HEALTH AND WELLBEING BOARD

Thursday, 11 February 2016 at 6.15 pm
Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

Contact: Penelope Williams
Board Secretary
Direct : 020-8379- 4098
Tel: 020-8379-1000
Ext: 4098
E-mail: penelope.williams@enfield.gov.uk
Council website: www.enfield.gov.uk

Dear All

To Follow Papers

Please find attached the “to follow” papers mentioned on the agenda for the next meeting of the Health and Wellbeing Board.

These relate to Item 5 – Sub Board Updates

- Joint Commissioning Update
- Primary Care Update

Please bring these papers with you to the meeting next week.

If you have any queries in the meantime please let me know, details above.

Thank you

Yours faithfully

Penelope Williams

Penelope Williams
Board Secretary

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Agenda Item 5

Health and Wellbeing Board
11 February 2016

Agenda – Part: 1	**Item: 5**
Subject: Joint Commissioning Board Report	
Date: Thursday 11th February 2016	

REPORT OF:

Bindi Nagra

Assistant Director, Strategy & Resources

Housing, Health & Adults Social Care

020 8379 5298

E mail: bindi.nagra@enfield.gov.uk

1. EXECUTIVE SUMMARY

1.1 This report provides an update on the work of joint commissioning across health and social care in Enfield

1.2 Updates for all key commissioning areas are included, as are relevant updates on commissioning activity from Partnership Boards

1.3 This report notes:

- Accessible homes for older people with learning disabilities update re Carterhatch Lane, Jasper Close and Parsonage Lane [p.3]
- Development of Integrated Locality Teams and services for Older People [p.3]
- Smoking update [p.4]
  - Plans to run a Turkish smoking conference
  - Success of Trading Standards re confiscating illegal or illicit cigarettes
- Review of Dementia Register indicated post-diagnostic support, which has resulted in a voluntary sector service link to the Memory Service [p.6]
- Learning Disabilities [p.7]
  - NHSE chief Nursing Officer's visit to the Integrated Learning disabilities Service in January
  - Fund awarded from Skills for Care for implement Positive Behaviour Support approaches and models of care
  - Procurement and agreed collaborative contract framework with LB Waltham Forest and LB Hackney
- Commissioning partnership with a local voluntary and community sector provider to implement the strategy for adults with autism [p.8]
- Latest ratified data confirming upward trajectory in Drug and Alcohol treatment users [p.9-12]

1. EXECUTIVE SUMMARY (CONTINUED)

- Update on work with voluntary organisations in receipt of core funding [p.12]
- Safeguarding [p.13-14]

  - Launch of project working on addressing risk factors with adults who are socially isolated

  - Outline of work to be carried out to establish the quality of activities in Care Homes

- Carers [p.15-16]
  - Outline of activities supporting Carers
  - Update on Carers Centre
- Partnership Board updates [p.17-18]:

  Safeguarding Adults Board (SAB) [p.17]

  Carers Partnership Board (CPB) [p.18]

  Sexual Health Partnership Board (SHPB) [p.18]

2. RECOMMENDATIONS

2.1 It is recommended that the Health & Wellbeing Board note the content of this report (with appendices).

3. SECTION 75 AGREEMENT FOR ADULTS

Discussions are taking place regarding 2016/17 amendments.

4. SPECIALIST ACCOMMODATION

4.1 Work to redevelop specialist accommodation located off **Carterhatch Lane,** to provide 14 accessible homes for older people with learning disabilities and dementia, in the form of a specialist **Extra Care** service is now complete. People will be supported to move into their new homes over January 2016. The new service will provide much improved, fully accessible accommodation with communal facilities and 24 hour on site support for older people with disabilities who wish to live independently within the community.

4.2 The development of wheelchair accessible homes for people with disabilities on **Jasper Close** (for social rent) and **Parsonage Lane** (for home ownership) is now near completion. Following a number of information sessions, suitable

tenants / purchasers have now been identified. The Parsonage Lane development is a pilot project that will enable people with long term disabilities who are not in work to secure a mortgage and part purchase a suitably adapted home in the borough. Potential benefits of this pilot project are cross cutting, including opportunities to support people who are placed in local authority housing or residential placements to purchase an accessible home of their own.

4.3 A pilot project with the **Housing Gateway** is underway to consider purchasing accommodation to meet the specific needs of adults with disabilities wishing to move on to independent living in the community. Developing this pathway will increase secure, affordable and appropriate accommodation options for people with disabilities, as acquisitions can be tailored to meet specific needs of individuals requiring care.

5. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

5.1 Identification and Primary Care Management

Working in partnership between NHS Enfield CCG, London Borough of Enfield and Enfield Community Service, Integrated Locality Teams were formed comprising of social workers, community matrons & therapists, to deliver a multi-disciplinary, approach to supporting GPs as Lead Accountable Professionals in their practices. The CCG in collaboration with NHS England offered a GP Local Incentive Scheme for Jan – Mar-16 to primary care practices to support GPs to work with ILTs and CHAT to manage the more complex cases on their caseload.

The Care Homes Assessment Team (CHAT) fulfils a similar role for care home residents and is a nurse-led team with geriatrician input to manage the individual cases of older residents in homes, help develop lasting nursing staff skills in these homes and engage with GPs of residents. CHAT now covers 40 older people's residential & nursing care homes in the Borough, and will cover the remaining older people's homes by the end of Mar-16.

The CCG and LBE have also recently invested in 2 voluntary sector services, one to enable post-diagnostic support for dementia, the other to promote falls prevention, aligned to the new partnership approach to working with the sector. Age UK Enfield and its partners were awarded both services following a competitive tender process open to all voluntary sector organisations, and both services are currently being mobilised.

5.2 Rapid Response

This function includes a range of services with a focus either on time-limited help for people to return home safely after hospital or providing a crisis management response in the community to help people avoid hospitalisation 7 days a week.

Part of this service includes an out-of-hours Community Crisis Response Team (5pm-2am), a nurse prescriber team to respond to crisis situations in the community or in care homes within 20 minutes–2 hours in which individuals would otherwise attend A&E unnecessarily. A Task & Finish Group developed an

operational policy and mobilised this service, linked to all other care & support community out-of-hours, including Barndoc, 111, LAS and Safe & Connected. The service started on 18th Jan-16.

Rapid response includes time-limited community rehabilitation, and a draft Service Specification incorporating hospital & community bed-based and home-based rehabilitation has been developed, including an analysis of the likely need for fast- and slow-stream rehabilitation beds. A commissioner-led review of the existing intermediate care at home and enablement is planned, which has been agreed with providers, with a view to inform further development of the Integrated Locality Teams in 2016/17.

6. PUBLIC HEALTH

6.1 Smoking

Working with communities

Work is progressing with Cllrs Keazor and Brett to run a Turkish smoking conference. The aim will be to work with the Turkish community to recognise that smoking is a problem in their community and that if prevalence is to come down then smoking needs to become unacceptable in their community.

