NHS
North Tyneside
Clinical Commissioning Group

NHS North Tyneside CCG Commissioning Intentions 2019/20

Introduction

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

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

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

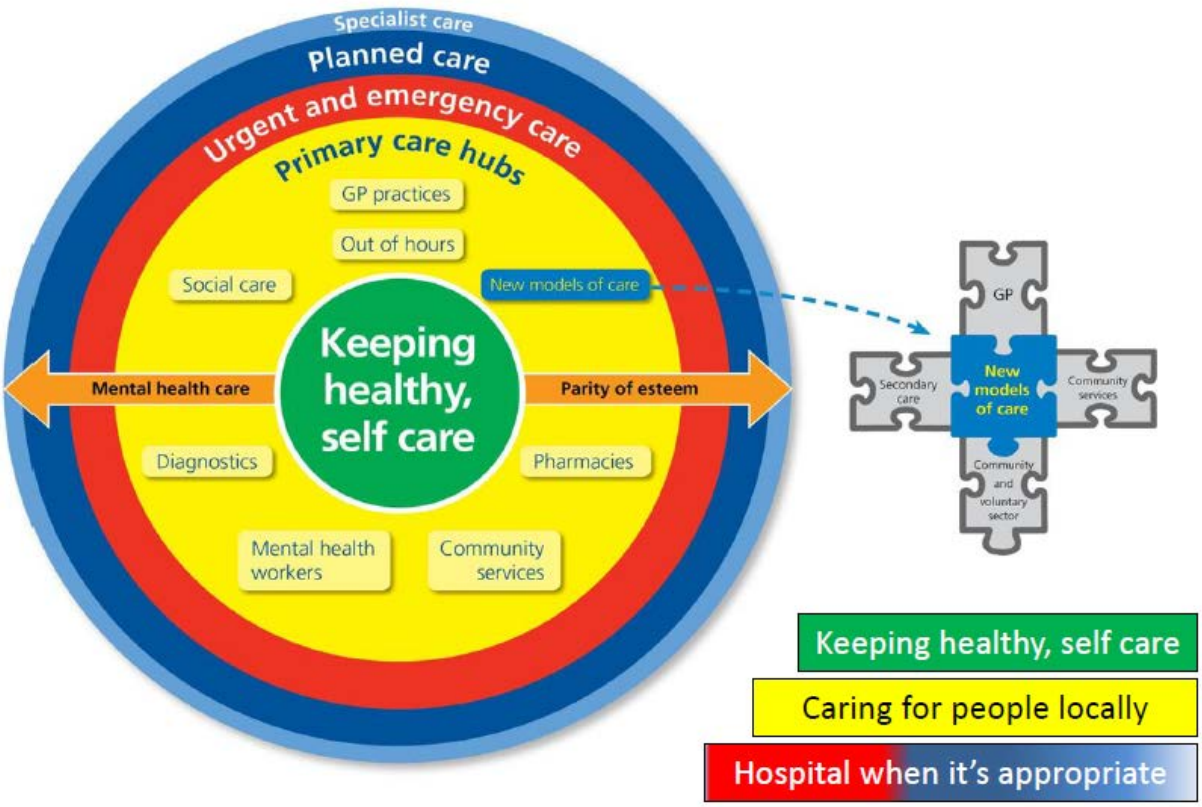
NHS North Tyneside CCG works with its partners for its population on many different geographies including at place in local neighbourhoods and communities.

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

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

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

Our strategic vision is supported by ambitious plans to change the way that care is delivered. The figure below gives a pictorial representation of the CCG's commissioning priorities which echoes our vision.



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

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

Finance

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

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

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

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

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

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

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

Future Care

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

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

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

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

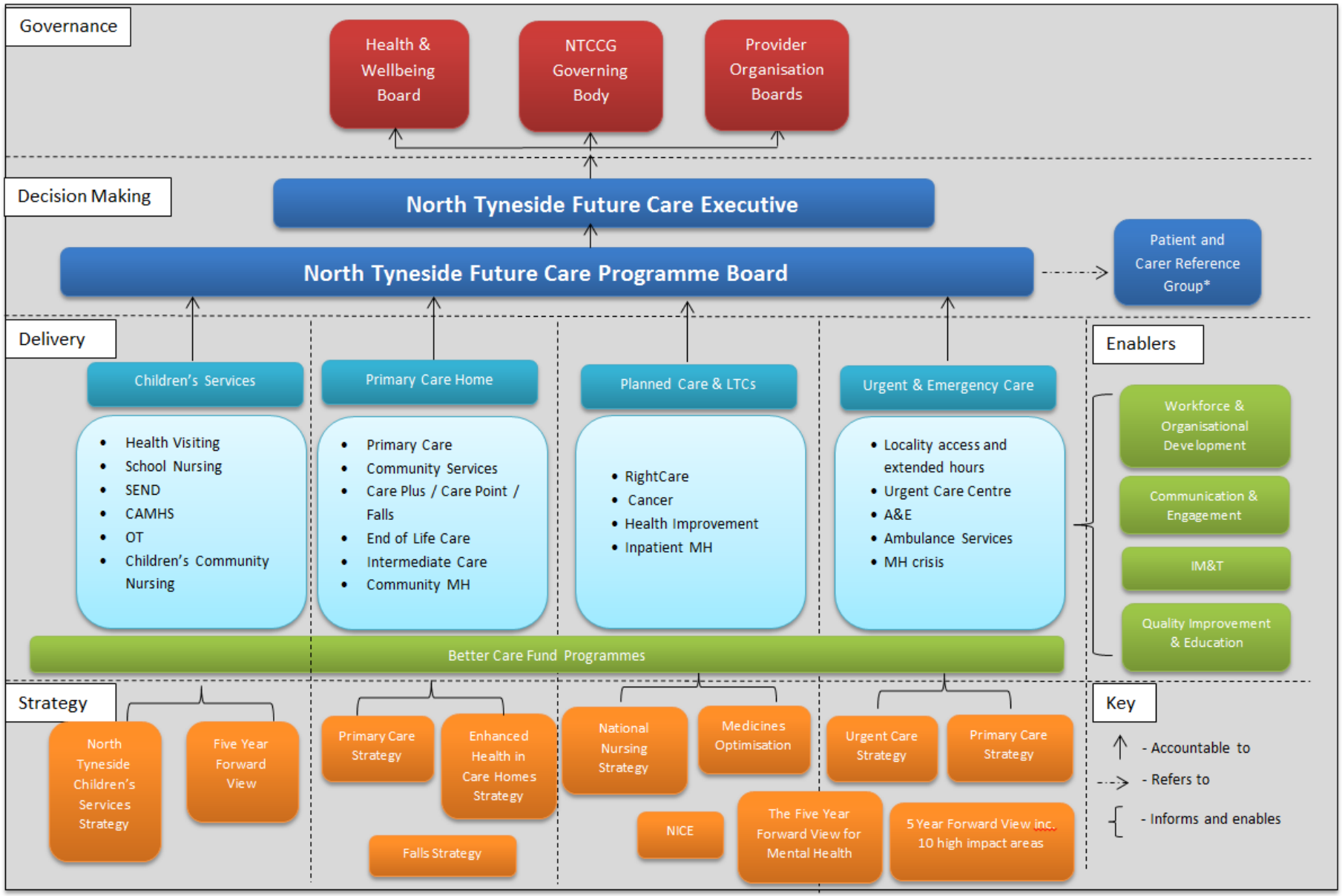
The programme of work has the following themed work streams which will focus on achievement of agreed outcomes:

