HEALTH & WELL-BEING BOARD (CROYDON)

To: **Elected members of the council:**
Councillors Alisa FLEMMING, Yvette HOPLEY, Maggie MANSELL (Chair), Margaret MEAD (Vice-Chair), Louisa WOODLEY

Officers of the council:
Paul GREENHALGH (Executive Director of Children, Families & Learning)
Hannah MILLER (Executive Director of Adult Services, Health & Housing)
Dr Mike Robinson (Director of public health)

NHS commissioners:
Dr Agnelo FERNANDES (NHS Croydon Clinical Commissioning Group)
Dr Jane FRYER (NHS England)
Paula SWANN (NHS Croydon Clinical Commissioning Group)

Healthwatch Croydon
Vanessa HOSFORD (Healthwatch Croydon)

NHS service providers:
Steve DAVIDSON (South London & Maudsley NHS Foundation Trust)
John GOULSTON (Croydon Health Services NHS Trust)

Representing voluntary sector service providers:
Kim BENNETT (Croydon Voluntary Sector Alliance)
Steve PHAURE (Croydon Voluntary Action)
Nero UGHWUJABO (Croydon BME)

Representing patients, the public and users of health and care services:
Mark JUSTICE (Croydon Charity Services Delivery Group)
Karen STOTT (Croydon Voluntary Sector Alliance)

Non-voting members:
Ashtaq ARAIN (Faiths together in Croydon)
Marie T BROWN (Croydon College)
TBA (Metropolitan Police)
Adam KERR (National Probation Service (London))
David LINDRIDGE (London Fire Brigade)
Andrew McCOIG (Croydon Local Pharmaceutical Committee)
Lissa MOORE (London Probation Trust (Croydon))

A meeting of the **HEALTH & WELL-BEING BOARD (CROYDON)** will be held on **Wednesday 10th December 2014** at **2:00pm**, in **The Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX**.

JULIE BELVIR
Council Solicitor & Monitoring Officer,
Director of Democratic & Legal Services,
London Borough of Croydon
Bernard Weatherill House
8 Mint Walk
CR0 1EA

MARGOT ROHAN
Senior Members Services Manager
(Democratic Outreach)
(020) 8726 6000 Extn.62564
margot.rohan@croydon.gov.uk
www.croydon.gov.uk/agenda
1 December 2014

Members of the public have the opportunity to ask questions relating to items on this agenda of the Health & Wellbeing Board, either in advance or at the meeting, at the discretion of the chair.
Written questions should be addressed to:
Margot Rohan, Democratic Services & Scrutiny, Bernard Weatherill House, 4th Floor Zone G, 8 Mint Walk, Croydon CR0 1EA or email: margot.rohan@croydon.gov.uk
Questions should be of general interest, not personal issues. Written questions for raising at the meeting should be clearly marked.
Other written questions will receive a written response to the contact details provided (email or postal address) and will not be included in the minutes.
There will be a time limit for questions which will be stated at the meeting.
Responses to any outstanding questions at the meeting will be included in the minutes.

AGENDA - PART A

1. Minutes of the meeting held on Wednesday 22nd October 2014 (Page 1)

To approve the minutes as a true and correct record.

2. Apologies for absence

3. Disclosure of Interest

In accordance with the Council's Code of Conduct and the statutory provisions of the Localism Act, Members and co-opted Members of the Council are reminded that it is a requirement to register disclosable pecuniary interests (DPIs) and gifts and hospitality in excess of £50. In addition, Members and co-opted Members are reminded that unless their disclosable pecuniary interest is registered on the register of interests or is the subject of a pending notification to the Monitoring Officer, they are required to disclose those disclosable pecuniary interests at the meeting. This should be done by completing the Disclosure of Interest form and handing it to the Business Manager at the start of the meeting. The Chairman will then invite Members to make their disclosure orally at the commencement of Agenda item 3. Completed disclosure forms will be provided to the Monitoring Officer for inclusion on the Register of Members' Interests.

4. Urgent Business (if any)

To receive notice from the Chair of any business not on the Agenda which should, in the opinion of the Chair, by reason of special circumstances, be considered as a matter of urgency.

5. Exempt Items

To confirm the allocation of business between Part A and Part B of the Agenda.

6. Commissioning intentions 2015/16 (Page 9)

The report of Croydon Council's Executive Directors of Adult Services, Health & Housing and Children, Families & Learning, the Chief Officer, Croydon Clinical Commissioning Group, the Director of Public Health, Croydon Council and the Medical Director for South London, NHS England, is attached.

7. Health protection update (Page 125)

The report of the Director of Public Health, Croydon Council, is attached.

8. Croydon Food Flagship (Page 129)

The report of the Director of Public Health, Croydon Council, is attached.

9. Public Questions

For members of the public to ask questions relating to the work of the Health & Wellbeing Board.

Questions should be of general interest, not personal issues.

There will be a time limit of 15 minutes for all questions. Anyone with outstanding questions may submit them in writing and hand them to the committee manager or email them to: Margot.Rohan@croydon.gov.uk, for a written response which will be included in the minutes.

10. Report of the Chair of the Executive Group (Page 137)

The report of the Executive Group is attached, covering the Work Programme and Risk Summary.

11. Camera Resolution

To resolve that, under Section 100A(4) of the Local Government Act, 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information falling within those paragraphs indicated in Part 1 of Schedule 12A of the Local Government Act 1972, as amended.

AGENDA - PART B

None

This page is intentionally blank

HEALTH & WELL-BEING BOARD (CROYDON)
Minutes of the meeting held on Wednesday 22 October 2014 at 2pm in The Council Chamber, The Town Hall, Katharine Street, Croydon CR0 1NX

Present:

Elected members of the council:
Councillors Alisa FLEMMING, Yvette HOPLEY, Maggie MANSELL (Chair), Margaret MEAD (Vice-Chair), Louisa WOODLEY

Officers of the council:
Paul GREENHALGH (Executive Director of Children, Families & Learning)
Hannah MILLER (Executive Director of Adult Services, Health & Housing)
Dr Mike Robinson (Director of public health)

NHS commissioners:
Dr Agnelo FERNANDES (NHS Croydon Clinical Commissioning Group)
Dr Jane FRYER (NHS England)
Paula SWANN (NHS Croydon Clinical Commissioning Group)

Healthwatch Croydon
Vanessa HOSFORD (Healthwatch Croydon)

NHS service providers:
John GOULSTON (Croydon Health Services NHS Trust)

Representing voluntary sector service providers:
Kim BENNETT (Croydon Voluntary Sector Alliance)
Sarah BURNS (Croydon Voluntary Action)

Representing patients, the public and users of health and care services:
Stuart ROUTLEDGE (Croydon Charity Services Delivery Group)
Karen STOTT (Croydon Voluntary Sector Alliance)

Non-voting members:
Not represented.

A55/14 Minutes of the meeting held on Thursday 11th September 2014

The Board **RESOLVED** that the minutes of the meeting of the Health & Wellbeing Board (Croydon) on 11 September 2014 be agreed as an accurate record.

Regarding Minute A49/14, Given the issues raised about GPs and pharmacists making child protection referrals at the previous meeting, a letter has been sent out to all GPs and pharmacists clarifying these issues.

A56/14 Apologies for absence

Apologies were received from Mark Justice (Stuart Routledge deputising) and Steve Davidson and, for lateness, Cllr Alisa Flemming and Dr Mike Robinson.

A57/14 Disclosure of Interest

There were no disclosures of a pecuniary interest not already registered.

A58/14 Urgent Business (if any)

There was no urgent business.

A59/14 Exempt Items

There were no exempt items.

A60/14 Focus on outcomes: primary care : general practice

Dr Jane Fryer elaborated on the attached presentations.

- 90% of consultations happen in GP surgeries and pharmacies but only 7-8% of budget is spent in those areas.
- Need to strengthen and transform primary care.
- Many recommendations regarding primary care are in Mayor of London's report on health this week.
- South London areas piloting approach of making access to primary care 24 hours a day.
- Need to work together with CCGs so commissioning for primary care will be much more local.
- Way to deliver care will be vary from borough to borough.

Paula Swann explained the role of the CCG in relation to General Practice:

- Commissioner of specific local services outside of the standard contract
- Quality improvement in General Practice
- Quality improvement - Primary Care variation
- Additionally, the CCG now had an opportunity to explore co-commissioning of Primary Care. To avoid conflict of interests this was being explored across NHS England.

Issues raised:

- How do we make primary care a more attractive career?
- How do we keep GPs in London - how many short are we?
- Seen quality improvements in supporting change for patients.
- Challenges - created more work for primary care but logical solution.
- Funding gap getting wider.
- Here and now is burning platform for Croydon.
- How do we deliver services with reduced funding?
- Co-location of services would make being a GP more attractive/interesting.
- How can we encourage GP practices to work together in the community?
- Co-commissioning - interface between primary care and care - does the model recognise the whole system?
- Challenges in designing commissioning system - matching services to areas in an integrated way. A committee is being formed around how to commission primary care.

The Board **NOTED** the content of the presentations.

A61/14 JSNA key dataset 2014/15

David Osborne (Senior Public Health Information Analyst) gave a presentation to explain the report.

Issues raised:

- Concern that there are still people who are unsure about MMR and other immunisations.
- Public Health is aware of the low uptake of IAPT (Improving Access to Psychological Therapies).
- Need to pick a smaller number of main issues which do not have strategies in place, to address them for the next HWB Strategy.
- Diabetes identification.

Having considered the public sector equality duty and the Joint Health and Wellbeing Strategy, the Health and Wellbeing Board **RESOLVED** to:

- Provide approval for the 2014/15 JSNA Key Dataset, allowing this to be disseminated to stakeholders in a timely fashion.
- Note the findings highlighted by this report, and consider the report alongside the broader information included in the Key Dataset, in the refresh of the Joint Health and Wellbeing Strategy.
- Use the findings from the Key Dataset in their ongoing work to oversee health and wellbeing in Croydon.

A62/14 Outcomes based commissioning for over 65s

Paula Swann (Chief Officer of Croydon's Clinical Commissioning Group) introduced the report.
Stephen Warren (Director of Commissioning Designate) gave a presentation, including an illustrative video entitled 'Sam's Story' - available online: http://www.kingsfund.org.uk/audio-video/joined-care-sams-story

- Looking at integrated solutions for care for the over 65s
- Gone through initial stages - identified funding - in the design stage
- Will need sign off from Council and CCG
- Next stage - commissioner funding and vehicle and provider contracting
- Aim to have contract in place by April 2016

Issues raised:

- Duplication is an irritation
- Residents welcome being able to stay in their own homes
- Communication between the carers and services crucial
- Will secondary care choice be reduced?

The Board **NOTED** the report.

A63/14 Partnership groups report

Alan Hiscutt (Head of Integrated Commissioning - Working Age Adults & Contracts Support Services) gave a summary of the Partnership Groups report on Adults with learning disabilities:

- Croydon had the best results in London
- Winterbourne Review - implications for Croydon: there were only 2 people who were reported on in Panorama programme and clear plans are in place for the future of these 2 individuals

Steve Morton (Head of Wellbeing) summarised the Partnership Groups Summary report:

- All but one of the partnership groups is now reporting every 6 months
- Need to ensure connection with Health & Wellbeing Strategy
- Structure need clarifying for how partnership groups report into the Board
- Partnership groups are delivering the work of the Board

The Board **NOTED** the reports.

A64/14 Public Questions

A member of the public raised the issue of deprivation of liberty which is a huge issue nationally. Councils all over the country have been addressing the issue without any increase in funding. Hannah Miller suggested raising a paper on the topic to be brought to a future Health & Wellbeing Board meeting. *(See Appendix)*

A65/14 Report of the Chair of the Executive Group

Steve Morton asked for comments on the reports:

- Highest rated risk is around financial constraints

Issue raised:

- Croydon has permission to have a deficit in the CCG

The Board **NOTED** the report.

A66/14 FOR INFORMATION:
Adult social care commissioning plan 2014/15

The report was circulated with the agenda.

A67/14 Dates of Future Meetings

All Wednesdays in the Council Chamber in the Town Hall:
10 December 2014
11 February 2015
25 March 2015

The meeting ended at 4:10pm.

This page is intentionally blank

QUESTION FROM MR PETER HOWARD

On 23rd March 2014, Lord Hardie submitted his report on Deprivation of Liberty Orders, and 5 days prior the Supreme Court handed down a Judgement on 2 cases involving Deprivation of Liberty Orders, both criticised the Mental Capacity Act 2005. I have had conversations with Lord Hardie on his report & read the Supreme Court Judgement. There are very real concerns regarding this matter. A very recent High Court Action again criticised another County Council for depriving a young adult of his liberty. Has this Committee & Council taken note of these judgements? If so what, if not why not?

RESPONSE

The Council is aware of the Supreme Court ruling and its implications.

To date:

- We have provided extensive training sessions to providers of residential and nursing care so that, as Managing Authorities, they are aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and understand the implications of the ruling.
- The Mental Capacity Act/Deprivation of Liberty Safeguarding (DOLS) lead has additionally met individually with providers who have sought additional advice.
- We have ensured that all Best Interest Assessors are up to date with the implications of the new ruling.
- As a result of awareness-raising we have seen an 8 fold increase in the numbers of DOLS applications being made. This is leading to a review of existing resources within the Council to carry out this work as a Supervisory Body.
- Of note, all Local Authorities are in a similar position in terms of substantial increases in applications and resourcing pressures as is the Court of Protection. DOLS forms are being revised nationally to make the process more streamlined.
- It is worth noting also that it is not necessarily a bad thing that a person is deprived of their liberty. There are many people who, because of cognitive difficulty, are not able to make decisions to keep themselves safe and who require 24/7 supervision in order to remain safe. The Supreme Court ruling does not prevent this; it seeks to ensure that, in such cases, people have the added protection of a Deprivation of Liberty Safeguard in place to ensure their situation is fully assessed and authorised.

The Health and Wellbeing Board has acknowledged the importance of this issue. An agenda item is proposed for the meeting on 25 March 2015 to allow for a fuller discussion.

This page is intentionally blank

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **10 December 2014**
AGENDA ITEM:	**6**
SUBJECT:	**Commissioning intentions 2015/16**
BOARD SPONSORS:	**Paul Greenhalgh, Executive director of children, families and learning, Croydon Council** **Hannah Miller, Executive director of adult services, health and housing, Croydon Council** **Dr Mike Robinson, Director of public health, Croydon Council** **Paula Swann, Chief officer, Croydon Clinical Commissioning Group** **Dr Jane Fryer, Area medical director, NHS England**

BOARD PRIORITY/POLICY CONTEXT:

The Health and Social Care Act 2102 ('the Act') created statutory health and wellbeing boards as committees of the local authority. Their role is to improve the health and wellbeing of local people by promoting integration and partnership working between the NHS, social care, children's services, public health and other local services, and to improve democratic accountability in health.

Clinical Commissioning Groups, NHS England and local authorities have a duty under the Act to have regard to relevant joint strategic needs assessments (JSNAs) and joint health and wellbeing strategies (JHWSs) in the exercise of relevant functions, including commissioning.

The health and wellbeing board (the Board) has a duty under the Act to encourage integrated working between commissioners of health services and commissioners of social care services and , in particular, to provide advice, assistance or other support for the purpose of encouraging use of flexibilities under NHS Act 2006. It also has the power to encourage close working (in relation to wider determinants of health) between itself and commissioners of health related services and between commissioners of health services or social care services and commissioners of health-related services.

In terms of the alignment of commissioning plans, the Board has the power to give its opinion to the local authority which established it on whether the authority is discharging its duty to have regard to relevant JSNAs and JHWSs. In addition, CCGs have a duty to involve the Board in preparing or significantly revising their commissioning plan – including consulting it on whether the plan has taken proper account of the JHWS.

The Board also has a duty to provide opinion on whether the CCGs final commissioning plan has taken proper account of JHWS and has the power to provide NHS England with that opinion on the commissioning plan (copy must also be supplied to the relevant CCG). Croydon CCG's commissioning plan will be presented to the board alongside the plans of other commissioners on 25 March 2015.

FINANCIAL IMPACT:

Financial implications for each area within the commissioning intentions will be subject to the respective commissioning organisation's financial planning processes. Detailed financial impact will be considered within the framework of the governance mechanisms set out in each organisation's constitution.

1. RECOMMENDATIONS

1.1 This report recommends that the board comments on the alignment of 2015/16 commissioning intentions to the joint health and wellbeing strategy 2013-18.

2. EXECUTIVE SUMMARY

2.1 This report sets out the high level commissioning intentions for Croydon Council, Croydon Clinical commissioning Group and NHS England so that the health and wellbeing board can comment on their alignment with the priorities identified in the joint health and wellbeing strategy 2013-18 as informed by the joint strategic needs assessment (JSNA). Detailed intentions are provided in the appendices.

2.2 The aim of commissioning is to ensure that people's identified needs are addressed within the resources available; that commissioners commission the appropriate services to meet local needs; and, that the right services are in place in order to improve health and to reduce health inequalities. Commissioning can be undertaken across a range of geographical areas depending on the nature and scale of the needs and services required. This can be at a national level for some highly specialised services, regionally and locally (for example, at borough or sub-borough level).

3. DETAIL

The commissioning landscape

3.1 Most of the NHS commissioning budget is now managed by **clinical commissioning groups** (CCGs). These are groups of general practices which come together in each area to commission services for their patients and population. **NHS England** commissions specialised services, primary care, offender healthcare and some services for the armed forces.

3.2 CCGs and NHS England are supported by **commissioning support units** (CSUs). Their role is to carry out transformational commissioning functions, such as service redesign; and transactional commissioning functions, such as market management, healthcare procurement, contract negotiation and monitoring, information analysis and risk stratification.

3.3 Commissioning of public health services is undertaken by **Public Health England** (PHE) and by local authorities, although NHS England commissions, on behalf of Public Health England, many of the public health services delivered by the NHS, for example immunisations and vaccinations.

3.4 **Local authorities** are responsible for commissioning adults and children's social care services. As noted above, they are responsible with Public Health England for commissioning public health services. They also commission or directly provide a wide range of services which contribute to the overall health and wellbeing of the population.

Local commissioning intentions

3.5 The commissioning intentions detailed in the appendices to this report include both joint and individual intentions from the CCG, NHS England and the council.[1] Croydon CCG is also working with other CCGs and NHS England as part of the South West London Commissioning Collaborative which is a collective response to 'Everyone Counts: Planning for Patients 2014/15 to 2018/19' to develop long term sustainable improvements across south west London. Commissioning intentions have been informed by identified need through the JSNA, other formal needs assessments, needs and issues identified by stakeholders and engagement of partners, service users, patients and the wider public to respond to health, social care and wellbeing needs of Croydon residents.

3.6 The council's children's and adults' social care commissioning intentions for 2015/16 have been developed in the context of the establishment of an Integrated Commissioning Unit by the council and CCG, and as such have been devised to include linkages not just between council and CCG, but between children and adult services where appropriate. The council's public health commissioning intentions are also included in these documents.

Joint health and wellbeing strategy priorities

3.8 The priorities of the health and wellbeing board are set out in the joint health and wellbeing strategy 2013-18. Whilst the board is currently reviewing its priorities these have not yet been finalised in a revised document. Priorities are grouped into six areas for improvement. These are:

- Giving our children a good start
- Preventing illness and injury and helping people recover
- Preventing premature death and long term health conditions
- Supporting people to be resilient and independent
- Providing integrated safe, high quality services
- Improving people's experience of care

3.9 A summary of the priorities set out in the joint health and wellbeing strategy 2013-18 is at appendix 1. The full strategy document can be accessed at www.croydonobservatory.org/Strategy_Health_and_Social_Care/

3.10 The commissioning intentions for children form part of the programme of delivery for the Children and Families Partnership (CFP) and as such are aligned to the CFP's priority themes. These are to:

- Reduce childhood obesity

[1] The report covers children's and adults social care commissioning and does not include intentions for the wider range of services referred to in paragraph 3.4.

- Improve the emotional wellbeing and mental health of children and young people.
- Increase the impact of early intervention
- Strengthen the consistency of engagement of children, young people and families across partnership
- Increase participation in education, employment and training and improve outcomes at age 19
- Reduce child poverty and mitigate impact of poverty
- Improve integration of services for children and young people with learning difficulties/disabilities
- Improve health and education/training outcomes for Looked After Children

Appendices

Appendix 1 joint health and wellbeing strategy priorities for action
Appendix 2 Croydon CCG commissioning intentions 2015/16
Appendix 3 SW London commissioning intentions 2015/16
Appendix 4 NHS England commissioning intentions 2015/16 for prescribed specialised services
Appendix 5 Integrated Commissioning Unit draft commissioning priorities (adults)
Appendix 6 Integrated Commissioning Unit draft commissioning priorities (children)

4. CONSULTATION

4.1 The development of commissioning intentions is part of the commissioning cycle which entails ongoing engagement with stakeholders. This report is part of that engagement process.

5. SERVICE INTEGRATION

5.1 In April 2014 the Integrated Commissioning Unit ("ICU") was formally established having been in shadow form since the preceding February. The establishment of the ICU has enabled a joint approach to commissioning and delivery of a number of services.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 Financial implications for each area within the commissioning intentions will be subject to the respective commissioning organisation's financial planning processes. Detailed financial impact will be considered within the framework of the governance mechanisms set out in each organisation's constitution.

.

7. LEGAL CONSIDERATIONS

7.1 Legal advice has not been sought on the content of this report.

8. HUMAN RESOURCES IMPACT

8.1 No human resources impacts have been identified for the purposes of this report.

9. EQUALITIES IMPACT

9.1 Equality analysis will be carried out where service or policy change is indicated by the commissioning intentions. Taken together the priorities will enable commissioning organisations to address their duties under the Equalities Act.

10. ENVIRONMENTAL IMPACT

10.1 No environmental impacts have been identified for the purposes of this report.

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 Re-commissioning of drug and alcohol services with an enhanced treatment focus should contribute to reduced crime and disorder linked to substance misuse.

CONTACT OFFICERS:

Stephen Warren, Director of Commissioning, Croydon CCG,
Email: Stephen.warren@croydonccg.nhs.uk ; tel: 020 3668 1334

Brenda Scanlan, Director of Adult Care Commissioning, DASHH, Croydon Council
Email: Brenda.scanlan@croydon.gov.uk; Tel: 020 8760 5727 (Ext 62476)

Jane Doyle, Director, Community and Support Services, Children, Families and Learning, Croydon Council
Email: Jane.doyle@croydon.gov.uk; Tel: 020 8760 5671

BACKGROUND DOCUMENTS [None]

This page is intentionally blank

Appendix 1

CROYDON JOINT HEALTH AND WELLBEING STRATEGY

Priorities for action

1. Giving our children a good start in life	2. Preventing illness and injury and helping people recover	3. Preventing premature death and long term health conditions
Reduce **low birth weight**	Reduce **smoking** prevalence	Early detection and management of people at risk for **cardiovascular diseases and diabetes**
Increase **breastfeeding** initiation and prevalence	Reduce **overweight and obesity** in adults	Early detection and treatment of **cancers**
Improve the uptake of childhood **immunisations**	Reduce the harm caused by **alcohol** misuse	
Reduce **overweight and obesity** in children	Early diagnosis and treatment of **sexually transmitted infections** including HIV infection	
Improve children's **emotional and mental wellbeing**	Prevent illness and injury and promote recovery in the **over 65s**	
Reduce the proportion of **children living in poverty**		
Improve **educational attainment** in disadvantaged groups		

4. Supporting people to be resilient and independent	5. Providing integrated, safe, high quality services	6. Improving people's experience of care
Rehabilitation and reablement to prevent repeat admissions to hospital	**Redesign of mental health pathways**	**Improve end of life care**
Integrated care and support for people with long term conditions	**Increased proportion of planned care delivered in community settings**	**Improve patient and service user satisfaction with health and social care services**
Support and advice for **carers**	Redesign of **urgent care pathways**	
Reduce the number of households living in **temporary accommodation**	Improve the **clinical quality and safety** of health services	

Appendix 1

Reduce the number of people receiving **job seekers allowance**	Improve early detection, treatment and quality of care for people with **dementia**

Croydon CCG

Commissioning Intentions 2015/16

Overview

1. Purpose of our Commissioning Intentions

2. Our Vision and Priorities

3. The Commissioning Landscape

4. Transformational Commissioning

5. Known Commissioning Intentions

6. Commissioning Intentions from member practices

7. Next Steps

1. Purpose of our Commissioning Intentions

- To set out how our 2 Year Operating Plan and 5 Year Strategy, and other supporting strategies and pathway redesign programmes, shaped by previous engagement will specifically impact on our current and future providers in 2015/16.

- To consider that patient need identified through the Joint Strategic Needs Assessment (JSNA) is addressed and that the right services are in place to reduce health inequalities.

- Specify the requirements for greater integrated working outlined in the Better Care Fund.

- To ensure that our commissioning is clinically driven by addressing the needs and issues identified by our member practices.

- To drive up quality in service provision across the range of services we commission and by working collaboratively with other commissioners.

- To ensure that changes in legislation and clinical guidance is reflected in practice and service delivery.