Trading Standards

This year trading standards have confiscated 125,000 illegal or illicit cigarettes and 10 tons of handrolling tobacco. This is encouraging and will help to reduce the availability of cheap tobacco in the borough. It is also recognised that reducing demand is the most effective means of reducing supply e.g. selling cigarettes to people who do not smoke is difficult.

Smoking quitters

Q3 data will not be available until mid-March but we fully expect to meet our yearly smoking quitters' target.

Contract

The current contract ends on 31st March 2016. The outline of a new contact has been written and will be tendered once PH budgets have been set and it is clear what capacity can be put into the service for next year.

6.2 Healthchecks

Healthchecks delivery for 2015-16 has been very successful and has already achieved the annual target within 10 months.

Work is taking place with the CCG to use IT systems to target healthchecks to those of greatest risk – by individual risk factors rather than geography.

6.3 Sexual Health Services

6.3.1 Rates of EHC are increasing steadily. 25 pharmacies across the borough are in the scheme offering a service seven (7) days per week

6.3.2 There has been a slight increase in the number of teenage pregnancies.

6.3.2.1 Data on the ethnicity of teenage mothers (16-19) show demographic changes, which might be impacting on the rate of teenage pregnancies

- Figures for 2013-15 show a decrease of teenage mothers in Black African, Black Caribbean and White & Black Caribbean population, which is positive as TP was high in these groups previously
- Figures for 2013-15 show an increase of teenage mothers in Gypsy Roma, White British, White Eastern European and Polish population

6.3.2.2 The Teenage Pregnancy Team are working with all colleges in the borough – Enfield, Conel, Southgate, Capel manor – to discuss how to increase distribution amongst the students.

6.3.3 The new providers (North Middlesex University Hospital Trust) for Integrated Sexual Health Community Services will be holding a Stakeholders Engagement with the Voluntary Sector to discuss ways of working in the borough and how to engage with the hard-to-reach population

6.3.4 NMUH has carried out a complete review of the service based on feedback about what is needed, to provide an improved service.

6.4 Family Nurse Partnership

6.4.1 In the last quarter – Oct-Dec 2015 – the FNP service received 32 notifications of which 21 were eligible for the programme:

- 7 enrolled
- 1 declined
- 13 remain pending

6.4.2 The team will have its first Graduation from Enfield ENP in March 2016

6.4.3 Following an period of workshops, nationwide, Family Nurse Partnership National Unit has presented initial plans for short-term improvements and the development of longer-term, more complex changes

· More **flexible eligibility criteria to** support local commissioning needs

· A **toolkit** to evidence FNP's impact on safeguarding

· **Simplified local dashboards** and the ability to view data by local authority

· **Additional learning offers for FNP teams** in key areas such as smoking cessation in pregnancy, child development and preventing obesity

· **Flexible learning programme** – to support hiring outside the training cycle

7. SERVICE AREA COMMISSIONING ACTIVITY

7.1 Older People – Dementia

NHS Enfield CCG has been working with GPs to identify those patients with a formal diagnosis of dementia who need to be added to individual GPs Dementia Registers, as well as those individuals who may need to be assessed for a formal diagnosis from the Memory Service. The Review indicated an improvement area was post-diagnostic support for people with dementia, and a voluntary sector service linked to the Memory Service is being mobilised (see Integrated Care).

The post-diagnostic service will support Enfield to increase the proportion of older people likely to have dementia in Enfield (estimated at around 3,000) who were known to be on GPs' Dementia Registers to increase. There was a gradual long-term improvement in the proportion of people with dementia with a formal diagnosis from 45% to 68% (the BCF Plan target for Mar-16) between Jun-14 and Nov-15.

7.2 Mental Health

7.2.1 An updated National Mental Health Crisis Care Concordat (MHCCC) has been developed and will continue to focus on the four pillars of the Crisis Care Concordat

- ❖ Access to support before crisis point
- ❖ Urgent and emergency access to crisis care
- ❖ Quality of treatment and care when in crisis
- ❖ Recovery and staying well

7.2.2 Next Steps – Continue to work with all stakeholders across the health and social care system to ensure that clinical pathways, timescales and social/housing pathways are aligned to ensure appropriate and effective communication processes to develop solutions to enable timely and sustainable discharge from inpatient beds.

7.3 Learning Disabilities

7.3.1 <u>Transforming Care for adults with learning disabilities (Winterbourne View)</u>

Enfield continues to be one of the leading areas in terms of implementation of the Transforming Care programme and the Concordat.

NHSEs Chief Nursing Officer, Jane Cummings visited the Integrated Learning Disabilities Services on the 5th of January 2016 to better understand our nurse led community intervention services and meet the individuals who were successfully moved from hospitals back to the community. The Chief Nursing Officer was quoted as saying "There is a person centred care at Enfield, and a real drive to keep people out of

hospital. This is really good practice and not the kind that you see elsewhere".

Commissioners from Adults and children's services across health and social care are working together to develop Enfield's Transforming Care Plan for all people with learning disabilities. The aim of the transformation plan is develop a sustainable system and new model of service delivery for the NCL area that is focussed on supporting people to remain healthy and well in the community and reduce avoidable admissions to assessment and treatment services. Enfield is sharing good practice with its NCL partners. The Transformation Plan will need to be submitted by the 8th of February 2016 and then a quality assurance process will be followed with NHSE and ADASS providing formal feedback by 19th of March 2016.

The Integrated Learning Disabilities Service was notified at the beginning of January 2016 that they have been awarded £21 k from the Skills for Care. The funding is to be used to implement Positive Behaviour Support (PBS) approaches and models of care. PBS is used to deescalate behaviour that can prove challenging by understanding triggers, communications, conducting environmental assessments with a view to minimising those triggers and supporting the learning of new skills and behaviours.

7.3.2 Collaborative contract framework for people with learning disabilities

Waltham Forest, Hackney and Enfield have commenced procurement and agreed a collaborative contract framework for people with learning disabilities who require health, care and support to live independently.

The tender commenced in October and closed at the beginning of November. Commissioners from Waltham Forest, Hackney and Enfield have evaluated all the 24 bids that were submitted and are currently developing internal processes with a view to start drawing off of the contract framework by the end of February 2016. Experts by Experience (Parent / Carers and people with learning disabilities) were supported to take part in the procurement and the interview process, and actively contributed towards evaluation.

The aim of the contract framework is to diversify the local supported living market and improve quality, safety and efficiency outcomes for people with learning disabilities who meet the eligibility criteria for specialist health and care. Enfield CCG will be able to utilise this contract framework also.

7.3.3 New developments

Commissioning is currently working in partnership with the Council's Housing Gateway to develop a process for accessing accommodation through this means. We are also in communication with the Housing Policy team to ensure that people with learning disabilities can access housing and housing advice, advocacy and support where necessary.

