Public Document Pack

HEALTH AND WELLBEING BOARD

Tuesday, 14 April 2015 at 6.30 pm
Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

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MEMBERSHIP

Leader of the Council – Councillor Doug Taylor
Cabinet Member for Health and Adult Social Care – Councillor Donald McGowan (Chair)
Cabinet Member for Education, Children's Services and Protection – Councillor Ayfer Orhan
Vacancy
Chair of the Local Clinical Commissioning Group – Dr Mo Abedi
Healthwatch Representative – Deborah Fowler
Clinical Commissioning Group (CCG) Chief Officer - Liz Wise
NHS England Representative – Dr Henrietta Hughes
Director of Public Health – Dr Shahed Ahmad
Director of Health, Housing and Adult Social Care – Ray James
Director of Schools and Children's Services – Andrew Fraser
Director of Environment – Ian Davis
Voluntary Sector Representatives: Vivien Giladi, Litsa Worrall (Deputy)

Non-Voting Members

Royal Free London NHS Trust – Kim Fleming
North Middlesex University Hospital NHS Trust – Julie Lowe
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright

AGENDA – PART 1

1. WELCOME AND APOLOGIES

2. DECLARATION OF INTERESTS

Members are asked to declare any disclosable pecuniary, other pecuniary or non pecuniary interests relating to items on the agenda.

3. CLINICAL COMMISSIONING GROUP (CCG) OPERATING PLAN 2015/16 - DRAFT SUBMISSION (6:35-6:50PM) (Pages 1 - 68)

To receive a report on the draft submission of the Clinical Commissioning Group (CCG) Operating Plan 2015/16.

4. PHARMACEUTICAL NEEDS ASSESSMENT (6:50-7:10PM) (Pages 69 - 306)

To receive a report on the Pharmaceutical Needs Assessment.

5. ADJUSTMENTS TO THE BETTER CARE FUND PLAN REDUCING EMERGENCY ADMISSIONS TARGET (7:10-7:25PM) (Pages 307 - 312)

To receive a report setting out adjustments to the Better Care Fund Plan Reducing Emergency Admissions Target.

The board is asked to approve the recommendation from the Enfield Integration Board and agree Option 1 (a new target admissions reduction of 1,065 admissions based on the existing percentage reduction 3.5% target) as set out in the report.

6. ADULT SAFEGUARDING STRATEGY (7:25-7:45PM) (Pages 313 - 348)

To receive and consider a report on the draft Adult Safeguarding Strategy.

7. SUB BOARD UPDATES (7:45-8:25PM) (Pages 349 - 392)

To receive the following updates from the sub boards:

a. Health Improvement Partnership Board
b. Joint Commissioning Board
c. Improving Primary Care Board
d. Enfield Integration Board

8. MINUTES OF THE MEETING HELD ON 12 FEBRUARY 2015 (8:25-8:30PM) (Pages 393 - 402)

To receive and agree the minutes of the meeting held on 12 February 2015.

9. DATES OF FUTURE MEETINGS

To note that the dates for future meetings will not be agreed until the Annual Council meeting on the 13 May 2015.

10. EXCLUSION OF PRESS AND PUBLIC

If necessary, to consider passing a resolution under Section 100A(4) of the Local Government Act 1972 excluding the press and public from the meeting for any items of business moved to part 2 of the agenda on the grounds that they involve the likely disclosure of exempt information as defined in those paragraphs of Part 1 of Schedule 12A to the Act (as amended by the Local Government (Access to Information) (Variation) Order 2006).

Agenda Item 3

NHS Enfield Clinical Commissioning Group

MEETING TITLE AND DATE	Agenda - Part:1	Item: 3
Health and Wellbeing Board **April 2015.**	**Subject:** NHS Enfield CCG Operating Plan	
	Wards: All	
Report of: Graham MacDougall Director of Strategy and Performance	**Cabinet Member consulted:** H&WBB Development Session	
Contact officer - Richard Young **Telephone number**: 0203 688 2834 **Email**: richard.young@enfieldccg.nhs.uk		

1. EXECUTIVE SUMMARY

NHS England has indicated that each Clinical Commissioning Group (CCG) will be

This paper updates the Health & Wellbeing Board on the progress that has been made with the Operating Plan Refresh process.

The CCG has successfully submitted the Operating Plan Narrative, Finance and Activity Plan and the UNIFY submission is accordance with the guidance. Feedback is awaited from NHS England.

Owing to difficulties agreeing the national tariffs, a new timetable for contracting and planning submissions has been issued.

Attached to this covering report is the draft Operating Plan Narrative document submitted to NHS England on 27th February. The document is put before the Health & Wellbeing Board for comment.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the requirements and progress within the report.

3. BACKGROUND

National Guidance to support the planning process, Everyone Counts, Planning for Patients 2014/15 to 2018/19, was published in December 2013 for the original operating Plan 2014-16. This has been augmented by The Forward view into Action (Dec 2014) and Supplementary Information for Commissioner Planning 2015/16.

4. ALTERNATIVE OPTIONS CONSIDERED

No alternative are appropriate.

5. REASONS FOR RECOMMENDATIONS

There is an expectation that CCG's will work with HWBB's, and specific agreement is required in relation to specific areas.

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

6.1. Financial Implications – There are no direct risks arising directly from this report. However, the Operating Plan and the contracting process will contents will be the subject of risk and performance management.

6.2. Legal Implications - No direct implications from this report.

7. KEY RISKS

There are no direct risks arising directly from this report. However, the Operating Plan and its contents will be the subject of risk and performance management.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

The Operating Plan refresh will actively support the strategy and delivery of the Health & Wellbeing Strategy.

9. EQUALITIES IMPACT IMPLICATIONS

Equality Impact Assessments and Quality Impact Assessments are undertaken routinely as part of each project under the CCG Transformation Programme, and reported to the Transformation Programme Group as part of business as usual. However, the Operating Plan and its contents may require an EIA.

10. BACKGROUND PAPERS

- Operating Plan 2014-16
- NCL SPG Five Year Plan on a Page
- Supplementary Information For Commissioner Planning 2015/16

1. INTRODUCTION

This paper updates the Health & Wellbeing Board on the refresh of NHS Enfield CCG's Operating Plan.

Recent guidance from NHS England has revealed that is now a more substantial exercise than originally indicated.

2. BACKGROUND

NHS England (NHSE), working with Monitor and the NHS Trust Development Authority, produced joint guidance on the 2015/16 NHS planning process for commissioners, NHS Trusts and Foundation. The guidance was published in December 2014, setting out full details of the planning process for 2015/16 with further supplementary guidance published in mid-January.

NHS England indicated that each CCG will be required to undertake a "refresh" of its Operating Plan for 2015/16. Subsequent guidance from NHS England has indicated that the process for 2015/16 is more substantial exercise than originally indicated.

The Operating Plan refresh process is being managed through the CCG Strategic Planning Group (SPG) (chaired by the Director of Strategy & Partnerships), with leads present from each directorate and public health. In addition, ECCG Officers attend fortnightly meetings between NCL CCGs and the CSU to co-ordinate responses (where appropriate) across the wider Strategic Plan work.

There is a further expectation of alignment of plans through a "Triangulation" process involving providers and other commissioning organisations and with Health and Wellbeing Board and Better Care Fund Plans.

This paper updates the Health & Wellbeing Board on the progress that has been made to date and the Draft Submission (27th February) is attached for comment.

3. NHS ENFIELD CCG OPERATING PLAN 2014/15-2015/16

Planning Guidance for 2015/16 was published by NHS England on 19th December 2014, with further supplementary guidance published in mid-January. The full guidance for the 2015/16 planning round can be found on: http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf. The planning timetable is attached as Appendix 1.

In summary the focus for clinical commissioning groups in 2015/16 will be on:

- Quality;
- NHS Constitution commitments;
- Financial sustainability;
- Planning around single-year financial settlement for 2015/16;
- Collaboration and joint leadership as key enablers.

Contents of the guidance include:

- New access standards and waiting time standards for mental health services in support of parity of esteem;
- Requirements for NHS Constitution standards. This reflects a year of questionable performance nationwide, particularly in London;
- Further detail on implications of the *NHS Five Year Forward View;*
- Emerging system changes and new models of care;
- Revised financial planning assumptions, allocations and non-recurrent reserves;
- Revised activity planning assumptions including alignment of commissioner and provider plans will be a top priority and CCGs will need to secure alignment between BCF plans and refresh of CCG operational plans to ensure that these ambitions are fully reflected in activity plans and therefore contract models;
- Strategic enablers.

For 2015/16, CCGs are expected to submit a one year Operating Plan, which consists of two templates plus a narrative document:

i. Finance and activity.
ii. A UNIFY template covering Constitution standards and other requirements.
iii. A full narrative setting out the CCG's approach to achieving the national and local targets.

There is an expectation that CCG's will work with HWBB's, and specific agreement is required in relation to specific areas. The Operating Plan refresh will actively support the strategy and delivery of the Health & Wellbeing Strategy.

4. PROGRESS TO DATE

Substantial work has already been undertaken on reviewing existing Operating Plan trajectories and developing the Five Year Strategic Plan for the 5 NCL CCG's.

This has culminated in the production of the draft Operating Plan (attached) and the initial completed UNIFY template submission – together with the CCG finance and activity plans – all submitted on the 28^{7h} February 2015 in line with the published guidance.

The CCG is awaiting feedback from NHS England which is due later in March.

5. Changes to the National Timetable

In light of the difficulties in agreeing the tariff structure for NHS PbR (Payment by Results) activity, the original timetable has been significantly altered. A copy of the new timetable is attached at appendix 1.

Monitor / TDA are now running to a slightly different timetable. The 7th April deadline represents an extension for providers in submitting their draft operating plans (as Monitor / TDA did not require them to submit full draft plans in February due to delays in resolving the tariff). For CCGs, the 7th April submission deadline for full plans is therefore *earlier* than the 10th April deadline that was originally indicated in the planning timetable.

Plans submitted on 7th April should be based on agreed contracts (signature deadline of 31st March), however. If contracts are not signed by 31st March and plans submitted on 7th April are ***not*** based on ***agreed*** contracts, CCGs need to ensure full plans are submitted plans on 7th April and then a final 'refreshed' version submitted on 14th May.

6. NEXT STEPS:

The CCG is required to submit a 'Full Draft Plan' of the refreshed Operating Plan 2015/16 by 7th April 2015. (This is a different deadline to that previously published – see section 8 above) This plan will need to detail the CCG's approach to achieving the national and local targets and should be based on agreed contracts with providers.

7. RESOURCE IMPLICATIONS:

The resource implications of the operating plan are not yet finalised owing to the on-going contract negotiations. However, all of the implications contained within the draft Operating Plan Narrative are contained within the draft Financial Plan.

8. EQUALITY IMPACT ANALYSIS:

There has been no EQIA on this document. Equality Impact Assessments and Quality Impact Assessments are undertaken routinely as part of each project under the CCG Transformation Programme, and reported to the Transformation Programme Group as part of business as usual.

9. RISKS:

There are no risks directly arising from this document. However, several of the projects contained within the Operating Plan will require further risk assessment if commissioned.

10. PATIENT & PUBLIC INVOLVEMENT (PPI):

There has limited direct PPI on this document. However, once approved the draft Operating Plan will be the subject of extensive engagement and several of the projects contained within the Plan have been engaged upon.

11. RECOMMENDATIONS

The CCG Governing is asked to note the 2015/16 Operating Plan requirements and progress within the report and comment upon the Draft Operating Plan Narrative.

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Appendix 1

Revised Contracting and Planning Submission Timetable

Timetable item (applicable to all bodies unless specifically referenced)	Original timetable	Revised timetable
Contract negotiations	Jan – 11 Mar	Jan – 31 Mar
Weekly contract tracker to be submitted each Thursday	From 29 Jan	From 29 Jan
Submission of draft activity plan data (NHS Trusts, NHS FTs (except distressed NHS FTs))	n/a	27 Feb
Submission of draft finance and activity plan data (CCGs, NHS England and distressed NHS FTs)	n/a	27 Feb
Confirmation by providers of chosen tariff option - ETO or DTR (NHS Trusts and NHS FTs)	n/a	By 6pm on 4 Mar
Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)	13 Feb	20 Mar
National contract stocktake – to check the status of contracts	20 Feb	27 Mar
Contract Signature Deadline	**11 Mar**	**31 Mar**
CCGs Draft plans approved by NHS Trusts and NHS FTs	n/a	By 31 Mar
Post-contract signature deadline: where contracts not signed, local decisions to enter mediation*	By COP 25 Feb	By COP 1 Apr
Submission of full commissioner plans (CCGs, NHS England)** Submission of draft plans (NHS Trusts & NHS FTs)	27 Feb (noon)	7 Apr (noon)
Assurance of most recent plan submissions by national bodies	27 Feb – 30 Mar	7 Apr – 13 May
Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)	6 Mar	14 Apr
Contracts signed post-mediation	11 Mar (by noon)	17 Apr (by noon)
Entry into arbitration where contracts not signed; and submission of Dispute Resolution Process paperwork*	11 Mar (noon)	17 Apr (noon)
Contract arbitration panels and / or hearings*	13 – 24 Mar	20 – 29 Apr
Arbitration outcomes notified to commissioners and providers*	By 25 Mar	By 30 Apr
Plans approved by Boards of NHS Trusts and NHS FTs	By 31 Mar	**By early May**
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties*	By 31 Mar	By 7 May
Submission of final plans (NHS Trusts & NHS FTs) Commissioner plan refresh if required (CCGs and NHS England)**	**10 Apr (noon)**	**14 May (noon)**
Assurance and reconciliation of operational plans	From 10 Apr	From 14 May

NHS Enfield Clinical Commissioning Group

NHS Enfield CCG Operating Plan Refresh 2015-16

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Reader Information

NHS Enfield Clinical Commissioning Group

Document Title	NHS Enfield CCG Operating Plan refresh 2015-16	
Publisher	NHS Enfield Clinical Commissioning Group	
Owner	Claire Wright – Joint Acting Assistant Director of Transformation	
Approved by	Graham MacDougall – Director of Strategy and Partnerships	
Publication Date	10th April 2015	
Expiry Date	31st March 2016	
Overview	The document contains the refresh of the CCG's Operating plan for 2015-16 to support planning and engagement with providers and commissioning partners.	
Information type	Strategy & Planning	Secondary Info type: Finance, Policy & Performance, Communications
Primary Audience(s)	NHS England	Member Practices, CCG Staff, Local Authority, Clinical Staff, Existing & Potential Providers.

Version Control

Version	Author	Changes accepted by	Date	Description of Change
0.1	Richard Young	RBY	Jan 2015	Basic document structure
0.2 – 0.6	Richard Young	RBY	Feb 2015	Inclusion of management leads contributions
0.7	Richard Young	Graham MacDougall	18/02/15	GM amendments
0.8-0.9	Richard Young	Graham MacDougall	23/02/15	PH Update and BCF figures inserted
1.0	RBY / GM	Liz Wise	24/02/15	General Amendments throughout
1.1	RBY / GM / RW	Graham MacDougall	26/02/15	General amendments & PH Revision and draft Finance Plan inserted
1.2	All	Graham MacDougall	27/02/15	'Final' Draft version sent to NHSE 27/02/2015

Enfield CCG Operating Plan

NHS Enfield Clinical Commissioning Group

1.0 Introduction

This document details a substantial refresh of NHS Enfield Clinical Commissioning Group's Operating Plan for 2015-16. It builds on the Plans developed for 2014/15 and 2015/16 submitted in June 2014. The Plans are the product of on-going engagement with our clinical community, stakeholders, including the Health and Wellbeing Board, and represent our current planning and preparation for 2015-16.

They primarily support provider engagement through the planning and contracting round and are a development of our Plans previously set out in 'ECCG Commissioning Intentions 2015/15', Enfield 'Joint Health & Well-Being Strategy' (JHWB) and both our 5-Year strategic vision and the North Central London 5 Year Strategic Plan.

We have a well established Transformation Programme consisting of six individual programmes and a number of cross-impact initiatives. We have reviewed our programmes as part of our financial recovery process and any amended programmes will be geared around supporting our financial recovery. It should be noted that some of our ambition is impacted upon by our financial position.

The CCG recognises the importance of quality in all its work and has embedded processes within the Transformation Programme to ensure that the planned service changes meet the requirements for high quality, safe services: i.e. we have put in place a robust Quality Impact Assessment (QIA) and monitoring process for our Quality, Innovation, Productivity & Performance (QIPP) Transformation programmes.

To support delivery of our key programmes we have a number of cross cutting initiatives including redesign of community services, development of GP federations or networks, development of locality commissioning to better manage demand, Better Care Fund and outcomes based commissioning.

Our Transformation Programme has six programmes supporting the delivery of the CCG Strategic Goals and Corporate Objectives as well as supporting delivery for the key priorities set out in the Joint HWB Strategy.	They are: • Prevention and Primary Care; • Integrated Care ; • Planned Care and Long Term Conditions; • Children, Young People and Maternity; • Mental Health, Learning Disability and Continuing Healthcare; • Unscheduled care.

Enfield CCG Operating Plan

NHS Enfield Clinical Commissioning Group

1.1 Background

Enfield is a financially challenged CCG. It was under its "fair shares" allocation by £33.0m in 2013/14 and £24.0m in 2014/15. In 15/16 the CCG will be £16.4m below target. The plan assumes that the CCG moves to target allocation in 2016/17, in line with latest expectations following the large move towards target in 2015/16.

The CCG broke even in 2013/14 with the aid of £6.3m support via the NCL risk share arrangements.

A recently commissioned benchmarking review demonstrates that CCG acute activity and costs were closely aligned to our peer group. It did however highlight several areas on which we will focus in targeting future savings.

We are part of the North Central London Health Economy. Acute and Mental health providers face significant financial and operational challenges. Primary Care is relatively under developed, with one of the lowest GP to patient ratios in the country.

Enfield CCG continues to have an ambition to significantly move towards our vision for and aims for the local NHS and to deliver on our strategic goals and corporate objectives outlined below. Whilst we have been able to put in place some of the building blocks for change to secure safe, resilient and sustainable systems, we must now begin to accelerate the transformation of services and systematically improve the standards of care and outcomes our population experiences. At the same time our decision making must support our financial recovery

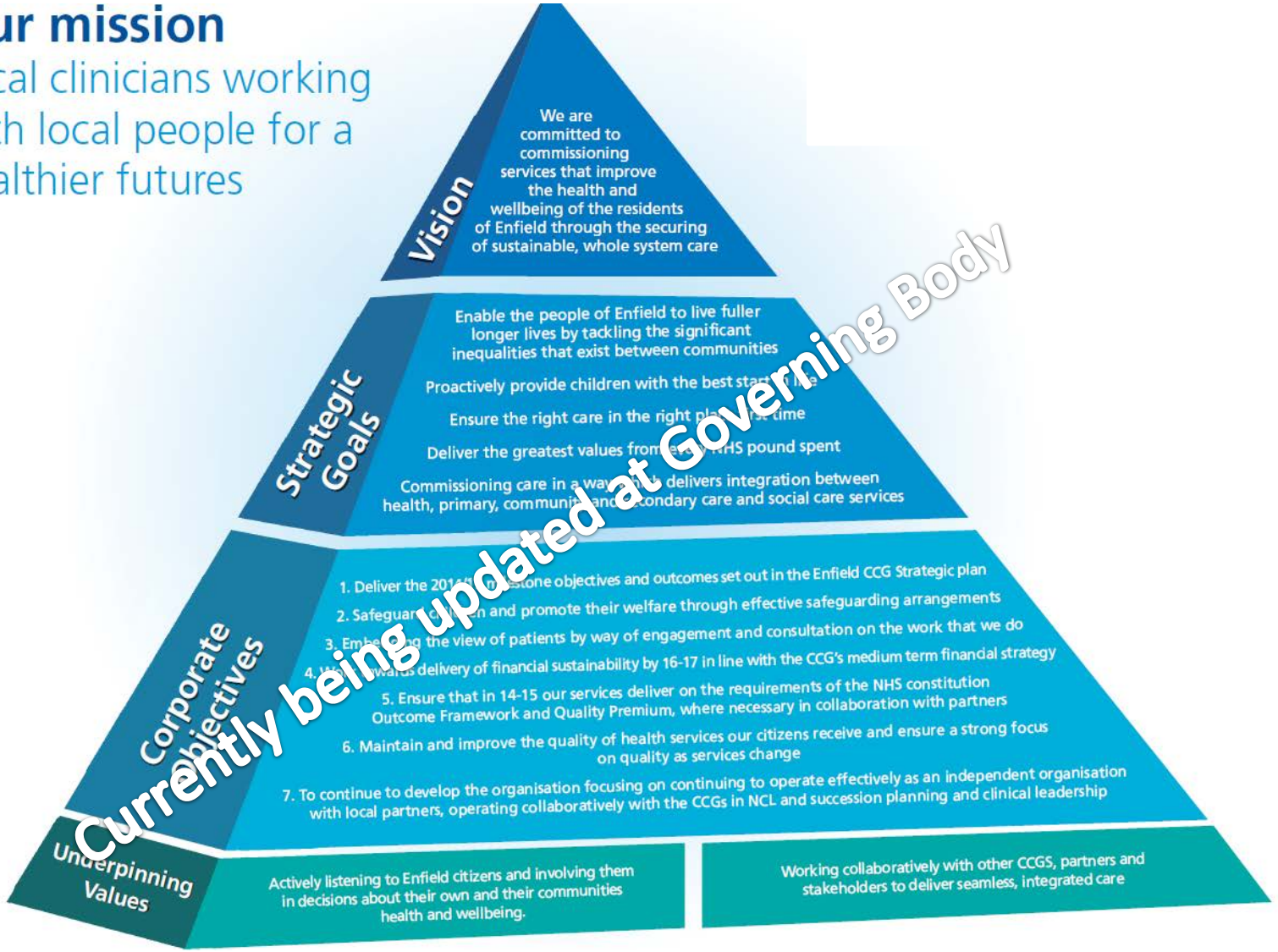
The CCG is committed to serving its population to ensure that the services it commissions meet their needs and provide value for money. We are very conscious that the financial challenge ahead of us remains significant and our focus for change is therefore on transforming services into systems that are able to deliver affordable coordinated, responsive and high quality care.

Enfield CCG

NHS Enfield Clinical Commissioning Group

1.3 Our mission

Local clinicians working with local people for a healthier futures



Corporate Objectives

NHS Enfield Clinical Commissioning Group

1.3	Our Aims
Objective	**Suggested measures of success – this means we will……**
Deliver the Milestone objectives and outcomes set out in the Enfield CCG Strategic Plan	✓ Achieve the measures set out in the Quality Premium both the local and national standards ✓ Deliver on the 15/16 outcomes from the NCL 5 Year Strategy
Deliver the requirements of the NHS Constitution with our partners	✓ Improve performance against the National Constitution measures taking 14/15 as a baseline
Embed the views of patients and citizens in all of our work	✓ Improve ECCG ratings in the MORI survey taking March 2014 results as a baseline ✓ Deliver on the 15/16 objectives within our Communications and Engagement Strategy
Deliver improvements in the quality of local health services	✓ Improve our performance against the Friends & Family Standards taking previous year as a baseline ✓ Deliver improvements in the Mental Health services and achieve the Access & Waiting time standards and deliver specific improvements in IAPT and Dementia standards ✓ Deliver reductions in avoidable emergency attendances and admissions ✓ Deliver on our commitments to invest in and develop our primary care Localities
Deliver effective safeguarding arrangements for those who are vulnerable	✓ Deliver on the health requirements of the Assurance Framework for protecting vulnerable people
Deliver financial sustainability	✓ Deliver on the control total agreed with NHSE ✓ Remain within our maximum cash drawdown limit ✓ Achieve the Better Practice Code target of 95% in 2015/16 ✓ Implement effective transformational and transactional QIPP evidenced by reductions in activity and expenditure
Develop our organisation and ensure effective collaboration with our partners	✓ Deliver on the programmes within the Better Care Fund ✓ Effectively develop the North Central London 5 year Strategy ✓ Implement the key objectives within ECCG Organisational Development Plan ✓ Deliver effective arrangements for co-commissioning of primary care

Collaborative Commissioning

NHS Enfield Clinical Commissioning Group

1.4 North Central London Health Economy

The issues that our local NHS faces are not unique to Enfield and so we are working with the other CCGs within North Central London (NCL) as part of the NCL Strategic Planning Group.

The North Central London Health Economy is a system comprising of Barnet CCG, Camden CCG, Enfield CCG, Haringey CCG, and Islington CCG who have come together to agree, refine and implement the following strategic intent: To drive improvement in the delivery of high quality, evidence-based and compassionate services, defined and measured by outcomes not process, to the population of north-central London.

Our approach is:

A changed emphasis…

- Developing a systematic approach to prevention
- Earlier diagnosis of disease
- Reducing inequalities in health outcomes targeting vulnerable groups
- Encouraging individuals to take greater responsibility for their health
- Supporting self-management of illness

Integration of care through…

- Shared digital record for clinical records, data sharing, measurement and evaluation
- Commissioning and contracting in ways that drive partnership and integration

Patients at the centre…

- Compassionate, high quality, effective and efficient care pathways shaped by them
- Care that is integrated and focussed around delivery of outcomes defined by them
- Easy access to services delivered in ways and places convenient to them

Financial sustainability through…

- Clinically-driven focus on quality of services
- Delivery of effective (evidence-based) and efficient (right first time) care achieving savings through 'cutting the cost of chaos'

NCL: Strategic Interventions and Enablers

Across NCL, the current model of care and provider landscape is unsustainable. Rising demand and the requirement to meet NHS constitution commitments mean that the NHS faces unprecedented future demand. Growing numbers of patients with long term conditions, complex multiple pathologies and an increasingly complex provider landscape, means that the opportunity for multiple handoffs, poor coordination of care and a focus on outputs of care rather than outcomes has increased. If we do nothing, the increases in activity, funded predominantly through a payment by results model with limited financial growth, will mean NCL is facing a funding gap that will be unaffordable and our base case scenario rises to just under £500m by 2019.

Over the coming 5 Years, NCL Commissioners will transform the way services are Commissioned and therefore delivered, in order to respond proactively to the issues around increased demand, variable service quality and patient outcomes and unsustainable financial costs. The main areas (Strategic Interventions) which will be targeted for key changes are Primary Care, Mental Health, Pathway Transformation and Urgent and Unscheduled Care. Commissioners will seek to further change how services are contracted by using the 'Value Based Commissioning' approach and conducting a Clinical Services Review.

Our interventions need to deliver system-wide impact and transform the way we do business by 2019. Those selected for further review and modelling are collaborative in nature and ambitious in scale. They will be supported by cross-cutting enabling activities to facilitate implementation and deliver change.

NHS Enfield Clinical Commissioning Group

Slide taken from Draft NCL Strategy

NCL: Outcome Ambitions

To progress the delivery of the Strategic Interventions, each NCL CCG has set levels of ambitions and trajectories for the 2015-16 Operating Plan and 2015/16 Better Care Fund Plan measures based upon local population needs, and these have been combined to form the overall NCL target. The NCL targets are outlined below:

Ambition 1. Secure additional years of life for people with treatable mental and physical health conditions.

NCL Target: 4.8% (to be updated) reduction in potential years of life lost from treatable conditions.

Ambition 2. Improve the health-related quality of life for people with one or more long-term condition/s, including mental health.

NCL Target: 2.3% improvement in average EQ-5D score for people reporting 1+ long-term conditions

Ambition 3. Reduce the amount of time people spend avoidably in hospital through better and more integrated care, out of hospital.

NCL Target: 3.6% reduction in emergency admissions composite indicator

Ambition 4. Increasing the proportion of older people living independently at home following discharge from hospital.

NCL Target: 90% of older people (65+) still at home 91 days after discharge from hospital into reablement / rehabilitation

Ambition 5. Increase the number of people with mental and physical health conditions having a positive experience of hospital care

NCL Target: 2.3% increase in number of patients having a positive experience of hospital care

Ambition 6. Increase the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.

NCL Target: 8.2% increase in number of patients having a positive experience of GP and out of hours services

Ambition 7. Make significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

NCL Target: Zero instances of MRSA C.Diff to be on trajectory for each CCG

NB: NCL Targets are yet to be agreed and are based on 2014/15 plans.
Slide taken from Draft NCL Strategy

Local Planning

NHS Enfield Clinical Commissioning Group

1.6	Triangulation between Operating Plan and Joint Health & Wellbeing Strategy

The Joint Health & Wellbeing Strategy (JHWS) sets out how the partnership will work with the population of Enfield to improve health and wellbeing across the borough over the next five years. The strategy will ensure greater integration between health and social care.

The HWB are committed to the aim of supporting individuals to plan and control their care and bring together services to achieve the outcomes important to them. The Board will develop integration plans, which will involve the HWB in dialogue with both the population of Enfield and with local stakeholders.

The Health and Wellbeing Board vision is: Working together to enable you to live longer, healthier, happier lives in Enfield.

The Enfield HWB Priorities

- Ensuring the best start in life
- Enabling people to be safe, independent and well and delivering high quality health and care services
- Creating stronger, healthier communities
- Reducing health inequalities – narrowing the gap in life expectancy
- Promoting healthy lifestyles and making healthy choices

Joint Health & Wellbeing Strategy And The Operating Plan And The 5 Year Strategy Plan	The vision is underpinned by five supporting principles: • Prevention and early intervention • Integration • Equality and Diversity • Ensuring good quality services • Addressing health inequalities where it is needed most	The principles are supported by investments in: • RAID • Children & Young People's Mental Health / Looked After Children • GP Provider Networks & Co-Commissioning • Integrated Care (with Better Care Fund) • Direct Access Pathology • LTC & Disease Risk Stratification • "Big White Wall" • Medicine Management: Education with Patients in community

Local Planning

NHS Enfield Clinical Commissioning Group

1.6	Triangulation between NCL 5 Year Strategy Plan, Operating Plan and Better Care Fund Plan
We have worked closely with the Health and Wellbeing board (HWB) on the development of the Joint Health and Wellbeing Strategy, Better Care Fund plans and our strategic and operational plans. The London Borough of Enfield and Enfield CCG's Better Care Fund is based on accelerating our progress to deliver the priorities and outcomes agreed by our Health and Wellbeing Board – and in particular – accelerating the integration agenda. Section 75 arrangements have been reviewed and agreed by the Enfield Health & Wellbeing Board setting out how the partnership will operate and conduct its commissioning in the future.	
BCF and the Operating Plan	We are home to a larger than average population of young people, but our older population is also set to increase dramatically to over 16.6% of our population by 2032. For these reasons, and because of our particular demographic pressures, our plan is targeted at improving outcomes across four population groups. The population groups are: 1. Older People – focussed on those experiencing frailty and/or disability. 2. Working Age Adults – focussed on those with long term conditions. 3. Adults experiencing Mental Health problems. 4. Children & Young People.
BCF and the 5 Year Strategy Plan	The BCF Plan actively supports the delivery of several key elements in the 5-year strategic plan, most notably: • Developing a range of integrated services with key partners such as the local authority as part of an over-arching drive to embed integrating working across the Borough; • Reducing unplanned admissions by optimising the right care in the right place at the right time to prevent avoidable admissions, • Enhancing seven day services across the Borough • Developing access for Mental Health and IAPT • Increasing focus on prevention agenda

DRAFT

Better Care Fund Plan Measures

NHS Enfield Clinical Commissioning Group

1.6	Triangulation between NCL 5 Year Strategy Plan, Operating Plan and Better Care Fund Plan

Better Care Fund

Emergency Admissions Reduction Target

INITIAL BASELINE

The baseline for the initial Better Care Fund Modelling for the emergency admissions reduction target was devised using actual data from Q4 2013/14, and *projected* levels of activity for Q1-Q3 of 2014/15.

The Q4 data included all Emergency admissions as defined by the nationally mandated Admission Method codes. (The data source was SUS.)

The projected levels of activity for Q1-Q3 of 2014/15 was based on the same methodology used for NHS Enfield's 5 year planning intentions submitted to NHS England - to reduce the rate of admissions per 1,000 in Enfield to a phased, statistically adjusted, top quartile position in London by 2018/19. Activity was adjusted for seasonality as per the pattern of previous year's activity.

Original Submission

INITIAL BCF MODELLING

The initial BCF modelling reduced the initial baseline activity and cost by the minimum 3.5% reduction expected nationally, which resulted in an expected reduction of **908 admissions**, at a **cost of £1,352,920**.

	2013	2014			TOTAL
	Q4	Q1	Q2	Q3	
INITIAL BASELINE ACTIVITY	7,242	6,245	6,127	6,351	25,965
REQUIRED EMERGENCY ADMISSIONS REDUCTION	253	219	214	222	908
INITIAL BASELINE COST	£10,790,580	£9,305,050	£9,129,230	£9,462,990	£38,687,850
INITIAL SAVING	£376,970	£326,310	£318,860	£330,780	£1,352,920

BCF Measures

NHS Enfield Clinical Commissioning Group

1.6	Triangulation between NCL 5 Year Strategy Plan, Operating Plan and Better Care Fund Plan

6.3 Revised Baseline

REVISED BASELINE

In light of the known increase in Accident & Emergency attendances and resultant Non-Elective admissions nationally in the last 12 months, NHS England sent a survey to all CCGs on 22nd January 2015 to gauge the potential for local areas to revise their non-elective admissions reduction ambition.

As a result, work was done within NHS Enfield CCG to re-calculate a new baseline of non-elective admission from the most up to date actual activity. The new baseline therefore covers Q4 2013/14 to Q3 2014/15, and includes all Emergency admissions as defined by the nationally mandated Admission Method codes.

The new baseline shows significantly increased levels of activity to the initial baseline. (Data source = SUS.)

Revised Submission

REVISED BCF MODELLING

The H&WB Integration Board agreed an option is to keep the minimum expected 3.5% reduction, and apply it to the revised baseline. This has increased the expected level of activity and cost savings, due to the increased activity in the revised baseline. The new target reduction is **1,065 admissions**, at a **cost of £1,586,850**.

The increase can be absorbed within the existing Contingency Fund within the BCF Plan.

	2013	2014			TOTAL
	Q4	Q1	Q2	Q3	
REVISED BASELINE ACTIVITY	7,526	7,830	7,557	7,550	30,463
REVISED SAVING	263	274	264	264	1,065
REVISED BASELINE COST	£11,213,740	£11,666,700	£11,259,930	£11,249,500	£45,389,870
REVISED SAVING	£391,870	£408,260	£393,360	£393,360	£1,586,850

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

Section 2	Assumptions, Clarifications and Points Of Note
The following Slides (section 2) are based around the headings found in the "Operating Plan Measures" template. While the format and the order replicates the template, we have also added in slides covering current performance and future trajectories as well as a commentary on our plans submitted via UNIFY identifying issues, assumptions and actions.	
General Assumptions	**Overall assumptions:** • Month 1-6 activity for 2014/15 has been doubled to get an annual forecast, and then divided by 12 to get a monthly figure • For 2015/16, in line with the finance and activity submission, 2015/16 Plan has 1.6% demographic uplift plus 1.5% non-demographic growth added for all areas (total 3.1% uplift). • QIPP and demand management implications have not been added / subtracted at this stage. • Adjustment made according to % working days in each month • There is no allowance for seasonality in the trajectories ~(at this stage)

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

Operating Plan Measures	Assumptions, Clarifications and Points Of Note
2.1 RTT – Admitted	**Trajectory Calculated To Meet Constitution Targets In 2015/16** **Issues** CCG is meeting the year to date performance for admitted pathway but not non-admitted and incompletes. Performance was impacted by the backlog clearing exercise which was completed in December 2014. Performance standards were met in December for all 3 pathways. CCG plans exclude data for Barnet & Chase Farm sites of RFL due to lack of reporting since September 2014. **Planning Assumption:** CCG plans to achieve the standards each month in 2015-16. The flat projection takes into account recent improvements in performance and also recognises on-going challenges in sustaining performance. Trajectory is based on 1.6% ONS estimated population growth on 2014-15 and an additional 1.5% for increase in demand. Further adjustment for the impact demand management initiatives will be applied to the final submission after further analyses is completed. **Actions:** CCG will actively engage with providers in 2015-16 to ensure recent improvements are sustained. Assumptions could not be made on activity levels and performance as the RTT Programme Board has not yet completed their assessment and validations of the data and backlog. CCG has therefore not used proxy figures for Barnet & Chase Farm Hospital as there is no confidence they will be accurate. Trajectory only covers Royal Free Hospital site (Hampstead) and all other providers.
2.2 RTT – Non -Admitted	
2.3 RTT – Incomplete	

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

Operating Plan Measures	Assumptions, Clarifications And Points Of Note
2.4 Diagnostics	**Trajectory Calculated To Meet Constitution Targets In 2015/16** **Issue** Performance against the 99% standard for <6 week diagnostic waits has deteriorated in recent months due to capacity issues at Royal Free London (RFL) relating to gastroscopy and colonoscopy services. **Planning Assumption:** CCG plans to achieve the standards each month in 2015-16. Whilst there are concerns resulting from RFL's failure to achieve the standard in recent months the CCG is reasonably assured by provider recovery plans that the current underperformance will be addressed by April 2015. CCG plans therefore reflect the recovery plans of RFL and also incorporates 1.6% demographic and 1.5% non-demographic growth assumption. **Action** CCG in collaboration with NELCSU and lead commissioner (Barnet CCG) will actively monitor progress against recovery action plans through performance and contract review groups meetings.

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

Operating Plan Measures	Assumptions, Clarifications And Points Of Note
2.5 Cancer Waiting Times - 2 week wait	**Trajectory Calculated To Meet Constitution Targets In 2015/16,** **Issue** Enfield CCG has met all cancer waits standards year-to-date in 2014-15 with the exception of the 62 day standard. Breaches have been primarily due to long waits for biopsies at RFL for patients on the urology pathway. A CQN has been issued and Remedial Action Plans (RAP) are being monitored through CQRG and Performance meetings. **Planning assumptions** CCG plans to meet all standards in each quarter. Activity plans includes 1.6% and 1.5% demographic and non-demographic growth assumptions. The net impact of the new NICE referral guidelines is expected to be minimal hence no additional adjustment has been made as a result. The ambition to achieve the targets from Q1 of 2015-16 is also based on RFL revised performance trajectories which shows that trust will be complaint with the 62 day standard in June 2015 and aims to achieve the standard in Q1 overall. **Actions** RFL has submitted recovery plans to address the current underperformance which should result in a recovery in performance by April 2015. CCG in collaboration with NELCSU and lead commissioner (Barnet CCG) will actively monitor progress against recovery action plans through performance and contract review groups meetings.
2.6 Cancer Waiting Times - 2 week (breast symptoms)	
2.7 Cancer Waiting Times - 31 Day First Treatment	
2.8 Cancer Waiting Times - 31 Day Surgery	
2.9 Cancer Waiting Times - 31 Day Drugs	
2.10 Cancer Waiting Times - 31 Day Radiotherapy	
2.11 Cancer Waiting Times - 62 Day GP Referral	
2.12 Cancer Waiting Times - 62 Day Upgrade	
2.13 Cancer Waiting Times - 62 Day Screening	

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

Operating Plan Measures	Assumptions, Clarifications And Points Of Note
2.14 Ambulance Performance:	To Be Completed by Lead Commissioner (Brent CCG) and referenced in April 2015 submission
2.15 A&E Performance **(Note: Enfield CCG is not a lead commissioner for an A&E provider.)**	**A&E Performance – RFL (incl Barnet & Chase Farm)** Following two Tripartite meetings NHSE challenged the local healthcare system to reduce NHSE the DToC & medically fit patients by 50% over a 4-week period along with developing a systems model and a demand & capacity review. This model and plan has been presented and actions are already underway to deliver the plan including super MDTs at each site. Resilience schemes and 7, 30 & 90 days plans are tracked via the urgent care summit. On-going weekly summit meetings with senior representations from all key stakeholders is expected to sustain the recent improvements.
	A&E Performance – NMUH The CCG will be working with Haringey CCG and other leads to work with NMUH (see slide XX).An exercise to discover findings of the '*Perfect Week – Break the Cycle*' was undertaken and 4 work streams have been identified with multi-agency representation on each; • Rehab pathway • Discharge pathway • Continuing Health Care process • Community Equipment pathway Actions identified during the perfect week continue to be implemented. There will be a renewed focus on ambulance handovers. Trust was tasked to improve discharge processes at the weekend, in order to break the cycle of poor performance at the beginning of the week due to bed capacity.

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

Operating Plan Measures	Assumptions, Clarifications And Points Of Note
2.16 C. Difficile	**Issue** Enfield CCG acknowledges its 2015-16 C Difficile objective of 76 cases (same as 2014-15). The CCG exceeded its annual 2014-15 objective in January 2015 reporting 77 cases year to date. **Planning Assumption** There is a robust system of Root Cause Analysis to investigate each case of Clostridium Difficile, with regular monitoring of the outcomes of investigations to ensure that organisation learning has occurred. RCA conducted shows 28% of cases at NMUH and 64% at RFL were as a result of lapses in care. Regular reporting on target compliance, monitoring of improvement plans and ongoing learning is to monthly Clinical Quality Review Groups through reporting of Infection, Prevention and Control Committee business which has CCG representation. Royal Free Hospital NHS Foundation Trust (incorporating Barnet and Chase Farm Hospitals) continues to implement its Trust wide Clostridium Difficile action plan which includes integration of infection control measures currently in place at RFH site, across all sites. Further risk control includes a contractual lever for financial sanctions against providers in case of trajectory breach.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	2015-16 Total
C. Difficile Trajectory	5	5	5	5	5	5	5	8	9	9	8	7	76

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

Operating Plan Measures	Assumptions, Clarifications And Points Of Note
2.17 Dementia	The 2014/15 target for dementia diagnostic rates is '59% of people with dementia have a formal diagnosis and are on GP registers' and for 2015/16 it is 67%.

The expectation is this target will be achieved if there is improved post-diagnostic support for patients & families, with investment planned in 2015/16. The CCG has committed funding (in part through the BCF plan) into GP education and improving post diagnostic support through fully incorporating support for people with dementia into Enfield's Better Care Fund Plan to improve integrated care.

Specific initiatives include:

- Developing Dementia Friendly Communities across the public, voluntary and private sectors to provide effective post-diagnostic support to individuals and their families from their initial visit to their GPs onwards;
- This provide more support options for GPs and this will be reinforced through specialist GP training which will continue into 2015/16;
- A key part of integrated care is expansion of the multi-disciplinary health & social care Integrated Locality Teams working in GP practices to support older people with frailty – including people with advanced dementia. The Teams assessed over 500 cases by the end of Feb-15;
- Two-thirds of people with advanced dementia live in care homes. One element of integrated care is the nurse-led Care Homes Assessment Team who work in homes to manage individual cases with the homes & GPs and train nursing & care home staff to improve their skills & knowledge;
- Developing rapid response services including crisis response services in the community, and
- Improve the quality of consultant to consultant referrals for suspected dementia.

Our new Trajectory for 2015/16:

			april	may	june	july	august	september	october	november	december	january	february	march
Dementia - Estimated diagnosis rate	2015-16 Plan	Number of People diagnosed	1,817	1,836	1,856	1,875	1,895	1,914	1,934	1,953	1,973	1,992	2,012	2,032
		Estimated number with dementia	3,045	3,045	3,045	3,045	3,045	3,045	3,045	3,045	3,045	3,045	3,045	3,045
		%	59.67%	60.30%	60.95%	61.58%	62.23%	62.86%	63.51%	64.14%	64.79%	65.42%	66.08%	66.73%

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

Operating Plan Measures	Assumptions, Clarifications And Points Of Note
2.18 IAPT Access	**Issue** CCG is on track to achieve the planned exit run rate of 10% for 2014-15 but not the planned 50% recovery rate. The CCG acknowledges the requirement to achieve 15% access rate in 2015-16 and 50% recovery rate by Q4 of 2015-16 which is a stretch on current performance. A number of initiatives have been put in place to improve performance to achieve a minimum exit run rate of 15% for 2015-16. **Planning Assumption:** A review of current performance and action plans show the 15% run rate is unlikely to be achieved in Q1 of 2015-16 due to referral, staffing and accommodation issues which are not expected to be adequately addressed in time to deliver full compliance in Q1. Enfield CCG has therefore adopted a phased trajectory to deliver the 15% access target across the year in quarterly increments; and a recovery rate trajectory to 50% in Q4; **Actions** CCG is implementing recommendations from the National IAPT IST and has committed additional resource to the service in 2015-16 to meet expected demand and target. Monthly IAPT performance meetings are in place to monitor action plans with provider. CCG is also undertaking marketing exercises to increase referrals.
2.19 IAPT Recovery	

		Q1 2015-16	Q2-2015-16	Q3 -2015-16	Q4 -2015-16
IAPT Access	Plan	3.0%	4.0%	4.0%	4.0%
	Target	3.75%	3.75%	3.75%	3.75%
Recovery Rates	Plan	40.2%	43.5%	46.9%	50.1%
	Target				50%

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

Operating Plan Measures	Assumptions, Clarifications And Points Of Note
2.20 Mental Health Access - 18 Weeks RTT 2.21 Mental Health Access - 6 Weeks RTT	**Issue** CCG acknowledges the new IAPT waiting time targets being introduced in 2015-16 for planning and monitoring purposes. The service provider has been working on providing a robust baseline to support CCG planning trajectories. This is expected to be fully completed for the April submission. **Planning Assumption** CCG is planning to achieve the national standard as set out the 5 Year Forward View; 75% of people referred to IAPT to be treated within 6 weeks of referral and 95% within 18 weeks of referral. Currently planning assumption is modelled on provisional information from service provider which indicates 79% of people are treated within 4 weeks of referral during Q2 of 2014-15. CCG trajectory also takes into account the significant increase in referrals that is anticipated from the marketing campaigns.

		Q1 2015-16	Q2-2015-16	Q3 -2015-16	Q4 -2015-16
IAPT RTT – 6 Weeks	Plan	79%	79%	79%	79%
	Target				75%%
IAPT RTT – 18 Weeks	Plan	85%	87%	91%	95%
	Target				95%

Actions

Service provider to submit more robust baseline information to inform planning assumptions by the final submission in April. Improvement plans will be jointly developed with service provider if the data suggests further work, in addition to current action plans, will be required to deliver on the new standards.

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

Operating Plan Measures	Assumptions, Clarifications And Points Of Note
2.22 Satisfaction at a GP Practice	A significant part of the CCG's Primary Care Strategy in the three years to 31st March 2015, has been the Improving Access Programme. This includes the Improving Access Scheme for Enfield's GP Practices, Patient Experience Tracker and Non-Clinical Primary Care Navigator. The Programme was established as a response to stakeholder feedback gathered in 2013. The feedback highlighted that patients in Enfield were reporting difficulty in getting an appointment with their GP and that satisfaction rates were particularly low. The feedback was supported by the results of the national Ipsos Mori GP Patient Survey. The results showed that Enfield patients found it difficult to access their GP practice for an appointment and that 26% of Enfield patients said that their experience of making an appointment with their GP practice was poor as opposed to 22% nationally. At the same time practices were reporting that demand was outstripping capacity and that they were having difficulty in coping with unsustainable workloads.
2.23 Satisfaction at a Surgery	We have delivered an on-going programme of customer care training for frontline medical reception staff, ensure that practices actively promote their successes and improvements to patients via their PPGs and actively manage and respond to feedback received.
2.24 Satisfaction with access to primary care	We continue to build on the work commenced in 2012/13 of our primary care access programme. This has included ensuring that practices understand their demand and aim to match their capacity to it, offer telephone as well as face to face appointments and free up capacity in GP practices, by commissioning a Minor Ailment Scheme from Community Pharmacy for patients who do not pay a prescription charge. This has resulted in an additional 600 appointments per week being offered by Enfield's practices.

Annex A: Enfield CCG Planning Submission 2015/16

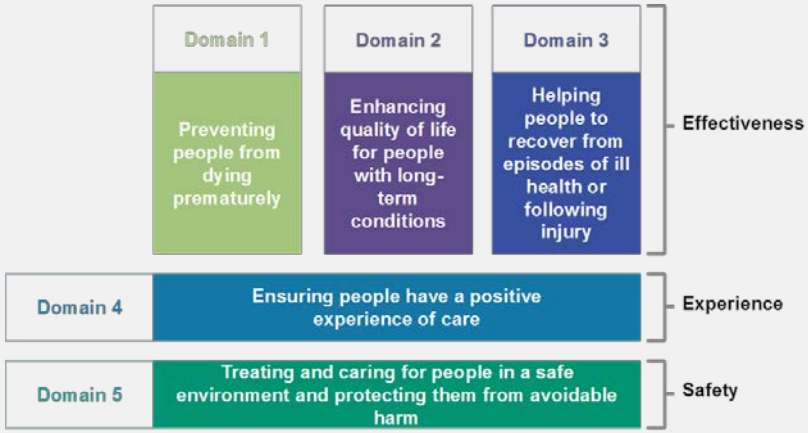
NHS Enfield Clinical Commissioning Group

Section 3	Annex A

The following Slides (section 3) are based around the headings found in the "**Annex A**" template within the *Forward view into Action – supplementary Information for Commissioner Planning 2015/16*.

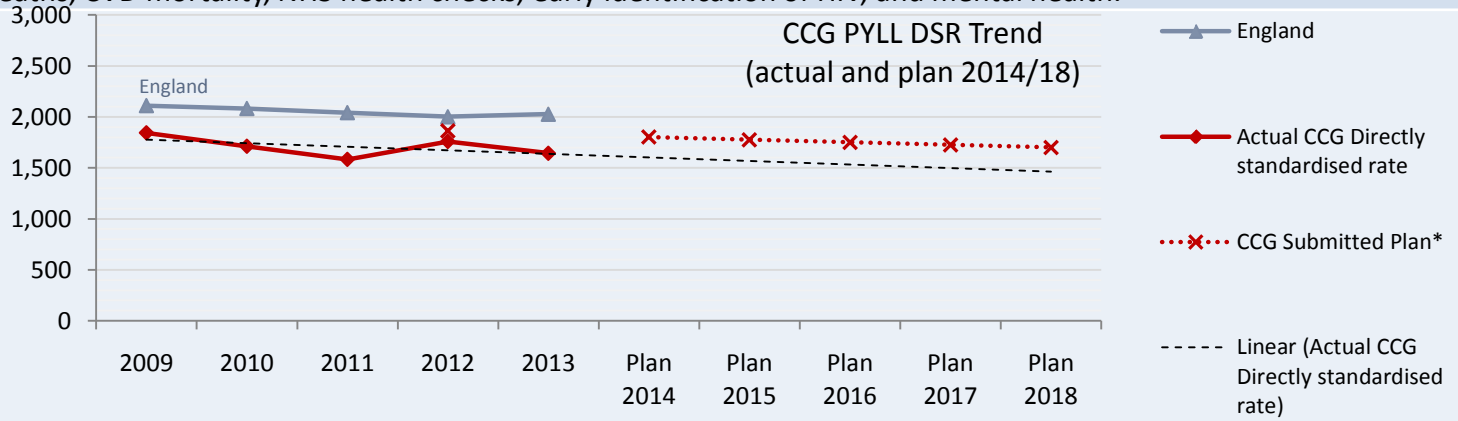
While the format and the order replicates the template, we have also added in slides covering current performance and future trajectories as well as a commentary on our plans submitted via UNIFY identifying issues, assumptions and actions.

3.1	Delivery Across The Five Domains and 2015/15 Operating Plan
Your understanding of your current position on outcomes as set out in the NHS Outcomes Framework	The following slides in this section set out the latest understanding of the CCG performance against the relevant trajectories and targets. The slides setting out a detailed commentary on the performance position and (where appropriate) setting out actions required to improve upon current performance.



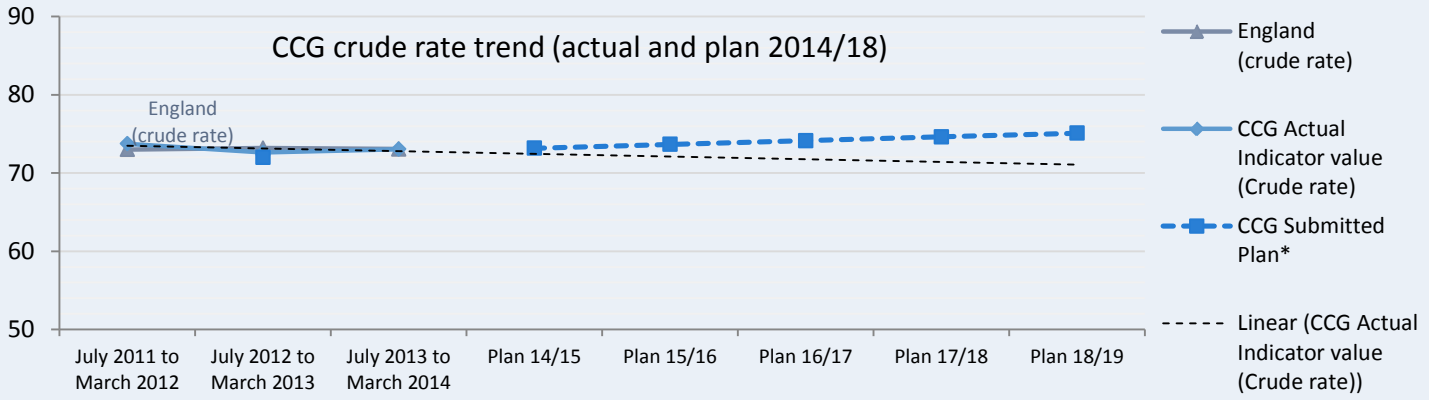
Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.2	Delivery Across The Seven Outcome Measures (1)
The actions you need to take to improve outcomes	**Ambition 1: Securing Additional Years of Life from Conditions Considered Amenable to Healthcare** The CCG has performed strongly against this target and aims to continue to improve in this area. The CCG originally set a Quality Premium target of a 3.2% for 14/15 modelled on past performance with an average annual decrease of 1.4% used for subsequent years. **Performance to date shows an average annual decrease of 6.5%.** As noted in the draft NCL Strategy, all CCG's are focused on shifting the balance of spend from acute and residential care services towards self-management and prevention whilst providing co-ordinated and integrated care support to patients. In line with the ambitions set out in the Enfield Health & Wellbeing Strategy, through the CCG Transformation Programme, NHS Enfield CCG is focussing on a number of areas that will impact on this trajectory: cardiac; respiratory, diabetes, and cancer screening. PYLL pathway indicators have been developed for excess winter deaths, CVD mortality, NHS health checks, early identification of HIV, and mental health.
Enfield CCG is currently in the best quintile [2013 data], and best in its Commissioning for Value (CfV) peer group of similar CCGs. Lower values are better	

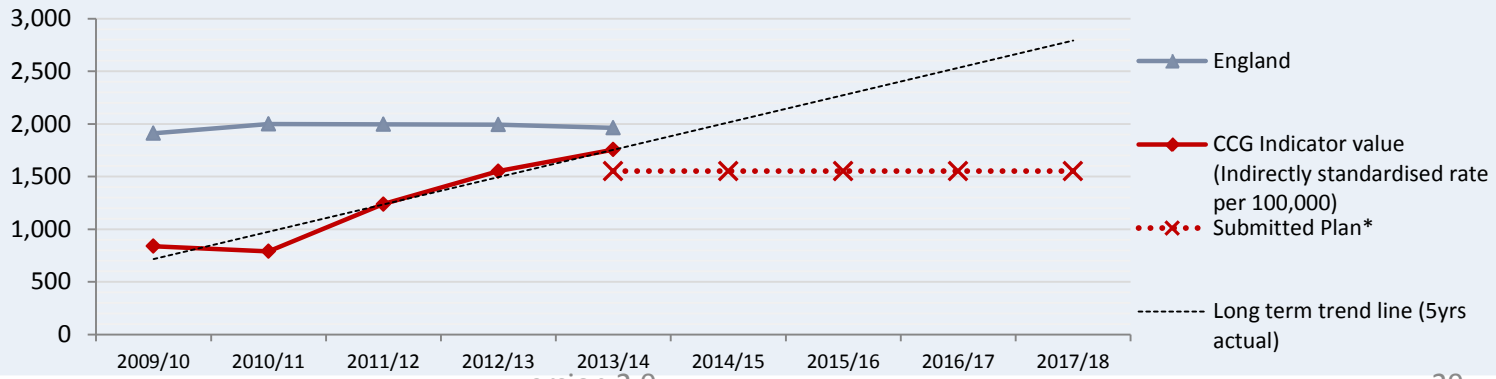
Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.2	Delivery Across The Seven Outcome Measures (2)
The actions you need to take to improve outcomes	**Ambition 2: Improving the Health Related Quality of Life for Persons with Long Term Conditions** The CCG has performance has remained largely static against this target but has measures in place to improve in this area. The CCG originally set a trajectory that would take the CCG to the second best quintile. The CCG believes that this trajectory remains correct and achievable. As noted in the NCL draft Strategy, the work on value based commissioning is focussed on improving outcomes for people with long term conditions (including frailty and mental health). **Enfield CCG is required to deliver a 4.3% improvement in the composite score to achieve its submitted plan.** We aim to achieve this through risk-stratification schemes and a renewed emphasis on risk early diagnosis of LTCs – particularly BP and cholesterol management and diabetes to raise length and quality of life scores. In addition NHS Enfield CCG is working on the transformation areas described above, and integrated care for older people living with frailty is a major programme for the CCG, and the cornerstone of the Better Care Fund submission.
Enfield CCG is currently in the middle quintile [2013/14 data], and slightly below its CfV peer group average. **Higher values are better**	

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.2	Delivery Across The Seven Outcome Measures (3)
The actions you need to take to improve outcomes	**Ambition 3: Reducing Emergency Admissions** This trajectory is also a Better Care Fund indicator and it has recently been agreed with the Council, following the recalculating of the baseline on actual data, to align the BCF trajectory based on 3.5% reduction of emergency admissions for both the BCF and Operating Plans. The long term trend line in the graph below illustrates the position the CCG will be in if no actions are taken. Our current ambition is to ensure that emergency admissions remain flat following the reduction by 3.5% To support delivery we have a number of initiatives: long term conditions, integrated care for older people, value based commissioning, mental health liaison, and audits of emergency admissions in both main acute providers. The CCG and LBE have an ambitious plan for the development of integrated care for older people which will prevent a significant number of avoidable admissions. We are currently reviewing emergency and urgent care pathway for our two main acute providers to ensure that those pathways support alternatives to admission. In addition, the CCG is working collaboratively with NCL partners through the Urgent & Unscheduled Care work programme to direct patients to an urgent and unscheduled care service that signposts patients to the appropriate care setting, based on the principles of right care, right place, right time.
Enfield CCG is currently in the second best quintile [2013/14 HES data], but was in the best quintile for 2012/13. **Lower values are better**	CCG Avoidable admissions Trend (national published actual and plan 2014 to 2018) 

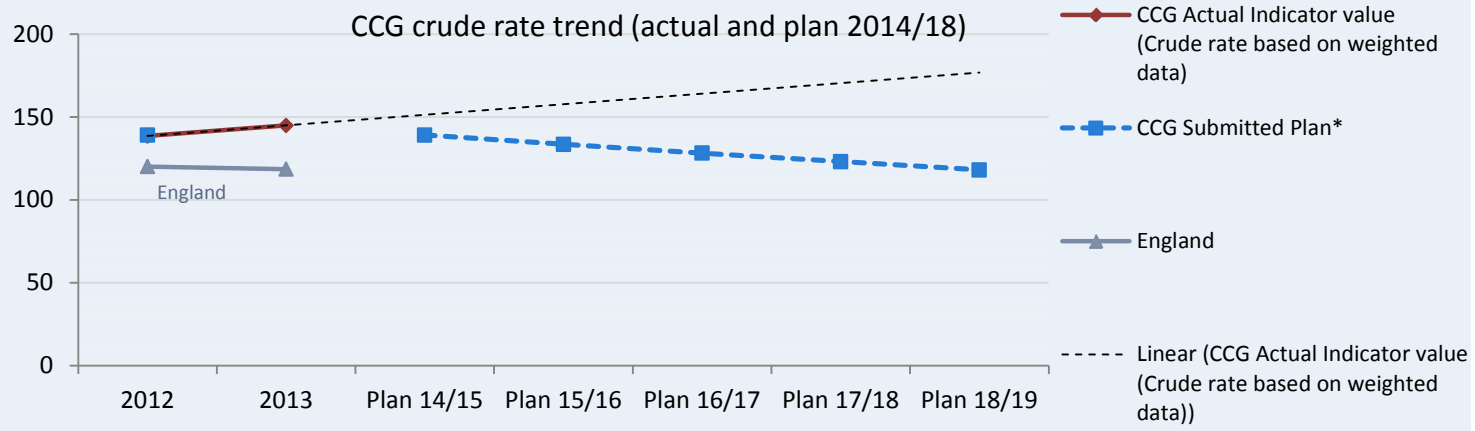
Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.2	Delivery Across The Seven Outcome Measures (3)
The actions you need to take to improve outcomes	**Ambition 3: Reducing Emergency Admissions** Although there is no requirement to resubmit this trajectory, the rebasing of the BCF target on reducing emergency admissions and the subsequent agreement of an increased target (in terms on numbers of admissions to avoid – the percentage reduction remains at -3.5%) will mean that the BCF plan and the original Operating Plan submission (see previous slide) are no longer aligned. A new trajectory will be calculated and included in this narrative.
	Insert new trajectory here

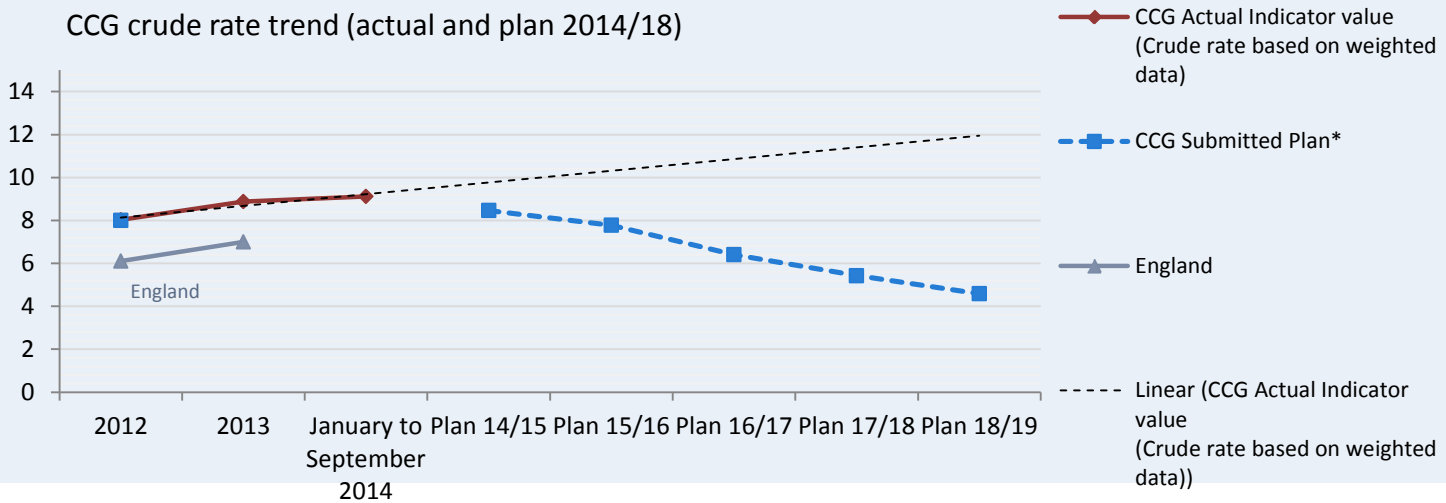
Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.2	Delivery Across The Seven Outcome Measures (4)
The actions you need to take to improve outcomes	**Ambition 5: Positive Experience of Hospital Care** CCG performance on this ambition is yet to improve at the desired rate. The original trajectory was set to take the CCG to the NHS England average/middle quintile. Whilst it is understandable that service user satisfaction will have dropped during a period of high demand and significant change at a local level (e.g. Changes at the Chase farm Hospital, reduced car parking facilities, etc.) the CCG will continue to monitor this data and challenge providers through the contract management meetings and Clinical Quality Meetings. We will use our PPE events to look at the quality of hospital care. In addition, we will be using Call to Action feedback, quality indicators review, the work on value based commissioning, and contractual mechanisms to improve performance. The results of the patients' survey will not be known until summer 2015, in the interim, the CCG is monitoring closely the results of the staff and family FFTs for our main providers. The results for all the North London sector providers combined, for inpatients, shows improvement over the year and at least one of our main acute provider's (NMUH) results are above London average.
Enfield CCG is currently in the worst quintile [2013 survey data], and worse than the average of its CfV peer group. **Lower values are better**	

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.2	Delivery Across The Seven Outcome Measures (5)
The actions you need to take to improve outcomes	**Ambition 6: Positive experience of Non Hospital Care** The reported CCG performance has continued to deteriorate against this target but local data provides a more positive picture and the CCG has measures in place to improve in this area. The CCG originally set a trajectory that would take the CCG to the NHS England average/middle quintile. The CCG believes that this trajectory remains correct and achievable. We will be working with our constituent practices and NHS England to improve performance. As noted in the NCL draft Strategy from service user involvement, we have identified that joining up care is key to improving patient experience.
Enfield CCG is currently in the worst quintile [2013/14 survey data], and close to the average of its CfV peer group. **Lower values are better**	

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.3	Improving Health (1)

Enfield has a well-established Health and Wellbeing Board, chaired by Cllr Don McGowan . The CCG has actively worked with Partners, including the London Borough of Enfield, to develop a refreshed Health and Wellbeing Strategy for the Borough for 2015-19. The Strategy has been guided by our local Joint Strategic Needs Assessment and the shared priorities of Partners.

The Enfield HWB Priorities are:

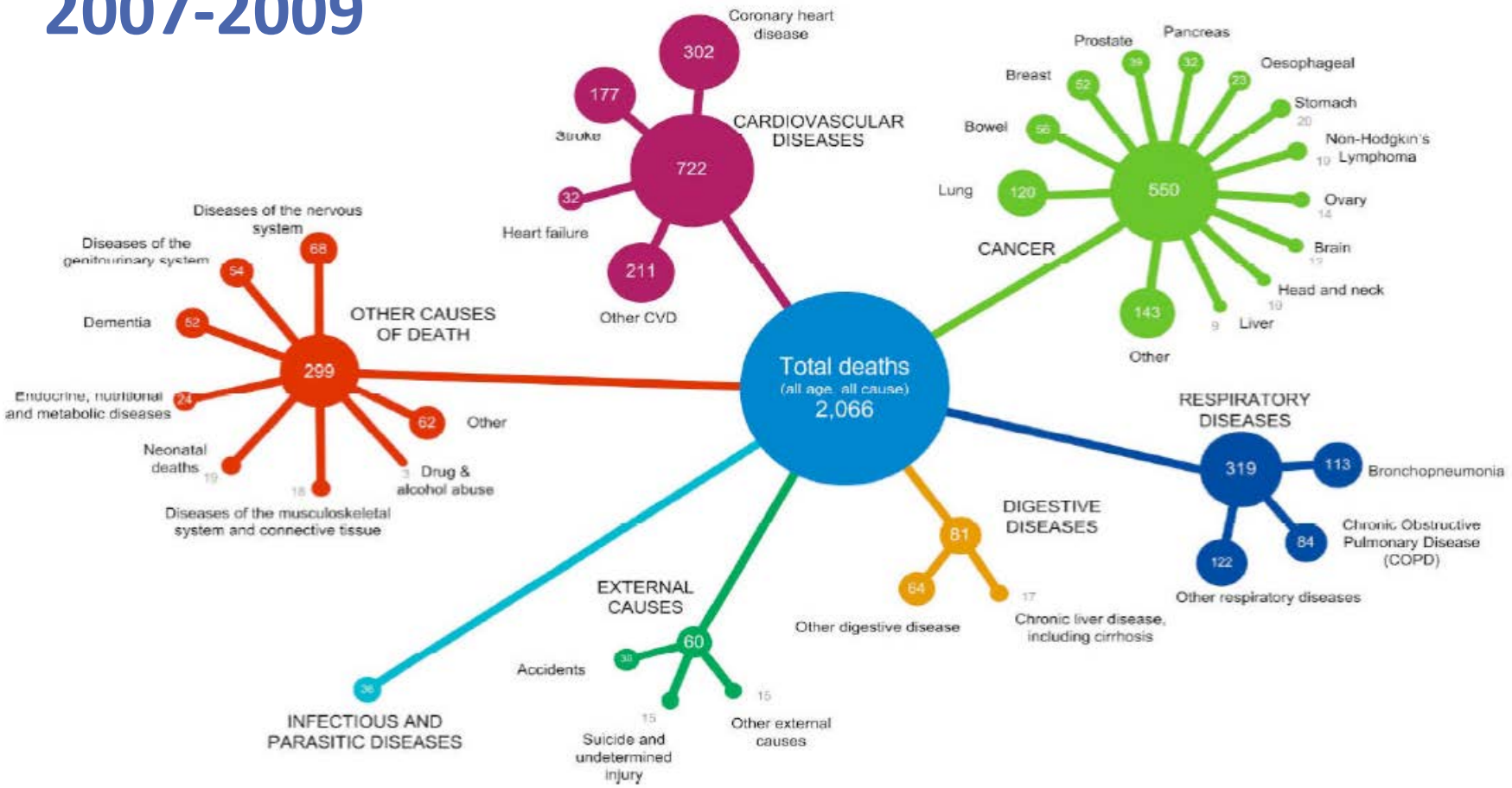
- Ensuring the best start in life
- Enabling people to be safe, independent and well and delivering high quality health and care services
- Creating stronger, healthier communities
- Reducing health inequalities – narrowing the gap in life expectancy
- Promoting healthy lifestyles and making healthy choices

The joint Health & Wellbeing Strategy sets out an action plan with short, medium & Long-term actions to tackle the identified priorities and the CCG will work with partners to develop and implement this plan.

The largest cause of death in Enfield is CVD followed by cancer. Effective control of blood pressure and high quality clinical care can prevent many deaths.	Much of the burden of early mortality, and its associated morbidity could be avoided by changes in lifestyle. For example: • Meeting the Chief Medical Officer's guidelines on physical activity reduces the risk of heart disease, stroke and cancer by 30% • Not smoking reduces the risk of respiratory disease by up to 95% and eating the recommended levels of fruit and vegetables may reduce the risk of cancer • Alcohol is associated with 7 cancers including breast and bowel

Annex A: Outcomes - Causes of death in Enfield, 2007-2009

NHS Enfield Clinical Commissioning Group



Extract from Joint H&WB Strategy 2014-19.
More recent data is being sought

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.3	Improving Health (2)
Working with HWB partners, your planned outcomes from taking the five steps recommended in the "commissioning for prevention" report	
1 Analyse the most important health problems at population level. (At the start)	Data on premature death, chronic disability & risk factors finds cardiovascular disease, cancer and respiratory diseases (in this order) remain the causes of the life expectancy gap. We have used this intelligence to underpin our plans (e.g. transformation programmes and integrated care) and inform the development of the JSNA and joint H&WB Strategy (JHWS). JSNA and local needs assessment are refreshed with available data. As a point of note, national benchmarking with peers shows Enfield is the best performing CCG among its peers in 'Living for Longer' analysis.
2 Working together with partners and the community, set common goals or priorities. (Emerging)	Health and Wellbeing Board priorities are supported by all major stakeholders in local health economy. However more commitment of NHS England on primary care performance is required to achieve goals in the JHWS. There is a small set of priorities (Ref: Health and Wellbeing Board Strategy 2014-19). These are set out at 1.3 (slide 33). The HWB target of reducing the difference in female life expectancy between the worst and best wards to 10 years has already been achieved.
3 Identify high-impact prevention programmes focused on the top causes of premature mortality and chronic disability. (Mature moving back to emerging)	There are jointly commissioned primary & secondary care initiatives focused on risk factors & key causes of morbidity and mortality such as atrial fibrillation detection and management. Early detection initiatives have been implemented in long-term conditions diseases areas (e.g. opportunistic diabetes screening, NHS Health Check, COPD, Hilo pilot and blood pressure health kiosks). Results for the first year show blood pressure control where 10mmHg drop was observed in 900 poorly controlled patients. A plan for high-impact prevention programmes is currently in development to expand successful pilots or replace initiatives which have shown patchy success. The plan will be presented at the HWB this summer.

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NHS Enfield Clinical Commissioning Group

3.3	Improving Health (3)
Working with HWB partners, your planned outcomes from taking the five steps recommended in the "commissioning for prevention" report	
4. Plan the resource profile needed to deliver prevention goals **(At the start to emerging)**	Enfield Integration Board was set up to oversee all integrated care schemes including Better Care Fund (BCF) in Enfield. BCF will act as enabler and there will be re-allocation in resources for integration and prevention. Outcome-based and value-based commissioning is being used and economic models utilise future needs based on projection rather than static baseline. The CCG has developed a Primary Care Strategy that will be delivered through GP (provider) networks to enable prevention and early intervention. In addition, a business case is being jointly produced by the CCG and Enfield Council to commission a 3-year integrated long-term condition early detection scheme – this will promote NHS Healthcheck delivery and LTC management strategy - delivered through primary care networks. This will be co-funded by the CCG and Enfield Council.
5. Measure impact and experiment rapidly **(mature)**	Outcome & process metrics are in place to measure progress on of each WWB priority. Relevant measures for the CCG include: the percentage of children receiving the full course of MMR by their fifth birthday to increase to 95% by 2019; access to psychological therapies (IAPT) improve locally by increasing uptake to 15% by the end of 2014/2015; health-related quality of life for people with long-term conditions to improve to 75.10 by 2018/2019; to involve local people in improving their health and wellbeing; by 2019, 75% of Enfield GP practices to achieve 90% in the percentage of patients with coronary heart disease whose blood pressure is controlled; the percentage of Year-6 pupils classified as obese to reduce from 24% to 22% by 2019; the percentage of obese and overweight adults in Enfield to improve from the bottom five London boroughs to the top 25% by 2024; and the percentage of people smoking to reduce from 18.5% in 2012 to 12% by 2030. Evaluation frameworks are also in place for a number of innovations such as atrial fibrillation (AF), pulmonary rehabilitation, Hilo (blood pressure and cholesterol) and diabetes early recognition.

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NHS Enfield Clinical Commissioning Group

3.4	Reducing Health Inequalities (1)	
Identification of the groups of people in your area that have a worse outcomes and experience of care, and your plans to close the gap	Life expectancy at birth reflects the overall mortality level of a population and is used as a summary of health outcomes of a population. Although Life Expectancy in Enfield is higher compared to regional and national averages, there are wide variation within the borough. These areas with worst outcomes are identified through Enfield JSNA, APHR and various health needs assessment.	
	Short term high-impact, Medium term and Long term actions to tackle inequalities are set out in the Annual Public Health Report 2014	• JHWS targets the five wards with the lowest life expectancy (i.e. Upper Edmonton, Jubilee, Ponders End, Chase and Lock (DPH Enfield, APHR 2014). • High impact plans are recommended as short-term (blood pressure control, lipid control, smoking cessation, NHS Healthcheck, diabetes awareness and early recognition of cancers and HIV), medium term (reducing smoking prevalence and obesity), • BME communities are engaged to improve awareness on diabetes, hypertension and stroke, female genital mutilation and domestic violence. • Mental Health: Access to IAPT services has improved in the last year. Integration Board will ensure the physical health of patients of mental health are not overlooked.

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.4	Reducing Health Inequalities (2)

The first Workforce Race Equality Standard (WRES) requires NHS organisations employing almost all of the 1.4 million NHS workforce to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.

Examination of how the organisation compares against the first NHS Workforce Race Equality Standard	**Enfield CCG compares well against the first NHS Workforce Race Equality Standard**: • Since April 2013 Enfield CCG continues to monitor , report and publish its workforce data • This includes race equality information about governing body members, existing workforce, recruitment and leavers	**The CCG has already analysed its data as part of the EDS2 self-assessment. In 2015-16 the CCG will:** • Update equality information of all staff and governing body members • Produce staff equality information by using the Workforce Race Equality Standard (WRES) metrics – to establish whether there is any difference between different groups of staff(BME and White) it will look at band/ grade, grievances, disciplinaries, dismissals and right through to leavers in order to build up a picture of workforce and identify any areas where problems might occur. • Implement the EDS2 action plan which includes specific actions relating to workforce equality.
Implementing EDS2	**Implementing EDS2:** The CCG is committed to implement EDS2 by: • Conducting a self-assessment and reviewing the grades on an annual basis; • Engaging the key stakeholders including Healthwatch and the local authority; • Working closely with providers; • Publishing the grades in the CCG's annual equality information report in January; • Developing actions to deliver equality objectives; and • Revising equality objectives	**Examination of how the organisation compares against the first NHS Workforce Race Equality Standard:** The CCG has been publishing and monitoring its workforce data since April 2013. This concludes race equality information about governing body members, existing workforce, recruitment and leavers. The CCG has already analysed its data as part of the EDS2 self-assessment. In 2015-16 the CCG will: • Update equality information of all staff and governing body members; • Produce staff equality information by using the WRES metrics; • Implement the EDS2 action plan which includes specific actions relating to workforce equality; • Monitor providers' equality performance against the WRES (and EDS2) through contract monitoring.

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NHS Enfield Clinical Commissioning Group

3.4	Reducing Health Inequalities (3)
Implementation of the five most cost-effective high impact interventions recommended by the NAO report on health inequalities	
The CCG is committed to implement most cost-effective high impact interventions identified in NAO Report on health inequalities, and the Public Accounts Committee Repot into Tackling Inequalities in life expectancy. These are:	- improving control of blood pressure through prescribing anti-hypertensive medications to patients at risk of or already diagnosed with cardiovascular disease; - reducing cholesterol levels through prescribing statins to patients at risk of or already diagnosed with cardiovascular disease; - increasing the number of smoking quitters through smoking cessation services; - Increased anticoagulant therapy in atrial fibrillation; - Improved blood sugar control in diabetes; - Improving NHS Health check delivery
Increased prescribing of drugs to control blood pressure	Health Kiosks are sited in all GP surgeries to aid early diagnosis and monitoring of blood pressure. Since 2009/10, 3500 more patients were diagnosed and managed for hypertension. Primary care medicine management informs GPs of the most effective and efficient drugs according to NICE. A primary care dashboard is regularly produced jointly by Public health and CCG to inform the GPs of their performance against the peers so that variation in the performance can be reduced by learning from peers. Currently 80% of patients with high blood pressure are controlled according to QOF standards. New integrated clinical pathways to be delivered by Primary Care Networks are aimed to further improve blood pressure control across Enfield. In addition, Public Health at Enfield Council encourages GPs to improve blood pressure control by letters and newsletters. In the areas of high need, Hilo initiative is commissioned to improve the control of blood pressure and lipids among poorly controlled patients. At 9 months into the pilot, an average of 10mmHg drop in blood pressure is noted among 900 patients who blood pressure is otherwise not controlled.

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NHS Enfield Clinical Commissioning Group

3.4	Reducing Health Inequalities (4)
Implementation of the five most cost-effective high impact interventions recommended by the NAO report on health inequalities	
Increased prescribing of drugs to reduce cholesterol	Primary care medicine management informs GPs of most effective and efficient drugs according to NICE. A primary care dashboard is produced to inform the GPs of their performance against the peers so that variation in the performance can be reduced by learning from peers. New integrated clinical pathways to be delivered by Primary Care Networks are aimed to improve cholesterol control among those with known cardiovascular disease across Enfield. In addition, the new pathways will indirectly improve delivery of NHS Healthcheck and the recognition of high cholesterol and subsequent management. In the areas of high need, the 'Hilo' initiative is commissioned to improve the control of blood pressure and lipids among poorly controlled patients. The improvement was 0.5 mmol/L among the 1000 patients. This equates to 3.5 % increase in prescription rate (ADQ/STAR.PU) of lipid-regulating drugs from 2013 to 2014.
Increase smoking cessation services	Referrals to smoking cessation services are integral to Cardiology, COPD and other long-term condition pathways. Smoking cessation service commissioned by Public Health at Enfield Council is easily accessible by GPs and patients. A new delivery model was developed between H&WB partners – including primary care network delivery. Public Health will continue to increase the quitting rates and reduce the smoking prevalence.

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3.4	Reducing Health Inequalities (5)
Implementation of the five most cost-effective high impact interventions recommended by the NAO report on health inequalities (continued)	
Increased anticoagulant therapy in atrial fibrillation	Primary care medicine management informs GPs of most effective and efficient drugs according to NICE. A primary care dashboard is produced to inform the GPs of their performance against the peers so that variation in the performance can be reduced by learning from peers. An initiative to detect and manage patients with atrial fibrillation who are not on optimal treatment is jointly funded by the CCG and Public Health at Enfield Council. In addition, the CCG has commissioned an anti-coagulation service from GP practices using hub and spoke model. A forward plan is required to sustain the positive changes. This could be in the form of prevention infrastructure that will be integrated into clinical pathways to be delivered by primary care networks.
Improved blood sugar control in diabetes	Blood glucose control in diabetes in Enfield improved from 80.9% in 2012/13 to 82.7% in 2013/14 (QOF), and this needs to be further improved. A primary care dashboard is produced to inform the GPs of their performance against the peers so that variation in the performance can be reduced by learning from peers. New diabetes pathways have been commissioned utilising MDTs and focus on a primary care led outcomes-based approach to improve primary care management of glucose control. In addition, Public Health at Enfield Council is engaging with high risk communities to raise awareness and prevent development of new diabetes. Moreover, high risk communities can access NHS Healthcheck before the eligible age if the GP think necessary to assess the risk. Primary care medicine management informs GPs of most effective and efficient drugs according to NICE.

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.5	Parity Of Esteem (1)
The resources you are allocating to mental health to achieve parity of esteem	The CCG is working with its mental health providers to ensure that the Increasing Access to Psychological Therapies (IAPT) access and recovery targets are met. The CCG is also working with Public Health to develop strategies to reach populations within Enfield which have mental health needs but which have traditionally found it harder to access services effectively. In 2014/15 the CCG identified £1.2m of non-recurrent funding to support the development of Psychiatric Liaison Services at NMUH and Barnet Hospitals – the CCG intends to continue this funding for 2015/16. the CCG is finalising demographic and non-demographic growth for the 2015/16 contract. In 2014/15 the CCG identified £65k of non-recurrent funding to improve access to Dementia Memory Clinics – the CCG intends to continue this funding for 2015/16 . In 2015/16, initiatives such as 'Big white wall' and 'Sign health' will open up psychological therapies.
Identification and support for young people with mental health problems	Enfield CAMHS partnership working is well and is firmly established. The Joint Commissioning Strategy is currently being revised. Early identification and intervention across all age groups is a priority, with a focus on work with schools, Head teachers are being encouraged to commission Tier 2 services with some success. There is concern about the increase in CAMHS Tier 4 inpatient admissions and a piece of work is currently underway with BEH MHT to review the pathway for young people. Previous implementation of a pathway for young people with severe and complex mental health needs, with a focus on Tier 3.5 provision had a significant impact on improving performance. We are keen to work closely with the NHSE team to enable us to maintain a grip. A good working relationship has been established.

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3.5	Parity Of Esteem (2)
Plans to reduce the 20 year gap in life expectancy for people with severe mental illness	The CCG will work closely with the partners including local authority to ensure people with severe mental illness will receive appropriate care and support. This will include; • Substantial focus on enablement and recovery of patients through the transformation of all mental health services to work together and to be recovery focused • Addressing the wider determinants of mental health and wellbeing through the health and wellbeing strategy. • Substantially strengthening early diagnosis and intervention in psychosis services with system focus on recovery to reduce the need for adult services • Reducing inequalities in mental health and wellbeing ensuring substantial focus on physical health . • Improving the mental health and wellbeing of all carers and recognising and improving support for carers of adult mental health. • Ensuring adults with mental health problems to lead independent, meaningful life as active members of the communities in which they live and work. • Ensuring delivery of personalised services focussed on supporting recovery and positive outcomes for adults with mental health problems. • Improving the accessibility and effectiveness of secondary care services. • Enablement utilising primary care & community mental health models • Developing a strong partnership between mental health services commissioners and providers and ensure that service users and carers are fully involved in services improvement and planning.
The planned level of real terms increase in spending on mental health services	The CCG is planning to increase expenditure on mental health by 5.0% which is less than the 7.1% outlined in the planning guidance in terms of our overall allocation. Given our financial challenges the CCG is unable to commit to the full planning guidance and this has been discussed with NHS England as part of our financial recovery. CCG.

Annex A: Access

NHS Enfield Clinical Commissioning Group

3.6	Convenient Access For Everyone
How you will deliver good access to the full range of services, including general practice and community services, especially mental health services in a way which is timely, convenient and specifically tailored to minority groups	The strategic direction of travel is for providers across primary, community, mental health and acute to work together to integrate service delivery around the needs of our patients and focused on the outcomes that are important to our patients. We are currently working with our Voluntary and Community Services to deliver low level care and case management as part of this integrated model, including those working with specific minority groups Two **GP Networks** were established in August 2014 and have been tasked with ensuring that their constituent practices collaborate to provide a full range of primary care services to populations in a geographical locality. **Mental Health Access**: By ensuring diagnosis and intervention earlier in the course of someone's illness and access to timely assessment, treatment and support, particularly in crisis, which is substantially focussed on recovery and enablement for he individual. This includes a substantial transformation of all mental health services to an enablement model of care, improving access to psychological therapies for adults with common mental health problems and further developing effective local mental health liaison service. In addition, the CCG will support a primary care / community model of mental health care to further assist enablement. **The integrated care network** is designed to help identify and support **older people with frailty** plan and access a range of coordinated and seamless health & social care services specifically tailored around their needs and those of their carers, with an emphasis on managing these services in the community through primary care. The support offered is tailored to the stratified needs of the population, including to those who are particularly frail, such as those with multiple conditions, those who are very elderly, those in care homes and/or those living with advanced dementia. The integrated care network is delivered through teams operating in the CCG's 4 localities, which allows the support to reflect the needs of local populations, e.g. communities with many very elderly people or those from ethnic minorities. **Urgent Care**: We have a substantial focus on urgent and emergency care given the continued challenges to meeting the A&E targets locally. Emergency and Urgent care pathways are being reviewed at both acute Trusts with a view to reshaping to support alternatives to admission and to maximise the effectiveness of urgent care centres. In addition we will lead the procurement of an integrated 111 and OOH service on behalf of NCL.

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NHS Enfield Clinical Commissioning Group

3.6	Convenient Access For Everyone (2)
Plans to improve early diagnosis for cancer and to track one-year cancer survival rates	Improving outcomes and patient experience for cancer patients through early diagnosis is an approach described in the 2010 Model of Care for London and refreshed in the 2014 5 Year Cancer Commissioning Strategy for London. The strategic approach taken by the pan-London Transforming Cancer Services Team is to deliver improvements to cancer services through transformational change driven by cancer commissioning intentions. These pan-London commissioning intentions focus on a range of early diagnosis initiatives, including direct access to diagnostics and best practice commissioning pathways. Providers of cancer services in NCL are monitored against the cancer commissioning intentions within the cancer quality assurance framework of Clinical Quality Review meetings in NCL (part of business as usual). The 5 Year Cancer Commissioning Strategy for London recommends that CCG's consider these areas for development in local plans. These plans may tailor an approach for a CCG or within a locality group or SPG with a focus on early diagnosis initiatives in both primary and secondary care. A strategic focus on cancer planning is recommended. The NHS standard contract includes an information requirement to monitor the percentage of cancers which are stageable and staged at diagnosis with a threshold of 70%. This is monitored within the cancer quality assurance framework of Clinical Quality Review meetings in NCL (part of business as usual). This underpins the data quality of survival data submitted to the National Cancer Registration Service's Cancer Outcomes and Services Dataset and is the basis for the 1 year survival indicator in the CCG outcome indicator set. From April 2015 1 year survival published by the HSCIC from ONS data will be monitored within this framework.

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3.7		Meeting the NHS Constitution Standards
That your plans include commissioning sufficient services to deliver the NHS Constitution rights and pledges for patients on access to treatment as set out in Annex B and how they will be maintained during busy periods		Mental Health: the CCG's contracting arrangements for mental health service reflect the access rights detailed in the NHS Constitution Urgent Care: NHS Enfield CCG Participates in two System Resilience Groups; Barnet Covering the Royal Free System and Haringey which covers the NMUH system. The groups provide a forum for whole systems planning between Health, Social Services and Voluntary Organisations to address capacity planning and in particular winter surge planning, urgent care needs, that stimulates new initiatives, informs commissioning intentions, and contributes to service specifications. The Groups work to ensure that appropriate plans are in place ahead of known peaks in demand, such as holiday and winter period, that promote integration and focus in delivery
How you will prepare for and implement the new mental health access standards	Mental Health Access - 18 Weeks Mental Health Access - 6 Weeks	The CCG is confident that the provider is on target to meet these standards as 2014/15 data for Q1 shows 63% of IAPT referrals were treated within 4 weeks – this improved to 79% of referrals being treated within 4 weeks in Q2. Note: provider data systems do not currently capture 6 and 18 week waiting periods – this information will be routinely available from 1.4.15.

Annex A: Quality

NHS Enfield Clinical Commissioning Group

3.8	Response to Francis, Berwick and Winterbourne View
How your plans will reflect the key findings of the Francis, Berwick and Winterbourne View Reports – including how your plans will make demonstrable progress in reducing the number of inpatients for people with a learning disability and improve the availability of community services for people with a learning disability	Our plans also reflect the key findings of the Francis, Keogh, Berwick and Winterbourne View reports by: • Regular monitoring and reporting to the CCG Quality & Risk Sub-group (1) a CCG Patient Safety Improvement Plan (incorporating recommendations from Francis, Keogh & Berwick) and (2) Winterbourne View update and action plan which reflects level of compliance with the DH concordat. • Quality and Safety Report to every Governing Body Meeting • Monitoring provider compliance with recommendations through provider the Clinical Quality Review Group including ongoing assurance of their quality standards compliance and exception reporting where necessary. • Continuing to engage with the CCG's own staff on recommendations and subsequent responsibilities including updating of job descriptions, reading of key CCG policies (e.g. incidents, complaints, safeguarding), presentation at all staff meetings and providing staff workshops on governance and risk In relation to demonstrable progress in reducing the number of inpatients for people with a learning disability and improve the availability of community services for people with a learning disability, the CCG intends to achieve this by: • Continuing to implement the principles of the Winterbourne Transformation Programme • Sustaining commitment to supporting the remaining small number of individuals, who are detained under the MHA and are in clinically appropriate placements, to undergo treatment in line with discharge plans and move people on to community settings that are closer to home. • Continuing to work with service users, parent / carers and advocates in a personalised way and ensure that people are supported to live rich and fulfilling lives in the Enfield community. Progress on CCG and Local Authority partnership implementation of Winterbourne View: • Of 5 patients identified as meeting criteria for transfer to more appropriate accommodation, arrangements have been enacted upon or transition plans are in place for them all

Annex A: Quality

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3.9	Patient Safety (1)
How you will address the need to understand and measure the harm that can occur in healthcare services, to support the development of capacity and capability in patient safety improvement	• Monthly monitoring of compliance with relevant indictors including incidents, never events, mixed sex accommodation breaches and infection rates (MRSA, C Diff). This will be managed through challenge on contractual requirements and added incentives schemes for improvement (such as the Safety Thermometer CQUIN). Design of indicators through contractual management is clinically led. • Utilising local and London benchmarking, themes and trends analysis in serious incident recommendations by service line and triangulated with complaints where service line issues or risks are identified through quality groups. • Undertaking a programme of insight and learning visits to commissioned services, in response to evidence which may include early warning signs and recommendations from CQC inspection visits and subsequent enforcement action. • Monitoring and responding to soft intelligence raised by member practices through an early warning system (previously referred to as the "Quality Alerts" process), reporting themes and trends experienced. • Utilising the provider Clinical Quality Review Group to review themes and trends from Patient Safety incidents
How you will increase the reporting of harm to patients, particularly in primary care and focused on learning and improvement	• Work with the NHS England Patient Safety Team and Primary Care Commissioning Team to ensure practices are aware of the NHS England Serious Incident Policy for Primary Care • Review and discuss themes and trends from primary care incidents and serious complaints through the NHS England Quality Surveillance Group, CCG Clinical Reference Group and Primary Care Quality Improvement Group • Reminding member practices of obligations to report and investigate incidents in line with agreed procedures. • Sharing through Protected Learning Time (PLT) meetings the findings, learning and actions that result from (1) investigations into community acquired infections and (2) CQC inspection visits citing deficiencies in governance arrangements and infection, prevention and control.

Annex A: Quality

NHS Enfield Clinical Commissioning Group

3.9	Patient Safety (2)
Your plans for tackling sepsis and acute kidney injury	Monitoring of provider compliance with recommendations from recent Health Service Ombudsman Report (HSO) into a sepsis related serious incident in Devon, and discussion at Protected Learning Time (PLT) for General Practice Anticipated receipt of revised sepsis guidelines July 2016 for discussion at Protected Learning Time (PLT) for General Practice. Anticipated monitoring of compliance with NHS England plans on management of acute kidney injury, with review following publication of revised NICE guidelines after June 2015. Monitoring of provider compliance with associated Quality Account priorities. For Royal Free this is currently proposed to include: increased number of patients who recover from Acute Kidney Injury within 72 hours of admission by 25% by 31/03/18, reduce severe sepsis related serious incidents by 50% across all sites (A&E and maternity) by 31/03/18.
How you will improve antibiotic prescribing in primary and secondary care	Building on the success of Enfield's prescribing quality and savings scheme, where a reduction in antibiotic prescribing has been seen, we are proposing an antibiotics indicator in future GPs schemes for 15-16. In 14-15 we worked with Public Health and local providers running education sessions for GPs, Pharmacists and patient representatives. There is a proposed Quality Premium on Reducing antimicrobial resistance for 15-16, the CCG will engage fully with the Quality Premium with the aim of reducing our antibiotic prescribing volume and improving the selection of antibiotics across Enfield.

Annex A: Quality

NHS Enfield Clinical Commissioning Group

3.10	Patient Experience (1)
How you will set measureable ambitions to reduce poor experience of inpatient care and poor experience in general practice	• Monthly monitoring of provider compliance with relevant indictors and associated learning including response complaints to enquires received and safer staffing levels, together with thematic findings, learning and actions associated with implementation of the Friends and Family Test (FFT) in secondary care. This will be reviewed as appropriate at service line level, with an expectation that this also be reported in provider Quality Accounts. • Continued use of a "Patient Experience Tracker" tool using tablet technology in General Practice reported through the Primary Care Quality Improvement Group, and continuing to develop Patient Participation Groups and escalate their feedback within the CCG governance structure.
How you will assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients	• Methods to monitor patient experience through acute hospitals and General Practice (as described above) will also be used to assess the quality of care experienced by vulnerable groups of patients and how and where experiences can be improved. It would also be expected that this be reported in provider Quality Accounts. • Where possible this will involve working with local borough and nursing homes, on pressure ulcer trends for example, and supported better care fund (BCF) pooled budget. • Care of vulnerable patients is also a key line of enquiry for CQC inspections of General Practice, from which findings, learning and actions are shared through Protected Learning Time (PLT) and the CCG Primary Care Quality Improvement Group • A contractual indicator will also require providers to submit a quarterly return on their Safeguarding Adults Framework (SAF) dashboard that has been developed by all 5 CCGs in North Central London.

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3.10	Patient Experience (2)
How you will demonstrate improvements from FFT complaints and other feedback	• Monthly monitoring of provider compliance with relevant indictors and associated learning including response to complaints and enquiries received and safer staffing levels, together with thematic findings, learning, London average benchmarking and resulting actions associated with implementation of the Friends and Family Test (FFT) in secondary care (both inpatients and A&E). Regular reporting and monitoring via the CCG Integrated Quality & Performance Report to the Quality & Safety Committee& Governing Body • We will continue to receive and respond to feedback obtained through the CCG website.
How you will ensure that all the NHS Constitution patient rights and commitments given to patients are met	• The CCG has in place an effective governance framework for managing and monitoring compliance with the domains of quality (Patient Safety, Clinical Effectiveness and Patient Experience) within commissioned services, which it uses to ensure constitution rights are met. • Where acute providers have not met all expected commitments, improvement trajectories are agreed and monitored accordingly.
How you will ensure you meet the recommendations of the Caldicott Review that are relevant to the patient experience	• Compliance with DH IG toolkit requirements • CCG policies and staff training on Information Governance • Quarterly report on Information Governance to the Quality & safety Committee includes IG incidents, risks and Caldicott report • Review of provider IG serious incidents via the provider Clinical Quality Review Group • Ensuring providers comply with the IG toolkit through contract and KPIs

Annex A: Quality

NHS Enfield Clinical Commissioning Group

3.11	Compassion in Practice
How your plans will ensure that local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans	As part of the Enfield CCG Francis Action plan, all providers have been be asked to embed the CNO strategy of the 6Cs into their culture of care and recruitment. Nursing and quality strategies continue to be reviewed at CQRG. Patient and staff FFT response rates and scores are a standing item at CQRG Performance during 2014 has strengthened. Accident and Emergency and Maternity remain a focus for improvement. Trusts are required to provide details of actions in place to address poor/ deteriorating performance.
How the 6Cs are being rolled out across all staff	Commitment to the 6Cs outlined within Compassion in Practice (Caring, Compassion, Courage, Communication, Competence, and Commitment) is reflected in ECCGs approach to each work programme and fundamental principles adopted in building positive working relationships with all our stakeholders. The action areas are incorporated within the contracts with providers and progress monitored through the regular quality reviews held with them.

Annex A: Quality

NHS Enfield Clinical Commissioning Group

3.12	Staff Satisfaction
An in-depth understanding of the factors affecting staff satisfaction in the local health economy and how staff satisfaction locally benchmarks against others	Factors affecting staff satisfaction in the local health economy: • Increased pressure on services from higher than anticipated demand which follows the unsettling nature of the reconfiguration of Accident and Emergency services at Chase Farm (to a 12 hour Urgent Care Centre) and acquisition of Barnet and Chase Farm Hospitals by Royal Free London. • Provider Trust staff opinions on increasing workload pressure, particularly in community and mental health services, with a continually changing demographic profile and increasing older population. • Workforce indicators such as turnover and sickness rates, and safer staffing levels, as indicators of staff satisfaction, are not significantly performing outside expectations for local trusts.
How your plans will ensure measureable improvements in staff experience in order to improve patient experience	• Regular reporting through provider contract management on staff survey results to help the CCG continue to understand the factors affecting satisfaction, used to continue benchmarking against corresponding services elsewhere and ensure measurable improvements in staff experience in order to improve patient experience. • More specifically is the monitoring, also through provider contract management, of the staff Friends and Family Test introduced from April 2014.

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3.13	Seven Day Services
How you will make significant further progress in 2015/16 to implement at least 5 of the 10 clinical standards for seven day working	Additional investment in the integrated care network across care agencies, including in primary, community & acute care settings, will support delivery of the clinical standards for seven day working, as the Better Care Fund includes investment in services to support extended working in 2015/16. The BCF Plan to develop integrated care network supports:

Standard 1: Patients and carers must be involved in shared decision making about their investigations, treatment & ongoing care and this should happen 7 days a week. Ensuring patients & carers are involved in their assessment, planning & delivery of care including arrangements for 7-day delivery and crisis management is a key objective of integrated care, particularly within primary care management. Individuals' GP-led multi-disciplinary plans are being developed and implemented tailored to their needs & preferences;

Standard 9: Support services in the hospital and primary and community setting must be available seven days a week: The BCF Plan includes specific investment to support multi-disciplinary extended working, early supported hospital discharge and crisis management in the community and in care homes to help avoid hospitalisation as part of our integrated care programme.

Standard 4: Handovers must be led by a competent senior decision maker and take place at a designated time. Handover processes, including communication and documentation, must be standardised. Arrangements are well-established in acute & intermediate care settings, but the BCF Plan includes investment to ensure multi-disciplinary early hospital discharge is consistent 7-days a week; whilst primary care management processes include rapid response arrangements and are standardised across all 4 CCG localities;

Standard 8: All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily. The BCF Plan includes investment in consultant-led day Assessment Unit and day ambulatory care unit for older people with frailty in which every patient is seen by a consultant and discharged the same day;

Standard 10: All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement consistent with the delivery of high-quality, safe patient care, 7-days a week. The BCF Fund includes multi-agency quality expectations relating to quality improvement within and across individual care agencies involved in delivery, including arrangements for hospital discharge & crisis management; and these principles are reinforced within individual service contracts.

Annex A: Quality

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3.14	Safeguarding
How your plans will meet the requirements of the accountability and assurance framework for protecting vulnerable people	• Holding quarterly safeguarding subcommittees for Children and Adults at Risk, which includes assurance from provider indicator dashboards. • The Designated Nurse and the Head of Safeguarding attending provider Safeguarding children and Adults committees chaired by the respective providers. • Being a statutory partner of the Enfield Safeguarding Children Board (ESCB) and the Enfield Safeguarding Adult Board (ESAB).
The support for quality improvement in application of the Mental Capacity Act	• Following a recent conference on application of the Mental Capacity Act for nursing homes, the CCG now is part of a tri borough programme of work (with Barnet and Haringey) which includes an audit to benchmark provider MCA and DoLS compliance • There will be a further conference which will provide an opportunity to deliver more training to front line staff, and a bespoke series of workshops 'surgeries' for providers. • The CCG is also cited on quarterly provider returns on the application of the Mental Capacity and Deprivation of Liberty Safeguards.
How you will measure the requirements set out in your plans in order to meet the standards in the PREVENT agenda	• The CCG has a PREVENT lead in post • Enfield CCG ensures that their staff and provider staff have had PREVENT training • Assurance there is a PREVENT strategy in place for each provider • The CCG requests quarterly populating of a safeguarding adults dashboard from each provider that reflects the number of staff trained in PREVENT • The CCG monitors compliance with the PREVENT agenda through Clinical Quality Review Group (CQRG) meetings. • All CCG have had training workshops on PREVENT to its own staff. • The Governing body will receive training in PREVENT in April 2015

Annex A: Innovation

NHS Enfield Clinical Commissioning Group

3.15	Research and Innovation
How your plans fulfil your statutory responsibilities to support research	Enfield CCG recognises that it has a considerable distance to travel in terms of promoting and supporting research. We are testing new models of care and commissioning – integrated care, outcomes based commissioning, provider partnerships to deliver integrated services and that these would best lend themselves being underpinned by ongoing research. Enfield CCG recognises that it needs to strengthen its relationship with UCLP as its main Academic Health Sciences Partnership and discussion have taken place as to how we can work together in the future and this has led to the implementation of some joint projects. UCLP also works with Enfield CCG as part of the NCL Strategic Planning Group and currently lead with Camden CCG the Clinical Services Review across all providers within NCL.
How you will adopt innovative approaches using the delivery agenda set out in Innovation Health and Wealth: accelerating adoption and diffusion in the NHS	The CCG recognises that it has some distance to travel in terms of commissioning and implementing the 6 high impact innovations but the following provides some examples: 1. Reducing face to face consultation for patient by testing out clinical conversations between GPs and Consultant fore cardiology and respiratory ands part of pathway redesign 2. Tested out telehealth successfully as part of our integrated care system and this will form part of our programme moving forwards 3. Develop substantial digital revolution in primary care if successful with the prima ministers challenge fund 4. Significant focus on dementia both diagnosis and follow-up care with an additional 100 patients added to GP registers and further development of care options through the Better Care Fund 5. CQUIN has been used across NCL to support delivery of integrated care and outcomes based commissioning

Annex A: Innovation

NHS Enfield Clinical Commissioning Group

3.15	Research and Innovation (2)
How you will use Academic Health Science Networks to promote research	The CCG has been working with Academic Health Science Networks to improve health and well-being of the population in Enfield. The CCG is implementing a couple of pilot programmes to improve health of the population as well as promoting innovation . These projects include: **UCLPartners (Academic Health Science Partnership):** UCLPartners' purpose is to translate cutting-edge research and innovation into measurable health and wealth gains for patients and populations across our designated area, across the UK and globally. UCLPartners are focusing programmes of work to support earlier intervention and primary health care, as we believe this is where the biggest differences can be made. Atrial Fibrillation Pilot Project and Secondary Prevention: Retrospective case records review pilot project has been implemented at 17 Enfield GP practices in partnership with UCLPartners. The project will inform the primary care prevention strategy and direction, potentially being rolled out across the remaining Enfield GP sites. **HiLo Programme:** HiLo is a GP based intervention that has been developed based on the ASCOT criteria for implementation in general practice. HiLo intervention targets individual patients within GP practice who have high blood pressure and/cholesterol which is difficult to treat. The Enfield CCG has been working closely with William Harvey Research Institute to implement this programme at Enfield GP practices. Key deliverables includes procuring and providing education and training events that 'up skill' the local clinical workforce; being creative in maintaining an emphasis of CVD management within primary care; and ensuring techniques learnt can be applied.