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

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

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

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


Governance
Health & Wellbeing Board
NTCCG Governing Body
Provider Organisation Boards
Decision Making
North Tyneside Future Care Executive
North Tyneside Future Care Programme Board
Patient and Carer Reference Group*
Delivery
Children's Services
Primary Care Home
Planned Care & LTCs
Urgent & Emergency Care
Health Visiting
School Nursing
SEND
CAMHS
OT
Children's Community Nursing
Primary Care
Community Services
Care Plus / Care Point / Falls
End of Life Care
Intermediate Care
Community MH
RightCare
Cancer
Health Improvement
Inpatient MH
Locality access and extended hours
Urgent Care Centre
A&E
Ambulance Services
MH crisis
Better Care Fund Programmes
Enablers
Workforce & Organisational Development
Communication & Engagement
IM&T
Quality Improvement & Education
Strategy
North Tyneside Children's Services Strategy
Five Year Forward View
Primary Care Strategy
Enhanced Health in Care Homes Strategy
Falls Strategy
National Nursing Strategy
Medicines Optimisation
NICE
The Five Year Forward View for Mental Health
Urgent Care Strategy
Primary Care Strategy
5 Year Forward View inc. 10 high impact areas
Key
- Accountable to
- Refers to
- Informs and enables

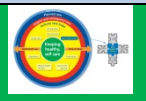
Detailed Commissioning Intentions

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

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

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

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

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
Strategic Priority Themes - Keeping healthy, self care 				
High quality affordable health care	Reduce smoking prevalence rates	We will continue to work with our partners across health and social care and the third sector to improve access to a number of initiatives to enable more smokers to quit smoking. Evidence suggests that the provision of local stop smoking services offers the best chance of success and is four times more effective than no help or over the counter nicotine	Reduce smoking prevalence rates to 12% by 2022 7500 less smokers in North Tyneside by 2022	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		replacements. The CCG has developed with partners a stop smoking plan that aims to promote good health and reduce the harm and impact of smoking. Key elements of the plan include: • Embedding 'Very Brief Advice' and 'Making Every Contact Count' within all commissioned health services. • Improving clinical outcomes for smokers and reducing the demand placed on health and social care as a burden of disease caused by addiction to tobacco through use of preventative campaigns, and targeted support to areas in North Tyneside where smoking rates are significantly higher than the national average. • Working with Public Health to ensure appropriately designed Stop Smoking Services/interventions within the following settings: o Drug and Alcohol Services o Community Mental Health Services o Community settings in areas of high prevalence o Maternity Services and early years (0-19) • Implementing 'stop before your op' for all elective procedures • Building on the achievements of Northumbria Healthcare NHS Foundation Trust's 'Smoke	Regional target of 5% by 2025 (19,500 fewer smokers) Improved health and wellbeing at a population level Reduced smoking related mortality and morbidity Lower demand on primary and secondary care Improved outcomes following elective surgery. Reduced bed day usage & readmissions Potential to make savings on reduced demand on inhalers (short term) and costs associated with treating cancer (longer term)	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		Free NHS' policy and improving the pathway flow into community and primary care based interventions following discharge from hospital.		
High quality affordable health care	Diabetes Prevention	NHS North Tyneside CCG is the lead for the Wave 3 National Diabetes Prevention Programme (NDPP). The aim is to: • Provide evidence based interventions that will support those at high risk of developing type 2 diabetes in reducing their level of risk e.g. weight management and physical activity programmes. • Use the NHS health checks programme as an effective way to identify those at risk of developing type 2 diabetes and develop local systems to refer patients into the NDPP. Delivery of the NDPP will continue during 2019/20 and will continue to be monitored by the regional NDPP Steering Group.	Increased identification of patients with a high risk of developing type 2 diabetes Lower type 2 diabetes prevalence as a result of providing appropriate and timely interventions to reduce the risk of developing type 2 diabetes (Public Health England estimates 26% reduction compared to usual care). Lower level of adult obesity in North Tyneside Reduction in demand on primary and secondary care associated with the	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
			ongoing management of type 2 diabetes	
High quality affordable health care	Alcohol	In line with the Sustainability and Transformation Plan, we will begin to implement the following initiatives to tackle alcohol-related issues within NHS settings: • Develop and deliver systematic approaches to alcohol identification and brief advice (IBA) using the “Have a Word” approach and AUDIT C tool across all NHS settings including primary and secondary care. • Support alcohol hospital teams and ensure a well-resourced, clinician-led alcohol liaison team/service is available. • Amplify and embed Balance alcohol harm reduction campaigns in NHS settings, including primary care by utilising existing NHS communication channels. • Contribute to treating treatment-resistant drinkers in NHS settings and participate in the North Tyneside multi-agency blue light initiative via MEAM to move the most frequent attendees into more appropriate, supported, community environments.	Reduction in the number of alcohol attributable admissions Reduction in alcohol related harm	Strategic priority
High quality affordable health care	Health At Work	Promote the Better Health at Work programme: The CCG has recently achieved the Better Health at	Healthy, productive workforce with reduce sickness absence	Strategic priority

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		Work Silver Award, and is now working towards the Gold Award. • As part of the gold award we will be promoting healthy eating, healthy mind and healthy body. We invite and encourage the GP practices and other partner organisations to join us whenever they can. • We will be providing opportunities for staff to engage in new activities that they may have not tried before, these will include, cycling, running, Pilates, yoga and some crafting. • We will be encouraging staff to sign up for dry January and promoting lots of ways to ensure we mentally stay fit and well. • Some staff from the CCG and GP practices will be completing the Mental Health First Aid course.	Reduce NHS Trusts sickness absence rates to 3.8% by 2021 Supporting the long term health of staff by ensuring that they have mechanisms in place to stay fit and healthy both physically and mentally.	
High quality affordable health care	Up-Scaling Prevention	Key actions for 2019/20 include working with the Integrated Care System (ICS) prevention work stream and Public Health to implement the priorities within the agreed plan into the delivery of health care in North Tyneside. To date, this plan includes: • Smoking (which has already been identified separately) • Alcohol (which has already been identified separately) • Embed Very Brief Advice (smoking, alcohol	A regional approach that places prevention within every aspect of the health and social care infrastructure. A health and social care delivery model that prevents the known causes of mortality and morbidity.	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		and weight management) in Primary Care. • Giving every child the best start in life • Reducing the prevalence of excess weight in adults and children through the application of evidence based programmes that involve physical activity and interventions to improve diet • Health at work (which has already been identified separately) • Increasing flu immunisation rates amongst specific groups including staff in primary and secondary care, staff in residential/care homes and amongst at risk groups. • Increase screening uptake rates and reduce the health inequality gaps in uptake at a practice level. • Increase of preventive spending across the health and care system • Development of community centred and asset based approaches to enhance self-care, increase independence, self-esteem and self-efficacy • Mandatory training for NHS staff in Making Every Contact Count • Develop a targeted prevention programme that includes tobacco and cancer awareness and deliver this in primary care.		

