was ongoing within the groups to provide support and engage with staff.

Peter Studd requested the Trust to ensure that staff from NTW Solutions are included in the engagement process.

The Board approved the proposal as outlined in the report and noted the timeline for progress that was based on the current knowledge and expectations.

Item 10i - CEDAR Stage 1 Proposals Board Paper Final Draft.pdf

Regulatory

13. Annual Quality Account

Decision
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed Quality Account for 2017-18 and reminded the Board of its inclusion in the Trust's Annual report.

Martin Cocker advised the Board that the Audit Committee and external auditors Mazars had reviewed the Quality Account in detail. Martin Cocker, on behalf of the Audit Committee, recommended that the Board approve the Quality Account.

The Board of Directors approved the content of the Quality Account, Statement of Director's responsbilities in respect of the content of the quality Account and the 2017-18 performance indicators that were included.

Item 11i - BoD Quality Account 2017-18 (23 May 2018).pdf

14. Annual Governance Statement

Decision
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed Annual Governance Statement 2017-18 and reminded the Board of its inclusion in the Trusts Annual Report. The Board were advised that due to the creation of NTW Solutions the Annual Governance Statement covered both the Trust and Group.

Martin Cocker made the Board aware that the Annual Governance Statement had been considered by the Audit Committee at their meeting on the 16 May 2018 and had been reviewed by the Trust's External Auditors.

Discussion took place in relation to the alignment of Governance and the Trust's risk appetite.

The Board of Directors approved the Annual Governance Statement 2017-18.

Item 11ii- Annual Governance Statement.pdf

15. Self-Certification G6 and CoS7

Decision
Executive Director Of Commissioning And Quality Assurance

Lisa Quinn spoke to the enclosed Board Self-Certification to NHS Improvement report and explained that NHS Foundation Trusts are required by NHS Improvement to self-certify the declarations by 31 May 2018 to maintain their Provider Licence. Lisa referred to the evidence provided within the report that demonstrates the Trusts compliance.

The Board were asked to confirm compliance in relation to Condition G6(3) of the Provider Licence which confirms that the Trust complies with the NHS Act 2009, Health Service Act 2012 and has regard to the NHS Constitution.

The Board were further asked to confirm compliance with Condition CoS7(3) that the Trust has the required resources available to provide services if providing commissioner requested services.

Martin Cocker commented on the format of the report which he found to be more user friendly.

The Board approved that the Trust is compliant with Provider Licence Condition G6(3) and CoS7(3).

Item 11iii - BoD Compliance with Licence Declaration May 2018.pdf

16. Operational Plan 2018/19

Decision
Executive Director Of Finance And Deputy Chief Executive

James Duncan provided a verbal update in relation to the Operational Plan and Budget for 2018-19. James explained that following the last Board meeting a revised final version of the plan and budget report was distributed to Board members for approval. James confirmed that the Board approved the revised final version and it was submitted to NHS Improvement on time.

The Board received the Operational Plan update.

17. Annual Accounts and Management Representation Letter

Decision
Executive Director Of Finance And Deputy Chief Executive

James Duncan distributed copies of the Annual Account and Management Representation letter and apologised for the late distribution. The Board were made aware that it had been the first time the Trust had prepared Group accounts and that External Auditors were still reviewing the accounts that morning.

James explained that since the review of the accounts conducted by the Audit Committee no figures had changed. However, there was an issue raised by audit in relation to how the Trust treated a sale as a finance lease and it was agreed that an adjustment would be made to treat it as an operating lease. James confirmed that this made no difference to the bottom line of the Trust or Group.

Martin Cocker advised that Mazars had conducted an external audit of the accounts and no material matters were highlighted, only the minor disclosure adjustment was required. Martin advised that the Audit Committee recommend the Board to approve the financial statements and sign the management representation letter.

Peter Studd expressed his appreciation to the finance team in acknowledgement of the extra work as there are now two sets of accounts to prepare (Trust and Group).

Alexis Cleveland, on behalf of the Board, thanked Martin Cocker and the Audit Committee for all their work in relation to the Annual reporting requirements.

The Board approved the Annual Accounts and Management Representation letter.

Item 11v - Board Paper for approval of NTW Group Annual Accounts.pdf
Item 11v a - NORTHUMBERLAND Group Accounts Template 2017-18 (Final linked).pdf
Item 11v b - Management Representation Letter Group 2017-18.pdf

Minutes / Papers for information

18. Committee updates

Information
Non-Executive Directors

There was nothing to update from Committees.

19. Council of Governors Issues

Information
Chair

There were no Governors Issues.

20. Questions from the public

There were no questions from the public.

21. Any Other Business

The were no further items raised.

22. Date, time and place of next meeting

Wednesday 27 June 2018, 1.30pm - 3.30pm,
The Large Training Room, Hopewood Park, Waterworks Road, Ryhope, Sunderland, SR2 0NB

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Action Sheet

Item No.	Subject	Action	By Whom	By When	Update/Comments
Month May 2018					
21/18	Safer staffing	Possible development session re care hours per patient day	Gary O'Hare	To be added to Board cycle	
50/18	Safer Care Embedding learning from Actions	Learning and Improvement Group will consider this further to make sure that learning is embedded in practice.	Damian Robinson/ Gary O'Hare	ongoing	
50/18	Safer Care Summary of changes to practice	Changes to practice to be added to all serious incident templates	Damian Robinson/ Gary O'Hare	July 2018	
50/18	Safer Care Violence and Aggression	Board to be kept updated on progress within the Positive and Safe Strategy	Damian Robinson/ Gary O'Hare	ongoing	
(8) 23.05.18	Annual Security Management Report	The Board to receive progress reports in relation to lone working devices	Tony Gray/ Gary O'Hare	24/10/18	Update to be included in the Q2 Safer Care Report
(8) 23.05.18	Annual Security Management Report	Update to be provided on our Smoke Free Strategy.	Tony Gray/ Gary O'Hare	25/07/18 24/10/18	Board to receive the Annual Smoke free update and a development session on smoking in July 2018. An update on progress will also be added to the Q2 Safer Care report.
(9) 23.05.18	Integrated Commissioning and Quality Assurance Report	The Board to receive an update on the outcome of discussions relating to Payroll costs and Legal costs	James Duncan	July 2018	

Complete					
21/18	Safer staffing	Quarterly report to be presented to CDT Workforce group	Gary O'Hare/Lisa Crichton Jones	asap	CDT – Workforce agenda 4 June 2018
50/18	Human Factors Training	Board members Human Factor training session	All	28th June 2018	Booked 28 June 2018
(11) 23.05.18	Whistleblowing/Raising Concerns update	Summary paper regarding statutory and legal requirements relating to FTSU to be circulated to the Board	John Lawlor	24.05.18	Freedom to speak up: guidance for NHS FT Board circulated via e-mail on 24.05.18
(8) 23.05.18	Annual Security Management Report	The Board to receive further detail in relation to the aggression and violence statistics within the report	Tony Gray/ Gary O'Hare	24/05/18	E-mail to John Lawlor in relation to the specific question. Addendum to be made to future reports to include the level of detail required.

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date:	27 June 2018

Title and Author of Paper:	Chief Executive's Report John Lawlor, Chief Executive

Paper for Debate, Decision or Information: Information

Key Points to Note:

Trust update

1. **CQC Inspection**
2. **Annual Members Meeting – 19 July 2018**

Regional update

3. **Gateshead System Partnership**
4. **Applied Research Collaborations (ARC)**

National update

5. **A 10 year plan for the NHS**
6. **Increase in Funding announced for the NHS**
7. **NHSI Q4 Report**
8. **Carter report on operational productivity in mental health and community health services**
9. **NHSE and NHSI Joint working**
10. **Health and Social Care Select Committee care report**

Outcome required: For information

Chief Executive's Report

27 June 2018

Trust updates

1. **CQC Inspection**
   The Trust awaits the outcome of our recent CQC Inspection and action is being progressed in the small number of areas for improvement identified. We anticipate receiving our draft report for comment in the coming weeks.

2. **Annual Members Meeting – 19 July 2018**
   We are looking forward to our Annual Members Meeting on the 19th July 2018 in the Jubilee Theatre at St Nicholas Hospital. The theme of this year's event, in recognition of the 70th anniversary of the NHS, is "past, present and future".

Regional updates

3. **Gateshead System Partnership**
   As discussed at the Board last month, a week long rapid system development workshop took place for partners across the Gateshead Health and Care system during the week beginning 5th June. This included partners from health provider organisations, CCG, local authority, GPs and the VCS. The Trust had representation on all days of the event at Executive and Group level. It was a challenging but fruitful event, which culminated in a "report out" to senior representatives of partner organisations and members of Gateshead Council, including the Health and Wellbeing Board.

   The "report out" and proposed actions have been well received. The intention is to repeat this report out at the Boards and Governing Bodies of each partner organisation, and this has been scheduled as part of the Board Development session in July.

4. **Applied Research Collaborations (ARC)**
   The National Institute for Health Research has launched the process to accept bids to fund Applied Research Collaborations (ARCs), with a submission deadline of 20th August. This new funding is for applied health and care research and to support its implementation into practice, making improvements for patients, the public and to health and care services. Priorities include: the need to increase research in public health, social care and primary care; the challenges of an ageing society; multimorbidity; and the increasing demands placed on our health and care system.

   The North East and North Cumbria region has missed out on two rounds of funding, estimated at about £20 million over 10 years. There is a strong regional will, led by the AHSN, for the NENC to win an ARC this time. Benefits, in addition to the regional funding (maximum £8.1 million over 5 years for a new ARC, due to phasing in the first year), include significantly enhanced applied research capability in the region and translation of applied research into service improvements for areas identified as key themes.

   The proposed Director for the ARC is Prof Eileen Kaner (Prof of Public Health and Primary Care, Newcastle University), who has been running a Senior Leadership Team (SLT) charged with preparing the ground for the call for approximately 6

months. Paula Whitty has been representing NTW at the SLT. Discussions are underway to gain support of NHS and Local Authority organisations for a bid to be submitted, including agreement on the host organisation.

National updates

5. **A 10 year plan for the NHS**
   In return for the additional funding announced for the NHS last week, the NHS has been tasked to develop a 10-year plan, via an "assembly" convened by national leaders. The Prime Minister has emphasised that this should have strong clinical input.

   The 10-year plan, which will likely be announced in the Autumn Budget, should set out how the service intends to deliver major improvements, including;

- Ministers may be considering legislative reform: the Prime Minister described the number of contracts held between NHS organisations as a "problem", and said she wanted the service to suggest ways of breaking down any barriers that might hold up progress, including in the regulatory framework.

- The Prime Minister set out five priorities for the NHS: Putting the patient at the heart of how care is organised; a workforce empowered to deliver the NHS of the future; harnessing the power of innovation; a focus on prevention; and "true parity of care" between mental and physical health.

- The Prime Minister said she would like to see the 10-year plan set out ambitious "clinically defined access standards" for mental health.

- And, she said clinicians should confirm the NHS is focused on the right performance targets for both physical and mental health – indicating that Ministers may be willing to reconsider key performance standards.

6. **Increase in Funding announced for the NHS**

The Prime Minister recently announced proposals for a new funding settlement for the NHS. The key points are as follows.

- The government has announced a major new package of funding for the NHS covering the five financial years from 2019-20.

- The average annual uplift is 3.4 per cent per year above inflation – based on Office for Budget Responsibility projections.

- The funding is frontloaded, meaning the annual rates of growth are: 3.6%; 3.6%; 3.1%; 3.1%; 3.4%.

- This will equate to £20.5bn more revenue in real terms by 2023-24 compared with 2018-19.

- A further £1.25bn has been found to deal with an increase in pensions costs associated with the new Agenda for Change pay deal.

- The funding is for the NHS England commissioning budget only. This means it does not include capital funding, public health, workforce development, or social care.

- In an appearance in front of the Public Accounts Committee, Simon Stevens said there was an explicit commitment from the government that the adult social care budget would be set to not put further pressure on the NHS.

- Although there have been assurances that these will be protected, it is not clear whether these budgets, which have been cut in the past, will be restored to or simply ring-fenced at their current levels.

- Simon Stevens has told MPs the extra money does include funding for an increase in Agenda for Change salaries from next year.

- How the increase will be funded is unclear. While the Prime Minister has emphasised that some of it will come from monies no longer being paid to the European Union, along with tax and borrowing rises, the "Brexit" element has been disputed by economists.

7. NHSI Q4 report

NHSI has published its quarter 4 report on NHS provider performance. This is based on full year financial and activity information for 2017/18. The headlines of the report are shown below.

Unprecedented demand for A&E

More than 5.87 million people went to A&E in January, February and March 2018 – that's over 220,000 more than the same period last year.

Of those who attended 1.1 million people were admitted for treatment, which is 70,000 more than the same period last year. This led to significant pressure on A and E services, with the proportion of patients seen within four hours falling to 89.1% against a target of 95%

Staff vacancies

At the end of the year, the sector was faced with 92,694 staff vacancies – which equates to an 8% vacancy rate. This includes 35,794 nursing vacancies and 9,982 doctor vacancies. However, providers ensured that 95% of nursing and 98% of medical vacancies were filled with temporary workers so that patient safety would not be compromised. This led to £976 million more being spent on NHS bank staff than planned.

The sector spent £527 million (18%) less on filling shifts from agencies compared to the previous year. This reduction marks a significant achievement for the sector.

Impact on finances

The high level of demand and a combination of other pressures led to an overspend in the NHS provider sector in 2017-18. While more than two thirds of providers (156 out of 234 trusts) finished the year at or better than planned financially, the surge in patient demand contributed to the provider sector as a whole having a deficit of £960 million at the end of 2017-18.

This figure is £464 million above what was anticipated by trusts at the start of the year and it is £30 million above what the sector anticipated at the end of December. It is, however, an £1.5 billion improvement from 2015-16, when the sector's deficit stood at £2.45 billion, although this has been underpinned by Sustainability and Transformation Funding.

While the provider sector was in deficit during 2017-18, viewed as a whole the NHS was broadly in balance. NHS England provisionally reported a £955m underspend for the healthcare commissioning sector in 2017-18.

Acute hospitals have been largely responsible for the sector's deficit, mainly due to the increase in demand within A&E mainly over the winter months, with all other providers, including ambulance, mental health and community healthcare trusts, collectively underspending during 2017-18.

The number of NHS trusts in deficit fell to 102 in 2017-18, down from 157 in 2015-16 and 105 the year before (2016-17).

A useful briefing from NHS providers is attached **(Appendix 1)**

8. Carter report on operational productivity in mental health and community health services

NHSI has published a report *NHS operational productivity: unwarranted variations* following the review led by Lord Carter of the productivity and efficiency of mental health and community health services. The report follows a significant amount of work that has taken place over a year, and in which the Trust has been heavily involved. As part of the initial cohort of 24 Trusts that agreed to work with NHSI on developing the Carter approach for mental health and community services the Trust attended workshops to help shape the programme, engaged in data collection and analysis to support various aspects of the programme, and has taken on and adapted some of the work already into its improvement approach.

The report highlights the initial findings of the work, and the fact that it has not reached firm conclusions at this stage is welcome. It highlights a number of recommendations for making progress and the Trust will continue to actively engage and influence the work.

The attached NHS Providers On The Day Briefing **(Appendix 2)** outlines the report's recommendations for those areas where operational improvement can be made and the structural issues that need to be resolved in order for efficiency and productivity savings to be achieved.

9. NHSE and NHSI Joint working

NHSE and NHSI have announced proposals to improve joint working across their organisations. These include the creation of seven integrated regional teams, each led by a Regional Director, who will have much wider responsibilities and greater power compared to the current structure. The proposals also include changes to a number of national roles, with the function of the national level arms-length bodies changing to being one of supporting the Regional Directors and working with them to create the national level strategic framework.

The proposals to further integrate working across NHSI and NHSE are welcome as this will support the move to avoid duplication across the system, as well as supporting move towards more integrated systems of delivery. However, there are also risks in that this

joint working is taking place within the existing statutory framework with the inevitable tensions that this will bring. The attached briefing **(Appendix 3)** from NHS Providers sets out their view of the potential benefits, the risks and the critical success factors of these proposals.

10. Health and Social Care Select Committee Care Report

Health and Social Care Select Committee has published a report following its inquiry into the development of new integrated ways of planning and delivering integrated health and care services. This timely inquiry focusses on sustainability and transformation partnerships (STPs), integrated care systems (ICSs) and accountable care organisations (ACOs).

NHS Providers supported the Committee to develop its inquiry, including suggesting trusts and local areas they might visit. The attached NHS Providers 'On the day briefing' **(Appendix 4)** outlines the themes explored by the Committee and sets out its key recommendations.

2017/18 Quarter 4 finances and performance

NHS Improvement (NHSI) has released the quarter four (Q4) finance and operational performance figures for the provider sector. These figures cover the period 1 April 2017 to 31 March 2018. This briefing summarises the key headlines for those figures as well as our view on what they mean.

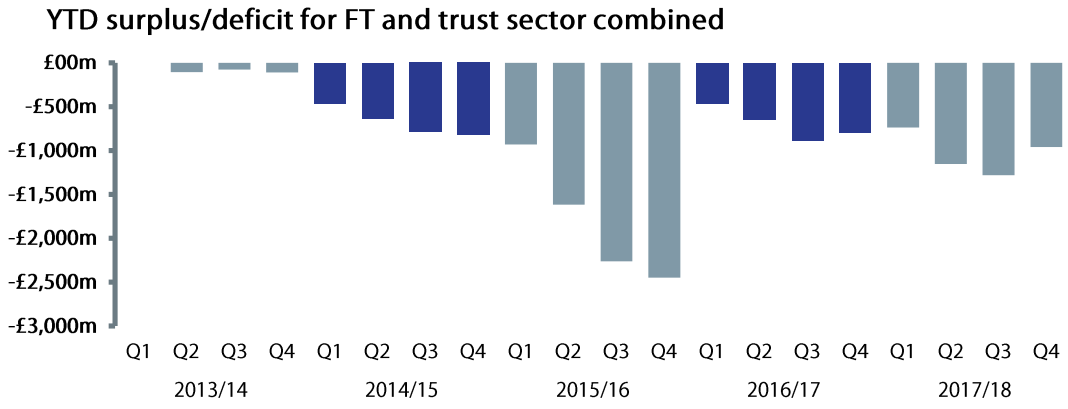
If you have any feedback or questions regarding any of the content in this briefing please contact: David.Williams@NHSProviders.org or Adam.Wright@NHSProviders.org

Key headlines

- The Q4 net deficit for the sector is £960m, compared to the £791m deficit reported at year end in 2016/17 (figure 1). At the beginning of the year the sector had planned for a £496m deficit.
- The year end position represents an improvement on the £1.28bn actual deficit recorded at Q3, but a slight deterioration (£29m) on the £931m year end forecast that quarter.

FIGURE 1

Year to date surplus/deficit for NHS provider sector (£m)

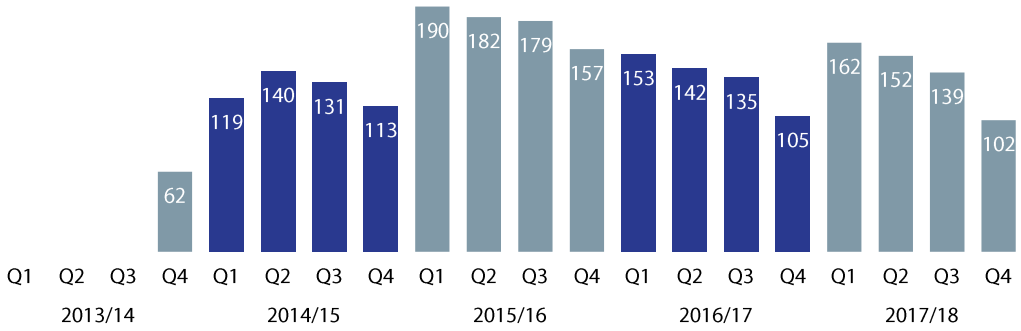


- The year end outturn was £464m worse than the £496m planned deficit, set by NHS Improvement at the start of the financial year. CCGs finished the year £251m overspent, but the commissioning sector overall underspent by £955m due to NHS England central underspends.
- 102 (44%) of 234 trusts have ended the year in deficit, down from 139 at Q3; these were largely in the acute sector. Just under two thirds (89) of acute trusts finished the year in deficit, compared to only 13 ambulance, community, mental health and specialist providers. Results at Q4 last year showed a similar pattern. The deficit continues to be heavily concentrated in the acute sector is in part due to the unprecedented winter pressures faced by emergency departments. Winter demand also appears to

have impacted ambulance trust finances. The overspend in the CCG sector risks undermining necessary investment in community and mental health services.

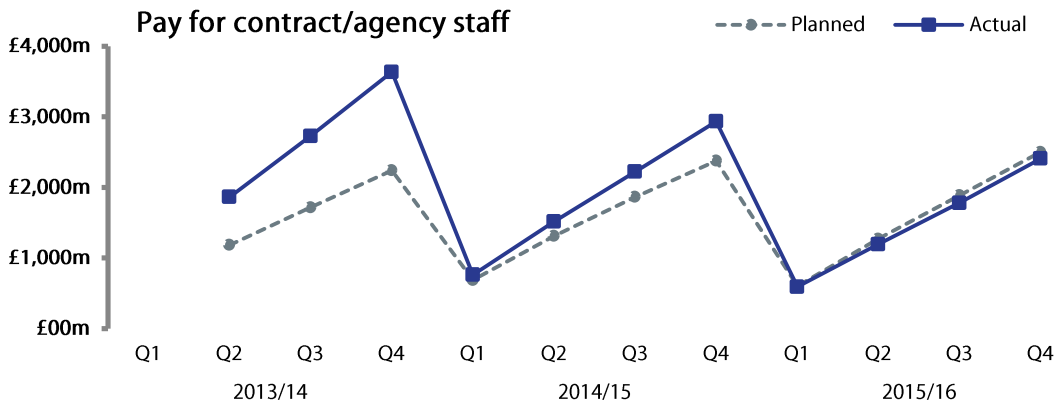
FIGURE 2

Number of providers in deficit



- The larger than planned deficit was mainly driven by:
  - **Under delivery of planned efficiency savings.** Trusts delivered Cost Improvement Plans (CIPs) worth £3.2bn in total, but this was £477m under plan. The largest under-delivery was in savings related to pay, with a £521m shortfall.
  - **Unprecedented winter pressures.** A&E attendances increased by 3.4% compared with Q4 last year. Elective income across the trust sector was £358m under plan at year end, with less lucrative non elective activity up by 3.8%. A contributing factor was the National Emergency Pressures Panel's recommendation to postpone planned operations, which is estimated to have reduced elective activity by around 22,800 admissions over the course of winter.
  - **Overspend on pay costs.** At year end trusts overspent on employee costs by £1.49bn, and overall spend increased by 1.2% in real terms on 2016/17 levels. The sector overspent on bank staff by £976m. However thanks to the continued success in reducing spend on agency workers (down 18% on last year), the overall spend on temporary staff decreased by £67m, or 1.2%. Given the widespread workforce shortages across all sectors, this demonstrates the hard work trusts have made this year in continuing to reduce their temporary staffing costs.
  - **Overspend on non-pay costs.** Spend on non-pay items significantly increased during the last quarter, with trusts ending the year £681m overspent. The main causes were overspends in clinical and general supplies and services (£203m), purchase of healthcare from other providers (£278m, of which £173m was spent with non-NHS bodies), and spend on premises (£105m). Following the publication of the community and mental health operational productivity review earlier this month, NHS Improvement will be asking all trusts to tackle non-pay costs.

FIGURE 3



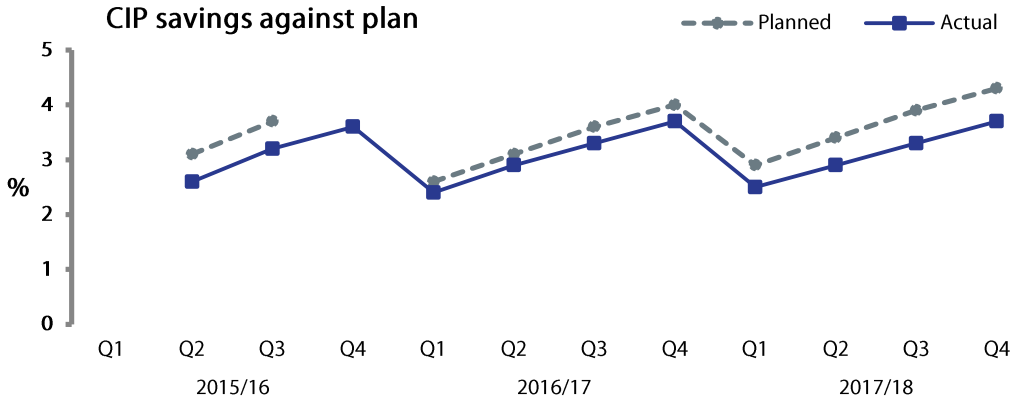
Other key finance data at Q4

- Trusts received £1.78bn in STF payments throughout the year. NHS Improvement distributed £824m through the core element, £350m through the pound for pound incentive scheme, £199m through the bonus scheme and for the first time £410m was allocated via the general distribution. Around £17m of the original STF envelope has been withheld from trusts. Of this, £10m will eventually be distributed to providers between draft and final accounts, while £7.3m has been diverted to the Getting It Right First Time (GIRFT) programme. It is not clear exactly how this funding for the GIRFT programme has been used to support the sector.
- 22 trusts did not sign up to control totals in 2017/18 and subsequently did not receive any STF funding throughout the year.
- Ambulance, community and mental health trusts received £72m more in STF compared to last year. Acute trusts received around £355m of STF in the year-end general distribution, which represents 27% of the total STF funds distributed to the sector. While we welcomed the fact that this funding was distributed across the sector, we were concerned at how late the additional funds were communicated to the sector.
- Of the £337m winter funding announced by the chancellor at the last Autumn Budget, around £50m has been held back by NHS England. The Q4 report states that £25m of that has been included in NHS England's accounts, but the same sum has also been reflected in the revised position for the provider sector. It is not clear how this £25m has been used, given it appears to have been included in both NHS England finances and provider income.
- Capital expenditure was £3bn, which represents an underspend against plan of £1.3bn. The underspend grew by £256m in the final quarter. The report notes there is no mechanism for the return of this funding in 2018/19. We know there are ongoing concerns about the way in which the capital regime currently works for the sector, and are engaging in the Department's capital review.
- Total CIP delivery was £3.2bn (figure 4), £110m more than what was delivered in 2016/17. Trusts are increasingly relying on non recurrent savings (which now account for 26% of the total delivered), and under delivered on planned recurrent savings by £1bn. Recurrent savings represented 2.73% of total spend, down 2.75% on last year.

- The implied productivity for the year was 1.2%, which is significantly better than the wider UK economy. However NHS Improvement makes clear this level of productivity is unstainable in the long run given the increasing reliance on non recurrent savings.
- Financial penalties imposed on trusts by commissioners continue to fall, and now stand at around £40m nationally. However impact of the marginal rate emergency tariff continues to have an impact on acute trusts, with £338m being withheld (up £70m on 2016/17) with only £15m reinvested in demand management schemes.

FIGURE 4

Forecast CIP savings against plan



Key performance and workforce information at Q4

- Around 5.34 million patients attended A&E departments during Q4, an increase of 3.4% (like for like) on the same period last year. Across the twelve months of the year, 21.88 million people attended A&E. NHS England data shows 84.97% of A&E patients were treated, admitted or discharged within four hours, although NHS Improvement's data shows trust performance at 83.53%. However trusts treated more people within four hours this year compared to last. It is clear that there was a fundamental mismatch between demand and capacity over 2017/18.
- There were 6.26 million non elective admissions across the year, which is 2.2% above plan and 3.5% more than the same period in 2016/17.
- The elective waiting list now stands at 3.84 million, a 2.9% increase compared to a year ago. However when taking into account non reporting trusts, the total waiting list is likely to stand at around 4.1 million. Referral-to-treatment (RTT) performance was 87.2%, down from 88.2% at Q3, and 90% for Q4 2016/17. The number of patients waiting longer than 52 weeks has also increased, up by 75% compared to the same period last year. The continue slippage of performance against waiting time targets is a symptom of the capacity constraints across the system.
- Only one of the six new ambulance performance targets were met. This was for Category 1 calls, 90th percentile under 15 minutes.
- In terms of capacity, there were fewer general and acute beds at Q4 this year compared to the same period last year. In 2017/18 the sector ended the year with 101,326 beds, while in 2016/17 the number was 101,827. The £337m winter funding was welcome, but NHS Improvement acknowledges "static

bed supply and the marked increase in postponed elective activity suggests this extra funding would have had a greater impact if it were received earlier in the year".

- There are around 92,694 vacancies within NHS trusts, which is about 8% of the total 1.1m whole time equivalent workforce. Vacancies across the sector are driving spend on temporary staff. In terms of nursing vacancies, around 65% of posts are being filled with bank staff, with a further 35% filled with agency staff. The rates are highest in London (14.1%) and the South (10.9%). For medical vacancies, posts are being filled by a mix of bank (45%) and agency or locum staff (55%), with the midlands and east experiencing the highest vacancy rates (10.1%).

Next steps

The Q4 figures reflect the considerable effort undertaken by NHS trusts and their staff. The provider sector continues to outperform the rest of the UK economy in terms of productivity, and trusts should be commended for the level of savings they have delivered this year and continued progress towards reducing agency spend. But it is clear the situation is unsustainable, trusts are increasingly reliant on non-recurrent measures and the financial regime is not effective for the vast majority of the sector.

- The current financial framework, including control totals and sustainability funding, needs to be revisited. We are starting to work with NHS Improvement to help shape their planning framework for 2019/20 and beyond.
- Trusts must be able to access capital funding to address their growing backlog maintenance and transformational requirements. The Department of Health and Social Care is undertaking a review of the current capital regime but this needs to be done in partnership with NHS trusts and NHS central bodies.
- The upcoming health and care workforce strategy is welcome, and it must address with urgency given the immediate workforce challenges faced by trusts.
- We are continuing to engage with the Department of Health and Social Care and Treasury on proposals for a long term financial settlement. As the government continues these discussions, we need to be realistic about how much funding might be required to close the current financial, workforce and operational gaps.

Press release

Commenting on the year-end financial and performance figures for the NHS provider sector, the chief executive of NHS Providers, Chris Hopson, said:

"NHS trusts and frontline staff are working harder than ever in the face of a relentless rise in demand for care, severe workforce pressures and a continued funding squeeze.

"The figures we see today reflect the worrying gap between what the NHS is being asked to deliver and the resources available following almost a decade of austerity. And we must remember that today's figure

masks the full underlying deficit which is much higher, and how reliant the NHS continues to be on one-off savings.

"These pressures are being felt by patients and staff right across health and social care. There are not enough staff, ambulances, community and mental health capacity or hospital beds to cope.

"This has become a year-round challenge, but the problems were compounded by severe winter conditions, with the result that too often, standards of care fell short of what trusts want to provide, and what the public has a right to expect.

"These pressures have had a substantial impact on trust finances. There was also a significant financial impact. The additional A&E activity and the sharp rise in emergency admissions meant there was less income than expected from planned procedures such as knee and hip replacements. There were also extra staffing costs to cover increased vacancies, sickness and staff turnover.

"In those circumstances, the overall deficit of £960mwas a creditable performance. Once again, the NHS has also outperformed the wider economy on productivity. Spending on agency staff fell by more than £500mcompared with the previous year, and trusts delivered cost improvements equivalent to £3.2bn ([3.7]% of trust turnover) – £110mmore than 2016/17.

"However, looking ahead to 2018/19, financial and workforce pressures continue to increase. For the longer term, we welcome the prime minister's recent commitment to increase long term funding for health and care and look forward to the new comprehensive health and care workforce strategy.

"But today's figures show a substantial part of any additional spending on the NHS in the future, will be spent on fixing the shortfalls that have built up in recent years."

24 May 2018

on the day BRIEFING

NHS Providers

NHS operational productivity: unwarranted variations in mental health and community health services

This briefing provides a summary of the key findings and recommendations of *NHS operational productivity: unwarranted variations – mental health and community health services*. The review, led by Lord Carter, covers the operational productivity of English NHS community[1] and mental health[2] services. Since early 2017, Lord Carter's review team has been working with a cohort of 23 mental health and community trusts[1], who account for over 20% of total expenditure in the sectors. The final report makes 16 recommendations and indicates productivity benefits worth £1bn can be achieved by 2020/21. It is expected that around 80% of this will be achieved in clinical and workforce productivity, including through the Getting it Right First Time Initiative (GIRFT). This briefing contains:

- The key findings and recommendations of the review
- NHS Providers view of the report and our press statement.

Mental health and community health services

The review team found a **disparity in leadership capacity and focus from the Department of Health and Social Care (DHSC), NHS England (NHSE) and NHS Improvement (NHSI) between mental health and community health services.** While the Five Year Forward View (5YFV) for mental health services has engendered a clear ambition, delivery programme and strong leadership, there is a **lack of national work and evidence base on community services.** The report suggests that NHSI and NHSE should do more to recognise and strengthen the role of community health services. This should bring together existing national work streams within a single delivery plan and support local areas to achieve it.

Recommendations

1 **Learning from new models of care.** NHSE should codify and share the learnings from new models of care and the successful 'vanguards' to support community health services to play their full role in supporting the wider system. This will involve identifying how to work across STPs and ICSs.

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[1] The review team defined community health services as physical health services delivered in community settings and community hospitals, but not by general practice or acute inpatient services. It includes health services commissioned by local authorities.

[2] Mental health services were defined as all mental health services including those for children, delivered in the community and in mental health inpatient wards. The review team did not look at learning disability services, but thinks the recommendations can be applied to some of these services.

[1] 2gether NHS FT; Barnet, Enfield and Haringey Mental Health NHS Trust; Birmingham Community Healthcare NHS FT; Central and North West London NHS FT; Central London Community Healthcare NHS Trust; Derbyshire Community Health Services NHS FT; East London NHS FT; Hertfordshire Community NHS Trust; Hertfordshire Partnership University NHS FT; Kent Community Health NHS FT; Lancashire Care NHS FT; Leeds Community Healthcare NHS Trust; Leicestershire Partnership NHS FT; Lincolnshire Partnership NHS FT; Norfolk Community Health and Care NHS Trust; Northumberland Tyne and Wear NHS FT; North West Boroughs Healthcare NHS FT; Nottinghamshire Healthcare NHS FT; Oxford Health NHS FT; South West London and St George's Mental Health NHS Trust; Sussex Partnership NHS FT; Torbay and South Devon NHS FT; Wirral Community NHS FT; other partner trusts.

Quality and efficiency across the pathway

The GIRFT programme will be extended to community health services, in addition to mental health services.

The report recommends that local commissioners, overseen by NHSE, should specify standard response times, including at weekends, for community health providers to support hospital discharges and avoidable admissions. While the implementation of the 5YFV for mental health is developing outcomes standards for a range of mental heath conditions, there is a lack of consistent and comparable patient outcomes data for community health services.

The review team believes there is scope to simplify existing commissioning and contracting arrangements, and to standardise service specifications (while some will need to be locally sensitive). NHSI and NHSE should support the development of more contracts with activity or outcome based payment mechanisms, and further develop currencies and payment systems for mental health and community health services.

The review found significant variation in the nursing cost on wards in community hospitals. Greater costs are associated with small and isolated wards. The data indicates that nearly half of patients could have been managed at home with one quarter of beds freed up. Generally, there is a lack of information and clear definition of community hospitals, which raises questions about their role in the system.

Recommendations

2 **Quality of care and GIRFT.** The GIRFT programme should ensure that the role of community health services is considered in all relevant clinical specialities and make rapid progress on mental health. This should include supporting the elimination of inappropriate out of area placements for adult mental healthcare by 2021.

3 **Driving standardisation in the community health services 'offer'.** NHSE should help strengthen commissioning and contracting mechanisms. This should include supporting STPs to work together to develop model frameworks for specifications of community services.

4 **Restricted patients.** The DHSC, Ministry of Justice and their arm's length bodies should work more closely to improve the administrative management of restricted patients.

Workforce

The report is clear that **workforce is a key driver for efficiency improvements in mental health and community services**, and emphasises the link between productivity and the culture, leadership and staff engagement of organisations.

Mental health and community trust staff report poorer levels of overall satisfaction compared with the acute hospital sector. The report points to good examples of staff innovation within trusts, but accepts that NHSI must speed up shared learning and deliver more support at a national level. The report makes

clear that trusts should have leadership strategies, with trust boards drawing on experience from across the public and private sectors. Training also needs to be offered to staff that move into management.

The review team was struck by levels of bullying, harassment, sickness absence and vacancy rates in these services. Community and mental health trusts on average lose an extra two days per staff member per year to sickness compared to the acute sector. The intensity of work, varied geography, work-life balance and levels of patient acuity are identified as reasons for this disparity. NHSI is now reviewing sickness absence policies and scoping a programme to reduce sickness and absence rates by 1%across the sector.

Staff working in mental health trusts in particular are more likely to experience physical abuse, bullying or harassment. NHSE and NHSI have also set up a pilot programme to reduce violent incidents against staff.

In terms of staff turnover rates, the mental health and community sector performs worse than the acute, with **turnover rates ranging from 9% to 45%**. The report highlights several factors behind these high rates, such as an ageing workforce, national pay policy and access to continuous professional development. NHSI and NHS Employers will be rolling out their retention programme to all mental health and community trusts with high turnover rates. The report recommends that all community and mental health trusts should also have a fully developed retention strategy.

Recommendations

5 **Optimising workforce wellbeing and engagement**: NHSI should work with all mental health and community trust boards to help improve the engagement, retention and wellbeing of their staff. The report notes that trusts should be reviewing their training offer to explore whether they can adopt more efficient processes to improve staff productivity by spring 2019.

Optimising clinical resources in the community

The report estimates that 70% of mental health and community trusts' clinical work is delivered in the community. It focuses on the productivity of community nursing and adult community mental health services, but states they are representative of other services they examined.

The review found significant unwarranted variation in productivity across trusts, such as the average time clinicians spend with patients ranging from 33% to 80% in community nursing and the number of contacts ranging between 14 to 45 during the reporting period.

Managing productivity

- The review team believes **all providers of community services would benefit from having access to reliable, regular and transparent national benchmarking on workforce productivity**. NHSI should develop the Model Hospital to achieve this. **Further standardisation of the mental health services data set and the community services data set will be needed**, including defining services.

- The report recommends that trusts should ensure they report to all relevant mandatory national data collections by April 2019 and review how they oversee and manage the productivity of community services, and report to their boards by April 2019.

Improving the way services are delivered

- **The review found significant variation in the structure, composition and skill mix of community nursing and adult community mental health teams**. Trusts should review these areas, including referral management and maximise the use of digital technology. The review team estimated that 29% of district nursing services still use predominantly paper-based processes, and electronic patient record systems are often cumbersome.
- The review also found that most **providers still maintain a range of access routes into their services**, resulting in increased administration and poor communication and that on average 16% of mental health appointments are missed, leading to significant waste of clinical capacity and compromised patient outcomes.
- The report recommends that **NHSI should develop guidance on good operating models for services delivered in the community**, starting with community health services, by autumn 2018. All providers should then deliver plans by April 2019 for how to improve service delivery models, including technological improvements and mobile working. **All providers should benchmark their service delivery models against Model Hospital metrics by summer 2019**.

Recommendations

6 **Strengthening the oversight of workforce productivity for services delivered in the community.** With support from NHSI and NHS Digital, and using the Model Hospital, providers should improve their understanding and management of productivity at organisational, service and individual level.

7 **Improving the productivity of the clinical workforce for services delivered in the community.** Community service providers should increase the productivity of their clinical workforce by improving and modernising their delivery models, through better use of digital solutions and mobile working.

Optimising inpatient services and other clinical resources

Around 30% of clinical spend is on inpatient services in mental health and community services. The report found significant levels of variation in nursing spend per occupied bed across all service lines. **Smaller, more isolated wards have increased safe staffing costs and challenges with recruitment and retention.** While local services play a critical role, the report concludes that they need to be delivered on an appropriate scale.

The care hours per patient day metric (CHPPD) for inpatient services provides a consistent means of interpreting productivity and efficiency. The review team recognises that further work is needed to develop CHPPD to provide a useful resource for trusts, but states their **initial analysis showed no correlation between outcomes (e.g. DTOCs) and staffing levels**, but will continue to review this. The review team also intends to explore acuity further to enhance CHPPD and the analysis of variations.

The report suggests that trusts should review their existing ward structures, and regularly review CHPPD against patient outcomes metrics, and recommends that CHPPD should be collected monthly (beginning April 2018) across all community and mental health inpatient wards. This will include collections on allied health professional CHPPD should be collected monthly from September 2018.

E-rostering

- The review found that **there is scope for significant improvements to better manage unused hours, approve rosters at least six weeks in advance, and reduce spend on bank and agency staff**.
- **The review found variation in the management of unused hours**. On average, the cohort trusts lost about 3,800 inpatient staff hours each month that were paid for but not used in the roster. At a national level, using all these hours effectively would be the equivalent of having about 1,100 additional nurses and 600 additional healthcare support workers providing inpatient care. The report estimates that these unused hours could be costing trusts as much as £70m to £80m per year.
- Learning from the improvement collaborative programme which focused on rostering practices will be shared across mental health and community trusts by summer 2018.
- Trusts should make measurable progress by 2018/19 on implementing an effective roster approval process and tackling areas that require improvement. NHSI should deliver further improvement collaboratives to extend e-rostering to all community services by spring 2019.

Medical staff

- **The review team found variations within and between organisations in medical staff pay spend, medical rostering**, use of e-rostering systems and leave planning, as well as a lack of medical staff productivity metrics that meaningfully reflect the use of doctors' time and their deployment.

Medicines and pharmacy optimisation

- The review team concluded that **pharmacy services are underused** in both community and mental health services, and identified opportunities for streamlining dispensing practices, more pharmacist prescribers, clinical pharmacy staff to provide medicines optimisation, and the implementation of electronic prescribing and medicines administration.

Recommendations

8 **Cost of inpatient care and care hours per patient day.** NHSI should develop and implement measures for analysing workforce deployment, and trusts should use these to report on the cost and efficiency of their inpatient services to their boards during 2018/19.

9 **Inpatient rostering and e-rostering.** All community and mental health trusts should use an effective e-rostering system and set up formal processes to tackle areas of rostering practice that require improvement. NHSI should undertake a review of the rostering good practice guidance to ensure it is inclusive of all sectors.

10 **Medical job planning.** NHSI should work with trusts to ensure that the right doctor is available for patients at all times using effective and comprehensive job planning and rostering, and identify improvements in clinical efficiency and productivity.

11 **Medicines and pharmacy optimisation.** Trusts should develop plans to ensure their pharmacists and other pharmacy staff spend more time with patients and on medicines optimisation.

Non-clinical resources

Although mental health and community trusts operate smaller corporate entities, the spend in these areas benchmarks higher than other organisations. The report suggests that **trusts consider the most appropriate scale of their business functions** as part of the implementation.

Corporate services

- **Mental health and community trusts spend on corporate services is 2% higher than the acute sector.** There may be some justification for this, as mental health and community trusts respond to a larger number of tenders each year, which cost round 2% of annual contract value. However if all mental health and community trusts were able to limit spend to the median level, the sectors would save around £140m per year.
- The review found clear efficiency of scale, with larger organisations spending less on corporate services as a proportion of turnover, and advise all trusts to examine where they can collaborate to standardise and share corporate services, especially for smaller trusts.