7.3.4 Implementation of the Joint Strategy for People with Autism
Commissioning is working with a local voluntary and community sector provider - One-2-One - to implement the strategy for adults with autism.

a. We are developing a set of standards and principles for practitioners to work towards when supporting someone with autism. Membership includes: ILDS, BEHMHT, Royal Free London, Social care workforce, Children's and young people clinicians and experts by experience.

b. The Peer Support Group applied for social inclusion funding and was awarded an amount through a small grants process.

c. Commissioners from across Barnet, Enfield and Haringey are working together to identify existing demand, access, trends, activity and expenditure for people with autism. This information will inform pathway redesign with a commitment to commissioning more local provision for diagnosis and post-diagnostic support.

d. One-2-one has been successfully awarded funding from the Big Lottery Fund to establish a learning disabilities Council for Enfield. This will include people with autism including people with higher functioning autism such as conditions like Asperger's syndrome.

7.4 **Children's Services**

7.4.1 Joint Enfield Council and CCG Strategy for Emotional Wellbeing and Child and Adolescent Mental Health for 0-18 year olds in Enfield
Implementation of the plan is being progressed through the CAMHS Partnership Group, which is in in turn accountable to the Joint Commissioning Board. A progress report will be provided in the next update.

7.4.2 Strengthening the Team Around You (STAY) (formerly the Enhanced Behaviour Support Service)
STAY was approved at the 13 October 2015 BCF Management Group meeting. The new service aims to avoid residential accommodation for (approximately) four children/young people per year through a combination of timely and intensive therapeutic support and the provision of regular, planned short breaks. This service will work closely with adult and transition services and follows the success of a similar model in Ealing. BEH Mental Health Trust have struggled to recruit to posts but an interim solution is being sought. The STAY team is a key element of the local response for children and young people of Transforming Care: A national response to Winterbourne View Hospital.

7.4 DRUG AND ALCOHOL ACTION TEAM (DAAT)

7.5.1 Performance for Drug Users in Treatment

The latest NDTMS ratified data for the 12 month rolling period December 2014 to November 2015 is confirming that Enfield has seen 1069 drug users In Treatment during the year; 92 more than at the start of the financial period. This performance has continued on an upward trajectory but the London ranking has been maintained at 13th. As a consequence of the continued growth in Numbers in Treatment, Enfield has witnessed a negligible decline of 2 patients less Successfully Completing Treatment but the percentage rate has stabilised at 24.2%. It is important to note that Enfield is 2.8% above the end of year Target, 4.6% above the London average and 9% above the National average for Successful Treatment Completions. The DAAT is currently ranking 9th for this measure.

The Numbers of drug users in Treatment and the Successful Treatment Completion rate for Enfield DAAT is summarised in Fig. 1 below:-

Fig. 1: Enfield All Drug Users

Partnership	Apr 2014 to Mar 2015 Baseline	Oct-14 to Sep-15	Nov-14 to Oct-15	Dec-14 to Nov-15	Apr 2015 to Mar 2016 Target
Number of Successful Completions	177	264	261	259	**217**
Numbers in Treatment	977	1055	1066	1069	**1014**
% Successful Completions	**18.1%**	**25.00%**	**24.50%**	**24.20%**	**21.4%**
% London Average	19.6%	**19.90%**	**19.60%**	**19.60%**	
% National Average	15.8%	**15.30%**	**15.20%**	**15.20%**	

7.5.2 Numbers of Alcohol Users in Treatment

The performance for Alcohol has equally remained good with the Numbers in Treatment slightly increasing to maintain the upward trend while equally achieving stability in the Successful Treatment Completion rate at 47.49%. This is 5.59% above the London average and 8.39% above the National average.

While this performance is excellent it is important to note that the estimated dependent drinkers in Enfield are 3,648; equating to a penetration rate of 9.82%. Coupled with the recently announced 16.1% reduction in the PHE Grant the challenges to the DAAT Board remain considerable.

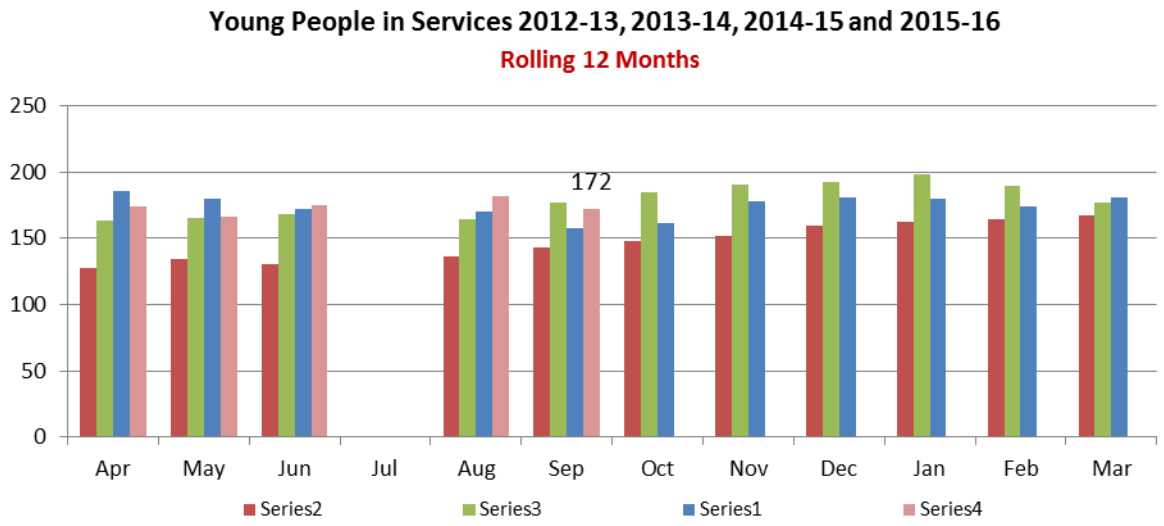
The Numbers of alcohol users in Treatment and the Successful Treatment Completion rate for Enfield DAAT is summarised in Fig. 2 below:-