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
High quality affordable health care	Commitment to Carers	North Tyneside CCG aims to address the changes needed in the way in which carers' health and wellbeing needs are identified, addressed and supported. We will work with our providers to develop an integrated approach to identifying and meeting carers' health and wellbeing needs (of all ages). This will be achieved by promoting positive practice in supporting carers, with particular focus on carers from vulnerable communities or at key transition points in order to reduce health inequalities. The CCG will lead on the development of a three year action plan for carers and this will be overseen by a multi-agency Carers Partnership Board. Key Priorities include: • Support the identification and recognition of carers in primary care, working directly with 'Care Navigators' in improving the registration and assessments process of carers including young carers. • Work with all providers to ensure carers are supported in the choices they make about their caring role and access appropriate services and support for them and the person they care for. • Improve access to support for those caring for people with a diagnosis of a mental health	• Improve access to support for Young Carers. • Aim to achieve a 2% increase in the numbers on the GP carers register. • Increase numbers of carers receiving a carer's assessment.	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		condition. • Improve the carers' experience in secondary care by: o Raising the profile of carers amongst staff through raising awareness of carers needs. o Promote a holistic approach from initial diagnosis, improved care-coordination, discharge planning and; o Ensuring the carer is provided with information and/or refer early for support and in doing so, reduce the risk of a crisis situation or breakdown in the carer's health. • Increase capacity in the Young Carers and families support service.		
High quality affordable health care	Diabetes Structured Education	Structured education for patients with diabetes has been proven to prolong the period of time that patients stay well and do not require medication National Institute Clinical Excellence (NICE) Technology Appraisal 60 states: "structured education is made available to all people with diabetes at the time of initial diagnosis and then as required on an ongoing basis, based on a formal, regular assessment of need." The NHS Five Year Forward View also described the need to develop evidence based diabetes prevention programmes. The Sustainability & Transformation Plan (STP) for	• More structured education availability in North Tyneside • Improved self-management opportunities for patients with diabetes • Reduced reliance on hospital care	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		Northumberland Tyne and Wear and North Durham commits to rolling out the diabetes prevention programme, which includes the provision of education services around type 2 diabetes. The CCG increased the number of places available on its structured education programme for patients with type 2 diabetes during 2018/19. It has also improved access to training by introducing direct booking and self-referral. In 2019/20 the CCG will continue to focus on maintaining high fill-rates for its commissioned structured education programmes and working with practices to increase the number of referrals.		
High quality affordable health care	Asset-based approaches	We will put greater focus on supporting the reorientation of care towards place based whole population approach and encouraging greater participation from the Voluntary and Community Sector to work in partnership across health and social care to effectively promote self-care and wellbeing and reduce loneliness.	Development of partnership framework between health, social care and the Voluntary and Community Sector.	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
Strategic Priority - Caring for people locally				
Care for older people	Continuing healthcare (CHC) - quality and value	There are a number of strands of work already in place to meet demographic changes in North Tyneside. These include implementation of the revised Continuing Health Care (CHC) framework (October 2018), focussing on meeting national timeframes from check list to decision making, quality and value for money, and providing the opportunity for Personal Health Budgets (PHBs). Other work strands include: • Assessing, monitoring and reviewing fast track packages of care in an appropriate time frame and ensuring support is proportionate to needs • Ensuring all reviews are up to date, prioritising high cost cases • Ongoing review of all shared care cases • Joint monitoring and quality reviews in nursing homes in partnership with the Local Authority • Commissioning domiciliary services from the joint provider framework • Further develop the Broadcare IT system to ensure accurate reporting • Ensure all CHC patients living in their own homes are offered PHBs	Commissioned packages of care will respond to assessed needs, taking patient preferences into consideration in line with CCG Policy and transparency and equality in relation to the care packages will be achieved as well as quality and value for money. In relation to quality of service provision, the initiatives will: • Provide ongoing assurance in relation to CHC assessment toolkit recommendations in order to promote equity • Ensure providers meet the quality	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
			Key Performance Indicators • Ensure commitment to working with the Local Authority in an integrated way so that the care needs of people in North Tyneside are met and transition into CHC is a seamless process • Ensure existing commissioned providers understand their contribution to care packages • Ensure that activity data is accurate and accessible • PHBs will offer patients flexible opportunities to meet their care needs	

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Care for Older People	Maintaining a High Level of dementia diagnosis and good quality care for people with dementia	The CCG currently has an early dementia diagnosis rate which exceeds the national target of at least two-thirds of the estimated number of people with dementia. The CCG continues to review the national information to ensure that it continues to meet this target. The CCG is also working with GP Localities to ensure that patients who have been diagnosed with dementia have their care plan reviewed annually. This is audited nationally and the CCG aims to improve its rating in this area. During 2017/18, the CCG agreed to fund an Admiral Nurse post with Age UK North Tyneside, aiming to improve post diagnostic support for people with dementia and their carers. The CCG has worked with Age UK North Tyneside to review the impact of this post and the CCG has agreed to continue funding this post on a recurrent basis	Identification of service improvement areas with joint responsibility established and a relevant Action Plan developed	Strategic priority
Care for older people	Development of a single model of mental health care for older people across North Tyneside	We will secure a more consistent service experience across North Tyneside for older people with mental health problems, working with both current older people mental health providers to effect this. This will involve: - Data gathering - Pathway mapping	• Deliver service outputs, waiting times and patient outcomes to ensure that all older people with mental health have timely and appropriate access to mental health	Strategic priority

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		- Benchmarking The aim will be to develop, agree and implement a service specification with both mental health providers providing older peoples mental health services to people in North Tyneside. We have also finalised a joint strategy with North Tyneside Council on mental health services for older people, including dementia. Following this, a joint action plan will be developed and presented to the Health & Wellbeing Board for approval. Progress against the actions will be monitored by the Health & Wellbeing Board. We will also review and implement new pathways for older people who are experiencing a mental health crisis. This work will be undertaken via the appropriate Mental Health Board.	provision. • Reduce variability in service provision and access to services • Access to the most appropriate service to meet the specific needs to older people experiencing a mental health crisis	
Care for Older people	Intermediate Care	We will continue to extend the range of services and level of provision for Intermediate Care. Key features to include: • an increase in community bed based rehabilitation provision for people stepping down from hospital based care • strengthening peripatetic resource supporting rehabilitation at home • an increase in 'step up' support for patients	More community provision will be available, enabling people to return to their own homes appropriately and timely.	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		who are at risk of a hospital admission.		
Care for Older People	Falls Minimisation	**Aim** To reduce falls and fracture risk and ensure effective treatment, rehabilitation and secondary prevention for those who have fallen. To promote independence and support people to age well in North Tyneside. **Objectives** • Ensure that the population understands what they can do to reduce their risk of falls. • Prevent frailty, promote bone health and reduce falls and injuries • Early intervention to restore independence • Respond to the first fracture and prevent the second • Improve patient outcomes and increase efficiency of care after hip fracture	100% of patients seen in the falls clinic within 3 months of first fall Reduce the number of inpatient falls Reduction in the number of admissions for falls in patients aged >65 Reduction in % of patients aged >75 sustaining a fracture Increase in % of patients returning to usual place of residence after fracture	Strategic priority