Estates and facilities, energy and rationalising estates

- Spend on estates and facilities is worth £1.3bn a year, with costs ranging from 5% to 28% of trust turnover (average 10%). It represents the largest area of non-clinical spend. Some of this variation is warranted due to the dissimilarities of service provision across the sector.
- The review uncovered **unwarranted variation in terms of estates and facilities staffing**, with limited succession planning and extended staff vacancies. There are also opportunities for trusts to improve sustainability and reduce energy consumption.
- The review found that on average 3.7% of space in the community and mental health sectors is left empty, with a further 2.2% underused. In terms of leasing property, the report recommends that NHS Property Services and Community Health Partnerships arrangements should be reviewed.
- The report states that in later 2018 NHSI will support trusts through a 'new-for-old' estate strategy to address issues around the quality of the existing estate. Work also needs to be done to improve estates data collection, as under the current system some smaller sites are not getting captured in estates return information collection returns.
- The report mentions the need to rationalise the estate, within the STP and ICS footprints but provides limited detail on how to do this.

Procurement

- Mental health and community trust spend on procurement is around £970m per year, about 7% of overall expenditure. The review found few trusts switching to products that are equivalent and more cost-effective and urge trusts to use benchmark data. In addition, the report states trusts are not leveraging their buying power or collaborating to secure better prices.

- The largest variation in terms of procurement spend was for business fees, which may include audio visual service fees, courier services, room hire and other building fees, as well as consulting services.
- The review team believe there are a number of common products that should be added to the NHS Business Services Authority's Nationally Contracted Products programme or prioritised for national procurement via the relevant NHS Category Towers.

Recommendations

12 **Corporate services:** Trusts should reduce variation in the cost of their corporate service functions, and should examine the opportunities to collaborate and share corporate service functions. Trusts need to complete the corporate services opportunity list self-assessment by October 2018.

13 **Estates and facilities management:** NHSI should develop a comprehensive and tailored set of benchmarks for the sector by 2019/20, and all mental health and community trusts should review their existing states and facilities and provide a report to their boards by April 2019. Trusts need to review and identify opportunities for estate consolidation and improved data capture by autumn 2018. In addition to this trusts need to have a sustainable development management plan signed off by their boards by winter 2018.

14 **Procurement:** Trusts should reduce unwarranted price variation in procurement of goods and services by improving procurement practices, local and national collaboration and price benchmarking. All trusts should be using the Purchase Price Index and Benchmarking tool during 2018/19 should achieve accreditation of level 1 of the NHS Procurement & Commercial Strategy by March 2019, with level 2 achieved by March 2020.

Implementation, the Model Hospital and next steps

The report recommends that the Model Hospital tool extend its existing data to incorporate mental health and community trusts (particularly for non-clinical services), and be expanded to include data on clinical services beyond acute hospital settings. Work also needs to be undertaken on the branding of the tool as in its current state community and mental health trusts feel it is focused too much on the 'hospital'. Underpinning these expansions will be increased data submissions, via the Mental Health Services Data Set (MHSDS) and the Community Services Data Set (CSDS) collections. NHSI hopes to incorporate additional metrics on the Model Hospital by April 2019.

Implementing the recommendations of the review will rest on genuine support and expertise, over a prolonged period. The review team accept that progress implementing the recommendations of the original review of acute hospitals has been slow because of a lack of capacity and capability. The report acknowledges the recommendations of the Kirkup review and references the changes to the NHSI operating model. Based on this information, the implementation methodology will be extended for trusts, STPs, ICSs and NHSI.

A review implementation team, within the NHSI operational productivity directorate, will be responsible for tracking delivery of all the report's recommendations. **A universal support offer will be made to all mental health and community trusts.** The team will also look to align its work with NHS Digital and

NHSE, in particular the Five Year Forward View for Mental Health programme, the Hospitals to Home and 'vanguards' teams as well as the data development teams looking to introduce the MHDS and CSDS.

Recommendations

15 **Model Hospital:** NHSI should develop the current Model Hospital and underlying metrics to ensure there is one repository of data benchmarks and good practice so all trusts can identify what good looks like. Trust boards need to ensure that mandatory data fields are submitted to the minimum datasets.

16 **Implementation:** Trusts, NHSI and NHSE and others should work together to take the action required to implement these recommendations.

NHS Providers view

We support the focus on efficiency in community and mental health services in this report. By highlighting variation in key areas of spend for the first time, this review presents a new opportunity for trusts providing community and mental health services to improve their productivity, and trusts will welcome this focus.

Overall view

The recommendation that NHSE should share learnings from the successful vanguards is sensible. As the vanguard programme was explicitly aimed at testing new models of care and sharing learning across the country, it is important that lessons can be spread as STPs look to find practical ways of transforming care. System-level working provides an opportunity to apply a degree of consistency and standardisation to community services that has been lacking up till now.

Focusing GIRFT on reducing out of area placements for mental health patients is sensible as this is currently a key challenge for trusts and contributes to poor patient experience. The inclusion of community and mental health services in GIRFT is a welcome – if overdue – recognition that the programme has relevant learnings for community and mental health services, as is the recommendation that the Model Hospital be developed to meet the needs of community and mental heath services.

The impact of fragmented commissioning on community mental and physical health services impacts their efficiency and productivity. The transaction costs caused by trusts working with many different commissioners must be reduced, along with the number of performance indicators they are being asked to report on. Standardising and simplifying the commissioning landscape is necessary, although it is important that the national bodies recognise that not all community service providers will run comparable bundles of services, often because of tendering behaviours from commissioners dating back several years which disproportionately affect community services. More strategic STP-level commissioning could reduce this wasteful activity.

The findings on workforce wellbeing and engagement in community and mental health trusts are concerning. While trusts are already working hard to improve these results and many have begun to make

progress, the widespread nature of the problems suggests this issue is a national one. Trusts therefore need to be better supported by the national bodies to implement effective retention programmes that are sector-specific. The review's identification of external factors affecting retention, such as national pay policies and the ageing workforce is helpful.

It is clear more work need to be done to address the unwarranted variation found in corporate services, estates and facilities management and procurement. But the solution to some of these issues will require national leadership, particularly as smaller community and mental health trusts will struggle to make efficiencies of scale.

The recommendation that NHSI provides "bespoke and intensive support offers" for trusts to implement Lord Carter's findings is sensible and recognises the diverse nature of the issues experienced by individual organisations. Trusts that worked with the Carter team to produce this report have said the experience was very positive and constructive. As the programme rolls out more widely it is important that this is preserved. The recommendation to provide a universal offer to trusts via a dedicated implementation team is encouraging, and we hope it will be resourced adequately to enable widespread progress to be made quickly.

Although the report does not explicitly state this, Lord Carter has separately suggested in an HSJ interview that trusts which run both acute and community services are inherently more efficient than the alternatives. However, we recognise that there are various organisational forms which currently exist, each with their own benefits, and each capable of delivering seamless care as part of a wider system.

Community services

In our recent report *NHS community services: taking centre stage*, we showed that community services have, for many years, had an insufficient profile and lack of priority at both national and local levels. This means the expansion of care in the community has struggled to gain wider momentum, recognition or investment at a local level. One of our recommendations in the report was for greater national leadership for community services to ensure the Five Year Forward View ambitions are realised, and we are pleased to see that the review has also highlighted this gap. Hopefully our report and now this publication represent the beginning of a shift in attitudes.

We have continued to highlight the lack of robust national data, quality indicators and performance metrics, which means that there is less national focus on, and no national improvement approach for, community services. We are pleased to see that the review team have also flagged that a standardised national dataset is necessary if community providers are to properly monitor changes in demand, activity, funding and quality. While the new community services data set is a welcome development, it needs to be refined further to add real value and not add any additional burden on trusts.

Mental health services

In our report published last year on the state of the mental health provider sector, we welcomed the government and national bodies' commitment to address longstanding inequalities in care for people with mental health needs. The increase in funding has started to improve service provision in the targeted areas, but there remains a disparity between these commitments and the deteriorating state of core mental health services.

We have concerns over the focus on variation in care hours per patient day in inpatient mental health and community health settings. In general there seems to be clear recognition that the metric in the report is only for inpatient services, which by the review team's own admission, makes up only 30% of activity in the community sector. This part of the analysis not yet well enough developed to be safely acted upon: while that CHPPD varies between trusts, the report has not demonstrated the extent to which this is unwarranted. Although the report says there is no correlation between CHPPD and rates of readmission, delayed transfers or length of stay, these are very general measures. There may be more specific outcome indicators which better capture the impact of the care given. Because of the highly specialist nature of some mental health services in particular, we do not feel it is safe to generalise about CHPPD for adult acute mental health as a whole. We also note that this is an inpatient services metric – the lack of an equivalent analysis of care hours in other settings, suggests much more work is needed to understand the impact, quality, and efficiency of community and home based care.

NHS Providers press statement

Responding to the Carter report into operational productivity in mental and community health services. Amber Jabbal said:

"These findings highlight many of the concerns we raised this week in our report on NHS community services.
"Highlighting unwarranted variation in key areas for the first time presents a new opportunity for trusts to improve their productivity and providers look forward to working with NHS Improvement to implement the recommendations
"The inclusion of mental health services in GIRFT is a welcome – if overdue – recognition that this is as important as acute physical health services, and we strongly support the recommendation to extend this to community health services.
"This report is right to draw attention to the complex commissioning and contracting environment, discrepancies in the way performance is measured, and the importance of harnessing IT to provide better care.
"It is also clear – as this report points out - that we need stronger leadership at national level and within STPs and ICSs, to support the work of community services in bridging barriers and delivering new models of care.
"Above all, these services need adequate funding, and action to address staff shortages.
"We need to seize the opportunities presented by the push for integrated care and the Prime Minister's commitment to increase long term health and care funding to make good on past promises, and bring NHS community services centre stage."

on the day BRIEFING

NHS Providers

Next steps on aligning the work of NHS England and NHS Improvement

NHS Improvement (NHSI) and NHS England (NHSE) have published a board paper which sets out the detail of how NHSI intends to shift its primary focus from regulating the trust sector to supporting improvement and how the two organisations will work together to provide more joined-up, effective, leadership to the NHS. This briefing provides a brief overview and our view on the proposals which are a combination of changes to how NHSI will operate and how NHSI and NHSE work together.

Background

Local health and care systems are responding to the challenges of a growing and ageing population by collaborating across organisational boundaries and developing more integrated models of care. NHSI and NHSE recognise that they need to adapt and transform the way they work to create an operating model that best supports local health systems and the people they serve and provide more joined up national system leadership. NHSI is also seeking to change its primary focus from regulation to supporting improvement.

NHSI and NHSE acknowledge that primary legislation sets out the need for separate board governance, chairs and CEOs for the two organisations and that the statutory frameworks assign NHSI (Monitor) and NHSE distinctive functions. In addition, under the statutory framework, clinical commissioning groups (CCGs) and NHS trusts and foundation trusts have different, distinct, functions which are reflected in the functions of NHSI and NHSE, including those Secretary of State functions delegated to the NHS Trust Development Authority (TDA). However, the board paper sets out ways that the two bodies can enhance joint working within the current legislative framework.

Proposals

Joint governance, systems and processes

NHSI and NHSE will establish a new NHS Executive Group, co-chaired by the two CEOs and comprising membership of all national directors and Regional Directors from the two organisations (see below for more details of these posts). A new NHS Assembly (provisional title) will be created to ensure better engagement with the wider NHS and its users, and its membership will include a wide range of statutory and non-statutory organisations. It will become the forum that oversees progress on the NHS Five Year Forward View and will help co-design the proposed upcoming NHS 10 Year Plan.

NHSI and NHSE will align their core processes so that all interactions with the frontline NHS are conducted once. This includes establishing a single financial and operating planning process for the NHS, a single

performance management process and the alignment of regulatory interventions, a single internal management process and a single process for establishing and reviewing national strategic programmes such as cancer, mental health and digital. The two bodies will establish a joined up and aligned approach to reporting and sharing information about the system.

The NHSI and NHSE boards will also be considering, over the next several months, the extent to which some of NHSE's and NHSI's non-executive led board committees might be reshaped and aligned.

Regional level changes

The proposed structure involves a potentially very significant change at regional level through the creation of seven integrated (i.e. spanning both NHSI/NHSE) Regional Directors with much wider responsibilities and greater power compared to the current structure. The new regional teams will have a major leadership role driving improvement and transformation for local health systems and providing joined-up oversight across the NHS in their region. They will act as 'translators' between the national level and local health and care systems, helping to ensure that national work is responsive to local system needs.

The Regional Directors will have full responsibility for the performance of all NHS organisations in their region. They will make decisions about how best to support and assure performance within their region as well as support the development and identity of local STPs and ICSs. The regional teams will decide when and how to intervene in systems, providers or CCGs in their region, or - where required - make the relevant recommendations to the national NHS Executive Group. They will also be responsible for creating clear strategic visions for how the pattern of services and the pattern of provider configuration (e.g. mergers etc.) should develop within their regions.

The Regional Directors will report to the two NHSE and NHSI CEOs and be full members of the national NHS Executive Group, with responsibility for working with the national directors to develop the overarching strategy and architecture for the NHS as well as translating that into operational plans.

The integrated regional teams will deliver a number of core functions, including: performance, improvement and intervention; strategy and system transformation; commissioning; operational management; finance; specific quality responsibilities; workforce and leadership; information, digital and technology; estates and procurement; analysis and insight; communications and engagement; and corporate functions (including HR). There will be a particular emphasis on developing a much more proactive approach to senior leadership talent management within each region. The plan is for Regional Directors to oversee a more planned approach to Chair, CEO and executive board appointments and development, though the details of this are still being worked through.

In this structure, the current functions of NHSI's central Regulation Directorate are devolved to the Regional Directors as, for example, are the NHSI Medical Director's current responsibilities for special measures trusts. These changes are emblematic of the proposed scale of devolution from "central NHSI" to the integrated new Regional Directors.

It is important to note that the shift to seven regions, rather than four, is designed to enable Regional Directors to exercise these functions effectively. There are concerns that the existing four region structure gives regional directors an impossibly large number of providers within their region. 230 trusts divided by four regions equates to 58 trusts per region. 230 trusts across seven regions equates to 33 trusts per region. The intention is to enable the seven Regional Directors to have a much closer and deeper relationship with every trust in their region as opposed to only being able to concentrate on those that most require attention.

National level changes

As part of the devolution of power and responsibility to the more powerful Regional Directors, the role of the national level arms-length bodies' functions changes to being one of supporting the regional directors and working with them to create the national level strategic framework. Within NHSI the new national level structure, combined with the new approach to the regional directors, is designed to enable the change of primary focus from regulation to improvement support.

There will be a number of national director roles, which will report to both CEOs:

- A single NHS Medical Director
- A single NHS Nursing Director/Chief Nursing Officer for England
- A single Chief Financial Officer, who will have responsibility for a single NHS financial and operational planning framework and performance oversight process
- A single National Director for Transformation and Corporate Development – who will lead most corporate operations across both organisations including people and organisational development functions, both internally and with respect to system transformation.

A number of 'do-once' functions will be led by individual national directors in NHSE and NHSI, including:

- NHS England Deputy CEO – national service programmes such as cancer and mental health, implementation of the Five Year Forward View, and leadership of NHSE's distinct responsibilities including commissioning specialized services and primary care
- National Director for Strategy and Innovation (NHSE) – strategic programmes such as life sciences, commissioning development, patient choice and personalization, innovation and research
- Chief Provider Strategy Officer (NHSI) – a new strategic approach to configuration of the provider landscape
- Chief People Officer (NHSI) – a new post based in NHSI which is designed to develop a more systematic approach to leadership and development and people management issues+
- Chief Improvement Officer (NHSI) – a senior level post designed to support improvements in quality, access and efficiency with particular emphasis on supporting trusts to deliver improvements in these areas
- Chief Commercial Officer (NHSI) – supporting improvements to estates, procurement, back office services and clinical support services

- National Director for Emergency and Elective Care (NHSI) – shared approach to urgent and emergency care and elective care.

Taken together, the last five of these posts are designed to enable the shift in primary NHSI focus from regulation to supporting improvement. These post holders, working with the regional directors, will be seeking to support improvement at a trust level as well as at a sector wide level.

The effect of these changes is that the two organisations will be increasingly be working in a combined way on a single set of system priorities, covering most key functions, including:

- System strategy
- Planning and performance
- Supporting STPs and ICSs
- Service transformation
- Improvement
- NHS leadership and workforce
- NHS information and digital technology
- NHS estates, procurement, back office services and clinical support services.

There will however be some functions that remain distinct to each organisation. NHSI's regulatory functions in relation to pricing, competition and patient choice, and its hosting of the Healthcare Safety and Investigation Branch, and NHSE's responsibility for tariff currency development, commissioning of specialised services and primary care, and Emergency Preparedness, Resilience and Response (EPRR), will remain separate and distinct.

STPs and ICSs

Under the new integration regional model, STPs and ICSs will relate to a single Regional Director. As they develop and mature, the national bodies envisage ICSs holding more responsibility, including:

- Developing a system vision, strategy and plans to meet operational, financial and quality requirements
- Developing and maintaining relationships with local people, staff, local government, voluntary and independent sectors
- Leading on provider transformation including integrated providers and primary care networks
- Providing first line support to organisations within their system, drawing down national and regional expertise where needed
- Some commissioning (including current direct commissioning) not performed at national level.

Implementing the proposals

Changes to the most senior roles will be made by September and to the roles at the next level during the autumn. The aim is for all changes to be made by the end of this financial year. NHSI and NHSE recognise that this work requires a reshaping of the culture, mind-sets and ways of working for the two organisations so that they collectively see their role and purpose as providing system leadership to the NHS, and are not

defined by traditional boundaries. The implementation of this change programme has been titled 'Project 70'.

It is worth noting that there are major structural, cultural and behavioural shifts required to make this proposed approach work, including:

- Genuine commitment to devolve power from the centre to the regions
- Much greater alignment between NHSI and NHSE to work as a single system leader than at present
- Finding ways to overcome the natural split between commissioning and provision inherent in the 2012 Act, the ongoing need for separate boards and CEOs and the way the Act requires the NHS to work e.g. the NHS budget formally being allocated to NHSE.

NHS Providers' view

These proposals represent a significant change for NHSE, NHSI and the wider NHS. Over time they could herald a profound shift in the way the NHS is led at national and regional level and how trusts experience that leadership on the ground.

Trusts have consistently told us, for example via our latest regulation survey and informal feedback, that:

- They want the two organisations to work more closely together and provide single, integrated, system leadership of the NHS
- They want NHSI to provide more support and focus less on regulation, recognising there are inherent tensions between the two roles
- They want access to a more empowered and integrated regional structure that can give them clear, rapid and trusted guidance on issues such as whether it is worth them pursuing a merger, reconfiguration or capital project, confident in the knowledge that, if positive, the appropriate support will quickly follow
- They want more help, where needed, to create the right strategic framework for the larger regional and sub regional geographic footprints in which they work, helping resolve issues that affect multiple trusts or local systems where there may be competing interests.

NHSI has told us that these proposals are designed to address these concerns. We think they offer significant potential benefits, but there are also significant risks, and a lot depends on successful implementation and some major cultural/behavioural changes that are far from assured. We set out the potential benefits, the risks and the critical success factors, as we see them, in three short sections below.

Potential benefits

Reduce duplication and eliminate contradictory messaging / activity

The "do it once" new structure offers potential to eliminate the duplicative interactions trusts currently report in their dealings with NHSI and NHSE as different national and regional teams, both within and across the two organisations, act in an uncoordinated way on the same issue – for example asking for the same information or promoting contradictory approaches. A single approach to finances and contracting,

for example, offers the chance to solve financial challenges collaboratively rather than pit providers and commissioners unhelpfully against each other.

Single system framework

As the NHS moves to local system working, with the distinctions between CCGs and providers starting to blur, the new structure offers the opportunity to create a single, aligned, local system focussed, NHS performance, financial and operational framework.

An effective empowered regional level offering support

This structure offers the opportunity to create empowered integrated regional teams that really understand the problems and challenges facing local providers and can then provide appropriate advice and support on a systematic and trusted basis. That could include:

- Providing advice and guidance and then acting as a champion on issues that require arms length body or national system level input, approval or support such as capital projects, reconfigurations and transactions.
- Acting as solution facilitator for regional or sub regional issues where competing provider/local system interests or competing provider / commissioner issues occur;
- Regional Directors providing CEOs and boards with high quality, effective, advice and personal support and helping develop a more systematic approach to senior NHS talent.

Greater value for money

Greater joint working between NHSI and NHSE has the potential to deliver better value for money and increase efficiency. Given current NHS financial pressures, it is more important than ever that the national bodies are realising potential efficiencies and that any cost savings are diverted to frontline care.

Risks

Importance of provider sector understanding and influence

The NHS national strategic framework over the last few years has been the product of an explicit, often hard fought, private, negotiation between a provider-focussed NHSI and a commissioner-focussed NHSE. Whilst this is potentially wasteful, the duality inherent in this structure has ensured that the provider sector has had a robust and effective champion in NHSI arguing the provider cause in these negotiations. Trusts tell us that they don't always feel that NHSE understands the provider perspective or scale of challenge. For example there is a strong perception that excessive financial and performance risk has been loaded on to providers and this would have been even greater had there not been strong provider sector/NHSI pushback. It is important that this proposed joint venture is therefore a genuine joint venture of equal partners. For example, the single NHS finance and planning framework needs to be led by a single Finance Director who understands provider needs, will ensure an appropriate level of provider risk and will be committed to creating a provider task that is genuinely achievable.

The need for the right behaviours from regional leaders

This structure devolves power to the new Regional Directors that needs to be used in the right way. Trusts tell us that the behaviours exhibited in these or similar roles have sometimes been inappropriate and short of supportive. The desire for a support-led, rather than regulation-led, approach to the national arms length body/local trust relationship must be consistently expressed in the right behaviours, particularly in a context where the NHS will continue to experience considerable financial and operational pressures.

Potential loss of provider autonomy

Trusts tell us that the burden of regulation is significant and growing. Integrated regional teams with greater powers and a smaller number of trusts within each region creates risk as well as opportunity. Trusts will welcome appropriate, effective, extra support, particularly if it is provided in areas where the support is requested. Trusts will be less comfortable with unwanted activity that adds burden and complexity, intervenes unnecessarily or unreasonably curtails provider freedom and autonomy.

The creation of an unmanageable monolith

NHSI and NHSE together create a very large organisation that is likely to be significantly more difficult to manage and lead.

Critical success factors

In our view, successful implementation of this new structure will therefore require the following:

Much greater alignment between NHSI and NHSE than is currently the case. Dual reporting lines are difficult to manage and the existence of two boards and two CEOs will bring difficult tensions (though we would argue they also bring the potential advantage of a guaranteed strong, equal, voice for providers/frontline delivery organisations).

Genuine commitment to devolving power to Regional Directors and their teams. Trusts tell us they feel that executive power is currently strongly concentrated at the top of both organisations. There has to be a genuine and equal commitment across both organisations to devolve power to the new integrated regional structure.

The right appointments, skills, behaviours and appointment process. Effective, powerful, Regional Directors require senior level appointments who can carry the required credibility and authority with provider CEOs, Chairs and boards. We will struggle to make this system work effectively without them. It is also important NHSI/E are seen to go through due process in making these and the national director level appointments – setting out proper job descriptions and person specifications which frontline leaders can help shape, and then running open competitions. Understanding of the frontline delivery challenge and what is needed to support leaders to meet that challenge will be crucial in whoever is appointed.

The right single planning, finance and performance framework and process that is also based on a proper understanding of what provider leaders need to deliver effectively and is not an over ambitious, impossible to deliver, commissioner-led framework. The approach of the new joint Finance Director will be crucial here.

Effective management of a difficult change process, without adversely impacting other major priorities like the new, post PM funding commitment, NHS plan and the financial/planning reset required in 2019/20.

Genuine commitment to involve frontline leaders in the details of these changes as they develop. This new structure and approach will only work if local leaders feel they own and support it too.

Greater clarity on the relationship between the new regional structures and the STPs/ICSs that sit within their region and assurance that we are not creating new layers of bureaucracy for local leaders to navigate.

Next steps for NHS Providers

We have, as you would expect, been inputting the provider sector perspective as this work has developed. This included a successful member roundtable ten days ago as today's Board paper was being drafted, where members shared the concerns and welcomed the opportunities we set out above.

We would welcome your feedback on our views above and will continue to try to influence this process. NHSI have told us that they are strongly committed to involving providers in the detail of this work as it progresses.

11 June 2018

on the day BRIEFING

NHS Providers

Health and Social Care Select Committee report Integrated care: organisations, partnerships and systems

The Health and Social Care Select Committee (the Committee) has published the report of its inquiry into 'the development of new integrated ways of planning and delivering local health and care services[1]. This timely inquiry focusses on the development of Sustainability and Transformation Partnerships (STPs), Integrated Care Systems (ICSs) and Accountable Care Organisations (ACOs). This briefing provides an overview of the Committee's key findings and recommendations.

Unusually, in addition to providing oral evidence to the inquiry, NHS England (NHSE) and NHS Improvement (NHSI) published a written submission to the Committee, which effectively summarises the shift in national policy focus from competition to collaboration.

Summary of key recommendations

- The Government and the NHS must improve how they communicate NHS reforms to the public, making the case for change in the health service, clearly and persuasively.
- The Department of Health and Social Care (DHSC) and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The law would need to change to enable the structural integration of health and care.
- The national bodies should clearly define the outcomes they are seeking to achieve for patients by promoting more integrated care, and the criteria they will use to measure this.
- DHSC, NHS England (NHSE), NHS Improvement (NHSI), Health Education England (HEE), Public Health England (PHE) and Care Quality Commission (CQC), should develop a joint national transformation strategy setting out how they will support STPs and ICSs.
- STPs should be encouraged to adopt the principle of subsidiarity so that decisions are made at the most appropriate local level
- ACOs should be introduced in primary legislation as NHS bodies, if a decision is taken, following a careful evaluation of pilots, to extend their use. The national bodies must take proactive steps to dispel misleading assertions about the privatisation and Americanisation of the NHS including the publication of an annual assessment of private sector involvement in NHS care.

[1] P.4 of the Committee's report

- The greatest risks to accelerating progress are the lack of funding and workforce capacity to design and implement change. The Government must recognise the importance of adequate transformation and capital funding in enabling service change. The long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention.

Integrated care

The Committee found that more integrated care will improve patient experience, particularly for those with long-term conditions. However while it may reduce demand on hospital services, the Committee concluded there is a lack of evidence that integration, at least in the short term, saves money.

The Committee recommends that:

- DHSC, NHSE and NHSI clearly define what outcomes should be delivered from integrating care, from the patient's perspective, and the criteria they will use to measure this.
- Government should confirm whether it will meet its target to achieve integrated health and care across the country by 2020, as well as plans for 50% of the country to be covered by new care models.

STPs and ICSs

Sustainability and transformation partnerships

The Committee highlights the challenges which local bodies have faced in coming together through STPs to make very difficult decisions about changes to local health and care services within a very tight timeline. These challenges have been exacerbated in those areas without a history of collaborative working. In many STPs, proposals were not supported by robust evidence of population need or workforce plans.

The national bodies' initial mismanagement of the process, including misguided instructions not to share plans, made it very difficult for local areas to explain the case for change. Poor consultation, communication and financial constraints have fuelled concerns that STPs were secret plans and a vehicle for cuts.

The practical issues arising from STP boundaries have significantly affected progress so far. STP footprints with a smaller population, a smaller number of partners, boundaries that align with patient flows between services and coterminous organisational boundaries between partners tend to be further ahead.

STPs have become the vehicle for delivering national priorities and targets, improving financial management across the system and managing demands, particularly on acute care, despite the governance and infrastructure being fragile and in development. However the STP dashboard has no indicators to measure integration or the progress local areas have made in transforming care, such as progress made against their STP plans.

The Committee recommends that:

- STPs, particularly those with more complex geographical boundaries, should be supported to allow local areas to identify, define and develop meaningful boundaries within their patch in which local services can work together around the needs of the population.
- STPs should be encouraged to adopt the principle of subsidiarity in which decisions are made at the most appropriate local level. NHSE and NHSI should set out in their planning guidance for 2019/20 advice and support to achieve these recommendations.
- Although STPs provide a useful forum through which local bodies can come together in difficult circumstances to manage finite resources, they are not, the sole solution to the funding and workforce pressures on the system. The national bodies must not overburden STPs by increasingly making them the default footprint for the delivery of national policies.

Integrated Care Systems

The Committee explored the achievements of the ICSs, and the challenges still facing them. The Committee recommends that:

- The national bodies, including the DHSC, NHSE, NHSI, HEE, PHE and CQC, develop a joint national transformation strategy setting out how national bodies will support STPs, at different stages of development, to progress to achieve integrated care system status. This strategy should:
  - set out how national bodies plan to support local areas to cultivate strong relationships;
  - strengthen the programme infrastructure of STPs;
  - consider whether, and how, support, resources and flexibilities currently available to ICSs could be rolled out to other help other areas;
  - develop a more sophisticated approach to assessing the performance of STPs and their readiness to progress to integrated care status. This should include an assessment of local community engagement, the strength of local relationships and the progress towards preventative and integrated care. An assessment of prevention should encompass a broader definition than preventing demands on hospitals and integration should focus on how to improve patients' experience and outcomes;
  - how they will judge whether an area is ready to be an ICS;
  - how they will support STP areas to become ICSs;
  - what they will do in areas that fail to meet the criteria or which will never meet the criteria;
  - how they will monitor the performance of existing ICS areas and provide support including the necessary funding to ensure they continue to make progress; and
  - how they will address serious performance problems in ICS areas.

Accountable Care Organisations (ACOs)

The Committee reviewed the arguments for and against ACOs. It concludes that, rather than leading to increasing privatisation and charges for healthcare, the consequence of the introduction of ACOs is more likely be less competition and a diminution of the internal market and private sector involvement.

Given the controversy surrounding their introduction in the NHS, the Committee recommends that:

- ACO models should be piloted before being rolled-out. There should be an incremental approach to the introduction of ACOs, with areas choosing to go down this route carefully evaluated.
- If a decision is made to introduce ACOs more widely, they should be established in primary legislation as NHS bodies. This will require a fundamental revisiting of the Health and Social Care Act 2012 and other legislation. These organisations should have the freedom to involve, and contract with, non-statutory bodies where that is in the best interests of patients.
- The national bodies take proactive steps to dispel misleading assertions about the privatisation and Americanisation of NHS. The DHSC should publish an annual assessment of the extent of private sector in the NHS, including the value, number and percentage of contracts awarded to NHS, private providers, charities, social enterprises and community interest companies.

The case for change

The Committee concludes that there has not been a sufficiently clear and compelling explanation of the direction of travel and the benefits of integration to patients and the public. It recommends that:

- The case for change must be made in a way that is meaningful to patients and local communities. The DHSC and national bodies should develop a narrative in collaboration with representatives of communities, NHS bodies, local government, national charities and patient groups and should explain how they plan to support efforts to engage and communicate with the public.
- NHSE and NHSI should make clear that they actively support local areas in communicating and co-designing service changes with local communities and elected representatives.

Funding and workforce pressures

The Committee believes that funding and workforce pressures on NHS, social care and public health services present significant risks to the ability of the NHS to maintain standards of care, let alone to transform. The NHS and local government have not been given adequate investment, support and time to embark on the scale of transformation envisaged.

The Committee recommends that:

- Government's long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention.
- National and local bodies should develop an estimate of the transformation funding they require by looking at the experience of new care models and Greater Manchester. This should include an estimate of funding required in each area to provide staff with the capacity to engage in transformation, develop new skills and facilitate the double running of services.

Oversight and regulation

The Committee reports there is a widespread perception of competing priorities between the key national bodies, particularly the DHSC, NHE, NHSI and the CQC and concludes that incoherence in the approach of national bodies is a key factor holding back progress. The Committee therefore welcomes the recent

announcement from NHSE and NHSI on how they will work more collaboratively and align priorities and processes. The Committee did not hear clear evidence about how the arms-length bodies, particularly NHSE and NHSI, are seeking to accelerate the scale-up and spread of transformative changes to the delivery of care, such as the new models of care.

The Committee recommends that:

- CQC and NHSI conduct a joint survey in one years' time to assess whether these commitments have made a tangible difference to those on the frontline.
- NHSE and NHSI undertake a review of the first cohort of ICSs in April 2019, including the level of financial support underpinning transformation, and make the key findings available to all STP areas.

The Committee requests:

- A joint response from the DHSC, NHSE, NHSI, HEE and CQC setting out how their roles, responsibilities, functions and policies support the factors that are critical to transformation and integrated care including skills and capacity of frontline staff; NHS leadership; financial incentives; infrastructure; and coherent oversight and regulation.

Governance and legislation

The Committee has set out the main problems and challenges posed by the current legislation and views on legislative reform. It highlights that legal decision-making powers rest with the organisations involved rather than the STPs or ICSs. These constituent NHS and local government bodies have different legal duties and powers. For example, local councils are democratic institutions in their own right, and are unable to run a deficit, unlike NHS bodies.

The Committee is concerned that providers and commissioners are operating with significant risks to their governance and decision-making, as these arrangements increase the distance of decision-makers from the decisions they are taking. This approach is also time-consuming. The most limiting aspect of the existing framework are requirements covering CCGs' procurement of NHS services. There are also immediate legal obstacles that the Government and national bodies should seek to address to enable local areas to progress before primary legislation can be introduced, for example, differences in VAT exemptions covering NHS and local government.

- The Committee believes the law will need to change to enable greater collaboration and integration. The Department and NHSE should establish an advisory group, or groups, comprised of local leaders from across the country, including areas that are more advanced and those further behind, and representatives from the health and care community, to lead on and formulate legislative proposals to remove barriers to integrated care.
- Until legislation is introduced, national bodies should support local areas to develop transparent and effective governance arrangements that allow them to make progress within the current framework. National bodies should also provide greater clarity over what is permissible within current procurement law and develop support for local areas in working through these issues.

NHS Providers' view

The Committee's report offers a valuable insight into the challenges, opportunities and complexities, facing providers and their partners as they seek to integrate health and care services. This is all the more pertinent as the NHS approaches its 70th birthday with the promise of a new funding settlement and a ten year plan for delivery.

We were pleased to engage with the Committee as it shaped its inquiry (including suggesting a number of trusts and local areas they chose to visit) and we are pleased that the committee has reflected many of the concerns we raised both in our written submission and during the oral evidence session.

We need a clearer strategy to support the move to integrated care. But as the Committee highlights, there is a growing tendency to pin performance and financial obligations on STPs, even though they lack the mandate, the means and the legal authority to deliver them. We are concerned that providers are operating with significant risks to their governance and decision-making and are pleased that the Committee has recommended that the national bodies provide more support for local areas on governance frameworks that allow them to make progress within the current legislation.

Our recent regulation survey demonstrated that NHS trusts do not feel the current direction of travel is clear and that considerable duplication and fragmentation persists among the national bodies. We believe that the Committee's recommendation for the national bodies to develop a joint national transformation strategy could play an important part in giving providers and their local partners a clearer, enabling framework within which to lead transformation programmes locally.

Press statement

Saffron Cordery, Director of Policy and Strategy and Deputy Chief Executive said:

"This is a valuable and timely report which reflects many of the concerns we raised with the committee.

"It highlights the growing tendency to pin performance and financial obligations on STPs, even though they lack the mandate, the means and the legal authority to deliver them.

"The report also helpfully identifies the conditions and characteristics required for closer integration, while recognising that some areas have been able to move ahead much more quickly than others.

"We agree with the committee that much of the debate around accountable care organisations (ACOs) has been confused and misleading.

"We need a clearer strategy to support the move to integrated care.

"The forthcoming long term funding settlement presents a good opportunity to invest in transforming the NHS, adapting it to meet the changing needs of local communities."

Contact: Ella Jackson, Policy Advisor (Regulation) ella.jackson@nhsproviders.org

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 27th June 2018

Title and Author of Paper: Integrated Commissioning & Quality Assurance Report (Month 2 May 2018) – Anna Foster, Deputy Director of Commissioning & Quality Assurance

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

Paper for Debate, Decision or Information: Information & Discussion

Key Points to Note:

- This report provides an update of Commissioning & Quality Assurance issues arising in the month, including progress against quality standards.
- Challenges remain waiting times across many adult and children's services, in particular South of Tyne Services for Children and Young People
- The training figures relating to Doctors in Training have been reviewed and now show significant improvement
- There has been little change in the month in relation to other workforce, training and quality standards.
- The provisional in month sickness absence rate for May 2018 of 5.53% is an increase in comparison to April 2018, which is now confirmed as 5.2%. The 12 month rolling average sickness rate has increased to 5.66%.
- The executive summary on page 1 provides further points to note.

Risks Highlighted: waiting times and sickness.

Does this affect any Board Assurance Framework/Corporate Risks: Yes

Equal Opportunities, Legal and Other Implications: none

Outcome Required / Recommendations: for information and discussion

Link to Policies and Strategies: NHS Improvement – Single Oversight Framework, 2017/18 NHS Standard Contract, 2017-19 Planning Guidance and standard contract, 2017-18 Accountability Framework

Northumberland, Tyne and Wear NHS Foundation Trust

NTW Integrated Commissioning & Quality Assurance Report

2017-18 Month 2 (May 2018)

Contents:

1. Executive Summary:

- The Trust remains assigned to segment 1 by NHS Improvement as assessed against the Single Oversight Framework (SOF). (page 4).
- At Month 2, the Trust has a year to date deficit of £0.7m which is £0.3m behind plan. The Trust is forecasting to meet its control total of £3.5m by delivering a surplus before Provider Sustainability Funding of £1.5m and receiving its Sustainability funding of £2.0m. The Trust's finance and use of resources score is currently a 3 (this is a sub theme of the Single Oversight Framework) and the forecast year-end risk rating is also a 3. The main financial pressures during month 2 were staffing pressures in the Autism Unit and smaller pressures across the Trust. See page 27-28.
- South Tyneside and NHS England fully achieved the contract requirements during month 2 however, there are a number of contract requirements largely relating to CPA metrics which were not achieved across other local CCGs during the month. (page 14)
- There are continuing pressures on waiting times across the organisation, particularly within community services for children and young people. Each locality group has developed action plans which are being monitored via the Business Delivery Group and the Executive Management Team. (page 25)
- All but one CQUIN scheme requirements are forecast to be achieved during Quarter 1 with the exception of Transitions out of Children and Young People's Mental Health Services which has been rated amber as this is dependent on CCG's agreeing the audit which was undertaken during quarter 4. (page 15)
- All of the four of the quality priorities are internally forecast as amber at month 1. (page 30)
- The Accountability Framework for each group is currently forecast as 4 due to the continuing underperformance in each group against a number of quality metrics. (p 31)
- Reported appraisal rates have increased in the month to 84.4% (was 83.6% last month). (p29)
- The provisional in month sickness absence rate for May 2018 of 5.53% is an increase in comparison to April 2018, which is now confirmed as 5.2%. The 12 month rolling average sickness rate has increased to 5.66%.(p 29)
- Training rates have continued to see most courses above the required standard. The only course more than 5% below the required standard is MHA Combined Training (78.1% was 76.2% last month) (p 29)
- The service user and carer FFT recommended score has remained at 88% in May which is slightly below the national average. (page 32)
- There have been two Mental Health Act reviewer visits (Bede and Lindisfarne). The main issue identified on Lindisfarne related to the seclusion room as there was no blind at the window. On Bede there are currently two outstanding issues regarding the clock which was slow and the outdoor space which was fit for purpose but required repair. (page 7)

NHS
Northumberland, Tyne and Wear
NHS Foundation Trust

SOF:	1	The Trust's assigned shadow segment under the Single Oversight Framework remains assigned as segment "1" (maximum autonomy).

Waiting Times

- The number of people waiting across adult services has decreased in the month (excluding gender dysphoria, adult autism diagnosis etc), the number waiting over 18 weeks has also decreased significantly in the month.
- The number of people waiting for specialised adult services has increased slightly in the month along with the proportion of those waiting more than 18 weeks which has continued to increase.
- Waiting times to treatment for children and young people have increased in the month across all areas with the exception of Northumberland, those waiting more than 18 weeks have reduced in the month across most areas, whilst those waiting over 30 weeks has increased in Gateshead, South Tyneside and Sunderland.

Quality Priorities:

Quarter 1 forecast:	Quarter 1 forecast part achieved:	Quarter 1 forecast not achieved	
0	4	0	In total there are four quality priorities identified for 2017-18 and at month 2 all have been forecast as part achieved at month 2

CQUIN:

Quarter 1 forecast:	Quarter 1 forecast part achieved:	Quarter 1 forecast not achieved	
9	1	0	There are a total of ten CQUIN schemes in 2017-18 across local CCGs and NHS England commissioned services. All have been internally forecast as achieved at month 2 with the exception of Transitions out of Children and Young People's Mental Health Services which is forecast amber.

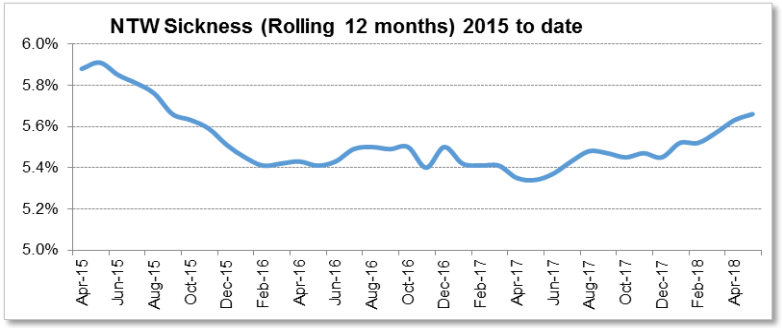
Workforce:

Statutory & Essential Training:

Standard Achieved Trustwide:	Performance <5% below standard Trustwide:	Standard not achieved (>5% below standard):	
14	4	1	Rapid Tranquilisation training (84.6%), PMVA Basic training (80.9%), PMVA Breakaway (84.0%) and Information Governance (93.6%) are within 5% of the required standard, MHA combined training (78.1%) is more than 5% below the standard.

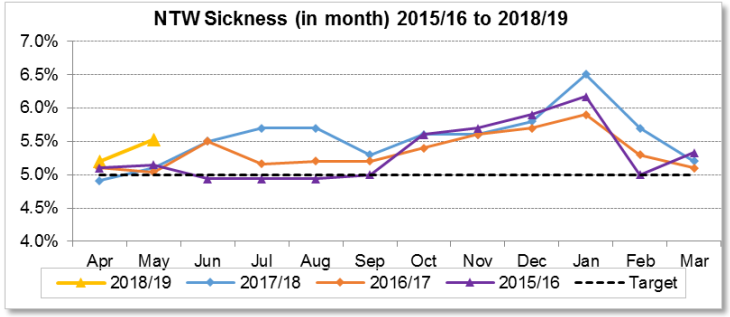
Appraisals: Appraisal rates have increased to 84.4% in May 18 (was 83.6% last month).

Sickness Absence:



The provisional "in month" sickness absence rate is above the 5% target at 5.53% for May 2018

The rolling 12 month sickness average has increased to 5.66% in the month



Finance:	At Month 2, the Trust has a year to date deficit of £0.7m which is £0.3m behind plan. Pay spend at Month 2 was £42.4m which is £0.3m above plan and includes £1.5m agency spend which is slightly above the planned trajectory to hit our agency ceiling of £8.0m but £0.4m above planned spend. The Trust is forecasting to meet its control total of £3.5m by delivering a surplus before Provider Sustainability Funding of £1.5m and receiving its Sustainability funding of £2.0m. The Trust's finance and use of resources score is currently a 3 (this is a sub theme of the Single Oversight Framework) and the forecast year-end risk rating is also a 3. The main financial pressures at Month 2 relate to pay costs. There is a significant staffing pressure in the Autism Unit and there are smaller pressures across the Trust. The Trust needs to reduce pay spend to bring the financial position back in line with plan and to achieve this year's control total. To achieve this, spending on temporary staffing (agency, bank and overtime) needs to reduce. Work is ongoing to deliver the required staffing reductions and to improve efficiency and productivity across the Trust.