Annex A: Delivering Value

NHS Enfield Clinical Commissioning Group

3.16	Financial Resilience; Delivering Value For Money For Taxpayers And Patients And Procurement
Meeting the business rules on financial plans including surplus, contingency and non-recurrent expenditure	The CCG forecasts a deficit of £14.4m in 2015/16. The financial recovery plan paper sets this out in detail. The plan includes a 1% contingency. The minimum required is 0.5% however we are clearly in a high risk period and 1% is considered prudent. Running costs are planned to fall by 10% per head and the CSU have confirmed a 5.5% reduction for 2015/16.
Clear and credible plans that meet the efficiency challenge and are evidence based, including reference to benchmarks	The CCG have commissioned external help to provide support in building a robust recovery plan. The terms of reference were signed off jointly with NHS England. Whilst the remit covered contracting, monitoring and reporting the main focus is on helping us build a credible and implementable QIPP programme for 2015/16. The output from this work to date is presented in detail in the financial recovery plan.
The clear link between service plans, financial and activity plans	Financial plans are based on 2014/15 forecast outturn vales and activity levels. These meet the guidance criteria with the exception of Mental Health Investment, which is 5% as opposed to the 7.17% uplift in our allocation. This has been discussed with NHSE.

Financial Plan

NHS Enfield Clinical Commissioning Group

4.1	Summary of Financial Plan
The Draft Finance Plan	The draft Finance plan sets out our current financial position, our proposed recovery actions and the resources required to deliver. It covers the period up to 2018/19. The 2015/16 plan forecasts an in year deficit of £14.4m. The start point is an in year deficit of £19.0m in 2014/15 which reflects our recent validation exercise. The underlying recurrent position is a deficit of £18.8m. We have used the generic assumptions set out in the 2015/16 planning guidance and these are reflected in the plan. The CCG have commissioned external help to provide support in building a robust recovery plan and have jointly commissioned a Financial Governance Review with NHS England. Growth is included at 3.1% for planning purposes. Most provider offers do not include growth currently whilst we negotiate inclusion of QIPP. 3.1% represents a risk given recent activity trends. The Enhanced Tariff Option has been costed at £0.834m. This is not included in the base figures and will represent a risk if contracts are settled on this basis. NHSE have funding available to offset and this will become clear before a final plan is published. The Enhanced Tariff Option will be used to inform the official plan submission on the 27th February. The gross provider efficiency reduces to 3.5%. The plan represents a realistic view of risk and opportunity. However there is a risk that the CCG will fail to achieve the £12.5m QIPP savings target. External assistance will focus heavily on improving savings delivery through QIPP. As the CCG has already used all of its non-recurrent resources in 14/15, any QIPP failure or significant over performance on contracts not covered by reserves will place immediate pressure on the financial forecast.

Activity Trajectories

NHS Enfield Clinical Commissioning Group

4.2	Activity Trajectories

Referrals

Summary of total planned activity (all acute hospitals) for:

- Non-Elective Admissions
- Elective Admissions
- First Outpatient Attendances
- Subsequent OPAs
- A&E attendances

NB: Planning data correct as at 28/2/15 and NOT agreed with providers.

	Acute Services (Activity) All Specialties				
	Spells	Spells	Outpatients		A&E
	Non-elective admissions - all specialties E.C.23	Elective admissions - ordinary - all specialties E.C.21	All first outpatient attendance - all specialties E.C.24	All subsequent outpatient attendancies - all specialities E.C.6	A&E attedances all types E.C.8
2014/15	34,359	6,146	124,099	269,479	151,715
2015/16	33,675	6,239	125,963	273,519	148,682
2014/15 - 2015/16 Change	(684)	93	1,864	4,040	(3,033)
2014/15 - 2015/16 Change %	-2%	2%	2%	1%	-2%

Risk Register

NHS Enfield Clinical Commissioning Group

4.3	Risk or Issue	Mitigation
The major risk facing the CCG is the unpredictability of acute activity. The CCG has planned on the basis of 3.1% growth in acute contracts. Recent national trends suggest this is a risk.		This will be mitigated by increased contract management resource. The CCG has already recruited a Deputy Director of contracts who is experienced in managing PbR agreements Effective management of PbR contract negotiation may result in block contracts or cap and collar alternatives being agreed. In addition the 2015/16 budgets will be set at 2014/15 forecast outturn, plus growth and the reserve for RTT.
Potential failure to deliver QIPP.		The CCG is working closely with Deloitte to build a robust deliverable QIPP programme for 2015/16 and beyond.
Finally we understand that further investment in the London Ambulance Service may be required at £1.0m on average per CCG.		This is not in our submission and would be a pressure should it materialise.
RTT activity: The quantity and value of the backlog of RTT activity at Chase Farm Hospital remains an unknown liability		A financial reserve has been established within the Draft Finance Plan.
C. Difficile		RCA for each C.Diff case and aggressive monitoring through CQR. Individual providers also have extensive recovery and prevention plans
IAPT Access & Recovery: BEHMHT does not have sufficient capacity to deliver the target and is in a financially challenged position.		A tapered trajectory has been agreed with the Trust in principle and commissioners are working with the provider to establish a financially viable recovery plan.

Enfield CCG Operating Plan Conclusion

NHS Enfield Clinical Commissioning Group

5.0 CONCLUDING REMARKS

Overall 2015-16 will be another challenging year. We will focus on improving patient experience, delivering value for money and ensuring excellent clinical outcomes, but by planning for the longer-term, we can have confidence that we will continue to deliver for patients.

NHS Enfield CCG Operating Plan Refresh (2015/16) sets out our commissioning priorities (including our QIPP schemes) for 2015/16. It has been informed by the feedback received from our GP members, the public, the Enfield Joint Strategic Needs Assessment and the Enfield Health and Wellbeing Strategy. We welcome our shared responsibility to deliver the JHWB Strategy and our shared commitments working closely with the London Borough of Enfield.

We will continue to develop our transformation programmes as well as cross-cutting programmes which include: Transformation of Community Services, Value Based Commissioning, Managing Demand and developing Locality Commissioning. We will work together to create an environment where we can build resilience for the whole system during a time of major transitions. It should be noted that some of our ambition is directly impacted by our financial position.

As part of the North Central London Health Economy Strategic Planning Group, we will drive improvement in the delivery of high quality, evidence-based and compassionate services, defined and measured by outcomes not process, to the population of North-Central London.

This document is a framework for how we intend to commission local health services during the next year. Our Operating Plan Refresh has been developed to show how we intend to make best use of our available resources to ensure that Enfield people receive high quality, safe health services that meet their needs and are good value for money.

We will only be successful if we can continue to work effectively with our member practices; build on our strong collaborative working with the local authority, health care providers, NHS England and NCL; and work in partnership whilst with our local communities, Healthwatch and voluntary/ third sector organisations.

Enfield CCG Operating Plan Refresh for 2015/16 represent an ambitious commissioning plan within our financially constrained environment; but we believe that it is only by being transformational in our approach that we will be able to respond effectively to the significant challenges facing the NHS.

Agenda Item 4

MUNICIPAL YEAR 2014/2015 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board** **14 April 2015**	**Agenda - Part: 1** **Item: 4** **Subject:** **Enfield Pharmaceutical Needs Assessment 2015** **Wards: All**
Director of Public Health	**Cabinet Member consulted:**
Contact officer and telephone number: **Allison Duggal**, Consultant in Public Health T: 020 83792894 E mail: **allison.duggal@enfield.gov.uk**	**Approved by:**

1. EXECUTIVE SUMMARY

A Pharmaceutical Needs Assessment (PNA) is the way in which HWBs, local Authorities, The NHS and other public sector partners work together to understand the current and future pharmaceutical needs of the local population. The Health and Wellbeing Board (HWB) has a statutory duty to produce a PNA every 3 years and there is currently a requirement for a PNA to be published by April 2015.

This paper outlines the steps taken to ensure that the PNA produced for Enfield is fit for purpose, including a 60 day consultation period. The PNA has been considered by the PNA Steering Group and found to be ready for publication

Failure to produce a robust PNA can lead to legal challenges because of the PNA's relevance to decisions about commissioning services and the opening of additional, new pharmacies.

2. RECOMMENDATIONS

It is recommended that the health and wellbeing board:

- Agrees to the publication of the new Pharmaceutical Needs Assessment attached as appendix 1 of this report.
- Takes into consideration the statutory requirement to meet its obligation to publish the PNA by April 2015.

3. BACKGROUND

3.1 The NHS (Pharmaceutical and local Pharmaceutical Services) Regulations 2013 require Health and Wellbeing boards (HWB)s to produce a Pharmaceutical Needs Assessment (PNA), identifying any changes and producing updated maps and Statements for their respective areas. A steering group, sponsored by the Director of Public health, and chaired by a Consultant in Public Health was set up to oversee the production of the PNA. This was a multiagency group consisting of key local stakeholders. The group reported to the HWB on a quarterly basis. Any decisions that were made outside the steering group meeting were ratified by the group at the next meeting hence there is full accountability from the steering group.

3.2 A revised assessment of the pharmaceutical needs was necessary in order to prevent significant detriment to the provision of pharmaceutical services in Enfield because of the significant changes in the population since 2011, particularly with respect to the underestimation in total population revealed by the census (1.6%;n=5044).

3.3 The steering group ensured that the statutory guidelines were followed and process was inclusive to all stakeholders and all sections of the community. The minimum requirements of the good PNA are outlined in Regulation 4 and schedule 1 of the 2013 Regulations. The matters to which each HWB must have regard in preparing its PNA are outlined in Regulation 9. Consultation on the draft PNA took place between 1 December 2014 and 31 January 2015, meeting the 60 day consultation requirement. The consultation process is outlined in *Appendix G, Stakeholder Engagement,* of the PNA document. Responses to the consultation are attached as *Appendix H* and these were incorporated in the final draft of the PNA. An equalities impact assessment was undertaken and will be published with the PNA**.**

3.4 The PNA will be reviewed after three years. Arrangements to keep the maps up-to-date and update any changes which are likely to impact on pharmaceutical services through supplementary statements are being negotiated. Any supplementary statements will be logged with NHS England and published alongside the PNA document on the council's website.

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 There were no alternative options considered because of the information detailed in para 3.2, which eliminated the option of a review of the existing PNA of 2011 produced by the PCT.

5. REASONS FOR RECOMMENDATIONS

5.1 Enfield HWB has a duty to publish a fit for purpose PNA by April 2015. The Steering group which was appointed to oversee the production of the PNA is giving assurance that the process met the statutory guidelines, it was fair and inclusive.

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

6.1 Financial Implications

The Pharmaceutical Needs Assessment was produced by an external consultant and the work on it has now been completed. Payment has been made in 14/15 to the consultant for around £25k (with a further £5k incurred for the costs of running the PNA consultation). This was a scheduled piece of work within the Public Health area in 14/15 which is now complete and pending publication given the approval of the Health & Wellbeing Board

6.2 Legal Implications

Pursuant to the NHS (Pharmaceutical and local Pharmaceutical Services) Regulations 2013 require Health and Wellbeing boards (HWB)s to publish a Pharmaceutical Needs Assessment (PNA). Failure to do so would be a breach of the Council's statutory duty.

A representative from Legal Services was on the PNA Steering Group. The PNA is in a form approved by Legal Services.

7. KEY RISKS

Failure to produce a robust PNA can lead to legal challenges because of the PNA's relevance to decisions about commissioning services and the opening of additional, new pharmacies. This can have an adverse impact on the Council's reputation.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Ensuring the best start in life

The PNA will guide commissioners to ensure that pharmaceutical services are easily accessible and provide the necessary service to promote health and dispense medicine to support and improve antenatal and perinatal health and provisions for 0-5year requirements, which will improve the chances of the best start in life for families in Enfield.

8.2 Enabling people to be safe, independent and well and delivering high quality health and care services

The PNA shows the opening hours for all pharmacies and the pharmacies that are commissioned to deliver additional specialist health services like sexual health, methadone management, electronic dispensing and others.

This enables the local residents to be safe and independent knowing that they have a pharmacy within walking distance, knowing the pharmacy is able to meet their specific health needs and allows commissioners to be sure that the services are well distributed across the borough to ensure that local needs are proportionately catered for across the borough. This constitutes a high quality care service.

8.3 **Creating stronger, healthier communities**

The PNA will facilitate accurate and up to date information to commissioners which will enable fit for purpose commissioning and opening the market to the right providers. This means that Enfield residents will have access to the right level of pharmaceutical services resulting in stronger, healthier communities.

8.4 **Reducing health inequalities – narrowing the gap in life expectancy**

Rigorous consultation took place during the process of developing the PNA. Local residents and all major groups and organisations with vested interest in health service provision in Enfield were invited to be part of the steering group or consulted throughout the process. Responses were incorporated in the PNA document. Pharmaceutical service mapping was aligned with some of the key major health pressure points to ensure those areas had the relevant and adequate service levels. Future developments were taken into consideration to ensure that the pharmaceutical needs cater for the potential population growth in particular areas will be catered for.

8.5 Promoting healthy lifestyles

Having the right numbers of pharmacies which are within walking distance as well as commissioning pharmacies to provide specific services in targeted areas will improve healthy lifestyles.

9. EQUALITIES IMPACT IMPLICATIONS

An Equalities impact Assessment was conducted and the PNA considers the protected characteristics under the Equalities Act 2010.

Background Papers
None

Pharmaceutical Needs Assessment 2015

Enfield Health and Wellbeing Board

Contents

Executive summary

Every Health and Wellbeing Board (HWB) is now required to produce a Pharmaceutical Needs Assessment (PNA).

This mapping of pharmaceutical services against local health needs provides Enfield HWB with a framework for the strategic development and commissioning of services. It will enable the local pharmacy service providers and commissioners to:

- understand the pharmaceutical needs of the population
- gain a clearer picture of pharmaceutical services currently provided
- make appropriate decisions on applications for NHS pharmacy contracts
- commission appropriate and accessible services from community pharmacy
- clearly identify and address any local gaps in pharmaceutical services
- target services to reduce health inequalities within local health communities.

The PNA Steering Group for Enfield HWB has overseen the production of this PNA. The consultation on the draft PNA took place between 1st December 2014 and 31st January 2015.

NHS Pharmaceutical Services in England

NHS Pharmaceutical Services are provided by contractors on the 'Pharmaceutical List' held by NHS England. Types of providers are:

- community pharmacy contractors, including distance-selling pharmacies
- dispensing appliance contractors
- local pharmaceutical service providers
- dispensing doctors

Community pharmacies operate under a contractual framework agreed in 2005 which set three levels of service:

Essential services:	Negotiated nationally. Provided from all pharmacies
Advanced services:	Negotiated nationally. Provided from some pharmacies, specifically accredited
Enhanced srvices:	Negotiated locally to address local health needs. Provided from selected pharmacies, specifically commissioned

This contractual framework enables NHS England area teams to commission services to address local needs, whilst still retaining the traditional dispensing of medicines and access to support, for self-care from pharmacies.

Health in Enfield

The area

Enfield is a borough in the north of London. It has borders with the other London boroughs of Barnet, Haringey and Waltham Forest as well as Hertfordshire to the north. Enfield is one of the largest boroughs in London, yet two thirds is open spaces or designated green belt land. Enfield is also the home to the largest Cypriot community outside of Cyprus.

The population

The population has grown by 20% over the last 15 years and by 26% over the last 25 years. The current estimated population is 322,295. This number is projected to rise to:

- 337,259 by 2021 (4.6%)
- 356,396 by 2031 (10.6%)

These rates are significantly lower than the London average (8.7% and 16.5% respectively). For both Enfield and England the highest increment will be amongst the persons aged 65 years and over.

Enfield Council plans to develop 6,870 homes during 2015-2020 which will help support the growing population and demand for housing. Detailed plans on when the dwellings will be available are not yet known. The HWB will continue to monitor the development of new homes and, as information becomes known, will reflect within the updates to the PNA. A number of proposed health provision changes are planned, in particular within Chase Farm Hospital site and Boundary Court Surgery. Again, timescales and scale of these changes are not yet certain, but will be reflected within future updates to the PNA once confirmed. The HWB has considered other potential changes to social traffic e.g. shopping developments. There are no firm plans for any major changes during the time horizon of this PNA.

Enfield has a considerably larger proportion of black ethnic populations (17.2%) compared to the London average of 13.3% and the England average of 3.5%. Enfield also has larger proportion of "White Other" which includes Turkish / Kurdish. Enfield has the largest Turkish community in London

The increasing population and its diversity will require significant planning for the delivery of services, in particular to meet its varied health and social care needs.

Health inequalities

Enfield on the whole is a relatively deprived area with pockets of affluent areas. It is often described as “a borough of two halves”. The most deprived areas within the borough are concentrated largely in the south east: Edmonton Green, Upper Edmonton, Lower Edmonton, Ponders End and Turkey Street. The three Edmonton wards are within the most deprived 10% of wards in England.

Particular populations which may have specific health needs include asylum seekers, refugees, travellers, minority ethnic communities and disabled people.

Health and illness

Average life expectancy in Enfield is slightly greater than the London and national averages. However, there is a wide variance between Enfield's wards with male life expectancy ranging from 74.7 years to 82.4 years and female life expectancy ranging from 76.6 years to 90.1 years. In general, life expectancy is greater in the western wards in Enfield.

Premature all-cause mortality rates in Enfield are the 23rd lowest of the 150 local authorities in England. However, rates are significantly higher in the Edmonton Green and Upper Edmonton wards than the national average.

Diabetes prevalence is significantly greater in Enfield than in London and England as a whole. Prevalence by locality in Enfield varies dramatically - from 5.5% of population in North West locality to 7.9% in South East locality.

Lifestyle

Alcohol-related hospital admissions in Enfield are increasing at a significantly faster rate than the London and national averages.

Teenage pregnancy rates in Enfield have been falling in recent years and remain below both the London and national averages. However, the Upper Edmonton, Lower Edmonton and Haselbury wards have rates up to five times higher than the lowest wards in Enfield.

Locally commissioned services, through the Local Authority, are provided by several community pharmacies to address many of these lifestyle issues.

Pharmacies in Enfield

Enfield has 61 community pharmacies (as at 29th January 2015) for a population of about 322,295. Provision of current pharmaceutical services and locally-commissioned services are well distributed serving all the main population centres. There is excellent access to a range of services commissioned by, and privately provided from, pharmaceutical service providers.

Table 1 shows the change in the numbers of community pharmacies compared with regional and national averages. Using current population estimates, the number of community pharmacies per 100,000 population for Enfield is currently 18.9 (England: 21.7, London: 22.3). Enfield is well-served with community pharmacies although the rate of provision is currently less than both the London average and the national average.

Table 1 - Number of community pharmacies per 100,000 population

	Community pharmacies per 100,000 population		
	England	**London SHA**	**Enfield**
2013/14	21.7	22.3	18.9
2012/13	21.6	22.5	19.4
2011/12	21.2	22.2	19.4
2010/11	21.1	23.3	21.0

The majority of community pharmacies in Enfield are open weekday evenings (74%) and Saturdays (90%).

A lesser number are open on Sundays (20%), mainly in shopping areas.

There is also a much higher than national ratio of independent providers to multiples providing a good choice of providers to local residents (national average is 39% independent providers versus 49% in Enfield).

Feedback on pharmaceutical services

Views of pharmacy service users were gained from a questionnaire circulated for comments from the general public. The results provide an insight to Enfield residents' views on pharmaceutical service provision in Enfield HWB area.

From the 231 responses received from the public questionnaire:

- **96%** rated their overall **satisfaction on the service** received from their local pharmacy as **'Excellent'** or **'Good'**
- **40%** indicated that they **used pharmacies up to every month** for the purchase of over the counter medicines; with **88%** having a **regular or preferred pharmacy** they use
- **95%** rated their **confidence in the pharmacist's knowledge** and advice as **'Excellent'** or **'Good'**
- **45%** rated as important that the pharmacy is **close to their GP surgery**; **71%** that the pharmacy is **close to their home**; **15%** that the pharmacy is **close to where they work** and **57%** that the pharmacy **has friendly staff**
- **55%** walk to their community pharmacy; **28%** use a **car**; **11%** use **public transport**; **4%** use a **bicycle**
- **79%** had **no difficulties travelling** to their pharmacy; **13%** had **parking difficulties**; **5%** had **problems with the location** of the pharmacy and **3%** had **problems with public transport availability**
- The greatest percentage of respondents had no **most convenient day (34%)** or **time (59%)** to **visit their pharmacy**

- **65%** of respondents report having a **journey time of no more than 10 minutes**; **91%** of respondents have a **journey time no greater than 20 minutes**
- **96%** indicated that the **ease of obtaining prescription medication** from their pharmacy was **'Very easy'** or **'Fairly easy'**

Conclusions

Enfield has 61 community pharmacies (as at 29th January 2015) for a population of about 322,295. Provision of current pharmaceutical services and locally-commissioned services are well distributed serving all the main population centres. There is excellent access to a range of services commissioned, and privately provided from, pharmaceutical service providers.

Current provision – necessary and other relevant services

Enfield HWB has identified essential services and advanced services as necessary services.

Enfield HWB has identified enhanced services as pharmaceutical services which secure improvements or better access, or have contributed towards meeting the need for pharmaceutical services in the area of the HWB.

Enfield HWB has identified locally commissioned services as pharmaceutical services which secure improvements or better access, or have contributed towards meeting the need for pharmaceutical services in the area of the HWB.

Necessary services – gaps in provision

Access to essential services

In order to assess the provision of essential services against the needs of the residents of Enfield, the HWB consider access and opening hours as the most important factors in determining the extent to which the current provision of essential services meets the needs of the population. The rate of community pharmacies per population in Enfield is below the average for England and providers in Enfield currently dispense more prescriptions compared with the average community pharmacy in England.

The patient survey did not record any specific themes relating to pharmacy opening times. Enfield HWB therefore concludes there is no significant information to indicate there is a gap in the current provision of pharmacy opening times.

Access to essential services normal working hours

Enfield HWB has determined that the access and opening hours of pharmacies in all four localities and across the whole HWB area are reasonable in all the circumstances.

There is no gap in the provision of essential services during normal working hours across the whole HWB area.

Access to essential services outside normal working hours

Supplementary opening hours are offered by all pharmacies in each locality. There are also four 100 hour contract pharmacies and a further ten “late night” pharmacies open to at least 7.30pm within the HWB area. These are geographically spread across HWB area and the four PNA localities. Over one in five, or 23%, of pharmacies within HWB area are either 100 hour or late night pharmacies. This is a significant proportion of pharmacies.

There is no gap in the overall provision of essential services outside of normal working hours within the whole HWB area.

Access to advanced services

There is no identified gap in the provision of advanced services as medicines use reviews (MURs) are available in 94-100% of pharmacies across the four localities and the new medicines service (NMS) is available in 85-100% of pharmacies across localities.

There are no gaps in the provision of advanced services in across the whole HWB area.

Access to enhanced services

There is no identified gap in the provision of enhanced services as immunisation services are accessible across all four localities with between 72-100% of pharmacies providing the service.

There are no gaps in the provision of enhanced services (immunisation services) across the whole HWB area.

Future provision of necessary services

Enfield HWB has not identified any pharmaceutical services that are not currently provided but that will, in specified future circumstances, need to be provided in order to meet a need for pharmaceutical services in any of the four localities.

No gaps in the need for pharmaceutical services in specified future circumstances have been identified across the whole HWB area.

Improvements and better access – gaps in provision

As described in Section 6 and required by Paragraph 4 of Schedule 1 to the 2013 Regulations:

Current and future access to essential services

Enfield HWB has not identified services that would, if provided either now or in future specified circumstances, secure improvements, or better access, to essential services in any of the four localities.

No gaps have been identified in essential services that, if provided either now or in the future, would secure improvements, or better access, to essential services across the whole HWB area.

Current and future access to advanced services

Across the whole HWB area in 2012/13, MURs were available in 100% of pharmacies and NMS were available in 78.7% of pharmacies. Where applicable, NHS England will encourage all pharmacies and pharmacists to become eligible to deliver the service in all pharmacies so that more suitable patients are able to access and benefit from this service.

Demand for the appliance advanced services (stoma appliance customisation (SAC) and appliance use reviews (AUR)) is lower than for the other two advanced services due to the much smaller proportion of the population that may require them. Pharmacies and dispensing appliance contractors (DACs) may choose which appliances they provide and may also choose whether or not to provide the two related advanced services.

There are no gaps in the provision of advanced services at present, or in the future, that would secure improvement or better access to advanced services across the whole HWB area.

Other NHS services

Enfield HWB has had regard for any other NHS services that may affect the need for pharmaceutical services in the area of the HWB as required by Paragraph 5 of Schedule 1 to the 2013 Regulations.

Based on current information no gaps have been identified in respect of securing improvements, or better access, to other NHS services either now or in specified future across the whole HWB area.

Locally commissioned services

With regard to enhanced services and locally commissioned services, the HWB is mindful that only those commissioned by NHS England are regarded as pharmaceutical services. The absence of a particular service being commissioned by NHS England is, in some cases, addressed by a service being commissioned through Enfield Council (as in the case of emergency hormonal contraception (EHC), needle exchange, supervised consumption of opiates services and transforming community equipment services (TCES)) or Enfield CCG (as in the case of the minor ailments service MAS)). This PNA identifies these services as locally commissioned services (LCS).

Enfield HWB notes that all enhanced services and LCS are accessible to the population in all PNA localities.

However, Enfield HWB has not been presented with any evidence to date which concludes that any of these enhanced services or LCS should be expanded. Based on current information, Enfield HWB has not identified a need to commission any enhanced pharmaceutical services not currently commissioned.

The HWB notes that all enhanced services and locally commissioned services are accessible to the population in all localities. The HWB has not been presented with any evidence to date which concludes that any of these enhanced services or locally commissioned services should be decommissioned; or that any of these enhanced services or locally commissioned services should be expanded. Based on current information, the HWB has not identified a need to commission any enhanced pharmaceutical services not currently commissioned.

Although the HWB has identified locally commissioned services as relevant services for the purpose of the PNA, the HWB understands the 'necessity' of provision of some of these services from community pharmacies, in certain locations at certain times e.g. EHC service availability at weekends and evenings.

Regular PNA reviews are recommended in order to establish if currently, and in future scenarios, locally commissioned services secure improvement or better access in the HWB area.

Overall, Enfield residents are satisfied with the provision of pharmaceutical services. The most important location for choosing a community pharmacy is 'close to home'. Nine out of ten community pharmacies in Enfield are open on Saturdays, almost three out of four are open after 6pm weekdays and one in five are open on Sundays. The majority of Enfield residents report walking to their community pharmacy. Four out of five had no difficulties travelling to their pharmacy.

It is the belief of Enfield HWB that this PNA is compliant with the Pharmaceutical Regulations 2013.

Acknowledgements

Enfield Health and Wellbeing Board would like to thank the members of the steering group (listed in Appendix B) and colleagues in Enfield Council's Public Health and Communications and Engagement teams for their support in producing this document. The HWB would also like to express gratitude to Soar Beyond Ltd for their assistance with the preparation of this needs assessment.

Section 1: Introduction

1.1 Background

The Health Act 2009, 128A[1], made amendments to the NHS Act 2006 requiring Primary Care Trusts (PCTs) to assess the needs for pharmaceutical services in its area and publish a statement of its assessment and any revised assessment. The regulations required the Pharmaceutical Needs Assessment (PNA) to be published by the 1st February 2011. There was also a requirement to re-write the PNA every three years or earlier if there were significant changes to the pharmaceutical needs of the area. Enfield PCT produced their first PNA in February 2011.

The responsibility for the development, publishing and updating of PNAs became the responsibility of Health and Wellbeing Boards (HWBs) as a result of the Health and Social Care Act 2012[2]. The act dramatically reformed the NHS from 1st April 2013: PCTs were abolished and Health and Wellbeing Boards (HWBs), Clinical Commissioning Groups (CCGs) and NHS England were formed:

- HWBs, hosted by each 'upper tier' local authority, have their membership drawn from local leaders (including NHS England, CCGs and local government) and are responsible for the continual improvement of the health and wellbeing of the local population
- CCGs are GP led NHS bodies responsible for planning, purchasing and monitoring the majority of local health services including hospital, community, emergency and mental health care
- NHS England oversees the operations of the CCGs as well as commissioning primary and specialist services (such as cancer care). Along with CCGs, it has the responsibility of improving health outcomes and reducing health inequalities

The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (SI 2013/349)[3], hereafter referred to as the 'Pharmaceutical Regulations 2013', came into force on 1st April 2013. Unless required to be produced earlier, these regulations permitted HWBs to a temporary extension of the PNAs previously produced by the PCT; HWBs are now required to publish their first PNA by 1st April 2015 latest.

The 2013 Regulations were updated to The National Health Service (Pharmaceutical and Local Pharmaceutical Services) (Amendment and Transitional Provision) Regulations 2014 on 1st April 2014. This PNA has considered these amendments but the 2013 Regulations[3] have been referenced throughout.

[1] Health Act 2009 - http://www.legislation.gov.uk/ukpga/2009/21/part/3/crossheading/pharmaceutical-services-in-england?view=plain
[2] Health and Social Care Act 2012 - http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[3] Pharmaceutical Regulations 2013 - http://www.legislation.gov.uk/uksi/2013/349/contents/made

1.2 Purpose of the PNA

NHS England is required to publish and maintain a 'Pharmaceutical List' for each HWB area. Any person wishing to provide NHS pharmaceutical services is required to be listed on the 'Pharmaceutical List'. NHS England must consider any applications for entry onto the 'Pharmaceutical List'. The Pharmaceutical Regulations 2013[3] requires NHS England to consider applications to fulfil unmet needs determined within the PNA of that area or applications for benefits unforeseen within the PNA. Such applications could be for the provision of NHS pharmaceutical services from new premises or to extend the range or duration of current NHS pharmaceutical services offered from existing premises. As the PNA will become the basis for NHS England to make determinations on such applications, it is therefore essential that the PNA is compiled in line with the regulations and, with due process, that the PNA is accurately maintained and up-to-date. Although decisions made by NHS England regarding applications to the 'Pharmaceutical List' may be appealed to the NHS Family Health Services Appeals Unit, the final published PNA cannot be appealed. It is likely the only challenge to a published PNA will be through application for a judicial review of the process undertaken to conclude the PNA.

The PNA should also be considered alongside the local authority's Joint Strategic Needs Assessment (JSNA)[4]. The PNA will identify where pharmaceutical services address public health needs identified in the JSNA[4] as a current or future need. Through decisions made by the local authority, NHS England and the CCGs these documents will jointly aim to improve the health and wellbeing of the local population and reduce inequalities.

1.3 Scope of the PNA

The Pharmaceutical Regulations 2013[3] details the information required to be contained within a PNA. A PNA is required to measure the adequacy of pharmaceutical services in the HWB area under five key themes:

- necessary services: current provision
- necessary services: gaps in provision
- other relevant services: current provision
- improvements and better access: gaps in provision
- other services

In addition, the PNA also details how the assessment was carried out. This includes:

- how the localities were determined
- the different needs of the different localities

[4] Enfield Joint Strategic Needs Assessment: http://www.enfield.gov.uk/healthandwellbeing/info/3/joint_strategic_needs_assessment_jsna

- the different needs of people who share a particular characteristic
- a report on the PNA consultation

As already mentioned, the PNA is aligned with the Enfield JSNA[4].

To appreciate the definition of 'Pharmaceutical Services' as used in this PNA, it is firstly important to understand the types of NHS pharmaceutical providers comprised in the 'Pharmaceutical List' maintained by NHS England. They are:

1. Pharmacy contractors
2. Dispensing appliance contractors
3. Local pharmaceutical service providers
4. Dispensing doctors

For the purposes of this PNA, 'Pharmaceutical Services' has been defined as those which are / may be commissioned under the provider's contract with NHS England. A detailed description of each provider type and the pharmaceutical services as defined in their contract with NHS England, is detailed below.

1.3.1 Pharmacy contractors

Pharmacy contractors operate under the Community Pharmacy Contractual Framework initially agreed in 2005. This sets three levels of service under which they operate:

Essential services - these can be found in Schedule 4 of the Pharmaceutical Regulations 2013[3]. They are nationally negotiated and must be provided from all pharmacies:

- dispensing of medicines
- repeat dispensing
- safe disposal of unwanted medicines
- promotion of Healthy Lifestyles
- signposting
- support for self-care
- clinical governance

Advanced services - these can be found in parts two and three of The NHS Act 2006, the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013 and '2013 Directions'[5].

[5] The 2013 Directions - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193012/2013-03-12_-_Advanced_and_Enhanced_Directions_2013_e-sig.pdf, and amendment - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266023/pharmaceutical_services_directions_amendment_2013.pdf

They are negotiated nationally and any contractor may provide:

- medicines use reviews (MURs)
- new medicines service (NMS) - this service is temporarily commissioned and is currently under review nationally
- appliance use reviews (AURs)
- stoma appliance customisation (SAC)

A full list of provision of advanced services provided by pharmacies in Enfield HWB area (correct as of 19th October 2014) can be found in Appendix A.

Enhanced services - these can be found in part four of the 2013 Directions[5]. They are negotiated locally by NHS England Area Teams and may only be provided by contractors directly commissioned by NHS England:

- anticoagulant monitoring service
- antiviral collection service
- care home service
- disease specific management service
- emergency supply service*
- gluten free supply service
- independent prescribing service
- home delivery service
- language access service
- medication review service
- minor ailment service
- needle and syringe exchange service*
- on demand availability of specialist drugs service
- out of hours service
- patient group direction service
- prescriber support service
- schools service
- screening service*
- stop smoking service*
- supervised administration service*
- supplementary prescriber service

The responsibility for public health services transferred from PCTs to local authorities with effect from 1st April 2013. Where these services* are currently commissioned by local authorities, they are not considered enhanced or pharmaceutical services. The 2013 Directions, however, permit NHS England to commission them from pharmacy contractors if asked to do so by a local authority.

In this case, if commissioned by NHS England, they are enhanced services and fall within the definition of pharmaceutical services. In Enfield HWB area, NHS England does not currently commission any public health services from pharmacies.

Pharmacy contractors comprise both those located within the Enfield HWB area as listed in Appendix A, those in neighbouring HWB areas and remote suppliers - such as distance-selling pharmacies. Although distance-selling pharmacies may provide services from all three levels as described above, and must provide all 'essential' services, they may not do so 'face-to-face' at the pharmacy premises.

Additionally, they must provide services to the whole population of England. There is one distance-selling pharmacy located within Enfield HWB area:

- Care Home Meds, 20 Jute Lane, Enfield, EN3 7PJ

It should also be noted that distance-selling pharmacies throughout England (there were 211 in 2013/14[6]) are capable of providing services to Enfield HWB area.

1.3.2 Dispensing appliance contractors

Dispensing appliance contractors (DACs) operate under the Terms of Service for Appliance Contractors as set out in Schedule 5 of the 2013 Regulations[3]. They can supply appliances from an NHS prescription such as stoma and incontinence aids, dressings, bandages etc. DACs must provide a range of essential services such as dispensing of appliances, advice on appliances, signposting, clinical governance and home delivery of appliances. In addition, DACs may provide the advanced services of appliance use reviews (AURs) and stoma appliance customisation (SAC). Pharmacy contractors, dispensing doctors and Local Pharmaceutical Service (LPS) providers may supply appliances but DACs are unable to supply medicines.

There are currently no DACs in the Enfield HWB area however residents can access DACs from elsewhere in the UK if required. There were 112 DACs in England 2013/14[6].

1.3.3 Local pharmaceutical service providers

A pharmacy provider may be contracted to perform specified services to their local population or a specific population group.

[6] General Pharmaceutical Services in England - 2003-04 to 2013-14**:** http://www.hscic.gov.uk/article/2021/Website-Search?productid=16440&q=general+pharmaceutical+2014&sort=Relevance&size=10&page=1&area=both#top

This contract is locally commissioned by NHS England and provision for such contracts is made in the 2013 Regulations[3] in Part 13 and Schedule 7.

Such contracts are agreed outside the national framework although may be over and above what is required from the national contract. Payment for service delivery is agreed and funded locally.

There are no LPS pharmacies in the Enfield HWB area.

1.3.4 Dispensing GP practices

The 2013 Regulations[3], as set out in Part 8 and Schedule 6, permit GPs in certain areas to dispense NHS prescriptions for defined populations. These provisions are to allow patients in rural communities who do not have reasonable access to a community pharmacy, to have access to dispensing services from their GP practice. Dispensing GP practices therefore make a valuable contribution to dispensing services although they do not offer the full range of pharmaceutical services offered at community pharmacies. Dispensing GP practices can provide such services to communities within areas known as 'controlled localities' - see Section 3.3 for further details. GP premises for dispensing must be listed within the 'Pharmaceutical List' held by NHS England and patients retain the right of choice to have their prescription dispensed from a community pharmacy if they wish.

There are no dispensing GP practices in Enfield HWB area.

1.3.5 Other providers of pharmaceutical services in neighbouring HWB areas

There are four other HWB areas which border the Enfield HWB area:

- Haringey HWB
- Barnet HWB
- Waltham Forest HWB
- Hertfordshire HWB

Thus in determining the needs of, and pharmaceutical services provision to, the population of the Enfield HWB area, consideration has been made to the pharmaceutical service provision from the neighbouring HWB areas.

A number of maps can be found in the appendices. Map A provides a detailed analysis of pharmacy contractors which lie across the Enfield HWB border but are within easy reach of the Enfield area.

1.3.6 Other services and providers in the Enfield HWB area

As mentioned earlier, for the purpose of this PNA, 'pharmaceutical services' have been defined as those which are, or may be, commissioned under the provider's contract with NHS England.

The following are providers of pharmacy services in the Enfield HWB area but are not defined as pharmaceutical services under the regulations.

NHS hospitals

- North Middlesex University Hospital NHS Trust
  Sterling Way
  London
  N18 1QX
- Chase Farm Hospital (Royal Free Hospital NHS Trust)
  127 The Ridgeway
  Enfield
  EN2 8JL
- St Michael's Hospital
  Gater Drive
  Enfield
  EN2 0JB
- St Andrew's Court
  1-4 River Front
  Enfield Town
  Enfield
  EN1 3SY

In all hospitals listed above, pharmaceutical service provision is provided to patients by the hospital.

Urgent care centres

- Chase Farm Hospital Urgent Care Centre
  The Ridgeway
  Enfield
  EN2 8JL

  Open daily 9.00am to 9.00pm
- North Middlesex Hospital Urgent Care Centre
  Sterling Way
  Edmonton
  N18 1QX

  Open daily 8.00am to 10.00pm
- Edmonton NHS Walk-in Centre
  Evergreen Primary Care Centre
  1 Smythe Close
  Edmonton
  N9 0TW

  Open weekends and bank holidays only from 8.00am to 8.00pm.

The following are services provided by NHS pharmaceutical providers in the Enfield HWB area and are commissioned by organisations other than NHS England or provided privately.

Local authority public health services - Enfield Council commission the following 'locally commissioned services' from community pharmacies in the Enfield HWB area:

- emergency hormonal contraception services
- supervised administration of medicines (opiates)
- needle and syringe exchange service

Privately provided - many NHS pharmaceutical providers offer the following services privately:

- care home service
- home delivery service
- patient group direction service
- screening service

Services will vary between provider and in some cases may be provided free of charge.

1.4 Process for developing the PNA

As a direct result of the Health and Social Care Act[2], a paper was presented to Enfield HWB on 13th February 2014.

The purpose of the paper was to inform the HWB of its statutory responsibilities under the Health and Social Care Act[2] to produce and publicise a PNA for its area by 1st April 2015.

The HWB accepted the content of the paper at the meeting and the recommendation to delegate responsibility of the PNA to a steering group. It also agreed to the funding necessary to research and produce the PNA.

Public Health Enfield has a duty to complete this document on behalf of the HWB.

Step 1: Steering group

On 16th June 2014, Enfield's PNA Steering Group was established. The terms of reference and membership of the PNA Steering Group can be found in Appendix B.

Step 2: Project management

At its first meeting, the Local Authority presented and agreed the project plan and ongoing maintenance of the project plan. Appendix F shows an approved time line for the project.

Step 3: Review of existing PNA and JSNA

Through the project manager, the PNA Steering Group reviewed the existing PNA and subsequent supplementary statements[7] and JSNA[4].

It was agreed that the existing PNA and subsequent supplementary statements[7] were accurate and up-to-date and the Consultant in Public Health would be responsible for the ongoing maintenance of the current PNA until this PNA is published.

Step 4a: Public survey on pharmacy provision

A public survey to establish views about pharmacy services was produced by the Steering Group which was circulated to:

- all pharmacy contractors in Enfield to distribute to the public
- all GP practices in Enfield to distribute to the public
- a number of voluntary community groups in Enfield
- Enfield Voluntary Action (EVA)
- Enfield HealthWatch

A total of 231 responses were received. A copy of the public survey can be found in Appendix C and the detailed responses can be found in Appendix I.

Step 4b: Pharmacy survey

The steering group agreed a survey be distributed to the local community pharmacists to collate information for the PNA. The local LPC supported this survey to gain responses.

A copy of the pharmacy survey can be found in Appendix D.

Step 4c: Commissioner survey

The steering group also agreed a survey be distributed to all relevant commissioners in Enfield to inform the PNA.

A copy of the commissioner survey can be found in Appendix E.

Step 5: Preparing the draft PNA for consultation

The steering group, facilitated by the Director of Public Health reviewed and revised the content and detail of the existing PNA. The process took into account the JSNA[4] and other relevant strategies in order to ensure the priorities were identified correctly. A draft PNA was approved for consultation by the PNA Steering Group at its meeting on 20th November 2014.

[7] Enfield PNA and subsequent supplementary statements, accessed on 11/9/14 – http://www.Enfield.gov.uk/downloads/download/3050/pharmaceutical_needs_assessment

Step 6: Consultation

In line with the 2013 Regulations[3], a consultation on the draft PNA was undertaken for 60 days between 1st December 2014 and 31st January 2015. The draft PNA and consultation response form were issued to all identified stakeholders. These are listed in Appendix G. The draft PNA was also posted on Enfield Council's website.

Step 7: Collation and analysis of consultation responses

The consultation responses were collated and analysed by the Council's Engagement Manager. A summary of the responses received and analysis is noted in the final PNA.

Step 8: Production of final PNA

The collation and analysis of consultation responses was used by the project manager to revise the draft PNA and a final PNA was presented to the PNA Steering Group. The final PNA was presented to the Enfield HWB for approval and publication before 1st April 2015.

1.5 Localities for the purpose of the PNA

The PNA Steering Group, at its second meeting, considered how the localities within the Enfield HWB geography would be defined.

The majority of health and social care data is available at local authority council ward level and at this level provides reasonable statistical rigor.

It was agreed that the four CCG localities, which are defined by clustering council wards, would be used to define the localities of the Enfield HWB geography.

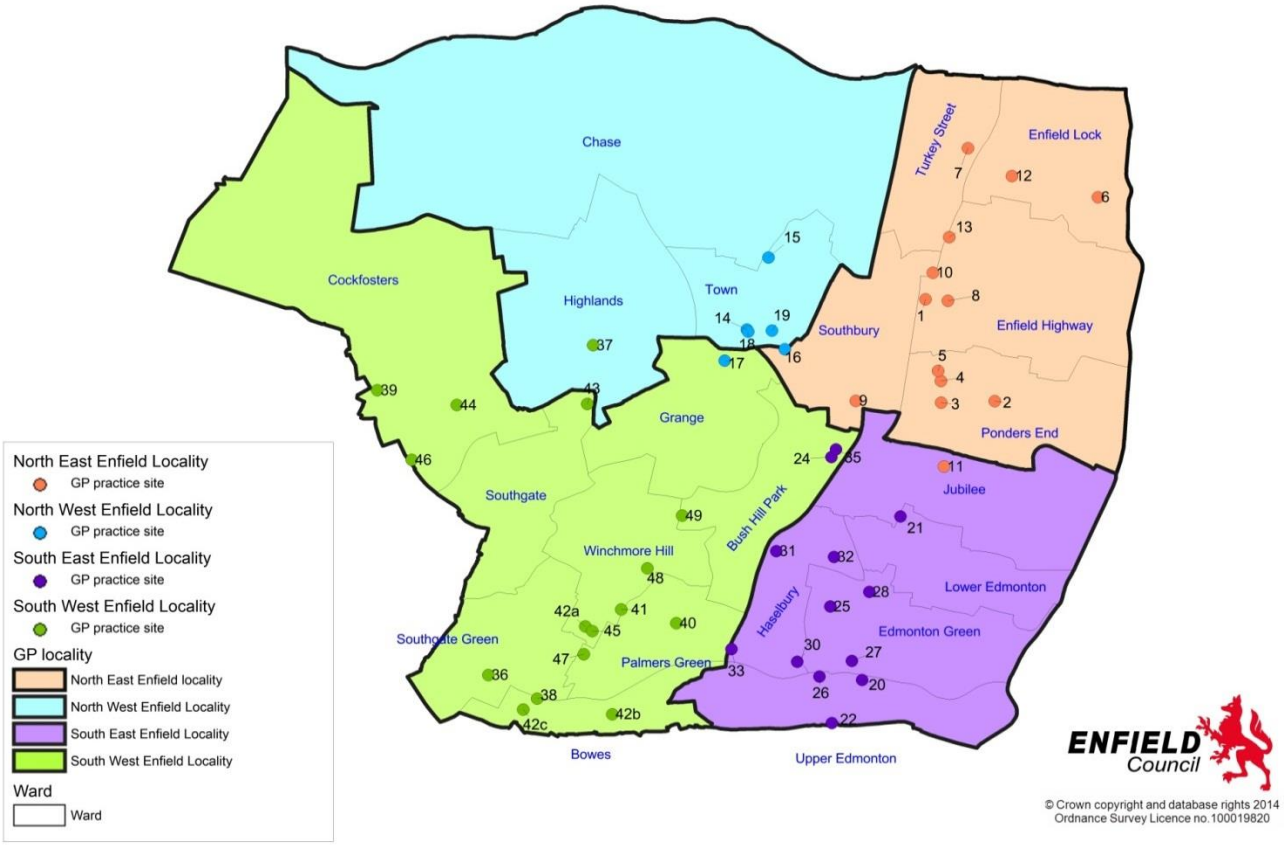
The localities used for the PNA for Enfield HWB area are:

- South West Enfield
- South East Enfield
- North West Enfield
- North East Enfield

Figure 1 below maps the relationship between the localities, wards and GP practices in Enfield. A list of providers of pharmaceutical services in each locality is found in Appendix A. The information contained in Appendix A has been provided by NHS England (who are legally responsible for maintaining the 'Pharmaceutical List' of providers of pharmaceutical services in each HWB area) and checked by Brent, Enfield and Haringey LPC, Enfield Council and Enfield CCG.

1.6 GP Practices, locality and ward mapping

Figure 1 - Map of GP practices, ward and locality boundaries



North East Enfield Locality

1 Brick Lane Surgery
2 Curzon Avenue Surgery
3 Dean House Surgery
4 Eagle House Surgery
5 East Enfield Practice
6 Enfield Island Surgery
7 Freezyw ater Primary Care Centre
8 Green Street Surgery
9 Lincoln Road Med Practice
10 Moorfield Road Health Ctr
11 Nightingale House Surgery
12 Ordnance Road Surgery
13 Riley House Surgery

North West Enfield Locality

14 Abernethy House Surgery
15 Carlton House Surgery
16 Southbury Surgery
17 Tow n Surgery
18 White Lodge Medical Practice
19 Willow House Surgery

South East Enfield Locality

20 Angel Surgery
21 Bounces Road Surgery
22 Boundary Court Surgery
23 Boundary House Surgery
24 Bush Hill Park Medical Centre
25 Chalfont Road Surgery
26 Dover House Surgery
27 Edmonton Medical Centre
28 Evergreen Surgery Ltd
29 Forest Rd Group Practice
30 Green Cedars Medical Centre
31 Keats Surgery
32 Latymer Road Surgery
33 Morecambe Surgery
34 Rainbow Surgery
35 Trinity Avenue Surgery

South West Enfield Locality

36 Arnos Grove Medical Centr
37 Bincote Road Surgery
38 Bow es Medical Centre
39 Cockfosters Medical Ctre
40 Connaught Surgery
41 Gillan House Surgery
42a Grovelands Medical Centre
42b Grovelands Medical Centre - Grenoble Gardens Surgery Site
42c Grovelands Medical Centre - Natal Road Practice Site
43 Highlands Practice
44 Oakw ood Medical Centre
45 Park Lodge Medical Centre
46 Southgate Surgery
47 The North London Health Centre
48 Woodberry Practice
49 Winchmore Practice

Source: Registered population data breakdown by practice and ward: PDS Extract of Registered Population as at 31st December 2011; Enfield CCG

Enfield CCG localities have been formed by GP practices in neighbouring areas within Enfield. As of July 2014, there are 49 GP practices with one practice operating from three different sites in Enfield and four localities; South East Enfield locality, North East Enfield locality, South West Enfield locality and North West Enfield locality.

Enfield wards have been assigned to an Enfield CCG locality according to the residence of patients who are registered with GP practices in Enfield. For example, almost 70% of Jubilee ward residents are registered to GP practices assigned to the South East locality – on the map these are numbered 21, 24 and 35 and are all part of the South East locality (Source of Registered population data breakdown by practice and ward: PDS Extract of Registered Population as at 31st December 2011).

Table 2 below lists the GP practices in Enfield CCG, their localities and the wards within Enfield.

Table 2 - List of GP practices, wards, and allocated localities in Enfield

PLT Locality Name	Practice Code	Ref. on Map	Practice Name	Ward
North East Enfield	F85654	1	Brick Lane Surgery	Enfield Highway
	F85684	2	Curzon Avenue Surgery	Enfield Lock
	F85024	3	Dean House Surgery	Ponders End
	F85004	4	Eagle House Surgery	Southbury
	F85634	5	East Enfield Practice	Turkey Street
	F85707	6	Enfield Island Surgery	
	F85076	7	Freezywater PCC	
	F85681	8	Green Street Surgery	
	F85703	9	Lincoln Road Medical Practice	
	F85048	10	Moorfield Road HC	
	F85058	11	Nightingale House Surgery	
	F85023	12	Ordnance Road Surgery	
	F85003	13	Riley House Surgery	
North West Enfield	F85029	14	Abernethy House	Chase
	F85027	15	Carlton House Surgery	Highlands
	F85652	16	Southbury Surgery	Town
	F85678	17	Town Surgery	
	F85025	18	White Lodge MC	
	F85036	19	Willow House Surgery	
South East Enfield	Y00057	20	Angel Surgery	Edmonton Green
	F85044	21	Bounces Road Surgery	Haselbury
	F85043	22	Boundary Court Surgery	Jubilee
	F85676	23	Boundary House Surgery	Lower Edmonton
	F85656	24	Bush Hill Park Medical Centre	Upper Edmonton
	F85682	25	Chalfont Road Surgery	
	F85015	26	Dover House Surgery	
	F85666	27	Edmonton MC	
	Y03402	28	Evergreen Surgery	
	F85002	29	Forest Road Group Practice	
	Y00612	30	Green Cedars Medical Centre	
	F85010	31	Keats Surgery	
	F85663	32	Latymer Road Surgery	
	F85650	33	Morecambe Surgery	
	F85039	34	Rainbow Practice	
	F85686	35	Trinity Avenue Surgery	
South West Enfield	F85700	36	Arnos Grove Medical Centre	Bowes
	F85625	37	Bincote Road Surgery	Bush Hill Park
	F85011	38	Bowes Medical Centre	Cockfosters
	F85016	39	Cockfosters Medical Centre	Grange
	F85055	40	Connaught Surgery	Palmers Green
	F85701	41	Gillan House Surgery	Southgate
	F85072	42a	Grovelands Medical Centre	Southgate Green
		42b	Grovelands Medical Centre - Grenoble Gardens Surgery Site	Winchmore Hill
		42c	Grovelands Medical Centre - Natal Road Practice Site	
	F85035	43	Highlands Practice	
	F85687	44	Oakwood Medical Centre	
	F85053	45	Park Lodge Medical Centre	
	F85032	46	Southgate Surgery	
	F85642	47	The North London Health Centre	
	F85020	48	Woodberry Practice	
	F85033	49	Winchmore Practice	

Section 2: Context for the PNA

2.1 Joint Strategic Needs Assessment

The Pharmaceutical Needs Assessment (PNA) is undertaken in the context of the health, care and wellbeing needs of the local population as defined in the Enfield Joint Strategic Needs Assessment (JSNA)[4]. The JSNA defines the needs of the local population and also identifies a strategic direction of service delivery to meet those needs. In addition, the JSNA sets out commissioning priorities to improve the public's health and reduce inequalities. The PNA should therefore be read alongside the JSNA.

2.2 Health and Wellbeing Board strategy

The Health and Wellbeing Board (HWB) has agreed a strategy[8] for 2014-2019. This strategy is guided by the JSNA[4] and other relevant sources of information. The vision of Enfield's HWB is that the people of the borough live longer, healthier and happier lives. As a result of their consultation involving over two thousand people, the HWB was heartened not only by the numbers, but also that the vast majority agreed with their vision and aims.

This strategy is as much about wellbeing as it is about health. Along with its commitment to promoting and supporting wellbeing throughout the life course, the HWB wants to build flourishing communities and places some emphasis on good mental health being as important to wellbeing as good physical health.

The following are the five priority areas that have been identified as key to the improvement of the health of the local population and in reducing health inequalities:

- ensuring the best start in life
- enabling people to be safe, independent and well; and delivering high quality health and care services
- creating stronger, healthier communities
- reducing health inequalities – narrowing the gap in life expectancy
- promoting healthy lifestyles and making healthy choices

Regulation 9 of the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations[5] requires that HWBs, when carrying out assessments for the purpose of publishing PNAs, have regard to:

- the number of people in its area who require pharmaceutical services
- the demography of its area

[8] Enfield Health and Wellbeing Board Strategy: *http://www.enfield.gov.uk/healthandwellbeing/info/4/health_and_wellbeing_strategy/229/executive_summary_and_strategy*

- the risks to the health or wellbeing of people in its area

Pharmaceutical service providers have the potential to play a greater role in identifying and helping address priority health needs as they are strategically placed in the community and have daily interactions with the local population. Evidence from the Healthy Living Pharmacy Initiative[10], implemented since 2010, shows that community pharmacies can make a significant impact in the improvement of the health and wellbeing of local populations.

In consideration of the three areas highlighted above, Section 2.3 and 2.4 further examine Enfield's population characteristics and major causes of ill health as a pre-requisite to understanding local health needs and how pharmaceutical service providers can be involved in various interventions.

2.3 Population characteristics

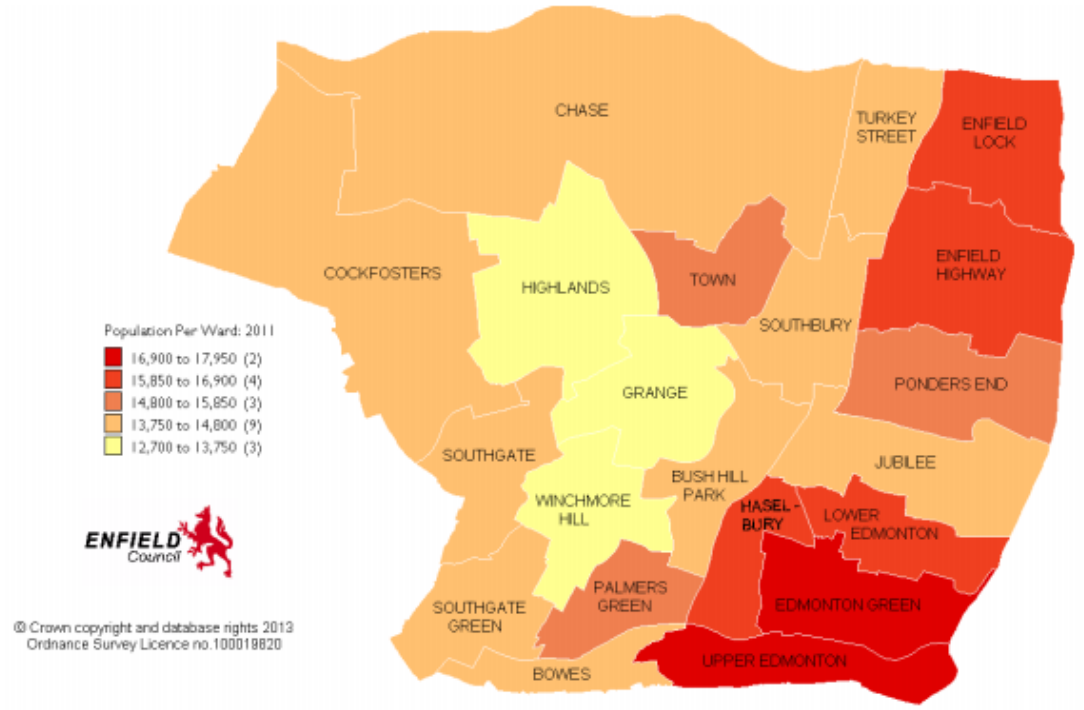
2.3.1 Overview

Enfield is the most northerly of the London boroughs with 100% of the borough classified as urban. It is a borough characterised by an east-west divide. The east of the borough is generally more deprived with three of the most deprived wards in England, whilst many wards in the west of the borough are affluent. The population of Enfield is ethnically diverse and has grown by 20% over the last 15 years and 26% over the last 25 years. The current estimated population is 322,295 with Figure 2 below showing the population per ward. Of the 32 boroughs of London, Enfield currently boasts the fourth highest population figure.

There is a high level of childhood poverty in the borough with 32.8% of children under 16 living in poverty.

Figure 2 - Population density in Enfield

Population per Ward: 2011



Source: Census 2011

In terms of where people live in Enfield, the 2011 Census shows us that the highest concentration of the population can be found in the eastern wards, particularly the south eastern wards of Edmonton Green and Upper Edmonton.

2.3.2 Age

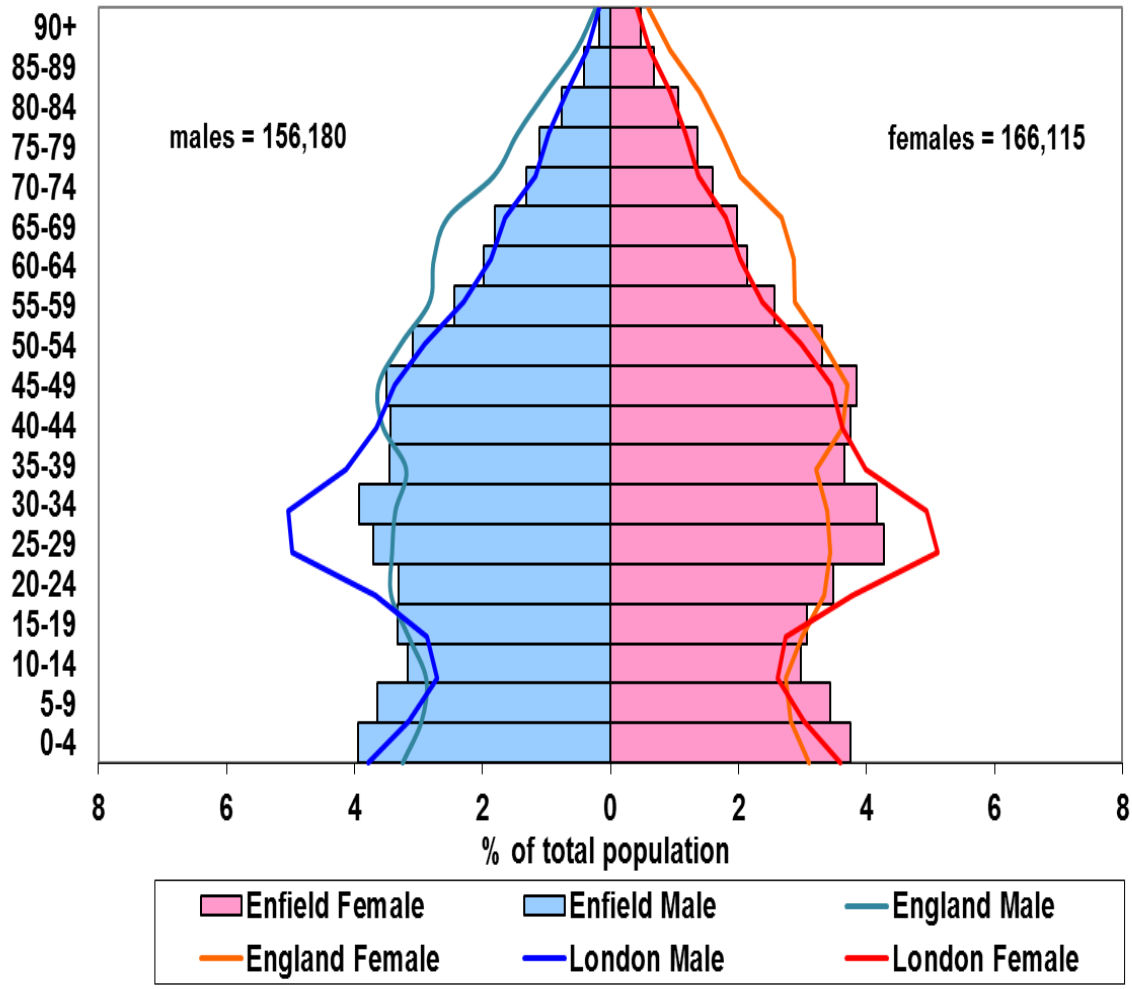
Enfield's population is younger than both the England and London averages with 21.2% of the population under 15. Table 3 provides a summary of the population by age group with Figure 3 showing that the proportion of 0-19 year olds in Enfield (27.3%) is higher compared to London (24.5%) and England (23.8%) averages.

Table 3 - Summary of the population by age group

Age band	Enfield			London			England		
	Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
0-4	12698	12079	24777	319814	303749	623563	1736916	1656440	3393356
5-9	11762	11057	22819	265398	255156	520554	1578490	1505092	3083582
10-14	10230	9610	19840	228976	219961	448938	1539837	1468034	3007871
15-19	10697	9903	20599	242303	231594	473896	1685620	1600686	3286306
20-24	10652	11201	21853	309945	319610	629555	1833395	1788156	3621551
25-29	11926	13758	25684	420164	432117	852281	1825589	1833988	3659577
30-34	12656	13437	26093	424319	416976	841295	1798016	1809201	3607217
35-39	11113	11773	22886	349101	336061	685162	1707213	1716140	3423353
40-44	11063	12088	23151	308815	306055	614870	1901368	1941348	3842716
45-49	11298	12396	23695	284764	291826	576590	1939398	1982210	3921608
50-54	9959	10667	20626	244869	250988	495856	1748433	1775088	3523521
55-59	7835	8254	16089	193115	200783	393898	1509855	1543814	3053669
60-64	6360	6878	13238	157860	171336	329197	1476180	1536714	3012894
65-69	5809	6377	12187	138508	151939	290447	1358608	1433449	2792057
70-74	4236	5139	9375	99477	116228	215705	972550	1079883	2052433
75-79	3576	4385	7961	81902	99424	181326	777026	927064	1704090
80-84	2438	3398	5836	57289	78750	136039	538259	749163	1287422
85-89	1308	2180	3488	30662	51575	82238	285447	496978	782425
90+	564	1536	2100	14482	34111	48593	121248	316833	438081
Total	156180	166115	322295	4171764	4268241	8440005	26333448	27160281	53493729

Sources:
Enfield population - GLA 2013-round population projection (Borough Preferred Option), Greater London Authority
London population - GLA 2013-round SHLAA capped population projection, Greater London Authority
England population -Mid-2012 population estimates, Office for National Statistics

Figure 3 - Population pyramid 2013, Enfield, London and England



Sources:
Enfield population - GLA 2013-round population projection – Borough Preferred Option Variant, Greater London Authority
London population - GLA 2013-round SHLAA capped population projection, Greater London Authority
England population - Mid-2012 population estimates, Office for National Statistics

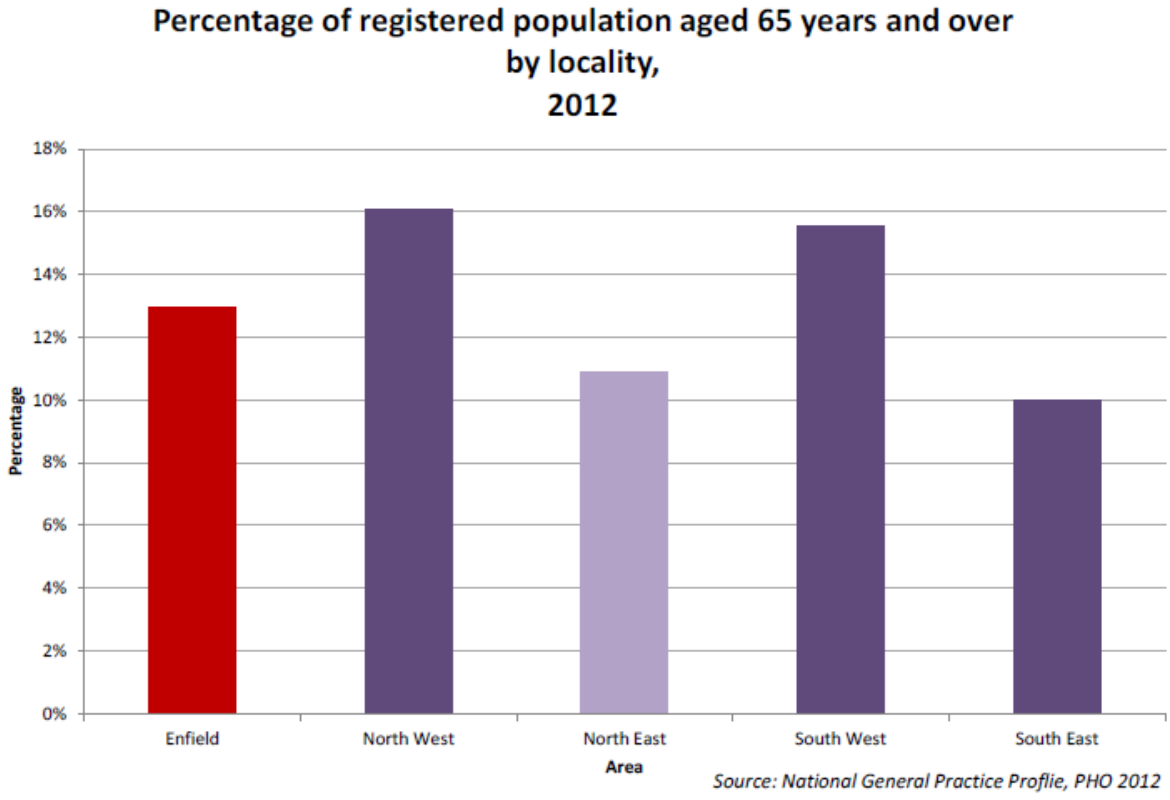
Table 4 shows that the proportion of 65 years and older in Enfield (12.7%) is similar to the London average (11.3%) but below that of England (16.9%). Figure 4 shows this percentage by locality.

Table 4 - Proportion of population by broad age group

	0-4	5-19	20-64	65+	85+
Enfield	7.7%	19.6%	60.0%	12.7%	1.7%
London	7.4%	17.1%	64.2%	11.3%	1.6%
England	6.3%	17.5%	59.2%	16.9%	2.3%

Sources:
Enfield population - GLA 2013-round population projection – Borough Preferred Option Variant, Greater London Authority
London population - GLA 2013-round SHLAA capped population projection, Greater London Authority
England population - Mid-2012 population estimates, Office for National Statistics

Figure 4 - Percentage of registered population aged 65 years and over by locality



The age profiles have been broken down for each of the four localities and can be viewed in Figures 5 to 8.

South West Enfield locality (Figure 5) has a generally older population compared to the Enfield average. Of the South West Enfield locality, 16% of the registered population is 65 years and over compared to the Enfield average of 13%.

The ethnic breakdown of the South West locality is broadly similar to the Enfield average with 49.4% White British.

South East locality (Figure 6) has a generally younger population compared with the Enfield average. Of the registered population in this locality. 16% is 0-9 years old, compared with 13% in Enfield. The South East locality has the most diverse population amongst all the Enfield localities with only 23% of the borough's population from a White British background. There is a large Turkish population in this part of the borough.

The North West locality (Figure 7) has a generally older population than the Enfield average and 16% of the locality's registered population is 65 years and over compared to 13% in England. Of the locality population, 35% is under 30 years old compared to 43% in Enfield as a whole and 69% of the locality population is from a White British background.

Figure 8 shows that North East locality has a younger population (22%) compared to the borough of Enfield as a whole (20%). Just 11% of the population was 65 years and over compared with 11% in the Enfield population.

Figure 5 - Population profile for South West Enfield

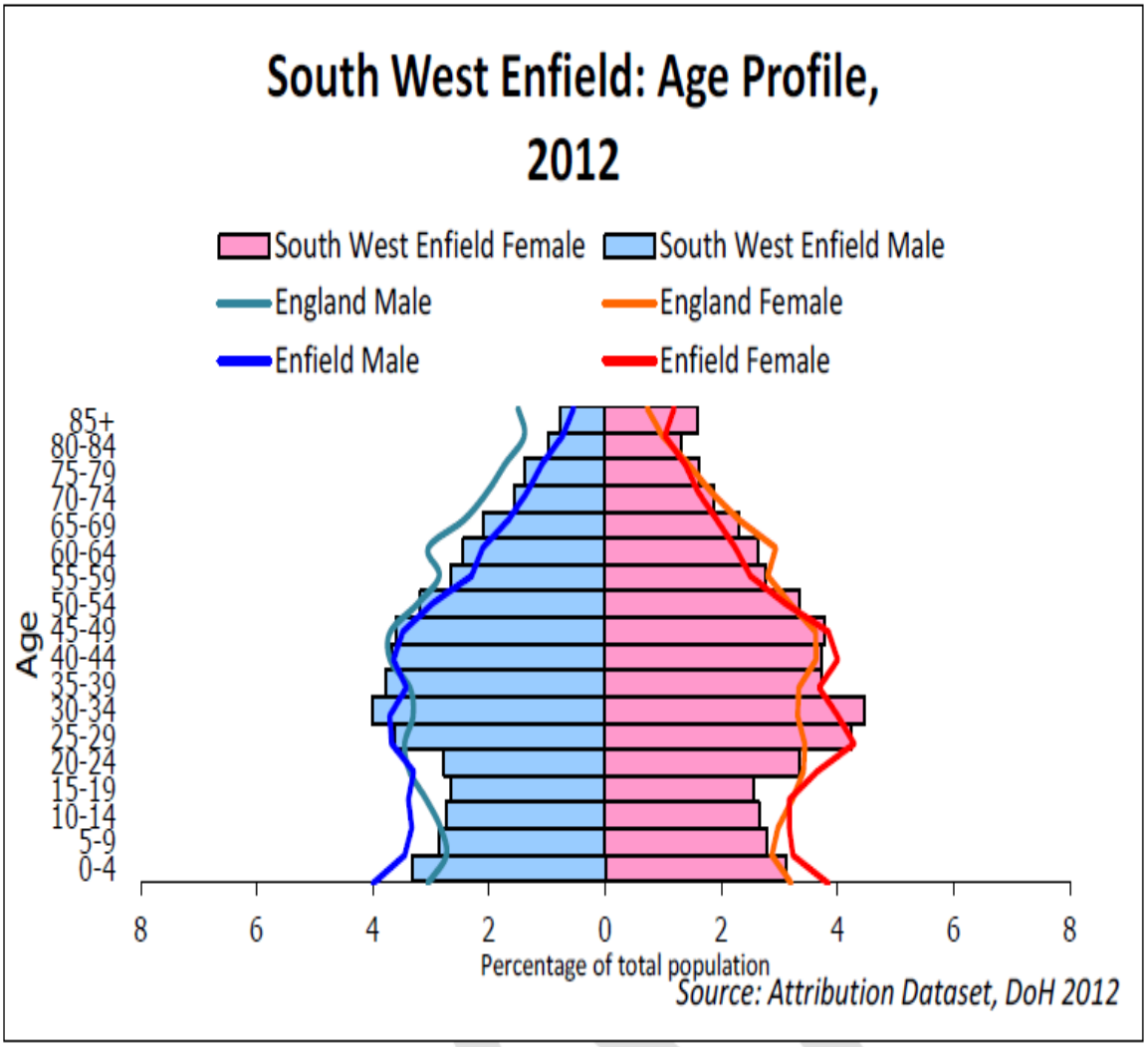


Figure 6 - Population profile for South East Enfield

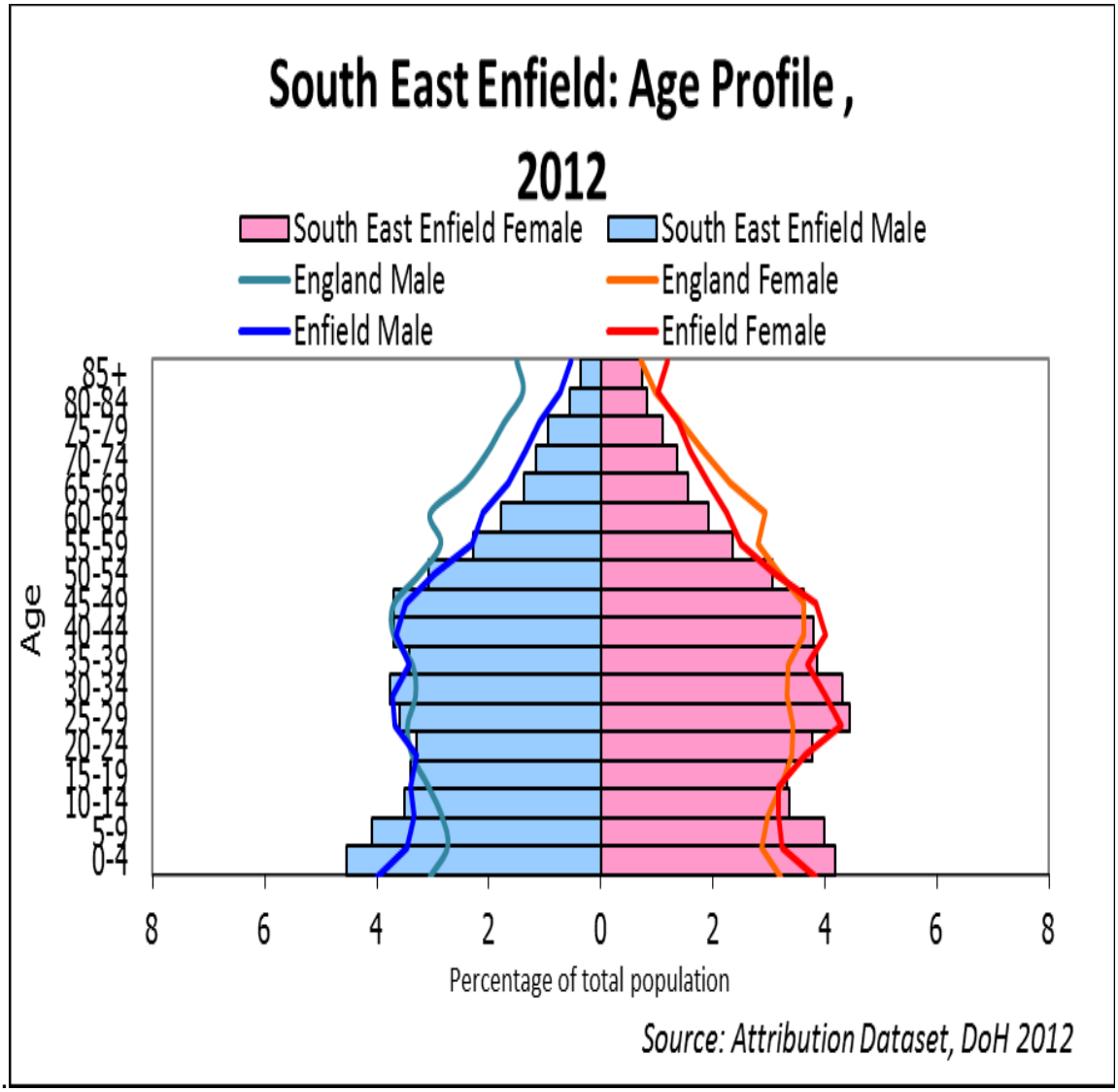


Figure 7 - Population profile for North West Enfield

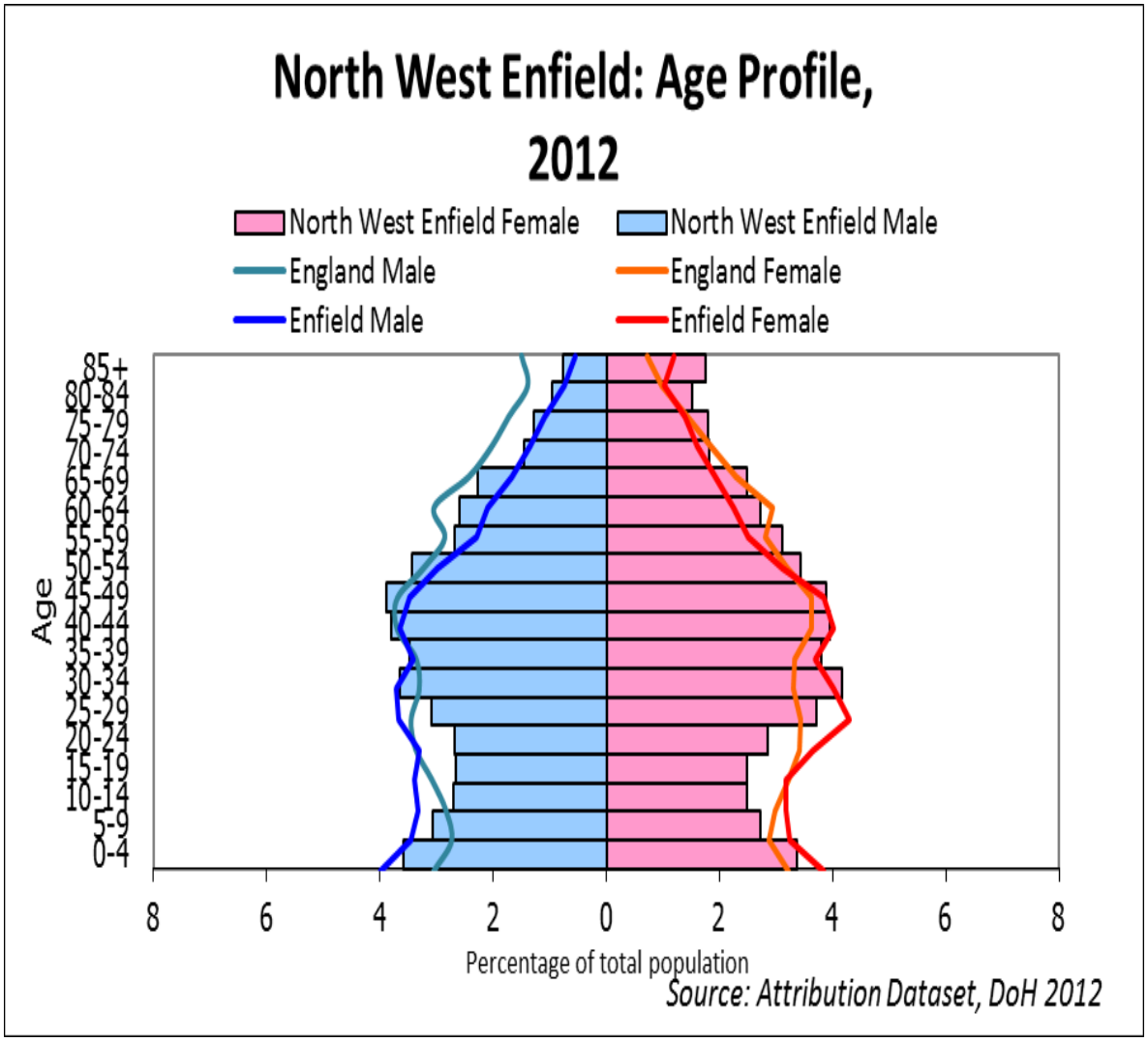
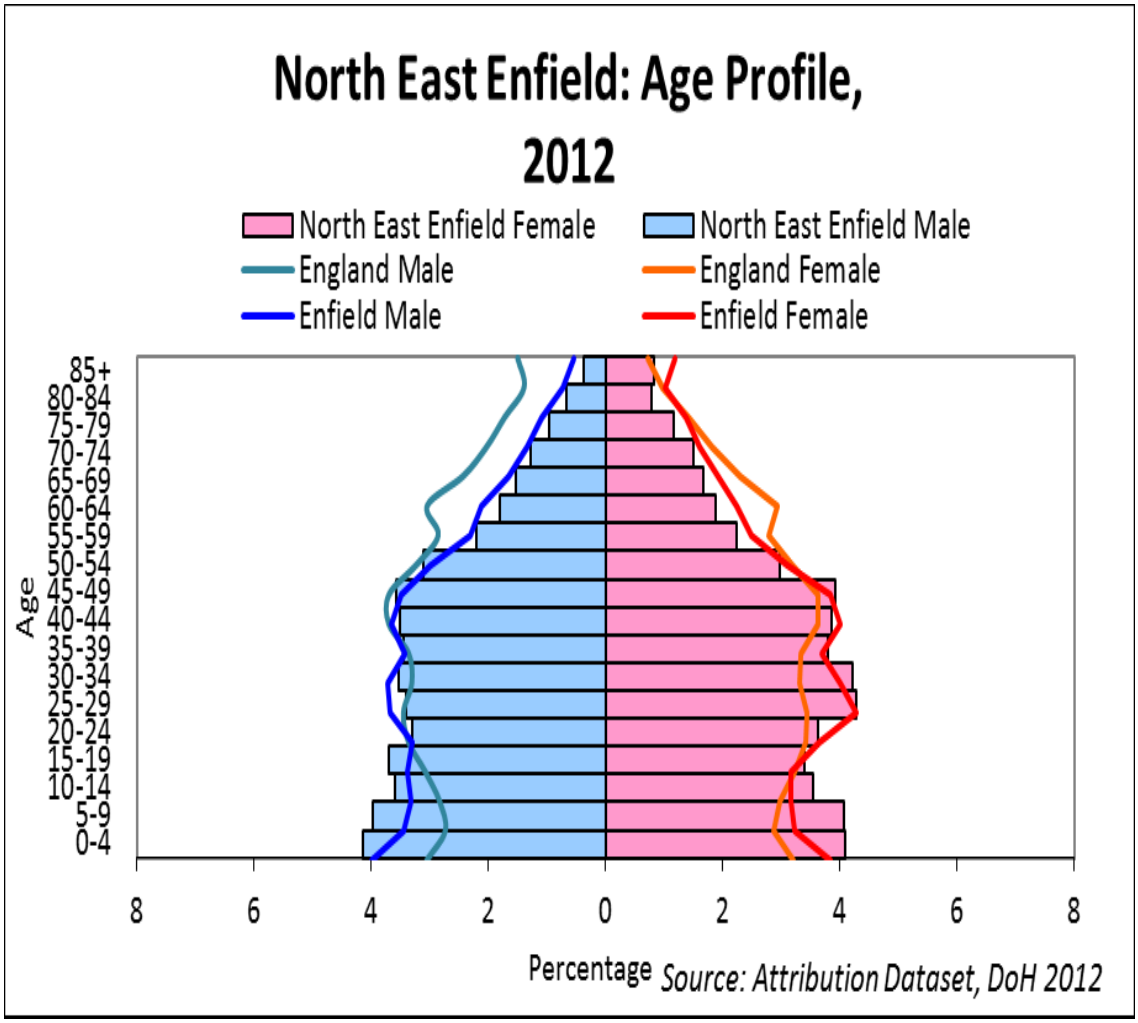


Figure 8 - Population profile for North East Enfield



2.3.3 Predicted population growth

The population of Enfield is projected to rise to around 359,000 by 2041. Table 5 demonstrates this in comparison to London and England with Table 6 breaking down the Enfield projection by locality.

Table 5 - Population projection – Enfield, London and England

Enfield				London			England		
Year	Total Population	Difference	% change from 2013	Total Population	Difference	% change from 2013	Total Population	Difference	% change from 2013
2013	322,295			8,440,005			54,068,352		
2021	337,259	14,964	4.6%	9,178,100	738,095	8.7%	57,687,784	3,619,432	6.7%
2031	356,396	34,101	10.6%	9,829,503	1,389,497	16.5%			
2041	358,597	36,302	11.3%	10,268,553	1,828,548	21.7%			

Sources:
Enfield population - GLA 2013-round population projection (Borough Preferred Option), Greater London Authority
London population - GLA 2013-round SHLAA capped population projection, Greater London Authority
England population - Mid-2012 population estimates, Office for National Statistics

Table 6 - Population projection by Enfield locality

	2013	2021	2031	2041	% change between 2013 and 2041
North East	78952	81710	83956	86810	10.0%
North West	42445	44401	46966	49635	16.9%
South East	83932	88563	96411	98808	17.7%
South West	113759	119987	123362	127601	12.2%

Source: 2013-round SHLAA capped ward population projection, Greater London Authority

Enfield's Spatial Strategy, set out in the Core Strategy, seeks to focus growth within four broad locations referred to as Regeneration Priority Areas (London Borough of Enfield, 2010, p.29). These are:

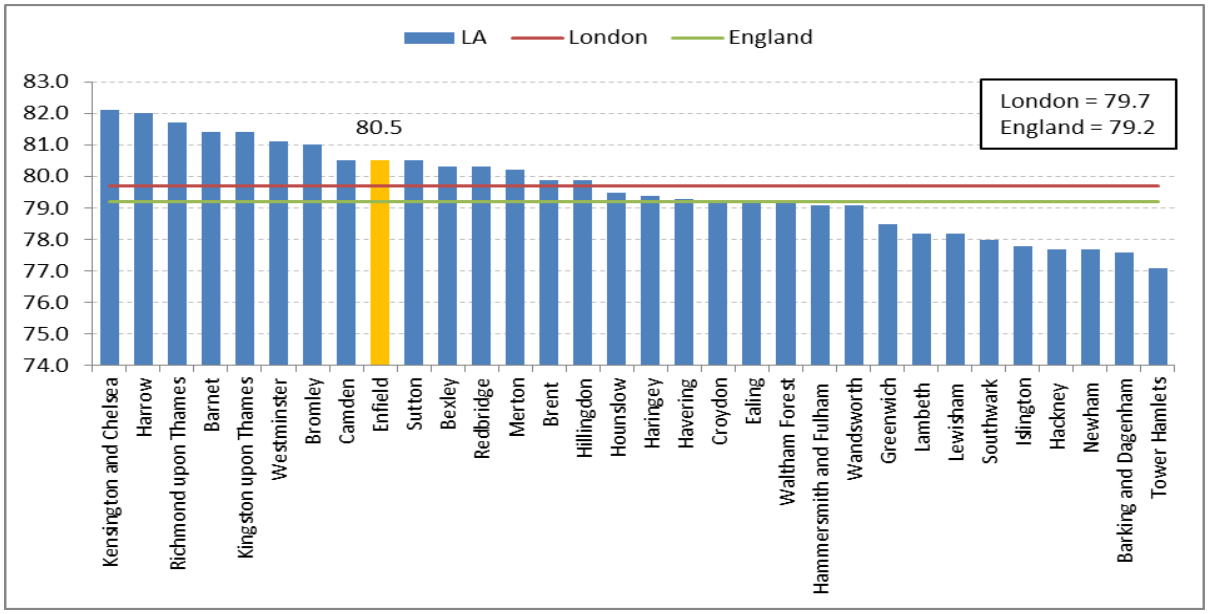
1. North West including the affluent areas of Cockfosters and Oakwood
2. South West including Palmers Green and the more deprived area around Bowes
3. South East including Central Leeside which is a large area where growth will be focused south of the North Circular in an area known as the Meridian Water Regeneration Area
4. North East of the borough including Enfield Lock

The HWB is aware that significant housing developments are planned for the future, within the borough. Detailed plans and timescales for these are not yet published. The HWB will monitor changes during the time horizon of this PNA.

2.3.4 Life expectancy

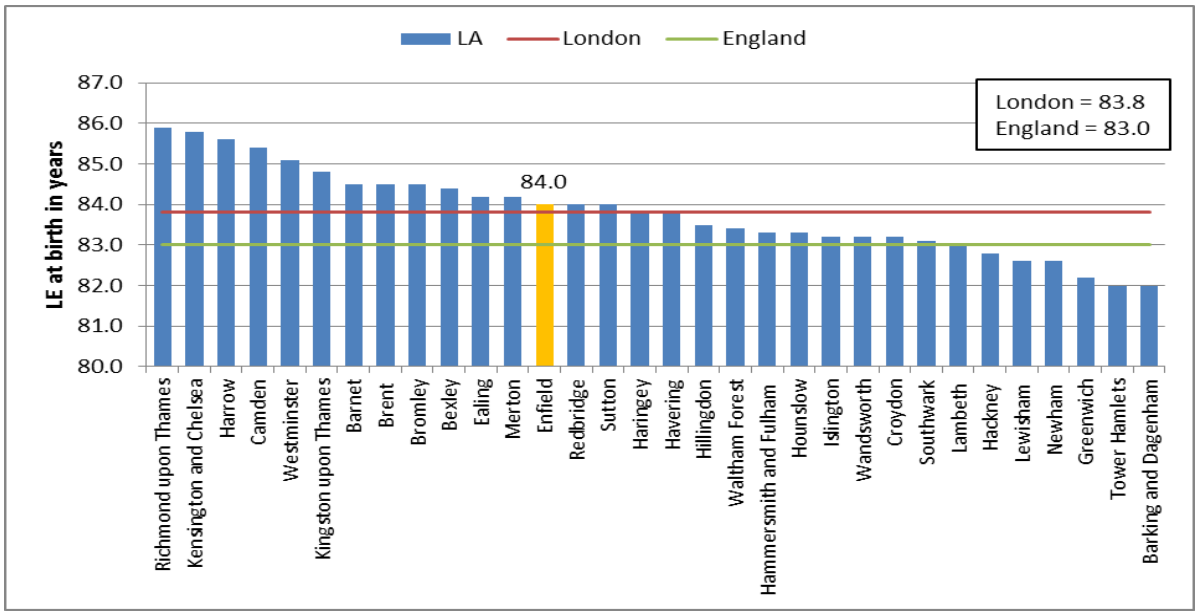
Life expectancy at birth for males living in Enfield is 80.5 years and for females is 84.0 years (life expectancy at birth for 2010-2012, Office for National Statistics). Life expectancy in Enfield varies hugely by geography and is above London and England averages, however within Enfield there are areas with lower life expectancy compared to London and England (see Figures 9 and 10).

Figure 9 - Life expectancy at birth, males, 2010-2012



Source: Office for National Statistics

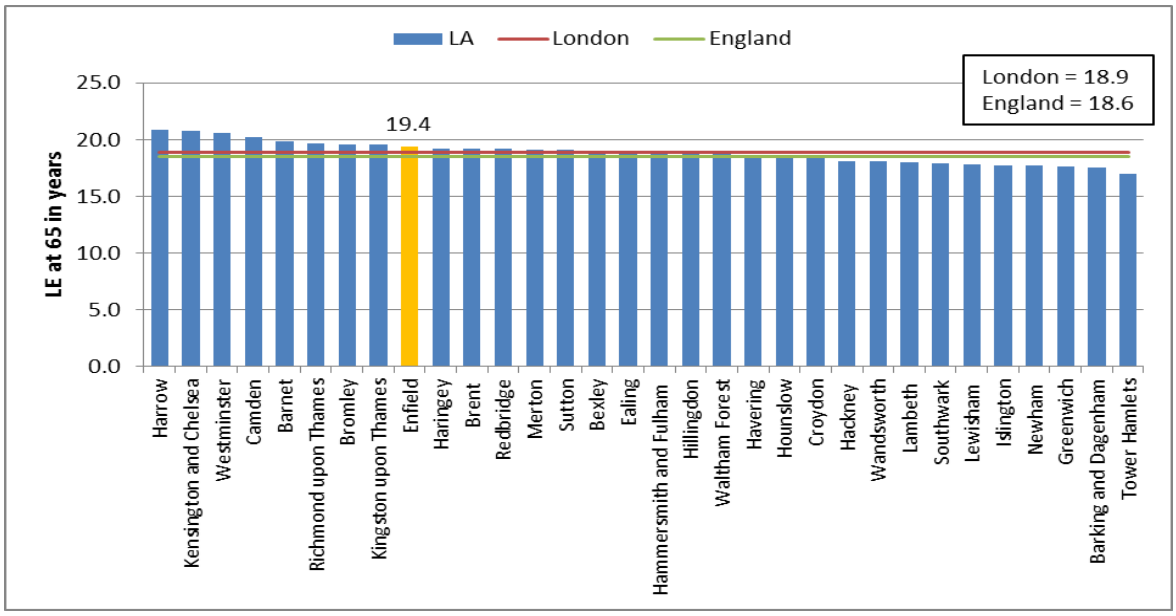
Figure 10 - Life expectancy at birth, females, 2010-2012



Source: Office for National Statistics

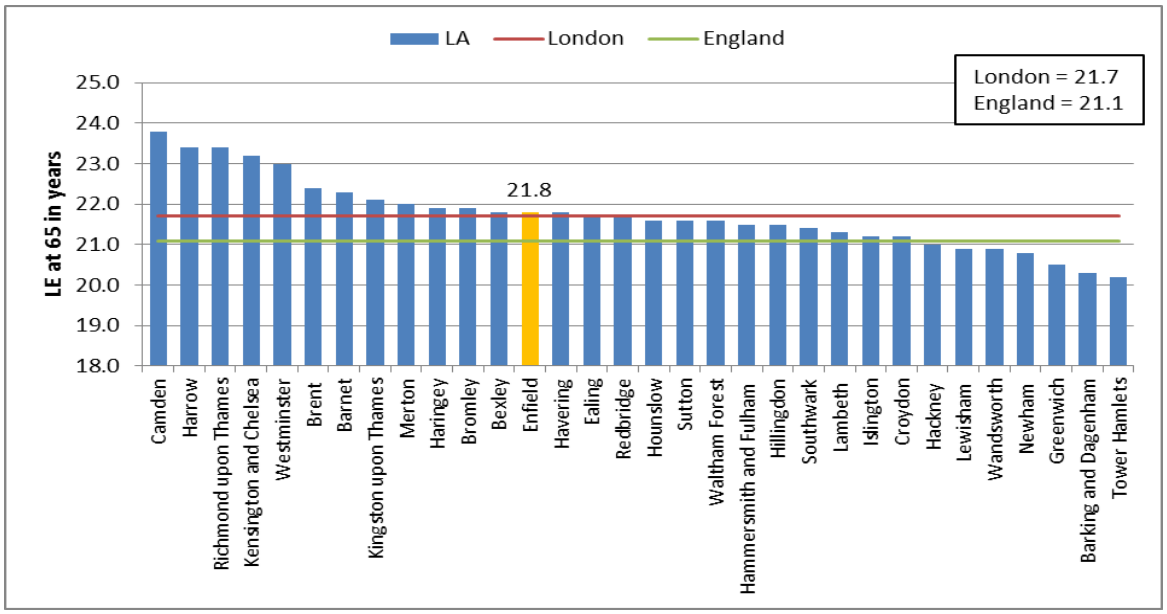
Life expectancy at 65 years for males living in Enfield is 19.4 years and for females is 21.8 years which is similar to London and England averages (life expectancy at birth for 2010-12, Office for National Statistics). See Figures 11 and 12.

Figure 11 - Life expectancy at 65, males, 2010-2012



Source: Office for National Statistics

Figure 12 - Life expectancy at 65 years, females, 2010-2012

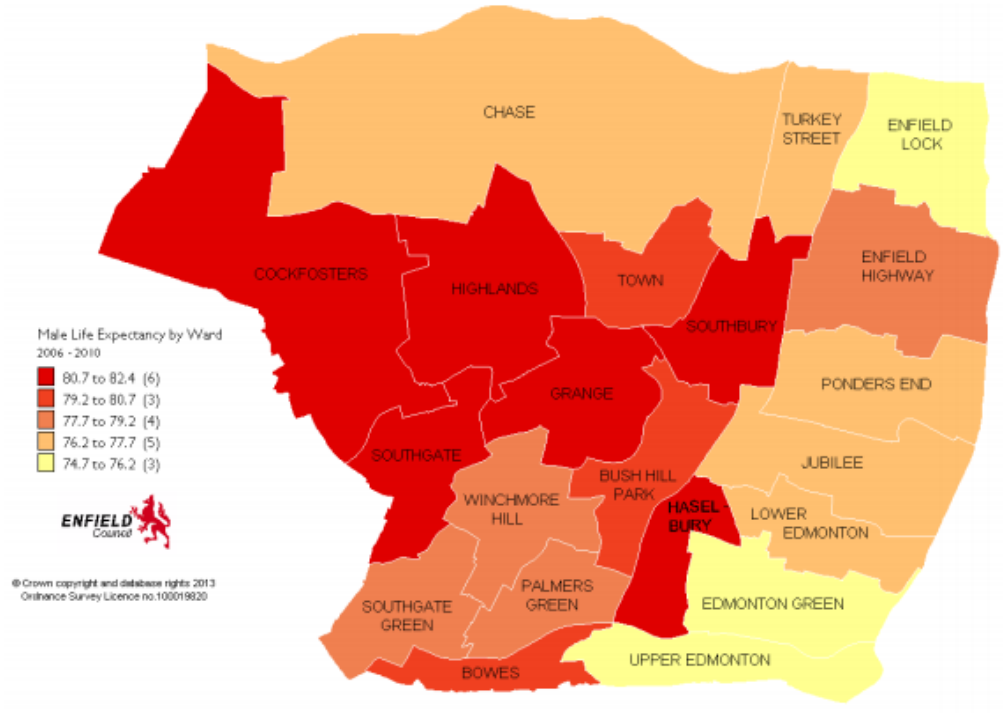


Source: Office for National Statistics

Life expectancies across the different wards is variable.