To support our work we will be seeking to:

- Improve patient outcomes and reduce health inequalities
- Ensure we engage with partners to maximise opportunities for joint working where this will support improved outcomes through better coordinated care.
- Develop engagement with patients and public in all aspects of commissioning and development through our PPE strategy

2. The Commissioning Landscape

NHS Croydon CCG faces significant challenges including an ageing population, rising demand for services and high public expectations of those services.

In addition to this Croydon Clinical Commissioning Group also faces significant financial challenges during 2015/16 and in future years with the consequence that funding will not be able to match the increasing demand for NHS services. The CCG in 2013/14 was funded £46m below target and is expected from 2014/15 to receive an additional 1% (£4m) pa to reduce the funding gap. The CCG's 5 Year Financial Plan reflects the ethos that financial recovery is clinically and quality lead following the principles of QIPP (Quality, Innovation, Productivity, Prevention). The plan provides a pathway for service redesign and innovative contracting to deliver run-rate balance from Year 5. The CCG will not be in a position to repay the modelled £64m cumulative deficit which NHSE business rules requires.

Croydon CCG will commission health services for its population, based on patient need, current performance, the 2 Year Operating Plan and South West London 5 Year Strategy and the current definition of CCG commissioning responsibilities.

The Commissioning Intentions should also be read in the context of the South West London Collaborative 5 Year Commissioning Strategy, Better Care Fund and the London Standards that recognises that that services will no longer be focused on secondary sector acute provision, but instead the whole health economy.

The SWL Commissioning Strategy sets out initiatives across eight areas of work:

- Children's services
- Integrated services
- Maternity
- Mental Health
- Planned Care
- Primary Care Transformation
- Urgent and Emergency Care
- Cancer Care

All 6 CCGs support the clinical case for change and will commission to London Quality Standards, 7 day working and Keogh Review recommendations. The CCGs also want to set clear standards for mental health, community services and primary care.

CCGs want to be clear about the standards they expect for patients and to work with the local providers of care to determine the best way to achieve that change.

Consequently the SWL CCGs will also shortly be issuing joint collaborative Commissioning Intentions which will provide a clear vision and priorities for delivery in 2015/16 and beyond which will complement these local Commissioning Intentions.

The improvements set out in the Commissioning Intentions are key enablers to us meeting our planned reduction in non-elective admissions over the next 5 years. In 2015/16 in this context the CCG will be developing 'outcome based commissioning' for over 65s and the contractual mechanisms related to this form of contracting, subject to Governing Body approval. We expect that by focusing on outcomes providers will be incentivised to transform service delivery, ensuring true integration between services and providers and achieving at scale the required shifts to community and primary care to ensure that care is delivered in the most appropriate setting. Providers should therefore be actively reviewing their services now to ensure that they are best places to meet these objectives.

Commissioners understand the need to work with other specialist services in order that Croydon can deliver an integrated and effective response to people.

3. Transformational Commissioning

Given the challenges referred to above and in the context of the CCGs very challenging financial position, providers should anticipate a net reduction in real terms of the cash envelope over and above the PBR deflator.

In line with the CCGs 5 year Financial Plan the QIPP saving identified for 2015/16 is £9.5 million. This is over and above the 4% provider efficiency requirement embedded into tariff/uplift and assumes the current 2014/15 QIPP forecast.

Consequently there is a continued need for whole system transformational change in order to tackle these constraints in a focused, joined up and achievable way, realising improvements through whole system transformation. The Transformation Programme, in addition to improving quality outcomes, aims to release efficiencies and reduce an over reliance on hospital services. We have worked with the South West London Collaborating Commissioning principles and reviewed our targets to stretch the reduction in hospital activity through our transformation programme.

To ensure that there is choice available in settings other than hospital we aim to transform the way we deliver services at the intermediate, primary and community level. There are several key strategies which are part of the wider transformation programme:

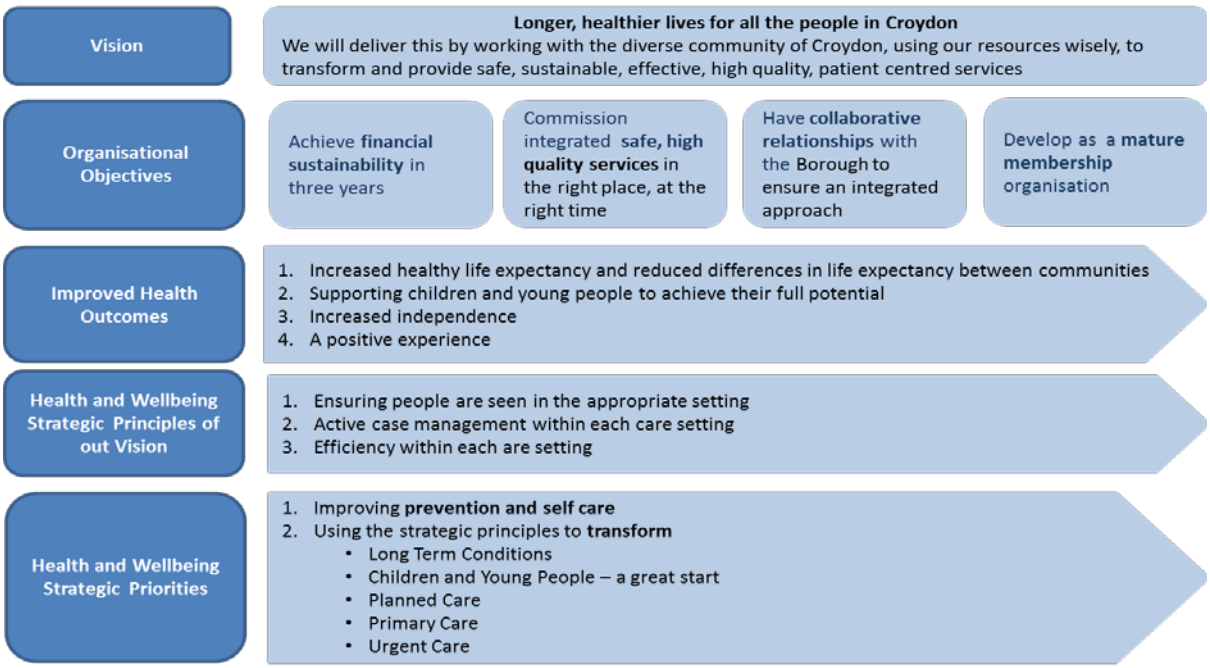
- Prevention, Self-Care and Shared Decision Making Strategy
- Primary and Community Strategy
- Long-term conditions
- Urgent Care
- End of Life Care
- Making best use of medicines
- Planned Care
- Children and Young people

The strategies and key work streams are summarised overleaf and we expect providers working together to be proactive in shaping their services to ensure greater integration and to meet the strategic priorities identified in these strategies.

Strategy	Objective
Prevention, Self-Care and Shared Decision Making Strategy	Improve patient's life expectancy and quality of life by helping people to look after themselves better, avoid illness where possible and, if they do become ill, to get better care using shared decision making with professionals where appropriate. We therefore expect providers to ensure that these areas and in particular shared decision making are embedded in day to day to day practice.
Primary and Community Strategy	More convenience and control for patients, with primary (GP) and community services delivery more care closer to where people live. Providers will be expected to proactively maximise e the benefits of integration to achieve this.
Long-term conditions	Help people maintain their independence and keep as well as possible for as long as possible.
End of Life Care	Ensuring coordinated care and best practice for those patients reaching their last year of life
Urgent Care	Reducing the reliance on urgent and emergency care services by improving access to primary and community care and helping patients use services more appropriately.
Making best use of medicines	Supporting people to get the most benefit from their medicines and cut the amount of medicine wasted each year.
Older People's Services	Older People's Services are a key focus for 15/16 and in particular a significant initiative around outcomes based commissioning for over 65s, with a view to an outcomes based contract being in place by 1st April 2016. We will work collaboratively with providers to develop the model with an expectation of movement towards implementation.
Planned Care	The right care in the right place – high quality services, with more care delivered closer to people's homes.
Children and Young People	Supporting children and young people to achieve their full potential

4. Our Vision and Priorities

Through working with our Member Practices and our Public, Patients and providers and through the development of the Health and Wellbeing Strategy, Croydon Clinical Commissioning Group has jointly developed the following overarching Vision, Organisation Objectives, Outcome and Priorities, which are reflected in our 2 Year Operating Plan.



5. Known Commissioning Intentions

In a number of areas, the focus for 2015/16 will be to roll out or implement service improvements which are the result of initial work happening now but also to look at further opportunities.

These early commissioning intentions are currently being built upon and refined through the involvement and engagement of our member practices in shaping our commissioning intentions and ensuring that they deliver our stated priorities.

A number of changes will be taking place to the commissioning landscape over the next few months. In addition, national and London guidance has yet to be issued for 2015/16 and we will need to jointly review our 2015/16 plans in the context of this guidance when it is available.

Nevertheless the following section outlines the specific Commissioning Intentions that have been identified to date and the likely impact on providers.

Known Commissioning Intentions – Planned Care

Service Performance Area	Commissioning Intention
Vascular Surgery	Croydon Health Services (CHS) is expected to work with other local providers to ensure full compliance with the arrangements relating to the transfer of complex vascular procedures as per the London Guidance
Effective Commissioning Initiative (ECIs)	ECIs are currently under review and there are likely to be further changes in 2015/16. The providers will be informed in due course where capacity will be required to be reduced.
First/Follow up Ratios	Commissioners will expect the Trust to achieve or exceed upper quartile ratios in 15/16 in all specialties where benchmarked data is available. This ratio will continue to be applied at individual specialty level and will not include any off-setting. In addition, outpatient procedures will be included in the calculation of the ratios.
Multiple 1st Attendances	Commissioners require outpatient attendances to be counted in line with DH PbR (query response PbR636320 issued by the DH on 5.8.11). It is expected that the coding and counting of outpatient attendances where a patient is expected to return to the provider for a further outpatient attendance at some point in the future, regardless of whether it is within 6 months or not and regardless of whether the appointment is booked within 6 months or not, is to be counted as a follow up attendance.
Urology	Commissioners will continue the work commenced from 2014/15 into 2015/16 which will impact on urology outpatient and elective activity. We will therefore be looking for CHS to reduce capacity in accordance with the new pathway and planned reductions in demand.
Gastroenterology	Commissioners will continue the work commenced in 2014/15 into 2015/16 which will impact on Gastroenterology outpatient and elective activity. We will therefore be looking for CHS to reduce capacity in accordance with reductions in demand.
MSK - Musculorskeletal	The review of the whole MSK pathway, with a view to embedding service redesign in 2015/16. Elements of the ECI work will also focus on MSK.
Dermatology	Commissioners are looking to develop a pilot for a community-based service which utilises new technologies to aid the diagnosis of skin cancers. This is intended to reduce the

	number of 2-week wait Dermatology referrals sent to the Trust.
CReSS (Croydon referral and assessment service)	The CCG will continue with the full implementation of the Referral Facilitation system including for Consultant to Consultant referrals and Effective Commissioning Initiatives. There will therefore be a subsequent reduction in Out-patient referrals, first appointments and follow-ups. It is expected that the Trusts will continue the programme of reducing consultant to consultant referrals.
Medicines Optimisation	The CCG will pursue: • Cost effective prescribing in-line with locally agreed CPC decisions and LPP QIPP targets. • Embedding the principles of medicines optimisation including safe transfer of care at discharge. Meet the secondary care requirements within the medicines optimisation dashboard and medicines helpline for patients and GPs. • Meeting the recommendations of MHRA Patient Safety Alert Stage Three: Directive, improving medication error incident report and learning 20 March 2014 including piloting the medications safety thermometer • Exploring the opportunities for gain share with high cost drugs.

Known Commissioning Intentions – Integrated Cancer Services

Service Performance Area	Commissioning Intention
Integrated Cancer Services	Cancer remains a key government and DH priority and in London we now have a target to save 1,000 lives through more effective early diagnosis and better treatment. This should in part be achieved by the *Cancer Model for Care* (2011), which outlined the differential experiences and outcomes for patients in London and the need to make changes to the way cancer care is managed and organised, and remains a key priority underpinning all cancer services development across London. In London, cancer commissioning is undertaken by two different organisations. Specialised Commissioning Services based in the NHS England commission the more complex and rarer cancers, and specialist treatments such as chemotherapy and radiotherapy, and this accounts for about 60% of expenditure on cancer services. The other 40% of spend relates to the more common cancers, prevention, early diagnosis, living with and beyond cancer (survivorship), and palliative care. This is commissioned through the CSUs on behalf of their CCGs, and each CCG has access to a Cancer Commissioning Team to give leadership to the contracting process for cancer. At a Pan-London level the Transforming Cancer Services for London Programme, based in NHS England, leads cancer service change, and this programme has identified a number of key priority areas for cancer for 2015/16. Services will be commissioned from London providers which are active participants in their Integrated Cancer System. Providers are expected to implement the London Cancer Pathways as part of the service development and improvement plan. The London wide cancer standards are attached at Appendix 4 of the SWL Commissioning Intentions. Croydon CCG is also currently developing its own local Cancer Implementation Strategy, which will be available in October.

Known Commissioning Intentions – Urgent Care

Service Performance Area	Commissioning Intention
Stroke and Atrial Fibrillation	The CCG in 2014/15 is reviewing the whole pathway including early identification of AF in primary care plus a reduction in length of stay for stroke patients. This will continue in 2015/16. Therefore a reduction in non-elective admissions and length of stay is anticipated. The Acute Service Specification is broadly the same as last year. The change to note is the London Minimum Dataset and Stroke Improvement National Audit Programme (SINAP) are due to be replaced by the Stroke Sentinel National Audit Programme (SSNAP) and when this comes online this should be used by Hyper Acute Stroke Units and Stroke Units to report performance against the London Stroke Standards.
Urgent Care Centre	The Commissioners expect the providers; namely, CHS, the UCC, Minor Injury Units at Purley and Parkway and Primary Care GP Led Walk in Centre based at Edridge Road to continue to work together across the whole system to ensure effective integrated working and that A&E Performance standards are consistently met.
Non Elective Activity from Nursing Homes	The CCG is planning on a coordinated and extensive programme to improve Nursing Home performance in collaboration with social care and thus we are projecting a subsequent fall in A&E attendances and admissions in 2015/16 for CHS as a consequence.
Deep Vein Thrombosis (DVT)	Having established a new pathway for DVT with CHS in 2014/15 the CCG will be looking to improve this by introducing self-administration of Rivaroxaban (prescribed by the Trust) for patients requiring repeat dopler scans. It is anticipated that this will reduce the cost of the current local tariff agreed for the pathway for patients requiring rescans. We are seeking to renegotiate a local tariff for this cohort of patients.

Known Commissioning Intentions – Transformation/ Community Services

Service Performance Area	Commissioning Intention
Transforming Adult Community Services and Falls Services	The CCG expects the provider to continue with the implementation of these initiatives at pace and to achieve the stated reduction in non-elective admissions and excess bed days. In particular commissioners wish to see more effective in reach to A&E from the Rapid Response Service to avoid unnecessary admissions.
Cardiology	We intend to continue the ***roll*** out of a community based model of care for cardiology and embed this in 2015/16. We will expect to see all direct access testing moving out to community based clinics. The fundamental shift in the way cardiology will be delivered will have a clear impact on out patient, day case and inpatient activity. We will therefore be looking for CHS to reduce capacity in accordance with reductions in acute demand. The new service model will specifically impact on the following areas: • Chest pain of recent onset/stable angina/Percutaneous Coronary Interventions/Rapid Access Chest Pain Clinic • Heart failure through to end of life care • Arrhythmia • Cardiac and heart failure rehabilitation
Anti-coagulation	Commissioners will continue to redesign anti-coagulation services to maximise the number of patients on long-term warfarin managed in the community setting, with a subsequent reduction of capacity in the acute setting. Commissioners also anticipate reductions in first referrals into the acute setting due to the expansion of community providers, currently being procured, to include initiation of warfarin for certain patient groups.
COPD	Commissioners are expecting the continued implementation of COPD services in the community. This will include a review of the whole pathway including care that is currently provided in Primary Care. This is expected to reduce A&E attendances and emergency admissions for respiratory conditions, which should, in turn, result in a reduction of Length of Stay and subsequent reduction in bed capacity required within acute hospital services.

Diabetes	The re-provision of community diabetes services will be embedded and further developed in 2015/16, including the redesign of the whole pathway. There will be a continued subsequent reduction in diabetic out-patients and also related non-elective admissions. Aspects of this delivery include: • A new integrated diabetes model of care with a primary focus on primary care and community care whilst increasing patient self-management and prevention • A clearly defined education programme for professionals and patients
End of Life Care	Commissioners will take forward plans to improve EOLC including Advanced Care Plans, Medicines Management, Education and Training. The CCG understands this will reduce non-elective admissions in 2015/16. Commissioners from health and social care will work with the Providers to ensure that contractual and operation arrangements are appropriate and in the best interest of patients and their carers.

Known Commissioning Intentions – Mental Health

Service Performance Area	Commissioning Intention
Working jointly with social care to achieve reduced requirements for Adult Acute Inpatient Psychiatric Beds	Croydon CCG will work in partnership with Lambeth, Southwark and Lewisham CCGs and SLaM to reduce the requirement for acute inpatient services, with a view to improving quality, delivering future QIPP and CIP savings. Integral to this strategy is the implementation of the Adult Mental Health Community based model of care, to address the current over dependence on inpatient care and address the issues of acute inpatient overspill.
Rebalancing Responsibilities for the care of People with Serious Mental Illness	The CCG has already submitted a project plan to deliver improved patient flows across primary and secondary care. It is expected that during 2015/16 this will bear fruit, and reduce the current burden on community based mental health services provided by South London and Maudsley (SLaM).
Prescribing	Integral to the above project is the possibility of achieving QIPP efficiencies from CCG and Trust prescribing budgets through joint formulary work, and agreement of choices for the first line drugs in certain therapeutic areas. Work has already begun in this area, but it is important that reasonable targets are set, based on an understanding of drug use and expenditure in primary and secondary care. With this in mind, SLaM is expected to build on this year's commitment to meet prescribing information requirements on a trust wide basis by providing specified data on a quarterly basis, working towards (London Procurement Programme) LPP QIPP targets, meeting agreed communication standards on transfer of prescribing and/or discharge. Funding flows will need to be monitored and transferred if appropriate with transfers of care.
MHOA and Dementia	Croydon Council and Croydon CCG have developed a four part project plan which will improve the quality of care for local older adults with mental health needs, particularly dementia. The project will deliver improved community services, a reduction in the size of community mental health teams for older adults, the introduction of a mental health Home Treatment Team for older adults, and a reduction in the requirement for acute psychiatric

	inpatient services for older adults. Funding flows will need to follow with regard to anti-dementia prescribing transferring to primary care.
Reduced Reliance on Specialist Services	Commissioners will review use of specialist services, particularly for assessment and treatment of clients with Autistic Spectrum Disorder (ASD), with a view to enhancing local services to provide specialist support where there is a clinical and economic case for such a change.
Commissioning for Quality and Outcome	Once finalised, the mental health strategy will express the commissioners' ambition to increase the emphasis on commissioning to achieve specific client outcomes. During this year the CCG, working through the Integrated Commissioning Unit (ICU) and Commissioning Support Unit (CSU) will also review current contract information requirements to identify gaps in commissioners' knowledge of the quality of services. Changing the emphasis on quality and outcome measures will see the introduction of new information reporting requirements for the Trust.
Talking and Psychological Therapies	The 2012/13 JSNA has highlighted the need for improved capacity in psychological therapies in primary care and secondary care. As savings are achieved through implementation of the mental health strategy, new financial resource will be made available from within the mental health budget, and current talking therapies services will be re-commissioned, in order to increase opportunities for service users to receive therapies that are known to be effective. Recovery rates will continue to be monitored and achievement of the 6% IAPT target will be key in 2015/16 as a minimum with movement towards the national target.
Older People's Mental Health – Continuing Care:	The pathway improvements and service changes made in has led to an improvement in the management of the number of people in NHS Continuing Care for mental health reasons. This progress must be maintained and reviewed, in order to achieve the more efficient use of resource in 2015/16. Croydon will review the provision of NHS continuing Care services to people with dementia as their primary need including contract arrangements with Care UK (Amberley Lodge) and residential nursing care beds spot purchased from a wide range of other private sector providers.

Placements / Long Term Care Services:	Forensic step down provision: Croydon intends to reduce expenditure on forensic "step down" provision for people who have been discharged from secure hospital beds. The contract with Care UK (Evergreen Lodge) will be reviewed and comparable outcome measures introduced across all "step down" service providers.
Adults experiencing Mental Ill-Health who have a Learning Difficulty	The Learning Disability Commissioner has been engaged with the Croydon Community Learning Disability Mental Health Team and SLaM Inpatient Services to undertake a service redesign to improve the management of community placements following discharge. Added to this development the Croydon Community Learning Disability Mental Health Team will have the lead role in moderating and overseeing admissions to inpatient services for this client group. The focus of the Commissioner and Croydon Community Learning Disability Psychiatrist will be on: • Admission to Inpatient Beds and Personalisation • Clear and rational assessment and treatment regimes The Learning Disability Integrated Commissioner will commission for outcomes that are person driven, reflect their life experiences, aspirations, aid recover and facilitate resilience and citizenship. Croydon's approach to implementation of the Autism Act is to ensure that services are developed and delivered in line with the requirements of the Act through commissioning and procurement processes. The NHS and Local authorities have specific duties and responsibilities under the Act, such as appropriate training for staff, understanding and responding to the support needs of people with Autistic Spectrum Disorder (ASD) and meeting certain requirements when carrying out commissioning and procurement activities. To support these service specifications will contain specific reference to the Act and providers will be required to demonstrate how they intend to ensure services are appropriate and accessible for people with ASD. Similarly, providers will be required to evidence how this has been achieved as part of the regular service monitoring with commissioners.

Known Commissioning Intentions – Primary Care

Service Performance Area	Commissioning Intention
Co-commissioning	The CGG intends to explore the potential around co-commissioning with NSHE with a particular focus on linkages to work around developing outcomes based commissioning for over 65s.
Primary Care Variation	In conjunction with NHS England the CCG intends to proactively support practices in improving their quality and performance to reduce variation between practices. We expect that this will have an impact on reducing referrals to secondary care and improve quality across primary care.
Medicines Optimisation	Commissioners will work to reduce the 4 – 6% of unplanned admissions that are due to the inappropriate use of medicines.
Hub and Spoke Model	To enable equitable and quality care across Primary and Community Services the CCG will continue to develop Level 1 and Level 2 services across its Networks creating 'Hub and Spoke' models of care in line with the Community and Primary Care Strategy.
Facilitation of Collaborative Provider Models	The CCG will facilitate the development of provider models that support care across all geographical and network areas to ensure high quality services closer to the patient's home.

Known Commissioning Intentions- Children

Service Performance Area	Commissioning Intention
Children's Emotional Wellbeing and Mental Health	Commissioners will work with the LA and partners to refresh the borough strategy for emotional wellbeing and mental health, to include: • Mapping of existing provision • The development of a clear offer of mental health support at tiers 1 to 3 and in relation to tier 4, and • Specific identified service pathways to improve access and outcomes for children and young people.
Looked After Children	Work with the LA and Partners to improve health outcomes (including mental health outcomes) for Looked After Children including the: • Agreeing health outcomes which need to be prioritised for improvement • The timely provision of initial and follow up healthcare assessments • Commissioning review of health services for looked after children.
Children with special educational needs and disabilities	Work with the LA and partners to support robust outcome focused Education, Care and Health Plans for children with SEND including • Improving access and quality of relevant services within available resources (speech and language therapy, occupational therapy, physiotherapy and CAMHS) • Improved engagement with children, young people and carers (as reflected in the Plan of the Children and Families Partnership) in service development • Commissioning reviews of Special School Nursing, Children's Occupational Therapy, Physiotherapy services and health services for looked after children are in progress. The outcome of these reviews will be recommended to CCG (and Croydon Council where it jointly holds commissioning responsibility) in 2015, including commissioning strategies that identify the appropriate commissioning route for each.

6. Commissioning Intentions from Member Practices

During July and August we have been working with our member practices through the Network meetings to seek their views on services or improvements which need to be commissioned.

This has included feeding back to practices the results of last years suggested interventions. Additionally it builds on the engagement last year where through the networks and GP Open Meeting, members were encouraged to develop their commissioning intentions, which then fed into the Clinical Leaders forum where these ideas were consolidated, prioritised and formalised and then fed into the 2 Year Operating Plan.

7. Summary

The route we have taken to develop our commissioning intentions is one of partnership, engaging as much as possible with our members and clinical leaders so that all service improvements are truly needs based and clinically driven.

In order that we demonstrate the impact of these commissioned improvements, the CCG will be looking to use outcome measures to monitor the success of each initiative. Outcome based commissioning will use a rich variety of data and "softer" information and views to demonstrate how our new services will have improved the lives and experience of Croydon residents.