Contract Summaries:	NHS England	Northumberland & North Tyneside CCGs	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	Cumbria CCG
	100% of metrics achieved in month 2	90% of metrics achieved in month 2	90% of metrics achieved in month 2	100% of metrics achieved in month 2	93% of metrics achieved in month 2	87% of metrics achieved in month 2	62% of metrics achieved in month 2
	The areas of under performance continue to relate mainly to CPA metrics and 7 day follow up						

2. Compliance

a) NHS Improvement Single Oversight Framework

Self assessment as at Quarter 1 2018 to date against the "operational performance" metrics included within the Single Oversight Framework:

Metrics: (nb concerns will be triggered by failure to achieve standard in more than 2 consecutive months)	**Frequency**	**Source**	**Standard**	**Quarter 1 to date self assessment**	**NTW % as per most recently published MHSDS/RTT/EIP/IAPT data**	**National % from most recently published MHSDS data**	**Comments.** NB those classed as "NEW" were not included in the previous framework	**Data Quality Kite Mark Assessment**
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	Monthly	UNIFY2 and MHSDS	92%	100%	100%	86.90%	National data includes all NHS providers and is at March 2018	
People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral	Quarterly	UNIFY2 and MHSDS	*53%*	83.3%	95%	75.90%	Published data is as at March 2018	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:								
a) inpatient wards	Quarterly	Provider return / CQUIN audit	90%	99%	no data	no data	Q1 YTD Metric 1426	
b) early intervention in psychosis services	Quarterly	Provider return / CQUIN audit	90%	93%	no data	no data	Q1 YTD Metric 1427	
c) community mental health services (people on Care Programme Approach)	Quarterly	Provider return / CQUIN audit	65%	97%	no data	no data	Q1 YTD Metric 1425	
Data Quality Maturity Index Score (DQMI)			95%	92%			Published data is at Quarter 3 2017	
Number of Out of Area Placements (Active at period end)				1	0	640	Published data relates to February 2018. NTW self assessment data relates to March 2018	
Improving Access to Psychological Therapies (IAPT)/talking therapies							NTW data relates to March	
· proportion of people completing treatment who move to recovery	Quarterly	IAPT minimum dataset	50%	50.5%	48.0%	51.9%	NEW metric 1079 published data February 2018	
· waiting time to begin treatment :								
- within 6 weeks	Quarterly	IAPT minimum dataset	75%	99.7%	99.0%	89.3%	published data February 2018	
- within 18 weeks	Quarterly	IAPT minimum dataset	95%	99.8%	100.0%	98.7%	published data February 2018	

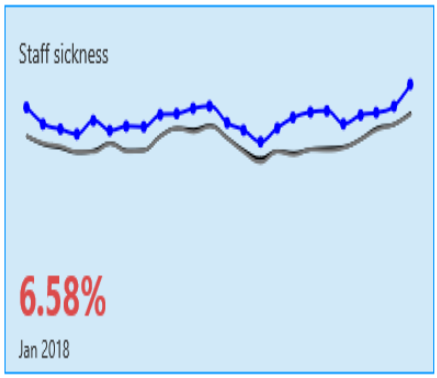
*NB EIP target has increased to 53% from April 2018

NHS Improvement Single Oversight Framework & Model Hospital Portal

As at the end of May 2018, the Trust remains segment 1 within the Single Oversight Framework as assessed by NHS Improvement. There are currently 16 mental health providers nationally achieving this rating. There is currently one MH providers in the lowest segment (segment 4), 26 providers within segment 2 and five providers remain in segment 3.

Sickness

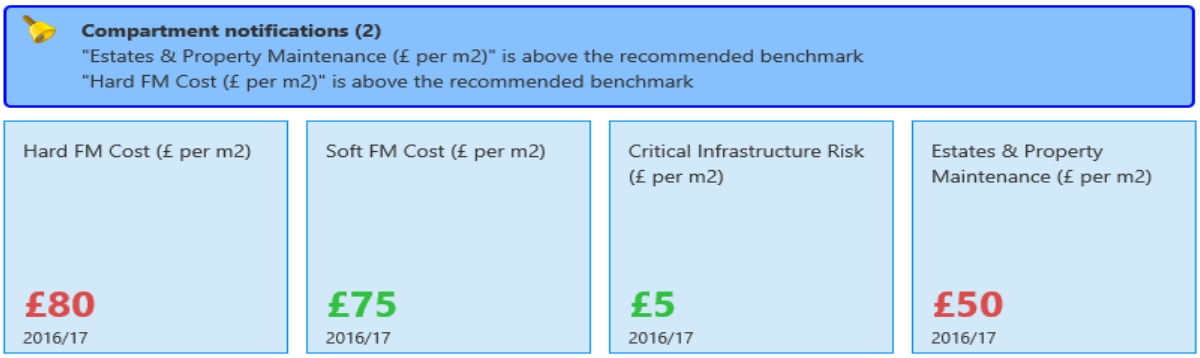
The model hospital shows two notifications for the Trust in relation to sickness. The overall staff sickness rate is showing 6.58% and sickness for nursing and health visitors at 6.7% which puts the Trust into the upper quartile for both of these metrics. It should be noted that the data in the model hospital is as at January 2018.



Estates and Facilities

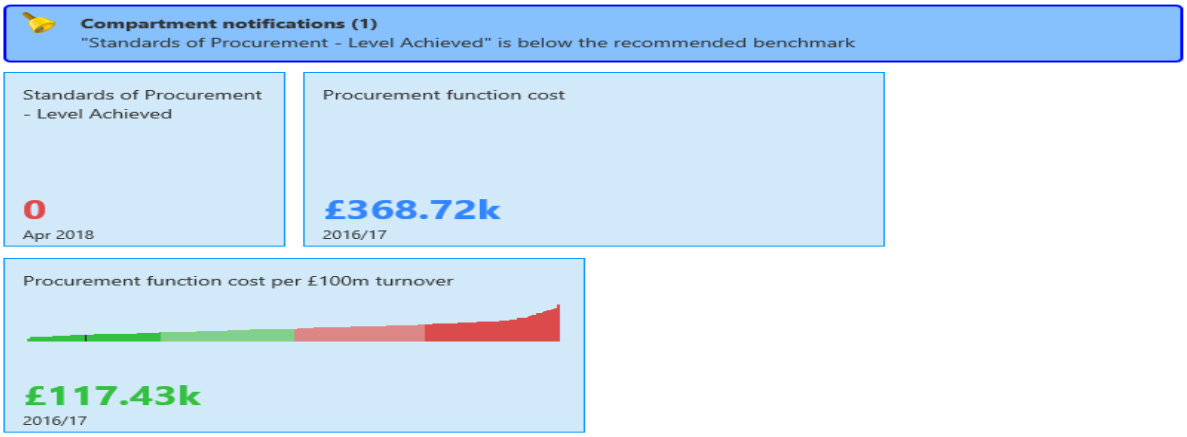
There remains two notifications against metrics for Estates and Facilities, the notification for Food Costs (£ per meal) has been removed:-

- Hard FM Cost
- Estates and Property Maintenance



Procurement Function

There is a new notification showing in the procurement function compartment, this is in relation to “Standards of Procurement – level achieved” and shows that as at April 2018 the Trust is yet to be accredited, it should be noted that this is a new standard for Mental Health Trusts and has in the past only applied to Acute Trusts, the Trust is currently looking into the accreditation process.



Finance Function, Payroll Function, Legal Function

There remains as reported in last month’s update three notifications in relation to the above functions:-

Finance	Cost of Accounts Receivable per Invoice Raised
Payroll	Payroll Function Cost per £100m Turnover
Legal	Legal Function Cost per £100m Turnover

All of the notifications which are currently showing in Model Hospital (with the exception of the Procurement notification) are taken from available data for the period 2016/2017. This will be updated when 2017/2018 data is available.

It should be noted that the information shown within this report is exception based, there is further data on a wide range of other metrics available within the model hospital portal.

2. Compliance
b) CQC Update May 2018

CQC Well Led with Core Service Inspection

- Inspections to the following core services have taken place - CAMHS inpatient wards, specialist community CAMHS, acute wards for adults of working age and psychiatric intensive care units and wards for older people with mental health problems. These inspections took place between 16 April 2018 and 27 April 2018.

- The well-led review took place between 15 and 17 May 2018 and high level feedback has been received. The draft inspection reports are due to be issued to the trust at the end of June for factual accuracy checks.

Never Event Thematic Review

A team of inspectors went to Hopewood Park on the 23 April 2018 as part of a national thematic review of never events and visited the following services – Beckfield, Aldervale, Bridgewell, Longview and the IRS team. As part of this review a number of interviews took place with members of the senior management team on the 14 May 2018. The trust awaits the findings from this review and the CQC plan to publish their report in autumn 2018.

Focussed Inspections

Publication of the reports following a focussed inspection visit to two core services (acute wards for adults of working age/psychiatric intensive care units and long stay rehabilitation mental health wards for working age adults) in May 2017 are awaited. The delay in publication relates to an ongoing investigation.

Registration notifications made in the month:

No registration notifications have been made to the CQC this month.

Mental Health Act Reviewer visits in the month:

<u>Bede – visited 19 April 2018</u>

During the previous visit on 10 May 2016, five actions were identified, two of which remain partially resolved and these relate to the following issues, the clock in the seclusion room was one hour behind and the outdoor space which was now fit for use, however was in a poor state of repair.

<u>Lindisfarne – visited 27 April 2018</u>

During the previous visit on 11 May 2016, six actions were identified, one of which remains partially resolved and this relates to an issue with the seclusion room – the window still had no blind and it did not appear there was a plan to address the issue.

Recently published CQC inspection reports to note:

Trust	Date of Inspection	Date of Report	Overall rating	Comments	Link to Report
Devon Partnership NHS Trust	Feb 2018 5 core services visited	May 2018	Good	The trust's overall rating has improved to good overall. Their rating for the safe and effective key question has improved from requires improvement to good.	here
Lancashire Care NHS Foundation Trust	Feb 2018 5 core services visited	May 2018	Requires improvement	The trust's overall rating has changed from good to requires improvement overall. Their ratings for the effective and well-led key question has changed from good to requires improvement.	here

CQC Recent News Stories:

Business plan 2018-19

The CQC have published their business plan for 2018-19 which builds on their 2016-21 strategy. The business plan sets out nine key priorities to be delivered, these are:

1 – Transform registration so it focuses on high-quality services, supports innovation, improves information, and uses a risk-based approach that is more proportionate for providers

2 – Ensure we are able to respond to changing models of care, including use of new technology so we can effectively register and inspect them

3 – Develop our approach to assessing the quality of care in a place enabling improvement, and efficient information gathering and sharing

4 – Roll out changes to the regulation of independent health providers Inspection frequency based on ratings for some and other changes in line with what we have done in other sectors

5 – Strengthen our independent voice and engagement including building relationships with local stakeholders to maximise intelligence to support our inspectors

6 – Deliver our digital programme User-focused technology that drives efficiency

7 – Enable CQC to become intelligence-driven making best use of data about quality of care to deliver enhanced insight, and an always-on service to collect information from providers

8 – Develop a quality improvement culture within CQC Transfer expertise in quality improvement to staff so they have skills and experience to make improvements to the way we work

9 – Improve the experience of our staff Increase staff engagement - ensure we continue to have people with the right skills and experience

Brief Guides

The following new CQC guides were published recently:

New guides

- Assessing mental health care in the emergency department
- Assessing quality improvement in a healthcare provider
- Rapid tranquilisation (by the parenteral route) in mental health
- Recovery orientated practice
- The use of blanket restrictions in mental health wards
- Transitions out of children and young people's mental health services CQUIN

Updated guides

- Assessing how providers implement Mental Capacity Act 2005
- Assessment by inspectors of how a provider applies the Mental Health Act
- Assessment of same sex accommodation
- Capacity and competence to consent in under 18s
- Covert medication in mental health services
- Education arrangements for children in Tier 4 CAMHS settings
- Inspection safeguarding
- Interpreting and reporting incident data
- Ligature points
- Physical healthcare in mental health settings
- Restraint - physical and mechanical
- Seclusion rooms
- Smoke free policies in mental health inpatient services
- Substance misuse services – people in vulnerable circumstances
- Substance misuse services – ligature risks
- Substance misuse services – detoxification or withdrawal from drugs or alcohol
- Substance misuse services – workforce qualifications
- Waiting time for community child and adolescent mental health services

There are now 42 brief guides that have been published by the CQC, all of which can be accessed here. All new and updated guides will be considered by the CQC Quality Compliance Group.

Briefing – Mental health rehabilitation inpatient services

This briefing looks at mental health rehabilitation inpatient services, including ward types, bed numbers and use by clinical commissioning groups and NHS trusts. The information contained in this briefing was sought via an information request sent to all providers in October 2017.

The CQC are concerned about the high number of beds situated a long way from the patient's home. This could result in people becoming isolated from their friends and families and cut off from the local services that will provide care following discharge.

Findings relating to NTW:

- Only 2 patients identified as being the responsibility of NTW were in a bed not managed by the trust.
- 131 patients received aftercare from NTW. This placed the trust in the highest quartile of trusts nationally.
- The median length of stay in hospital continuously was 2989 days (compared with the national median of 934 days).
- No patients were situated further than 50 km from their home address.

CQC Insight

Last year, NHS acute trusts were invited to access their online CQC Insight dashboard. This will be extended to standalone NHS community trusts in late June and trusts providing mental health services in July.

The dashboard is a tool that has been developed to support monitoring across a wide number of quality indicators. CQC Insight will be updated either monthly (acute) or every second month (ambulance, community health services, and mental health) to show the most up-to-date information held about each trust.

Four further local system reviews published

This month the CQC have published four further reviews of how local health and social care systems are working together. CQC reviewers in Birmingham found there was a system-wide commitment to serving the people of Birmingham but that services had not always worked effectively together. In Cumbria, older people had inconsistent experiences of health and social care, although there were examples of excellent leadership in primary care that was helping drive change and improvement. Reviewers in Liverpool found there was a clear strategic direction for health and social care, focused on the needs of the people living in the city. However, the experiences of people using health and social care varied. Bradford was

also found to have a clear shared and agreed purpose, vision and strategy, however variation was found when it came to access to GPs and district nurses.

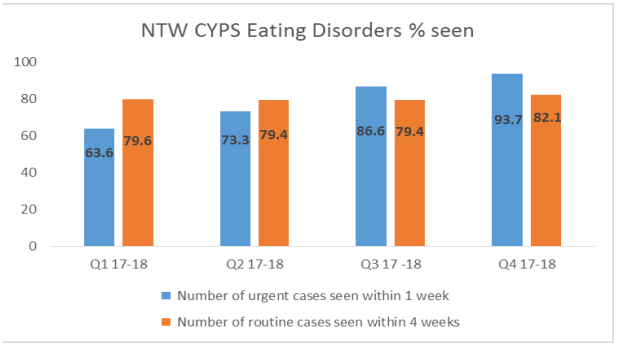
Understanding the impact of enforcement on providers

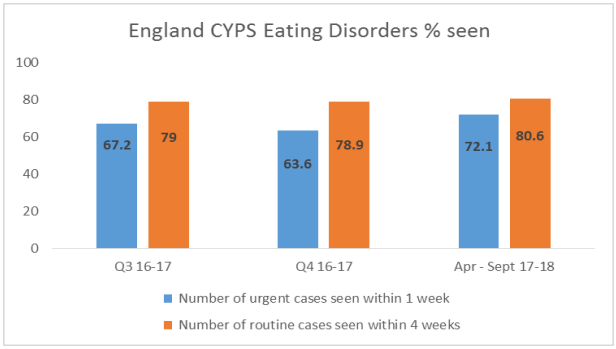
Two of CQC's priorities for 2016-21 include becoming a more efficient and intelligence-driven regulator. One way in which the CQC intends to deliver on these priorities is through deepening their understanding of the impact of their enforcement activity on people who use services and on providers. In May and June interviews will be taking place with providers from across the sectors to understand how enforcement has had an impact on organisations. NTW are participating in this process.

2. Compliance

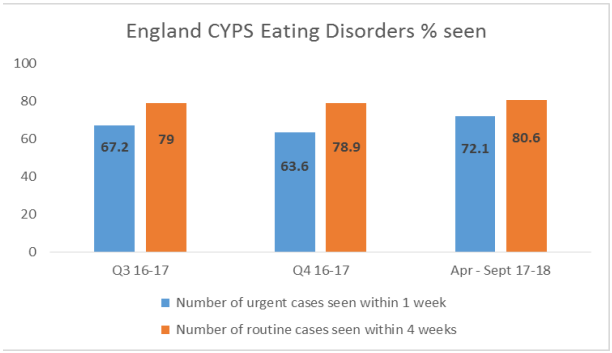
c) Five Year Forward View for Mental Health

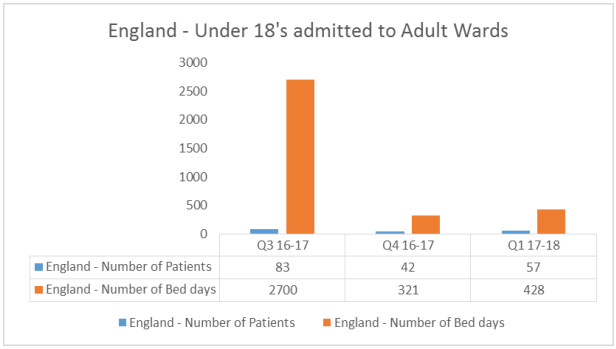
Children and Young People Eating Disorders



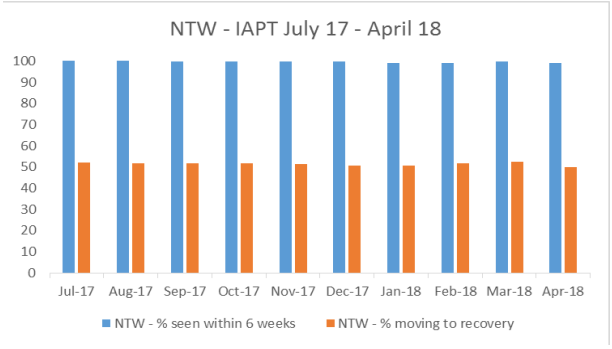


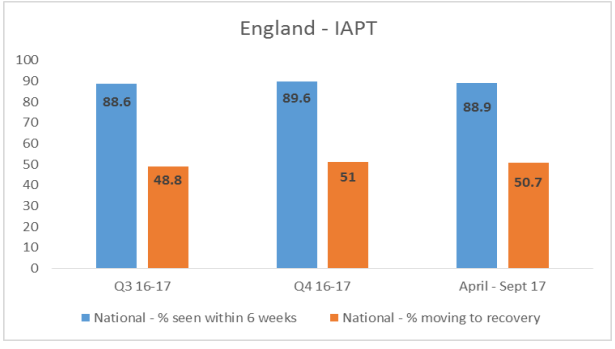
Under 18's admitted to an Adult Ward



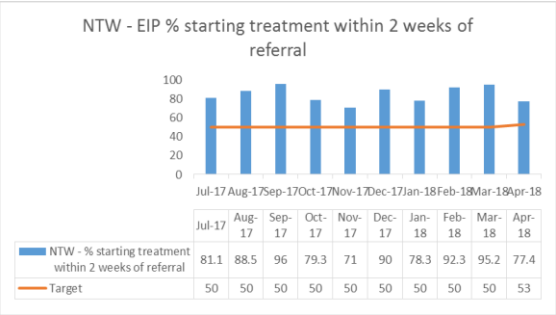


Improving Access to Pyschological Therapies (IAPT)

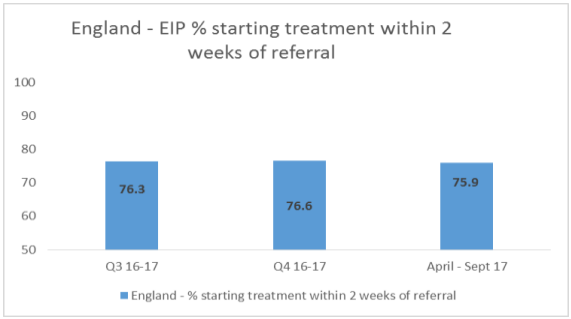




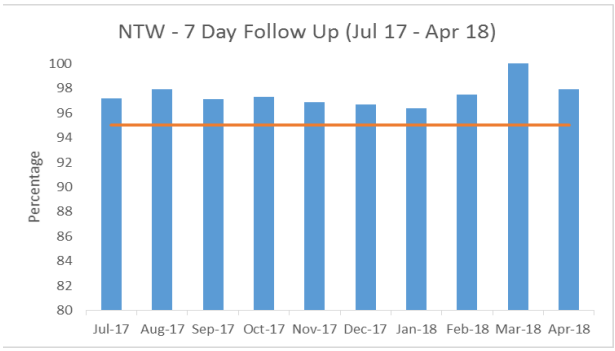
Early Intervention in Psychosis (EIP)

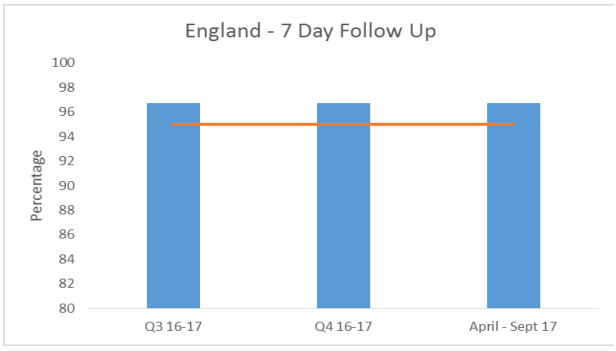


	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
NTW - % starting treatment within 2 weeks of referral	81.1	88.5	96	79.3	71	90	78.3	92.3	95.2	77.4
Target	50	50	50	50	50	50	50	50	50	53

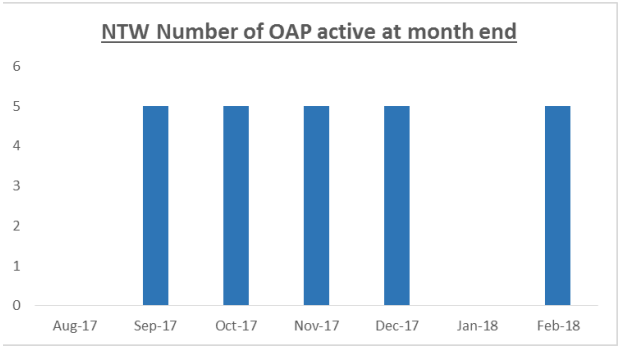


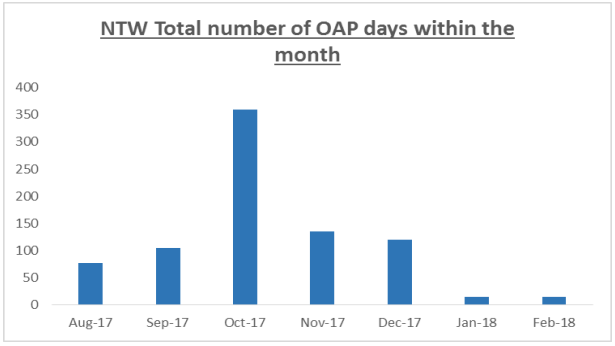
Seven Day Follow Up





Out of Area Placements

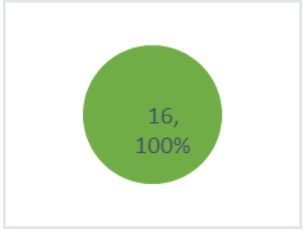
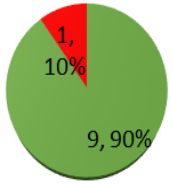
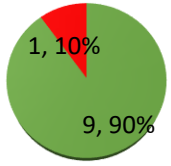
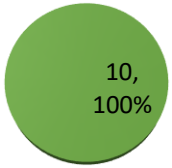
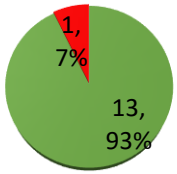
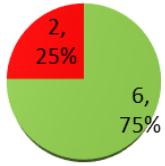
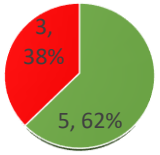




Latest NHS England Five Year Forward View CCG dashboards are available here

3. Contract Update May 2018

a) Quality Assurance – achievement of quality standards May 2018

NHS England	Northumberland & North Tyneside CCGs	Newcastle / Gateshead CCG	South Tyneside CCG	Sunderland CCG	Durham, Darlington & Tees CCGs	Cumbria CCG
						
All achieved in month 2	The contract underperformed in month 2 on Crisis & Contingency (46 patients, 94.3%)	The contract underperformed in month 2 on 7 day follow up (3 patients, 92.9%)	All achieved in month 2	The contract underperformed on IAPT numbers accessing service in month 2	The contract under performed in month 2 on Crisis & Contingency (3 patients, 92.1%) and CPA review in 12 months (2 patients, 93.5%)	The contract under performed in month 2 on Completion of Risk assessment (4 patients, 60.0%), Crisis & Contingency (1 patient, 75.0%) and CPA review in 12 months (1 patients, 83.3%)

3. Contract update May 2018

b) CQUIN update May 2018

CQUIN Scheme:	Annual Financial Value	Requirements	Quarterly Forecast:				
			Q1	Q2	Q3	Q4	Comments
1.Improving Staff Health and Wellbeing	£208k	To improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well.	£0	£0	£0	£208k	
	£208k	Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff	£0	£0	£0	£208k	
	£208k	Healthy food for NHS staff, visitors and patients	£0	£0	£0	£208k	
2. Improving physical healthcare to reduce premature mortality in people with serious mental illness(PSMI)	£500k	Improving physical healthcare to reduce premature mortality in people with serious mental illness - 3a) Cardio metabolic assessment and treatment for patients with psychoses	£50k	£0	£0	£450k	
	£125k	Improving physical healthcare to reduce premature mortality in people with serious mental illness 3b)- Collaboration with primary care clinicians	£25k	£63k	£13k	£25k	
3. Improving services for people with mental health needs who present to A&E	£625k	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.	£0	£125k	£0	£500k	
4. Transitions out of Children and Young People's Mental Health Services	£625k	To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services.	£31k	£281k	£0	£313k	This is dependent on the CCGs accepting the results from the expanded Q4 audit
5. Preventing ill health by risky behaviours – alcohol and tobacco	£625k	To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.	£0	£0	£0	£625k	
6. Health and Justice patient Experience	£5k	NHS England has a national priority and focus on patient experience in order to improve the quality of services.	£1.25k	£1.25k	£1.25k	£1.25k	
7. Recovery Colleges for Medium and Low Secure Patients	£312k	The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services.	£16k	£16k	£16k	£264k	
8. Discharge and Resettlement	£496k	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	£124k	£124k	£124k	£124k	
9. CAMHS Inpatient Transitions	£248k	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.	£62k	£62k	£62k	£62k	
10. Reducing Restrictive Practices within Adult Low & Medium Secure Services	£188k	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.	£47k	£47k	£47k	£47k	
Grand Total	**£4.37m**		**£356**	**£718**	**£262**	**£3,035**	

3. Contract update May 2018

c) Service Development and Improvement Plan – Quarter 4 Update for CCGs

Description	Milestones	Progress
Children & Young People's Mental Health (Community CYPS) Joint working between CCGs, NTW and other relevant providers to review the Local Transformation Plans for Children & Young People's 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	Assessment of current position against future trajectories / Requirements. Assessment of potential gaps and the requirements to address the gaps Development of service and workforce plan. Following service review – refresh of service specification to update for any material changes (if required)	Newcastle/Gateshead – NTWFT is fully engaged with the CCG and other partners in the work on the CCG transformation plans including the development of a single point of access. This single point of access has gone live from 1.12.17 but is carrying out a phased roll out as recruitment can be achieved. Work is currently ongoing on mobilisation plans to move from current service provision to that proposed in the "getting help" and "getting more help" draft service specifications although further work needs to be done in conjunction with CCGs to determine how this will work without a "lead provider" and who will co-ordinate this work. Guidance in relation to National Crisis Waiting Times now available. Potential impact currently being assessed by the Trust
Children & Young People's 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 People's 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	Assessment of current position against future trajectories / Requirements. Data set to be agreed to support the jointly agreed plan Assessment of potential gaps and the requirements to address the gaps Development of service and workforce plan. Following service review – refresh of service specification to update for any material changes (if required)	The service has continued to contribute to the existing transformation work streams and to provide the necessary information where requested. CYPS Waiting Time improvement plan developed and shared with CCG. On-going monitoring via Contract meeting. . Guidance in relation to National Crisis Waiting Times now available. Potential impact currently being assessed by the Trust and will be included into 2018/19 SDIP.

Description	Milestones	Progress
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.	*To be added when review complete*	The service continues to work towards achieving the access and waiting time standards published in 2016. Data quality continues to improve incrementally. NTWFT are committed to working with the CCGs on a review of EDICT and this has been rolled into 18/19 as part of the SDIP. Under the NTW New Care Models program consideration has been given as to how to compliment the current CYP community based eating disorder services within NTW, to meet the increasing needs of this young person's population. It has reviewed a number of options the ultimate aim being to be able to provide a much broader range of services to children and young people with an eating disorder, within their locality, in a timely manner that is both clinically effective and sustainable. It is proposed to discuss these more fully in the work plan meeting to be arranged.
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	During Year 1 plan to be developed for the review of the sustainability of service post 18/19	Progress report for Q4 embedded PMH CSDF Progress report April 2018.do

Description	Milestones	Progress
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.	For each quarter NTW to report against action plan & demonstrate compliance against required EIP targets as per national requirements.	A meeting is being held with NTW, CCGs and the NHS Improvement team (IST) in April 18. NHS Improvements will be carrying out a deep dive on EIP services reporting against the requirements of the 5YFV and what has been achieved to date. The outcomes of this should provide clarity on what can be achieved within the resource envelope or whether additional funding would be required to achieve the 5YFV recommendations. 2017/18 National audit has been completed and CCQI shared the headlines for England at an event at the end of March. Local data has not yet been released.
Adult Mental Health: Liaison Teams During 2017/18 - CCGs (in conjunction with NTW and relevant stakeholders) to review current Liaison services.	Report in line with agreed action plans once developed. Plan to incorporate review of longer term sustainability of service . NTW, CCGs and relevant stakeholders to link into A&E delivery board for any bids to access national monies & to monitor requirements for 24 hr Liaison services and Core 24/7 requirements (dependant on national funding availability) and agree process for STP sign off	Review of Liaison services currently underway and results will impact on future service and funding. Results to be shared and discussed in 18/19. Draft guidance in relation to National Waiting Times now available. Potential impact currently being assessed by the Trust
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.	Implementatiion in line with Early Implementer project plan Business Case to support recurring funding to developed and agreed by Q3.	The Expanded service was implemented during 2017/18. The Trust will work with the CCG during 2018/19 to develop a business case for recurring funding to support the 5YFV access requirement.

Description	Milestones	Progress
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	Report in line with agreed action plans	Draft guidance in relation to National Waiting Times now available. Potential impact currently being assessed by the Trust and will be shared with commissioners as part of the 18/19 SDIP requirements
Adult Mental Health: Community Services NTW working with CCGs and other stakeholders to review community services	To be developed	As a 5YFV priority we would recommend this be rolled over into the 18/19 SDIP if agreed with commissioners.
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.	To be developed	
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	NTW to provide support to CCG where required – review to be led by Public Health	NTW to identify support and information as and when requested by commissioner.
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.	CCGs to feedback on outcome of service reviews & service specification development and joint working between NTW & CCGs to implement any changes required resulting from the work underway during during 2016/17	Further information shared with CCGs & NECS (see below) and project plans developed incorporating performance frameworks to ensure understanding of work carried out by services. Additional meeting currently being arranged to discuss the shared papers and future plans in more detail

Description	Milestones	Progress
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.	To be developed	Discussions on-going NTW/CCG
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.	To work collaboratively with CCGs towards the implementation of transforming care including the following areas: • Developing shared plans for the future configuration of services To embed a MDT approach to support the delivery of individual care plans	We continue to work closely with the CCG & Transforming care Board on the requirements around the future models of Care for Learning disabilities.
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	• Review to be completed in April 2017 • Findings and any next steps to be incorporated into an implementation plan by end of Q1	In March a workshop was held to review the current position & potential future of RoseLodge. A number of proposals resulted from this workshop which will be taken for further discussion to NORIG on the 26th April 18 and to the CCG Work plan meeting on the 3rd May 18.
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	To be developed	The Trust is continuing to work towards embedding an outcomes focussed culture across the organisation. During the quarter a workshop facilitated by NTW took place with NECS and Sunderland Commissioners to clarify the position on outcomes linked payment schemes. It was agreed that we would collectively work towards all CCGs adopting the national currency of clusters from 2019/2020. It was also proposed that proposed any outcomes linked payment would start initially with existing contract quality standards. The Trust has also participated in research being undertaken by the University of York, looking at the use of HONOS in London mental health trusts and NTW.

Description	Milestones	Progress
SEND Comply with new requirements of Children and Families Bill response to requests for input in accordance with the SEN code of practice to be implemented from 2014. Covering children and young people 0-25 years	Develop the systems to enable NTW to comply with the following: • Ensure all relevant staff are aware of the requirements of the Children and Families Bill and inspection process • Agree process with LA regarding notification of EHC plan. Ensure NTW contribution in line with statutory timescales of 6 weeks. • Agree process with LA regarding NTW contribution to the annual review process – attendance at the review or submission of a report • Identify staff to participate in SEN steering groups where required • Agree format and structure of the NTW element of the SEN report • Identify new referrals from 01.10.2017 with an SEN statement • Provide information and support to develop the local offer following agreement and implementation of new process in conjunction with partners and other stakeholders	A lead for SEND has been identified and a working group has been established with clear terms of reference and deliverables (see below). The group continue to work though the actions associated with this element of the SDIP
SEND Inspection Covering children and young people 0-25 years	• Identify a named NTW Lead for SEN – and notify the CCG/ NEC's. • Identify Key operational and clinical staff to participate in the Inspection focus groups as they arise • Contribute to action plans arising from SEND inspections • Contribute to SEND continuous improvement processes from a specialist mental health perspective	The group continues to work through their action plan to ensure the requirements of SEND are fully embedded. There are representatives from each locality area identified to lead on SEND who are part of this working group. Key deliverables for the group are set out below. The group continues to meet monthly and to work through the actions associated with this. Plan and deliver a training and awareness programme to all staff - this is almost completed and will be shared with the lead for |Northumberland as requested. Agree and implement a system to capture the information required to meet SEND inspection requirements – changes have been made to the clinical record to enable the organisation to capture those where

Description	Milestones	Progress
		SEND applies. Guidance has been written for staff and a central process put in place to support timely reporting. Agree local protocols to ensure we are responding to requests for EHCP and to ensure we have systems in place to report this and meet required timeframes for return – central process to track requests for reports and to ensure timeframes are met are now in place. Development of a template for our EHCP reports and annual review updates – template has been developed. A standard operating procedure has also been written and is expected to be ratified in the April 2018 meeting Agree we can identify outcome measures that will demonstrate our effectiveness - we intend to audit and monitor our compliance internally – timeframes for this to be agreed once the process is up and running fully. Ensure that all the above is in place to capture where SEND applies to someone aged 0-25 years -- ongoing discussion with adult Mental health teams is taking place Share good practice from previous inspections to ensure all Teams are Inspection ready. The group has also identified the need to include SEND in the CYPS specific induction programme.

3. Contract update May 2018

d) Mental Health Currency Development Update

Mental Health Currency Development Update																	
			Q4 2017-18			Q1 2018-19			Q2 2018-19			Q3 2018-19			Q4 2018-19		
Key Metrics	Contract Standard	Internal Standard	Jan	Feb	March	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Current Service Users, in scope for CPP, who are in settled accommodation			60.1%	60.3%	60.2%	60.6%	60.7%										
Current Service Users on CPA			9.4%	9.4%	9.4%	9.4%	9.4%										
Current in scope patients assigned to a cluster			88.1%	88.2%	88.2%	88.7%	88.9%										
Number of initial MHCT assessments that met the mandatory rules			85.6%	86.1%	84.3%	81.9%	83.8%										
Number of Current Service Users within their cluster review threshold		85%	79.5%	79.3%	79.7%	81.1%	82.1%										
Current Service Users with valid Ethnicity completed MHMDS only	90%	90%	93.6%	93.8%	93.8%	94.0%	94.1%										
Current Service Users on CPA, in scope for CPP who have a crisis plan in place	95%	95%	91.3%	91.8%	91.6%	91.9%	92.1%										
Number of CPA Reviews where review cluster performed +3/-3 days either side of CPA review within CPP spell		85%	75.0%	77.5%	74.0%	74.8%	74.6%										
Number of Lead HCP Reviews where review cluster performed +3/-3 days either side of review within CPP spell		85%	57.3%	58.0%	58.6%	57.4%	54.4%										
Current Service Users on CPA reviewed in the last 12 months	95%	95%	97.0%	96.5%	96.4%	97.1%	97.1%										

1. **Contracts**
   e. **Commissioner Quality Assurance Visits May 2018**

None to report this month

4. Waiting Times

As at 31st May 2018, there were almost 6,200 people waiting for a **first contact** to NTW adult community services and 1,850 waiting for treatment within community CYPS. There were also 3,000 people waiting for a healthcare professional allocation.

Key points to note from May 2018:

- The number of people waiting has decreased in the month across adult services (excluding gender dysphoria, adult autism diagnosis etc), those waiting over 18 weeks in these areas has also decreased during the month.
- The number of people waiting to access specialised adult services has slightly increased in the month and the proportion of these waiting more than 18 weeks for specialised adult services continues to increase.
- Waiting lists for treatment for children and young people have increased slightly in the month across all areas, in South Tyneside and Sunderland there have been increases in the number of young people waiting more than 30 weeks for treatment.

Waiting Times Summary May 2018	As at 31st May 2018:		As at 30th April 2018:	
1. Number of service users waiting to access **Adult Services ***	4641		4850	
Proportion waiting 18 - 30 weeks at that date:	**115**	**2.5%**	**238**	**4.9%**
Proportion waiting more than 30 weeks at that date:	**56**	**1.2%**	**90**	**1.9%**
excluding ** gender dysphoria, adult autism diagnosis, adult ADHD etc*				
2. Number of service users waiting to access **Specialised Adult services** *:	1599		1552	
Proportion waiting 18 - 30 weeks at that date:	**329**	**20.6%**	**329**	**21.2%**
Proportion waiting more than 30 weeks at that date:	**737**	**46.1%**	**705**	**45.4%**
** gender dysphoria, adult autism diagnosis, adult ADHD etc*				
3. Total number of children and young people waiting for **treatment** by **community CYPS** services:				
Northumberland	201		216	
Proportion waiting 18 - 30 weeks at that date:	0	0.0%	0	0.0%
Proportion waiting more than 30 weeks at that date:	0	0.0%	0	0.0%
Newcastle	393		331	
Proportion waiting 18 - 30 weeks at that date:	38	9.7%	38	11.5%
Proportion waiting more than 30 weeks at that date:	2	0.5%	2	0.6%
Gateshead	319		266	
Proportion waiting 18 - 30 weeks at that date:	55	17.2%	40	15.0%
Proportion waiting more than 30 weeks at that date:	2	0.6%	0	0.0%
South Tyneside	201		189	
Proportion waiting 18 - 30 weeks at that date:	34	16.9%	51	27.0%
Proportion waiting more than 30 weeks at that date:	67	33.3%	56	29.6%
Sunderland	754		741	
Proportion waiting 18 - 30 weeks at that date:	200	26.5%	233	31.4%
Proportion waiting more than 30 weeks at that date:	116	15.4%	101	13.6%
4. Services in scope for RTT (**referral to treatment**) measurement:				
Incomplete waiters less than 18 weeks	*100% achieved*		*100% achieved*	
Incomplete waiters more than 52 weeks	*100% achieved*		*100% achieved*	
5. Number of service users with **no recorded HCP/care co-ordinator** or **record of CPA status**	3084		3057	

Gender RTT Waiting Times

The service is working towards achievement of an RTT 18 week standard and has recently commenced submission of waiting times data to NHS England, which is shown below for information. Note that the national procurement exercise is still pending.

There has been a slight increase during May and currently there are 594 people waiting for treatment to commence, of whom 405 have not yet had a first contact.