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		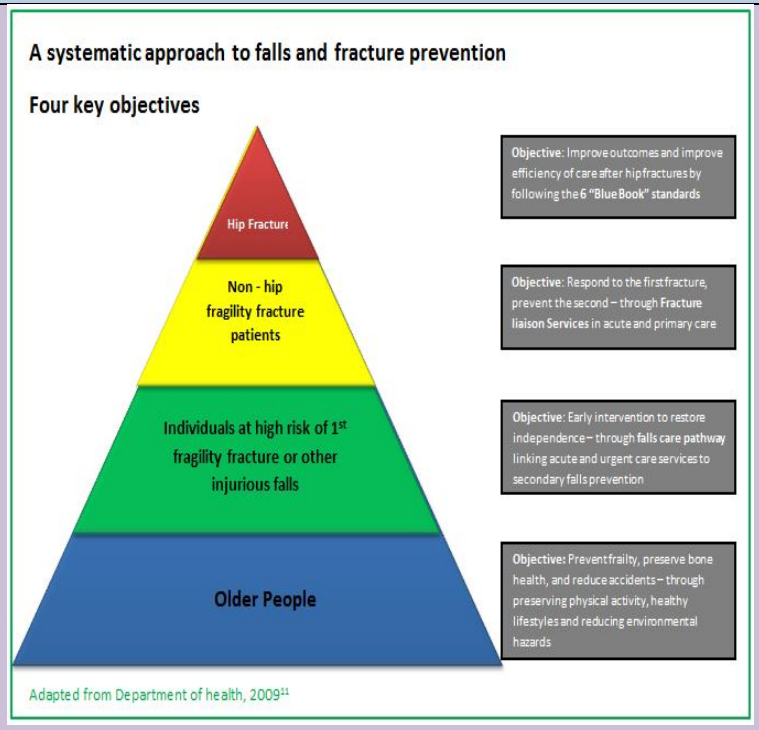		
Care for Older People	Community frailty services	Care Plus provides specialist multi-disciplinary input to support Practices, to see patients in surgery or in their own home. It also delivers dedicated specialist clinics with members of the team to support patients, e.g. Geriatrician clinic, Physio clinic etc. The team works with frail patients who are able to engage with and likely to benefit from input from the multidisciplinary team.	The first iteration of the model showed: • admissions *(a count of both elective and non-elective spells)* reduced by 20% for the patients within	Strategic priority

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		Examples of patients who may benefit: • Rockwood frailty score – 4 to 6 are the most likely group to benefit from interventions as those with higher scores are often too frail and ill to engage, or are approaching end of life. • EFI score indicating moderate frailty • Falls • Frequent GP appointments • Recent hospital admissions • Multiple comorbidities • Under multiple hospital specialities • Polypharmacy • Socially isolated • Confidence problems Care Plus provides a specialist assessment and MDT review of patients within 2 weeks of referral, and often sooner. Following the MDT review it works with the patient to set goals with regular review dates, aimed at minimising the impact of their frailty, and improving their quality of life. During 2019/20 the CCG will review the role of Care Plus with a view to increasing its role in the provision of home-based care for more severely frail patients. This could include changing the pathways from the specialist acute frailty service so that Care Plus can be used as a community-based 'step-down' option	the service over the same period in the previous year • length of hospital stay has reduced by 36% for the patients within the service over the same period the previous year • A&E attendances have reduced by 15% for the patients within the service over the same period in the previous year • an average of 5.8 per patient appointments have been dealt with by the Care Plus service. This equates to circa 1100 appointments being saved in primary care.	

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		for patients who no longer require acute-based support but would be at high risk of readmission if discharged back to the care of their GP.		
Care for Older people	Enhanced Health in Care Homes	The Enhanced Health in Care Homes Framework lays out a clear vision for working with care homes to provide joined up primary, community and secondary, social care to residents of care and nursing homes, via a range of in-reach services. • Enhanced primary care support • MDT in-reach support • Reablement and rehabilitation to promote independence • High quality end of life care and dementia care • Joined-up commissioning and collaboration between health and social care • Workforce development • Harnessing data and technology	Deliver framework objectives	Strategic priority
High quality affordable health care	Community based mental health services	Northumberland, Tyne and Wear NHS Foundation Trust (NTWFT) implemented new pathways and structures for community based mental health services in North Tyneside during 2016/17. Since then, a review was undertaken of some of these new pathways, focusing specifically on the pathway for people experiencing a mental health crisis aiming to ensure that people receive timely access to appropriate services to manage their		Strategic priority

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		needs. The review was undertaken in partnership with Healthwatch to gain patient and carer input into the pathways work and to help inform future commissioning decisions. As a result of this work and the subsequent Healthwatch published report, the CCG will, during 2019/20: • Commission a low level crisis support service for people who feel they are experiencing a crisis but do not meet the threshold for the Crisis Resolution and Home treatment Team • Review the availability of carer support to ensure that their support needs are identified. The CCG already funds one mental health carer support worker and will identify how further support can be provided • Continue to work with GP Practices to increase mental health awareness, knowledge of services available and referral mechanisms This work will be monitored at the bi-monthly North Tyneside Mental Health Crisis Concordat Strategy Group and will be reported to the appropriate Mental Health Board and, ultimately, the Health and Wellbeing Board.	• Increase the proportion of people who are assisted with a non-clinical urgent mental health need • Reduce demand on statutory urgent care resources • Support the service user to make use of appropriate relevant resources which could include peer-support, community, third sector or	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
			statutory services • Improve the proportion of people who have a plan to improve their mental health and emotional resilience • Provide safe, flexible, high quality support to people in crisis • Support families and carers to care for their own needs and to support the person in crisis	
High quality affordable Health Care	Implementation of Mental Health Forward View	We are committed to delivering the Mental Health Five Year Forward View. The Mental Health Boards which include Public Health, North Tyneside Local Authority, NTWFT, NHCFT, voluntary sector organisations, patient and carer representatives as well as the CCG, continue to meet regularly. Three strategy documents have	People who require access and treatment for those identified mental health services should be able to do so within national timescales.	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		been produced mirroring the Boards: • Children & Young People's Mental Health & Emotional Well-Being Strategy, incorporating the CAMHS Transformation Plan • Adult Mental Health Strategy • Older Peoples Mental Health Strategy In relation to children and young people's mental health provision, we implemented new pathways during 2018/19 to enable school headteachers and SENCOs to refer directly into the CAMHS service. Additionally, there is now access for schools to urgent appointments and professional telephone advice. The CCG also funded, along with the Wellcome Trust, an innovative project called MI:2K. The MI:2K project was a year-long engagement programme, run by national charity Involve and Leaders Unlocked. A team recruited and trained young people in our area, including at-risk groups, on how local mental health prevention, support and services can be most effective and supported them to conduct a research project resulting in key recommendations to be taken up by the CYP MHEWB Strategic Group for action. CAMHS provision remains a priority for the CCG in 2019/20. The CAMHS Local Transformation Plan is a five year Plan and is now entering its fourth year. The current, 2017/18 Plan is available on the CCG's		