Version 30th September 2014

This page is intentionally blank

Appendix 3

NHS SOUTH WEST LONDON COMMISSIONING COLLABORATIVE

South West London Commissioning Intentions 2015/16

V0.15

9/19/2014

Contents

1.0 Executive Summary

2.0 Introduction

- **2.1 Context**
- **2.2 Five Year Strategy and Better Care Fund – Why we are working together**

3.0 Strategic Contracting Principles and Intentions

- **3.1 Model for collaboration**
- **3.2 Strategic Contracting Principles**
  - **3.2.1 Strategic Contracting Principles**
  - **3.2.2 QIPP and CIPP**
  - **3.2.3 Common Incentive Framework**
  - **3.2.4 Common payment structures**
  - **3.2.5 Pathways and Outcomes Based Contracting**
  - **3.2.6 Maintaining Operational Performance**

4.0 Acute Provider Collaboration

5.0 South West London Collaborative commissioning intentions

- **5.1 Children's services**
- **5.2 Maternity Services**
- **5.3 Planned Care**
- **5.4 Integrated Care**
- **5.5 Mental Health**
- **5.6 Urgent and Emergency Care**
- **5.7 Cancer Services**

6.0 Enablers

7.0 Stakeholder Engagement

8.0 Conclusion

1. Executive Summary

This document sets out to South West London (SWL) acute healthcare providers notice of South West London CCGs' Collaborative Commissioning Intentions for children's, maternity, planned care, urgent/emergency care, integrated care and mental health services for 2015/16. Commissioning intentions are based on the medium-term strategic vision outlined in the CCGs' Five Year Plan, of which 2015/16 represents year two. Commissioning intentions for 2015/16 reflect the content of CCG two-year operational plans. We anticipate that in subsequent years commissioning intentions will be refreshed to reflect progress against achieving the strategy.

In previous years commissioners have developed independent commissioning intentions as single organisations in isolation. However this year the six SWL CCGs have decided to work together under the umbrella of the SWLCC to produce joint intentions for six work areas outlined in the five year strategy to signal our intent to continue to work closely to achieve our vision.

A single set of intentions is being provided to acute providers outlining what is anticipated to be required of them in 2015/16 in relation to the six work areas. This will be supported by an additional set of local intentions that CCGs will produce independently to address wider service development. Local commissioning intentions will be congruent with and supportive of SWL intentions.

The commissioning intentions provide the context for constructive engagement with providers, with a view to achieving the shared goal of improved patient outcomes and service improvement within the fixed resources available. To support patient-centred care, SWL CCGs are committed to securing alignment across all aspects of NHS commissioning. We are working with NHS England, partner NHS oversight bodies and local government to secure the best possible outcomes for patients and service users within available resources.

We have aligned our commissioning intentions to areas of the five year strategy, on which Clinical Design Groups have focused, with the addition of cancer:

- Children's services
- Maternity Services
- Planned Care
- Integrated care
- Mental Health
- Urgent and Emergency Care
- Cancer Services

The commissioning intentions for Cancer Services included in this document are those developed centrally on behalf of all London CCGs. We have excluded commissioning intentions relating to the transformation of primary care as these are being developed by NHS England with support from individual CCGs.

Whilst working to achieve the vision for services in SWL, commissioners expect providers to continue to maintain strong operational performance and to continue to meet national performance standards.

These commissioning intentions have been signed off by CCG Accountable Officers through the Joint Commissioning Group and were agreed in draft form by CCG Governing Bodies in September.2014.

2. Introduction

2.1 Context

There is recognition both nationally and locally that the NHS needs to change if we are to continue to provide high quality services to our local populations. The service must adapt to meet the demands of a growing population with higher expectations and more complex needs. Existing services, which have evolved over many decades, are often fragmented and inconsistent, unable to meet the challenges of caring for a population that has changed fundamentally since the system was designed.

At the same time, we are faced with a significant financial challenge across the local NHS; whilst our budgets have not been reduced in real terms, rising demand from an ageing population and the costs of new technologies and drugs mean we have to address a gap of around £209m a year by the end of 2018/19.

In SWL:

- There is a population of 1.45 million people
- The population is ageing and up to a third of people are living with long term conditions, meaning we need to provide more and better care out of hospital and closer to where people live
- None of our hospitals in SWL meets all the minimum safety and quality standards set out by clinicians based on Royal College guidance – the London Quality Standards
- There is variation in the quality of care between different hospitals and different times of the day, week and year
- The NHS is unlikely to be given extra money in the foreseeable future, yet the costs of providing healthcare are rising much faster than the rate of inflation
- We need to reshape mental health services so that they achieve the highest possible standards and are focused primarily in the community
- We need to ensure that primary care and other community-based services meet the highest possible standards
- We need to do more to prevent people becoming ill and to provide better information to patients about the most appropriate place to get help when they become ill

2.2 Five Year Strategy and Better Care Fund - Why we are working together

The publication by NHS England of *Everyone Counts: Planning for Patients* in December 2013 was a clear indication for local health and social care economies to work together to achieve the transformational change needed to address the challenges facing the NHS. The simultaneous launch of the Better Care Fund by NHS England and the Local Government Association also continues to promote closer collaboration and espouses the merits of integration.

In SWL the six local CCGs, along with NHSE (as commissioners of specialist and primary care services) worked together as the SWL Commissioning Collaborative to develop a common five-year strategy for the local NHS in SWL that aspires to achieve the following vision:

> "People in SWL can access the right health services when and where they need them. Care is delivered by a suitably trained and experienced workforce, in the most appropriate setting with a positive experience for patients. Services are patient centred and integrated with social care, focus on health promotion and encourage people to take ownership of their health. Services are high quality but also affordable."

The five year strategy draws on previous work over the last two years as well as more recent discussions with clinical colleagues across the health system; the initiatives are outlined across eight areas of work. This document includes six of the work areas in the five year strategic plan, excluding the Transformation of Primary Care for which CCGs will take an individual lead on in partnership with NHS England. Cancer services are also included.

1. Children's services
2. Maternity Services
3. Planned Care
4. Integrated care
5. Mental Health
6. Urgent and Emergency Care
7. Cancer

As NHS England is the lead commissioner for Primary Care, our work on Transforming Primary Care is not included in this document.

We believe that our shared strategy and combined BCF plans provide strong foundations on which to build future collaborative success and that issuing shared commissioning intentions is a clear signal of our intention to work cohesively in future to address local health challenges.

Our services are interdependent and the challenges we face cross borough boundaries. We need closer working between our hospitals and also between hospitals, GPs, community services and mental health services if we are to improve the quality of care for everyone in SWL and make the local NHS sustainable. We do not believe it would be possible to achieve the scale of change that is required by working independently at borough level. We have therefore chosen to continue to work together to commission as a collaboration of CCGs to:

- Raise safety and quality standards
- Address the financial gap
- Address the workforce gap
- Confront rising demand for healthcare

3. Strategic Contracting Principles and Intentions

3.1 Strategic Contracting Principles

We will continue to use the national acute contract and to sign up to national schemes intended to promote innovation, improve quality and reduce cost, such as national CQUIN schemes. This letter is notice of our intent to additionally adopt innovative ways of contracting which reflect our collaborative commissioning approach but also require greater collaboration from providers. The specifics of our approach will be refined over the second half of 2014/15 in conversation with providers, but the following ideas are indicative of current thinking.

3.2.1 QIPP and CIP

Commissioners will continue to implement local QIPP schemes, mindful that acute providers are also implementing CIP schemes. Commissioners will seek to liaise with providers to ensure that QIPP and CIP schemes are complementary.

3.2.3 Common incentive framework

We will develop local mechanisms for using CCG funding to creative a common incentive framework that will allow us to take a more strategic whole system approach to the use of incentives to achieve desirable system change.

3.2.4 Common payment structures

We will continue to support the use of national currencies such as PbR, Best Practice Tariffs and the extension of Maternity Pathway Payment. In addition we will develop innovative local payment structures outside traditional block contracts and PbR.

3.2.5 Pathway and outcome-based commissioning

We will consider how best to take forward work in both of these areas, with a focus on reducing fragmentation across pathways and reviewing the way services are commissioned to ensure the alignment of incentives and payment to outcomes.

3.3 Maintaining Operational Performance

Whilst working to achieve the vision for services in SWL, commissioners expect providers to continue to maintain strong operational performance and to continue to meet national performance standards, for example (but not limited to):

- 18 Weeks Referral To Treat (RTT) targets for elective care
- 2 Week Wait targets for urgent cancer referrals
- Four-hour A&E target
- Healthcare Associated Infection (HCAI) targets
- Increasing Access to Psychological Therapies (IAPT) target

4. Acute Provider Collaborative

CCGs recognise that the acute providers are increasingly working together through a collaborative programme to consider how best to respond to the case for change and ambitions described by CCGs in the five year strategic plan. This is a welcome development and CCGs will engage with the programme through a re-scoped governance structure and offer programme management support to enable the acute collaborative to take forward the agreed programme of work.

5. SWL Collaborative Commissioning Intentions

We have aligned our collaborative intentions to the areas of work set out in our five year strategy, six of which are pertinent to acute care and included in this document, in addition to Cancer Services:

1. Children's services
2. Maternity Services
3. Planned Care
4. Integrated care
5. Mental Health
6. Urgent and Emergency Care
7. Cancer Services

For each area of work, this chapter sets out:

1. Key challenges
2. The strategic vision by 2018/19 (as detailed in the five year strategy)
3. 2015/16 SWL commissioning intentions
4. Work in 2014/15 that will support 2015/16 commissioning intentions
5. Work in other areas that will support 2015/16 commissioning intentions

5.1 Children's services

5.1.1 Key challenges

- We do not have a comprehensive understanding across SWL of the capacity and capability of children's services that will allow NHS and Local Authority commissioners to assess needs, plan and coordinate commissioning to ensure that resources are targeted efficiently to secure high quality integrated pathways
- Clinicians are uniquely placed to identify their patients' needs, the standards of care, skills and outcomes required. We need to ensure that improvements in the quality of children's services are supported by strong clinical leadership and collaboration with children and their families, local authorities and public providers, to ensure consistent standards of care across SWL based on a foundation of strong evidence
- Too many children and young people are treated in hospital settings which are often more expensive and stressful to children and their families. Paediatric emergency care consultants feel that services are overwhelmed and that more children could be treated in the community to reduce admissions, improve outcomes and patient experience
- There is not enough focus on ill health prevention and early intervention for children and their families
- There is variable compliance with recommended staffing levels across paediatric units. We need to achieve London Quality Standards and make improvements to the quality of care in children's acute and urgent services

5.1.2 Strategic vision for Children's services in SWL in 2018/19

We will have a service that works efficiently and effectively across settings of care, despite the challenge of increasing demographic and system pressures facing children's services. We want to ensure our children receive high quality care, regardless of where they live in SWL. We want to provide our children with the best start in life to ensure that they remain healthy and achieve their social and educational potential. This means strengthening the whole system, including focusing on prevention and early years intervention.

We want children and young people to receive as much of their care as possible out of hospital, with highly skilled staff able to look after children in their own homes wherever achievable. Our hospitals

will adhere to the London Quality Standards (LQS) and will deliver the same standard of acute care, seven days a week, with senior input 'around the clock'. Where children need to attend hospital as urgent or emergency cases, frontline care will be delivered by consultant paediatricians and trained children's nurses. Some of these children will not need to stay in hospital overnight and a short stay model of care will be promoted as appropriate and safe. We will ensure that there are alternatives in place for hospital care wherever possible.

There will be a focus on the prevention of ill health in children as well as promotion of health education and healthier lifestyles, taking on a family focus where possible and appropriate. To enable this vision for children's care, we will need a highly skilled workforce across community and hospital settings, where generalists and health promotion skills work alongside specialist paediatric care accessible in and out of hospital.

5.1.3 2015/16 SWL Commissioning Intentions

The children's section of the 5 year strategic plan is aimed at improving access to, and the quality of, services and outcomes for children up to the age of 18 years in SWL. It covers acute and urgent care, community services, child and adolescent mental health services (CAMHS), health promotion and ill health prevention. Acute care includes neonatal intensive care and paediatric intensive care.

i. **Children's Network**

Commissioners will continue to support the Children and Young People's Network being created in the second half of 2014/15 in recognition of its pivotal role in developing a model of high quality and sustainable care for children and their families in SWL, in all care settings.

Action Required by Providers

a. Commissioners expect providers to engage fully with the Network as defined by the terms of reference
b. Commissioners expect providers to supply benchmarking data to support the development of a clinical dashboard to provide regular reporting on activity, access and clinical outcomes across paediatric services in south west London.

ii. Workforce

In the second half of 2015/16, in conversation with providers, commissioners will seek to establish the viability of inpatient paediatric and neonatal units across SWL in view of the requirement to

meet LQS and NHSE standards (for neonatal care) within five years. Commissioners will ensure that this is aligned with the Urgent and Emergency Care work.

Actions Required by Providers

To meet LQs within 5 years, providers will need to work with commissioners to review current service provision for inpatient paediatrics and neonatal units across SWL in the second half of 2015/16

5.1.4 Work in 2014/15 that will support 2015/16 commissioning intentions

A Children and Young People's network is currently being created and commissioners anticipate that this group will have a pivotal role in developing a model of high quality and sustainable care for children and their families in SWL. Commissioners expect providers to engage fully with the network and provide appropriate clinical and managerial input as defined by the Terms of Reference.

The Children and Young People's network will lead work to establish a baseline of the provision of and demand for children's services, including community services, in the second half of 2014/15. The baselining of provision will cover both capability and capacity. Commissioners expect providers to support this process by providing an agreed set of metrics in a timely manner.

5.1.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Urgent and emergency care
- Primary care transformation
- Maternity
- Mental health services (including CAMHS)

SWLCC will continue to maintain strong links to NHS England's specialist commissioning team to ensure that SWL commissioning intentions are aligned with NHS England's commissioning intentions.

5.2 Maternity Care

5.2.1 Key challenges

- Outcomes and intervention rates vary widely between maternity units
- Rising maternal age is leading to increasing complexity
- Services are focused on the needs of organisations rather than the needs of women
- Key clinical staffing standards are either not met, or not met consistently
- Continuity of carer could be improved
- Hospital and community postnatal care experience can be poor
- There is variation in the quality and quantity of antenatal care provided by GPs
- Screening programmes are not always well integrated into usual care, and there is variation in uptake and follow up

5.2.2 Strategic vision for Maternity services in SWL in 2018/19

In alignment with the SWL Maternity Network's vision, SWL commissioners want maternity services that provide care to women as individuals with a focus on their needs and preferences. There will be a strong emphasis on improving continuity of carer for all women whilst increasing the proportion of suitable women who receive care within a midwifery led setting. The existing disparity of outcomes and performance between SWL units must be addressed, with all units improving provision, quality and outcomes of care that meet national as well as London Quality Standards.

In SWL maternity services will be designed in a way that:

- Prepares women for pregnancy and becoming a parent through education and up to date evidence based information
- Provides care to women as individuals, with a focus on their needs and preferences
- Invests in improving continuity of care and carer, with a strong emphasis on midwifery led care for normal pregnancy and birth
- Provides care which meets the LQS for women with more complex needs, where obstetric care will be provided in our hospitals, with enhanced on site presence of consultant obstetricians and dedicated obstetric anaesthetists, supported by a range of emergency services, should they be needed

- Values and takes on board feedback from women we look after and their families in order to drive continuous improvement in the quality of care

Commissioners, in consultation with providers, will review and develop a model of care for out of hospital antenatal and postnatal care.

5.2.3 SWL Commissioning Intentions

i. Workforce

Actions Required by Providers

By 1st April 2015 all providers of maternity services are expected to ensure:

- A minimum of 98 hour consultant obstetrician presence on all acute labour wards. (24/7 (168 hours) consultant presence by 1st April 2019.)
- A minimum ratio of one clinical midwife to every 30 births and one consultant midwife to every 900 expected normal births.
- Support for clinicians to work collaboratively via the SWL maternity network with aim of improving outcomes for women, babies and families.

By 31st March 2016 all providers are expected to ensure:

- A minimum of 15% of women's care to be midwifery led and delivered. Includes antenatal, intrapartum and postnatal care.
- A minimum of 2% of births to take place out of hospital/at home
- Women with uncomplicated pregnancies to have no more than 2 midwives providing their antenatal and postnatal care within a community setting

Providers exceeding these standards in 2014/15 are expected to maintain, and not reduce, their performance.

5.2.4 Work in 2014/15 that will support 2015/16 commissioning intentions

Commissioners will begin to develop a model of care for out of hospital antenatal and postnatal care in the second half of 2014/15 with engagement from providers. Progress made in this area may lead to further service developments in 2015/16.

5.2.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Children's Services
- Urgent and emergency care
- Mental health services (including CAMHS)

5.3 Planned care

5.3.1 Key Challenges

- There is a lack of sufficiently integrated end to end planned care pathways for specific conditions
- There are variable outcomes from planned care procedures
- There is variable patient experience across the system
- Planned care services are often disrupted by peaks in non-elective activity

5.3.2 Strategic vision for planned care services in SWL in 2018/19

Clinicians in SWL have developed a vision for a future model of care that responds to regional challenges and meets the needs of people in the area for the years ahead. In SWL we believe that the separation of planned care and non-elective care provided as part of an end to end pathway, with planned care being delivered in a Multi-Specialty Elective Centre (MSEC), will provide safer, higher quality and more convenient care for patients.

The planned care service in SWL will:

- Separate elective and non-elective surgery, reducing the rate of cancellation for non-clinical reasons owing to peaks in demand for non-elective surgery
- Be delivered in a single MSEC for SWL by 2018/19
- Improve efficiency, quality, safety for patients through the centralisation of routine inpatient procedures in a centre of excellence
- Improve patient experience through the use of efficient surgical care pathways, which are predictable, uninterrupted and encourage greater continuity of care
- Optimise post-operative care for the condition provided by senior decision-makers and specialist nurses
- Reduce length of stay in hospital with highly coordinated discharge and after care delivered in the community where possible
- Build easier access to enabling or recovering services into the care pathway, providing continuous and integrated support through the entire patient journey
- Utilise existing estate to maximum effect, with any capital investment focussed on building technology-enabled care pathways

5.3.3 SWL Commissioning Intentions

Actions Required by Providers

Commissioners expect providers to collaborate in the development of an outline business case for the redesign of elective inpatient services, with phase 1 (a single specilaity to be agreed) to be implemented in 2015/16 and subsequent phases refined for future implementation and inclusion in 2016/17 commissioning intentions.

Redesign of a single surgical specialty should be seen as the minimum action required by commissioners, who are willing to consider more ambitious business cases for additional elective inpatient specialties.

Commissioners expect providers to continue to maintain strong operational performance and to continue to meet national performance standards relating to planned care, including RTT.

5.3.4 Work in 2014/15 that will support 2015/16 commissioning intentions

In the second half of 2014/15 commissioners will review existing and planned demand management schemes and local QIPP plans to gauge progress and ensure that schemes are complementary to this area of work.

5.3.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Primary care
- Integrated care
- Urgent and emergency care

5.4 Integrated care

5.4.1 Key Challenges

- The burden and complexity of Long Term Conditions (LTCs) is rising, and patients and service users are experiencing fragmented care which does not meet their needs appropriately
- There is an imperative to implement local BCF plans and improve outcomes at an aggregate level across SWL
- Non-elective (NEL) admissions and urgent care needs are rising, and without the redirection of funds through the BCF, our current community based provision will not meet this demand
- We do not have the inter-organisational systems and infrastructure in place to enable delivery of integrated services
- We have a pressing community and social care workforce gap

5.4.2 Strategic vision for integrated care services in SWL in 2018/19

Our collaborative vision has harnessed common areas of preparation and planning which has been undertaken by each CCG for the delivery of their BCF plans, and other key planning stages such as commissioning intentions and two year operating plans.

We aim to expand and improve services provided outside hospital, up-skill the workforce, increase specialisation in the community and commission high quality care provided out of hospital wherever appropriate. We want people to experience an uninterrupted journey through services, ensure that patients' families and carers receive education and support, and improve connections to the voluntary sector. In addition, integrated services will make better provision for mental health care to enhance overall wellbeing, independence and social capital.

In SWL we believe that people should experience integrated care which:

- Helps people to self-manage their condition and helps understand how, when and who to access care from when their condition deteriorates. This means that preventative advice is given by their care coordinator and they can access structured education.
- Helps to keep people with one or more LTC and complex needs stable. This means that patients who are at risk have been identified and assigned a care coordinator who intervenes when appropriate.
- Helps people who are at risk of losing their independence to access services which increase their ability to live independently and improve their quality of life. When they are at risk,

their GP or practice nurse is able to signpost them to a care navigator (or equivalent) to help access services.

- Allows people to get timely and high quality access to care when they are ill, delivered in the community where appropriate. Improved signposting to services will ensure people know when and where to access the right services.
- Allows professionals to be familiar with the patient's circumstances, to support their preferences, and to provide continuity where agreed, while including them in making choices about their care through a care plan which is reviewed each time there is contact with their care coordinator.
- Supports people who are in hospital to be discharged back home as soon as they no longer require hospital care, with appropriate plans in place for care to continue at home. People will know how they will be looked after when they leave hospital and their care coordinator or primary care team will contact them when they are discharged.
- People who are discharged from hospital with the right level of support delivered at home or in the community to prevent readmission or promote independence. This means they receive appropriate re-enablement therapy whether at home or in the community; professionals will provide regular care until they are independent again.
- Helps people requiring end of life care to be supported to receive their care and to die in their preferred place. People who are identified as being at the end of their lives are registered on Coordinate my Care which will hold information about their preference of care and place of death and prevent unnecessary admissions to hospital.

5.4.3 SWL Commissioning Intentions

i. Better Care Fund

The refinement and implementation of Better Care Fund schemes that shift activity away from acute settings will be central to commissioners work over 2015/16 and 2016/17. BCF schemes are local to each CCG and Local Authority, however commissioners expect providers to collaborate as needed.

Actions Required by Providers

Commissioners have agreed in discussion with providers to work closely with and support the implementation of BCF schemes, particularly the reduction in NEL admissions in line with the targets of each individual CCG.

ii. Workforce

Commissioners recognise that implementing BCF is likely to require additional capacity and capability in the community.

Actions Required by Providers

Commissioners will work with providers to support the realignment of the workforce to meet new models of care, including 7 day working.

iii. Improving the sharing of patient data

Delivering integrated care requires the sharing of patient information across multiple care settings and provider organisations.

Actions Required by Providers

Commissioners expect providers to engage in the process for resolving information governance issues to facilitate this.

iv. Improving the quality and availability of data

Commissioning genuinely integrated care that improves quality of outcomes and patient experience requires high quality performance data that are shared in a consistent and timely manner.

Actions Required by Providers

Commissioners expect providers to engage in the process for developing and implementing both standardised and ad hoc data reports and adhering to agreed timescales for delivery.

5.4.4 Work in 2014/15 that will support 2015/16 commissioning intentions

Commissioners will share any refreshed BCF plans with providers for their input and support in the delivery of BCF schemes for the remainder of 2014/15 and 2015/16.

5.4.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Transformation of Primary Care and Primary Care Commissioning
- Urgent and emergency care

5.5 Mental Health

5.5.1 The key challenges for this area of work

- Pathways are not systematically integrated to respond to both physical and mental health needs
- There are inequalities in access to mental health care
- Not enough care is delivered outside hospitals; we need improved access to community based services
- We need to ensure that more patients suffering from mental health problems are identified earlier
- We need to improve the wellbeing and quality of life for all patients suffering from mental health conditions, and promote recovery
- We need to ensure parity of esteem, valuing mental health equally with physical health

5.5.2 Strategic vision for mental health services in SWL in 2018/19

People who need to use mental health services in SWL will experience services that:

- Have been developed and shaped with the help of service users and their carers
- Offer patients a choice of provider from within the NHS, the independent sector or the voluntary sector
- Are focused on evidence based recovery models with a greater emphasis on peer led interventions, that continue to support patients into recover
- Are delivered in the locations that best suit service users and their carers, including a greater range of services for patients with dementia delivered in primary care
- Promote social inclusion and parity of esteem by continuing to provide care in a community or primary care setting for those patients who no longer have a secondary care mental health need
- Promote the inclusion of mental health in multi-disciplinary teams that support people with physical and mental health needs, such as those with Long Term Conditions
- Are compliant with the National Crisis Care Concordat (2014) to improve the system of care and support so people in a mental health crisis are kept safe and helped to find the support they need

- Promote community pharmacists, patients and GPs working collaboratively to improve the management of psychotropic medication
- Effectively manage physical health needs, particularly with people who have severe and enduring mental illness to improve the disparity in mortality rates
- Have taken into account and acted on the recommendations set by the Schizophrenia Commission
- Safely manage the transition of young people from CAMHS into adult services and prevent young people from 'falling through the net'
- Engages carers as partners in the care planning process and ensures that their views are taken into consideration

Services will be provided in a system that:

- Facilitates the use of personalised budgets and places greater emphasis on delivering services that have successful recovery outcomes and excellent patient experience
- Continually takes action to address inequalities in mental health services and improvements made, which reflect the needs of Black and Asian and Minority Ethnic (BAME) communities, the socially disadvantaged and vulnerable groups
- Has aligned care pathways to the clustering within the Mental Health Tariff (Payment System) to provide benefits to Service and provider greater clarity to commissioners

5.5.3 SWL Commissioning Intentions

Commissioners recognise that much of the action required to achieve the strategic vision for mental health services in 18/19 sits with mental health trusts, community providers and primary care.