	As at 31.10.17	**As at 30.11.17**	**As at 31.12.17**	**As at 31.01.18**	**As at 28.02.18**	**As at 31.03.18**	**As at 30.04.18**	**As at 31.05.18**
Number of Patients waiting for first contact	360	374	374	372	356	366	378	405
Proportion waiting less than 18 weeks for first contact	30%	36%	28%	28%	24%	24%	25%	24%
Proportion waiting more than 18 weeks for first contact	70%	64%	72%	72%	76%	76%	75%	76%
Number of Patients waiting for treatment	576	590	580	577	559	576	574	594
Proportion waiting less than 18 weeks for treatment	15%	21%	16%	15%	12%	14%	15%	14%
Proportion waiting more than 18 weeks for treatment	85%	79%	84%	85%	88%	86%	85%	86%

5. Finance Update May 2018

Financial Performance Dashboard

NTW Income & Expenditure

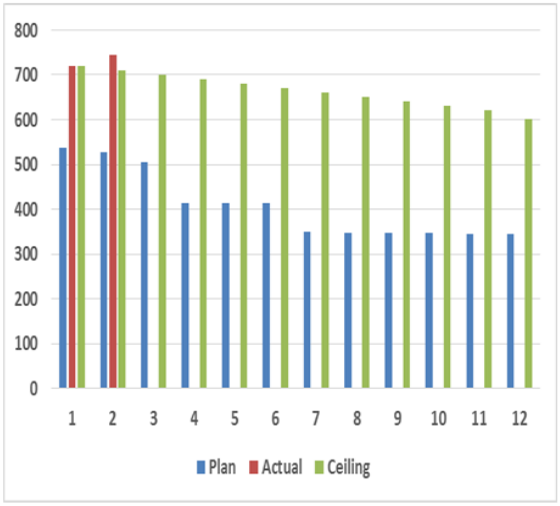
	YTD Plan £m	YTD Actual £m	YTD Variance £m
Income	52.3	52.1	0.2
Pay	(42.1)	(42.4)	0.3
Non Pay	(10.6)	(10.4)	(0.2)
Surplus/(Deficit)	**(0.4)**	**(0.7)**	**0.3**

Control Totals

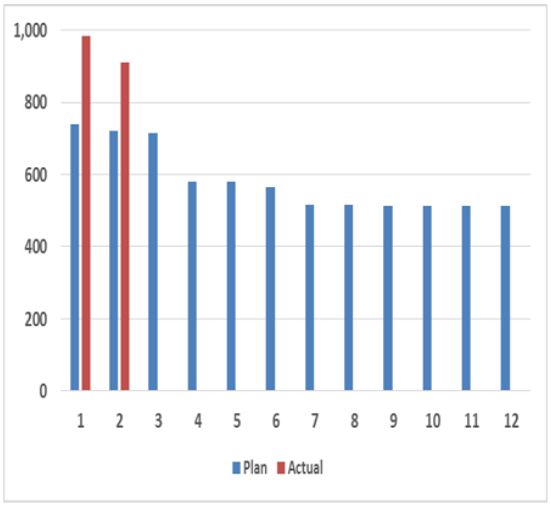
	YTD Plan £m	YTD Actual £m	YTD Variance £m
North	3.8	3.8	0.0
Central	3.9	3.7	0.2
South	4.7	4.8	(0.1)
Central Depts	(12.8)	(13.0)	0.2
Surplus/(Deficit)	**(0.4)**	**(0.7)**	**0.3**

Key Indicators	Current	Annual Plan
Risk Rating	3	3
Agency Spend	£1.5m	£4.9m
FDP Delivery	£0.9m	£12.6m
Cash	£18.0m	£19.6m
Capital Spend	£0.6m	£13.2m

Agency Spend



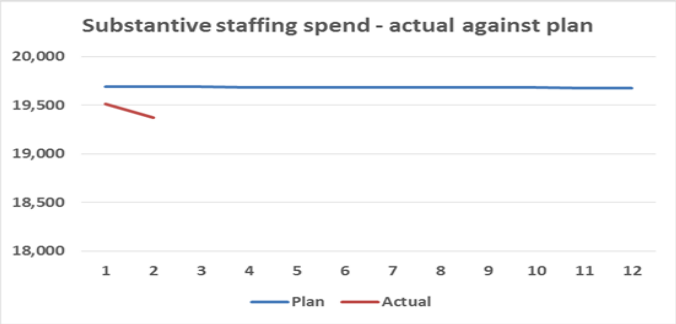
Bank Spend

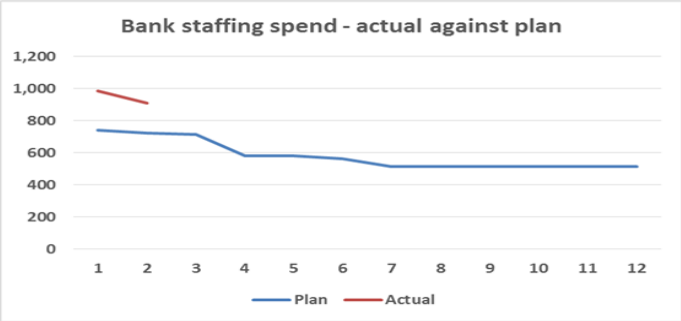


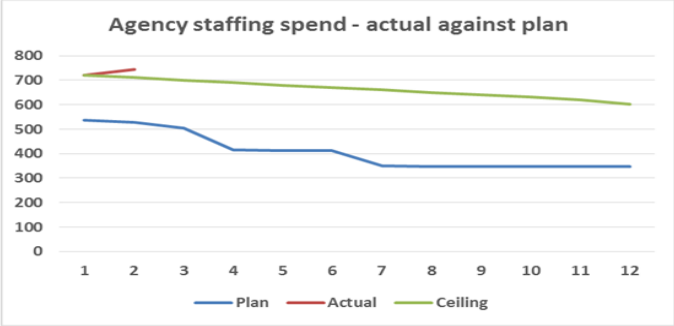
Key Issues/Risks

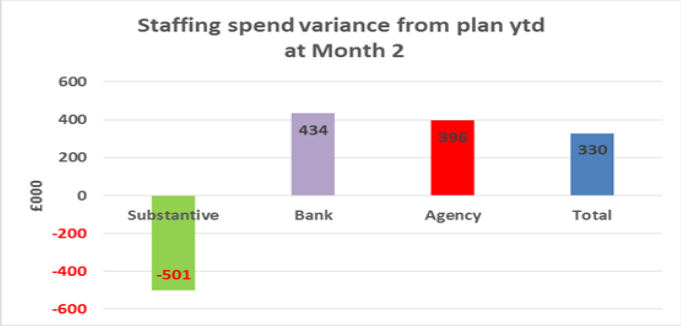
- Surplus/Deficit - £0.7m deficit at Mth2 which is £0.3m behind plan.
- Control Total – The Trust is forecasting delivery of its £3.5m Control Total.
- Risk Rating – The Use of Resources rating is a 3 at Mth2 & the forecast year-end rating is also a 3.
- Pay costs are £0.3m above plan at Mth2. Monthly pay spend needs to reduce if the Trust is to meet its control total.
- Main pressures - Autism Unit staffing and other smaller staffing pressures across the Trust.
- Agency Spend – Agency ceiling is £8.0m and Trust planned spend is £4.9m in 18/19. Spend at Mth2 is £1.5m which is slightly above the ceiling trajectory but £0.4m above plan.
- Financial Delivery Plan - Savings of £0.9m have been achieved at Mth2 which is £0.3m behind plan.
- In addition to its planned £12.6m efficiency savings the Trust needs to deliver £2.3m of service retractions to support Northumberland CCG's Recovery Plan.
- Cash – £18.0m at Mth2 which is £0.6m above plan.
- Capital Spend - £0.6m at Mth2 which is £0.6m less than plan.

Staffing Dashboard – Month 2 2018/19









Staffing spend is £0.3m above plan at month 2, as a result of spend on temporary staffing being £0.8m above plan offset by spend on substantive staffing being £0.5m below plan. The Trust's agency ceiling for 18/19 is £8m. Agency spend at Mth2 is £1.5m which is £0.4m above plan and £0.1m above the ceiling.

	30/04/2018		07/05/2018		14/05/2018		21/05/2018		28/05/2018	
Medical	97	20	106	25	91	21	91	21	90	21
Qual Nursing	129	5	131	5	123	5	128	5	126	5
Unq Nursing	398		255		305		334		325	
A&C	197		168		189		172		177	
	821	**25**	**660**	**30**	**708**	**26**	**725**	**26**	**718**	**26**

In May the Trust reported an average of 27 price cap breaches (22 medical and 5 qualified nursing). In May 3 medics were paid over the price cap.

6. Monthly Workforce Update May 2018

Workforce Dashboard

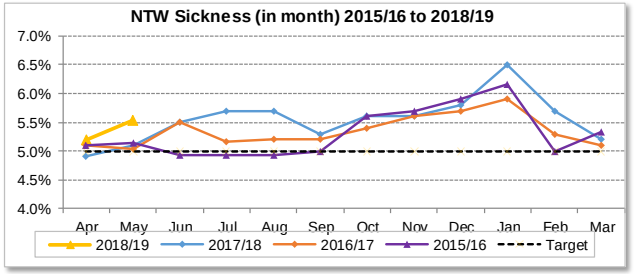
Training and Appraisals	Standard	M2 position	Overall Trend	North Locality Care Group	Central Locality Care Group	South Locality Care Group	Support & Corporate	Doctors in Training *	Staffing Solutions - Nursing	Staffing Solutions - Psychology	NTW Solutions
Fire Training	85%	91.4%	▲	93.0%	92.0%	91.7%	89.2%	80.6%	84.6%	66.7%	95.8%
Health and Safety Training	85%	95.4%	▲	96.7%	95.3%	95.5%	93.8%	80.6%	93.1%	95.8%	98.2%
Moving and Handling Training	85%	96.1%	▲	97.4%	95.2%	96.3%	94.9%	81.4%	97.2%	95.8%	98.2%
Clinical Risk Training	85%	91.9%	▼	91.7%	92.6%	92.3%			83.0%		
Clinical Supervision Training	85%	85.4%	▲	84.3%	87.0%	85.3%			82.0%		
Safeguarding Children Training	85%	94.1%	▲	94.0%	93.1%	94.4%	93.4%	83.7%	95.9%	100.0%	97.2%
Safeguarding Adults Training	85%	95.7%	▲	96.9%	95.7%	95.6%	94.3%	84.5%	96.3%	95.8%	97.1%
Equality and Diversity Introduction	85%	95.2%	▲	97.2%	94.9%	95.4%	93.4%	82.9%	92.9%	100.0%	96.6%
Hand Hygiene Training	85%	94.2%	▲	96.3%	94.0%	94.9%	93.0%	81.4%	92.9%	100.0%	92.2%
Medicines Management Training	85%	87.5%	▲	89.9%	86.9%	86.6%	93.4%		80.0%		
Rapid Tranquilisation Training	85%	84.6%	▲	91.3%	91.8%	88.9%			47.0%		
MHCT Clustering Training	85%	91.7%	▲	88.1%	91.5%	94.4%					
Mental Capacity Act/ Mental Health Act/ DOLS Combined Training	85%	78.1%	▲	80.4%	81.1%	80.5%			54.8%		
Seclusion Training (Priority Areas)	85%	94.7%	▲	93.8%	95.9%	93.3%					
Dual Diagnosis Training (80% target)	80%	88.6%	▲	94.6%	92.7%	87.6%			60.1%		
PMVA Basic Training	85%	80.9%	▲	85.9%	84.0%	83.8%			68.3%		
PMVA Breakaway Training	85%	84.0%	▲	88.1%	81.4%	82.5%					
Information Governance Training	95%	93.6%	▲	94.8%	94.6%	94.0%	91.8%	73.6%	86.9%	70.8%	98.5%
Records and Record Keeping Training	85%	98.8%	▲	99.7%	99.3%	99.1%	96.9%	83.7%	99.5%	100.0%	100.0%

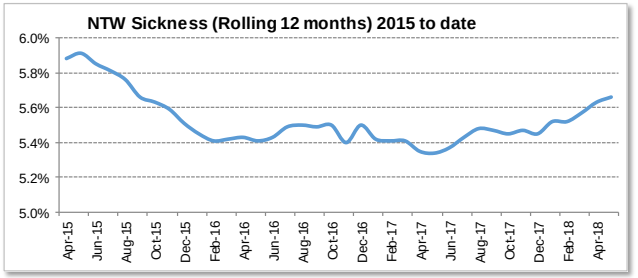
* NB Prior learning may not be reflected in these figures and is being investigated

Appraisals	85%	84.4%	▲	85.6%	85.2%	85.2%	73.0%				93.6%

Managing Attendance - includes NTW Solutions	Target	M2 position	Trend
In Month sickness (provisional)	<5%	5.53%	▼
Short Term sickness (rolling)		1.52%	
Long Term sickness (rolling)		4.14%	
Average sickness (rolling)	<5%	5.66%	▼

NB - NTW Solutions Sickness absence in the month was 4.19%





Best Use of Resources	Target	M2 position	Trend
Agency Spend		£742,988	▼
Admin & Clerical Agency (included in above)		£118,614	▼
Overtime Spend		£166,037	▲
Bank Spend		£909,800	▲

Recruitment, Retention & Reward	Target	M2 position	Trend
Corporate Induction	100%	100.0%	–
Local Induction	100%	99.6%	–
Staff Turnover (includes NTW Solutions)	<10%	*8.46%	▲
Current Headcount		6291	

*this is a rolling 12 month figure

Behaviours and Attitudes	M2 position
Disciplinaries (new cases since 1/4/18)	37
Grievances (new cases since 1/4/18)	4

* Trainee Doctors rotate every 4-6 months and it takes approx. one month for them to complete all of the training they are required to complete. There have been issues identified relating to the different systems used to record training completion. These issues are being addressed as part of the streamlining process, which should be in place for the rotation in August 2018 whereby the training record will move with the Doctor.

Please note that to improve data quality, the in month sickness figure reported in this report is provisional and will be updated each month with the final figure.

The April 2018 in month sickness figure provisionally reported as 5.14% last month, is now confirmed as 5.20% and the graph above has been updated to reflect this

7. Quality Goals/Quality Priorities/Quality Account Update May 2018

Progress for the quarter one requirements for each of the 2018-19 quality priorities is summarised below.

All of the four priorities are currently forecast as amber against the Quarter 1 milestones.

Quality Goal:	2017-18 Quality Priority:		Quarterly Forecast Achievement:				
			Q1	Q2	Q3	Q4	Comments
Keeping you safe	1	Improving the inpatient experience					
Working with you, your carers and your family to support your journey	2	Improve waiting times for referrals to multidisciplinary teams.					
	3	Implement principles of the Triangle of Care					
Ensure the right services are in the right place at the right time to meet all your health and wellbeing needs	5	Embedding Trust values					

8. Accountability Framework

N.B reflects the revised Accountability Framework for 2017-18 which took effect from 1st April 2017 (please see Appendix 2)

		North Locality Care Group				Central Locality Care Group				South Locality Care Group				Comments:
	Overall Rating	Q1 forecast	Q2	Q3	Q4	Q1 forecast	Q2	Q3	Q4	Q1 forecast	Q2	Q3	Q4	
		4				4				4				
Quality Governance	Performance against National Standards:	1				1				1				
	CQC Information:	2				1				1				
	Performance against Contract Quality Standards:	3				3				3				Central Locality Care Group - The CYPS DNA requirements and Elements of the CQUINS (i.e. discharge summaries) will not be achieved in the quarter
	Clinical Quality Metrics:	3				4				4				Central Locality Care Group - This has been rated as a 4 due to the failure to meet the a number of internal requirements
Use of Resources	YTD Contribution	3				4				1				
	Forecast Contribution	4				4				1				
	Agency Spend	4				1				1				

9. Service User & Carer Experience Monthly Update May 2018

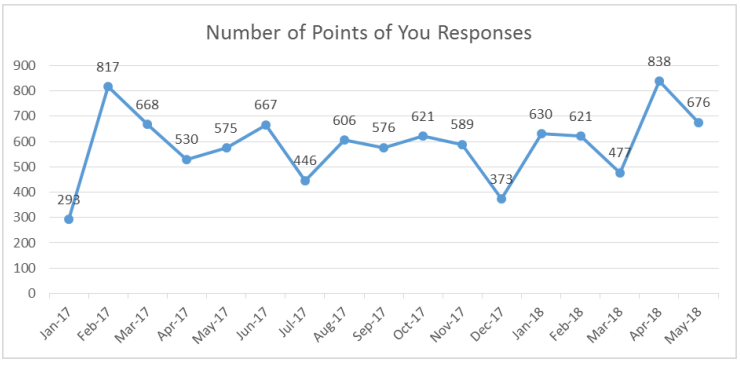
Experience Feedback:

Feedback received in the month – May 2018:

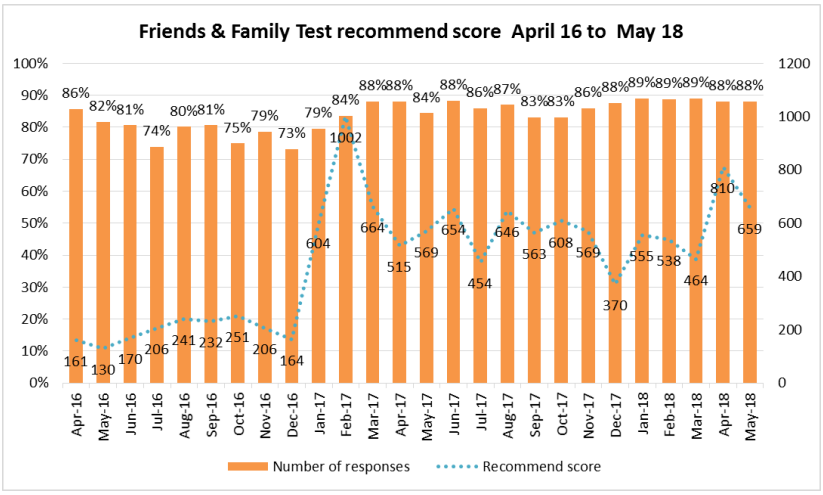
	Responses received May 2018	Results April 2018
Points of You Feedback from Service Users ('Both' option included here)	465	Overall, did we help? Scored: 8.9 out of 10* (8.7 in April)
Points of You Feedback from Carers	211	
Total Points of You responses received	676	FFT Recommend Score**: 88% (89% in April)

* score of 10 being the best, 0 being the worst
** national average recommend score resides around 89%

Graph showing Points of You responses received by month:



In May the number of Points of You responses decreased compared to the previous month of April this is related to the previous reported system issue which was rectified in April. The results have remained static with 88% of respondents identifying they would recommend our services to family or friends, which is slightly below the national average of 89%.



Nb 17 of the 659 PoY responses in the month did not answer the FFT question within the survey

10. Mental Health Act Dashboard

Mental Health Act Dashboard												
Key Metrics	**April**	**May**	**June**	**July**	**August**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**March**
Record of Rights (Detained) Assessed within 7 days of detention start date	93.3%	93.7%										
Record of Rights (Detained) Revisited in past 3 months (inpatients)	97.4%	96.1%										
Record of Rights (Detained)Assessed at Section Change within the Period	92.0%	97.4%										
Record of Capacity/CTT for Detained clients Part A completion within 7 days of 3 month rule Starting	30.6%	22.1%										
Community CTO Compliance Rights Reviewed in Past 3 months	95.7%	94.9%										
Community CTO Compliance Rights Assessed at start of CTO	70.0%	100.0%										

Compliance with the provision of rights to detained and CTO patients is above 90% across all of the key metrics.

Monthly reports are provided to each of the Locality Care Groups with any exceptions highlighted.

A quarterly activity and monitoring which includes compliance with the provision of rights is reviewed by the Mental Health Legislation Steering Group.

The inclusion of the provision of a repeat explanation of rights within the review date set is to be included in the ‘At a Glance’ boards which are currently being redeveloped.

Compliance with the completion and recording of capacity assessments in relation to Section 58 type treatment (medication for mental disorder) is low across all metrics measured via the dashboards. In relation to completing and recording a capacity assessment close to the point of detention (Part A of the local form) the dashboards show compliance as 22.1%.

However some detailed investigation/analysis of the dashboard data for that metric has been undertaken and has shown that (as at 19/05/18) capacity assessments had been undertaken in around a further 55% cases. However the dashboard was not counting these as they had been completed/recorded outside of the required timescales, the recording form was not completed fully or a combination of both. Had the above issues not prevailed then actual compliance at that date would have been around 78%

Some promotional work to address these issues will take place.

11. Outcomes/Benchmarking/National datasets Update and Other Useful Information

Benchmarking

The specification has been received from the NHS Benchmarking regarding the collection for Mental Health Community and Inpatient data which is due for submission at the end of June 2018. The submission for the CAMHS data collection has also been received and is due for submission by early July 2018. Both collections are currently being collated within the organisation.

The community report has been received back from the NHS Benchmarking team and this is currently being reviewed internally.

Mental Health Services Data Set (MHSDS) v4.0 changes from 1st April 2019

The MHSDS is a patient level, output based, secondary uses data set which delivers robust, comprehensive, nationally consistent and comparable person based information for children, young people and adults who are in contact with mental health services located in England. All activity relating to people who receive specialist mental health care services are within scope of MHSDS and organisations are required to submit record level data.

The changes that will be mandatory from 1st April 2019 relate to new government policy initiatives, resolution of issues within the current collection, and inclusion of other key stakeholder requirements which includes:

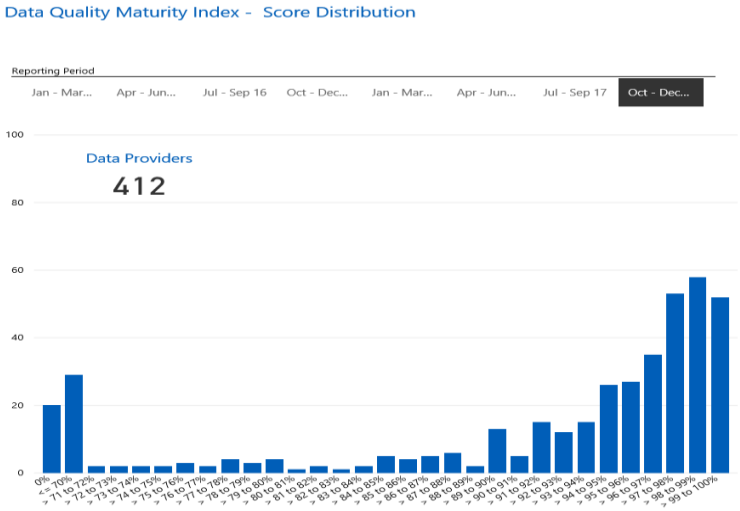
- Enhanced data collection in support of children and young people's mental health to allow improved service provision and outcomes
- Changes to support reporting of patients in contact with mental health services but who also are subject to the youth justice process
- Changes regarding restrictive interventions to ensure effective national data capture regarding restraint incidents
- Collection of medication data to improve the use of medicines as a tool in the treatment of mental health issues including reduction in over or inappropriate medication
- A requirement to implement the Overseas Visitor Charging Status (OVCC) DCB3017 standard through MHSDS
- Minor maintenance changes related to issues raised by the NHS Data model and dictionary to ensure the data set remains up to date
- To include the flow of data for family members and carers in support of the EIP care pathway, this will enable pre-defined metrics to be measured consistently nationally.
- To facilitate the flow of data relating to non-English organisations where it relates to services commissioned by English CCGs or specialised commissioners to improve data set coverage.

The Data Quality Maturity Index (DQMI) is a quarterly publication produced by NHS Digital to highlight the importance of data quality in the NHS. It provides data submitters with information about their data quality. The first publication (May 2016) focussed on the quality of a set of core data items identified by a National Information Board (NIB) working group as being important to commissioners and regulators. Subsequent and future versions of the DQMI have been, and will be, refined based upon stakeholder feedback, and further DQMI's will be developed to include additional data items and data sets submitted nationally by providers.

The DQMI publication includes data from the following datasets relevant to NTW:

- Admitted patient care (APC)
- Outpatient (OP) (including CDS dataset)
- Mental Health Services Dataset (MHSDS) – NB This became part of the SOF from October 2017
- Improving Access to Psychological Therapies (IAPT)

The data below relates to Quarter 3 17/18 (Oct – Dec 17) which is the latest available data. The Trusts overall DMQI score remains at 91.7%.



Provider DQMI Values

The Data Quality Maturity Index (DQMI) is a quarterly publication intended to highlight the importance of data quality in the NHS. It provides data submitters with timely and transparent information about their data quality. The first publication focused on the quality of a set of core data items identified by a National Information Board (NIB) working group as being important to commissioners and regulators. Subsequent and future versions of the DQMI have been, and will be, refined based on stakeholder feedback, and further DQMIs will be developed to include additional data items and datasets submitted nationally by providers.

NHS Digital

Return to 'Title Sheet'

Notes:

[1] A hyphen is used to indicate that a dataset was not submitted by a provider.

[2] This score is not used to calculate the final DQMI Score, please refer to the methodology document.

PROVIDER CODE	PROVIDER NAME	DQMI (%)					DATASET SCORE (%) [1,2] Oct 17 - Dec 17							
		Oct 17 - Dec 17 NEW	Jul 17 - Sep 17	Apr 17 - Jun 17	Jan 17 - Mar 17	Oct 16 - Dec 16	A&E	APC	CSDS	DID	IAPT	MHSDS	MSDS	OP
RX4	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	91.7	91.7	91.7	92.0	91.9	-	91.2	-	-	99.8	99.1	-	85.1

This information can be found at the NHS Digital website link here

12. Improving Access to Psychological Therapies (IAPT)

Listed below are the Sunderland IAPT Outcome Measures for May 2018.

SUNDERLAND CCG PATIENTS - IAPT Only Patients - Quality Metrics in 2018-2019

Outcome Measure	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Access - BAME (% of total service users entering treatment)	TBA	1.55%	3.55%										
Access - Over 65 (% of total service users entering treatment)	TBA	6.06%	5.74%										
Access - Specific Anxieties (% of total service users entering treatment)*	TBA	11.38	10.81%										
Choice - % answering no	TBA	0%	0%										
Choice - % answering partial	TBA	3.25%	2.20%										
Choice - % answering yes	TBA	96.75%	97.80%										
Employment Outcomes - Moved from Unemployment into Employment or Education	TBA	4	3										
Patient Satisfaction (Average Score)	TBA	19.70	19.47										
Recovery	50% of patients completing treatment	49.80%	50.50%										
Reduced Disabilty Improved Wellbeing	TBA	35.02%	30.79%										
Reliable Improvement	TBA	70.03%	69.84%										
Self Referrals (% of discharges who had self referred)	TBA	74.73%	73.97%										
Waiting Times	95% entering treatment within 18 weeks	99.85%	100.00%										
Waiting Times	75% entering treatment within 6 weeks	99.23%	99.66%										

An element of the IAPT contract payment will be linked to these outcomes from April 2018

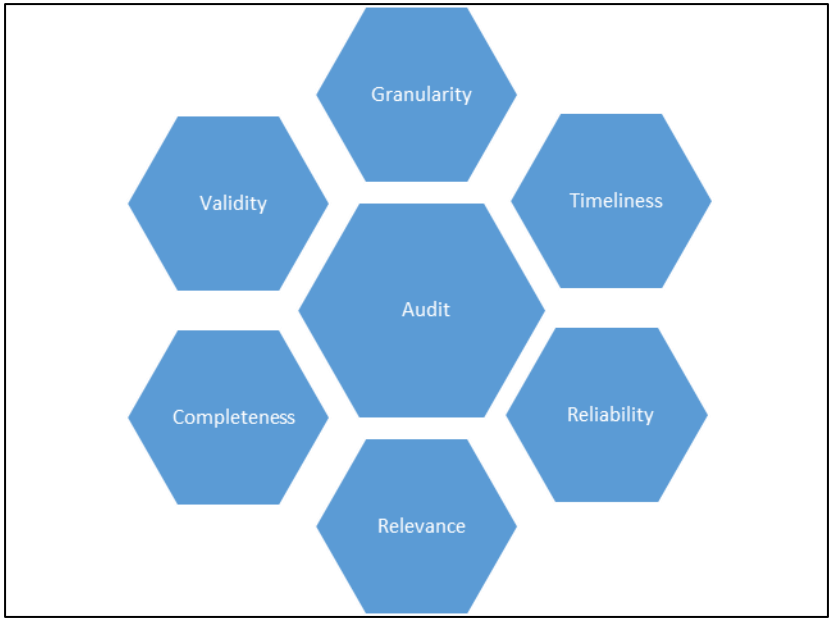
13. Data Quality Plan

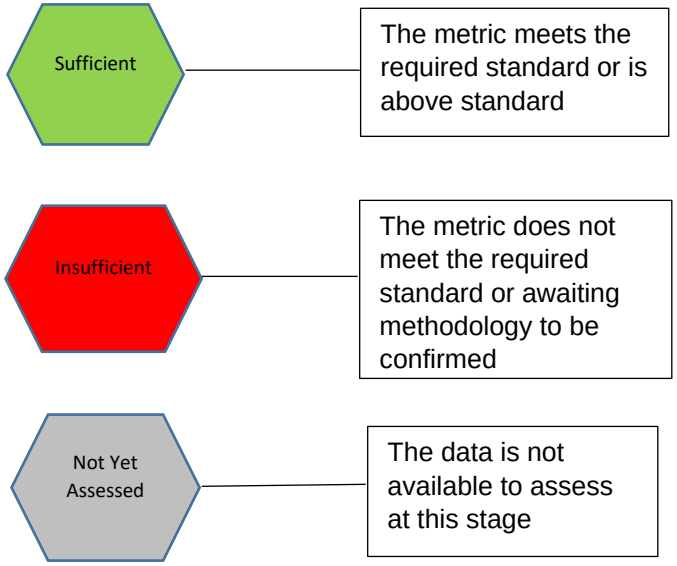
Good quality information underpins the effective delivery of care and is essential if improvements in quality of care are to be made. The Trust has already made extensive improvements in data quality. During 2017/18 the Trust will build upon the actions taken to ensure that we continually improve the quality of information we provide.

Clinical Record Keeping	We will continue to monitor the use of the RiO clinical record system, learning from feedback and incidents, measuring adherence to the Clinical Records Keeping Guidance and highlighting the impact of good practice on data quality and on quality assurance recording. We will continue to improve and develop the RiO clinical record system in line with service requirements.
NTW Dashboard development	We will continue to review the content and format of the existing NTW dashboards, to reflect current priorities including the development and monitoring of new and shadow metrics that are introduced in line with national requirements. We will continue to develop the Talk 1st and Points of You dashboards.
Data Quality Kitemarks	We will continue to roll out the use of data quality kitemarks in quality assurance reports further.
Data Quality Group	We will implement a Trust wide data quality group.
Mental Health Services Dataset (MHSDS)	We will continue to understand and improve data quality issues and maintain the use of national benchmarking data. We will seek to gain greater understanding of the key quality metric data shared between MHSDS, NHS Improvement and the Care Quality Commission. We will improve our data maturity index score and understand areas where improvement is required.
Consent recording	We will continue to redesign the consent recording process in line with national guidance and support the improvement of the recorded consent status rates.
ICD10 Diagnosis Recording	We will continue to increase the level of ICD10 diagnosis recording across community services.
Mental Health Clustering	We will increase the numbers of clinicians trained in the use of the Mental Health Clustering Tool and improve data quality and data completeness, focusing on issues such as cluster waiting times analysis, casemix analysis, national benchmarking and HoNOS 4-factor analysis to support the consistent implementation of outcomes approaches in mental health.
Contract and national information requirements	We will continue to develop quality assurance reporting to commissioners and national bodies in line with their requirements.
Quality Priorities	We will develop a robust reporting structure to support the quality priorities relating to waiting times and improving inpatient care.
Outcome Measures	We will enhance the current analysis of outcome measures focusing on implementing a system for reporting information back to clinical teams. We will also focus on Improving Access to Psychological Therapies (IAPT) outcomes to ensure preparedness for the introduction of IAPT outcomes based payment in 2018-19.
Sexual orientation monitoring information standard	We will work towards meeting the requirements of the sexual orientation monitoring standard.
Electronic Staff Record (ESR)	We will develop data quality monitoring of ESR data and develop action plans to address issues identified.

Appendix 1 Data Quality Kite Marks

Data Quality Kite Mark Assessment





Each metric has been assessed using the seven elements listed in blue to provide assurance that the data quality meets the standard of sufficient, insufficient or Not Yet Assessed

Data Quality Kite Mark – This page provides guidance relating to how the metrics have been assessed within NHS Improvements, Single Oversight Framework and Contract Standards

Data Quality Indicator	Definition	Sufficient	Insufficient	What does it mean if the indicator is insufficient	Action if metric is insufficient
Timeliness	Is the data the most up to date and validated available within the system?	The data is the most up to date available	Data is not available for the current period due to problems with the system or process	The data is not the most up to date and decisions may be made on inaccurate data	Understand why the data was not completed within given timeframes. Report this to relevant parties as required
Granularity	Can the data be broken down to different levels e.g. Available at Trust level down to client level?	Where relevant the Trust has the ability to drill down into the data to the correct level	The Trust is unable to drill down into the data to the correct level	It is not possible to drill down to the relevant level of data to understand any issues	Work with relevant teams to ensure the data can be broken down to varying levels
Completeness	Does the data demonstrate the expected number of records for that period?	There is assurance that effective controls are in place to ensure 100% of records are included within the metrics as required and no individual records are excluded without justification	There is inadequate assurance or no assurance that effective controls are in place to ensure 100% of records are included within the metrics	Performance cannot be assured due to the level of missing data	Understand why the data was not complete and request when the data will be updated. Report this to relevant parties as required

Data Quality Indicator	Definition	Sufficient	Insufficient	What does it mean if the indicator is insufficient	Action if metric is insufficient
Validity	Is the data validated by the Trust to ensure the data is accurate and compliant with relevant rules and definitions?	The Trust have agreed procedures in place for the validation and creation of new metrics and amendments to existing metrics	A metric is added or amended to the dashboard without the correct procedures being followed	The data has not been validated therefore performance cannot be assured	The metrics are regularly reviewed and updated as appropriate
Audit	Has the data quality of the metric been audited within the last three years?	The data quality of the metric has been audited within the last three years	The metric has not been audited within the last 3 years	The system and processed have not been audited within the last three years therefore assurance cannot be guaranteed	Ensure metrics that are outside the three year audit cycle are highlighted and completed within the next year. Review the rolling programme of audit
Reliability	The process is fully documented with controls and data flows mapped	Mostly a computerised system with automated controls	Mostly a manual system with no automated controls	Process is not documented and/or for manual data production controls and validation procedures are not adequately detailed	Ensure processes are reviewed and updated accordingly and changes are communicated to appropriate parties
Relevance	The indicator is relevant to the measurement of performance against the Performance question, strategic objective, internal, contractual and regularity standards	This indictor is relevant to the measurement of performance	This indicator is no longer relevant to the measurement of performance	The metric may no longer be relevant to the measurement of standards	Ensure dashboards are reviewed regularly and metrics displayed are relevant and updated or retired if no longer relevant

Accountability Framework – Appendix 2

		1	2	3	4
Quality Governance	**Performance against national standards**	All Achieved or failure to meet any standard in no more than one month	Failure to meet any standard in 2 consecutive months triggered during the quarter	Failure to meet any standard in 3 or more consecutive months triggered during the quarter	Trust is assigned a segment of 3 (mandated support) or 4 (special measures)
	CQC Information	No Concerns -all core services are rated as Good or Outstanding and there are no "Must Do's" with outstanding actions.	No Concerns - all core services are rated as Good or Outstanding however there are "Must Do's" with outstanding actions.	Concerns raised – one or more core services are rated as "Requires Improvement"	Concerns raised – one or more core services are rated as "Inadequate"
	Performance against contract quality standards *(measured at individual contract level)*	All Achieved	All but a small number of contract metrics are achieved for the quarter and there is a realistic plan in place to recover the underperformance within the following quarter.	Quarterly standard breached in 2nd consecutive quarter, or there is a contract metric not achieved which is not recoverable within the following quarter.	Quarterly standard breached and contract penalties applied or are at risk of being applied.
	Clinical Quality Metrics	All Achieved	All but a small number of contract metrics are achieved for the quarter and there is a realistic plan in place to recover the underperformance within the following quarter.	Quarterly standard breached in 2nd consecutive quarter, or there is a contract metric not achieved which is not recoverable within the following quarter.	Quarterly standard breached in 3rd consecutive quarter.
Use of resources	**YTD contribution**	Exceeding or meeting plan.	Just below plan (within 1%).	Between 1% and 2% below plan	More than 2% below plan
	Forecast contribution				
	Agency Spend	Below or meeting ceiling.	Up to 25% above ceiling.	Between 25% and 50% above ceiling.	More than 50% above ceiling.
	Use of resources metrics	TBC	TBC	TBC	TBC

NHS Improvement and NHS England

Meeting in Common of the Boards of NHS England and NHS Improvement

Meeting date: Thursday 24 May

Agenda item: 01

Report by: Ben Dyson, Executive Director of Strategy, NHS Improvement
Emily Lawson, National Director: Transformation & Corporate Operations, NHS England

Report on: **Next steps on aligning the work of NHS England and NHS Improvement**

Progress on delivering joint working between NHS England and NHS Improvement; specifically proposals for:
a) Joint governance and accountability
b) Integrated regional teams and new regional geographies
c) Aligning appropriate national functions
d) Managing change well

Request: The Boards are asked to consider and endorse the proposals

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Introduction

1. The National Health Service is turning 70 on 5 July 2018. Over the last seven decades the NHS has helped transform the health and wellbeing of the nation and in turn has earned the enduring support of the British people. Through a process of continuous evolution and modernisation it has delivered huge medical advances, improvements in population health and innovations in patient care.

2. Now, as the NHS moves into its next decade, local health and care systems across the country are rising to the challenge of a growing and ageing population by collaborating across organisational boundaries to develop more integrated models of care. In line with the vision of the NHS Five Year Forward View, we are seeing a growing movement towards commissioners and providers focusing on population health supported by local system-wide action. This means working together to mobilise community assets and collective capabilities to improve quality of care for individuals, health outcomes for populations, and wise stewardship of taxpayers' resources.

Rationale

3. Faced with that challenge, NHS England and NHS Improvement now need themselves to evolve and adapt, to transform the way we work to provide a single system view that supports and enables integrated care.

4. In March, our Boards agreed ambitious proposals to transform the way we work together to provide more joined-up, effective and comprehensive system leadership to the NHS. This paper sets out our next steps in moving from fragmentation to coherence, to create an operating model that best supports local health systems and the patients and public they serve. This reflects both our organisations' duties to co-operate with each other in the exercise of our functions; to exercise those functions economically, efficiently and effectively; and to facilitate, where beneficial, integrated provision of healthcare services

5. For NHS Improvement, this will represent a shift from regulation to improvement in order to protect and promote the needs of all those who use the NHS over the next period of its history. NHS Improvement will focus more clearly on the areas that will bring greatest value in driving improvement and transformation both for the provider sector and for local health systems – see more detail in Appendix One. This will include a significant change in the senior organisational structure in NHS Improvement to enable it to deliver its refocused purpose.

6. In designing this new approach to joint working, we recognise that the statutory framework established by Parliament assigns NHS England and NHS Improvement (Monitor) some distinctive and non-shareable functions, and that primary legislation implies separate board governance, chairs and CEOs for the two organisations. The statutory framework also establishes distinct functions for clinical commissioning groups (CCGs) and NHS trusts and foundation trusts, which are also reflected in part in the functions of each organisation, including those Secretary of State functions delegated to the NHS Trust Development Authority (TDA).

7. That need not, however, stand in the way of enhanced joint working in many areas where the NHS will benefit from our doing so. Specifically, we want to:

    a. Move from a world where local health organisations (trusts, CCGs) sometimes receive different and conflicting messages from the national bodies, to one where – through our integrated regional teams – we have a single conversation with them.

    b. Take a more holistic view of NHS resources across commissioners and providers, both locally and nationally, better aligning financial incentives and architecture for whole-system improvement.

    c. Leverage NHS England's and NHS Improvement's distinctive competencies across both organisations (such as NHS Improvement's work on patient safety and trust procurement efficiencies, and NHS England's on cancer and mental health, on care integration and on pharmaceuticals).

d. Build out capabilities where there has been a gap in national leadership (such as on NHS people management and leadership development).

e. Mobilise national implementation resource for the forthcoming NHS 10 Year Plan.

f. Reduce administrative costs for redeployment into frontline patient care, recognising the differing requirements of this on our separate organisations, and agreeing what this means for our collective resources as we work together more closely.

Transforming the way we work: key proposals

8. Our guiding principle in this work is setting ourselves up to provide effective system leadership to the NHS. This will require us to be agile and adaptive, developing a learning culture that allows us to be flexible to the changing needs of the health and care system. We are now proposing our next set of changes to support this, encompassing all aspects of our current operating models: governance, systems and processes; organisation structures and capabilities; and culture and behaviours.

9. In terms of **governance, systems and processes**:

   a. While respecting the legal need for the NHS England and NHS Improvement Boards separately to oversee their distinctive responsibilities, the Boards will also want to consider over the next several months the extent to which some of NHS England's and NHS Improvement's non-executive led *board committees* might be reshaped and aligned, building on the recent experience of the joint finance advisory committee.

   b. NHS England and NHS Improvement will establish a new *NHS Executive Group*. Co-chaired by the two CEOs, membership will comprise all national directors and regional directors from the two organisations.

   c. A new *NHS Assembly* (provisional title) will be created, drawn from – amongst others – national clinical, patient and staff organisations; the voluntary, community and social enterprise (VCSE) sector; the NHS Arm's Length Bodies (ALBs); and frontline leaders from integrated care systems (ICSs), sustainability and transformation partnerships (STPs), trusts, CCGs and local authorities. It will become the forum where stakeholders discuss and oversee progress on the NHS Five Year Forward View and help co-design the proposed upcoming NHS 10 Year Plan, and will build on the recommendations of NHS England's Empowering People and Communities Task Force.

   d. We will align all our core processes so that both our internal management and our interactions with the system are conducted once with clear accountabilities at national, regional and system level. This will include establishing a single financial and operational planning process for the health system; a single performance management process and alignment of

regulatory interventions; a single internal talent management process; and a single process for establishing and reviewing national strategic programmes such as mental health. This builds on our already integrated management of IT across the system. And we will establish a single version of the truth in reporting and sharing information about the system.

10. In terms of **organisational structures and capabilities**:

    a. At a regional level, we will create integrated regional teams covering both NHS England and NHS Improvement functions, and led by regional directors with full responsibility for the performance of all NHS organisations in their region in relation to quality, finance and operational performance.

       The Regional Directors will play a major leadership role in the geographies that they manage, making decisions about how best to support and assure performance within their region, as well as support the development and identity of local STPs and ICSs. This is a move to a different kind of local leadership of the NHS, where Regional Directors promote, encourage and support local systems to achieve more integrated and sustainable models of care. It also means that the locus of decision-making will be centred more on the Regional Directors and their teams, with national teams generally providing support and intervention where agreed with Regional Directors.

       The Regional Directors will report to the two CEOs and be full members of the national NHS Executive Group, with responsibility for developing the overarching strategy and architecture for the NHS as well as translating that into operational plans. Through this, they will help agree where a more standardised model to policy and delivery makes sense to ensure a unified approach, alongside the areas where regional teams should have the authority and discretion to design their own approaches or to implement in a more locally specific way. Appendix Two has more detail.

    b. At a national level we will increasingly align functions across the two organisations, creating a set of new roles to support delivery:

       i. Three national director roles will be created which will report to both CEOs:
          1. A single *NHS Medical Director.*

          2. A single *NHS Nursing Director/Chief Nursing Officer for England.*

          3. A single *Chief Financial Officer* (responsibilities include leadership of the integrated financial and operational planning and performance oversight process).

       ii. Individual national directors in NHS England and NHS Improvement will take on responsibility for a number of 'do-once' functions supporting both organisations, with shared governance and oversight. These functions include:

1. National service programmes such as cancer and mental health; implementation of the FYFV and NHS 10 Year Plan, the move to ICSs, digital/tech, and the health/social care interface, led by the *NHS England Deputy CEO* – who will also lead NHS England's distinct responsibilities including commissioning specialised services (£17bn portfolio), primary care, oversight of CSUs, and emergency preparedness, resilience and response (EPRR) *(NHS England).*

2. Strategic programmes such as life sciences, commissioning development, primary care policy, patient choice and personalisation of care, innovation and research, led by the *National Director for Strategy and Innovation (NHS England).*

3. A new strategic approach to configuration of the provider landscape led by the *Chief Provider Strategy Officer (NHS Improvement)*.

4. NHS leadership and NHS people management, led by a new role of *Chief People Officer (NHS Improvement).*

5. System-wide improvements in quality, access and efficiency, led by a new role of *Chief Improvement Officer (NHS Improvement).*

6. A system-wide approach to improving estates, procurement and back-office services, led by a new role of *Chief Commercial Officer (NHS Improvement).*

7. A shared approach to urgent and emergency care and elective care, led by a *National Director for Emergency and Elective Care (NHS Improvement)*.

iii. A single *National Director for Transformation and Corporate Development,* who reports to both CEOs, leading most corporate operations across both organisations, including organisational development – both internally and with respect to system transformation – and people functions.

iv. For other areas of our work, where the nature of the organisation's statutory functions requires, the activity and structure will remain separate and distinct, for instance NHS Improvement's regulatory functions in relation to pricing, competition and patient choice, and its hosting of the Healthcare Safety and Investigation Branch; and NHS England's responsibility for tariff currency development, commissioning of specialised services and primary care, and EPRR.

v. For communications and engagement, each organisation will need its own dedicated resources to support its own distinctive functions, but we are planning further work to align our approach more closely.

vi. For analysis, we propose further work to agree where we need to establish a single team for core areas of analysis to provide 'one version of the truth'; how we develop a shared approach to professional

development across our shared analytical community; and how we develop greater agility and flexibility in deploying our collective analytical skills, knowledge and experience in ways that best support our shared business.

11. We recognise that the proposed governance and structures must operate within constraints of the existing legal framework, including the requirement that, subject to some exceptions, each body's functions must be exercised by its own committees or staff. Specific governance and decision-making arrangements will enable effective and legally compliant joint working, and provision to avoid or manage the actual or potential conflicts which may arise in relation to the exercise of different functions.