Figure 13 - Life expectancy at birth by ward, males, 2006-2010

Male Life Expectancy at Birth, by Ward: 2006-2010

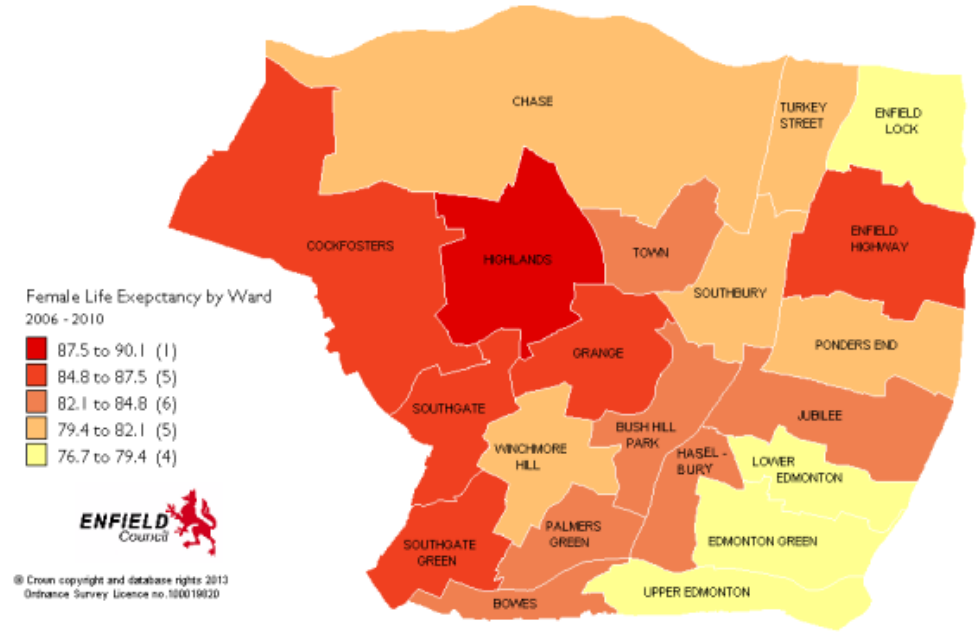


Source: London Health Programmes

Source: Office for National Statistics

Figure 14 - Life expectancy at birth by ward, females, 2006-2010

Female Life Expectancy at Birth, by Ward: 2006-2010

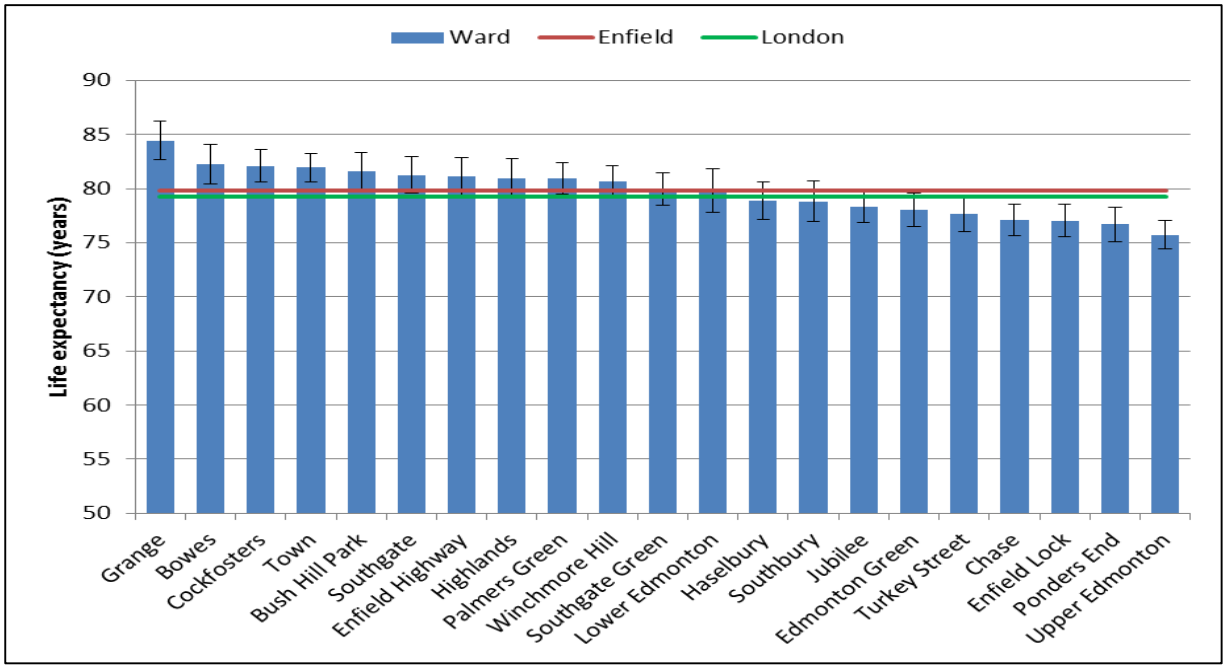


Source: London Health Programmes

Source: Office for National Statistics

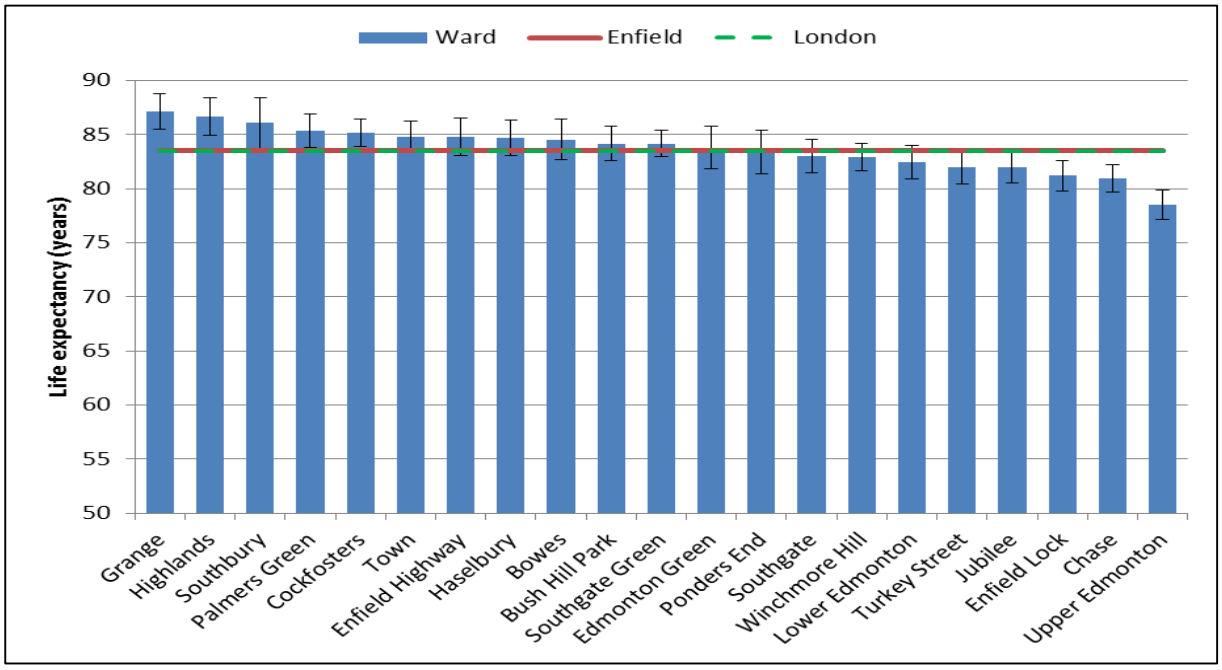
There is a wide variation in life expectancy within Enfield. The gap between the highest and lowest life expectancy is 8.7 years for male and 8.6 years for female. Male life expectancy ranged from 75.7 years in Upper Edmonton ward to 84.4 years in Grange ward (Figure 15). Female life expectancy was also lowest in Upper Edmonton at 78.5 years and highest in Grange ward at 87.1 years (Figure 16).

Figure 15 - Male life expectancy at birth, Enfield wards, 2008-2012



Source: Greater London Authority using ONS mortality data and ONS mid-year population estimates

Figure 16 - Female life expectancy at birth, Enfield wards, 2008-2012



Source: Greater London Authority using ONS mortality data and ONS mid-year population estimates

2.3.5 Specific populations

2.3.5.1 Ethnicity

As well as having an unusual age mix amongst its residents, another interesting characteristic of Enfield is the ethnic diversity of its population (Table 7).

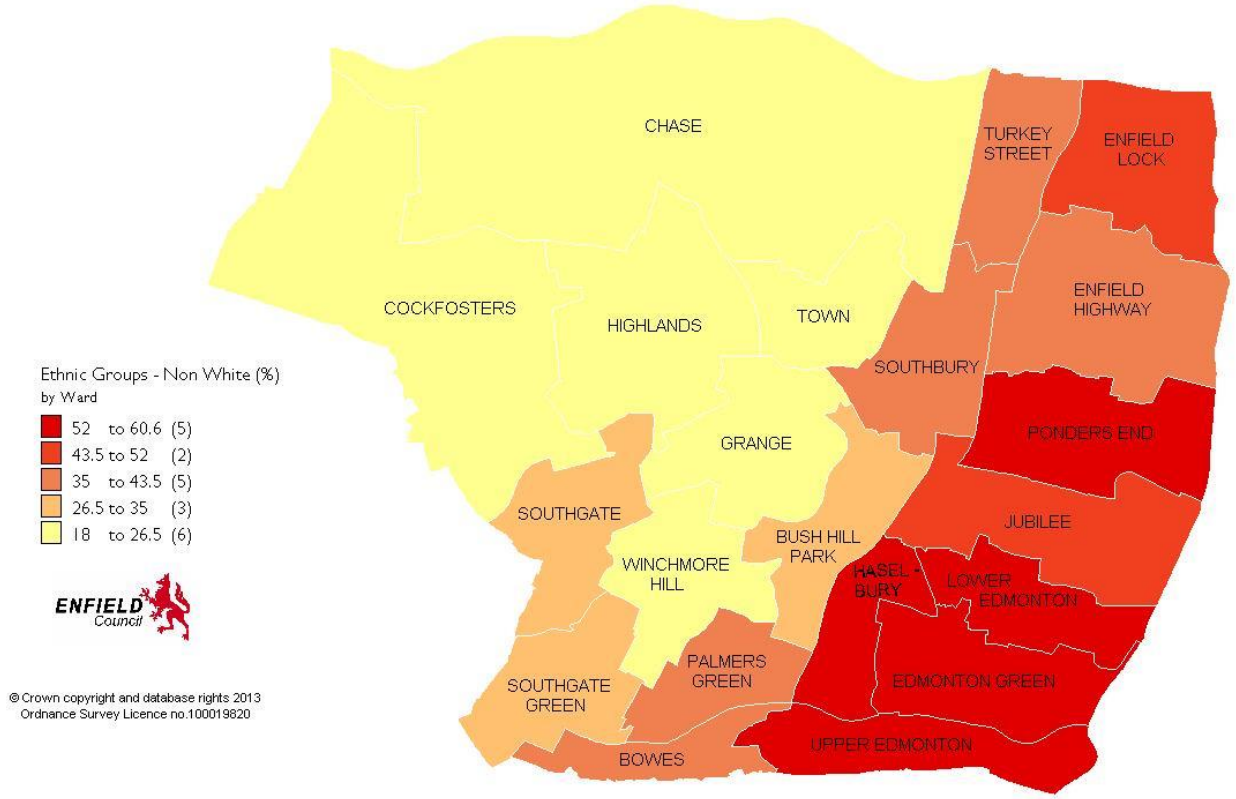
Table 7 - Ethnicity comparison: Enfield, London and England

	Total	Whit British		White Others		Mixed		Asian / Asian British		Black African/ Black Carribean / Black British		Other Ethnic Group	
	No.	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Enfield	312466	126450	40.5%	64190	20.5%	17183	5.5%	34893	11.2%	53687	17.2%	16063	5.1%
London	8173941	3669284	44.9%	1218151	14.9%	405279	5.0%	1511546	18.5%	1088640	13.3%	281041	3.4%
England	53012456	42279236	79.8%	3001906	5.7%	1192879	2.3%	4143403	7.8%	1846614	3.5%	548418	1.0%

Source: Census 2011, Office for National Statistics

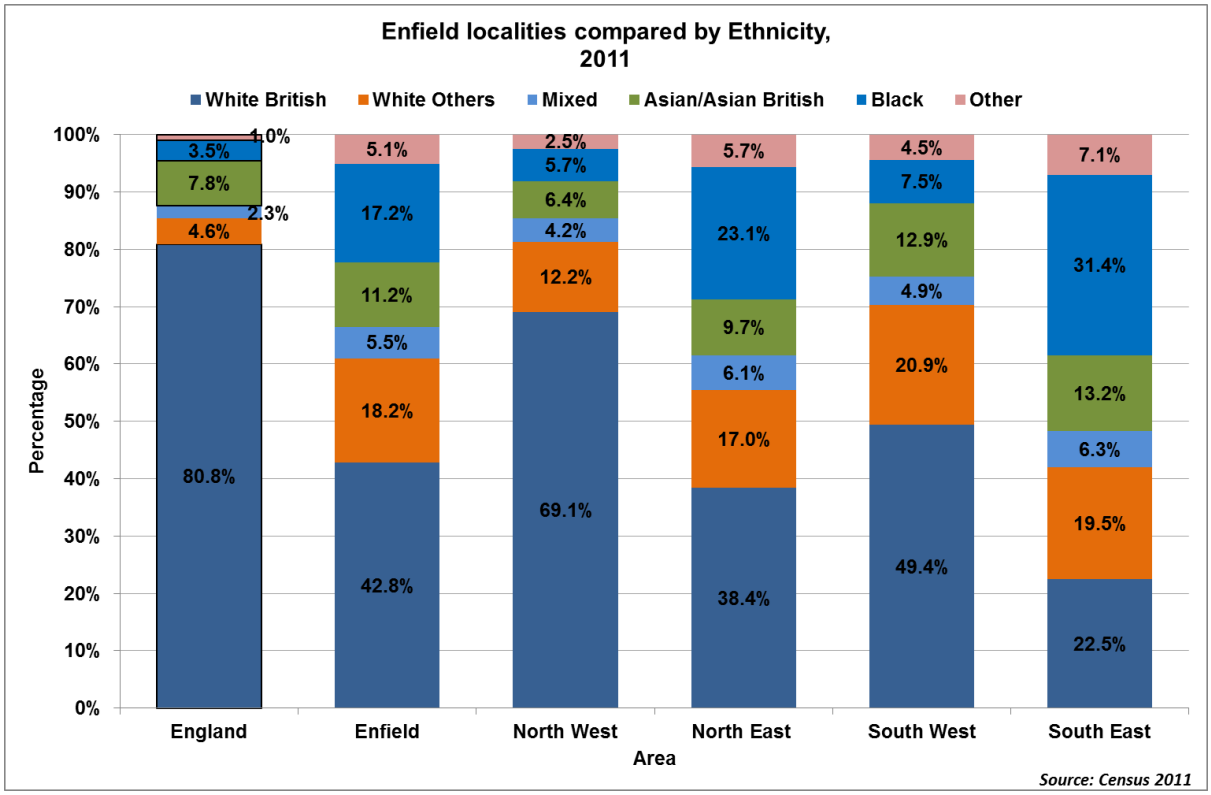
Enfield has an ethnically diverse population with more than half classifying themselves as ethnicity other than White British. See Figures 17 and 18 showing the diversity by ward and locality.

Figure 17 - Percentage of Non-White Ethnic Groups in Enfield, by Ward, 2011



Source: Office for National Statistics

Figure 18 - Ethnic breakdown in Enfield, by locality

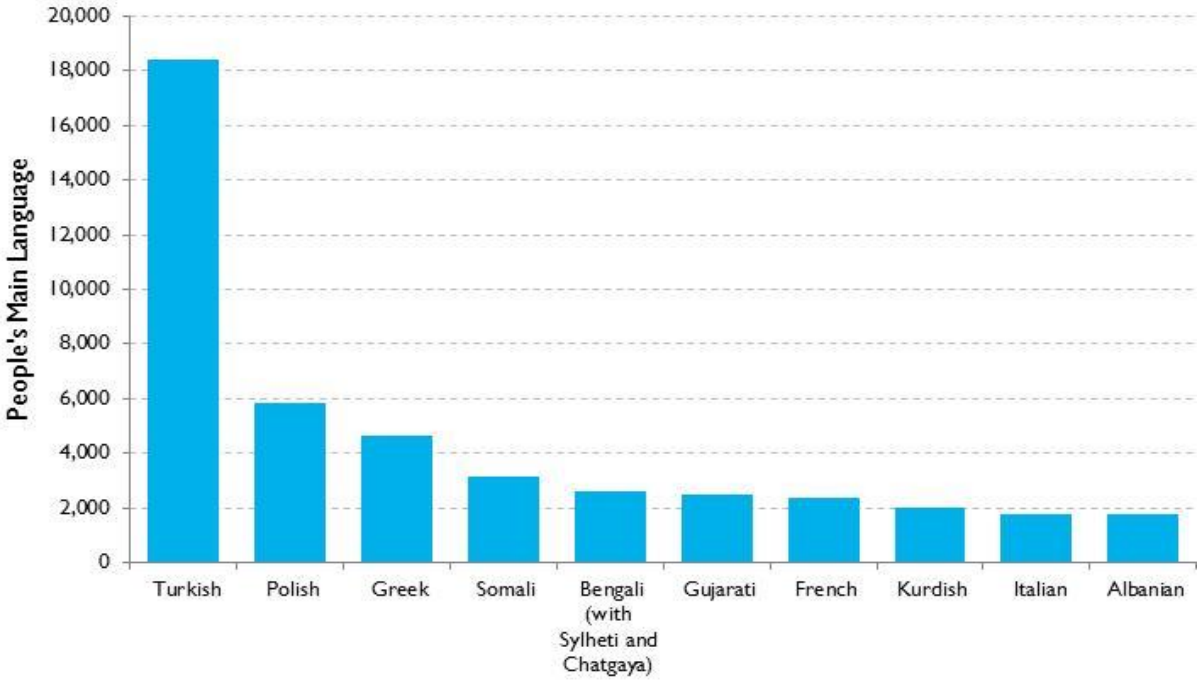


According to the 2011 Census, there were a total of 296,692 people aged three and over living in the borough. Of this number, 229,660 individuals (77%) stated their main language was English.

Figure 19 shows that the most commonly spoken language in Enfield other than English was Turkish (18,378 people, 6.2% of people aged three and above). This was followed by Polish (5,837 speakers, 2.0%), Greek (4,627 speakers, 1.6%), Somali (3,127, 1.1%) and Bengali (2,549, 0.9%). The extent to which they are spoken tends to vary by geography. Individuals speaking the same language tend to congregate in specific areas of the borough. For each respective language, these areas tend to be different. There is also a strong Central African, French-speaking population in the east of the borough

There is no significant traveller population in Enfield.

Figure 19 - Main language spoken in Enfield by those aged three years and over (excluding English) 2011

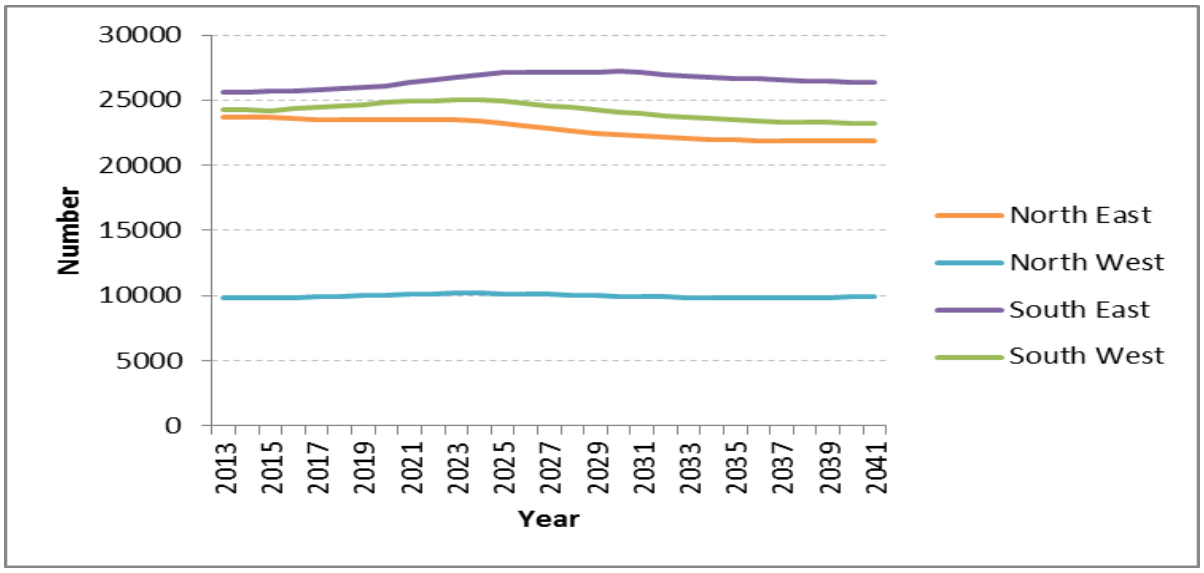


Source: 2011 Census, Office for National Statistics

2.3.5.2 Children and young people

Figure 20 below shows the population projection for children and young people (0-18 year olds) by locality. The number of 0-18 year olds is projected to increase in South East Enfield locality, while it is projected to decrease in North East Enfield locality. In North West Enfield locality, it is projected to increase for the next ten years then decrease afterwards. In North West Enfield, 0-18 year olds population is projected to be stable over the next 27 years.

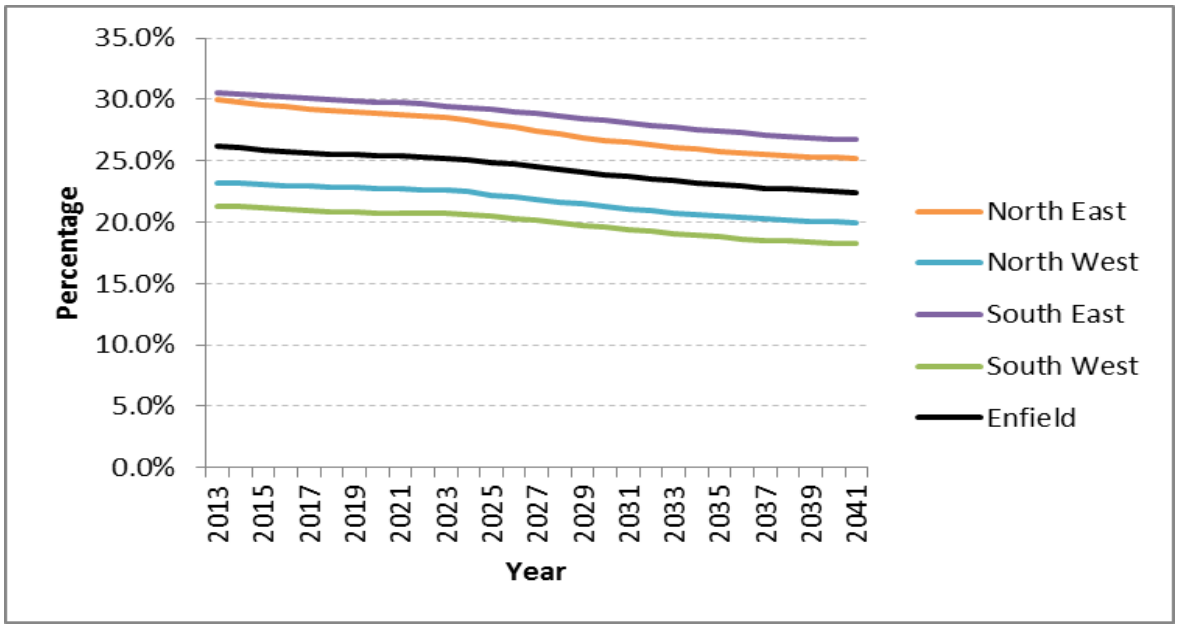
Figure 20 - Population projection for 0-18 year olds, by locality



Source: 2013-round SHLAA capped ward population projection, Greater London Authority

Although the number of 0-18 year olds is projected to increase for some localities, the proportion if 0-18 year olds is projected to decrease through to 2041 (Figure 21).

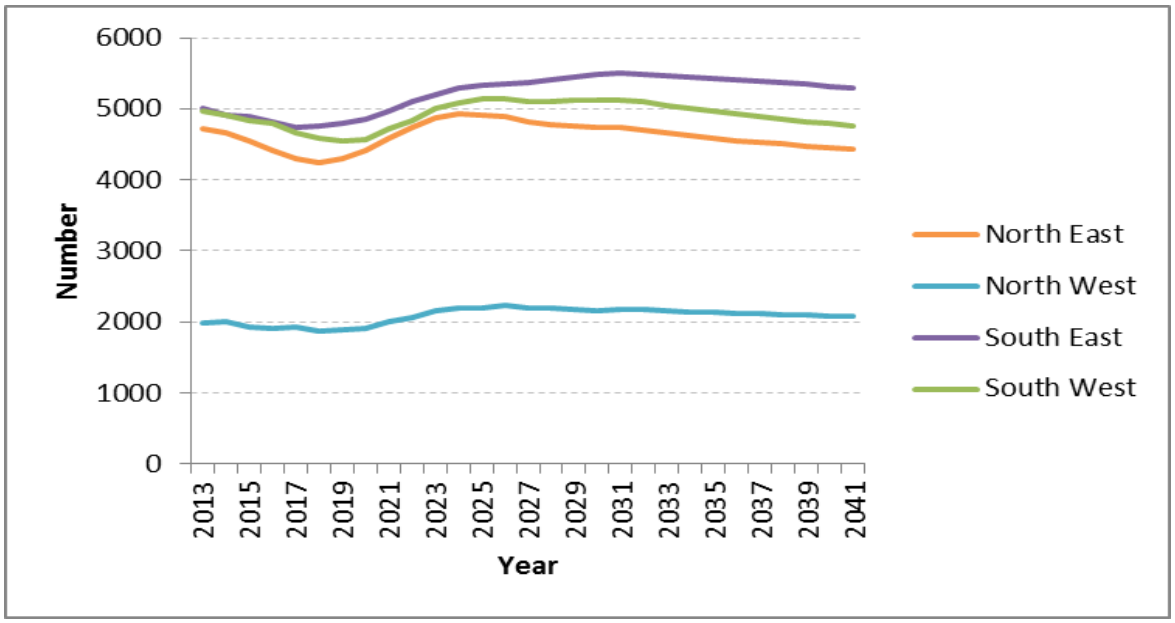
Figure 21 - Population projection for 0-18 year olds as a percentage of total population, by Enfield localities



Source: 2013-round SHLAA capped ward population projection, Greater London Authority

For 15-18 year olds in North East Enfield locality, the population is projected to decrease thorough to 2019 followed by an increase before it starts to decline from around 2025. The other three localities follow a similar pattern (Figure 22).

Figure 22 - Population projection for 15-18 year olds, by locality

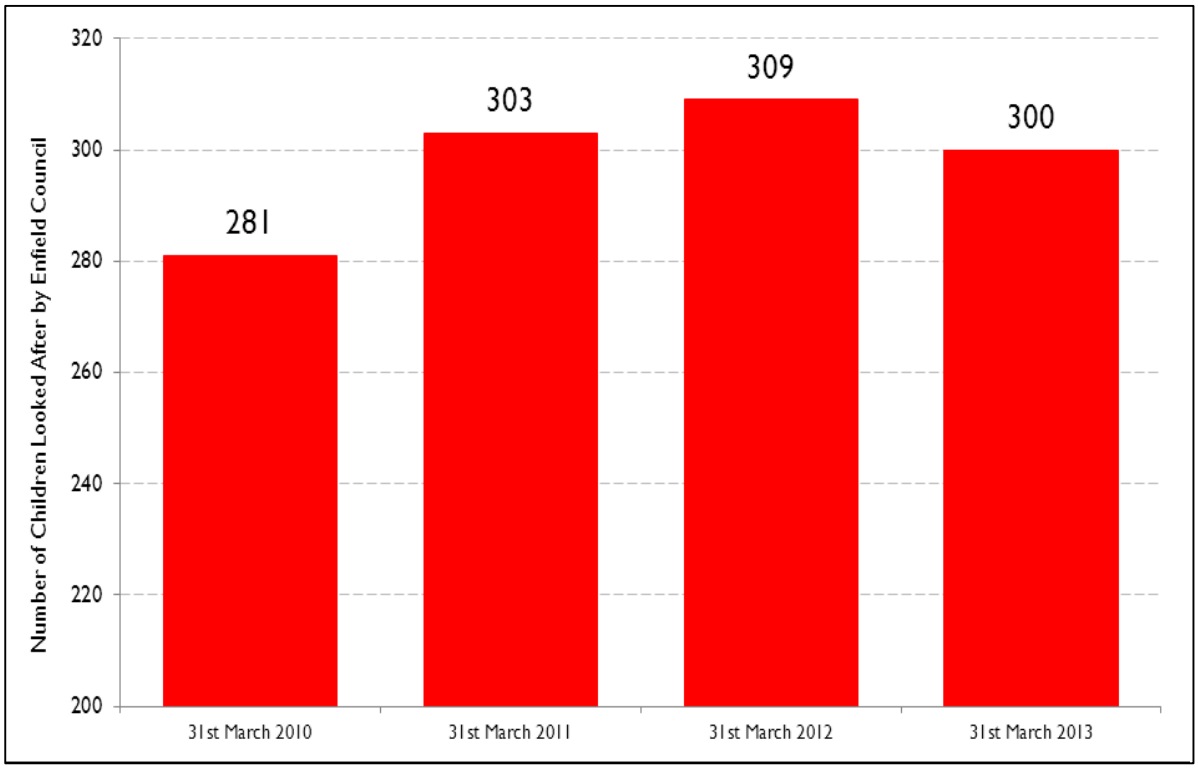


Source: 2013-round SHLAA capped ward population projection, Greater London Authority

2.3.5.3 Children in care

The chart below presents the trend in the number of looked-after children in Enfield between 2010 and 2013.

Figure 23 - Number of children looked-after by Enfield Council: 31st March 2010 - 31st March 2013



Source: JSNA 2013, London Borough of Enfield based on data from SCS

At 31st March 2013 there were 300 looked-after children in Enfield but the latest picture, as of 31st October 2013, shows the number of looked-after children to be 297.

2.3.5.4 Older people

The proportion of older people aged 65 years and older (Figures 24 and 25) in Enfield (12.7%) is slightly above the London average (11.2%) but considerably below the England average (16.9%). Within Enfield, South West locality has the highest number of people aged 65 years and over and is projected to increase in all four localities in future. By 2041, 17% of Enfield residents are projected to be aged 65 years and older with more than one fifth of the people living in the west of the borough expected to fall into this age range.

Figure 24 - Number of people aged 65 years and over, projection Enfield locality

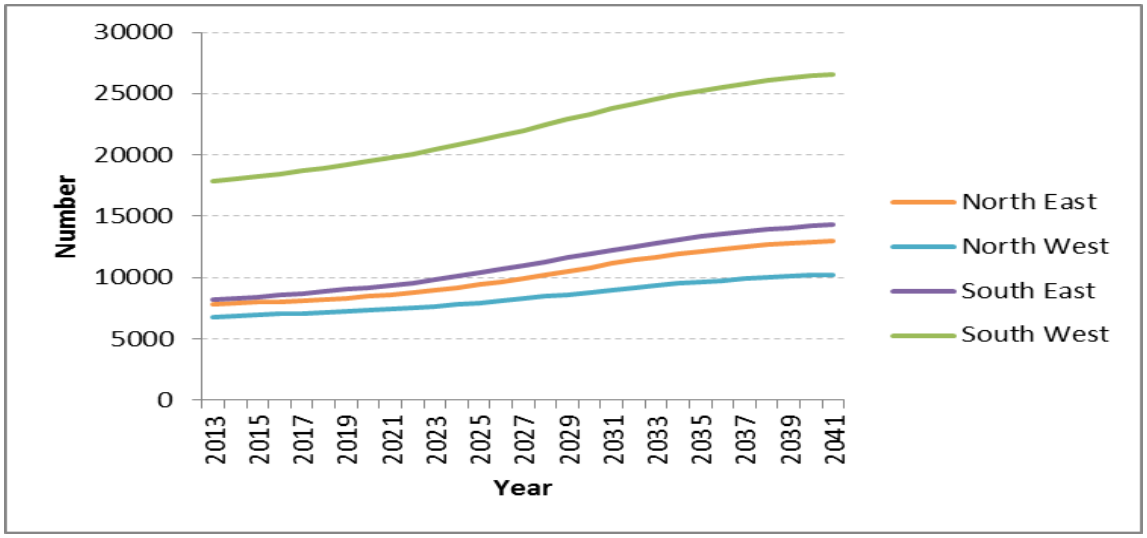
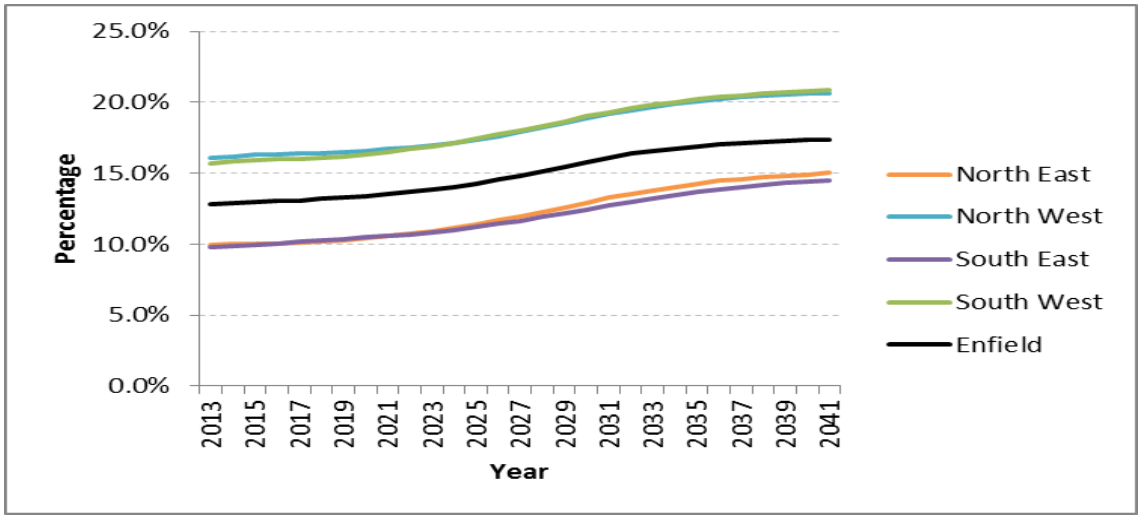


Figure 25 - Proportion of people aged 65 years and over, projection Enfield locality



Source: 2013-round SHLAA capped ward population projection, Greater London Authority

In Enfield, 1.7% of residents are aged 85 years and over (Figures 26 and 27). This compares to 1.6% in London and 2.3% in England. The proportion of people aged 85 years and older is expected to increase steadily over the next decades, reaching 3.5% by 2041. Within Enfield, the number of people aged 85 years and older is highest in South West Enfield locality. Around 2.5% of residents in the locality are aged 85 years and older. This is expected to increase to almost 5.0% by 2041.

Figure 26 - Number of people aged 85 years and over, projection, Enfield locality

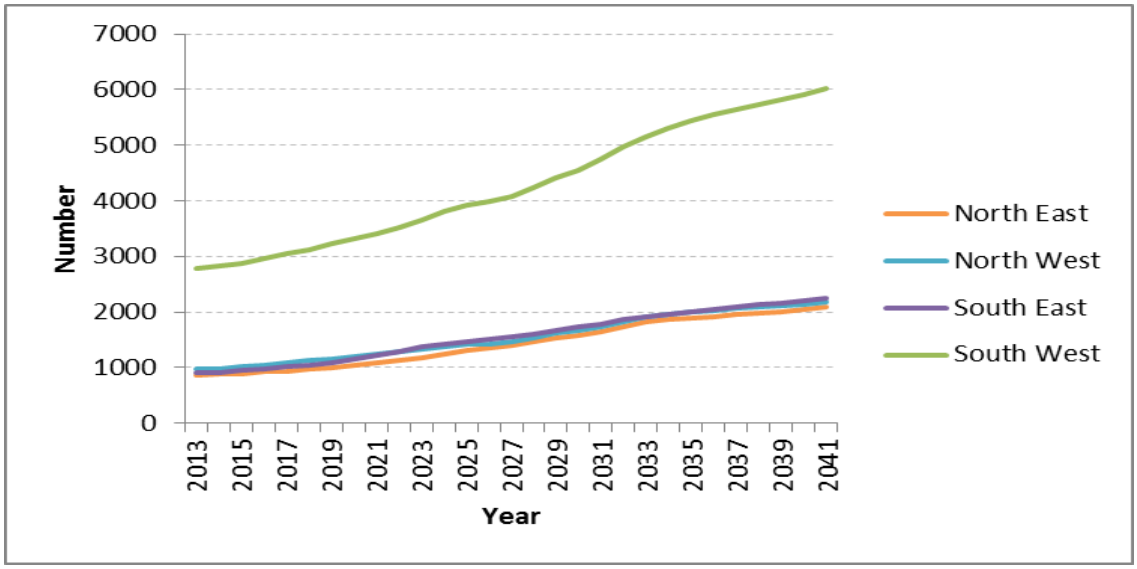
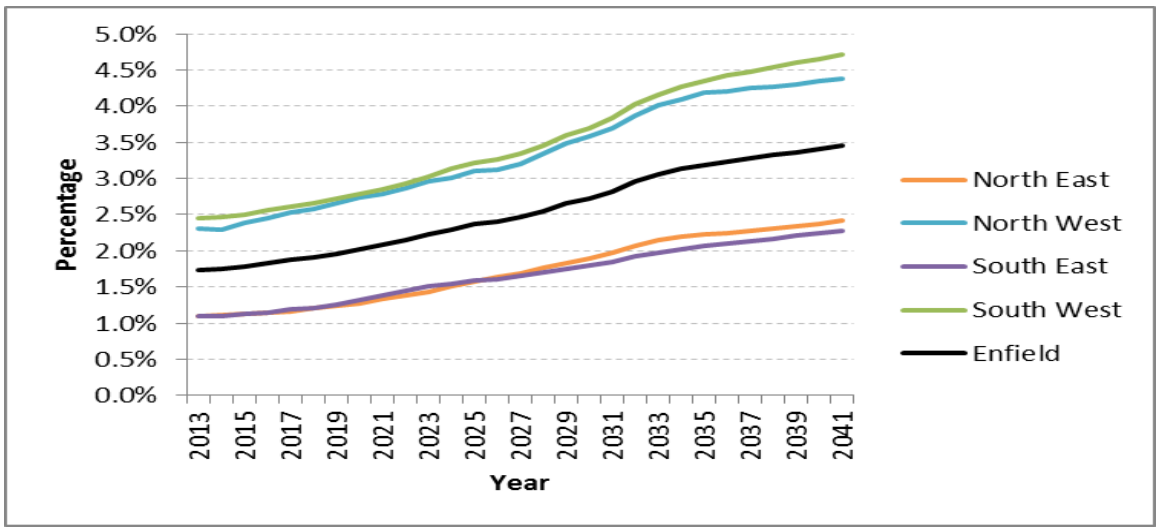


Figure 27 - Proportion of people aged 85 years and over, projection, Enfield locality



Source: 2013-round SHLAA capped ward population projection, Greater London Authority

2.3.5.5 Prison populations

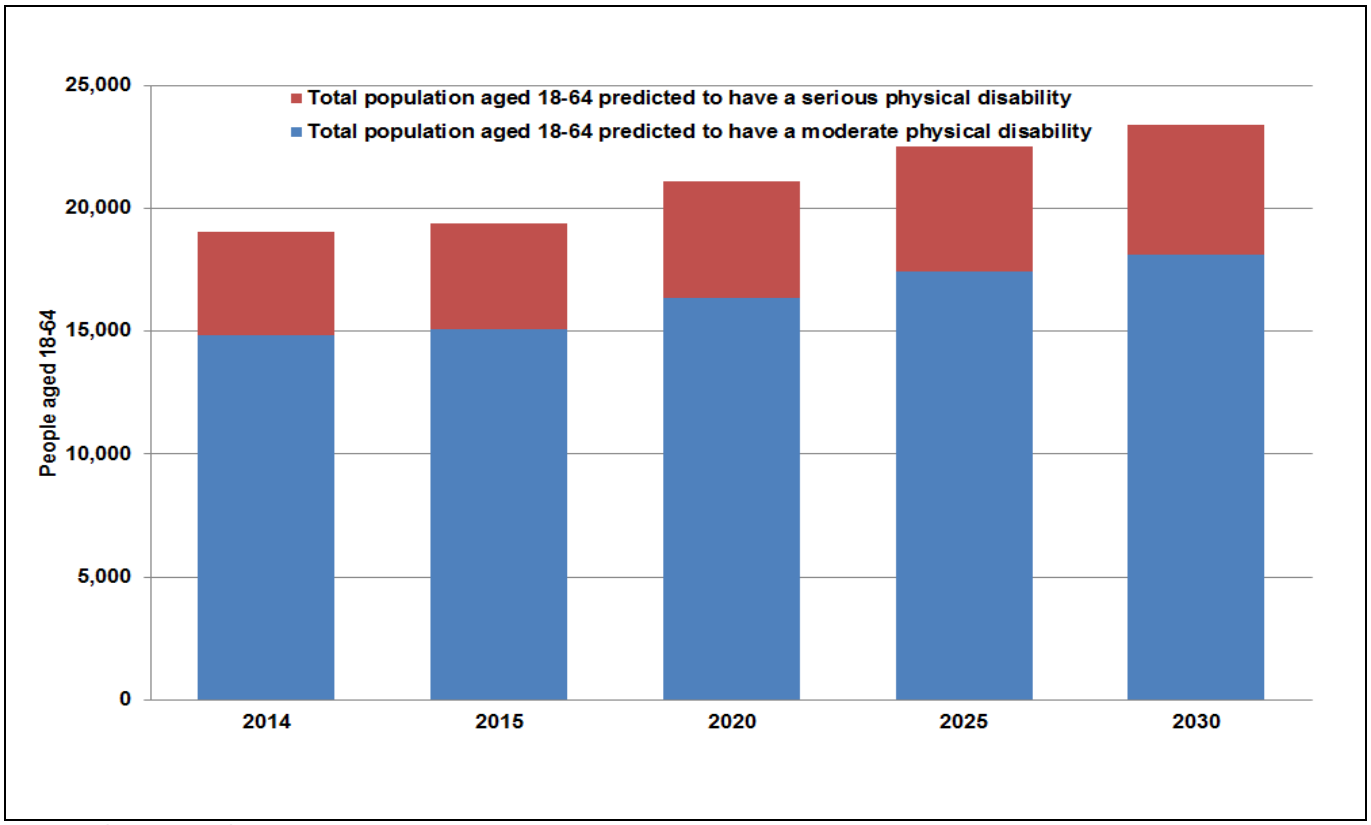
There is no prison or youth offender institute in the borough.

2.3.5.6 Less-abled populations

2.3.5.6.1 Physical disability

Figure 28 shows that in 2014 the number of adults aged 18-64 with a moderate disability is 14,837 and this is predicted to rise to 18,120 in 2030 which is an increase of 3,283. In the same year the number of adults with a serious disability is 4,197 and this is expected to increase by 1,103 to 5,300 in 2030.

Figure 28 - Projected number of adults aged 18-64 years in Enfield with either a moderate or serious physical disability: 2014-2030

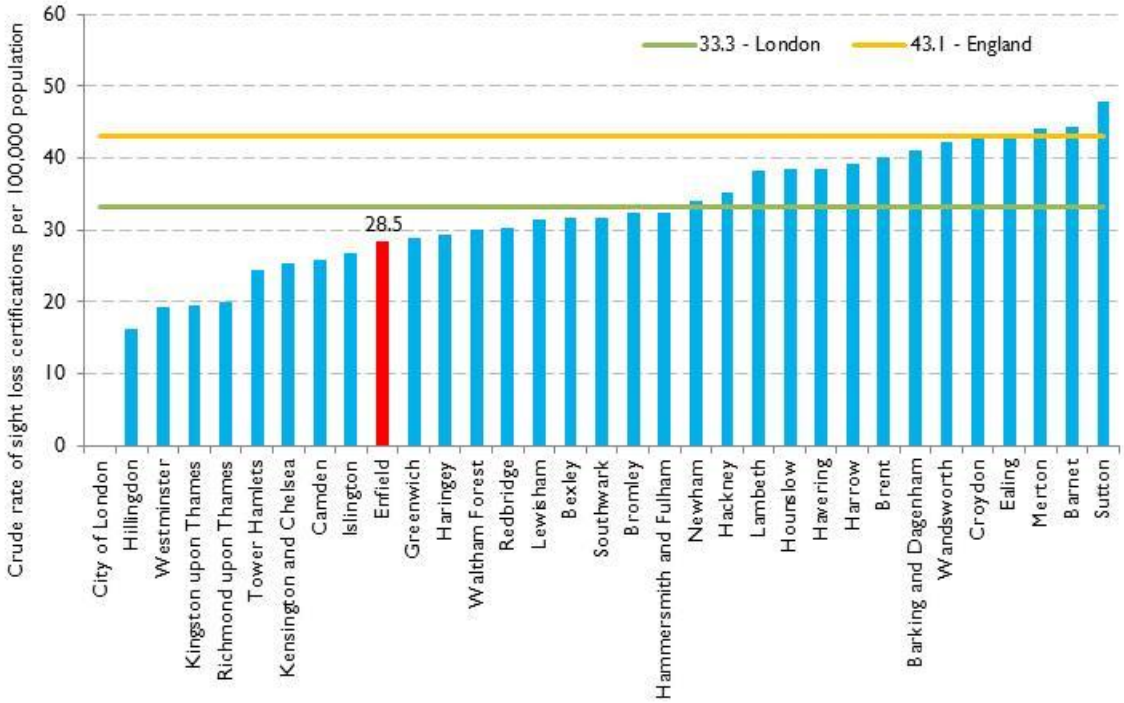


Source: PANSI

2.3.3.6.2 Sight impairment

There was a total of 605 people recorded on Enfield's blind register (Figure 29), and 545 people registered as partially sighted in 2010/11 with 84 new cases of sight impairment registered in Enfield during 2010/11. These 84 registrations of sight impairment gave Enfield a sight loss certification rate of 28.5 per 100,000 population, which was below the London and England rates of 33.3 and 43.1 respectively.

Figure 29 - Crude rate of sight loss certifications per 100,000 population, by London borough: 2010/11



Source: Public Health Outcomes Framework (PHOF) data tool

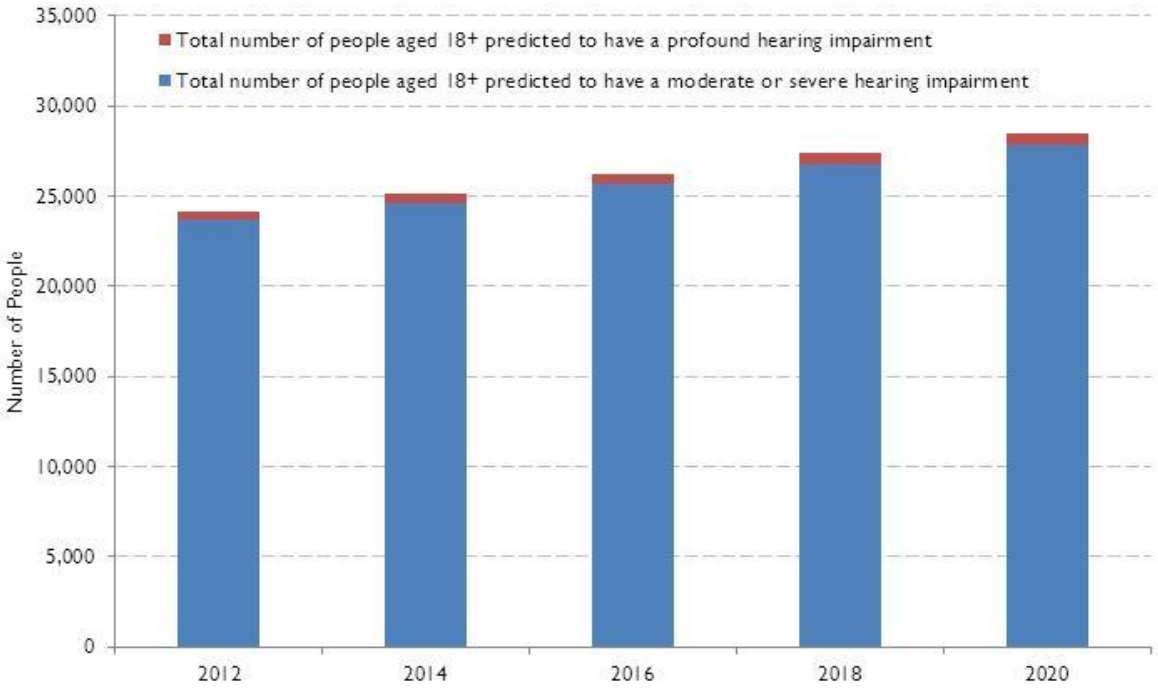
Local intelligence suggests that annual sight loss registrations have increased to approximately 100-120 per year although it is thought that there is still a proportion of people who would be eligible for registration who are currently not on Enfield's register. As of July 2013, a total of 700 people were recorded on Enfield's blind register, with an additional 547 people registered as partially sighted.

2.3.5.6.3 Hearing impairment

Figure 30 shows that the total number of people aged 18+ with moderate or severe hearing impairment in Enfield is set to rise from 23,657 in 2012 to 27,884 in 2020. This equates to 4,227 people or an 18% increase from 2012. While the number of people living with profound deafness in Enfield is significantly smaller than those with moderate or severe hearing loss, the number of profoundly deaf adults is projected to rise from 505 in 2012 to 611 in 2020 – a numerical rise of 106 people that equates to a 21% increase from 2012.

The prevalence of hearing impairment and deafness increases with age, with 72% of adults predicted to have moderate or severe hearing impairment and 89% of those predicted to have profound hearing impairment in 2012 being over 65 years of age. It is thought that 85% of males and 85% of females over the age of 85 suffer from moderate to severe hearing impairment.

Figure 30 - Projected number of adults aged 18 and over in Enfield with moderate or severe; or profound hearing impairment: 2012-2020

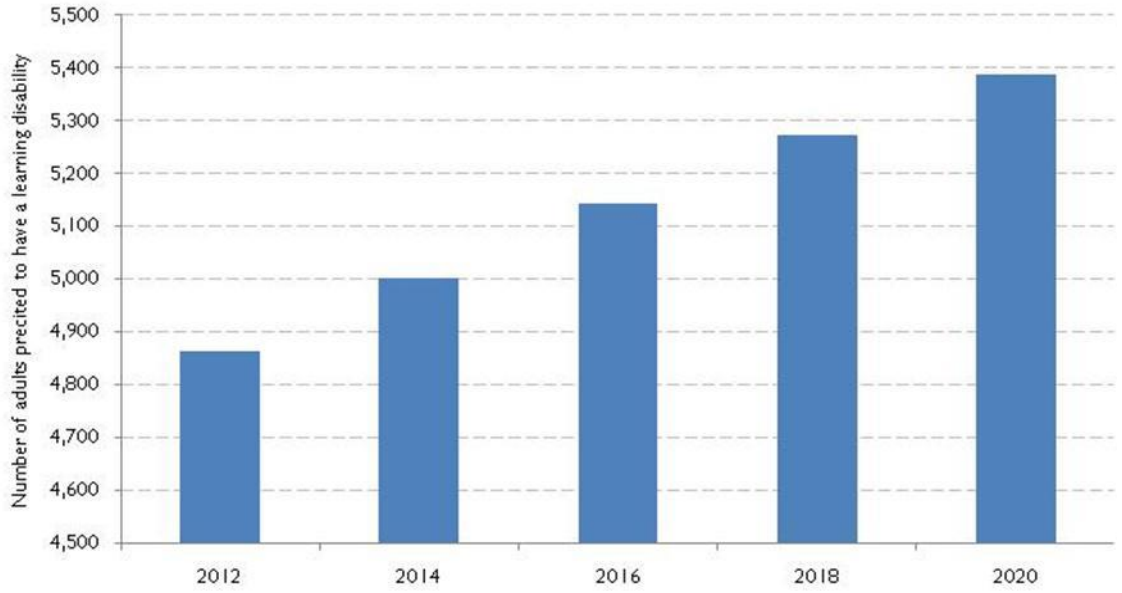


Source: Projecting Adult Needs and Service Information (PANSI)

2.3.5.6.4 Learning disabilities

The projected number of adults expected to be living with a learning disability is set to rise steadily until at least 2020, with numbers predicted to increase from approximately 4,850 in 2012 to close to 5,400 in 2020.

Figure 31 - Projected trend of the number of adults aged 18-64 years with a learning disability in Enfield: 2012-2020



Source: Projecting Adult Needs and Service Information (PANSI)

Table 8 below highlights the predicted trends in the number of adults with learning disabilities in Enfield. Increases in the number of adults with each disability group are expected, with a projected rise of between 11% and 13% for each of the disability type shown below.

Table 8 - Projected trend of the number of adults living with learning disabilities in Enfield: 2012-2020

	2012	2014	2016	2020
Total population aged 16-18 to have a moderate or severe learning disability	1,090	1,126	1,197	1,230
Total population aged 16-18 to have a severe learning disability	292	301	310	319
Total population aged 16-18 to have with a learning disability, predicted to display challenging behaviour	89	92	95	99
Total population aged 16-18 predicted to have autistic spectrum disorders	1,922	1,987	2,051	2,159
Total population aged 16-18 predicted to have Down's Syndrome	124	128	131	138

Source: Projecting Adult Needs and service Information (PANSI)

Source: Projecting Adult Needs and Service Information (PANSI)

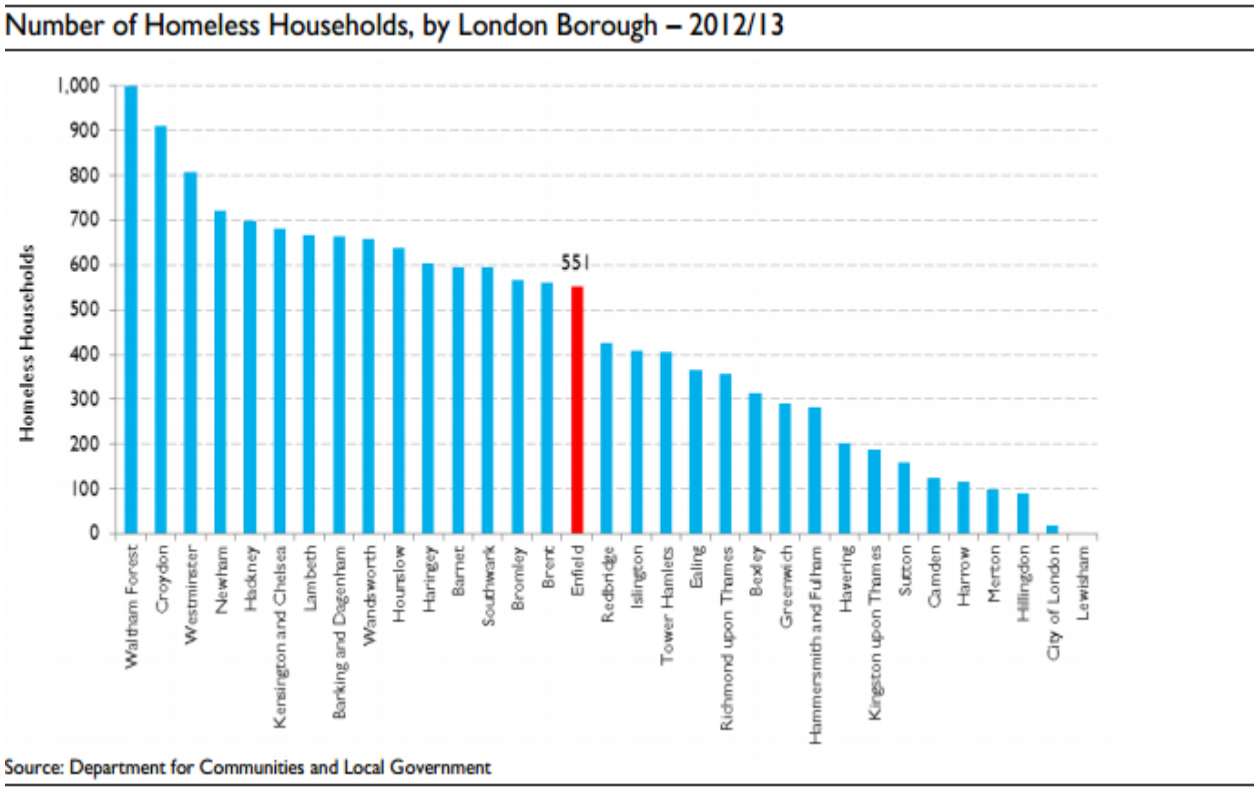
2.3.5.7 Breastfeeding populations

In 2012/13, 88.8% of mothers (3,884) initiated breastfeeding in Enfield. This is above the London average of 86.8% and the England average of 73.9%.

2.3.5.8 Homeless populations

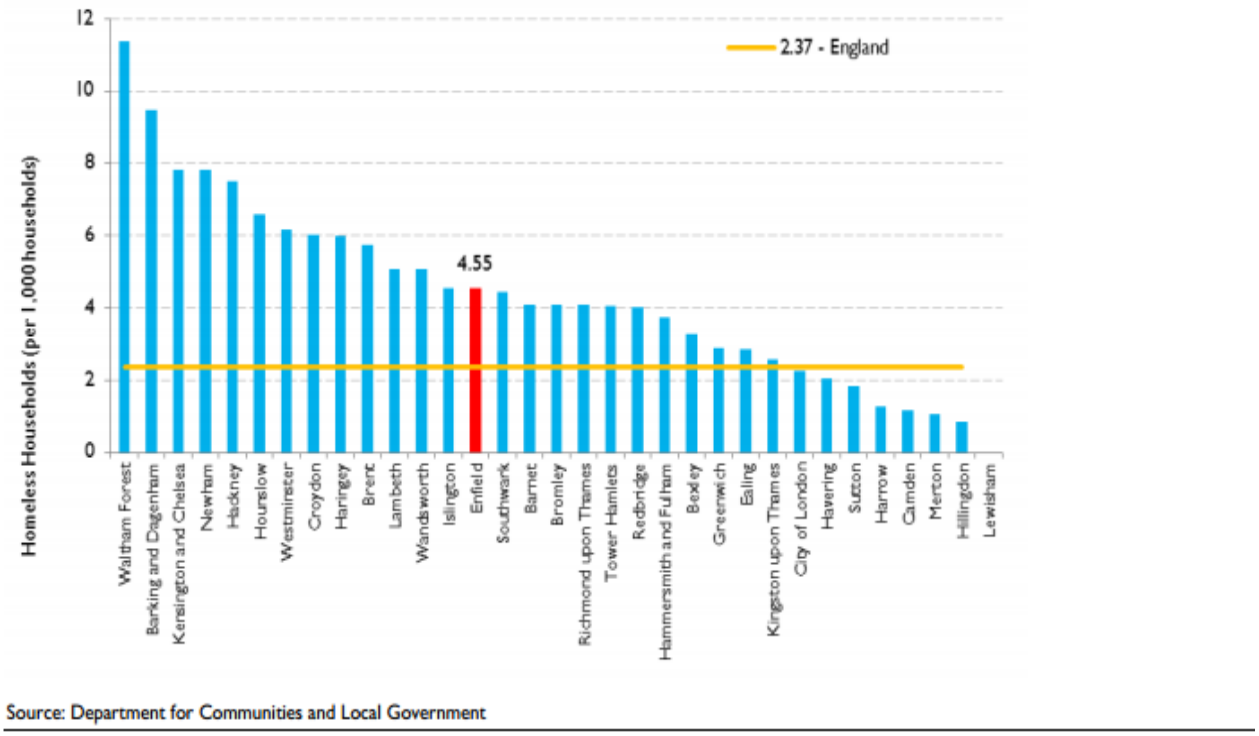
As the Annual Public Health Report from 2012 states, "lack of secure, permanent accommodation is a major stress factor and contributor to poor health and wellbeing". In Enfield in 2012/13, 551 households were identified by the Council as being statutory homeless, giving the rate of statutory homeless households as 4.5 meaning that per 1,000 households, 4.5 were without a permanent home (Figures 32 and 33).

Figure 32 – Number of homeless households, by London borough 2012/13



N.B. No data for Lewisham was available

Figure 33 – Homeless household rate, by London borough 2012/13



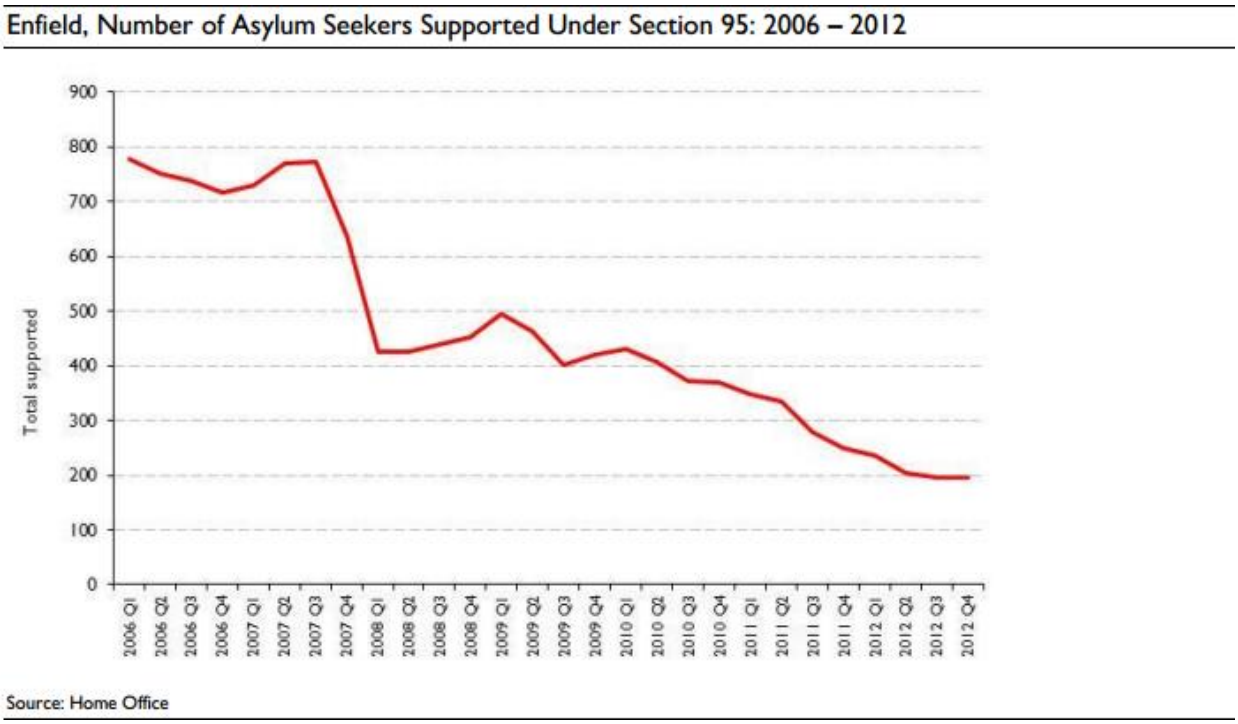
N.B. No data for Lewisham was available

In a London context, this homeless household rate is fairly low and the 14th highest across the capital. However in a national context the figure is high – significantly above the national average of 2.37. Furthermore, the count figure of 551 is relatively high and means Enfield has the 20th highest number of homeless households amongst district and borough councils in England.

2.3.5.9 Asylum seekers and refugees

Asylum seekers are excluded from claiming mainstream welfare benefits and, in most cases, from working. They can access support in the form of housing and / or basic living expenses while in the UK through Section 95 support (Figure 34). This is aimed at asylum seekers whose claims are ongoing, who are destitute or about to become destitute and their dependents.

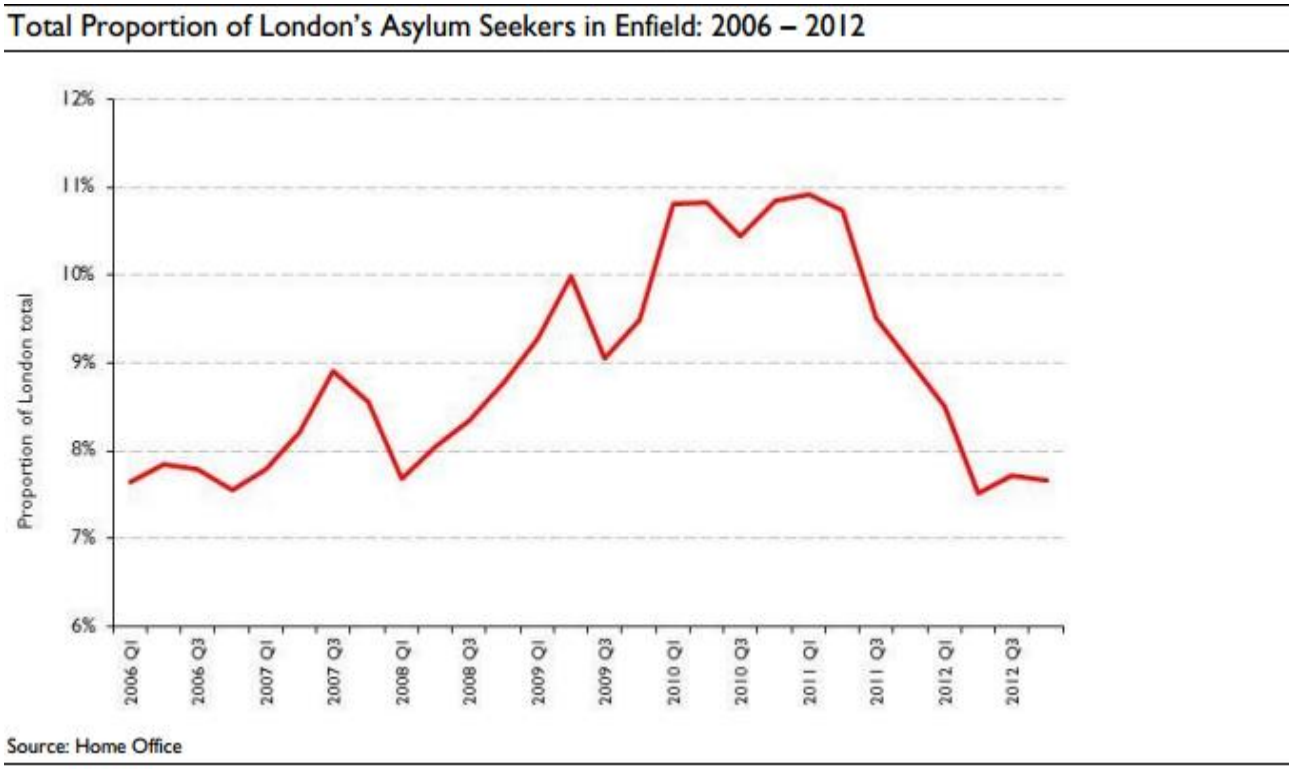
Figure 34 – Number of asylum seekers in Enfield supported under Section 95 2006-2012



As recently as 2006, Enfield was offering Section 95 support to almost eight hundred asylum seekers, a quarter of whom were being provided with accommodation. However, there has been a rapid decline in the number of asylum seekers in the borough since and, as of 2012, the number receiving Section 95 support has fallen to 196, with around half of these being provided with accommodation.

In a London context, the proportion of asylum seekers receiving Section 95 support living in Enfield is now the lowest it has been since 2006 (Figure 35). Having peaked at close to 11% in 2011, the figure is now 7.7%.

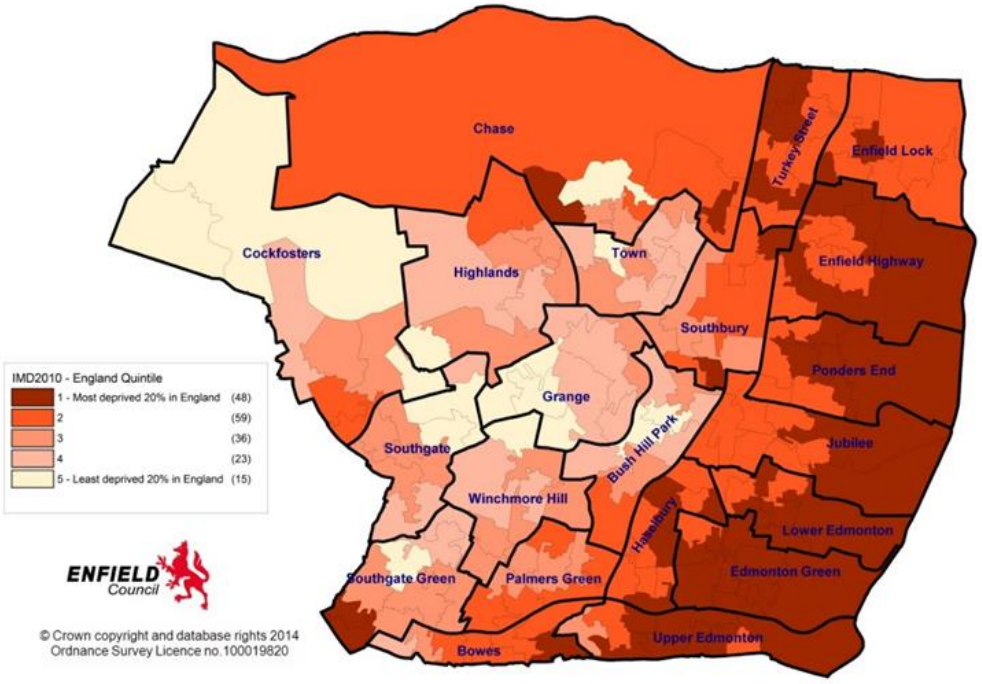
Figure 35 – Total proportion of London's asylum seekers in Enfield 2006-2012



2.3.6 Deprivation

Deprivation can be considered to be a key determinant of ill health. Overall the deprivation structure in Enfield is very similar to the London average, but more deprived than England, with nearly 60% of the Enfield population falling in the two most deprived quintiles. In Enfield, the more deprived areas using deprivation quintiles are in the east of the borough, with the south-east of the borough particularly deprived (Figure 36). In rank order, these are Edmonton Green, Upper Edmonton, Lower Edmonton, Ponders End and Turkey Street. Such are the levels of deprivation in the three Edmonton wards that all three are within the most deprived 10% of wards in England.

Figure 36 - Index of Multiple Deprivation 2010, Enfield LSOAs, based on national quintiles

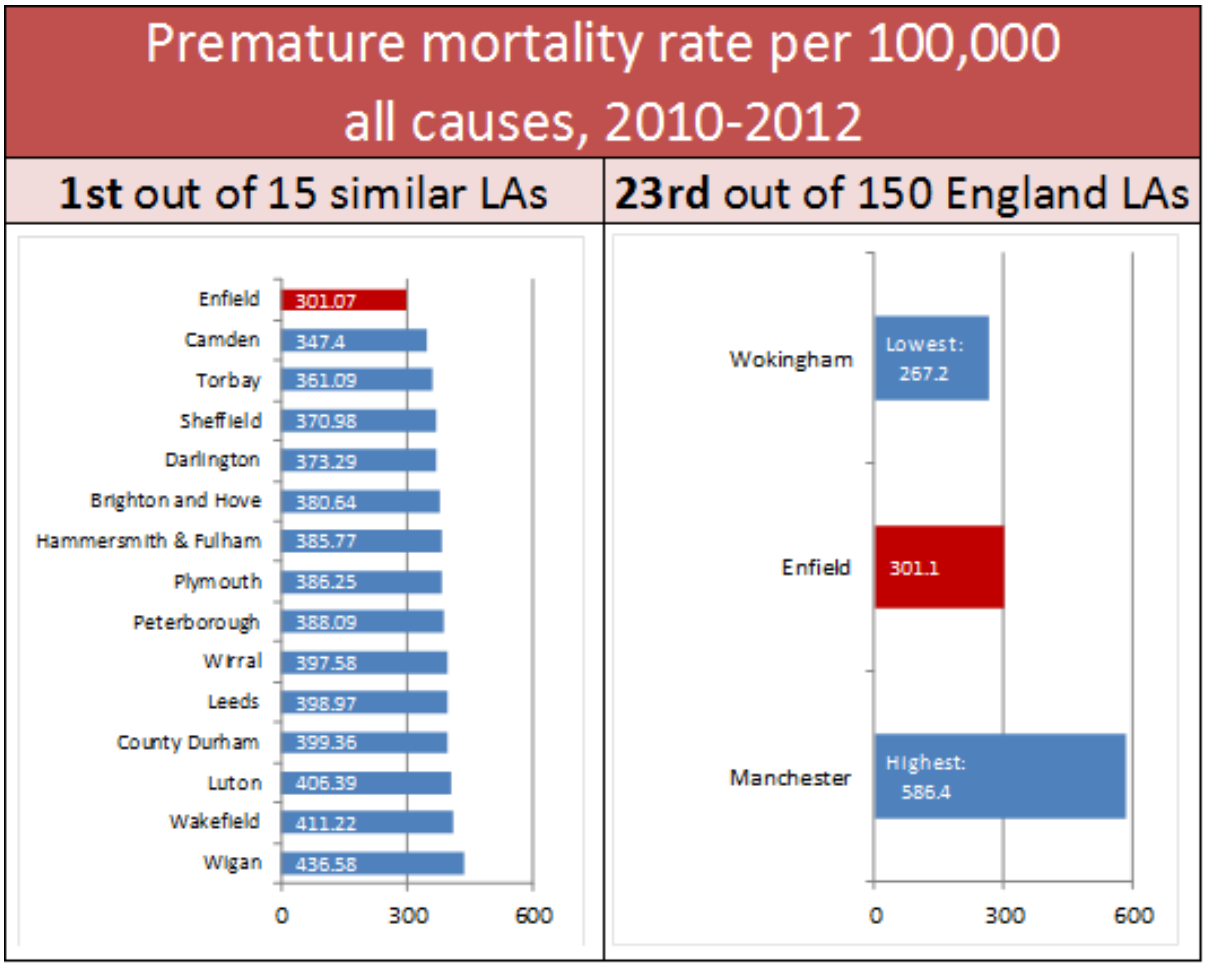


Source: IMD 2010

2.4 Causes of ill health

The standardised rate for premature mortality (persons under 75 years) due to all causes in Enfield was 301.1 per 100,000, below the England average of 350.0 per 100,000 population and the 23rd lowest out of 150 England local authorities (Public Health England based on ONS Mortality File, 2010-2012) (Figure 37).

Figure 37 - Directly age, sex-standardised mortality rate per 100,000 population, all causes and people under 75 years, 2010-2012



Source: Public Health England based on ONS mortality file

Within Enfield, Edmonton Green and Upper Edmonton ward has a premature mortality rate significantly higher compared to the England average and corresponds with the high level of deprivation rate. In addition to Edmonton Green and Upper Edmonton, Turkey Street also has the all causes mortality rate (all ages) significantly above the national average (Figures 38 and 39).

Figure 38 - Indirectly age, sex-standardised ratio, all causes, persons aged 75 years and under, 2006-2010

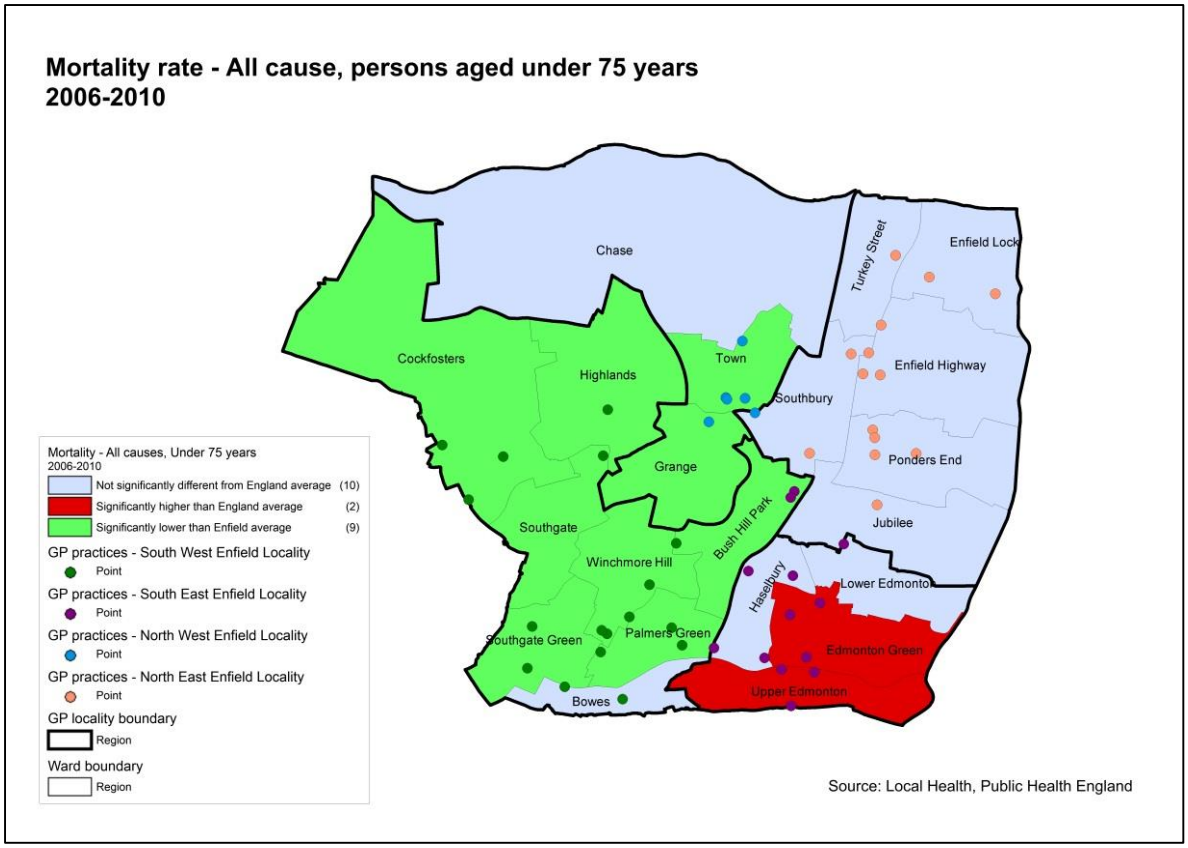
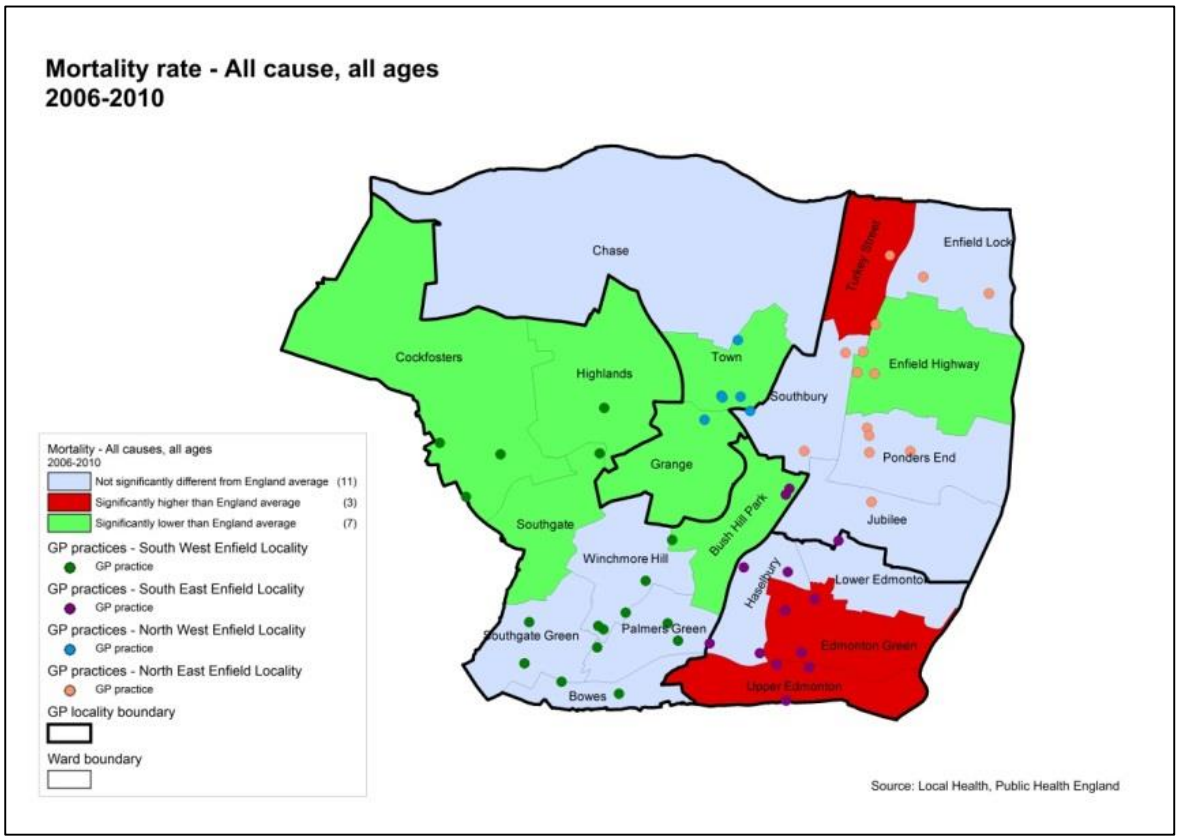


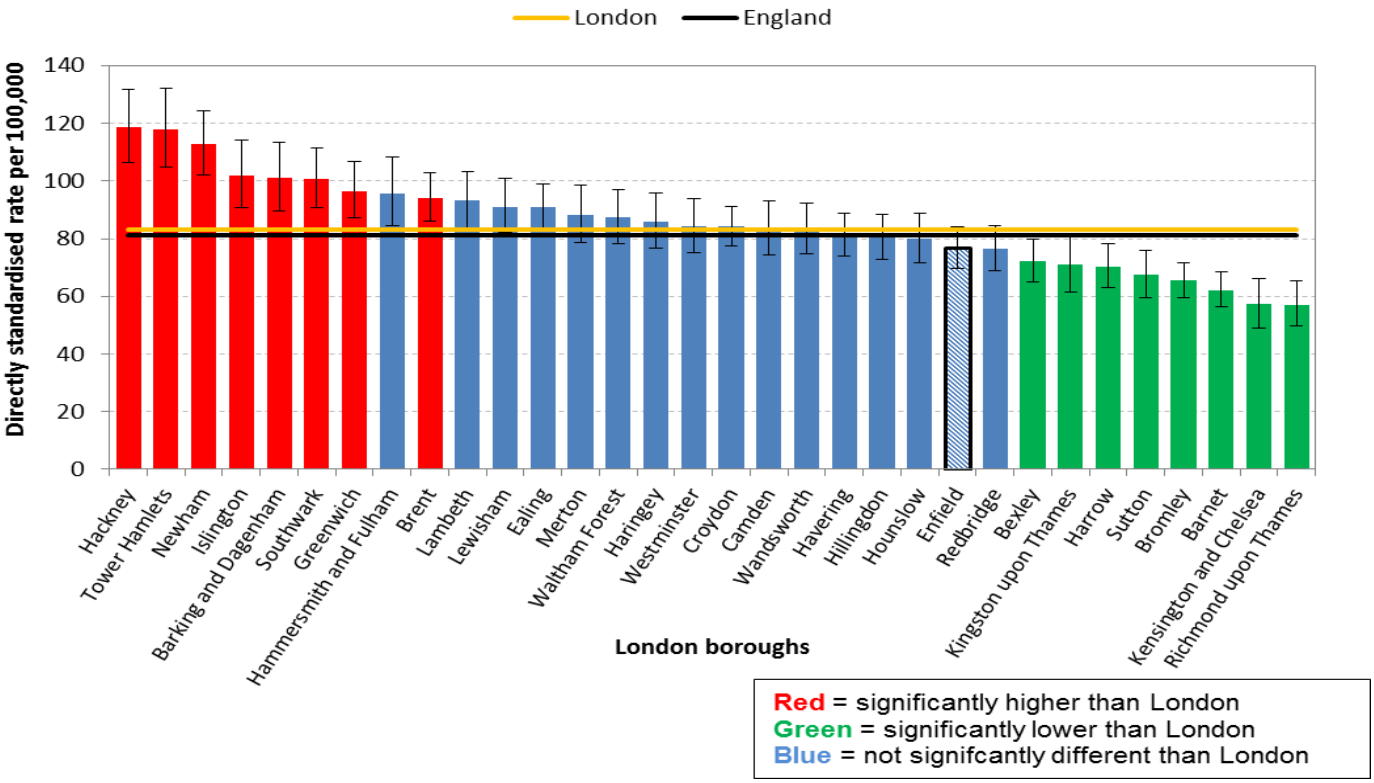
Figure 39 - All age (all-cause) mortality rate for Enfield as a whole and for each of the localities 2010-2012



2.4.1 Cardiovascular disease

Enfield's premature mortality rate (under 75 years) from cardiovascular disease (CVD) (76.8 per 100,000) is the 10th lowest amongst 32 London boroughs (Figure 40). It is similar to the London (83.1 per 100,000) and England (81.1 per 100,000) averages.

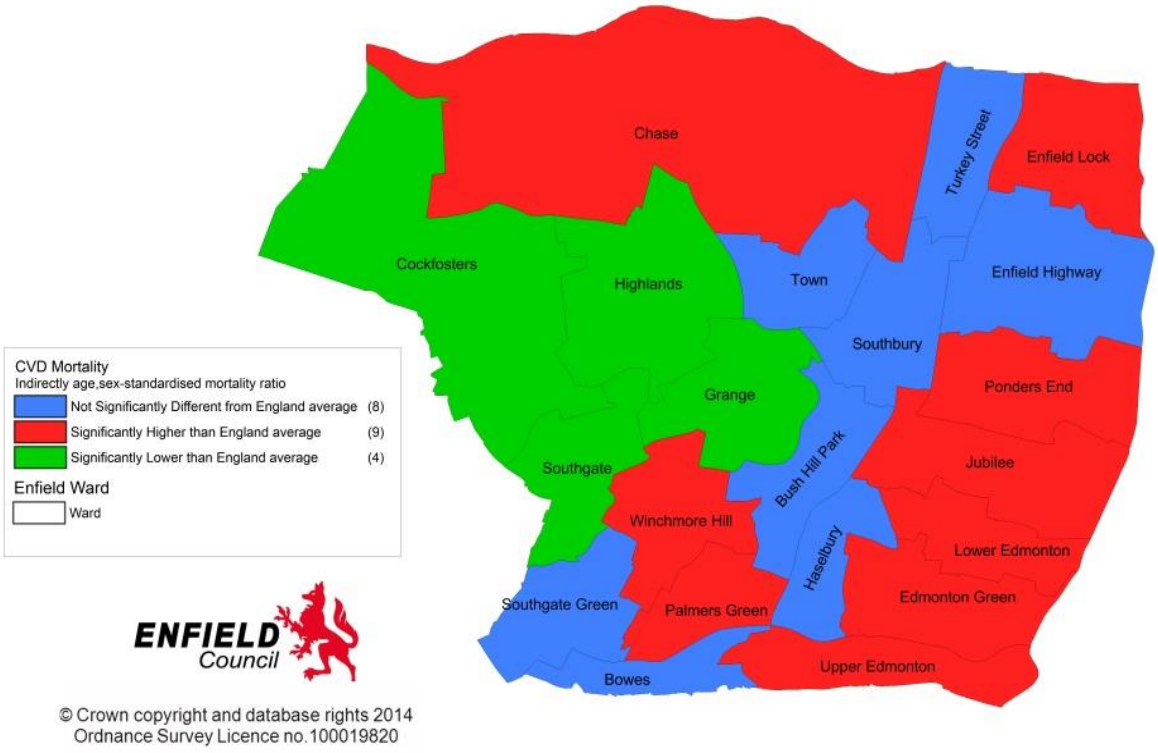
Figure 40 - Directly age, sex standardised rate for cardiovascular disease, persons aged under 75 years, London boroughs, 2010-2012 (pooled)



Source: Public Health Outcomes Framework (PHOF), Public Health England

Within Enfield, CVD mortality (under 75 years) is significantly higher than the England average in the following nine wards: Chase, Enfield Lock, Ponders End, Jubilee, Lower Edmonton, Edmonton Green, Upper Edmonton, Winchmore Hill and Palmers Green (Figure 41).

Figure 41 - CVD mortality - indirectly age and sex standardised ratio for persons aged under 75 years in Enfield wards, 2006-2010 (pooled)

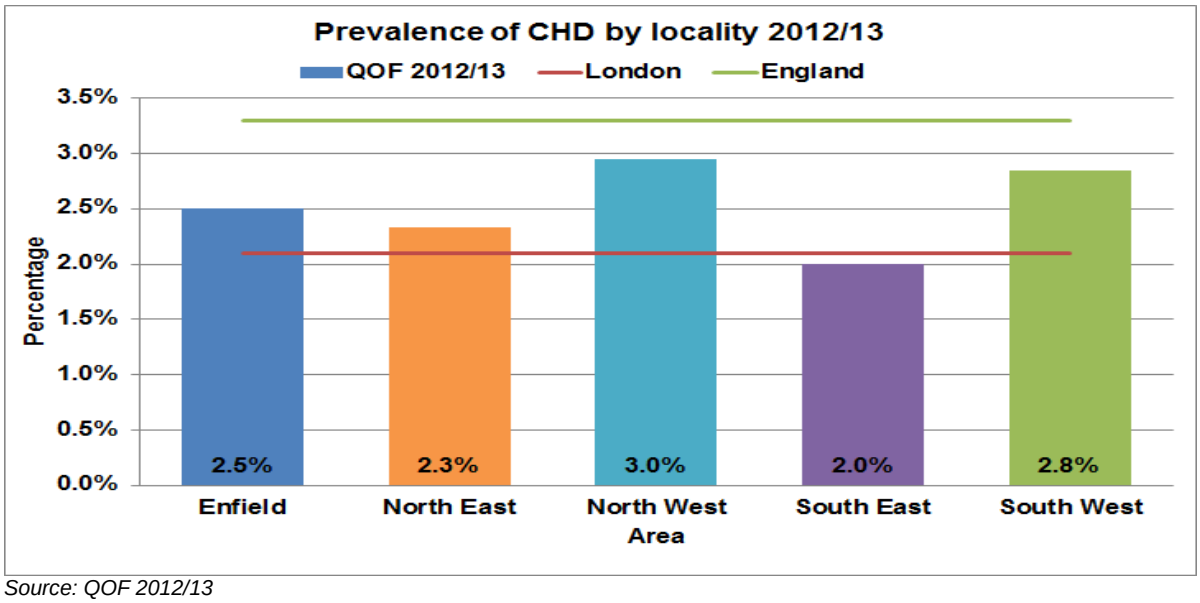


Source: Local Health, Public Health England

2.4.1.1 Coronary heart disease

Enfield's recorded prevalence of coronary heart disease (CHD) (2.5%) is above London (2.1%) and below England (3.3%) averages. Within Enfield, North West and South West Enfield localities have higher recorded prevalence compared to the East of the borough.

Figure 42 - Recorded prevalence of CHD, Enfield localities, 2012/13

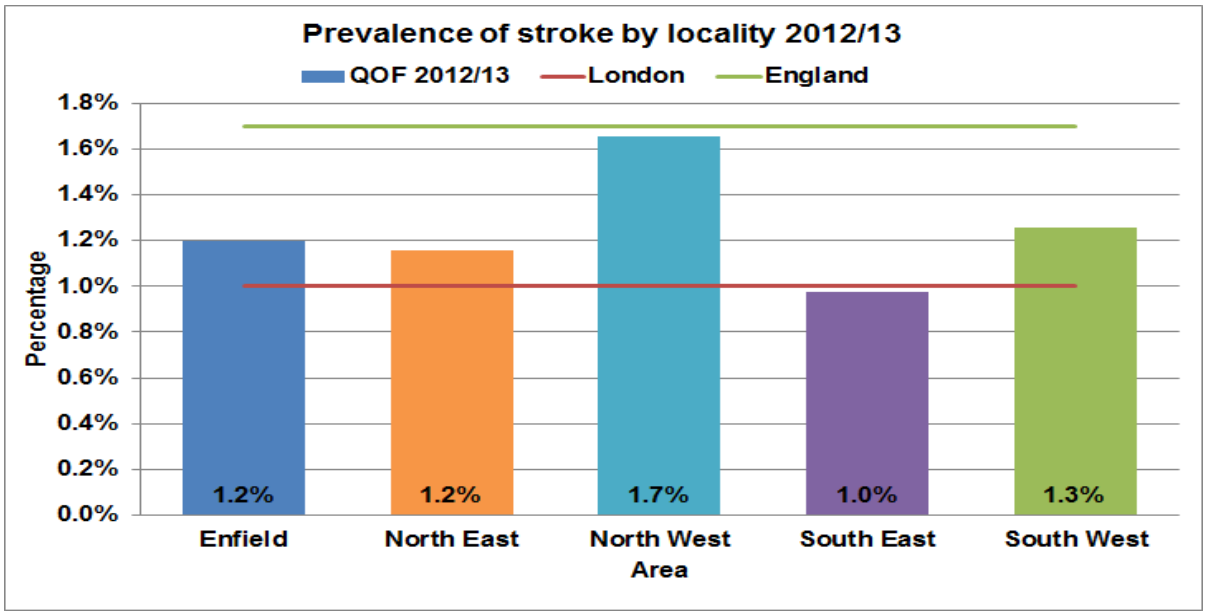


Source: QOF 2012/13

2.4.1.2 Stroke

Enfield's recorded prevalence of stroke (1.2%) is above London (1.0%) and below England (1.7%) averages. Within Enfield, North West and South West Enfield localities have higher recorded prevalence compared to the east of the borough.

Figure 42 - Recorded prevalence of stroke, Enfield localities, 2012/13



Source: QOF 2012/13

Figure 43 - Standardised admission ratios emergency hospital admissions (SAR) due to stroke, 2008/09 to 2012/13

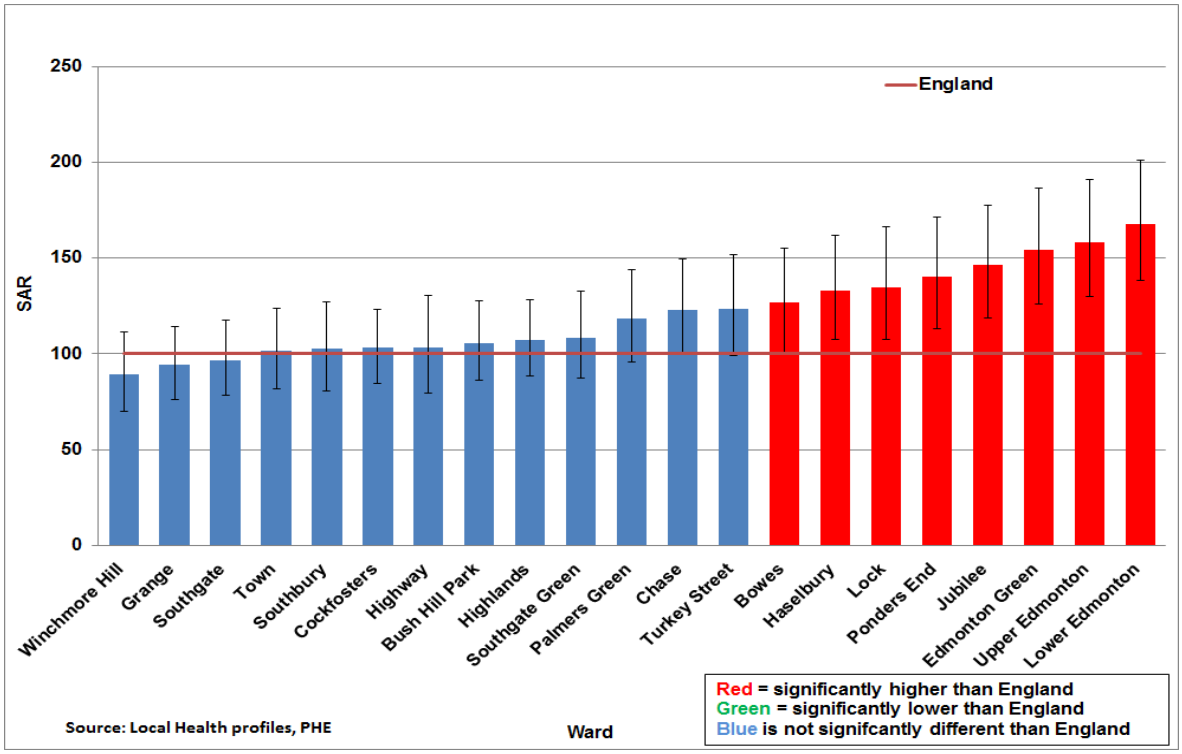
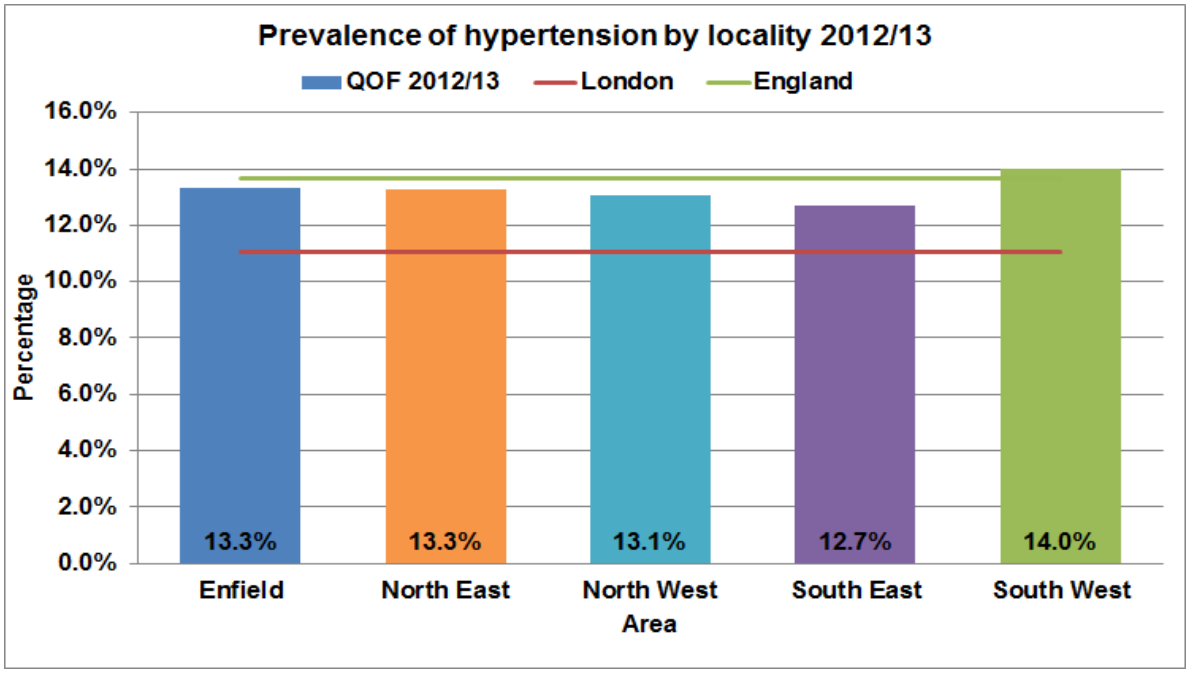


Figure 43 above shows standardised admission ratios due to stroke for Enfield wards. Eight wards have a significantly higher ratio than England. The highest ratio is in Lower Edmonton (168) which means that residents in this ward are 1.7 times more likely to be admitted to hospital for stroke.

2.4.1.3 Hypertension

Enfield's recorded prevalence of hypertension (13.3%) is above London (11%) and below England (13.7%) averages. Within Enfield, prevalence is similar with the lowest being in South East locality (12.7%) and the highest recorded prevalence in South West locality (14%).

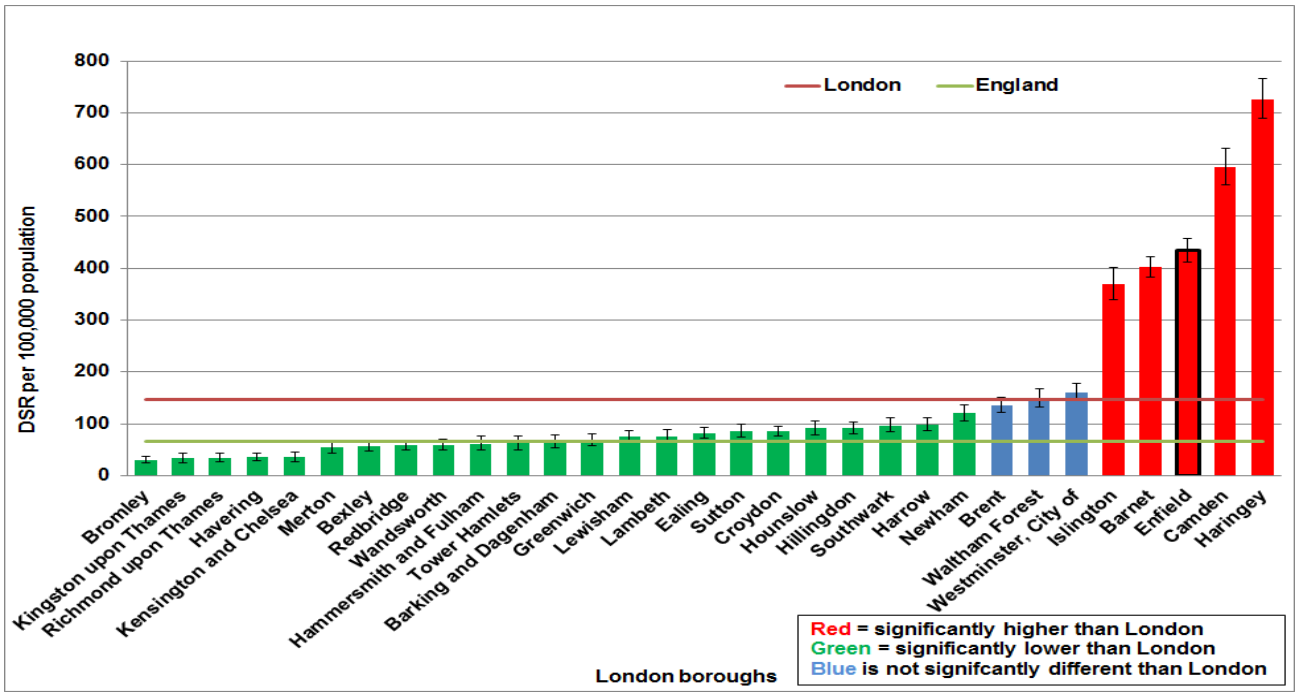
Figure 44 - Recorded prevalence of stroke, Enfield localities, 2012/13



Source: QOF 2012/13

Figure 45 below shows directly age-standardised rates for hospital admissions due to acute hypertensive disease for London boroughs in 2010/11. Enfield (434 per 100,000 population) has the third highest rate out of all London boroughs and this is significantly higher than London.

Figure 45 - Directly age-standardised hospital admissions due to acute hypertensive disease, 2010/11



Source: London Health Programmes, HNA toolkit

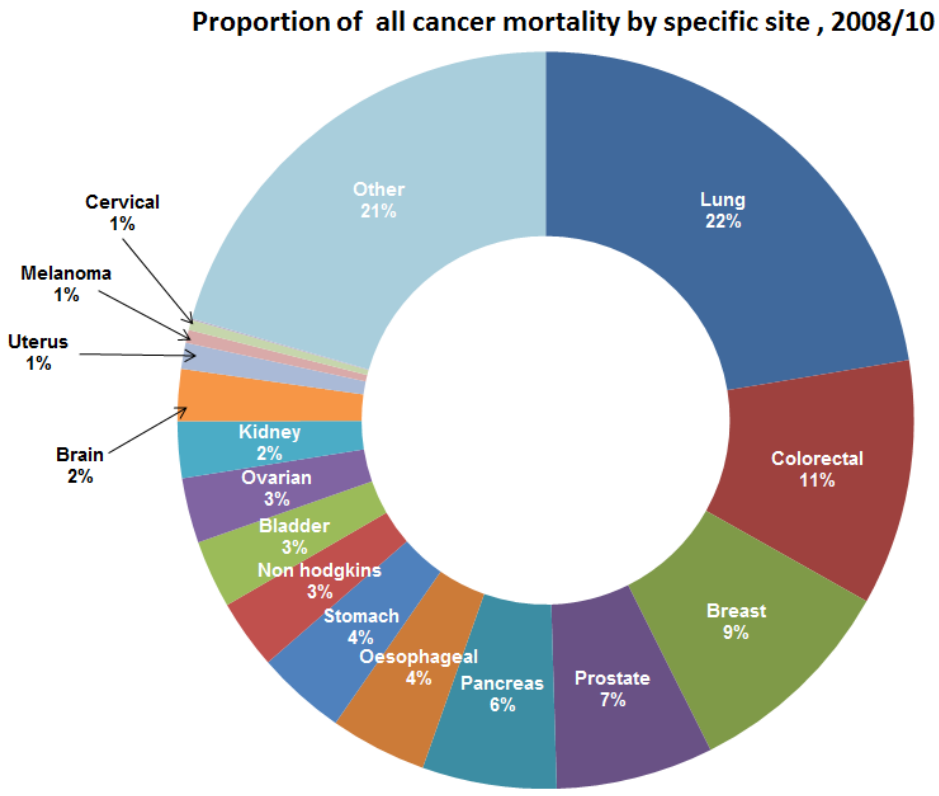
2.4.2 Cancers

The impact of lifestyle on the development of cancer is very important. For example, in a review of the epidemiology of a wide range of cancers, it was identified that about one third overall can be attributed to just four lifestyle choices – alcohol, overweight and obesity, inappropriate diet and tobacco.

