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HEALTH & WELLBEING BOARD

AGENDA

Wednesday 11 December 2013

1.30 pm – 3.30 pm

Committee Room 1, Town Hall

1. CHAIRMAN'S ANNOUNCEMENTS

   The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2. APOLOGIES FOR ABSENCE

   (If any) – receive

3. DISCLOSURE OF PECUNIARY INTERESTS

   Members are invited to disclose any pecuniary interest in any of the items on the agenda at this point of the meeting. Members may still disclose any pecuniary interest in any item at any time prior to the consideration of the matter.

4. MINUTES (Pages 1 - 8)

   To approve as a correct record the minutes of the Committee held on 13 November 2013 and to authorise the Chairman to sign them.

5. MATTERS ARISING (Pages 9 - 10)

   To consider any matters arising from the minutes and review of the Action Log.

6. INTEGRATED CARE COALITION REPORT

   Verbal report by Joy Hollister.

7. WINTER PRESSURES/WINTER PLANNING & GP SURGE

   Joint verbal report/powerpoint presentation by Joy Hollister and Alan Steward.

8. PHARMACY SERVICES (Pages 11 - 14)

   Written report presented by Suman Barhaya, NHS England.

9. EMERGENCY HORMONAL CONTRACEPTION

   Presentation by Dr. Mary E. Black.

10. HAVERING CCG COMMISSIONING STRATEGIC PLAN 2014/2015 **(**Pages 15 - 32)

    Written report presented by Alan Steward.

11. ANY OTHER BUSINESS

12. DATE OF NEXT MEETING

    Members of the Board are asked to note that the next meeting will be held on 8 January 2014 at 1.30 pm.

MINUTES OF A MEETING OF THE HEALTH & WELLBEING BOARD

Committee Room 1 Town Hall
13 November 2013 (1.30 pm – 4.15pm)

Present

Cllr Steven Kelly (Chairman) Cabinet Member, Individuals, LBH
Cheryl Coppell, Chief Executive, LBH
Dr Atul Aggarwal, Chair, Havering CCG
John Atherton, NHS England
Dr Mary E Black, Director of Public Health, LBH
Conor Burke, Accountable Officer, Havering CCG
Cllr Andrew Curtin, Cabinet Member, Culture, Town and Communities, LBH
Anne-Marie Dean, Chair, Health Watch
Joy Hollister, Group Director, Social Care and Learning, LBH
Cllr Paul Rochford, Cabinet Member, Children & Learning, LBH
Dr Gurdev Saini, Board Member, Havering CCG
Alan Steward, Chief Operating Officer (non- voting) Havering CCG

In Attendance

Dr Steve Feast, Executive Medical Director, NELFT
Jacqui Van Rossum, Executive Director, Integrated Care London & Integration, NELFT
Dr Afifa Qazi, Consultant Psychiatrist, NELFT
Caroline O'Donnell, Managing Director, North East London Community Services, NELFT
Neil Kennett-Brown, Programme Director, NHS England
Prof. Kathy Pritchard, Chief Medical Officer, London Cancer
Louise Dibsdall, Senior Public Health Strategist, Public Health, LBH
Lorraine Hunter, Committee Officer, LBH (Minutes)

Apologies

Joy Hollister, Group Director, Social Care and Learning, LBH
Councillor Lesley Kelly, Cabinet Member, Housing & Public Protection, LBH

62 **APOLOGIES FOR ABSENCE**

Apologies were received and noted.

63 **DISCLOSURE OF PECUNIARY INTERESTS**

None disclosed.

64 MINUTES

The Board considered and agreed the minutes of the meeting held on 9 October 2013 which were signed by the Chairman.

65 MATTERS ARISING/REVIEW OF ACTION LOG

A review of teenage pregnancies/emergency hormonal contraception (EHC) had commenced and that a report would be presented to the Board in the New Year.

The JSNA had been deferred however discussions were progressing

66 FRAIL ELDERLY AND THE INTEGRATED CARE STRATEGY

The Chairman welcomed Dr Steve Feast, Jacqui Van Rossum, Dr Afifa Qazi and Caroline O'Donnell from the North East London Foundation Trust (NELFT). Members of the Board were asked to note the following:

The Trust had been through many changes, originally a mental health trust, (NELFT) now provided mental and community health services for Waltham Forest, Redbridge, Barking and Dagenham, South West Essex and Havering.

The area of North East London increasingly presented many challenges and the NELFT team welcomed the opportunity to engage with the Health and Wellbeing Board acknowledging the importance of holding cross borough dialogue and working together.

New relationships were being built with the Integrated Care Coalition, Urgent Care Coalition and the provision of community mental health services to Barking Havering Redbridge University Trust and Barts Health. The changes within the NHS and the inspection regime made for challenging times ahead.

Following the Francis Report, NELFT staff were on 7 day working, however, the Trust needed to recruit more staff and were finding it difficult competing with the inner London Trusts. In response to the Francis Report, a number of initiatives were organised including the setting up of communication campaigns, conferences, focus groups and the promotion of relevant policies. Whistleblowing was also available as a last but open resort. NELFT had doubled their focus on quality and moved to borough based quality care.

In past years, mental health services had been transformed following the closure of asylums. In addition, there had been a change in approach to medication use and consolidation of community beds into a single high quality unit. A similar pattern had been seen in the care of the frail elderly although it was noted that these patients often have very complex drug

regimes. The model on which only 3% of mental health patients attend an inpatient unit needed to be replicated with the frail elderly.

Members were informed that Havering's award winning service in dementia care had resulted in zero acute admissions for two years. As a result, wards had been closed and funds moved into the community. RAID (Rapid Assessment Interface and Discharge) teams had also saved 2,600 bed days resulting in £1.4M in savings. There were now 2200 staff in partner hospitals who had received training in working with people with mental illness in addition to a 24/7 helpline.

There are now close links with GPs/practice nurses, care homes and Community Mental Health Teams with a consultant mobile number available, same day responses, clinic emergency slots for patients in crisis and contact with all patients who fail to attend clinic appointments. Patients are also encouraged to call the clinic if there are any problems. Stimulation therapy is also available as well as Reminiscence therapy. As a result, care home admissions have dropped.

Average waiting times have been reduced for Memory clinics, Havering has a three week waiting list which compared to the national average is very positive. With regards to acute services, Havering has a new facility at Sunflowers Court and the number of acute admissions has fallen owing to the development of home treatment.