Actions Required by Providers

Commissioners expect that providers will work across organisational boundaries to support implementation of the vision, improve outcomes and deliver services differently as needed.

For example, commissioners expect providers to engage with:

- Improving the inclusion of mental health in multi-disciplinary teams that support people with physical and mental health needs, such as those with Long Term Conditions
- Improving the link between urgent and emergency care and mental health services, including the development of psychiatric liaison services

- Continuing to support the diagnosis of dementia through the national CQUIN, and reducing A&E attendances and NEL admissions for patients with dementia

Commissioners will support providers to understand the process for adoption and impact of the mental health tariff.

Commissioners expect providers to continue to maintain strong operational performance and to continue to meet national performance standards relating to mental health, e.g. achieving IAPT targets.

5.5.4 Work in 2014/15 that will support 2015/16 commissioning intentions

The commissioning intentions set out for 2015/16 are in part a continuation of the work of CCGs in 2014/15.

5.5.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Primary care
- Integrated care
- Urgent and emergency care
- Maternity
- Children's Services

5.6 Urgent and Emergency Care

5.6.1 Key Challenges

- Patients do not always understand how, or feel empowered, to access the right care, in the right place the first time
- Providers do not consistently meet quality standards (national and local)
- There is a projected workforce gap to delivering the LQS
- We need to ensure that our workforce is sufficiently trained to deliver new models of care
- We are not exploiting the full opportunities of ambulatory care pathways

5.6.2 Strategic vision for urgent and emergency care services in SWL in 2018/19

Our vision is to strengthen the urgent and emergency care whole-system service model through improving the quality of urgent care services and ensuring that the provision of integrated urgent care is timely and robust.

In SWL we believe that the urgent and emergency care system model needs to be transformed so people are:

- Supported to manage their conditions in their own homes through improved self-care and shared decision making
- Aware of the different parts of the urgent care system and when and where to access the care they need
- Provided with improved access to a well-connected and clearly defined urgent care system including Urgent Care Centres, Primary Care, GP out of hours, 111, social care, London Ambulance Service, and other health professionals such as pharmacists and dentists
- Diagnosed, treated and able to go home on the same day through wide scale implementation of the Ambulatory Emergency Care (AEC) services as part of our work to improve the overall urgent and emergency care pathway
- Treated in high quality and safe emergency departments that meet the recommended levels of senior staffing and access to specialist equipment, as per London Quality Standards with pathways designed to improve patient flow
- Supported with their health and social care needs in the community, enabled through Better Care Fund schemes
- Able to access emergency departments that deliver high quality specialist care; this will be achieved by implementing the recommendations in the Keogh report (to be published later

in 2014) and taking into account any national guidance on standards for urgent and emergency care services and consistency in the naming of such services. Commissioners will work with providers to understand the local implications of these recommendations, including the introduction of two levels of emergency departments

- Able to access alternative forms of high quality urgent care services which meet LQS and other nominated best practice standards, to alleviate pressure on hospital emergency departments and expedite diagnosis and treatment
- Given access to seven day services in hospitals, complemented by 7 day services across the system to enable timely discharge
- Able to benefit from strengthened links between urgent and emergency care services and mental health psychiatric liaison services

5.6.3 SWL Commissioning Intentions

The focus of this area of work in 2015/16 should be to work towards the provision of services that facilitate 7/7 discharge and meet local and national quality standards.

i. Workforce

Commissioners expect providers to achieve LQS compliance by 20818/19. The roadmap to achieving this will be informed by a baselining exercise to be undertaken in the second half of 2014/15.

Actions Required by Providers

Commissioners will specifically expect providers to support the implementation of 7 day working across the urgent and emergency care system to support delivery of the four hour A&E target.

ii. Ambulatory & Emergency Care Models

Actions Required by Providers

Commissioners expect providers to develop and implement a local model for AEC services in SWL by the end of quarter 2 in 2015/16.

iii. Increasing integration of services

Actions Required by Providers

Providers will work with the UEC Clinical Design Group and local system resilience groups to strengthen integration across the whole system and in particular with London Ambulance Service, community pharmacies, 111 and Out of Hours services.

Commissioners expect providers to continue to maintain strong operational performance and to continue to meet national performance standards including the 4 hour A&E target.

5.6.4 Work in 2014/15 that will support 2015/16 commissioning intentions

In the second half of 2014/15 commissioners will expect to work with providers to baseline compliance against LQS, including workforce capacity. Commissioners will work with the urgent and emergency care CDG to review the current use of AEC pathways and identify areas for wider use.

Commissioners will work with providers to understand the local implications of the Keogh recommendations for the introduction of two levels of emergency departments and implementation of necessary reforms.

5.6.5 Work in other areas that will support 2015/16 commissioning intentions

This CDG area is primarily interdependent with the following CDG areas:

- Primary care
- Integrated care
- Mental Health
- Maternity
- Children's services

5.7 Cancer Services

5.7.1 Key Challenges

The challenges facing cancer services are:

- Increasing the focus on primary prevention
- Improving early diagnosis through promotion of patient awareness and screening uptake
- Addressing the variation in outcomes and patient satisfaction across secondary care providers
- Delivery of chemotherapy in more convenient settings for patients
- Improving utilisation of radiotherapy technology
- Improving access to support for patients living with and beyond cancer
- Optimising delivery of end of life care based around the lives of patients and cases
- Improving patient experience

5.7.2 Strategic vision for urgent and emergency care services in SWL in 2018/19

By 2018 cancer services will focus on prevention of disease, early diagnosis and patient experience. There will be an emphasis on patient choice and the provision of care in the community during active treatment, recovery and, where necessary, the end of life phase. Every patient will be treated as an individual and offered the full support of the healthcare professionals involved.

5.7.3 SWL Commissioning Intentions

Cancer is one of the four priority areas for improvement identified by NHS England (London) to transform the health, wellbeing and lives of Londoners. The Five-year Cancer Commissioning Strategy for London was launched in February 2014. The strategy was developed collaboratively by NHS England with significant input from cancer clinicians, representatives from the Integrated Cancer Systems linking into the clinical pathway groups, CCG clinical commissioners as well as commissioners from Public Health England and NHS England.

These commissioning intentions have been developed from the strategy with the intention of being included in all acute provider commissioning intentions across London.

i. Earlier detection of cancer

To promote the early detection of cancer we will commission:

- GP direct access to diagnostics (chest x-ray, including same day chest x-ray for high risk of cancer, non-obstetric ultrasound)
- GP direct access to flexible sigmoidoscopy, colonoscopy via a diagnostic triage service that will assign the most appropriate diagnostic test. Age of referral for low risk, but not no risk of cancer to service lowered from 55 to 45

In order to promote the earlier diagnosis of ovarian cancer, services will be commissioned to support US and CA125 concurrently.

We will expect all endoscopy services to be JAG accredited.

Action required by providers

Commissioners expect providers to respond to service changes or tenders that facilitate direct access to diagnostics, specifically chest x-ray and non-obstetric ultrasound, flexible sigmoidoscopy, and colonoscopy.

Commissioners expect providers to respond to service changes or tenders that seek to support the concurrent use of ultrasound and CA125.

Commissioners expect providers to actively engage in the process for defining robust reporting systems, including A&E and UCC attendances and chest x-rays, to support early detection of cancer.

Providers of endoscopy services must achieve Joint Advisory Group (JAG) accreditation.

ii. Reducing variation in secondary care

In order to reduce variation in the quality of services provided by secondary care, we will:

- Ensure that endobronchical ultrasound (EBUS) services are commissioned to an agreed service specification and tariff
- Engage with the London Cancer Alliance to support the development of a best practice timed pathway for lung cancer and encourage providers to implement this
- Engage with the London Cancer Alliance to support the development of a best practice timed pathway for breast cancer, including the provision of a one stop diagnostic service and encourage providers to implement this
- Engage with the London Cancer Alliance to support the development of a best practice timed pathway for colorectal cancer and support providers to implement this – with all

teams completing 60 new surgical cases with curative intent. Providers must ensure that all people who need emergency treatment should be treated by a colorectal cancer team

- Commission prostate cancer services in line with NICE guidance (2014)
- Commission pathways for the management of treatment related fertility issues (NICE Guidance 2013)
- Commission services that manage those with a family history of moderate risk breast cancer to a Pan London specification (NICE Guidance 2013)
- Commission services that manage metastatic spinal cord compression in line with NICE QS56 (Feb 2014).

Action required by providers

Commissioners expect providers to ensure that all services participate in national cancer peer review or other assurance programme defined by commissioners. All cancer MDTs are quorate for 95% of meetings and individual members attend 66% of meetings (in order to support improved MDT decision making).

Commissioners expect providers to respond to service changes or tenders to provide endobronchial ultrasound (EBUS).

Commissioners expect providers to engage with the London Cancer Alliance to develop a best practice timed pathway for lung cancer and to implement this.

Commissioners expect providers to engage with the London Cancer Alliance to develop a best practice timed pathway breast cancer, including the provision of a one stop diagnostic service, and to implement this.

Commissioners expect providers to engage with the London Cancer Alliance to develop a best practice timed pathway for colorectal cancer and support providers to implement this – with all teams completing 60 new surgical cases with curative intent - and to implement this.

Commissioners expect providers to respond to service changes or tenders to provide prostate services in line with NICE guidance 2014

Commissioners expect providers to respond to service changes to ensure the management of those with a family history of moderate risk breast cancer to a pan-London standard (NICE guidance 2013)

Commissioners expect providers to respond to service changes or tenders to provide care for metastatic spinal cord compression in line with NICE QS56 (February 2014)

iii. Living with and beyond cancer - recovery package (National Cancer Survivorship Initiative)

In order to support patients living with and beyond cancer we will:

- Ensure that all commissioned services deliver a recovery package (holistic needs assessments and care plans, treatment summaries, health and well-being events)
- Commission pathways for the consequences of treatment of pelvic radiotherapy, lymphedema and treatment related sexual dysfunction

Action required by providers

Commissioners expect providers to respond to service changes to ensure that all cancer pathways offer a holistic recovery package.

5.7.4 Work in 2014/15 that will support 2015/16 commissioning intentions

The commissioning intentions set out for 2015/16 are in part a continuation of the work of the London Cancer Alliance in 2014/15.

6. Enablers

We have developed a bold and ambitious vision for health and care services in 2018/19 in our five year strategy and recognise that to achieve this we must invest in a number of key enabling schemes. In the second half of 2014/15 as we refine commissioning intentions we will work with providers to scope those enabling schemes that may require investment in 2015/16.

Commissioners recognise that the following areas will require additional focus to ensure progress in 2015/16 towards the vision set out in the five year strategy.

6.1 Workforce

The case for change in SWL is predicated on providers not yet meeting London Quality Standards and recommended Royal College staffing guidelines consistently across SWL. Specifically we know that there is a shortage of obstetric, paediatric and emergency medicine consultants. In addition, General Practice recruitment is becoming increasing challenging and there are gaps in some areas of the community workforce which will make it difficult to integrate services and transfer care in to the community where possible. There is also recognition that the skill mix of the wider workforce requires review and investment.

Commissioners will work with providers and bodies such as Health Education England to understand the impact of commissioning intentions for 2015/16 and the longer term vision for 2018/19 on:

- Recruitment and retention
- Training
- Workforce pipeline
- Transition and succession planning

6.2 Information

Commissioning and delivering integrated care across multiple care settings and provider organisations requires the sharing of information.

To commission high quality services that improve patient outcomes and experience whilst delivering value for money, we need to have better, more timely, access to better quality activity, operational performance and outcome data that can inform the way in which we prioritise resources and scrutinise quality.

Similarly, to deliver joined up patient care across multiple settings and professional and/or organisational boundaries requires the prudent sharing of patient data more widely than is practised currently.

Where providers deliver services across multiple sites, commissioners require providers to share quality and activity data split by site.

Commissioners will work with providers to understand how they can support the adoption of systems that will better facilitate the sharing of information across the whole system.

6.3 IT Infrastructure

Commissioners understand that fragmented and occasionally outdated IT infrastructure is a hindrance to the progression of flexible working practices and innovation in the way care is delivered, as well the sharing of information.

We will work with providers to understand the priorities for investment in this area.

6.4 Estates

Commissioners have committed to providing more care away from hospitals and closer to patients' homes by 2018/19. We will work with providers to understand how best to facilitate this shift, to ensure that there is sufficient capacity in the community and that providers are supported to agree a process for managing potential stranded costs as a result of estates rationalisation.

It is likely that there will be capital costs associated with the development of a Multi-Specialty Elective Centre (MSEC) and this will require further investigation.

Commissioners will continue to liaise with NHS England, commissioners of primary care, to support plans to ensure that primary care estate is fit for purpose and can absorb increased levels of activity.

6.5 Better Care Fund

Unlike the five year strategy, Better Care Fund plans have been developed independently by each CCG to reflect the nuances of each local unit of planning (including local authorities). BCF schemes are expected to be vehicles for delivering the change required to achieve our vision for 2018/19.

7. Stakeholder Engagement

We are committed to working with local providers, service users and the public to develop solutions that will deliver safe, high quality care for everyone. Much public engagement was carried out prior to the establishment of SWL Collaborative Commissioning and we have continued to listen to a wide range of stakeholders when developing the 5 year strategic plan.

We engaged local patients, the public and the voluntary/community sector in the development of the five- year strategy from the beginning, which is in line with best practice engagement. We sought the advice of the Consultation Institute on the best approach to doing so.

Over the past three years a great deal of engagement has taken place with patients, public and partners and we have gathered views and feedback from a range of different stakeholders. In particular, through the Better Services Better Value programme and more recently, each of the six CCGs ran their own local engagement programmes as part of the national 'Call to Action' programme, in advance of agreeing Commissioning Intentions. Focus groups have also taken place across south west London to inform the six CCGs in developing their two year operational plans.

The advice of the Consultation Institute was that the overall approach to engagement in the development phase of work should be to:

i. Build on the engagement activity already completed over the past three years and;
ii. Carry out a listening and learning exercise to test the feedback we had already gathered from the BSBV programme and A Call to Action

During April and May 2014, engagement activity focused on two areas;

i. A listening event/forum for different stakeholders from across south west London
ii. A series of focus groups with a cross section of the south west London community

A number of consistent themes were discussed and fed back both at the listening event and by the focus groups. They were considered and reflected in the final version of the strategy. These included views on workforce, integration of services, patient education and information about accessing services and working more closely with the voluntary sector. Of note, participants in one of the focus groups said that they thought that patient and stakeholder feedback from previous engagement work had helped influence the strategy.

A report on this engagement activity is available at http://www.swlccgs.nhs.uk/documents/listening-and-learning-engagement-report-june-2014/

8. Conclusion

This document has set out the commissioning intentions for SWL CCGs. They are intended to drive major transformation across the services we provide to ensure that patients receive higher quality, more integrated care with an enhanced patient experience. We expect providers to respond positively and proactively to our intentions and work with us to ensure our vision is realised.

Six-month Notice Letter - Cancer

Cancer is one of the four priority areas for improvement identified by NHS England (London) to transform the health, wellbeing and lives of Londoners.

The *Five-year Cancer Commissioning Strategy for London*[1], launched in February 2014. The strategy was developed collaboratively by NHS England with significant input from cancer clinicians, representatives from the Integrated Cancer Systems linking into the clinical pathway groups, CCG clinical commissioners as well as commissioners from Public Health England and NHS England.

The approach taken for 2015/16 is to refine last year's commissioning intentions as they will not all have been delivered by April 2015 and only to add limited additional areas. Commissioning intentions for 2015/16 are outlined below.

Earlier detection of cancer

- GP direct access to diagnostics (chest x-ray (same day chest x-ray for high risk of cancer), non-obstetric ultrasound)
- GP direct access to flexible sigmoidoscopy, colonoscopy via a diagnostic triage service that will assign the most appropriate diagnostic test. Age of referral for low risk, but not no risk of cancer to service lowered to 45 (from 55)
- In order to promote the earlier diagnosis of ovarian cancer, services will be commissioned to support US and CA125 concurrently
- In order to support the reduction of the risk of delayed diagnosis, all commissioned services will be required to formally report A&E, Urgent care centres and inpatient chest x-rays(CxR)
- JAG accreditation for endoscopy services

Reducing variation in secondary care

- All services will participate in national cancer peer review or other assurance programme defined by commissioners. All cancer MDT's are quorate for 95% of meetings and individual members attend 66% of meetings (in order to support improved MDT decision making)
- Endobronchical US (EBUS) services are commissioned to an agreed service specification and tariff.
- Best practice timed pathway for lung cancer
- Best practice timed pathway for breast cancer – all to provide a one stop diagnostic service. All surgeons to have a minimum caseload of 50 per annum.
- Best practice timed pathway for colorectal cancer – all teams completing 60 new surgical cases with curative intent. All people who need emergency treatment should be treated by a colorectal cancer team
- Prostate cancer services commissioned in line with NICE guidance (2014)
- Agree and implement service consolidation plans
- Services will be commissioned to provide pathways for the management of treatment related fertility issues (NICE Guidance 2013)
- Services will be commissioned for the management of those with a family history of moderate risk breast cancer to a Pan London specification (NICE Guidance 2013)
- Services for the provision of Metastatic spinal cord compression will be commissioned in line with NICE QS56 (Feb 2014).

Living with and beyond cancer - recovery package (NCSI)

- All cancer services commissioned to deliver the recovery package (holistic needs assessments and care plans, treatment summaries; health and well-being events)
- Stratified pathways (breast, colorectal and prostate)

[1] www.england.nhs.uk/london/2014/01/22/cancer-strategy/

- Pathways for the consequences of treatment of pelvic radiotherapy, lymphedema and treatment related sexual dysfunction

APPENDIX 5

The Clinical Commissioners' Approach to Proposed Changes to Coding & Counting Practices for Acute and Community Services from 2015/16

1 Introduction

1.1 The aim of this guidance is to share the Clinical Commissioning Groups' (CCGs) approach to proposed changes to coding and counting practices for acute and community services from 2015/16 onwards. (For nationally mandated changes please see section 3 below).

2 The Process

Area	Requirement
Start Date	In line with NHS Standard Contract 2014/15 Service Condition (SC) 28.10 "any change of practice agreed must be implemented on 1 April of the following Contract Year".
Notice Period	In line with the NHS Standard Contract 2014/15 Service Condition (SC) 28.8 the minimum notice period will be 6 months and correspondingly the last notification date will be 30 September in the current year for the following year.
Materiality	Coding and counting practice mandated by HSCIC or required by the National Tariff will be notified, planned and implemented as required. Proposals for local prices must be cost-neutral to CCGs, ie increases in one service must be off-set by a reduced price in another. Local price proposals that create transactional costs that are disproportionate to the service being delivered and the benefits to patients will not be considered.
Justification	To ensure value for money, all local proposals will have to demonstrate benefits for patients, commissioners and providers in terms of both service provision and data quality.
Implementation	To ensure that any changes of coding and counting can be transacted and effectively monitored, a minimum of 6 consecutive months shadow monitoring should be undertaken and validated by CCGs/CSU before implementation. Proposals will not be considered unless this process is adhered to. Where shadow arrangements are not already in place the exact detail of monitoring requirements will be set out during October to ensure there is a realistic expectation that robust information will be available for all parties. Where shadow monitoring and validation has been undertaken, and implementation agreed this will start from 1 April 2015.
Financial stability	Any cumulative change to the contract value in excess of

	0.25% will be subject to transitional arrangements of up to 3 years depending on the scale of agreed changes (SC28.11)
Assurance	All agreed changes will be subject to clinical coding audit and the results shared with all parties.

Coding and Counting Changes
The NHS Standard Contract 2014/15 Service Condition 28 sets out the high level governance regarding any proposed changes to the coding and counting of NHS activity.

The lessons from 2013/14 and 2014/15 show that a considerable amount of NHS management and clinical resource was used negotiating incomplete and delayed proposals, often without robust financial values and poor implementation plans, the majority of which were not agreed.

CCGs are specifying that all proposals to change the coding and counting of acute services are:

- Presented on the standard template
- Submitted to the Director of Commissioning of the Lead CCG and the CSU Contract Lead

To enable better evaluation of the wider system impact with commissioning partners fully completed submissions must be received by 31 October 2014. Incomplete submissions will be put into a longer-term 18 month process, including the establishment of shadow monitoring where it is not already in place

Providers and Commissioners will be expected to reach pragmatic agreement on the materiality of proposals. Proposals will not be considered where transaction costs to agree, implement, monitor and audit any changes do not offer value for money for the tax-payer.

Proposals must demonstrate benefit for patients in terms of supporting service provision and data quality and this must be clearly set out in the proposal.

There will be a requirement for a minimum of 6 months consecutive shadow monitoring. The standard template and guidance is attached at Appendix D.

2.1 This process will apply to all proposed coding and counting changes for CCG commissioned services. (This includes activity not currently charged for, but where there is an intention to apply National Tariff, and activity for which a local price is proposed).

2.2 All proposals will be shared using the standard template provided by no later than 31 October 2013. Providers should submit proposals to *dboothroyd@nhs.net*.

2.3 Incomplete proposals will be put into a longer-term 18 month process, including the establishment of shadow monitoring where this is not already in place.

2.4 For further information and guidance on the process and completion of the template please email *dboothroyd@nhs.net*.

3 Alignment with National Changes

3.1 National changes mandated by the HSCIC or required by the National Tariff will be implemented in accordance with appropriate nationally prescribed time-line.

3.2 CCGs will expect the impact of these changes to be calculated at individual CCG level for all CCG commissioned services.

Appendix 5a

Standardised Approach to Coding and Counting

Summary of Coding and Counting Proposals

N.B For each proposal use a separate line for different activity type and code as appropriate. Where a proposal shifts activity / costs between NHS England and CCGs, please provide information for each commisisoner type by proposal.

Proposed by:	Name:	
	Organisation	
	Job Title	
	Contact Email	
	Contact Telephone	

Organisation Code :	Provider Organisation Name	Title of Proposed Change	Proposal Number	How Service / Activity (12 months prior to change) is currently coded and charged											Proposed Service / Activity (12 months After Change)								Year on Year Net Impact	Monthly Shadow Monitoring Provided since:
				Commissioner Code	Point of Delivery	Activity Type (s)	Code(s)	Volume(s)	Date From	Date to	Currency(s)	Tariff(s)	Total Value £		Commissioner Code	Point of Delivery	Activity Type	Code(s)	Volume	Currency	Tariff	Total Value		
			1					-				£ -	£ -								£ -	£ -	£ -	
												£ -	£ -								£ -	£ -	£ -	
												£ -	£ -								£ -	£ -	£ -	
												£ -	£ -								£ -	£ -	£ -	
												£ -	£ -								£ -	£ -	£ -	
												£ -	£ -								£ -	£ -	£ -	
												£ -	£ -								£ -	£ -	£ -	
Total													**£ -**									**£ -**	**£ -**	

Authorised by:	Name:	
	Organisation	
	Job Title	Director of Finance
	Contact Email	
	Contact Telephone	
	Signature	

Proposals should be shared locally and submitted nationally to the following email address by no later than 30 September xxxxxxxxxx@NHS.net.

Ref MW v1 14-08-2014

APPENDIX 5a

Template for notification of intended Coding / Counting Changes to 2014/15 Contract for 2015-16

Organisation Name and Code	
Proposal *(Title, reference number & date)*	

☐ **Justification for the proposed change**
Summarise the benefits of the change for patients, the commissioner and provider.

Does the proposed change constitute (tick all that apply)	
☐	Coding change
☐	Counting change
☐	Local quality requirement / Local incentive scheme
☐	Agreed service development
☐	Agreed pathway change

Current Service / Activity	**Proposed Service / Activity and how this differs from current provision**
Narrative description (service code e.g. TFC and/or HRG code(s) must be used where relevent)	**Narrative description** (service code e.g. TFC and/or HRG code(s) must be used where relevent)
Activity type(s) (e.g. IP / DC / OP, etc., and whether consultant-led or other)	**Detail of proposed new activity type(s)**
How is activity currently coded? (Please include specialty codes, as well as clinic codes for out-patients and HRG or other coding)	**How will proposed activity change be transacted / coded? (Please include specialty codes, as well as clinic codes for out-patients and HRG or other coding)**
What is the current contractual arrangement?	**Proposed contractual arrangement**
Cost and volume - national tariff ☐	Cost and volume - national tariff ☐
Cost and volume - local price ☐	Cost and volume - local price ☐
Cost and volume - with marginal rate ☐	Cost and volume - with marginal rate ☐
Block ☐	Block ☐
Indirect funding (within other tariff / funding) ☐	Indirect funding (within other tariff / funding) ☐
Other - please specify ☐	Other - please specify ☐
Annual volume of activity by activity type	**Proposed annual volume of activity by activity type**
Current unit price paid (excluding MFF & CQUIN) for activity by activity type at 2014/15 prices (please include unit currency i.e. spell, year of care etc.)	**Proposed unit price paid for activity (excluding MFF and CQUIN) by activity type at 2013/14 prices (please include unit currency).**
Current annual quantum of income received for activity (volume x price, including MFF but excluding any CQUIN) at 2014/15 prices	**Proposed annual quantum of income received for activity (volume x price, including MFF but excluding any CQUIN) at 2014/15 prices**
	Net change in quantum at 2014/15 prices (including MFF but excluding CQUIN)
	£0

Are there any implications for other services, drugs, devices etc.?	
Other services that will change or cease (include current activity and finance)	**Other service after changes (include proposed activity and finance levels)**
	Is any activity moving between providers as part of a planned service change? If so give full details.
	Is any activity moving from or into specialised services? If so give full details.