Overall, cancer is responsible for around 250 premature deaths per year i.e. persons aged less than 75 years (based on 2010-2012 data). It is also the largest contributor to premature mortality within the borough (40%), although according to Public Health England, premature deaths in Enfield (under the age of 75 years) are below the national average for cancers overall and for those cancers that are considered to be preventable.

Figure 46 shows the contribution of specific cancer sites to the overall mortality (persons all ages) due to cancer within Enfield in 2008-2010.

Figure 46 - Proportion of cancer deaths by specific site 2008-2010 Enfield

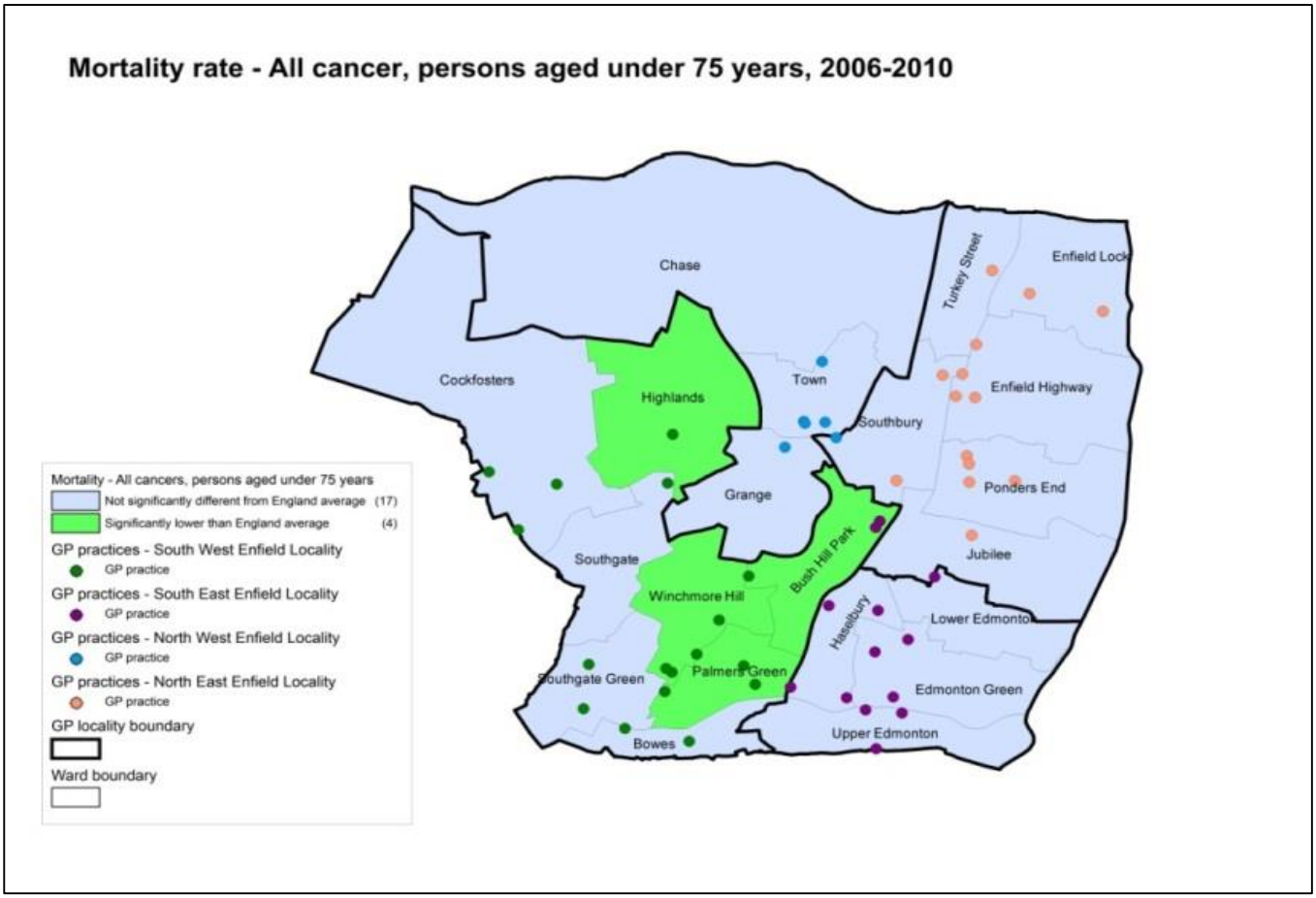


Source: Health and Social Care Information Centre, Indicator Portal

Deaths due to lung cancer are the biggest cause of mortality related to cancer, accounting for 22% of all cancer deaths in Enfield between 2008 and 2010. Colorectal accounts for 11% and breast cancer and prostate cancers are responsible for 9% and 7% respectively.

Within Enfield, under 75 mortality rate for cancer is significantly lower than England in the following wards: Highlands, Winchmore Hill, Palmers Green and Bush Hill Park (Figure 47).

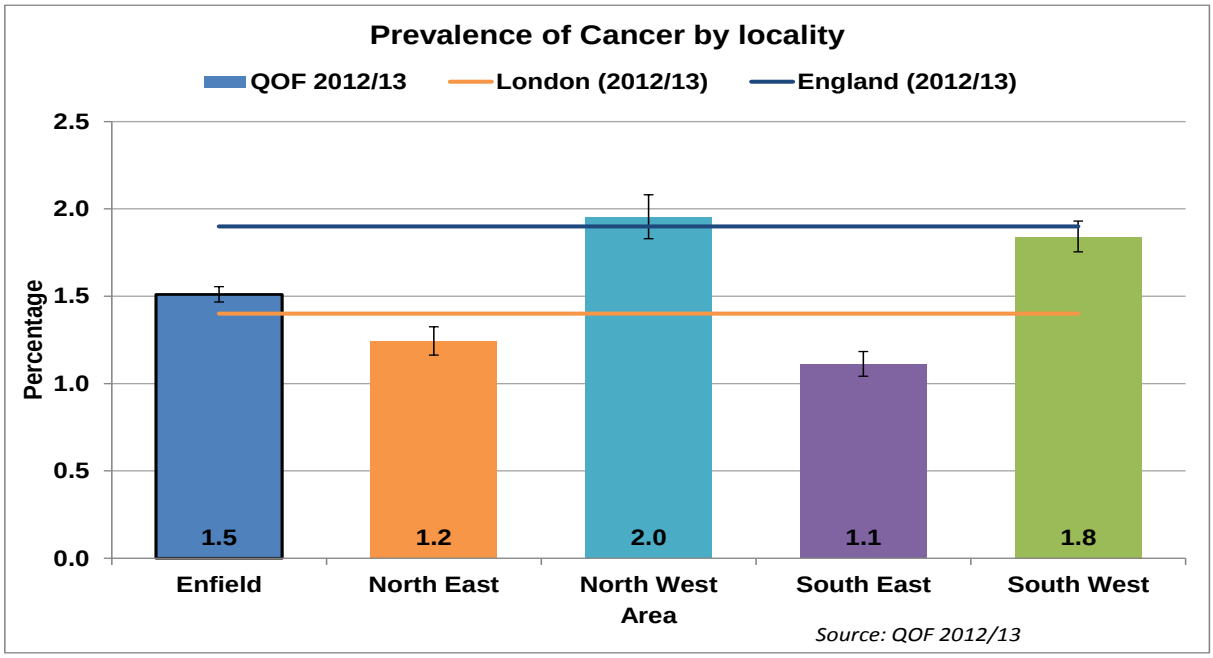
Figure 47 - Cancer mortality – indirectly age and sex standardised ratio for persons aged under 75 years in Enfield wards, 2006-2010 (pooled)



Source: Local Health, Public Health England

Enfield's recorded prevalence of cancer (1.5%) is similar to London (1.4%) and below England (1.9%) averages. Recorded prevalence of cancer is significantly higher in the west of the borough compared to Enfield average, which is a likely reflection of the older population in the west of the borough (Figure 48).

Figure 48 - Recorded prevalence of cancer, Enfield locality, 2012/13

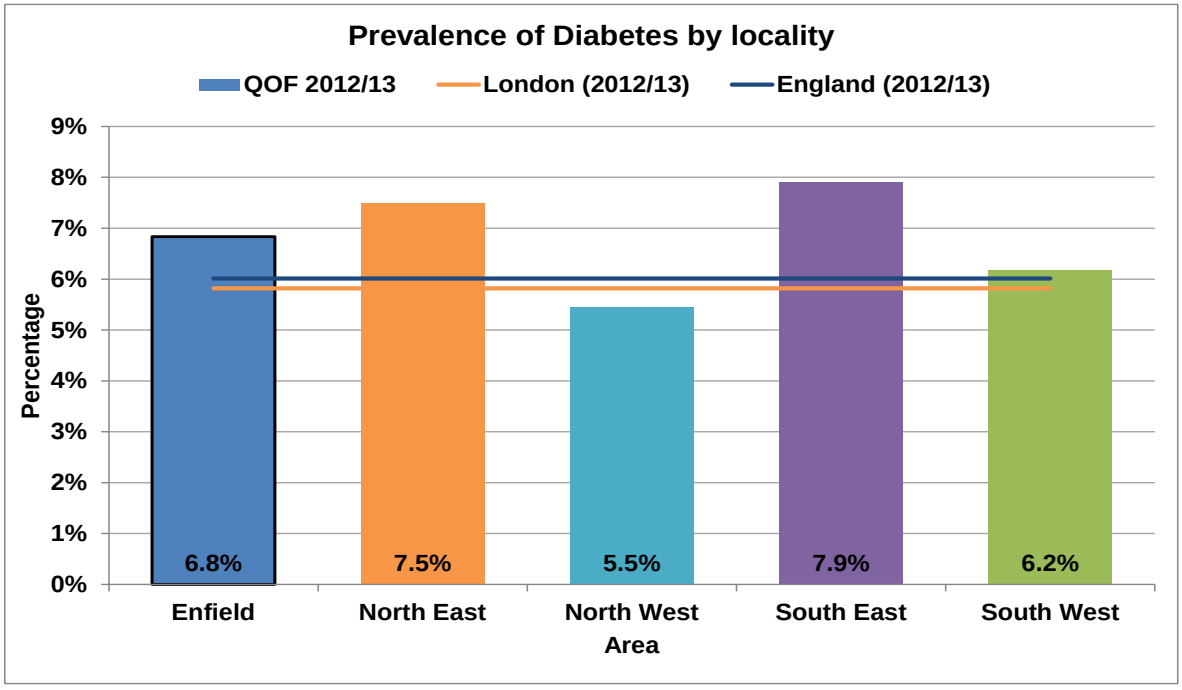


Source: Quality Outcomes Framework, Health and Social Care Information Centre

2.4.4 Diabetes

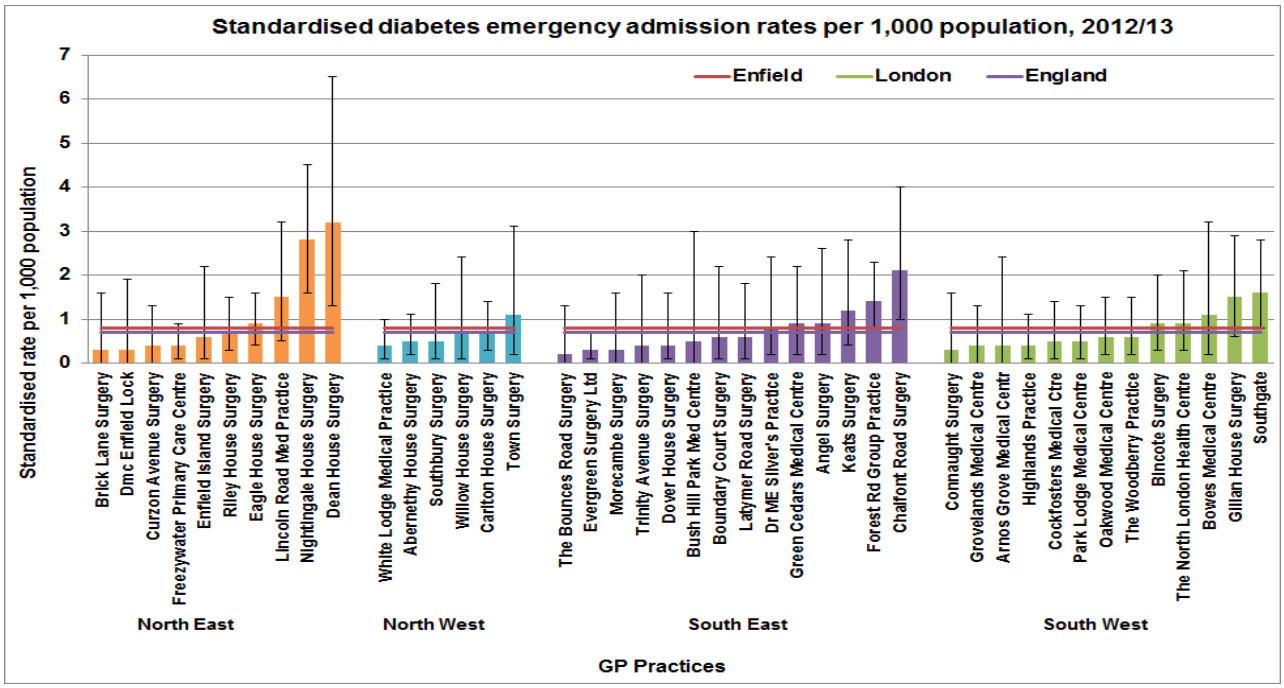
Enfield's recorded prevalence of diabetes (6.8%) is above London (5.8%) and England (6.0%) averages (Figure 49). Within Enfield, North East and South East localities have higher recorded prevalence compared to the west of the borough.

Figure 49 - Recorded prevalence of diabetes, Enfield localities, 2012/13



Source: Quality Outcomes Framework, Health and Social Care Information Centre

Figure 50 - Standardised diabetes emergency admission rates per 1,000 population, 2012/13



Source NHS comparators

Please note that data for six practices was not available.

Figure 50 above shows diabetes emergency admission standardised rates per 1,000 population for GP practices in Enfield. The rates range from 0.1 to 3.2 per 1,000 population. Two practices, Nightingale House and Dean House, have rates significantly higher than Enfield.

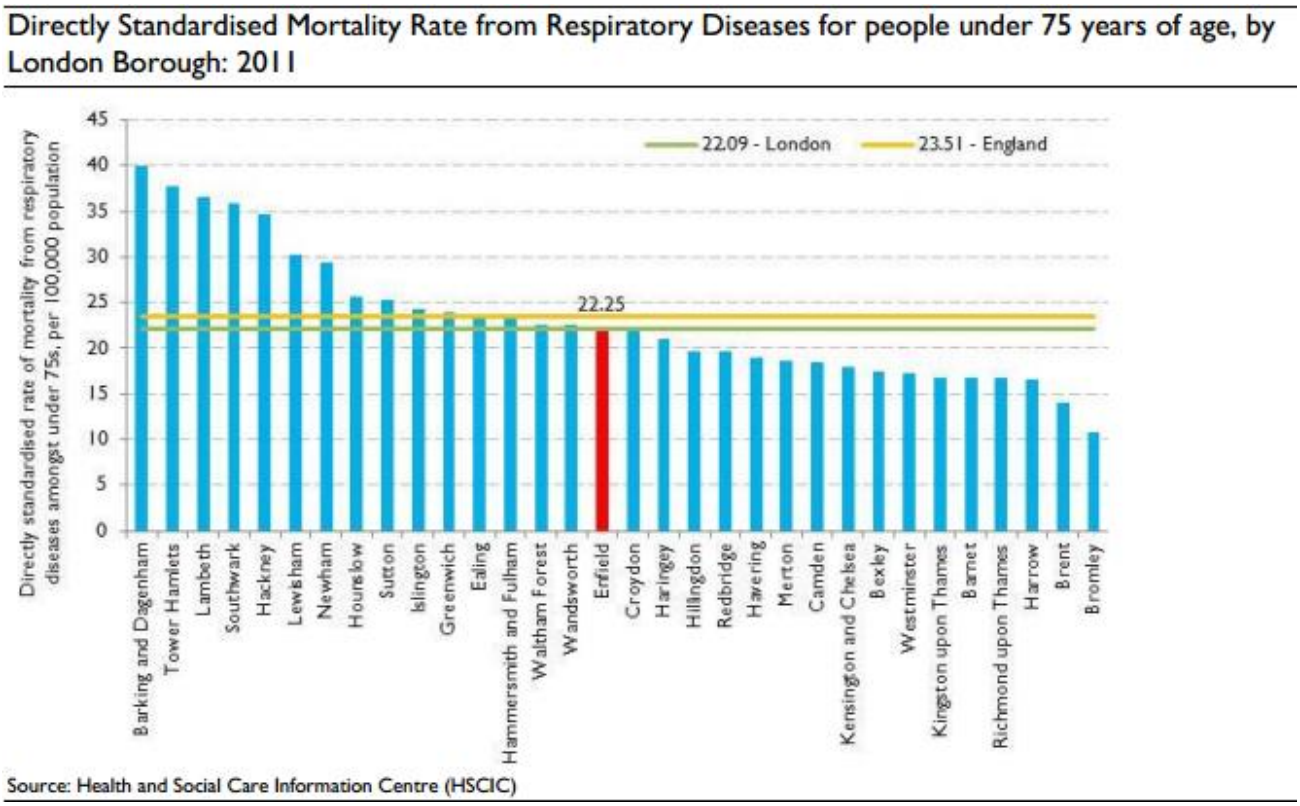
2.4.5 Respiratory disorders

There are more than 40 conditions affecting the lungs and / or airways which can have a significant impact on a person's ability to breathe. These conditions include asthma, chronic obstructive pulmonary disease (COPD), pneumonia, flu, cystic fibrosis, tuberculosis and many others. Conditions that significantly affect breathing can have serious implications for an individual's mobility and their ability to undertake day-to-day activities.

In Enfield, respiratory diseases are the third most common cause of all age mortality, accounting for 14% of deaths between 2007 and 2009. Respiratory disease in Enfield is lower at 1.02% compared to the London rate of 1.1% and the England average of 1.7%.

As Figure 51 below shows, in 2011, Enfield had the 16th highest standardised mortality rate from respiratory disease in London. Enfield's rate was below the England rate of 23.51 but above the London rate of 22.09.

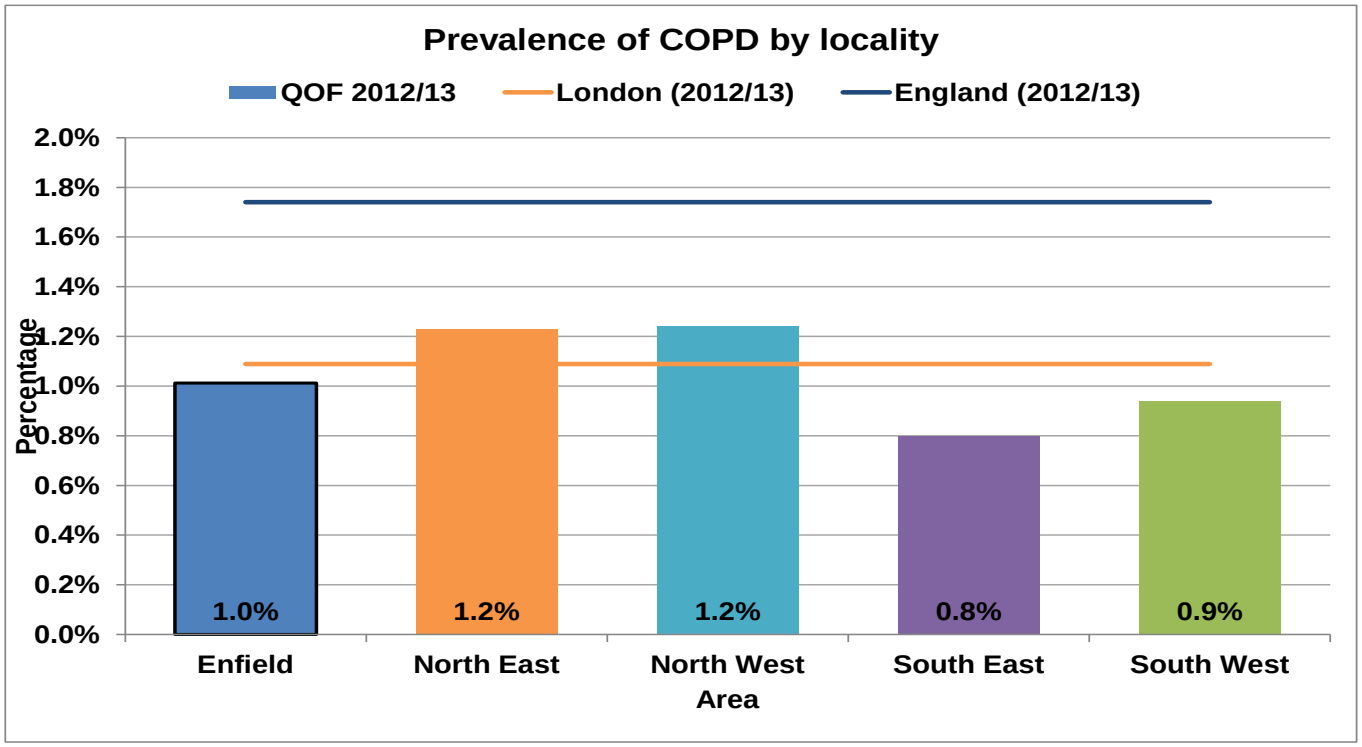
Figure 51 – Directly standardised mortality rate from respiratory diseases for people under 75 years of age by London borough: 2011



2.4.5.1 Chronic obstructive pulmonary disease

Recorded prevalence of chronic obstructive pulmonary disease (COPD) in Enfield (1.0%) is below the London (1.1%) and England (1.7%) averages. Within Enfield, North East and North West Enfield localities have higher recorded prevalence of COPD (Figure 52).

Figure 52 - Recorded prevalence of COPD, Enfield localities, 2012/13

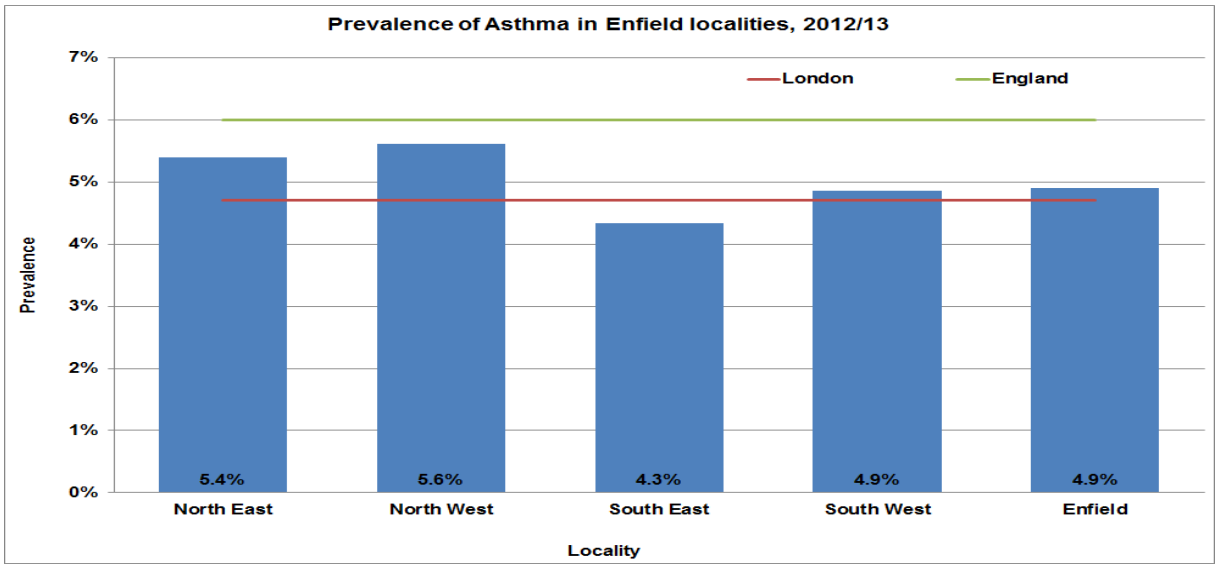


Source: QOF 2012/13

2.4.5.2 Asthma

In 2012/13, 4.9% of the Enfield population was recorded as having asthma. The locality with the highest recorded prevalence is the North West (5.6%), with South East locality having the lowest recorded prevalence (4.3%).

Figure 53 - Prevalence of asthma in Enfield localities



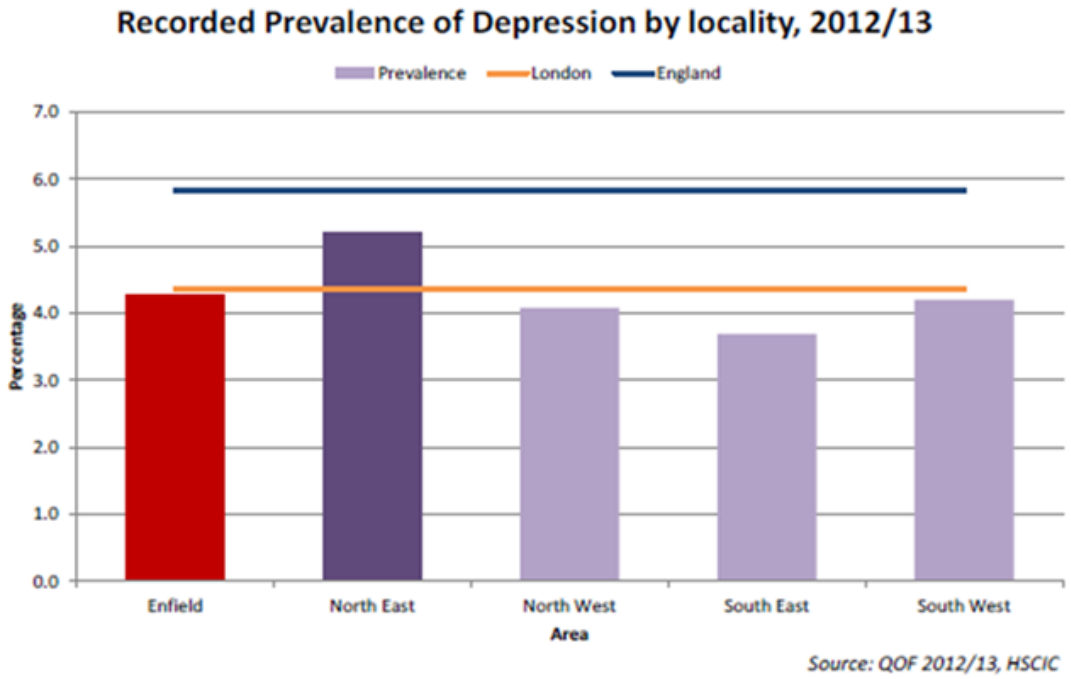
Source QOF 21012/13

2.4.6 Depression and mental health

It is estimated that one in every four people will suffer from some form of mental health problem at some point in their life, with one in six adults thought to be affected by mental ill health at any one time. Mental ill health can have a significant impact upon people's physical and mental wellbeing and is associated with an increased risk of premature death. People suffering from severe mental illnesses die on average 20 years earlier than the general population.

Figure 54 shows that in 2012/13, 4.3% of the Enfield population was recorded as having depression. Recorded prevalence in the North East Enfield locality (5.2%) is above Enfield (4.3%) and London (4.4%) averages, but was below the national average of 5.9%.

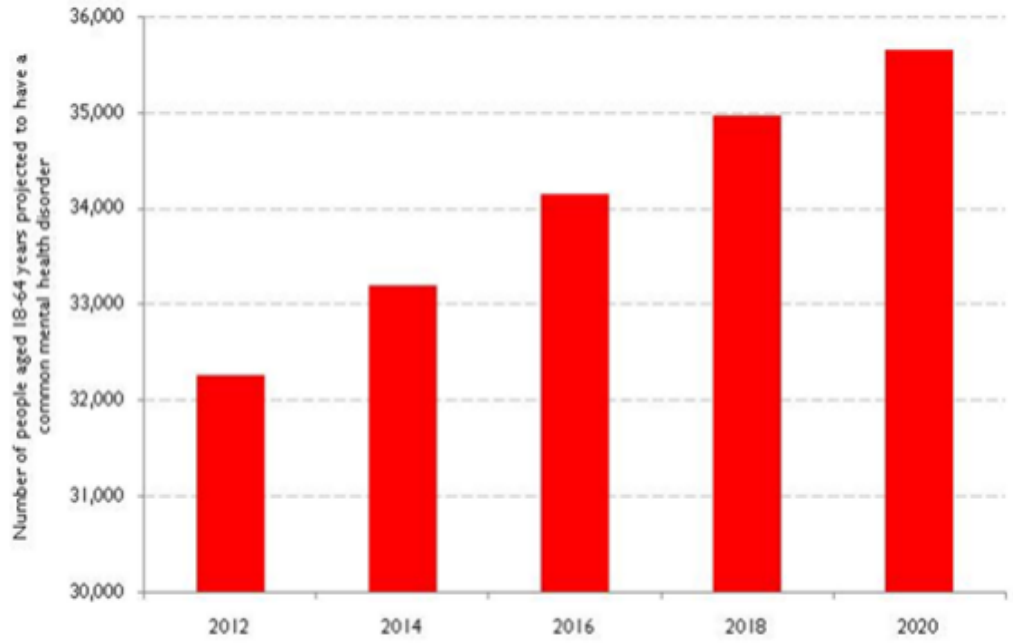
Figure 54 – Recorded prevalence of depression by locality 2012/13



In 2012, it was estimated that 32,263 adults aged 18-64 years in Enfield were living with a common mental health disorder such as depression, anxiety or obsessive compulsive disorder. As Figure 55 shows, factoring in the increase in population size, it is estimated that around an additional 3,500 people between 18 and 64 years will be living with a common mental health disorder in Enfield by 2020.

Figure 55 – Projected number of adults aged 18-64 with a common mental health disorder in Enfield 2012-2020

Projected Number of Adults aged 18-64 years with a Common Mental Health Disorder in Enfield: 2012 - 2020



Source: Projecting adult needs and service information (PANSI)

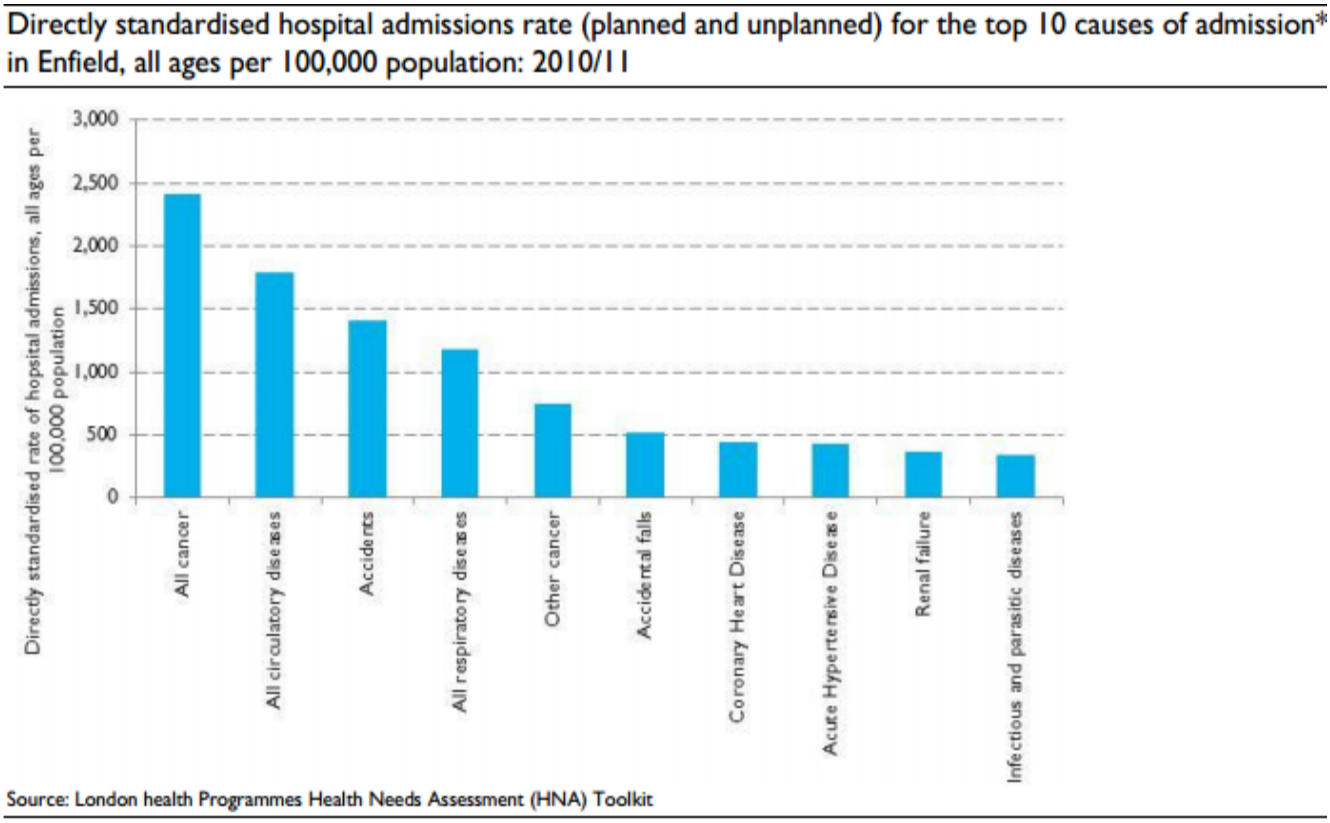
2.4.7 Hospital admissions and accidental injuries

Figure 56 shows that the most common cause of hospital admissions in Enfield in 2010/11 were 'all cancers', accounting for 7,539 admissions and giving a directly standardised admission rate of 2,407 per 100,000 population. Admissions for 'other cancers' (including cancers of the blood, bone, and brain) had the highest rate of admissions of the cancer groups but this may be influenced by the wide range of cancer types that fall within the 'other cancer' category.

*There is no single correct definition of the top ten causes of hospital admissions. In place of a top ten, the Health Needs Assessment (HNA)[9] toolkit provides hospital statistics for a range of common causes of admission. The conditions below represent the ten greatest causes of admission in Enfield from a list of 37 conditions, the full list can be found at the HNA toolkit website.

[9] http://hna.londonhp.nhs.uk/

Figure 56 - Common causes of hospital admissions

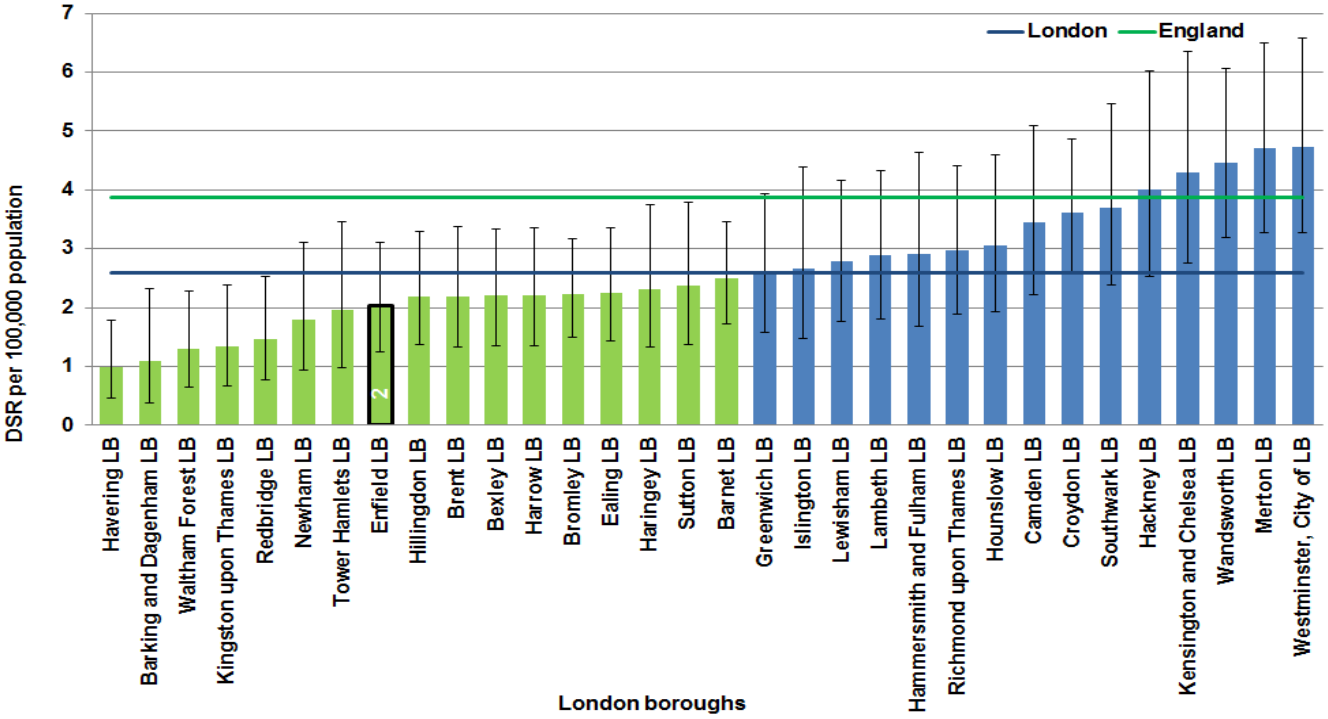


Accidents accounted for 4,716 admissions in Enfield in 2010/11, with an admission rate of 1,404.45 per 100,000 population and an additional 1,974 admissions (or 519.15 per 100,000 population) caused by accidental falls. Compared to London, in 2010/11 Enfield had significantly higher rates of admissions for all cancers, all circulatory disease, diabetes and stroke; similar admission rates for CHD and significantly lower admission rates for all respiratory disease and COPD.

Information from NHS England (http://www.england.nhs.uk/statistics/tag/emergency-admissions/) shows that the standardised emergency admission ratio for Enfield in 2010/11 was significantly above the London ratio of 94.3, but not significantly different to the England ratio. Enfield had the tenth highest emergency admission ratio in London. The emergency admission ratios of a number of wards in the eastern half of the borough, including Enfield Lock, Enfield Highway and Edmonton Green, have significantly higher emergency admission ratios than the overall Enfield ratio, with 13 of Enfield's wards having significantly higher ratios than that of London.

Figure 57 shows that Enfield had the eighth lowest rate (two per 100,000 population) of mortality due to accidental falls in persons in 2010-2012. The rate is significantly lower than England (3.9) but not significantly different than London (2.6).

Figure 57 - Directly standardised rates per 100,000 population, mortality due to accidental falls, persons, 2010-2012



Source: HSCIC

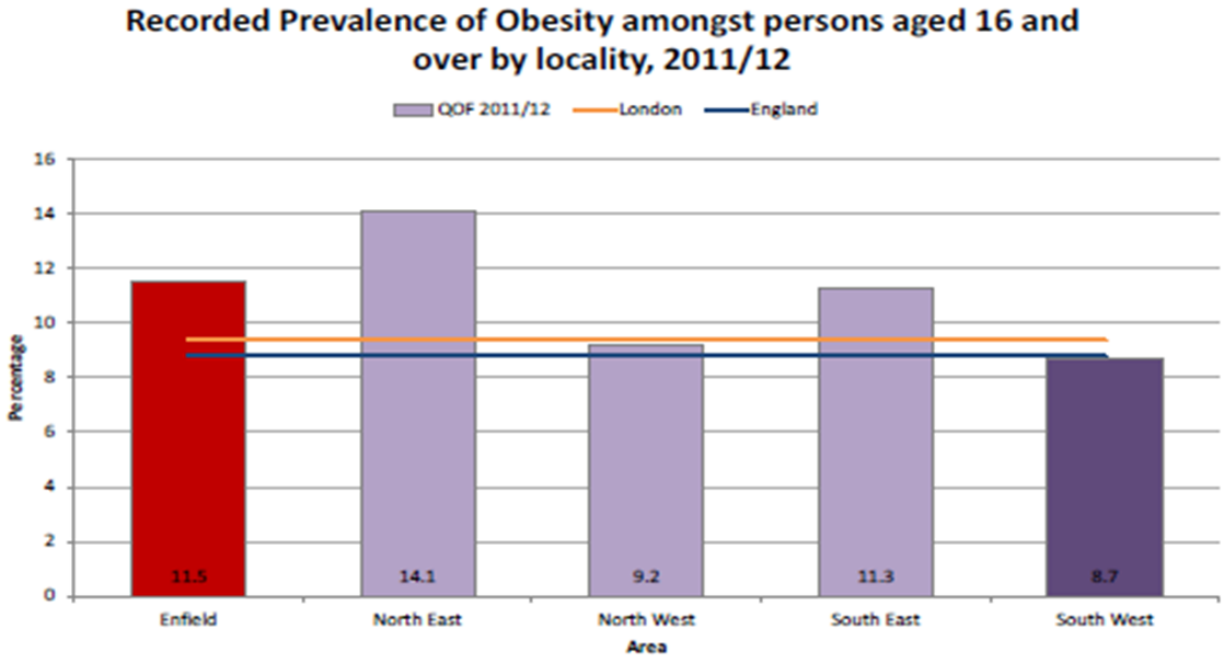
2.4.8 Obesity

Obesity is defined as an excess of adiposity (body fat) and should be measured as such. Unfortunately, gold standard measures (bioelectrical impedance, hydro densitometry) are impractical or expensive at a macro level and proxy measures such as skin fold thickness and waist circumference are difficult to use consistently across populations. Body mass index (BMI) therefore tends to be the measure of choice in assessing obesity in adults and children.

Data from the National Obesity Observatory indicates that obesity in adults (aged 16+) has risen from 15% in 1993-1995 to just below 25% in 2009-2011. Since 1994, prevalence of normal weight has declined, that of overweight has remained relatively static and prevalence of obesity has increased by approximately 60%.

For adults there is little reliable local obesity data. However, 12% are recorded as obese in Enfield, although this is likely to be an underestimate and the real figure is modelled to be approximately 23% (Figure 58).

Figure 58 - Recorded prevalence of obesity amongst persons aged 16 and over by locality 2011/12



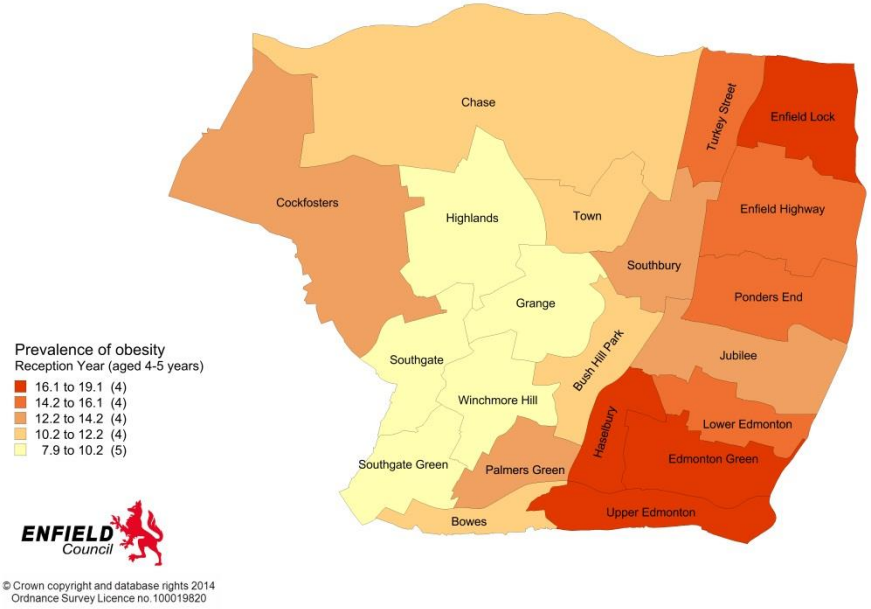
Source QOF 2011/12

Childhood obesity is an area of concern within Enfield due to the high levels of overweight and obese children in the borough. Obesity rates amongst Enfield's population of reception pupils are at their highest in the east of the borough, particularly in the south east of this area. Obesity in reception year was 12.6% compared to 10.8% in London and 9.3% nationally (Figure 59). In year 6, the rates of obesity in Enfield are 24.1% compared to 22.4% in London and 18.9% nationally.

The highest rates of obesity in reception year are in Enfield Lock, Haselbury, Edmonton Green and Upper Edmonton wards.

The wards of Highlands, Grange and Winchmore Hill have the borough's lowest rates of obesity amongst reception pupils.

Figure 59 - Percentage of reception year children (4-5 years) who are obese, 2010/11-2012/13



2.4.9 Palliative care

Many people are living longer due to improved lifestyles and treatments of previously fatal long-term diseases such as cancer. Death rates from serious illnesses such as cancer and heart disease have fallen in Enfield over the past ten years and remain below the England average (Table 9).

Table 9 - Prevalence of diseases by locality

	North East	North West	South East	South West	ENFIELD	LONDON	ENGLAND
Stroke or TIA	1.2%	1.7%	1.0%	1.3%	1.2%	1.0%	1.7%
CHD	2.3%	3.0%	2.0%	2.8%	2.5%	2.1%	3.3%
Hypertension	13.3%	13.1%	12.7%	14.0%	13.3%	11.0%	13.7%
COPD	1.2%	1.2%	0.8%	0.9%	1.0%	1.1%	1.7%
Diabetes	7.5%	5.5%	7.9%	6.2%	6.8%	5.82%	6.0%

Source: Quality Outcomes Framework (QOF) 2012/13, Health and Social Care Information Centre

The experience of people nearing end-of-life and families using services is generally positive and in line with national findings. Although more Enfield residents need to benefit from the approach, these findings may reflect the range of high-quality and well-coordinated care and support across different sectors, strengthened by development of a palliative care community support service to help people plan for and die at home if this is what they preferred.

Table 10 shows the number of people on the palliative care register by locality.

Table 10 - Palliative care register for Enfield localities (2012/13)

Locality	Number on Palliative Care Register QOF 2012/13
North East Enfield	53
North West Enfield	30
South East Enfield	58
South West Enfield	137
Grand Total	278

2.5 Lifestyle issues

2.5.1 Drug misuse

In England 2.7 million adults used an illegal drug in the last year and there are 299,000 heroin and crack users in the country. Of all prisoners, 40%have used heroin and 1,200,000 people are affected by drug addiction in their families, most of these reside in deprived communities. The total cost of drug misuse to society is £15.4bn each year and the NHS incurs annual costs of £488 million on drug misuse. The cost of looking after drug misusing parents' children who have been taken into care is £42.5m a year. Public Health England (PHE) has noted that for every £1 spent on drug treatment it saves society £2.50 (PHE 2014). In 2011/12 approximately 1,128 individuals over the age of 18 received specialist treatment from one or more of Enfield's substance misuse services at some point during the year (National Drug Treatment Monitoring System, 2014).

2.5.1.1 Alcohol

The latest Public Health England analysis has confirmed that there are 1.6m people in England who show signs of an alcohol dependency. Alcohol is the third biggest factor correlated with illness and premature death and it costs society £21bn a year. For every 5,000 patients screened in primary care for alcohol misuse it prevents 67 A&E presentations and 61 hospital admissions (costs £25,000 but saves £90,000). One alcohol liaison nurse can prevent 97 A&E presentations and 57 hospital admissions (costs £60,000 but saves £90,000). For every 100 people with an alcohol dependency treated by specialist community drug and alcohol services it prevents 18 A&E presentations and 22 hospital admissions (costs £40,000 but saves £60,000) (PHE 2014). Drinking alcohol is a very common behaviour in this country and, although the majority of people drink responsibly, there is still an estimated 9 million people in England who drink alcohol at levels that pose risks to their health.

It is estimated that about 45,904 adults in Enfield drink at levels which puts them at risk of harm to their health, known as “increased risk drinking” and “higher risk drinking” (Local Alcohol Profiles for England (LAPE), 2013) and a further 3,648 adults in Enfield are thought to be dependent drinkers (HM Government, 2012), of which approximately 10% are currently being supported in specialist treatment services.

Whilst Enfield has been below both London and national averages for the number of alcohol-related hospital admissions in the past, numbers have increased in the borough at a faster rate than both London and national averages in recent years. Between 2007/08 and 2011/12 the rate increased by 114%, demonstrating a sharp rise especially in the 45 to 64 year age group (Figure 60).

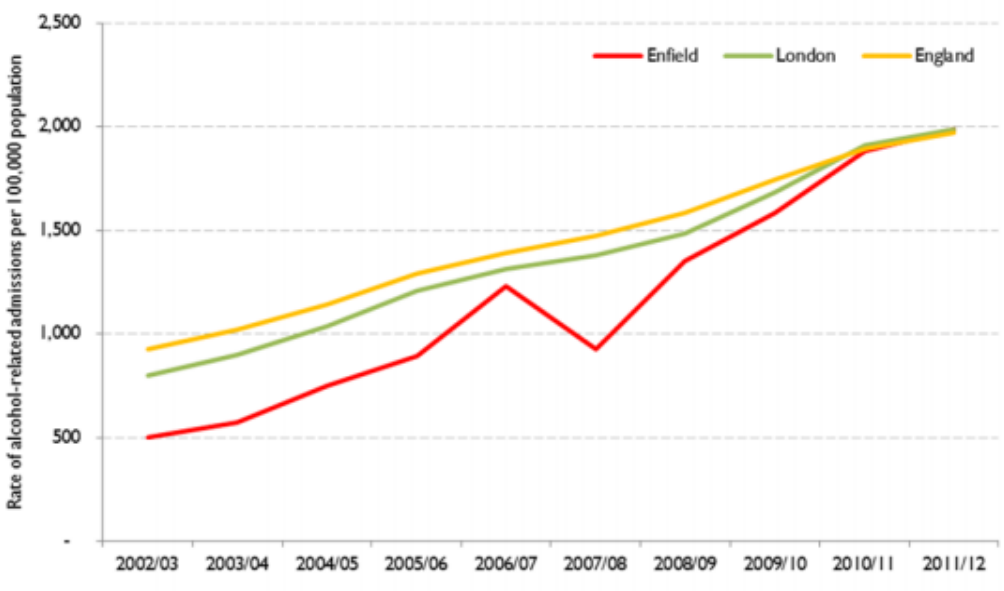
Between 2010 and 2012, there were 56 deaths caused by alcohol in Enfield. Of these deaths, 75% were males and 25% females (LAPE, 2013). The number of deaths where alcohol is a possible cause is higher, a total of 255 deaths (LAPE, 2013).

Compared to London and the national average, Enfield has significantly lower rates of chronic liver disease, lying on the 75th percentile. For alcohol-related recorded crimes, Enfield is significantly worse than the England average, lying below the 25th percentile, although it has a lower rate than London (LAPE, 2013).

Of those requiring treatment for harmful drinking, 80% reside in those areas of the borough where life expectancy is ten years lower than for those who live in the more affluent areas.

Figure 60 – Trend in rate of hospital admissions due to alcohol related harm for all ages per 100,00 population in Enfield, London and England 2002/03-2011/12

Trend in the Rate of Hospital Admissions due to Alcohol Related Harm, for all ages per 100,000 population in Enfield, London and England: 2002/2003 - 2011/2012



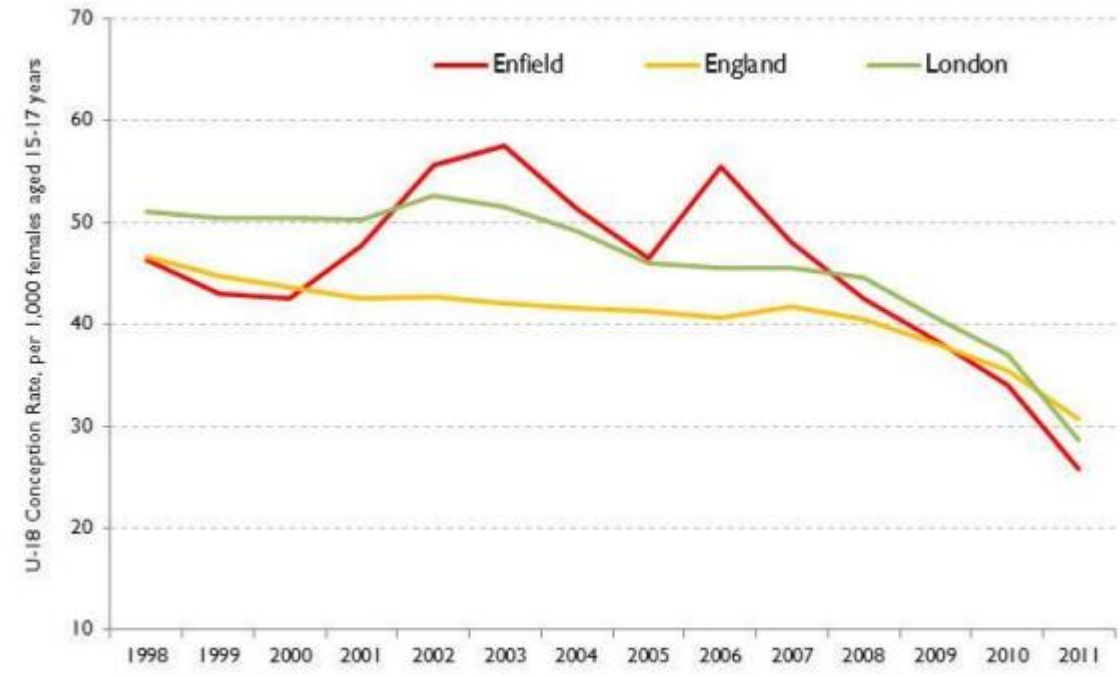
Source: Local Alcohol Profiles England, North West Public Health

2.5.2 Teenage pregnancy

Enfield's teenage pregnancy rate in 2011 was 25.8 per 1000 females aged 15-17 years. This was lower than the London rate of 28.7 and the England rate of 30.7. It was a 24.3% reduction from the Enfield rate in 2010 of 34.1 and a 44.4% reduction from the baseline rate in 1998 of 46.4 per 1000 females aged 15-17 years. The teenage pregnancy rates in Enfield have been going down since 2007 as illustrated in Figure 61.

Even though the teenage pregnancy rates in Enfield have been reducing, there is still a disproportionate rate of teenage conceptions taking place in Upper Edmonton, Lower Edmonton and Haselbury which are within the most deprived areas of Enfield. The rates in these areas are more than five times higher than the teenage conception rates in the areas of the borough with the lowest rates.

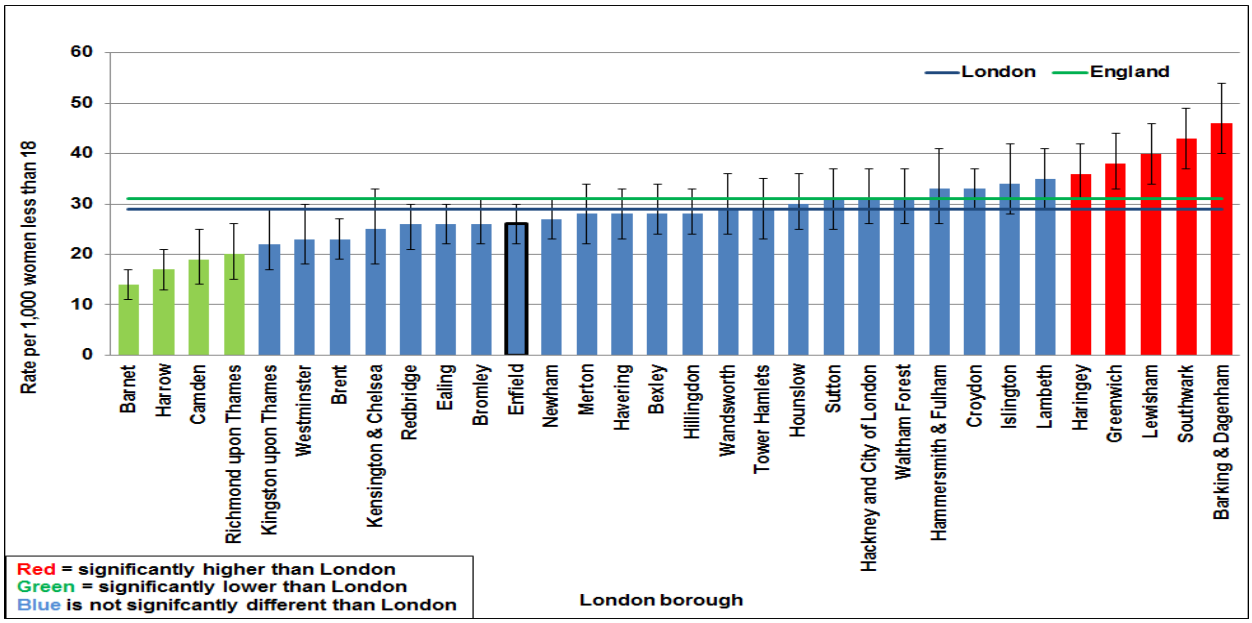
Figure 61 – Under 18 conception rate in Enfield, London and England: 1998 to 2011



The Office of National Statistics (ONS), 2012

Figure 62 shows teenage conception rates in London boroughs in 2011. Enfield (26 per 1000) has the 12th highest rate of all London boroughs. The rate is not significantly different to either London (29 per 1000) or England (31 per 1000). Figure 63 shows teenage conception rates in Enfield by ward

Figure 62 - Conception rate per 1,000 women aged less than 18 years, London boroughs, 2011



Source: ONS

Figure 63 - Teenage conception rates in Enfield by ward

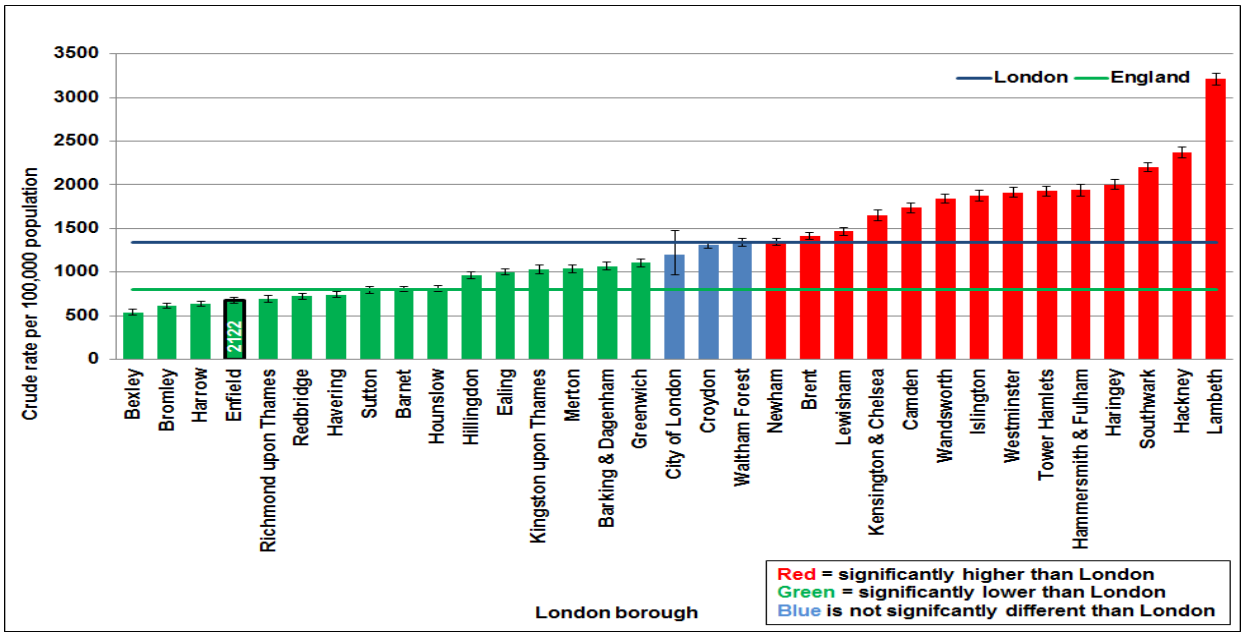
2.5.3 Sexually transmitted infections

Rates of gonorrhoea in Enfield in 2012 were 53.2 per 100,000 population, a decrease from 57.3 recorded in 2011. This is a reversal of the trend since 2009 when the rates showed a year on year increase from 42.6. The 2012 rate is higher than the England average of 45.9 but considerably lower than the London average of 129.8. Rates of syphilis in 2012 were 2.9 per 100,000 showing a marked decrease from the 2011 rate of 5.7 and lower than the 2012 England rate of 5.4. The London rate was 17 in 2012. The decreasing trend for syphilis in Enfield is in marked contrast to an increasing trend in both London and England between 2009 and 2012. This may be due to differences in population groups.

Figure 64 shows crude rates of acute sexually transmitted infections (STIs) for London boroughs in 2012. All diagnosis of chancroid / LGV / donovanosis, chlamydia, gonorrhoea, herpes, molluscum contagiosum, non-specified genital infection (NSGI), PID and epididymitis, scabies / pediculosis pubis, syphilis, trichomoniasis and warts are included in this data.

Enfield's rate of 675.9 per 100,000 population is the 4th lowest rate of all London boroughs. This rate is significantly lower than both London (1,336.7 per 100,000 population) and England (803.7 per 100,000 population). The Enfield rate equates to a total of 2,122 infections recorded in 2012.

Figure 64 - Crude rate of acute STI diagnosis, per 100,000 population, 2012

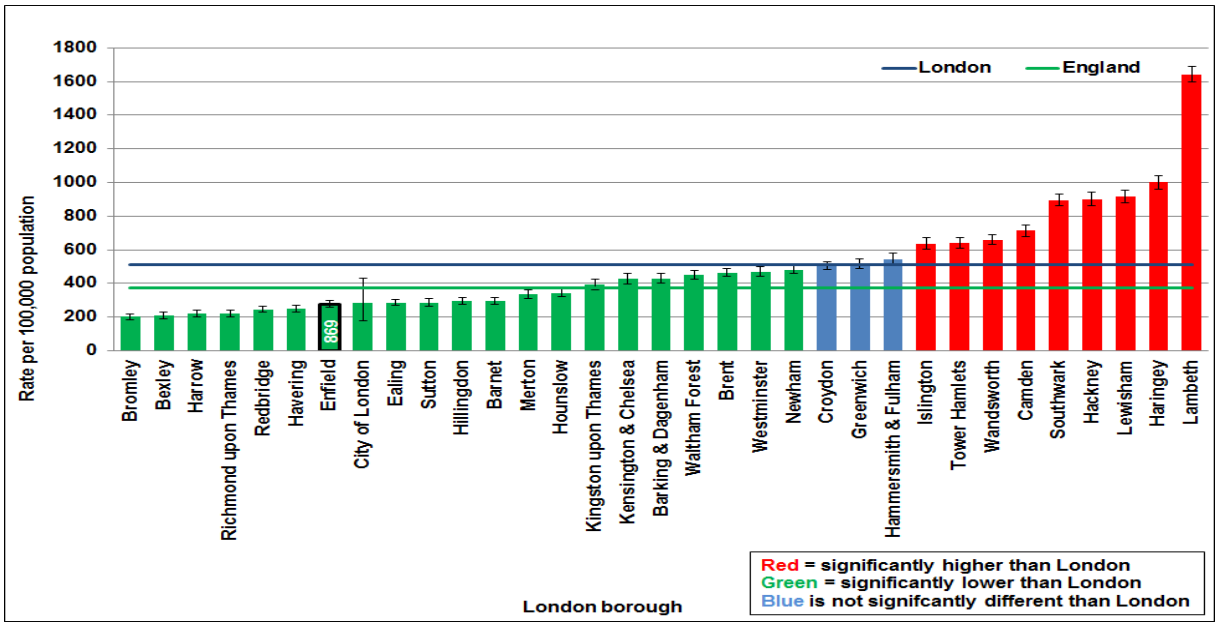


2.5.3.1 Chlamydia

Chlamydia is the most common STI and accounted for around 46% of all acute STIs in England in 2012. If left untreated it can cause infertility and ectopic pregnancies. Chlamydia screening in Enfield is now embedded in core sexual health services.

In 2012, Enfield had a chlamydia diagnosis crude rate of 276.8 per 100,000. This is significantly lower than London (512.2) but is not significantly different to England (371.6). The Enfield rate is the seventh lowest rate of all London boroughs and the rate equates to a total of 869 cases in 2012 (Figure 65).

Figure 65 - Rates of chlamydia diagnoses, per 100,000 population, 2012



Source: PHE

2.5.3.2 HIV

Continuing transmission of HIV nationally, and also improved survival, has led to a shift in the age distribution of people living with HIV. In 2011 one in five adults (22% or 16,550) accessing HIV care were aged 50 years and over, compared with one in nine (12% or 3,640) in 2002 (HPA 2012).

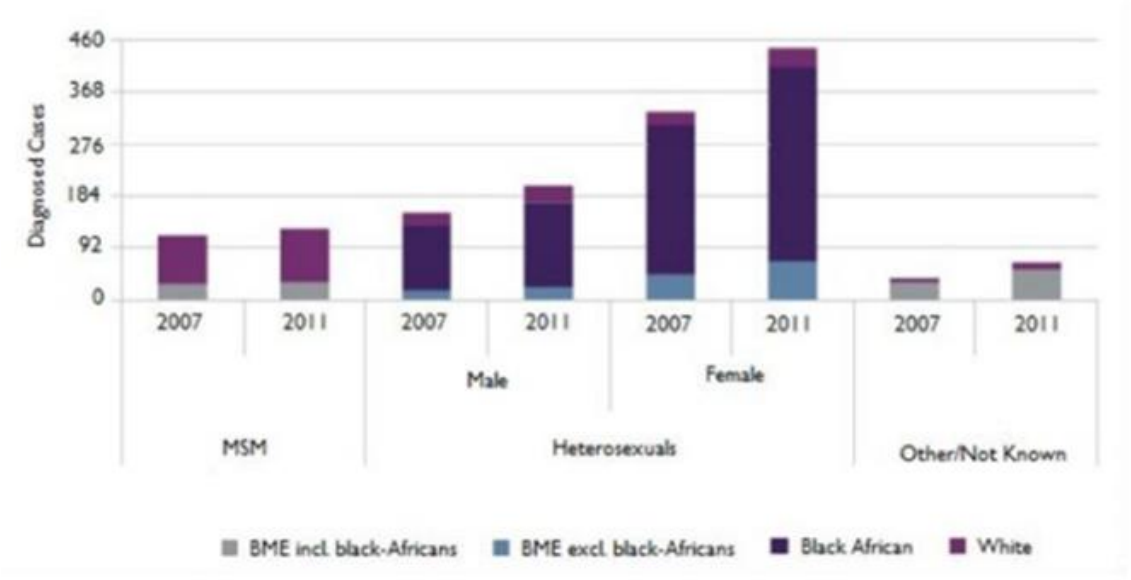
This pattern is similar locally in Enfield with 58% of people accessing care aged 45-54 in 2012, compared to 45% in 2008. This compares to the reduction seen in persons aged 25-34 (48% in 2008 to 32% in 2012).

Looking at variation by smaller geographic area in Enfield, rates by middle layer super output area (MSOA) range from between 0.4 and 5.1 per 1,000 population. High prevalence is described as being two (or over) per 1,000 population. In Enfield, 24 out of the 36 MSOAs have a rate of two or above per 1,000 population and therefore considered high prevalence. In 2011, HIV prevalence in Enfield was 4.0 per 1000 population aged 15-59 compared to 2.0 in England and 5.4 in London.

Incidence of HIV in adults aged between 15 and 59 years in Enfield has fallen by 34% in the past year, from 56 diagnoses in 2010 to 37 in 2011 as shown in Figure 66. There were 842 Enfield residents that accessed HIV related care in 2011 (372 males and 470 females), an increase of 26 residents from the 816 that accessed HIV related care in 2010 (355 males and 461 females). Between 2007 and 2011 there has been a 31% increase in the number of people living with HIV in Enfield.

In Enfield, those most at risk of HIV infection are heterosexual black African women, followed by heterosexual black African men. The greatest numbers of patients accessing care were in the black African (64%) and white (20%) ethnic groups.

Figure 66 - Number of adults (aged between 15 and 59 years) with diagnosed HIV living in Enfield by route of transmission, ethnicity and gender: 2007 and 2011



Source: Health Protection Agency, 2013

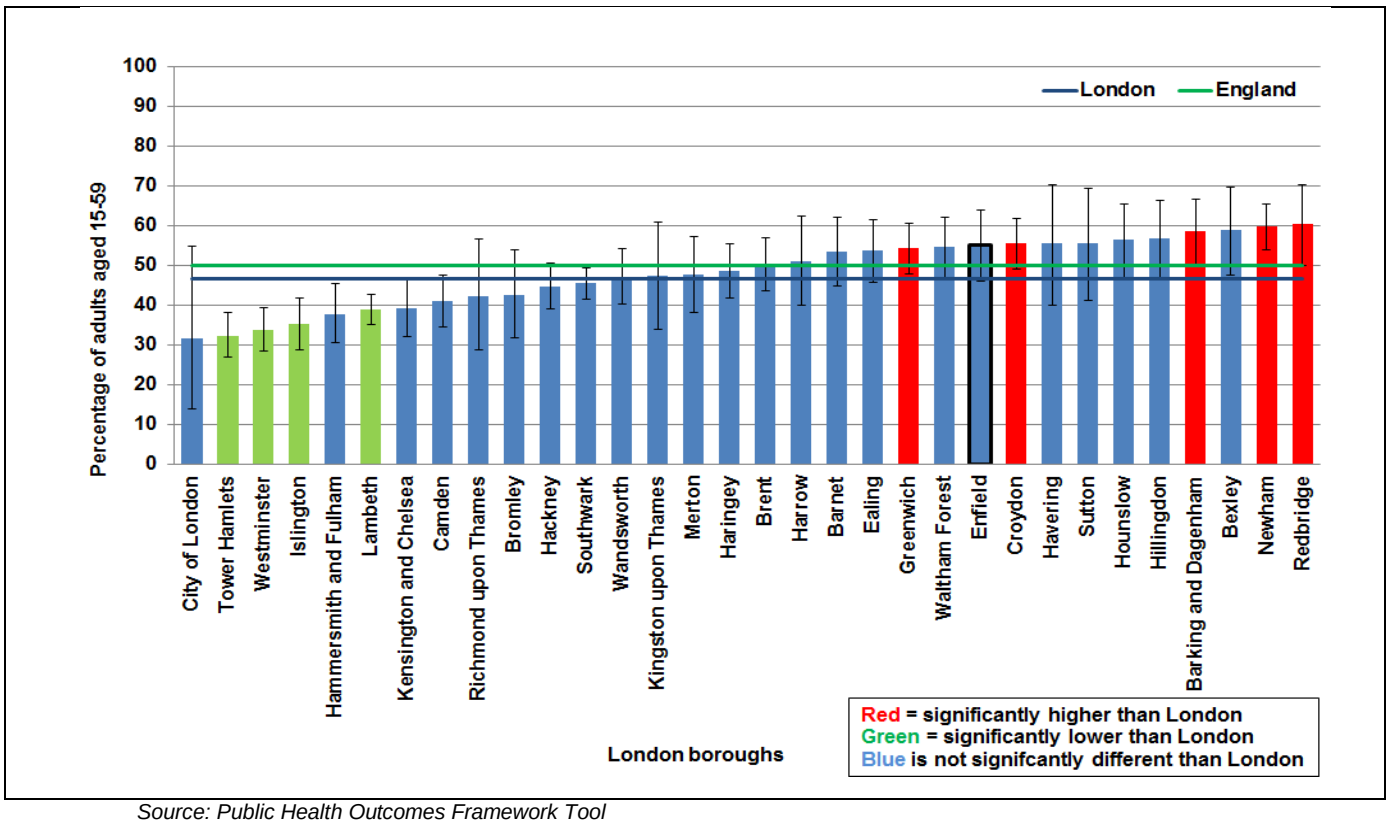
2.5.3.2.1 Late diagnosis of HIV

In Enfield in 2010, 58% of people with HIV were diagnosed late (with a CD4 count of less than 3501) compared to 44% overall in London and 52% in England. The median age of those accessing care for HIV in Enfield was 41.

Individuals diagnosed with HIV infection with CD4 cell counts of less than 350 cells per mm^3 cannot start anti-HIV therapy because of guidelines concerning underlying immune function. These people may not fully benefit from therapy and subsequently have a higher risk of HIV-related death (Figure 67).

In 2009-2011, Enfield had the tenth highest proportion (55%) of all London boroughs of patients presenting with HIV at a late stage of infection (CD4 count of less than 350 cells per mm^3). However, this was not significantly different to either London (47%) or England (50%).

Figure 67 - Percentage of people presenting with HIV at a late stage of infection, CD4 count of less than 350 cells per mm³, 2009-2011

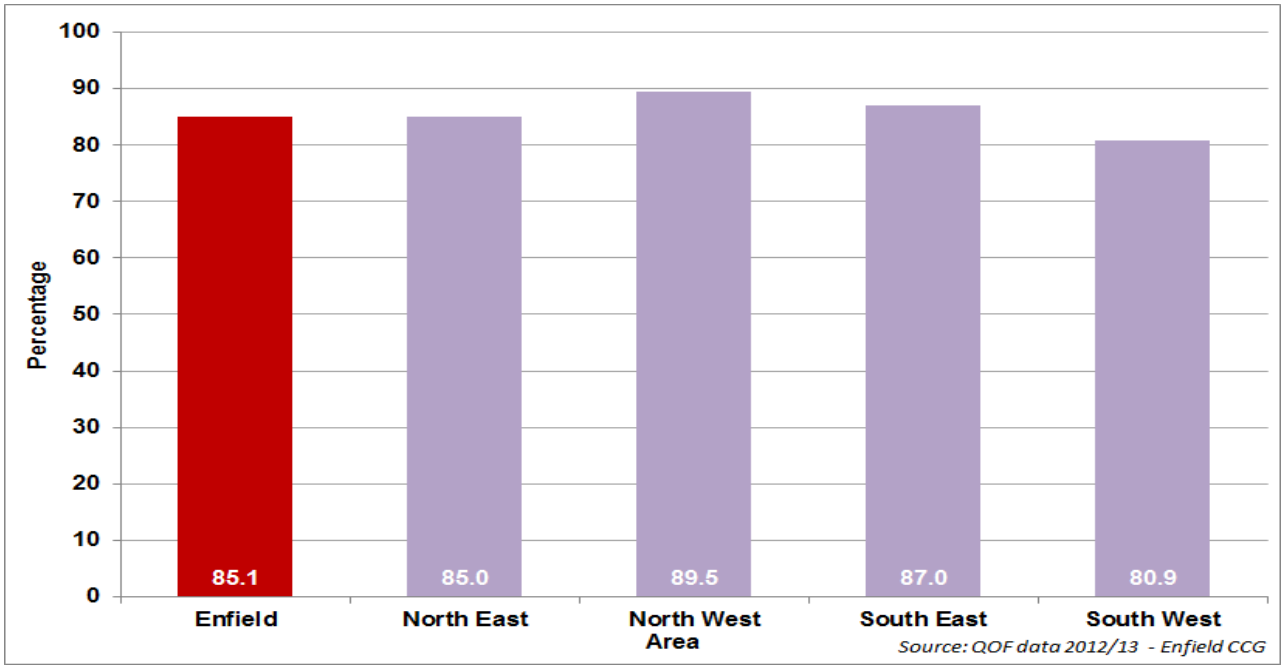


Source: Public Health Outcomes Framework Tool

2.5.4 Smoking

Some two-thirds of smokers would like to stop smoking. Those who access NHS support for quitting are nearly four times more likely to quit than those who go 'cold turkey'. Recording smoking status and referring smokers to stop smoking services is therefore of fundamental importance. In 2012/13 the percentage of patients aged 15 years and over recorded as current smokers, and who have a current record of an offer of support and treatment within the preceding 27 months (Quality Outcomes Framework (QOF) Smoking Outcomes Indicator 8), ranged from 80.9% in South West locality to 89.5% in North West locality. The Enfield average was (85%) (Figure 68).

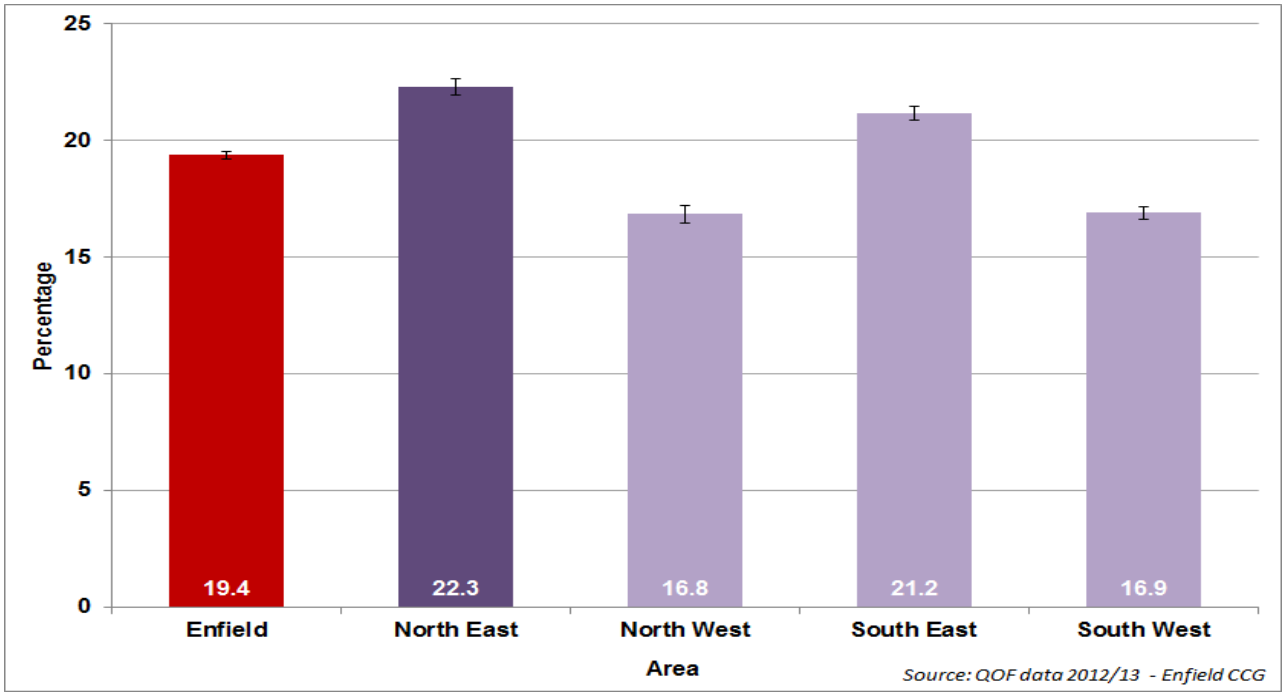
Figure 68 - Percentage of patients, aged 15 years and over, who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months by locality, 2012/13



Source: QOF 2012/13

In 2012/13, recorded smoking prevalence in Enfield localities ranged from 16.9% in South West locality to 22.3% in North East locality compared to 19.4% in Enfield (Figure 69).

Figure 69 - Prevalence of smoking for population aged 15 and over by locality, 2012/13

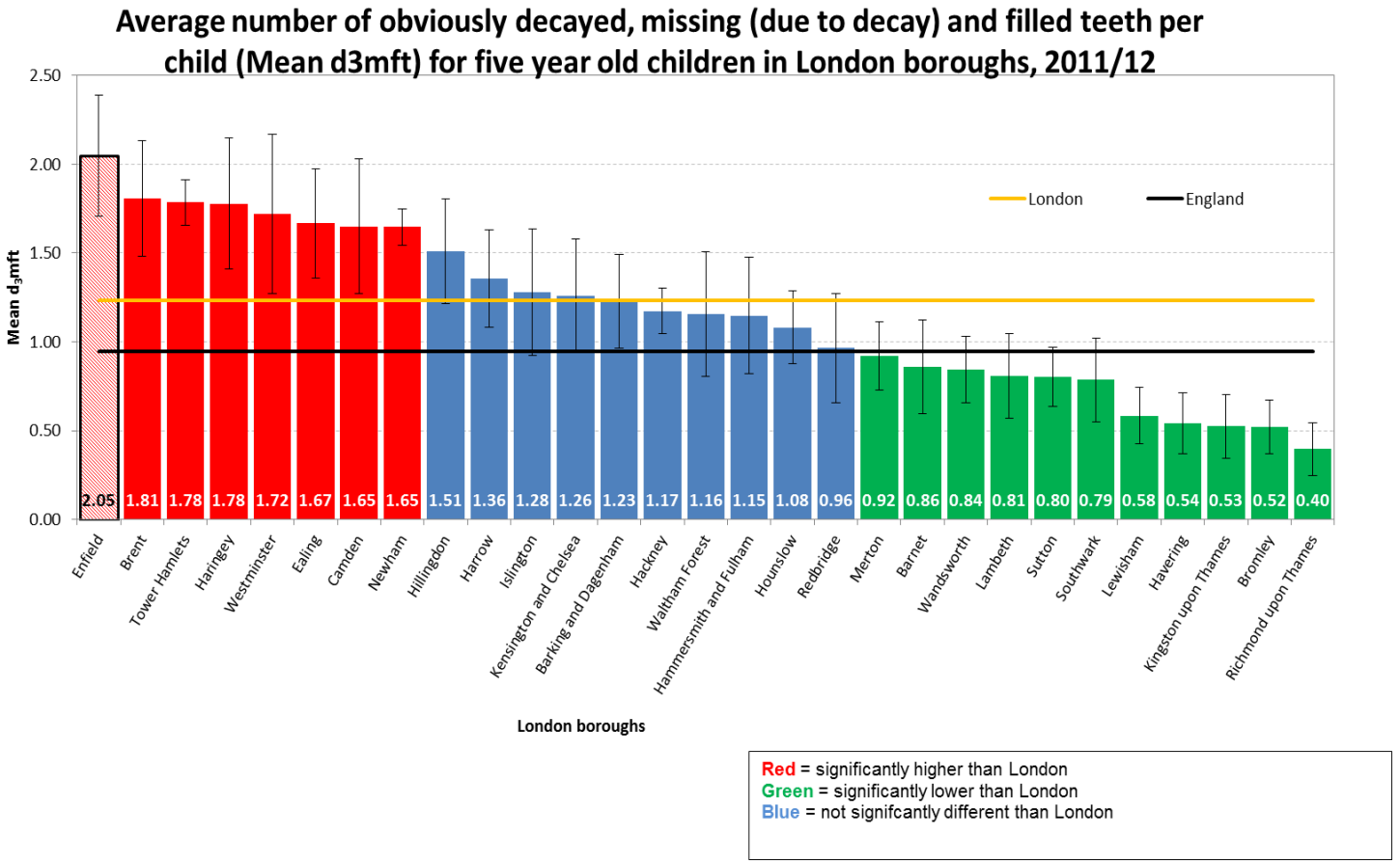


Source: QOF 2012/13

2.5.4 Oral health

The average number of obviously decayed, missing (due to decay) and filled teeth per child amongst five year old children in Enfield (2.05 $d_3$mft) is the highest amongst 29 boroughs in London where data was available. It is also significantly above London (1.23 $d_3$mft) and England (0.94 $d_3$mft) averages.

Figure 70 – Average number of obviously decayed, missing (due to decay) and filled teeth per child (mean d3mft) for five year old children in London boroughs 2011/12



Source: Public Health Outcomes Framework, Public Health England[10]

[10] Protecting Older People Population Information, Institute of Public Care: http://www.poppi.org.uk/

Section 3: NHS pharmaceutical services provision; currently commissioned

3.1 Community pharmacies

There are 61 community pharmacies in Enfield HWB area (as at 29th January 2015) for a population of 322,295. This equates to an average of 18.9 pharmacies per 100,000 population. Latest data[6] shows the England average is 21.7 community pharmacies per 100,000 population and the London average is 22.3 community pharmacies per 100,000 population. London has a transient population with generally good transport links. Populations may therefore find community pharmacies in neighbouring HWB areas more accessible and / or more convenient. There is a high rate of community pharmacies per 100,000 population in neighbouring HWB areas to Enfield: Barnet (21.5), Haringey (22.2), Waltham Forest (22.7) and Hertfordshire (22.2).

The pharmacy user questionnaire, undertaken in the summer of 2014, received 231 responses. Over 88% of respondents use the same or a preferred, pharmacy. When asked what factors they considered when choosing their pharmacy, over 71% indicated 'Close to home' and over 45% 'Close to GP surgery' as important reasons. Almost 55% respondents walk to their community pharmacy whilst 28% use a car. The full results of the pharmacy user survey is detailed in Section 5 and Appendix I.

Table 11 provides a breakdown, by locality, of the average number of community pharmacies per 100,000 population. All localities have at least one community pharmacy. The number and rate of community pharmacies vary widely by locality.

Populations in all localities have access to extensive public transport links and road networks and, for some populations, the nearest community pharmacy provision from their home may be in a neighbouring locality or HWB area.

Table 11 - A breakdown of average community pharmacies per 100,000 population[6]

Area	Number of community pharmacies (as of 29th Jan 2015)	Total population (mid-ONS 2013 estimates)	Average number of community pharmacies per 100,000 population (as of 29th Jan 2015)
South West locality	20	115,250	17.4
South East locality	18	85,100	21.2
North West locality	6	42,900	14.0
North East locality	17	80,000	21.3
Enfield Health and Wellbeing Board area (mid 2013 population estimates data)	**61**	**322,295**	**18.9***
London region (2013/14 data)	1,851*	8,308,000	22.3*
England (2013/14 data)	11,647*	-	21.7*

**Data includes distance-selling (internet) pharmacies, which do not provide face-to-face services at the pharmacy premises*

Section 1.3 lists the essential services of the pharmacy contract. It is assumed that provision of all of these services is available from all contractors. Further analysis of the pharmaceutical service provision and health needs for each locality is explored in Section 6.

3.1.1 Choice of community pharmacies

Table 12 shows the breakdown of community pharmacy ownership in Enfield. The data shows that independent pharmacy ownership is at levels higher than those seen nationally and slightly lower than those seen regionally, with no one provider having a monopoly in any locality. People in Enfield therefore have a good choice of pharmacy providers.

Table 12 - Community pharmacy ownership, 2013/14[6]

Area	Multiples (%)	Independent (%)
England	61.2	38.8
London	38.9	61.1
Enfield	50.8	49.2

3.1.2 Intensity of current community pharmacy providers

For most community pharmacy providers, dispensing provides the majority of their activity. Table 13 shows the average monthly dispensing activity from community pharmacies. The data shows that average activity in Enfield is higher than the London region average and higher than the England average.

Table 13 - Average dispensed items per community pharmacy, 2013/14[6]

Area	Average number of monthly dispensed item per community pharmacy
England	6784
London region	5393
Enfield (2012/13 data)	7238

3.1.3 Weekend and evening provision

It is estimated that, collectively, community pharmacies in England are open approximately 150,000 hours per week more than 10 years ago[11]. This has been mainly driven through the opening of '100 hour' pharmacies. There are over 700 community pharmacies in England open for 100 hours or more per week.

Table 14 shows that Enfield has a similar percentage of its pharmacies open for 100 hours or more compared with England, but a higher percentage compared to London. Most 100 hour pharmacies are open late and at the weekends.

Table 14 - Numbers of 100 hour pharmacies (and percentage of total)

Area	Number (%) of 100 hour pharmacies
England (2022/13 data) [6]	773 (6.7%)
London region	71 (3.8%)
Enfield	4 (6.5%)
South West locality	0
South East locality	2 (11.1%)
North West locality	0
North East locality	2 (11.7%)

[11] 'Who do you think we are? Community Pharmacy: dispensers of health', Pharmacy Voice: http://www.dispensinghealth.org/wp-content/uploads/2014/01/DH-Launch-FINA1.pdf

3.2 Dispensing appliance contractors

There are no dispensing appliance contractors (DACs) in Enfield HWB area however DAC services are available to the population from elsewhere in the UK. Appliances may also be dispensed from community pharmacies. Of the responses, 54 (89% of contractors) were received from the community pharmacy contractor questionnaire, 79% of respondents reported that they provide all stoma and incontinence appliances with over a further 8% indicating that they provide some, but not all, appliances.

As part of the essential services of appliance contractors, a free delivery service is available to all patients. It is therefore likely that patients will obtain appliances delivered from DACs outside the HWB area. There were 112 DACs in England in 2013/14[6].

3.3 Distance-selling pharmacies

A distance-selling pharmacy provides services as per the Pharmaceutical Regulations, 2013[3]. It may not provide essential services face-to-face at the pharmacy premises and therefore provision is by mail order and / or wholly internet. As part of the terms of service for distance-selling pharmacies, provision of all services offered must be offered throughout England. It is therefore likely that patients within Enfield HWB area will be receiving pharmaceutical services from a distance-selling pharmacy outside Enfield HWB area. There is one distance-selling pharmacy in Enfield HWB area. Figures in 2013/14[6] show that in England there were 211 distance-selling pharmacies, accounting for 1.8% of the total number of pharmacies (London: 14 (0.8%)).

3.4 Access to community pharmacies

The majority of community pharmacy providers in Enfield HWB area are sited in areas co-located with shops, GP practices or other routine destinations. Many also provide extended opening hours and as such they attract a high level of convenience.

The white paper, 'Pharmacy in England: Building on strengths – delivering the future'[12] noted that 99% of the population – even those living in the most deprived areas – can get to a community pharmacy within 20 minutes by car and 96% by walking or using public transport. A list of community pharmacies in Enfield HWB area and their opening hours can be found in Appendix A.

[12] 'Pharmacy in England: Building on strengths – delivering the future', Department of Health (2008) - http://www.official-documents.gov.uk/document/cm73/7341/7341.pdf

3.4.1 Routine daytime access to community pharmacies

A recently published article[13] suggests that over 89% of the population of England has a maximum 20 minute walk to a community pharmacy, however this figure falls to as low as 14% in rural areas.

The same study found that access is greater in areas of high deprivation. Higher levels of deprivation are linked with increased premature mortality rates. There are many wards in Enfield with populations amongst the most deprived in England. Map B demonstrates pharmacies in Enfield and deprivation score by ward.

Appendix A lists the pharmacies in Enfield by locality and opening times. Results of the pharmacy user survey show that 45% rated as important that the pharmacy is close to their GP surgery and 71% that the pharmacy is close to their home.

Table 11 above shows that the rate of pharmacies per 100,000 population varies significantly across Enfield.

Of pharmacy user responses 55% walk to their community pharmacy, 28% use a car, 11% use public transport and 4% use a bicycle. The user responses also report that 79% had no difficulties travelling to their pharmacy, 13% had parking difficulties, 5% report that they had problems with the location of the pharmacy and 3% had problems with public transport availability. The greatest percentage of respondents had no most convenient day (34%) or time (59%) to visit their pharmacy.

3.4.2 Routine weekday evening access to community pharmacies

Contractor's opening hours information was provided by NHS England. Contractors also provided their opening hours information through the pharmacy contractor survey. In a number of cases there were discrepancies found and, in these cases, the information provided in this PNA is the opening hour information provided by the contractor. Whilst this may differ from the contractual information held by NHS England, it nonetheless reflects the actual opening hours of the contractor.

The number, location and opening hours of community pharmacy providers open beyond 6pm, Monday to Friday (excluding bank holidays) varies within each locality; they are listed in the table below. 'Average' access is difficult given the variety of opening hours and locations. Access is therefore considered at locality level and, as seen in Table 15, the population of Enfield have reasonable access to community pharmacies in the evening as the majority of providers in Enfield HWB area are open after 6pm. A further analysis of provision in each locality is detailed in Section 6.

[13] 'The positive pharmacy care law: an area-level analysis of the relationship between community pharmacy distribution, urbanity and social deprivation in England', BMJ Open 2014, Vol. 4, Issue 8 - http://bmjopen.bmj.com/content/4/8/e005764.full.pdf%20html

Table 15 - Community pharmacy providers open Monday to Friday (excl BHs) beyond 6pm

Locality	Pharmacy name and address	Opening hours (Mon-Fri, excl BHs)
South West locality	Aldermans Pharmacy, 30 Aldermans Hill, Palmers Green, N13 4PN	9:00am - 7:00pm
	Asda Pharmacy, 130 Chase Side, Southgate, N14 5PW	8:30am - 1:00pm 2:30pm - 10:00pm
	Boots UK Limited, 315-317 Green Lanes, Palmers Green, N13 4YB	8:30am - 6:30pm
	Boots UK Limited, 78 Chase Side, Southgate, N14 5PH	8:00am - 7:00pm
	C & M Whipman Chemists, 73 Bramley Road, Oakwood, N14 4EY	9:00am - 7:30pm
	Capricorn Pharmacy, 16 Enfield Road, Enfield, EN2 7HW	9:00am - 7:00pm
	Greens Pharmacy, 48 Green Lanes, Palmers Green, N13 6JU	9:00am - 1:00pm 2:00pm - 6:30pm Thurs close 6:00pm
	Lloydspharmacy, 4 Florey Square, Highlands Village, Winchmore Hill, N21 1UJ	8:30am - 6:30pm Thurs close 6:00pm
	Morrisons Pharmacy, Aldermans Hill, Palmers Green, N13 4YD	9:00am - 8:00pm
	Nr Patel Chemists, 153 Bowes Road, Palmers Green, N13 4SE	9:00am - 7:00pm Mon close 8:00pm
	Parkview Pharmacy, 195 Bramley Road, Southgate, N14 4XA	9:00am - 6.30pm
	Sainsbury's Pharmacy, 681 Green Lanes, Winchmore Hill, N21 3RS	8:00am - 8:00pm
	Walker Pharmacy, 410-412 Green Lanes, N13 5XG	9:00am - 7:00pm
	Simmons Chemist, 111 Cockfosters Road, Herts, EN4 0DA	9:00 am - 1:00pm 2:00 pm - 6:30 pm Wed close 6:00pm

Locality	Pharmacy name and address	Opening hours (Mon-Fri, excl BHs)
South East locality	Aqua Chemists, 55 Bounces Road, Edmonton, N9 8JE	9:00am - 6:30pm Wed close 5:30pm
	Asda Pharmacy, Edmonton Green Shop Centre, The Broadway, N9 0TS	Mon 8:00am - 11:00pm Tue-Fri 7:00am - 11:00pm
	Bees Dispensing Chemist, 172 Fore St, Edmonton, N18 2JB	9:00am - 7:00pm
	Boots UK Ltd, 29 North Square, Edmonton Green, N9 0HW	8:00am - 2:00pm 3:00pm - 8:00pm
	Estons Pharmacy, 93 Fore Street, Edmonton, N18 2TW	9:30am - 7:30pm
	Forest Pharmacy, Forest Primary Care Centre, 308a Hertford Road, Edmonton, N9 7HD	8:3 am – 7:00pm
	Green Cross (London) Ltd, 213 Fore Street, Edmonton, N18 2TZ	9:00am - 7:00pm
	Green Lanes Pharmacy, Green Lanes Surgery, 808 Green Lanes, Winchmore Hill, N21 2SA	8:00am - 8:00pm
	Hayward Chemist Ltd, 10 Queen Anne's Place, Bush Hill Park, Enfield, EN1 2PT	9:00am - 7:00pm Wed close 6:00pm
	Lloydspharmacy, 261 Fore Street, Edmonton, N18 2TY	9:00am - 7:00pm
	Rocky's Pharmacy, 14 Kendal Parade, Silver Street, N18 1ND	9:00am - 7:00pm Wed close 4:00 pm
	Scotts Pharmacy, 97-99 Silver Street, Edmonton, N18 1RP	9:00am - 6:30pm
	Tesco Extra, 1 Glover Drive, Upper Edmonton, N18 3HF	Mon 8:00am - 10:30pm Tue-Fri 6:30am - 10:30pm
North West locality	Boots UK Ltd, 30-32 Palace Gardens, Enfield, EN2 6SN	8:30am - 6:00pm Thurs 8:30am - 7:00pm
	C Atkinson Chemist, 20 The Grangeway, Grange Park, N21 2HG	9:30am - 6:00pm
	LloydsPharmacy, 198 Lancaster Road, Enfield, EN2 0JH	9:00am - 6:00pm

Locality	Pharmacy name and address	Opening hours (Mon-Fri, excl BHs)
North West locality	LloydsPharmacy, 304 Baker Street, EN1 3LD	8:45am - 7:30pm
	The Co-Operative Pharmacy, 66 Silver St, Enfield, EN1 3EP	8:30am - 7:00pm Mon and Thurs close 8:00pm
	Whitakers Pharmacy, 68 Silver Street, Enfield, EN1 3EW	9.00am - 1:00pm 2:00 pm - 6:30pm Mon 8:30am - 8:00pm
North East locality	Boots UK Ltd, Enfield Retail Park, 2a Crown Road, Enfield, EN1 1TH	8:00am - 8:00pm
	Elgon (Enfield) Ltd, Eagle House Surgery, 291 High Street, Ponders End, EN3 4DN	9:00am - 7:00pm
	Healthfare Pharmacy, 9 Coleman Parade, Southbury Road, Enfield, EN1 1YY	9:30am - 7:00pm
	Lloydspharmacy, 226-228 Hertford Road, Enfield, EN3 5BH	9:30am - 7:00pm
	Lloydspharmacy, 98a South Street, Ponders End, EN3 4QA	9:00am - 6:30pm
	MK Shah Pharmacy, 734-736 Hertford Road, Enfield, EN3 6PR	9:00am - 8:00pm
	Ronchetti Pharmacy, 68 Island Centre Way, The RSA Island Centre, Enfield Lock, EN3 6GS	9:00am – 6:30pm
	Ronchetti Pharmacy, 619 Hertford Road, Enfield, EN3 6UP	9:00am - 7:00pm
	Sainsburys Pharmacy, 3 Crown Road, Enfield, EN1 1TH	7:00am - 11:00pm
	Tesco In-Store Pharmacy, 288 High Street, Ponders End, EN3 4DP	8:00am - 10:30pm Tue-Fri 6:30am – 10:30pm
	The Co-Operative Pharmacy, 255-257 Hertford Road, Enfield, EN3 5JL	9:00am – 7:00pm
	The Co-Operative Pharmacy, 417 Hertford Road, Enfield, EN3 5PT	8:30am - 6:30pm
	The Co-Operative Pharmacy, 670 Hertford Road, Enfield, EN3 6LZ	9:00am - 7:00pm

Locality	Pharmacy name and address	Opening hours (Mon-Fri, excl BHs)
North East locality	Virens Chemist, 560 Hertford Rd, Edmonton, N9 8AG	9:00am - 6:30pm
	VMS Pharmacy Ltd, 291 Hertford Road, Edmonton, N9 7ES	9:00am – 6:30pm

3.4.3 Routine Saturday daytime access to community pharmacies

The number, location and opening hours of community pharmacy providers open on a Saturday vary within each locality.

'Average' access is difficult given the variety of opening hours and locations. Access is therefore considered at locality level. Table 16 shows that 90% of all pharmacies in Enfield HWB area are open on Saturdays. A further analysis of provision is detailed in Section 6.