The Community Care Treatment Team was launched in April 2013 and was working with the CCGs, Queens Hospital and the A&E interface as well as the ICC resulting in a 14% reduction in admissions into acute services. The savings in funding has been returned to the Commissioners.

NELFT acknowledged that winter was a challenging period and that contingency plans were in place.

The Chairman thanked the NELFT team for their presentation. It was agreed that it was useful to know that any concerns about services in Havering could be discussed with the Managing Director of Community Services responsible for area. Members of the Board underlined the need to ensure that people in Havering were getting the best care and that mental health services required further development. It was agreed that there was further to work to do in developing projects around prevention linking in with Public Health and the CCG.

67 **INTEGRATION WITH HEALTH**

a) Joint Report from Adult Social Care and Havering CCG on section 256 monies.

The Board noted the report on the provision of section 256 money to local authorities from the NHS for 2013/2014 which required discussion by the Board prior to formal sign off. The report outlined what the money

would be used for, measurable outcomes that the initiatives would achieve together with linkage to the Joint Strategic Needs Assessment (JSNA) and the CCG as well as monitoring arrangements to ensure delivery.

The funding for 2013/2014 for Havering is £3,599.507 and the release of the monies was subject to the following criteria:

- That the money should support adult social care services, which also have a health benefit. Beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.
- To respond to the JSNA and the existing commissioning plans for both health and social care.
- To provide a positive difference to social care services and outcomes for service users.

The Board were asked to approve the use of the S256 money as outlined in the attached matrix.

Several Board members were of the view that the matrix was not detailed enough and it was agreed that this should be refined next year giving more information on cost improvements, cost savings and outcomes.

A request was made for further discussion on the prevention of falls programme and that this should transfer from being a project to a mainstream health issue. In addition, further discussion and review was requested on mental health needs in the borough.

The Board noted the report and agreed to approve the use of the S256 money as outlined in Appendix 2.

b) Future Work on Integrated Transformation Fund

This report informed the Board about the new Integration Transformation Fund which replaces some previous funding streams, including the s.256 money and adds new requirements for partnership working. The fund is contingent upon agreement between the CCG and the Local Authority on areas for joint commissioning to deliver preventative services and reduce pressure on acute services. The proposals would be subject to the Board's approval in February 2014.

The Board noted the report and that the proposals are to be finalised before February 2014.

68 **CANCER AND CARDIOVASCULAR PROGRAMME**

The Board received a report entitled **Improving Specialist Cancer and Cardiovascular Services in North and East London and West Essex**

produced by the North and East London Commissioning Support Unit. The report was presented by Professor Kathy Pritchard-Jones, Chief Medical Officer, London Cancer Academic Health Science Network. Neil Kennett-Brown, London Cancer and the Programme Director, NHS England was also in attendance to offer additional comments.

This report was presented as part of a wide consultation about configuration of cancer services and members of the Board were asked to note the following:

North and East London have expert cancer and cardiovascular doctors but these specialist services were not organised in a way that gave patients the best outcomes with specialists, technology and research being spread across too many hospitals. Evidence gathered by the London Cancer Academic Health Science Network suggested that focused specialist centres would lead to better outcomes. With 15 different pathways in London, a London wide review was underway. Formal engagement, if appropriate, would commence at the beginning of 2014 with NHS England and the CCGs to make decisions by mid-2014.

Cancer

Clinicians had reviewed specialist services for five rare or complex types of cancer:

Brain cancer
Head and neck cancer
Urological cancer (bladder, prostate and kidney)
Blood cancer (treatment of acute myeloid leukaemia and stem cell transplants)
Oesophago-Gastric cancer (stomach or gullet cancer)

The proposal was to create an integrated system of care. It was outlined that there would be a small amount of change within BHRUT as Queens Hospital had provided a range of cancer services for some years, however, it was envisaged that there would be a 3% decrease in Upper Gastro-Intestinal Bladder and Prostrate and Renal activities.

Professor Pritchard-Jones advised Board members that London cancer patients did not always report good experiences with their care and that specialist teams were fragmented and unable to provide a 7 day service. Specialist centres would work with local hospitals and GPs to improve the patient journey and follow up care and would also attract innovation and investment for research as well as attracting the best trainees. Patients would have a better chance of survival, quicker recovery and better quality of life, support from specialist care teams, joined up sustainable 24/7 care and more access to clinical trials with access to the latest treatments. Local services would be more robust and resilient as part of a system, with access to 24/7 specialist teams, better support to introduce innovation and

clinical trials, better training opportunities and more precise outcomes, measurement and benchmarking.

Cardiovascular

A similar review was underway for Cardiovascular services due to patients waiting too long for treatment, surgery cancellations and hospitals unable to deliver 24/7 care by specialist teams.

It was proposed to create a world class integrated Cardiovascular Centre and develop a joined up network of care covering prevention and earlier diagnosis through to treatment of which a majority would be provided closer to people's homes. Patients would have improved experience and outcomes, prompt access to treatment and state of the art equipment, specialist 24/7 care as well as shorter waiting times.

A period of engagement with the public to discuss the above proposals was currently underway. A number of public meetings had been arranged within the inner and greater London areas to obtain feedback and further engagement with Public Health authorities was planned.

Members of the Board raised concerns about the following:

- At times it was not clear that the exercise was actually a consultation and not the presentation of a decision that had already been made.
- The demographic changes within the borough in terms of overall population size and the aging population should be considered in future planning of services. The centralisation of services to London did not make good sense when looking at future population growth across London.
- Survival rates were presented and the proposals aimed at improving survival rates. As survival rates reflect both quality of care and early diagnosis, the need to address lower survival rates without working out how much those rates relate to late diagnosis was not a robust argument.
- The impact of patients having to travel into London to UCL should be assessed as this could have an effect on overall outcomes. This would also have an impact on the elderly, the poor and those who need family support.
- Quality of care is a key factor in decision making about what services configuration is likely to be best and this was not brought out fully in the report. Some of the relevant units in BHRUT have higher quality indicators on a range of measurements than the same units in UCL. It was noted though that there was no standardisation of quality indicators so it was difficult to draw conclusions on quality.
- Why were cancers with the minimum number of cases being centralised?
- It was not clear to what extent consultants agreed with these the proposals.

- Overall there appeared to be a lack of ambition for outer London with specialism being concentrated in inner London hospitals. This has been the pattern for many years and could become a self-fulfilling prophecy.