Ability to transact the proposal - For how long has monitoring been provided?	
☐	6 consecutive Months? (minimum requirement)
☐	12 consecutive months? (recommended time period)
Please confirm that any coding changes will be included in the Trust's coding audit programme and the results shared with all parties.	

Any other relevant information?

Required supporting information
Please append the following information: - Last 3 years reference costs appropriate for the relevant service(s) - Service expenditure (current year-to-date and previous 3 years) - Supporting analysis files

Template completed by (name, job title, email, phone number and date)
Approved for submission by (name, job title, email, phone number and date)

Ref: Coding change template 240914

APPENDIX 6

South West London Trust notification letter (23/09/2014)

This section sets out the expectations for 2015/16 with regards to high cost drugs and devices by the lead CCG commissioner, on behalf of itself and associate commissioners.

1. We expect Trusts to adhere to the following documents which are included in the existing contract and are reviewed and agreed by the SWL Medicines Commissioning Group (which has representation from all SWL Acute Trusts, community services providers and CCGs) on an annual basis:
    - "SWL Interface Prescribing Policy" and associated appendices and
    - "Commissioning Principles for PbR excluded drugs and devices" and associated appendix

    See link for 2014/15 version. We intend to review these documents for 2015/16, also including the information set out below.

Horizon scanning

2. In view of (annual and in-year) updates and adjustments to the "NHSE Manual for Prescribed Specialist Services" and NHS England's PbR excluded drug list, we intend to vary CCG commissioned PbR excluded drugs and associated services accordingly. CCG commissioned drugs will be listed in the SWL CCG Commissioned PbR excluded drug list 2015/16 which will published on www.swlmcg.nhs.uk and included in Trust 2015/16 contracts.

3. It is the responsibility of providers to inform commissioners of any cost pressures anticipated in the forthcoming year including those relating to NICE technology appraisals within prioritisation round timescales. We would expect the Trust to horizon scan implications of NICE approved drugs / technologies, those in development and other developments and set out financial and service implications and the pathway they are proposing to use. New excluded drugs and devices will not be funded in-year unless approved by NICE or previously identified and planned for within the prioritisation round.

4. London CCGs intend to commission treatment pathways in line with NICE guidance and will recognise charges derived from NICE costing templates. NICE costing templates include information on activity charges used to cost the full treatment pathway (this includes cost of drug, price of activity associated with the drug, price of activity when patient is followed up). We would expect the Trust to implement these charges (or less) unless specifically agreed otherwise.

Notification and invoicing for high cost drugs

5. In order to secure funding for PbR excluded drugs or drugs not routinely commissioned, PbR excluded drug funding application forms ("tick box forms") and Individual Funding Request (IFR) forms should be screened by suitably trained Trust pharmacy staff before submission. This is to ensure that only valid applications are submitted that meet all contractual requirements for PbR excluded drugs or the IFR policy (for IFR applications) and that applications are not submitted where this is not the case. We have noticed deterioration in the quality of applications for some Trusts, resulting either in delays of processing or a return of applications to the Trust.

6. For PbR excluded drugs, Trusts are reminded to notify the CCG/CSU within 2 weeks of starting treatment. Invoices for PbR excluded drugs without notification and funding approval will not be paid until such time that an application is made in which case only future (not retrospective) invoices will be paid. This reinforces and further clarifies contractual arrangements already specified in "Commissioning Principles for PbR

excluded drugs and devices". The same will be applied to patients for whom initial or subsequent funding has expired.

7. Patients who have been receiving PbR excluded drug treatment for a while without any record of approval, require submission of an initial PbR excluded drug application form (submitted with Blueteq) with data reflecting the situation prior to starting treatment. If treatment has been given beyond the initial approval period as specified on the application form, the Trust should also apply for a re-approval at the same time in order to seek approval for continued funding.

8. Drugs which are subject to IFR approval must be invoiced monthly separately from the main contract.

9. London CCGs will only pay the actual cost of the drug or technology at which the provider procured the treatment (including any LPP discounts, Patient Access Scheme discounts or other discounts), in line with PbR guidance. Any additional (administrative or other) charges applied to drugs or technologies will not be honoured unless specifically agreed otherwise in the contract. The same will apply to drugs/technologies which have been approved following submission to the IFR panel of the relevant CCG. CCGs will reserve the right to audit provider costs to demonstrate compliance with this term.

10. Trusts are required to respond to challenges raised for PbR excluded drugs in a timely manner (within 10 working days). If no response is received within this timeframe, Trusts will be required to credit the challenged amount.

High cost drugs- post verification audits

11. Trusts are reminded that information provided to request (initial and ongoing) funding for PbR excluded high cost drugs (usually via Blueteq) is part of and should mirror patient clinical records.
    As part of the quarterly review process we will visit the Trust on an agreed audit day to jointly carry out post verification audits comparing submitted data for requesting funding for PbR excluded high cost drugs versus patient's clinical records. This will be on an ad hoc basis (maximum 2 audits per year). Data will have to be extracted from patient's notes by Trust staff on the audit day on a pre-set representative sample of patients. This information will be checked by CCG/CSU staff against data submitted to the CCG/CSU when requesting funding (with honorary contracts in place to cover patient confidentiality regulations).
    If the sample of the audit identifies that there are discrepancies, an appropriate action plan will be agreed between the Trust and the CCG. If the discrepancies are showing that funding for PbR excluded drug applications are not filled in honestly, this may ultimately result in a applying the % breach identified in the sample across the total high cost drug charges for that year and a rebate payment will be expected from the Trust.

Better Procurement, Better Care, Better Value

12. In line with the DoH Better Procurement, Better Care, Better Value strategy we ask Trusts to suggest proposals to further increase quality and cost- effectiveness of using CCG commissioned PbR excluded high cost drugs. Any proposals on sharing benefits will be considered in line with NHSE "Principles for sharing the benefits associated with more efficient use of medicines not reimbursed through national prices" and expected guidance from NHS England Specialised Commissioning Medicines Optimisation Clinical Reference Group (CRG).

13. The provider will work with the commissioner when contracts are negotiated for the procurement or supply of items which may require ongoing prescribing in primary care.

This includes procurement of incontinence and stoma products, glucose monitoring devices, dressings and feeds (including oral nutritional supplements).

14. As per current contractual agreement, Trusts should only supply enteral feeds on discharge if accompanied with a nutritional management plan including MUST score. For clarification, Trusts are requested to ensure measures are in place to ensure that all patients discharged and supplied with oral nutritional supplements have:
    - been properly assessed as needing ONS on discharge
    - clear communication sent to the GP explaining the reason (including MUST score) and, whether any further supplies are needed once hospital supply runs out
    - a future follow up plan i.t.o targets, reviews etc.
    - been changed on the most cost effective product for primary care on discharge. Note that SWL CCGs intend to work with SWL Trusts to ensure that preferred formulary products in primary care will be available to the Trust for suitable patients on discharge.

Other

15. Providers will be expected to prescribe and supply in a manner that minimises the potential for waste.

16. If chemotherapy commissioning is transferred back to CCGs in the future, robust systems and processes must be put in place to manage the entry of new drugs and chemotherapy protocols in the preceding year to ensure that there is appropriate governance in place and that evidence based, clinically safe, cost effective decisions are made.

17. Providers are expected to put active systems in place to ensure that the interface prescribing policy is adhered to by all clinicians. This would include measures to ensure that the policy is brought to the attention of new clinicians and that breaches are followed up as a matter of urgency within clinically appropriate timescales. To avoid delays to continuity of care, named contacts for resolution of these breaches must be in place

This page is intentionally blank

Commissioning Intentions 2015/16 for Prescribed Specialised Services

NHS England INFORMATION READER BOX		
Directorate		
Medical	**Commissioning Operations**	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**02305**
Document Purpose	Guidance
Document Name	Commissioning Intentions 2015/16 for Prescribed Specialised Services
Author	NHS England / Operations / Specialised Services
Publication Date	30 September 2014
Target Audience	Foundation Trust CEs , NHS England Regional Directors, NHS England Area Directors, NHS Trust CEs
Additional Circulation List	CCG Clinical Leads, CCG Accountable Officers, Directors of Finance
Description	
Cross Reference	Commissioning Intentions 2014/15-2015/16 (GW:00505)
Superseded Docs (if applicable)	N/A
Action Required	Use to inform contracts and business plans for 2015/16
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Peter Huskinson National Support Team - Specialised Commissioning NHS England Skipton House 80 London Road SE1 6LH

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

Contents

Contents 3
Executive summary 5
Purpose 6
Context 6
Strategic direction 6
Changes to the scope of specialised services 7
Strategic service review 8
Clinically driven change 8
Service development and reinvestment strategy for cost effectiveness 8
Clinical thresholds and unwarranted variation in access to care 9
Clinical utilisation review 9
Service Specifications 10
CQUIN 11
Evaluation through Commissioning (EtC) 12
Networks 12
Individual funding requests and Cancer Drug Fund 12
Contracting for specialised services 12
Prime contractor opportunities 12
Priorities for early engagement for 2015/16 13
Capacity planning and engagement on potential QIPP solutions 13
Coding and counting for services with a national tariff price 13
Acute services without a national tariff price 14
Top up payment arrangements and local price modifications to national prices 15
Securing best value for patients from drugs and devices 15
Device spend – reference prices 16
Performance monitoring 17
Post-transplant immunosuppressants 17
Chemotherapy drugs 18
Consistency in practical arrangements 18
Service specific issues 19
Mental health 19
Case management 19
High secure 20
Offender personality disorder 20
Care pathways 20
Women and children's services 20
Genomic and genetic services 20
Congenital heart disease pathways and services 21
Paediatric long term ventilation 21
Cancer and blood 21

Haemophilia tendering & HIV drugs 21
Consistency in Bone Marrow Transplant Service Contracting.....21
Radiotherapy for Prostate Cancer 21
Hepatitis B & C and HIV 21
PET-CT 21
Radiotherapy 22
Proton beam therapy.....22
Trauma.....22
Stereotactic radiosurgery and radiotherapy.....22
APPENDIX 23

Executive summary

Commissioning Intentions serve as formal notice to providers of NHS England's plans in respect of specialised services for 2015/16. They reflect the central challenge of improving patient outcomes whilst constraining levels of spend to match available resources. For NHS England and its providers, collaborating to adopt the most efficient service models through delivering change is a key priority.

The **scope of services** in 2015/16 and beyond will reflect corrections to the Information Rules, and changes to the list of specialised services previously agreed by Ministers. The Commissioning Intentions are also set in the context of future devolution of some services to CCGs and co-commissioning arrangements.

The **NHS Five Year Forward View**, to be published in the autumn, will inform the strategic direction for specialised care. A programme of **strategic service reviews** will inform future plans.

Long term partnership opportunities for tertiary centres will form part of future commissioning arrangements. Service quality and efficiency together with evidence of maturity of relationships in win/win contracting behaviours will inform the selection of providers. Preparations for prime contracting will take place with a small number of area team- led arrangements awarded during 2015/16 where these offer strong benefits.

The **prioritisation round** in December will consider investment and disinvestment to achieve best outcomes for patients within available resources. Providers should not initiate service developments unless these are required as a result of prioritisation.

NHS England is developing a small number of additional **service specifications**, which will be resource neutral. NHS England will monitor service specification KPIs and **quality dashboards** through core quality standards. CQUIN will continue to be used to improve quality and efficiency. NHS England is considering whether provider compliance with core service specification measures should be a condition for attracting CQUIN in some circumstances.

Clinical thresholds are being reviewed and will be audited. NHS England will only make payment where treatment complies with policies so providers need to ensure monitoring systems are in place. **Coding and counting changes** for nationally priced services will be subject to national notification and standard template reporting.

For acute services, NHS England will promote redesign to achieve convergence to prices reflecting **most efficient quartile costs** and subject to national guidance, where contract level **risk share** is not in place, expand marginal cost arrangements for **locally priced services**

For nationally priced services, payments above **mandatory tariffs** will not be made except through local tariff modification applications supported by Monitor.

The **NHS standard contract** will be used, with a uniform standard price/activity matrix and local price list format to improve transparency and benchmarking capability.

Providers have identified that **better value in excluded drugs and devices** is key to protecting available resources for clinical services. NHS England intends to improve reporting and price transparency to ensure NHS England pays the best available price. Reference prices for devices will be introduced reflecting maximum reimbursement, together with updated risk and reward sharing arrangements and consistency in funding **supportive medicines**.

NHS England plans to make **service-specific changes** including: expanding case management in mental health; taking national approaches to stereotactic radiosurgery, genetic laboratories, genomic medicine centres; and procuring PET-CT services.

Purpose

1. These intentions provide notice to healthcare providers about changes and planned developments in commissioning and delivery of prescribed specialised services by NHS England. Together with planning guidance, the NHS contract, National Tariff Document and CQUIN guidance, they form an agenda which will be reflected in contracts, in-year service development plans, service reviews and procurement opportunities for 2015/16.

2. Their prime purpose is to enable providers: to make early preparations; to engage with clinical service leads and commissioners; and to realise change that benefits patients. They should inform providers' strategic, operating, financial, workforce and business plans, and contract negotiation plans.

Context

3. There have been many positive achievements within the sector: extensive national clinical leadership engagement; the adoption of expert-led service specifications; more consistent contract management; and, for the first time, equity for patients through nationally consistent evidence-based treatment policies.

4. However, levels of growth in spending on specialised services have been unaffordable. The specialised services sector of the NHS is operating at a substantial deficit relative to the recurrent money available with growth eclipsing resources. The central leadership challenge for commissioners and providers in the coming year is to achieve the best outcomes possible for patients within the constrained resources available.

5. This means planning for constrained provider income and leading change to adopt the practices of the most efficient clinical services. These changes will need to be reflected in contractual arrangements with early action taken on QIPP plans. For commissioners, it will mean prioritising carefully, identifying the disinvestment required to fund new obligations and working in collaboration with partners where preventive action in upstream services can reduce pressure on complex care.

Strategic direction

6. Building on the Call to Action in July 2014 and the planning framework published in December, the NHS will be publishing a Five Year Forward View in the autumn.

7. On grounds of quality or efficiency for some tertiary conditions, NHS England will choose to work with a smaller number of leading hospitals. The selection of these long term partners will be influenced by the maturity of the relationships these hospitals exhibit, both in terms of win-win contractual behaviours over the next 12-24 months and their shared understanding of the medium term financial context within which the whole NHS is having to operate.

8. NHS England's plan for implementing its element of the 'UK Strategy for Rare Diseases' will inform the strategic approach for specialised services. NHS England 'Statement of Intent' outlines how it intends to achieve the commitments and work with partners on all other commitments in the strategy.

Changes to the scope of specialised services

9. Ministers have already agreed that the following services should no longer be commissioned by NHS England and should be reflected in CCGs contracts from April 2015:
    - specialised wheelchair services
    - outpatient neurology referrals made by GPs to Adult Neurosciences Centres
    - outpatient neurology referrals made by GPs to Adult Neurology Centres

10. Ministers have also agreed that the following services will no longer be commissioned by CCGs; these services will be reflected in NHS England contracts from April 2015:
    - some highly specialised adult male urological procedures
    - some adult oesophageal procedures
    - services for patients with homozygous familial hypercholesterolaemia
    - some adult specialist haematology services

11. NHS England has recommended to the Prescribed Services Advisory Group that the following services currently commissioned by NHS England should in future be commissioned by CCGs:
    - renal dialysis (excluding encapsulating sclerosing peritonitis surgery)
    - surgery for morbid obesity

    Once a ministerial decision is confirmed, any change in responsible commissioner will need to be reflected within NHS England and CCG contracts with providers.

12. In addition, the information rules (IR) software and guidance will be updated with technical changes to better reflect the detail of clinical service specifications, and ensure full alignment with the Manual. Subject to confirmation by the HSCIC, it is expected that the IR will be reflected in the HRG grouper software and the replacement for the Secondary User Service to which providers submit data

13. Providers are, through data quality improvement plans, making revisions to data flows in 2014/15 that will enable national adoption of the IR toolkit in 2015/16, which will be mandatory. Contracts should reflect the updated IR to provide national consistency in the scope of services. This will require liaison between providers, NHS England and CCGs to jointly manage the alignment of contracts, activity flows and commissioning budgets.

14. NHS England will be establishing arrangements to co-commission the majority of specialised services in partnership with CCGs. This will enable better aligned decision making to help restore pathway integrity and improve the transition for patients between specialised and non-specialised services. The detailed arrangements for co-commissioning are being developed and will be shared in due course.

15. Regardless of whether services are commissioned by NHS England or CCGs we expect to be able to exemplify for CCGs the usage being made by their populations of specialised services, and to incentivise them to work alongside NHS England in ensuring appropriate prioritisation decisions are made.

Strategic service review

16. In commissioning and sourcing provision of clinical services NHS England, in line with legislation, will act with a view to:
    - securing the needs of the people who use the services;
    - improving the quality of the services;
    - Improving efficiency in the provision of services.

17. The annual contractual review of existing services and providers and reprocurement where contracts are due to expire are two vehicles for doing this.

18. To ensure that services are commissioned from the most capable provider(s), NHS England undertakes Strategic Service Reviews and, where a service review indicates testing a service will bring clinical and/or financial benefits, reviews will inform the procurement plans for services. NHS England has previously agreed to undertake a rolling prioritised programme to assess all specialised service lines, typically over a three year period. This wider programme of strategic service reviews will be published in the spring. The needs assessment and review of stereotactic radiosurgery and the national procurement of PET CT services are examples of early work in this area.

19. Other factors influencing the service review programme priorities include:
    - Strategic solutions to address those services where providers are unable to meet national service specifications
    - Significant interest from potential providers with credible potential to significantly drive greater financial or clinical benefits for patients than incumbents
    - Services where progress towards the adoption of most efficient service models agreed through contract negotiations has been limited
    - Where Quality, Innovation, Productivity and Prevention opportunities are significant.

20. The scope of service review and procurement will have regard to clinical dependencies between services. The programme will assess national priorities, with a regionally co-ordinated area team assessment to add to the programme where there are locally specific issues for services. The work programme will reflect best use of available change management capacity to ensure at all times continuity of services for patients and the involvement of patients and communities.

21. Further details of the process for potential providers of services to provide evidence for financial and clinical advantages compared to existing services to register with NHS England for consideration within the rolling review programme will be published this autumn. NHS England will advertise market testing through the government 'Contracts Finder' website and respect the objectives of proportionality, transparency and non-discrimination for current or potential providers from the NHS, independent or third sector.

Clinically driven change

Service development and reinvestment strategy for cost effectiveness

22. As outlined in its previous Commissioning Intentions, NHS England is developing a transparent prioritisation framework to guide the work of Clinical Reference Groups and Programmes of Care to enable decisions to be made about investment and disinvestment in services to best meet need within the resources available. These proposals are assessed by the national Clinical Priorities Advisory Group, which advises NHS England on all directly commissioned services

23. Investment in new services and interventions will be prioritised using the prioritisation framework. This will ensure that the range of services and interventions are optimised to best meet the needs of patients.

24. Service developments with a financial impact for existing providers of a given service will only be approved where they were initiated with NHS England's formal agreement. They will need to demonstrate measurable outcome and value improvements and will need to be agreed as part of the national prioritisation process and where resources have been released from elsewhere within an achievable balanced national financial plan. Where development or changes to the clinical eligibility policy for a treatment would warrant new provider entry or revisiting the assessment of existing providers as the most capable to provide a significantly changed service, this will be managed through the service and commissioning review process with existing and potential providers considered for procurement.

25. The prioritisation round for 2015/16 will take place in December 2014 with decisions ratified in January. Where required, contractual notice periods will be observed for any changes except where, by mutual agreement, more rapid implementation is jointly agreed.

26. For the avoidance of doubt, area teams are unable to give support to cost increasing business case proposals outside of the national process. Providers should not initiate in-year service developments unless formally requested by commissioners as a result of the national prioritisation process.

Clinical thresholds and unwarranted variation in access to care

27. A programme of review is being undertaken to ensure thresholds and criteria for access to specialised services are set so as to optimise patient outcomes within the resources available. Work will also ensure that opportunities for prevention, pathway improvement and efficiencies are identified and action taken across the commissioning landscape for delivery.

28. To treat patients equitably, adherence to defined thresholds and criteria for treatment is a condition of payment for services. NHS England will be expanding its work in auditing compliance, so healthcare providers should ensure effective internal clinical governance controls assurance are in place to avoid undertaking activity that cannot be reimbursed.

29. A wider programme within 2015/16 will be developed to review differences in population intervention rates relative to need, involving provider clinical teams, NHS England and CCG commissioners, supported by Public Health England, to understand and resolve the addressable causes of outlying practice.

Clinical utilisation review

30. Clinical utilisation review (CUR) technology is widely used internationally to provide evidence-based decision support for clinicians to ensure patients are cared for in the optimal setting and to address barriers to optimal patient flow.. NHS England introduced a substantial CQUIN to support providers in adopting the technology for specialised admitted patient care and critical care in 2014/15. Building on this approach, CUR will form a central element of the scheme in 2015/16.

31. Providers should register interest with their area team commissioner by 31 October and will be invited to a day where the leading providers of services and clinician leaders with experience in using the technology to underpin hospital care will be available to share learning.

32. Providers should note that the CUR CQUIN scheme is being made for use by CCG commissioners where it fits with local priorities such as underpinning changes to meet the goals of the Better Care Fund and improved Urgent & Emergency care so should discuss CUR opportunities with all commissioners.

Service Specifications

33. Clinical Reference Groups (CRGs) are the primary source of clinical advice to NHS England for the development of prescribed specialised services. CRGs continue to review and develop the clinical service specifications, introduce clinical access policies, define quality measures and build quality dashboards.

34. A range of service specifications will be added or significantly amended for April 2015 and are listed in the appendix. Specifications aim to be deliverable within existing resources, and, for services without a national price, within current resources for efficient service costs. Providers should use the consultation period to identify any issues that need to be addressed to ensure this is achievable. Self-assessment will be required against all new or amended service specifications and action plans to achieve compliance will need to be agreed with area team commissioners. Any new or revised specifications that require investment by NHS England will be subject to agreement via the annual prioritisation process.

35. Some service specifications describe requirements or good practice in pathway elements that are beyond the scope of the Manual and IRs. In these cases, the latter take precedence in determining funding and commissioning responsibility.

36. Where Service specifications contain KPIs, these will be incorporated for routine monitoring through the contract quality schedule. Providers should prepare for regular reporting of the identified KPIs.

37. Since 2013, all services have been required to meet service specification standards. In 2014/15, derogation, (time-limited permission to operate at less than full compliance subject to a compliance plan) has been used. Aside from ‘commissioner derogations’ (which address structural issues outside of providers’ control), unless notified to the contrary providers should be fully compliant before April 2015 so that all patients benefit from consistent standards of care.

CQUIN

38. NHS England is reviewing arrangements for national incentives schemes, including CQUIN, for 2015/16. Detailed arrangements will be published later this year.

39. Providers and commissioners should engage early in the contracting round and include dialogue with local clinical leaders and commissioners to inform stretching but achievable improvement goals. Planning should be on the basis that:

    - Established Quality Dashboards will move to the routine quality schedule. Where previously linked to CQUIN payments, funding will be moved to other priorities.

    - The 2014/15 quality initiatives that were developed by CRGs and which made care more cost effective were mandated for inclusion as an element of CQUIN which thereby also contributed to QIPP goals. The 2015/16 scheme will build on this with earlier engagement and design on QIPP priorities.

    - Where published CQUIN schemes were based on a two year implementation period, such as Clinical Utilisation Review, these will continue to be available.

    - Currently, CQUIN is not payable on certain areas such as excluded drug and devices spend, and this is expected to continue next year. The national CQUIN guidance, published later in the year, will provide more detail about this.

    - NHS England is considering whether provider compliance with core service specification measures should be a condition for attracting CQUIN for those services, other than where commissioner derogation is in place. This will be clarified in the national CQUIN guidance.

40. Recognising the high potential to reduce substantially the cost and improve patient care, NHS England is exploring a number of additional early implementer grants in addition to CQUIN payments, where hospitals commit to roll out clinical utilisation review technology on a whole hospital basis. Whilst every Trust has opportunity to secure a CQUIN, which fully funds the cost of implementation, early implementer grants are likely to aimed at those providers with current specialised contracts above £50m per annum. A decision on early implementer grants will be made by 31 January. Further information will be published alongside CQUIN measures for specialised services.

41. Building on the CQUIN made available last year, NHS England is aiming to identify up to six pioneer sites to implement and evaluate the impact of hand hygiene RFID technology solutions. International evidence of substantial reduction in healthcare acquired infection rates suggests this is a promising intervention. Early implementer grant support per site may be made available over and above the fully funded CQUIN for providers undertaking more substantial deployment. The CQUIN is open to all providers of care who have acute admitted patient care wards that regularly treat a high proportion of specialised patients. The CQUIN scheme is also available for CCGs to commission.