Table 16 - Community pharmacy providers open Saturdays

Locality	Pharmacy name and address	Saturday opening hours
South West locality	Aldermans Pharmacy, 30 Aldermans Hill, Palmers Green, N13 4PN	9:00am - 1:00pm
	Asda Pharmacy, 130 Chase Side, Southgate, N14 5PW	8:30am - 10:00pm
	Atkinson Chemist, 750 Green Lanes, Winchmore Hill, N21 3RE	9:30am - 6:00pm
	Boots UK Ltd, 315-317 Green Lanes, Palmers Green, N13 4YB	8:30am - 6:30pm
	Boots UK Ltd, 78 Chase Side, Southgate, N14 5PH	8:00am - 7:00pm
	Capricorn Pharmacy, 16 Enfield Road, Enfield, EN2 7HW	9:00am - 7:00pm
	Coopers Chemist, 364 Bowes Road, Arnos Grove, N11 1AH	9:00am - 7:00pm
	Greenacre Pharmacy, 9 Station Parade, Cockfosters, Barnet, EN4 0DL	9:00am - 6:00pm
	Greens Pharmacy, 48 Green Lanes, Palmers Green, N13 6JU	9.00am - 6:00pm
	Jhoots Pharmacy, 44 Cannon Hill, Southgate, N14 6LH	9:00am - 1:00pm

Locality	Pharmacy name and address	Saturday opening hours
South West locality	LloydsPharmacy, 4 Florey Square, Highlands Village, Winchmore Hill, N21 1UJ	9:00am - 5:00pm
	Morrisons Pharmacy, Aldermans Hill, Palmers Green, N13 4YD	9:00am - 8:00pm
	NR Patel Chemists, 153 Bowes Road, Palmers Green, N13 4SE	9:00am – 5:00pm
	Palmers Chemist, 325 Green Lanes, Palmers Green, N13 4YB	9.00am - 6:00pm
	Parkview Pharmacy, 195 Bramley Road, Southgate, N14 4XA	9:00am - 6:00pm
	Sainsbury's Pharmacy, 681 Green Lanes, Winchmore Hill, N21 3RS	8:00am - 8:00pm
	Simmons Chemist, 111 Cockfosters Road, Herts, EN4 0DA	9:00 am - 1:00 pm 2:00 pm - 5:30 pm
	Walker Pharmacy, 410-412 Green Lanes, N13 5XG	9:00am - 5:00pm
	Waterhouse K Ltd, 88 Crown Lane, Southgate, N14 5EN	9:00am - 1:00pm
South East locality	Aqua Chemists, 55 Bounces Road, Edmonton, N9 8JE	9:00am - 1:00pm
	Asda Pharmacy, Edmonton Green Shop Centre, The Broadway, N9 0TS	7:00am - 10:00pm
	Bees Dispensing Chemist, 172 Fore St, Edmonton, N18 2JB	9:30am - 6:00pm
	Boots UK Ltd, 29 North Square, Edmonton Green, N9 0HW	8:00am - 6:00pm
	Estons Pharmacy, 93 Fore Street, Edmonton, N18 2TW	9.30am - 6:30pm
	Forest Pharmacy, Forest Primary Care Centre, 308a Hertford Road, Edmonton, N9 7HD	10.00am - 2:00pm
	Green Cross (London) Ltd, 213 Fore Street, Edmonton, N18 2TZ	9:00am - 5:30pm

Locality	Pharmacy name and address	Saturday opening hours
South East locality	Green Lanes Pharmacy, Green Lanes Surgery, 808 Green Lanes, Winchmore Hill. N21 2SA	9:00am - 1.30pm
	Hayward Chemist Ltd, 10 Queen Anne's Place, Bush Hill Park, Enfield, EN1 2PT	9:00am - 6:00pm
	Lamis Chemists, 20 Bush Hill Parade, Village Road, EN1 2HB	9:00am - 4:00pm
	LloydsPharmacy, 13 The Concourse, Edmonton Green, N9 0TY	9:00am - 5:00pm
	LloydsPharmacy, 261 Fore Street, Edmonton, N18 2TY	9:00am - 5:00pm
	Reids Pharmacy, 1 Cambridge Terrace, Bury Street West, Edmonton, N9 9JJ	9:00am - 5:30pm
	Rocky's Pharmacy, 14 Kendal Parade, Silver Street, N18 1ND	9:00am- 2:00pm
	Skot Dispensing Chemists, 139 Victoria Road, Edmonton, N9 9BA	9:00am - 1:00pm
	Superdrug Pharmacy, 21 Market Square, Edmonton Green, N9 0TZ	9:00am - 6:00pm
	Tesco Extra, 1 Glover Drive, Upper Edmonton, N18 3HF	6:30am - 10:00pm
North West locality	Boots UK Ltd, 30-32 Palace Gardens, Enfield, EN2 6SN	8:30am - 6:00pm
	C Atkinson Chemist, 20 The Grangeway, Grange Park, N21 2HG	9:30am - 6:00pm
	LloydsPharmacy , 198 Lancaster Road, Enfield, EN2 0JH	9:00am - 5:30pm
	LloydsPharmacy, 304 Baker Street, EN1 3LD	9:00am - 4:00pm
	The Co-Operative Pharmacy, 66 Silver St, Enfield, EN1 3EP	8:30 am - 12:30 pm
	Whitakers Pharmacy, 68 Silver Street, Enfield, EN1 3EW	8:30am - 11:00am

Locality	Pharmacy name and address	Saturday opening hours
North East locality	Boots UK Ltd Enfield Retail Park, 2a Crown Road, Enfield, EN1 1TH	8:00am - 8:00pm
	Elgon (Enfield) Ltd, Eagle House Surgery, 291 High Street, Ponders End, EN3 4DN	9.00am - 12:00pm
	Healthfare Pharmacy, 9 Coleman Parade, Southbury Road, Enfield, EN1 1YY	9:30am – 5:30pm
	LloydsPharmacy, 226-228 Hertford Road, Enfield, EN3 5BH	9:00am - 5:30pm
	LloydsPharmacy, 98a South Street, Ponders End, EN3 4QA	9:00am - 1:00pm
	MK Shah Pharmacy, 734-736 Hertford Road, Enfield, EN3 6PR	9:00am - 6:00pm
	Ronchetti Pharmacy, 619 Hertford Road, Enfield, EN3 6UP	9:00am - 6:00pm
	Sainsburys Pharmacy, 3 Crown Road, Enfield, EN1 1TH	7:00am - 10:00pm
	Tesco In-Store Pharmacy, 288 High Street, Ponders End, EN3 4DP	6:30am - 10:00pm
	Zara Pharmacy, 247 High Street, Ponders End, EN3 4DR	9:00am - 5:00pm
	The Co-Operative Pharmacy, 670 Hertford Road, Enfield, EN3 6LZ	9:00am - 6:00pm
	Virens Chemist, 560 Hertford Road, Edmonton, N9 8AG	9:30am - 1:00pm
	VMS Pharmacy Ltd, 291 Hertford Road, Edmonton, N9 7ES	10.00am - 2:00pm

3.4.4 Routine Sunday daytime access to community pharmacies

The number, location, and opening hours of community pharmacy providers open on a Sunday vary within each locality. Fewer pharmacies are open on Sundays than any other day in Enfield HWB area, however each of the main shopping areas has a pharmacy open on Sundays.

Table 17 - Community pharmacy providers open on Sundays

Locality	Pharmacy name and address	Openings hours (Sundays)
South West locality	Asda Pharmacy, 130 Chase Side, Southgate, N14 5PW	11:00am - 5:00pm
	Boots UK Ltd, 78 Chase Side, Southgate, N14 5PH	10:00am - 6:00pm
	Morrisons Pharmacy, Aldermans Hill, Palmers Green, N13 4YD	10:00am - 4:00pm
	Sainsbury's Pharmacy, 681 Green Lanes, Winchmore Hill, N21 3RS	10:0 am - 4:00pm
South East locality	Asda Pharmacy, Edmonton Green Shop Centre, The Broadway, N9 0TS	11:00am - 5:00 pm
	Boots UK Ltd, 29 North Square, Edmonton Green, N9 0HW	10:00am - 6:00 pm
	Green Cross (London) Limited, 213 Fore Street, Edmonton, N18 2TZ	10:30am - 2:00 pm
	Tesco Extra, 1 Glover Drive, Upper Edmonton, N18 3HF	11:00am - 5:00 pm
North West locality	Boots UK Ltd, 30-32 Palace Gardens, Enfield, EN2 6SN	10:3am - 4:30pm
North East locality	Boots UK Ltd, Enfield Retail Park, 2a Crown Road, Enfield, EN1 1TH	10:30am - 4:30pm
	Sainsbury's Pharmacy, 3 Crown Road, Enfield, EN1 1TH	10:00am - 4:00pm
	Tesco In-Store Pharmacy, 288 High Street, Ponders End, EN3 4DP	10:00am - 4:00pm

3.4.5 Routine bank holiday access to community pharmacies

Community pharmacies are not obliged to open on nominated bank holidays. Whilst many opt to close, a number of pharmacies (often those in regional shopping centres, retail parks, supermarkets and major high streets) opt to open - often for limited hours.

The number, location and opening hours of community pharmacy providers open on a bank holiday vary within each locality and on different bank holidays.

Annually, NHS England requests feedback from community pharmacies on their bank holiday intentions. For most bank holidays, a number of providers have planned to open and NHS England has deemed provision as satisfactory and not commissioned any further provision. NHS England may often need to commission a bank holiday rota service from a small number of pharmacies, particularly in some areas for Easter Sunday and Christmas Day.

3.4.6 Pharmacy providers in surrounding HWB areas

As mentioned in Section 3.1, there is a high rate of community pharmacies per 100,000 population in neighbouring HWB areas to Enfield. In many parts of Enfield HWB area, the nearest pharmacy provider will be in a neighbouring area.

Table 18 lists a number of those providers in neighbouring areas within close proximity to the Enfield HWB area. These are also presented on Maps A and B.

Table 18 - Some pharmacy providers within close proximity to Enfield HWB borders

HWB area	Map ref	Pharmacy name and address	Openings hours
Barnet	1	Boots UK Ltd, 788 High Road, North Finchley, N12 9QR	Mon-Sat 8:30am - 6.30pm Sun 10:30am - 4.30pm
	2	Brand - Russell Chemists Ltd, 280 East Barnet Road, East Barnet, EN4 8TD	Mon-Sat 9:00am - 6:00pm
	3	H Haria Chemists, 25 Friern Barnet Road, New Southgate, N11 1NE	Mon, Tue, Wed, Fri 9:00am - 6:00pm Thurs, Sat 9:00am - 1:00pm
	4	Hampden Square Pharmacy, 14 Hampden Square, N14 5JR	Mon-Fri 9:00am - 6:30pm Sat 9:00am - 1:00pm
	5	Wilkinson Chemist, 190 High Street, Barnet, Barnet Road, EN5 5SZ	Mon-Sat 9:00am - 5.30pm
	6	Mountford Chemists Ltd, 11 East Barnet Road, New Barnet, EN4 8BR	Mon-Fri 9:00am - 7:00pm Sat 9:00am - 2:00pm
	7	Svr Chemist, 145-147 East Barnet Road, East Barnet, EN4 8QZ	Mon-Fri 8:30am - 6:30pm
	8	Oakleigh Pharmacy, 253 Oakleigh Road, Whetstone, N20 0TX	Mon-Fri 9:00am - 7:00pm Sat 9:00am - 6:00pm
	9	Tesco Stores Ltd, Coppetts Centre, North Circular, North Finchley, N12 0SH	Mon-Sat 8:30am - 9:00pm Sun 10:00am - 4:00pm

HWB area	Map ref	Pharmacy name and address	Openings hours
Haringey	20	Warwick Pharmacy Ltd, 48-50 Bounds Green Road, New Southgate, N11 2EU.	Mon-Fri 9:00am - 7:00pm Sat 9:00am - 6:00pm
	10	Alpha Pharmacy, 18 Commerce Road, Wood Green, N22 8ED	Mon, Tue, Wed, Fri 9:00am – 6:30pm Thurs 9:00am - 4:00pm Sat 10:00am - 2:00pm
	11	Beauty Chem Ltd, 11 Great Cambridge Road, Tottenham, N17 7LH	Mon, Tue, Wed, Fri 9:00am - 6:00pm Thurs, Sat 9:00am - 1:00pm
	12	Clockwork Pharmacy, 9 Queens Parade, Brownlow Road, Bounds Green, N11 2DN	Mon, Tue, Wed, Fri 9:30am - 7:00pm Thurs, Sat 9:30am - 1:00pm
	13	GF Porter Chemist, 48 Great Cambridge Road, Tottenham, N17 8BU	Mon, Tue, Wed, Fri 9:00am - 7:00pm Thurs, Sat 9:00am - 6:00pm
	14	Grace Pharmacy, 165-167 Park Lane, Tottenham, N17 0HJ	Mon-Fri 9:00am - 7:00pm Sat 9:00am - 6:30pm
	15	Lloyds Pharmacy Ltd, 352 High Road, Wood Green, N22 8JW	Mon-Sat 9:00am – 7:00pm
	16	Napclan Ltd, 753 High Road, Tottenham, N17 8AH	Mon, Tue, Thurs, Fri 9:00am - 6:30pm Wed, Sat 9:00am -1:00pm
	17	Pharmaocare, 65A White Hart Lane, Tottenham, N17 8HH	Mon, Tue, Wed, Fri 9:00am - 7:00pm Thurs, Sat 9:00am - 1:00pm
	18	Shan Chemist, Unit 3, Rear of 867-869 High Road, Tottenham, N17 8EY	Mon-Fri 9:00am - 7:00pm Sat 9:00am – 5.30pm
	19	Somerset Gardens Pharmacy, 4 Creighton Road, Tottenham, N17 8NW	Mon-Sat 7:00am - 10:30pm Sun 10:00am – 5:00pm
Hertfordshire	21	Boots UK Ltd, Waltham Cross Shopping Centre, Pavilion, Waltham Cross, EN8 7BZ	Mon-Fri 9:00am - 6:00pm Sat 9:00am - 5:30pm

HWB area	Map ref	Pharmacy name and address	Openings hours
Waltham Cross	22	Benjamin Pharmacy, 263 Chingford Mount Road, Chingford, E4 8LP	Mon, Tue, Fri 9:00am - 7:30pm Weds, Thurs 9:00am - 7:00pm Sat 9:00am - 5:30pm
	23	The Co-Operative Pharmacy, 267 Chingford Mount Road, Chingford, E4 8LP	Mon-Fri 9:00am - 6:30pm Sat 9:00am -1:00pm
	24	Boots UK Ltd, 9-11 Church Road, Chingford, E4 6SJ	Mon-Sat 8:00am - 6:00pm
	25	Michael Franklin Chemists Ltd, 59 Swardstone Road, Chingford, E4 7PA	Mon-Fri 9:00am - 6:00pm Sat 9:00am - 5:30am
	26	Sainsbury's Supermarket Ltd, 11 Walthamstow Avenue, Chingford. E4 8ST	Mon-Fri 7:00am - 11:00pm Sat 7:00am - 10:00pm Sun 10:00am - 4:00pm

3.5 Advanced service provision from community pharmacies

Section 1.3 lists all advanced services which may be provided under the pharmacy contract. As these services are discretionary, not all providers will provide them all of the time.

Data supplied from NHS England has been used to demonstrate in Appendix A which pharmacies have previously claimed (and therefore provided) MURs and NMSs until 31st March 2014.

Table 18 lists a summary of the latest available data (2012/13) on provision of advanced services.

Table 18 - Advanced service provision

Advanced Service	Percentage of providers currently providing (Average number per provider, 2012/13)		
	England	London	Enfield
Medicines Use Reviews (MURs)	92% (267)	89.9% (263)	100% (277)
New Medicines Service (NMS)	82.3% (68)	78.7% (74)	78.7% (73)
Appliance Use Review (AUR)*	1.2% (197)	0.5% (242)	0
Stoma Customisation (SC)*	15.2% (635)	4.1% (921)	11.5% (9)

**AUR and SC data includes provision from Dispensing Appliance Contractors*

The number of providers and rate of provision of the MUR service in Enfield HWB area is greater than the regional and national levels, whereas the rate and provision of the NMS service is similar to regional and national levels.

Appendix A lists those community pharmacies who have provided these services (up until 31st March 2014). Six community pharmacies in Enfield HWB area (10% of providers) had not provided the NMS service and one community pharmacy in Enfield HWB area (1.6% of providers) had not provided the MUR service.

No respondents to the community pharmacy contractor questionnaire indicated that they do not have a consultation room which complies with the requirements to perform NMS / MUR services.

Provision of the SC service is low compared with nationally but higher than rates seen regionally. There has been no recorded provision of the AUR service from community pharmacy providers in Enfield HWB area up until 31st March 2014.

The number of providers of the AUR is very low regionally and nationally. There were only 143 community pharmacy or DAC providers nationally (1.2%), and nine community pharmacy or DAC providers (0.5%) in the whole of London in 2012/13.

3.6 Enhanced service provision

Under the pharmacy contract, enhanced services are those directly commissioned by NHS England. Therefore any 'locally commissioned services' commissioned by CCGs or the Local Authority are not considered here. They are outside the scope of the PNA but are considered in Chapter 4.

There are currently two enhanced services commissioned by NHS England from pharmacies in Enfield HWB area:

- immunisation services
- pharmacy urgent repeat medication (PURM) service

A list of pharmacies contracted to provide the immunisation service is detailed in Appendix A. In December 2014 NHS England launched the PURM service, which is to run to April 2015. NHS England has indicated that this service will be evaluated, and if successful consideration will be given to future commissioning of it.

There are 37 (61%) community pharmacies in Enfield HWB area commissioned to provide the immunisation service.

The vaccines are administered under a patient group direction (PGD) to patients who meet the criteria for inclusion of the PGD and service specification.

In a 2013/14 campaign across London, there was a mean rate of 13 provider pharmacies per 100,000 population (SD 6.85 per 100000 to 18.74 per 100,000). In Enfield the mean rate is 11.5 per 100,000 and the 37 pharmacies providing the service are geographically spread across the borough and are listed in Appendix A.

Immunisation services are commissioned as a pan-London service by NHS England and are open to any pharmacy within Enfield via criteria for inclusion.

3.7 Pharmaceutical service provision provided from outside Enfield HWB area

Enfield HWB area is bordered by four other HWB areas: Barnet, Haringey, Waltham Forest and Hertfordshire. As previously mentioned, like most London boroughs, Enfield has a comprehensive transport system. As a result, it is anticipated that many residents in Enfield HWB area will have reasonable access to pharmaceutical service providers in neighbouring HWB areas and beyond.

It is not practical to list here all those pharmacies outside the HWB area by which Enfield residents are able to access pharmaceutical services. A number of providers lie within close proximity to the borders of Enfield HWB area boundaries and are demonstrated on Maps A and B. Further analysis of cross-border provision is undertaken in Section 6.

Over 71% of respondents to the pharmacy user questionnaire noted that they choose a pharmacy provider close to their home, whilst over 45% chose a provider close to their GP. Over 79% had no difficulties in accessing their community pharmacy, whilst over 13% had difficulties with parking. Almost 96% rated ease of obtaining medication as ‘Very easy’ or ‘Fairly easy’.

Section 4: Other services which may impact on pharmaceutical services provision

Community pharmacies and GP practices provide a range of other services. These are not considered 'pharmaceutical services' under the 2013 Pharmaceutical Regulations[3] and may be either free of charge, privately funded or commissioned by NHS England, the local authority or the CCG.

Examples of such services include delivery services, allergy testing, care homes services and sexual health services; this is not an exhaustive list.

4.1 Local Authority commissioned services provided by community pharmacies in Enfield

Enfield Council commission the following services from community pharmacies:

- emergency contraception service
- supervised consumption service (opiates)
- needle exchange service
- transforming community equipment (TCES) service

Some services are also provided from other providers e.g. GP practices. A full list of services and community pharmacy providers can be found in Appendix A.

4.2 Clinical commissioning group commissioned services

Enfield clinical commissioning group CCG currently commissions a minor ailments scheme from 51 community pharmacies in Enfield HWB area. A full list of community pharmacy providers is listed in Appendix A.

Local authority and CCG commissioners were asked for their views on which services they would consider commissioning from community pharmacy providers. Many services are already commissioned by the CCG or local authority from other providers. The CCG or local authority would be willing to commission the majority of services from community pharmacies. A copy of the survey can be found in Appendix E and the full results of the survey in Appendix K.

4.3 Other services provided from community pharmacies

As part of the community pharmacy contractor survey, found in Appendix D, community pharmacies were asked to indicate against a range of other services which they currently provide, would be willing to provide or would not be willing to provide. A number of pharmacies indicated that they currently provide a number of these services. Apart from those services commissioned by the local authority, these services are not currently commissioned. Therefore any services are privately provided and funded.

A summary of the community pharmacy contractor survey is detailed in Appendix J.

4.4 Collection and delivery services

From the pharmacy contractor survey, 73% of pharmacies offer a free delivery service of dispensed medicines, upon request while 26% offer a chargeable delivery service and 71% offer this service only to selected patient groups. Almost all pharmacies who responded offer a repeat prescription service, to order repeat prescription on the patient's behalf, collect the prescription from their surgery and dispense it ready for the patient to collect/be delivered.

4.5 Language services

Of those pharmacies who responded to the community pharmacy contractor questionnaire, 4% reported that they offer at least a language access service for people who do not speak English well. If commissioned, 71% reported that they would be willing to provide this service. Out of the 54 pharmacies responding to the survey, 45 (83%) reported that they employ staff who can speak a language other than English. Most common spoken additional languages were Gujarati (76% of respondents), Hindi (60% of respondents), Turkish (33% of respondents), Greek (22% of respondents) and Swahili (16% of respondents).

4.6 Services for less-abled people

As a requirement of the Equalities Act 2012, community pharmacies are required to make 'reasonable adjustments' to their services to ensure they are accessible by all equalities groups, including less-abled persons. From the patient survey, 9% of respondents visit a pharmacy on behalf of someone else because of access (for example disability or transport) reasons.

4.7 Electronic prescription service

Many GP practices are now able to transmit prescriptions electronically (electronic prescription service - EPS) to a pharmaceutical service provider (community pharmacy or dispensing appliance contractor). This system is known as EPS Release 2 and means that the patient no longer needs to obtain a paper prescription and present it at their pharmacy for dispensing. Electronic prescriptions are sent directly to the pharmacy nominated by the patient. GP practices who provide this service are only able to transmit electronic prescriptions to a pharmacy who has a dispensing system set up to receive electronic ('Release 2') prescriptions.

Of respondents to the community pharmacy contractor questionnaire, 100% report that they have a system which is compliant to receive electronic prescriptions. Data available on which pharmacies in England are enabled to offer the EPS is available from NHS Choices[14]. Appendix A contains information (correct as at 19th October 2014) from the NHS Choices website showing that all pharmacies in Enfield HWB area are enabled to provide the EPS.

[14] NHS Choices website: http://www.nhs.uk/Service-Search/Pharmacy/LocationSearch/10

Section 5: Findings from the public survey

A public survey about pharmacy provision was developed (Appendix C) and compiled by Enfield PNA Steering Group. This was circulated by the Local Authority to a range of stakeholders listed below:

- all pharmacy contractors in Enfield to distribute to the public
- all GP Practices in Enfield to distribute to the public
- a number of voluntary community groups in Enfield
- Enfield Voluntary Action (EVA)
- Enfield HealthWatch

A total of 231 surveys were received. A summary of the results can be found in Appendix I and Table 19 provides the demographic analysis of respondents.

- **96%** rated their overall satisfaction on the service received from their local pharmacy as **'Excellent'** or **'Good'**
- **40%** indicated that they used pharmacies **up to every month** for the purchase of over the counter medicines, with **88%** having a **regular or preferred pharmacy** they use
- **95%** rated their confidence in the pharmacist's knowledge and advice as **'Excellent'** or **'Good'**
- **45%** rated as important that the pharmacy is **close to their GP surgery; 71%** that the pharmacy is **close to their home**; **15%** that the pharmacy is **close to where they work** and **57%** that the pharmacy **has friendly staff**
- **55%** walk to their community pharmacy; **28%** use a **car**; **11%** use **public transport; 4%** use a **bicycle**
- **79%** had **no difficulties travelling** to their pharmacy; **13%** had **parking difficulties**; **5%** had **problems with the location** of the pharmacy; and **3%** had **problems of public transport availability**
- The greatest percentage of respondents had no **most convenient day (34%)** or **time (59%)** to **visit their pharmacy**
- **65%** of respondents report having a **journey time of no more than 10 minutes; 91%** of respondents have a **journey time no greater than 20 minutes**
- **96%** indicated that the **ease of obtaining prescription medication** from their pharmacy was **'Very easy'** or **'Fairly easy'**

A summary of the results can be found in Appendix I. Table 19 provides the demographic analysis of respondents.

Table 19 - Demographic analysis of the community pharmacy user questionnaire respondents

Sex (%)									
Male				**Female**					
28.14%				71.86%					
Age (%)									
16-19	**20-29**	**30-39**	**40-49**	**50-59**	**60-69**	**70-79**	**80-89**	**90+**	**Do not wish to state**
1.49 %	7.96%	11.94%	22.39%	14.93%	18.91%	10.45%	8.96%	1.99%	1%
Illness or disability (%)?									
Yes				**No**					
28.92%				71.08%					

Ethnic origin (%)	**Survey**	**2011 census**
Arab	0%	0.6%
Asian / Asian British- Bangladeshi	0.51%	1.8%
Asian / Asian British – Indian	11.62%	3.7%
Asian / Asian British – Pakistani	2.53%	0.8%
Asian / Asian British – Chinese	0.51%	0.8%
Asian / Asian British – Other	1.52%	4%
Black / African / Caribbean / Black British – African	0%	9%
Black / African / Caribbean / Black British – Caribbean	2.53%	5.5%
Black / African / Caribbean / Black British – Other (please state)	1.01%	2.6%
Mixed / Multiple Ethnic Groups – White and Asian	0.51%	1.3%
Mixed / Multiple Ethnic Groups – White and Black African	1.01%	0.8%
Mixed / Multiple Ethnic Groups – White and Black Caribbean	0%	1.6%
Mixed / Multiple Ethnic Groups – Other	0%	1.8%
English / Welsh / Scottish / Northern Irish / British	55.05%	40.5%
Irish	3.54%	2.2%
White Gypsy or Irish Traveller	0%	0.1%

Ethnic origin (%)	Survey	2011 census
Greek	2.02%	Other White: 18.2%
Greek Cypriot	3.03%	
Turkish	2.02%	
Turkish Cypriot	3.03%	
Italian	1.52%	
Do not wish to state	3.03%	-
Other	5.05%	4.5%

Section 6: Analysis of health needs and service provision

As described within Section 1.5, the PNA Steering Group decided that the Enfield HWB PNA should be divided into four localities – South West, South East, North West and North East. Substantial health data are available at this level and populations and their health needs vary widely between wards.

Each locality has pockets of marked health inequalities. This chapter analyses the health needs of each of the localities of Enfield and considers the pharmaceutical service provision.

The demographics of the population of Enfield is characterised by a geographical split. This is most noticeable comparing North West and South East localities. North West locality comparably has an older population with 16% of the population aged over 65 (compared to 13% in England). In this locality, 69% of the population are White British (in Enfield it is 43%). South West locality has a relatively more diverse, younger population where 23% are White British. Enfield as a whole has a younger age profile compared with London and England. Of the population of Enfield, 27.3% is aged 0-19, compared to 24.5% and 23.8% in London and England respectively. Enfield also has high levels of child poverty with 32.8% of children under the age of 16 living in poverty. Pharmaceutical services commissioning within Enfield's localities should consider the needs of the varying populations of each locality.

Enfield HWB's vision is for its people to live longer, healthier, happier lives. It has developed a strategy to enable this. The Enfield Health and Wellbeing Board Strategy for 2014-2019[8] focusses on five priority areas identified as key to the improvement of the health of the local population and reduction in health inequalities:

1. Ensuring the best start in life
2. Enabling people to be safe, independent and well, and delivering high quality health and care services
3. Creating stronger, healthier communities
4. Reducing health inequalities – narrowing the gap in life expectancy
5. Promoting healthy lifestyles and making healthy choices

The PNA is an opportunity to further the aims of the HWB strategy and a number of recommendations are made here to facilitate this.

For the purposes of this PNA, necessary services are defined as:

- essential services provided at all premises on the pharmaceutical list during all the opening hours of the pharmacy in line with their terms of service as set out in the 2013 Regulations[3]
- advanced services in line with their terms of service as set out in the 2013 Regulations[3]

The HWB have considered the White Paper Pharmacy in England: Building on Strengths – Delivering the Future (2008)[12] which states that it is a strength of the current system that community pharmacies are easily accessible. The HWB consider that the population of Enfield currently experience this situation in all four PNA localities.

The HWB has considered the following when assessing the provision of necessary services in the HWB area and each of the five PNA localities:

- population density by ward by Census 2011 Output Area (Figure 2)
- index of multiple deprivation (IMD) and deprivation ranges compared to the relative location of pharmacy premises.(Map B)
- BME % population compared to the relative location of pharmacy premises.(Map A)
- the location of pharmacies within each of the four PNA localities and across the whole Enfield HWB area (Maps A and B)
- the number, distribution and opening times of pharmacies within each of the four PNA localities and across the whole Enfield HWB area (Appendix A and Tables 15, 16 and 17)
- the choice of pharmacies covering the each of the four PNA localities and the whole Enfield HWB (Appendix A)
- the average number of items per month per pharmacy dispensed within Enfield HWB area (Table 13)
- results of the patient survey (Section 5)
- projected population growth (Section 2.3.3)

6.1 Pharmaceutical services and health needs

The core purpose of the Joint Health and Wellbeing Strategy (JSNA[4]) and Action Plan[8] is to ensure that the needs identified through the JSNA[4] are addressed. It remains important that the strategy should pick up the key messages from the JSNA, these are highlighted in Section 3 of the PNA.

Many of these priorities can be supported by the provision of pharmaceutical services within the HWB area.

Medicines optimisation is vital in the successful control of many long-term conditions e.g. circulatory diseases, mental health, diabetes which will in turn have a positive impact on morbidity and mortality. Disease-specific guidance e.g. National Institute for Clinical and Healthcare Excellence (NICE) regularly emphasises the importance of medicines optimisation and adherence in control of conditions such as hypertension, asthma and stroke.

6.1.1 Essential services

The essential services (ES) of the community pharmacy contract must be provided by all contractors:

- ES 1: Dispensing of medicines
- ES 2: Repeat Dispensing
- ES 3: Disposal of unwanted medicines
- ES 4: Promotion of healthy lifestyles
- ES 5: Signposting patients to other healthcare providers
- ES 6: Support for self-care
- ES 7: Clinical governance

ES1 and ES2 support patients living with long-term conditions by providing timely supply of medicines and advice to patients. ES2 may be of particular benefit to patients on lifelong medicines as part of their treatment e.g. statins or insulin.

Using ES3, pharmacies can direct patients in the safe disposal of medicines and reduce the risk of hoarding medicines at home which may increase the risk of errors in taking medicines or in taking out-of-date medicines.

ES4 can support local and national campaigns informing people of managing risk factors associated with many long-term conditions such as smoking, healthy diet, physical activity and alcohol consumption.

ES4 provides the ability to:

- improve awareness of the signs and symptoms of conditions such as stroke e.g. FAST campaign
- promote validated information resources for patients and carers
- collect data from the local population on their awareness and understanding of different types of disease and their associated risk factors
- target “at risk” groups within the local population to promote understanding and access to screening programmes e.g. men in their 40s for NHS Health Checks

Community pharmacy also plays a vital role in the management of minor ailments and self-care. Evidence shows that community pharmacists are potentially the most accessed healthcare professionals in any health economy. They are an important resource in supporting people in managing their own self-care and in directing people to the most appropriate points of care for their symptoms[12].

Although the evidence base is currently very small in measuring the effectiveness and cost effectiveness of community pharmacies’ contribution to urgent care, emergency care and unplanned care, there is a growing recognition of the importance of this role and also for further research. This has been highlighted as a key area for improving health outcomes in the Enfield Health and Well Being Action Plan and in particular in reducing unplanned and general hospital admissions.

Using ES5, pharmacies can signpost patients and carers to local and national sources of information and reinforce those sources already promoted.

Through ES6 pharmacy staff can advise patients and carers on the most appropriate choices for self-care and also direct queries to the pharmacist for further advice when purchasing over-the-counter medicines or general sales lists products. Some over-the-counter medicines are contraindicated e.g. decongestant use in circulatory disease and inappropriate use could increase the risk of an unplanned hospital admission. Equally, some symptoms can be much more significant in certain long-term conditions e.g. foot conditions in diabetes and the attempted purchase of an over-the-counter medicine by a patient or carer could alert a pharmacist leading to an appropriate referral.

ES7 provides the governance structure for the delivery of pharmacy services. This structure is set out within the 2013 Regulations[3] and includes:

- a patient and public involvement programme
- a clinical audit programme
- a risk management programme
- a clinical effectiveness programme
- a staffing and staff programme
- an information governance programme

It provides an opportunity to audit pharmacy services and influence to the evidence base for the best practice and contribution of pharmacy services, especially in meeting local health priorities within Enfield.

6.1.2 Advanced services

Advanced services are not mandatory for providers to provide. In many cases, there are restrictions within the provision and / or availability of these services. For example, in the case of MURs, a pharmacy providing these services must have a consultation room which fits the service requirements, the pharmacist must be accredited to perform the service and the patient must have obtained dispensing services from the pharmacy for the previous three months. Although the HWB have determined advanced services as necessary services, for the purpose of the PNA, the HWB contend that a lack of provision or access to an advanced service from a particular pharmacy may not necessarily translate into a gap and may not necessitate the granting of further applications. Enfield HWB would wish to support all existing pharmaceutical service providers to make available all advanced services where a need exists.

Evidence shows that up to half of medicines may not be taken as prescribed or simply not taken at all. Advanced services have a role in highlighting issues with medicines or appliance adherence issues and also in reducing waste through inappropriate or unnecessary use of medicines or appliances.

Polypharmacy is highly prevalent in long-term conditions management. Advanced services provide an opportunity to identify issues with side effects, changes in dosage, confirmation that the patient understands the role of the medicine or appliance in their care and opportunities for medicine optimisation.

Appropriate referrals can be made to GPs or other care settings resulting in patients receiving a better outcome from their medicines and, in some cases, cost saving for the CCG. Advanced services may also identify other issues such as general mental health and well-being providing an opportunity to signpost to other local services or service within the pharmacy e.g. seasonal flu immunisation or repeat dispensing.

Promotion of self-care is an important aspect to the management of many long-term conditions and advanced services provide a key opportunity for the pharmacist to do so e.g. promoting the importance of dry weight monitoring in heart failure management.

The rate and provision of the MUR and NMS services from pharmacies in Enfield is at levels similar to the London and England averages.

Most recent data shows that there are no pharmacies in Enfield providing AURs. Numbers of this service are low nationally and there is no data to suggest that there is an unmet need in Enfield. Should a need be identified in Enfield then current providers should be invited to provide this service.

The percentage of contractors in Enfield providing Stoma Customisation services is at a level greater than London and slightly less than seen nationally. Numbers of this service are also low nationally and there is no evidence to suggest that there is any unmet needs in Enfield.

6.1.3 Enhanced services

In Enfield there are two pharmaceutical enhanced services commissioned by NHS England (Section 3.6) which are immunisation services and the PURM service. The PURM service allows pharmacies to provide emergency repeat medications at NHS expense, without the need for a prescription or GP appointment. The service recognises that on occasions patients may mistakenly run out of urgent repeat medication when their GP surgery is closed and it prevents the need to access urgent care to obtain a prescription for the medication. The service is being run as a trial and is planned to be evaluated from April 2015. Enhanced services are included within this assessment where they affect the need for pharmaceutical services, or where the further provision of these services would secure improvements or better access to pharmaceutical services. Appendix A provides details of the pharmacies providing enhanced services.

Commissioning, delivery and regulation of immunisation services are now shared at national level between NHS England, Public Health England (PHE) and the Department of Health (DH). The local operating model divides responsibilities between NHSE, PHE, and Enfield Local Authority.

Immunisation is a key intervention to protect at-risk groups such as older people, people living with diabetes, COPD, CVD or carers against diseases such as seasonal flu or shingles, which can cause additional health complications that can be associated with unplanned hospital admissions. Therefore, there is a vital need for this service.

There is a strong evidence base for the role of immunisation in reducing morbidity and mortality in the adult and child population. For example, seasonal flu immunisation is established as an effective and cost effective intervention in reducing unplanned hospital admissions in many long-term conditions e.g. respiratory disease, circulatory disease.

In 2014/15, two vaccination services were commissioned from pharmacies by NHS England in line with national immunisation programmes. These services are:

- seasonal influenza immunisation programme
- pneumococcal immunisation programme

It is also noted that NHS England is considering future plans to expand the immunisation service to include other vaccinations, including:

- pneumococcal vaccine
- shingles vaccine

6.1.4 Locally commissioned services

Appendix A provides a summary of enhanced and locally commissioned services within Enfield pharmacies and Section 4.1 and 4.2 provide a description. It is important to note the commissioning status of each service as this defines whether or not it is a locally commissioned service.

Locally commissioned services are included within this assessment where they affect the need for pharmaceutical services or where the further provision of these services would secure improvements or better access to pharmaceutical services.

6.1.4.1 Minor ailments service

Enfield CCG commissions a minor ailment service from 51 (84%) pharmacies across all localities in Enfield. The minor ailment service allows pharmacists to supply medicines free of charge to patients to treat minor ailments without the need for a GP appointment.

6.1.4.2 Stop smoking services

Smoking is the UK's single greatest cause of preventable illness and early death. Adults who smoke lose on average 13 to 14 years of their lives and more than 86,000 people in the UK die from smoking each year. It is a priority health issue highlighted in the JSNA[4] for Enfield.

Nationally the number of people who smoke is estimated at 21%. In Enfield, it is estimated 19.4% of the population smoke compared to 19.5% in London.

However, there is a variation of 16.9% to 22.3% across the borough with smoking prevalence higher in areas of greater deprivation.

Enfield Council currently commission pharmacies to provide stop smoking services through a contract with Innovision Healthcare.

6.1.4.3 Emergency hormonal contraception

Sexual health has a major focus in the Joint Health and Well Being Strategy and action plan with pharmacies' role already highlighted in the provision of emergency hormonal contraception (EHC).

Teenage conception includes all conceptions before the mother's 20th birthday but the national focus is on conception under 18. The conception rate is the number of pregnancies that start before the mother's 18th birthday (per 1,000 young women aged 15 to 17) and includes pregnancies that end either in birth or in termination.

Teenage pregnancy is a significant public health issue in England. Teenage parents are prone to poor antenatal health, lower birth weight babies and higher infant mortality rates. Their health, and that of their children, is likely to be worse than average. Teenage mothers are less likely to finish their education, less likely to find a good job and more likely to end up both as single parents and bringing up their children in poverty. The children themselves run a much greater risk of poor health, and have a much higher chance of becoming teenage mothers themselves

Enfield had a lower teenage conception rate compared to England and London averages in 2011. There was a crude rate of around 25.8 conceptions for every 1,000 women aged between 15 and 17 years. The England rate in 2011 was 30.7 per 1,000 females aged 15 to 17 and the London rate was 28.7 per 1,000 females aged 15 to 17. Notably, rates in Enfield have been steadily falling since 2007, however there are a number of deprived wards within South East locality in Enfield where teenage pregnancy rates are more than five times higher than the areas in the borough with the lowest rates.

EHC is provided as a free service to females aged 13 to 24 years of age presenting at a commissioned pharmacy in Enfield. Of pharmacies in the HWB area, 24 pharmacies or 39% are commissioned to provide this service.

Activity data for this service was not available however there is a very strong evidence base for the use of EHC in reducing unplanned or unwanted pregnancies, especially within teenage years. Its use forms part of an overall national strategy to reduce the rate of teenage pregnancy with England (NICE).

The drug levonorgestrel is used for emergency hormonal contraception. Through this service it is supplied under a Patient Group Direction (PGD) service to women who meet the criteria for inclusion of the PGD and service specification. The drug can also be prescribed using an NHS prescription.

It may also be bought as an over-the-counter medication from pharmacies, however the user must be 16 years or over, hence the need for a PGD service within pharmacies which provides access from 13 years of age.

6.1.4.4 Screening services

Increasingly, community pharmacies have been commissioned to provide screening services providing additional choice and access to local populations. Currently there are no screening services commissioned from pharmacies within the Enfield HWB area. Some examples are chlamydia screening, HIV screening, alcohol screening, weight management and NHS Health Checks. The commissioners survey (Appendix E) highlighted the potential for utilising pharmacies for diabetes, cholesterol and HbA1c screening.

Access to screening services have a significant role in supporting the numerous outcomes highlighted in priorities two, four and five of the Enfield Health and Well Being Action Plan.

6.1.4.5 Drug and alcohol misuse services

Community pharmacies have been utilised for a number of years by drug and alcohol action team (DAAT) service providers in the provision of supervised consumption of opiates services and needle exchange services.

Most recent data suggests that there are over 1,100 adults aged over 18 years old receiving specialist treatment for substance misuse. Currently there are two DAAT services commissioned from community pharmacies: needle exchange and supervised consumption of opiates. There are 25 pharmacies (41%) in Enfield commissioned to provide supervised consumption of opiates and 10 (16%) commissioned to provide needle exchange.

Access to these two DAAT services play a significant role in supporting several outcomes highlighted in priority two of the Health and Well Being Action Plan. There are no providers of the locally commissioned needle exchange services in North West locality. In many cases providers may be in neighbouring localities, although in some cases these are not easily accessible. Whilst a potential gap in provision may have been identified, there has been no information available to ascertain whether there is a need for these services in these areas. Commissioners may wish to review current provision and needs and consider it as a priority to commission further provision from existing providers.

Alcohol-related admissions in Enfield have risen sharply in recent years and are growing at a faster rate than London and England averages. There is no alcohol-related service currently commissioned locally through community pharmacies in Enfield.

6.1.4.6 Transforming community equipment services

The transforming community equipment services (TCES) is aimed at improving access to disability living aids to residents living in the community.

There are a range of providers of the TCES service in Enfield HWB area and currently three community pharmacies are commissioned to provide this service, as listed in Appendix A. There are, in addition, a further three other providers (other than community pharmacies) providing this service:

South East locality:

- Forest Mobility and Visual Aids Service,
  Forest Primary Care Centre,
  308a Hertford Road,
  Edmonton,
  N9 7HD

South West locality:

- Home Care Preferred,
  49 Station Road,
  Winchmore Hill,
  N21 3NB

North East locality:

- Fortuna Mobility Centre,
  4 Northgate Business Centre,
  Crown Road,
  Enfield.
  EN1 1TG

6.2 South West locality

6.2.1 Necessary services: current provision

There are 20 community pharmacies in this locality, 19 of which are open on Saturdays. Of these,15 are open after 6pm weekdays and four are open on Sunday. The majority of pharmacies provide the MUR and NMS advanced services. Access to necessary services is satisfactory.

6.2.2 Necessary services: gaps in provision

No gaps have been identified in South West locality for the provision of necessary services.

6.2.3 Other relevant services: current provision

Almost half (nine) of community pharmacies in this locality are commissioned through Enfield Council to provide the EHC service. Four providers of this service are open weekday evenings after 6pm, eight providers are open on Saturdays and one is open on Sunday.

There are two community pharmacy providers of the TCES (equipment) service.

The CCG commissioned MAS is commissioned from 18 pharmacies in this locality, 13 of which are open weekday evenings after 6pm, 17 are open on Saturdays and three are open on Sundays.

The immunisation service is provided by 18 pharmacies in this area.

6.2.4 Improvements and better access: gaps in provision

The HWB consider it is those services provided in addition to those considered necessary for the purpose of this PNA that should reasonably be regarded as providing either an improvement or better access to pharmaceutical provision.

The HWB recognises that any addition of pharmaceutical services by location, provider, hours or services should be considered however a principle of proportionate consideration should apply.

There are two providers of the needle exchange service in this locality, one of which is open after 6pm on weekday evenings and Saturday mornings. There are no providers of this service open Saturday afternoons or Sundays.

Six community pharmacies in this locality are commissioned to provide the methadone supervision service, five of which are open weekday evenings after 6pm, three are open Saturday all day and one on Saturday morning. There are no providers of this service open on Sundays.

There is no data to confirm any unmet needs but should commissioners deem it a priority, improvements and better access to these services are possible by commissioning provision from a provider to open on a Sunday. These potential gaps in provision should be able to be met by an existing provider: no new pharmacies need be commissioned.

6.2.5 Other services

A number of community pharmacies provide free prescription delivery services which it is anticipated many residents may rely upon.

6.3 South East locality

6.3.1 Necessary services: current provision

There are 18 community pharmacies in this locality, the majority of which (13) are open on weekday evenings after 6pm. There are 17 providers in this locality open on Saturdays, 14 are open after 6pm weekdays and four are open on Sunday. The majority of pharmacies provide the MUR and NMS advanced services. Access to necessary services is satisfactory.

6.3.2 Necessary services: gaps in provision

No gaps have been identified in South East locality for the provision of necessary services.

6.3.3 Other relevant services: current provision

The local authority-commissioned emergency contraception service is commissioned from seven community pharmacy providers in this locality of which six are open weekday evenings after 6pm, six are open on Saturdays and three are open on Sundays.

The methadone supervision service is commissioned from eight community pharmacy providers in this locality. Six of these providers are open weekday evenings after 6pm, six are open on Saturdays and one is open on Sundays.

There are 14 community pharmacies in this locality commissioned by Enfield CCG to provide the MAS. Ten of which are open weekday evenings after 6pm, 13 are open on Saturdays and four are open on Sundays.

In this locality, 12 pharmacies provide the immunisation service.

There is one community pharmacy provider of the TCES (equipment) service.

6.3.4 Improvements and better access: gaps in provision

There are three providers of the needle exchange service in this locality all of which are open after 6pm on weekday evenings and two are open on Saturdays. There are no providers of this service open on Sundays.

There is no data to confirm an unmet need but should commissioners deem it a priority, improvements and better access to this service is possible by commissioning provision from a provider to open on a Sunday. This potential gap in provision should be able to be met by an existing provider so no new pharmacies need be commissioned.

6.3.5 Other services

A number of community pharmacies provide free prescription delivery services which it is anticipated many residents may rely upon.

6.4 North West locality

6.3.1 Necessary services: current provision

There are six community pharmacies in this locality, all of which are open on Saturdays and four of which are open on weekday evenings after 6pm. There is one provider in this locality open on Sundays.

All pharmacies provide the MUR and NMS advanced services. Access to necessary services is satisfactory.

6.4.2 Necessary services: gaps in provision

No gaps have been identified in North West locality for the provision of necessary services.

6.4.3 Other relevant services: current provision

There are two providers of the EHC service in this locality. Both providers are open weekday evenings after 6pm and Saturdays, one provider is open on Sundays.

The methadone supervision service is commissioned from two community pharmacy providers in this locality. One provider is open weekday evenings after 6pm and Sundays. Both providers are open on Saturdays.

All six community pharmacies in this locality are commissioned to provide MAS. All six are open on Saturdays, four are open on weekday evenings after 6pm and one is open on Sundays.

Four pharmacies provide the immunisation service in this locality.

No pharmacies provide the TCES (equipment) service and there are no other providers of this service in this locality.

6.4.4 Improvements and better access: gaps in provision

Although there is provision in neighbouring localities, there are no providers of the needle exchange service in this locality. There is no data to confirm an unmet need, but should commissioners deem it a priority, improvements and better access to this service is possible by commissioning provision from a provider in this locality.

This potential gap in provision should be able to be met by an existing provider so no new pharmacies need be commissioned.

6.4.5 Other services

A number of community pharmacies provide free prescription delivery services, which it is anticipated many residents may rely upon.

6.5 North East locality

6.5.1 Necessary services: current provision

The North East locality has 16 community pharmacy providers and one distance-selling pharmacy. The distance-selling pharmacy is not currently commissioned to provide any local authority or CCG commissioned services.

Of the 16 community pharmacies in this locality, only two are not open weekday evenings after 6pm and only three are not open on Saturdays. There are three providers open on Sundays. With the exception of the distance-selling contractor, all community pharmacies in this locality provide the MUR and NMS advanced services. Access to necessary services is satisfactory.

6.5.2 Necessary services: gaps in provision

No gaps have been identified in North East locality for the provision of necessary services.

6.5.3 Other relevant services: current provision

There are 13 community pharmacies commissioned by Enfield CCG to provide the MAS in this locality. Three providers are open on Sundays, ten are open on Saturdays and 12 are open on weekday evenings after 6pm.

Ten pharmacies provide the immunisation service in this locality.

No pharmacies provide the TCES (equipment) service however there is one other (non-pharmacy) provider of this service in this locality.

6.5.4 Improvements and better access: gaps in provision

There are six community pharmacy providers of the EHC service in this locality, all of which are open weekday evenings after 6pm. Four are also open on Saturdays. There is no community pharmacy provider commissioned to provide the EHC service open on Sunday in this locality.

The needle exchange service is commissioned from five community pharmacies in this locality. All five providers are open on Saturdays and four are open after 6pm on weekday evenings. No commissioned providers are open on a Sunday in this locality.

Eight community pharmacies in North East locality are commissioned to provide the supervised consumption of opiates service. All are open on Saturdays and only one is not open on weekday evenings after 6pm. There are no commissioned providers of this service open on a Sunday in this locality.

There is no data to confirm any unmet needs and providers of these services are open in neighbouring localities on Sundays. However, should commissioners deem it a priority, improvements and better access to these services are possible by commissioning provision from a provider open on a Sunday in the North East locality. These potential gaps in provision should be able to be met by an existing provider: no new pharmacies need be commissioned.

6.5.5 Other services

A number of community pharmacies provide free prescription delivery services which it is anticipated many residents may rely upon.

Section 7: Conclusions and recommendations

Enfield HWB has identified essential services and advanced services as necessary services.

Enfield HWB has identified enhanced services in Section 3.6 as pharmaceutical services which secure improvements or better access, or have contributed towards meeting the need for pharmaceutical services in the area of the HWB.

The HWB have considered the White Paper Pharmacy in England: Building on strengths-delivering the future (2008)[12] which states that it is the strength of the current system that community pharmacies are easily accessible. The HWB consider that the population of Enfield currently experience this situation in all PNA localities.

The HWB has considered the following when assessing the provision of necessary services in the HWB area and each of the four PNA localities:

- the Index of Multiple Deprivation and deprivation ranges compared to the relative location of pharmacy premises (Map A)
- the location of pharmacies within each of the four PNA localities and across the whole Enfield HWB area (Map A and Map B)
- the number, distribution and opening times of pharmacies within each of the four PNA localities and across the whole Enfield HWB area (Appendix A)
- the choice of pharmacies covering each of the four PNA localities and the whole Enfield HWB (Appendix A)
- results of the patient survey (Section 5)

It is recognised that pharmacies may be present in 'clusters' near to shopping areas or GP surgeries. Whilst this provides a choice of provider, it may result in a concentration of pharmacies in one area and an absence in another. The PNA has considered the spread and access to pharmacies in Enfield and is satisfied that provision is overall satisfactory for the provision of necessary and relevant services.

In each locality, there are pharmacies open beyond what may be regarded as normal hours in that they provide pharmaceutical services during supplementary hours in the evening, on Saturday and Sunday. There are four 100 hour pharmacies spread across two localities (Table 25, Section 3.13).

7.1 Necessary services - current and future access

Enfield HWB has identified locally commissioned services in Section 4.1, 4.2 and 6.1.4 which secure improvements or better access, or have contributed towards meeting the need for pharmaceutical services in the area of the HWB.

In order to assess the provision of essential services against the needs of the residents of Enfield, the HWB consider opening hours as the most important factor in determining the extent to which the current provision of essential services meets the needs of the population.

Enfield HWB has determined that opening hours of pharmacies in all four localities and across the whole HWB area are reasonable in all the circumstances. Supplementary opening hours are offered by all pharmacies in each locality. There are also four 100 hour contract pharmacies and ten “late night” pharmacies (open after 7.30pm) within the HWB area.

These are geographically spread across the HWB area and the four PNA localities. Enfield HWB has not identified services that would, if provided either now or in future specified circumstances, secure improvements to or better access to essential services in any of the five localities.

No gaps have been identified in the provision of essential services in South West, South East, North West and North East localities or across the whole HWB area. No gaps have been identified in essential services that if provided either now or in the future, would secure improvements, or better access, to essential services in South West, South East, North West, and North East localities or across the whole HWB area.

Section 6.2 defines the level of access to advanced services. There is no identified gap in the provision of advanced services as NMS and MURs are available in almost 100% of pharmacies across all localities. Where applicable, NHS England will encourage all pharmacies and pharmacists to become eligible to deliver the service so that more patients are able to access and benefit from it.

Demand for the SAC and AUR is lower than for the other two advanced services due to the much smaller proportion of the population that may require the services.

Pharmacies and DACs may choose which appliances they provide and may also choose whether or not to provide the two related advanced services. NHS England will encourage those contractors in the area that do provide appliances to become eligible to deliver these advanced services where appropriate.

No gaps have been identified in the provision of advanced services in South West, South East, North West, and North East localities or across the whole HWB area.

Section 6.1.3 defines the level of access to enhanced services. NHS England commissions two enhanced services (immunisation services and the PURM service) from pharmacies. It also commissions the immunisation service from other non-pharmacy providers, principally GP practices. The PURM service is currently being run as a pilot until April 2015.

There is no identified gap in the current provision of enhanced services as immunisation services are accessible across all four localities.

Some of the enhanced services listed in the 2013 Directions[5] (Section 1.3.1) are now commissioned by Enfield CCG (MAS) or Enfield Council (EHC, supervised consumption of opiates and needle exchange and Stop Smoking) and therefore fall outside of the definition of both enhanced services and pharmaceutical services.

There are no gaps identified in respect of securing improvements, or better access, to enhanced services provision on a locality basis as identified in Section 6.1.3 either now or in specified future circumstances. The HWB will monitor the uptake and need for immunisation services within the HWB area to establish if immunisation services are meeting the needs of the local population.

No gaps have been identified in the provision of enhanced services (immunisation services and PURMS services) in South West, South East, North West, and North East localities or across the whole HWB area.

Enfield HWB has not identified any pharmaceutical services that are not currently provided but that will, in specified future circumstances, need to be provided in order to meet a need for pharmaceutical services in any of the four localities.

No gaps have been identified in the need for pharmaceutical services in specified future circumstances have been identified in South West, South East, North West, and North East localities or across the whole HWB area.

Comprehensive service reviews are required in order to establish if currently and in future scenarios immunisation services secure improvement or better access as an enhanced services in South West, South East, North West, and North East localities or across the whole HWB area.

7.2 Other NHS services

As required by Paragraph 5 of Schedule 1 to the 2013 Regulations[3], Enfield HWB has had regard for any other NHS services that may affect the need for pharmaceutical services in the area of the HWB.

Based on current information no gaps have been identified in respect of securing improvements, or better access, to other NHS services either now or in specified future circumstances have been identified in South West, South East, North West, and North East localities or across the whole HWB area.

7.3 Locally commissioned services

With regard to enhanced services and locally commissioned services, the HWB is mindful that only those commissioned by NHS England are regarded as pharmaceutical services. The absence of a particular service being commissioned by NHS England is, in some cases, addressed by a service being commissioned through the Enfield CCG, such is the case with a minor ailments service, and through Enfield Council as in the case of EHC, supervised consumption of opiates and needle exchange. This PNA identifies those as locally commissioned services (LCS).

Although the HWB has identified locally commissioned services as relevant services for the purpose of the PNA, the HWB understands the 'necessity' of provision of some of these services from community pharmacies, in certain locations at certain times e.g. EHC service availability at weekends and evenings.

The HWB notes that all enhanced services and LCS are accessible to the population in all PNA localities. The TCES (equipment) service is not currently commissioned from a provider in North West locality. Based upon the results of the patient survey, there does not appear to be a gap in service which would equate to the need for access to the TCES (equipment) service in this locality. Enfield HWB will monitor the uptake and need for TCES (equipment) services. It will also consider the impact of any changes in this locality in the future which may provide evidence that a need exists.

The HWB also notes that it is unclear if these services are meeting the needs of the local population due to a lack of activity data and a lack of service review. Nevertheless the HWB has not been presented with any evidence to date which concludes that any of these enhanced services or LCS should be decommissioned; or that any of these enhanced services or LCS should be expanded. Based on current information, the HWB has not identified a need to commission any enhanced pharmaceutical services not currently commissioned.

Regular service reviews are recommended in order to establish if currently and in future scenarios locally commissioned services secure improvement or better access in South West, South East, North West, and North East localities.

Appendix A: List of pharmaceutical service providers in Enfield HWB area

Map index	Name of Pharmacy	Address	Opening hours			Electronic prescription service, as per NHS Choices (Y/N)	Provide appliances (Y/N)	NHS England advanced service providers			NHS England enhanced service providers 2014/15	CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15			
			Mon-Fri opening hours	Sat opening hours	Sun opening hours			MURs	NMS	Stoma customisation	Immunisation service	Minor ailment service	Equipment service (TCES)	Methadone supervision	Needle exchange	Emergency contraception
South West Enfield																
5	Aldermans Pharmacy	30 Aldermans Hill, Palmers Green, N13 4PN	9:00am - 7:00pm	9:00am - 1:00pm	Closed	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y
7	Asda Pharmacy	130 Chase Side, Southgate, N14 5PW	8:30am-1:00pm 2:30pm - 10:00pm	8:30am - 10:00pm	11:00 am - 5:00 pm	Y	N	Y	Y	N	Y	Y	N	N	N	Y
8	Atkinsons Chemist	750 Green Lanes, Winchmore Hill, N21 3RE	9:30am - 6:00pm	9:30am - 6:00pm	Closed	Y	N	Y	Y	N	Y	Y	Y	N	N	Y
13	Boots UK Ltd	315-317 Green Lanes, Palmers Green, N13 4YB	8:30am - 6:30pm	8:30am - 6:30pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	N
14	Boots UK Ltd	78 Chase Side, Southgate, N14 5PH	8:00am - 7:00pm	8:00am - 7:00pm	10:00 am - 6:00 pm	Y	N	Y	Y	N	Y	Y	N	N	N	N
15	C & M Whipman Chemists	73 Bramley Road, Oakwood, N14 4EY	9:00am - 7:30pm	Closed	Closed	Y	N	N	N	N	N	N	N	Y	N	N
17	Capricorn Pharmacy	16 Enfield Road, Enfield, EN2 7HW	9:00am – 7:00pm	9.00am - 7.00pm	Closed	Y	N	Y	N	N	Y	Y	N	N	N	N
19	Coopers Chemist	364 Bowes Road, Arnos Grove, N11 1AH	9:00am - 6:00pm	9:00am – 1:00pm	Closed	Y	N	Y	N	N	Y	Y	N	Y	Y	Y
23	Greenacre Pharmacy	9 Station Parade, Cockfosters, Barnet, EN4 0DL	9:00am - 6:00pm	9.00am - 6:00pm	Closed	Y	Y	Y	Y	N	Y	Y	N	N	N	Y

Map index	Name of Pharmacy	Address	Opening hours			Electronic prescription service, as per NHS Choices (Y/N)	Provide appliances (Y/N)	NHS England advanced service providers			NHS England enhanced service providers 2014/15	CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15			
			Mon-Fri opening hours	Sat opening hours	Sun opening hours			MURs	NMS	Stoma customisation	Immunisation service	Minor ailment service	Equipment service (TCES)	Methadone supervision	Needle exchange	Emergency contraception
26	Greens Pharmacy	48 Green Lanes, Palmers Green, N13 6JU	9:00am - 1:00pm 2:00pm - 6:30pm Thurs 9:00am - 6:00 m	9.00am - 6:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	Y
29	Jhoots Pharmacy	44 Cannon Hill, Southgate, N14 6LH	9:00am - 6:00pm Wed 9:30am - 7:00pm	9:00am - 1:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	N
36	LloydsPharmacy	4 Florey Square, Highlands Village, Winchmore Hill, N21 1UJ	8:30 am - 6:30 pm Thurs close 6pm	9:00am - 5:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	N
39	Morrisons Pharmacy	Aldermans Hill, Palmers Green, N13 4YD	9:00am - 8:00pm	9:00am - 8:00pm	10:00am - 4:0 pm	Y	N	Y	Y	N	Y	Y	N	N	N	N
40	Nr Patel Chemists	153 Bowes Road, Palmers Green, N13 4SE	9:00am - 7:00pm	9:00am - 5:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	Y	N	N
41	Palmers Chemist	325 Green Lanes, Palmers Green, N13 4YB	9:00am - 6:00pm	9.00am - 6:00pm	Closed	Y	Y	Y	Y	N	Y	Y	N	N	N	Y
42	Parkview Pharmacy	195 Bramley Road, Southgate, N14 4XA	9:00am - 6.30 pm	9:00am - 6:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	Y	N	N
47	Sainsbury's Pharmacy	681 Green Lanes, Winchmore Hill, N21 3RS	8:00am - 8:00pm	8:00am - 8:00pm	10:00am - 4:00pm	Y	N	Y	Y	N	N	N	N	N	N	N

Map index	Name of Pharmacy	Address	Opening hours			Electronic prescription service, as per NHS Choices (Y/N)	Provide appliances (Y/N)	NHS England advanced service providers			NHS England enhanced service providers 2014/15	CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15			
			Mon-Fri opening hours	Sat opening hours	Sun opening hours			MURs	NMS	Stoma customisation	Immunisation service	Minor ailment service	Equipment service (TCES)	Methadone supervision	Needle exchange	Emergency contraception
49	Simmons Chemist	111 Cockfosters Road, EN4 0DA	9:00am - 1:00pm 2:00pm - 6:30pm Wed close 6:00pm	9:00am - 1:00pm 2:00pm - 5:30pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	N
59	Walker Pharmacy	410-412 Green Lanes, N13 5XG	9:00am - 7:00pm	9:00am - 5:00pm	Closed	Y	Y	Y	Y	N	Y	Y	N	Y	N	Y
60	Waterhouse K Ltd	88 Crown Lane, Southgate, N14 5EN	9:00am - 6:00pm	9:00am - 1:00pm	Closed	Y	Y	Y	Y	N	Y	Y	N	N	N	Y

Map index	Name of Pharmacy	Address	Opening hours			Electronic prescription service, as per NHS Choices (Y/N)	Provide appliances (Y/N)	NHS England advanced service providers			NHS England enhanced service providers 2014/15	CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15			
			Mon-Fri opening hours	Sat opening hours	Sun opening hours			MURs	NMS	Stoma customisation	Immunisation service	Minor ailment service	Equipment service (TCES)	Methadone supervision	Needle exchange	Emergency contraception
South East Enfield																
1	Asda Pharmacy	Edmonton Green Shop Centre, The Broadway, N9 0TS	Mon 8:00am - 11:00pm Tue-Fri 7:00am - 11:00pm	7:00am - 10:00pm	11:00am - 5:00pm	Y	N	Y	Y	N	Y	Y	N	Y	N	Y
6	Aqua Chemists	55 Bounces Road, Edmonton, N9 8JE	Mon-Fri 9:00am - 6:30pm Wed close 5:30pm	9:00am - 1:00pm	Closed	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y
9	Bees Dispensing Chemist	172 Fore St, Edmonton, N18 2JB	9:00am - 7:00pm	9:30am - 6:00pm	Closed	Y	Y	Y	Y	N	Y	Y	N	Y	N	Y
12	Boots UK Ltd	29 North Square, Edmonton Green, N9 0HW	8:00am - 2:00pm 3:00pm - 8:00pm	8:00am - 8:00pm	10:00am - 6:00pm	Y	N	Y	Y	N	Y	Y	N	N	N	Y
21	Estons Pharmacy	93 Fore Street, Edmonton, N18 2TW	9:30am - 7:30pm	9.30am - 6:30pm	Closed	Y	N	Y	N	N	Y	Y	N	Y	N	N
22	Forest Pharmacy	Forest Primary Care Centre, 308a Hertford Rd, Edmonton, N9 7HD	9:00am - 7:00pm	10.00am - 2:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	N
24	Green Cross (London) Ltd	213 Fore Street, Edmonton, N18 2TZ	9:00am - 7:00pm	9:00am - 5:30pm	10:30am - 2:00pm	Y	N	Y	Y	N	Y	Y	N	N	N	Y
25	Green Lanes Pharmacy	Green Lanes Surgery, 808 Green Lanes, Winchmore Hill, N21 2SA	8:00am - 8:00pm	9:00am - 1.30pm	Closed	Y	Y	Y	Y	N	Y	Y	N	N	N	N

Map index	Name of Pharmacy	Address	Opening hours			Electronic prescription service, as per NHS Choices (Y/N)	Provide appliances (Y/N)	NHS England advanced service providers			NHS England enhanced service providers 2014/15	CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15			
			Mon-Fri opening hours	Sat opening hours	Sun opening hours			MURs	NMS	Stoma customisation	Immunisation service	Minor ailment service	Equipment service (TCES)	Methadone supervision	Needle exchange	Emergency contraception
27	Hayward Chemist Ltd	10 Queen Anne's Place, Bush Hill Park, Enfield, EN1 2PT	9:00am - 7:00pm Wed close 6:00pm	9:00am - 6:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	Y	Y	N
30	Lamis Chemists	20 Bush Hill Parade, Village Road, Enfield, EN1 2HB	9:00am - 6:00pm	9:00am - 4:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	N
34	LloydsPharmacy	13 The Concourse, Edmonton Green, N9 0TY	9:00am - 6:00pm	9:00am - 5:00pm	Closed	Y	N	Y	Y	N	N	N	N	Y	N	N
37	LloydsPharmacy	261 Fore Street, Edmonton, N18 2TY	9:00am - 7:00pm	9:00am - 5:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	Y	N	N
43	Reids Pharmacy	1 Cambridge Terrace, Bury Street West, Edmonton, N9 9JJ	9:00am - 6:00pm	9:00am - 5:30pm	Closed	Y	N	Y	Y	N	Y	Y	N	Y	N	Y
44	Rocky's Pharmacy	14 Kendal Parade, Silver Street, N18 1ND	9:00am - 7:00pm Wed close 4pm	9:00am – 2:00pm	Closed	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y
48	Scotts Pharmacy	97-99 Silver Street, Edmonton, N18 1RP	9:00am - 6:30pm	Closed	Closed	Y	N	Y	Y	N	N	N	N	N	N	N
50	Skot Dispensing Chemists	139 Victoria Road, Edmonton, N9 9BA	9:00am - 6:00pm	9:00am - 1:00pm	Closed	Y	Y	Y	N	N	Y	Y	N	N	N	N
51	Superdrug Pharmacy	21 Market Square, Edmonton Green, N9 0TZ	9:00am - 1:15pm 1:45pm - 6:00pm	9:00am - 6:00pm	Closed	Y	N	Y	Y	N	N	N	N	N	N	N

Map index	Name of Pharmacy	Address	Opening hours			Electronic prescription service, as per NHS Choices (Y/N)	Provide appliances (Y/N)	NHS England advanced service providers			NHS England enhanced service providers 2014/15	CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15			
			Mon-Fri opening hours	Sat opening hours	Sun opening hours			MURs	NMS	Stoma customisation	Immunisation service	Minor ailment service	Equipment service (TCES)	Methadone supervision	Needle exchange	Emergency contraception
3	Tesco Extra	1 Glover Drive, Upper Edmonton, N18 3HF	8:00am - 10:30pm, Tue-Fri 6:30am – 10:30pm	6:30am - 10:00pm	11:00am - 5:00pm	Y	N	Y	Y	N	N	N	N	N	N	N

Map index	Name of Pharmacy	Address	Opening hours			Electronic prescription service, as per NHS Choices (Y/N)	Provide appliances (Y/N)	NHS England advanced service providers			NHS England enhanced service providers 2014/15	CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15			
			Mon-Fri opening hours	Sat opening hours	Sun opening hours			MURs	NMS	Stoma customisation	Immunisation service	Minor ailment service	Equipment service (TCES)	Methadone supervision	Needle exchange	Emergency contraception
North West Enfield																
11	Boots UK Limited	30-32 Palace Gardens, Enfield, EN2 6SN	8:30am - 6:00pm Thurs 8:30am - 7:00pm	8:30am - 6:00pm	10:30am - 4:30pm	Y	N	Y	Y	N	Y	Y	N	Y	N	Y
16	C Atkinson Chemist	20 The Grangeway, Grange Park, N21 2HG	9:30am - 6:00pm	9:30am - 6:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	N
32	LloydsPharmacy	198 Lancaster Road, Enfield, EN2 0JH	9:00am - 6:00pm	9:00am - 5:30pm	Closed	Y	N	Y	Y	N	Y	Y	N	Y	N	N
33	LloydsPharmacy	304 Baker Street, 304 Baker Street, EN1 3LD	8:45am - 7:30pm	9:00am - 4:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	Y
61	Whitakers Pharmacy	68 Silver Street, Enfield, EN1 3EW	9.00am-1:00pm 2:00pm - 6:30pm Mon 8:30am - 8:00pm	8:30am - 11:00am	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	N
53	The Co-Operative Pharmacy	66 Silver St, Enfield, EN1 3EP	8:30am - 7:00pm Mon and Thurs 8:30am - 8:00pm	8:30am - 12:30pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	N

Map index	Name of Pharmacy	Address	Opening hours			Electronic prescription service, as per NHS Choices (Y/N)	Provide appliances (Y/N)	NHS England Advanced service providers			NHS England enhanced service providers 2014/15	CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15			
			Mon-Fri opening hours	Sat opening hours	Sun opening hours			MURs	NMS	Stoma customisation	Immunisation service	Minor ailment service	Equipment service (TCES)	Methadone supervision	Needle exchange	Emergency contraception
North East Enfield																
10	Boots UK Ltd	Enfield Retail Park, 2a Crown Road, Enfield, EN1 1TH	8:00am - 8:00pm	8:00am - 6:00pm	10:30am - 4:30pm	Y	N	Y	Y	N	Y	Y	N	N	N	N
18	Care Home Meds (Distance Selling Pharmacy)	20 Jute Lane, Enfield, EN3 7PJ	9:00am - 6:00pm	10:00am - 12.00pm	10:00am - 4:00pm	Y	N	N	N	N	N	N	N	N	N	N
20	Elgon (Enfield) Ltd	Eagle House Surgery, 291 High St, Ponders End, EN3 4DN	9:00am - 7:00pm	9.00am - 12:00pm	Closed	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y
28	Healthfare Pharmacy	9 Coleman Parade, Southbury Road, Enfield, EN1 1YY	9:30am - 7:00pm	9:30am - 5:30pm	Closed	Y	N	Y	Y	N	Y	Y	N	Y	Y	Y
31	LloydsPharmacy	226-228 Hertford Rd, Enfield, EN3 5BH	9:00am - 7:00pm	9:00am - 5:30pm	Closed	Y	N	Y	Y	N	Y	Y	N	Y	Y	N
35	LloydsPharmacy	98a South Street, Ponders End, EN3 4QA	9:00am - 6:30pm	9:00am - 1:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	Y
38	Mk Shah Pharmacy	734-736 Hertford Road, Enfield, EN3 6PR	9:00am - 8:00pm	9:00am - 6:00pm	Closed	Y	N	Y	Y	N	N	N	N	Y	N	N
45	Ronchetti Pharmacy	68 Island Centre Way, The RSA Island Centre, Enfield Lock, EN3 6GS	9:00am - 6:30pm	Closed	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	Y
46	Ronchetti Pharmacy	619 Hertford Road, Enfield, EN3 6UP	9:00am - 7:00pm	9:00am - 6:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	Y	Y	Y
2	Sainsbury's Pharmacy	3 Crown Road, Enfield, EN1 1TH	7:00am - 11:00pm	7:00am - 10:00pm	10:00am - 4:00pm	Y	N	Y	Y	N	Y	Y	N	N	N	N

Map index	Name of Pharmacy	Address	Opening hours			Electronic prescription service, as per NHS Choices (Y/N)	Provide appliances (Y/N)	NHS England Advanced service providers			NHS England enhanced service providers 2014/15	CCG commissioned service providers in 2014/15	Local Authority commissioned service providers in 2014/15			
			Mon-Fri opening hours	Sat opening hours	Sun opening hours			MURs	NMS	Stoma customisation	Immunisation service	Minor ailment service	Equipment service (TCES)	Methadone supervision	Needle exchange	Emergency contraception
4	Tesco In-Store Pharmacy	288 High Street, Ponders End, EN3 4DP	8:00am - 10:30pm Tue-Fri 06:30am – 10:30pm	6:30am - 10:00pm	10:00am - 4:00pm	Y	N	Y	Y	N	Y	Y	N	N	N	N
52	The Co-Operative Pharmacy	255-257 Hertford Road, Enfield, EN3 5JL	9:00am - 7:00pm	Closed	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	Y
54	The Co-Operative Pharmacy	417 Hertford Road, Enfield, EN3 5PT	8:30am - 6:30pm	Closed	Closed	Y	N	Y	Y	N	Y	Y	N	N	N	N
55	Zara Pharmacy	247 High Street, Ponders End, EN3 4DR	9:00am - 6:00pm	9:00am - 5:00pm	Closed	Y	N	Y	Y	N	Y	Y	N	Y	Y	N
56	The Co-Operative Pharmacy	670 Hertford Road, Enfield, EN3 6LZ	9:00am - 7:00pm	9:00am - 6:00pm	Closed	Y	N	Y	Y	N	N	N	N	Y	N	N
57	Virens Chemist	560 Hertford Road, Edmonton, N9 8AG	9:00am – 6:30 m	9:30am - 1:00pm	Closed	Y	N	Y	Y	N	N	N	N	N	N	N
58	VMS Pharmacy Ltd	291 Hertford Road, Edmonton, N9 7ES	9:00am - 6:30pm	10.00am - 2:00pm	Closed	Y	Y	Y	Y	N	Y	Y	N	Y	N	N

Appendix B: PNA steering group terms of reference

Background

The Health and Social Care Act[2] 2012 transferred responsibility for the developing and updating of a Pharmaceutical Needs Assessment (PNA) to Health and Wellbeing Boards (HWBs). The first PNAs were produced by Primary Care Trusts (PCTS) in 2011. "*Healthy lives, healthy people"* the public health strategy for England (2010) states: "Community pharmacies are a valuable and trusted public health resource".

Purpose of the PNA

- The PNA will identify the pharmaceutical services that are needed and those that are currently provided. It will also identify pharmaceutical services that could bring about improvements in or better access to pharmaceutical services.
- The PNA will include details of NHS services commissioned in the borough that could have an impact on the need to commission pharmaceutical services.
- The PNA is a market analysis tool, used to determine market entry in the borough (decisions regarding new contracts and movement of existing pharmacies).
- The PNA is an important tool for identifying how pharmacy services can be used to deliver on the principles and values set out in the NHS Constitution.
- The PNA is of importance to all commissioners of health and wellbeing services.

Health and Wellbeing Board responsibilities

The Health and Wellbeing Board (HWB) has a statutory duty to produce the PNA which has to be published by April 2015.This will require board level sign-off and a minimum period of 60 days public consultation before publication. Failure to produce a robust PNA can lead to legal challenges because of the PNA's relevance to decisions about commissioning services and the opening of additional, new pharmacies.

A good PNA should cover the following:

Regulation 4 and Schedule 1 of the 2013 Regulations[3] outline the minimum requirements for PNAs. A good PNA should cover the following:

- include pharmacies and other services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users
- look at other services, such as dispensing by GP surgeries and services available in neighbouring HWB areas that might affect the need for services in its own area
- examine the demographics of its local population, across the area and in different localities and their needs

- look at the gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs
- contain relevant maps relating to the area and its pharmacies.

Steering group responsibilities

The steering group has responsibility to oversee the production of Enfield's PNA for the Health and Wellbeing Board (HWB) for Enfield, in accordance with the Department of Health (DH) regulations and deadlines:

- the group will ensure that the PNA specifically captures the specific needs of the local population with a focus on reducing inequalities and aligning the existing corporate plans of the HWB, where relevant
- the group will strive to work to the agreed project plan, to ensure that the process falls in line with the timelines and requirements prescribed by the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 which sets out the legislative basis for developing and updating PNAs[3].
- the group will ensure that the findings of the published PNA are disseminated to those who need to know information and who will work towards implementation of any recommendations.

Policy implications

- The PNA will overlap with other corporate strategies and plans such as the Joint Strategic Needs Assessment (JSNA[4]) and other relevant strategies like the Children and Young People's Plan, the local Housing Plan and the Crime and Disorder strategy,
- The PNA should take into account these other relevant strategies and plans to avoid duplication but should not be subsumed into these other documents. It can however be annexed to them.
- The PNA should be treated as a separate document that compliments the other relevant documents.
- The PNA can be used as part of the Joint Strategic Needs Assessment to inform future commissioning strategies.

Governance

The steering group will be governed by the Enfield Health and Wellbeing Board (HWB) and will report the progress of the PNA to the HWB on a quarterly basis.

The HWB will be responsible for approving the consultation document, approving the draft PNA to go for consultation along with the consultation questions and signing off the final PNA.

The Director of Public Health will act as the responsible member of the HWB to maintain the PNA going forward. A suitable member of the Public Health Department, usually a Consultant of Public Health, will chair the meetings and report directly to the Director.

The chair of the PNA steering group has delegated authority from the HWB to make decisions between the quarterly meetings in order to remove blockages and barriers. The chair of the steering group will need to give an account of any actions or decisions to the HWB via the Director of Public health who is the responsible member to the HWB.

All members will be asked to sign a conflict of interest declaration and this will be documented from the onset of the project. Where members declare a conflict which would impact on their ability to make impartial judgement, they will abstain from that decision making process. The PNA is a public document available to all. Some pharmacy data is commercially confidential and cannot be released in the public domain hence this data will be suppressed in accordance with information governance arrangements surrounding their use.

Membership

Membership is drawn from across agencies with a vested interest in the pharmaceutical services. It reflects that pharmacy commissioning involves: NHS England, Public Health and the CCG.

The following will be core members of the steering group:

Name	Job title	Organisation	Role / interest in group
Shahed Ahmad	Director of Public Health	LBE	Project sponsor
Allison Duggal	Public Health Consultant	LBE	Project lead
Estella Makumbi	Public Health Strategist	LBE	Project manager
Naheed Rana	Head of Public health Intelligence	LBE	Public health intelligence lead
Kate Gill-Martin	Legal service	LBE	Legal
Shaun Rogan	Head of Communities, Partnerships and external Relations	LBE	Stakeholder engagement and external relations

Name	Job title	Organisation	Role / interest in group
Janice Green	Communications and Marketing Officer	LBE	Communication and planning
Paul Gouldstone	Heads of Medicines Management	CCG	Medicines management
Subrina Ramdarshan	Prescribing Adviser	CCG	Prescribing advice and author of previous PNA
John James	Board member	Health Watch Enfield	Independent consumer of health and social care
Litsa Worrel	Chair	EVA	Voluntary sector interest
Gerald Alexander	Chair	Enfield, Haringey and Barnet LPC	Local pharmaceutical committee
Greg Cairn	Chair	LMC	Local medical committee
Jason Nair	Senior Commissioning Manager	NHS England	NHS England's input in the process

Communications, Communities and Partnerships and Legal will attend the meetings to provide information and advice to the PNA steering group. Other representatives of partner agents may be invited by the chair to attend the PNA steering group for specific items.

Frequency of meetings

The steering group will meet quarterly each year:

- June 2014
- September 2014
- November / December 2014
- February / March 2015
- June 2015

Some additional business may be performed outside of meetings, but will need to be ratified by the steering group at the next available meeting.

Review

The terms of reference will be reviewed every six months. Next review date is 4th December 2014.

Appendix C: Patient survey

Tell us what you think of pharmacy services

Your local health services want to get a better understanding of how pharmaceutical services are used in your local area. Pharmaceutical services are mostly provided by pharmacies (chemists), though some or all may also be provided by GP dispensing practices and Dispensing Appliance Contractors.

We want to make sure Enfield residents receive the highest quality services and would like to hear all about:

1. Your experiences and opinions of the pharmaceutical services you receive
2. What you would like to change or see improved

We would be grateful if you would take a few minutes to answer the questions below about your own experience and views.

Your answers to this survey are private and will be kept in line with the Data Protection Act 1988. This information will be stored and held by Soar Beyond Ltd on behalf of Enfield County Council

Closing date for this questionnaire is 30th September 2014

Please post the completed questionnaire to:

XXXXXX
XXXXXX
XXXXXX
XXXXXX

Or e-mail the completed form to XXX@XXXX.XXX.XX.X

If you prefer to answer our survey online, please go to

https://www.surveymonkey.com/s/EnfieldPNA_Public_Survey

Should you require this questionnaire in any other format, please contact XXXX on XXXX XXX .

Please base the answers to this questionnaire on the pharmacy that you usually use

Transport, access, and choice of pharmacy

1) How often do you visit your pharmacy in a six month period?

For yourself ☐ For someone else ☐

2) Do you have a regular or preferred pharmacy that you visit?

☐ Yes ☐ No

3) When considering choice of pharmacy, which of the following helps you choose? (You may tick more than one answer)

☐ Close to home
☐ Close to work
☐ Friendly staff
☐ Prefer not to say
☐ Close to GP surgery
☐ They offer a specific service
☐ Other (please specify) ☐

4) Who would you normally visit the pharmacy for?

☐ Yourself ☐ A family member

☐ Someone you are a carer for ☐ Other

5) If you visit your pharmacy on behalf of someone else, please give a reason why

☐ You are the main carer

☐ Opening hours of the pharmacy not suitable for patient

☐ Access (for example disability/transport)

☐ Other

6) How do you usually travel to your regular pharmacy? (Please tick one only)

☐ Walk ☐ Car ☐ Public transport ☐ Bicycle

☐ Other - please specify

7) On average, how long does it take you to travel to a pharmacy?

☐ 0 to 10 minutes ☐ 10 to 20 minutes ☐ 20 to 30 minutes

☐ Over 30 minutes ☐ Don't know/ not sure/ varies

8) Do you have any difficulties when travelling to your pharmacy? (Please tick one only)

☐ Location of pharmacy ☐ Parking difficulties

☐ Public transport availability ☐ No difficulties

9) What is the most convenient day(s) for you to visit your pharmacy?

☐ Monday to Friday ☐ Saturday ☐ Sunday ☐ Don't mind/ varies

10) What time is most convenient for you to visit your pharmacy

☐ Morning ☐ Afternoon ☐ Lunchtime ☐ Early Evening ☐ Late Evening

☐ Don't mind/ varies

Over-the-counter medicines

11) How regularly do you buy an over-the-counter medicine from a pharmacy?

☐ More than once a week ☐ Weekly

☐ More than once a month ☐ Monthly

☐ More than once a year but less than monthly ☐ Yearly

☐ Less regularly ☐ Never

☐ Prefer not to say

12) Do you buy over-the-counter medicines anywhere else?

☐ Nowhere else ☐ Supermarket

☐ The internet ☐ Garage/ petrol station

☐ Local/ community shop ☐ Other Shop

☐ Vending machine ☐ Prefer not to say

Medication and Illness

13) How do you rate the ease of obtaining prescription medication (for example – waiting time or stock availability)?

☐ Very easy ☐ Fairly easy ☐ Fairly difficult ☐ Very difficult

14) Are you provided with sufficient information about your medication (such as dosage and side effects)?

☐ Yes ☐ No

Advice

15) Would you ask your pharmacist for advice about medication prescribed by your GP?

☐ Yes ☐ No

Please give examples

16) Do you know that your pharmacist can provide advice on general health, lifestyle and disease prevention (such as smoking or weight issues)?

☐ Yes ☐ No

17) How would you rate your confidence in the pharmacist's knowledge and advice?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

18) Did you know the pharmacists can give private consultations?

☐ Yes ☐ No

19) Is there a private consultation room available?

☐ Yes ☐ No ☐ Don't know

Services

20) Would you like to see any other services provided by pharmacies?

Such as: Annual review of medication
Cholesterol/lipid measurement and advice
Head lice management
Pregnancy testing
Prescription home delivery service
Smoking Cessation

☐ Yes ☐ No

Other services not identified above

The pharmacy you use

21) Please could we have the name and address of your pharmacy?

22) How would you rate your overall satisfaction with this pharmacy?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

If you have any other comments you would like to make about your pharmacy please write them below

Thank you for your time completing this questionnaire

If you wish to be kept informed about the Pharmaceutical Needs Assessment and the consultation we will be running in the near future, you can give us your contact details here:

Your information will only be used for the purpose of informing you of the consultation.

Name

Address

Telephone

Email

Alternatively, you can contact XXXXX by either:

Emailing XXXX@XXXX.XXX.XXX

Calling XXXX XXX XXXX

Writing to: Freepost, XXXX, XXXX, XXXX,XXXX,XXXX.

Equalities Monitoring

The completion of the following will be a great help to us in planning appropriate services for the whole community. Please put a tick in the boxes that apply to you.

1) Please tick the box that best describes your ethnicity?

- ☐ British
- ☐ White and Black Caribbean
- ☐ Greek Cypriot
- ☐ Pakistani
- ☐ Kurdish
- ☐ Caribbean
- ☐ Russian
- ☐ Nigerian
- ☐ Chinese
- ☐ Do not wish to state
- ☐ White and Black African
- ☐ Greek
- ☐ Indian
- ☐ Turkish Cypriot
- ☐ Sri Lankan
- ☐ Polish
- ☐ Ghanaian
- ☐ Gypsy / Romany
- ☐ Other - please state
- ☐ Irish
- ☐ White and Asian
- ☐ Turkish
- ☐ Bangladeshi
- ☐ Italian
- ☐ African
- ☐ Traveller
- ☐ Somali

2) Are you: ☐ Male ☐ Female

3) Do you consider yourself to have a disability or long-term illness? ☐ Yes ☐ No

4) How old are you?

☐ 16 - 19 ☐ 20 - 29 ☐ 30 - 39 ☐ 40 - 49 ☐ 50 – 59
☐ 60 – 69 ☐ 70 – 79 ☐ 80 - 89 ☐ 90 and over ☐ Do not wish to state

5) Please tick the postcode area you live in:

☐ EN1 ☐ EN2 ☐ EN3 ☐ EN4 ☐ EN8 ☐ N9 ☐ N11 ☐ N13
☐ N14 ☐ N18 ☐ N21 ☐ N22 ☐ Other - please state

6) How did you find out about this questionnaire?

- ☐ From the Enfield Council website
- ☐ Through my social worker / care manager
- ☐ An advert in the local paper
- ☐ GP surgery / clinic
- ☐ Other - please state
- ☐ From another website
- ☐ Voluntary / community group
- ☐ From a poster
- ☐ Library

Appendix D: Pharmacy contractor survey

Enfield Pharmacy Contractor Questionnaire

Premises Details

***1. Contractor Code (ODS Code)**

***2. Name of contractor (i.e. name of individual, partnership or company owning the pharmacy business)**

***3. Trading name**

***4. Is this pharmacy a Distance Selling Pharmacy? (i.e. it cannot provide Essential Services to persons present at the pharmacy)**

- ◯ Yes
- ◯ No

***5. Pharmacy email address**

***6. Pharmacy telephone**

7. Pharmacy fax

8. Pharmacy website address

***9. Can we store the above information and use this to contact you?**

- ◯ Yes
- ◯ No

***10. Core opening hours**

	Open from	To	Lunchtime (From - To)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Enfield Pharmacy Contractor Questionnaire

11. Total opening hours

	Open from	To	Lunchtime (From - To)
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Consultation Facilities

***12. On the premises, is there a consultation area (meeting the criteria for the Medicines Use Review service)?**

- ◯ None
- ◯ Available (including wheelchair access)
- ◯ Available (without wheelchair access)
- ◯ Planned within the next 12 months

Other (please specify)

13. Where there is a consultation area, is it a closed room?

- ◯ Yes
- ◯ No

***14. Does the pharmacy have access to an off-site consultation area (i.e. one which the former PCT or Area Team has given consent for use)**

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Not applicable

***15. Is the pharmacy willing to undertake consultations in patient's home/ other suitable site?**

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Not applicable

Enfield Pharmacy Contractor Questionnaire

***16. During consultations, are there hand-washing facilities?**

- ◯ In the consultation area
- ◯ Close to the consultation area
- ◯ None

***17. Do patients attending consultations have access to toilet facilities?**

- ◯ Yes
- ◯ No

18. Languages spoken (in addition to English)

IT Facilities

***19. Electronic Prescription Service (select any that apply)**

- ☐ Release 1 enabled
- ☐ Release 2 enabled
- ☐ Intending to become Release 1 enabled within next 12 months
- ☐ Intending to become Release 2 enabled within next 12 months
- ☐ No plans for EPS at present

Services

***20. Does the pharmacy dispense appliances?**

- ◯ Yes, all types
- ◯ Yes, excluding stoma appliances
- ◯ Yes, excluding incontinence appliances
- ◯ Yes, excluding stoma and incontinence appliances
- ◯ Yes, just dressings
- ◯ None

Other (please specify)

Enfield Pharmacy Contractor Questionnaire

***21. Does the pharmacy provide the following advanced services?**

	Yes	Intending to begin within next 12 months	No - not intending to provide
Medicines Use Review service	◯	◯	◯
New Medicine Service	◯	◯	◯
Appliance Use Review service	◯	◯	◯
Stoma Appliance Customisation service	◯	◯	◯

***22. Which of the following services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Anticoagulant Monitoring Service	◯	◯	◯	◯	◯
Anti-viral Distribution Service	◯	◯	◯	◯	◯
Care Home Service	◯	◯	◯	◯	◯
Chlamydia Testing Service	◯	◯	◯	◯	◯
Chlamydia Treatment Service	◯	◯	◯	◯	◯
Contraceptive Service (not EHC)	◯	◯	◯	◯	◯

Enfield Pharmacy Contractor Questionnaire

***23. Which of the following Disease Specific Medicines Management services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Allergies	○	○	○	○	○
Alzheimer's/dementia	○	○	○	○	○
Asthma	○	○	○	○	○
CHD	○	○	○	○	○
COPD	○	○	○	○	○
Depression	○	○	○	○	○
Diabetes type I	○	○	○	○	○
Diabetes type II	○	○	○	○	○
Epilepsy	○	○	○	○	○
Heart Failure	○	○	○	○	○
Hypertension	○	○	○	○	○
Parkinson's disease	○	○	○	○	○

Other (please specify)

***24. Which of the following services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Emergency Hormonal Contraception Service	○	○	○	○	○
Gluten Free Food Supply Service(i.e. not via FP10)	○	○	○	○	○
Home Delivery Service (not appliances)	○	○	○	○	○
Independent Prescribing Service	○	○	○	○	○

If currently providing an Independent Prescribing Service, what therapeutic areas are covered

Enfield Pharmacy Contractor Questionnaire

***25. Which of the following services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Language Access Service	◯	◯	◯	◯	◯
Medication Review Service	◯	◯	◯	◯	◯
Medicines Assessment and Compliance Support Service	◯	◯	◯	◯	◯
Minor Ailment Scheme	◯	◯	◯	◯	◯
MUR plus/ Medicines Optimisation Service	◯	◯	◯	◯	◯

If currently providing MUR plus/ Medicines Optimisation Service, what therapeutic areas are covered?

Enfield Pharmacy Contractor Questionnaire

***26. Which of the following services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Needle and Syringe Exchange Service	◯	◯	◯	◯	◯
Obesity management (adults and children)	◯	◯	◯	◯	◯
On Demand Availability of Specialist Drugs Service	◯	◯	◯	◯	◯
Out of Hours Services	◯	◯	◯	◯	◯
Patient Group Direction Service (name the medicines covered by the Patient Group direction below)	◯	◯	◯	◯	◯
Phlebotomy Service	◯	◯	◯	◯	◯
Prescriber Support Service	◯	◯	◯	◯	◯
Schools Service	◯	◯	◯	◯	◯

Name here

Enfield Pharmacy Contractor Questionnaire

***27. Which of the following screening services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Alcohol	○	○	○	○	○
Cholesterol	○	○	○	○	○
Diabetes	○	○	○	○	○
Gonorrhoea	○	○	○	○	○
H.pylori	○	○	○	○	○
HbA1c	○	○	○	○	○
Hepatitis	○	○	○	○	○
HIV	○	○	○	○	○
Seasonal Influenza Vaccination Service	○	○	○	○	○

Other (please specify)

***28. Which of the following other vaccination services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Childhood vaccinations	○	○	○	○	○
Hepatitis (at risk workers or patients)	○	○	○	○	○
HPV	○	○	○	○	○
Travel vaccines	○	○	○	○	○

Other (please specify)

Enfield Pharmacy Contractor Questionnaire

***29. Which of the following services does the pharmacy provide, or would be willing to provide?**

	Currently providing under contract with Area Team	Currently providing under contract with CCG	Currently providing under contract with Local Authority	Willing to provide if commissioned	Not able or willing to provide
Sharps Disposal Service	◯	◯	◯	◯	◯
Stop Smoking Service	◯	◯	◯	◯	◯
Supervised Administration Service	◯	◯	◯	◯	◯
Vascular Risk Assessment Service (NHS Health Check)	◯	◯	◯	◯	◯

Supplementary Prescribing Service (what therapeutic areas are covered?)

Non-commissioned Services

Enfield Pharmacy Contractor Questionnaire

***30. Does the pharmacy provide any of the following?**

	Yes	No
Collection of prescriptions from GP practices	◯	◯
Delivery of dispensed medicines - Free of charge on request	◯	◯
Delivery of dispensed medicines - Selected patient groups (list criteria in Other below)	◯	◯
Delivery of dispensed medicines - Selected areas (list areas in Other below)	◯	◯
Delivery of dispensed medicines - chargeable	◯	◯

Other (please specify)

***31. Contact name of person completing questionnaire, if questions arise**

***32. Contact telephone number**

Appendix E: Commissioner survey.

Enfield Locally Commissioned Services - Community Pharmacy

1. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Anticoagulant Monitoring Service	○	○	○	○	○
Anti-viral Distribution Service	○	○	○	○	○
Care Home Service	○	○	○	○	○
Chlamydia Testing Service	○	○	○	○	○
Chlamydia Treatment Service	○	○	○	○	○
Contraceptive service (not EHC)	○	○	○	○	○

Disease Specific Medicines Management Service

Enfield Locally Commissioned Services - Community Pharmacy

2. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Allergy management service					
Alzheimers/dementia management service					
Asthma management service					
CHD management service					
COPD management service					
Depression management service					
Diabetes type I management service					
Diabetes type II management service					
Epilepsy management service					
Heart Failure management service					
Hypertension management service					
Parkinson's disease					
Emergency Hormonal Contraception Service					
Gluten Free Food Supply Service (i.e. not via FP10)					
Home Delivery Service (not appliances)					
Independent Prescribing Service					
If currently providing an Independent Prescribing Service,					

Enfield Locally Commissioned Services - Community Pharmacy

what therapeutic areas are covered?					
Language Access Service	○	○	○	○	○
Medication Review Service	○	○	○	○	○
Medicines Assessment and Compliance Support Service	○	○	○	○	○
Minor Ailment Scheme	○	○	○	○	○
MUR Plus/Medicines Optimisation Service	○	○	○	○	○
If currently providing an MUR Plus/ Medicines Optimisation Service, what therapeutic areas are covered?	○	○	○	○	○
Needle and Syringe Exchange Service	○	○	○	○	○
Obesity management (adults and children)	○	○	○	○	○
On Demand Availability of Specialist Drugs Service	○	○	○	○	○
Out of Hours Services	○	○	○	○	○
Patient Group Direction Service (name the medicines covered by the Patient Group Direction)	○	○	○	○	○
Phlebotomy Service	○	○	○	○	○
Prescriber Support Service	○	○	○	○	○
Schools Service	○	○	○	○	○
Other (please state)	○	○	○	○	○

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Enfield Locally Commissioned Services - Community Pharmacy

Screening Service

3. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Alcohol screening service	○	○	○	○	○
Cholesterol screening service	○	○	○	○	○
Diabetes screening service	○	○	○	○	○
Gonorrhoea screening service	○	○	○	○	○
H. pylori screening service	○	○	○	○	○
HbA1C screening service	○	○	○	○	○
Hepatitis screening service	○	○	○	○	○
HIV screening service	○	○	○	○	○
Seasonal Influenza Vaccination Service(2)	○	○	○	○	○
Other (please state below)	○	○	○	○	○

Other Vaccinations

Enfield Locally Commissioned Services - Community Pharmacy

4. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Childhood vaccinations					
Hepatitis (at risk workers or patients)					
HPV					
Travel vaccines					

Other miscellaneous

5. Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Sharps Disposal Service					
Stop Smoking Service					
Supervised Administration Service					
Supplementary Prescribing Service (what therapeutic areas are covered?)					
Vascular Risk Assessment Service (NHS Health Check)					
Other (please state below)					

Enfield Locally Commissioned Services - Community Pharmacy

Thank you for completing this survey.

Your answers to this survey are private and will be kept in line with the Data Protection Act.

Appendix F: PNA timeline

Stage	Dates	Key actions	Outcomes
Set up	June-Sept 2014	• HWB paper to outline PNA responsibilities • First steering group meetings • Produce project plan and secure resources. • Agree work stream plans and timelines.	• Delegated authority to PNA Steering Group for PNA production. Isolation of necessary funding and resource for PNA production • Formation of PNA Steering Group and PNA Project Group. Roles and responsibilities defined. Terms of Reference and meeting dates agreed
Information finding	Sept-Oct 2014	• Second steering group meeting	• Work streams and timeline agreed • Public and pharmacy questionnaires agreed • Consultation plan drafted • Localities agreed • Maps agreed • Public Health and Pharmaceutical provision information presented • Results from public and pharmacy questionnaires presented • Pharmaceutical provision and access maps presented
Analysis	Oct-Nov 2014	• Third steering group meeting • Further, focussed public engagement	• Analysis of information finding. Collation of findings to inform draft PNA. Consideration of need for further public qualitative feedback • Identification and agreement to any potential gaps in provision of services • Agreement of consultation plan
Draft PNA production	Nov 2014	• Electronic circulation of various draft PNA documents to steering group members • HWB Board paper	• Agreement of final draft PNA for consultation • Presentation to HWB on progress and draft PNA

Stage	Dates	Key actions	Outcomes
Consultation	1st Dec 2014 to 31st Jan 2015	• Complete 60 day consultation as per regulations	• Distribution and (60 day) consultation on draft PNA • Feedback obtained on draft PNA • Collation of responses to consultation
Final considerations	Feb 2015	• Fourth steering group meeting	• Analysis of consultation responses • Agreement on Final PNA
HWB approval	March 2015	• Health and Wellbeing Board report	• Approval and sign-off by HWB Board of Final PNA • Obtain HWB approval and resource allocation for ongoing review / update PNA
Publish Final PNA	March 2015	• Circulate final PNA and host on HWB / Council website	• HWB PNA now 'live' and used by NHS England to consider 'Control of Entry' applications

Appendix G: Consultation plan and list of stakeholders

PNA Engagement and Consultation Plan								
Stakeholder		**Engagement during PNA production**			**Draft PNA consultation**			
	Role	**PNA briefing letter sent (Y/N)**	**Steering group representation (Y/N)**	**Questionnaire (pharmacy contractor / service user / commissioner)**	**Briefing letter sent (Y/N)**	**Draft PNA summary and link to full document sent (Y/N)**	**Meeting / workshop attendance**	**Other**
Consultees as required by Pharmaceutical regulations, 2103, Part 2 (8)	HWB Area LPC	Y	Y	User questionnaire	Y	Y	No further activity undertaken	
	HWB Area LMC	Y	Y	User questionnaire	Y	Y		
	All pharmacy contractors in Enfield	Y	N	User questionnaire Pharmacy questionnaire	Y	Y		
	Pharmacy commissioner CCG	N	N	Commissioner questionnaire	Y	Y		
	Dispensing appliance contractor	N	N	Commissioner questionnaire	Y	Y		
	LA participation groups and forum	N	N	User questionnaire	Y	Y		
	Various relevant focus groups	N	N	User questionnaire	Y	Y		
	Various relevant participation group	N	N	User questionnaire	Y	Y		

PNA Engagement and Consultation Plan								
Stakeholder		Engagement during PNA production			Draft PNA consultation			
	Role	PNA briefing letter sent (Y/N)	Steering group representation (Y/N)	Questionnaire (pharmacy contractor / service user / commissioner)	Briefing letter sent (Y/N)	Draft PNA summary and link to full document sent (Y/N)	Meeting / workshop attendance	Other
	Various relevant forum	N	N	User questionnaire	Y	Y	No further activity undertaken	
	GP Surgeries	Y	N	User questionnaire	Y	Y		
	Enfield Local Healthwatch	Y	Y	User questionnaire	Y	Y		
	Voluntary community groups	N	N	User questionnaire	Y	Y		
	Physical disability residential homes	N	N	User questionnaire	Y	Y		
	Older people's residential homes	N	N	User questionnaire	Y	Y		
	Various relevant patient groups	Y	Y	User questionnaire	Y	Y		
	Enfield Voluntary Action (EVA)	N	Y	User questionnaire	Y	Y		
	Various relevant community groups	N	Y	User questionnaire	Y	Y		
	Royal Free Hospital NHS Trust (Chase Farm Hospital)	N	N	None	Y	Y		

PNA Engagement and Consultation Plan								
Stakeholder		Engagement during PNA production			Draft PNA consultation			
	Role	PNA briefing letter sent (Y/N)	Steering group representation (Y/N)	Questionnaire (pharmacy contractor / service user / commissioner)	Briefing letter sent (Y/N)	Draft PNA summary and link to full document sent (Y/N)	Meeting / workshop attendance	Other
	North Middlesex University Hospital	N	N	None	Y	Y		
	NHS England Area Team	Y	Y	Commissioner questionnaire	Y	Y		
	Hertfordshire HWB	N	N	None	Y	Y		
	Waltham Forest HWB	N	N	None	Y	Y		
	Barnet HWB	N	N	None	Y	Y		
	Haringey HWB	N	N	None	Y	Y		
	Hertfordshire LPC	N	N	None	Y	Y		
	Enfield public	N	N	User questionnaire	Y	N	No further activity undertaken	Enfield Staff Matters -e newsletter and posters

PNA Engagement and Consultation Plan								
Stakeholder		**Engagement during PNA production**			**Draft PNA consultation**			
	Role	**PNA briefing letter sent (Y/N)**	**Steering group representation (Y/N)**	**Questionnaire (pharmacy contractor / service user / commissioner)**	**Briefing letter sent (Y/N)**	**Draft PNA summary and link to full document sent (Y/N)**	**Meeting / workshop attendance**	**Other**
	Enfield public	N	N	User questionnaire	Y	N	No further activity undertaken	Use of Council social media accounts to promote: Twitter etc
		N	N	User questionnaire	Y	N		TV screens in entrance and posters
		N	N	User questionnaire	Y	N		Article in local news paper
Other consultees	Waltham Forest LPC	N	N	None	Y	N	No further activity undertaken	
	Barnet LPC	Y	Y	None	Y	N		
	Haringey LPC	Y	Y	None	Y	N		

PNA Engagement and Consultation Plan								
Stakeholder		Engagement during PNA production			Draft PNA consultation			
	Role	PNA briefing letter sent (Y/N)	Steering group representation (Y/N)	Questionnaire (pharmacy contractor / service user / commissioner)	Briefing letter sent (Y/N)	Draft PNA summary and link to full document sent (Y/N)	Meeting / workshop attendance	Other
	Hertfordshire LMC	N	N	None	Y	N	No further activity undertaken	
	Waltham Forest LMC	N	N	None	Y	N		
	Barnet LMC	N	N	None	Y	N		
	Haringey LMC	N	N	None	Y	N		
	Enfield CCG	Y	Y	Commissioner questionnaire	Y	N		

Appendix H: Summary of consultation responses and comments

As required by the Pharmaceutical Regulations 2013[5], Enfield HWB held a 60 day consultation on the draft PNA from 1st December 2014 to 31st January 2015.

The draft PNA was hosted on the both the front page and the Current Consultation sections of the Enfield Council website and invitations to review the assessment, and comment, were sent to a wide range of stakeholders including all community pharmacies in Enfield. The Council website has a translation function (including the most commonly used languages in the borough) that translates the text into various languages, including the most commonly used languages in the borough. The website also has the functionality to be listened to or format the content so that the colour and size of the font can be changed. The website also provided contact details for anyone who required assistance to get involved or had any queries.

A number of members of the public had expressed an interest in the PNA and were invited to participate in the consultation as well as a range of public engagement groups in Enfield as identified by Enfield Council and Enfield Healthwatch. Responses to the consultation were possible via an online survey, paper or email.

There were in total 29 responses. Of the 29, 24 provided details on what basis they were responding to the consultation. Of responses, 50% were received from the public, 12.5% from pharmacists, 12.5% from healthcare or social care providers, 4% from pharmacy owners, 8.5% from GPs and 12.5% from 'other'.

The following are the main themes, and PNA Steering Group's response, to feedback received during the consultation on the draft PNA:

- information provided in the PNA
- consideration which services are 'necessary' and 'relevant':
- issues over access to services:
- availability of services currently, and not currently, provided by pharmacies
- correction of data in the PNA

All responses were considered by the PNA Steering Group at its meeting on 26th February 2015 for the final report.

A number of additional comments were received that were considered by the steering group in the production of the final PNA. A copy of these comments have been published separately to this PNA. Should you wish to view these comments please contact Allison Duggal, Public Health Consultant, Community Housing services, Housing Strategy Team, Enfield Council, FREEPOST NW5036, 9th Floor, Civic centre, Enfield EN1 3BR.

Below is a summary of responses to the specific questions asked during the consultation.