Professor Pritchard-Jones thanked the Board for their comments and said that their concerns would be noted.

The Chairman thanked both Professor Pritchard-Jones and Neil Kennett-Brown for a frank and open discussion.

69 **ANY OTHER BUSINESS**

None.

70 **DATE OF NEXT MEETING**

Members of the Board were asked to note that the next meeting would be held on 11 December 2013 at 1.30 pm.

Chairman

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Health & Wellbeing Board

Action Log

Minute Ref	HWB Meeting Date	Agenda Item	Actions	Estimated Completion by	HWB Lead / Actioning Officer	on future agenda?	Date Complete
5b (i)	Dec-13	Teenage Pregnancy	Teenage Pregnancy Research/Sexual Health Report	TBA	Chairman & Dr M Black	01/02/2014?	
5b (iii)	Mar-13	Havering Cancer Urology Services	Chair of Havering CCG to write to Chief Executive of NHS England to request public consultation in retaining Cancer Urology Services within the locality	Jul-13	Chairman & Dr M Black	?	
7	Jul-13	Joint Strategic Needs Assessment		On-going	Dr M Black	?	
9	Sep-13	Children & Families Bill	Children's Services to provide further update	Deferred to a later meeting	J Hollister	TBA	
55	Oct-13	Review of Queens Hospital	Invite Chair and/or CEO to address Committee on progress and answer questions		Chairman & Dr M Black	?	
34		Operations/Working Group	Chairman and Director of Public Health to discuss formation of Operations/Working Group linked to Health and Wellbeing Board		Chairman & Dr M Black	TBA	
54	Oct-13	CQC	CQC to provide update to HWB Board	Feb-14	Chairman & Dr M Black	Feb-14	

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Havering
LONDON BOROUGH

HEALTH & WELLBEING BOARD

Subject Heading:	**Community Pharmacy**
Board Lead:	***John Atherton***
Report Author and contact details:	***Suman Barhaya*** ***NHS England***

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☐ Priority 1: Early help for vulnerable people
- ☐ Priority 2: Improved identification and support for people with dementia
- ☐ Priority 3: Earlier detection of cancer
- ☐ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☐ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

This report has been written at the request of the Health and Wellbeing Board, to detail the role of pharmacy. It focuses on what the government guidance is on what pharmacists are expected to deliver, their role and how this ties in with delivery of Emergency Hormonal Contraception.

Pharmacists and chemists play a key role in providing quality healthcare to patients. Working in the community, primary care and hospitals, pharmacists use their clinical expertise together with their practical knowledge to ensure the safe supply and use of medicines by patients and members of the public. The remit of pharmacy clearly goes beyond primary care, however this report predominately focuses on the role of community pharmacy as this is the service which NHS England commission via the contractual framework.

A wide range of services are commissioned through community pharmacy such as minor ailments, public health services e.g. substance misuse services, stop smoking services etc.

RECOMMENDATIONS

- Integration of pharmacies into the provision of primary and public health services such as Emergency hormonal contraception access, free Condom distribution, advice on long term contraception, sign posting and referrals

- A pharmacy emergency contraception service should be commissioned, in line with the majority of boroughs in London and in line with the JSNA recommendations

- Capitalise on the opportunities within pharmacies to provide easy access to sexual health services such as Chlamydia testing, screening and preventative interventions on areas with high sexually transmitted infection rates.

REPORT DETAIL

Pharmacists have to meet standards of conduct, ethics and performance set by the General Pharmaceutical council (GPhC). They set out the behaviors, attitudes and values expected of pharmacy professionals and explain the minimum standards that all pharmacy professionals must comply with. They also inform patients and the public of the standards that they can expect from pharmacy professionals. The standards can be accessed via the link below. http://www.pharmacyregulation.org/sites/default/files/Standards

A community pharmacist works within the contractual framework and is responsible for controlling, dispensing and distributing medicine. The responsibility of performance management of this contract sits with NHS England. Community Pharmacies work within legal and ethical parameters such as the Pharmaceutical Regulations and the Medicines Act to ensure the correct and safe supply of medical products to the general public. They are involved in maintaining and improving people's health by providing advice and information as well as supplying prescription medicines.

Pharmacists are the 3rd largest health profession. For many patients this is the first point of call, not only for medicines expertise but also for health related issues such as minor ailments, healthy living advice and long term conditions. The public appreciate not having to make an appointment and using the service at their

convenience. The anonymity of the service allows patients to confidently access and seek advice, when they routinely might avoid asking for help.

Community pharmacists play a pivotal role in empowering people to look after their own health and can reduce health inequalities by opportunistic targeting. Their expertise in not only utilised in NHS services but in also in public health and social care services. The public has most to gain from community pharmacy being integrated into wider care pathways.

The government has plans for community pharmacy development to improve health outcomes through optimising medicines use and provisions of other health services. This overall strategic direction has a clear focus on the public health agenda. Achieving this will only be possible with commissioner and patient engagement. Community pharmacies are contractually required to have a public health role. They deliver this by health promotion, sign posting, self-care advice and referrals. Anything beyond this would have to be commissioned by relevant commissioning bodies. The remit of commissioning health services such as access to free emergency hormonal contraception would be via local Public Health teams.

The access and footfall that Community pharmacy offers can make a significant contribution to primary care services.

Sexual health services should be accessible by patients in any borough regardless of where the individual resides in the UK. It may be possible to determine if Havering residents access these services in neighbouring boroughs from community pharmacies, as most of the surrounding boroughs commission this service from their community pharmacies. This information should be accessible from Public Health teams if it is collected.

How community pharmacy can contribute:
Key Points:

- A pharmacy emergency contraception service should be commissioned, in line with the majority of PCTs in London and in line with the JSNA recommendations
- A contraceptive service though pharmacy can be piloted in the specific wards in line with successful pilots in other PCTs and in line with the JSNA recommendation to investigate ways of improving access to contraceptive services

The JSNA recommended Decision Makers to Investigate ways of improving access to contraceptive services (such as free emergency contraception for young people, introducing a community based contraceptive service and improving access to the most effective long acting reversible contraception methods).

Community Pharmacy can make a positive contribution by working effectively with commissioners to deliver on local strategies and improving patient outcomes.
Investment will be required to commission a service such as access to emergency hormonal contraception and could be a potentially progress limiting factor.

IMPLICATIONS AND RISKS

Financial implications and risks: To commission any services would have financial implications for local authorities and potential CCGs.

