NEWCASTLE CCG – 2 YEAR COMMISSIONING PLAN 2014-2016

To commission, in collaboration with local people and with our partners, personalised, high quality and cost effective services that discharge all of our statutory duties, are evidence based and flexibly responsive to the changing needs of the communities we exist to serve

CONTEXT	STRATEGIC PROGRAMME	STRATEGIC OBJECTIVES	2014- 2016 FOCUS	OUTCOME AMBITIONS
High socio economic deprivation Major reductions to Local Authority Funding Increasingly diverse population Poor self care and unhealthy lifestyles Excellent NHS and VCS services Good patient Experience Over reliance upon hospital support	**Children & Young People and Families**			
	Children & Young People and Families Improving long term health & wellbeing of children & young people *(Health & Social Care Integration and Transformation Programme)*	**Early Intervention** Improve long term health outcomes through early intervention **Complex Needs** Develop and implement a high quality, accessible integrated health & social care pathway for children & young people with complex care needs **Emotional Health** Enhance emotional wellbeing of children and young people	Early Years Primary & Community Pathways Looked After Children Continuing Care	Additional years of life by 6.5% (OA1) Reduced time spent in hospital through integrated care by 1.8% (OA3) Improve experience of hospital care by 1% (OA5) Improve experience of care outside of hospital by 2% (OA6)
	Mental Health & Learning Disabilities			
	Mental Health & Learning Disabilities - Developing high quality, effective and accessible mental health and learning disability services	**Health Outcomes** Enhanced recovery and/or support to manage condition **Quality of Life** Enable more people with MH to live their lives to their full potential **Early Intervention** Improve health & wellbeing through prevention & early intervention.	Pathway Development Quality & Safety	Additional years of life by 6.5% (OA1) Improve Quality of Life for people with LTC by 2% (OA2) Increase percentage of Older people living independently 2.3% (OA4) Improve experience of care outside of hospital by 2% (OA6)
	System Resilience			
	Long Term Conditions, Cancer and End of Life Promoting self-management. Empowering and supporting people with long term conditions to lead full and active lives. Ensuring easy access to clinical expertise and holistic personalised care delivered with human compassion	**Early Intervention** Improve long term health outcomes through early intervention **Quality of Life** Improve QOL through enhanced management of long term condition **Access** Increasing opportunities for admission avoidance through ambulatory care **Improve Services and Support** Extend and improve range of services for people living with cancer **Promote choice & experience** Embed shared decision making within normal working practice to empower people to make choices about end of life care **Enhance care outside of hospital** Support professionals to deliver high quality services	Pathway Development Quality & Safety Community based services End of Life	Additional years of life by 6.5% (OA1) Improve Quality of Life for people with LTC by 2% (OA2)

<table>
<tr><td rowspan="6">Default by patients and services to high end and urgent intervention

High alcohol misuse and consequences</td><td>Urgent Care
Ensuring people with acute care needs can be seen in right place at the right time by the right professional</td><td>Pathway Redesign
Effective implementation of an urgent care pathway which ensures appropriate, accessible and timely care delivery</td><td>Alternative Dispositions

Primary Care</td><td rowspan="3">Reduced time spent in hospital through integrated care by 1.8% (OA3)

Increase percentage of Older people living independently 2.3% (OA4)

Improve experience of care outside of hospital by 2% (OA6)

Improve experience of hospital care by 1% (OA5)

Reducing avoidable deaths in hospital – min 20 (OA7)</td></tr>
<tr><td rowspan="2">Older Person
Promoting quality of life and independence for individuals, carers and families of the older person with complex health & social care needs
Health & Social Care Integration and Transformation Programme</td><td>Integrate Services
Provision of a high quality, safe integrated health and social care pathway</td><td rowspan="2">Case Finding

Intermediate Care

Hospital Care</td></tr>
<tr><td>Enhance management
Older people with complex needs outside of hospital</td></tr>
<tr><td rowspan="2">Planned Care
Ensuring appropriate demand and increasing access to high quality, safe out of hospital pathways for planned care</td><td>Improve Community Access
Management and monitoring of planned care</td><td rowspan="2">Community Assessment, Monitoring & Management

Community Elective Care Pathways Referral Management</td></tr>
<tr><td>Pathway Redesign
Reduce unnecessary hospital attendances</td></tr>
<tr><td colspan="4">New Models of Care</td></tr>
<tr><td rowspan="4">General Practice
Ensuring a modern and flexible offer from general practice to support care delivery outside of hospital.</td><td>Access
Improving choice and responsiveness through extended hours and collaborative models of general practice</td><td rowspan="4">General Practice Strategy

Co-Commissioning

Practice Development and Engagement Programme

Risk Stratification & Case Management</td><td rowspan="2">Additional years of life by 6.5% (OA1)

Reduced time spent in hospital through integrated care by 1.8% (OA3)

Improve experience of care outside of hospital by 2% (OA6)</td></tr>
<tr><td>Quality
Improving quality of care and reducing variation in general practice</td></tr>
<tr><td>Scope
Developing extended range of services delivered from and by general practice</td></tr>
<tr><td>Sustainability
Ensuring a vibrant general practice sector integrated with other health and care system providers and able to meet changing needs and expectations</td></tr>
<tr><td>Community Services
Ensuring an integrated response to health and care needs of people in Newcastle</td><td>Access
Deliver services closer to home that support individuals to retain their independence and reduce the need for hospitalisation</td><td>Risk Stratification & Case Management</td><td></td></tr>
</table>

		Quality Improving quality of care and experience of services through provision of a seamless health and care response	Intermediate Care Better Care Fund Plan Community Response Team	Improve Quality of Life for people with LTC by 2% (OA2) Increase percentage of Older people living independently 2.3% (OA4)
		Scope Offering an extended range of person centred, coordinated care packages		
		Sustainability Promoting interagency collaborative working		
	Voluntary Sector Maximising the out of hospital care and support offer to communities	**Access** Aligning voluntary sector services to create an extended primary and community network of services and support	Extended Case Management Social Prescribing Community Resilience	
		Quality Improving quality of care and experience of services through provision of a seamless health and care response		
		Scope Offering an extended range of care package response		
		Sustainability Promoting interagency collaborative working		