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		website. During 2018/19, mental health in education and improved involvement and engagement were the two key priorities. Building on the success of the Emotionally Healthy Schools Resource Pack which was launched in May 2017, we worked with the Local Authority, the Anna Freud National Centre for Children and Families and the Department for Education as part of the Schools Link Programme 2017-18 to strengthen communication and joint working arrangements between schools and mental health professionals. During 2019/20, the CCG will: • Form a strategic alliance with Barnardo's and the local authority, in relation to childrens and young people's emotional health and wellbeing. The focus will be on early intervention and prevention. The purpose is to identify challenges, examine service delivery and service design. The process will begin with workshops to identify what is working and where there are challenges. A school survey regarding children and young people's mental health will be undertaken and the New Forest Parenting training programme will be rolled out across social care and health. • Review existing CAMHS Tier 2 & 3 provision to identify areas of efficiency and improved pathways	• Development of an early intervention and prevention strategy, ensuring that children and young people and their families have access to the right support at the right time. • Improved and quicker access to CAMHS specialist services for schools	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		• Review the outcomes from the MI:2K project to inform and influence service design and development for CAMHS • Work with partners to continue to work with schools to implement some of the improvements identified in the Schools Link Programme workshops during the coming year which will include establishing a termly Mental Health School Mental Health Leads Network where school staff would come together with CAMHS, Educational Psychology and School Improvement staff. • Fund additional resource into the CAMHS neurodevelopmental pathway where we have already identified specific issues with the current pathway and waiting times for assessment • Develop CAMHS services in preparation for implementation of the requirements of the Children & Young People Mental Health Green Paper, focussing on mental health provision in schools and improved access times. • Review, with the Local Authority, the pilot of the Kooth online counselling service to determine how it may be commissioned in the future. • The CCG continues its involvement in the regional work on the national New Care Models programme, whereby secondary mental health providers are given the opportunity to take responsibility for tertiary commissioning budgets for children and adolescent mental health services	• Children & Young People will have a voice in how services are designed so they better meet needs. • Improved access to support and therapies for children and young people • Timely access for children and young people to specialist services • Provision of community based services closer to people's homes	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		(CAMHS) Tier 4 inpatient services, adult secure and adult eating disorders services. The aim of New Care Models is to innovate and transform services in the best interests of service users and their families and to provide care as near to home as possible. For working age adults services, the CCG will provide additional funding to enable to expansion of IAPT services for people with Long Term Condition and to also improve waiting times for access to Step 3 therapy. We will also work with VODA to re-establish the North Tyneside Recovery College, offering a range of courses and workshops related to mental health and wellbeing. The CCG is also working with provider partners to implement closer ways of working between services and organisations, minimising multi-referrals between services for individual patients and	• Increased number of trained IAPT staff in the area • Increased access to IAPT services • Reduction in mental health assessment waiting times • Increased opportunity for people with mental health needs to receive appropriate low level support • A wider range and type of services will be available • Smoother transitions between services • Prevention of	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		rejection of referrals. We are also working at a Locality level to develop mental health nursing posts, based in GP Practices, who will be able to assist patients, signpost and provide education and training for GPs on mental health issues. This project will initially be based in the North Shields and Wallsend locality areas and may be considered for future cross-Borough roll-out. We will continue to fund both the national Core 24 model of liaison psychiatry, based at the A&E department of The Northumbria Hospital and the older people's liaison psychiatry services, based in inpatient and rehabilitation wards at North Tyneside General Hospital. We are closely monitoring the impact of these services and will evaluate their outcomes.	delays while patients access the service most appropriate to their needs • Improved access to mental health support in GP Practices • Improved education and awareness of mental health issues in GP Practices • Reduction of admissions • Will ensure model(s) of provision will meet patients' needs and will be based on evaluation of the existing services	
High quality affordable Health Care	ADHD & Autism	A joint review with regional CCGs of adult ADHD and autism services concluded during 2017/18 From this review, a new pathway was implemented by the Northumberland, Tyne & Wear NHS Trust, aiming to	• Improved transition pathway, eradicating delays and waits in the	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		reduce waiting lists and waiting times for assessment as it had grown at a significant rate. The aim was to develop a service which involves: • Specialist assessment • Community focus for ongoing management of people diagnosed with ADHD/Autism A model of delivery and implementation plan was agreed between the Trust and CCGs. During 2019/20, the CCG will work in partnership with other CCGs to review this new model of delivery to determine if it has achieved its aims and reduced waiting lists and times. The CCG will also work with local partners in North Tyneside to develop a system-wide strategy for ADHD and autism in North Tyneside. This strategy will include benchmark information of other services around the country, highlighting areas of good practice and will provide an analysis of potential areas for development.	system • Improved adult ADHD and autism services, based in the community • Provision of specialist assessment hub with community input for ongoing support and management	
High quality affordable Health Care	Learning Disabilities Services	The Local Authority and North Tyneside CCG have established joint processes to enhance and/or integrate services that underpin living well in the community. The North Tyneside Implementation plan for people	• Appropriate use of hospital beds • Greater focus on early intervention • Greater focus on crisis prevention	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		with learning disabilities and/or autism takes into account the STP planning assumptions and the CCG will continue to work as part of the regional Transformational Board on developing system-wide out of hospital care and allow people with complex learning disabilities to be appropriately and safely supported closer to home. In line with the Transforming Care agenda, North Tyneside will work with other CCGs and Local Authority Commissioners as part of the North Region Implementation Group to develop a complex case framework that will ensure community based pathways are robust, fit for purpose with clear 'step up and step down' processes to ensure the delivery of community-based care for the people with the most challenging and complex behaviours is of a high quality and meeting the assessed needs of individuals. Alongside this development a review of assessment and treatment beds will be undertaken across the North Region. The North Tyneside Disability Integration Board will be focussing on the following in 19/20: • Developing an autism strategy for North Tyneside, informed by the submitted Self-Assessment Framework. • Revisit the STOMP (Stopping Over-Medication of People with a Learning Disability, Autism or Both) baseline practice	• Delivery of a sustainable, integrated outcome focused community model, which is of high quality, affordable and safe to use.	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		audit as a benchmark for developing a robust clinical pathway for the review of psychotropic medication prescribed to people with learning disability. The CCG continues to work with NTW NHS FT and Northumbria Healthcare NHS FT on a medicines optimisation programme to ensure patients and carers are involved in decision making about medication, its use and review. • Developing an assurance framework for physical health screening and exploring how this offer can be extended to people with a diagnosis of just autism. • Together with our various stakeholders in community and acute services, continue to carry out Mortality Reviews for people who are known to services as having a learning disability, who have died. • Undertake a pathway mapping exercise in relation to community service provision,(which incorporates New Care Models) ensuring that the local offer is inclusive of a wrap-around service, including crisis provision.		
High quality affordable Health Care	Better Care Fund	The Better Care Fund remains an important vehicle for driving forward the integration agenda across Health and Social Care in North Tyneside. In our *Better Care Fund Plan* we are developing our aspiration to collectively design a North Tyneside	Development of a data sharing agreement between health and social care.	QIPP plan

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		system to address the broader determinants of health that affect people's lives, enabling change through joint commissioning, system redesign and joining up workforce capacity and capability to deliver against shared goals and ambitions. Following a recent review of all initiatives included in the Better Care Fund, three key areas of improvement have been identified for 19/20: 1. Remodelling of those schemes within the BCF from individual silo initiatives bringing them together towards a more cohesive model with a focus on supporting the fragility agenda. 2. Align BCF schemes more closely with the Future Care Programme. 3. Scaling up the use of reliable evidence based information across the whole health and social care system that will help to inform future development of schemes.		