Fig. 2: Enfield - Alcohol

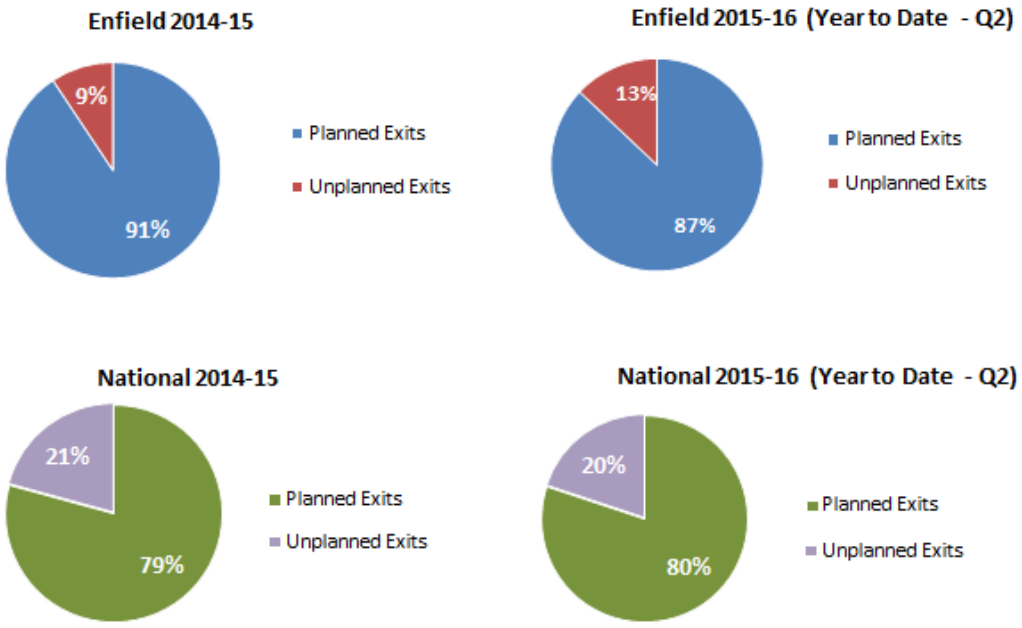
Partnership	Apr 2014 to Mar 2015 Baseline	Oct-14 to Sep-15	Nov-14 to Oct-15	Dec-14 to Nov-15	Apr 2015 to Mar 2016 Target
Number of Successful Completions	113	160	169	170	**122**
Numbers in Treatment	326	354	356	358	**326**
% Successful Completions	**34.7%**	**45.20%**	**47.50%**	**47.49%**	**37.4%**
% London Average	39.3%	**41.30%**	**41.80%**	**41.90%**	
% National Average	39.2%	**39.10%**	**39.10%**	**39.10%**	

7.5.3 Number of Young People in Substance Misuse Treatment

The most recent PHE Q2 ratified performance for young people has confirmed that 172 young people received substance misuse treatment for the 12 month period to September 2015. This performance is relatively consistent with the previous year's data and remains good compared to the level of investment afforded to the young people's substance misuse provision. The Numbers of Young People in Treatment and the Planned Treatment Exit Rate for Enfield DAAT is summarised in Fig. 3 below:-



7.5.4 Planned Treatment Exit Rates Young People's Drug and Alcohol



7.5.5 During the 2015/16 Q2 period NDTMS has confirmed that Enfield has slightly witnessed a decrease in performance for Young People leaving treatment in a Planned Way as the performance is now at 87%. However, this is still 7% above the National average and it needs to be born in mind that any change in this measure is influenced due to the low numbers involved.

7.5.6 Substance Misuse Crime Reduction Recovery Performance

There are three revised targets under the amended 2015/16 MOPAC Grant Agreement which are as follows:-

- The key target is the Percentage of Offenders with Reduced Offending and Q3 is showing that Enfield has achieved 31% against a minimum target of 20%;

- The target for Successful Treatment Completions has to be above the London average of 19.6% and Enfield is currently achieving 33.7%, 14.1% over the minimum target;

- The target for Numbers in Treatment was based upon the 2013/14 Baseline of 149 with a 40% minimum growth factored in to equal 208. Enfield is currently achieving 323 for the latest 12 month rolling period.

- It was agreed that Enfield would continue to report on the Total Number of Convictions and maintain an ambition to ensure these did not exceed the 2013/14 Baseline. Q3 progress is positive and indicating that Enfield is forecasting to remain below the end of year target of 221; with 104 Convictions YTD against a risk failure target of >166 for the period in question (e.g. 166 is ¾ of 221).

Fig 4. Enfield MOPAC Q3 Re-offending Report 2015-16

MOPAC Re-Offending Cohort: 42	2013-2014 BASELINE				2015-2016 CURRENT					
Period	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	YtD	TARGET
Total Number of Convictions	62	33	75	51	21	48	35		104	<221
Cumulative Number of Convictions	62	95	170	221	21	69	104		104	<166
Clients with Increased Conviction Rate YTD	N/A	N/A	N/A	N/A	6	12	8		8	N/A
Clients with Static Conviction Rate YTD	N/A	N/A	N/A	N/A	17	19	21		21	N/A
Clients with Decreased Conviction Rate YTD	N/A	N/A	N/A	N/A	19	11	13		13	>8
IMPROVED MOPAC TARGET % of Cohort Achieving Reduced Offending Behaviour	N/A	N/A	N/A	N/A	45.2%	26.2%	31%		31%	>20%
DIP NDTMS Successful Completions 12 Month Rolling	N/A	N/A	N/A	N/A	28.3%	35.1%	33.7%	-	33.7%	>19.6%
DIP NDTMS In Treatment Drug/Alcohol 12 Month Rolling	N/A	N/A	N/A	N/A	329	319	323	-	323	>208

7. REPROVISION PROJECT

Building works continue on the build of a new 70 bed care home on the former Elizabeth House site in eastern Enfield. Morgan Sindall are now in week 25 of the build programme; steel frame has been erected to first floor level and internal drainage to the new building has commenced. Communication and engagement is ongoing with all external stakeholders including local schools and also the Old Enfield Charitable Trust.

The tender process for care provision is scheduled to go live during week commencing 25th January 2016 with the market being regularly alerted and updated to engage with this opportunity. The service model takes account of input from health and social care professionals and users and carers, with the latter being invited to participate in evaluation of tenderers bids.

Further updates on progress of the tender will be provided in future reports.

9. VOLUNTARY & COMMUNITY SECTOR STRATEGIC COMMISSIONING FRAMEWORK (VCSSCF)

Further to the update provided in the last report ;

- Following the issue of notice to organisations in receipt of core funding, commissioners have been meeting with affected organisations to offer support during the transition period.

- This support has included :
  - the facilitation of potential partnership working with other groups providing similar activity and services;
  - support to develop recovery and business plans, capacity building and support with funding applications.

  The offer of ongoing support remains.

- The prevention workshops described in the previous report are scheduled to be held during January 2016. Following these workshops a suggested list of priority areas of activity will be reviewed and a commissioning and procurement programme developed and initiated.

- Officers will be exploring opportunities with the VCS for it to complement and enhance the Council's support planning and brokerage offer to Enfield residents.

- A market engagement event will be held in the coming weeks to share the Council's vision and key requirements and to seek input and feedback from the VCS on it.