Legal implications and risks: none to consider.

Human Resources implications and risks: none to consider

Equalities implications and risks: none to consider

BACKGROUND PAPERS

1. **Havering PNA**

PharmaceuticalNeeds Assessment[1].pdf

HEALTH & WELLBEING BOARD

Subject Heading:	**Commissioning Strategic Plan 2014/15 and planning update**
Board Lead:	**Dr. Atul Aggarwal, Chair, Havering CCG**
Report Author and contact details:	**Jessica Arnold, Senior Locality Lead, Havering CCG (*Jessica.arnold@haveringccg.nhs.uk*)**

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- ☒ Priority 1: Early help for vulnerable people
- ☒ Priority 2: Improved identification and support for people with dementia
- ☒ Priority 3: Earlier detection of cancer
- ☒ Priority 4: Tackling obesity
- ☒ Priority 5: Better integrated care for the 'frail elderly' population
- ☒ Priority 6: Better integrated care for vulnerable children
- ☒ Priority 7: Reducing avoidable hospital admissions
- ☒ Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

The planning process for 2014/15 is now well underway at Havering CCG. This covers the CCG's commissioning intentions, Commissioning Strategic Plan, joint commissioning plans with the local authority and QIPP plan.

NHS England has given initial indications to CCGs that they will be required to produce a two-year operational plan and five-year strategic plan.

Havering CCG has been engaging with its stakeholders since early September as part of the planning process, ensuring that clinicians, patients and partners are able to influence plans.

RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the CCG's progress towards planning for 2014/15 and its engagement with various stakeholders, as summarised in this report.

REPORT DETAIL

1.0 Purpose of the Report

1.1 This report aims to update the Havering Health and Wellbeing Board about Havering CCG's progress in developing commissioning intentions, a Commissioning Strategic Plan, a Joint Commissioning Plan and a QIPP Plan for 2014/15. The report covers the engagement that has been undertaken by the CCG to date to shape our plans, and the next steps in the planning process.

2.0 Introduction

2.1 The planning process for 2014/15 is now well underway at Havering CCG. This paper sets out the progress against developing the CCG's commissioning intentions, Commissioning Strategic Plan, joint commissioning plans with the local authority and QIPP plan. The appendices set out draft summaries of each of these plans, except the QIPP Plan which is still in the early stages of development.

2.2 Engagement has been a driving force behind planning for 2014/15, with the CCG undertaking numerous engagement events early with key stakeholders and using the feedback to develop the first drafts (rather than simply consulting on drafts once they have been written). This report sets out the engagement on planning and priorities that has taken place to date, and that is planned for coming months.

2.3 Guidance, templates and tools have not yet been issued from NHS England and are not expected until 16th December. However, Havering CCG is forging ahead with the planning process and is on target with its project plan for developing plans and getting them signed off by the CCG decision-making bodies (Executive Committee or governing body) and the Health and Wellbeing Board prior to submission.

2.4 NHS England has given initial indications to CCGs that they will be required to produce a two-year operational plan and five-year strategic plan.

2.5 External deadlines from NHS England are:

- First submission – 14th February
- Contracts signed – 28th February
- Second submission following contract sign off – 5th March
- Submission of final operational plans and draft strategic plans – 4th April
- Submission of final strategic plans – 20th June

3.0 Identifying need and drivers of the planning cycle

The CCG's planning cycle is driven by the intelligence provided by the Joint Strategic Needs Assessment (JSNA). The JSNA has been used to actively inform our engagement events, setting the scene with a focus on the demographics and identified health needs of the Havering population. The CCG is also playing an active role in the refresh process for the JSNA, attending the JSNA steering group and providing input into the chapters on acute care and children's services in particular.

This use of the JSNA has meant that the draft plans to date reinforce the commitments made by the CCG, local authority and partners through the Health and Wellbeing Strategy. As the CSP develops, the CCG will ensure final versions are consistent with, and where applicable, linked to, Health and Wellbeing Strategy actions.

4.0 Commissioning Intentions for 2014/15

4.1 Havering CCG submitted its commissioning intentions to its main acute, community and Mental Health providers in late September 2013, giving providers six months notice of high level intentions for 2014/15. The submitted commissioning intentions can be found in Appendix A.

4.2 Commissioning intentions were developed through a Joint Executive Team workshop with senior officers and clinicians across BHR CCGs, building on earlier discussions and plans within each CCG.

5.0 Commissioning Strategic Plan progress

5.1 Building on the commissioning intentions and further to the engagement undertaken by the CCG (outlined in section 7.0), the CCG has developed a draft Commissioning Strategic Plan for 2014/15. A summary of the draft CSP can be found in Appendix B.

5.2 The full version of the draft CSP will be developed further during December and January as discussions continue with the local authority and across BHR CCGs, and as the CCG expands individual plans into projects in readiness for 1st April 2014.

6.0 Joint Commissioning Plan progress

6.1 Following discussions with local authority colleagues and a successful planning workshop with adults and children's social care, education and public health, a draft Joint Commissioning Plan has been prepared and circulated for further development to the local authority. This can be found in Appendix C.

6.2 Each of the plans and projects set out in the draft will be developed in coming months to agree between the local authority and CCG the outcomes aimed for, the approach to be taken and joint funding arrangements. Work will commence as soon as possible (or in some cases, has already commenced) to get many of the projects or new contracts in place ready for 1st April.

6.3 Our joint commissioning plans with LBH will form the foundation of Havering's proposals to NHS England and the LGA for using our Integrated Transformation Fund allocation. This will build on the integrated working that has been consolidated between the local authority and CCG throughout 2013, working closely with other partners and our providers. It will also seek to draw out our joint vision of the future, in terms of joint contracts, pooled budgets and shared team working.

7.0 QIPP Development for 2014/15

7.1 The estimated QIPP savings target for 2014/15 will be £14.7m. This is considerably more than the 2013/14 target of £11m, but is yet to be confirmed. The message from the Finance team regarding QIPP, is that a small number of large schemes (preferably contract-driven schemes) will be the key to meeting demanding QIPP savings targets.

7.2 QIPP development began in mid November. The CCG has submitted a long list of high level ideas, drawn from the commissioning intentions, to the CSU Delivery Improvement Unit (DIU). The DIU are providing data analysis to scope the extent of savings for each idea, and also to 'deep dive' planned and unplanned data to identify potential new QIPP schemes. This will be presented back to clinicians and officers at a workshop on 6th December. Clinical input will be gathered from Clinical Directors in each of the three CCGs, and inform development of a QIPP short list. The short list will be presented at a second workshop on 20th December.