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
High quality affordable Health Care	Medicines Optimisation & Prescribing	Medicines Optimisation continues to be an important feature of the CCG's commissioning intentions for 2019/20, as it has been in previous years. We will: • Implement interventions to support optimal medicine-taking to enhance the quality of life and experience of care for people with long term conditions. For example, we will deliver medicine optimisation solutions for patients who are less visible to healthcare services but who are becoming frailer, with a reducing ability to cope, helping to maintain their independence whilst minimising the risk of harm and supporting more adherent medicine taking behaviour • Continue to reduce waste within the overall system through increasing use of electronic prescribing and repeats systems, and systems to manage products that can be provided by more value adding processes • Work closely with care homes to optimise medicines and medicine processes to minimise avoidable waste. • Support judicious use of antibiotics to appropriately manage infections and minimise the risk of the development of healthcare-acquired infections • Support prescribers to prescribe	Ensure efficient and effective use of the CCG's prescribing budget, enabling people to manage their own health, reduce the need for acute intervention, maintain independence, support improved medicine-taking behaviour, reduce variation and improve outcomes.	QIPP plan, Practice Activity Scheme and Prescribing Engagement Scheme

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		appropriately for patients with difficult to treat persistent symptomology, reducing the risk of harm, variation in treatment and improve quality. • Support local implementation of NICE clinical and technical guidance supporting the development of local integrated pathways and guidance, allied to effective horizon scanning. • Improve the management of prescribed oral nutrition-optimising treatment and delivering more defined outcomes.		
High Quality Affordable Healthcare	Primary Care Strategy and GP Forward View	We will implement the North Tyneside Primary Care Strategy and the GP Forward View in conjunction with the local GP Federation, TyneHealth, and Newcastle & North Tyneside Local Medical Committee. There are four components to our Strategy: **1. Redesigning Access to Primary Care** **2. Extended Primary Care Team (EPCT)** **3. Integrating Specialist Support** **4. Prevention and Self care** Through 2018/19 the CCG and TyneHealth GP Federation have been engaging with member practices to develop and support delivery of projects to deliver this strategy including but not limited to:	• Improve sustainability and quality in General Practice. • Improve access to General Practice • Ensure that resources match patients' needs and in the right location	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		• additional recurrent investment to each GP practice to use to improve access, improve patient experience, and improve staff experience • additional non-recurrent investment to each GP practice to support practice improvements • the provision of extended access to GP services in evenings and on weekends for all practices in North Tyneside • completion of a gap analysis and support to practices to implement the 10 high impact changes identified in Releasing Time to Care • ongoing support to local practices to develop the role of Care Navigators • the piloting of new technology such as online consultation software • the training of clerical coders within general practice • the pilot of a peripatetic care home team • the pilot of a Physio First model to allow faster access to specialist MSK support • the pilot of a respiratory hub including specialist spirometry, FeNO testing and treatment • implementation of a GP career start programme • initiation of a nurse career start programme In 2019/20 we will continue to support GP practices		

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		to implement these projects, and make the changes identified to increase resilience and make general practice more sustainable. These projects include: • the further development of locality groups / primary care networks to support the delivery of Primary Care Home • development of a workforce strategy for primary care • development of a general practice estates strategy • development of a support package for practices that are looking to work more collaboratively • development of a home visiting service • provision of additional pharmacist support into localities to provide home based medication reviews • pilot of integrated mental health workers into general practice in 2 localities • increase roll out of new technology such as online consultation software to additional practices • increased coordination of the care navigator role • additional training of clerical coders within general practice • continued implementation of the 10 high impact changes identified in Releasing Time		

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		to Care		
GP Information Technology	GP Information Technology	General practice is a fundamental part of the NHS, playing a pivotal role in coordinating patient care and seeing millions of patient interactions every week. The challenge of achieving high quality care in the face of growing demand, changing patient needs and rising expectations can only be met if we harness the power of innovative digital technology, as highlighted in the General Practice Forward View. To operate within known financial constraints, we must ensure that every pound spent on IT improves patient care, reduces bureaucracy for practitioners and drives efficiencies across the health and care system. NTCCG will maximise the opportunity that technology can bring to deliver its vision for North Tyneside communities. NTCCG GPIT strategy consists of the following core areas: • Integrated Digital Care Records • Patients and Clinicians working together to Maximise Health • GP Clinical Systems • CCG Corporate and Business Development These core areas have a number of priorities which must be aligned to them, they are as follows;	To improve General Practice IT to enable more effective and efficient care delivery	Strategic Priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		• Digitisation of GP records • The continued development of the medical interoperability programme (Great North Care record) • The implementation of Black Pear across practice systems resulting in the sharing of live patient information. • Hardware replacement programme • The implementation of remote access for GP practices • GP2GP – NHS Digital process for transferring patient records between practices • The implementation of a digital system across the North Tyneside health estate • Continued development and implementation of data quality, governance and security • Asset management registers and the secure disposal of hardware • The continued development of GP practice web sites • The implementation of nationally mandated systems		
High quality affordable health care	Cancer	North Tyneside CCG will continue to lead a system wide approach working directly with local services and those people directly impacted by cancer on delivering better outcomes for those patients at risk of cancer and those living with cancer. In addition, we will work closely with the North East and Cumbria	• Increased numbers of smoking quitters • 85% target for 62 urgent GP referral for	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		Cancer Alliance Team to ensure the commissioning, provision and accountability processes are fit for purpose and aligned with integrated care systems. The CCG has developed in partnership with local providers a three year strategic plan to make the changes necessary to ensure that people identified and diagnosed with cancer receive the highest level of care possible and maximise life expectancy. The Strategic plan focusses on six priorities areas: 1. Prevention and early identification of cancers. 2. Achieve earlier diagnosis using evidence based clinical pathways to achieving faster diagnosis. 3. Improve patient experience 4. Delivery of Living with and Beyond Cancer Survivorship Pathways in breast, colorectal and prostate. 5. Make necessary investments to deliver a modern high quality service. 6. Ensure commissioning of local services is aligned to region based integrated systems where necessary. Key actions identified for 2019/20 include: • Improving access to stop smoking services and increase smoking quit rates.	suspected cancer • Achieve 28 day referral to diagnosis pathway • Improved patient experience survey results	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		• Continue community based approaches to target populations at greater risk of cancer and design and deliver interventions which: a) Inform people about what action to take in response to cancer signs, symptoms and screening invitations b) Provide targeted support to help people manage their weight, reduce their levels of alcohol and or smoking intake. • Roll out national “Optimal colorectal pathway” • Develop systems and process in preparation and readiness for the 28 day pathway on referral to diagnosis which comes into effect in 2020. • Establish a Patient experience cancer group to advise, inform and challenge commissioners and providers on those aspects of cancer care can be greatly improved in terms of quality based outcomes. • Encourage primary care participation in the National Cancer Audit • Implement a Lung Cancer Case finding pilot. • Consolidate the successful roll out of the Living With and Beyond Breast Cancer pathway • Roll out the Living with and Beyond Colorectal Cancer pathway.		