10. SAFEGUARDING

10.1 Quality Checkers Programme

10.1.1 Social Isolation

There is considerable evidence which links both social isolation and perceived loneliness to a number of risk factors, including risk to wellbeing, mental health and vulnerability to abuse. A project has been commenced with aims to provide android tables and enable internet access for adults who are social isolated. In this respect, social isolation refers to adults over 18 years of age who have less than one contact per week. This contact would exclude paid care workers or professional visits. This scheme is expected to be with trialled with twenty individuals across all client groups (learning disabilities, mental health, older people and carers). This will allow the scheme to be tailored while in action and in production from those whom would use the service. This would enable resources and funding streams to be explored with evidence of a project that has tangible benefits for socially isolated individuals.

10.1.2 Activities in Care Homes Project

The Quality Checker Project are embarking on a piece of work to establish the quality of activities in Care Homes across the borough. With the support and direction of the Quality Improvement Board the Quality Checkers will be visiting twenty residential care homes across the borough to collect feedback from residents, their families and friends and the care home staff and managers. In addition to this the Quality Checker volunteers will be taking part in activities and observing activity sessions and the daily routines followed in the care home setting. The Quality Checker volunteers involved in the project will receive some 'feelings based ' training from an activity therapist to ensure they have a good understanding of the therapeutic benefits meaningful activities provide to people

with a wide range of needs. The project will collate the feedback and information into a report to identify and share good practices, and produce a resource for care homes to use to promote wellbeing to their residents by developing and providing meaningful activities. This project aims to engage with care homes across the borough to drive service improvements and developments to maximise care home residents experience. A focus of the project is to highlight the need for activities to be person centred and meet the changing needs of people with dementia and complex communication issues.

10.1.3 Review of London Borough of Enfield's Complaints Process

The Dignity in Care Panel are working with the LBE complaints team to gather customer feedback on their experience of the complaints process. Previous attempts to gather this feedback revealed customers were reluctant to be visited in their homes to meet with a Quality Checker face to face. In consideration of this the Quality Checker volunteers will be offering customers who have made complaints within a 12 month period the opportunity to give feedback via their choice of engagement. This includes attending a focus group at a popular community venue, via a telephone conversation or via email correspondence. In addition to this the Quality Checker volunteers will be collecting feedback from a further twenty social care customers regarding their awareness and knowledge of how to make a complaint. This exercise will assist the council to understand if social care customers are confident enough to make a formal complaint and the support mechanisms they may require should they need to make a complaint in the future.

10.2 **Safeguarding Information Panel**

The multi-agency Safeguarding Information Panel continues to meet regularly and supports the safeguarding of vulnerable adults by collecting and analysing safeguarding alert levels and soft intelligence to identify failing social care providers. Once identified these providers are supported through the Provider Concerns process to make required improvements and extensive monitoring to ensure improvements are sustained. The panel is now working with the Care Home Assessment Team and community health partners to raise awareness of the work of the panel and of the SIP referral form which allows soft intelligence information to be borough to the attention of the panel.

10.3 **The Adult Multi-Agency Safeguarding Hub (MASH)**

10.3.1 **Staffing -** MASH is currently fully staffed with six social work posts with two recently recruited permanent social workers due to take up posts by the end of January 2016.

10.3.2 Referrals **-** Between 20th April 15 and 22nd January 16, the MASH received 2331 referrals averaging between 270 and 300 per month. A table showing the distribution of referrals is shown below.

Initial delays with police and London Ambulance risk assessments and batched deliveries of these referrals have been resolved but continue to be reviewed.

MASH Referral	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Sum:
CQC					2			1	2	1	6
London Ambulance Service	9	29	37	43	25	27	34	25	27	14	270
NHS 111	4	7	3	6	3	5	7	4	4	2	45
Other	6	12	2		2	6	7	29	10	10	84
Police (Risk Assessment / Merlin)	54	48	194	138	122	164	122	128	140	94	1204
Safeguarding	13	58	62	96	73	78	99	74	90	79	722
TOTAL	86	154	298	283	227	280	269	261	273	200	2331

10.3.3 Statistics **–** A full suite of performance and activity measures has been agreed and electronic forms developed to support the MASH and its information and reporting requirements. There have been some delays in embedding this due to system access and reporting issues. These have now been resolved and a full suite of performance and activity information is available to the mash manager and staff.

10.3.4 Partner Agencies **–** inter-agency work is generally working well. Where there are issues with response times, this continues to be monitored. Police attendance at strategy meetings has improved but MASH staff are still having to ring 101 to share information with police – this was the case at the time of the last update and is still the case. Where there are more complex cases these are discussed directly with named individual officers.

10.3.5 Technology **-** There is limited access to RIO (Mental Health Client information system) for business support staff but not for professionals with in the MASH. The matter has been escalated again to the Council's IT support company SERCO and the Mental Health Trust.

11. CARERS

11.1 The Care Act and Carers Assessments

Work has been ongoing to delegate authority for standalone Carers Assessments to Enfield Carers Centre. Enfield Carers Centre will undertake a one year pilot project to undertake standalone Carers Assessments and have employed two members of staff to undertake these. This contract began on the 1st December 2015. The newly appointment Officers have now undergone all their training and shadowing and starting undertaking assessment in January 2016. To date they have undertaken over 30 assessments. Monthly monitoring meetings have been arranged to look at the arrangements, the impact on carers and how to ensure the pilot is a success.

11.2 Young Carers and Transition

Joint work between Adults and Children's Services has been ongoing in terms of the Children and Families Act and the new duties to Young carers and transition. The contract for the young carers' service delivery has just been awarded to DAZU following a tender exercise.

Work continued to develop a pathway for young carers in transition and the look at options in terms of young carers' assessments.

11.3 **The Employee Carers' Support Scheme**

An awareness session was held in November 2105 for staff to find out more about the Equalities Groups. Discussions have been held between all Chairs of the respective equalities groups to look at how we can improve attendance and impact of the groups.

The Carers Action Group meetings dates have been set for 2016 and circulated.

11.4 **Carers Week (6 to 12 June)**

Carers Week will take place in the week beginning 6th June this year. A planning meeting with Enfield Carers Centre has been set up for early February. The theme this year is 'Creating Carer Friendly Communities'.

11.5 **Enfield Carers Centre**

Statistics are from Quarter 3 – September to December 2015

The Centre now has 4352 carers on the Carers Register (an increase of 825 from this previous year's quarter). In addition, 960 carers hold a Carers Emergency Card. In the September-December 2015 quarter the Centre registered 247 new carers.

The Carers Centre respite programme has allowed 228 carers to receive a break between September – December.

In the Sept-Dec quarter, 74 carers received benefits advice from the ECC Benefits Advisor. This has highlighted the real need for benefit advice specifically for carers and is an excellent addition to the range of support the Centre provides.

The Hospital Liaison Worker continues to work on the wards at North Middlesex, Chase Farm and Barnet Hospital. Leaflets and posters are distributed and supplies kept topped up throughout all hospitals. Barnet Hospital has also a permanent pop up banner advertising Enfield Carers Centre near the lifts next to the outpatients department. In the quarter of September-December 2015 the Hospital Worker identified 67 new carers.