Evaluation through Commissioning (EtC)

42. The Commissioning through evaluation programme, now known as 'Evaluation through Commissioning' (EtC) was established in 2013 as an innovative mechanism to capture further evaluative data to inform future clinical commissioning policy in areas that show significant promise, but with insufficient existing evidence of clinical and/or cost effectiveness. Five schemes are already in progress. Selected participating trusts will be reimbursed for provision at prices agreed through national review. Patient selection and data submission requirements in full are a condition of funding. NHS England will consider the potential for any further schemes as part of the wider resource prioritisation process where these can be delivered within a balanced financial plan.

Networks

43. Strategic Clinical Networks, Academic Health Science Networks, and Operational Delivery Networks (ODN) are a significant resource to the NHS to address the challenging agenda ahead. In particular, providers and commissioners should be satisfied the work programmes address unwarranted clinical variation and secure adoption of most efficient practice in services to free up resources for patient care. ODN membership is mandatory for all commissioned providers of critical care, neonatal care, paediatric neurosciences, burns and major trauma to be compliant with service specifications.

44. For ODNs, providers should review arrangements against the four key success factors for ODNs set out by the Chief Nursing Officer and Chief Medical Officer:
    - Improved access and egress to/from services at the right time
    - Improved operating consistency
    - Improved outcomes
    - Increased productivity

45. NHS England has provided supplementary funding for ODNs through setting aside 0.1% of CQUIN funding for the last two years and this will continue in 2015/16. Future arrangements for the funding of ODNs will be reviewed during 2015/16

Individual funding requests and Cancer Drug Fund

46. Arrangements for Individual Funding Requests and the Cancer Drug Fund (CDF) will continue in 2015/16. CDF applications prior to commencement of treatment, (or within 48 hours in exceptional circumstance), invoicing within three months and returns made to the Systemic Anti-Cancer Therapy (SACT) database remain conditions of reimbursement. All CDF drugs will be funded at cost without additional charges and are not within scope of gain-sharing arrangements with providers.

Contracting for specialised services

Prime contractor opportunities

47. During 2015/16, NHS England will lead a process to invite proposals for prime contractor delivery for a whole pathway of care or model of care where tiers of provision are closely networked. Under prime contracting arrangements, activity funding and clinical outcomes are attributed to the lead centre that manages clinical and corporate governance on a hub and spoke basis. Proposals will be taken forward as a result of strategic clinical service reviews and providers are invited to engage with local teams to identify areas of opportunity for clinical and financial benefits from potential arrangements and to identify willingness to partner as a lead or a spoke centre. Development of new arrangements will reflect principles of openness, transparency and non-discrimination for both current and potential providers in line with regulatory requirements.

Priorities for early engagement for 2015/16

Capacity planning and engagement on potential QIPP solutions

48. The 2015/16 contract requires all activity plans and local price lists to be in a mandatory common format. Capacity planning to inform contract discussions will take place in the autumn and should start from a 'no intervention'[1] basis. Area teams will be provided with demographic and non-demographic growth assumptions to jointly build activity plans. There may be local reasons for variation to these national assumptions which will need to be documented and agreed where robustly evidenced. Commissioners will take responsibility for the final decision on these forecasts in line with their responsibilities to determine the level of care to commission.

49. Area teams and providers will have early discussions to inform the affordable contract envelope for services, and develop solutions to ensure continued delivery of care within available resources.

50. Initiatives which impact on a 'no intervention' plan, with clear responsibilities and constructive engagement will be vital to ensure that contracts remain affordable. Area teams will discuss a range of QIPP projects which have been developed by clinical reference groups on a national basis, as well as locally identified projects. In many cases, provider clinical teams are in a good position to identify local opportunities and should add to the portfolio of planned change, to ensure that the volume growth and efficiency of pathways and episodes of care are addressed in plans

Coding and counting for services with a national tariff price

51. NHS England recognises the benefits of improvements in the accuracy of coding. In the context of an overall reduction to spending within available financial resources, changes in counting may lead to increased expenditure without additional clinical benefit, which will require disinvestment in other services and reduced access to services by patients. It is therefore important that all change proposals are robustly evidenced and a national assessment of the wider system impact of proposals can be made.

52. Commissioners are mindful that consideration is being given to a moratorium on coding and counting changes to ensure service stability. For the coming year:

    - Notice for coding and counting change proposals for services with a national price must be submitted using the standard documentation template and email address, which was issued in August 2014 by circular via area team commissioners. Submissions were requested by 30 September 2014 in line with the requirements in national contract provisions.

    - Additional backing information will be worked through with area team commissioners who will also provide to the national team an initial assessment of validity of proposals that are likely to be supportable, should a decision be made to accept such changes for 2015/16

[1] Forecasting future activity with existing demand management and QIPP measures but prior to incorporating additional QIPP measures or initiatives

Acute services without a national tariff price

53. NHS England will operate in line with the National Tariff Document (NTD) when published. The intentions set out below reflect an assessment from the direction of travel set out by Monitor and NHS England in the Tariff Engagement Document published earlier this year.

54. Current arrangements for locally priced services vary significantly between block contracts, marginal price arrangements and cost and volume pricing. Prices vary widely, and overall spend growth is unsustainable, far exceeding that of nationally priced care, and there is evidence that providers with a larger share specialised services enjoy substantially higher EBITDA[2] margins than other hospitals. The tariff engagement document proposes options for change to default arrangements for services to avoid rolling over unsustainable arrangements and prices.

55. Unless risk share agreements are in place, full cost and volume contracts create the incentives for services to achieve profitability through growth in activity. This approach is not aligned to the constrained financial resources available to the NHS and results in unintended disinvestment in services such as primary care and mental health. Through marginal cost arrangements, provider fixed costs are covered and the additional variable costs associated with extra activity are provided for, with the benefits of economies of scale being available to preserve access to care in other services. NHS England will look to expand marginal cost arrangements with existing providers for the majority of services.

56. Monitor and NHS England are engaging on options for change to the approach to setting local prices. Where services do not already reflect the most efficient quartile of unit costs, commissioners want to work with providers, who need to engage clinical service leads to:

    - Agree a programme of clinically-led service redesign to realise changes for April 2015 and any other changes needed to match the most efficient operating models for services
    - Reflect anticipated improvements in agreed prices for 2015/16 and the timing of when any further benefits realised after April will flow through into prices.

57. Building on previous work last year to assess standards compliance and benchmarks in some areas such as critical care, a range of benchmark costs and prices is being compiled for area team commissioners and providers to use this autumn. Commissioners and providers should identify early areas of opportunity and agree goals for change, which can be confirmed and enhanced by benchmarking evidence once available.

58. Services that remain under block contract arrangements in 2015/16, for example due to poor quality data available to commissioners, will need to demonstrate with transparency equal or greater efficiency improvement than services commissioned using other forms of contracting arrangements including convergence to most efficient costs.

59. For services operating in line with efficient costs, and those where planned improvements can be reflected in prices, enhanced marginal rates may be agreed. These enhanced rates will also be possible for admitted patient care services where providers have committed to implement clinical utilisation review tools. A substantial CQUIN payment is also available to support this approach.

60. NHS England's approach to these services will be informed by an assessment of any further opportunities to achieve greater value for patients once the NTD is published, which should inform local contract discussions

[2] EBITDA is a recognised measure of operating profitability: Earnings before interest, taxes, depreciation, and amortization.

Top up payment arrangements and local price modifications to national prices

61. The national tariff payment system sets prices based on the average complexity of a group of patients treated with particular diagnoses and procedures. Differences in complexity are recognised for some specialties at designated providers through a top up payment. Even with these adjustments, no payment system perfectly reflects the distribution of complexity. This continues to be the subject of debate between larger and smaller providers.

62. Although NHS England supported some transitional arrangements where above tariff payments were made to some providers, addressing issues in the distribution of income between providers is not possible though the payment of supplements where additional financial resources are not available.

63. Where formal local modification joint agreements were notified to Monitor and approved for 2014/15, these will be reviewed on a case by case basis. NHS England will engage constructively on solutions but no new local modification agreements for above tariff payments will be entered into until commissioner spend is within available resources. Where providers meet the conditions set out in guidance for a local modification application, NHS England will abide by the relevant determination.

64. Commissioners look forward to the outcome of the complex care working group, and the introduction of HRG4+, both of which will inform future arrangements to more accurately account for complexity. Addressing the distribution of funding between trusts based on the available financial quantum of income – and aligning CCG and NHS England purchasing power through a full impact assessment – are needed to achieve a sustainable solution for patients.

Securing best value for patients from drugs and devices

65. Feedback from provider and commissioner reference groups has indicated that, in order to protect limited financial resources for clinical services, more should be done jointly to secure better value from the rising spend on excluded drugs and devices, which represents around a quarter of acute spend. NHS England already invests significantly in supporting this agenda with a Medicines Optimisation Clinical Reference Group, area team commissioner pharmacists and embedded pharmacist support in many trusts. NHS England is looking to expand work in this area as a key shared goal in 2015/16, including:

    - Validating clinical usage decisions at source to address unwarranted variation in prescribing practice
    - Improving transparency in prices paid to better target shared areas on procurement opportunity
    - Best Value Reference prices for devices and some drugs – to ensure all reimbursed payments reflect achievable efficiencies but allow local flexibility for trusts who wish to purchase at different rates and fund the difference
    - Harmonised supportive drug payments to improve consistency
    - Updated risk and reward sharing protocols to provide practical approaches to covering the resources needed where providers and commissioners aim, in addition to usual therapeutic switching, to dedicate additional resources to ‘go the extra mile’ together on more significant projects

66. Budgets for excluded drugs and devices will be set annually based on the provider's assessment of need through horizon scanning, subject to a 'confirm and challenge' meeting with the provider, with review of any outliers in rates of growth by the national specialised pharmacy lead. New excluded drugs and devices will not be funded in-year unless approved by NICE or previously identified and planned for within the prioritisation round.

67. Clinicians in a large number of trusts already use the Blueteq system for individual funding requests. NHS England intends to roll out use of such systems to support usage decisions for excluded drugs and devices on a wider basis during 2015/16. All acute trusts with a current contract spend on excluded drugs and devices above £15m will have a CQUIN to support this change. Trusts with lower spend who wish this to be considered as a local CQUIN priority should discuss this with their area team. Once in place, invoices will be authorised based on recorded compliance with commissioned treatment indications.

68. Excluded drugs and device costs charged to NHS England will be reflective of actual product costs to hospitals and will be subject to audit to demonstrate this. Providers will charge all drugs subject to discounts, rebates or other such Patient Access Schemes will to NHS England at net cost.

69. Significant variation is experienced in the prices that commissioners pay for excluded drugs and devices. For specialised indications, these drug and device charges are directly 'passed through' to NHS England. Significant benefits can be obtained from better procurement. NHS England, through the Commercial Medicines Unit in the Department of Health, will continue to support a national process for procurement of high cost medicines. NHS England will maintain a central repository of prices for excluded drugs, updated as national procurements are implemented. This will represent the maximum that commissioners will pay. Trusts are not expected to tender for medicines included in the national framework.

Device spend – reference prices

70. NHS England is working to establish best value prices available to the NHS beginning for 2015/16 with implantable cardiac devices, bone anchored hearing devices and TAVI, with the involvement of Clinical Reference Groups. There are significant variations in prices paid by trusts for the same product. NHS England will agree commissioning approaches for devices within a category of treatment as well as reference prices. Where hospitals purchase at higher cost, the provider will bear the financial risk.

71. NHS England will shortly publish operating principles to inform arrangements for collaborative working on improving value for patients. The principles include identifying standard methods of payment for cash releasing schemes and expectations for when sharing of risk and reward is appropriate. Where agreement cannot be reached on share of gains or proposals offer limited value, the full value of best price and best prescribing practice will be passed through in line with national guidance.

72. Where drugs and devices are used outside of commissioned services, as defined as nationally commissioned by NHS England, any consequential costs that are incurred will not be funded. This includes the costs associated with the entire treatment.

73. Non-excluded drugs prescribed concurrently with the excluded drugs are not chargeable as these are covered within national tariff. No additional charges above cost will be accepted unless specifically identified in 2015/16 national tariff guidelines, explicitly agreed with NHS England and specifically in advance within the contract.

74. Drugs as detailed in the current NHS England excluded drug list will be commissioned in line with NHS England commissioning policies and NICE Technology Appraisals (TAs). NICE approved drugs/ devices recommended within a NICE TA that are excluded from tariff will be automatically funded from day 90 of publication. Some approved drugs and devices may be funded before this time at the discretion of NHS England. Trusts are expected to meet the requirements of NICE TAs and be able to demonstrate compliance through completion of innovation scorecard returns.

75. Those excluded drugs and devices that are not NICE approved or endorsed within a national clinical commissioning policy can be considered via an individual funding request, if there is evidence that the patient has clinically exceptional circumstances in comparison with other patients with the same condition presenting at the same stage of the disease and there is an exceptional ability to gain clinical benefit from the treatment.

76. Excluded drugs/devices recommended within a NICE Interventional Procedures Guidance and/or guideline will not be routinely funded unless endorsed within a national clinical commissioning policy

77. An updated policy covering requests for excess treatment costs for research will be published later this year.

Performance monitoring

78. All providers will be required to fully populate the national (in full) IVIG data base to ensure patient safety. This includes indication, dose, administration and outcome. Invoices for IVIG will be matched to the national database entries.

79. From April 2015, providers of hepatitis C treatments will be required to report a minimum data set to include treatment provided, genotype of patient and whether a sustained virological response has been achieved.

80. Providers will need to submit the national standard minimum data set for drugs and devices expenditure set out in the Schedule 6 of the NHS Standard Contract, which will be enhanced for 2015/16. Providers will be required to provide assurance to commissioners that drugs and devices have been used in accordance with agreed national policy including through audit. Any use of a drug/device outside the agreed criteria without express authority from NHS England will not be funded. Validation queries will be raised on a monthly basis in line with national payment timetables. Where further action is required, validation meetings will be convened on a quarterly basis.

81. Shared access to the data from the Pharmex system by a combined commissioner and provider project group has significant potential to improve transparency and targeting of cost saving opportunities whilst minimising the data collection burden for trusts. Following discussions with user representatives NHS England intend to adopt this requirement for its contracted providers in 2015/16. Where trusts do not use the Pharmex system, regular provision of equivalent information in a prescribed format will be required in line with the standard contract provisions.

Post-transplant immunosuppressants

82. The programme of planned change from primary care to secondary care prescribing of post-transplant immunosuppressants and inhaled antibiotics for cystic fibrosis will continue in 2015/16 once NHS England is assured there is a stable homecare market. The aim is that the process will be complete by April 2016. To ensure changes take place once commissioning budgets with CCGs are aligned, trusts should implement changes in a coordinated way with GPs only once notified to do so by area teams.

Chemotherapy drugs

83. Chemotherapy drugs should be considered for funding via the Cancer Drugs Fund by application to the national chemotherapy panel.

84. All trusts are required to provide Systemic Anti-Cancer Therapy (SACT) data for all patients at each cycle of chemotherapy. This in turn will support the audit of drugs within the Cancer Drugs Fund. Trusts are expected to audit activity data quarterly and demonstrate that over 90% of activity data maps to the SACT data submitted per month. Trusts must have an action plan agreed with commissioners to address any shortfall in SACT data fields and findings of the audit of activity compared to SACT data submissions. Reimbursement is conditional on meeting the 90% target.

85. National chemotherapy algorithms will be published for 2015/2016. Only those drugs which are identified within the algorithm will be funded as part of the pass through arrangements. This does not include drugs which are provided for symptoms that arise post-chemotherapy (e.g. anti-emetics, unless given to all patients as part of the standard regimen). Where local arrangements that offer better value are not yet in place, a standard ceiling price for supportive medicines will be paid to trusts for each cycle of chemotherapy delivered. Non-chemotherapeutic agents such as bisphosphonates and hormone therapies unless specifically identified as excluded by the national tariff or by agreement with NHS England, are considered in tariff.

86. Where outpatients or admitted patient care is nationally priced, any diagnostic testing and pathology is included prices and is for Monitor and NHS England jointly to take into account when considering annual updates to the national tariff. Where molecular diagnostic testing is used to help optimally target the use of drugs to patients who are most likely to benefit, trusts will need to factor in adoption of NICE guidelines as set out in the NHS Contract duties. Where a new test meets the criteria for exclusion from national tariff arrangements, NHS England will consider separate funding. The management arrangements for the introduction of molecular tests for a cohort of patients potentially eligible for the specific targeted drug will be considered on a drug by drug basis by NHS England following discussion with the relevant pharmaceutical company and other key stakeholders.

87. An agreed price will be paid to trusts for each cycle of chemotherapy delivered to cover pharmacy procurement costs.

88. All trusts are expected to work with area teams to maximise opportunities for dose banding and vial sharing where such activity does not exist.

Consistency in practical arrangements

89. Since 2013/14, NHS England, CCGs and providers have been collaborating to implement the NHS England single national operating model whilst seeking to maintain service and financial stability. Area teams will continue to work with providers to ensure local practice is transitioned to the single national operating model.

90. Mandated currencies will be adopted. For the first two years of introduction, providers will need to provide monitoring information for the baseline year and current year in both the mandatory currency, and previous currency, to assure the accuracy of prices against the new currencies given the financial quantum involved.

91. Contracts will use a standard format indicative activity plan and non-tariff price list, including drugs and devices, providing clarity and transparency. There will be a single stated price per service line in each provider contract.

92. NHS England will normally only hold (or be party to) one NHS Standard Contract with any provider. Secondary care dentistry and public health services from each NHS England area team will be included as separate contract schedules within specialised service provider contracts, in a similar way that providers hold schedules for lead and associate CCG commissioners and, for those services, providers should bill the relevant area team based on responsible commissioner for that population.

93. No national changes are planned to contract arrangements for those area teams commissioning health and justice services and those services used by the armed forces that are normally aligned to NHS England prescribed services contracts.

94. It is likely that the e-contract system for 2015/16 will be focussed on generating the modular content needed for contract documentation. NHS England expect to use the e-contract functions where they speed up the inclusion of standard elements to the contract, whilst making use of standard document management methods (such as PDF and MS Office documents) to make the contracting process easier to deliver in 2015/16.

Service specific issues

95. Service reviews are planned for hyperbaric oxygen, paediatric burns, and vascular amputation with further development of enhanced recovery pathways in cancer surgery.

Mental health

96. In 2014/15 NHS England stated its intention to move towards all inclusive pricing for specialised mental health services, particularly in relation to observations and special packages of care. This remains a priority and it is expected that all providers will move to inclusive pricing in 2015/16.

97. Providers of specialised mental health services will be commissioned with increased consistency of contracting terms. This will include consideration of percentage occupancy rates for child and adolescent mental health services (CAMHS) and adult mental health services as well as activity-related contracts with risk share arrangements and controls between provider and commissioner provided this offers value for money.

98. Further work is required to ensure consistency across the range of outreach services commissioned, which is supported by a service specification for all specialised mental health services.

Case management

99. The function of case management will be widened during 2015/16 to cover all specialised mental health services commissioned by NHS England, to support commissioning and providers and to ensure that patients receive the right level of care, at the right time in appropriate, safe, high quality services.

100. CAMHS Tier 4 and medium and low secure services will be tendered during 2015/16 to ensure treatment offered and location of services best meets patients' clinical needs. The procurement will also achieve increased consistency in pricing and contract terms across regions.

101. For these services, local dialogue and mutual accountability with CCG and local authority commissioners is needed to ensure capacity is aligned and sufficient in less restrictive settings. Service usage per head of population for each CCG and local authority area, along with length of stay and commonly defined delayed transfers of care, will be a key measure developed in 2015/16 to jointly address unwarranted variation in equity of access to both intensive and preventative services and to improve joint planning, This will build on learning from the best examples where CAMHS Tier 3+ services are making a difference for patients.

High secure

102. Currently, a high secure capacity assessment is underway. It is intended that this assessment will inform future commissioning intentions.

Offender personality disorder

103. There will be continued support for the implementation of the Offender Personality Disorder Programme within the overall funding available to the programme. This will be achieved by decommissioning services in hospital settings for offenders who meet the criteria for Dangerous and Severe Personality Disorder (DSPD), and by commissioning new services, mainly in prisons. In 2015/16 NHS England will conclude the de-commissioning of the DSPD service at Nottinghamshire Healthcare NHS Trust.

Care pathways

104. A review of gender pathways, including access to treatment, will be undertaken to identify area how existing pathways can be strengthened and improve services for patients.

Women and children's services

Genomic and genetic services

105. NHS England is currently completing preparations to carry out a formal procurement exercise to support the establishment of a stronger, more responsive, modernised and efficient genetic laboratory service. This will provide a new configuration of Central Genomic Laboratories and will affect both current regional, local and speciality-based genetic laboratory services. A public consultation, clarifying the scope and draft service specification requirements of the new service, will begin in the autumn. It is anticipated that the new pattern of service delivery will be in place in 2016, with a current planned 'go live' date of January 2016. NHS England is exploring the potential to use the prime contractor model to commission the tests for which NHS England is responsible via the selected Central Genomic Laboratories.

106. NHS England is a key delivery partner in the Department of Health-led 100,000 genome project. NHS England is currently inviting applications from providers wishing to act as NHS Genomic Medicine Centres, which will help identify suitable patients wishing to consent to participate in the project and provide sample DNA to be sequenced as part of this important national development programme.

107. The medical genetics CRG will continue to identify opportunities to reduce variation and potential duplication in genetic testing practice. A specific proposal for Fragile X testing will be introduced shortly.

Congenital heart disease pathways and services

108. Many providers are already working towards the new children's and adult service standards, which will have been consulted upon and finalised by March 2015. The 12 months following this will be used to ensure progress against meeting those standards, and making clear the intended future form and function of the provider landscape

Paediatric long term ventilation

109. Complexities in putting in place the package of care at home can lead to extended lengths of stay for patients who are fit for discharge from paediatric critical care. Area teams will work with providers and ODNs to ensure early identification through a monthly long term ventilation status report and alerts to the responsible CCG to support timely discharge. Providers will be required to provide information in line with the service specification to improve pathway management for children and their families.

Cancer and blood

Haemophilia tendering & HIV drugs

110. Following a tendering exercise in 2014/15 the national frameworks for the supply of blood clotting factor products are in place. All centres using blood clotting factor products for NHS patients will be expected to purchase factor products in line with these agreed national arrangements. A similar requirement will also apply to the use of regional contract framework agreements for HIV drugs.

Consistency in Bone Marrow Transplant Service Contracting

111. A project on to achieve greater consistency in the scope of services commissioned within BMT packages of care is now underway to inform a more consistent approach to commissioning this activity in 15/16. In line with other acute services without a national price, the aim is to achieve convergence to prices reflecting most efficient quartile costs.

Radiotherapy for Prostate Cancer

112. In line with the emerging clinical evidence an updated commissioning policy may result in a reduced number of fractions being delivered for patients. The policy will be for immediate implementation. Providers should note this significant potential change when assessing demand and planning capacity.

Hepatitis B & C and HIV

113. Increases in blood borne virus testing of offenders are planned by Public Health England during 2015/16 and 2016/17. This will impact on growth rates for these services; commissioners and providers should take this into account when capacity planning these services. An assessment of the scale of impact is being undertaken and further information will be provided to area teams and providers later this year. It is likely that the NHS will embark on a procurement process to identify optimal Hepatitis C treatments from amongst the new therapies becoming available

PET-CT

114. A national procurement is in progress for PET-CT contracts covering over 50% of scanning in England. A mix of static and mobile provision is expected, with transition to new long term contract arrangements in April 2015 to secure new capacity and capital investment. A decision on tendering the remaining arrangements will be taken by September and formal notice will be served to remaining contracts following this.

Radiotherapy

115. NHS England in partnership with Cancer Research UK published “Vision for Radiotherapy, 2014-2024 in March 2014 in order to communicate NHS England's broader ambitions around equitable access to the most clinically and cost effective radiotherapy treatments. Reducing clinical variation is an aspiration of the Vision document and NHS England will continue to support the development of clinical commissioning policies to help address this as well as exploring opportunities to review the coding and pricing structure to ensure best value for money.

Proton beam therapy

116. High energy proton beam centres in Manchester and London are being commissioned. In the meantime care will continue to be commissioned from selected overseas providers where patients meet the published commissioning policy.

Trauma

Stereotactic radiosurgery and radiotherapy

117. Following a needs assessment and national strategic review and consultation in 2014, a national procurement of this treatment will be undertaken during 2015 to address both capacity and equity of access across the country and to ensure prices reflect best value for the NHS as usage increases in line with NHS England commissioning policy. A public consultation on proposals for these services will take place this autumn.