The consultation returned only 29 responses so the analysis must be considered indicative rather than authoritative. Within the very small sample of responses, a number of trends were identified:

- on the whole, the majority of respondents believed that the PNA was fit for purpose and that its purpose was clear
- the majority of respondents believed that the analysis that there are no gaps in the provision of pharmaceutical services was true
- the majority of respondents believed that the PNA reflects current pharmaceutical services, needs and future needs in Enfield
- the majority of respondents believed that the PNA provides an accurate picture of pharmaceutical services currently provided in the borough
- participants who responded to a question directed at NHS England largely believed that the PNA provides adequate information to inform market entry decisions
- participants who responded to a question directed at commissioners largely believed that the PNA provides adequate information to inform future commissioning decisions
- the majority of respondents believed that the PNA will help commissioners and local pharmacy service providers identify and address any gaps in pharmaceutical services
- the majority of respondents believed that the PNA will help commissioners and local pharmacy service providers target services to reduce health inequalities within local health communities
- the majority of respondents were not aware of any pharmaceutical services currently provided in Enfield which had not been included
- the majority of participants who responded to a question directed at those who own or represent community pharmacies believed that the information relating to opening hours and that the information relating to service provision is correct
- the majority of respondents felt confident that the current version of the Enfield PNA will help to improve the commissioning of pharmaceutical services

In order to encourage residents to engage in the PNA consultation an awareness campaign was coordinated. The campaign involved:

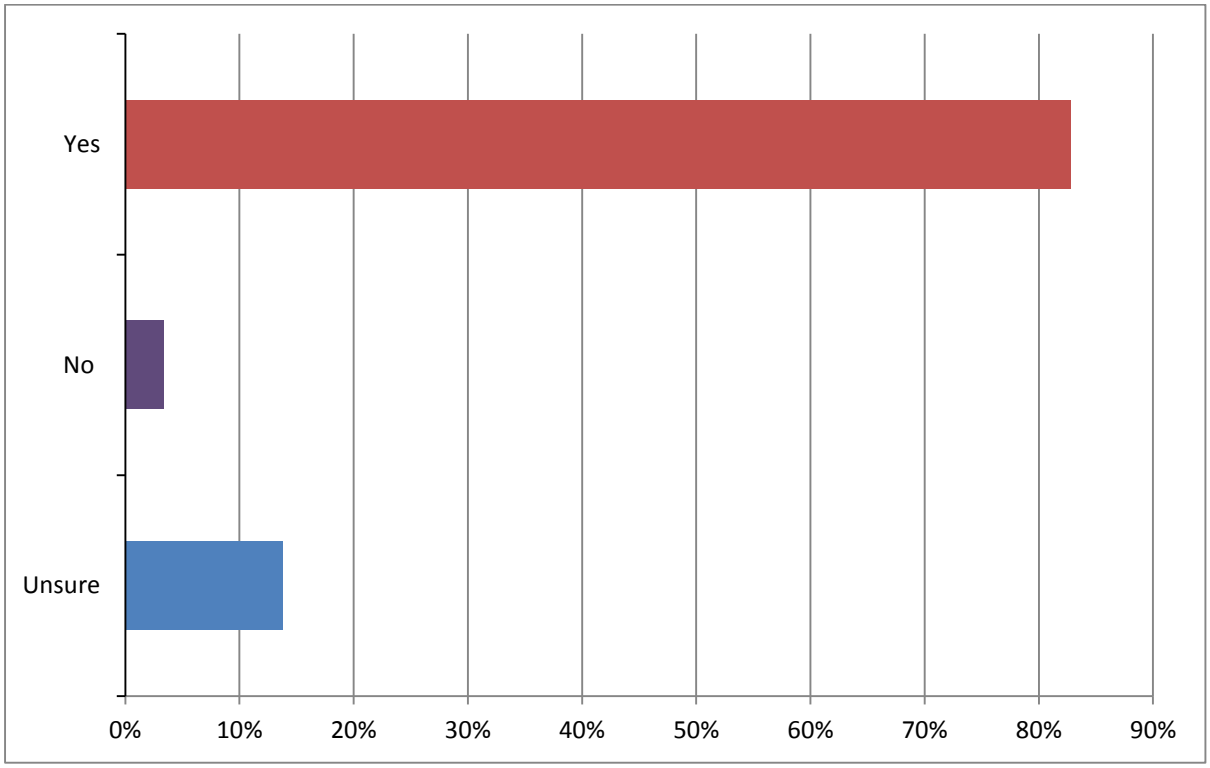
- posters in family centres / pharmacies / GPs / civic buildings / libraries etc
- distributing A5 flyers in family centres / pharmacists / GPs / civic buildings / libraries etc

- putting an article / advert in local and ethnic papers
- internal publicity in the Council
- social media publicity
- a press release

The PNA consultation summary and survey, 2000 copies in total, were sent out to various council buildings (libraries, council reception etc) for consultation. From these, 29 completed questionnaires were returned. The following sections describe the results of the questionnaire.

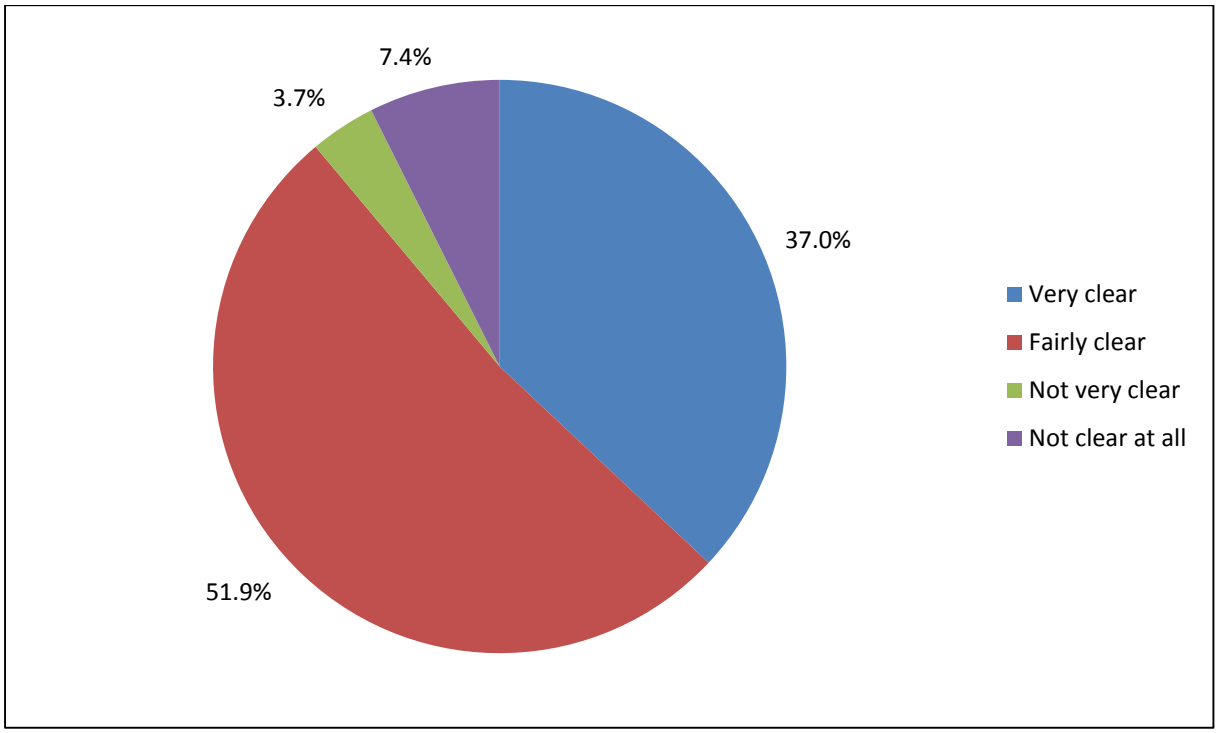
Section 1: Responses to the PNA questionnaire

1. On the whole, do you think the draft Enfield Pharmaceutical Needs Assessment is fit for purpose?



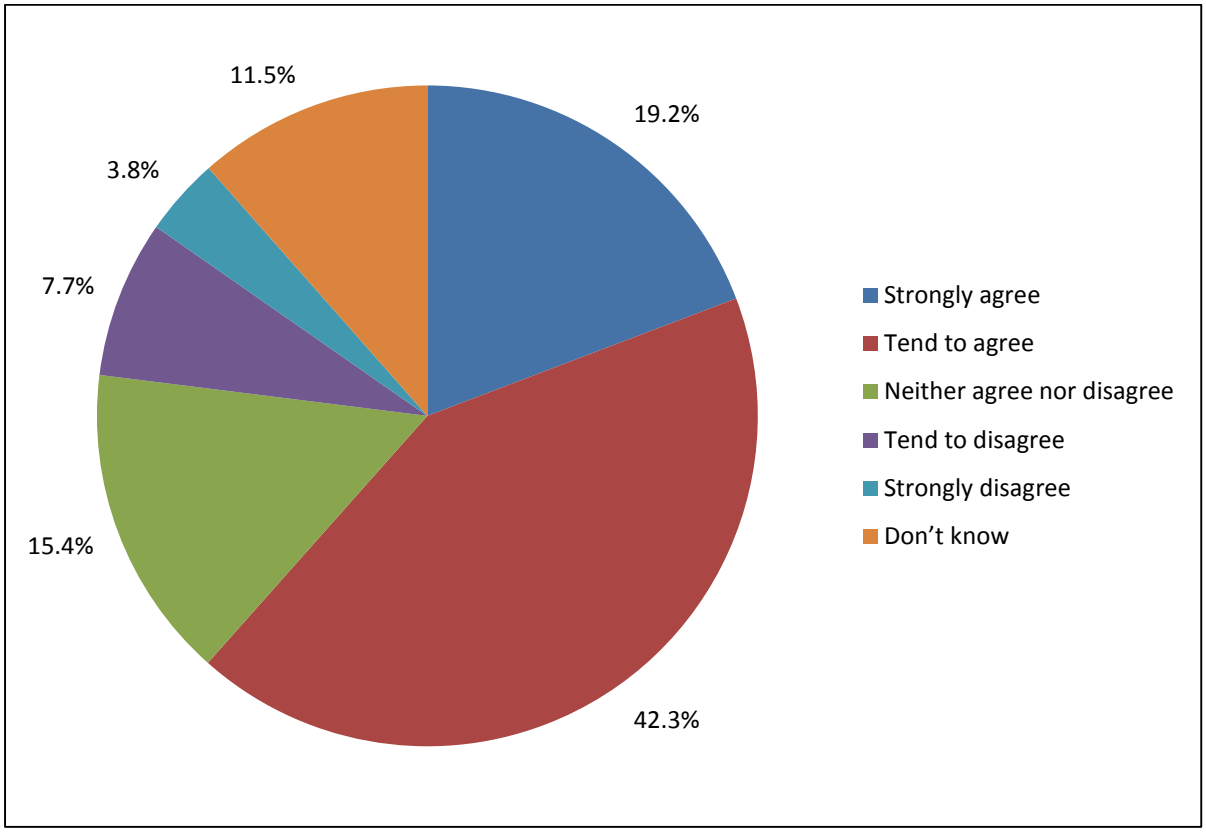
Answer Choices	Responses (%)	Responses (number)
Yes	82.8%	24
No	3.4%	1
Unsure	82.8%	4

2. Do you think the purpose of the Enfield PNA, as described on page 14 of the draft PNA document, is clear?



Answer Choices	Responses (%)	Responses (number)
Very clear	37.0%	10
Fairly clear	51.9%	14
Not very clear	3.7%	1
Not clear at all	7.4%	2

3. In producing the draft Enfield PNA, analysis indicates there are no identified gaps in the provision of pharmaceutical services. To what extent do you agree or disagree with this indication?

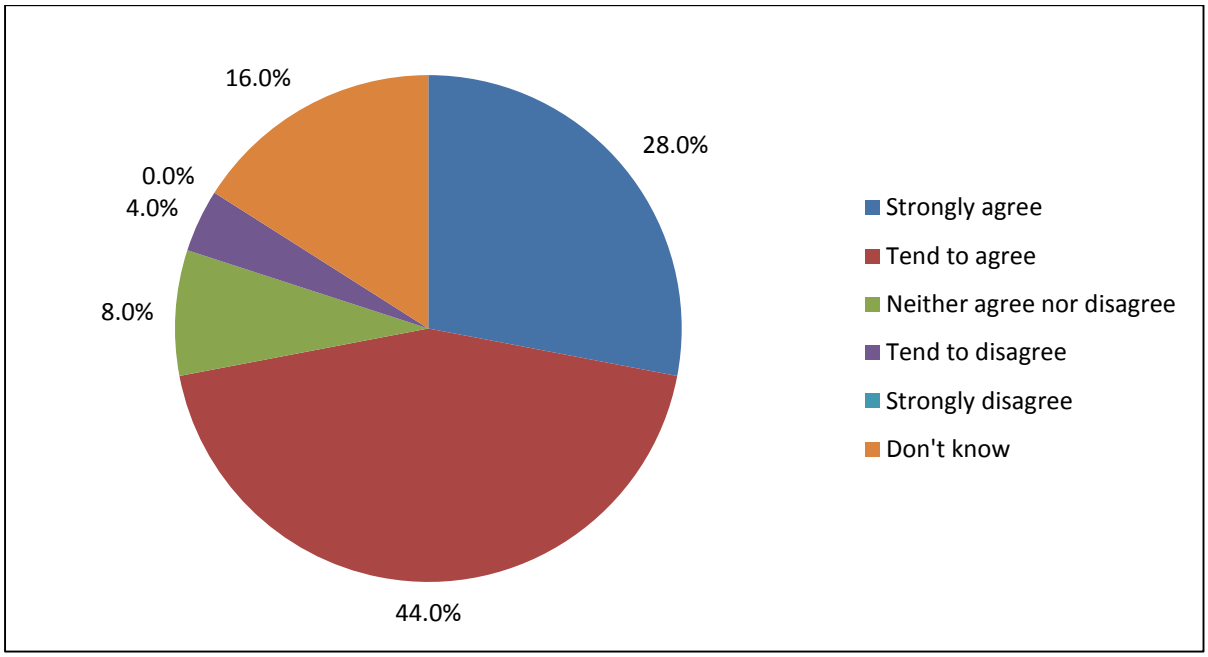


Answer Choices	Responses (%)	Responses (number)
Strongly agree	19.2%	5
Tend to agree	42.3%	11
Neither agree nor disagree	15.4%	4
Tend to disagree	7.7%	2
Strongly disagree	3.8%	1
Don't know	11.5%	3

3a. Please tell us why you disagree.

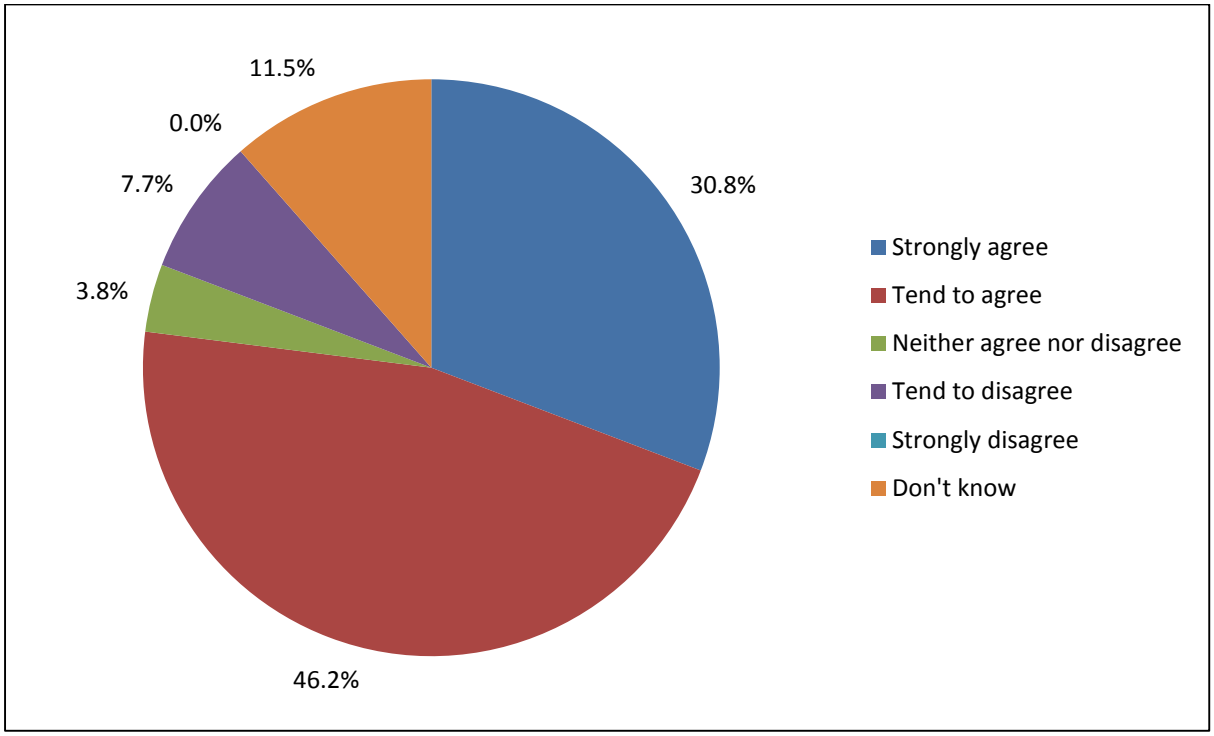
In some places there are 2 - 3 pharmacists within a small distance away and other places there are none.
I have found it hard to obtain medication to treat my type 1 diabetes.

4. To what extent do you agree or disagree the PNA reflects the current pharmaceutical services in Enfield?



Answer Choices	Responses (%)	Responses (number)
Strongly agree	28.0%	7
Tend to agree	44.0%	11
Neither agree nor disagree	8.0%	2
Tend to disagree	4.0%	1
Strongly disagree	0.0%	0
Don't know	16.0%	4

5. To what extent do you agree or disagree the PNA reflects the current pharmaceutical need in Enfield?

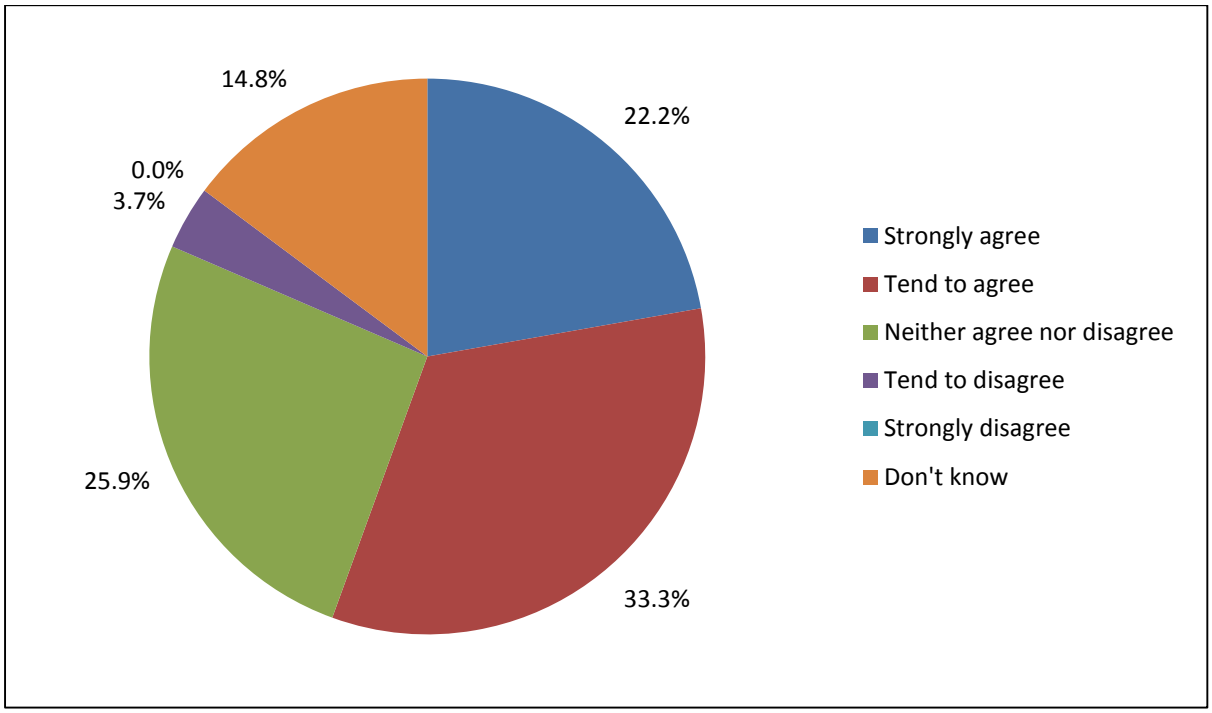


Answer Choices	Responses (%)	Responses (number)
Strongly agree	30.8%	8
Tend to agree	46.2%	12
Neither agree nor disagree	3.8%	1
Tend to disagree	7.7%	2
Strongly disagree	0.0%	0
Don't know	11.5%	3

5a. Please tell us why you disagree.

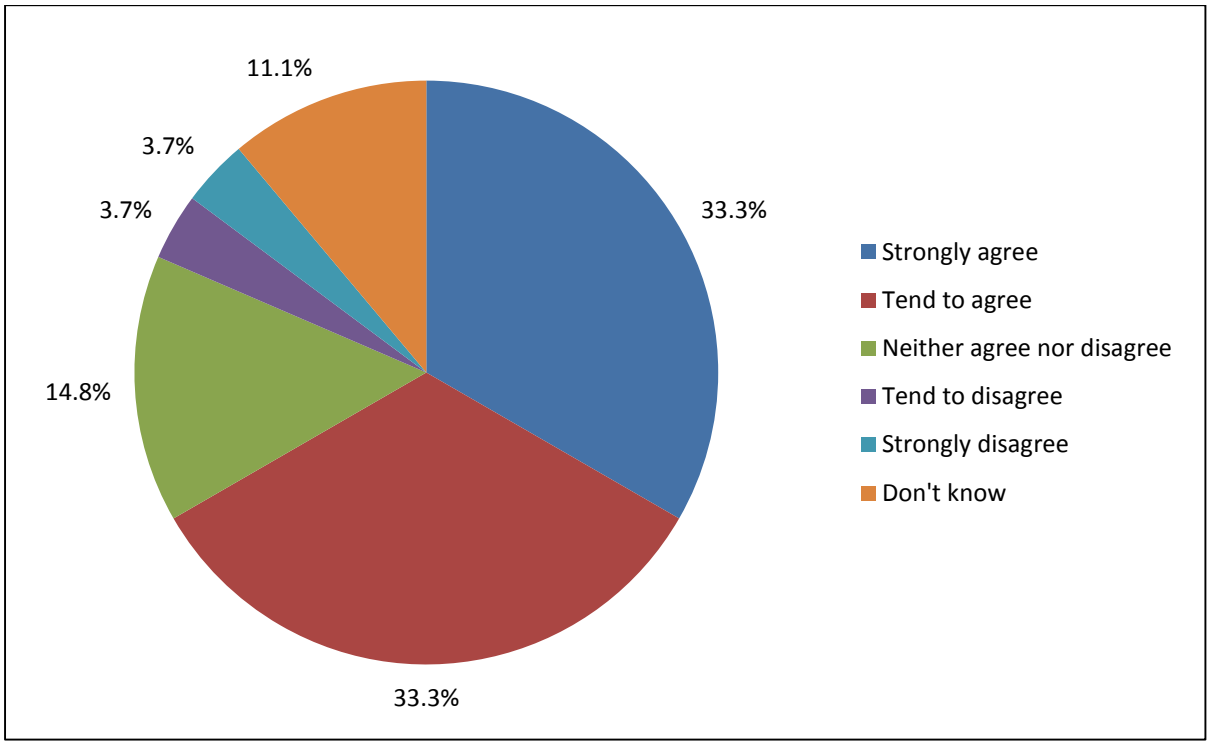
I am unable to obtain the medication prescribed by my diabetic consultant.

6. To what extent do you agree or disagree the PNA reflects the future needs of Enfield population over the next three years?



Answer Choices	Responses (%)	Responses (number)
Strongly agree	22.2%	6
Tend to agree	33.3%	9
Neither agree nor disagree	25.9%	7
Tend to disagree	3.7%	1
Strongly disagree	0.0%	0
Don't know	14.8%	4

7. To what extent do you agree or disagree the PNA provides an accurate picture of pharmaceutical services currently provided in the borough of Enfield?

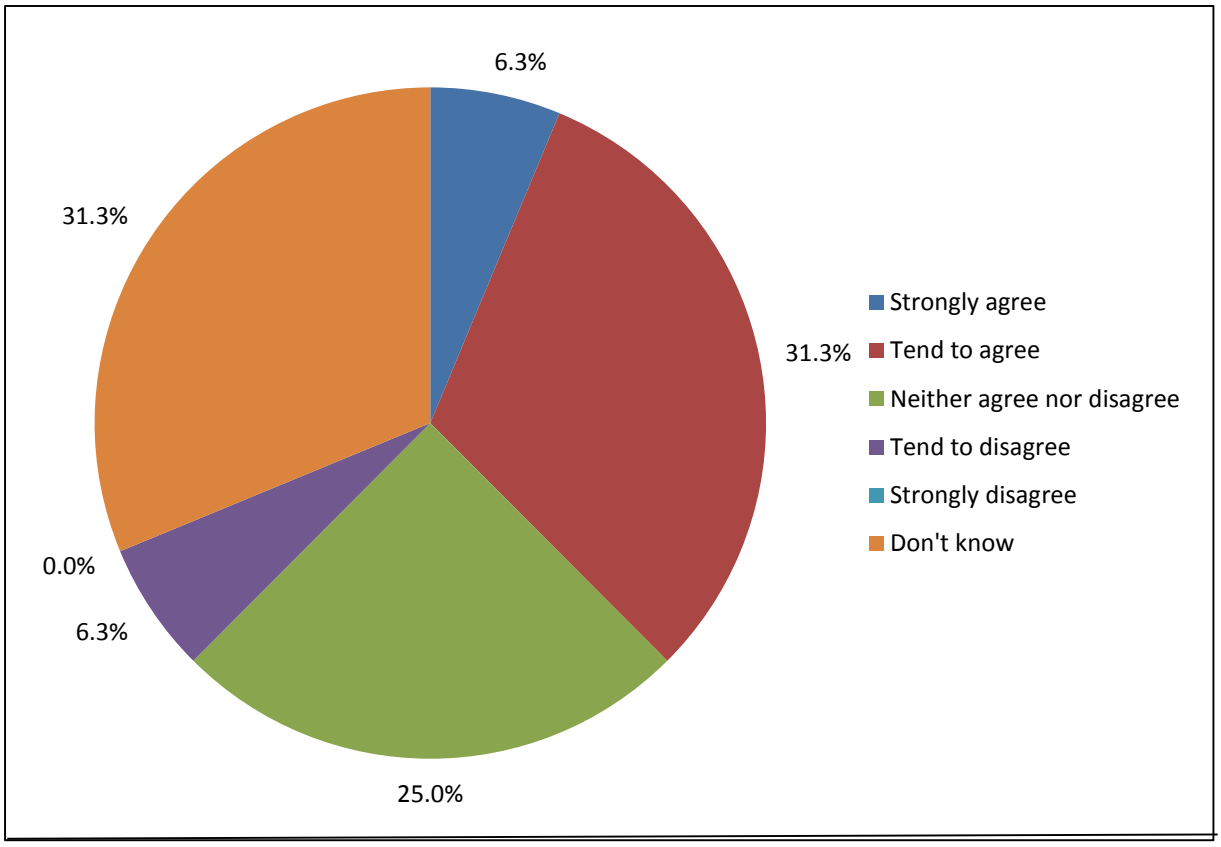


Answer Choices	Responses (%)	Responses (number)
Strongly agree	33.3%	9
Tend to agree	33.3%	9
Neither agree nor disagree	14.8%	4
Tend to disagree	3.7%	1
Strongly disagree	3.7%	1
Don't know	11.1%	3

7a. Please tell us why you disagree.

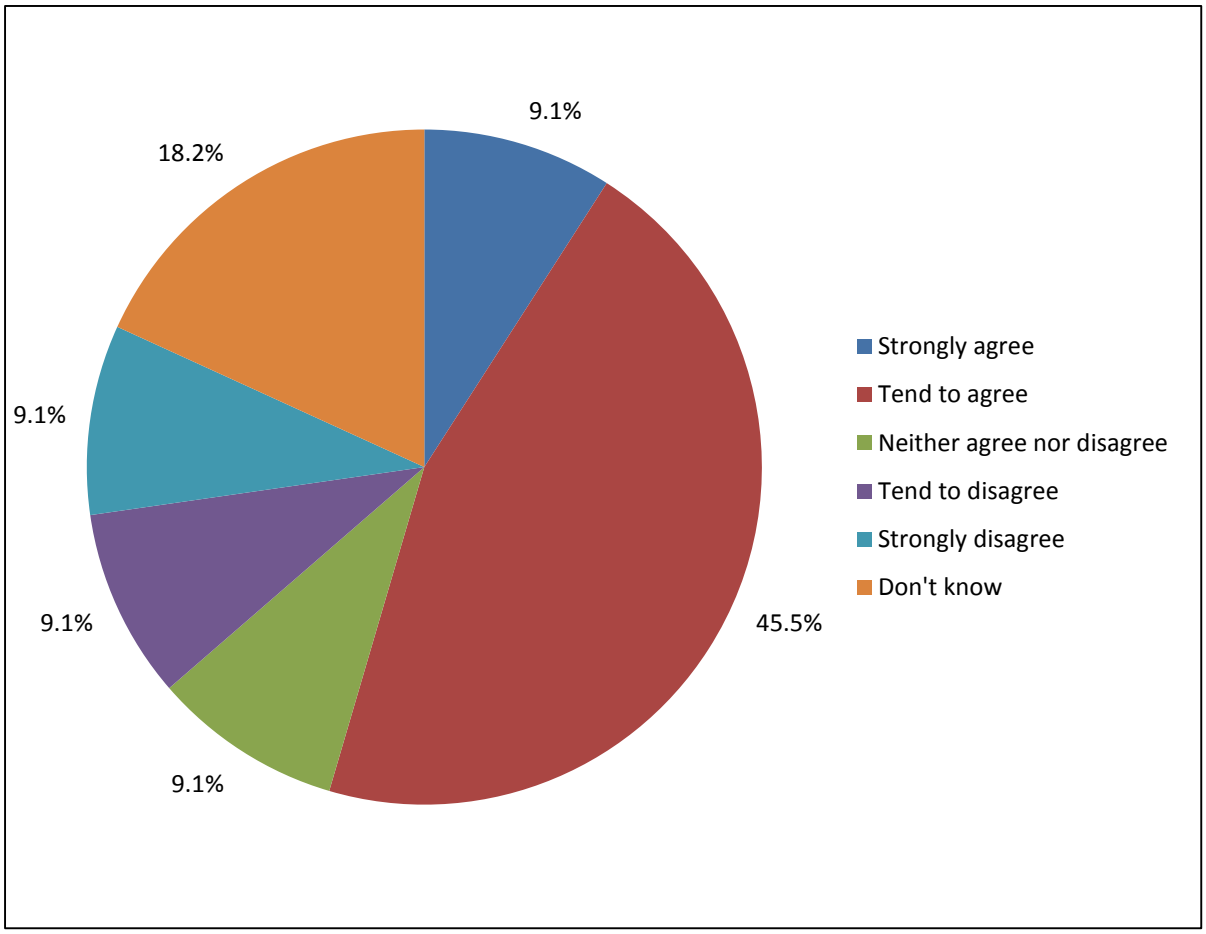
More needs to be done for diabetic people.

8. This question is for NHS England only. To what extent do you agree or disagree the PNA has provided adequate information to inform market entry decisions?



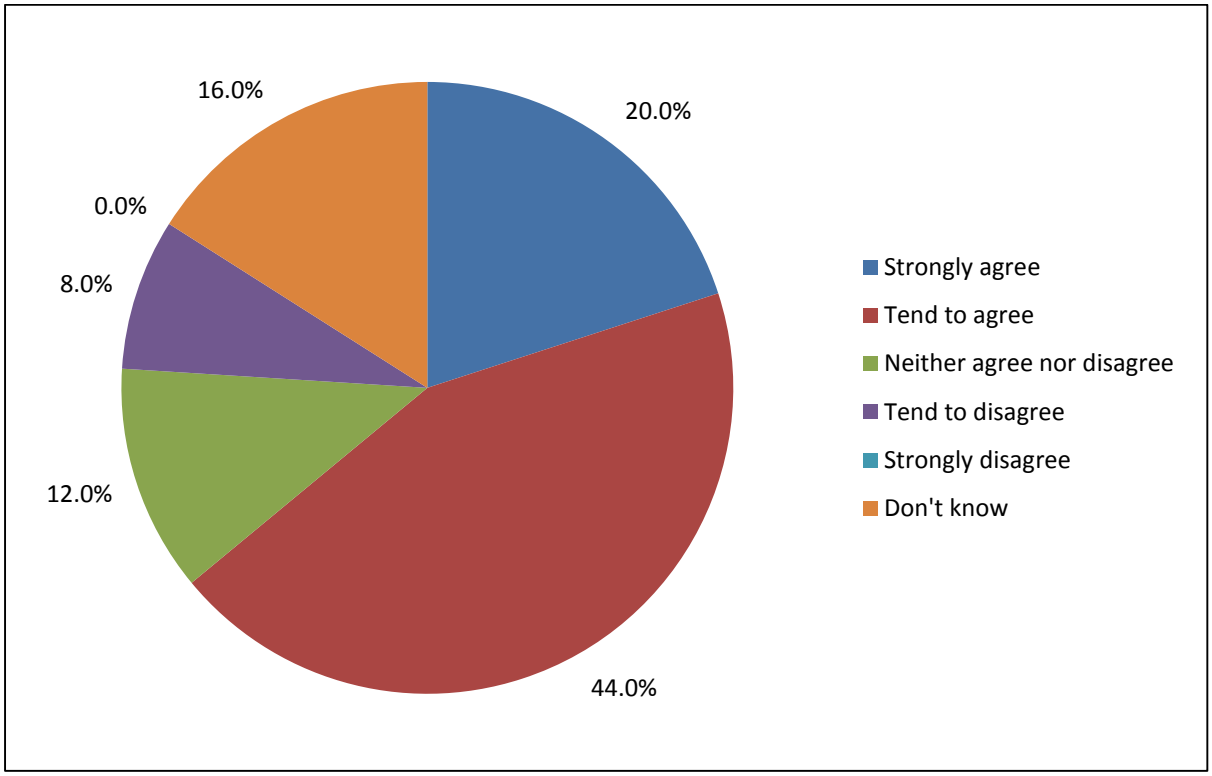
Answer Choices	Responses (%)	Responses (number)
Strongly agree	6.3%	1
Tend to agree	31.3%	5
Neither agree nor disagree	25.0%	4
Tend to disagree	6.3%	1
Strongly disagree	0.0%	0
Don't know	31.3%	5

9. *This question is for service commissioners only*. To what extent do you agree or disagree the PNA has provided adequate information to inform future commissioning decisions?



Answer Choices	Responses (%)	Responses (number)
Strongly agree	9.1%	1
Tend to agree	45.5%	5
Neither agree nor disagree	9.1%	1
Tend to disagree	9.1%	1
Strongly disagree	9.1%	1
Don't know	18.2%	2

10. To what extent do you agree or disagree the PNA will help commissioners and local pharmacy service providers identify and address any gaps in pharmaceutical services?

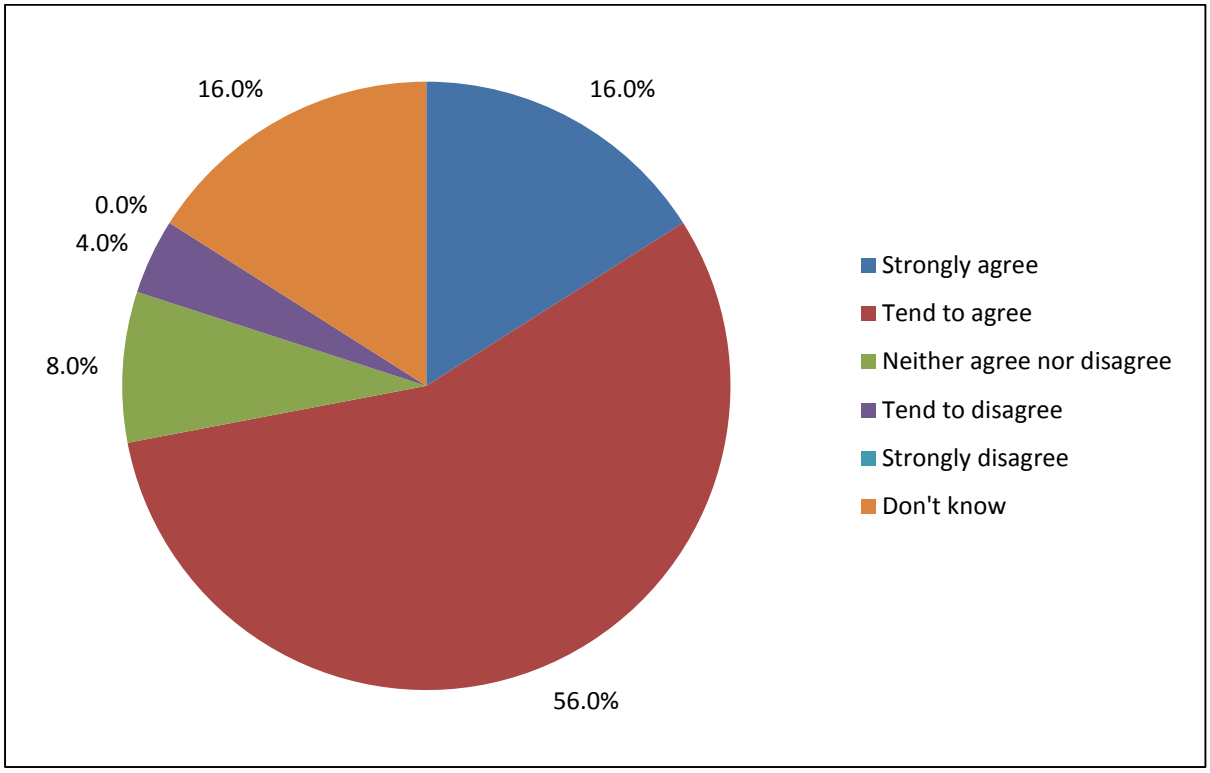


Answer Choices	Responses (%)	Responses (number)
Strongly agree	20.0%	5
Tend to agree	44.0%	11
Neither agree nor disagree	12.0%	3
Tend to disagree	8.0%	2
Strongly disagree	0.0%	0
Don't know	16.0%	4

10a. Please tell us why you disagree.

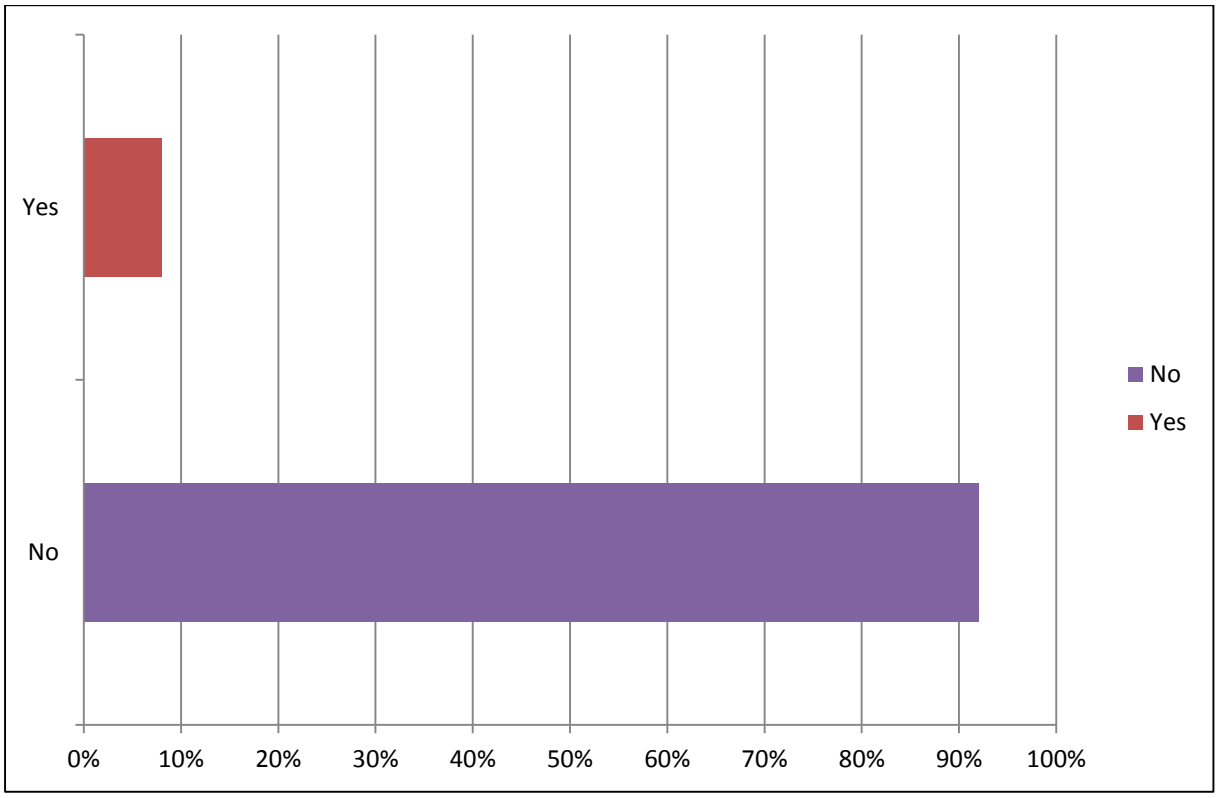
They are ignoring the needs of diabetic patients.

11. To what extent do you agree or disagree the PNA will help commissioners and local pharmacy service providers target services to reduce health inequalities within local health communities?



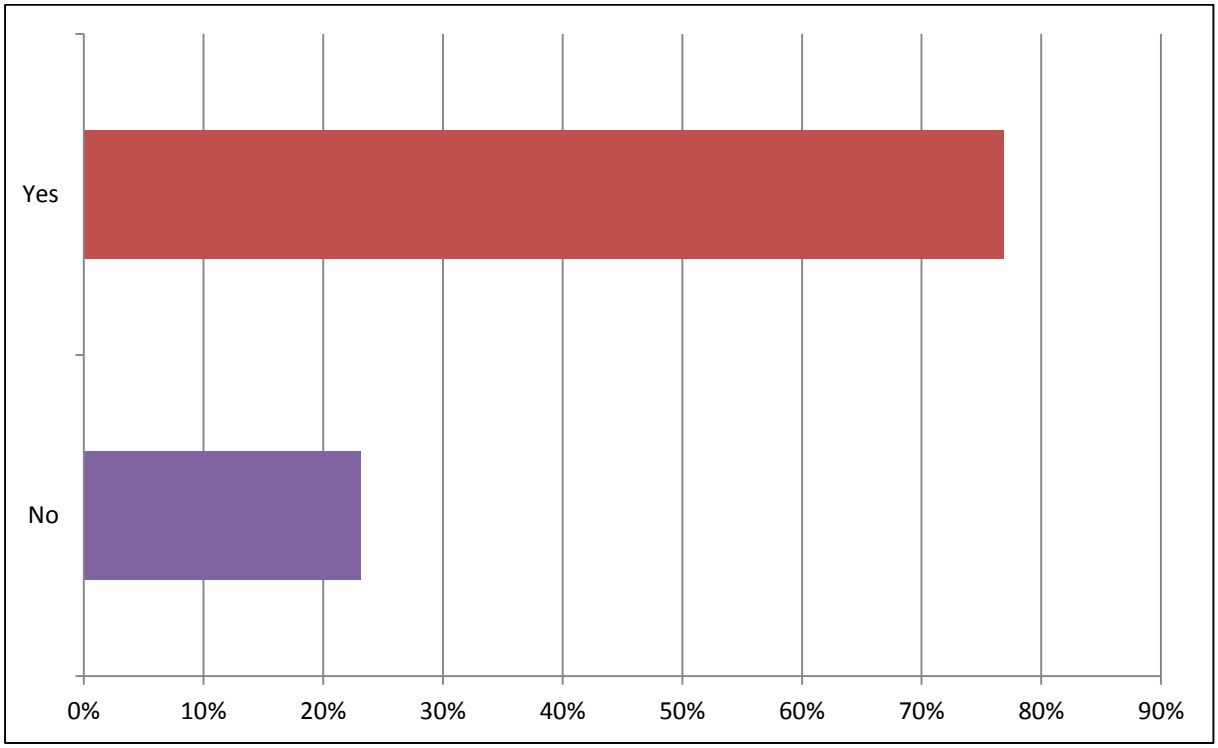
Answer Choices	Responses (%)	Responses (number)
Strongly agree	16.0%	4
Tend to agree	56.0%	14
Neither agree nor disagree	8.0%	2
Tend to disagree	4.0%	1
Strongly disagree	0.0%	0
Don't know	16.0%	4

12. Are you aware of any pharmaceutical services currently provided in Enfield, which have not been included?



Answer Choices	Responses (%)	Responses (number)
Yes	8.0%	2
No	92.0%	23

13. *This question is to be answered only by those who own or represent community pharmacies.* After reviewing Appendix A of the draft PNA, would you say the information relating to opening hours is correct?

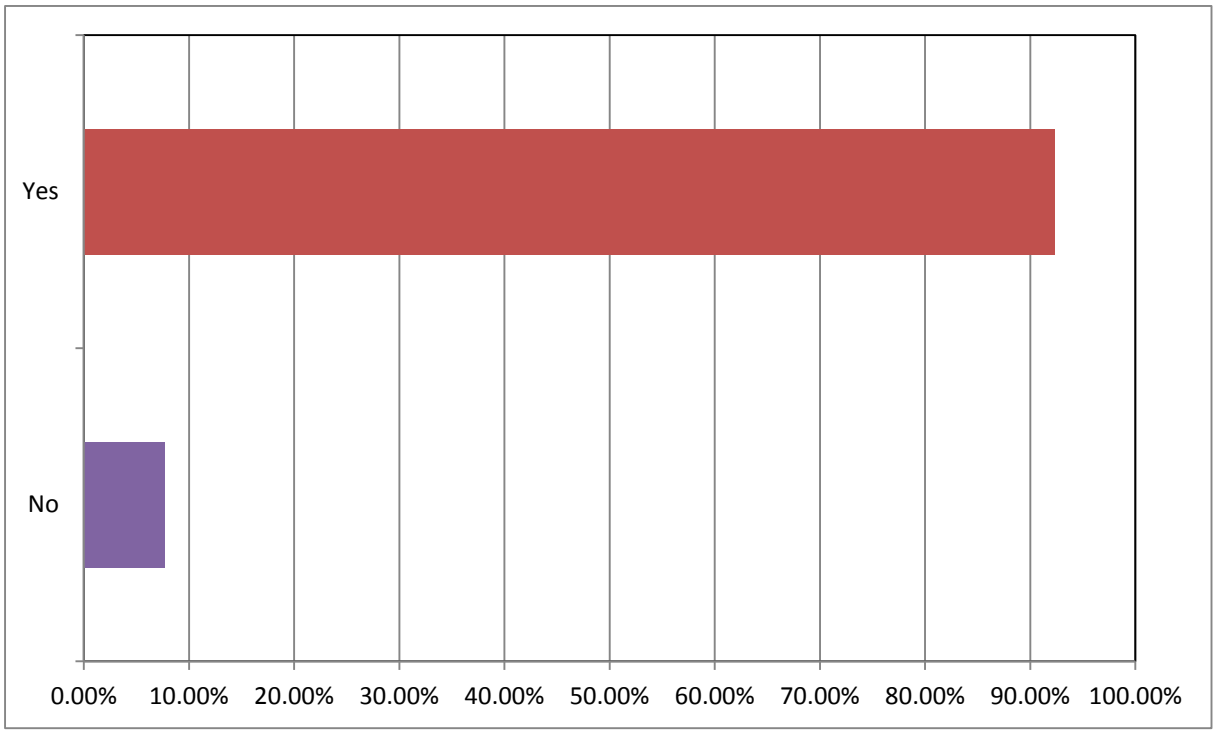


Answer Choices	Responses (%)	Responses (number)
Yes	76.9%	10
No	23.1%	3

If 'no', please provide details.

Re Co-Op branch 417 Hertford Rd, Enfield, EN3 5PT (Index - 54): Mon-Fri opening hours are 8:30am - 6:30pm. All other info relating to Co-Op branches is correct

14. ***This question is to be answered only by those who own or represent community pharmacies.*** **After reviewing Appendix A of the draft PNA, would you say the information relating to service provision is correct?**

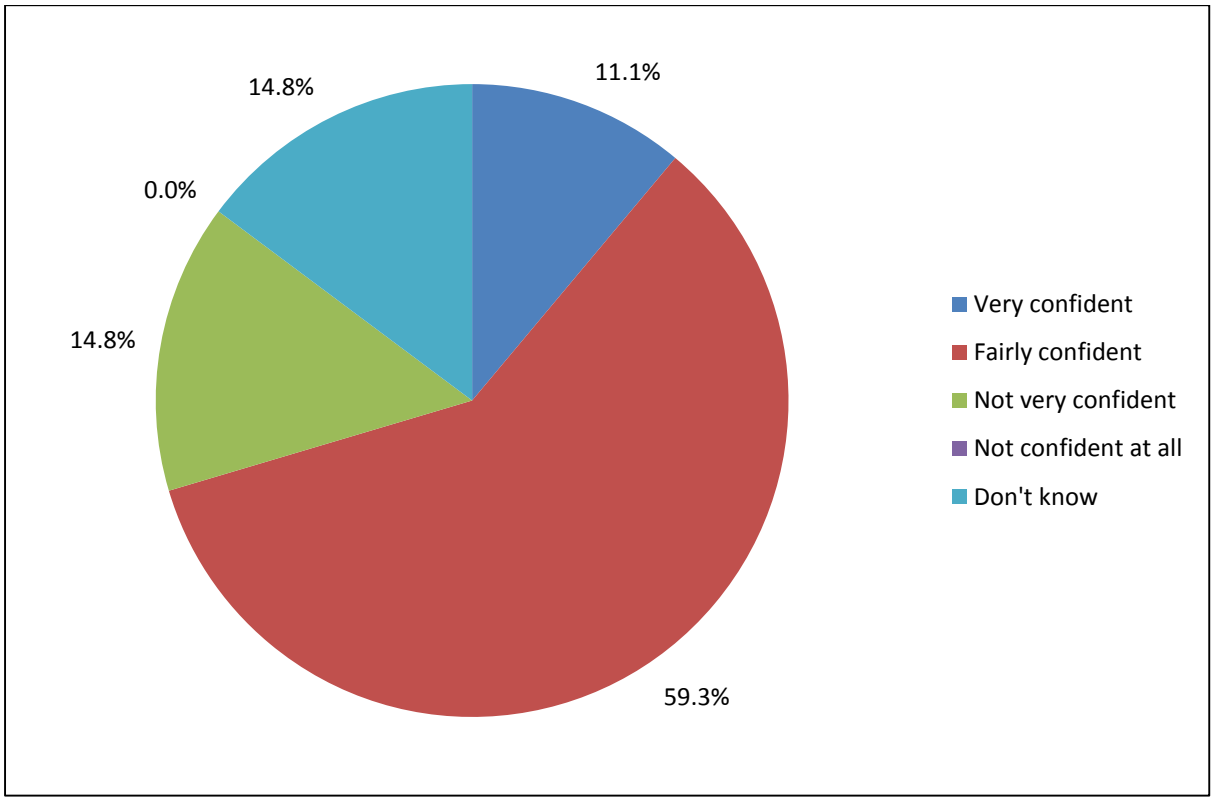


Answer Choices	Responses (%)	Responses (number)
Yes	92.3%	12
No	7.7%	1

If 'no', please provide details.

Yes for Co-Op branches only; not sure on any other provider

15. Overall, how confident are you that the current version of the Enfield PNA will help to improve the commissioning of pharmaceutical services?



Answer Choices	Responses (%)	Responses (number)
Very confident	11.1%	3
Fairly confident	59.3%	16
Not very confident	14.8%	4
Not confident at all	0.0%	0
Don't know	14.8%	4

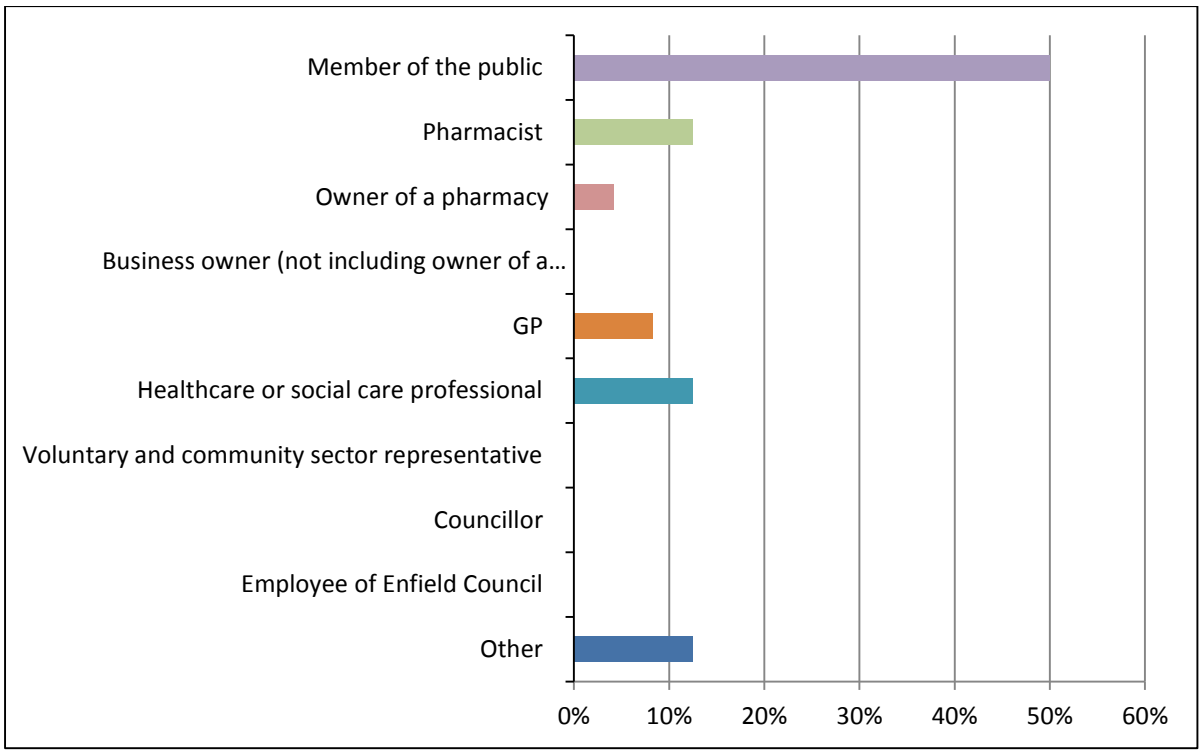
15a. Please tell us why you are not confident.

Although one may have good intentions, one may not carry them through!
More attention needs to be given to diabetes management and care

16. If you have any further comments you would like to make about the PNA, let us know.

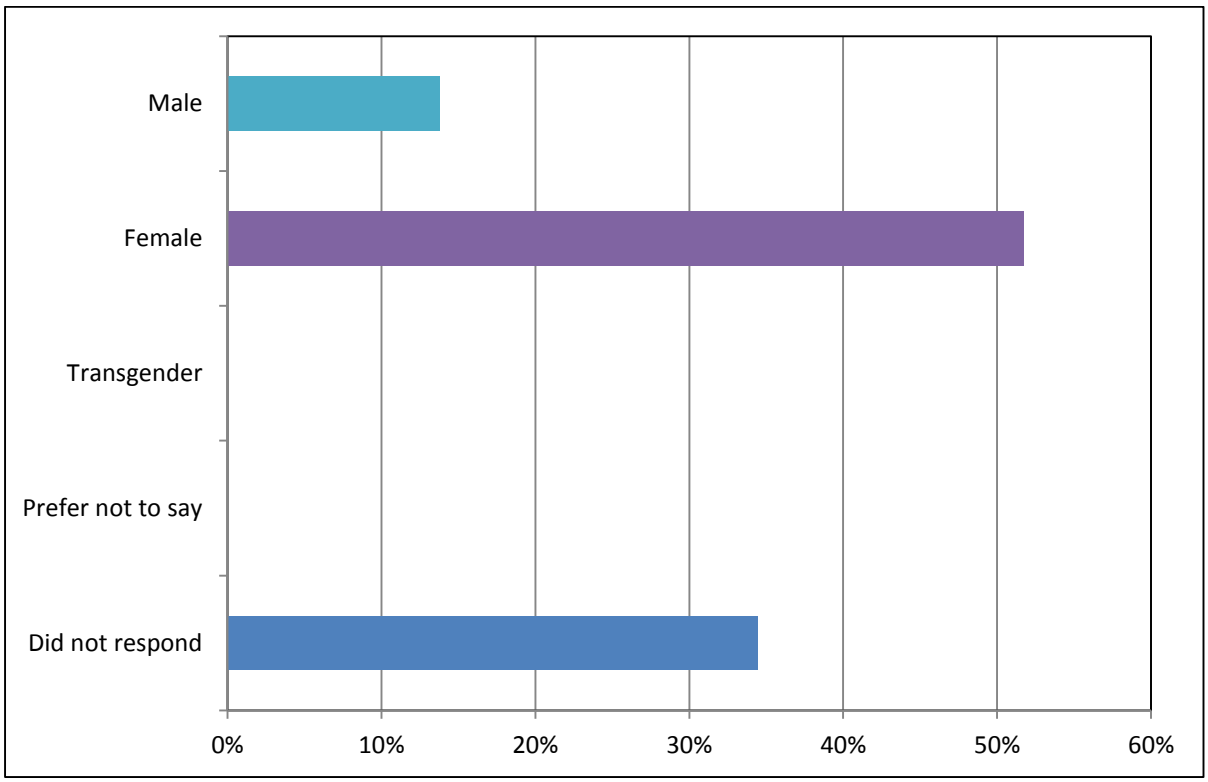
None
I haven't seen a copy of the PNA!
Excellent service. They go that one extra i.e. helpful in re-ordering
Hopefully it will be used for the purpose intended, as a measure of the public's views and not discarded
Am satisfied that there are no gaps in current pharmaceutical provision

17. On what basis are you responding to this consultation?



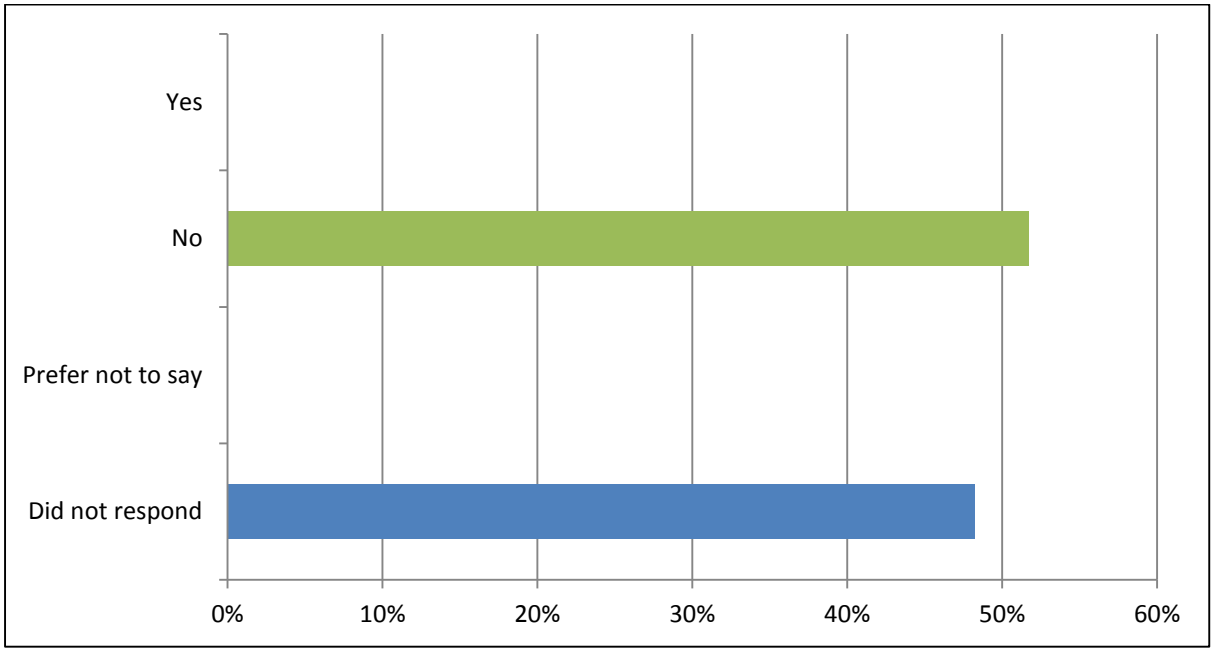
Section 2: Demography of the respondents

1. Are you male, female or transgender?



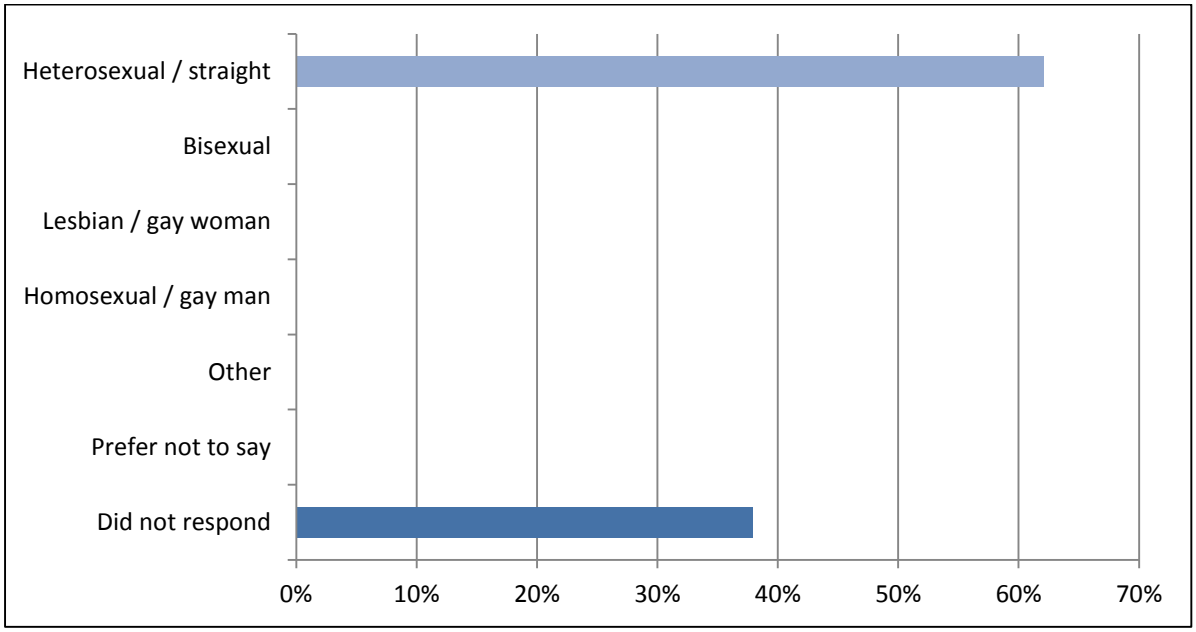
Answer choices	Responses (%)	Responses (number)
Male	13.8%	4
Female	51.7%	15
Transgender	0.0%	0
Prefer not to say	0.0%	0
Did not respond	34.5%	10

2. Are you currently pregnant or have given birth in the last six months?



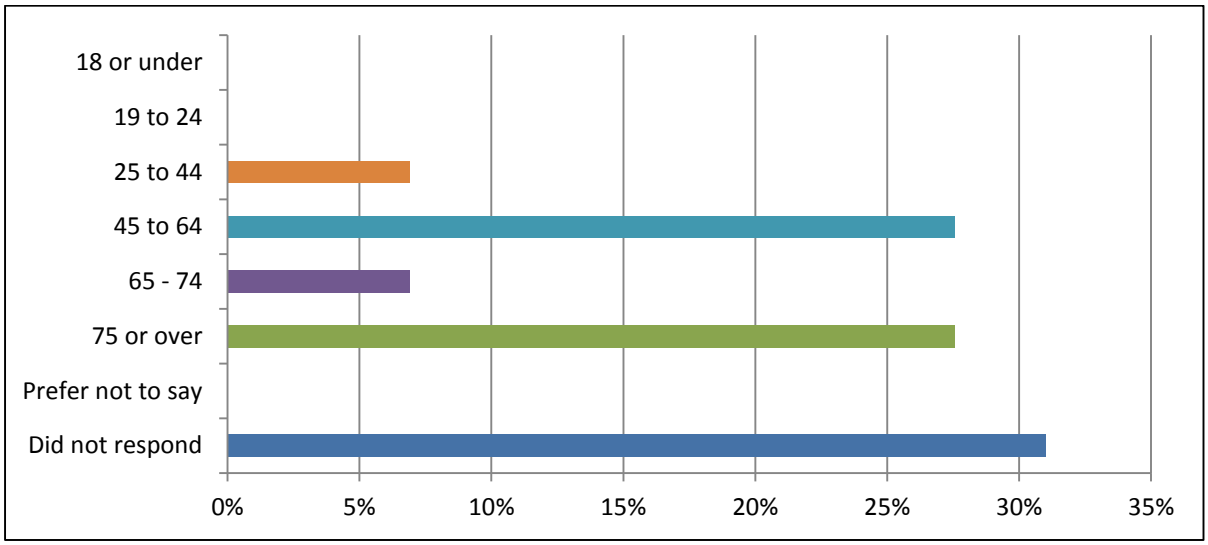
Answer choices	Responses (%)	Responses (number)
Yes	0.0%	0
No	51.7%	15
Prefer not to say	0.0%	0
Did not respond	48.3%	14

3. How would you describe your sexuality?



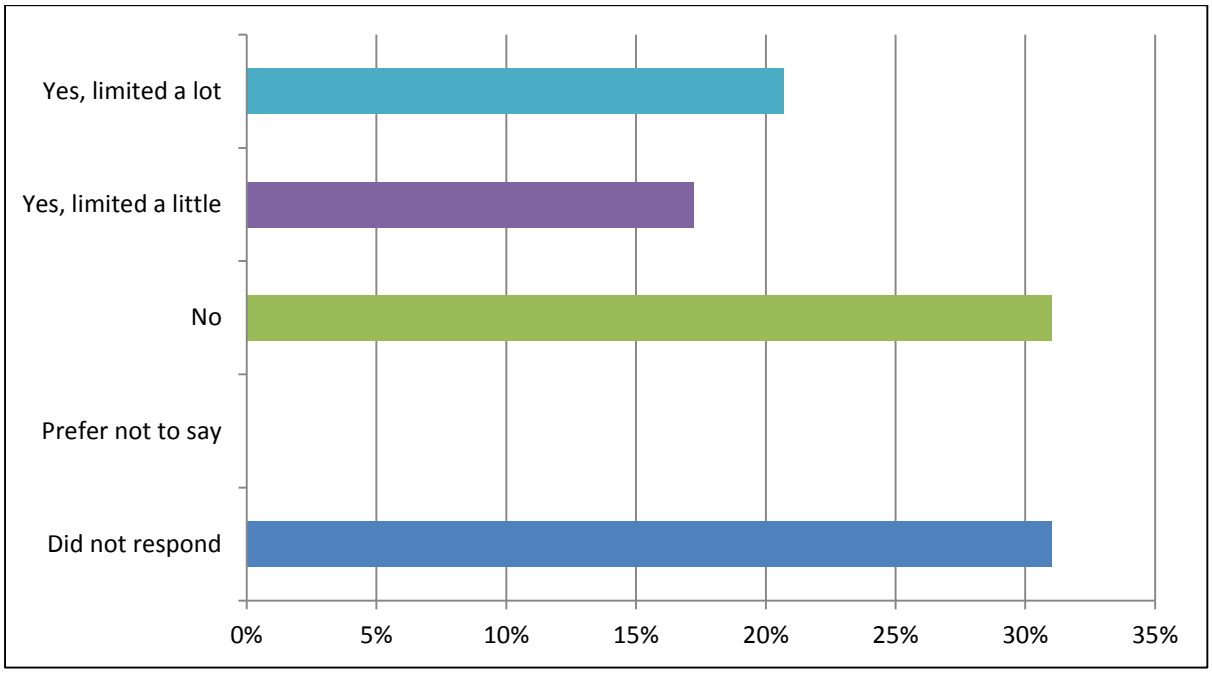
Answer choices	Responses (%)	Responses (number)
Heterosexual / straight	62.1%	18
Bisexual	0.0%	0
Lesbian / gay woman	0.0%	0
Homosexual / gay man	0.0%	0
Other	0.0%	0
Prefer not to say	0.0%	0
Did not respond	37.9%	11

4. How old are you?



Answer choices	Responses (%)	Responses (number)
18 or under	0.0%	0
19 to 24	0.0%	0
25 to 44	6.9%	2
45 to 64	27.6%	8
65 - 74	6.9%	2
75 or over	27.6%	8
Prefer not to say	0.0%	0
Did not respond	31.0%	9

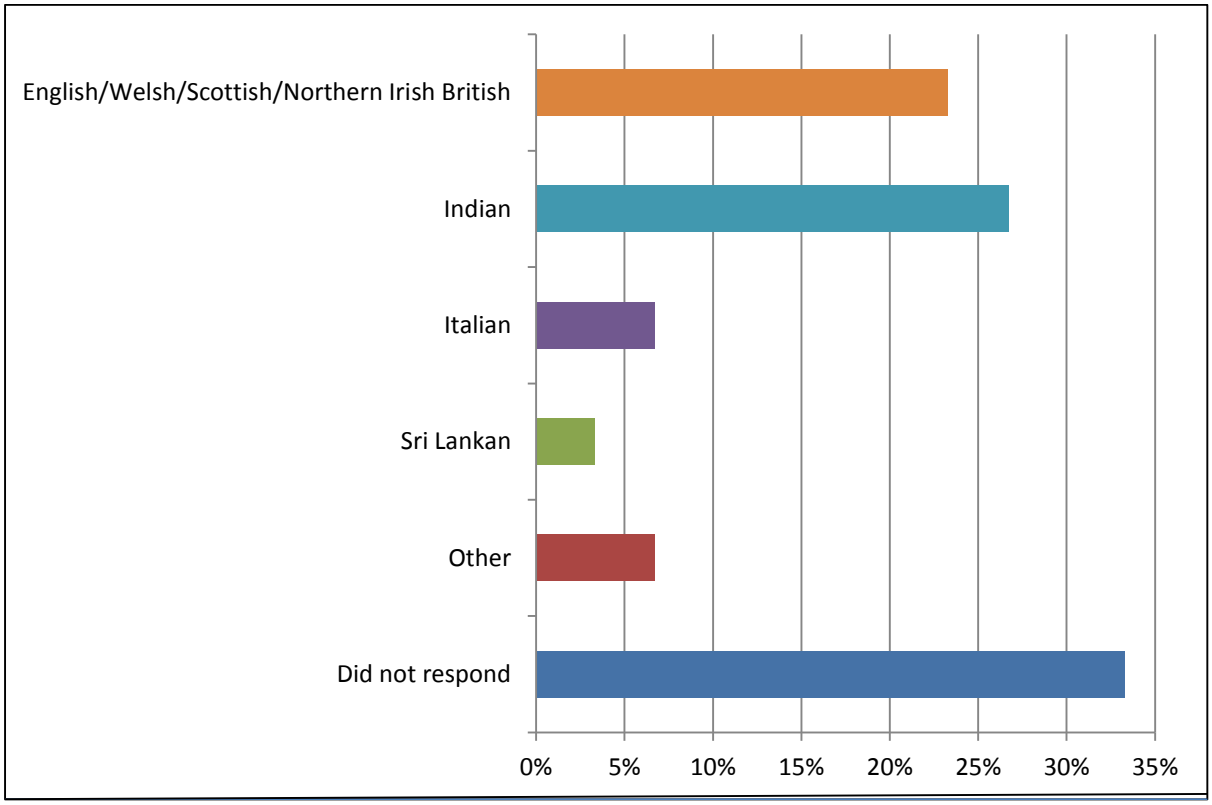
5. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?



Answer choices	Responses (%)	Responses (number)
Yes, limited a lot	20.7%	6
Yes, limited a little	17.2%	5
No	31.0%	9
Prefer not to say	0.0%	0
Did not respond	31.0%	9

6. How would you describe your ethnic origin?

N.B. The questionnaire listed 25 ethnicities but only those which returned a positive response are included in the chart and table below.

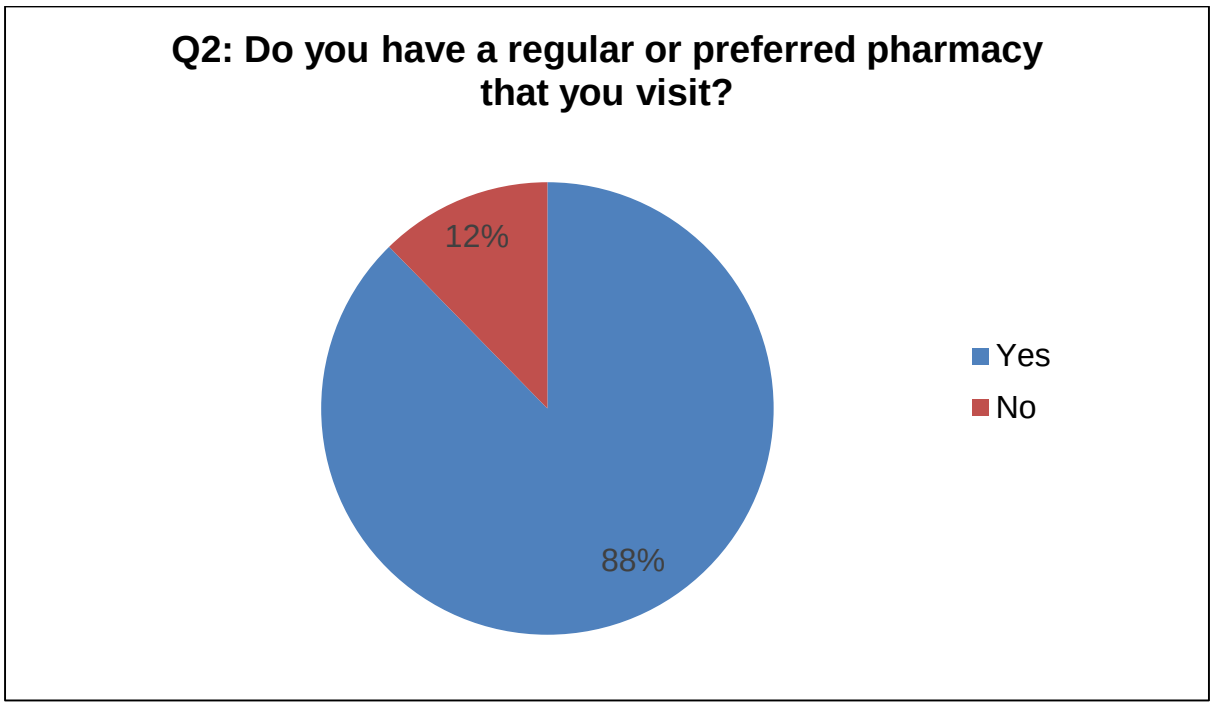


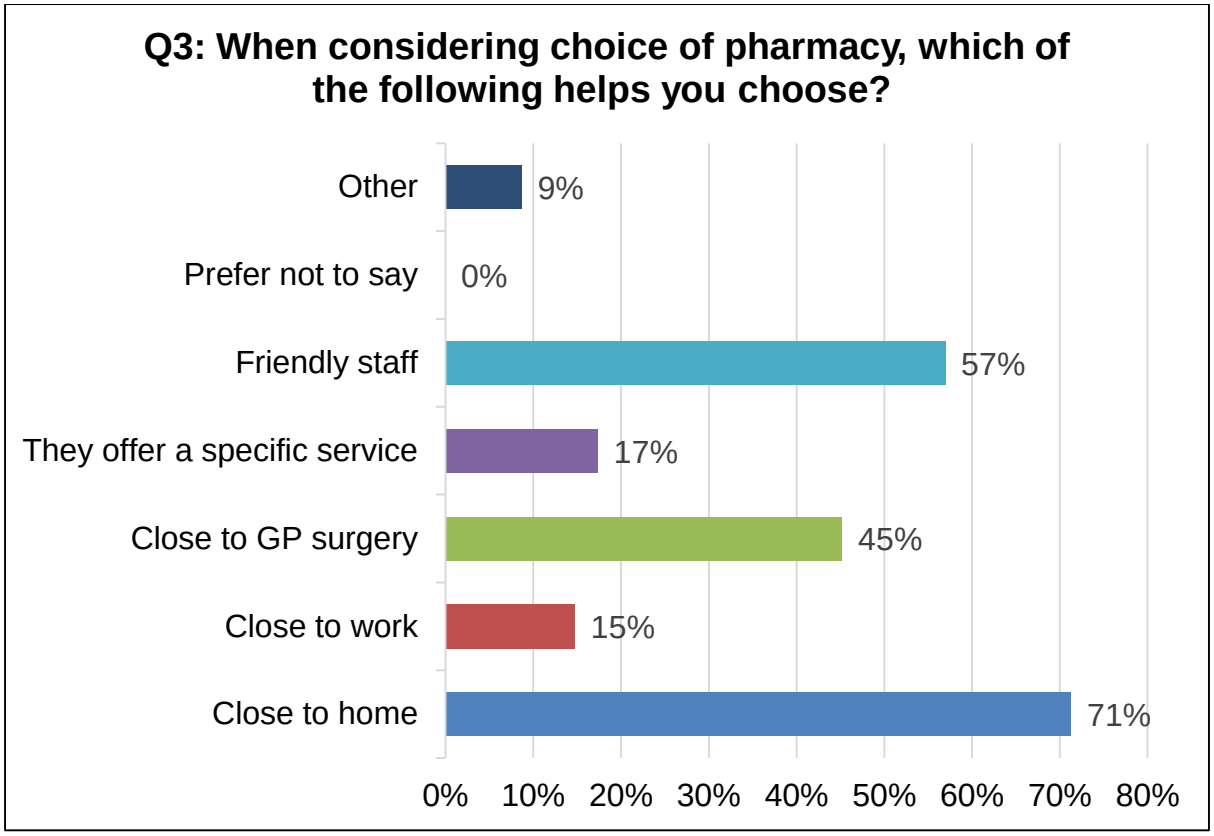
Answer choices	Responses (%)	Responses (number)
English / Welsh / Scottish / Northern Irish British	24.1%	7
Indian	27.6%	8
Italian	6.9%	2
Sri Lankan	3.4%	1
Other	3.4%	2
Did not respond	34.5%	10

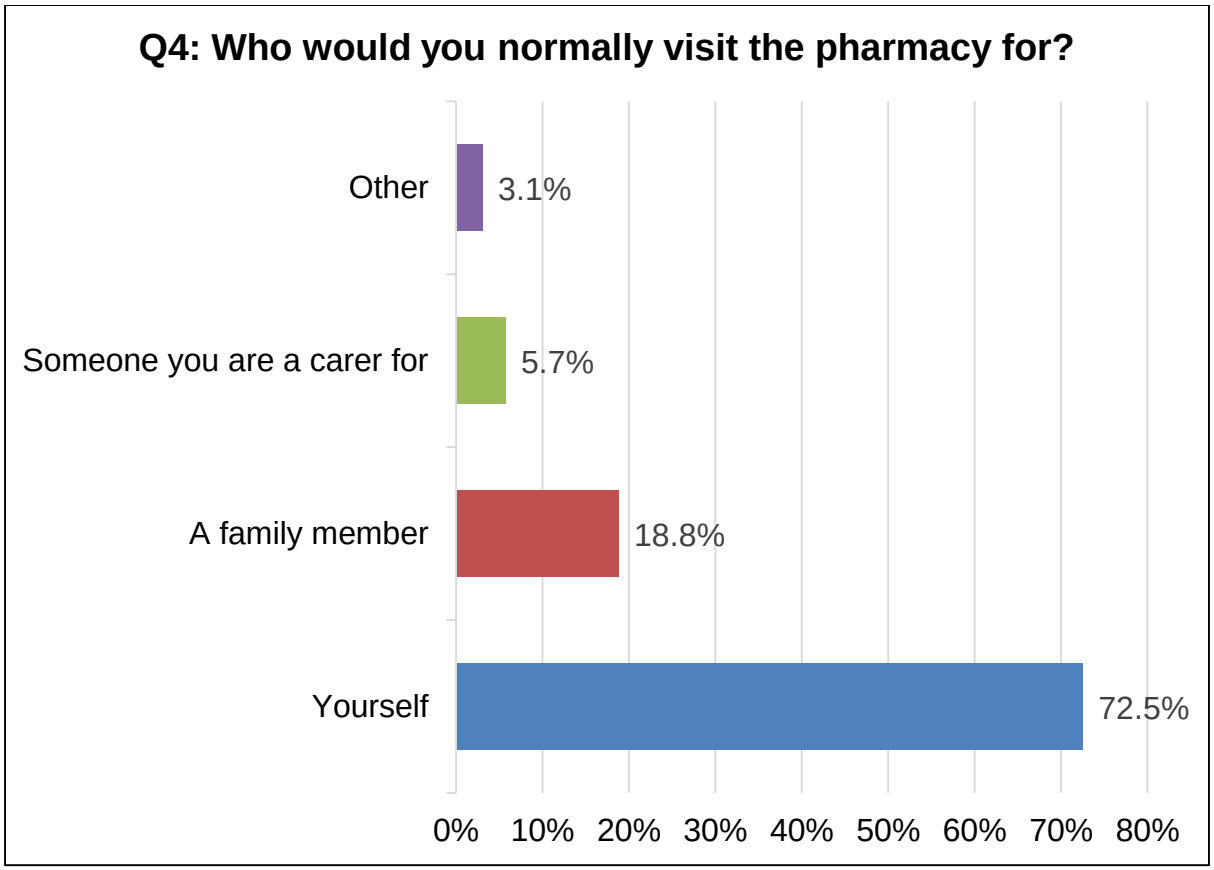
If other, please specify.

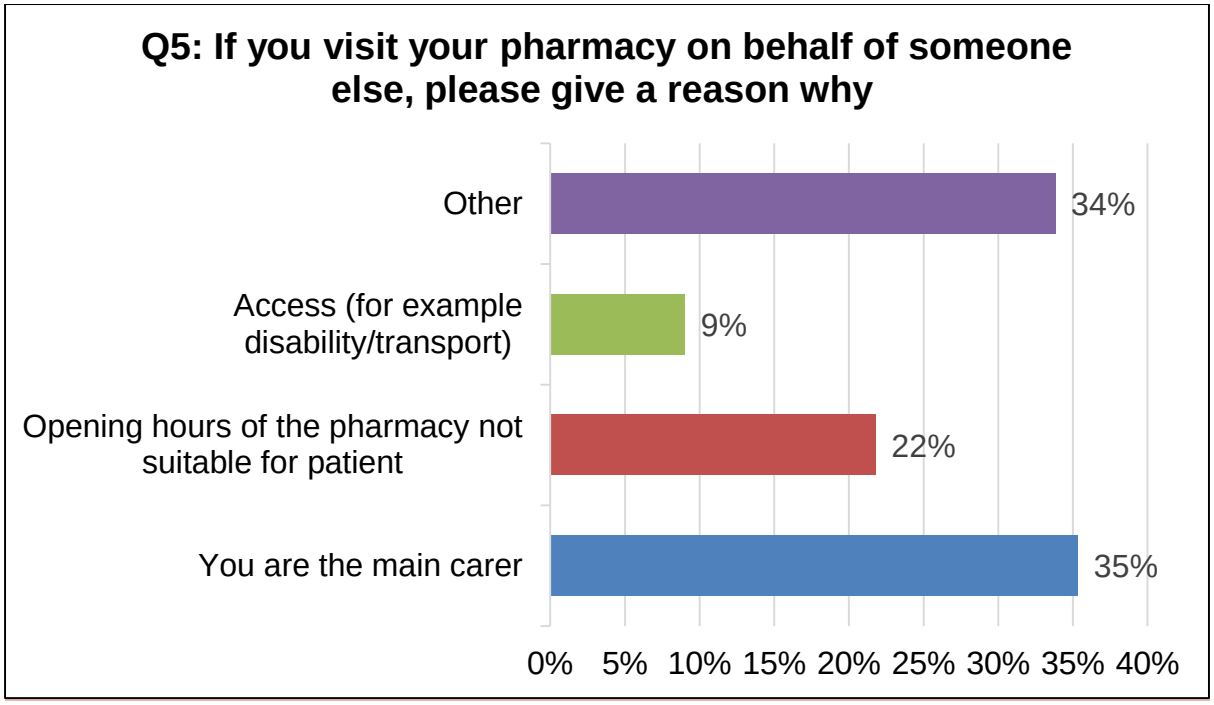
Chinese and Welsh
Asian

Appendix I: Results of the patient survey



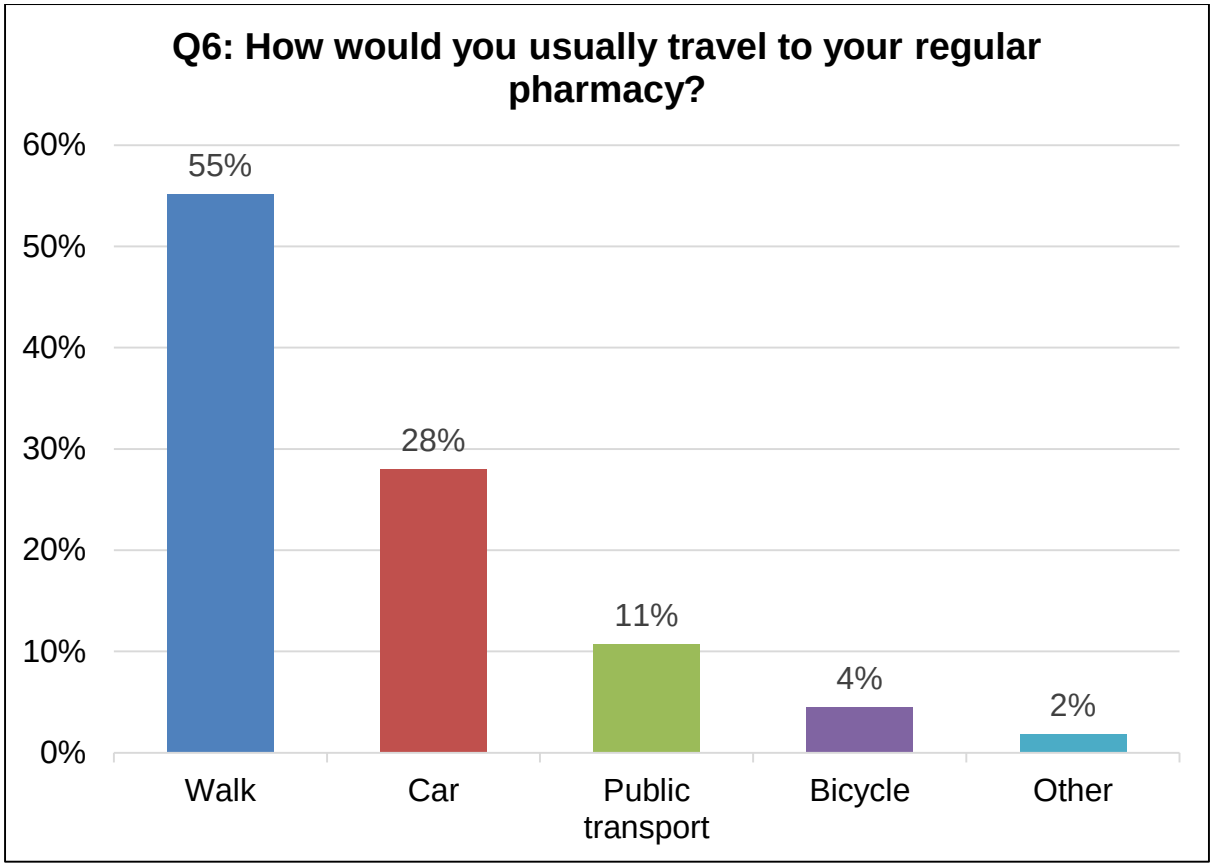

Q3: When considering choice of pharmacy, which of the following helps you choose?
Other
9%
Prefer not to say
0%
Friendly staff
57%
They offer a specific service
17%
Close to GP surgery
45%
Close to work
15%
Close to home
71%
0%
10%
20%
30%
40%
50%
60%
70%
80%

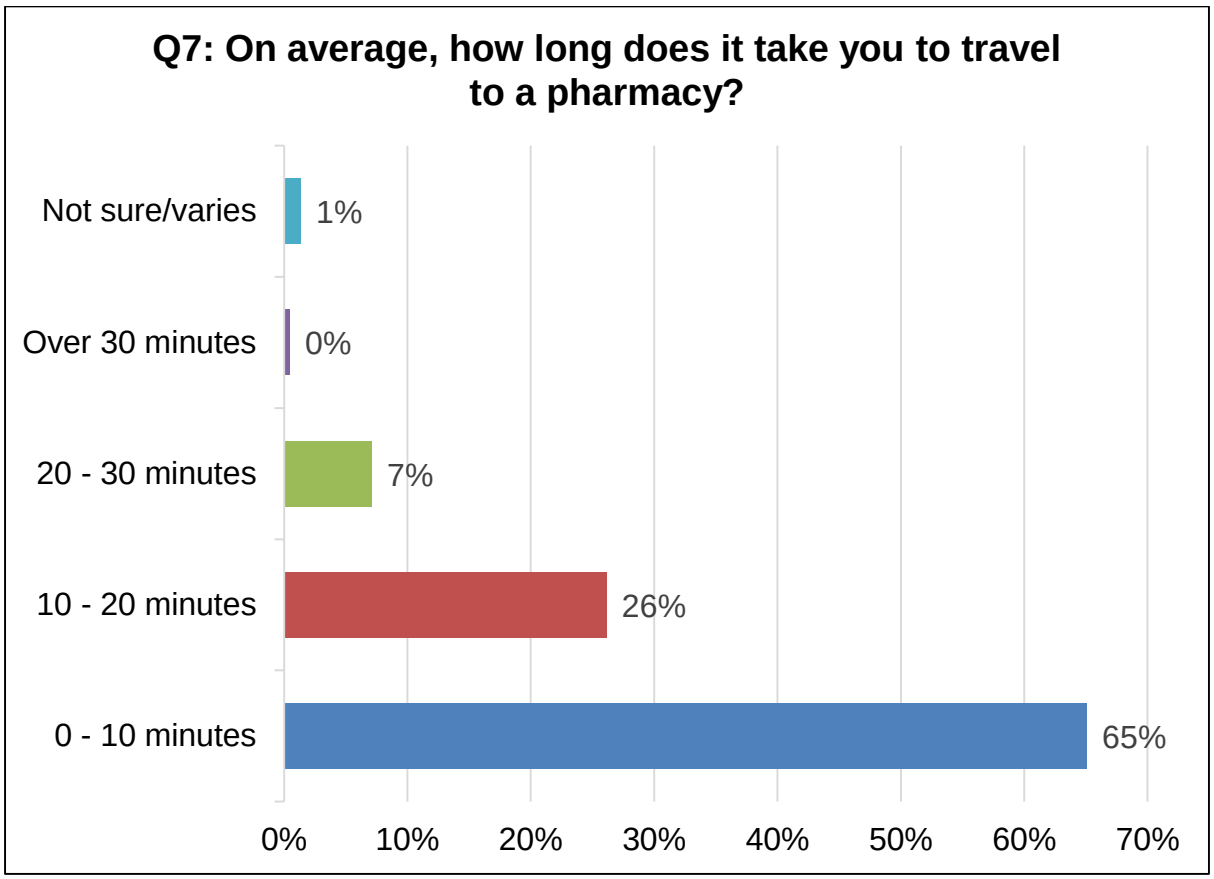

Q4: Who would you normally visit the pharmacy for?
Other
3.1%
Someone you are a carer for
5.7%
A family member
18.8%
Yourself
72.5%
0%
10%
20%
30%
40%
50%
60%
70%
80%

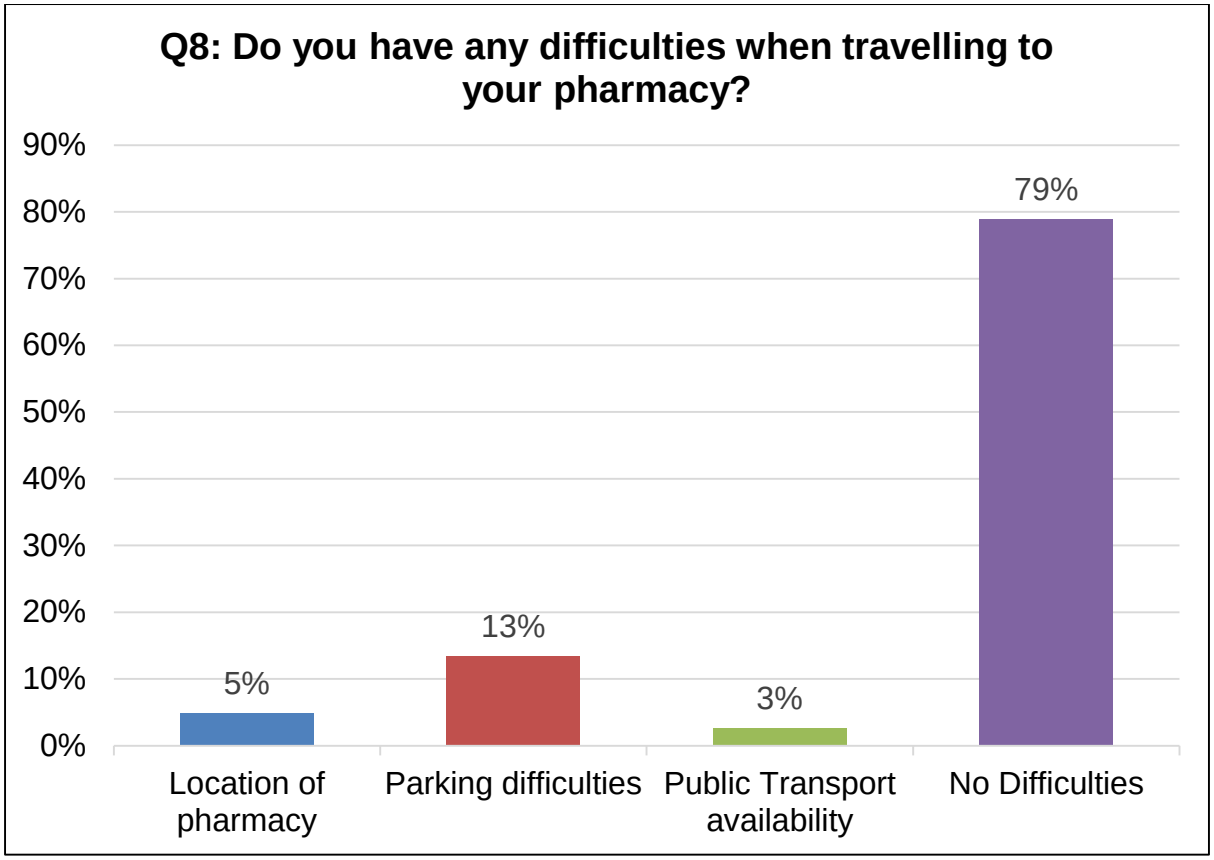


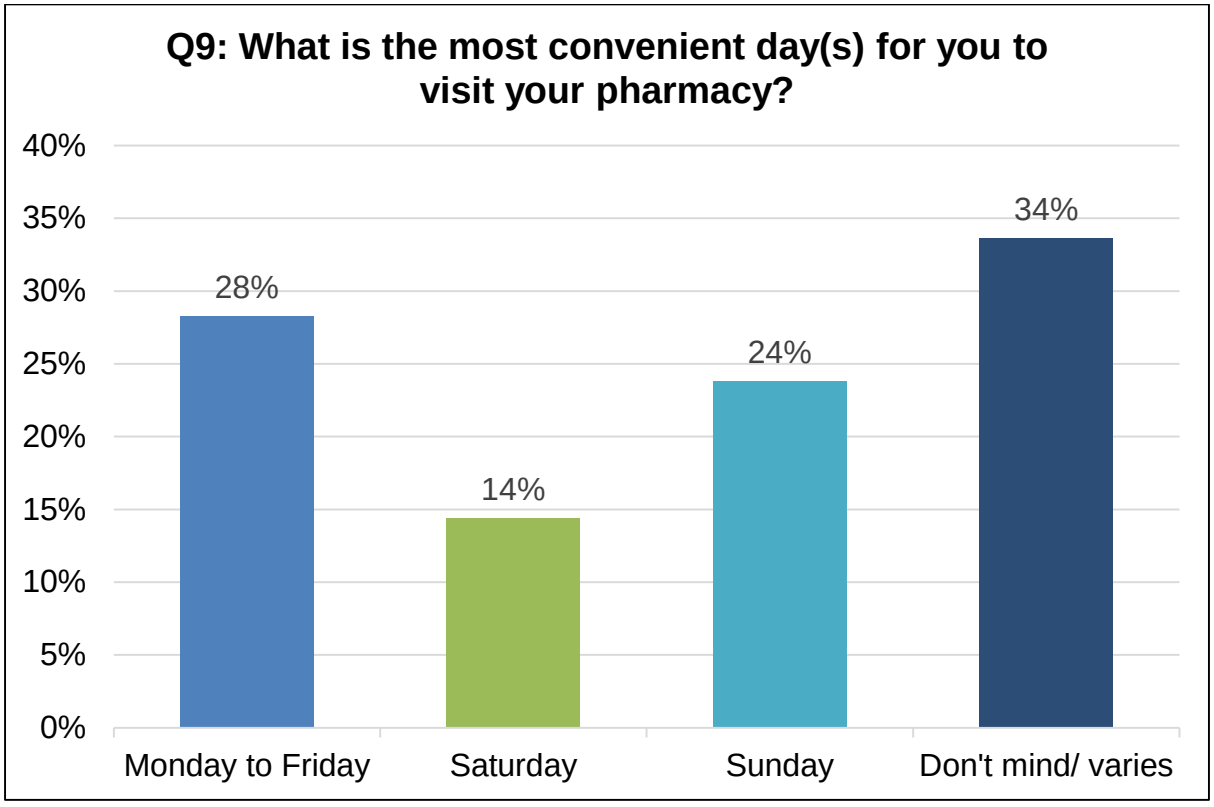
Reasons

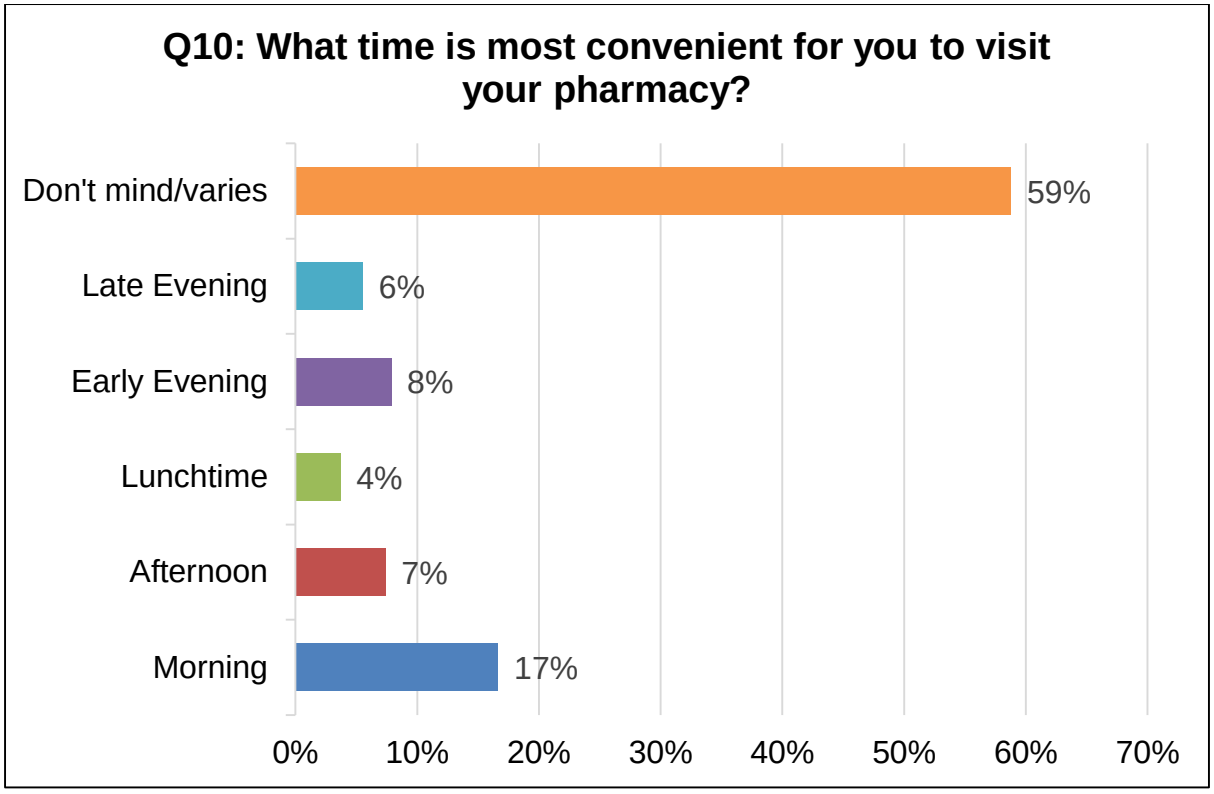
To be helpful	If they were unwell / ill
For my children / partner / neighbour / wife / husband	I have the time
If they are at work	Convenient to collect meds for both of us
Convenient pick up or drop in	I drive
Patient unable to get there	Electronic prescriptions
Elderly / disabled not able to come	Residents in a care home
It is a bit easier for me to stop at on way to work	Childcare arrangements
My husband still works, it's easier for me to do	Can pop in on way to work