7.3 Members will be consulted on QIPP development and proposed schemes during December and January. A draft QIPP Plan will come back to the Executive Committee or governing body as soon as it is available.

8.0 Engagement with stakeholders to shape our plans

8.1 Havering CCG has been engaging with its stakeholders since early September to develop its commissioning intentions and strategic plans for 2014/15. Engagement is a crucial part of the planning cycle, ensuring that clinicians, patients and partners are able to influence plans to make them robust, appropriate and yet ambitious.

8.2 Havering CCG has held engagement events to discuss and develop it's CSP and joint commissioning priorities with the following groups: Patient Engagement and Reference Forum; Dementia Partnership Board; Children's Health Overview and Scrutiny Committee topic group; London Borough of Havering (various services); Public Health; Joint Executive Team and Joint Management Team; Barking and Dagenham CCG; and Redbridge CCG.

8.3 Further engagement events are planned in December-March with the CCG member GP practices; community and voluntary sector; and local authority. The stakeholder feedback from this engagement had been constantly incorporated into drafts of plans.

9.0 Next steps in the planning process

9.1 Contract negotiations with the CCG's main providers – BHRUT, NELFT and NELCS – will be ongoing over coming months following submission (and six

months notice) to the providers of the CCG's commissioning intentions. This will be managed by the CSU Contracting team on behalf of BHR CCGs.

9.2 Guidance from NHS England is due to be released in December giving more detail about what NHS England expects from CCGs and what will need to be submitted for the deadlines set out in section 2.5 of this report. Until the guidance is released, Havering CCG will continue to develop the anticipated content and project paperwork for its plans, prior to the final templates being available.

9.3 Development of the CCG's Joint Commissioning Plan and preparations for using the Integrated Transformation Fund will continue with directors and senior managers at the London Borough of Havering. This has proven a productive and mutually beneficial relationship that continues to be strengthened as we discuss joint delivery models and pooled funding with colleagues delivering social care alongside the health services. Commitment has been shown on both sides towards integrated working and joint commissioning from 2014/15 (or sooner in some areas).

9.4 Next steps for development of a QIPP Plan that delivers challenging savings targets in 2014/15 have been set out in section 7.0 of this report.

9.5 Engagement and steps towards approval of the CCG's plans will continue throughout December-March. This includes a final draft been taken for approval by the Health and Wellbeing Board on 12th February, and a final draft been signed off at the CCG governing body on 26th March.

IMPLICATIONS AND RISKS

Financial implications and risks: There are no resource implications arising from the planning cycle. The QIPP Plan will set out the suite of projects that form the CCG's financial savings plan for 2014/15. The level of savings modelled within the QIPP Plan will need to total the CCG's budget gap (when confirmed by Finance but expected to be circa £15m) to achieve financial stability and sustainability.

Legal implications and risks: There are no legal implications arising from the planning cycle.

Human Resources implications and risks: There are no HR implications arising from the planning cycle.

Equalities implications and risks: There are no equalities implications arising from the planning cycle.

BACKGROUND PAPERS

Appendices:

1. Appendix A: Havering CCG Commissioning Intentions for 2014/15
2. Appendix B: Summary of draft Commissioning Strategic Plan
3. Appendix C: Draft Joint Commissioning Plan with LBH

Appendix A:
Havering CCG Commissioning Intentions for 2014/15

	COMMISSIONING INTENTIONS	***DRIVERS***
1	Review Urgent Care pathway - end to end	Ineffective urgent care pathway with duplication and inappropriate attendances
2	Improve Urgent Care Centres at KGH / Queens to provide primary care front door to A&E for all age ranges including paediatric patients	PELC run KGH, BHRUT Queens but the conversion rates to the UCC are low and not comparable with other units
3	Review of provision for patients with mh/sub use problems at A&E, increase psychiatric liaison support to A&E/improve response times, consider alternative care pathways	Current concerns about access to MH for A&E at Queen's. Frequent attendees at A&E with MH problems
4	Review walk-in centres capacity and use and enhanced service model that will work more closely with general practice as part of an urgent care pathway	Harold Wood / Orchard Village utilisation and effectiveness to improve
5	Improved pathways for patients with chronic conditions to bypass A&E	e.g. Cancer patients, fractures, Parkinson's accessing services via A&E as found in the frequent attendees audit
6	Improved primary care access for urgent care appointments	Patients access to primary care limited at weekend CCG is piloting weekend opening scheme
7	Review of 111 service and OOH	111 service and OOH contracted separately
8	Frail Elders Pathway review	Ineffective and disjointed pathways for Frail elder care
9	Commissioning of diagnostics	A range of diagnostics are commissioned from In Health currently but the contract finishes on 31/3/14 and will need to be re-procured
10	Review of Urology pathway across primary and secondary care	Disjointed pathway
11	Develop and commission integrated Pain service	Concerns re access to/waiting times for physio, lack of coordination of services relating to pain management, elective procedures and diagnostics. High rate of rheumatology follow-ups
12	Commission a post op wound care and leg ulcer service.	Current gap in service identified
13	Implement POLCV policy across all providers.	Policy has recently been approved and is not yet embedded.
14	Review commissioning of phlebotomy services.	poor local access
15	Demand management of outpatient activity at locality level.	Patients are receiving services in secondary care that could be managed in primary care.
16	full year effect of new community services – ophthalmology, dermatology, gynaecology and ENT	Review to see if the activity levels can been increased to reduce the patients needing to attend secondary care
17	Increase access for GPs to advice and guidance	
18	Review of cardiology pathway across	disjointed pathway