12. The net effect of these changes is that the two organisations will increasingly be working in a combined way on a shared set of system priorities, covering most key functions and capabilities:

    a. System strategy: encompassing, amongst other topics, health inequalities reduction, patient choice/personalisation, developing the provider landscape, innovation and research.

    b. Planning and performance: operational and financial planning, performance reporting and intervention.

    c. The move to integrated care systems: a single approach to supporting STPs and ICSs.

    d. Service transformation: single national service transformation programmes, for the Five Year Forward View clinical and service priorities such as mental health, cancer, learning disabilities, maternity and integrated care for older people.

    e. Improvement: a single approach to developing specialist resources that regional teams use with local health systems to deliver continuous improvement in quality, access and efficiency.

    f. NHS leadership and workforce: a single approach to developing senior leadership in the NHS and supporting the NHS in recruiting, retaining, deploying and developing today's NHS workforce.

    g. NHS information and digital technology: a single approach to transforming how the NHS uses digital information and technology to improve quality of care, health outcomes and efficiency.

    h. NHS estates, procurement and back office services: a single approach to helping the NHS manage its estates/facilities, equipment, consumables and corporate services more efficiently and effectively.

Transforming the way we work: Creating a shared culture and managing change well

13. At its heart, this programme of work is about reshaping the culture, mind-sets and ways of working of our two organisations, so that rather than defining ourselves around the traditional boundaries between commissioners and providers, primary and secondary care, or the identity of NHS England or NHS Improvement (including Monitor and TDA), we collectively see our role and purpose as providing system leadership to the NHS.

14. A joint approach to culture and behaviours will be developed with all staff, building on their input about what should be maintained and what needs to change in our current operating styles and our leadership behaviours. We will also work with colleagues across both organisations to redesign core processes, using a continuous improvement methodology, in parallel with the redesign, to ensure what we put in place is both effective and efficient.

15. As part of managing this change well, we will provide support to colleagues through various mechanisms, including:

    a. Ensuring all 'people processes' are fair and transparent, and adhere to our existing organisational policies.

    b. Providing support on how to 'manage through change' to all colleagues who want to participate, including support to develop resilience and manage stress.

    c. Providing additional support to line leaders to ensure they can support and engage their teams effectively through this period of change and beyond.

16. In light of this, we will be launching a joint staff engagement programme, as part of the joint All Staff briefings on 25 May, under the umbrella of '*Project 70.'* This programme of work will enable us to learn from staff across our organisations and ensure that they are involved in the development and implementation of this work. Appendix Three sets out more detail.

Timeline and next steps

17. We will make the changes to the most senior roles (at a minimum, roles reporting to the two CEOs) by September and to the changed roles at the next level during the autumn. We will continue to move quickly so as to minimise the period of uncertainty for colleagues while minimising the risk to the system of a lack of continuity. We are aiming for all changes to be made by the end of this financial year.

18. We will be agile and responsive in our approach to implementation, identifying a clear set of measurable goals so we can measure success. We will also engage regularly with our staff, Trade Unions and system partners, both to involve them

in the detailed design, including the creation of a shared culture and leadership model, and to enable us to learn as we go and course correct where necessary.

Conclusion

19. The Boards are asked to endorse these proposals.

Appendix One

Refocusing NHS Improvement's Purpose and Operating Model

1.1 NHS Improvement has recently completed a major programme of work to identify how to improve organisational purpose and operating model to better drive continuous improvements in the quality and efficiency of the NHS provider sector.

1.2 The conclusions from this work represent a significant change in focus, operating model and senior structures that will need to form an integral part of how we develop and implement the proposed approach to joint working. It has significant implications for how we shape the proposed new functions that will be led by NHS Improvement or hosted by NHS Improvement on behalf of both organisations, particularly our Provider Strategy, People, Improvement and Commercial functions, and for the new integrated regional teams. This will entail significant changes both to the senior executive structure of NHS Improvement and to ways of working, including the style of our relationship with the provider sector.

Key conclusions

1.3 The key conclusions from this work are that NHS Improvement, both through its new partnership with NHS England – including integrated regional teams – and through the distinctive functions that it will in future host or lead, needs to orientate itself more fully towards supporting improvements in quality and efficiency of care, rather than acting primarily as (and being seen primarily as) a regulator.

1.4 By gathering evidence from our staff and from the providers and systems with whom we interact, this work has identified where the greatest sources of value lie in our work to support the provider sector and what this means in terms of our future operating model and senior executive structures. It has also provided valuable insight into the distinctive skills, capabilities and behaviours that will be needed to realise greater benefits for patients and taxpayers.

1.5 Our work identified seven sources of value where NHS Improvement and its national partners could have the greatest impact in supporting the provider sector to drive sustainable improvements in quality of care and efficient use of resources. All of these sources of value are reflected in the proposals set out in the main paper to align the work of NHS Improvement and NHS England. Four of these sources of value map to functions that NHS Improvement will lead or will host on behalf of both organisations:

- **Configuration of the provider landscape.** There is a clear need to be more proactive in shaping the future provider landscape, including organisational models (eg 'group' or 'chain' models for hospitals, mental health services or other services) and service models. Working with NHS England, providers and with local health systems, we need to identify changes that will best support long-term improvements in clinical and

financial sustainability, agree collectively the strategic benefits to be gained from these changes, and better manage the realisation of those intended benefits, supported by a stronger focus on clinical leadership and clinical engagement. Integrated regional teams will in future lead this agenda, supported by national work – led by NHS Improvement's proposed new Provider Strategy function – to distil evidence and best practice.

- **Quality and operational improvement.** We need to streamline and consolidate the way we support both providers and local health systems in driving continuous improvements in quality and efficiency of care. This will include developing the way we work with the most challenged providers to address persistent performance problems (taking into account the context of their wider local health system), more rigorous prioritisation of improvement priorities, and more hands-on support for providers and local health systems. The new integrated regional teams will lead work on improvement in local health systems, supported by a Chief Improvement Officer who will lead national work to develop tools, data, resources and specialist support, building on the existing work of NHS Improvement's current directorates for operational productivity and improvement.

- **NHS workforce and leadership.** While Health Education England (HEE) has a clear national role in the education and training of the future NHS workforce, there are a number of organisations working – without sufficient coordination – to support NHS organisations to recruit, retain and develop today's workforce. Our work identified a clear need to develop a more proactive and coherent approach to supporting leadership development, including talent management and succession planning, and helping the NHS to improve its people management processes. Under the proposals in the main body of the paper, NHS Improvement will host a new directorate, led by a Chief People Officer, working on behalf of both organisations to improve leadership and people management, working closely with Health Education England, NHS Employers and other national partners. This focus on leadership and people management will also be reflected in the design and resourcing of integrated regional teams.

- **NHS estates, equipment and consumables.** A further key source of value is the work we do to support the NHS in using all its physical assets more efficiently and effectively, improving quality of care and unlocking additional resources for patient care. This is already a key part of the NHS Improvement operational productivity. The proposed new Chief Commercial Officer will lead this work on behalf of both organisations, including continuing to increase our support for local health systems in managing their estates on a more system-wide basis to support new models of care and enhance value for money.

1.6 These four sources of value will be at the heart of the work undertaken by the new Provider Strategy, People, Improvement and Commercial directorates in NHS Improvement. The functions currently carried out by NHS Improvement's Regulation Directorate will in future be carried out by Provider Strategy, People, and Improvement, working with integrated regional teams.

1.7 A further key source of value identified through the work is in relation to **NHS information and digital technology**. NHS England and NHS Improvement are already jointly responsible – with DHSC and NHS Digital – for a programme of work to transform the way the NHS uses digital information and technology to improve quality of care, health outcomes and efficiency. Our work identified the need to go further in embedding the importance of the digital agenda in all the work we do with the provider sector, so that it is an integral part of improving quality and efficiency. Under the proposed new joint working arrangements, NHS England will host the national digital programme (which will be led by the Deputy CEO of NHS England), with shared governance and oversight to help mainstream this work in all our engagement with the provider sector.

1.8 The two final sources of value identified from this work go to the heart of the proposals for joint working between the two organisations:

- **Planning and performance review.** The work identified a range of ways to support providers and local health systems in producing credible but realistic plans, allowing more productive and supportive discussions of key risks and the support needed to address them. The work identified significant opportunities to refresh the approach to monitoring and managing performance through a greater focus on understanding what improves performance, joint problem-solving (not simply upwards assurance) and using data and analysis to identify risks at an earlier stage. This work will now feed into a single programme of work between NHS England and NHS Improvement to design our future joint approach to planning and performance, including the interface between regional teams and local health systems (STPs and ICSs), trusts and CCGs.

- **System incentives and financial architecture.** We have identified a number of practical ways of simplifying and rationalising financial flows and incentives, helping us to go further in improving efficiency and quality within provider organisations and at the same time improving value across patient pathways. This will feed into a joint programme of work, led by the new Chief Financial Officer, to design and implement a new approach to managing collective NHS resources and driving value.

Conclusion

1.9 In the absence of the proposed new approach to joint working, NHS Improvement would have wanted in other ways to reflect these key conclusions in its own operating model and organisational structure. The new approach to joint working across NHS England and NHS Improvement makes it easier in some ways to make the necessary changes to our operating model, particularly in relation to financial architecture and performance management. The implementation of these changes will nonetheless require considerable change management and organisational development in relation to the new Provider Strategy, People, Improvement and Commercial functions hosted by NHS Improvement and the transition from current ways of working within NHS Improvement. This will require, in particular, the development of a strong improvement-focused and engaging culture.

Regional Teams

2.1 In March, the Boards agreed a new integrated regional model, with seven integrated regional teams each led by a single Director, working for and reporting into both NHS England and NHS Improvement. Since March, we have been working closely with the current Regional Directors and teams across our two organisations to develop proposals for a new integrated regional operating model, including the core functions that regional teams will be responsible for and the underlying principles that will guide their ways of working.

2.2 The new integrated regional teams will have a major leadership role driving improvement and transformation for local health systems and providing joined-up oversight across the system. We see the new regional teams as playing a crucial role as 'translators' between the national level and local health and care systems, helping to ensure that all our work is responsive to local system needs.

2.3 As part of moving to joint working, we need to set up the single regions to better support local health systems. NHS England and NHS Improvement are working towards an oversight model that empowers systems to take a shared or leading role in functions that affect their populations. Under this model, STPs and ICSs will relate to a single Regional Director acting on behalf of both NHS England and NHS Improvement. As they develop and mature, we envisage ICSs holding more responsibility, including:

- Developing a system vision, strategy and plans to meet operational, financial and quality requirements.
- Developing and maintaining relationships with local people, staff, local government, voluntary and independent sectors; making sure they feel engaged in their system.
- Leading on provider transformation including integrated providers and primary care networks.
- Providing first line support to organisations within their system, drawing down national and regional expertise where needed.
- Some commissioning (including current direct commissioning) not performed at national level.

2.4 Regional teams will adopt a differentiated approach as they work with local health systems at different levels of maturity. They will be agile and adaptive in their delivery of the functions outlined below, working to strengthen the leadership, capacity and capability of local systems so that they are able to becoming increasingly self-governed and require less support and oversight from regional teams.

Core functions of regional teams

2.5 We have been working across our current national and regional teams to develop the proposed core functions for the new integrated regional teams, focusing on those areas that will deliver the most value in supporting local health and care systems.

2.6 We propose that the new integrated teams deliver the following core functions:

- **Performance, improvement and intervention** – tracking performance in relation to quality of care, access, efficiency and health outcomes, developing and maintaining capacity and capability for targeted improvement support, managing regulatory interventions and promoting peer support between providers, CCGs, STPs and ICSs.

- **Strategy and system transformation** – development and oversight of STP/ICS transformation strategies, shaping national programmes and leading the regional implementation of agreed national priorities, proactively shaping the provider and commissioner landscape, and prioritising and supporting improvements in service configuration where needed.

- **Commissioning** – commissioning of specialised services, primary care services, prison healthcare, s7a public health services, and oversight of CCGs with delegated responsibility for commissioning primary medical care. There will be a clear separation between the work of these commissioning teams and NHS Improvement's regulatory oversight of those commissioning functions.

- **Operational management** – ensuring the safe and effective day-to-day running of the NHS and providing support in the face of any emerging issues (eg temporary A&E closures, cybersecurity attacks). Working with the Local Resilience Forums to support local emergency preparedness, resilience and response.

- **Finance** – oversight of local system financial planning and performance to a national framework, to manage system control totals that combine commissioning expenditure and the income and expenditure of NHS providers, oversee delivery of cost improvement programmes across local systems, support systems in the design of new payment and risk-sharing methods, and prioritise STP capital proposals.

- **Specific quality responsibilities** – professional leadership for quality improvement programmes, professional leadership for clinical staff, safeguarding, managing clinical senates and networks, the statutory duties discharged by the Medical Director (Controlled Drugs Accountable Officer, Caldicott Guardian, Performers list management), oversight and governance for patient safety and clinical support and review of reconfiguration decisions.

- **Workforce and leadership** – overseeing regional systems of leadership development, talent management and succession planning, identifying pipeline of future leaders for national leadership development, working with HEE to develop robust regional workforce strategies and improvement plans.

- **Information, digital and technology** – development and oversight of system strategies to deliver the national strategy, working with NHS Digital to ensure the robustness of local systems and local implementation programmes for care records and data sharing, and overseeing the development of services to exploit opportunities of new technology.

- **Estates and procurement** – ensuring that systems develop and implement strategies to improve the use of estates and facilities, and the efficiency of procurement and back-office services.

- **Analysis and insight** – processing and analysis of specific data to inform performance and transformation interventions, assurance of local data quality, to enhance the national core data sets.

- **Communications and engagement** – communication, engagement and partnership with regional stakeholders, including local government, MPs and patient groups, alongside relationship management with ALB and government departments where relevant.

- **Corporate functions (including HR)** – utilising and overseeing locally assigned corporate resource dedicated to the region from nationally managed functions.

Principles: interface between national and regional teams

2.7 We propose the following principles to guide the implementation of a new integrated regional operating model, relating in particular to the interaction between regional and national teams and the authority, freedoms and accountabilities of the new Regional Directors.

2.8 Regional teams will:

- Be led by Executive Directors who are part of the senior national leadership team of NHS England and NHS Improvement, together helping to design the right support and intervention for local health systems, ensuring we create maximum value and avoid unnecessary burden.

- Decide when and how to intervene in systems, providers or CCGs in their region, or – where the seriousness of the intervention requires a national decision – make the relevant recommendations to the decision-making group.

- Be responsible for managing all interventions with – or seeking information/assurances from – systems, providers or CCGs, except where

the regional team ask another team to act on their behalf or where the wider national leadership team collectively agree a different approach.

- Treat performance management and improvement as a continuum, not only holding systems, providers and CCGs to account but having the right capacity and capability to help solve them complex problems and access the right improvement support.

- Help develop standardised national approaches to improvement and performance, but have discretion to allow systems, providers or CCGs to depart from standardised approaches where they are performing well or where the regional team consider the system, provider or CCG has a cogent alternative approach to making performance improvements.

- Have access to all relevant data and analysis about their region, easily accessible at the right time to inform local decisions.

- Are trusted to manage their resources in a way that meets the needs of their region, subject to organisational designs and policies that are agreed collectively by the senior national leadership team.

- Be held to account for the responsibilities delegated to them.

Regional geographies

2.9 In March, based on learning from our existing regional model and the complexity of supporting systems across large geographies, the Boards agreed that we should have seven regional teams, by splitting the North and Midlands and East regions into two. Working with the Regional Directors in the North and Midlands and East, and using detailed analysis of regional populations, patient flows and performance, we developed proposals for the new regional geographies to test with staff, trade unions and local health and care systems:

Initial proposals

2.10 For the North, this was:

- **North West**: Lancashire and South Cumbria; Greater Manchester; and Cheshire and Merseyside.

- **North East and Yorkshire**: Cumbria and the North East; West Yorkshire; Humber, Coast and Vale; and South Yorkshire and Bassetlaw.

2.11 For Midlands and East region, this was:

- **Midlands**: Staffordshire; Shropshire and Telford and Wrekin; Derbyshire; Lincolnshire; Nottinghamshire; Leicester, Leicestershire and Rutland; Black Country and West Birmingham; Birmingham and Solihull; Coventry and Warwickshire; and Herefordshire and Worcestershire.

- **Central and East of England**: Northamptonshire; Cambridgeshire and Peterborough; Norfolk and Waveney; Suffolk and North East Essex; Bedfordshire, Luton and Milton Keynes; Hertfordshire and West Essex; and Mid and South Essex.

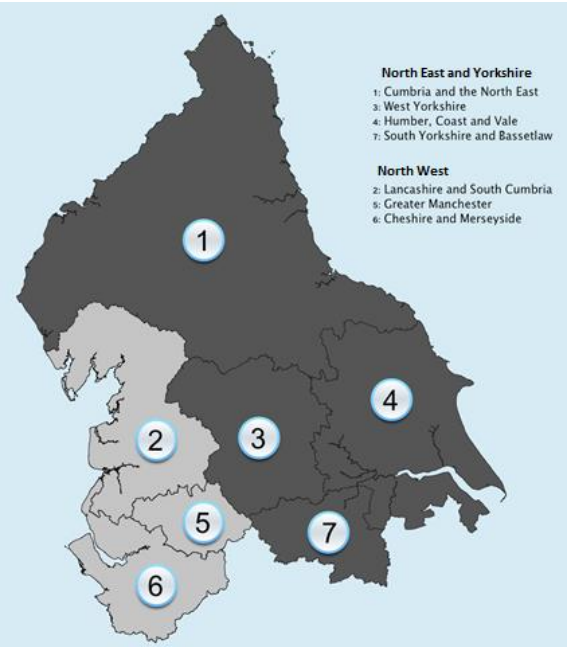
System engagement

2.12 To ensure the most appropriate decision could be made for local systems, we then engaged with our trade unions, NHS England and NHS Improvement staff, system leaders in both regions – including CCG Accountable Officers, STP leaders, Trust Chief Executives and Chairs and the Local Government Association.

2.13 We received 69 responses to our joint letters, 28% from individuals in the North region and 72% from those in the Midlands and East region. Of these, the large majority supported the split proposed for the North region, whilst concerns were raised about the Midlands and East proposal. It appears that this would significantly impact Northamptonshire's patient flows with Leicester and Warwickshire, especially direct commissioning of primary care and public health.

Revised proposals

2.14 Based on the feedback, we now would like to propose to the Boards that the North be split as initially proposed – North West; and North East and Yorkshire.

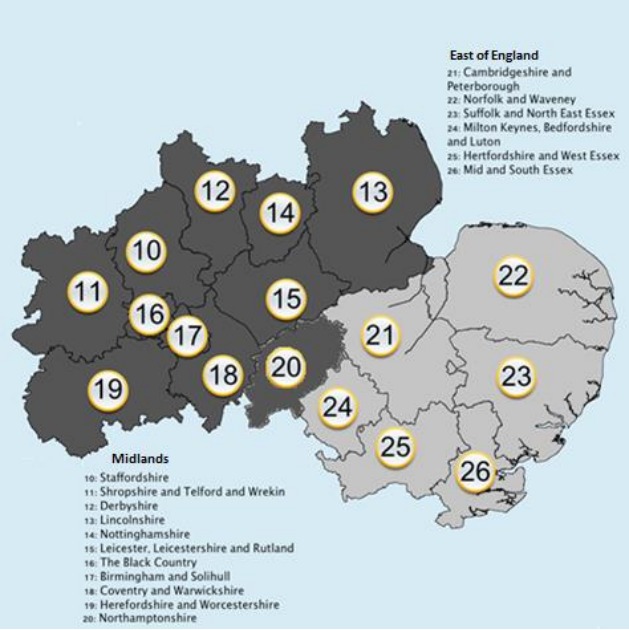


2.15 Taking into account feedback from staff and system partners, for the Midlands and East, we propose that Northamptonshire should become part of the Midlands.

2.16 This would mean that the regions would split into:

- **Midlands**: Staffordshire, Shropshire and Telford and Wrekin; Derbyshire; Lincolnshire; Nottinghamshire; Leicester, Leicestershire and Rutland; Black Country and West Birmingham; Birmingham and Solihull; Coventry and Warwickshire; Herefordshire and Worcestershire, and Northamptonshire.

- **East of England**: Cambridgeshire and Peterborough; Norfolk and Waveney; Suffolk and North East Essex; Bedfordshire, Luton and Milton Keynes; Hertfordshire and West Essex; and Mid and South Essex.



2.17 These proposals are supported by system leaders in the two regions.

Appendix Three

Creating a shared culture

3.1 Staff have generally welcomed the direction of travel to transform how we work together, to improve the coherence and impact of our collective system leadership role. We know that working with staff to shape the implementation of these changes and agree which ways of working we want to leave behind and which we want to take forwards will be crucial to success. We are also conscious that uncertainty can be unsettling for us all and we need to take care to engage and support our staff through this process. In light of this, both organisations are committed to managing this transition well in ways that best support our staff and realise the intended benefits.

3.2 Across our two organisations, there is a wealth of knowledge on how to manage change using lessons learned from previous change programmes. We have started a dialogue with staff to hear about their experiences and ideas of how to manage this joint change programme well. In addition, we have also held a very productive initial session with both Executive teams, Chairs and Deputy Chairs, focused on agreeing what our shared change approach might look like in light of lessons learned from previous examples of leading change, both within the NHS and other sectors.

3.3 We have identified the following characteristics as key to success, and will build these into our shared change approach:

- **Clear vision and goals** – having a clear purpose and narrative of what we are trying to achieve and why, alongside a focused plan of how to get there.

- **Honesty and clarity** – communicating clearly with staff, through a frequent dialogue about what we want to achieve and how we can work together to get there. Being honest and authentic about uncertainty and sensitive to the personal impacts of change.

- **Strong leadership and transparency** – ensuring leaders at all levels authentically model the importance of this change programme and the related mind-sets, culture and ways of working. Being proactive about training leaders within our organisations to lead this programme through a network of ambassadors, with authority to identify problems and find solutions.

- **A well-managed and resourced process** – a well-resourced and well-led programme and process, with the necessary speed and agility to enable pace and the ability to course correct.

- **Stamina and perseverance** – ensuring the necessary resilience and stamina across the two organisations to ensure that lasting changes are made to culture, mind-sets and behaviours to fully transform the ways we work.

'Project 70' – our engagement and organisational development approach

3.4 On 25 May, at our two all-staff briefings, we will launch the new operating model with colleagues. This approach, called 'Project 70' will facilitate a cross-organisation dialogue with staff, about how we should transform our ways of working to provide effective system leadership for the NHS as it heads into its next 70 years. We will also be asking staff their reflections on lessons learned from previous change programmes and their views on the key success factors to get this process right. To prepare for this, we have already started to pilot a series of structured conversations across our two organisations, and staff have welcomed the chance to share honest views and shape our future ways of working.

3.5 Colleagues from our joint working programme will bring both communications and engagement and organisational development expertise to deliver 'Project 70', and we will source additional resource if required to deliver this engagement approach at the necessary scale. We see this engagement approach as a crucial part of enabling a frequent and frank dialogue with our staff, whilst also helping us to identify the building blocks of that shared culture and way of working that we want to build.

Resourcing and managing change

3.6 We have mobilised a joint programme team to support the implementation of this change programme. The team, reporting jointly to Emily Lawson and Ben Dyson, is operating as a joint resource across both organisations to coordinate the overall operating model design work alongside key enablers such as HR processes and organisational development activities. A snapshot of key activities is provided below:

- **Supporting teams through change**. Alongside implementation of our change policies and HR processes, we will be providing a bespoke offer of career transition support to teams and individuals affected by change. There will also be a broader offer of support to equip all line-managers with the resources they need to support their teams and ensure their own personal resilience.

- **Leadership and culture change**. We are developing a joint set of leadership capabilities, working with staff across both organisations to co-create a leadership model and culture fit for the future. This will be followed by development sessions for all staff, focused on:
  - equipping staff to live the new leadership model
  - equipping staff to take responsibility for improving their area of work
  - supporting staff to build resilience and adaptability so that they can deliver their best work even through periods of uncertainty and change.

- **Developing effective team working capability**. We are developing a programme of work to support the development of new joint teams and inter-team working across both organisations and with our system partners.

- **Ensuring that the right enablers are in place**. We are working to ensure that the right enablers, including the use of IT and Estates, our internal finance and budgeting processes are in place to support this transition.

- **Engaging system partners and the public.** In addition to engaging with staff, we are working closely to jointly engage our Trade Union partners at key points within this process. We will be developing a broader external engagement strategy to engage more fully with the public, patients, local systems and ALB partners through the next phase of this work.

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors

Meeting Date: 27 June 2018

Title and Author of Paper:
Integrated Care System (ICS) Bid (formerly STP) Integrated Secure Site
Mark Knowles, Programme Director

Executive Lead: James Duncan

Paper for Debate, Decision or Information:
Information and debate

Key Points to Note:
The Board are aware that the CEDAR Board was set up to co-ordinate and develop the estates and site planning regarding the major developments enshrined with the Trust strategy. These are:

- The Future Development of Adult Secure Services
- Delivering sustainable services as part of the Transforming Care agenda
- Development of a secure future for Adolescent Secure Services
- Delivering on the in-patient model for Deciding Together

Over the last six months considerable work has been undertaken to progress these developments, and develop a coherent estates and site strategy given the interdependent nature of these schemes. The Board has been kept informed of this work through reports from the CEDAR Board. One of the key challenges in successfully moving forward this work has been the restriction in NHS capital, arising from the overall financial challenges facing the NHS. Capital funding announcements for the current year have articulated that the only route for approval of capital schemes will be through the Integrated Care System (formerly STP), in line with the developing ICS estates and financial strategy. As part of this process, a bidding process for capital schemes has been initiated, including a prescribed format for submitting information. This process was initiated in April with schemes to be submitted by June 13th for the first stage of the process through the ICS. This was seen as a significant opportunity to attract capital funds to enable the CEDAR programme. This scheme covers the development of an integrated site for secure services, bringing together, Adult Mental Health and LD secure services, and Adolescent Medium Secure Services. As part of this it proposes the release of the Bamburgh Clinic on the St Nicholas Hospital site, which would then be partially redeveloped to provide the permanent location for Adult Acute Services for Newcastle and Gateshead. This meets a number of local and national strategic requirements:

- Completion of the in-patient requirements of the Deciding Together Consultation
- National Secure Services Review
- Transforming Care

- Mental Health Five Year Forward View
- New Models of Care - alongside our partners TEWV, this would enable a self-contained and sustainable solution for secure services across the ICS patch.

An Initial brief was short listed by the ICS and the Trust was requested to produce more detailed templates, which have now been submitted. The main template is attached. The scheme requires investment of £64.6m offset by land sales of £10.4m, with a payback period of 11 years. Further work will now be undertaken to further develop the bid and develop an outline business case to be presented to the Board in November.

• The proposal is aligned to the priorities identified in the Mental Health ICS mandate and is also in alignment with the Trust's strategy. The development of the specialist provision on one site will present an opportunity to progress a centre of excellence in the North East and North Cumbria region.

A decision on whether this will be supported by the ICS will be made in July, with a national decision expected in November.

Risks Highlighted:

- Described in alternative options
- Failure to secure funding via this process will result in the need to look at alternative funding sources to support the proposals

Does this affect any Board Assurance Framework/Corporate Risks:
Please state Yes or No:- Yes
If Yes please outline: This development will support a number of the Trust's strategic ambitions and reduce a number of risks including:-
SA1.2 If successful this will reduce the risk re lack of capital funding to achieve first class environments.
SA4.1 & 4.2 This supports making services sustainable through increases in productivity and new income streams for secure services to offset income reductions as a result of Transforming Care.
SA5.5 This supports making the Trust a centre of excellence and reduces environmental safety risks by moving out of aging estate such as Alnwood and Hadrian Clinic.

Equal Opportunities, Legal and Other Implications:
Staff consultation process relating to ward moves

Outcome Required / Recommendations: For information and support from Board members.

Link to Policies and Strategies:
CEDAR Programme Initiation Document, NTW Capital Programme, NTW FDP, ICS Capital allocation process, New Models of Care, Delivering Together.

Sent on behalf of DHSC by NHS Improvement / NHS England

STP CAPITAL SCHEME BID TEMPLATE

The full template should be returned by 13/06/2018 to XXX for all STP schemes for which STP capital is requested.

Finance tables should be submitted in the associated Excel Value for Money (VfM) template workbook as well as copied from there into this document. Headline figures should be provided in this document with any additional detail in Excel and any notes on workings.

Please note where the scheme materially involves more than one organisation the relevant tables should be completed for each organisation

A **KEY SCHEME INFORMATION**	**STP name:** **Lead organisation for scheme:** Northumberland, Tyne & Wear NHS Foundation Trust (NTWFT) **Title of the scheme that this bid is for:** NTWFT Secure Services and Newcastle/Gateshead Adult Acute Inpatients **One line descriptor of scheme:** The development of a single integrated secure service centre of excellence and the re-provision of Newcastle and Gateshead adult acute inpatient services **Specific sites for investment:** *Hospital/site names* Northgate Hospital, Morpeth, Northumberland NE61 3BP St Nicholas Hospital, Newcastle upon Tyne NE3 3XT **STP capital scheme priority number (should reconcile to section B4 in the STP Estates strategy template):** (To be added by STP) **List the other organisations impacted by this scheme**: Gateshead Health NHS Foundation Trust, Newcastle Upon Tyne Hospitals NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT). In the table below, set out below the full value of the current capital plans for the whole ICS and their sources of funding. This is separated into three parts: The capital requirement of the scheme in this application; the total capital requirement for other bids to this fund; and the ICS capital requirement for schemes not seeking support from this fund (and the associated sources of funding).

£,000	19/20	20/21	21/22	22/23	23/24	24+	**Total**

Capital requirement for this scheme (i.e. the bid from the fund for the scheme detailed within this template).							
Sources of funding:							
• Internal cash/ depreciation							
• Land/property disposals			10,415				**10,415**
• DHSC borrowing							
• DHSC PDC	8,850	26,985	16,371	1,994			**54,200**
• Private finance (e.g. LIFT)							
• Other							
Total capital requirement for this scheme	8,850	26,985	26,786	1,994			**64,615**
Total bid requirement for this scheme (DH borrowing and PDC)	8,850	26,985	16,371	1,994			**54,200**
Capital requirement for other schemes seeking support from this fund (i.e. to support other schemes detailed in other templates)							
Sources of funding:							
• Internal cash/ depreciation							
• Land/property disposals							
• DHSC borrowing							
• DHSC PDC							
• Private finance (e.g. LIFT)							
• Other							
Total capital requirement schemes in other templates	Sum of sources of funding listed above	Sum of sources of funding listed above	Sum of sources of funding listed above	Sum of sources of funding listed above	Sum of sources of funding listed above	Sum of sources of funding listed above	Sum of sources of funding listed above
Total bid requirement for schemes in other templates (DH borrowing and PDC)							
STP capital programme (excluding all schemes seeking support from this fund)							
Sources of funding:							
• Internal cash/ depreciation							
• Land/property disposals							
• DHSC borrowing							
• DHSC PDC							
• Private finance (e.g. LIFT)							
• Other							
Total of "sources of funding" for schemes not seeking support from this fund (sum of lines above)	Sum of sources of funding listed above	Sum of sources of funding listed above	Sum of sources of funding listed above	Sum of sources of funding listed above	Sum of sources of funding listed above	Sum of sources of funding listed above	Sum of sources of funding listed above

I confirm that this bid is a priority for the STP as set out in the STP estates strategy, that the plans and costings set out within this have been reviewed and are approved by me and that the proposals within this are aligned across commissioners and providers.

Template submitted by:			
Name:	John Lawlor		(Chief Executive of lead organisation)
Name:			(STP Lead)
Template completed by: (for further queries)			
Name:	David Muir	Role:	Group Nurse Director
Email:	David.muir@ntw.nhs.uk	Phone:	0191 245 6611

Notes:

- A separate template is required for each scheme applying for STP capital.
- In most cases this template should be completed as if a SOC. If this is sufficiently robust, it will enable the scheme to move straight to OBC stage. In some cases (specifically if the scheme size means it needs to go to the NHS England Investment Committee) a full SOC may be required.
- STPs may bid for capital for property held by providers, NHS Property Services, Community Health Partnerships or primary care. However, if this is the case, any complexities or assumptions around this must be clearly stated and signup from all those involved must be confirmed.

B **BRIEF SCHEME DESCRIPTION**	1. Set out the physical assets obtained. 2. Set out an overview of the scheme, including the current service issues, how the scheme will address these, those organisations which will be impacted by the scheme, what the scheme actually encompasses and the key benefits of the scheme (e.g. reductions in activity, financial savings, and delivery of targets) for the individual organisation and the whole STP.

Physical Assets Obtained

On the Northgate site a secure services facility with 130 beds (94 new build) covering medium, low and rehabilitation services for adults and 16 beds for children and young people consolidating the provision which currently spans across 2 existing sites.

Consolidation of adult acute mental health beds on the St Nicholas site with 68 beds (14 new build 54 existing refurbished beds) that will provide 2 male and 2 female wards. This will replace the 2 current sites which are spread across Newcastle and Gateshead.

The bed configuration for Secure Services only is shown in Table 1 below.

	NTW Beds 1/4/18	18/19 Bed Reductions	NTW Beds 1/4/19	Proposed Increase in beds	Proposed Number of Beds	Proposed Number of Wards
Medium Secure Mental Health	26		26	2	**28**	2
Medium Secure Prison Transfer	0		0	6 (New Service)	**6**	1
Medium Secure Personality Disorder	0		0	12 (New Service)	**12**	1
Medium Secure Learning Disability (11 NHSE + 1 spot)	24	-12	12		**12**	1
Medium Secure Personality Disorder (NOMS - Oswin)	16		16		**16**	1
Low Secure Mental Health (10 NHSE + 4 spot)	14		14	2	**16**	1
Low Secure Learning Disability (11 NHSE + 1 spot)	24	-12	12		**12**	1
Learning Disability Hospital Rehab	24	-15	9	3	**12**	1
Children & Young Peoples Service Medium Secure	14		14	2	**16**	2
Totals	**142**	**-39**	**103**	**27**	**130**	**11**

Overview of Scheme

NTWFT are in the planning phase of three major capital developments which have been identified as strategic priorities over the next five years: the development of a single integrated secure service centre of excellence; the re-provision of Newcastle and Gateshead Adult Inpatient Services and the re-provision of Adolescent Medium Secure Inpatient Services.
All three major developments are linked to wider national and regional care model initiatives: NHSE New Care Models for Adult Secure Services (NCM); Transforming Care (TC); Newcastle and Gateshead Deciding Together, Delivering Together Programme (DT); NHSE National Adolescent Medium Secure Services review and implementation of the 5 Year Forward View for Mental Health.

The above are interdependent and revolve around the efficient use of current estate at Northgate and St Nicholas Hospitals. Due to the implications for NTWFT's overall estate strategy and the level of interdependency these schemes cannot be delivered efficiently independent of each other, therefore they have been developed as a single overall scheme. They are intrinsically linked to the NTWFT's financial delivery and the sustainability of national and regional specialist services. They support delivery of the Five Year Forward View for Mental Health by enabling the repatriation of service users who are currently receiving services out of area, primarily within the private sector. Finally the schemes ensure the long term delivery of mental health in-patient services in line with the outcome of the Deciding Together Delivering Together Consultation as well as addressing the recommendations from the CQC in relation to the environmental shortfalls within the children's service.

The new integrated single site model would involve the transfer of nationally and regionally commissioned secure service beds from the St Nicholas Hospital site to existing and new purpose built facilities on the Northgate Hospital site. This would enable site rationalisation, attainment of required environmental standards, improved service productivity and expansion enabling repatriation in line with national strategy, the National Review of Secure Services and the Five Year Forward View for Mental Health.

The transfer of secure beds from St Nicholas Hospital as outlined above would then allow for the refurbishment of the vacated buildings in order to re-provide adult acute mental health assessment and treatment facilities from two acute hospital sites in Gateshead and Newcastle, both of which have insurmountable environmental issues and risks that make the long term use of those sites unviable. This would enable services to be delivered in the long term in line with a public consultation, deliver site rationalisation and support financial efficiencies.

Key issues currently faced as a result of the existing model:

The standard of the current estate is deteriorating and increasingly there are issues linked to the age of the buildings, which is requiring greater investment to maintain. There is a great divergence in the quality and standard of NTWFT's estate, something that has been commented on through feedback from the Royal College of Psychiatry Quality Network. Buildings are no longer future-proof as there is only so much that can be done with the current footprint. This has resulted in a lack of flexibility in the delivery of care and ability to meet with patient demand. While we currently deliver outstanding care (CQC, 2016/7), we recognise that we face challenges which must be addressed to enable long term sustainability from environments that are fit for purpose.

The implementation of the Transforming Care Programme for People with Learning Disabilities has led to a significant reduction in site utilisation at the Northgate Hospital site. This gives the opportunity for retraction and consolidation of use of the overall site and offers the opportunity to redeploy the considerable expertise of staff to meet the needs of a different but related client group. This enables NTWFT to support the ICS to become entirely self-sufficient in its management of secure in-patient services for its local population. Funding which is currently invested outside of the ICS footprint or within the private sector will be brought back into the NHS and ICS footprint. It will enable a further land sale at the Northgate site which will part fund this proposal.

Additionally, the current split across multiple sites limits economies of scale, dilutes clinical expertise and fragments the patient pathway. Our aspiration is to co-locate services to a single integrated site. As outlined above, this project will provide benefits to secure, adult inpatient and child and young person's services due to the inter-connectedness of the schemes.

C **TIMELINE**	Provide a timeline of the recent milestones, forward key milestones and phases of the scheme. Include engagement, public/local authority consultation as legally required, planning, business case timings, date of procurement, planned start of works, estimated completion date(s) and dates of any asset disposal induced by the scheme. These timescales should be realistic and assume that if successful, an announcement will be made in November 2018.

Milestones	Approval / Completed Date	Forward Date*	Comments
Public engagement			The inpatient services in Newcastle and Gateshead have been subject to extensive public engagement including a formal public consultation process in 2016 called 'Deciding Together, Delivering Together'. This bid will support the decisions that were made by the CCG to re-provide inpatient services for Newcastle and Gateshead at a single site in Newcastle. Engagement in relation to the Northgate development would need to continue in line with the proposed alterations and build of the secure hospital. It is not envisaged this would require public consultation due to its current designation as a secure site.
Public/local authority consultation as legally required**			Local Authorities (including Overview and Scrutiny Committees and Health and Wellbeing Boards) have been fully involved in the Deciding Together, Delivering Together consultation in line with statutory duties.
Planning	July 19		The planning process will commence in Nov 18 on the basis of approval, this is estimated to take around 7-8 months to complete
SOC	June 2018		
OBC	November 2018		
FBC	March 2019		
Procurement Dates	N/A		Capital procurement of the project will be via the PAGABO National Framework for Major Construction Works. NTWFT is currently using this framework and is successfully delivering projects with our framework partner Sir Robert McAlpine.
Planned start date of capital work	Sept 19		This date relates to commencing work on the major development at Northgate Hospital.
Planned end date of capital work	Feb 22		
Related target asset disposal date	2021		NTWFT has previously disposed of part of the Northgate site for housing. A further section of surplus land would be released for further housing as a result of this development. The exact timing of this may vary in order to maximise sale potential.

* i.e. Date to be submitted for approval	
Refer to NHS England guidance *Planning, assuring and delivery service change for patients revised March 2018* * If approved state whether under organisation own delegated authority, and give date of trust board approval or approved through powers by NHS England / NHS Improvement and state date.	
Please note: Other key milestones may be added as appropriate	

D **SERVICE NEED & OPTIONS APPRAISAL**	Outline the main options considered for this service change and why this is the preferred option in terms of service improvement, capital cost and revenue savings.

Option One: Do nothing

There are a number of limitations associated with this option, therefore this option has not been considered in the financial viability proposal as it would result in key business failure as outlined below:

- Failure to deliver on the outcome of the Deciding Together, Delivering Together consultation, leaving significant quality and financial stresses within adult acute in-patient services across Newcastle and Gateshead
- Lack of viability of the secure service, making it potentially unsustainable, jeopardising the future of the provision of this business, and de-stabilising the provision of secure services across the North East and North Cumbria
- Closure of nationally commissioned in-patient secure service for Young People at a time when nationally there is a recognised under-provision of beds, leading to Young People receiving in-patient services outside of the ICS footprint
- Failure to deliver on a range of national strategies
- Significant under-utilisation of the Northgate site, with services such as NTWFT's Specialist Autism Service (Mitford) becoming increasingly isolated

Option Two: Co-location over two sites with investment into existing environments

We would continue to provide services from both Northgate and St Nicholas' hospital sites, with refurbishment of existing stock. The limitations of this option include the fact that adolescent medium secure service is not included, and that it fails to accommodate the changing context in which healthcare is delivered. This would require a new building to provide Adult Acute in-patient facilities. This option offers little flexibility to adapt to changing healthcare needs and demands and would not address the CQC expectations.

Option Three: Co-location of children and young persons, mental health and learning disability secure services onto one site and the utilisation of the Bamburgh Clinic for an adult acute mental health treatment and assessment unit for Newcastle and Gateshead

This option would deliver a full redesign of the whole pathway and provides an opportunity to create a 'heart of the hospital model', incorporating state of the art facilities, whilst creating new business opportunities for growth to meet demand and repatriate out of area placements.

We propose building the single secure service hospital on the Northgate site which would become a centre for excellence offering a world class provision for the secure pathway offering services and facilities for people with learning disability, mental health and complex need within a secure setting. This, aligned with services provided by TEWVFT, and developments in community forensic services, would enable the ICS to be a national lead in the provision of comprehensive secure services for its population.

This would ensure the Northgate site would be fully utilised to maximise the potential site capacity and would also prevent the Mitford Unit from becoming geographically isolated.
In addition to the in-patient units, the new facility would also include:

- MHA/tribunal suite, primary health facility, patient banking facility, shop, café/dining area, child visiting area, multi-faith room, training and development facility, conference centre, clinical skills laboratory (for scenario-based training), IT and court/business skype facility.
- Redesigned services will include a management and administration facility (providing office accommodation for community teams, medics, nursing, AHPs, and support services including domestic, catering, finance, estates and staff facilities).
- It would also encompass a physical health treatment centre, including dentistry, triage, GP, chiropody, opticians.
- Family and visitors centre/reception centre, including family overnight accommodation (national service).
- Recovery college and seminar/training facility, offering opportunities for training and vocational real-life work experience facilities.
- Therapeutic Activity Service (education, occupational psychological therapy, library and reading room, self-catering and accessible kitchens, horticultural facility, and IT systems).

The scheme would also include an extension and upgrade of the Bamburgh Clinic facility on the St Nicholas Hospital site to provide state of the art adult acute mental health in-patient facilities for the population of Newcastle and Gateshead.

Preferred Option

Based on the service improvements identified in the overview above and opportunities to make efficiency savings and develop sustainable services, Option 3 is the preferred option. This option would ensure a sustainable secure services model which would meet the ever changing demands of its patient group. In addition, the co-location of the secure services beds on Northgate site would contribute to the delivery of financial savings through economies of scale across the workforce, whilst still maintaining a safe and quality service delivered from a highly skilled and expert staff group.

In terms of additional financial benefits, these are covered in more detail in Section H, however the preferred option delivers net revenue savings of £3.7m over the 'Do minimum/Business as Usual' option.