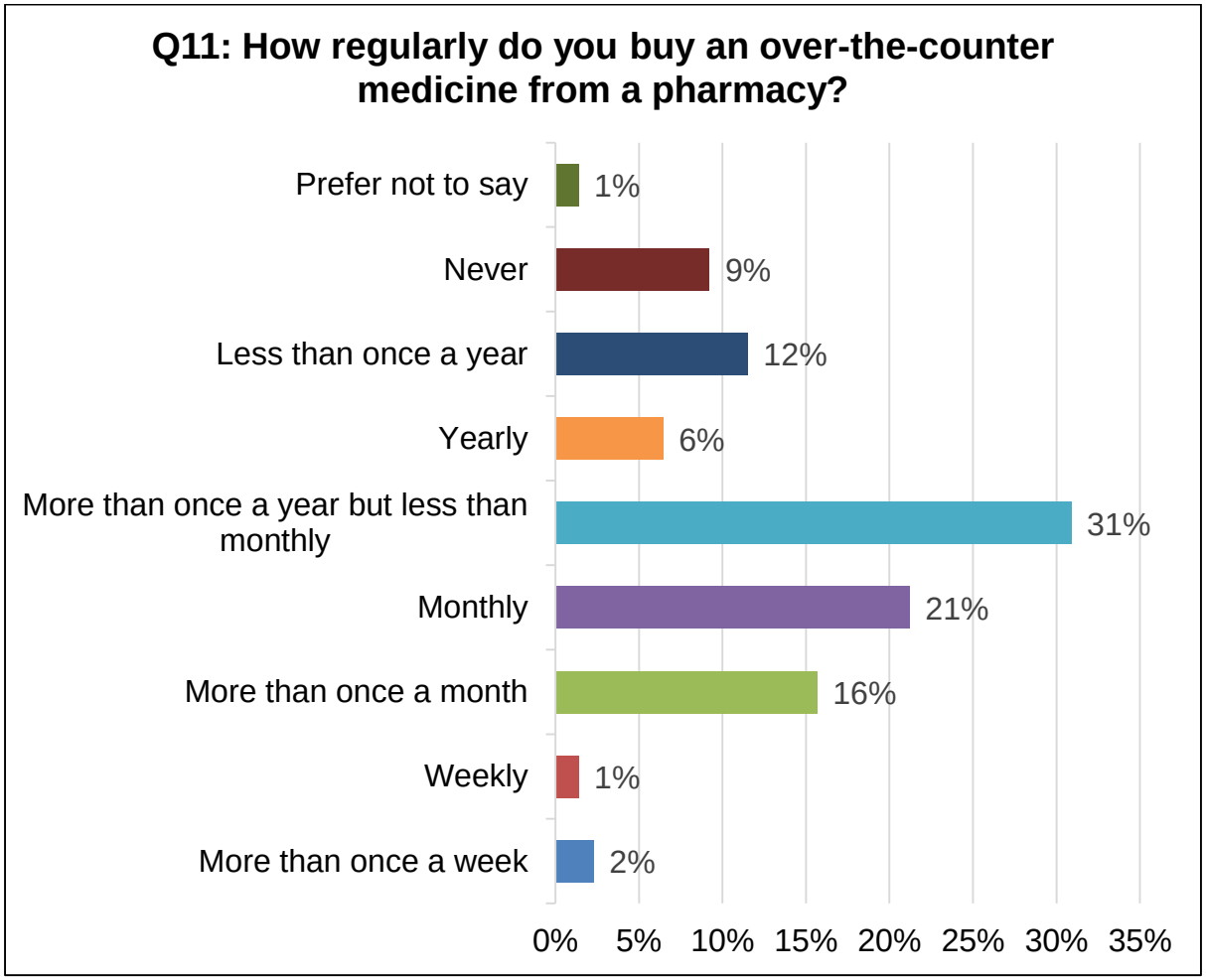

Q6: How would you usually travel to your regular pharmacy?
60%
50%
40%
30%
20%
10%
0%
55%
28%
11%
4%
2%
Walk
Car
Public transport
Bicycle
Other

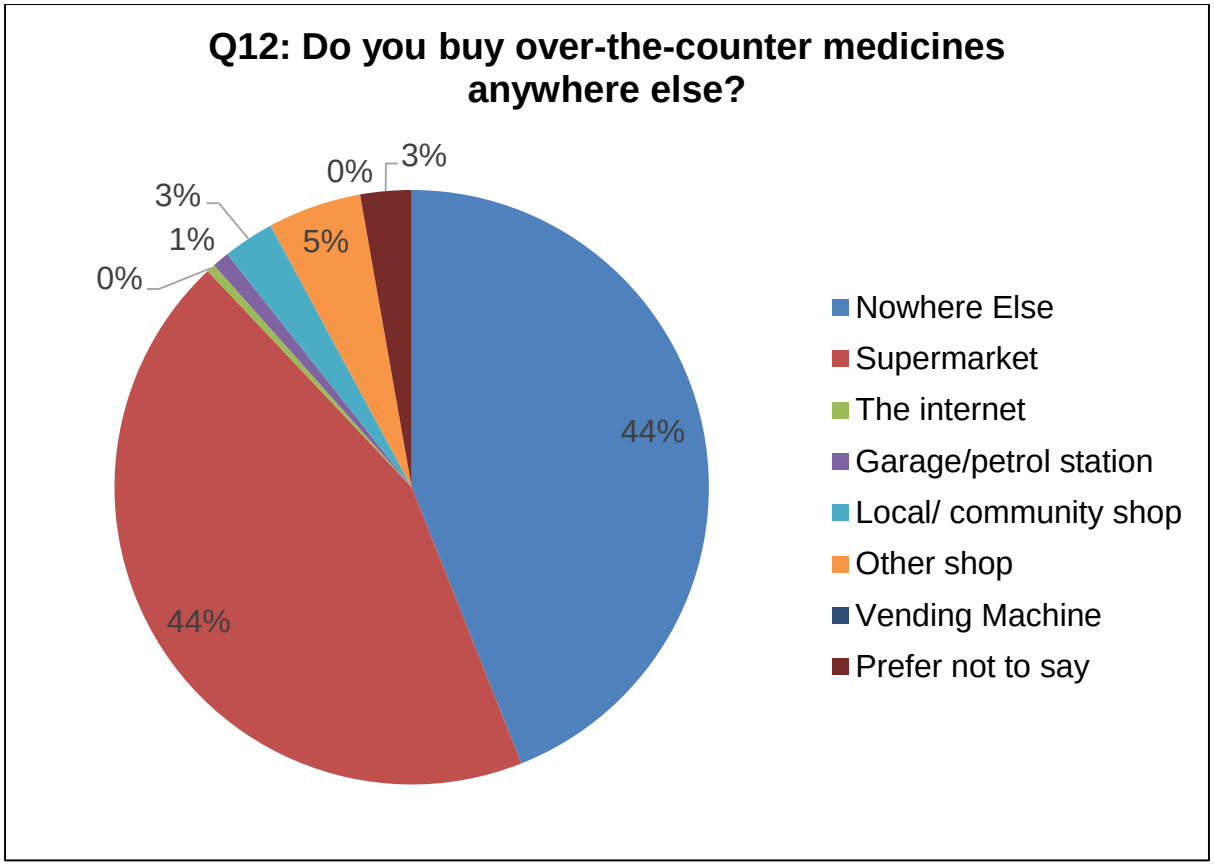

Q7: On average, how long does it take you to travel to a pharmacy?
Not sure/varies
1%
Over 30 minutes
0%
20 - 30 minutes
7%
10 - 20 minutes
26%
0 - 10 minutes
65%
0%
10%
20%
30%
40%
50%
60%
70%

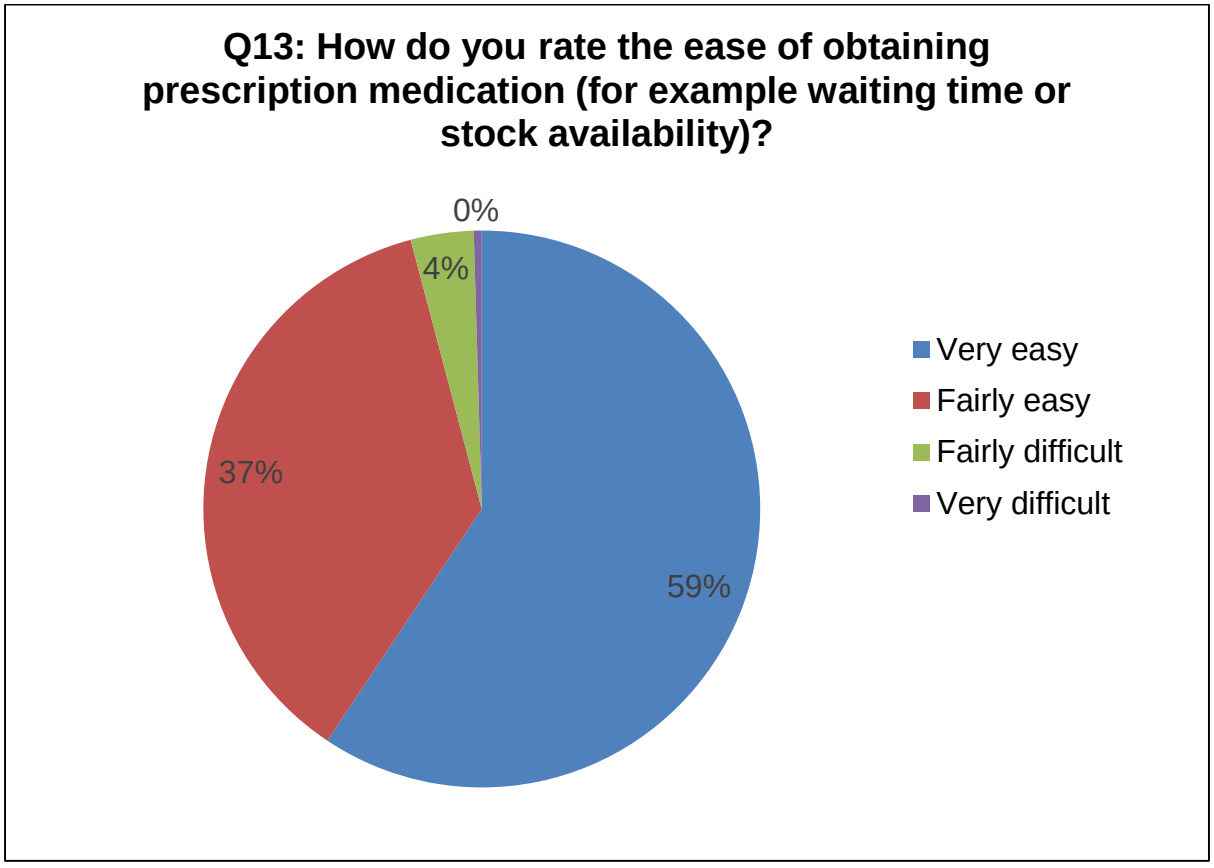

Q8: Do you have any difficulties when travelling to your pharmacy?
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
5%
13%
3%
79%
Location of pharmacy
Parking difficulties
Public Transport availability
No Difficulties

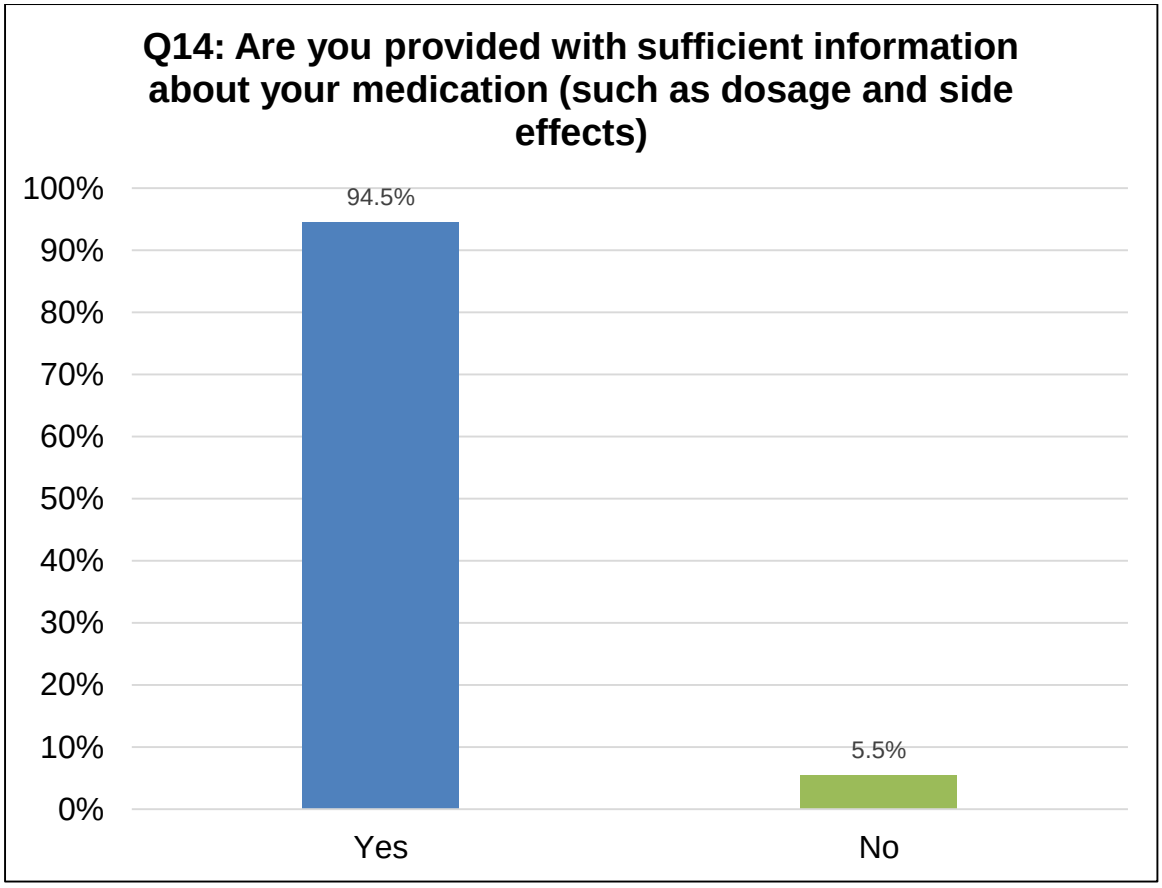

Q9: What is the most convenient day(s) for you to visit your pharmacy?
40%
35%
30%
25%
20%
15%
10%
5%
0%
28%
14%
24%
34%
Monday to Friday
Saturday
Sunday
Don't mind/ varies

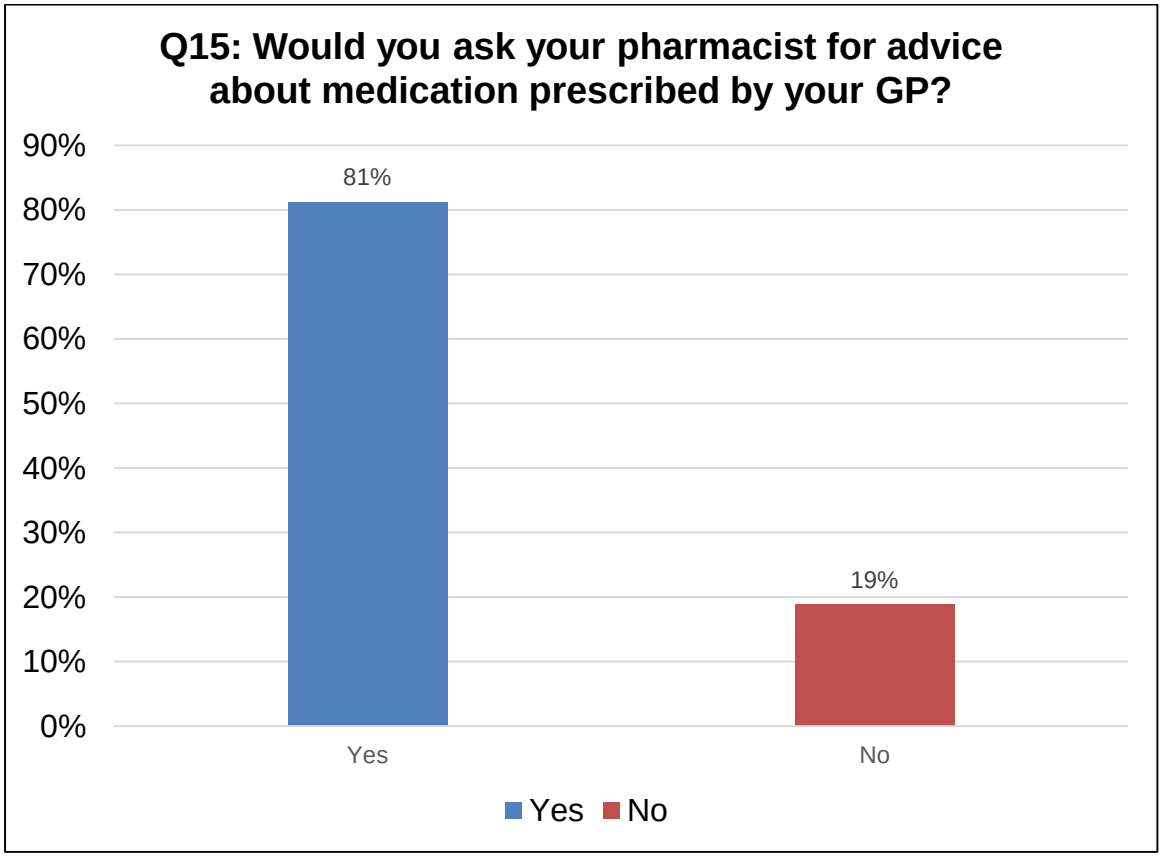

Q10: What time is most convenient for you to visit your pharmacy?
Don't mind/varies
59%
Late Evening
6%
Early Evening
8%
Lunchtime
4%
Afternoon
7%
Morning
17%
0%
10%
20%
30%
40%
50%
60%
70%


Q11: How regularly do you buy an over-the-counter medicine from a pharmacy?
Prefer not to say
1%
Never
9%
Less than once a year
12%
Yearly
6%
More than once a year but less than monthly
31%
Monthly
21%
More than once a month
16%
Weekly
1%
More than once a week
2%
0%
5%
10%
15%
20%
25%
30%
35%


Q12: Do you buy over-the-counter medicines anywhere else?
0%
3%
3%
1%
0%
5%
44%
44%
Nowhere Else
Supermarket
The internet
Garage/petrol station
Local/ community shop
Other shop
Vending Machine
Prefer not to say


Q13: How do you rate the ease of obtaining prescription medication (for example waiting time or stock availability)?
0%
4%
37%
59%
Very easy
Fairly easy
Fairly difficult
Very difficult

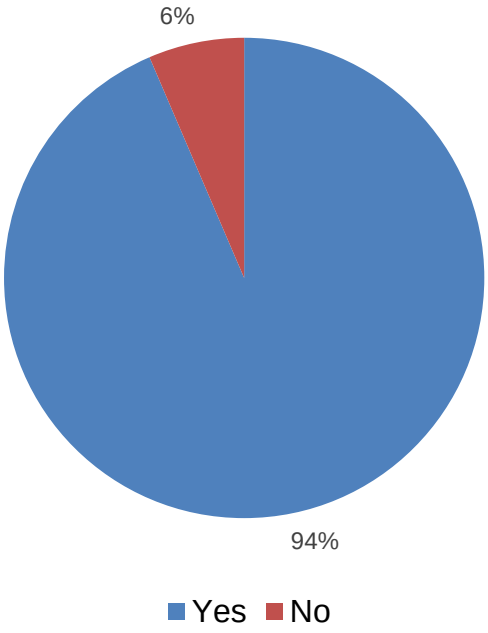

Q14: Are you provided with sufficient information about your medication (such as dosage and side effects)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
94.5%
5.5%
Yes
No


Q15: Would you ask your pharmacist for advice about medication prescribed by your GP?
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
81%
19%
Yes
No
Yes
No

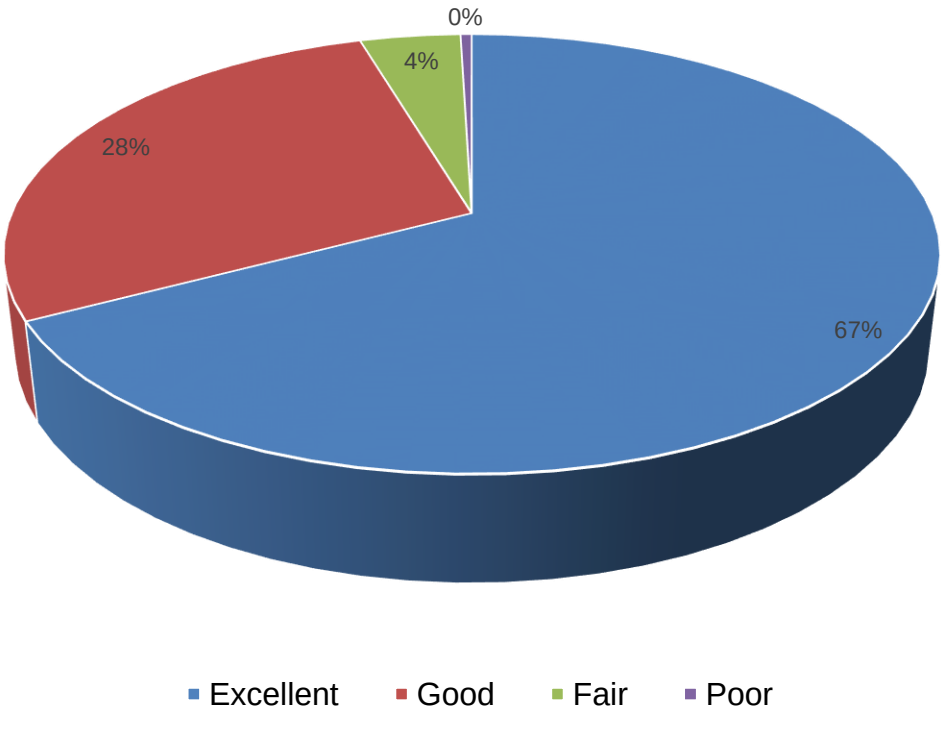
Reasons

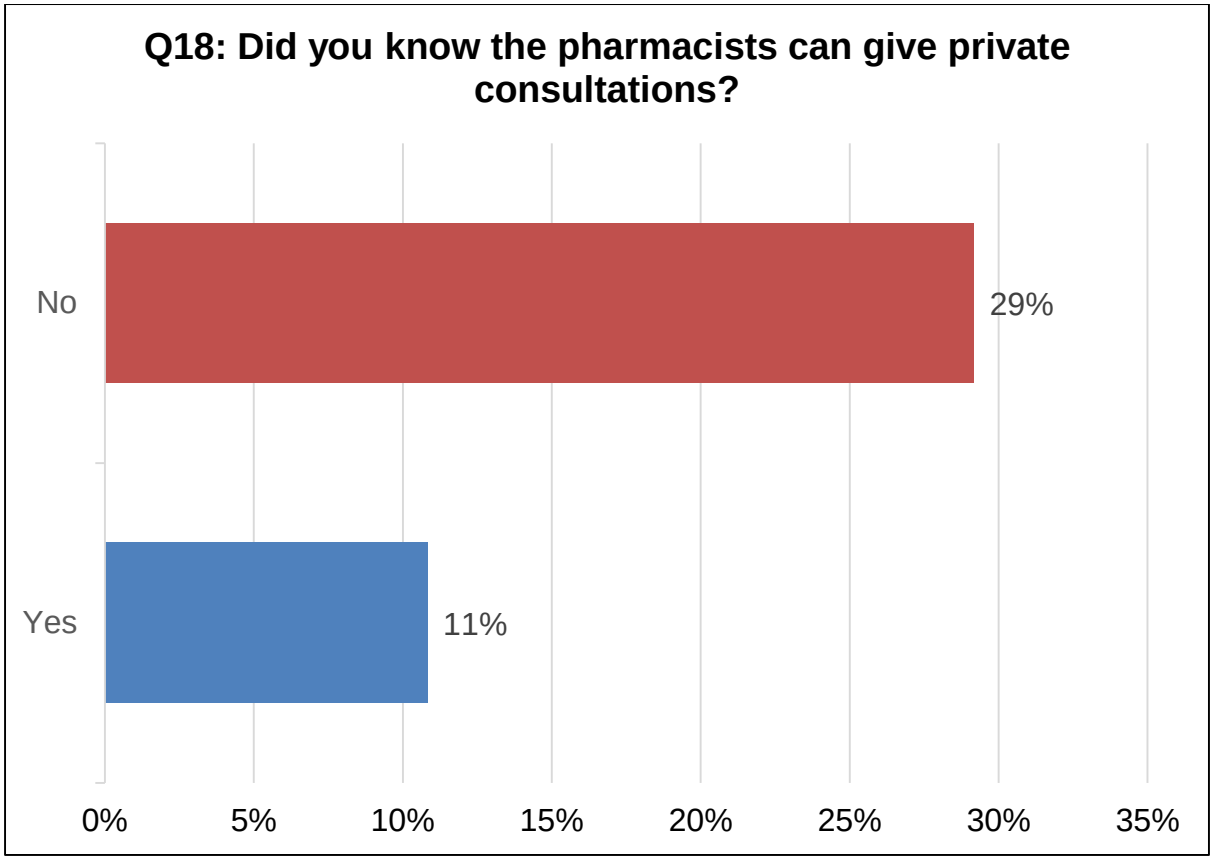
I usually ask about the side effects, if only taken with other over the counter medicines	What the medicine is for, its dosage and usage
Compatibility with other medication if not sure	The pharmacy and all pharmacists all seem to know their job and are very helpful if I ask a question
Usually the GP is very supportive and has knowledge on individual residents	Advice on taking new medicines, what to avoid eg alcohol etc
If prescribed a medication, the pharmacist always discusses information with me	Taking antibiotics with other medicines and advice about side effects that are not listed
Sometimes the dose would not match what I take and the pharmacist would notice and check (he always helps me)	Dossett box management
Clarification on what time of day to take the medicine, usually they explain without having to ask	Yes, in case I needed advice when the surgery is closed.
Blood pressure checking	Changes in medication and impact on other medications
Time gap between dosage, health concerns, information about medicine	About medication and other minor problems
To confirm or question doctor's instructions	Why do they give the cheap one and it does not work?
For diabetes and pain	Easier to ask Pharmacist than ringing the surgery
Time between medication if for example late three times we would confirm time gap with pharmacy	How to use an inhaler

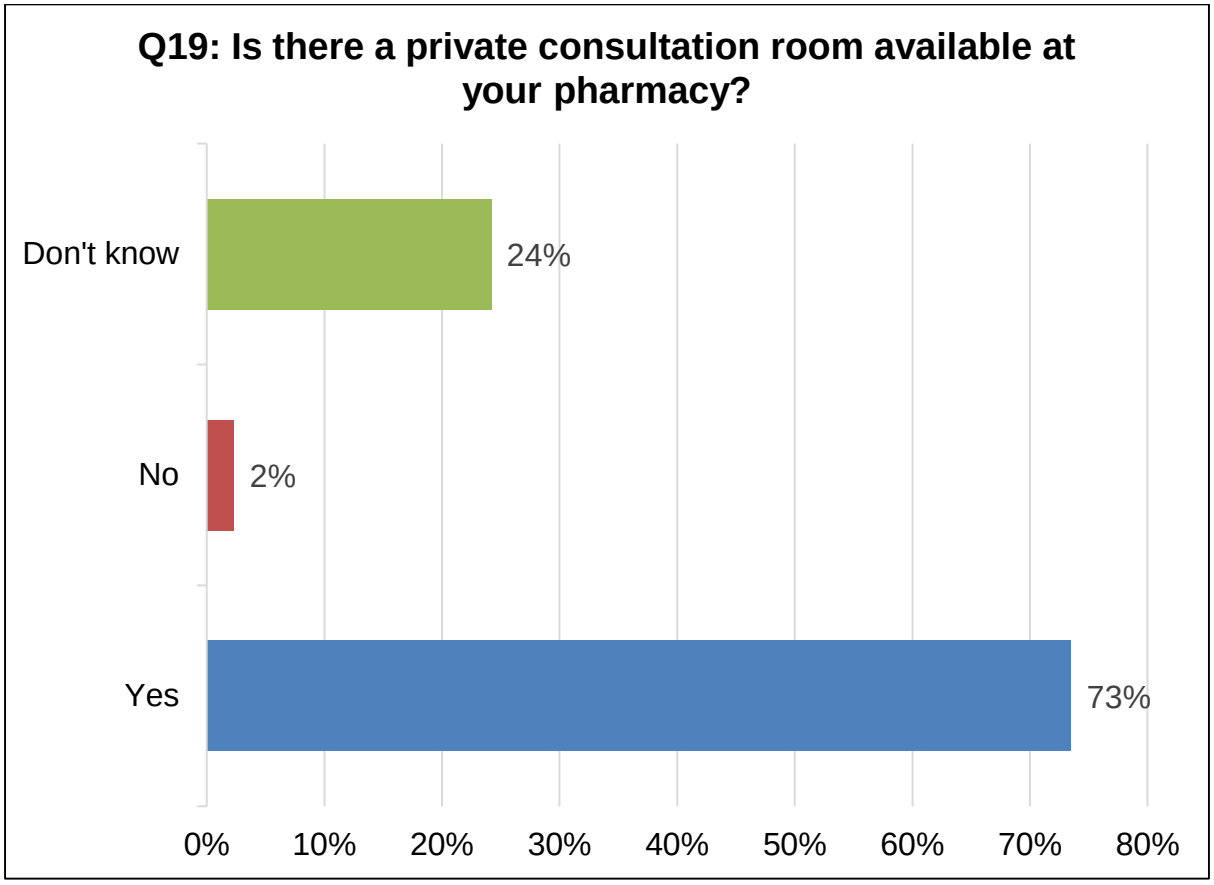
Q16: Do you know that your pharmacist can provide advice on general health, lifestyle and disease prevention (such as smoking or weight issues)?

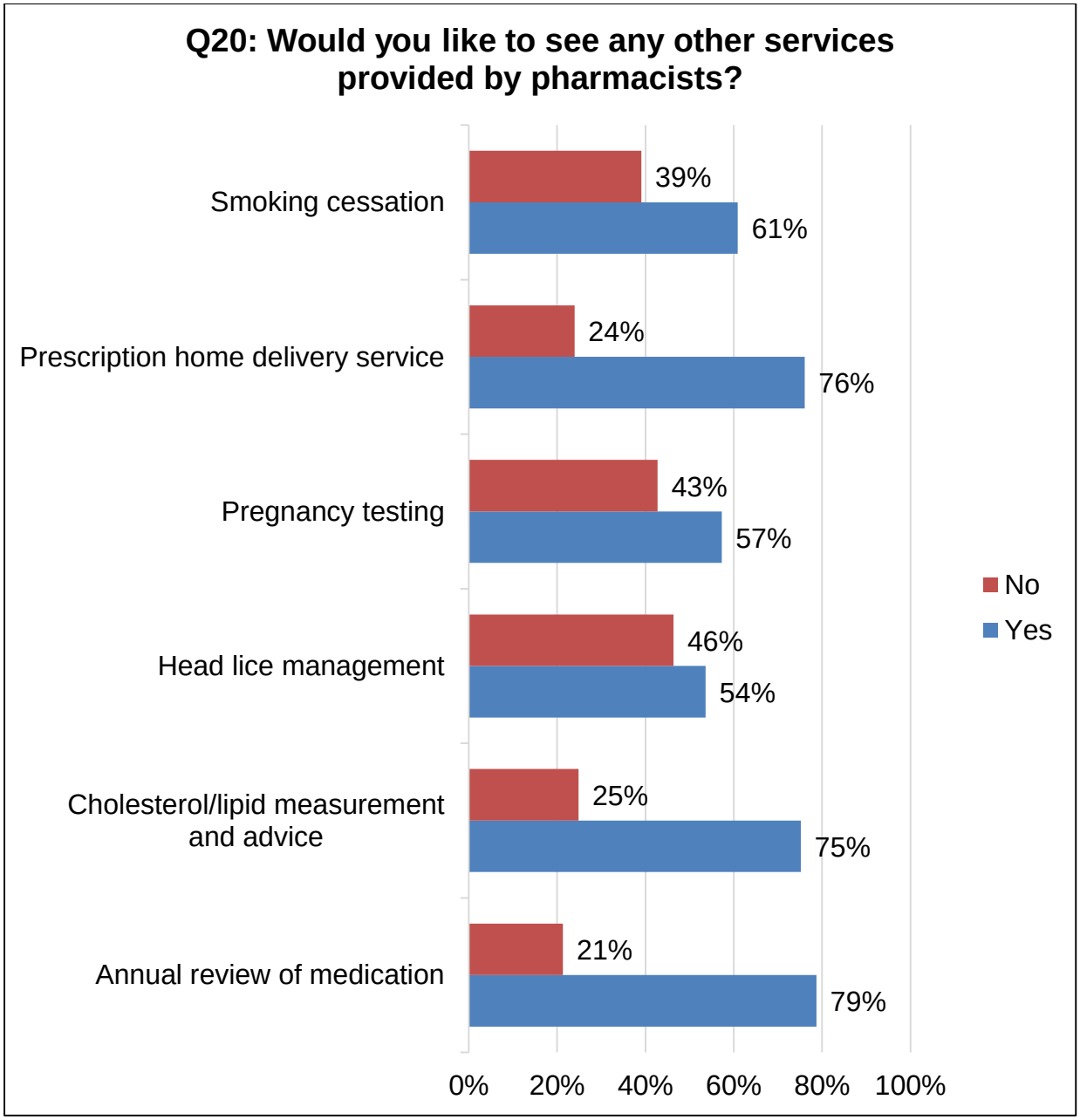


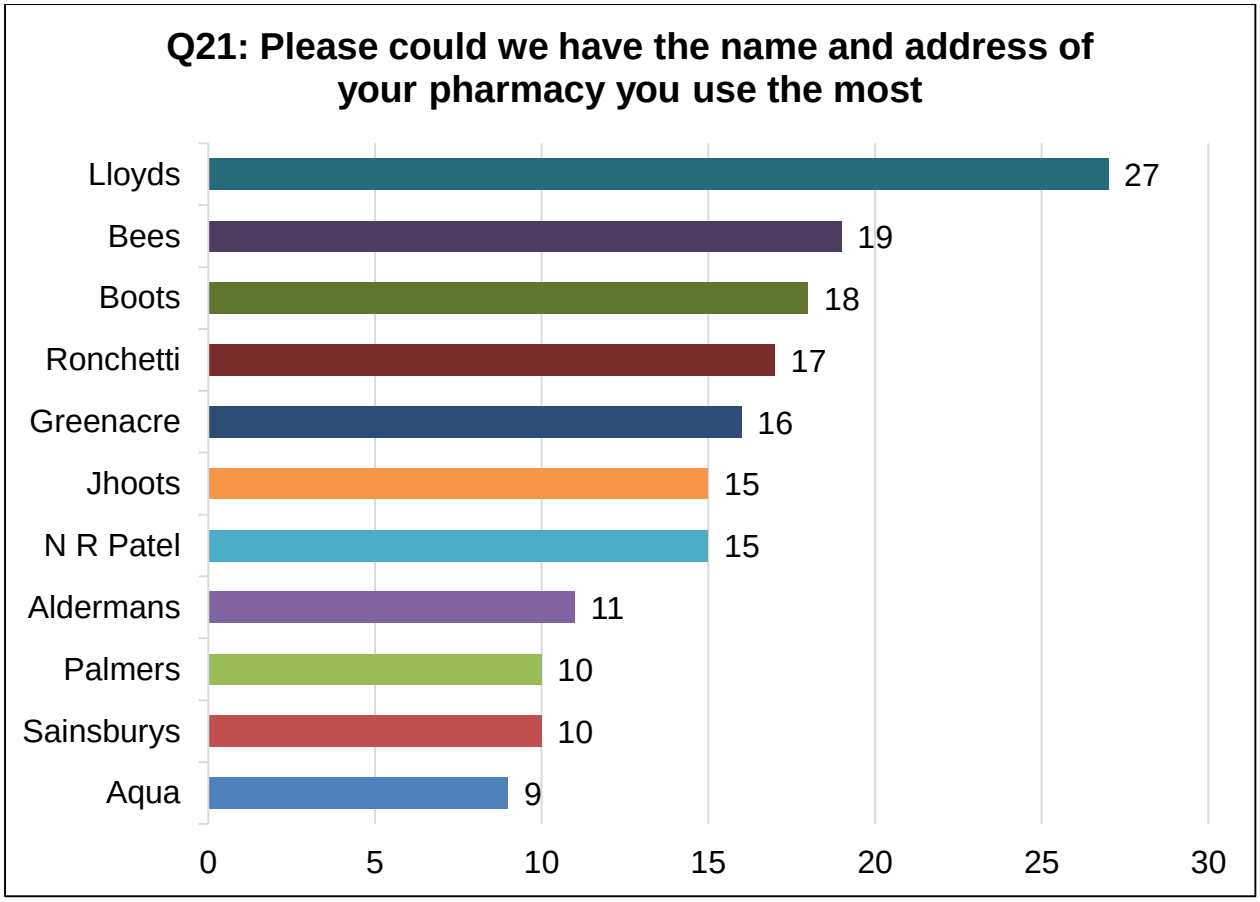
Q17: How would you rate your confidence in the pharmacist's knowledge and advice?

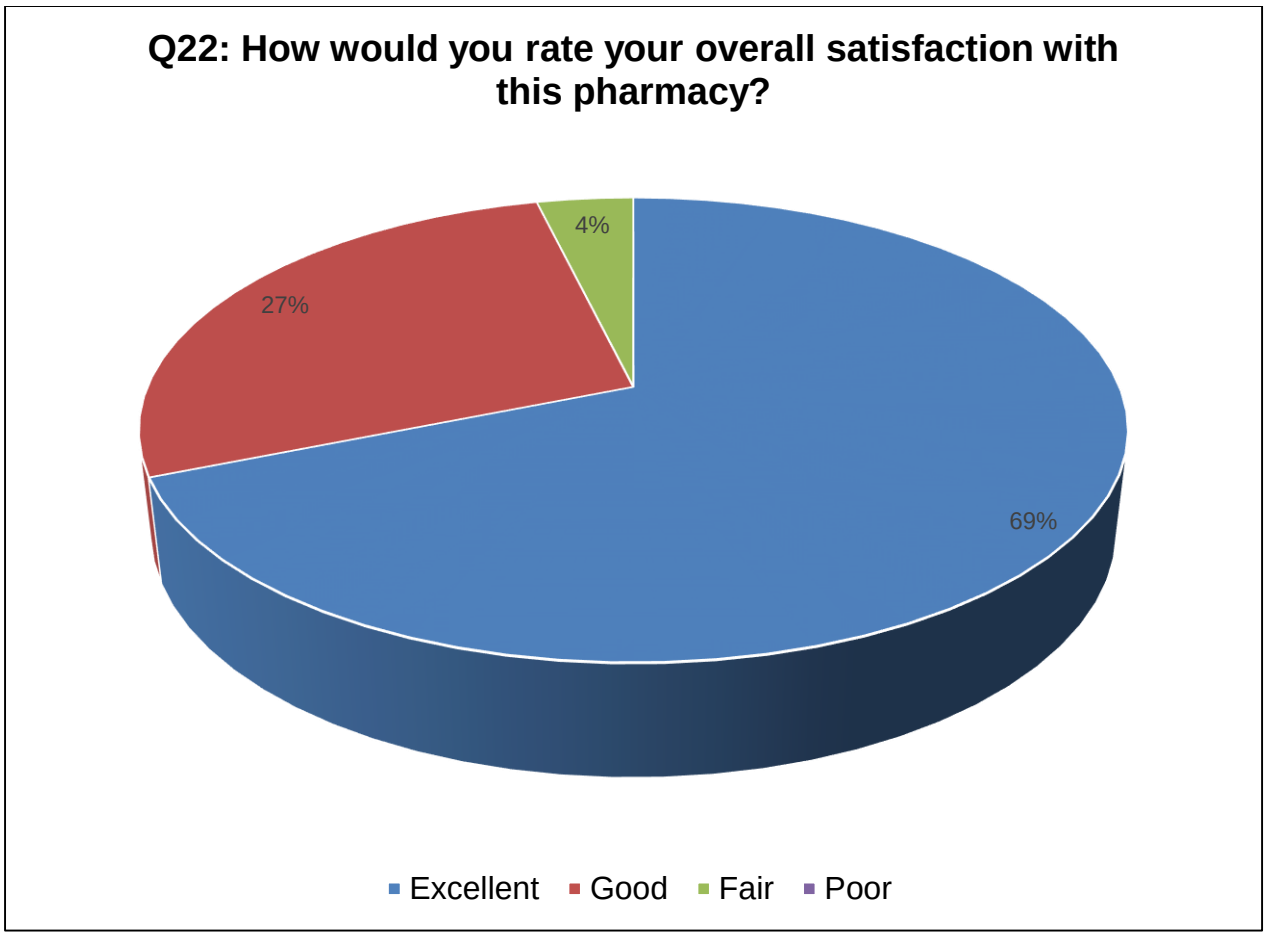



Q18: Did you know the pharmacists can give private consultations?
No
29%
Yes
11%
0%
5%
10%
15%
20%
25%
30%
35%

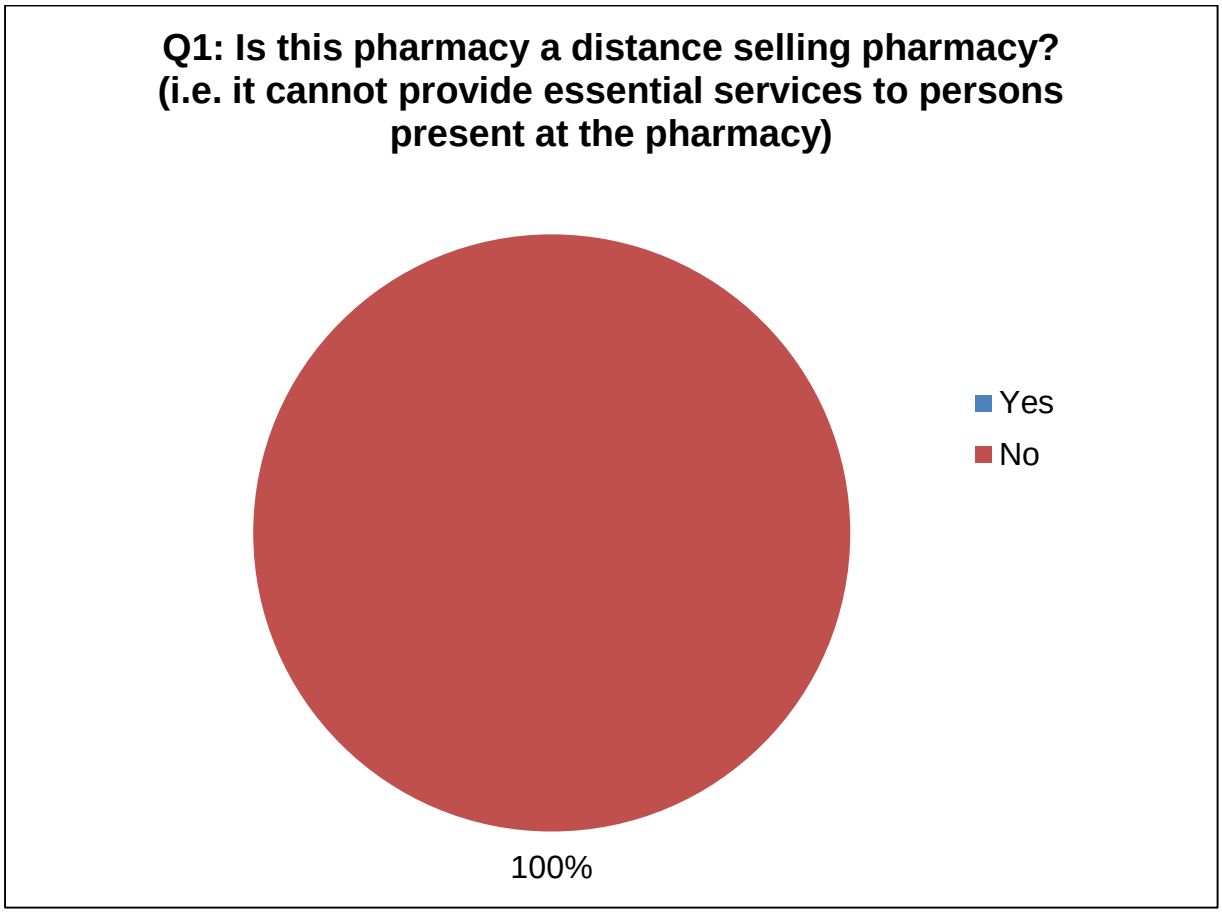

Q19: Is there a private consultation room available at your pharmacy?
Don't know
24%
No
2%
Yes
73%
0%
10%
20%
30%
40%
50%
60%
70%
80%


Q20: Would you like to see any other services provided by pharmacists?
Smoking cessation
39%
61%
Prescription home delivery service
24%
76%
Pregnancy testing
43%
57%
Head lice management
46%
54%
Cholesterol/lipid measurement and advice
25%
75%
Annual review of medication
21%
79%
No
Yes
0%
20%
40%
60%
80%
100%


Q21: Please could we have the name and address of your pharmacy you use the most
Lloyds
Bees
Boots
Ronchetti
Greenacre
Jhoots
N R Patel
Aldermans
Palmers
Sainsburys
Aqua
27
19
18
17
16
15
15
11
10
10
9
0
5
10
15
20
25
30


Q22: How would you rate your overall satisfaction with this pharmacy?
4%
27%
69%
Excellent
Good
Fair
Poor

Appendix J: Results of the pharmacy contractor survey



Q2: Please select the times your pharmacy is open from

	Open on or before 9am	Closed on or after 6pm
Monday	91%	78%
Tuesday	91%	78%
Wednesday	91%	74%
Thursday	91%	76%
Friday	91%	78%

	Yes	No	Open after 1pm
Saturday	80%	20%	59%

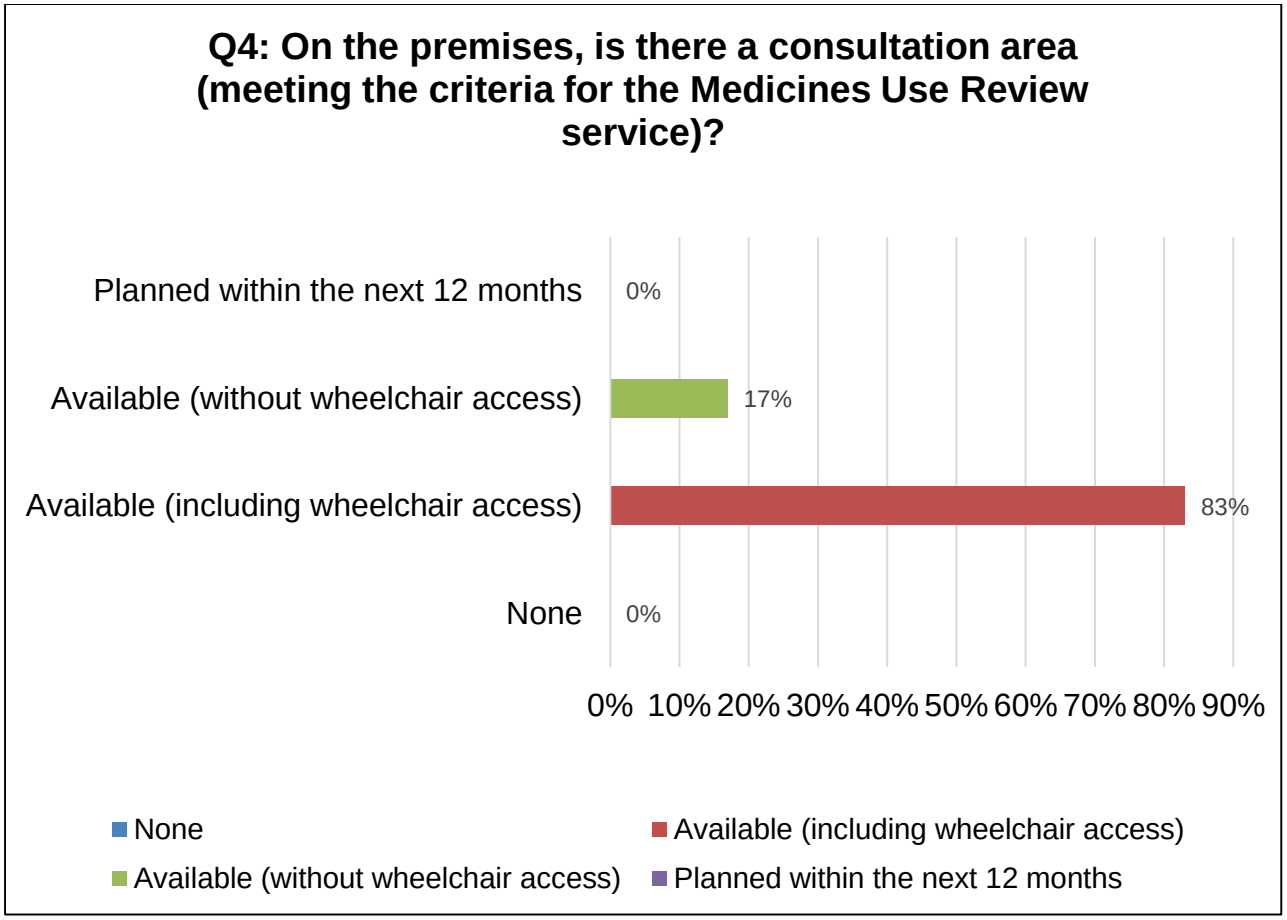
	Yes	No
Sunday	21%	79%

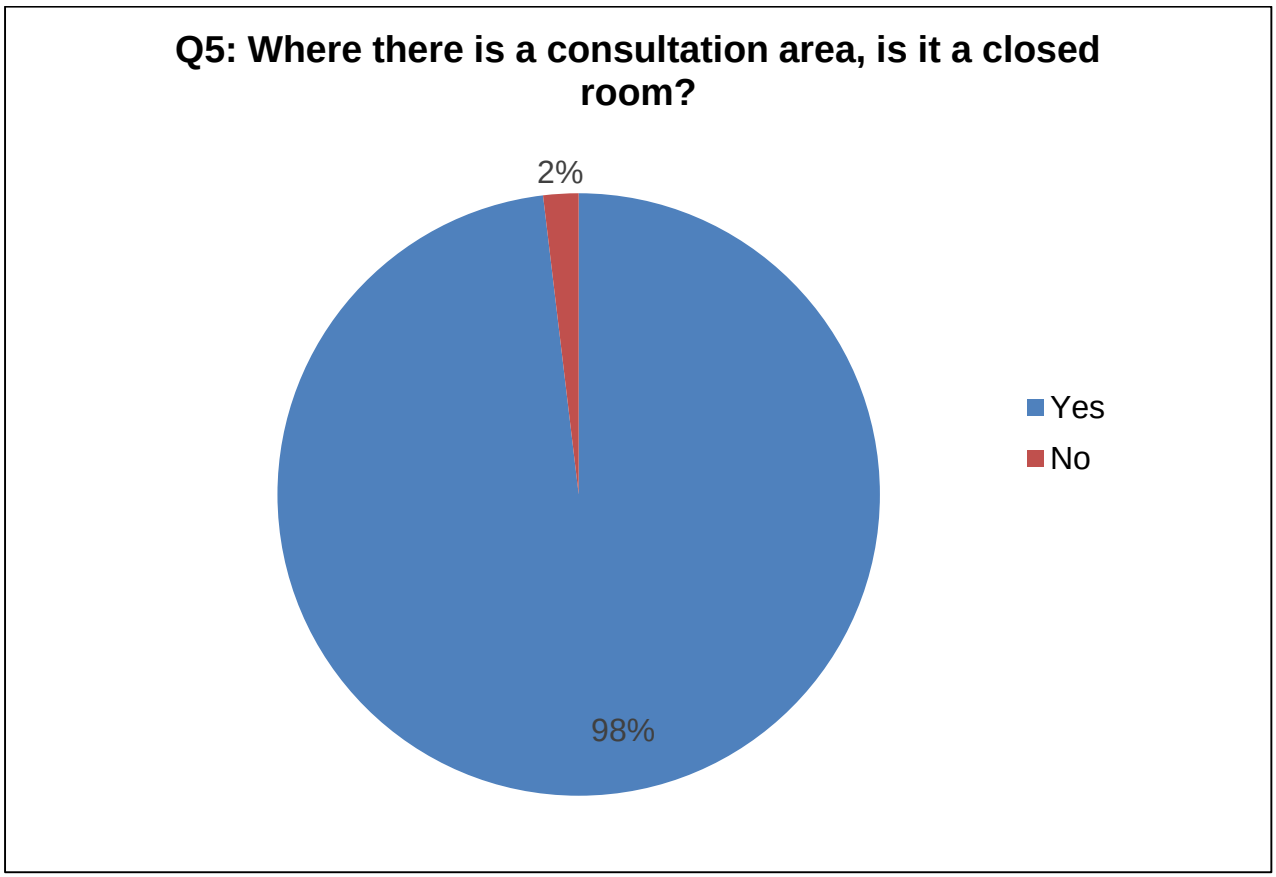
Q3: With regard to the above opening times, what are your core contracted hours at the pharmacy?

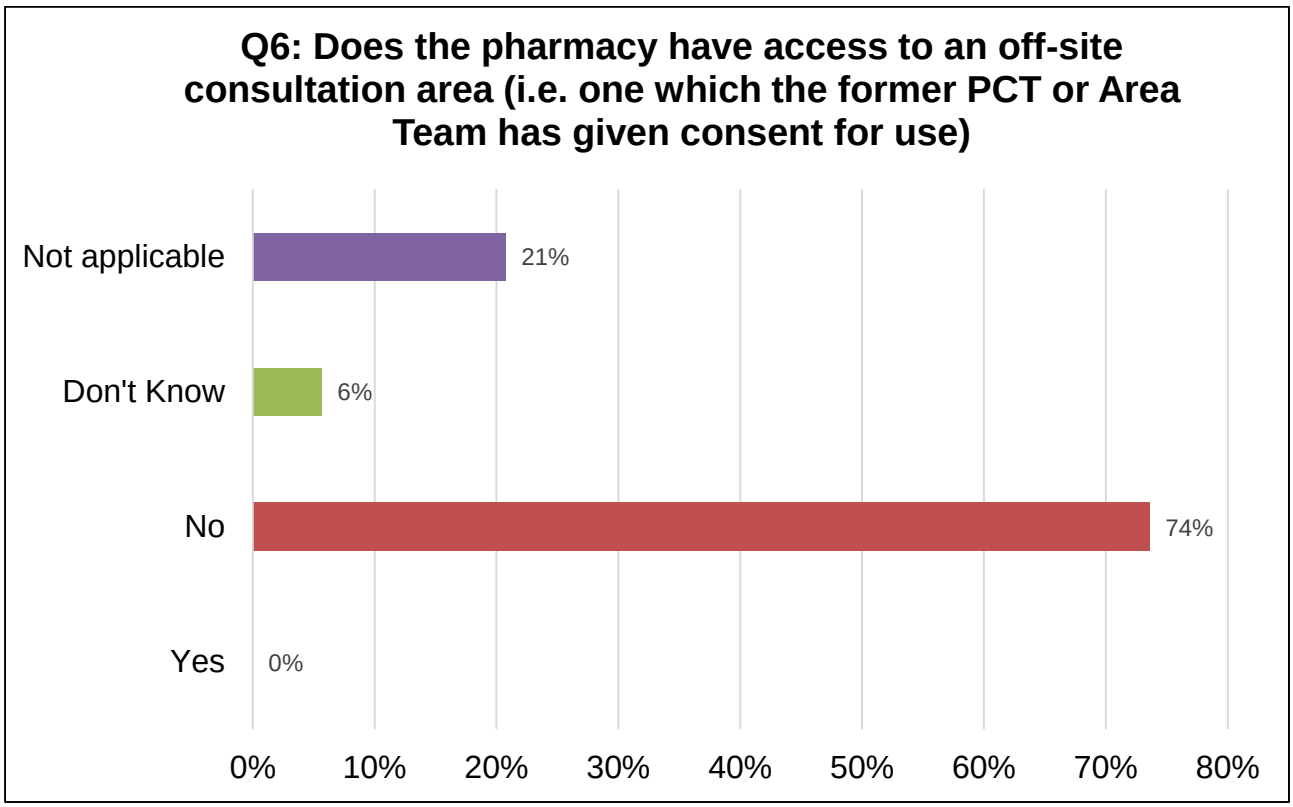
	Before 9am	Close after 6pm
Monday	96%	86%
Tuesday	96%	86%
Wednesday	96%	82%
Thursday	96%	86%
Friday	96%	86%

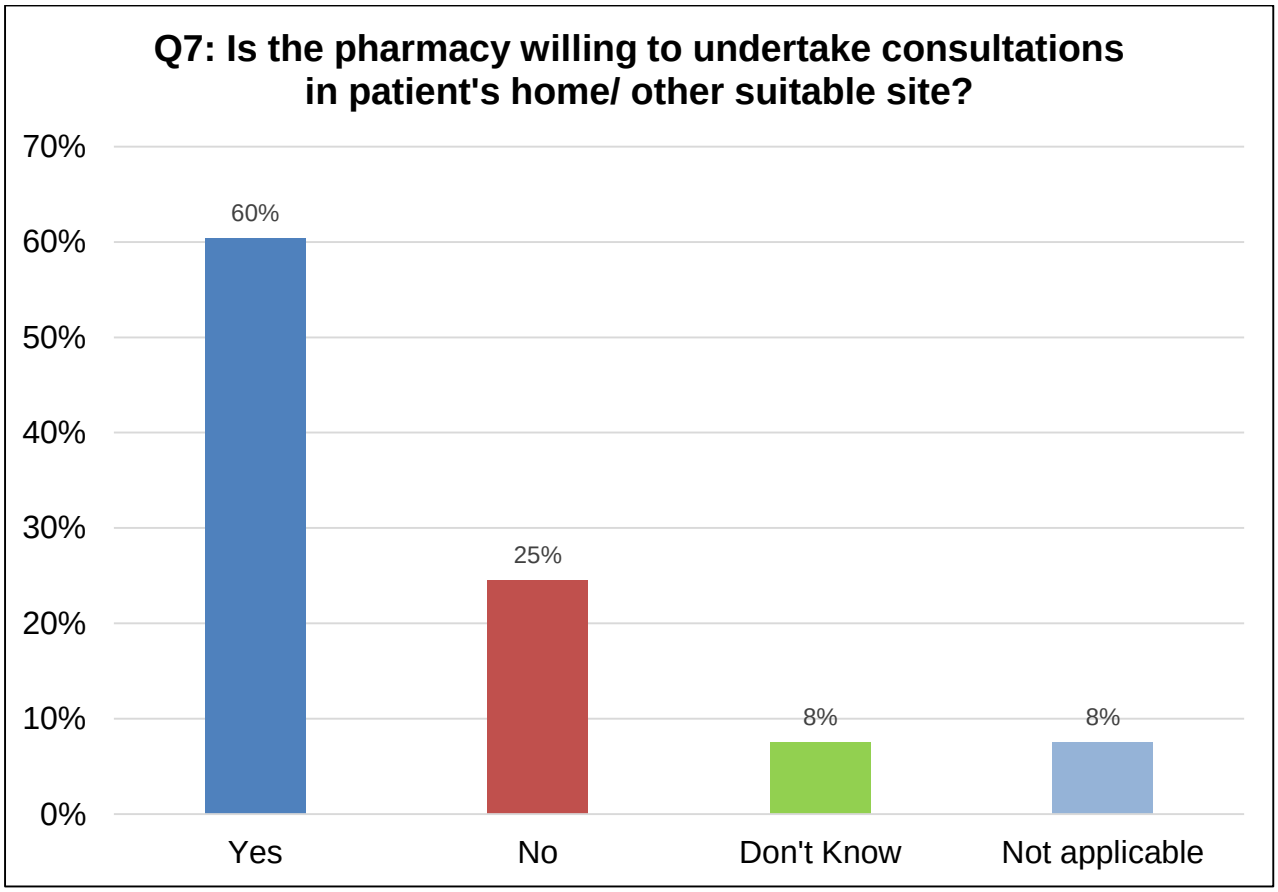
	Yes	No	Open after 1pm
Saturday	90%	10%	74%

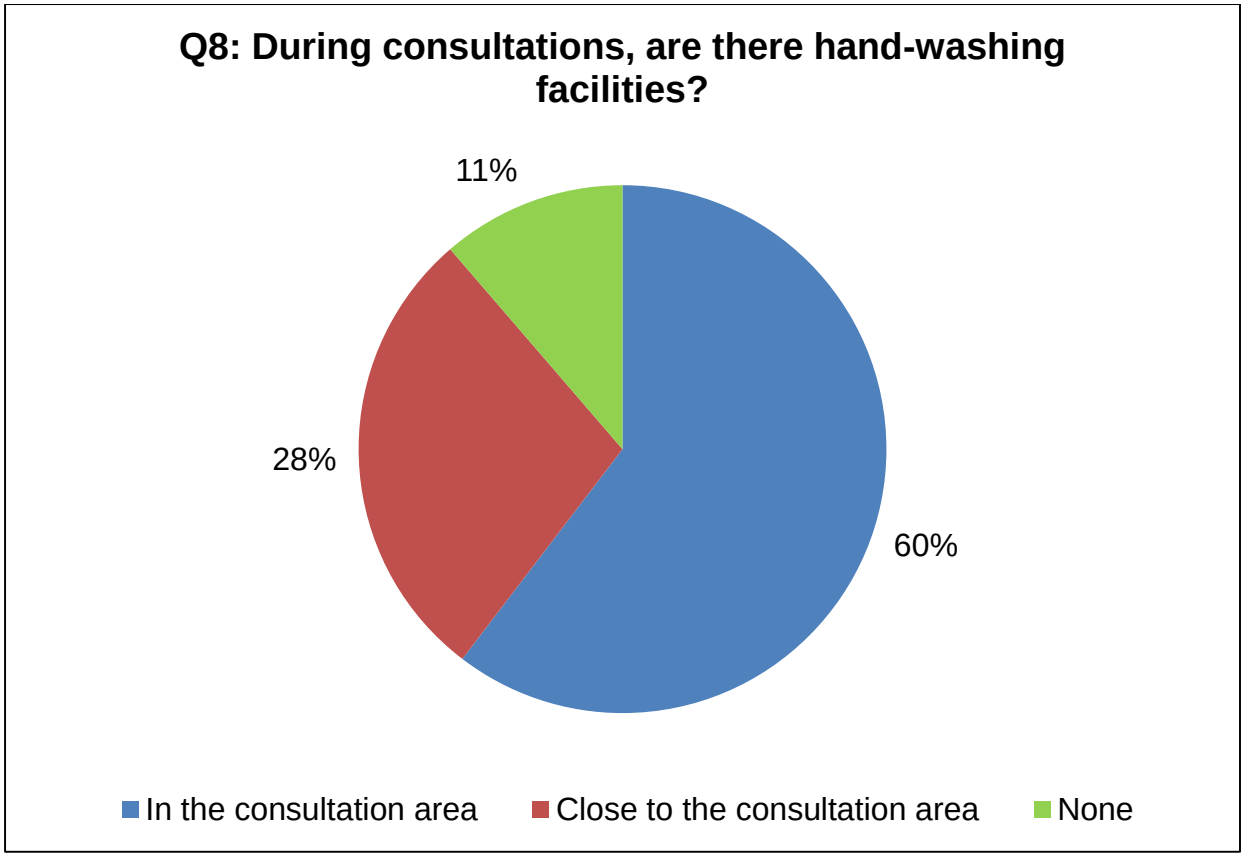
	Yes	No
Sunday	26%	74%

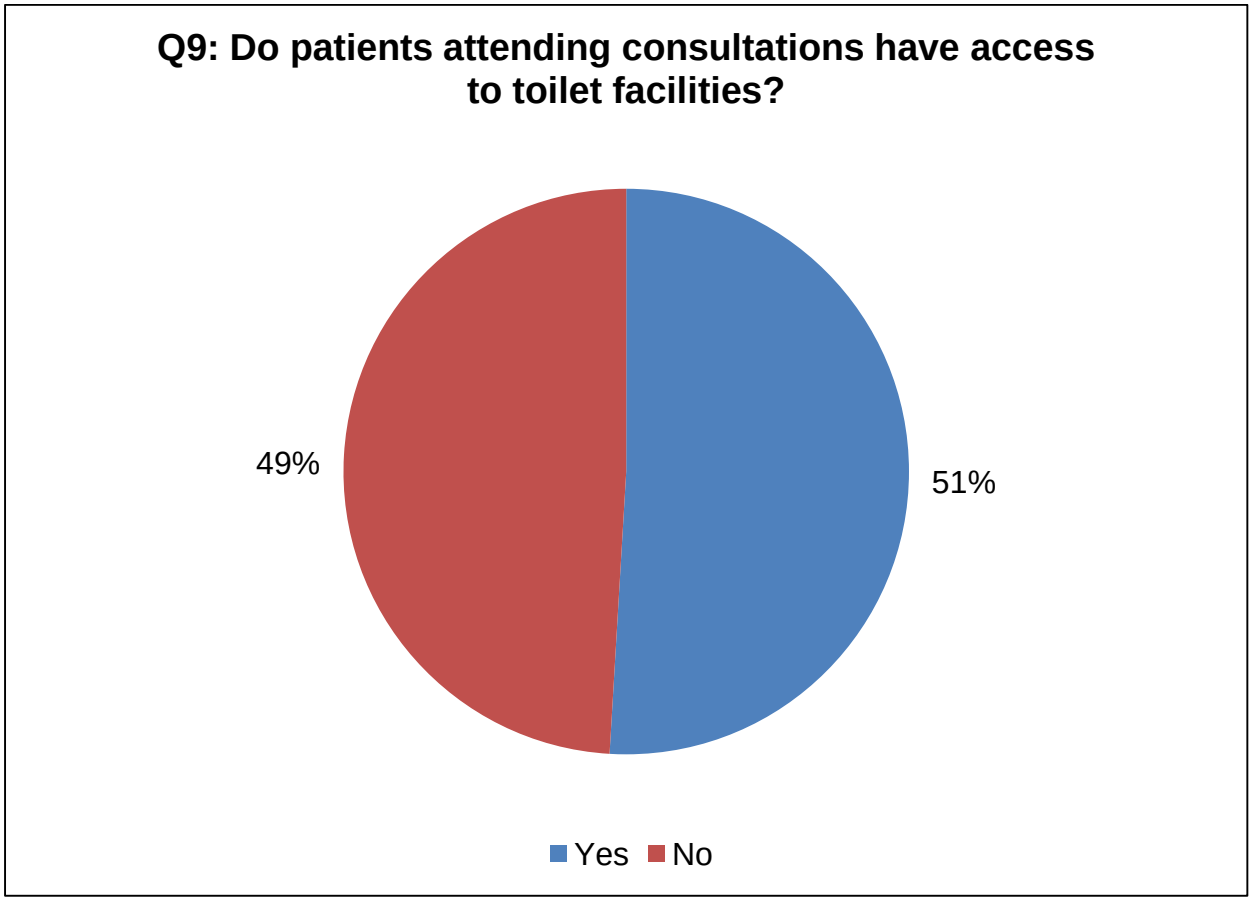

Q4: On the premises, is there a consultation area (meeting the criteria for the Medicines Use Review service)?
Planned within the next 12 months
Available (without wheelchair access)
Available (including wheelchair access)
None
0%
17%
83%
0%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90%
None
Available (including wheelchair access)
Available (without wheelchair access)
Planned within the next 12 months

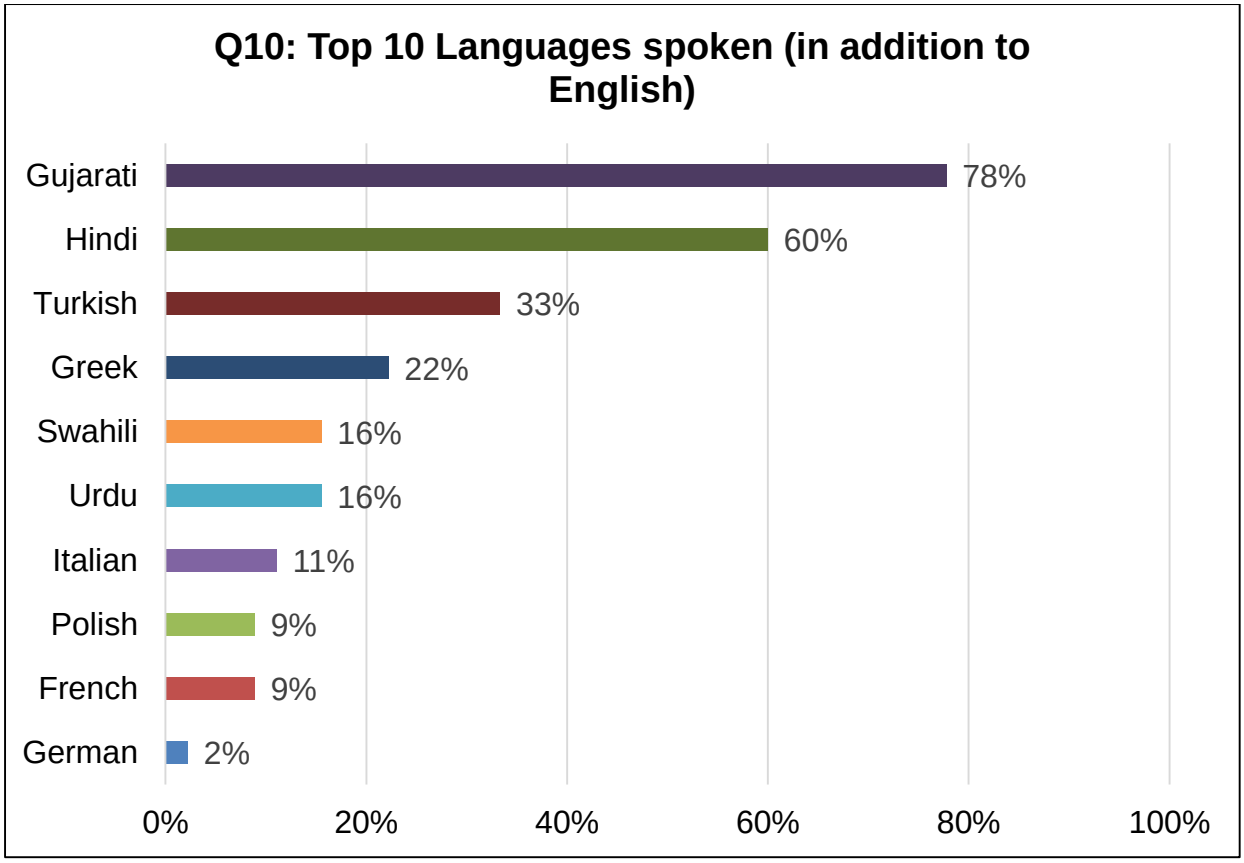

Q5: Where there is a consultation area, is it a closed room?
2%
98%
Yes
No

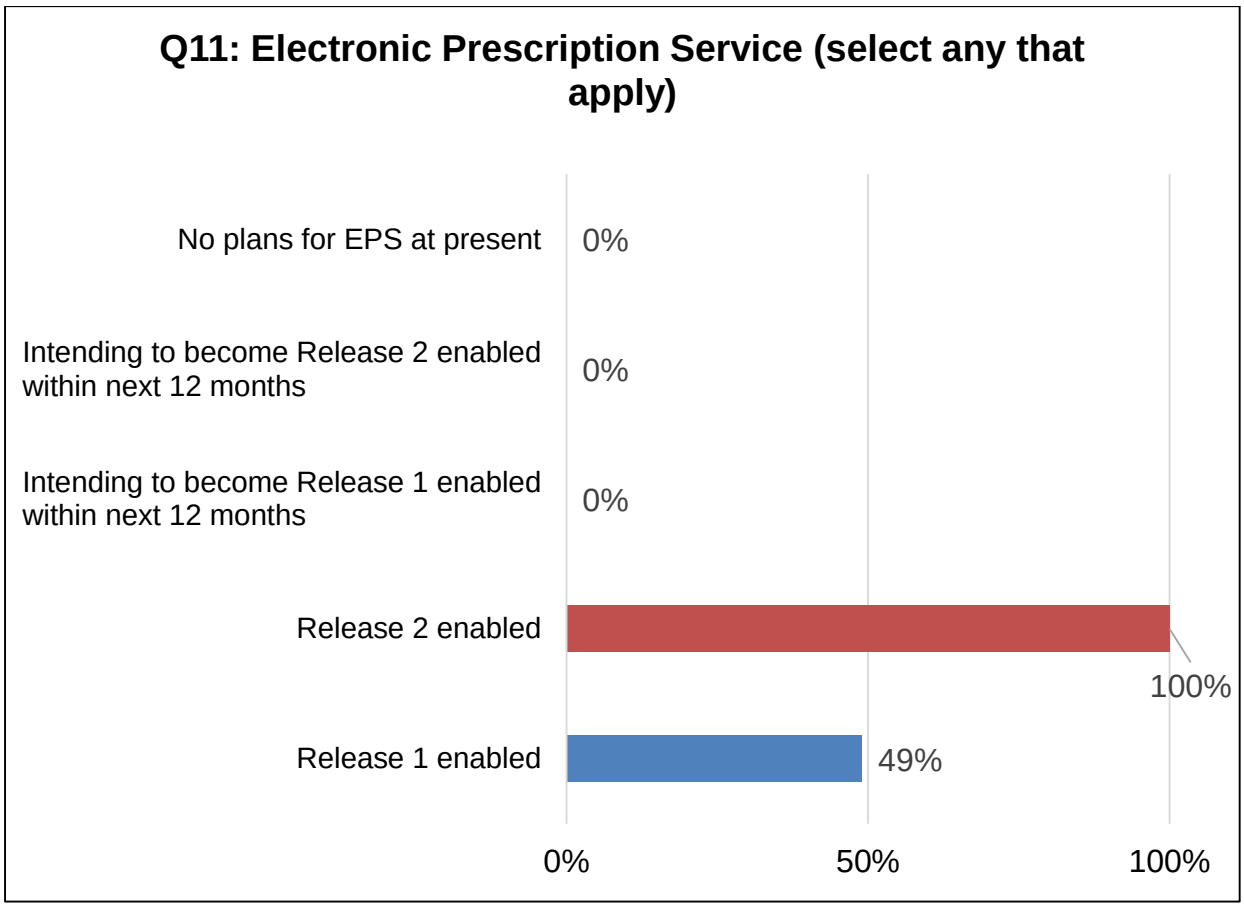

Q6: Does the pharmacy have access to an off-site consultation area (i.e. one which the former PCT or Area Team has given consent for use)
Not applicable
21%
Don't Know
6%
No
74%
Yes
0%
0%
10%
20%
30%
40%
50%
60%
70%
80%

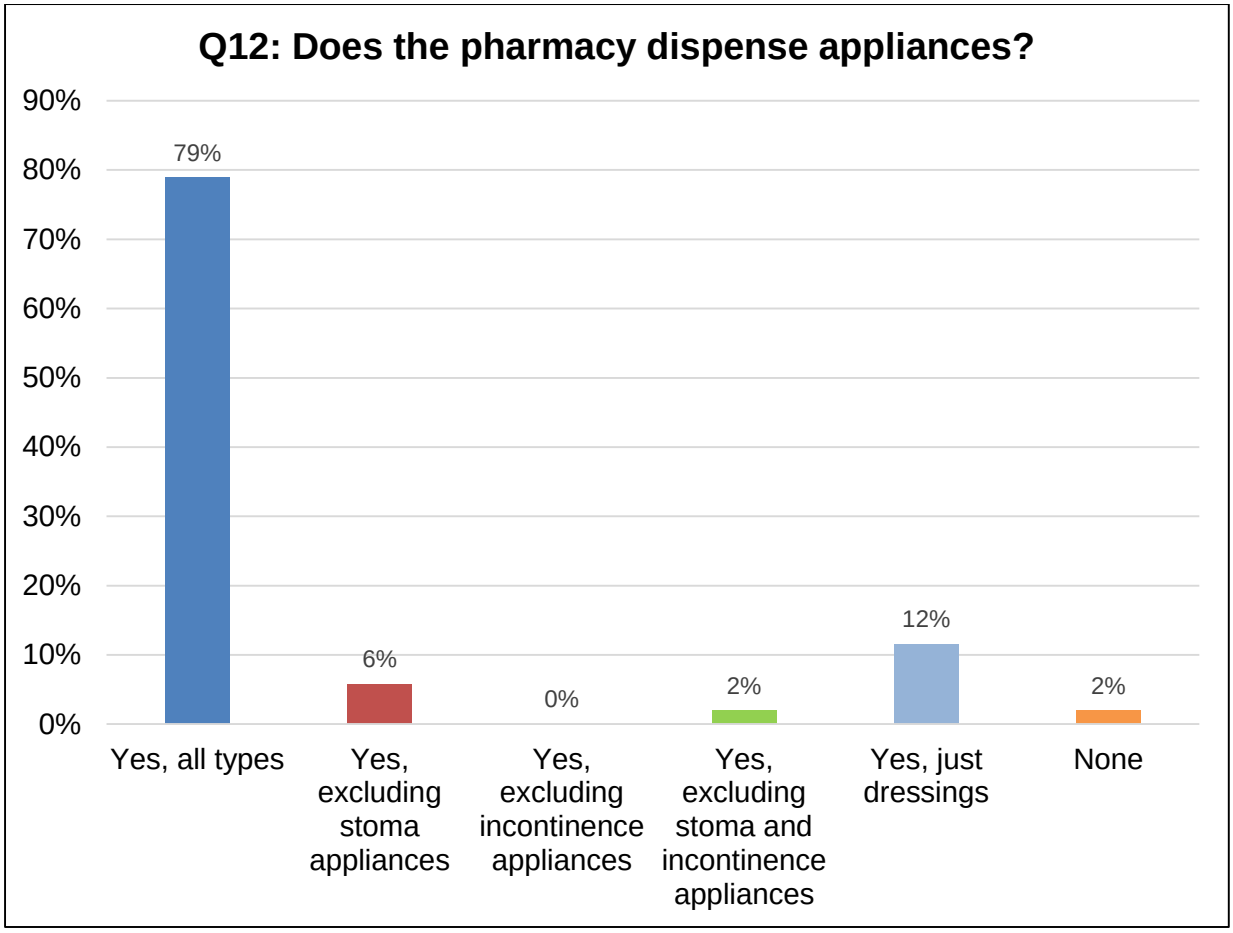

Q7: Is the pharmacy willing to undertake consultations in patient's home/ other suitable site?
70%
60%
50%
40%
30%
20%
10%
0%
60%
25%
8%
8%
Yes
No
Don't Know
Not applicable

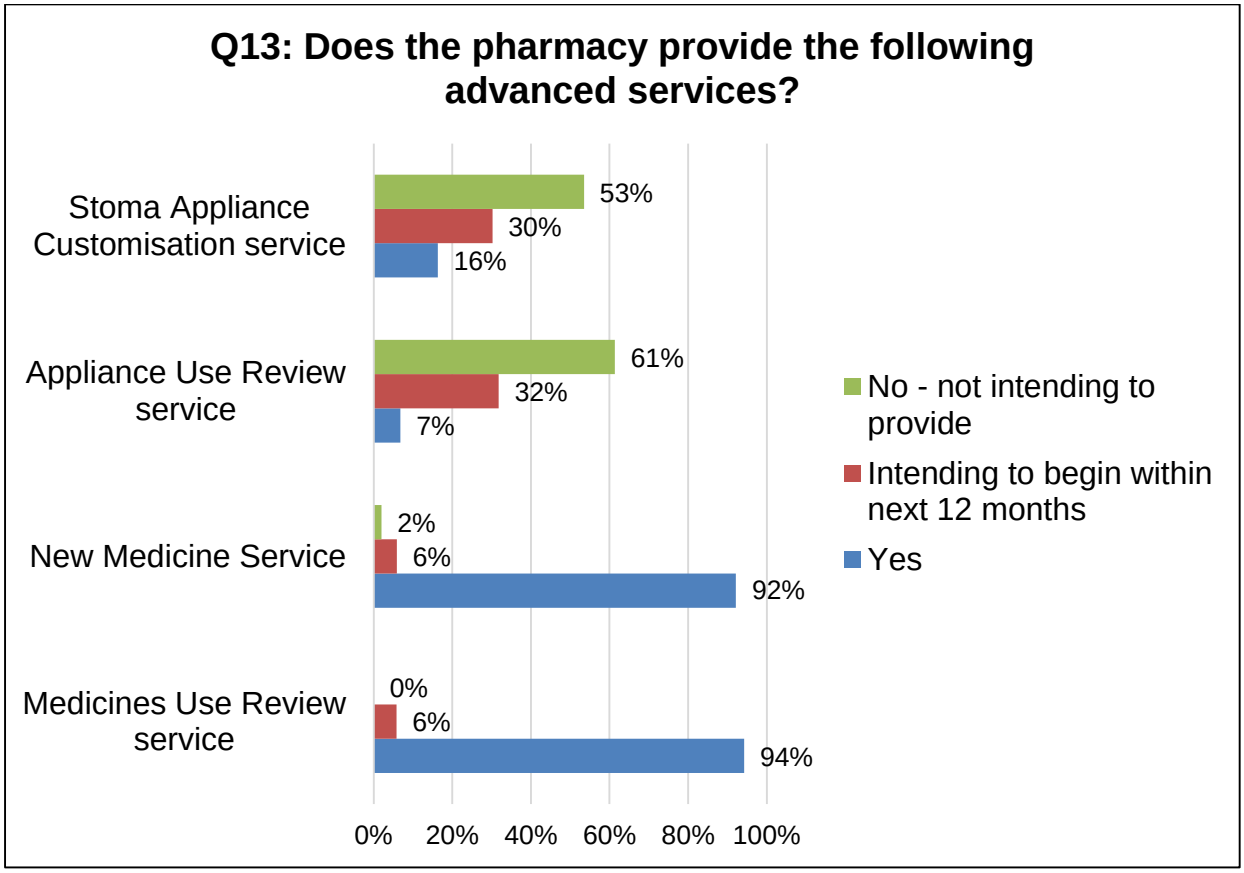

Q8: During consultations, are there hand-washing facilities?
11%
28%
60%
In the consultation area
Close to the consultation area
None

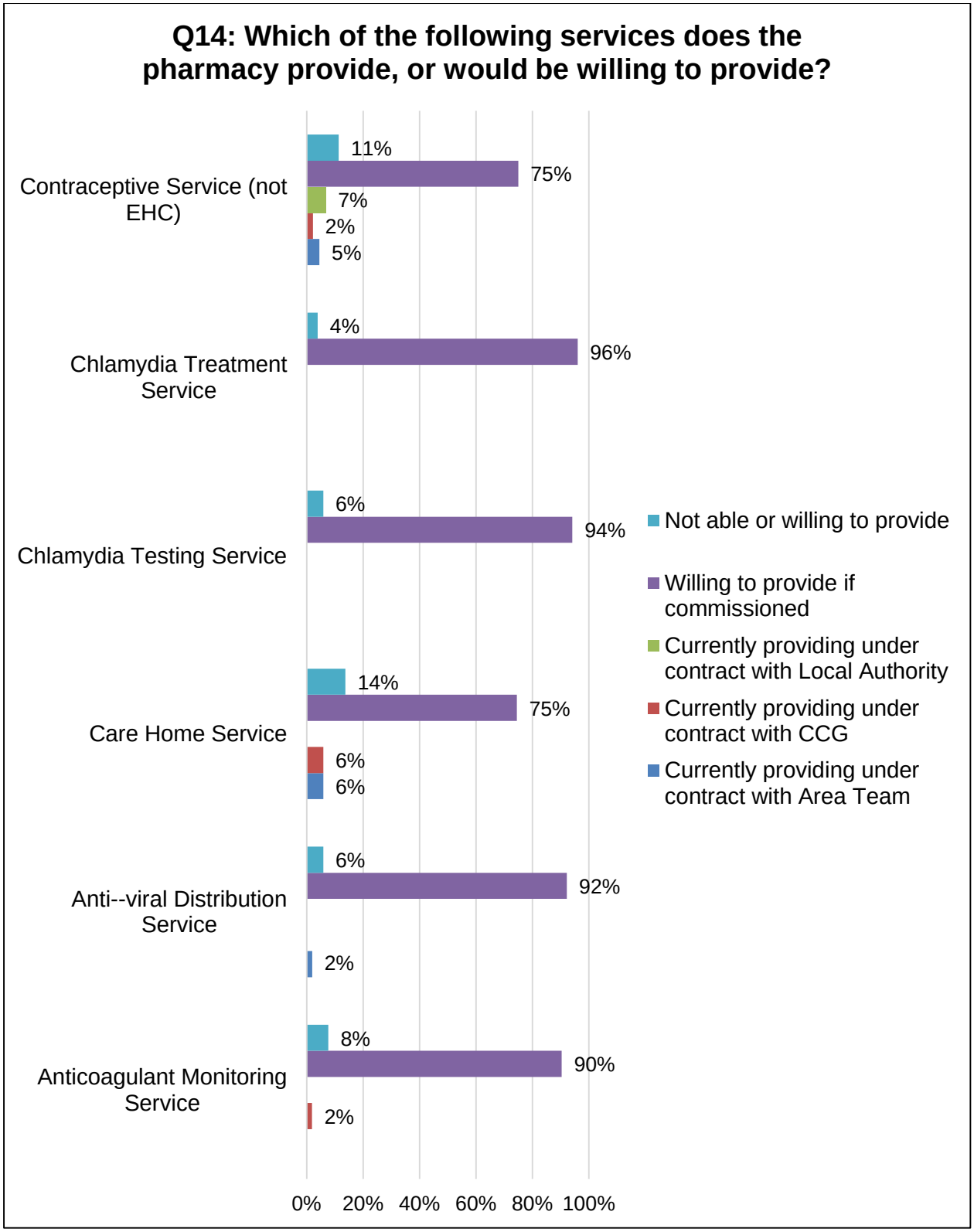

Q9: Do patients attending consultations have access to toilet facilities?
49%
51%
Yes
No


Q10: Top 10 Languages spoken (in addition to English)
Gujarati
78%
Hindi
60%
Turkish
33%
Greek
22%
Swahili
16%
Urdu
16%
Italian
11%
Polish
9%
French
9%
German
2%
0%
20%
40%
60%
80%
100%

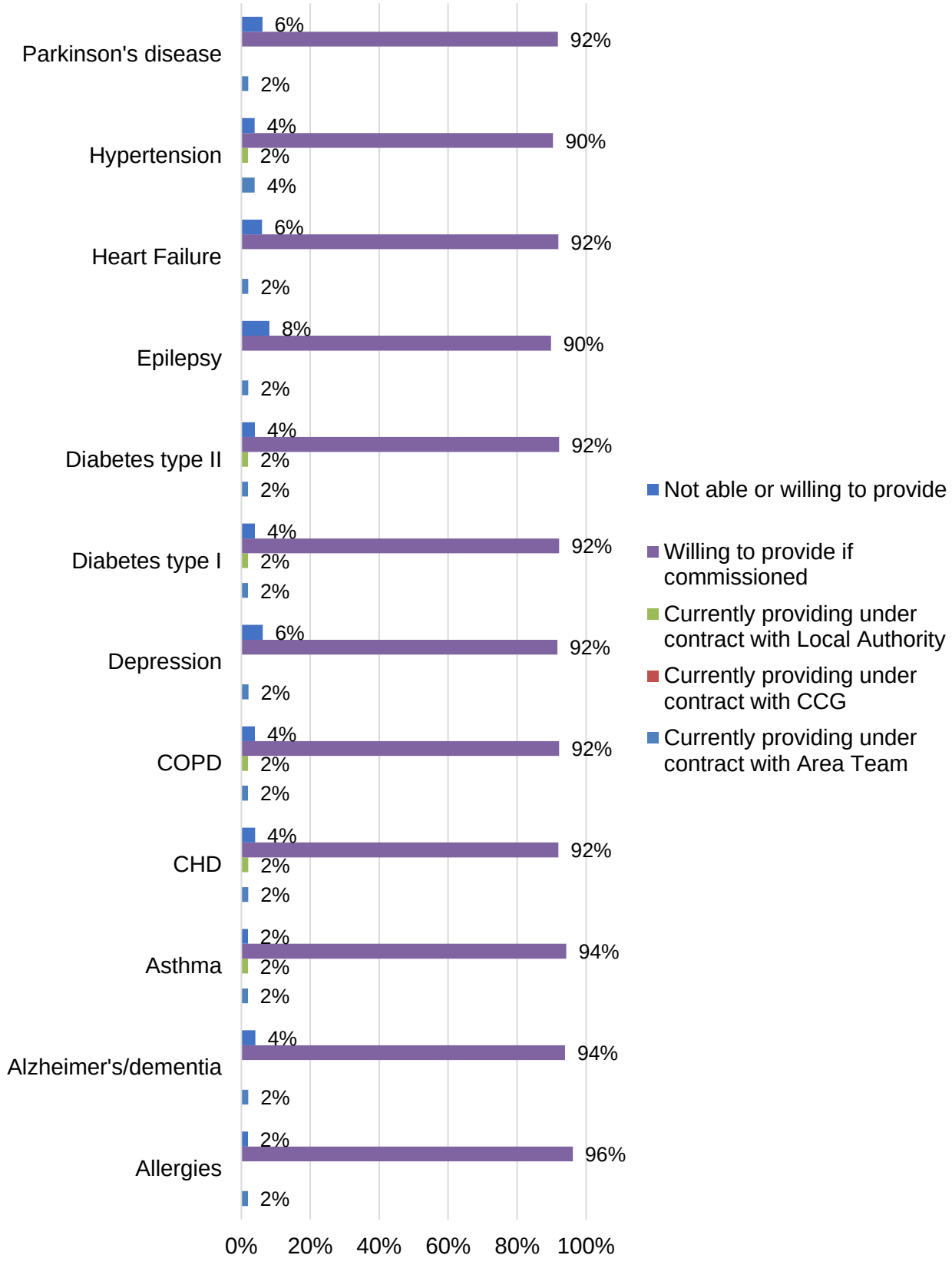

Q11: Electronic Prescription Service (select any that apply)
No plans for EPS at present
0%
Intending to become Release 2 enabled within next 12 months
0%
Intending to become Release 1 enabled within next 12 months
0%
Release 2 enabled
100%
Release 1 enabled
49%
0%
50%
100%

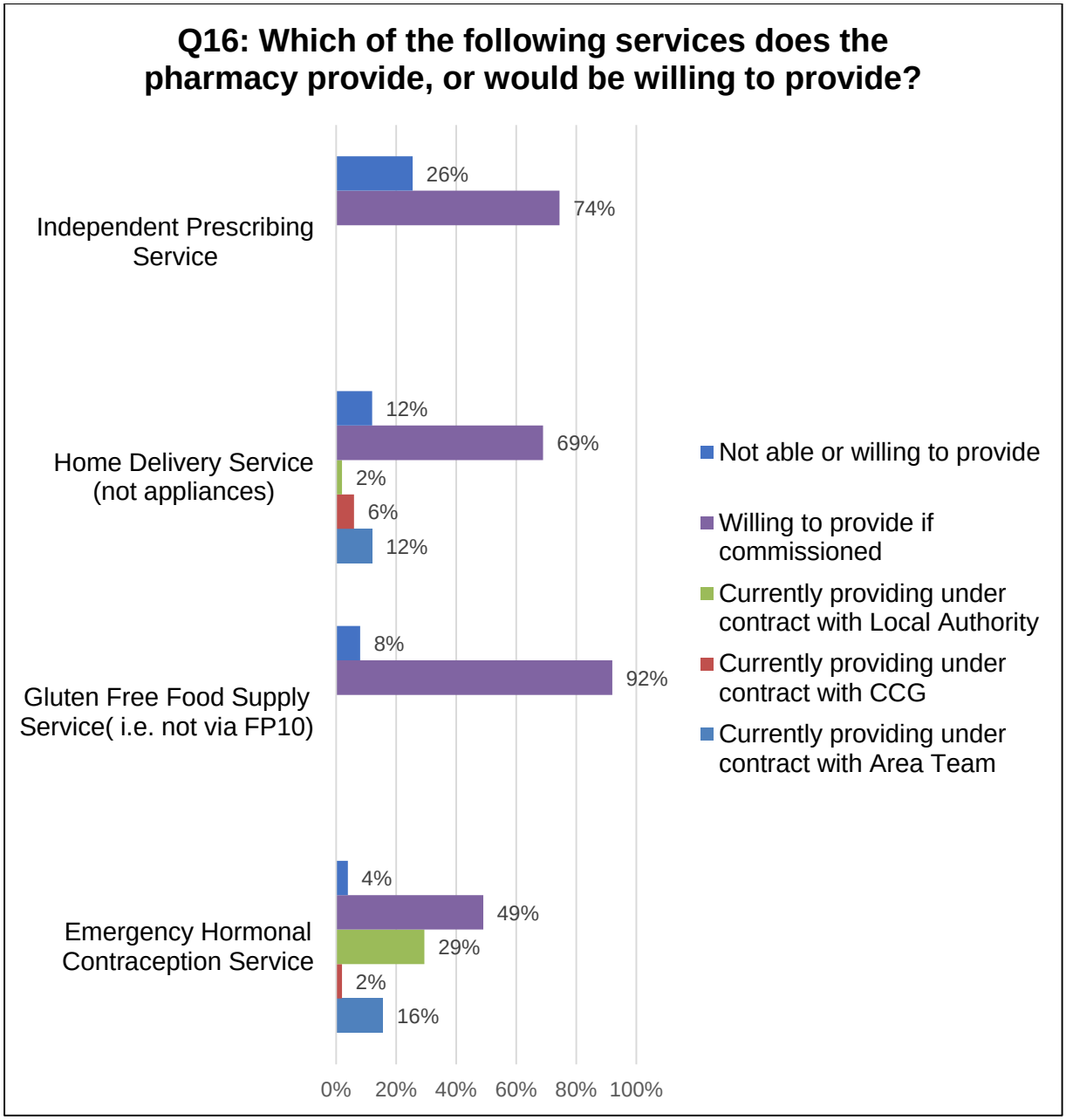

Q12: Does the pharmacy dispense appliances?
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
79%
6%
0%
2%
12%
2%
Yes, all types
Yes, excluding stoma appliances
Yes, excluding incontinence appliances
Yes, excluding stoma and incontinence appliances
Yes, just dressings
None

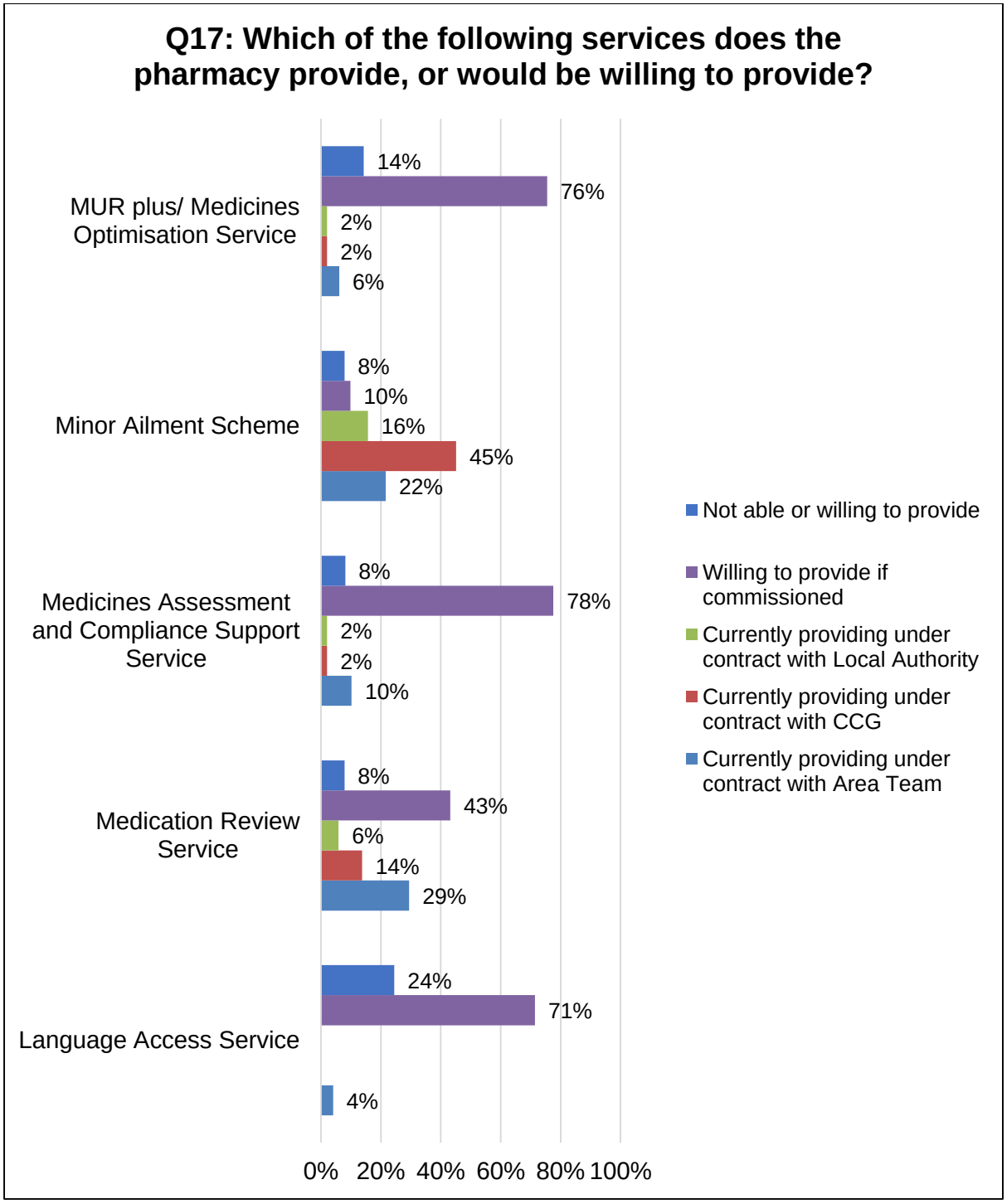

Q13: Does the pharmacy provide the following advanced services?
Stoma Appliance Customisation service
53%
30%
16%
Appliance Use Review service
61%
32%
7%
New Medicine Service
2%
6%
92%
Medicines Use Review service
0%
6%
94%
0%
20%
40%
60%
80%
100%
No - not intending to provide
Intending to begin within next 12 months
Yes

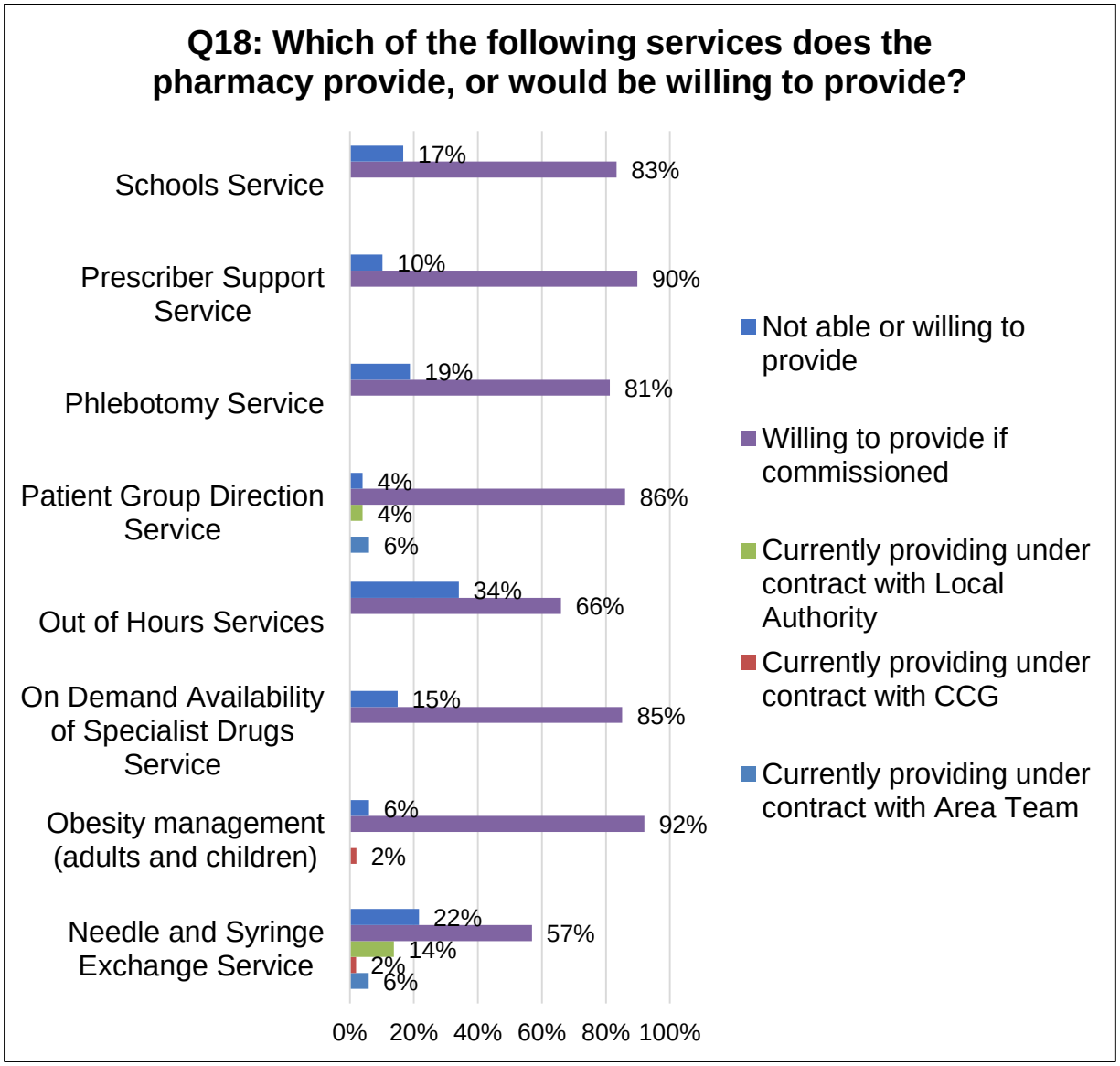

Q14: Which of the following services does the pharmacy provide, or would be willing to provide?
Contraceptive Service (not EHC)
11%
75%
7%
2%
5%
Chlamydia Treatment Service
4%
96%
Chlamydia Testing Service
6%
94%
Care Home Service
14%
75%
6%
6%
Anti--viral Distribution Service
6%
92%
2%
Anticoagulant Monitoring Service
8%
90%
2%
0%
20%
40%
60%
80%
100%
Not able or willing to provide
Willing to provide if commissioned
Currently providing under contract with Local Authority
Currently providing under contract with CCG
Currently providing under contract with Area Team

Q15: Which of the following Disease Specific Medicines Management services does the pharmacy provide, or would be willing to provide?