	primary and secondary care	
19	Review of rheumatology pathway across primary and secondary care	disjointed pathway
20	Winterbourne review - Learning Disabilities	Enter into joint commissioning arrangement with LBH for LD services ensuring implementation of Winterbourne concordat.
21	Dementia: • Havering is signed up to being a dementia friendly community, and expects services it commissions to be delivered by dementia friendly providers • Havering CCG will increase the rate of diagnosis of dementia • Havering CCG will consider commissioning primary care memory clinics or shared care diagnosis to increase access to diagnostic services	More patients are been screened for dementia and need to ensure that memory clinics have sufficient capacity
22	IAPT - widen to cover Pain, unexplained medical symptoms	IAPT provided by NELFT
23	Review commissioning of mental health employment services.	Services currently provided by providers, one jointly commissioned with LA.
24	Review falls service Enhanced falls service as part of integrated care service. Havering CCG serve formal notice on the Falls Community Exercise Programme and Outreach Service to Care Homes. This element of the falls service was commissioned during 11/12, with funding of £106k allocated (FYE). Havering CCG wish to work with NELFT and Public Health as part of contract negotiations for 14/15 to agree an optimal falls service model, within the reduced funding available.	Gap in falls service identified in relation to prevention and therapies post falls inc with fracture
25	Joint Assessment and Discharge service	5 different discharge teams commissioned/provided separately operating out of BHRUT: BHRUT discharge team; NELFT discharge team and discharge teams for B&D, Havering and Redbridge local authorities.
26	Community Bed Base: 44 beds to be commissioned 14/15-subject to system check processes. Bed centralisation: subject to the outcome consultation 13/14 and confirmation of timescales from BHRUT	Community Bed Base: anticipated that 75 beds will be in the system at year end-subject to productivity improvements
27	Community Treatment Team: mainstreamed 14/15. Consider move to activity based contract	Community Treatment Team: in place and proposals currently being considered to expand
28	Intensive Rehabilitation: mainstreamed 14/15	Intensive Rehabilitation: proposals currently being considered to develop this new

		service
29	Integrated Heath Teams: mainstreamed 14/15 with reconciliation from separate teams into one IHT per locality	Integrated Heath Teams: proposals currently being considered to reconfigure the ICM; district/community nursing; LTC services, community therapy; mental health link worker services into IHTs
30	Community LTC services to be reviewed in line with integrated care services and improved primary care	Separate LTC services need to be integrated with community services and primary care
31	Further develop the long term conditions year of care funding model.	Year 2 of DH pilot.
32	Improved quality of care for nursing home residents	High rates of hospital admissions from nursing homes, gaps in services
33	Assistive Technology / Telehealth	Some pilots funded through S256
34	Patients receiving continuing care to be offered personal health budgets.	Offer limited to patients who were part of the national pilot.
35	Commission community equipment service.	Gap in service
36	EOLC improved co-ordination via ICM, increased community nursing levels, local implementation of LCP	Fewer people dying in place of choice and being identified as EOLC than expected, national review of LCP leading to new recommendations on implementation
37	Review commissioning of SALT and portage services for children.	Growing population of children and young people.
38	Ensure commissioned health services for looked after children and young offenders are comprehensive and deliver best outcomes.	Growing population of looked after children. Community and mental health services are not integrated.
39	Implement the recommendations in the children and Families bill for children with special educational needs.	Health and education services are not coordinated for children with SEN.
40	Assurance that NHSE commissioning of primary care is line with Commissioning Intentions above	Gaps in primary care provision and over reliance on secondary care as noted above
41	Public health programmes to be fully supported/commissioned by LBH public health team	Need to address high rates of obesity, smoking and alcohol use in B&D, commission primary care to do e.g. IUCDs
42	IAPT services ensure a smooth transition from CAMHS into adult MH services, and ensure these transitions have a person-centred approach. CAMHS and CYP IAPT cover depression.	The transition of young people out of CAMHS when they reach 18 is problematic Growing numbers and high profile CYP with depression.

Appendix B:
Summary of draft Commissioning Strategic Plan 2014/15

1.0 Planned Care and General Practice

- Improve the currently disjointed pathway for frail elders, working across health and social care providers to reduce unplanned attendances and improve the quality of care homes
- Commission an integrated pain service to address persistent concerns about access to and waiting times for physiotherapy
- Review the rheumatology pathway across primary and secondary care, working with providers and GPSIs to reduce rheumatology outpatient attendances
- Review the currently disjointed urology pathway for patients across primary and secondary care, working with the acute trust and GPSIs
- Review the currently disjointed cardiology pathway for patients across primary and secondary care, working with the acute trust and GPSIs
- Explore the potential to shift provision of ECG tests from acute and independent providers into primary care
- Re-procure our contract with InHealth for the provision of diagnostics beyond 31st March 2014, reviewing the quality and cost effectiveness of each diagnostic and removing duplication
- Improve access to phlebotomy services, seeking to bring these services back into General Practice and the community
- Improve access to post operative wound care, seeking to bring these services back into General Practice and the community, to improve patient satisfaction and convenience and reduce costs
- Continue the outpatient demand management programme to reduce avoidable and unnecessary referrals, analysing data to identify the priority specialties for 2014/15. This will include increasing the availability of advice and guidance services for GPs; promoting use of existing community services; and exploring the potential to establish additional community services, e.g. for rheumatology and gastroenterology
- Work with clinicians in primary and secondary care across BHR to develop a new policy for Procedures of Limited Clinical Value (POLCV), and ensure the prior approval and challenge processes are robust

2.0 Unplanned Care and A&E

- Review the urgent care pathway from end-to-end, improving the currently ineffective pathway that sees frequent duplication and inappropriate attendances. This will include redirection of patients from A&E to the Urgent Care Centres (UCCs) as appropriate
- Reviewing the capacity, utilisation and effectiveness of the Walk-In Centres, and potentially shift to an enhanced service model
- Lobby Transport for London, alongside with the local authority, to improve public

transport access to the Harold Wood Walk-In Centre

- Mainstream the weekend opening pilot whereby GP practices will open for eight hours on a Saturday and Sunday to see patients who require urgent attention and reduce pressure on A&E
- Pilot the Patient Access Method in some GP practices, to offer telephone triage and same-day emergency appointments
- Examine the availability of nurses and appointments with nurses in GP practices
- Explore the possibilities of alternative emergency pathways for people with Mental Health, including psychiatric liaison support to A&E and the role of the crisis team
- Improve pathways for people with chronic conditions
- Work with NHS111 to ensure that local services and pathways are incorporated into the responses that NHS111 operatives give to Havering patients who call in
- Review the contracts for NHS111 and Out-of-Hours services and opportunities for streamlined services
- Towards patient education, explore the possibility of piloting a scheme whereby patients attending A&E are given a slip of paper when they leave the hospital that states how much their treatment cost today, and what it would have cost in primary care or a Walk-In Centre
- Encourage GPs to call patients following an unnecessary or avoidable A&E attendance to talk to them about why they went to A&E and what other routes they might take in future
- Work with the Public Health team to support any forthcoming projects or campaigns that aim to influence patient behaviour