E **CONSISTENCY WITH STP / COMMISSIONING PLANS**	1. Confirm that the proposed scheme is a priority in delivering the ICS's clinical strategies and better meet the assessed needs of the population. Clearly explain the benefits to the wider health economy beyond the lead organisation. 2. Outline how commissioners and providers are aligned. Where issues have been raised, outline how they are being addressed and any constraints that have been identified. 3. Outline how alignment with other stakeholders has been achieved (e.g. local authority or other impacted service providers), how they have been engaged and the level of support received. Where issues have been raised, outline how they are being addressed and any constraints that have been identified. 4. Explain the extent to which a) the proposal is either consistent with the outcome of a public or local authority consultation, or ii) is dependent on such a consultation; and b) how that could impact on delivery. 5. Explain how the ICS is progressing towards shared clinical and financial accountability and outline the key milestones and timeline.

<u>The proposed scheme is a priority in delivering the ICS's clinical strategies</u>

The proposal is aligned to the priorities identified in the Mental Health ICS mandate. The development of the specialist provision on one site will present an opportunity to progress a centre of excellence in the North East and North Cumbria region.

The Mental Health Five Year Forward View sets out an ambitious programme of work to transform mental health services in order to ensure that integrated systems of mental health and physical health care are provided to meet the needs of the population.

The challenge of delivering against 3 key gaps;

- Health and Wellbeing
- Care and Quality
- Finance and Sustainability

In recognition of the need to progress an integrated approach the North East and North Cumbria ICS developed a mental health work stream to ensure that adequate focus is given to this agenda. The ICS has also embraced the delivery of the Transforming Care for People with Learning Disabilities agenda. There is a clear commitment within the ICS to ensure parity of esteem and to commit to ensuring that equal weight is given to planning for the physical health, mental health and well-being of our local population. There is full commitment to the delivery of the Five Year Forward View for Mental Health. This development will support the ICS to deliver:

- NHSE New Care Models for Adult Secure Services (NCM).
- Transforming Care for People with Learning Disabilities agenda (TC).
- Newcastle and Gateshead Decide Together, Delivering Together Programme (DT) – implementing consultation outcome and delivering consistently high standards of adult acute in-patient provision across the NTWFT region.

- NHSE National Adolescent Medium Secure Services Review.
- Implementation of the Five Year Forward View for Mental Health particularly meeting standards for repatriation of service users from out of area and private sector placements.
- An integrated, flexible and adaptable model for world class secure services, in partnership with TEWVFT, to meet the needs of the population within the ICS footprint.

The proposal aligns with a number of the ICS priorities; the new build secure services facility will provide the physical health care facilities to ensure holistic patient needs are addressed reducing demand on acute services wherever possible. There will be a radical upgrade in our approach to ill health prevention and secondary prevention extended to health promotion and encourage personal responsibility through co-produced recovery plans.

The combined site will assist in implementing our CQC action plan to embrace the Greenlight Toolkit across all services including adults and children. Improving access to services and shared learning between learning disability and mental health staff in effectively supporting people with autism and people with learning disabilities to gain equal access to mental health services.

The provision of a single site facility for secure services will allow a skilled workforce to be further developed, reducing demand on the wider health and care economy. This will contribute to the acute optimisation priority area by reducing demand on acute services as well as primary care.

The service provision includes a focus on rehabilitation and this will align to the employment priority area through community integration and links to vocational and educational opportunities.

The development of a purpose built unit will ensure safety standards are maximised with regard to the physical environment (sight lines, access to fresh air, anti-ligature) and workforce development plans will focus on communication, engagement and relational security to align with zero suicide ambition.

The need to provide age appropriate care and relevant expertise to promote recovery is addressed through the provision of a children and young people services (CYPS) on site. The service will provide focused care planning that addresses the needs of individuals.

Alignment with commissioners and providers

- As part of the new care models pilot a robust governance structure has been introduced to provide strategic leadership and direction and to ensure effective alignment with commissioners.
- Commissioning Group - responsible for undertaking the detailed needs assessment and ensuring that the appropriate care pathway is commissioned in the most effective and efficient way
- Quality Governance Group - responsible for reviewing and providing assurance on the quality of service provision across the three domains of Safety, Experience and Effectiveness
- Implementation Group - responsible for delivering the changes to the clinical pathway in line with the contractual requirements and resolving any clinical issues that may arise from the implementation of the service model.

Representatives from NHS England and the two provider organisations attend all meetings. Each group records and monitors any associated issues or risks in an Assumptions, Issues and Risks

(AIR) log. These are discussed collectively and mitigating actions and resolutions agreed. Anything that cannot be resolved at this level is escalated to the NCM Partnership Board.

With regards to Newcastle Gateshead CCG, the proposals for adult acute services are consistent with the ongoing Deciding Together, Delivering Together consultation.

Alignment with other stakeholders

In relation to New Care Models, the programme has its own Partnership Board, the partnership consists of the two provider organisations and also includes representation from :

- NHS Cumbria Partnership Foundation Trust
- NHSE Specialised Commissioners Region and Hubs
- North East and Cumbria Transforming Care Partnership
- The sponsors of the Mental Health and Learning Disability Programme
- Local Authorities

Members of the NCM Board have considered this proposal and are in agreement to the proposed bed model. The Partnership Board also monitors any associated issues or risks in an Assumptions, Issues and Risks (AIR) log. These are discussed collectively by the wider stakeholder group to identify mitigating actions.

Other stakeholders include all CCGs across the North East and Cumbria footprint, NHS England, National Offender Management service (NOMS), Her Majesty's Prison Service (HMPS), and independent sector organisations.

Our Priority is engaging with relevant local authorities to ensure support for service provision. To achieve this we have developed a comprehensive communication and engagement matrix and plan. Within this are captured any risks that flag in terms of engagement, and supporting mitigating actions.

Consultation

The programme is consistent with the outcomes of the Deciding Together, Delivering Together consultations, with the preferred option being the provision of adult acute services for the Newcastle and Gateshead population to be consolidated onto the St Nicholas Hospital site. It is not expected that public consultation will be required for the proposals for secure services on the Northgate site, as there is a limited net change in the number of beds provided across this site which is already designated for Secure Services.

Financial Accountability

A finance leadership group and estates leadership group has been established as part of the ICS governance structure. The New Care Models programme covers the commissioning of secure services and details of the governance arrangements across the ICS patch are described above.

F1 **Transformation***	1. Briefly outline how this scheme will lead to things being done differently to the current situation. 2. Briefly outline how this scheme will transform care for patients and members of the public.

	3. Briefly outline what supporting evidence you have for these benefits *Note: Transformation covers how the scheme changes service model, care or integration for the better in the context of the wider STP. Schemes that replace assets (theatres, wards etc.) can be transformational if there is wider STP sign up; they improve efficiency or are vital to delivering a broader transformation strategy.*

Changes to current situation

It is not sustainable to continue to deliver services from existing buildings, however this scheme will address all of the current environmental challenges associated with ageing and deteriorating buildings. It will afford services the flexibility to tailor care around a wide range of complex patient needs and fluctuating demand. The shared services incorporated into the single integrated secure site will not only provide efficiencies via economies of scale, but will help to better integrate delivery of care for service users with complex needs, helping to de-stigmatise services and breakdown existing perceptual barriers. Services will be better placed to adapt to local, regional and national requirements.

The redesigned service will greatly improve the pathway facilitating reduced waiting times and offering additional beds to repatriate out of area patients to receive care closer to home. It is expected that this development alongside services provided by TEWVFT will be able to meet fully the demand for secure services across the ICS area. Appropriate triaging and placement of patients into services will alleviate pressures on other healthcare providers in the region for example A&E, GPs, community teams, police, prison and social services

The transfer of secure services from St Nicholas Hospital will allow for the redevelopment of the vacated facilities into state of the art adult acute mental health inpatient services for the population of Newcastle and Gateshead. Co-locating these adult beds on one site will enable cross cover and integrated working, across all professional staff groups which will also deliver financial savings through economies of scale.

Transformation

As outlined above, this bid will improve services for a wide ranging group of patients through improving quality of care through enhanced environments. Strengthening links with the community will aid recovery and smooth discharge pathways. The site will be community facing with an aspiration that facilities could be accessible to all. With access to social and leisure facilities, space to rent, workshops for local artisans and other initiatives it is envisaged the new secure services hospital and facilities would become a hub for the local community. This will enhance the surrounding area and contribute to wider cultural issues surrounding stigmas relating to mental health and learning disability. Other benefits include:

- Provision of new facilities with the means to address all challenges identified. Flexibility to deal with physical frailty, gender, age, security level, pathway, speciality, demand, needs (reducing any out of area placements)
- Individual care areas to improve the quality of care recognising safety, patient care need and their dignity
- Delivery of 21st century standard environments supporting modern healthcare
- Future-proofing - Flexibility in design to meet changing needs across the ICS across medium/low secure/ mental health and learning disability, demand for adult acute and PICU in-patient beds

Evidence

For secure services, feedback from the Royal College of Psychiatry Quality Network echoes the benefits listed above suggesting that current provision does not best cater to patient need. The provision will be improved through the building development facilitating more efficient pathways of care. New facilities will increase flexibility and remove challenges surrounding the refurbishment of existing stock to meet the required standard. Providing longevity of services and future-proofing the business.

For adult acute mental health services, substantial evidence was gathered through the consultation process regarding the limitations around current environments on existing sites across Newcastle and Gateshead and scoping out potential opportunities for future provision.

F2 **CLINICAL QUALITY & BENEFIT TO PATIENTS**	1. Given the response to F1 above, detail how this will lead to improved outcomes. 2. Outline how the scheme improves/sustains performance, especially on the following key priority areas – A&E, cancer, dementia, maternity, mental health, learning disabilities, diabetes, UEC including ambulance and primary care. For example increasing the % of total acute activity treated as ambulatory and day cases reduce demand for elective services, reducing out of area placements for mental health or reducing the number of conveyances for an ambulance provider. 3. Where the scheme involves acute bed reductions, set out how this can be achieved without adversely impacting A&E performance and delayed transfers of care. 4. Describe the scheme's impact on workforce. Include any risks and how these will be mitigated 5. For the above points please provide key STP metrics which highlight the need for, and benefit of, this scheme and how you expect these values to change once this scheme has been implemented.

Improved outcomes

The proposal recognises a clear responsibility not only to provide mental health services for people experiencing mental ill health, but to also ensure people with serious mental illness (SMI) have access to, and experience good physical health care. The flexibility planned for the resource will ensure that services can adapt to presenting need across the ICS area. Breaking down barriers between mental health and learning disability services and realigning provision to support the aim to ensure that all of those needing services are able to access services locally, which are appropriate to their need. Services provided will be focussed on rehabilitation and step down, working closely with community services, across an integrated pathway. This will ensure no inappropriate admissions, either out area or within the private sector where individuals experience long stays, limited therapeutic interventions, and limited opportunities for progress.

Performance

The proposal aligns with a number of the ICS priorities; the new building will provide the physical health care facilities to ensure holistic patient needs are addressed, reducing demand on acute services wherever possible. The physical health agenda will extend to health promotion and encourage personal responsibility through co-produced recovery plans. We have had early discussions with Northumbria Healthcare about improving secondary care links e.g. access to a sessional diabetologist on site.

The provision of a single site facility for secure services will allow a skilled workforce to be further developed, reducing demand on the wider health and care economy.

It would help alleviate pressure in relation to waiting times; at present there are issues surrounding this which include waiting times for care on a low secure unit being up to six months, Ministry of Justice recalls, ability for community treatment order recalls, clinical urgencies relating to prisoners and the ability to access services quickly. We foresee that this project would improve links with the third sector, and improve pathway flow due to its community facing element (in-keeping with the future of forensic services, which is heading towards a community forensic model with a need to deliver 24/7 crisis response).

The new build will significantly reduce the number of patients requiring secure care being placed in out of area facilities. There are currently 64 patients who require secure care placed out of area 58 of these patients are placed in units that are over an hour's drive away (greater than 60 miles) making it incredibly difficult to maintain healthy and therapeutic contact with family and friends. The maximum distance from home for a North East patient is currently 277 miles.

It is also important to note that there are presently no dedicated services for Forensic Personality Disorder patients within the North East footprint. Of those originating from the North East with a personality disorder diagnosis 12 are currently in mental health or learning disability beds and 15 people have been placed in specialist units out of area, 11 of these are over an hour's drive away (greater than 60 miles) the furthest being 192 miles away

Impact on A&E

This proposal does not reduce general hospital acute beds therefore has no impact on A&E targets. The reduction in adult acute mental health beds is planned as part of the consultation and delivery planning for Newcastle and Gateshead, and contingency plans are in place to manage any variation in expected levels of demand over the next four years.

Workforce

A workforce plan will be developed to maximise the expertise of staff in post. The development will provide an opportunity for employment in the area and attract wider interest as a centre for excellence. Links with academic partners will be actively encouraged to further develop existing opportunities for research and development. The workforce development plans will focus on communication, engagement and relational security to promote a culture of well-being for staff, patients, carers and others.

As part of this, we recognise a need for consultation, as well as the relocation of staff groups to centralised resource. Consideration will be given to upskilling the workforce to meet changing need and deploying workforce across the whole pathway.

Having all secure services staff on one site will enable us to provide more efficient deployment of human resources to meet ICS goal of 24/7 care. Furthermore, it will aid business continuity and build resilience.

NTWFT has a highly experienced workforce with vast levels of expertise across the secure services which it would seek to retain to support these proposals and has already started engaging with staff across both of its current secure sites. This existing resource gives NTWFT a huge advantage in being able to realise the opportunities for integrated secure service provision to provide a world class service offered within the ICS footprint.

Metrics

The metrics will be developed to align with the ICS priority areas, Five Year Forward View for Mental Health and monitoring of potential savings as outlined in the strategy unit report. We will monitor and would expect to see:

- The number of patients placed in secure services out of area decrease
- The distance patients are placed from home reduce
- A reduction in the length of stay in hospital
- Waiting times for a hospital bed / transfer from prison reduce
- A reduction of violence and aggression
- Ensuring no suicides and no never events

G **DEMAND**	Set out how the scheme will contribute to better management of service demand at health economy level – for example through service consolidation or streaming to new pathways such as scaling up of ambulatory care. Provide quantitative information to support this including arrangements by which providers and commissioners will work together to manage associated risks. Changes to activity as a result of this scheme should be quantified and clearly explained. Where the scheme is primarily around increasing capacity to meet increasing demand explain how this demand will be met efficiently and effectively for example show that the percentage increase in volume is higher than the percentage increase in cost.

The recent NHS England Mental Health Secure Services Review has identified the North East needs to create an additional 55 secure beds to meet projected demand. This can only be achieved by developing local capacity and capability to manage all types of patients.

We currently have limited provision for patients with Personality Disorders with many being admitted into learning disability, mental health beds or placed out of area in other specialist beds. The NHSE Mental Health Service Review has identified the need for 19 Male, Medium Secure PD beds to meet the demands of the future originating population.

There is a demand for step-down beds from high secure facilities to medium secure beds. Currently 5 people are waiting to step-down from Rampton High Secure Hospital with a further 11 on the active waiting list and approximately 19 people currently in out of area placements. The NHSE Mental Health Secure Services Review has identified the need for an increase of 22 male medium secure mental health beds to meet the demands of the future originating population.

Discussions have taken place at Executive Director level with TEWVFT and it has been confirmed that the proposed bed model is in line with the NCM Strategy, and is also in line with the NHSE Mental Health Secure Services Review which in turn meets the needs of the ICS population

We are currently unable to meet the requirements (14 days) in relation to identifying secure beds for prisoners (currently 9+ prisoners on the waiting list at least two waiting over 7 months). Although there is a 5 bedded Low Secure Prison Transfer ward available in Middlesbrough at TEWVFT there is no dedicated facility for Medium Secure Prison Transfers at NTWFT. Currently NTWFT have 4 people in a standard Medium Secure ward, 5 people waiting for a bed and 3 people in TEWVFT beds in Middlesbrough (longest wait for a bed is currently 9 months). The position will remain unchanged in that there will always be a demand for prison transfer beds due to the concentrating effect that prisons have,

The number of people currently on the waiting lists for our services are shown below:

Ward	Number of patients on ward waiting lists
Bede (Low Secure)	6
Cuthbert (Medium Secure)	3
Aidan (Medium Secure)	6
Oswin (Medium Secure PD)	4

A range of NHSE funded work-stream initiatives have been established in order to identify and address the mental health needs of young people within the secure estate in England from 2017-18. This includes the development of services within NTWFT (SECURE STAIRS / F-CAMHS (Forensic CAMHS).

It is anticipated that these initiatives whilst addressing the mental health needs of young people within non NHS mental health settings, it is also likely they will identify the need for more young people to require admissions to NHS mental health secure settings.

A recent NHSE review of the MSU National Network for Young People (2018) established that the reduction in the use of MSU beds over the past 3 years was primarily due to a range of issues (commissioning / environmental / practice) that had led to the MSU network struggling to meet demand for placements and that the following areas need to be addressed:

- Young People with Eating Disorders
- A limit on the capacity of the network to admit female patients (particularly in London and the South East)
- Young People with Autism
- The role of F-CAMHS in identifying mental health needs in the non- secure estate and the likely impact this may lead to an increase in requests for assessment for admission.

Demand is rising for NTWFT child and adolescent service in 2018/19. A number of request for assessment to admit to the service are increasingly being made from outside the NHS (Northern Ireland x3 and Wales x1) in the past 6 months due to such services not currently existing in these countries. It is anticipated therefore that demand for medium secure beds for young people is likely to rise given:

- Initiatives across England to identify and address mental health needs across the Non-NHS secure estate for young people.

- A requirement for the current medium secure unit's national network to expand the scope of the need of young people that are eligible to be admitted more generally.
- Continued lack of medium secure service provision for young people outside of England particularly in relation to the specialism of young people with a learning disability.

NTWFT serve a very challenging demographic. NTW is at the heart of the North East, one of the most challenging areas in the UK in terms of health and other inequalities. As a post-industrial region there are well-known issues within the population, including higher than average rates of drug and alcohol abuse, lower than average life expectancy, and significant levels of violent and destructive crime. The picture is complicated by extreme degrees of local inequality: a number of boroughs and wards contain both the highest and the lowest indicators of multiple deprivation (in England terms, according to 2013 IMD statistics) side by side. The prevalence of mental disorder, particularly where secure treatment is needed, is therefore expected to be significantly greater than in index areas.

Other challenges faced include:

- A range of services and quality issues, including:
    - People remaining in prison who require assessment and treatment
    - Scaffolding mainstream mental health wards for people who have been admitted and need to access secure services but are being accommodated in PICU (Psychiatric Intensive Care Unit) whilst waiting for admission
    - Scaffolding community services.
    - High demand but no capacity to meet, which shows need for expansion.

- The current infrastructure does not support patients moving through the secure system and into a least restrictive environment or admitting and then returning to prison following treatment in a timely manner. The extended service will provide increased flexibility and improved individualised pathways.

- The need for emergency beds or safe/turn-around bed. Demand is currently exceeding supply with some wards operating at 110% occupancy.

- Risk around dealing with future demand for learning disability secure beds should there be fluctuating demands or change in policy for those patients requiring bed based services.

- Difficulties meeting the reduction in bed numbers set out within the Transforming Care agenda. NHS Digital figures show that 700 people are in hospital and not seen as dischargeable, 995 have no discharge plan as yet, 600 are working towards discharge and 115 have a delayed discharge, waiting for appropriate community support. Barriers for discharge include lack of suitable housing (45 people), lack of specialist workforce, increasing complexity and readmissions. Out of area placements remain a problem with nearly 23 per cent, 545 people living more than 100km from home.

Given the issues faced, both as outlined above and in terms of NTWFT's local demographic we are proud to deliver good services. This is echoed by our recent 'Outstanding' CQC rating. This bid proposes that, if successful, these services could be even further improved, greatly enhancing patient care and health provision across the ICS footprint, through the provision of a new building and a more efficient pathway approach.

H **COSTS**	The metrics in the VFM template will be used as part of the below assessment. It should be assumed that, for small and medium schemes, any costs prior to FBC approval will have to be met from internal resource. 1. Set out the scheme's total capital costs and the intended funding sources. Capital costs should be robust and realistic and include contingency and optimism bias where appropriate. 2. Set out the main capital cost components and assumptions – e.g. the extent of contingencies included. This must reconcile to the answer to 1 and include a clear explanation of the assumptions regarding VAT. 3. Set out the non-recurrent revenue costs, including project development. Confirm on how these costs will be funded 4 Set out the current income, expenditure and activity to which the scheme relates and how this is expected to change over time in both the (a) do nothing scenario and (b) if the scheme is approved. This will clearly demonstrate the savings expected from the scheme compared to the do nothing scenario (c). Rows should be added to include additional activity types that will be impacted 5. Set out the savings generated by the scheme. 6. Provide a narrative on projected gross revenue savings to support the figures in the revenue table in 5 (build-up of recurrent revenue costs and estimated capital and revenue lifecycle costs). In the narrative please include comments on whether lifecycle costs refer in part or whole to backlog maintenance cost savings. This narrative needs to be clear as to which organisation revenue savings will accrue to (i.e. provider or commissioner) and where reductions in activity are planned, how providers will reduce their costs to ensure a net saving to the system as a whole. 7. Set out estimation, and the basis for that estimation, of the amount your backlog maintenance will reduce by as a result of this scheme. Populate the 'backlog' table in the accompanying VfM template (excel workbook) for the time horizon of the scheme. 8. Provide a narrative on any non-cash releasing savings for the lead organisation and any wider cash and non-cash savings for the STP along with timescales. 9. Set out the contribution of this scheme to the STP financial position over the next 5 years and any implications for achieving this.

Capital Requirements

The capital costs of this scheme total £62.4m which it is proposed will be funded by £10.4m from a land sale released by this scheme and £54.2m by PDC. The costs are based on detailed cost models that have been developed from recently completed schemes including the Hopewood Park a similar sized scheme.

£,000	19/20	20/21	21/22	22/23	23/24	24+	**Total**
Capital requirement for this scheme (i.e. the bid from the fund for the scheme detailed within this template).							
Sources of funding:							
• Internal cash/ depreciation							
• Land/property disposals			10,415				**10,415**
• DHSC borrowing							
• DHSC PDC	8,850	26,985	16,371	1,994			**54,200**
• Private finance (e.g. LIFT)							
• Other							
Total capital requirement for this scheme	8,850	26,985	26,786	1,994			**64,615**
Total bid requirement for this scheme (DH borrowing and PDC)	8,850	26,985	16,371	1,994			**54,200**

Main capital cost components

The main components of this scheme are identified in the table below:-

Northgate Hospital	**£m**
Site preparation including demolition, service provision etc	4.0
Construction costs associated with new development at Northgate including modifying existing estate on the site	53.4
St Nicholas Hospital	
Construction costs associated with extension to Bamburgh Clinic	7.2
Total Scheme Cost	64.6

The capital cost does not include VAT as these buildings are provided to the Trust as part of a fully managed estates and facilities service by the Trust's subsidiary company and the VAT will be fully reclaimable.

Non recurrent revenue costs

£,000	19/20	20/21	21/22	22/23	23/24	24+	**Total**
Total Revenue Costs	0	0	0	0	0	0	0
Breakdown							
• Staff Costs	0	0	0	0	0	0	0
• Non Staff Costs (please detail if appropriate)	0	0	0	0	0	0	0

There are no non-recurrent revenue costs. Planning/Project costs are included in the capital costs.

Income, activity and expenditure of service areas to which the scheme relates

- Do nothing scenario

£,000	19/20	20/21	21/22	22/23	23/24	24+	Total	Steady state
Income from commissioners	33,400	33,955	34,545	35,180	35,989	4,663,337	4,836,406	35,989
Expenditure								
• Of which pay	28,700	29,177	29,684	30,229	30,925	4,007,119	4,155,834	30,925
• Of which non pay	6,300	6,405	6,516	6,636	£6,788	£879,611	£912,256	6,788
• Of which lifecycle maintenance	0	0	0	0	£0	£0	£0	0
• Of which capital charges (PDC and depreciation)	900	915	931	948	970	125,659	130,323	970
TOTAL	-2,500	-2,542	-2,586	-2,633	-2,694	-349,052	-362,007	-2,694
EL Activity								
NEL Activity								
OP Activity								
A&E Activity								
Other activity (please specify)								

The services covered by the analysis above are Adult Secure In-patient Services (Medium, Low & Rehab), Children's and Young People's Medium Secure In-patient Service and Adult In-patient Services in Newcastle and Gateshead.

The figures in the table above reflect services maintaining current levels of income and expenditure going forwards with figures only reflecting inflationary increases. Services currently cost more than income received and make a loss of £2.5m. Although Transforming Care will result in the closure of beds during 2018/19, it is planned to offset this by repatriating out of area patients.

- If the scheme is approved

£,000	19/20	20/21	21/22	22/23	23/24	24+	Total	Steady state
Income from commissioners	33,400	33,955	34,545	35,601	36,528	4,733,147	4,907,176	36,528
Expenditure							0	
• Of which pay	28,700	29,177	29,684	28,228	28,231	3,658,067	3,802,087	28,231

• Of which non pay	6,300	6,405	6,516	6,109	6,034	781,877	813,241	6,034
• Of which lifecycle maintenance	0	0	0	0	0	0	0	0
• Of which capital charges (PDC and depreciation)	1,050	1,322	1,448	1,264	1,293	167,545	173,922	1,293
TOTAL	-2,650	2,948	-3,103	0	970	125,658	117,927	970
EL Activity								
NEL Activity								
OP Activity								
A&E Activity								
Other activity (please specify)								

- Difference between (a) and (b)

£,000	19/20	20/21	21/22	22/23	23/24	24+	Total	Steady state
Financial difference between (a) and (b) (i.e. net savings from the scheme)	-150	-407	-517	2633	3,664	474,710	479,933	3,664
Activity difference between (a) and (b) (i.e. net demand management from scheme):								
EL Activity								
NEL Activity								
OP Activity								
A&E Activity								
Other activity (please specify and add more rows if required)								

Detail of savings generated by the scheme

£,000	19/20	20/21	21/22	22/23	23/24	24+	Total	Steady state
Gross Revenue Savings								
• Of which Pay	0	0	0	2,423	3,233	418,863	424,518	3,233
• Of which Non pay	0	0	0	527	754	42,000	97,735	754
• Of which Other	0	0	0	0	0	0	0	0
Additional Revenue costs – Capital Charges	150	407	517	316	323	41,886	43,599	323
Additional Revenue lifecycle costs	0	0	0	0	0	0	0	0
Additional Capital lifecycle costs	0	0	0	0	0	0	0	0
Net Revenue savings	-150	-407	-517	2,633	3,664	418,977	478,654	3,664

When the scheme is fully operational the service is able to generate a surplus and becomes sustainable. This is achieved by the delivery of efficiency savings as a result of the co-location of services and services being delivered in fit for purpose accommodation. The consolidation of inpatient units from a number of sites will offer the opportunity to reduce recurring running costs through economies of scale and the development of shared site resources.

Financial benefits are also achieved by increasing the size of the two Children's and Younger People's units by 1 bed each as the increase in costs is proportionately less than the increase income.

The net recurring financial improvement as a result of this development is £3.7m. Based on net capital costs of £54.2m after land sales this gives a return on investment of 7.6%. The vacation of sites belonging to other organisations will offer opportunities to current host NHS organisations for asset sale and/or redevelopment.

This development ensures the longer term sustainability of secure services which means these services will continue to be provided within the STP. It also secures employment in Northumberland for a large workforce of 800 staff which is an economic benefit to the whole region.

Backlog Maintenance

If the scheme does not progress then there are a number of buildings predominantly on the Northgate site which will require significant investment to remove backlog maintenance. This is particularly around engineering services, roofs and general fabric as these buildings are now circa 50 years old and have substantially original services. Should the scheme progress then this backlog will be actively managed over the new build construction phase and following this work these buildings will predominantly be in the land sale area, therefore this backlog expenditure will not be required.

It should be noted that the backlog figure excludes any allowance for backlog maintenance issues associated with Hadrian Clinic which is located on the NUTHFT site. This building is circa 30 years old and is known to have numerous outstanding backlog maintenance issues.

It is estimated that NTW's estimated backlog maintenance at 31 March 2022 will reduce by circa £3m.

Contribution to STP financial position over next 5 years

£,000	19/20	20/21	21/22	22/23	23/24	Steady state
Net Revenue savings	-150	-407	-517	2,633	3,664	3,664

This scheme starts to contribute to the STP's financial position from 22/23. The contribution is the figures in the table above as this development improves the financial position of the Trust without any negative impact on commissioners.

FINANCIAL POSITION & SUSTAINABILITY **(to be completed by providers only)**	• Confirm the figures are consistent with the LTFM or equivalent strategic planning model? (Note the LTFM will need to be provided as part of the OBC submission if the scheme is taken forward for evaluation.) • Are there any implications for your cost improvement plan (CIP)? Please provide details on the level of CIP delivery planned for each year of planning period, value and percentage of income, and the amount to be delivered as a result of this investment. This should clearly reconcile to the previous statement around savings • Set out the incremental impact on the Statement of Comprehensive Net Income (SoCI) in the tables provided in the appendix along with narrative on key impacts. • Set out current and any changes the scheme is likely to have on Single Oversight Framework financial performance metrics. • Set out the levels of existing debt in the appendix. • Set out the process that the lead organisation has gone through to identify what capital contribution can be made from your own internal capital and from your own land disposals. • Please outline which disposals are directly linked to the scheme. • Set out the process that the STP has gone through to identify what capital contribution can be made from other land disposals and where these have been identified give details. • If you have an existing PFI, PF2 or LIFT scheme has the potential for this new scheme to be included been assessed? • Set out options you have explored in terms of is potential for funding from PF2, LIFT or its successor sources?

Cost Improvement Delivery

NTWFT's planned CIP delivery target is based on the current national NHS efficiency requirement of 2% applied to patient care income which equates to 1.8% of total income.

This development will deliver £3.7m of recurring efficiency across 22/23 and 23/24 which will increase the Trust's surplus back up to planned levels. The Trust's surplus has reduced in the short-term as a result of Transforming Care and other service retractions.

£,000	19/20	20/21	21/22	22/23	23/24	24+	Total	Steady state
Base case CIP Value	5,500	5,500	5,500	5,500	5,500	330,000	357,500	5,500
CIP as a result of STP investment				2,633	1,031		3,664	3,664
Total CIP Value	5,500	5,500	5,500	8,133	6,531	330,000	357,500	5,500
CIP as a percentage of income	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%

The incremental impact of the £3.664 saving from this development on the SOCI is set out in the Appendix below.

Impact on Single Oversight Performance Metrics

Due to a reduction in the NTWFT's surplus this year its Finance Risk rating has dropped from a 1 to a 3. This development would increase NTWFT's surplus in 22/23 and move its risk rating back up to a 1.

Debt Levels

NTWFT's debt at the 31/3/20 will be £84m (£46.6m DHSC loans & £37.4m PFI debt)

Trust Capital Contribution

NTWFT actively reviews its estate on an on-going basis to identify surplus assets and asset sale opportunities. This is evidenced by a number of asset sales over the last few years including the previous sale of part of the Northgate site that have been used to fund capital developments.

NTWFT has identified a further potential sale of land at Northgate hospital to support this development.

STP Capital Contribution

To be added

J **DELIVERABILITY**	1. Outline your STP governance arrangements around service change and major changes delivered in the last 3 years. 2. Outline your STP estates governance arrangements and any major schemes delivered in the last three years 3. What are the key organisational improvement priorities for the lead organisation identified by their Board or regulators (e.g. CQC, NHSI) (for example on governance, care quality, management capability) and what impact will this scheme have on those? 4. What are the key risks to delivery of this scheme and how will they be mitigated?

ICS Governance Arrangements

The ICS governance arrangements for the North East and North Cumbria are being finalised. A Regional Development Unit is in place to monitor the programme of work that is being progressed.

The Mental Health ICS priority area work streams report progress through to the steering group. The steering group reports into a regional oversight group.

ICS Estates Governance

NTWFT is working with the ICS Estate group around governance arrangements.

NTWFT has a successful track record in delivering major capital projects over the last 12 years. Recent schemes in the last 3 years include:

- Hopewood Park; this project delivered as part of the wider PRIDE program, saw the completion of a 122 bed hospital to replace Cherry Knowle Hospital. This scheme was completed in September 2015
- Mitford; an award winning purpose-built 15 bed unit with design features specially introduced to make it as supportive and as caring a place as possible for people with autism who are in need of highly specialist in-patient care. This scheme was completed in November 2016
- Cleadon Ward; the extensive refurbishment and extension of an 18-bed unit providing treatment and assessment for older people facing mental health problems. It replaced the 18-bed Rosewood ward at Ryhope. This scheme was completed in November 2016
- Community Transformation; there is an on-going investment in community based facilities across NTWFT geographical area

These schemes have contributed to care being delivered in safe, effective and clinically appropriate environments for our patient group.

Key Organisational Improvements

This scheme will incorporate CQC and NHSE requirements by improving environments, re-providing child and adolescent services (as instructed by the CQC), and catering to the Transforming Care and NCM agendas.

Key Risks

Key risks to service deliver are: Planning permissions, no funding, political climate (Local Authority resistance, Health watch), changes in patient demand (too many beds), changing context (national strategy changes), workforce implications (staffing skills), carer objections (travel, etc.). Mitigation - complex consultation and engagement plan; planning permissions; flexibility of wards to flex to national strategy changes; key player with NCM; lessons learned from previous capital projects. Preliminary discussions have taken place. More substantial discussions will be required going forward at the full business case stage.

K **ESTATES AND PROCUREMENT**	1. Briefly outline how the scheme is part of the wider STP estates strategy 2. Outline the level to which work has been completed on the design and procurement strategy. Include the design and procurement risks identified.

	3. Outline whether any planning permission (including change of use) is required for the scheme. Where issues have been raised, outline how they are being addressed. 4. Please outline who owns all the sites/buildings impacted by the scheme.

Estates Strategy

- Provide functionally suitable, safer and clinically appropriate accommodation on NTW premises for patients in the Newcastle and Gateshead area who are currently located in sub-optimal buildings on sites not run by NTW. These beds will be located at St Nicholas Hospital which is within the commissioning area.
- Moving beds from the Hadrian Clinic which is based on the former Newcastle General Hospital site will help facilitate the redevelopment of that site which is owned by Newcastle Hospitals NHSFT.
- Moving beds from the Tranwell Unit on the Queen Elizabeth site will help facilitate any site development at this location
- Backlog maintenance issues associated with current accommodation will be eradicated as part of the new build.

Procurement Strategy

The project is in strategic definition stage with the core project requirements identified and set out in the strategic brief. Initial sketch design proposals for option appraisals and initial cost appraisals have been completed. NTWFT has developed significant areas of the estate over the last 12 years and has a range of well thought through design solutions and experience that will be applied to this project. At this stage detailed design is yet to commence.

NTWFT have a proven track record of delivering large capital schemes within budget and within planned timescales.

Capital procurement of the project will be via the PAGABO National Framework for Major Construction Works. NTWFT is currently using this framework utilising the NEC3 contract and is successfully delivering projects with our framework partner Sir Robert McAlpine, and under this framework the trust will be able to mobilise progression under this scheme promptly after approval.

Planning Permission

Planning permission will be required for the schemes as they are new developments. However, the proposed construction is on existing hospital sites where previous applications have been successful and it is not anticipated there will be any issues surrounding planning approval.

Site Ownership

The new developments will be on sites owned by NTW. Other sites which will be impacted upon are the CAV (former Newcastle General Hospital) and the Queen Elizabeth Hospital site, in both these cases NTW will be vacating premises and relocating beds.

Appendix: Impact of scheme on the SOCI of lead organisation

Activity	Year 2019/20 £'000	Year 2020/21 £'000	Year 2021/22 £'000	Year 2022/23 £'000	Year 2023/24 £'000	Year 2024/25 £'000	Year 2025/26 £'000	Year 2026/27 £'000	Year 2027/28 £'000	Year 2028/29 £'000	Year 2029/30 £'000	Total £'000
Revenue costs												£0
Pay Costs	0	0	0	-2422	-811	0	0	0	0	0	0	-£3,233
Non-Pay Costs	0	0	0	-527	-227	0	0	0	0	0	0	-£754
Depreciation	0	0	0	0	0	0	0	0	0	0	0	£0
PDC dividends	150	257	110	-201	7	0	0	0	0	0	0	£323
Cash-releasing benefits	0	0	0	0	0	0	0	0	0	0	0	£0
Incremental impact on I&E surplus/ (deficit)	**150**	**257**	**110**	**-3150**	**-1031**	**0**	**0**	**0**	**0**	**0**	**0**	-£3,664

NHS Trust / Foundation Trust Statement of Comprehensive Net Income (whole trust position including the investment over the appraisal period)

Statement of Comprehensive Net Income	Year 2019/20 £'000	Year 2020/21 £'000	Year 2021/22 £'000	Year 2022/23 £'000	Year 2023/24 £'000	Year 2024/25 £'000	Year 2025/26 £'000	Year 2026/27 £'000	Year 2027/28 £'000	Year 2028/29 £'000	Total £'000
Gross employee benefits	248700	248700	248700	248700	246200	246200	246200	246200	246200	246200	£2,472,000
Other operating costs	54100	54100	54100	54100	53400	53400	53400	53400	53400	53400	£536,800
Revenue from patient care activities	289100	289100	289100	289100	289600	289600	289600	289600	289600	289600	£2,894,000
Other operating revenue	23600	23600	23600	23600	23600	23600	23600	23600	23600	23600	£236,000
Operating surplus/(deficit)	**9900**	**9900**	**9900**	**9900**	**13600**	**13600**	**13600**	**13600**	**13600**	**13600**	**£121,200**
Investment revenue	0	0	0	0	0						£0
Other gains and losses	0	0	0	0	0						£0
Finance costs	5500	5500	5500	5500	5500	5500	5500	5500	5500	5500	£55,000
Surplus/(deficit) for the financial year	**4400**	**4400**	**4400**	**4400**	**8100**	**8100**	**8100**	**8100**	**8100**	**8100**	**£66,200**
Dividends payable on public dividend capital (PDC)	1050	1300	1400	1200	1200	1200	1200	1200	1200	1200	£12,150
Net gains/(loss) on transfers by absorption	**0**	**0**	**0**	**0**							£0
Retained surplus/(deficit)	**3350**	**3100**	**3000**	**3200**	**6900**	**6900**	**6900**	**6900**	**6900**	**6900**	£54,050
Adjustments (including PPA, IFRIC 12 adjustment)	0	0	0	0	0	0	0	0	0	0	£0
Adjusted financial performance retained surplus/(deficit)	**3350**	**3100**	**3000**	**3200**	**6900**	**6900**	**6900**	**6900**	**6900**	**6900**	£54,050

Borrowing	As at 31 March 2018 £'000	As at 31 March 2019 £'000	As at 31 March 2020 £'000
Level of DHSC borrowing	56082	50,767	46,641
Level of Commercial Borrowing (Non PFI)	0	0	0
Level of Commercial Borrowing PFI/ other private finance	39,042	38,105	37,350
Total	95,124	88,872	83,991

STP CAPITAL VFM TEMPLATE

This template, referred to as the 'VFM template', is made up of two parts;

(1) detailed input and calculation tabs for assessing the value for money (VFM) of the scheme and

(2) The tables included within the Microsoft Word STP capital bid template, presented in Excel. The tables within part 2 should be submitted in this Excel workbook as well as copied from here into the STP capital bid template.

Information specific to each section is included on the relevant separator tabs. Throughout this template input cells are left as white, un-highlighted cells. This template has been left unlocked, it is your responsibility to ensure the figures are accurate.
Please note; where the scheme involves more than one organisation, the relevant tables in Part 2 should be completed for each organisation material to the scheme

STP Allocations Tranche 4: Part 1 - Value for Money Assessment

Instructions:

1. Complete the scheme information below and the following sheets for Part 1: Costs, Monetisable benefits, Unmonetisable benefits, Risks. Specific instructions for each sheet are provided below.
2. Information can be entered in all UN-FILLED (white) cells in each table.
3. Values must be input as £000s. All financial information must be input as positive values
4. Monetary information must be input in nominal terms (i.e. including inflation).
5. Some cells have comments with guidance. These cells will have a red flag in the top right hand corner, hover over these cells to display the guidance
6. Key metrics will be automatically calculated at the bottom of the summary sheets.
7. Local intelligence and plans should be used to complete this template, using key financial assumptions agreed across impacted organisations. Costs and benefits should be measured prudently.
8. For detailed guidance on appraisal and evaluation of capital projects see the Green Book, updated 6 March 2018: The Green Book: appraisal and evaluation in central government - GOV.UK

Lead organisation	**Northumberland, Tyne & Wear NHS FT**
Scheme name	**NTW Secure Services and Newcastle/Gateshead Adult Acute**
Select the base year	**2019/20**
Project life (whole years)	**60**

Contents

Sheet name	Description	Instructions
1. Economic Summary	Calculates the incremental economic costs and benefits to society of the proposed scheme and the resulting Value for Money ratio.	No input required
2. Financial Summary	Calculates the incremental financial costs and benefits to society of the proposed scheme, and the payback period and recurrent revenue impact.	No input required
4. Costs	Use this sheet to record information about both the Business As Usual (or Do Nothing) costs and the costs resulting from the proposed scheme. This information is used in the Summary sheets.	Apply the same timescale for the business as usual and the proposed scheme, based on the life of the proposed scheme. For all costs, users need to briefly explain the assumptions and methodology used to calculate the values in column B. Additional cost categories can be included by using the blank rows. The default setting is for all user-entered cost categories to apply to both the economic and financial analysis, denoted by a “Y” (yes) in columns C and D. If necessary, change “Y” to “N” (see FAQs for information about the types of costs included in economic and financial analysis).
5. Monetisable Benefits	Use this sheet to record the expected, monetisable incremental benefits of the proposed scheme, relative to Business as Usual. Both cash releasing and non-cash releasing benefits need to be included on this sheet. Users can enter a maximum of five cash releasing and five non-cash releasing benefits This information is used in the Summary sheets.	For all benefits, users need to specify what the benefit is (column B) and briefly explain the assumptions and methodology used to calculate the values (column C). For cash releasing benefits: Indicate whether or not the savings are recurrent revenue savings (column D). For non-cash releasing benefits: Identify whether or not the benefits have been calculated using Quality Adjusted Life Years (QALYs) (column E).
6. Unmonetisable Benefits	Use this sheet to record the expected unmonetisable incremental benefits of the scheme.	Identify the specific unmonetisable benefits of the proposed scheme and briefly describe how they will be generated. Where possible, the benefit should be quantified and the value reported in column E.
7. Risks	Enter the key risks of the scheme and provide an initial indication of their likelihood and impact.	Record the key risks of the scheme and planned mitigations. Use the dropdown boxes to indicate the risk impact and likelihood.