The Advocacy Worker has been taking up cases and has continued to promote the services within the VCS and with practitioners. In this quarter they provided support to 65 carers.

The newly established Transition project for young carers and young adult carers is running well, although funding is currently being sought to continue this work. In this quarter of operation the Young Adult Carer Project has identified 26 young adult carers.

The Centre's training programme has seen 220 carers attend a training sessions over this quarter. A further 21 carers have received one to one counselling during this period.

12. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

12.1 Safeguarding Adults Board (SAB)

The Safeguarding Adults Board held a half day business meeting in December 2015. Performance data was reviewed and it was noted that there had been a significant reduction in initial alerts (31.25%) with referrals decreasing across all teams. Multiple abuse and neglect continue to be reported most often, with abuse happening predominantly in people's own home and in care homes. It was noted that we have now added ethnicity of the adult at risk to our reporting, which has highlighted that majority of alerts are for white British and not representative of the demographics in Enfield. It was positive to note that 84% had a nominated advocate involved.

The Board used the opportunity of the away day to consider changes for safeguarding adults and the Board in light of the Care Act. In particular the Board considered the issues around Board duties and discretions and that the Board is indeed challengeable, in legal terms, due to the statutory functions. Further co-operation and information governance was considered and how the guidance set out in the Care Act can improve outcomes for adults at risk through information sharing and partnership work.

The Board received a presentation on the outcome of a Safeguarding Adults Review by an independent author following the death of an adult at risk. The key learning point for partners was the need to have a single point co-ordinating care and support for vulnerable adults. Following the presentation of this review the Board considered a revised Safeguarding Adults Review Protocol and referral form, both of which were agreed.

The sub groups which support the Safeguarding Adults Board were reviewed; partners were asked to consider if we could make efficiencies or reduce duplication in areas. It was confirmed that since November 2015 the Learning & Development group was operating jointly with the equivalent group from the Safeguarding Children Board. As a result of these discussions partners agreed that Quality, Performance and Safety sub group to continue with a review of its terms of reference and action plan for the coming financial year. The Policy Procedure and Practice sub group would cease to function, as work undertaken in this could be considered as part of the existing Best Practice Forum facilitated by LBE. The Safeguarding Adults & Safeguarding Children sub-group was recommended for closure, as all actions undertaken as part of this group were already managed in existing forums or working groups and seen as a duplication. Finally, the Service User, Carer and Patient sub group would continue but with a review of resources and assurance that this would be utilised more fully across the partnership.

Since the December Board meeting there has been two further requests for a Safeguarding Adult Review. Both of these have been agreed as meeting the criteria and are being progressed.

12.2 Carers Partnership Board

The Carers Partnership Board met on the 20th January and a number of issues were discussed.

The Terms of reference for the Board was refreshed and membership revised and updated. The Board is keen to recruit more Carer representatives for 2016 and recruitment will begin shortly.

A number of issues of particular interest were raised at the meeting, notably improvements required in terms of hospital discharge, finding appropriate residential and nursing care and how to reach and identify hidden carers particularly within the minority ethnic communities in Enfield.

The next meeting will be the away day where a work plan for 2016/7 will be produced.

12.3 Sexual Health Partnership Board

Terminations - The CCG reported that the central booking service for termination of pregnancies is now operational and the pathway to the Integrated Sexual Health Community Service will be improved for under 18s including working with School Nurses and healthy School Advisors.

CCG Communications will ensure that the link to LBE website is used.

Needs Assessments -
A Contraceptive Needs Assessment has been requested. Public Health has agreed to commence work in April 2016.

Public Health will commence a HIV Assessment in early 2016.

HIV - There has been a borough-wide HIV Health Promotion campaign to coincide with World Aids Day and HIV Testing Week. As part of the national campaign LBE had an opportunity to be involved in the home testing kit, however, Enfield decided not to take part in the purchase of additional test kits because the council would be required to pay for kits regardless if they were returned to the laboratory or not.

FGM - Public Health facilitated some awareness training for social workers and there were FGM presentations at White Ribbon Day last month.

Young people at risk / known to social care / existing safeguarding concerns -
A new CPIS (Child Protection Information System) is being developed and has been implemented at NMUH A&E. It was not clear whether this would be rolled out to other services such as sexual health.

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE
Health and Wellbeing Board
11 February 2016

Agenda - Part: 1	**Item: 5c**
Subject: Primary Care Update **Wards: All**	
Cabinet Member consulted:	
Approved by:	

Dr Mo Abedi, Chair
NHS Enfield CCG
Contact officer and telephone number:
E mail:
Jenny.Mazarelo@enfieldccg.nhs.uk
Tel: 020-3688-2156

1. EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board on Primary Care matters across the borough of Enfield, in particular:

- The Enfield Patient Offer
- Quality and Outcomes Framework Achievement 2014/15

2. RECOMMENDATIONS

The Enfield Health and Wellbeing Board is asked to note the contents of this report

3. ENFIELD PRIMARY CARE TRANSFORMATION PROGRAMME 2015/16

Patient Offer

At its last meeting, comments and feedback were sought from the Health and Wellbeing Board about the development of a CCG transformation framework and patient offer. Following consultation with a range of stakeholders, the four priority areas identified for implementation, subject to funding and business case approval by the Finance Committee, in respect of the patient offer (Appendix 1) are:

- Patients with Atrial Fibrillation, diabetes and CVD (CHD, Stroke, and Heart Failure) will receive a more co-ordinated multidisciplinary approach to their care where the philosophy of right care, right place and right time is emphasised.
- Primary Care Estates
- Primary Care Workforce Development
- Optimisation and Exploitation of Clinical IT Systems

Quality and Outcomes Framework 2014/15

The Quality and Outcomes Framework (QOF) was introduced as part of the new General Medical Services contractual arrangements on 1st April 2004 and rewards GP Practices for the provision of quality care and helps standardise improvements in the delivery of primary medical services. QOF gives an indication of the overall achievement of a GP Practice through a points system. Practices aim to deliver high quality care across a range of areas for which they score points.

In 2014/15, QOF measured practice achievement against 81 indicators:

- Clinical domain: sixty-nine indicators across 19 clinical areas (e.g. chronic kidney disease, heart failure, hypertension) worth up to a maximum of 435 points;
- Public Health domain: seven indicators across four clinical areas – blood pressure, cardiovascular disease – primary prevention, obesity 16+ and smoking 15+ worth up to 97 points;
- Public Health – additional services domain: five indicators across two service areas – cervical screening and contraception worth up to 27 points.

Enfield's rankings for 2014/15 reflect a significant improvement to 183rd of 206 CCGs (in 2013/14, Enfield ranked 207th of 211 CCGs) and in terms of our CCG peers (those with similar patient demographics) resulted in better outcomes than Greenwich, Thurrock, Haringey and Luton.