3.0 Integrated Care

- Commission 44 additional community beds, subject to system check process and productivity improvements
- Mainstream the Community Treatment Team and potentially move to an activity based contract
- Mainstream the Integrated Health Teams, conflating the separate teams into one IHT per locality
- Review provision of community services for people with long terms conditions (LTC), incorporating these into the wider integrated care model
- Review the falls service, from prevention through to therapies and treatment for fractures, and seek to move to an enhanced model of joint commissioning falls services with the local authority
- Review and improve the discharge process of patients from acute care back into their home, residential care or community or reablement beds, conflating five discharge teams towards an integrated model
- Work with LBH to develop an Intensive Rehabilitation service
- Support LBH's planned review of utilisation of Royal Jubilee Court, protecting against inappropriate referral of patients into RJC

- Mainstream Assistive Technologies and Telehealth jointly with the local authority, increasing independence of patients and supporting carers
- Ensure all residential care homes and Learning Disabilities homes in Havering are aligned to named GPs that provide frequent visits to homes
- Work closely with the BHR CCGs nursing directorate and the local authority to ensure patient safety and the quality of care provided in nursing homes is above and beyond expected standards
- Improve End of Life Care through an integrated approach with the local authority, linking in a more coordinated way to ICM and community nursing. This will include increasing identification of EoL patients and patients dying in their preferred place of choice, and implementing the Liverpool Care Pathway and the Gold Standard Framework in all nursing homes and GP practices
- Work closely with community and voluntary sector organisations to identify where the sector might provide health services
- Monitor and assess the new shared framework agreement for purchasing community equipment
- Review wheelchair commissioning arrangements, including wheelchairs for children
- Roll out personal budgets will be rolled out for children's and adults health care from 1st April 2014
- Use integrated commissioning funds to boost seven day working in primary and secondary care wherever possible

4.0 Mental Health

- Be a dementia friendly community and expect the services that we commission to be delivered by dementia friendly providers
- Continue working with GPs and practice staff to identify dementia and particularly to identify dementia earlier. This will include screening more patients and improving access to dementia diagnostics
- Review provision of memory clinics and seek to shift these into primary care where possible
- Continue to commission dementia advisory services from Age Concern Havering, assigning a caseworker from Age Concern to dementia sufferers
- Enter into joint commissioning arrangements for Learning Disabilities with LB Havering
- Re-procure Psychological Therapies to put into place an improved service, including identification and therapies for unexplained medical symptoms
- Explore the potential of psychological therapies and counselling services being offered within GP practices
- Re-procure services to help people with Mental Health problems to access employment, volunteering or training opportunities
- Review commissioning arrangements with our main Mental Health provider and

scope potential to jointly commission these services

- Expand CQINs used to monitor outcomes from Mental Health and community service contracts and incorporating local authority priority outcomes
- Produce a joint Mental Health commissioning strategy with LBH, covering children and adults mental health

5.0 Carers

- Invest in carers and community resilience jointly with the local authority, developing a joint plan and pooled budgets. This will cover training requirements, respite and benefits
- Increase identification of carers and develop a carers register

6.0 Children's Services

- Implement the changes to services for children with Special Educational Needs and Disabilities (SEND), working with the local authority, including implementing a single assessment process for at-risk children to develop joint Education, Health and Care Plans; offering children and young people and their parents and carers personal budgets; and appointing a Designated Medical Officer for children with SEND
- Re-procure Speech and Language Therapy to improve access and quality of service
- Review provision of Children and Adolescent Mental Health Services at all tiers, including specialist tiers 3 and 4 commissioned by NHS England
- Work with the local authority to ensure a smooth and person-centred transition of adolescents from CAMHS into adult Mental Health services when they reach 18 years old
- Meet CCG responsibilities towards Looked After Children (LAC) through working closely with the local authority and the BHR central nursing directorate
- Meet CCG responsibilities towards young offenders through working closely with the local authority, Police and other key stakeholders through the Youth Offending Service Chief Officer Group
- Continue to deliver the improvement programme around maternity services and care of new mothers and newborns
- Appoint a dedicated children’s commissioner to provide the vital support for delivering the new duties conferred on the CCG since it’s establishment in April 2013
- Work closely with Public Health colleagues to support projects and campaigns related to children’s health and wellbeing, e.g. smoking cessation during pregnancy
- Review opportunities for joint commission of children’s services with LBH

Appendix C:
Draft Joint Commissioning Plan with London Borough of Havering

1.0 Planned Care and General Practice

1.1 Frail elders pathways

We are aware of the disjointed pathways often experienced by frail elderly patients, and will work with the local authority, hospital, community services, voluntary sector and care homes to improve the experience and outcomes of frail elders. Key priorities are reducing the number of unplanned attendances to hospital amongst this group and improving the quality of care homes.

2.0 Unplanned Care and A&E

2.1 Urgent Care pathways

We intend to ensure there is an appropriate balance of provision in primary, secondary and social care across the whole working week and appropriately through the working day.

2.2 Mental Health emergencies

We acknowledge the feedback from patients and clinicians, that the A&E department is not a suitable place for many people with Mental Health conditions. The CCG will explore the possibilities of alternative pathways for people with Mental Health, which would be especially vital on weekend evenings when a large proportion of A&E attendances are alcohol related.

Psychiatric liaison support to A&E will be increased so that response and waiting times decrease. This will also cover patients attending A&E for due to substance abuse. The role of the crisis team will also be reviewed, and improvements made to keep people with Mental Health conditions away from A&E. The CCG will work with the local authority to look at the role of social workers in preventing A&E attendances amongst people with Mental Health conditions and Learning Disabilities.

2.3 Influencing patient behaviour

The CCG will work with the Public Health team to support any forthcoming projects or campaigns that aim to influence patient behaviour and thus improve health and wellbeing outcomes and reduce use of secondary care.

3.0 Integrated Care

3.1 Community services

The Integrated Health Teams will be mainstreamed from 2014/15, conflating the separate teams into the localities. This process will lead to improved ICM outcomes, district/community nursing, long term conditions services and community therapies. Mental Health link workers will be incorporated into IHTs.