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		• Ensure all patients diagnosed with cancer have a full holistic needs assessment.		
High Quality Affordable Healthcare	End of Life Care	NHS North Tyneside CCG has successfully commissioned a number of community based specialist palliative care and End of Life services that have demonstrably improved out of hospital services. The hospice at home service (RAPID) and the nursing home palliative care service are now well established and embedded within the End of Life pathway, providing necessary specialist nursing support for those people living in their place of residence who are at risk of a hospital admission. We will continue to work with leaders of local health and care systems to develop a plan for delivering good quality, equitable end of life care for everyone and in doing so, maximise good out of hospital care. In 2019/20 NHS North Tyneside CCG will continue to develop a whole systems approach that focuses on the current range of commissioned services across the care pathway and to identify further opportunities to maximise their effectiveness in the following ways: • Improve the facilitation of discharge from acute settings e.g. planned discharge from hospital for a person who requires palliative care and end of life support and reduce the risk of people dying in hospital when their	• Continued improvement of responsive and expert support and care for people with complex, advanced terminal illness and their families	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		preferred place of death is their own place of residence, and reduce the risk of unplanned discharges. • Improve the coordination of Advanced Care Planning processes across specialty conditions such as respiratory and cardiovascular disease. • Deliver shareable e-records across the healthcare system for people on the End of Life register. • Work with GPs and support practices to increase the percentage of North Tyneside practice patients on the palliative care register to meet the national target. • To achieve equality of access, provision and responsiveness for those populations where inequalities in access to palliative and end of life care currently exist e.g. BAME communities, LGBTQ, the homeless and travellers. • Increase the uptake of Emergency Healthcare plans for palliative care patients. • Develop a joined up bereavement policy applicable across health and social care which is inclusive and supports the provision of services available.		

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
High quality affordable health care	Review and Reconfiguration of Community Services	Improving how community services[1] proactively and reactively work with patients is critical to making the NHS more effective, efficient and therefore sustainable. It is well rehearsed that the majority of NHS contacts happen in the community, the majority of which come through Primary Care. "Transforming Community Services" resulted in the community contract transferring into acute hospitals in North Tyneside and Newcastle. At the time it was envisaged that the opportunity for pathway enhancement, transformation and improvement of community based care would be enhanced by this vertical integration. It was envisaged that proactive care in the community aligned with Primary Care would be realised, resulting in more patients being cared for at home and people attending hospital by exception with the expertise and staff being made available in a community setting. However, community services as a whole are not well coordinated with other services, causing patients to receive care that is fragmented and of variable quality and value for money. It could be argued that this is currently the case in North Tyneside with the community contract last being reviewed in 2011. The primary care strategy sets	As part of Future Care, development of locality working under the 'banner' of Primary Care Home which focusses on locality working with the following principles: • Locality working – c.50k population • Innovation / transformation • Agile workforce • Shift from Acute to Primary / Community • Care closer to patients home • Support new models of care • Patient at centre of decision making • Managing	Strategic priority

[1] In this context "community services" refers to services delivered in the community and include the current community contracts with FT's, primary care, independent contractors, voluntary organisations who deliver care for the population of North Tyneside

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		out the direction of travel for primary care in response to the NHS 'Five Year Forward View'[2] which envisions new models of care that break down the traditional divides between primary care, community services and hospitals. The aim is for patients to receive personalised and coordinated care from different types of services with clinicians working together. North Tyneside Clinical Commissioning Group is a level 3 commissioner in relation to Primary Care, which adds another opportunity to commission fit for purpose "community services" in order to ensure sustainability in response to the demographic and system challenges in North Tyneside previously detailed. NHS North Tyneside CCG now has an important opportunity to commission community services in a way that will support this shift to more coordinated care for patients closer to home. The community services contracts put in place three to five years ago are no longer fit for purpose, giving us an opportunity to: • Move to new ways of working or new models of care that are better for patients with a focus on outcome delivery.	resources efficiently and effectively • Right care, right place, right person, right time	

[2] NHS England. (2014) *Five Year Forward View.* Available at: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		• Test which providers are most likely to achieve the changes that commissioners want for patients to embrace a new "community services" delivery model • Move to new contracts that provide greater transparency and accountability for wider community services provision, as well as greater incentives for providers to improve services for patients. • Focus upon the population where the greatest need lies and provide a system approach to care delivery whilst maintaining universal services for other patients rather than a piecemeal approach to services[3].		
High quality affordable health care	Long Term Conditions	Better management of long term conditions is a key priority of North Tyneside CCG. There remains a strong case for taking further actions to improve the outcomes for people, remain relatively stable, be confident in self-management and enjoy a quality of life free from frequent crisis or frequent and often unnecessary hospital visits. North Tyneside CCG recognises that we need to work collectively with our providers in primary care, community and secondary care in changing our approach in how interventions are appropriately	• Improved patient experience • Preventing people from dying prematurely • Reduced reliance on hospital care • Improved accuracy in diagnosis of	Strategic priority

[3] Kings Fund (2014) The Reconfiguration of Clinical Services

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		targeted. This will require a whole system approach and to be more proactive with greater emphasis on prevention and achieving diagnosis and developing interventions that can help slow deterioration at the earliest stage possible. Greater priority will be to support patients to manage their condition more effectively and reduce the need for specialist interventions and hospital based care. Opportunities to design those specialist services in respiratory, diabetes and CVD to have a more community focussed approach will be explored. To achieve this, North Tyneside CCG will set out a vision that covers all aspects of the health and care system including public health, social care and the voluntary and community sector and will set out best practice in order to achieve improved outcomes and improve the quality of life. Key outcomes to be achieved: • Work with our partners in Public Health to commission an in depth Long Term Conditions needs assessment for the adult population of North Tyneside to understand the level of present and future needs on the health and social care system over the next three years. The assessment will focus will be on conditions with the highest prevalence: o Respiratory Disease, specifically COPD and asthma	COPD • Improved management of asthma	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		o Cardiovascular Disease o Diabetes o Chronic Kidney Disease • Identify opportunities to prevent onset long term conditions and identify opportunities to manage • Improve the well-being of all communities and minimise the inequalities that currently exist in North Tyneside with COPD and asthma being significantly more prominent in our poorest communities. • Reduce the number of people with co-morbidities who die prematurely through a proactive approach to early identification using risk stratification tools, multi-disciplinary working and proactive care management, greater use in technology and targeting of high areas of prevalence. • Develop a programme of delivery projects within 2019/20 which can deliver improvements in the **respiratory pathways** including: o Expansion of the Hospital at Home service and supported discharge service o Full delivery of a community based pulmonary rehab programme for patients with an MRC score of 2 and above. o Roll out of self-management tools such		