In terms of clinical outcomes, twenty practices (40%) scored above the national average for achievement of the clinical domain results. In terms of total achievement, twenty-four practices (51%) achieved or surpassed the national average overall. Regrettably, six practices (12%) scored between 15-25% below the national average.

As the CCG has a statutory duty to improve the quality of primary care, performance has been used to identify support to those practices that clearly have not been able to deliver the level of quality outcomes the CCG aspires to every patient receiving. The Primary Care Team has developed a search and reporting tool to enable the CCG to retrieve live QOF data from general practice. This solution will enable the CCG to track progress and performance of QOF per practice and identify opportunities to support practices to deliver enhanced clinical outcomes for patients.

In 2014/15, QOF performance has been the most successful since the CCG was established in April 2013 and demonstrates significant improvement. This is of particular note as Enfield has the lowest healthcare expenditure as well as the lowest number of potential years of life lost than their North Central London peers.

4. CONCLUSION

This report provides an update on Primary Care matters in Enfield.

TRANSFORMING PRIMARY CARE IN ENFIELD – TOP FOUR PATIENT OFFER PRIORITIES 2016-2017

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
LOCALITY COMMISSIONING DEVELOPMENT									
1	Patients with Atrial Fibrillation, diabetes and CVD (CHD, Stroke, and Heart Failure) will receive a more co-ordinated multidisciplinary approach to their care where the philosophy of right care, right place and right time is emphasised.	Programme Manager – Service Transformation	• **PD39 – PD44: £400K** subject to business case approval	**PD39** - Identify new patients with AF by pulse check **PD40** - Record more new patients with AF and Heart Failure in general practice via screening tools e.g. APL or GRASP tools **PD41** - Refer newly-	**LD25** - Locality Leads/locality managers to support practices to deliver high quality care of patients with AF, diabetes and CVD	**ND17** - Provider Networks should support their member practices to deliver the necessary outcome based care for patients with AF, diabetes and CVD	**CD41** - The AF, diabetes and CVD patient pathways will be streamlined to ensure a more effective and co-ordinated approach between primary, community and the hospital based care **CD42** - Ensure IT clinical information system e.g.	**LAD15** - Improve wider determinants of Health in Enfield **LAD16** - Reduce health inequalities in the five priority wards in Enfield **LAD17** - Promote joined up approach to health and social care	**NHSE15** - Contribution to deliver the national outcome domains **NHSE16** - Contribution to deliver the CCG operational standards

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
	Transforming Primary Care in London Patient Offer - C1-C5: Co-ordinated care			recorded AF/HF patients in a timely manner to the appropriate services. **PD42** - Patients with AF will be given the choice of appropriate treatment as per NICE/CCG clinical guidelines e.g. anticoagulation **PD43** - Patients with HF will			EMIS supports practices to extract patient information for informing better clinical improvement in care and for data reporting purposes **CD43** - To deliver an improvement in clinical outcomes: reduction of stroke and reduction of emergency admissions in patients with CVD **CD44** - To	agenda for patients with long term conditions. **LAD18** - Promote, support and design self-care/self-management/prevention programmes.	

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
				be reviewed and have their medication optimised as per NICE/CCG clinical guidelines e.g. ACEi/ Beta blockers **PD44** - Improvement of QoF in AF, hypertension, Heart Failure, stroke and diabetes across Enfield			deliver an improvement in patient experience e.g. friends and family test, patient experience questionnaire **CD45** - To implement full migration to a single integrated GP IT clinical system to support data reporting process (including important QOF indicators, immunisation and NHS Healthcheck)		

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
							and data analysis		
PRIMARY CARE DEVELOPMENT									
2	Primary Care Estates **Transforming Primary Care in London Enabler**	Programme Manager – Primary Care Estates	▪ **PD20 - £500,000** in on-going revenue consequences in respect of approved Primary Care Infrastructure ▪ **PD21 -** CCG Funded Programme Manager – Primary Care Estates ▪ **CD26 - £837,000**	**PD20 -** Provide safe and suitable of premises that people receive care in, work in, or visit safe surroundings that promote their wellbeing this needs re-writing slightly but should include promoting active transport	**LD06 -** Contribute to the development and production of the Strategic Estates Plan (SEP) **LD07 -** Promoting system transformation, new models of care and support commissioning and integration	**ND04 -** Work with practices, other providers and the CCG to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice. **ND05 -** Business	**CD19 -** CCG will ensure commissioning and delivery of such services will take place in viable, "fit for purpose" premises **CD20 -** CCG will wherever possible and where circumstances allow, ensure that the delivery of high	**LAD05 -** To support and work with CGG and local GPs and other providers to enable the development of new premises that meet the health and social care needs of local population and accessible to all.	**NHSE08 -** Robust management of GP contract compliance **NHSE09 -** To manage the Primary Care Transformation Fund (PCTF) process efficiently and in a timely manner that supports the implementation of the SEP and new

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
				(walking / cycling) **PD21 -** Support Practices in developing their premises to enable CQC, Infection Control and DDA compliance. **PD22 -** All practices to prepare and provide an access statement in support that their	within the SEP. **LD08 -** Pledging to working collectively with practices and patient groups to provide services from clean and safe environments that are fit for purpose based on and the current regulatory requirements to ensure " service	case proposals should demonstrate they will enable new service models to be delivered **ND06 -** All newly approved space should be available for use as a minimum of 84 hours per week and ideally 7 days a week to primary and community	quality care will be delivered from available, accessible safe, CQC and H&S compliant environments. **CD21 -** Strategic Estate plan to reflect the need and demand for local care hubs, including where appropriate, new developments that enable	**LAD06 -** To support and work with CCG and local GPs and other providers to ensure that the PC estate supports and promotes healthy lifestyles	developments and improvements to premises. **NHSE10 -** Priority will be given to business cases where the premises for delivering services are more than 50% over-utilised or where suitability (condition and function) is not to an appropriate standard

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
				premises comply with the Equality & Diversity Act 2010.	users" are protected against risks associated with unsafe and unsuitable premises **LD09 -** Practice staff model health behaviours asked of residents	contractors.	complete delivery of the Patient Offer. **CD22 -** Use the estate as an enabler to improve accessibility and reach of services. **CD23 -** Priority will be given to business cases where the premises for delivering services are more than 50% over-utilised or where suitability (condition and function)		

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
							is not to an appropriate standard. **CD24 -** SMART objectives will be agreed with practices linking funding approval to the realisation of intended benefits **CD25 -** Wherever possible estates will be used to support active transport (walking and		

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
							cycling) **CD26 –** Digitisation of patient records (support the emerging agenda and outcomes of Enfield's Estates Strategy, SEP, QIPP and community and social health plans, as well as the Personalised health and care 2020, IT Integration and paperless at the point of care (IT		