Provision of community services for people with long terms conditions (LTC) will be reviewed. Currently, these are separate services but they will need to be part of the wider integrated care model from 2014/15 and have a stronger link to primary care. Prioritisation of the different categories of long term conditions will be based on sound evidence within the refreshed JSNA. This will improve coordination of services for LTC patients, improving patient experience through a joined up approach and reducing costs from inefficiency. The Year of Care pilot for LTC will continue into its second year of operation, supporting better outcomes through integration.

3.2 Falls prevention and management

The CCG will holistically review its falls service, from prevention through to therapies and treatment for fractures, and seek to move to an enhanced model of joint commissioning falls services with the local authority.

3.3 Joint Assessment and Discharge

The CCG will review and improve the discharge process of patients into their home, residential care or community or reablement beds.

3.4 Rehabilitation and reablement

The CCG will work with the Local Authority to develop an Intensive Rehabilitation service seeking to increase independence and reduce A&E admissions and reliance on community beds.

Through section 256 funding, Assistive Technologies and Telehealth will be mainstreamed after successful piloting. This will grow the scope and reach of such technologies to patients that will tangibly benefit, e.g. dementia sufferers, and their carers. This will reduce stress, mitigate risk of accidents and increase independence of patients and carers. Awareness amongst all GPs will be raised so that both health and social care are recommending their use.

3.5 Improving quality of care in nursing homes

The CCG will work closely with the local authority to ensure patient safety and the quality of care provided in nursing homes is above and beyond expected standards. The CCG will work with nursing homes where falls and pressure sores are recurring problems, and seek to implement effective solutions to these and similar problems.

3.6 End of Life care

The CCG will improve End of Life Care through an integrated approach with the local authority, linking in a more coordinated way to ICM and community nursing. An End of Life sub-group of the Integrated Care steering group was set up in October 2013 across BHR CCGs and local authorities, with borough also having its own operational working group. The CCG with partners will seek to increase the number of people who are identified as End of Life patients and are able to die with dignity in their place of choice.

3.7 Integrated commissioning

Personal budgets will be rolled out for children's and adults health care from 1st April 2014. This will enable adults to buy their own care services where they opt out of the 'Local Offer' from the CCG and local authority. Parents will be able to do the same for their children, for the first time from April. Although the details of how personal budgets will be administrated, monitored and reviewed are yet to be developed working in partnership, the national personalisation programme aims to empower patients to commission their own care to suit their own needs and increase their satisfaction with health and life outcomes.

4.0 Mental Health

4.1 Dementia

The CCG is signed up to being a dementia friendly community, expecting the services that it commissions to be delivered by dementia friendly providers.

4.2 Learning Disabilities (LD)

The CCG will consider joint commissioning arrangements, working with the main NHS Mental Health provider, care homes and assessment and treatment units. A specific area of focus will be the transition of people with LD from childhood (children's social

care) to adulthood (adult's social care).

4.4 Employment Services

The CCG will consider reprocuring services to help people with Mental Health problems to access employment, volunteering or training opportunities. There is a well-documented link between participation in employment or other meaningful occupation, with greater and faster recovery from many Mental Health problems. Employment services have previously been disjointed and poorly contract managed to identify demonstrable outcomes for service users.

4.5 Approach to MH commissioning and contract management

Both the CCG and the local authority, as commissioners of Mental Health services, will need to provide a more proactive and assertive approach to procurement, contract negotiations and monitoring/management, all of which should be outcome focused. Rather than having two separate contracts, there is the potential to have one contract awarded by both commissioners, with scope for some variations as necessary. The CCG and local authority might also seek to procure services from other providers not previously commissioned, and instigate improvements to the market towards a more mixed economy.

The CCG will seek to expand its CQUINs, used to monitor outcomes from its Mental Health and community services, to incorporate local authority priority outcomes. This will hold providers to account against key performance indicators for both commissioners.

5.0 Carers

It is the intention of the CCG to invest in carers and community resilience jointly with the local authority, developing a joint plan and pooled budgets to support carers in the vital role they play.

Engagement with patients and the voluntary sector has identified a number of ideas and areas for developing support for carers.

6.0 Children's Services

6.1 Special Educational Needs and Disabilities (SEND)

The CCG will work closely with colleagues in the schools and social care services of the local authority to implement the changes to services for children with Special Educational Needs and Disabilities (SEND) likely to be mandated in the Children and Families Bill. The changes, most of which are due to be implemented from 1st April 2014, include:

- Implementing a single assessment process for at-risk children to develop joint Education, Health and Care Plans, delivered through a multi-agency approach centred on the child
- Offering children and young people and their parents and carers personal budgets to meet their care needs from an increasingly competitive care and health service economy
- Appointing a Designated Medical Officer for children with SEND

6.2 Children and Adolescent Mental Health Services (CAMHS)

The CCG will review provision of Children and Adolescent Mental Health Services at all tiers (tier one being low level, universal services and tier four being specialised, inpatient services). Access to CAMHS is limited and review of these services jointly with the local authority is intended to lead to improvements in the specification,

provision and management of contracts.

Specialised CAMHS at tiers three and four, which are commissioned by NHS England, are a particular concern as there has been poor communication and cess to the services. The CCG will work with the other BHR CCGs and the corresponding local authorities to working with NHS England to improve access and performance of specialised CAMHS. This is crucial given the correlation between adolescent Mental Health problems and young offending.

6.3 Looked after Children (LAC)

The CCG will seek to discharge its responsibilities towards Looked After Children (LAC) through working closely with the local authority. This particularly includes ensuring LAC receive Health and Dental Checks – an explicit responsibility following the transition to CCGs from PCTs. The CCG aims to improve health outcomes for LAC in 2014/15.

6.4 Young Offenders

CCGs now have responsibilities to assess and meet the health needs of young offenders. The CCG will explore how this responsibility can best be discharged, especially focusing on Mental Health and substance abuse services for young offenders.

6.5 Approach to children's commissioning

The CCG will be seeking to appoint a dedicated children's commissioner in early 2014 to lead implementation and improvement of the many projects and priorities regarding children's services and commissioning. This will be a joint post between the local authority and the CCG, and provide the vital support for delivering the new duties conferred on the CCG since its establishment in April 2013.

The CCG will work closely with Public Health colleagues to support projects and campaigns related to children's health and wellbeing.

The CCG will undertake a joint review with the local authority of all of the services for children that each organisation commissions, with a view to identifying the gaps that exists, any duplication and any areas where joint commissioning may lead to better outcomes for patients and increased cost effectiveness. This will ensure alignment of children's commissioning to our shared priorities and strategic goals.

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