ECONOMIC SUMMARY

Incremental costs and benefits	Project year	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 11	Yr 12	Yr 13	Yr 14	Yr 15
	Financial year	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35
(1) COSTS	Sum of Cashflows																
Capital Costs (including optimism bias)	63,103	7,590	25,059	23,687	504	-	-	-	-	-	-	-	-	-	75	1,507	-
Revenue Costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transitional & non-recurrent revenue costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
INCREMENTAL COSTS TOTAL	**63,103**	**7,590**	**25,059**	**23,687**	**504**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**75**	**1,507**	**-**
(2) BENEFITS																	
Capital Costs (including optimism bias)	33,809	-	-	-	-	16,042	999	151	57	1,531	898	637	3,137	85	-	-	271
Revenue Costs	76,147	-	-	-	2,165	2,788	2,694	2,603	2,516	2,430	2,348	2,268	2,192	2,118	2,047	1,977	1,910
Transitional & non-recurrent revenue costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash Releasing Benefits	9,477	-	-	9,477	-	-	-	-	-	-	-	-	-	-	-	-	-
Non-cash Releasing Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
INCREMENTAL BENEFITS TOTAL	**119,433**	**-**	**-**	**9,477**	**2,165**	**18,830**	**3,693**	**2,754**	**2,572**	**3,961**	**3,246**	**2,905**	**5,329**	**2,203**	**2,047**	**1,977**	**2,181**

Incremental costs and benefits	Yr 16	Yr 17	Yr 18	Yr 19	Yr 20	Yr 21	Yr 22	Yr 23	Yr 24	Yr 25	Yr 26	Yr 27	Yr 28	Yr 29	Yr 30	Yr 31
Financial year	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	2044/45	2045/46	2046/47	2047/48	2048/49	2049/50	2050/51
(1) COSTS																
Capital Costs (including optimism bias)	-	-	-	367	-	-	-	-	142	-	-	52	-	1,245	-	-
Revenue Costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transitional & non-recurrent revenue costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
INCREMENTAL COSTS TOTAL	**-**	**-**	**-**	**367**	**-**	**-**	**-**	**-**	**142**	**-**	**-**	**52**	**-**	**1,245**	**-**	**-**
(2) BENEFITS																
Capital Costs (including optimism bias)	132	13	96	-	910	115	132	43	-	324	368	-	139	-	209	65
Revenue Costs	1,846	1,783	1,723	1,665	1,608	1,554	1,501	1,451	1,401	1,354	1,308	1,264	1,221	1,180	1,140	1,107
Transitional & non-recurrent revenue costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash Releasing Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Non-cash Releasing Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
INCREMENTAL BENEFITS TOTAL	**1,977**	**1,796**	**1,819**	**1,665**	**2,519**	**1,668**	**1,633**	**1,493**	**1,401**	**1,677**	**1,676**	**1,264**	**1,360**	**1,180**	**1,349**	**1,171**

Incremental costs and benefits	Yr 32	Yr 33	Yr 34	Yr 35	Yr 36	Yr 37	Yr 38	Yr 39	Yr 40	Yr 41	Yr 42	Yr 43	Yr 44	Yr 45	Yr 46	Yr 47
Financial year	2051/52	2052/53	2053/54	2054/55	2055/56	2056/57	2057/58	2058/59	2059/60	2060/61	2061/62	2062/63	2063/64	2064/65	2065/66	2066/67
(1) COSTS																
Capital Costs (including optimism bias)	-	-	-	-	-	-	-	202	-	-	-	-	560	-	-	5
Revenue Costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transitional & non-recurrent revenue costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
INCREMENTAL COSTS TOTAL	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**202**	**-**	**-**	**-**	**-**	**560**	**-**	**-**	**5**
(2) BENEFITS																
Capital Costs (including optimism bias)	46	89	24	2,679	75	2,943	38	-	178	145	30	113	-	65	86	-
Revenue Costs	1,075	1,043	1,013	983	955	927	900	874	848	824	800	776	754	732	710	690
Transitional & non-recurrent revenue costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash Releasing Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Non-cash Releasing Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
INCREMENTAL BENEFITS TOTAL	**1,120**	**1,132**	**1,037**	**3,662**	**1,029**	**3,870**	**937**	**874**	**1,026**	**968**	**829**	**889**	**754**	**797**	**797**	**690**

Incremental costs and benefits	Yr 48	Yr 49	Yr 50	Yr 51	Yr 52	Yr 53	Yr 54	Yr 55	Yr 56	Yr 57	Yr 58	Yr 59	Yr 60	Yr 61	Yr 62	Yr 63	Yr 64
Financial year	2067/68	2068/69	2069/70	2070/71	2071/72	2072/73	2073/74	2074/75	2075/76	2076/77	2077/78	2078/79	2079/80	2080/81	2081/82	2082/83	2083/84
(1) COSTS																	
Capital Costs (including optimism bias)	25	264	-	-	-	-	-	-	-	5	-	488	-	-	19	-	1,307
Revenue Costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transitional & non-recurrent revenue costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
INCREMENTAL COSTS TOTAL	**25**	**264**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**5**	**-**	**488**	**-**	**-**	**19**	**-**	**1,307**
(2) BENEFITS																	
Capital Costs (including optimism bias)	-	-	463	27	42	33	42	48	137	-	40	-	42	39	-	35	-
Revenue Costs	670	650	631	613	595	578	561	545	529	513	498	484	470	456	443	430	417
Transitional & non-recurrent revenue costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash Releasing Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Non-cash Releasing Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
INCREMENTAL BENEFITS TOTAL	**670**	**650**	**1,094**	**640**	**637**	**611**	**603**	**592**	**666**	**513**	**538**	**484**	**512**	**495**	**443**	**465**	**417**

Value for Money Ratio	**1.9**

FINANCIAL SUMMARY

	Project year	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5	Yr 6	Yr 7	Yr 8	Yr 9	Yr 10	Yr 11	Yr 12	Yr 13	Yr 14	Yr 15	Yr 16
	Financial year	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36
(1) COSTS (INCREMENTAL)	Sum of Cashflows																	
Capital (including optimism bias)	140,029	7,590	26,366	26,244	589	-	-	-	-	-	-	-	-	-	155	3,299	-	-
Recurrent revenue	1,074	150	407	517	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Recurrent revenue exc PDC and depn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transitional & non-recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**141,103**	**7,740**	**26,773**	**26,761**	**589**	-	-	-	-	-	-	-	-	-	**155**	**3,299**	-	-
(2) CASH RELEASING SAVINGS (INCREMENTAL)																		
Capital (including optimism bias)	110,886	-	-	-	-	19,836	1,308	209	83	2,379	1,478	1,109	5,786	166	-	-	629	323
Recurrent revenue	410,240	-	-	-	2,212	3,125	3,196	3,270	3,346	3,422	3,500	3,581	3,665	3,749	3,835	3,924	4,013	4,105
Recurrent revenue exc PDC and depn	*452,767*	-	-	-	*2,528*	*3,448*	*3,527*	*3,608*	*3,692*	*3,776*	*3,863*	*3,952*	*4,044*	*4,137*	*4,232*	*4,329*	*4,428*	*4,530*
Transitional & non-recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash Releasing Benefits, of which:	10,500	-	-	10,500	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Recurrent revenue benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**531,626**	-	-	**10,500**	**2,212**	**22,961**	**4,504**	**3,479**	**3,429**	**5,801**	**4,978**	**4,690**	**9,451**	**3,915**	**3,835**	**3,924**	**4,642**	**4,428**
UNDISCOUNTED TOTAL OF COSTS AND BENEFITS CHANGES		-7,740	-26,773	-16,261	1,623	22,961	4,504	3,479	3,429	5,801	4,978	4,690	9,451	3,915	3,680	625	4,642	4,428
RECURRENT REVENUE IMPACT		-	-	-	2,528	3,448	3,527	3,608	3,692	3,776	3,863	3,952	4,044	4,137	4,232	4,329	4,428	4,530
Costs		-7,740	-26,773	-26,761	-589	-	-	-	-	-	-	-	-	-	-155	-3,299	-	-
Savings		-	-	10,500	2,212	22,961	4,504	3,479	3,429	5,801	4,978	4,690	9,451	3,915	3,835	3,924	4,642	4,428
Cumulative net impact		-7,740	-34,513	-50,774	-49,151	-26,190	-21,686	-18,207	-14,778	-8,977	-3,999	691	10,142	14,057	17,737	18,362	23,004	27,432

Project year	Yr 17	Yr 18	Yr 19	Yr 20	Yr 21	Yr 22	Yr 23	Yr 24	Yr 25	Yr 26	Yr 27	Yr 28	Yr 29	Yr 30	Yr 31	Yr 32
Financial year	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	2044/45	2045/46	2046/47	2047/48	2048/49	2049/50	2050/51	2051/52
(1) COSTS (INCREMENTAL)																
Capital (including optimism bias)	-	-	1,070	-	-	-	-	552	-	-	241	-	6,426	-	-	-
Recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Recurrent revenue exc PDC and depn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transitional & non-recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	-	-	**1,070**	-	-	-	-	**552**	-	-	**241**	-	**6,426**	-	-	-
(2) CASH RELEASING SAVINGS (INCREMENTAL)																
Capital (including optimism bias)	35	265	-	2,808	374	456	156	-	1,329	1,599	-	677	-	1,139	372	277
Recurrent revenue	4,199	4,296	4,395	4,496	4,600	4,706	4,814	4,924	5,037	5,154	5,273	5,393	5,517	5,643	5,774	5,907
Recurrent revenue exc PDC and depn	*4,633*	*4,740*	*4,850*	*4,961*	*5,075*	*5,192*	*5,312*	*5,433*	*5,558*	*5,687*	*5,818*	*5,951*	*6,088*	*6,227*	*6,371*	*6,518*
Transitional & non-recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash Releasing Benefits, of which:	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Recurrent revenue benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**4,234**	**4,561**	**4,395**	**7,304**	**4,974**	**5,162**	**4,970**	**4,924**	**6,366**	**6,753**	**5,273**	**6,070**	**5,517**	**6,782**	**6,146**	**6,184**
UNDISCOUNTED TOTAL OF COSTS AND BENEFITS CHANGES	4,234	4,561	3,325	7,304	4,974	5,162	4,970	4,372	6,366	6,753	5,032	6,070	-909	6,782	6,146	6,184
RECURRENT REVENUE IMPACT	4,633	4,740	4,850	4,961	5,075	5,192	5,312	5,433	5,558	5,687	5,818	5,951	6,088	6,227	6,371	6,518
Costs	-	-	-1,070	-	-	-	-	-552	-	-	-241	-	-6,426	-	-	-
Savings	4,234	4,561	4,395	7,304	4,974	5,162	4,970	4,924	6,366	6,753	5,273	6,070	5,517	6,782	6,146	6,184
Cumulative net impact	31,666	36,227	39,552	46,856	51,830	56,992	61,962	66,334	72,700	79,453	84,485	90,555	89,646	96,428	102,574	108,758

Project year	Yr 33	Yr 34	Yr 35	Yr 36	Yr 37	Yr 38	Yr 39	Yr 40	Yr 41	Yr 42	Yr 43	Yr 44	Yr 45	Yr 46	Yr 47	Yr 48
Financial year	2052/53	2053/54	2054/55	2055/56	2056/57	2057/58	2058/59	2059/60	2060/61	2061/62	2062/63	2063/64	2064/65	2065/66	2066/67	2067/68
(1) COSTS (INCREMENTAL)																
Capital (including optimism bias)	-	-	-	-	-	-	1,770	-	-	-	-	6,361	-	-	61	352
Recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Recurrent revenue exc PDC and depn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transitional & non-recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	-	-	-	-	-	-	**1,770**	-	-	-	-	**6,361**	-	-	**61**	**352**
(2) CASH RELEASING SAVINGS (INCREMENTAL)																
Capital (including optimism bias)	569	162	19,010	557	23,181	313	-	1,637	1,405	302	1,217	-	780	1,087	-	-
Recurrent revenue	6,043	6,182	6,323	6,469	6,618	6,770	6,926	7,085	7,250	7,415	7,585	7,760	7,937	8,121	8,307	8,498
Recurrent revenue exc PDC and depn	*6,668*	*6,821*	*6,978*	*7,139*	*7,303*	*7,470*	*7,642*	*7,818*	*7,999*	*8,182*	*8,370*	*8,563*	*8,759*	*8,961*	*9,166*	*9,378*
Transitional & non-recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash Releasing Benefits, of which:	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Recurrent revenue benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**6,612**	**6,344**	**25,333**	**7,026**	**29,799**	**7,083**	**6,926**	**8,722**	**8,655**	**7,717**	**8,802**	**7,760**	**8,717**	**9,208**	**8,307**	**8,498**
UNDISCOUNTED TOTAL OF COSTS AND BENEFITS CHANGES	6,612	6,344	25,333	7,026	29,799	7,083	5,156	8,722	8,655	7,717	8,802	1,399	8,717	9,208	8,246	8,146
RECURRENT REVENUE IMPACT	6,668	6,821	6,978	7,139	7,303	7,470	7,642	7,818	7,999	8,182	8,370	8,563	8,759	8,961	9,166	9,378
Costs	-	-	-	-	-	-	-1,770	-	-	-	-	-6,361	-	-	-61	-352
Savings	6,612	6,344	25,333	7,026	29,799	7,083	6,926	8,722	8,655	7,717	8,802	7,760	8,717	9,208	8,307	8,498
Cumulative net impact	115,370	121,714	147,047	154,073	183,872	190,955	196,111	204,833	213,488	221,205	230,007	231,406	240,123	249,331	257,577	265,723

Project year	Yr 49	Yr 50	Yr 51	Yr 52	Yr 53	Yr 54	Yr 55	Yr 56	Yr 57	Yr 58	Yr 59	Yr 60	Yr 61	Yr 62	Yr 63	Yr 64
Financial year	2068/69	2069/70	2070/71	2071/72	2072/73	2073/74	2074/75	2075/76	2076/77	2077/78	2078/79	2079/80	2080/81	2081/82	2082/83	2083/84
(1) COSTS (INCREMENTAL)																
Capital (including optimism bias)	3,889	-	-	-	-	-	-	-	101	-	12,148	-	-	552	-	42,263
Recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Recurrent revenue exc PDC and depn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Transitional & non-recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**3,889**	-	-	-	-	-	-	-	**101**	-	**12,148**	-	-	**552**	-	**42,263**
(2) CASH RELEASING SAVINGS (INCREMENTAL)																
Capital (including optimism bias)	-	7,195	449	729	604	806	963	2,921	-	946	-	1,113	1,071	-	1,076	-
Recurrent revenue	8,694	8,895	9,097	9,308	9,523	9,740	9,965	10,194	10,429	10,669	10,914	11,165	11,421	11,685	11,953	12,228
Recurrent revenue exc PDC and depn	*9,593*	*9,815*	*10,039*	*10,271*	*10,508*	*10,748*	*10,996*	*11,249*	*11,507*	*11,773*	*12,043*	*12,320*	*12,603*	*12,894*	*13,190*	*13,493*
Transitional & non-recurrent revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash Releasing Benefits, of which:	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Recurrent revenue benefits	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL	**8,694**	**16,090**	**9,546**	**10,037**	**10,127**	**10,546**	**10,928**	**13,115**	**10,429**	**11,615**	**10,914**	**12,278**	**12,492**	**11,685**	**13,029**	**12,228**
UNDISCOUNTED TOTAL OF COSTS AND BENEFITS CHANGES	4,805	16,090	9,546	10,037	10,127	10,546	10,928	13,115	10,328	11,615	-1,234	12,278	12,492	11,133	13,029	-30,035
RECURRENT REVENUE IMPACT	9,593	9,815	10,039	10,271	10,508	10,748	10,996	11,249	11,507	11,773	12,043	12,320	12,603	12,894	13,190	13,493
Costs	-3,889	-	-	-	-	-	-	-	-101	-	-12,148	-	-	-552	-	-42,263
Savings	8,694	16,090	9,546	10,037	10,127	10,546	10,928	13,115	10,429	11,615	10,914	12,278	12,492	11,685	13,029	12,228
Cumulative net impact	270,528	286,618	296,164	306,201	316,328	326,874	337,802	350,917	361,245	372,860	371,626	383,904	396,396	407,529	420,558	390,523

	2021/22	2022/23	2023/24	2024/25	2025/26
Revenue savings	-	2,528	3,448	3,527	3,608
Initial Capex	64,615				
Average annual revenue saving 21/22 - 25/26 (next Spending Review period)	2,622				
Revenue savings as a proportion of initial capex	**4%**				

Payback period	**11**

COSTS ANALYSIS - NOMINAL VALUES

OPTION 0 - BUSINESS AS USUAL	Brief description of methodology and assumptions used to calculate costs	Inc in Ec	Inc in Fin	Project year / Sum of Cashflows	Yr 0 2019/20	Yr 1 2020/21	Yr 2 2021/22	Yr 3 2022/23	Yr 4 2023/24	Yr 5 2024/25
(1) CAPITAL COSTS										
Initial Capital Costs (inc VAT), sourced by:				£0	£0	£0	£0	£0	£0	£0
Internal cash/depreciation		Y	Y	£0						
Land/property disposals		Y	Y	£0						
DHSC borrowing		Y	Y	£0						
DHSC PDC		Y	Y	£0						
Private finance (e.g. LIFT)		Y	Y	£0						
Other		Y	Y	£0						
Optimism Bias (inc VAT)		Y	Y	£0						
Lifecycle costs (inc VAT)	Lifecycle costs have been calculated across the entire building life using recognised industry norms for building elements and M&E services. Capital expenditure has been included for both the replacement of those buildings that will exceed their lifespan during the set period and for the replacement of Hadrian Clinic which is currently located on another Trusts site and due to the development of that site our tenure is limited.	Y	Y	129,088	170	60	46	768	19,874	1,337
Planned backlog maintenance spend (inc VAT)	The backlog expenditure is shown up to year 3 and addresses the immediate concerns surrounding the sub-standard facilities on the Northgate site.	Y	Y	2,788	1,090	559	496	643		
Other Capital costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
Residual Value (Enter a positive value. This will be subtracted from cost)	This is primarily based on the anticipated land value at the end of the period.	Y	Y	84,332						
TOTAL: CAPITAL COSTS (NOMINAL)				47,544	1,260	619	542	1,411	19,874	1,337
TOTAL: CAPITAL COSTS + OPTIMISM BIAS (NOMINAL)				47,544	1,260	619	542	1,411	19,874	1,337
VAT on ALL capital cost components above		Y	N	-						
(2) RECURRENT REVENUE COSTS				Sum of Cashflows						
Staff costs (inc VAT)	Based on current service costs	Y	Y	4,155,832	28,700	29,177	29,684	30,229	30,925	31,636
Public Dividend Capital	3.5% of NBV of assets currently utilised by services	N	Y	86,879	600	610	621	632	647	661
Depreciation	Based on current depreciation costs	N	Y	43,441	300	305	310	316	323	331
Non-staff costs (inc VAT) [Specify in this cell if appropriate]	Based on current service costs	Y	Y	912,260	6,300	6,405	6,516	6,636	6,788	6,944
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
TOTAL: RECURRENT REVENUE COSTS (NOMINAL)				5,198,412	35,900	36,497	37,131	37,813	38,683	39,572
VAT on ALL recurrent revenue cost components above	No VAT on staff costs. Minimal VAT on non-pay. Estates & Facilities service provided by subsidiary company, VAT reclaimable	Y	N	-						
(3) NON-RECURRENT REVENUE COSTS				Sum of Cashflows						
Staff costs (inc VAT)		Y	Y	-						
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
TOTAL: NON-RECURRENT REVENUE COSTS (NOMINAL)				-	-	-	-	-	-	-
VAT on ALL non-recurrent revenue cost components above		Y	N	-						
TOTAL: COSTS (UNDISCOUNTED)				5,245,956	37,160	37,116	37,673	39,224	58,557	40,909

OPTION 1 - PROPOSED SCHEME		Inc in Ec	Inc in Fin	Sum of Cashflows	Yr 0 2019/20	Yr 1 2020/21	Yr 2 2021/22	Yr 3 2022/23	Yr 4 2023/24	Yr 5 2024/25
(1) CAPITAL COSTS										
Initial Capital Costs (inc VAT), sourced by:	The Trust has sucessfully completed a number of capital schemes over the last 12 years and the capital costs for this scheme have been built up using detailed cost models that have been developed as a result of the extensive past program. These costs include inflation uplifts to reflect what it is expected would be included in the Guaranteed Maximum Price.			64,615	8,850	26,985	26,786	1,994	-	-
Internal cash/depreciation		Y	Y	-						
Land/property disposals	Land sale value based on previous sale of part of the site adjusted for current market conditions (ie reduced £/hectare)	Y	Y	10,415			10,415			
DHSC borrowing		Y	Y	-						
DHSC PDC		Y	Y	54,200	8,850	26,985	16,371	1,994		
Private finance (e.g. LIFT)		Y	Y	-						
Other		Y	Y	-						
Optimism Bias (inc VAT)	Optimism bias included in above costs	Y	Y	-						
Lifecycle costs (inc VAT)	Lifecycle costs have been calculated across the entire building life using recognised industry norms for building elements and M&E services. Costs have been inflated using GDP deflator.	Y	Y	54,238	0	0	0	6	38	29
Planned backlog maintenance spend (inc VAT)	Backlog maintenance at Northgate eradicated through proposed development	Y	Y	-						
Other Capital costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
Residual Value (Enter a positive value. This will be subtracted from cost)	This is primarily based on the anticipated land value at the end of the period and is lower than the Business as Usual option due to the land sale achieved as part of this development.	Y	Y	42,166						
TOTAL: CAPITAL COSTS (NOMINAL)				76,687	8,850	26,985	26,786	2,000	38	29
TOTAL: CAPITAL COSTS + OPTIMISM BIAS (NOMINAL)				76,687	8,850	26,985	26,786	2,000	38	29
VAT on ALL capital cost components above	No VAT on capital costs as these buildings are provided to the Trust as part of a fully managed service including capital works.	Y	N	-						
(2) RECURRENT REVENUE COSTS				Sum of Cashflows						
Staff costs (inc VAT)		Y	Y	3,802,086	28,700	29,177	29,684	28,228	28,231	28,880
Public Dividend Capital	3.5% of expected NBV of assets used in proposed model. NBV based on MEA methodology	N	Y	130,480	750	1,017	1,138	948	970	992
Depreciation		N	Y	43,441	300	305	310	316	323	331
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	813,239	6,300	6,405	6,516	6,109	6,034	6,173
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
TOTAL: RECURRENT REVENUE COSTS (NOMINAL)				4,789,246	36,050	36,904	37,648	35,601	35,558	36,376
VAT on ALL recurrent revenue cost components above	No VAT on staff costs. Minimal VAT on non-pay. Estates & Facilities service provided by subsidiary company, VAT reclaimable	Y	N	-						
(3) TRANSITIONAL & NON-RECURRENT REVENUE COSTS				Sum of Cashflows						
Staff costs (inc VAT)	Planning/Project costs included in capital costs	Y	Y	-						
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
Non-staff costs (inc VAT) [Specify in this cell if appropriate]		Y	Y	-						
TOTAL: TRANSITIONAL & NON-RECURRENT REVENUE COSTS (NOMINAL)				-	-	-	-	-	-	-
VAT on ALL non-recurrent revenue cost components above		Y	N	-						
TOTAL: COSTS (UNDISCOUNTED)				4,865,933	44,900	63,889	64,434	37,601	35,596	36,405

ECONOMIC ANALYSIS

Discount rate	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Non-QALY Discount Factors @ 3.5% / 3.0%	1.000	0.966	0.934	0.902	0.871	0.842

Inflation rates (to deflate nominal values to real values for economic analysis)	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
GDP deflator	1.00	0.98	0.97	0.95	0.93	0.91

OPTION 0 - BUSINESS AS USUAL (1) CAPITAL COSTS	Inc in Ec	Sum of Discounted Cashflows	Yr 0	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Initial Capital Costs (inc VAT), sourced by:		£0	£0	£0	£0	£0	£0	£0
Internal cash/depreciation	Y	£0	£0	£0	£0	£0	£0	£0
Land/property disposals	Y	£0	£0	£0	£0	£0	£0	£0
DHSC borrowing	Y	£0	£0	£0	£0	£0	£0	£0
DHSC PDC	Y	£0	£0	£0	£0	£0	£0	£0
Private finance (e.g. LIFT)	Y	£0	£0	£0	£0	£0	£0	£0
Other	Y	£0	£0	£0	£0	£0	£0	£0
Optimism Bias (inc VAT)	Y	£0	£0	£0	£0	£0	£0	£0
Lifecycle costs (inc VAT)	Y	£38,225	£170	£57	£42	£658	£16,072	£1,021
Planned backlog maintenance spend (inc VAT)	Y	£2,620	£1,090	£531	£448	£551	£0	£0

MONETISED BENEFITS

Benefits Analysis: Incremental benefits of proposed scheme relative to "Business as Usual"

Ref	Benefit Name	Brief description of methodology and assumptions used to calculate benefit	Recurrent revenue saving?	QALY or Non-QALY? (for discount rate)	Discounted Benefits	Total	Yr 0 2019/20	Yr 1 2020/21	Yr 2 2021/22	Yr 3 2022/23	Yr 4 2023/24	Yr 5 2024/25	Yr 6 2025/26	Yr 7 2026/27	Yr 8 2027/28	Yr 9 2028/29	Yr 10 2029/30	Yr 11 2030/31	Yr 12 2031/32	Yr 13 2032/33	Yr 14 2033/34	Yr 15 2034/35	Yr 16 2035/36	Yr 17 2036/37	Yr 18 2037/38	Yr 19 2038/39	Yr 20 2039/40	Yr 21 2040/41	Yr 22 2041/42	Yr 23 2042/43	Yr 24 2043/44	Yr 25 2044/45	Yr 26 2045/46	Yr 27 2046/47	Yr 28 2047/48	Yr 29 2048/49	Yr 30 2049/50	Yr 31 2050/51	Yr 32 2051/52	Yr 33 2052/53	Yr 34 2053/54	Yr 35 2054/55	Yr 36 2055/56	Yr 37 2056/57	Yr 38 2057/58	Yr 39 2058/59	Yr 40 2059/60	Yr 41 2060/61	Yr 42 2061/62	Yr 43 2062/63	Yr 44 2063/64	Yr 45 2064/65	Yr 46 2065/66	Yr 47 2066/67	Yr 48 2067/68	Yr 49 2068/69	Yr 50 2069/70	Yr 51 2070/71	Yr 52 2071/72	Yr 53 2072/73	Yr 54 2073/74	Yr 55 2074/75	Yr 56 2075/76	Yr 57 2076/77	Yr 58 2077/78	Yr 59 2078/79	Yr 60 2079/80	Yr 61 2080/81	Yr 62 2081/82	Yr 63 2082/83	Yr 64 2083/84
(1) CASH RELEASING BENEFITS																																																																						
CRB1	Land sales/ property disposals		N	NON-QALY	9,477	10,500			10,500																																																								
CRB2			N	NON-QALY	-	-																																																											
CRB3			[Please select]	NON-QALY	-	-																																																											
CRB4			[Please select]	NON-QALY	-	-																																																											
CRB5			[Please select]	NON-QALY	-	-																																																											
TOTAL: CASH RELEASING BENEFITS (NOMINAL)					9,477	10,500	-	-	10,500	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
(2) NON-CASH RELEASING BENEFITS																																																																								
NCRB1				[Please select]	-	-																																																												
NCRB2				[Please select]	-	-																																																											
NCRB3				[Please select]	-	-																																																											
NCRB4				[Please select]	-	-																																																											
NCRB5				[Please select]	-	-																																																											
TOTAL: NON-CASH RELEASING BENEFITS (NOMINAL)					-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL INCREMENTAL BENEFITS					9,477	10,500	-	-	10,500	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL RECURRENT REVENUE BENEFITS						-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Discount rates		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	2044/45	2045/46	2046/47	2047/48	2048/49	2049/50	2050/51	2051/52	2052/53	2053/54	2054/55	2055/56	2056/57	2057/58	2058/59	2059/60	2060/61	2061/62	2062/63	2063/64	2064/65	2065/66	2066/67	2067/68	2068/69	2069/70	2070/71	2071/72	2072/73	2073/74	2074/75	2075/76	2076/77	2077/78	2078/79	2079/80	2080/81	2081/82	2082/83	2083/84
Non-QALY Discount Factors @ 3.5% / 3.0%		1.00	0.97	0.93	0.90	0.87	0.84	0.81	0.79	0.76	0.73	0.71	0.68	0.66	0.64	0.62	0.60	0.58	0.56	0.54	0.52	0.50	0.49	0.47	0.45	0.44	0.42	0.41	0.40	0.38	0.37	0.36	0.35	0.34	0.33	0.32	0.31	0.30	0.29	0.28	0.27	0.27	0.26	0.25	0.24	0.24	0.23	0.22	0.22	0.21	0.20	0.20	0.19	0.19	0.18	0.18	0.17	0.17	0.16	0.16	0.15	0.15	0.14	0.14	0.13	0.13
QALY Discount Factors @ 1.5% / 1.286%		1.00	0.99	0.97	0.96	0.94	0.93	0.91	0.90	0.89	0.87	0.86	0.85	0.84	0.82	0.81	0.80	0.79	0.78	0.76	0.75	0.74	0.73	0.72	0.71	0.70	0.69	0.68	0.67	0.66	0.65	0.64	0.63	0.62	0.62	0.61	0.60	0.59	0.59	0.58	0.57	0.56	0.56	0.55	0.54	0.54	0.53	0.52	0.51	0.51	0.50	0.50	0.49	0.48	0.48	0.47	0.46	0.46	0.45	0.45	0.44	0.44	0.43	0.43	0.42	0.41

Inflation rates (to deflate nominal values to real values for economic analysis		2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	2044/45	2045/46	2046/47	2047/48	2048/49	2049/50	2050/51	2051/52	2052/53	2053/54	2054/55	2055/56	2056/57	2057/58	2058/59	2059/60	2060/61	2061/62	2062/63	2063/64	2064/65	2065/66	2066/67	2067/68	2068/69	2069/70	2070/71	2071/72	2072/73	2073/74	2074/75	2075/76	2076/77	2077/78	2078/79	2079/80	2080/81	2081/82	2082/83	2083/84
GDP deflator		1.00	0.98	0.97	0.95	0.93	0.91	0.89	0.87	0.85	0.83	0.81	0.79	0.77	0.76	0.74	0.72	0.71	0.69	0.68	0.66	0.65	0.63	0.62	0.60	0.59	0.58	0.56	0.55	0.54	0.53	0.51	0.50	0.49	0.48	0.47	0.46	0.45	0.44	0.43	0.42	0.41	0.40	0.39	0.38	0.37	0.37	0.36	0.35	0.34	0.33	0.33	0.32	0.31	0.30	0.30	0.29	0.28	0.28	0.27	0.27	0.26	0.25	0.25	0.24	0.24

Reference	Discounted Benefits	Total	Yr 0 2019/20	Yr 1 2020/21	Yr 2 2021/22	Yr 3 2022/23	Yr 4 2023/24	Yr 5 2024/25	Yr 6 2025/26	Yr 7 2026/27	Yr 8 2027/28	Yr 9 2028/29	Yr 10 2029/30	Yr 11 2030/31	Yr 12 2031/32	Yr 13 2032/33	Yr 14 2033/34	Yr 15 2034/35	Yr 16 2035/36	Yr 17 2036/37	Yr 18 2037/38	Yr 19 2038/39	Yr 20 2039/40	Yr 21 2040/41	Yr 22 2041/42	Yr 23 2042/43	Yr 24 2043/44	Yr 25 2044/45	Yr 26 2045/46	Yr 27 2046/47	Yr 28 2047/48	Yr 29 2048/49	Yr 30 2049/50	Yr 31 2050/51	Yr 32 2051/52	Yr 33 2052/53	Yr 34 2053/54	Yr 35 2054/55	Yr 36 2055/56	Yr 37 2056/57	Yr 38 2057/58	Yr 39 2058/59	Yr 40 2059/60	Yr 41 2060/61	Yr 42 2061/62	Yr 43 2062/63	Yr 44 2063/64	Yr 45 2064/65	Yr 46 2065/66	Yr 47 2066/67	Yr 48 2067/68	Yr 49 2068/69	Yr 50 2069/70	Yr 51 2070/71	Yr 52 2071/72	Yr 53 2072/73	Yr 54 2073/74	Yr 55 2074/75	Yr 56 2075/76	Yr 57 2076/77	Yr 58 2077/78	Yr 59 2078/79	Yr 60 2079/80	Yr 61 2080/81	Yr 62 2081/82	Yr 63 2082/83	Yr 64 2083/84
	Discounted benefits (incremental)																																																																		
CRB1	£9,477	Real terms	£0.0	£0.0	£10,152.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
		Discounted	£0.0	£0.0	£9,476.9	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
CRB2	£0	Real terms	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
		Discounted	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
CRB3	£0	Real terms	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
		Discounted	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
CRB4	£0	Real terms	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
		Discounted	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
CRB5	£0	Real terms	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
		Discounted	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
TOTAL: CRBS (REAL)		**£10,152**	£0.0	£0.0	£10,152.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
TOTAL: DISCOUNTED CRBS		**£9,477**	£0.0	£0.0	£9,476.9	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
TOTAL: REAL, RECURRENT REVENUE SAVINGS		**£0**	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
NCRB1	£0	Real terms	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
		Discounted	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
NCRB2	£0	Real terms	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
		Discounted	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
NCRB3	£0	Real terms	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
		Discounted	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
NCRB4	£0	Real terms	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
		Discounted	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
NCRB5	£0	Real terms	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
		Discounted	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE
TOTAL: NON-CASH RELEASING BENEFITS (REAL)		**£0**	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0	£0.0
TOTAL INCREMENTAL BENEFITS		**£9,477**	**£0.0**	**£0.0**	**£9,476.9**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**	**£0.0**

UNMONETISABLE BENEFITS

Number	Benefit Name	Benefit Description	Calculations/assumptions made
Example	Improved staff morale	Staff morale in the A&E department is likely to increase due to improved working conditions and more manageable workloads.	Estimate that staff survey scores for job satisfaction and motivation will revert to Trust-wide average of 80% and 70% respectively.
1	Fit for Purpose buildings	Improved patient experience, reduction in complaints	
2	Repatriation of Out of Area Patients	Improved patient experience, delivers national MH review of Secure Services	
3	Improved Secure Services Pathway	Improved patient experience, delivers national agenda	
4	Delivers efficiency savings	Savings achieved from co-location of services and economies of scale	
5			
6			
7			
8			
9			
10			

UNMONETISABLE RISK ANALYSIS

Number	Risk description	Mitigation of risk	Risk likelihood after mitigation	Risk impact after mitigation
Example	Incorrect cost and time estimates for decanting from existing buildings	Detailed decant plans drawn up in consultation with clinicians and contractors. Estimates of decant cost and time are based on similar, recent decants within the Trust and the wider NHS.	Medium	Medium
1	Reduction in patient demand	Demand has been assessed based on available data and MH Review of Secure Services.	Medium	Low
2	Planning permission not granted	Secure Services already provided on Northgate site. Local Authority will be keen to retain existing and increase employment in Morpeth.	Low	Low
3	Staff Recruitment & Retention	Trust has experience of large scale developments and of recruiting and redeploying staff. Engagement plans are already in place and will be further developed.	Medium	Low
4			[Please select]	[Please select]
5			[Please select]	[Please select]
6			[Please select]	[Please select]
7			[Please select]	[Please select]
8			[Please select]	[Please select]
9			[Please select]	[Please select]
10			[Please select]	[Please select]

INFLATION ASSUMPTIONS

GDP Deflator

Year	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
%	-	1.57%	1.66%	1.74%	1.84%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%

Year	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	2044/45	2045/46
%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%

Year	2046/47	2047/48	2048/49	2049/50	2050/51	2051/52	2052/53	2053/54	2054/55	2055/56	2056/57	2057/58	2058/59	2059/60
%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%

Year	2060/61	2061/62	2062/63	2063/64	2064/65	2065/66	2066/67	2067/68	2068/69	2069/70	2070/71	2071/72	2072/73	2073/74
%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%

Year	2074/75	2075/76	2076/77	2077/78	2078/79	2079/80	2080/81	2081/82	2082/83	2083/84	2084/85	2085/86	2086/87	2087/88
%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%

Year	% change on previous year	
2019/20	1.57%	
2020/21	1.66%	https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2018-quarterly-national-accounts
2021/22	1.74%	
2022/23	1.84%	
2023/24+	2.30%	http://cdn.obr.uk/FSR_Jan17.pdf

Project year	0	1	2	3	4	5	6	7	8	9	10	11	12
Category	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	2031/32
GDP deflator	-	1.66%	1.74%	1.84%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%
Cumulative	100.00%	101.66%	103.43%	105.33%	107.75%	110.23%	112.77%	115.36%	118.01%	120.73%	123.50%	126.34%	129.25%
Inflation rates	1	0.98	0.97	0.95	0.93	0.91	0.89	0.87	0.85	0.83	0.81	0.79	0.77
		1.00											

Project year	13	14	15	16	17	18	19	20	21	22	23	24	25
Category	2032/33	2033/34	2034/35	2035/36	2036/37	2037/38	2038/39	2039/40	2040/41	2041/42	2042/43	2043/44	2044/45
GDP deflator	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%
Cumulative	132.22%	135.26%	138.37%	141.56%	144.81%	148.14%	151.55%	155.04%	158.60%	162.25%	165.98%	169.80%	173.71%
Inflation rates	0.76	0.74	0.72	0.71	0.69	0.68	0.66	0.65	0.63	0.62	0.60	0.59	0.58

Project year	26	27	28	29	30	31	32	33	34	35	36	37	38
Category	2045/46	2046/47	2047/48	2048/49	2049/50	2050/51	2051/52	2052/53	2053/54	2054/55	2055/56	2056/57	2057/58
GDP deflator	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%
Cumulative	177.70%	181.79%	185.97%	190.25%	194.62%	199.10%	203.68%	208.36%	213.15%	218.06%	223.07%	228.20%	233.45%
Inflation rates	0.56	0.55	0.54	0.53	0.51	0.50	0.49	0.48	0.47	0.46	0.45	0.44	0.43

Project year	39	40	41	42	43	44	45	46	47	48	49	50	51
Category	2058/59	2059/60	2060/61	2061/62	2062/63	2063/64	2064/65	2065/66	2066/67	2067/68	2068/69	2069/70	2070/71
GDP deflator	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%
Cumulative	238.82%	244.31%	249.93%	255.68%	261.56%	267.58%	273.73%	280.03%	286.47%	293.06%	299.80%	306.69%	313.75%
Inflation rates	0.42	0.41	0.40	0.39	0.38	0.37	0.37	0.36	0.35	0.34	0.33	0.33	0.32

Project year	52	53	54	55	56	57	58	59	60	61	62	63	64
Category	2071/72	2072/73	2073/74	2074/75	2075/76	2076/77	2077/78	2078/79	2079/80	2080/81	2081/82	2082/83	2083/84
GDP deflator	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%	2.30%
Cumulative	320.96%	328.34%	335.90%	343.62%	351.53%	359.61%	367.88%	376.34%	385.00%	393.85%	402.91%	412.18%	421.66%
Inflation rates	0.31	0.30	0.30	0.29	0.28	0.28	0.27	0.27	0.26	0.25	0.25	0.24	0.24

STP Allocations Tranche 4: Part 2 - Financial tables

Instructions:

1. Fill out all **UN-FILLED (white)** cells on each sheet.

2. Values must be input as £000s. All financial information must be input as positive, nominal values (ie. including inflation)

3. Please check any pre-populated figures or formulae are correct and overwrite accordingly if not

4. The steady state column should be completed showing the requested costs/benefits forecast once any transitional, one-off or non-recurrent costs have subsided.

5. With the exception of the box on the 'backlog' tab, no narrative needs to be entered on the following tabs. All that is needed is the completion of the tables. The relevant questions that require a narrative response within the word template have been included above the financial tables for context but these should be addressed within the word template.

Contents:

Summary - Key Scheme Information

In the table below, set out below the full value of the current capital plans for the whole STP and their sources of funding. This is separa three parts: the capital requirement of the scheme in this application; the total capital requirement for other bids to this fund, from this contained in separate applications; and the STP capital requirement for schemes not seeking support from this fund (and the associated funding).

£,000	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25 onwards
Capital requirement for this scheme (i.e. the bid from the fund for the scheme detailed within this template).						
Sources of funding:						
· Internal cash/ depreciation						
· Land/property disposals			£10,415			
· DHSC borrowing						
· DHSC PDC	£8,850	£26,985	£16,371	£1,994		
· Private finance (e.g. LIFT)						
· Other						
Total capital requirement for this scheme	£8,850	£26,985	£26,786	£1,994	£0	£0
Total bid requirement for this scheme (DH borrowing and PDC)	£8,850	£26,985	£16,371	£1,994	£0	£0
Capital requirement for other schemes seeking support from this fund (i.e. to support other schemes detailed in other templates)						
Sources of funding:						
· Internal cash/ depreciation						
· Land/property disposals						
· DHSC borrowing						
· DHSC PDC						
· Private finance (e.g. LIFT)						
· Other						
Total capital requirement schemes in other templates	£0	£0	£0	£0	£0	£0
Total bid requirement for schemes in other templates (DH borrowing and PDC)	£0	£0	£0	£0	£0	£0
Any other STP capital schemes not seeking support from this fund						
Sources of funding:						
· Internal cash/ depreciation						
· Land/property disposals						
· DHSC borrowing						
· DHSC PDC						
· Private finance (e.g. LIFT)						
· Other						
Total of "sources of funding" for schemes not seeking support from this fund (sum of lines above)	£0	£0	£0	£0	£0	£0

Notes:
1) A separate template is required for each scheme applying for STP capital.
2) The funding sources of the capital for this scheme are analysed in a later section of this template.
3) This template should be completed as if a SOC. If this is sufficiently robust, it will enable the scheme to move straight to OBC stage

4) STPs may bid for capital for property held by providers, NHS Property Services, Community Health Partnerships or primary care. However, if this is the case, any complexities or assumptions around this must be clearly stated and signup from all those involved must be confirmed.

Costs

1. Set out the scheme's total capital costs and the intended funding sources.

2. Set out the main capital cost components and assumptions – eg the extent of contingencies included. This must reconcile include a clear explanation of the assumptions regarding VAT.

3. Set out the non-recurrent revenue costs, including project development. Confirm on how these costs will be funded

4. Set out the current income, expenditure and activity to which the scheme relates and how this is expected to change over t nothing scenario and (b) if the scheme is approved. This will clearly demonstrate the savings expected from the scheme com scenario (c). Rows should be added to include additional activity types that will be impacted

5. Set out the savings generated by the scheme.

6. Provide a narrative on projected gross revenue savings to support the figures in the revenue table in 5 (build-up of recurrer estimated capital and revenue lifecycle costs). In the narrative please include comments on whether lifecycle costs refer in pa maintenance cost savings. This narrative needs to be clear as to which organisation revenue savings will accrue to (ie provi where reductions in activity are planned, how providers will reduce their costs to ensure a net saving to the system as a whol

7. Set out an estimation, and the basis for that estimation, of the amount your backlog maintenance will reduce by as a resul

8. Provide a narrative on any non-cash releasing savings for the lead organisation and any wider cash and non-cash savings timescales.