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
							agendas), by repurposing file storage into clinical and non-clinical space).		
3	**Primary Care Workforce Development** **Transforming Primary Care in London Enabler**	Head of Primary Care	▪ **PD17 and PD18 – cost to practice as a regulated service** ▪ **PD19 - TBC**	**PD17** - Offering time and commitment to primary care staff to complete mandatory training and continuing professional development to meet CQC and revalidation requirements	**LD05** - Deploying primary care staff with skills that can be utilised across localities, accessible to all patients within the area;	**ND03** - Developing a range of skilled primary care staff to deliver high quality, primary care based services to local patents;	**CD17** - Working with new initiatives, such as CEPN GP nurses, to recruit and retain a better range of primary care staff within the borough **CD18** - Supporting the	**LAD02** - Supporting initiatives to develop staffing within, and allied to, primary care within Enfield; **LAD03** - Supporting staff to ensure that residents make use of Borough	**NHSE07** - To support the improvement of the primary care workforce within Enfield;

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
				PD18 - Offering time and commitment to develop additional primary care staff to provide improved services to patients. **PD19** - Participating in workforce and skill mix initiatives to offer new models of care			improvement of primary care outcomes that matters to population health	assets to improve their health. **LAD04** - To support the CCG in facilitating primary care outcomes including long-term conditions management in primary care	
4	**IT Delivery - Patient Online Programme**	Primary Care Development Manager	**PD01 & 02 -** Implementation of Patient Online	**PD01** - All practices to provide a minimum of	**LD 01** - Contribute to delivery at scale	**ND01** - Share knowledge and	**CD01** - Supporting the uptake and	**LAD01** - To supply with referral details (e.g.,	**NHSE01** - Produce a dashboard scoring

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
	IT - improved access to online booking, repeat prescribing and of viewing medical records **Transforming Primary Care in London Patient Offer - A2: Contacting the practice**		Programme is a contractual requirement. However proposed use of tech may be offered as part of PMS contract review negotiations. **(@ £1 per weighted patient – only for PMS practices).** **PD03** - **£100,000 per annum** for iPlato – if funding is not secured, costs will need to be met by	50% of total practice registered population have online accounts. **PD02** - All practices to provide a minimum of 50% of total practice bookable slots are made available online. **PD03** - All practices to register mobile phones and use iPlato (SMS text	**LD 02** - Exchange information – work collaboratively to refine, develop and trial new ideas to increase and enhance patient online features	experiences (bi-directional ebb and flow) to ensure any emerging experiences and good practices are cascaded to a wider audience. Is this not happening now through PLTs etc.? If not what needs to change so that it does?	utilisation of patient online access services **CD02** - Raise the profile of online access to patients and key stakeholders to improve awareness and interest **CD03** - Celebrate successes	forms, pathway and contact details) for GP IT systems to facilitate referrals to lifestyle interventions	individual, borough and regional utilisation **NHSE02** - Develop national metrics for assessing optimum baselines **NHSE03** - Identify exemplar practices nationally and cascade learning.

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
			practices. This is likely to result in a backward step in utilising SMS technology, potentially increasing DNA rates and undermine the functionality embedded in the last three years and funded by NHS England. **CD 01, 02 & 03 £10,000 for Comms and Engagement**	messaging) for communicating with patients **PD04** - All practices to work collaboratively with their PPGs to cultivate and 'polish' online access to best fit the expectations of their patient population					

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
	IT Delivery - Patient record (view only) – patient can expect clinicians across the local primary care health economy (GP Practice to GP Practice interoperability) to have access to a subsection of their patient records. **Transforming Primary Care in London**	Primary Care Development Manager	**CD04** - EMIS Web Clinical Service **£115,000** initial start-up/ setup costs. **CD04** - Docman Vault **£55,000** initial start-up/ setup costs.	**PD05** - Champion and actively promote the benefits of sharing patient level information. **PD06** - Ensure patients have an option to opt out where this is the patient's individual choice. **PD07** - GPs to determine what information			**CD04** - Co-develop the system architecture solution to enable sharing of patient records throughout the local primary care health economy. **CD05** - Co-develop the data sharing agreement that underpins the information that will be available to access.		

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
	Patient Offer – A1 Patient Choice of Access and A2: Contacting the Practice			is stored on line about vulnerable patients (redacted / no access) **PD08** - Signup to the data sharing agreements **PD09** - Ensure all patient correspondence and relevant information is recorded and accepted to the patient record within 48			**CD06** - Ensure the safe and effective delivery **CD07** - Work collaboratively with the remaining NCL CCGs to develop programmes that meets the 5 year forward view and Personalised Heath and Care 2020 agendas.		

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
				hours. **PD10** - Comply with all Information Governance policies and duties.					
	IT Development - Patients will be required to only make one call, click or contact in order to make an appointment. Primary care teams will maximise the use of	Primary Care Development Manager	**CD14 & PD13** - Enfield Global Library - **£15,000** **CD11** - Docman 'Health Checks' **£30,000** **CD09** - EMIS Additional Training **£15,000**	**PD11** - Practices actively participate in training and learning opportunities **PD12** - Implement and use the IT solutions available to facilitate	**LD03** - Identify Information Management and Technology (IM&T) opportunities and communicate these to the relevant commissioning leads. **LD04** -	**ND02** - Promote and champion the use of IT solutions.	**CD08** - Purchase IT solutions that support the exploitation and optimisation agenda of Primary Care IM&T **CD09** - To put on a range of EMIS training aligned to training needs		**NHSE04** - GPSoC Framework **NHSE05** – training support for national programmes **NHSE06** – development of national performance metrics

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
	technology and actively promote online services to patients including appointment booking, prescription ordering, putting alerts for important interventions such as (abuse of antibiotics, proactive management of long-term conditions) viewing medical records and email		**CD10 & CD13** - EMIS Enterprise **£55,000** **CD15** - E-Consult (email consultations) £0.63p + VAT per registered population (**£249,480** per annum) **CD16** - **£120,000**	appointment booking, prescription ordering, viewing medical records and email consultations. **PD13** - Implement and utilise the Enfield Global Library. **PD14** - Create or use EDT Docman email accounts as the practice generic	Standardising clinical coding		identified from membership feedback **CD10** - Develop EMIS Enterprise to support practices improve quality outcomes. **CD11** - Work collaboratively with practices to ensure optimal exploitation of Docman **CD12** - Co-author with service delivery partners the		

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
	consultations. **Transforming Primary Care in London Patient Offer – A2: Contacting the practice**			email account. **PD15** - Signup to and comply with the new CCG practice-agreement **PD16** - Improve performance of: - EPS - SCR - GP2GP			CCG Practice agreement offer. **CD13** - Support practices maximise QoF attainment via business intelligence. **CD14** – Continual development of EMIS global library **CD15** – purchase of an email consultation product. **CD16** – procurement of a free 'Wi-		

Priority	Patient Offer	Principle Lead	Funding Requirements	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
							Fi zone' for practice staff and the public		