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		as myCOPD o Localised Asthma clinical pathway o Localised COPD clinical pathway o Development of a stop smoking pathway o Patients with a known diagnosis of asthma who are discharged from Emergency and A&E will have a targeted asthma review from specialist respiratory services within 48 working hours. o Delivery of locality based respiratory hubs with direct access to spirometry and FeNO testing.		
High quality affordable health care	Enhanced care for long term conditions – diabetes	The priorities for commissioning diabetes services in 2019/20 are: - Implement a revised care planning LES for primary care. The LES contract has been co-produced with NHS Year of Care and will ensure that North Tyneside residents with type 1 and type 2 diabetes receive a care planning process which is consistent with nationally-recognised standards of best practice. - Commission a ground-breaking diabetes remission service for patients with type 2 diabetes. North Tyneside CCG is the first CCG in the country to commission a service based on the weight control programme developed	The aim will be to deliver high quality cost effective care, by shifting care outside of hospital. We will have quicker access to structured education for patients who have been newly diagnosed with diabetes (additional 500 places per annum compared to 2017/18).	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		during the DiRECT programme pilot in Scotland. We have commissioned 270 places on the programme this year and will evaluate the outcomes with a view to informing our commissioning intentions for 2020/21. - Exploring the possibility of developing community-based specialist diabetes clinics as part of our emerging Primary Care Home / Networks. This could include provision of community-based insulin and GLP1 clinics, as well as the delivery of more community-based diabetic foot checks and foot care.	We will also target access to structured education for patients who have been diagnosed as having diabetes but who have not yet had an opportunity to access diabetes structured education We will have improved pathways to access the specialised Diabetic Resource Centre and diabetic podiatry.	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
Strategic Priority - Hospital when it's appropriate 				
Urgent care	Reforming local urgent care services	• Continue to embed the recently established integrated urgent care pathway and improve the quality of the patient experience in all urgent care pathways demonstrating flexibility and supporting patients to make the right decision. • Continue to promote the Integrated 111 service to ensure those with an urgent care need can be booked in to the most appropriate service or/and receive the most appropriate advice on how to manage their own care. • Achieve and sustain the 4 hour A&E target by reducing avoidable attendances at NSECH through the development of alternative pathways and initiatives that support patients to be treated in an alternative setting where clinically appropriate. • Work with NuTH and Northumbria Healthcare to ensure a comprehensive model of Same Day Emergency Care, at least 12 hours per day, seven days a week, by September 2019.	• Improved patient outcomes and experience • Increase in the number of patients accessing booked appointments with urgent care services via NHS 111 • A financially sustainable urgent care system which is more cost effective to run and reduces discretionary demand for Type 1 A&E services. • A sustainably resourced urgent care	Strategic priority

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		• Develop a 'No Place like Home' communications strategy. • Deliver in partnership with the Local A&E Delivery Board a demand and capacity plan to ensure continued delivery during the next winter and period of high demand on reducing lengths of stay with specific focus on stranded and super stranded patients who have been in hospital for over 7 and 21 days respectively. • Work with the Local A&E Delivery Board to develop a new Urgent and Emergency Care Strategy. • Work with North East Ambulance Service NHS Foundation Trust (NEAS) to ensure: o Response standards are maintained for access, unscheduled care and scheduled care o That services provided by NEAS are adequately resourced o That NEAS deals with fluctuations in demand during periods of high demand, e.g. winter. • Work with NEAS and Northumbria Healthcare NHS Foundation Trust to reduce delays in	system. • Compliance with national commissioning standards • Reduction in number of patients presenting at A&E / UTCs and associated cost. • Increase in the proportion of 111 calls being passed to a clinician for consultation and completion. • High fill-rates for appointments with the extended access hubs.	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		ambulance handovers by ensuring fluidity in the admissions process. • Undertake a review of the North Tyneside provision of the Consultant Connect service, taking into account user experience, and identify opportunities for improvement.		
High quality affordable health care	Remodelling of the Pain Management Service	During 2019/20, the CCG will work with Northumbria Healthcare NHS Foundation Trust to complete and implement the remodelling of the pain management service, into a Living Well With Pain service, moving from a medical to a biopsychosocial model of care. The CCG will also build on the education provided to GPs during 2018 to enable them to be supported in having better conversations with patients about their pain.	• Increased ability of people to live well with their pain • Reduction in use of opioid medications	Service redesign and strategic priority
High quality affordable health care	Rapid Specialist Opinion / Advice & Guidance	The CCG will continue to monitor the impact of the Rapid Specialist Opinion service which was commissioned from October 2018. The CCG will continue to monitor the impact of the Advice & Guidance services commissioned during January to March 2019, and review whether there is a need for further Advice & Guidance services.	• To ensure appropriateness of secondary care referrals • To provide GPs with an alternative to referral where they are unsure whether this is	

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
			necessary	
High Quality Affordable Healthcare	System-wide Pathways Reviews	NHS RightCare is a system which uses data to identify areas of variation in clinical services across the country. It is an enabler for CCGs to look at those areas of variation and, using national and local data, to understand the reasons for the variation. Using this information, it can be used to identify opportunities to use robust clinical leadership to deliver sustainable service transformation and drive clinical change. We will continue to use RightCare methodology to identify areas of variation in North Tyneside and have developed a programme of review on those service areas which are identified as priority areas for North Tyneside. We have prioritised the following areas for improvement: ▪ Musculoskeletal ▪ Respiratory ▪ Circulation ▪ Gastrointestinal ▪ Cancer ▪ Trauma and Injuries These priority areas have been incorporated into five RightCare Delivery Plans which are aligned to savings within our QIPP plan. The plans are:	Quality improvements to identified services Potential financial savings	QIPP plan

Commissioning Intentions	Initiative	Summary	Impact & Outcomes	Status
		▪ Medicines Optimisation ▪ Respiratory ▪ Gastrointestinal ▪ Trauma and Injuries ▪ Complex Patients We are working collaboratively with NHS Northumberland CCG and Northumbria Healthcare NHS FT to continue to develop and implement change programmes, and ensuring that we use national support effectively to gain the maximum outcomes.		
High Quality Affordable Healthcare	Referral to Treatment Times (RTT)	The CCG will continue to work with providers to redesign outpatients to ensure right professional, right place, right time, delivering high quality pathways across primary and secondary care and adding value to people's lives. Particular areas of focus include rheumatology, ophthalmology and ENT.	• Improve rapid outpatient access • Reduce outpatient follow-up • Improve patient experience	Strategic priority