9. Set out the contribution of this scheme to the STP financial position over the next 5 years and any implications for achievir

1. Costs and funding sources

£,000	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25 onwards
Capital requirement for this scheme (i.e. the bid from the fund for the scheme detailed within this template).						
Sources of funding:						
· Internal cash/ depreciation	£0	£0	£0	£0	£0	£0
· Land/property disposals	£0	£0	£10,415	£0	£0	£0
· DHSC borrowing	£0	£0	£0	£0	£0	£0
· DHSC PDC	£8,850	£26,985	£16,371	£1,994	£0	£0
· Private finance (e.g. LIFT)	£0	£0	£0	£0	£0	£0
· Other	£0	£0	£0	£0	£0	£0
Total capital requirement for this scheme	£8,850	£26,985	£26,786	£1,994	£0	£0
Total bid requirement for this scheme (DH borrowing and PDC)	£8,850	£26,985	£16,371	£1,994	£0	£0

3. Non recurrent revenue costs

£,000	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25 onwards
Total Revenue Costs						
Breakdown						
· Staff Costs						
· Non Staff Costs (please detail if appropriate)						

4. Current income, activity and expenditure of service areas to which the scheme relates

(a) Do nothing scenario

£,000	2019/20	2020/21	2021/22	2022/23	2023/24	2024+
Income from commissioners	£33,400	£33,955	£34,545	£35,180	£35,989	£4,663,337
Expenditure						
· Of which pay	£28,700	£29,177	£29,684	£30,229	£30,925	£4,007,119
· Of which non pay	£6,300	£6,405	£6,516	£6,636	£6,788	£879,611
· Of which lifecycle maintenance	£0	£0	£0	£0	£0	£0
· Of which capital charges (PDC and depreciation)	£900	£915	£931	£948	£970	£125,659
TOTAL	-£2,500	-£2,542	-£2,586	-£2,633	-£2,694	-£349,052
EL Activity						
NEL Activity						
OP Activity						
A&E Activity						
Other activity (please specify and add more rows if required)						

(b) If scheme approved

£,000	2019/20	2020/21	2021/22	2022/23	2023/24	2024+
Income from commissioners	£33,400	£33,955	£34,545	£35,601	£36,528	£4,733,147
Expenditure						
· Of which pay	£28,700	£29,177	£29,684	£28,228	£28,231	£3,658,067
· Of which non pay	£6,300	£6,405	£6,516	£6,109	£6,034	£781,877
· Of which lifecycle maintenance	£0	£0	£0	£0	£0	£0
· Of which capital charges (PDC and depreciation)	£1,050	£1,322	£1,448	£1,264	£1,293	£167,545
TOTAL	-£2,650	-£2,948	-£3,103	£0	£970	£125,658
EL Activity						
NEL Activity						
OP Activity						
A&E Activity						
Other activity (please specify and add more rows if required)						

(c) Difference between (a) and (b)

£,000	2019/20	2020/21	2021/22	2022/23	2023/24	2024+
Financial difference between (a) and (b) (ie net savings from the scheme)	-£150	-£407	-£517	£2,633	£3,664	£474,710
Activity difference between (a) and (b) (ie net demand management from scheme):						
EL Activity	0	0	0	0	0	0
NEL Activity	0	0	0	0	0	0
OP Activity	0	0	0	0	0	0
A&E Activity	0	0	0	0	0	0
Other activity (please specify and add more rows if required)	0	0	0	0	0	0

5. Detail of savings generated by the scheme

£,000	2019/20	2020/21	2021/22	2022/23	2023/24	2024+
Gross Revenue Savings						
· Of which Pay				£2,423	£3,233	£418,863
· Of which Non pay				£527	£754	£42,000
· Of which Other *please add rows and give more detailed split if appropriate*						
Additional Revenue costs (*please specify*) : Capital Charges	£150	£407	£517	£316	£323	£41,886
Additional Revenue lifecycle costs	£0	£0	£0	£0	£0	£0
Additional Capital lifecycle costs	£0	£0	£0	£0	£0	£0
Net Revenue savings	-£150	-£407	-£517	£2,633	£3,664	£418,977

Financial position and sustainability

1. Confirm the figures are consistent with the LTFM or equivalent strategic planning model? (Note the LTFM will need to be provided as pa
the scheme is taken forward for evaluation.)

2. Are there any implications for your cost improvement plan (CIP)? Please provide details on the level of CIP delivery planned for each ye
and percentage of income, and the amount to be delivered as a result of this investment. This should clearly reconcile to the previous stat

3. Set out the incremental impact on the Statement of Comprehensive Net Income (SoCI) in the tables provided in the appendix along with

4. Set out current and any changes the scheme is likely to have on individual organisations' Single Oversight Framework financial perform

5. Set out the levels of existing debt in the appendix.

6. Set out the process that the STP has gone through to identify what capital contribution can be made from its own internal capital and fro

7. Please outline which disposals are directly linked to the scheme.

8. Set out the process that the STP has gone through to identify what capital contribution can be made from other land disposals and wher
give details.

9. If you have an existing PFI, PF2 or LIFT scheme has the potential for this new scheme to be included been assessed?

10. Set out options you have explored in terms of is potential for funding from PF2, LIFT or its successor sources?

2.

£,000	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25 onwards
Base case CIP Value	£5,500	£5,500	£5,500	£5,500	£5,500	£330,000
CIP as a result of STP investment	£0	£0	£0	£2,633	£1,031	£0
Total CIP Value	£5,500	£5,500	£5,500	£8,133	£6,531	£330,000
CIP as a percentage of income	1.8%	1.8%	1.8%	2.6%	2.1%	1.8%

Backlog maintenance

£,000	2016/17	Change to Y0	Yr 0 2019/20	Yr 1 2020/21	Yr 2 2021/22	Yr 3 2022/23	Yr 4 2023/24	Yr 5 2024/25	Yr 6 2025/26	Yr 7 2026/27	Yr 8 2027/28	Yr 9 2028/29	Yr 10 2029/30	Yr 11 2030/31	Yr 12 2031/32
Backlog	*2284*	*2196*	4480	4480	4480	4480									
Impact of this scheme						2788									
Impact due to other schemes															
Net annual reduction			£0	£0	£0	£2,788	£0	£0	£0	£0	£0	£0	£0	£0	£0

£,000	Yr 13 2032/33	Yr 14 2033/34	Yr 15 2034/35	Yr 16 2035/36	Yr 17 2036/37	Yr 18 2037/38	Yr 19 2038/39	Yr 20 2039/40	Yr 21 2040/41	Yr 22 2041/42	Yr 23 2042/43	Yr 24 2043/44	Yr 25 2044/45	Yr 26 2045/46	Yr 27 2046/47	Yr 28 2047/48	Yr 29 2048/49
Backlog																	
Impact of this scheme																	
Impact due to other schemes																	
Net annual reduction	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0

£,000	Yr 30 2049/50	Yr 31 2050/51	Yr 32 2051/52	Yr 33 2052/53	Yr 34 2053/54	Yr 35 2054/55	Yr 36 2055/56	Yr 37 2056/57	Yr 38 2057/58	Yr 39 2058/59	Yr 40 2059/60	Yr 41 2060/61	Yr 42 2061/62	Yr 43 2062/63	Yr 44 2063/64	Yr 45 2064/65	Yr 46 2065/66
Backlog																	
Impact of this scheme																	
Impact due to other schemes																	
Net annual reduction	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0

£,000	Yr 47 2066/67	Yr 48 2067/68	Yr 49 2068/69	Yr 50 2069/70	Yr 51 2070/71	Yr 52 2071/72	Yr 53 2072/73	Yr 54 2073/74	Yr 55 2074/75	Yr 56 2075/76	Yr 57 2076/77	Yr 58 2077/78	Yr 59 2078/79	Yr 60 2079/80	Yr 61 2080/81	Yr 62 2081/82	Yr 63 2082/83	Yr 64 2083/84
Backlog																		
Impact of this scheme																		
Impact due to other schemes																		
Net annual reduction	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0

Briefly explain the change in backlog between 2016/17 and Y0

There are a number of buildings predominantly on the Northgate site which will require significant investment to remove backlog maintenance. This is particularly around engineering services, roofs and general fabric as these buildings are now circa 50 years old and have substantially original services. The backlog has increased since 16/17 due to the continuing deterioration in the estate and the increasing cost of these works.

Appendix

Impact of scheme on the SOCI of lead organisation

Activity	Year 2019/20 £'000	Year 2020/21 £'000	Year 2021/22 £'000	Year 2022/23 £'000	Year 2023/24 £'000	Year 2024/25 £'000	Year 2025/26 £'000	Year 2026/27 £'000	Year 2027/28 £'000	Year 2028/29 £'000	Year 2029/30 £'000	Total £'000
Revenue costs												£0
Pay Costs	0	0	0	-2422	-811	0	0	0	0	0	0	-£3,233
Non-Pay Costs	0	0	0	-527	-227	0	0	0	0	0	0	-£754
Depreciation	0	0	0	0	0	0	0	0	0	0	0	£0
PDC dividends	150	257	110	-201	7	0	0	0	0	0	0	£323
Cash-releasing benefits	0	0	0	0	0	0	0	0	0	0	0	£0
Incremental impact on I&E surplus/ (deficit)	**150**	**257**	**110**	**-3150**	**-1031**	**0**	**0**	**0**	**0**	**0**	**0**	-£3,664

NHS Trust / Foundation Trust Statement of Comprehensive Net Income
(whole trust position including the investment over the appraisal period)

Statement of Comprehensive Net Income	Year 2019/20 £'000	Year 2020/21 £'000	Year 2021/22 £'000	Year 2022/23 £'000	Year 2023/24 £'000	Year 2024/25 £'000	Year 2025/26 £'000	Year 2026/27 £'000	Year 2027/28 £'000	Year 2028/29 £'000	Total £'000
Gross employee benefits	248700	248700	248700	248700	246200	246200	246200	246200	246200	246200	£2,472,000
Other operating costs	54100	54100	54100	54100	53400	53400	53400	53400	53400	53400	£536,800
Revenue from patient care activities	289100	289100	289100	289100	289600	289600	289600	289600	289600	289600	£2,894,000
Other operating revenue	23600	23600	23600	23600	23600	23600	23600	23600	23600	23600	£236,000
Operating surplus/(deficit)	**9900**	**9900**	**9900**	**9900**	**13600**	**13600**	**13600**	**13600**	**13600**	**13600**	**£121,200**
Investment revenue	0	0	0	0	0						£0
Other gains and losses	0	0	0	0	0						£0
Finance costs	5500	5500	5500	5500	5500	5500	5500	5500	5500	5500	£55,000
Surplus/(deficit) for the financial year	**4400**	**4400**	**4400**	**4400**	**8100**	**8100**	**8100**	**8100**	**8100**	**8100**	**£66,200**
Dividends payable on public dividend capital (PDC)	1050	1300	1400	1200	1200	1200	1200	1200	1200	1200	£12,150
Net gains/(loss) on transfers by absorption	**0**	**0**	**0**	**0**							£0
Retained surplus/(deficit)	**3350**	**3100**	**3000**	**3200**	**6900**	**6900**	**6900**	**6900**	**6900**	**6900**	£54,050
Adjustments (including PPA, IFRIC 12 adjustment)	0	0	0	0	0	0	0	0	0	0	£0
Adjusted financial performance retained surplus/(deficit)	**3350**	**3100**	**3000**	**3200**	**6900**	**6900**	**6900**	**6900**	**6900**	**6900**	£54,050

Northumberland, Tyne and Wear NHS Foundation Trust

Board of Directors Meeting

Meeting Date: 27th June 2018

Title and Author of Paper: Interim Accommodation for Newcastle and Gateshead Adult In-Patient Services
Keith Armstrong on behalf of Central Locality In-Patient CBU.

Executive Lead: Gary O'Hare

Paper for Debate, Decision or Information: Decision

Key Points to Note:

- The key aspect to this paper is to outline the proposals for the interim accommodation arrangements for Newcastle and Gateshead Adult in-patient services.
- The proposal being to consolidate 3 Adult wards on Hadrian Clinic and also utilise the Bede Ward on St Nicholas site for the 4th ward.
- This would be reliant on Low Secure Services currently in Bede Ward moving to Northgate Hospital and also the move of in-patient services out of the Tranwell Unit in Gateshead.
- Approval requested to refurbish Hadrian clinic with works to commence in July 2018.
- Timescales for completion of all work and ward transfers anticipated to be March 2019.

Risks Highlighted to Board :
Workforce Risk around staff consultations required for re-location of staff base.
Financial Risk around availability of capital funding to support the required work.

Does this affect any Board Assurance Framework/Corporate Risks?
Please state **Yes** or **No : No**

Equal Opportunities, Legal and Other Implications:
N/A

Outcome Required:
Approval of Business Case to commence immediate refurbishment work on Hadrian Clinic and then the re-location of services and staff to new base as articulated in paper.

Link to Policies and Strategies:
CEDAR Board Strategic Plan
STP / ICS Capital Programme Strategy
Deciding Together / Delivering Together

Northumberland, Tyne and Wear NHS Foundation Trust

Interim Accommodation for Newcastle and Gateshead Adult In-Patient Services

Summary Business Case

1. Introduction and Service Background

The purpose of this paper is to outline the current situation for Newcastle and Gateshead Adult Acute Assessment in-patient services and to present a proposed solution for interim accommodation arrangements. These plans support the long term proposal articulated in the STP / ICS Capital bid submitted by the Cedar Programme Board, which indicated services would co-locate on the St Nicholas site, primarily within the Bamburgh Clinic.

Newcastle and Gateshead locality currently provides Adult Acute Assessment and Treatment in-patient services across 2 sites in Newcastle and Gateshead.

The Newcastle in-patient services are currently located at the Hadrian Clinic which is on the Newcastle General Hospital (NGH) site which is owned by Newcastle Hospitals Foundation Trust and is situated in the West End of Newcastle.

The Gateshead Adult Services are currently located at the Tranwell Unit, which is on the Queen Elizabeth Hospital site which is owned by Gateshead Health Foundation Trust and is situated in Gateshead.

Current bed numbers are commissioned at:

Newcastle Beds (32 beds)

- 16 Collingwood (Male)
- 16 Lowry (Female)
- 0 Gainsborough (Male) (*currently not in use)*

Gateshead Beds (38 beds)

- 20 Fellside (Male)
- 18 Lamesley (Female)

Gainsborough ward is not presently in use, therefore the current number of available beds across the Newcastle and Gateshead footprint is 70. The 4 wards continually function at 100% occupancy however the longer term bed model as per the Deciding Together outcome, would be to work towards 3 x 18 wards (54 beds) across the Adult pathway.

These bed number reductions will not be implemented until the Trust can demonstrate capacity in the system linked to development of community service provision to safely manage this bed/ward reduction.

This proposed interim scheme reduces bed numbers from 70 down to 62 (3 x 16 beds at Hadrian and 14 beds at Bede) by March 2019. Therefore the CBU will need to manage admissions and throughput on the wards with enhanced support from Community Services. In addition support will be required from Bed Management team to maximise bed capacity across the Trust on a short term basis to avoid any Out of Area admissions.

2. Strategic context

There are long term plans being submitted as part of the ICS Capital bid around the development of a single site at Northgate Hospital, which would house all Secure Services across the Trust.

As a result this would free up the Bamburgh Clinic on the St Nicholas Hospital site, which would provide the opportunity for Newcastle and Gateshead Adult beds to be delivered from this facility in Newcastle which fits with the expectations of Deciding Together.

The timescales for this long term plan are likely to be 3-5 years before the Bamburgh Clinic will be ready to move into, therefore the Central In-Patient CBU have considered interim arrangements for these services.

Over recent years the environment in which these services have been delivered from has deteriorated, and it is becoming increasingly difficult to continue to provide desirable in-patient services from these premises without investment into the environment

In addition, it is recommended by the RCPsych that wards should not have 20 beds, as this can sometimes have an adverse impact on the care experience patients may receive whilst admitted, potentially due to an increase in incidents on the ward, greater proportion of patients on high levels of observations leading to increased staff presence on the ward. High bed numbers can also impact on staff wellbeing increasing the risk of burnout and subsequent recruitment and retention issues.

3. Interim Options Considered

Option 1 – Use Bede Ward and 3 wards on NGH site

The main objective to this proposal is to co-locate both Newcastle & Gateshead Adult In-patient services as much as possible in order to make progress towards the longer term option of all Adult Services being in Newcastle.

This proposal will result in 3 wards on Hadrian Clinic and also utilisation of Bede Ward at St Nicholas Hospital.

In order to support this option the Low Secure Services on Bede Ward would need to re-locate to Northgate site of which options and timescales will be considered and presented in a separate Business Case.

This will facilitate the re-location of Collingwood Court patients from Hadrian Clinic over to Bede, and then finally the 2 wards on Tranwell site at the Queen Elizabeth Hospital will be co-located into the 2 vacant wards at Hadrian Clinic alongside Lowry ward. Consolidating 3 wards onto the Hadrian Clinic site, with an additional ward on the St Nicholas site would bring benefits in terms of cross cover and more effective utilisation of staff, particularly clinical support staff

This option would also deliver financial savings from the rental costs paid to Gateshead Health Trust for the use of Tranwell site, although the timescales and value of such will vary depending upon other services vacating the site too.

Additional work is currently being undertaken to identify where the other services on Tranwell will re-locate to. Some options are being considered, however they will form part of a Community Services Accommodation Business Case. The environment is adversely affecting patient and carer experience.

Option 2 – Continue to use both NGH & Tranwell sites

The current standard of accommodation across both of these sites, is making it difficult to sustain delivering in-patient services, in a safe environment. It would therefore require significant financial capital investment to bring the wards up to an acceptable standard to retain these services within their current sites. There are also difficulties in managing staffing demands across the two sites.

Doing this across 2 non NTW sites would be more expensive than option 1. This option also defers the process of co-locating services in Newcastle.

It is therefore deemed that this is an unsuitable option to pursue further.

4. Proposed Option

The preferred option is Option 1 and the key aspects / impacts of this proposal are articulated below.

4.1. Key Enablers

There are numerous enablers to fulfilling this option, as outlined below:

Refurbishment of Hadrian Clinic
Due to the standard of the current environment on Hadrian Clinic, a full refurbishment of all 3 floors is required, which will ensure that services can be safely delivered within the next 3-5 years until the long term accommodation is complete.

The first phase of this would be to carry out all refurb work on the vacant Gainsborough Ward, which would then start the process of moving a ward in to the refurbished ward so that work can commence on the next ward until such time all 3 wards have been refurbished.

This will result in Collingwood and Lowry patients moving around the Hadrian Clinic into the refurbished wards whilst work is being carried out around them.

This will also require the re-location of Talking Helps Newcastle Service from the Ground Floor of Hadrian and options are being considered around this on St Nicholas site, with Collingwood Court building being the anticipated option. There will likely be some estates costs attached to this requirement, but this is being scoped out to be kept to a minimum.

Refurbishment of Bede Ward
There are some outstanding backlog maintenance issues on Bede Ward, which have been highlighted during this scoping exercise of potential accommodation options. It is proposed that this work is undertaken around the current services which will ensure the work is complete for acute in-patient services to move into. At this stage, we cannot guarantee that the use of Bede ward will be short term and therefore it is essential that the ward is maintained at an acceptable standard.

Re-location of Low Secure Services from Bede
The Low Secure Services will need to relocate from Bede Ward to the Northgate site, however this can only be carried out once the patient numbers on the Northgate wards reduce sufficiently to accommodate the patients from Bede. This is currently being managed through the Transforming Care Programme.

Appropriate options are currently being discussed and considered and these will be covered in a separate Business case for the re-location of Low Secure Services from Bede. This will be brought to the Board in the Autumn.

This will also require staff consultation, for those staff transferring from Bede at St Nicholas Hospital to Northgate site. Staff engagement on this option has already begun.

Transfer Collingwood to Bede
Once Secure Services have vacated the Bede Ward and transferred to the Northgate site, then patients on Collingwood will be re-located from Hadrian Clinic, over to St Nicholas Hospital.

This will also require staff consultation for those affected staff transferring from Hadrian Clinic to St Nicholas Hospital. Again staff engagement on this potential option has already begun.

Transfer 2 x Gateshead Wards from Tranwell Unit to Hadrian Clinic
The final stage of this process would see the transfer of the 2 Gateshead wards from Tranwell Unit at the Queen Elizabeth Hospital over to the 2 vacant wards on Hadrian Clinic.

This will also require staff consultation for those affected staff transferring from Tranwell Unit to Hadrian Clinic. Staff engagement has begun.

Vacating Tranwell Unit
As well as the 2 in-patient wards vacating the Tranwell site, in order to deliver the full financial savings from the rental costs of the Tranwell Unit, further work is also required in terms of identifying accommodation for other remaining services such as Community Services and ECT provision, both of which will have separate business cases to cover options and timescales. These will be brought to the Board in September.

4.2. Timescales

Should the proposed option be supported, the anticipated timescales are shown below:

July 2018 – Mar 2019 – Refurbishment of Hadrian

Sept 2018 – Business Cases on future location of community and ECT services

By Nov 2018 – Business Case regarding transfer of Bede to Northgate

Jan – Mar 2019 – Work undertaken on Bede

April 2019 – Transfer Bede to Northgate

April 2019 – Transfer Collingwood to Bede

April 2019 – Transfer Tranwell to Hadrian

4.3. Benefits

The benefits for the preferred option are articulated below.

Stakeholder benefits
This option would ensure that Adult In-patient Services would continue to be delivered within the Newcastle & Gateshead locality, which was one of the main requirement outcomes of the public consultation and expectations of external stakeholders. Stakeholders have been engaged concerning the options and the proposal has the support of Newcastle Gateshead CCG, Gateshead local authority and Overview and Scrutiny Committee. Further positive engagement having been undertaken with Newcastle Local Authority, Health watch for Newcastle and Gateshead, the Newcastle Gateshead Mental Health Programme Board, Voluntary Services for Newcastle and Gateshead (VOLSAG) and staff.

Service benefits
The co-location of Adult Beds on to Hadrian Clinic, would mean that wards could provide greater cross cover to respond to emergency situations, and would also see some economies of scale around Nursing and wider Multi-disciplinary teams.

There is an opportunity to review the medical cover within the Hadrian Clinic and potentially undertake a skill mix review of posts, including non-medical RC roles, use of clinical pharmacists & nurse consultants.

The opportunity to look at combined staffing resources across MDT would be available from a co-located service which could increase productivity.

Reduction in number of sites for out of hours medical cover to support illness and incidents. This will have a positive impact on responsiveness of junior doctor expertise to help manage these circumstances.

The improved environment would have a positive impact on service user, carer and staff wellbeing and potentially reduce incidents and promote recovery.

Co-location would mean a greater number of services remain based on the site, reducing the risks associated with isolation given the fact that the rest of the site is empty and unused.

Financial benefits
The main financial benefit attached to this proposal is that it facilitates the vacation of NTW services from the Tranwell site and reduces the number of bases the services operate from. This will result in a reduction of costs in relation to contracted services and rental costs for the Tranwell site.

Other NTW benefits

Reducing the number of operational sites and consolidating services in one area will give the potential for more effective resource management with regards to staffing, stock and non-staff budgets.

Potential Future benefits
Both the interim and long term plan is in keeping with the recent Deciding Together/Delivering Together consultation and workshops.

4.4. Quality Impacts

Safety

- Benefit to all wards regarding access to their own outside space.
- Scope of works includes improvement of environment to the current trust standards for refurbishment.
- On site with older people's services during the short term period provides an enhanced site based response and support network.
- This will put all adult services in Newcastle and is a positive step towards a future 1 site model.
- There will be an additional seclusion room available on Hadrian Clinic.

Clinical Effectiveness

- Systems and processes will be updated and reviewed, facilitated by NTW Innovations team.
- Access to outside space without current restrictive practices.
- Academic links to university remain on the NGH site. This will continue to provide a positive role in recruitment and retention of medical staffing.
- Links to community services and local services remain by continuing to provide service within the city.
- More access to members of MDT to enhance the service available to patients and providing cross cover opportunities.
- There will be parity of access to exercise therapy services within the unit.
- Scope of works includes improvement of environment to the current trust standards.

Patient Experience

- Potential for disturbance of current service users during the relocation/ refurbishment.
- Access to outside space without current restrictive practices.
- Minimised disruption for travel, visiting and pathway being in same locality.
- Benefit to patients of improved bathroom facilities available after refurbishment.
- There will be parity of access to exercise therapy services within the unit.
- Improved communal outside space.

General

- IS fully in line with the outcome of the Deciding Together consultation completed in June 2016.
- There will need to be some consideration around ECT provision, as it would be not be viable to continue to operate from the Tranwell Unit if the rest of NTW services were retracted.
- Therefore the Gateshead ECT service will need to be either absorbed into Newcastle and / or would need to consider opening the Hopewood Park suite and utilising the purpose built suite. Similarly, this work will form a subsequent business case.

4.5. Risks and Mitigations

Patient & Carer Risk

There would be minimal disruption and risk to patient and carers during this transition, however there will be some minor disturbance whilst the refurbishment work takes place and patients are transferred from one ward to another. Refurbishment will be managed accordingly by both the Service and Estates team carrying out the work to ensure the least possible impact on patients. There will also be various engagement sessions with patient and carers throughout the process.

Workforce Risk

The main workforce risk is around the re-location of staff and the requirement for staff consultation on change of base. Staff will continue to be appropriately engaged and consulted with and will be provided with progress and developments throughout the process, via various forms of communication. It should be noted that initial informal feedback from staff has been positive.

Reputational Risk

This option transfers in-patient beds from Gateshead to Newcastle, whilst this crosses the locality boundary the adult beds are still within the Central Locality and Delivering Together footprint. Therefore this should still support the expectations of key external stakeholders and also support the consensus of the general public consultation, therefore there is minimal reputational risk attached to this option. In order to avoid any adverse reaction, there will need to be various communication & engagement events to keep all relevant stakeholders informed of proposals, intentions and progress throughout this process.

Capital / Estates Risk

The Trust currently has limited funding for capital projects due to the national constraints on capital funding and loan availability. The capital programme includes an allocation of £1.5m this year in relation to Secure Services and

Newcastle/Gateshead in-patients. This scheme is seen as a priority development from this allocation but it should be recognised that if this scheme is approved this reduces the funding available for other capital schemes.

The Hadrian Clinic is owned by Newcastle Hospitals, therefore any proposals from NTW to continue to use the 3 wards on this site, will still require on-going support from them. Discussions with Newcastle Hospitals have been undertaken by the Estates team and support was granted for the work to commence.

4.6. Impact on Resources

Staffing
There would be no redundancy risk as staffing numbers across the wards would remain constant. However there would be a requirement for staff consultation, as a result of:

- Re-locating the base for staff currently working at Bede on St Nicholas Hospital to Northgate Hospital.
- Re-locating the base for staff working at Hadrian Clinic to St Nicholas Hospital.
- Re-locating the base for staff currently working at the Tranwell site to Hadrian Clinic.

Estates work and Capital Funding
Based on the detailed scope of works identified by NTW Solutions, the estimated Capital Requirement for the Hadrian Clinic and associated refurbishments are shown below:

- £1.3m Refurbishment of Hadrian Clinic
- £0.16m Refurbishment of Bede Ward
- £0.26m Potential spend re-locating Talking Helps Newcastle

Financial implications
The revenue implications of this re-location option will be cost neutral in terms of staffing costs, as the resource requirements for this re-location of wards will remain the same as at present, despite a slight bed reduction across the 4 wards. Although there should be some economies of scale from re-location and cover arrangements.

The net impact of exiting leasing arrangements for the Tranwell unit, set against charges for re-locating services will be £300k.

As no savings have been identified the only impact on patient care contracts will be a change in activity levels and the occupied bed day (OBD) price. Details of such can be found in Appendix A.

5. Recommendation

It is recommended that:

- The Trust Board supports the proposed option of utilising Hadrian Clinic and Bede Ward for Adult In-Patient Services for Newcastle and Gateshead as an interim arrangement.

- The Trust Board supports the need for refurbishment work to be carried out at Hadrian Clinic to support this interim arrangement being a viable option.

Financial impact on Commissioner Contracts

Existing SLAs 18/19 (70 beds)								
CCG	**Contract Type**	**POD**	**Occ rate**	**No of Beds**	**Plan Activity Annual**	**Plan Price Annual £**	**Tariff**	**% split of activity**
Collingwood Court (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	15.5	4,795	2,087,632	435	97%
NHS North Tyneside CCG	Block	OBD	85%	0.5	143	60,243	421	3%
NHS Northumberland CCG	Block	OBD	85%	0.1	26	11,320	435	1%
Total				**16.0**	**4,964**	**2,159,195**	**435**	**100%**
Lowry (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	12.4	3,862	1,598,136	414	78%
NHS North Tyneside CCG	Block	OBD	85%	1.7	522	204,056	391	10%
NHS Northumberland CCG	Block	OBD	85%	1.9	579	239,596	414	12%
Total				**16.0**	**4,963**	**2,041,788**	**411**	**100%**
Fellside (In Scope)								
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	18.9	5,865	1,912,612	326	95%
NHS South Tyneside CCG	Block	OBD	85%	0.5	142	41,412	292	2%
NHS Sunderland CCG	Block	OBD	85%	0.6	198	57,744	292	3%
Total				**20.0**	**6,205**	**2,011,768**	**324**	**100%**
Lamesley (In Scope)								
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	17.1	5,292	1,863,975	352	95%
NHS South Tyneside CCG	Block	OBD	85%	0.5	148	47,670	322	2%
NHS Sunderland CCG	Block	OBD	85%	0.5	166	53,468	322	3%
Total				**18.1**	**5,606**	**1,965,113**	**351**	**100%**

Proposed SLAs (62 beds)								
CCG	**Contract Type**	**POD**	**Occ rate**	**No of Beds**	**Plan Activity Annual**	**Plan Price Annual £**	**Tariff**	**% split of activity**
Collingwood Court (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	13.5	4,196	2,087,632	498	97%
NHS North Tyneside CCG	Block	OBD	85%	0.4	125	60,243	481	3%
NHS Northumberland CCG	Block	OBD	85%	0.1	23	11,320	498	1%
Total				**14.0**	**4,344**	**2,159,195**	**497**	**100%**
Lowry (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	12.4	3,862	1,598,136	414	78%
NHS North Tyneside CCG	Block	OBD	85%	1.7	522	204,056	391	10%
NHS Northumberland CCG	Block	OBD	85%	1.9	579	239,596	414	12%
Total				**16.0**	**4,963**	**2,041,788**	**411**	**100%**
Fellside (In Scope)								
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	15.1	4,692	1,912,612	408	95%
NHS South Tyneside CCG	Block	OBD	85%	0.4	114	41,412	365	2%
NHS Sunderland CCG	Block	OBD	85%	0.5	158	57,744	365	3%
Total				**16.0**	**4,964**	**2,011,768**	**405**	**100%**
Lamesley (In Scope)								
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	15.1	4,686	1,863,975	398	95%
NHS South Tyneside CCG	Block	OBD	85%	0.4	131	47,670	364	2%
NHS Sunderland CCG	Block	OBD	85%	0.5	147	53,468	364	3%
Total				**16.0**	**4,964**	**1,965,113**	**396**	**100%**

Variance between existing and proposed contracts (8 bed reduction)								
CCG	**Contract Type**	**POD**	**Occ rate**	**No of Beds**	**Plan Activity Annual**	**Plan Price Annual £**	**Tariff**	**% split of activity**
Collingwood Court (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	- 1.9	- 599	-	62.2	0%
NHS North Tyneside CCG	Block	OBD	85%	- 0.1	- 18	-	60.2	0%
NHS Northumberland CCG	Block	OBD	85%	- 0.0	- 3	-	62.2	0%
Total				**- 2.0**	**- 621**	**-**		**0%**
Lowry (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	-	-	-	-	0%
NHS North Tyneside CCG	Block	OBD	85%	-	-	-	-	0%
NHS Northumberland CCG	Block	OBD	85%	-	-	-	-	0%
Total				**-**	**-**	**-**		**0%**
Fellside (In Scope)								
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	- 3.8	- 1,173	-	81.5	0%
NHS South Tyneside CCG	Block	OBD	85%	- 0.1	- 28	-	72.9	0%
NHS Sunderland CCG	Block	OBD	85%	- 0.1	- 40	-	72.9	0%
Total				**- 4.0**	**- 1,241**	**-**		**0%**
Lamesley (In Scope)								
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	- 2.0	- 606	-	45.6	0%
NHS South Tyneside CCG	Block	OBD	85%	- 0.1	- 17	-	41.7	0%
NHS Sunderland CCG	Block	OBD	85%	- 0.1	- 19	-	41.7	0%
Total				**- 2.1**	**- 642**	**-**		**0%**

A rebasing exercise is being undertaken between local CCGs with an implementation date of 1st October 2018. As income will be rebased on actual activity this will change contracted income for these services. Below are details of the draft rebased position and the impact of the changes described in this business case.

Existing SLAs 18/19 (70 beds) rebased draft								
CCG	**Contract Type**	**POD**	**Occ rate**	**No of Beds**	**Plan Activity Annual**	**Plan Price Annual £**	**Tariff**	**% split of activity**
Collingwood Court (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	1.4	433	188,471	435	9%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	12.4	3,832	1,666,701	435	77%
NHS North Tyneside CCG	Block	OBD	85%	0.3	105	45,622	435	2%
NHS Northumberland CCG	Block	OBD	85%	0.7	216	93,862	435	4%
NHS South Tyneside CCG	Block	OBD	85%	0.3	84	36,647	435	2%
NHS Sunderland CCG	Block	OBD	85%	0.9	294	127,891	435	6%
Total				**16.0**	**4,964**	**2,159,195**	**435**	**100%**
Lowry (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	0.9	282	116,003	411	6%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	11.5	3,561	1,464,881	411	72%
NHS North Tyneside CCG	Block	OBD	85%	2.2	686	282,412	411	14%
NHS Northumberland CCG	Block	OBD	85%	0.7	209	85,966	411	4%
NHS South Tyneside CCG	Block	OBD	85%	0.0	15	6,214	411	0%
NHS Sunderland CCG	Block	OBD	85%	0.7	210	86,312	411	4%
Total				**16.0**	**4,963**	**2,041,788**	**411**	**100%**
Fellside (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	9.1	2,817	913,433	324	45%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	5.3	1,657	537,380	324	27%
NHS North Tyneside CCG	Block	OBD	85%	1.3	393	127,528	324	6%
NHS Northumberland CCG	Block	OBD	85%	1.9	583	188,878	324	9%
NHS South Tyneside CCG	Block	OBD	85%	0.9	266	86,344	324	4%
NHS Sunderland CCG	Block	OBD	85%	1.6	488	158,203	324	8%
Total				**20.0**	**4,868**	**2,011,768**	**413**	**100%**
Lamesley (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	5.9	1,820	638,141	351	32%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	5.5	1,697	594,995	351	30%
NHS North Tyneside CCG	Block	OBD	85%	2.3	699	244,998	351	12%
NHS Northumberland CCG	Block	OBD	85%	0.6	199	69,698	351	4%
NHS South Tyneside CCG	Block	OBD	85%	1.2	362	127,025	351	6%
NHS Sunderland CCG	Block	OBD	85%	2.7	828	290,256	351	15%
Total				**18.1**	**4,217**	**1,965,113**	**466**	**100%**

Proposed SLAs (62 beds) rebased draft								
CCG	**Contract Type**	**POD**	**Occ rate**	**No of Beds**	**Plan Activity Annual**	**Plan Price Annual £**	**Tariff**	**% split of activity**
Collingwood Court (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	1.2	379	188,471	497	9%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	10.8	3,353	1,666,701	497	77%
NHS North Tyneside CCG	Block	OBD	85%	0.3	92	45,622	497	2%
NHS Northumberland CCG	Block	OBD	85%	0.6	189	93,862	497	4%
NHS South Tyneside CCG	Block	OBD	85%	0.2	74	36,647	497	2%
NHS Sunderland CCG	Block	OBD	85%	0.8	257	127,891	497	6%
Total				**14.0**	**3,824**	**2,159,195**	**565**	**100%**
Lowry (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	0.9	282	116,003	411	6%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	11.5	3,561	1,464,881	411	72%
NHS North Tyneside CCG	Block	OBD	85%	2.2	686	282,412	411	14%
NHS Northumberland CCG	Block	OBD	85%	0.7	209	85,966	411	4%
NHS South Tyneside CCG	Block	OBD	85%	0.0	15	6,214	411	0%
NHS Sunderland CCG	Block	OBD	85%	0.7	210	86,312	411	4%
Total				**16.0**	**4,529**	**2,041,788**	**451**	**100%**
Fellside (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	7.3	2,254	913,433	405	45%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	4.3	1,326	537,380	405	27%
NHS North Tyneside CCG	Block	OBD	85%	1.0	315	127,528	405	6%
NHS Northumberland CCG	Block	OBD	85%	1.5	466	188,878	405	9%
NHS South Tyneside CCG	Block	OBD	85%	0.7	213	86,344	405	4%
NHS Sunderland CCG	Block	OBD	85%	1.3	390	158,203	405	8%
Total				**16.0**	**3,895**	**2,011,768**	**517**	**100%**
Lamesley (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	5.2	1,612	638,141	396	32%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	4.8	1,503	594,995	396	30%
NHS North Tyneside CCG	Block	OBD	85%	2.0	619	244,998	396	12%
NHS Northumberland CCG	Block	OBD	85%	0.6	176	69,698	396	4%
NHS South Tyneside CCG	Block	OBD	85%	1.0	321	127,025	396	6%
NHS Sunderland CCG	Block	OBD	85%	2.4	733	290,256	396	15%
Total				**16.0**	**3,734**	**1,965,113**	**526**	**100%**

Variance between existing and proposed contracts (8 bed reduction) rebased draft								
CCG	**Contract Type**	**POD**	**Occ rate**	**No of Beds**	**Plan Activity Annual**	**Plan Price Annual £**	**Tariff**	**% split of activity**
Collingwood Court (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	- 0.2	- 54.2	-	62.1	0%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	- 1.5	- 479.0	-	62.1	0%
NHS North Tyneside CCG	Block	OBD	85%	- 0.0	- 13.1	-	62.1	0%
NHS Northumberland CCG	Block	OBD	85%	- 0.1	- 27.0	-	62.1	0%
NHS South Tyneside CCG	Block	OBD	85%	- 0.0	- 10.5	-	62.1	0%
NHS Sunderland CCG	Block	OBD	85%	- 0.1	- 36.8	-	62.1	0%
Total				**- 2.0**	**- 620.5**	**-**		**0%**
Lowry (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	-	-	-	-	0%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	-	-	-	-	0%
NHS North Tyneside CCG	Block	OBD	85%	-	-	-	-	0%
NHS Northumberland CCG	Block	OBD	85%	-	-	-	-	0%
NHS South Tyneside CCG	Block	OBD	85%	-	-	-	-	0%
NHS Sunderland CCG	Block	OBD	85%	-	-	-	-	0%
Total				**-**	**-**	**-**	**-**	**0%**
Fellside (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	- 1.8	- 563.5	-	81.1	0%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	- 1.1	- 331.5	-	81.1	0%
NHS North Tyneside CCG	Block	OBD	85%	- 0.3	- 78.7	-	81.1	0%
NHS Northumberland CCG	Block	OBD	85%	- 0.4	- 116.5	-	81.1	0%
NHS South Tyneside CCG	Block	OBD	85%	- 0.2	- 53.3	-	81.1	0%
NHS Sunderland CCG	Block	OBD	85%	- 0.3	- 97.6	-	81.1	0%
Total				**- 4.0**	**- 1,241**	**-**		**0%**
Lamesley (In Scope)								
NHS Newcastle Gateshead CCG - Newcastle Locality	Block	OBD	85%	- 0.7	- 208.6	-	45.4	0%
NHS Newcastle Gateshead CCG - Gateshead Locality	Block	OBD	85%	- 0.6	- 194.5	-	45.4	0%
NHS North Tyneside CCG	Block	OBD	85%	- 0.3	- 80.1	-	45.4	0%
NHS Northumberland CCG	Block	OBD	85%	- 0.1	- 22.8	-	45.4	0%
NHS South Tyneside CCG	Block	OBD	85%	- 0.1	- 41.5	-	45.4	0%
NHS Sunderland CCG	Block	OBD	85%	- 0.3	- 94.9	-	45.4	0%
Total				**- 2.1**	**- 642**	**-**		**0%**

Northumberland, Tyne and Wear NHS Foundation Trust
Board of Directors Meeting

Meeting Date: 27 June 2018

Title and Author of Paper:
Board Self Certification to NHS Improvement – Governors Training
Caroline Wild, Company Secretary and Deputy Director of Communications and Corporate Relations

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

Paper for Debate, Decision or Information: Decision

Key Points to Note:

The Board of Directors is required to sign a Board Statement, having regard to the views of the Governors, confirming that during the financial year recently ended (2017/18) the Trust has provided the necessary training to its Governors to ensure they are equipped with the skills and knowledge they need to undertake their role. The statement has to be submitted by the end of June.

The Council of Governors, at their meeting on the 17 May 2018 confirmed that they are happy to recommend to the Board of Directors, completion of the Board Statement confirming that the Trust provided the necessary training to its Governors during 2017/18.

Risks Highlighted: BAF considered

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

Equal Opportunities, Legal and Other Implications: None

Outcome Required / Recommendations: Agreed Board declaration published by 30th June 2018

Link to Policies and Strategies: 2017-19 Planning Guidance and standard contract, integrated governance arrangements, Operational Plan 2017-18, NHS Improvement provider licence requirements

Training of Governors Statement

The Board is satisfied that during the financial year most recently ended (2017/18) the Trust has provided the necessary training to its Governors, as required in section 151 (5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Evidence:

The Trust's Council of Governors includes both elected and appointed governors. The Trust values their role and is committed to ensuring they are equipped with the skills and knowledge they need to undertake their role through the provision of appropriate training and development.

This includes:

- An induction programme for newly appointed Governors;
- Individual meetings with the Chair, on appointment to identify their areas of particular interest and existing skills, and on-going one to one meetings with the Chair;
- The provision of a Governor Handbook, including (i) general and Trust information and signposting to other resources, e.g. the Trust Constitution, Monitor's Code of Governance, etc, (ii) Council of Governors role and signposting to other information, e.g. Monitor's reference guide on governors' statutory duties, Council of Governors' committees' and groups' terms of reference, and (iii) Board of Directors' information, e.g. Board terms of reference, Trust governance arrangements, etc. The handbook is issued to governors on induction and involves an overview of the contents;
- Council of Governors' engagement sessions on specific / pertinent issues, e.g. Developments in Learning Disability Services, Transforming Care Programme and STOMP (Stop over-medicating people with a learning disability) Positive and Safe Care, new operational structures, staff survey, Council of Governors Working arrangements;
- Presentations and facilitated discussions at the Council of Governor Meetings on specific subjects, for example the Subsidiary Company, staff survey, freedom to Speak up Guardian, Sustainability and Transformation Partnership and Accountable Care Organisation discussions, Quality Goals and Priorities;
- CQC Inspection, the role of Governors in a devolved NTW, staff survey, financial position, deciding together, proposed clinical management Trust structure changes and quality accounts and priorities;
- Involvement in Council of Governors' Committees and Working Groups enabling them to gain specific skills and knowledge, these include the Nominations Committee and Quality Sub-Group;

- All Trust committees have representative Governors attending as observers, linking back to the Governors meeting to improve the flow of information and providing assurance;

- Attendance at key Trust Events, e.g. 'Valuing Excellence' staff awards, Annual Members Meeting to learn more about the Trust;

- Visits to wards and departments, enabling them to get acquainted with the Trust's services and staff, building up their knowledge base (ie PLACE visits);

- Providing management briefings outwith Council of Governors meetings, e.g. media interest;

- Providing external information and guidance, e.g. from the CQC, foundation trust network etc.

The Council of Governors meetings for 2017/18 were as follows:

- 9th May 2017
- 12th September 2017
- 7th November 2017
- 12th December 2017
- 6th March 2018

The Council of Governor' Engagement Sessions for 2017/18 were as follows:

- 6th April 2017
- 15th June 2017
- 12 October 2017
- 1st February 2018

The steering group has the opportunity to discuss and agree the agendas for both formal meetings and engagement sessions, and all governors are invited to suggest topics for future development opportunities.

Signed on behalf of the Board of Directors, and having regard to the views of the Governors.

Signature	Signature
Name	Name
Capacity	Capacity
Date	Date