APPENDIX

118. Service Specification additions and amendments for 2015/16:

A06/S/a In-Centre Haemodialysis
A06/S/b Home Dialysis
A06/S/c Peritoneal Dialysis
A06/S/d Acute Kidney Injury
A06/S/e Assessment and Preparation for Renal Replacement Therapy
A10/S/a Adult Cardiac Surgery
D01/S/d Complex Disability Equipment: Prosthetics
E07/S/a Paediatric Critical Care Level 3
E07/S/b Paediatric Critical Care Level 2
E07/S/c Paediatric Long Term Ventilation
E07/S/d Paediatric Critical Care Transport
E08/S/a Neonatal Critical Care
E08/S/b Neonatal Critical Care Transport
E10/S(HSS)/a Gestational Trophoblastic Disease
Paediatric Medicine – Specialised Allergy Services
Paediatric Medicine – Neurodisability
Specialised Services for Pain Management in Adults
Adult Critical Care
Teenager and Young Adult Cancer
Tier 4 Personality Disorder
Gender dysphoria
Fetal Medicine
Children's epilepsy service
Congenital gynaecology anomalies
Recurrent prolapse and urinary incontinence
ACHD surgery
Hepatitis C subsection of infectious diseases
Genomic Laboratory Services

This page is intentionally blank

Appendix 5

CROYDON
www.croydon.gov.uk

NHS
Croydon
Clinical Commissioning Group

Proposed adults commissioning priorities for Integrated Commissioning Unit

ICU Mission Statement: To focus on commissioning a comprehensive range of high quality "end to end" integrated health and social care services for people in Croydon and using health and social care commissioning resources more efficiently and, over time, achieving better value for money.

ICU Commissioning Principles: These overarching principles are based on CCG and Council principles.

- Commissioning will be evidence-based
- Focus on good outcomes for individuals, their families and communities
- Enhance quality and value for money via market development
- Promote personalised care and support, close to home
- Effective management of current and future demand for services.
- Promote Prevention, Self-Care/Management and Shared Decision making
- Promote integrated care & support which puts the patient or service user at its heart and gives them genuine choice
- Governance arrangements will be clear, workable and understood by everyone working in the ICU
- Our systems, processes and protocols with partners will assure quality and safety in commissioned services

Appendix 5

Service Lead	H&WB Priority	Commissioning Priority	Commissioning Objective
	Preventing Illness and Injury and helping people recover		
Working Age Adults Lead: Alan Hiscutt		Helping people to recover from substance misuse	• Complete implementation of Phase 2 of the drug and alcohol recommissioning project by April 2016
		Improving the health of people with learning disabilities	• LD healthchecks
Mental Health & Substance Misuse Lead: Susan Grose		Prevent mental health problems developing and to treat and support those with mental illness are enhanced through a focus on prevention and early intervention and increased resilience.	To increase capacity in the Promoting Recovery (Psychosis) Teams. Ensuring people with a diagnosis of significant psychosis receive care and treatment within promoting recovery teams. And reduce the caseloads of these teams to increase the quality of healthcare. • Increase capacity of the early intervention service so that caseloads reduce. Evidence suggests that outcomes for young people with psychosis can be positively affected if their duration of untreated psychosis is reduced. • Explore the possibility of developing an early detection service which will work with local GPs, colleges and youth organisations to educate people about psychosis and early signs and symptoms.
Older People, LTC, EoL & Carers		• Implement the re-procured framework for domiciliary care provision (including. care, support, re-ablement, end-of-life and health care, housing-based support – value c£85m) working to a clear	• Improve the quality of services which support people to live safely at home • Ensure appropriate services for people at the end of their life which gives them

Appendix 5

Lead: Amanda Lloyd		contract specification which incorporates commercial incentives if individual outcomes are achieved	confidence to die in their place of choice
	Preventing premature death and long term health conditions		
Working Age Adults Lead: Alan Hiscutt		• Work with public health to develop the integrated lifestyles approach. • Re-evaluate the options for systematic invitation of Croydon residents who are eligible for an NHS Health Check and implement the preferred approach. • Procure the redesigned sexual health service and ensure arrangements are in place for the intervening period in 2015/16.	• Improve the integration of existing lifestyle services to improve support for service users. • Systems/services are in place to ensure that all those eligible for an NHS Health Check are invited over a five-year period. • Ensure sexual health services meet the needs of our communities, with an appropriate focus on prevention of STIs, HIV and unintended pregnancy.
			• Implement QIPP project to reduce alcohol related A&E admissions
			• Review the hospital alcohol liaison service and the Palmer House alcohol service
Mental Health & Substance Misuse Lead: Susan Grose		Ensure 'parity of esteem 'is a key driver throughout the whole spectrum of Mental Health Commissioning and that a focus is maintained on links between poor mental health and physical health.	• Fully evaluate the four boroughs' Street Triage Pilot Service and work collaboratively with SLaM and South East London CCG's in order that the projects sustainability can be determined. • Development of CQUIN's which will focus mental health providers on patients physical health needs.
	Supporting people to be		

Appendix 5

	resilient and independent		
Older People, LTC, EoL & Carers Lead: Amanda Lloyd		Review PDSI strategy; and implement service redesign for physically disabled adults to provide appropriate support solutions that promote and support independence, as an alternative to residential and nursing care	Ensure high quality, value for money services for physically disabled adults which are aligned across health and social care
		Review Carers services with stakeholders in light of the Care Act	Carers able to continue in caring role
		Review and scaling of existing re-ablement and related schemes	To ensure people are re-abled to the highest possible level of independence
		Development of increased number and type of community resources	Develop community resilience and reduce statutory services spend
		Review dementia strategy in line with MHOA integrated work and increase speed of implementation	♠ Streamline and improve services ♠ Better outcomes for people with dementia and their carers ♠ Improved early diagnosis of dementia
		Greatly increase the take-up of Telecare/Telehealth solutions	Improved solutions for people to increase independence and quality of life
		increasing the uptake of direct payments and ensuring people receive a direct payment and can purchase care in a timely manner	
Working Age Adults Lead: Alan Hiscutt			Review supported housing services (complete single homeless review, shared lives, young people, generic floating support)
			♠ Recommission supported housing (mental health, single homeless/ rough sleepers, young people, domestic violence)
			♠ Review respite services for PWLD
			♠ Review and recommission advocacy and PWLD
Mental		Interventions provided in secondary or specialist	♠ Undertake a comprehensive inpatient

Appendix 5

Health & Substance Misuse Lead: Susan Grose		services will need to be able to focus on supporting people to identify and work towards achieving their own goals and aspirations. Services will also need to work closely with primary care and ensure people maintain links with other community services as appropriate.	barriers to discharge review with secondary care provider in order that commissioning recommendations can be across agencies to ensure support services are in place to enable people to leave inpatient services. • Develop a secondary care assessment and liaison service which will work with GP's to enable an easy in easy out approach to supporting GP's to support people to manage their mental health within the community. • Increase capacity within the Promoting Recovery mental health Team • Increase capacity within the Home Treatment Team • Evaluate the Project Primary Care Mental Health Support Services, for sustainability going and integrated in full adult mental health model.
	Providing integrated safe, high quality services		
Older People, LTC, EoL & Carers Lead: Amanda Lloyd		• MDT Case Management. Support delivery of TACS phase 2 in line with Better Care Fund objectives. • Reducing avoidable emergency admissions.	Improved outcomes for higher-risk patients
		• Implement System Resilience milestones as detailed in the Urgent and Emergency Care Strategy	Improved services
		• Supporting Outcomes Based Commissioning for over 65s across health and social care	Better services targeted to achieve population outcomes
		Review beginning to End Long Term Condition Pathways, Dementia, Diabetes, Cardiology, Respiratory, Cancer and Mental Health and Commissioning integrated community-based	

Appendix 5

		services for people with LTCs, along clear evidence-based pathways, delivered as close to home as possible	
		Streamline and target support delivered to Care Homes to ensure higher quality services and fewer hospital admissions	Care homes provide better, more efficient service
Working Age Adults Lead: Alan Hiscutt			Recommission sexual health services by April 2016
			Recommission health prevention services through a new integrated healthy living model
			Actively manage the market for health and social care services
			Implement contract monitoring of the new IFA
			In response to Winterbourne View implement the commissioning plan to develop community based services as a more appropriate alternative to A&T units
			Review day opportunities for PWLD, including daycare and employment support
Mental Health & Substance Misuse Lead: Susan Grose Grose		Implement the transformation of Adult mental health services for working adults and the MH services for older adults (MHOA)	To commission integrated , safe . high quality mental health services in the right place at the right time
	Improving People's		

Appendix 5

	Experience of Care		
Older People, LTC, EoL & Carers Lead: Amanda Lloyd		Sustain improvements in the care and support commissioned locally for people who are in the final year of life and to their families, including up-skilling front-line workers in a range of settings to feel confident in managing crises which otherwise could lead to hospital admissions and enabling people to have a good death in the place of their choice	Reduced deaths in hospitals, increased deaths in place of people's choice
		Implement findings of review of older people's housing strategy to achieve a better balance of special sheltered, extra care and retirement homes through a programme of re-commissioning and re-design of some existing provision	
Mental Health & Substance Misuse Lead: Susan Grose		Key priorities will be early intervention and treatment at home or in the community where possible and appropriate.	• Successful implementation of the Adult Mental Health Model • Involvement of the Voluntary Sector, Carers and Patient Voice to influence and be at the heart of Mental Health and Commissioning and Service Redesign. • Re-launch and continued sustainability of the Mental Health partnership Board.

This page is intentionally blank

Appendix 6
Croydon Children and Families Partnership 2015/16 draft priorities

- Reduce childhood obesity
- Improve the emotional wellbeing and mental health of children and young people.
- Increase the impact of early intervention
- Strengthen the consistency of engagement of children, young people and families across partnership
- Increase participation in education, employment and training and improve outcomes at age 19
- Reduce child poverty and mitigate impact of poverty
- Improve integration of services for children and young people with learning difficulties/disabilities
- Improve health and education/training outcomes for Looked After Children

Proposed children's commissioning priorities for Integrated Commissioning Unit

Appendix 6

Joint/Organisation priority 2015-16	Commissioning Objectives *[2014-15 shown as italics for reference during drafting]*	Outcomes to be Achieved	2015-16 Actions Required & Timeline	QIPP / Council Efficiency
Croydon Children and Families Partnership priority: Improve the emotional wellbeing and mental health of children and young people. LA Think Family Integration: aligned, holistic EWB support across children, adults and health Croydon CCG priority: supporting C&YP to achieve their full potential SW London Commissioning Collaborative (SWLCC) priority: build community resilience and capacity	**Strengthen emotional wellbeing and mental health** by continuing to implement the Partnership strategy, strengthening support at tier 1 and recommissioning tier 2 and 3 support as required – in line with the YP Mental Health Taskforce	◆ Improved children's emotional and mental wellbeing	◆ Implement new tier 3 specification including new performance framework through CCG block contract – Apr 15 ◆ Review opportunities to strengthen integration between children and adults and between services, including links to whole family support through adult mental health and substance misuse services – Jun 15 ◆ Develop plans for tier 3 recommissioning in 2016/17 – Jun 15 ◆ Implement tier 2 reconfiguration (phase 1) – Oct 15 ◆ Implement tier 2 reconfiguration (phase 2) – Apr 16	Family support commissioning (for consideration)
Croydon Children and Families Partnership priority: Improve health and education/ training outcomes for Looked After Children Croydon CCG priority: supporting C&YP to achieve their full potential	**Improve health outcomes for LAC** by strengthening service performance against an agreed outcomes framework.	◆ Improved LAC health out-comes	◆ Implement and monitor improved health assessment process clarifying health service role and performance expectations - Oct 15 ◆ Work with provider to strengthen service performance and with the provider and other partners to develop an outcomes framework and appropriate pathways for LAC health services – Mar 16	

Appendix 6

Appendix 6

Joint/Organisation priority 2015-16	Commissioning Objectives *[2014-15 shown as italics for reference during drafting]*	Outcomes to be Achieved	2015-16 Actions Required & Timeline	QIPP / Council Efficiency
Croydon Children and Families Partnership priority: Increase the impact of early intervention LA Think Family Integration: EY, CC, FS and PH services integrated around 0-5s SWLCC and Croydon CCG priority: reduce unnecessary A&E admissions SWLCC priority – build community resilience and capacity	**Strengthen early intervention** by assuring the smooth transfer of 0-5 public health services to local authority commissioning and ensuring they are optimised within the Best Start model	• Successful service transfer. Improved early intervention, child development and parental support outcomes • Reduce avoidable A&E attendance for aged 0-5 years	• Continue to input into national baselining and funding allocation processes - ongoing • Deliver commissioning review of services, drawing on data collection through Integrated Governance Framework – Jun 15 • Enable service changes to coincide with initial transfer in line with phase 1 of Best Start – Oct 15 • Implement updated specification for April 2016 (TBC)	
Croydon Children and Families Partnership priority: Increase the impact of early intervention LA Think Family Integration: Coordinated 5-19 HI provision	**Strengthen early intervention** by implementing commissioning strategy for school nursing and taking steps to increase integration with other 5-19 health improvement services	• Improved early intervention and risky behaviours outcomes through greater integration of 5-19 services	• Implement commissioning strategy for school aged nursing (agreed by the end of Mar 2015) within context of wider 5-19 health improvement services – Sep 15 • Identify and implement route map towards a 5-19 integrated service and closer integration with adult public health services – Mar 16 • Review weight management services at end of contract term and identify opportunities for greater integration with school nursing – Sep 15	
Croydon Children and Families Partnership priority: Increase the impact of early intervention	**Improve outcomes for expectant and young mothers** by delivering improved local maternity services in line with the SWL 5 year strategy	• Ensure strategy aligned to Croydon priorities effectively. • Successful implementation of the strategy	• Implement Commissioning Overview Plan to ensure local realisation of 5 Year Strategy – from Apr 15 • Ensure interfaces with Best	

Appendix 6

Appendix 6

Joint/Organisation priority 2015-16	Commissioning Objectives *[2014-15 shown as italics for reference during drafting]*	Outcomes to be Achieved	2015-16 Actions Required & Timeline	QIPP / Council Efficiency
Croydon Children and Families Partnership priority: improve outcomes for children with SEN and Disability SWLCC priority: build community resilience and capacity	**Strengthen the contribution of commissioned health services to the local Autism Spectrum Disorder pathway** in line with best practice guidelines	• Improved outcomes for children with ASD • Increased integration including between children's and adults' service	• Strengthen the evidence base to better understand the rate of ASD diagnoses and needs in the borough • Identify opportunities for increased integration between children's and adults' ASD services • Contribute to redesigning the ASD pathway in partnership with wider stakeholders – Sep 15 • Contribute to implementing new ASD pathway – Mar 16 • Implement improvement plan for community paediatric service in relation to ASD - Mar 16.	
Croydon Children and Families Partnership priority: improve outcomes for children with SEN and Disability LA Think Family Integration: critical component for all age disability SWLCC priority: build community resilience and capacity	**Implement service development priorities for services supporting children with SEN and Disability** (special school nursing, paediatric OT and physiotherapy services) including preparation for child development centre and a service review for audiology	• Improved life outcomes for YP with SEND and improvement in service user satisfaction.	• Support implementation of service development objectives – Sep 15 • Review development progress and consider whether commissioning strategy is effective - Sep 15 • Identify further opportunities for greater integration between children and adults' services – Sep 15 • Refresh service specification for audiology – Mar 16	

Appendix 6

This page is intentionally blank

FOR INFORMATION

REPORT TO:	**HEALTH AND WELLBEING BOARD (CROYDON)** **10 December 2014**
AGENDA ITEM:	**7**
SUBJECT:	**Health Protection Update**
BOARD SPONSOR:	**Dr Mike Robinson, Director of Public Health, Croydon Council**

CORPORATE PRIORITY/POLICY CONTEXT:

Health protection seeks to prevent or reduce the harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation.

The roles and responsibilities for the different aspects of health protection have changed as a result of the NHS reform.

Public Health England provides health protection planning, surveillance and response to incidents and outbreaks. NHS England commission major programmes such as national immunisation programmes and the provision of health services to diagnose and treat infectious diseases.

Local Authorities have a statutory responsibility to protect the health of their population from all hazards, and to prevent as far as possible, those threats arising in the first place. This duty includes advice and information to key agencies on where to target resources to maximum effect.

This report informs the review of the Joint Health and Wellbeing Strategy by updating on current health protection priorities for Croydon.

FINANCIAL IMPACT:

None

1. RECOMMENDATIONS

The Health and Wellbeing Board is requested to take note of the information on Health Protection priorities for Croydon.

2. EXECUTIVE SUMMARY

Following a previous update by the Director of the SW London Health Protection, the HWBB requested annual updates on local Health Protection issues.

FOR INFORMATION

Dr Miranda Mindlin, on behalf of Public Health England, will give an overview of the main health protection priorities based on surveillance data for Croydon. Key issues in Croydon are vaccine preventable diseases, sexually transmitted infections including HIV, and tuberculosis.

3. DETAIL

Based on data sources from the Public Health Outcomes Framework 2013, Croydon's health protection priorities fall in the following categories:

3.1. Vaccine Preventable Diseases

- Childhood infections (measles, mumps, whooping cough)
- Meningococcal disease
- Hepatitis A and B

3.2. Sexually Transmitted Infections (including HIV)

- High HIV prevalence (5.1/1000 population)
- High proportion of people with HIV are diagnosed at a late stage of the infection (57%) and are unlikely to benefit fully from treatment
- High rates of diagnosis with gonorrhoea, syphilis and genital herpes.

3.3. Tuberculosis

- Moderately high rates of diagnosis with tuberculosis, but variations across the borough. Relatively high rates of drug resistant TB compared to other boroughs in London.

3.4. New structures following from NHS reform

Since April 2013, Public Health England hosts the Health Protection Agency and provides health protection planning, surveillance and response to incidents and outbreaks.
NHS England commission immunisation programmes to protect populations from vaccine preventable infections such as childhood infections and seasonal flu.

Local Authorities have gained a mandate for Public Health which includes a responsibility to protect the health of the local population and to hold key agencies to account for the targeting and performance of local immunisation and screening services.

3.5. Recommendation

The Department of Health has suggested that local authorities may want to set up a Health Protection Forum, to provide an overview of health protection issues and ensure coordinated, close working arrangements between key agencies.

FOR INFORMATION

The aims the Health Protection Forum would be:

- To give assurance that the arrangements in place to protect the health of local residents are robust and are implemented appropriately to local health needs
- To support the local response to health protection emergencies and other incidents which directly or indirectly affect the health and wellbeing of local residents

---

CONTACT OFFICER: Dr Ellen Schwartz, Consultant in Public Health, Croydon Council, x 61644

This page is intentionally blank

REPORT TO:	**HEALTH AND WELLBEING BOARD** **10 December 2014**
AGENDA ITEM:	**8**
SUBJECT:	**Croydon – Food Flagship Borough**
BOARD SPONSORS:	Paul Greenhalgh, Executive director, children, families and learning Dr Mike Robinson, Director of public health
CABINET MEMBERS:	Councillor Alisa Fleming, Cabinet member for children, families and learning Councillor Louisa Woodley, Cabinet member for people and communities
WARDS:	**All wards**

BOARD PRIORITY/POLICY CONTEXT:

The programme is linked to the joint health and wellbeing strategy priorities of reducing obesity in children and adults. It will also contribute to the reduction of diabetes and aims to improve educational attainment in children from disadvantaged groups. The Food Flagship pilot provides an opportunity to improve health outcomes for communities and maximise the opportunities for sustained change via regeneration.

FINANCIAL IMPACT

This report is to update on progress to date.

1. RECOMMENDATIONS

1.1 The health and wellbeing board is asked to note progress on development of the Food Flagship pilot and the health outcomes it will support

1.2 The health and wellbeing board is asked to endorse the proposed approach to the delivery of the Food Flagship pilot in Croydon.

2. EXECUTIVE SUMMARY

2.1 Obesity is an increasing problem in Croydon. The causes are multi-factorial and include greater consumption of processed food, more sedentary lifestyles in both adults and children, and changes in employment and family norms. Obesity rates in Croydon children and adults are higher than the London average.

2.2 The national School Food Plan was published in 2013, with a recommendation that two London Boroughs be established as Food Flagship Pilots, with schools being the catalyst for change in a whole system transformation of the food landscape.

2.3 The high level outcomes for the food flagship which have been specified by the London Food Board are:

1. Reduction in levels of childhood obesity
2. Increase in school attainment
3. Decrease in the numbers of new cases of type-2 diabetes

2.4 The pilot is intended to last five years, to allow time for the whole system transformation needed and for this to make an impact on the chosen outcomes. Initial funding is for two years. Local intermediate outcomes have been identified for impact over the initial funding period.

2.5 The Food Flagship pilot links to Croydon Council's themes of "Ambitious for Croydon":

- Longer, healthier lives
- Healthy and resilient families
- Quality schools and learning
- Places that communities are proud of
- Financial resilience and affordable living

The connection between these outcomes and programme deliverables is set out in appendix 1 Food Flagship Plan on a Page.

2.6 The pilot links to Croydon Clinical Commissioning Group's objectives of reducing the difference in life expectancy between communities and enabling children to achieve their full potential. It will contribute to the local priority of reducing diabetes.

2.7 The principles underpinning the design of the pilot are as follows:

- When children experience the benefits of eating good food at school, this will encourage longer term behaviour change not only in themselves but also in their parents, wider family and local community
- Learning to cook real food at school (for parents as well as children) will influence food shopping habits and cooking at home

- Learning how to grow food, and experiencing the satisfaction of cooking and eating the produce will similarly change longer term shopping habits and diets.

2.8 Resources for the Food Flagship include a £530,000 GLA grant over 2 years. The council will provide a new cash match of £150,000 from the Public Health Grant, as well as other contributions in kind such as Healthy Schools.

3. DETAIL

3.1 Obesity is an increasing problem in Croydon. The causes are multi-factorial and include greater consumption of processed food, more sedentary lifestyles in both adults and children, and changes in employment and family norms. Obesity rates in Croydon children and adults are higher than the London average. 23.8% of children aged 4-5 years are overweight or obese in Croydon and, 38.2% by age 10-11. 62.1% of adults are overweight or obese in the borough.

3.2 The School Food Plan, published in 2013, recommended two London Boroughs be established as Food Flagships, with schools being the catalyst for change in transforming the food landscape. The plan and Flagships have cross party support within the GLA, from the Mayor of London and the London Food Board. In addition to the establishment of Food Flagships, the School Food Plan's three main objectives are to improve school food standards, roll out universal infant free school meals and make cooking skills a compulsory part of the curriculum up until the age of 14 years old. These three objectives provide a strong centrepiece around which other initiatives can be built, which together may deliver a whole system change.

3.3 The Food Flagship boroughs were identified following an application and interview process with twenty London Boroughs applying to become Food Flagship boroughs.

3.4 The principles underpinning the design of the pilot are as follows

1. When children experience the benefits of eating good food at school, this will encourage longer term behaviour change not only in themselves but also in their parents, wider family and local community
2. Learning to cook real food at school (for parents as well as children) will influence food shopping habits and cooking at home
3. Learning how to grow food, and experiencing the satisfaction of cooking and eating the produce will similarly change longer term shopping habits and diets

3.5 The overall programme outcomes are high level and are to be evaluated over five years rather than the shorter period for which the pilot is currently funded. It is therefore proposed to adopt a series of six local intermediate outcomes, and to design a portfolio of projects which should make a difference on these over the two year period of funding in conjunction with other relevant activity already happening or planned in Croydon.

3.6 Six intermediate outcomes have been identified in the project plan that are complementary to the Ambitious for Croydon themes in paragraph 2.3. These are:

- More children eat good quality food in schools at breakfast and lunch time
- More families eat good quality food in and out of home
- More children know how to cook real food and aspire to do so
- More families cook real meals
- More children and parents know how to grow their own food and aspire to do so
- More food eaten in Croydon has been grown in Croydon

3.7 The pilot will include the following specific projects which together will delivery the chosen local outcomes:

- School Food Projects – improving the quality of school meals and increasing uptake by involving children in growing and cooking from reception onwards
- Community Food Learning Centre – expanding the work of this innovative community regeneration project
- Developing Food Businesses – building on the planned Community Food Hub at Surrey Street, supporting the development of new small businesses which sell good quality food
- Community Grants - providing support and opportunity to those groups and individuals who have innovative ideas for growing and cooking healthy food
- Community Gardening Projects – building the communities capacity for growing and to optimise the potential of new growing areas in Croydon
- Food Partnership Board

3.8 The Children and Families Act 2014 placed a legal duty on state funded schools in England, including academies and free schools, to offer a free school lunch to all pupils in reception, year 1 and year 2. The duty came into force from September 2014. Schools are required to provide meals that comply with the School Food Standards. These standards are intended to ensure that children get the nutrition they need across the whole school day. They govern all food and drink on offer within the school and apply across the school day, including breakfast, mid-morning break, lunchtime and food served after school. All Croydon schools are delivering meals as required. An audit of take up in schools is currently underway. Early reports from schools indicate that the take up rate is high. More intensive work will take place in “Flagship Schools” and the outcomes in these schools will be compared to the borough average.

3.9 The development and establishment of a Food Partnership Board is a key objective in creating a governance framework for the Food Flagship activity. In addition, the Food Partnership Board will provide a legacy and continuity beyond the immediate effect of the Food Flagship lifespan. It will also ensure greater buy in from other stakeholders and create a coordinated approach for activity across the Borough. The partnership will foster community ownership and by being part of the Sustainable Food Cities network, Croydon will be able to tap into national expertise and best practice.

3.10 The Food Partnership Board membership will include Elected Members, Food Flagship Project Sponsor (Director of Public Health), the voluntary sector, retail sector, local restaurateurs and school caterers.

3.11 Resources for the Food Flagship include a £530,000 GLA grant over two years. The council will provide a new cash match of £150,000 from the Public Health Grant. The council will also provide support in kind through redesign of the Croydon Healthy Schools programme to emphasise healthy eating, and will encourage all schools to take part in the programme by reducing enrolment costs.

3.12 The council's regeneration programme will also contribute to the programme through a specific project to develop food businesses which will be Flagship funded, and through inclusion of food growing spaces in its own developments and encouragement of the same in those of third parties through the planning approval process. Planting in parks, improvements to food selling shop units and living bus shelters are other in kind contributions already happening or planned. Food Flagship objectives will also be embedded in Health and Wellbeing plans in new planning applications for any major developments.

3.13 Appendix 1 to this report summarises the links between "Ambitious for Croydon" themes, intended outcomes, and the individual component projects.

4. CONSULTATION

4.1 In constructing the successful bid to become a Food Flagship Borough a number of senior officers across the Council, third sector networks and existing food and healthy weight providers were consulted for their views on the flagship proposals.

4.2 The consultation process shaped the successful bid to the GLA and it is proposed that the evolution of the programme continue to be shaped by a Croydon Food partnership Board.

5. SERVICE INTEGRATION

5.1 The Food Flagship pilot aims to bring together a number of partners including statutory, third sector and private organisation to achieve shared objectives. The Food Partnership Board will be the main vehicle for promoting an integrated approach to transforming Croydon's food landscape. At this stage use of pooled budgets or use of NHS Act 2006 flexibilities are not planned as they would not be appropriate for the achievement of programme objectives.

6. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 Funding has been allocated for a two year pilot with future funding under consideration.

6.2 A Programme Board will be established to ensure delivery, and identify and manage risks.

7. COMMENTS OF THE COUNCIL SOLICITOR AND MONITORING OFFICER

7.1 This report is for information only.

8. HUMAN RESOURCES IMPACT

8.1 This report is for information only.

9. EQUALITIES IMPACT

9.1 An Equalities Impact Assessment will take place as part of the design phase of the project.

10. ENVIRONMENTAL IMPACT

10.1 Food growing is a significant feature of the Food Flagship plans. The proposed growing areas will be considered with wider environmental and spatial planning objectives so that the landscape is improved and usable space maximised.

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 None.

12. REASONS FOR RECOMMENDATIONS/PROPOSED DECISION

12.1 This report is for information only.

13. OPTIONS CONSIDERED AND REJECTED

13.1 This report is for information only.

CONTACT OFFICER: John Currie, Public Health Principal 020 8726 6000 ext.88751

BACKGROUND PAPERS - LOCAL GOVERNMENT ACT 1972

None.

Appendix 1. Croydon Food Flagship Borough Programme - Diagram to show link between Outcomes, Projects and Outputs

Relevant themes in "Ambitious for Croydon"		Longer healthier lives	Healthy and resilient families	Quality Schools and Learning	A place that communities are proud of	Financial Resilience and Affordable living	
Programme Outcomes (measure change over 5 years and beyond)		Improve attainment at KS2 and KS4 across all schools		Prevalence of childhood obesity as measured by NCMP		Incidence of Type 2 diabetes	
Local Intermediate Outcomes (measure change in first 2 years)		**More children eat good quality food in schools at breakfast and lunch time**	**More families eat good quality food in and out of home**	**More children know how to cook real food and aspire to do so**	**More families cook real meals**	**More children and parents know how to grow their own food and aspire to do so**	**More food eaten in Croydon has been grown in Croydon**
Rationale (link between local and overall programme outcomes)		Children who eat well at school will have improved concentration and hence attainment; will encourage their parents to provide good food at home and hence reduce obesity and diabetes	Good food at home will reduce consumption of sweets and other unhealthy snacks between home and school/pre-school so reducing childhood obesity	Children who know how to cook will encourage their families to do so and will cook real food themselves in the future reducing adult obesity and new cases of diabetes	Families who cook real meals will be more discerning about food shopping and takeaway choices, and are models for extended family and neighbours, hence reducing adult obesity and diabetes	Knowing how to grow food will encourage actual growing; change food shopping behaviour and raise interest in good food, hence reducing obesity and diabetes	Food grown locally will be tastier and more nutritious, raising expectations of the quality of bought food, and reducing the amount of junk food consumed
Flagship Projects to deliver Local Outcome (see separate project brief for each) NB Food Partnership Board covers all		**Croydon School Food Plan** **Healthy Schools**	**Croydon School Food Plan (Parent Involvement)** **Child Hunger Project (seeking funding)**	**Croydon School Food Plan (Cookery Skills in Curriculum))**	**Community Food Learning Centre** **Community Grants**	**Croydon School Food Plan (Growing)** **Community Grants** **Food Growing**	**Community Gardening Capacity Building** **Regeneration (Developing Food Businesses)**
Flagship Project outputs		Increased uptake of free school meals Increased overall uptake at breakfast / lunch clubs Improved quality of meals	Attendance at cookery demonstrations 2- and 3-year olds receiving healthy meal	Cookery lessons with positive evaluation from parents/children Awareness of food ingredients	Attendance at cookery courses Community bring cook and eat events	School growing areas Fruit and vegetables grown in schools and community Community education/taster events	Trained community gardening tutors, advisors and volunteers Pop-up food shops
Other Croydon activities supporting the Local Outcome (funded separately)		Croydon Healthy Schools Awards	Eat Well network of takeaways (Croydon Heart Town) Planning controls	Healthy Schools		Heart Town: Shared outcomes around prevention of diabetes and cardiovascular disease)	Community Food Hub (Surrey Street)
Local Indicator(s) and data source e.g **% of pupils eligible for free school meals take up offer. Source: School data**		**Numbers eating free school and all meals at schools – school data**	**Self reported food diary – parents and children's survey via app** **% Food outlets offering healthy option – council data**	**Food and cooking knowledge/attitudes – school quiz** **Supplementary height and weight measurements in sign flagship schools**	**Meals questionnaire – parents survey via app**	**Knowledge/attitudes – parents and children's survey** **Knowledge/attitudes – school quiz**	**Numbers of food businesses – council data** **Self-reported community growing activity – social media**

This page is intentionally blank

REPORT TO:	**HEALTH AND WELLBEING BOARD** **10 December 2014**
AGENDA ITEM:	**10**
SUBJECT:	**Report of the chair of the executive group: incorporating risk register and board work plan**
LEAD OFFICER:	**Hannah Miller, Executive director of adults services, health and housing & deputy chief executive, Croydon Council**

CORPORATE PRIORITY/POLICY CONTEXT:

The Health and Social Care Act 2102 created statutory health and wellbeing boards as committees of the local authority. Their role is to improve the health and wellbeing of local people by promoting integration and partnership working between the NHS, social care, children's services, public health and other local services, and to improve democratic accountability in health.

FINANCIAL IMPACT:

None

1. RECOMMENDATIONS

The health and wellbeing board is asked to:

- Note risks identified at appendix 1
- Agree changes to the board work plan set out in paragraph 3.4

2. EXECUTIVE SUMMARY

2.1 A number of strategic risks were identified by the board at a seminar on 1 August 2013. The board agreed that the executive group would keep these risks under review. A summary of risks is at appendix 1.

2.2 The health and wellbeing board agreed its work plan for 2013/14 at its meeting on 24 April 2013. The work plan is regularly reviewed by the executive group and the chair. This paper includes the most recent update of the board work plan at appendix 2.

3. DETAIL

3.1 The purpose of health and wellbeing boards as described in the Health and Social Care Act 2012 is to join up commissioning across the NHS, social care, public health and other services that the board agrees are directly related to

health and wellbeing, in order to secure better health and wellbeing outcomes for the whole population, better quality of care for all patients and care users, and better value for the taxpayer.

Work undertaken by the executive group

3.2 The board seminar on 1 August 2013 recommended that the chair of the executive group reported regularly to the board on the work undertaken by the executive group on behalf of the board. Key areas of work for the executive group in November and December 2014 are set out below:

- Review of the work plan including preparation of board meeting agenda and topic prioritisation against the joint health and wellbeing strategy
- Review of progress with the new pharmaceutical needs assessment
- Planned reports to overview and scrutiny committee and full council
- Liaison with other strategic partnerships including Croydon strategic partnership and children and families partnership
- Review of board strategic risk register
- Review of responses to public questions and general enquiries relating to the work of the board

Risk

3.3 Risks identified by the board are summarised at appendix 1. The executive group regularly review the board risk register. The executive group undertook a detailed review of the highest RAG rated risk at its meeting on 21 October 2014. This is expressed in the risk register as 'Limited or constrained financial allocations in health and social care which gives rise to the inability to balance reducing budgets with a rising demand.' The executive group agreed that whilst the nature and severity of the risk varies between partners and sector the risk rating should remain unchanged at 20 (Red).

Board work plan

3.4 Changes to the board work plan from the version agreed by the board on 22 October 2014 are summarised below. Changes were discussed by the executive group on 21 October 2014. This is version 51.0 of the work plan. The work plan is at appendix 2.

3.4.1 Addition of items on mental health crisis care concordat, healthy weight strategy update, and work on illicit tobacco agenda for 11 February 2015

3.4.2 Item on JSNA 2013/14 homeless households chapter moved from 11 February 2015 to June 2015.

4. CONSULTATION

4.1 A number of topics for board meetings have been proposed by board members. These have been added to a topics proposals list on the work plan.

5. SERVICE INTEGRATION

5.1 All board paper authors are asked to explicitly consider service integration issues for items in the work plan.

6 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

6.1 Where there are financial or risk assessment considerations board paper authors must complete this section and gain sign off from the relevant lead finance officer(s). Where there is joint funding in place or plans for joint funding then approval must be sought from the lead finance officer from both parties.

7. LEGAL CONSIDERATIONS

7.1 Advice from the council's legal department must be sought on proposals set out in board papers with legal sign off of the final paper.

8. HUMAN RESOURCES IMPACT

8.1 Any human resources impacts, including organisational development, training or staffing implications, should be set out for the board paper for an item in the work plan.

9. EQUALITIES IMPACT

9.1 The health and wellbeing board, as a committee of the council, has a statutory duty to comply with the provisions set out in the Equality Act 2010. The board must, in the exercise of all its functions, have due regard to the need to comply with the three arms or aims of the general equality duty. Case law has established that the potential effect on equality should be analysed at the initial stage in the development or review of a policy, thus informing policy design and final decision making.

9.2 Paper authors should carry out an equality analysis if the report proposes a big change to a service or a small change that affects a lot of people. The change could be to any aspect of the service – including policies, budgets, plans, facilities and processes. The equality analysis is a key part of the decision-making process and will be considered by board members when considering reports and making decisions. The equality analysis must be appended to the report and have been signed off by the relevant director.

9.3 Guidance on equality analysis can be obtained from the council's equalities team.

CONTACT OFFICER: Steve Morton, head of health and wellbeing, Croydon Council steve.morton@croydon.gov.uk, 020 8726 6000 ext. 61600

BACKGROUND DOCUMENTS

None

This page is intentionally blank

10 December 2014

Risk Status

			Risk rating		Control measures			
Risk Ref	**Business Unit**	**Risk**	**Current**	**Future**	**Future**	**Existing**	**Total**	**% Implemer**
HWB5	HWB	Limited or constrained financial allocations in health and social care which gives rise to the inability to balance reducing budgets with a rising demand	20	15	3	5	7	80%
HWB2	HWB	Failure to successfully integrate commissioning or service provision due to inability or unwillingness to share data	16	12	3	2	5	71%
HWB6	HWB	Failure to ensure that the Board continuously develops and has the capacity and capability to operate effectively and efficiently.	16	12	3	2	3	67%
HWB8	HWB	Board is not able to demonstrate improved outcomes for the population	16	12	4	4	4	60%
HWB4	HWB	Failure to understand the community's expressed wants and choices and to ensure that ongoing engagement with the public is maintained and views	16	12	5	2	6	40%
HWB1	HWB	Failure to ensure that the board's focus is balanced (for example, between statutory requirements / national guidance and local priorities; or health and wellbeing)	16	8	2	4	6	67%
HWB3	HWB	Failure to clearly understand the purpose, boundaries and remit of the Board	16	4	2	2	3	67%
HWB7	HWB	The Board fails to respond flexibly and effectively to changes in national policy or developing local issues	12	8	2	2	4	50%
HWB9	HWB	Failure to produce the pharmaceutical needs assessment	12	8	2	2	4	50%

ıted

HWB work plan version 51.0

Topic proposed: date to be agreed

Fairness Commission
Update on integrated care / Transforming Adult Community Services
Improving outcomes: people's experience of care (patient transport)
Care Act implementation
Services for people with autism

Date	Item	Purpose	Board sponsor	Lead officer / report author
11 February 2015	Focus on outcomes: health and wellbeing of offenders & their families	To enable the board to consider issues affecting the health and wellbeing of offenders and their families	tba	tba
	Mental health crisis care concordat (Partnership: Mental Health)	Decision	tba	Brenda Scanlan / Sue Grose
	Mental health strategy action plan (Partnership: Mental Health)	To inform the board of key actions to be undertaken to deliver the mental health strategy	Paula Swann / Hannah Miller	Brenda Scanlan / Sue Grose
	Pharmaceutical needs assessment final draft for agreement	The board has a statutory duty to publish a PNA by 31 March 2015	Mike Robinson	Sara Corben / Matt Phelan
	Update on dignity and safety	To assure the board that work to ensure dignity and safety reported to	Paul Greenhalgh / Paula Swann	Kay Murray / Michelle Rahman

HWB work plan version 51.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
		board in February 2014 has been progressed.		
	Heart Town annual report (Partnership: Heart Town)	To inform the board of progress in the delivery of Croydon Heart Town	Mike Robinson	Steve Morton
	Healthy weight strategy refresh	Decision	Mike Robinson	Sarah Nicholls/ Anna Kitt
	Drug and alcohol phase 2 recommissioning (Partnership: Drugs & alcohol)	Information	Hannah Miller	Susan Grose
	Progress report on work undertaken to determine the scale and nature of the illicit tobacco problem	Information	Mike Robinson	Katie Cuming/ Jimmy Burke
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Discussion & decision	Hannah Miller	Steve Morton
25 March 2015	Focus on outcomes: household income and health	Discussion	tba	tba
	Final commissioning plans 2015/16	Information	Paula Swann/Hannah Miller/Paul	Stephen Warren / Brenda Scanlan / Jane Doyle/PH &

HWB work plan version 51.0

Date	Item	Purpose	Board sponsor	Lead officer / report author
			Greenhalgh/Mike Robinson/Jane Fryer	NHS England leads tbc
	Joint health and wellbeing strategy 2015-20	Decision	Paula Swann / Paul Greenhalgh / Mike Robinson	Steve Morton
	Partnership groups report	Information	Paul Greenhalgh	Steve Morton
	Carers partnership group report	Information	Paul Greenhalgh	Amanda Lloyd / Harsha Ganatra
	Deprivation of liberty safeguarding	Discussion	Paul Greenhalgh	Kay Murray / Edwina Morris
	Report of the chair of the executive group • Work plan • Risk	Discussion & decision	Paul Greenhalgh	Steve Morton
June 2015	JSNA 2013/14 homeless households chapter final draft	Discussion & decision	Mike Robinson	Jenny Hacker / Dave Morris

Appendix 1b Summary record of topics covered at previous HWB meetings

n.b. minutes and papers of shadow health and wellbeing board meetings from 8 December 2011 to 13 February 2013 to can be found on the Council website by clicking on the following link: http://tinyurl.com/ShadowHWB.

Date	Items	Purpose	Board sponsor	Lead officer / report author
24 April 2013	Establishment of the health and wellbeing board	Decision	Councillor Margaret Mead	Solomon Agutu
	Focus on outcomes: adults with learning disabilities	Discussion	Geraldine O'Shea	Geraldine O'Shea / Mike Corrigan
	JSNA key data set 2012/13	Discussion	Mike Robinson	Jenny Hacker
	Heart Town proposal	Decision	Councillor Margaret Mead	Steve Morton / Bevoly Fearon
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
12 June 2013	Prevention, self-care and shared decision making	Discussion	Agnelo Fernandes	Daniel MacIntyre
	Better Services Better Value consultation	Discussion	Paula Swann / Agnelo Fernandes	Rachel Tyndall / Charlotte Joll
	Annual report of the director of public health	Information	Mike Robinson	Sara Corben
	Sign off JSNA deep dive chapters • Depression in adults • Schizophrenia	Decision	Mike Robinson	Bernadette Alves
	Update on integrated care (from September 2012)	Information	Agnelo Fernandes	Paul Young / Amanda Tuke / Brenda Scanlan
	Partnership groups proposal	Decision	Hannah Miller	Steve Morton

Appendix 1b Summary record of topics covered at previous HWB meetings

Date	Items	Purpose	Board sponsor	Lead officer / report author
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
18 July 2013	Board workshop on strategic risk			
11 September 2013	Improving outcomes for children with disabilities	Discussion and decision	Paul Greenhalgh	Linda Wright
	Reablement and hospital discharge programme – funding allocations 2013/14	Decision	Hannah Miller / Paula Swann	Andrew Maskell
	JSNA deep dive chapter • Emotional health and wellbeing of children	Decision	Mike Robinson	Kate Naish
	JSNA work plan 2013/14	Decision	Mike Robinson	Jenny Hacker
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
	Adult social care local account 2012	Information	Hannah Miller	Tracy Stanley
	Report from Croydon Congress health themed meeting 16 May 2013	Information	Mike Robinson	Sharon Godman
	Integrated commissioning unit for health and social care	Information	Hannah Miller / Paula Swann	Brenda Scanlan / Stephen Warren
	Integrated care pioneer status bid	Information	Hannah Miller / Paula Swann	Laura Jenner
23 October 2013	Focus on outcomes: homelessness, health and housing	Discussion	Hannah Miller	Peter Brown / Dave Morris
	Heart Town programme to prevent heart and	Discussion	Mike Robinson	Steve Morton

Appendix 1b Summary record of topics covered at previous HWB meetings

Date	Items	Purpose	Board sponsor	Lead officer / report author
	circulatory diseases			
	JSNA 2013/14 overview of health & social care needs	Discussion	Mike Robinson	Jenny Hacker
	Performance report (standing item)	Discussion	Hannah Miller/Paul Greenhalgh/Paula Swann	Martin Ellender
	Work plan (standing item)	Decision	Hannah Miller	Steve Morton
	Integration transformation fund	Information	Hannah Miller / Paula Swann	Andrew Maskell
	Safeguarding adults	Information	Hannah Miller	Kay Murray
	Safeguarding children	Information	Paul Greenhalgh	Jeneen Hatt
	Update on carers (from April 2012)	Information	Roger Oliver	Harsha Ganatra
	Update on children's primary prevention plan (from Feb 2013)	Information	Paul Greenhalgh	Dwynwen Stepien
4 December 2013	Commissioning intentions 2014/15	Discussion	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson	Stephen Warren / Brenda Scanlan / Jane Doyle
	Substance misuse commissioning plans	Discussion	Hannah Miller	Alan Hiscutt
	Pharmaceutical needs assessment	Decision	Mike Robinson	Kate Woollcombe
	Work plan and report of the chair of the	Decision	Hannah Miller	Steve Morton

Appendix 1b Summary record of topics covered at previous HWB meetings

Date	Items	Purpose	Board sponsor	Lead officer / report author
	executive group (standing item)			
	Risk register (standing item)	Discussion	Hannah Miller	Steve Morton
5 December 2013	Board seminar – dignity and safety in care			
12 February 2014	Better Care Fund (formerly the integration transformation fund) 2014/15	Discussion & decision	Hannah Miller / Paula Swann	Andrew Maskell
	Dignity & safety in care seminar report	Discussion	Hannah Miller / Paula Swann	Kay Murray / Fouzia Harrington
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk	Discussion & decision	Hannah Miller	 Steve Morton Martin Ellender Malcolm Davies
	Local account 2012/13	Information	Hannah Miller	Tracey Stanley
	Heart Town update	Information	Mike Robinson	Steve Morton
26 March 2014	CHS emergency care department business case	Decision	John Goulston	Karen Breen
	South west London collaborative commissioning	Discussion	Paula Swann	Stephen Warren
	Final commissioning intentions 2014/15 • CCG Operating Plan 2014/15 – 2016/17	For information	Paula Swann/Hannah Miller/Paul	Stephen Warren / Brenda Scanlan / Jane Doyle

Appendix 1b Summary record of topics covered at previous HWB meetings

Date	Items	Purpose	Board sponsor	Lead officer / report author
	• Children and families' plan 2014/15		Greenhalgh	
	JSNA 2013/14 domestic violence chapter final draft	Decision	Mike Robinson	Ellen Schwartz
	JSNA 2013/14 alcohol chapter final draft	Decision	Mike Robinson	Bernadette Alves
	Children & young people's emotional wellbeing & mental health strategy	Discussion	Paul Greenhalgh / Paula Swann	Geraldine Bradbury / Stephen Warren
	Pharmaceutical needs assessment work plan 2014/15	Information	Mike Robinson	Matt Phelan
	Report of the chair of the executive group • Work plan • Risk register	Discussion & decision	Hannah Miller	 Steve Morton Malcolm Davies
27 March 2014	Board engagement event: review of progress against joint health and wellbeing strategy			
16 July 2014	Board induction session			
16 July 2014	Appointment of chair	Decision	n/a	Solomon Agutu
	Annual report of the director of public health	Discussion	Mike Robinson	Jenny Hacker
	Focus on outcomes: Pressure ulcers in the community	Discussion	Paula Swann / Hannah Miller	Michelle Rahman / Kay Murray
	JSNA 2013/14 healthy weight chapter final draft	Decision	Mike Robinson	Sarah Nicholls / Anna Kitt

Appendix 1b Summary record of topics covered at previous HWB meetings

Date	Items	Purpose	Board sponsor	Lead officer / report author
	JSNA 2014/15 key chapter topics	Decision	Mike Robinson	Jenny Hacker
	SW London collaborative commissioning strategy	Information	Paula Swann	Paula Swann
	Joint mental health strategy	Discussion	Paula Swann / Hannah Miller	Paula Swann /' Stephen Warren / Brenda Scanlan
	Children's primary prevention plan	Discussion	Paul Greenhalgh	Dwynwen Stepien
	Reform of services for children who will be subject to education, care and health plans	Information	Paul Greenhalgh	Linda Wright
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item) • Risk register	Discussion & decision	Hannah Miller	 Steve Morton Laura Gamble Steve Morton
11 September 2014	Better Care Fund	Decision	Hannah Miller / Paula Swann	Andrew Maskell
	Adults safeguarding board annual report	Information	Hannah Miller	Kay Murray
	Children's safeguarding board annual report	Information	Paul Greenhalgh	Steve Love
	Report of the chair of the executive group • Work plan • Risk register	Discussion & decision	Hannah Miller	Steve Morton

Appendix 1b Summary record of topics covered at previous HWB meetings

Date	Items	Purpose	Board sponsor	Lead officer / report author
	Somewhere to go, something to do: a survey of the views of people using mental health day services in Croydon	Information	Maggie Mansell	Richard Pacitti
1 October 2014	Board public engagement event: joint health and wellbeing strategy review			

22 October 2014	Focus on outcomes: primary care : general practice	Information and discussion	Dr Jane Fryer	Dr Jane Fryer
	JSNA key dataset 2014/15	Discussion & decision	Mike Robinson	Jenny Hacker / David Osborne
	Outcomes based commissioning for over 65s	Information & discussion	Paula Swann / Hannah Miller	Brenda Scanlan / Stephen Warren
	Partnership groups report • Summary report from all partnerships • Update on adults with learning disabilities (from April 2013)	 Information & discussion Information & discussion	 Hannah Miller Hannah Miller / Paula Swann	 Steve Morton Alan Hiscutt / Suzanne Culling
	Adult social care commissioning plan 2014/15	Information	Hannah Miller	Brenda Scanlan
	Report of the chair of the executive group • Work plan • Performance against health and wellbeing strategy indicators (quarterly standing item)	Decision	Hannah Miller	 Steve Morton / Laura Gamble

Appendix 1b Summary record of topics covered at previous HWB meetings

	• Risk			
7 November 2014	Board half awayday on the review of the joint health and wellbeing strategy, to discuss findings from the engagement event on 1 October			
10 December 2014	Commissioning intentions 2015/16	The board has a duty to satisfy itself that commissioning intentions are aligned with the joint health and wellbeing strategy	Paula Swann/Hannah Miller/Paul Greenhalgh/Mike Robinson/Jane Fryer	Stephen Warren / Brenda Scanlan / Jane Doyle
	Health protection update	To inform the board of key health protection issues for the borough including uptake of immunisations & vaccinations	Mike Robinson	Ellen Schwartz / Miranda Mindlin
	Croydon Food Flagship	To inform the board on progress with the Food Flagship programme	Mike Robinson	John Currie
	Report of the chair of the executive group • Work plan • Risk	Discussion & decision	Hannah Miller	Steve Morton

This page is intentionally blank