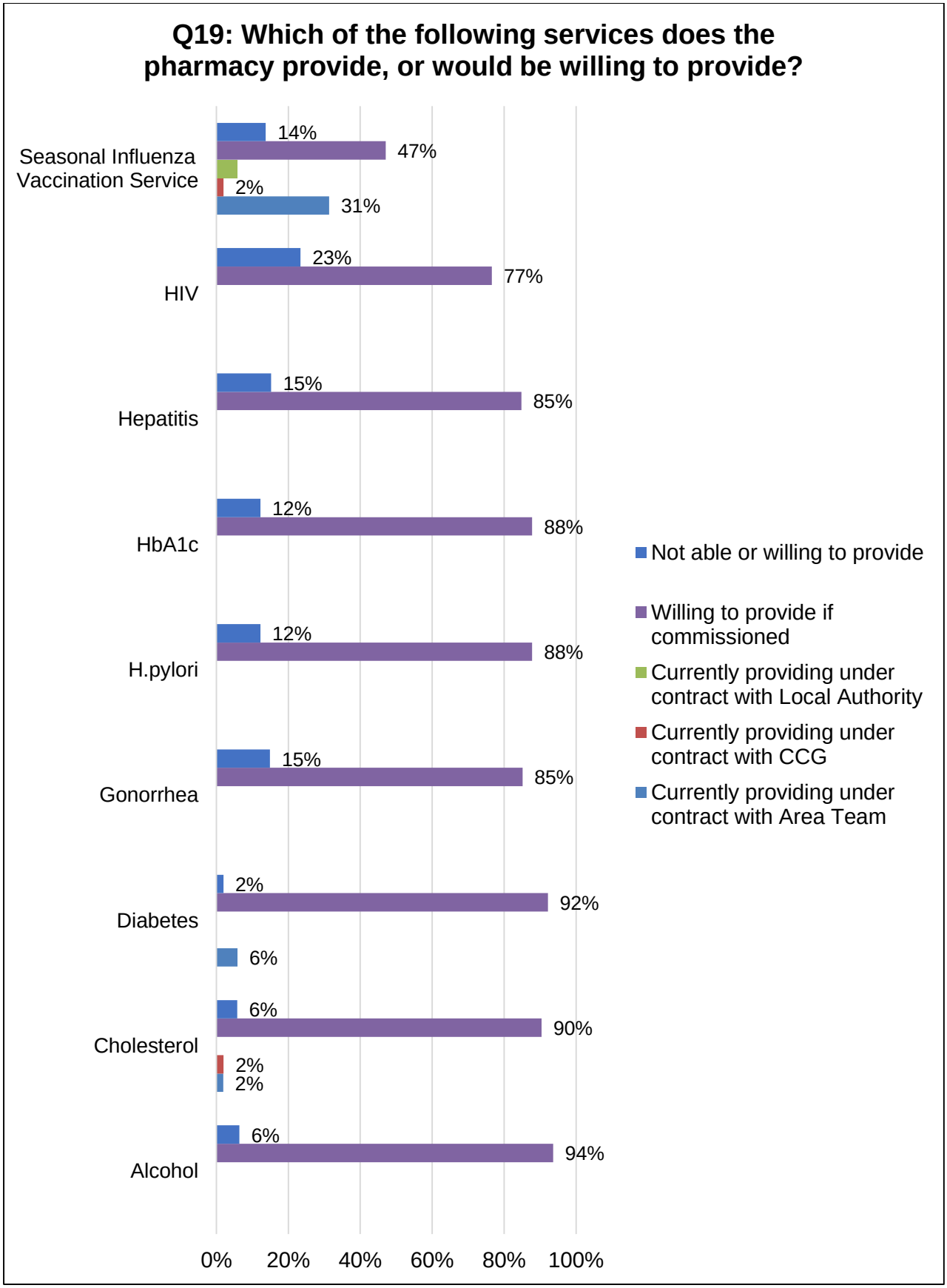



Q16: Which of the following services does the pharmacy provide, or would be willing to provide?
Independent Prescribing Service
26%
74%
Home Delivery Service (not appliances)
12%
69%
2%
6%
12%
Gluten Free Food Supply Service(i.e. not via FP10)
8%
92%
Emergency Hormonal Contraception Service
4%
49%
29%
2%
16%
0%
20%
40%
60%
80%
100%
Not able or willing to provide
Willing to provide if commissioned
Currently providing under contract with Local Authority
Currently providing under contract with CCG
Currently providing under contract with Area Team

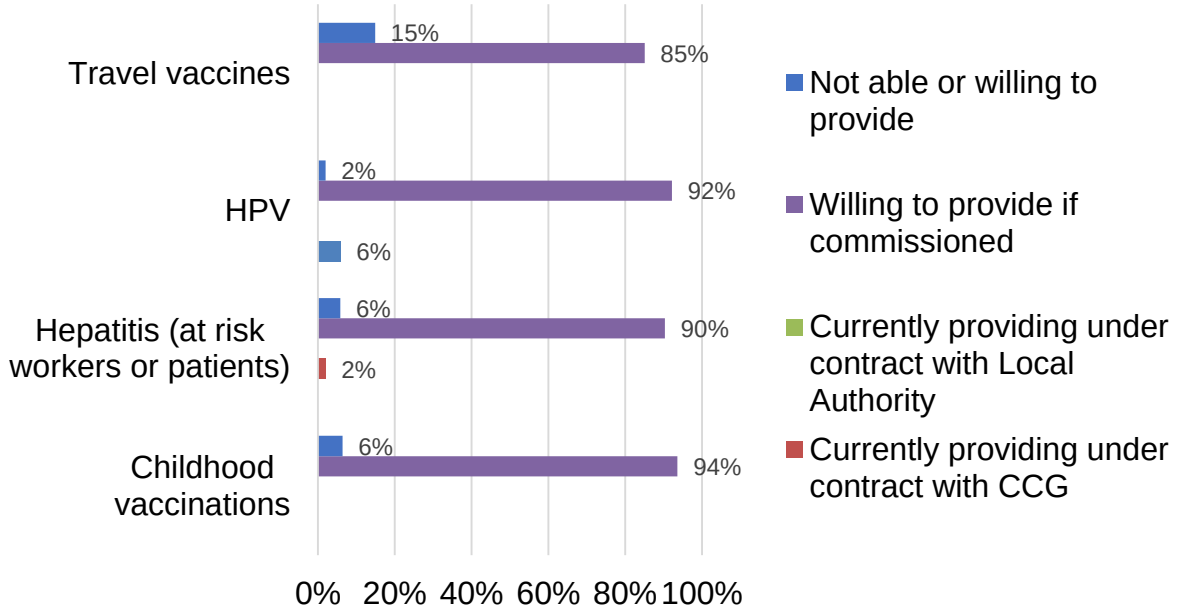

Q17: Which of the following services does the pharmacy provide, or would be willing to provide?
MUR plus/ Medicines Optimisation Service
14%
76%
2%
2%
6%
Minor Ailment Scheme
8%
10%
16%
45%
22%
Medicines Assessment and Compliance Support Service
8%
78%
2%
2%
10%
Medication Review Service
8%
43%
6%
14%
29%
Language Access Service
24%
71%
4%
0%
20%
40%
60%
80%
100%
Not able or willing to provide
Willing to provide if commissioned
Currently providing under contract with Local Authority
Currently providing under contract with CCG
Currently providing under contract with Area Team



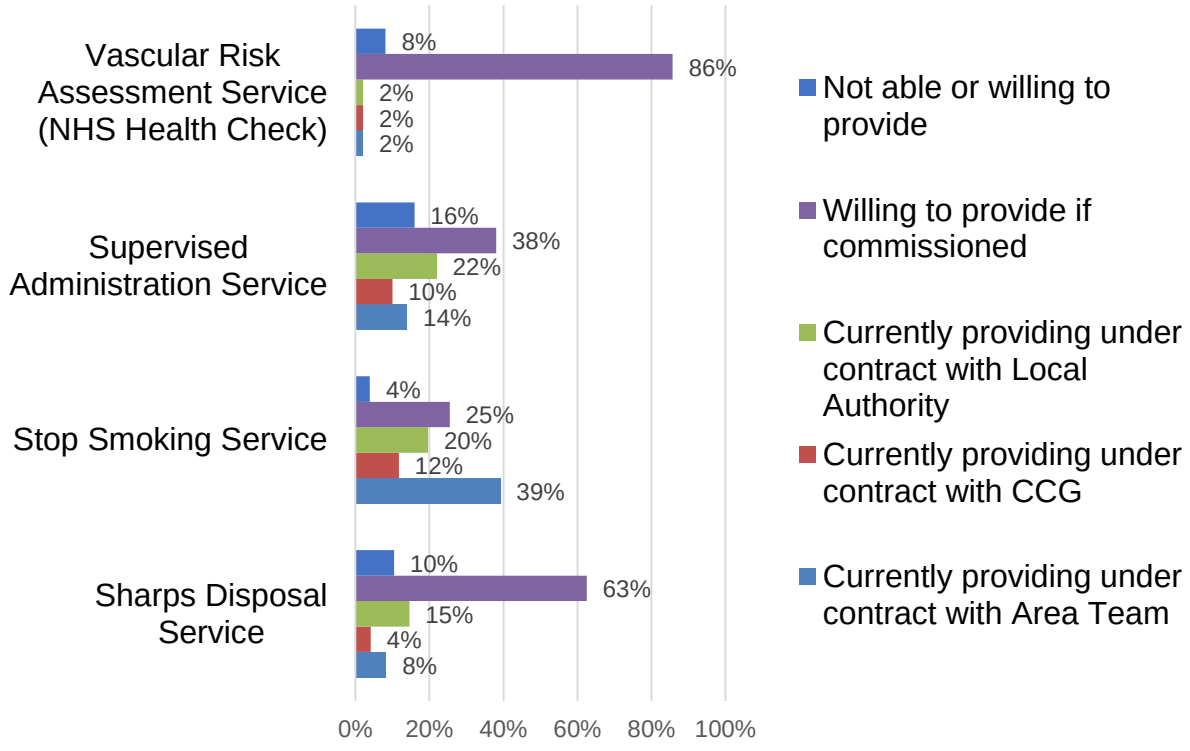
Patient Group Direction (medicines covered by the Patient Group Direction)	
1	Erectile dysfunction, flu vaccination
2	EHC, flu vaccination, minor ailments scheme
3	Malarone, Ventolin, Sildenafil (Viagra)
4	Levonelle
5	We offer a private PGD service for malaria prophylaxis and erectile dysfunction

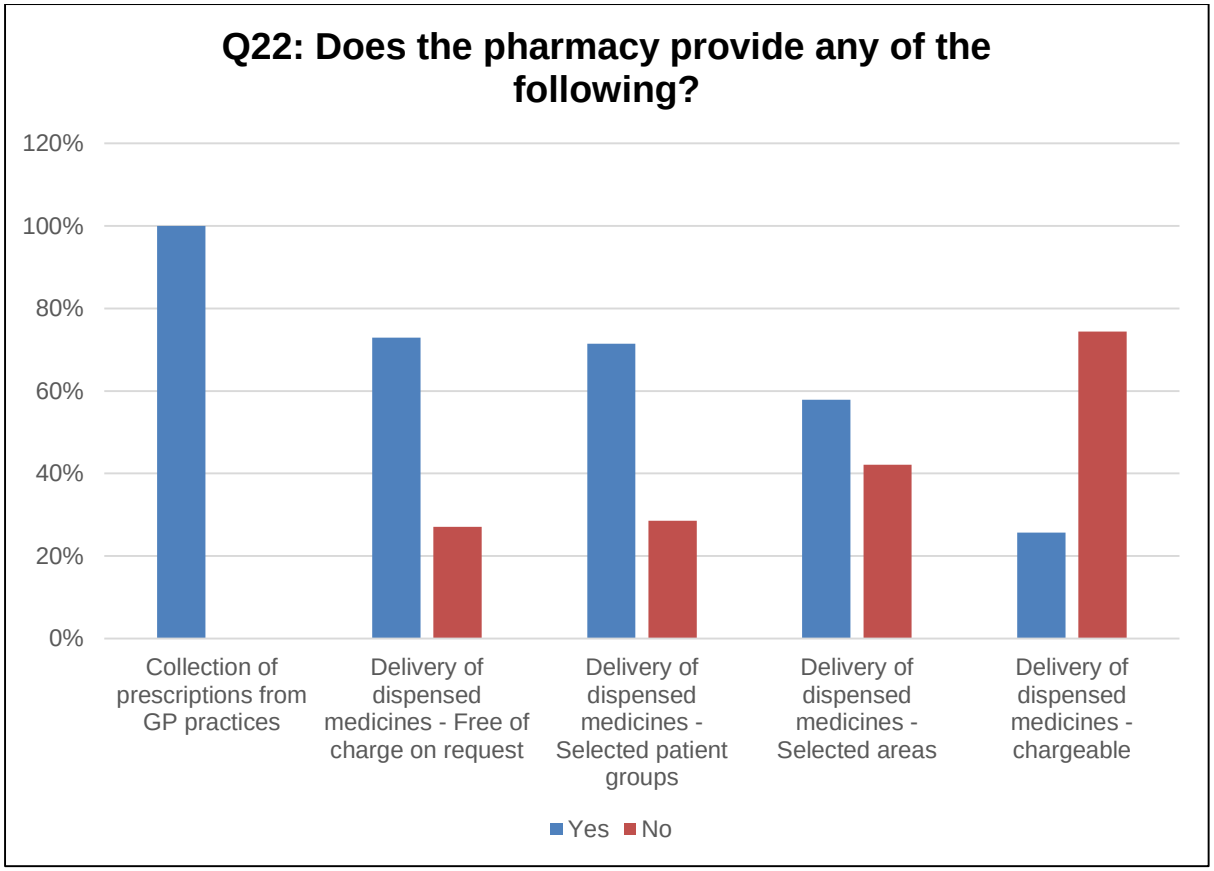

Q19: Which of the following services does the pharmacy provide, or would be willing to provide?
Seasonal Influenza Vaccination Service
14%
47%
2%
31%
HIV
23%
77%
Hepatitis
15%
85%
HbA1c
12%
88%
H.pylori
12%
88%
Gonorrhea
15%
85%
Diabetes
2%
92%
6%
Cholesterol
6%
90%
2%
2%
Alcohol
6%
94%
0%
20%
40%
60%
80%
100%
Not able or willing to provide
Willing to provide if commissioned
Currently providing under contract with Local Authority
Currently providing under contract with CCG
Currently providing under contract with Area Team

Q20: Which of the following other vaccination services does the pharmacy provide, or would be willing to provide?



Q21: Which of the following services does the pharmacy provide, or would be willing to provide?

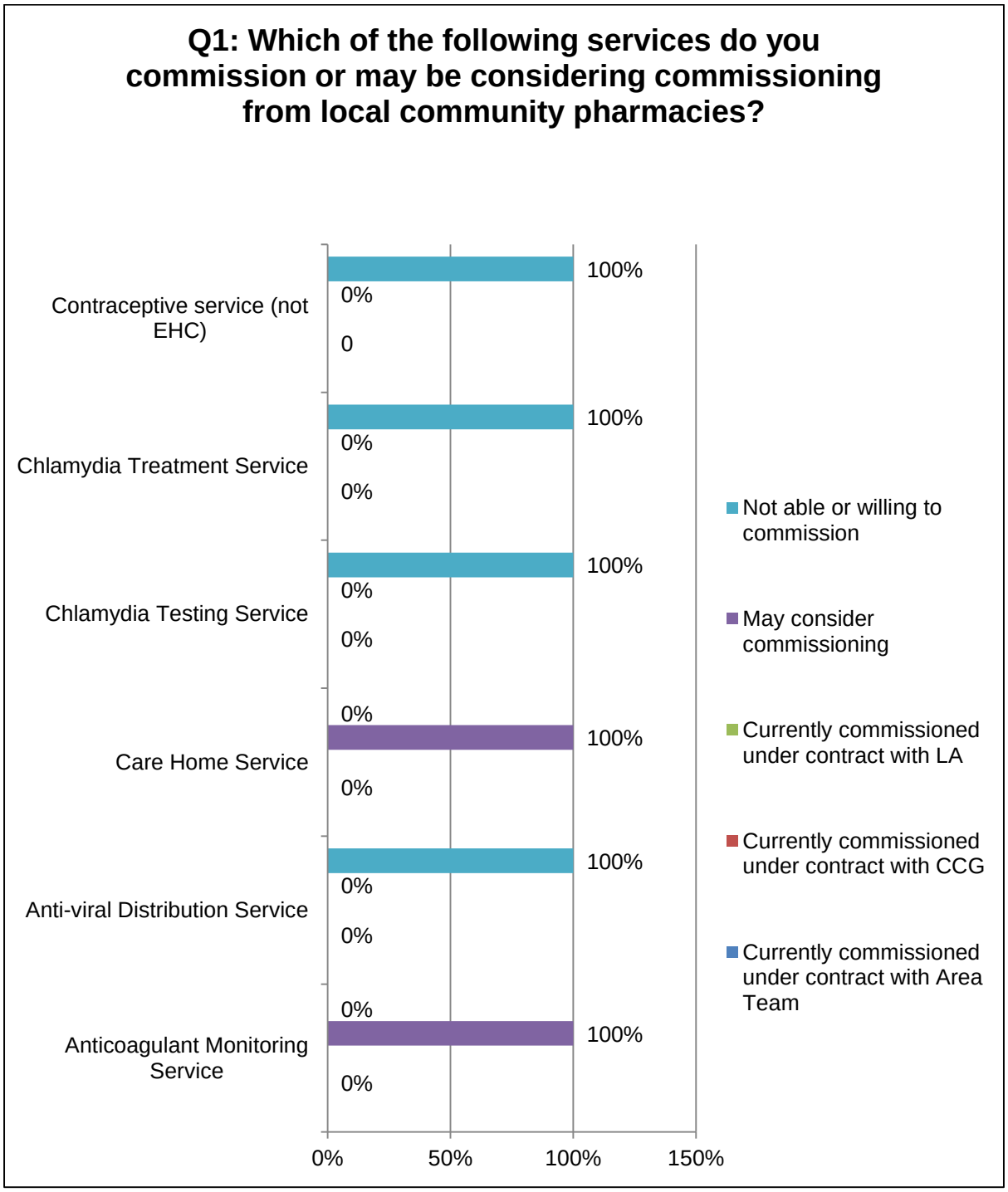




Selected patient groups	
1	Elderly and housebound - 10
2	Disabled – 4
3	All patients – 2
4	Dossett patients
Selected Areas	
1	N11 and N12
2	All areas – 2
3	Areas covered by Enfield and Barnet
4	Southgate, Enfield, Winchmore Hill, Palmers Green
5	Enfield, Edmonton and Walthamstow
6	Local N13, N14, N22, N21

Appendix K: Results of the commissioner survey

Local Authority and CCG commissioners were asked to respond to a series of questions regarding current and future service provision. The results of the survey are detailed below. It should be noted that neither commissioner highlighted any intended current plans to commission new services through community pharmacies in Enfield.



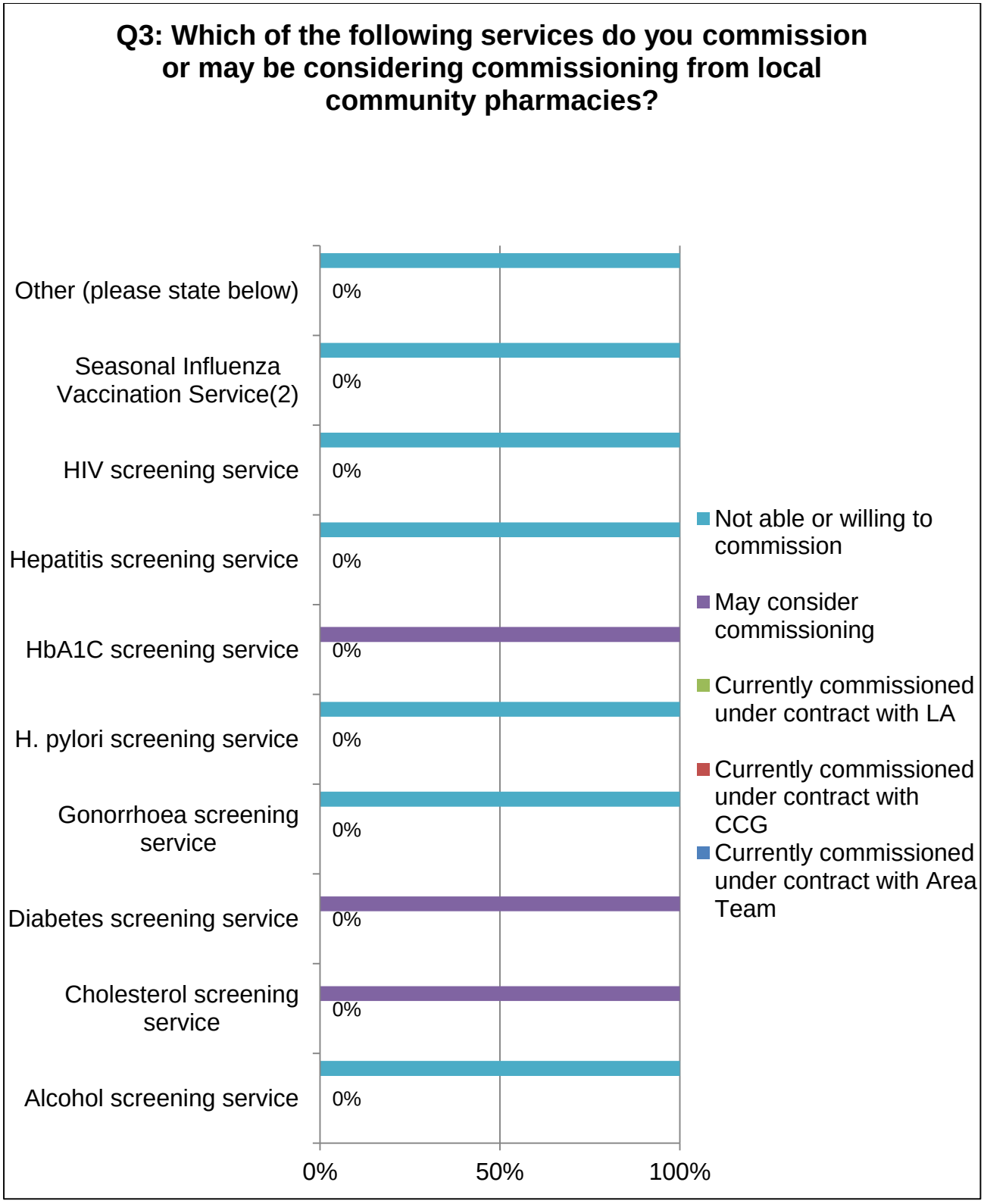
Q2: Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Allergy management service	0%	0%	0%	0%	100%
Alzheimer's / dementia management service	0%	0%	0%	0%	100%
Asthma management service	0%	0%	0%	0%	100%
CHD management service	0%	0%	0%	0%	100%
COPD management service	0%	0%	0%	0%	100%
Depression management service	0%	0%	0%	0%	100%
Diabetes type I management service	0%	0%	0%	0%	100%
Diabetes type II management service	0%	0%	0%	0%	100%
Epilepsy management service	0%	0%	0%	0%	100%
Heart failure management service	0%	0%	0%	0%	100%
Hypertension management service	0%	0%	0%	0%	100%

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Parkinson's disease	0%	0%	0%	0%	100%
Emergency hormonal contraception Service	0%	0%	0%	0%	100%
Gluten free food supply service (i.e. not via FP10)	0%	0%	0%	0%	100%
Home delivery service (not appliances)	0%	0%	0%	0%	100%
Independent prescribing service	0%	0%	0%	0%	100%
If currently providing an independent prescribing service, what therapeutic areas are covered?	0%	0%	0%	0%	100%
Language access service	0%	0%	0%	0%	100%
Medication review service	0%	0%	0%	0%	100%
Minor ailment scheme	0%	100%	0%	0%	0%
Medicines assessment and compliance support service	0%	0%	0%	0%	100%

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
MUR plus / medicines optimisation service	0%	0%	0%	0%	100%
If currently providing an MUR plus / medicines optimisation service, what therapeutic areas are covered?	0%	0%	0%	0%	100%
Needle and syringe exchange service	0%	0%	0%	0%	100%
Obesity management (adults and children)	0%	0%	0%	0%	100%
On demand availability of specialist drugs service	0%	0%	0%	0%	100%
Out of hours services	0%	0%	0%	0%	100%
Patient group direction service (name the medicines covered by the patient group direction)	0%	0%	0%	0%	100%
Phlebotomy service	0%	0%	0%	0%	100%
Prescriber support service	0%	0%	0%	0%	100%

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Schools service	0%	0%	0%	0%	100%
Other (please state)	0%	0%	0%	0%	100%


Q3: Which of the following services do you commission or may be considering commissioning from local community pharmacies?
Other (please state below)
Seasonal Influenza Vaccination Service(2)
HIV screening service
Hepatitis screening service
HbA1C screening service
H. pylori screening service
Gonorrhoea screening service
Diabetes screening service
Cholesterol screening service
Alcohol screening service
0%
0%
0%
0%
0%
0%
0%
0%
0%
0%
0%
50%
100%
Not able or willing to commission
May consider commissioning
Currently commissioned under contract with LA
Currently commissioned under contract with CCG
Currently commissioned under contract with Area Team

Q4: Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Childhood vaccinations	0%	0%	0%	0%	100%
Hepatitis (at risk workers or patients)	0%	0%	0%	0%	100%
HPV	0%	0%	0%	0%	100%
Travel vaccines	0%	0%	0%	0%	100%

Q5: Which of the following services do you commission or may be considering commissioning from local community pharmacies?

	Currently commissioned under contract with Area Team	Currently commissioned under contract with CCG	Currently commissioned under contract with LA	May consider commissioning	Not able or willing to commission
Sharps disposal service	0%	0%	0%	0%	100%
Stop smoking service	0%	0%	0%	0%	100%
Supervised admin service	0%	0%	0%	0%	100%
Supplementary prescribing service (what therapeutic areas are covered?)	0%	0%	0%	0%	100%
Vascular risk assessment service (NHS Health Check)	0%	0%	0%	0%	100%

Abbreviations

AURs - Appliance Use Reviews

BME - Black and Minority Ethnic Groups

CCGs - Clinical Commissioning Groups

COPD - Chronic Obstructive Pulmonary Disease

CHD - Coronary Heart Disease

DSR - Directly Standardised Ratio

EHC - Emergency Hormonal Contraception

HNA - Health Needs Assessment

HIV - Human Immunodeficiency Virus

HWB - Health and Wellbeing Board

IMD - Index of Multiple Deprivation

JSNA - Joint Strategic Needs Assessment

LAPE - Local Alcohol Profiles for England

LPS - Local Pharmaceutical Service

LSOAs - Lower Super Output Areas

MIU - Minor Injuries Unit

MURs - Medicines Use Reviews

NHS - National Health Service

NMS - New Medicines Service

ONS - Office for National Statistics

PCTs - Primary Care Trusts

PNA - Pharmaceutical Needs Assessment

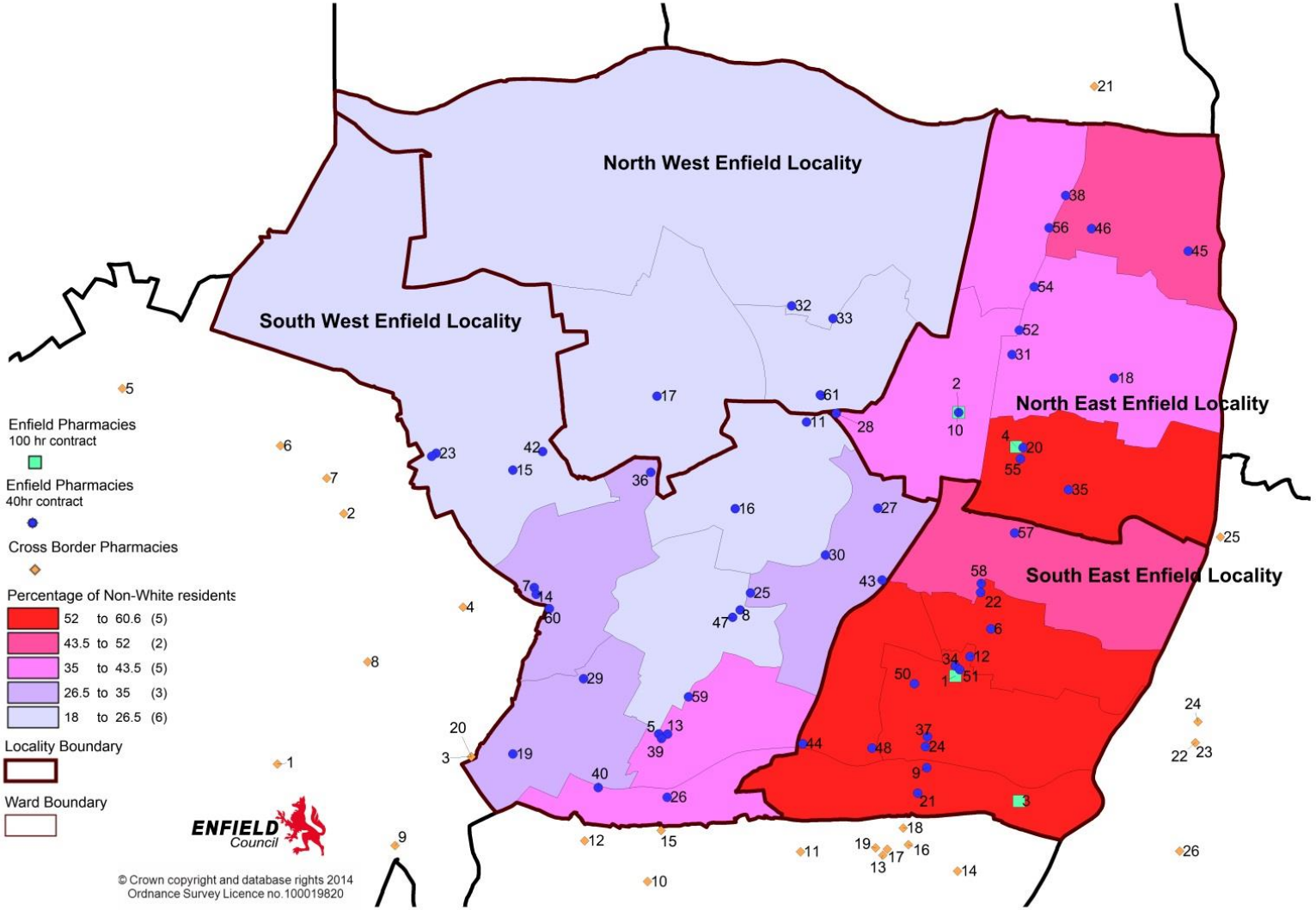
PSNC - Pharmaceutical Services Negotiating Committee

SAC - Stoma Appliance Customisation

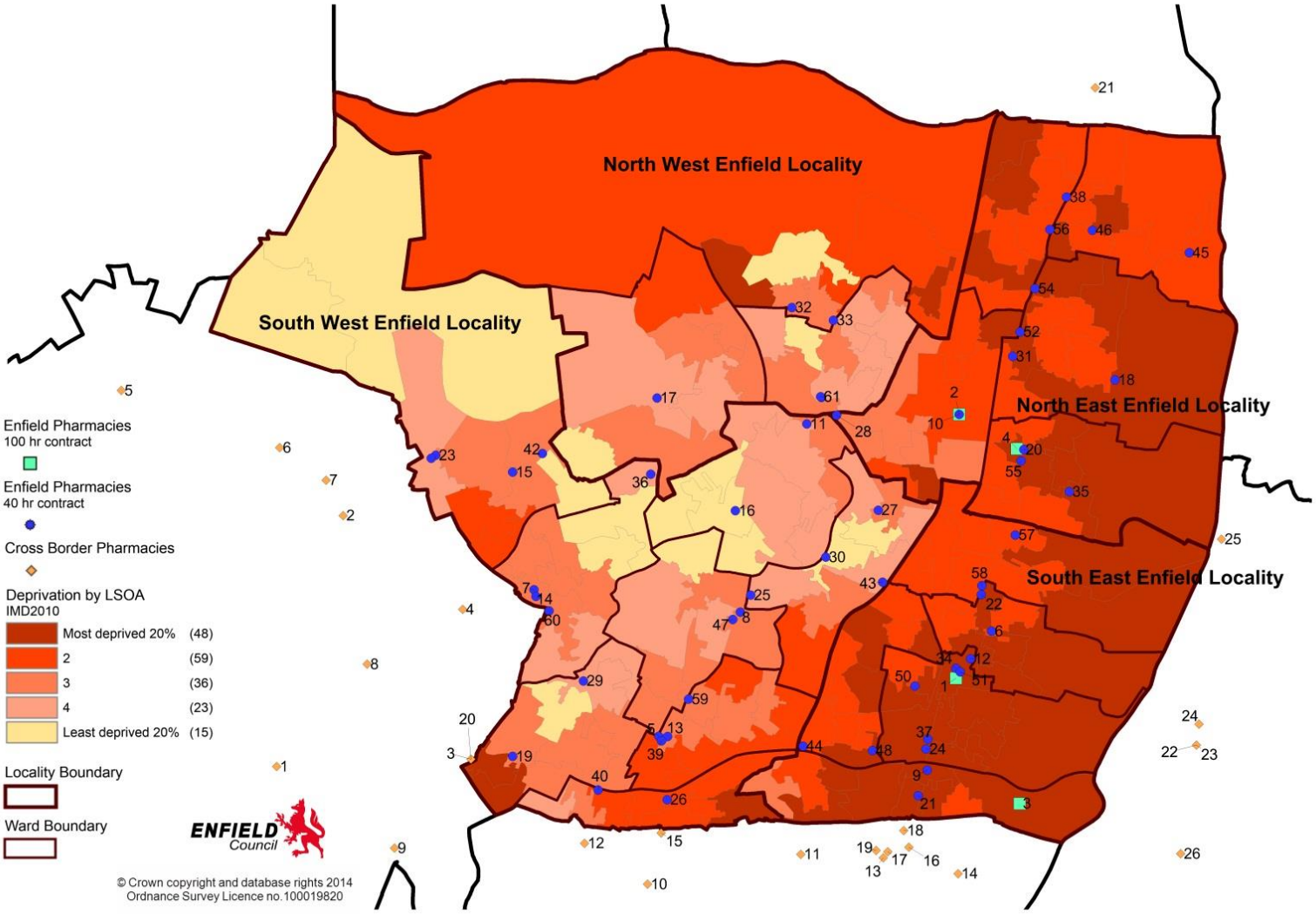
SHA - Strategic Health Authority

STI - Sexually Transmitted Infection

Map A: Pharmacies and BME population



Map B: Pharmacies and Index of Multiple Deprivation 2010 by Output Area



Agenda Item 5

MUNICIPAL YEAR 2013/2014 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board** **14th April 2015**	**Agenda - Part: 1** | **Item: 5** **Subject:** Adjustments To The Better Care Fund Plan Reducing Emergency Admissions Target **Wards: All**
Report of: Bindi Nagra – Assistant Director of Health, Housing and Adult Social Care and Graham MacDougall – Director of Strategy & Partnerships – Enfield CCG **Contact Officer:** Richard Young **E mail**: richard.young@enfield.gov.uk	**Cabinet Member consulted:** Cllr Don McGowan Cllr Doug Taylor

1. EXECUTIVE SUMMARY

NHS England has issued guidance that the ambition for the level of improvement agreed by CCGs and Councils in Better Care Fund plans should now be reviewed in light of the current operational circumstances.

The original BCF plan required a submission for this ambition with a trajectory partly based on known actual activity and partly on plans contained within the CCG Operating Plan. It is clear that the actual number of emergency admissions has significantly exceeded those assumptions in the BCF Plan.

The initial BCF modelling reduced the initial baseline activity and cost by the minimum 3.5% reduction expected nationally, which resulted in an expected reduction of 908 admissions, at a cost of £1,352,920. (See table 2).

As a result, work was done within NHS Enfield CCG to gauge a new baseline of non-elective admission from the most up to date actual activity. The new baseline therefore covers Q4 2013/14 to Q3 2014/15, and includes all Emergency admissions. The new baseline shows significantly increased levels of activity to the initial baseline. (See table 3).

This report sets out two potential options. The first recalculates the activity baseline and generates at new admissions reduction target based on the existing percentage reduction 3.5% target.

The second option maintains the existing admissions reduction target – which generates a new (reduced) percentage target reduction.

2. RECOMMENDATIONS

The Health & Wellbeing Board is asked to approve the recommendation from the Enfield Integration Board and agree Option 1 (a new target admissions reduction of 1,065 admissions based on the existing percentage reduction 3.5% target).

ADJUSTMENTS TO THE BETTER CARE FUND PLAN REDUCING EMERGENCY ADMISSIONS TARGET

3. BACKGROUND

NHS England has issued guidance ('The Forward View into Action: Planning for 2015/16' and 'Supplementary Information for Commissioner Planning, 2015/16') requiring Area BCF Plans and CCG Operating Plan submissions to be aligned as the local health & social care economy's contribution to the overall Health and Wellbeing Board (HWB) plan to reduce non-elective admissions.

The guidance suggests that the ambition for the level of improvement agreed by CCGs and Councils in Better Care Fund plans should now be reviewed in light of the current operational circumstances, taking into account the broad range of planning factors, including:

(i) Actual performance in the year to date, particularly through the winter;

(ii) The likely outturn for 2014/15; and

(iii) Progress with contract negotiations with providers.

Plans must be credible. It is likely, in light of the rise in emergency admissions we have seen in recent months that many of these ambitions will need to be revised downward. The review should be undertaken within the local BCF partnership and approved by the Health and Wellbeing Board.

There will not be a requirement to resubmit the BCF plan itself, however, it is expected that evidence of local agreement to any changes will be provided through the CCG operational plan.

The payment of a proportion of the £3.8bn mandatory element of the Fund will be linked to the performance of local areas in reducing non-elective admissions in line with the trajectory agreed in their BCF plan. Payments will be made in four quarterly instalments. The first of these will be made in May 2015, based on performance in the fourth quarter of 2014/15.

If the planned level of improvement is reduced, the HWB must also approve a balancing increase in the amount to invest in NHS commissioned out-of-hospital services, in line with the BCF planning guidance (unless that level of investment already exceeds the required minimum).

4. IMPLICATIONS

The original BCF plan required a submission for this ambition with a trajectory partly based on known actual activity and partly on plans contained within the CCG Operating Plan.

It is clear that the actual number of emergency admissions has significantly exceeded those assumptions in the BCF Plan. Therefore, in order to achieve the original target of 3.5% (a reduction of 908 from a total of 25,965 admissions), with an

out turn of 30,463 admissions, the required reduction would now be at 18%. (See table 1).

Table 1:

Original Baseline Activity	25,965
Original Saving Activity	908
Original Target	25,057
New baseline / actual outturn	30,463
Original Target	25,057
Difference /reduced admissions	5,406
% reduction	18%

5. INITIAL BASELINE

The baseline for the initial Better Care Fund Modelling was devised using actual data from Q4 2013/14, and projected levels of activity for Q1-Q3 of 2014/15.

The Q4 data included all Emergency admissions as defined by the nationally mandated Admission Method codes. The data source was SUS.

The projected levels of activity for Q1-Q3 of 2014/15 were based on the same methodology used for NHS Enfield's 5 year planning intentions submitted to NHS England - to reduce the rate of admissions per 1,000 in Enfield to a phased, statistically adjusted, top quartile position in London by 2018/19. Activity was adjusted for seasonality as per the pattern of previous year's activity.

6. INITIAL BCF MODELLING

The initial BCF modelling reduced the initial baseline activity and cost by the minimum 3.5% reduction expected nationally, which resulted in an expected reduction of 908 admissions, at a cost of £1,352,920. (See table 2).

Table 2	Estimate / Plan				
	Q4: 2013/14	Q1: 2014/15	Q2: 2014/15	Q3: 2014/15	**Total**
Initial Baseline Activity	7,242	6,245	6,127	6,351	**25,965**
Initial Saving	253	219	214	222	**908**
Initial Baseline Cost	£10,790,580	£9,305,050	£9,129,230	£9,462,990	**£38,687,850**
Initial Saving	£376,970	£326,310	£318,860	£330,780	**£1,352,920**

7. REVISED BASELINE

In light of the known increase in Accident & Emergency attendances and resultant Non-Elective admissions nationally in the last 12 months, NHS England sent a survey to all CCG's on 22nd January 2015 to gauge the potential for local areas to revise their non-elective admissions reduction ambition.

As a result, work was done within NHS Enfield CCG to gauge a new baseline of non-elective admission from the most up to date actual activity. The new baseline therefore covers Q4 2013/14 to Q3 2014/15, and includes all Emergency admissions as defined by the nationally mandated Admission Method codes. The data source again is SUS. The new baseline shows significantly increased levels of activity to the initial baseline. (See table 3).

Table 3	2014 (Actual)			
	Q4: 2013/14	Q1: 2014/15	Q2: 2014/15	Q3: 2014/15
Revised Baseline Activity	7,526	7,830	7,557	7,550
Revised Baseline Cost	£11,213,740	£11,666,700	£11,259,930	£11,249,500

Given the increased baseline, two options were discussed as a potential revision to the non-elective admissions reduction ambition.

8. REVISED BCF MODELLING - OPTION 1

The first option is to keep the minimum expected 3.5% reduction, and apply it to the revised baseline. This would in effect increase the expected level of activity and cost savings, due to the increased activity in the revised baseline.

Option 1 would result in an expected reduction of 1,065 admissions, at a cost of £1,586,850. (See table 4).

Table 4	OPTION 1: Keep The Minimum Expected 3.5% Reduction				
	Q4	Q1	Q2	Q3	Total
Revised Baseline Activity	7,526	7,830	7,557	7,550	30,463
Revised Activity Reduction	263	274	264	264	1065
Revised Baseline Cost	£11,213,740	£11,666,700	£11,259,930	£11,249,500	£45,389,870
Revised Saving	£391,870	£408,260	£393,360	£393,360	£1,586,850

9. REVISED BCF MODELLING - OPTION 2

The second option is to adjust the expected percentage reduction to a level so that the expected activity and finance savings from the initial modelling remain the same.

This results in a reduced reduction percentage of 2.98% to achieve a reduction of 908 admissions, at a cost of £1,352,920. (See table 5).

Table 5	OPTION 2: Activity / Finance Savings Remain the Same				
	Q4	Q1	Q2	Q3	Total
Revised Baseline Activity	7,526	7,830	7,557	7,550	30,463
Revised Activity Reduction	224	234	225	225	908
Revised Baseline Cost	£11,213,740	£11,666,700	£11,259,930	£11,249,500	£45,389,870
Revised Saving	£333,760	£348,660	£335,250	£335,250	£1,352,920

10. CONCLUSION

At its previous meeting in February, the Enfield Integration Board provisionally agreed Option 1 (i.e. that the original target of 3.5% would be applied to the new baseline generating a new target of reducing 1,065 admissions).

It was agreed that this planning assumption would be used for the purposes of submitting the draft Operating Plan (due at the end of February).

11. RECOMMENDATION

The Enfield Health & Wellbeing Board is recommended to approve Option 1.

David Sayers
Acute Commissioning Manager, NHS Enfield CCG

Richard Young
Interim BCF Programme Manager

March 2015.

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Agenda Item 6

MUNICIPAL YEAR 2014/2015

MEETING TITLE AND DATE **Health and Wellbeing Board** **14 April 2015**	**Agenda - Part: 1** **Item: 6** **Subject:** Adult Safeguarding Strategy **Wards: All**
Report of: Ray James: Director of Health, Housing and Adult Social Care	**Cabinet Member consulted:**
Contact officer and telephone number: Georgina Diba, 020 8379 4432 E mail: Georgina.diba@enfield.gov.uk	**Approved by:**

1. EXECUTIVE SUMMARY

The Care Act has placed Safeguarding Adults Boards on a statutory footing from April 1, 2015. One of the Board's three core duties is to publish a strategic plan for each financial year that sets how it will meet its main objective and what members will do to achieve this. The plan must be developed with local community involvement, and the SAB must consult the local Healthwatch organisation.

The Enfield Safeguarding Adults Board have had a strategy since 2009 and are currently consulting on the Safeguarding Adults Strategy 2015-2018. The plan which supports this strategy will be reviewed yearly to remain evidence based.

2. RECOMMENDATIONS

Feedback is sought from the Health and Wellbeing Board on the content of this strategy and action plan.

3. BACKGROUND

The strategy aims to be free from jargon and in plain English, with an easy read version to be developed once agreed. This is in line with Care Act requirements

The aims of the strategy are:

- Preventing abuse from occurring
- Ensuring adequate support where dignity is respected
- Providing support which is person centred once harm occurs and works to achieve the aspirations and outcomes of the adult at risk

The strategy and its action plan relate to the 6 key principles set out by the Government and included in the Care Act which are:

- Empowerment- people being supported and encouraged to make their own decisions and informed consent
- Protection – support and representation to those in greatest need

- Prevention –it is better to take action before harm occurs
- Proportionality – the least intrusive response appropriate to the risk presented
- Partnership – local solutions through services working with their communities
- Accountability- accountability and transparency in delivering safeguarding

The strategy sets out how we work with local people and partners, but most importantly those who use services. This includes not only co-production and challenge to the work of the Safeguarding Adults Board, but with adults at risk who have been abused and learning from practice.

4. ALTERNATIVE OPTIONS CONSIDERED

The Care Act places a duty on Safeguarding Adults Boards to publish its strategic plan each financial year. Guidance states this plan should address both short and longer-term actions and it must set out how it will help adults in its areas and what actions each member of the SAB will take to deliver the strategic plan and protect better. This plan could cover 3-5 years in order to enable to Board to plan ahead as long as it is reviewed and updated annually.

The Enfield Safeguarding Adults Board have taken a decision to produce a three year strategy.

5. REASONS FOR RECOMMENDATIONS

The Safeguarding Adults Board would like to hear the views of the Health and Wellbeing Board around the aims and priorities set out in the strategy, the outcomes the Board will report on and the content of the action plan.

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

6.1 Financial Implications

The strategic plan requires consultation with a range of individuals and partner organisations. The current cost of the consultation for this financial year is £500, which excludes the staff time of employees based in the Strategic Safeguarding Adults Service.

The current actions set out in the Safeguarding Adults Strategy are being managed within the resources of the various partners, primarily through input from members of staff. Those actions which have a cost, such as publicity and the development of risk panel, can only be progressed with agreed Safeguarding Adults Board funding. The issue of partner contributions towards these costs was raised at the March 2015 meeting of Board partners and a decision is still pending on this.

6.2 Legal Implications

Under The Care Act 2014 each local authority must establish a Safeguarding Adults Board (an “SAB”) for its area. The main objective of a SAB is to help and protect adults in its area. The Care Act 2014 also place a duty on a SAB to publish each financial year a plan (its “strategic plan”) which sets out its strategy for achieving its objective, and what each member is to do to implement that strategy. In preparing its strategic plan, the SAB must also consult the Local Healthwatch organisation for its area, and involve the community in its area.

7. KEY RISKS

Delivering on the strategy action plan is a key priority for the Board and risk has been mitigated through identifying a project manager in the Strategic Safeguarding Adults Service. The Board's action plan will be reviewed at each quarterly meeting, which will highlight progress against each action.

Co-production and challenge on safeguarding adults is crucial and a clear requirement in the Care Act. This risk has been mitigated by the Service User, Carer and Patient sub group of the Safeguarding Adults Board.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Ensuring the best start in life

There is representation on the Safeguarding Adults Board from safeguarding children, with a joint sub-group to enable issues which cross over to be addressed. While not explicit within the strategy, this group ensures that wellbeing and safety from abuse is considered across all ages, such as joint working between adults and children's services when parents or carers have mental ill health and/or drug and alcohol problems.

8.2 Enabling people to be safe, independent and well and delivering high quality health and care services

The strategy aims state clearly that we will work with local people and partners to promote an approach that concentrates on improving the life for the adults concerned; being safe is only one of the things people want for themselves and there is a wider emphasis on wellbeing. The strategy emphasizes prevention of abuse and work within services that provide care to evidence engagement with those who use services.

8.3 Creating stronger, healthier communities

Safeguarding practice includes working with people to resolve their circumstances, recover from abuse or neglect and realise the outcomes they want. In addition, we are setting ourselves the target of working with those who have harmed in an effort to prevent further abuse and contribute to safer communities.

8.4 Reducing health inequalities – narrowing the gap in life expectancy

The Strategy does not directly reduce health inequalities. It is intended that the actions directly taken to support adults at risk of harm and abuse through the safeguarding adults process will have an emphasis on an individual's well-being, which can include improved health outcomes.

8.5 Promoting healthy lifestyles

The strategy has set out action towards reducing social isolation within high risk groups which may be at risk of abuse.

9. EQUALITIES IMPACT IMPLICATIONS

An equalities impact assessment has been started and will be completed upon development of the final strategy document. The assessment to date has indicated that

the strategy as it stands, with an emphasis on prevention of abuse, enabling and empowerment of individuals and working towards self identified outcomes, contributes towards promoting equalities for those most disadvantaged in Enfield. For example, work being undertaken by the Service User, Carer and Patient Group intends to focus on improving experiences of Lesbian, Gay, Bisexual and Transgendered individuals accessing care services in Enfield.

Background Papers
None identified.

Enfield Safeguarding Adults Board

Safeguarding Adults Strategy 2015 – 2018

'Making Safeguarding Personal in Enfield'

LOGOS

Foreword from the Chair

Foreword from Councillor McGowan

What is abuse?

Abuse is a violation of an individual's human and civil rights by any other person or persons and is often a crime.

Adult safeguarding applies to all adults who are over 18 years of age who have care and support needs, and who are experiencing, or are at risk of, abuse or neglect, and are unable to protect themselves.

An adult with care and support needs may be:

- An older person,
- A person with a physical or learning disability or a sensory impairment,
- Someone with mental health needs, including dementia or a personality disorder,
- A person with a long-term health condition,
- Someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living,
- A carer, providing unpaid care to a family member or friend.

Adult safeguarding applies whatever setting people live in, and regardless of whether or not they have mental capacity to make specific decisions at specific times.

An adult at risk could also include someone who does not receive community care services but because they have been abused or are at risk of being abused, they could become vulnerable. The adult may not be able to protect themselves against harm or abuse. Abuse can take many forms, including the following:

- Physical abuse – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions

- Domestic violence – including psychological, physical, sexual, financial, emotional abuse; honour based violence

- Sexual abuse – including rape, sexual harassment, inappropriate looking or touching, subjection to pornography or sexual acts to which the adult has not consented or was pressured into consenting

- Psychological abuse – including emotional abuse, threats of harm or abandonment, humiliation, blaming controlling, intimidation, isolation or unreasonable and unjustified withdrawal of services or supportive networks

- Financial or material abuse – including theft, fraud, internet scamming, coercion in relation to an adult's financial transactions, or the misuse or misappropriation of property, possessions or benefits

- Modern slavery – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use coercion and deceit

- Discriminatory abuse – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion

- Organisational abuse – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home.

- Neglect and acts of omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

- Self-neglect – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding

Other types of abuse

The **Domestic Abuse** definition includes **coercive control** which is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Hate crime - A crime motivated by racial, sexual, or other prejudice.

Female Genital Mutilation – also known as female circumcision or female genital cutting, is defined by the World Health Organisation (WHO) as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons".

If you are concerned that somebody you know is being abused or you want to report abuse, please ring the adult abuse line on

020 8379 5212

CONTENTS

Introduction and Aims

This strategy is about preventing the abuse of some of the most vulnerable people in Enfield. It is about ensuring adults at risk are supported, their dignity is respected and they can live free from harm and abuse. We believe that everyone who works, lives and visits Enfield can contribute towards making the borough a safer place.

We (the Safeguarding Adults Board) are responsible for assuring ourselves that local safeguarding arrangements and partners act to help and protect people in Enfield. From April 1, 2015 Safeguarding Adults Boards will become statutory, which will have a positive effect on how we all work together to keep people safe.

It is often said that prevention is better than cure. We know that people are being harmed often by the very people they should trust. This strategy will help us to set out what we can do together to help stop abuse from happening in the first place.

We want to make sure that when harm does occur the care and support provided is person-centred and that adults at risk are able to maintain choice and control of their decisions. We want to enable people to resolve their circumstances, recover from abuse or neglect and realise the outcomes that they want. Where an individual might need assistance to make decisions we will ensure they have the necessary support to enable this.

People have complex lives and being safe is only one of the things they want for themselves. We believe professionals should work with the adult to establish what being safe means to them and how that can be best achieved.

One families experience A young woman with a severe physical disability was visited daily by her mother, who provided care and support. It was found that the mother sometimes hit her daughter, which was reported by a visiting domiciliary care worker. The local authority worked with the daughter to discover what she would like to happen. It was discovered that the mother often hit out when her daughter was anxious and being aggressive towards her. Support was offered to the mother to make the caring role easier, with additional sitting services and outreach workers.

Our aims is that we work with local people and our partners to:

- stop abuse or neglect wherever possible;
- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- safeguard adults in a way that supports them in making choices and having control about how they want to live;
- promote an approach that concentrates on improving life for the adults concerned;
- raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;
- provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- address what has caused the abuse or neglect.

What the law says

Although protecting adults from abuse or neglect has been a priority for local authorities for many years, there has never been a single legal framework for adult safeguarding.

The Care Act 2014 sets out the first statutory framework for safeguarding adults and uses as its terms of reference the report of the Law Commission into adult safeguarding published in 2011.

Key elements of the Care Act are:

- To place Safeguarding Adults Partnership Boards on a statutory basis.
- Core membership of the Board needs to consist of the local authority, Clinical Commissioning Group and Police.
- Partners or organisations must provide information to the Board as requested
- Carry out Safeguarding Adult Reviews when someone with care and support need dies or is seriously injured as a result of abuse or neglect and there is concern that the local authority or its partners could have done more to protect them
- Annual Report and Strategic Plan for the Board to be published.
- Arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required

The Local Authorities has the lead to make enquires, or ask others to make enquiries, when they think an adult with care and support needs may be at risk of abuse or neglect in their area and to find out what, if any, action may be needed.

This strategy has been developed to ensure that the requirements of the Care Act 2014 will be implemented with the support of the partnership and local communities.

Making Safeguarding Personal

In Enfield the adult at risk is the most important person in safeguarding; to be able to maintain their choice and control over their situation and have outcomes that not only make them feel safe, but contribute to their overall wellbeing.

Making Safeguarding Personal is to bring about more person-centred responses, which can be beneficial to people in safeguarding circumstances. It is about exploring with the adult at risk of abuse (and/or their representatives, advocates or Best Interest Assessors) the options that they have and what they choose to do about their situation. Our strategy is aimed at **improving outcomes,** which means asking the adult at risk what they want at the beginning and throughout the safeguarding intervention. It is important for the adult at risk and for those who support them that we ask at the end of the safeguarding process to what extent their outcomes have been achieved.

Mental Capacity Act

The Mental Capacity Act (MCA) says that a person is unable to make a particular decision if they cannot do one or more of the following four things:

- understand information given to them
- retain that information long enough to be able to make the decision
- weigh up the information available to make the decision

- communicate their decision

The Mental Capacity Act is a law about making decisions and what to do when people cannot make some decisions for themselves. When people cannot make a decision for themselves, this is called lacking capacity.

The MCA protects people's basic human right to live the lives that they choose as far as they are able. This strategy is about integrating the principles of the MCA into care planning and practice to transform the experience of adults with care and support needs.

One person's experience A young person with a learning disability and sight impairment lived in a care home where he stayed for his safety under a Deprivation of Liberty Safeguard. This young person was not allowed to access certain areas of the home during times, which London Borough of Enfield felt restricted this person's choice and control. Working with the care home the policies were changed to improve outcomes for all of those who used the service, giving them more freedom.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards are for people in a hospital or care home, who for their own safety and in their own best interests, need to receive care and treatment that may have the effect of depriving them of their liberty, but who lack the capacity to consent to these arrangements.

Deprivation of Liberty Safeguards are the way to give people the protection they need when they are being cared for or treated in ways that deprive them of their liberty.

The deprivation of a person's liberty is a serious matter and should not happen unless it is absolutely necessary. These safeguards have been created to ensure that any decision to deprive someone of their liberty is made following defined processes and in consultation with specific authorities.

Enfield's strategy has been developed to ensure not only compliancy with the DoLS, but that we can go further to prevent abuse and harm through identifying those who lack capacity and may be at risk.

Advocacy

The local authority must involve people in their assessments and in planning and checking their care and support.

If people find it difficult to be involved and there is no-one else to speak for them, the local authority must find that person an independent advocate.

Safeguarding Adults in Enfield

What is Safeguarding?

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent abuse and stop the experience of abuse or neglect.

Why a local strategy?

Safeguarding is everyone's business and a local strategy is key to supporting our work with local people and with partners to ensure that adults who may be at risk are:

- safe and able to protect themselves from abuse and neglect;
- treated fairly and with dignity and respect;
- protected when they need to be;
- able to easily get the support, protection and services that they need;
- and support people who may be at risk of harming others

Our strategy sets out where we want to get to and how we can evidence that we have achieved these aims.

The Safeguarding Principles

The Care and Support Statutory Guidance issued under the Care Act 2014 sets out six principles. These principles help us as a Board to set out how we will work together and with adults at risk of abuse.

Empowerment – People being supported and encouraged to make their own decisions and informed consent.
"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

Prevention – It is better to take action before harm occurs.
"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

Proportionality – The least intrusive response appropriate to the risk presented.
"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

Protection – Support and representation for those in greatest need.
"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

Accountability – Accountability and transparency in delivering safeguarding.
"I understand the role of everyone involved in my life and so do they."

How we will get there

These 6 principles form the basis of our safeguarding adults strategy action plan, in which we set ourselves, the partnership and community specific actions to prevent and respond to abuse. Our strategy action plan can be found in Appendix A.

The Safeguarding Adults Board will agree annual action plans and as required. New tasks identified throughout the delivery of this strategy will be included.

Working with local people and our partners

Safeguarding is everyone's business. There are a number of organisations in Enfield which work to stop abuse from happening in the first place and working with adults at risk when abuse does occur.

The local authority is the lead for making enquiries. They have a duty to work with adults at risk to help keep them safe where abuse is alleged. The local authority often work with people who offer health social care support, such as community nurses, GPs, social workers, psychologists and personal assistants; they can help to identify people who are at risk of being abused and often if a service is not maintaining the safety and well-being of people.

Social Services and Health Commissioners (like contracts managers) are responsible for planning, paying and commissioning services; providers in turn have a responsibility to provide safe and high quality care and support. As employers they should make sure they do not give jobs to people who might hurt or abuse. They carry out checks, (for example Disclosure and Barring Service (DBS) checks) to find out whether new staff have abused people in the past.

Some kinds of abuse are also crimes (for example sexual abuse, domestic abuse, stealing). These things should be reported to the police, who may carry out an investigation. The police have powers to initiate specific protective actions which may apply, such as Domestic Violence Protection Orders (DVPO). It is important that other options are available to people including restorative justice. This gives the person who has been abused the chance to tell their abuser the real impact of their action, to get answers to their questions and to give the person who has harmed the opportunity to explain why they carried out the abuse and the chance to repair the harm.

The Care Quality Commission (CQC) and Healthwatch are responsible for inspecting services. Their job is to make sure that services offer good, safe care and support.

Safeguarding Adult Board in Enfield has the main objective of assuring itself that local arrangements and partners act to help and protect adults at risk in its area from abuse.

Consulting with local people

Working with our local communities is important to help make sure everyone can access help and support if they are at risk and they can recognise abuse and report this. Often friends and family are good at noticing when people might have been abused or are in services where they are not safe. People who live, work and study in Enfield are important partners in helping to raise awareness, knowing how to protect people and how to report abuse. We actively seek views of service users or their representatives to ensure we hear what their views and experiences are, what we do well and where we can make improvements.

It's important that people feel listened to and are able to state what outcomes they want from the outset of any safeguarding processes and that they are involved throughout.

We want to make sure:

- People are aware of safeguarding and know what to do if they have a concern or need help
- Recognise abuse when it takes place
- Know who to contact in case of abuse
- Feel listened to and are able to say what they want
- Are involved and maintain choice and control
- People are communicated with clearly
- People are aware of risks and maintain choice and control over their circumstances
- People feel and are safer as a result of safeguarding action being taken

How we will measure our success

The Safeguarding Adults Board, along with partners and local people, has accomplished many actions which have strengthened the care and support to adults at risk experiencing abuse. But, we continue to look for innovative ways to improve on the safeguarding services we provide. Our strategy will be reviewed and updated annually through the course of 2015-2018.

1. We will measure our success by:
2. Demonstrating people can access support at the earliest time to reduce or prevent the risk of harm (prevention)
3. Where it is identified that people are isolated and lonely and potentially at risk, regular contact is made and a welfare assessment conducted (prevention)
4. Demonstrating work with people at risk of harming others (protection)
5. Demonstrating that everyone is supported to make decisions about keeping themselves safe (proportionate)
6. Ensuring Cabinet, Board and Executive level engagement across the partners in safeguarding adults (partnership)
7. Demonstrating that people are supported to achieve their outcomes (empowerment)
8. Demonstrating that the Safeguarding Adults Board fulfils its statutory responsibility (accountability)

9. Publishing our strategy and annual action plans (accountability)

Success means that we deliver on our action plans, we continue to work in partnership to achieve them, and we demonstrate that arrangements are in place to help prevent abuse so that people feel safer.

Key Priority 1: Empowerment

The person should feel in control and decide what they want to happen

Objective 1.1: Mental capacity assessments and the Deprivation of Liberty safeguards are carried out in compliance with new requirements under the Care Act 2014 and with regard to ensuring individuals who lack capacity have support to optimise their well-being and control.			
Action and Milestones	**By when**	**By Whom**	**Progress**
Provide guidance and clarity on supported decision making and how we capture this information to inform the SAB	January 2016	Lead for Policy, Practice and Procedures sub-group work	
Best Interest Assessor course for Continuing Healthcare Nurses ▪ Course design and dates arranged ▪ Course delivered	 Sept 2015 Jan 2016	AD Safeguarding, Enfield CCG	
An evaluation of the training program and its deliverance in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards	January 2016	Lead for Safeguarding BEH MHT	
Protocol for restraint in care is reviewed to ensure this is applied in line with legal requirements and with the least restriction to the safety and well-being of individuals	January 2016	Lead for Safeguarding BEH MHT	
To ensure adequate funding for MCA and DoLS by placing a bid with NHS England	April 2015	AD Safeguarding, Enfield CCG	

Objective 1.2: Enfield to become a gold status authority with the Local Government Association 'Making Safeguarding Personal' (MSP)			
Action and Milestones	**By when**	**By Whom**	**Progress**

The Safeguarding Adults Board to receive six monthly updates on the work plan being implemented in Adult Social Care to achieve gold standard level in Making Safeguarding Personal.	6 monthly, commencing Sept 2015	Head of Safeguarding Adults LBE	
SAB partners to develop an action plan on implementation of MSP; this is reviewed by partners with service user involvement on an annual basis	Commencing June 2015	All SAB partners	

Objective 1.3: To support a cultural shift and embedding of person centred safeguarding support and processes			
Action and Milestones	**By when**	**By Whom**	**Progress**
Set out a baseline to report progress which will measure and monitor this shift	September 2015	AD for Adult Social Care, LBE	
Training Action Plan	November 2015	Head of Learning and Development, LBE	
Interview service users to gain insight into person centred care within nursing homes via an audit	March 2016	Lead for Safeguarding, Enfield CCG	

Objective 1.4: Those who use services to have equal access to service through maximising the communication tools of the Safeguarding Adults Board partnership to raise awareness of abuse, prevention and services.			
Action and Milestones	**By when**	**By Whom**	**Progress**

Develop and implement a communication plan with the Service User, Carer and Patient sub-group of the SAB, which will include: ▪ Information for people who arrange their own care ▪ Support to carers at risk of harming or at risk of being harmed ▪ Use of all media options	Aug 2015	SCP Group but work allocated to all SAB partners	

Objective 1.5: Ensure all personalisation developments including risk management and the marketplace embed safeguarding adults			
Action and Milestones	**By when**	**By Whom**	**Progress**
Update report from Adult Social Care, LBE, on current safeguarding arrangements within marketplace Identify and set out within action plan any additional requirements for safeguarding as set out within Care Act 2014, which would impact upon personalisation and marketplace arrangements	June 2015	AD Adult Social Care, LBE	

Empowerment Outcomes we expect to see and report on:

Our safeguarding processes can demonstrate when audited that individuals or their advocates have person centred care and support

Information is available in a wide range of formats

Gold Standard Level in Making Safeguarding Personal is achieved

Key Priority 2: Protection

Stop abuse before it happens

Objective 2.1: For individuals in Enfield to have appropriate information on abuse and how to stop abuse before it happens			
Action and Milestones	**By when**	**By Whom**	**Progress**
To receive information from front line staff within partnership organisations to the SAB on any issues faced that prohibits or contributes to prevention of abuse	Current and ongoing	All SAB partners	
Target information about safeguarding services to groups in Enfield based upon demographic profile against number of alerts received (equality of access) ▪ Performance (LBE) to provide quarterly data on alerts against demographic profile ▪ LBE Safeguarding to arrange 1-2 targeted information sessions per quarter in response	Quarterly	Performance and Safeguarding, LBE	
Safeguarding Adults and Children's Awareness Week	Sept 2015	Voluntary Sector Partners on SAB (with support LBE Safeguarding)	

Objective 2.2: Individuals experiencing safeguarding concerns to have access to appropriate advocacy			
Action and Milestones	**By when**	**By Whom**	**Progress**
The criteria for access to advocacy and where this is available	April 2016	AD Strategy and	

		Resources, LBE	
Development of the advocacy market locally	April 2016	AD Strategy and Resources, LBE	
Consideration of a joint commissioning for advocacy to improve access to service	September 2016	AD Strategy and Resources, LBE	
Development of peer support, both individually and within group setting, for people at risk of whom have experienced abuse	September 2017	AD Strategy and Resources LBE	

Objective 2.3: Set up a new sub group of the Board to implement the requirements of the Care Act 2014			
Action and Milestones	**By when**	**By Whom**	**Progress**
Safeguarding Care Act Implementation Group set up and running – led by LBE	April 2015	Head of Safeguarding Adults LBE	
Briefings and guidance issued to SAB and implemented in partnership with the local authority	ongoing	Head of Care Act Implementation, LBE	
Communication plan set out which will ensure all staff are aware of safeguarding within the Care Act 2014 – information to be disseminated by all SAB partners within their organisations	April 2015 and ongoing	Head of Safeguarding Adults, & all SAB partners	

Objective 2.4: work undertaken by safeguarding volunteers – our 'Quality Checkers'- are acknowledged and used within the safeguarding adults process to improve the protection of adults at risk

Action and Milestones	By when	By Whom	Progress
Briefings from work undertaken by Quality Checkers which could improve safeguarding and personalisation adults practice disseminated to Adult Social Care and partners where appropriate	April 2015 and ongoing	Quality Improvement Team, LBE	

Protection Outcomes we expect to see and report on:

We can identify an improvement suggestion from a Quality Checker and directly correlate this to an improvement in practice or care

There is a Safeguarding Care Act Implementation Group running which reports and is accountable to the SAB

The number of individuals who are experiencing safeguarding and have been offered advocacy services is 100%, as identified through performance data

Key Priority 3: Prevention

Think about the risks when you decide what to do and do not interfere more than you need to

Objective 3.1: To support people to keep themselves safe (self-protection strategies) and recognise abuse; learning lessons from domestic violence campaigns and Domestic Homicide Reviews			
Action and Milestones	**By when**	**By Whom**	**Progress**
Review and maintain easy read information about preventing abuse and keeping safe	June 2015	Head of Safeguarding Adults LBE	
Continue to provide an up to date portfolio of web based information and advice	Ongoing	Head of Safeguarding Adults, LBE	
Review how we provide information to adults at risk who are experiencing domestic violence and update as necessary	Sept 2015	Sharon Burgess (Safeguarding) and Head of Community Safety LBE	
Development and implementation of risk panel that incorporates hoarding and self-neglect	Sept 2016	Head of Safeguarding Adults, LBE & Head of Community Safety LBE	
Actively engage all partners to jointly develop a 'one team approach' to domestic violence which is based on the coercive control theory.	January 2017	Head of Community Safety, LBE & Head of Public Health, LBE & Head of Safeguarding	

		Adults, LBE	

Objective 3.2: Raise the profile of domestic violence, honour based violence, female genital mutilation and trafficking within the Acute Hospital Trusts			
Action and Milestones	**By when**	**By Whom**	**Progress**
Communication plan for disseminating information and learning to hospital staff and those who use the service to be shared with the Board	June 2015	Safeguarding Leads at CFH Trust Rep (RFH) and NMH Trust Rep	
Information to be given to patients and their carers and displayed within the Trust, which can be evidenced as part of existing audit structures	June 2015 and ongoing	Safeguarding Leads at CFH Trust Rep (RFH) and NMH Trust Rep	

Objective 3.3: Local health economies are in place which are monitored and have indicators that ensure people are kept safe from abuse			
Action and Milestones	**By when**	**By Whom**	**Progress**
There are a range of policies in place for the health economy	April 2016	AD Safeguarding, Enfield CCG	
Assurances are provided to the Board that Health Economy follows action plan for each NHS Trust	April 2016	AD Safeguarding, Enfield CCG	

Objective 3.4: To take action before potential harm can occur through increased partnership work with Best Interest Assessors			
Action and Milestones	**By when**	**By Whom**	**Progress**
Improve awareness of adults who may be at risk of harm through sharing information from Best Interest Assessors to allocated support workers of individuals- local practice guidance	September 2016	Head Safeguarding Adults, LBE	

Objective 3.5: To create a more robust organisational learning system which is able to evidence practice change			
Action and Milestones	**By when**	**By Whom**	**Progress**
Increased sharing of learning outcomes and good practice examples in specific events and more general training	ongoing	Head of Learning and Development, LBE	
Review of safeguarding adults basic e-learning and update in line with the Care Act 2014	June 2015	Head of Learning and Development, LBE	

Objective 3.6: Partnership data, both qualitative and quantitative, to be shared at Board meetings to inform trend identification and practice issues for Board attention			
Action and Milestones	**By when**	**By Whom**	**Progress**
A minimum of two partners at each Board meeting to bring to the attention of the partnership any relevant data (audits, service user interviews, performance analysis, serious incidents and near misses) which may inform safeguarding work	June 2015 and ongoing	All SAB partners. Partners to be nominated in advance at each meeting	
Information matrix based on providers to be shared with Quality, Performance and	April 2015	AD Safeguarding, Enfield	

Safety sub-group of the Board		CCG	

Objective 3.7: Best practice embedded across partnership which helps to keep people safe and demonstrates effective responses through internal reporting arrangements			
Action and Milestones	**By when**	**By Whom**	**Progress**
SAB to receive from partners on the Board at least annually: ▪ Statistical information on alert within organisation and actions ▪ Learning from Serious Incident Panel ▪ Risk management arrangements in place	Annually	All SAB partners	

Objective 3.8: Reduce isolation of individuals in the community by linking people to resources			
Action and Milestones	**By when**	**By Whom**	**Progress**
People that receive care in their own homes who do not have friends and relatives are linked with voluntary agencies who can offer a befriending service	Jan 2016	AD for Strategy and Resources LBE	

Objective 3.9: Develop a multi-agency pressure ulcer protocol which will enable concerns related to pressure ulcer care to be appropriately managed and addressed.			
Action and Milestones	**By when**	**By Whom**	**Progress**

Working group of contributors to the drafting of a protocol to be identified	January 2016	AD Safeguarding Enfield CCG with SAB partners	
Drafting of protocol into working document for SAB approval	June SAB 2016	AD Safeguarding Enfield CCG	
Dissemination of Multi Agency Pressure Ulcer Protocol	Sept 2016	All SAB partners	

Prevention Outcomes we expect to see and report on:

We can do a spot check in our acute hospital trusts and easily see information on FGM, DV and Honour Based Violence

Our SAB meetings minutes can demonstrate that all partners are, at least annually, sharing information that can inform trends or practice

The SAB produces a Multi-Agency Pressure Ulcer Protocol which helps to reduce the number of preventable pressure ulcers and also impacts on our responses when these are raised under safeguarding, as evidenced by audits.

Key Priority 4: Proportionality

Support and speak up for people who are most at risk of abuse

Objective 4.1: To have a Multi-Agency Safeguarding Hub (MASH) for adults at risk			
Action and Milestones	**By when**	**By Whom**	**Progress**
MASH is functional and responding to queries and alerts in relation to adults at risk	March 2015	AD Adult Social Care LBE	
Mental Health Worker to be commissioned to sit on the MASH	April 2015	AD Safeguarding Enfield CCG	
Regular representation from acute hospital	April 2015	Safeguarding Lead The Royal Free (Chase Farm site)	

Objective 4.2: Focus on how adults at risk are treated with dignity and respect through service user interviews that seek to understand experience

Action and Milestones	By when	By Whom	Progress
Annual plan for completion of service users interview of the safeguarding adults process (year 1)	Throughout year	Head of Safeguarding LBE	
Feedback from service users interviews to be taken to SCP Group for suggestions on how to implement in practice	Jan 2016	SCP sub-group of the Board	

Objective 4.3: Pathway programme in place for people at risk of others			
Action and Milestones	**By when**	**By Whom**	**Progress**
To develop appropriate response and a referral pathway for people at risk of harming others – practice guidance and pathway	September 2017	Police lead for safeguarding with support of SAB partners	
To provide on line information and support to those at risk of harming others			
To provide independent t support and advice to those at risk of harming others (Detailed action plans to be developed 2016)	September 2017	All SAB partners	

Proportionality outcomes we expect to see and report on:

Our recording has been changed so that it can be used to inform practice and provide aggregated outcomes for the SAB

Feedback from adults at risk confirm that they feel safe and have a positive experience of care and support – in line with the Making Safeguarding Personal requirements of involvement from start to finish

People at risk of harming others access support to prevent abuse

Key Priority 5: Partnership

Work with local people to stop abuse, find out about abuse and tell services what is happening

Objective 5.1: To use all existing staff, engagement and partnership events (Board, team meetings, away days etc) to raise the profile of safeguarding adults			
Action and Milestones	**By when**	**By Whom**	**Progress**
Evidence from Board partners annually with respect to where and how safeguarding adults information was shared from front line staff up to senior managers	June 2015 and ongoing	All SAB partners	

Objective 5.2: For partner organisations to provide assurance to the Board that their service provision is in line with the Dignity Standards

Action and Milestones	By when	By Whom	Progress
Each SAB partner to provide annual update to the SAB which provides assurance and evidence of how their services meet the Dignity Standards.	2 partners per SAB meeting	All SAB partners	

Objective 5.3: For language of professionals to be simplified so that there is improved equality of access to services- as recommended by Making Safeguarding Personal			
Action and Milestones	**By when**	**By Whom**	**Progress**
A working party, including professionals and service users, to review templates to ensure appropriate language.	June 2016	Head of Safeguarding Adults LBE	
Quality Checkers 'Mystery shop' to check language used in Adult Social Care.	Sept 2016	Head of Safeguarding Adults LBE	
Partners on Board to identify service users able to 'mystery shop' their services to audit language.	Sept 2016	All SAB partners	

Partnership outcomes we expect to see and report on:

We can look at the strategic plans of partners on the SAB and find evidence of safeguarding adults

Key Priority 6: Accountability

Make sure people can see and check how safeguarding is done

Objective 6.1: Board to determine its arrangements for peer review and self audits as required under the Care Act 2014			
Action and Milestones	**By when**	**By Whom**	**Progress**
To outline options available for peer reviews and self audits and present for agreement to the SAB	Dec 2015	QSP Sub-group of the SAB	
Program of audits to be set out for financial year 2016 and moving forward	April 2016	QSP Sub-group of the SAB	

Objective 6.2: Ensure that there is clear recorded decision and justifications as to whether case is referred under safeguarding adults,

including decision to investigate and prosecute			
Action and Milestones	**By when**	**By Whom**	**Progress**
Clear guidance and pathway developed as part of the MASH	April 2015	Head of Safeguarding Adults, LBE	
Audit of safeguarding adults cases annually	Jan 2016	Head of Safeguarding Adults, LBE	
Review by Met Police on an annual basis of cases referred under safeguarding and any learning with respect to prosecutions or why cases did not progress	March 2016	Safeguarding Lead Met Police	

Objective 6.3: To evidence that patients are involved in their nursing care and feel engaged in decision making			
Action and Milestones	**By when**	**By Whom**	**Progress**
Audit by the CCG on patient involvement and engagement to be reported to the SAB	Sept 2016 and 6 monthly	AD Safeguarding Enfield CCG	

Objective 6.4: For children and young people to be aware of adults at risk and who they can speak to if they have concerns			
Action and Milestones	**By when**	**By Whom**	**Progress**
To identify the most appropriate mechanism for information to be shared, including	March 2016	Safeguarding Children	

age range in schools		LBE	
Information to be disseminated to children and young people	Dec 2016	Safeguarding Children LBE	

Accountability outcomes we expect to see and report on:

More children and young people understand that adults are also at risk of abuse and how to report

The Board can evidence how many cases went to prosecution and continue to try to improve access to the justice system for adults at risk

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Agenda Item 7

Health and Wellbeing Board
14 April 2015

REPORT OF:

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Agenda – Part: 1	**Item: 7a**
Subject: Health Improvement Partnership Board Report – March 2015	
Date: April 2015	

1. EXECUTIVE SUMMARY

This report updates the Health and Wellbeing Board of work of the Health Improvement Partnership Board.

2. RECOMMENDATIONS

It is recommended that the Health and Wellbeing Board note the content of this report.

3. Work with the CCG

The key changes in the previous quarter include:

- Public health team embedded in the CCG,
- The progress on QIPP planning including locality commissioning,
- CCG Operating Plan and
- Update from March Governing Body meeting.

By working closely with the CCG, Public health is putting in place measures to ensure that health outcomes are maximised, and health inequalities are not widened by any new policy, implementation strategy, infrastructure changes or operational procedures.

3.1 Embedding public health in the CCG: The public health core offer team and health intelligence team are now permanently based at Holbrook House where Enfield CCG operates. This co-location will improve the collaborative work between the CCG and Public Health team in improving the health outcomes of Enfield by maximising the effectiveness of healthcare.

3.2 Progress on Quality Innovation Prevention and Productivity (QIPP): Based on the hospital data provided by the Commissioning Support Unit and NHS Right care

reports, Public Health suggested a number of areas where there may be room for efficiency in elective admissions.

Locality commissioning for the prevention of A&E and emergency attendances, and the efficiency of outpatient referrals and primary care medicine management were approved by the transformation programme group for two localities in the East. The plan for two West localities requires extra work to provide benefit from primary care medicine management and prevention of A&E attendances.

3.3 CCG Operating Plan is being refreshed and will be submitted on the 7th April 2015. The plan highlighted that the CCG has put a number of cross cutting initiatives including redesign of community services, development of GP federations or network, development of locality commissioning to better manage demand, better care fund and outcomes based commissioning. The operating plan for 2015.16 include a chapter on prevention where the CCG described its plan to invest in prevention programmes in collaboration with public health.

3.4 Update from CCG Governing Body meeting (25 March 2015): Integrated NHS 111 and Out-of-Hours GP business case was approved. Enfield CCG is the Lead for Urgent Care across North Central London (NCL) Clinical Commissioning Groups (Barnet, Camden, Enfield, Haringey, and Islington CCGs). The Board also agreed for the CCG to participate in London Transformation, and to alter the constitution to allow North Central London (NCL) primary care co-commissioning. The next meeting will be on 10th June 2015.

3.5 Evidence-based support to clinical strategies and commissioning: Public health continues to support the CCG by participating in clinical reference group (CRG), Individual Funding Requests (IFR) panels, steering groups of transformation programmes, drafting of Operating Plan, objectively prioritising business cases and CCG financial recovery. In addition public health economist is supporting the re-writing of diabetes business case.

3.6 Health inequalities: Public Health team is drafting a plan to tackle health inequalities in five priority wards. The activities in the plan will use evidence-based approach which targets individual, communities and population. There will be joint work with various departments within the Council, Enfield CCG and local partners.

3.7 Integrated care update (presented at HIP meeting on 19 March 2015): Working in partnership between NHS Enfield CCG, London Borough of Enfield and their community care providers, a risk stratification tool was developed to identify those most at risk and Integrated Locality Teams, teams composed of social workers, community matrons and therapists, a multi-disciplinary, multi-agency approach to supporting GPs as Lead Accountable Professional in their practices in each of Enfield's 4 CCG localities. Future plans include working with the voluntary sector to develop pan-sector support for healthy ageing for older people with frailty. The Care Homes Assessment Team (CHAT) which is a nurse-led team with geriatrician input were formed to manage the individual cases of older patients in homes with the highest level of emergency hospital admissions, help develop lasting nursing staff skills in these care homes and engage with GPs with patients living in these homes. There was 8% reduction in the number of emergency admissions from those homes with which CHAT worked between

2012/13 and 2013/14, and this level continued in 2014/15. The CCG has increased its coverage from 17 to 31 homes in 2014/15, whilst also reducing CHAT service costs at the same time. The integrated care programme aims to commission voluntary sector when the programme become wider and the scope for the sector's involvement becomes clearer.

4. Physical activity (PA) / obesity

Cycle Enfield. A number of consultation events have now been held on the design and placement of proposed cycle routes. Further events will continue to be held. The Chief Executive of North Middlesex, the Chair of Enfield CCG and the Hospital Director at Chase Farm have all indicated their support for this project. If Enfield could achieve the same level of active transport as Croydon this would mean approximately 10,000 people being active every work day.

Active and Creative in Enfield, a strategy for leisure, sport, arts, heritage and culture 2015 - 2020 was out to consultation until 18th February. The results are still being collated.

A bid for £500k has been submitted to Sports England to increase levels of physical activity across the borough. The focus is on moving people who are not active at all to undertaking 1 * 30 min session of physical activity per week. Results from the bidding process are not expected until Easter.

Stepjockey – 19 teams of 10 people each in the Civic centre are competing in climbing the stairs 'up Everest'. It is intended that this will be rolled out to other Local Authority buildings.

Enfield Council has launched a MEDS website (www.enfield.gov.uk/meds) which has a wealth of data on food and physical activity. The emphasis is on actions that people can incorporate into their everyday lives.

A service is working in 10 schools to improve levels of physical activity and nutrition in both children and adults (as adults are often the gatekeepers for children's behaviour').

Work by the Healthy Lifestyles group has included producing and publishing a survey of health behaviours in staff, levels of overweight and obesity, levels of physical activity and suggestions of how staff might improve their health. Suggestions that have been acted up have included 'stepjockey' (see above), a walks programme and restriction of 'junk food' to Fridays following comments from staff 'that if it wasn't there I wouldn't eat it.

A 'wider determinants' group is being established with Environment with the intention of further incorporating active and healthy living into the built environment.

5. Alcohol

Following training Enfield's Public Health professionals are now inputting into alcohol licensing applications. This will help to influence licensing decisions according to potential public health impact.

In the North Middlesex an Identification and Brief Advice (IBA) nurse is employed to work with clients presenting with alcohol issues.

In Barnet (Royal Free) a nurse is employed to offer a similar service but also to train other staff in alcohol issues. This is being further developed to include in-reach from community services.

A pilot project of IBA in pharmacies is planned. This is likely to start in May with approximately 7 pharmacies, predominantly in the south and east of the borough but with some provision in the west. Exact details have still to be confirmed.

6. London Primary Care Transformation Board

We have helped the London Primary Care Transformation Board (LPCTB) think through a number of issues. In particular we have highlighted the value that practice level QoF data adds and that future potential models of pooling QoF risk losing this piece of information which is helpful in tackling health inequalities. The London Primary Care Transformation Board felt it important for commissioners of primary care networks to build data reporting into contracts. The London Primary Care Transformation Board also discussed the value of having public health trained advisors on primary care network management boards. We have helped Health Education England with their thinking on how they support primary care transformation.

7. Healthy workplaces

Enfield Council is the first London borough to be awarded Excellent by the GLA Healthy Workplace Charter. The reason this drive was initiated by public health colleagues was so that Enfield Council could act as a role model to other organisations. Colleagues at Enfield Council are now looking to encourage other local employers to participate in the GLA Healthy Workplace Charter.

Health and Wellbeing Board

Agenda – Part: 1	**Item: 7b**
Subject: Joint Commissioning Board Report	
Date: Thursday 14th April 2015	

REPORT OF:

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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:

- The finalising of the Council's Information and Advice offer in readiness for the launch of The Care Act on 01 April 2015
- The separate submission re Better Care Fund
- Value Based Commissioning for Older People with Frailty -
    - Feedback from GPs and patients continue to be positive about the service delivery of the borough's Older People's Assessment Units
    - Partners' view, of VBC NHS health contract for Older People with Frailty, is that arrangements need to be further developed before any contract is implemented
- The update on the Council's procurement programme for Reproductive and Sexual Health community services contract
- The End-to-end review and final Report of the Dementia Pathway has been completed
- The update on the borough's Autism Self-Assessment Framework and Autism Co-ordination Procurement
- The overall self-assessment for the Council's SAF was Amber / Green, which means meeting the requirements /exceeds requirements

1. EXECUTIVE SUMMARY (CONTINUED)

- The actions taken with regards to meeting the conditions of the Winterbourne view concordat
- The planning for activities for Carers Week (8th – 14th June)
- Children's Services:
  - The Council's preparation in taking responsibility for Family Nurse Partnership and Health Visiting services from 01 October 2015
  - Steady progress in improving mental health services for pregnant women and babies
  - The Joint Enfield Council and CCG Children & Adolescent mental Health Service (CAMHS) Strategy intention to commission a comprehensive and integrated Emotional Wellbeing and Child and Adolescent Mental Health service
- Local analysis of the number of young people in Substance Misuse treatment has confirmed that Enfield is reaching the previous best performance achievements target
- The development and achievements of HealthWatch, Enfield
- The Safeguarding Adults Board consultation is underway on the Safeguarding Adults Strategy 2015-18 (please see separate submission of the Safeguarding Adults Board Strategy 2015-18 consultation and draft Strategy)
- Planning permission conditions for the Reprovision Project – Elizabeth House - have been signed off
- Both the Council and CCG have confirmed the intention to continue the Section 75 Agreement for commissioned services
- Board updates, including the launch of the Sexual Health Partnership Board

2. RECOMMENDATIONS

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

3. THE CARE ACT 2014

The implementation of the Care Act 2014 and summary of progress made against key requirements

The council is making considerable progress in the key areas of implementation and is confident that it will be able to deliver the Care Act reforms required from April 2015. This is alongside recognising that implementation will continue and be further developed and strengthened during 2015/16 including putting in place measures to assess the impact of the Act. A summary of progress and highlights across the Care Act Board work streams is as follows:

3.1 **Market and Community Customer** – this includes the new duties for local authorities for the provision of Information and Advice (I&A). The Care Act Board is currently in the process of finalising the I&A offer in readiness for April and seeking to ensure that where required, these new duties are incorporated into future commissioning and contractual arrangements. The self-funders research is complete and a refresh of the market position statement underway.

3.2 **Finance and Risk Management** – as previously reported, a range of national financial tools have been completed and a local model developed. This is work that continues and local authorities will shortly be receiving further tools to complete, in order to assist with the financial modelling for 2016 and beyond i.e. the impact of the funding reforms. Consultation on the funding reforms has been published a local response being prepared for the deadline of 30 March. http://careact2016.dh.gov.uk/

3.3 **Workforce Capacity and Development** – a number of briefings and training courses have been delivered. Training on the legal framework on specific sections of the Care Act has been delivered at local level to key staff. In addition, a series of regional events covering a variety of topics such as legal literacy, assessment and eligibility, and commissioning have been made available to local authority lawyers, care act leads and other local authority staff. The launch of an e-learning training tool about the Care Act is imminent.

3.4 **Communications and Engagement** – a range of activities have taken place and a national public awareness campaign is underway. A webpage is available on the Council's website http://www.enfield.gov.uk/info/1000000845/the_care_act_2014 where you can access information about the Care Act.

3.5 **Operational Change Management** – there has been a particular focus on the key principles of wellbeing, preventing and reducing need and outcomes for local people, and ensuring this is embedded in practice. Where required, new forms are being produced, policy and procedures being revised and business practices reviewed. In response to the expected demand on the council of implementing key changes, for example applying the new eligibility framework, carers assessments, support planning etc., additional resources are being brought in to the affected service areas in the council.

3.6 IT and Business Intelligence – the new duties require a number of changes to systems including the HHASC e-Marketplace and customer contact and assessment. This is in being developed in conjunction with the council's transformation programme (Enfield 2017).

3.7 Safeguarding Adults – the key Care Act changes required of local safeguarding adults arrangements have been addressed including for Making Safeguarding Personal.

4. BETTER CARE FUND

Please note separate submission:

- Report From Enfield Integration Board
- Enfield Integration Board Terms of Reference
- BCF Schedule of Draft Section 75 Agreement
- Emergency Admissions Reductions Target

5. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

5.1 Diagnostics & Treatment

The *Older People's Assessment Units* (OPAUs) – one at Chase Farm, one at North Middlesex University Hospital (NMUH) – are consultant-led, multi-disciplinary non-inpatient units to facilitate GPs same or next day access to assessment, diagnostics, treatment and intervention to support primary care case management. Just over 2,500 older people with frailty to Enfield's OPAU between Jan-13–Dec-14; whilst feedback from GPs and patients continues to be overwhelmingly positive about the service and its outcomes, with an overall reduction in emergency hospital admission rates amongst those referred.

5.4 Value-Based Commissioning for Older People with Frailty

Enfield CCG and Haringey CCG are jointly working on a value based commissioning (VBC) approach to older people with frailty. This aims to deliver outcomes across the system through providers working together and with older people with frailty. VBC's underpinning principles are to:

- Identify the cohort of patients (older people with frailty);
- Identify how to improve outcomes for these patients – a mix of clinical outcomes (e.g. frailty fractures, diagnostic rates for dementia), patient experience and patient-defined outcomes (e.g. experience of well-coordinated care) *across the whole-system* as no one provider can deliver these outcomes;
- Define the finances associated with delivering services to the cohort;
- Define an "Integrated Practice Unit", a mechanism for delivering the multi-agency pathway older people with frailty need. To assure alignment and continuity, the IPU "blue-print" incorporates Enfield's Integrated Care Programme and future BCF Plans relating to the health support for older people in the first years of its operation.

Plans are progressing for a 5-year VBC NHS health contract for older people with frailty, but Enfield partners' view, led by the CCG, is that both clinical and contracting arrangements need to be further developed before any contract is implemented in Enfield. The CCG will therefore seek to learn the lessons from NHS Haringey CCG, who intend to press forward with contractual arrangements from Jul-15.

6. PUBLIC HEALTH GRANT

6.1 Reproductive and Sexual Health (RaSH) Procurement

Market Engagement Event took place – 05 March – at the Dugdale with 13 organisations represented. Since then, a further five organisations have made contact requesting details.

Surgeries have been held with interested parties with minutes taken, which will be made available, if appropriate, to ensure transparency.

6.1.1 RaSH Procurement Timetable

Activity	Timescales
SPB approval	1st April 2015
Portfolio member approval	3rd April 2015
Send OJEU notice for publication	7th April 2015, 12 noon
OJEU notice published	12th April 2015
PQQ published	10th April 2015
PQQ closing date	7th May 2015 (30 days)
Evaluation/ shortlisting	22nd May 2015 (2 weeks)
Issue ITT	26th May 2015
ITT closing date	24th June 2015 (30 days)
Evaluation	17th July 2015 (3 weeks)
DAR approval	29th July 2015
Call-in period ends (5 working days)	7th August 2015
Notify tenderers of award decision	10th August 2015
Standstill period	11th – 20th August 2015
Contract award	21st August 2015
Service commencement	1st October 2015

6.2 BEH MHT Community Services Contracts

School Nursing will remain as part of the CCG's block contract in the first instance, enabling the Council to review the service with Health visiting and Family Nurse Partnerships, which will be transferred from NHS to local authorities in October 2015.

The plan is to review the service delivery and pathway of these three services along with Therapies (commissioned by SCS - became part of the block from 01 April 2015), and the CCG's children's services to ensure that the Children's Programme is cohesive, fully integrated, appropriately managed and offering value for money.

7. SERVICE AREA COMMISSIONING ACTIVITY

7.1 Older People - Dementia

The End-to-End review of the Dementia Pathway has been completed and the final report is completed. The findings of the review are incorporated into commissioning intentions and will deliver via the Better Care Fund.

Waiting times for the Memory Service had increased to more than 13 weeks; NHS Enfield CCG invested additional funding to manage this and reduce waiting times; the current waiting time is 4 weeks.

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 GP's Dementia Registers, as well as those individuals who may need to be assessed for a formal diagnosis from the Memory Service. NHS England offered some additional resources to CCGs to improve GP identification and post-diagnostic support in the remainder of 2014/15, and Enfield CCG worked with GPs and the voluntary sector to put these plans into place quickly. As a result of all these initiatives, the proportion of older people likely to have dementia in Enfield (estimated to be around 3,000) who were known to be on GPs' Dementia Registers increased from 46% (around the national average) to 56% between the ends of Mar-14 & Jan-15. Enfield CCG's target is 59% for the end of Mar-15.

7.2 Mental Health

7.2.1 Update on Autism Self-Assessment Framework and Autism Co-ordination Procurement:

The self-assessment covers 2014 and includes the priorities set out in the Think Autism update to the Strategy published in 2014 and the emerging themes that feature in the statutory guidance for Local Authorities and the NHS. This process is also a key means of identifying progress in the implementation of the Strategy across the country. The Autism SAF was submitted on the 5th of March 2015 to IhaL (learning disabilities 'think tank'). The Autism SAF will be quality assured by NHSE and ADASS as it is statutory requirement and key milestones are being monitored nationally and regionally.

Autism is a lifelong development disability that affects how a person communicates with and relates to, other people. The severity and presentation of difficulties can vary significantly.

The government launched the first ever autism strategy in 2010 in response to the Autism Act 2009. This strategy was called "Fulfilling and rewarding lives". It was co-written with a number of national autism advocacy groups to act as a lever for change to address the challenges experienced by people with autism (especially when accessing health and care services) and highlighted the need to respond to the needs of those at the higher functioning end of the spectrum. The national strategy indicated that 1% of the population are predicted to be autistic and that there is anticipated growth in this area of over the coming years.

Enfield's Joint strategy for adults with autism meets the statutory requirements of the 'Fulfilling and Rewarding lives' strategy and 'Think Autism' strategy dated 2014. Our strategy sets out to achieve the following 5 key objectives:

- Increasing awareness and understanding of autism.
- Developing a clear and consistent pathway for diagnosis.
- Improving access for adults with autism to the support and services they need to live independently in the community.
- Enabling local partners to develop relevant services for adults with autism to meet identified needs and priorities.
- Helping adults with autism into work.

Local data

The Enfield council database indicates that **99 adults** with autism were known to the local authority and of these 90 were receiving services. The CCG has referred 6 referrals from GP's for screening or a diagnostic assessment for suspected ASD. We already work closely with the Children's commissioning team to identify the numbers of young people transitioning to adulthood whom will be eligible for services. We will now be capturing the number of young people with HFA who may not be eligible for adult care services to ensure that these individuals and their families have access to appropriate information, guidance and advice provided by low-level support services. This brief intervention is in line with the principles of the Care Act 2014.

• The number of people with autism living in Enfield will increase in the next 15 years. This is particularly striking in the case of children and young people moving into adulthood over the next few years with a diagnosis of autism.

• Maintaining contact with this group and their carers following transition into adulthood would significantly increase the numbers known to adult services and enable better planning for current and future needs for this population.

• From all the national and local information available, it is clear that the local HFA population will have a range of needs split into 3 broad groups:

  - Those with high needs and are generally able to access services at present.
  - Those with low needs who require preventive services from time to time and are currently not receiving services.
  - Those with no need for services.

There has not been any additional funding made available from central government to implement the statutory autism strategy. Enfield believe that with an awareness campaign and the development of a Champions for Change network, our health, housing, social care, support, advocacy and universal services and market can respond to the needs of people with moderate to substantial needs within the existing offer. We will need to review our specialist health and care offer to ensure that it meets the needs of people with severe autism to ensure that personalised outcomes can be achieved locally.

7.2.2 **Overview of Enfield's Joint Autism SAF 2014**

The Autism SAF requests CCG's and LA's to jointly self-evaluate where they are in terms of implementing the Autism Act 2009. The following areas are key themes of the Autism SAF:

- Introduction – identified single management lead
- Planning / demographics
- Training
- Diagnosis
- Care and support
- Accommodation
- Employment
- Engagement with the Criminal justice system
- Local good practice
- Self-advocates experience
- Sign off by Director of HASC and by CO of CCG

Enfield has self-assessed itself as' Amber' overall with a couple of areas rated as 'Green' – the Green areas are centred on partnership working (between the CCG and Council). We are confident in our self-evaluation and the ratings allocated and believe that our responses meet the criteria. The CCG's Director of Commissioning and Partnership has signed the SAF off on behalf of the Chief Officer and the Director of Health and Adult Social Care signed off the SAF on behalf of the Council.

We have recently gone through a small grants bidding process to commission an Access and Co-ordination service for people with autism from the VCS. This new service will implement our joint autism strategy, will co-ordinate our awareness campaign and stimulate the development of peer support opportunities for people with HFA. This service is described throughout the Autism SAF as the significant force in driving forward change. NHS social care funding of £70k (non-reoccurring) will be released to fund this service for a 2 year period along with the £18,500k DH capital funding that will be used to facilitate information guidance and advice sessions and peer support meetings at locations across the borough.

7.2.3 **Independent Mental Health Advocacy (IMHA) service**

Under the 2007 Amendments to the Mental Health Act 1983, the Independent Mental Health Advocacy (IMHA) role was created, as a new safeguard primarily for people detained and / or being treated under the terms of the Act. The IMHA service was commissioned by the PCTs until March 2013. Pursuant to the Health and Social Care Act 2012, this responsibility was transferred to local authorities from April 2013.

Following a transitional one year arrangement with Rethink Mental Health to provide the service in Enfield, in 203/2014, Enfield, Barnet and Haringey councils jointly tendered the service under a single contract along with the Independent Mental Capacity Advocate (IMCA) and the Deprivation of Liberty Safeguards (DOLS) services. The new consolidated joint contract was let to VoiceAbility Advocacy (**www.voiceability.org**) and came into force from April 2014 and is to run for two years with the option of extending for one year plus further one year (2+1+1 years). Enfield is the lead borough for the joint contract including coordinating monitoring.

As part of the efforts to clarify roles and improve the IMHA service, 12 new resources were launched at the House of Lords on 11 March. The resources were commissioned by the Department of Health and developed by the University of Central Lancashire (UCLan) in collaboration with the Social Care Institute for Excellence (SCIE), following a review carried out in 2013/2014. These resources are designed to be used by service users, service providers and commissioners in order to inform service users and improve the quality of commissioning and delivery. The resources can be found here http://www.scie.org.uk/independent-mental-health-advocacy/

7.3 Learning Disabilities

7.3.1 Learning Disabilities Self-Assessment Framework (SAF)

A number of services from across the Council and the CCG contributed to this year's SAF*. We would like to say a special "Thank you" to CAPE for the Carers contribution and to all the self-advocates and the people we support who shared their experiences and to EDA who supported individuals to contribute.

Our overall self-assessment was Amber / Green. In terms of the definition behind the RAG rating; 'Amber' means to meet the requirement and 'Green' denotes excellence or exceeds requirements. Enfield CCG and Council are confident in our self-assessment and responses. The quality assurance process is being completed by IHaL and areas will receive feedback on their submission in April 2015.

* *Public Health England is working in partnership with the Improving Health and Lives (IHaL) website to facilitate the development and delivery of the national SAF for 2013/14. This is a non-statutory return that Enfield is committed to completing. The SAF for this year focusses on the following themes:-*

- *joint working*
- *integration*
- *accessing universal services*
- *improving access to primary care services*
- *addressing health inequalities*
- *empowering people with learning disabilities by involving them and their carers in decision making processes.*

The SAF was launched at the end of September 2014 and the deadline for submission has been brought forward to the end of January 2015 instead of March. Enfield submitted its Joint SAF before the deadline.

7.3.2 Transforming Care for People with learning disabilities Programme (Winterbourne View)

NHS Enfield Clinical Commissioning Group (CCG) and the Council have developed a joint action plan in response to the Winterbourne View concordat. Key messages from the concordat are that each locality should commit to jointly reviewing all people with learning disabilities and / or autism in low-high in-patient facilities to ensure that people are appropriately placed and to have an aspirational discharge plan in place with a view to transitioning back to the community.

Where people are considered as inappropriately placed there is emphasis on considering community based services that are closer to home. Enfield completed reviews by the June 2013 deadline and are currently on track in terms of meeting the conditions of the concordat action plan. Patient choice and parent / carer involvement continues to be the focal point of implementation of the concordat action plan. Since the last update to the HWBB we have:-

- We have maintained our significantly reduced admissions rates to our local assessment and treatment service.

- We have transitioned 2 people with learning disabilities from hospital back to the community within the last month and are in the process of transitioning another individual from the remaining cohort back to the community by the end of April 2015.

- Diverted funding from assessment & treatment services into community intervention models of healthcare through section 75 partnership arrangements

- Provided learning disabilities specific mental health awareness training to service providers of people with complex needs and behaviour that can prove challenging at times

- Our clinicians have provided training to other areas on minimising the use of medication by offering holistic interventions for people with complex needs and behaviour that proves challenging.

- Worked with the local market to develop and commission bespoke specialist housing with care and support options for people with complex needs and those with behaviour that proves challenging at times

- Agreed a funding framework for individuals moving out of hospital back to the community that affords greater flexibility when considering transition arrangements and joined up and person centred services to be delivered based upon need.

- We have completed scheduled Care and Treatment Reviews with NHSE quality assurance panels that include experts by experience and been commended for our approaches especially with regards to transition packages.

- Have created information packs for patients and their parent / carers who are currently in long stay secure hospitals and those at risk of being admitted to assessment & treatment services. We are promoting the information booklet from NHSE “getting it right for people with learning disabilities” which is a guidance tool that was co-produced by Experts by Experience for people with learning disabilities who may be admitted to hospital and their parent / carers. It covers a multitude of scenarios and items of interest such as rights & responsibilities, advocacy, the Mental Health Act and returning to the community after a stay in hospital.

7.3.3 **Community Intervention Service for people with complex needs**
Our Community Intervention Service is fully operational and is part of the Multi-Disciplinary Team Integrated Learning Disabilities Service under Section 75 partnership arrangements. This service was developed in response to the Concordat Action Plan and has directly attributed to reducing the numbers of admissions to our in-borough assessment & treatment service. Lengths of stays have also been shortened due to the community intervention service offering intense resettlement support back to the community.

The CCG agreed reoccurring funding for the Community Intervention Service at the beginning of November. NHS England recognised the Community Intervention Service as a Good Practice healthcare model by requesting case studies for publication in national reports. Our service has supported 20 people with learning disabilities who were at risk of being admitted to assessment & treatment services and by working with them in a therapeutic and holistic way have prevented an admission to hospital.

It was indicated in the last report that our in borough assessment and treatment provider was undertaking a review of its service to look at the longer term sustainability of the service due to low admission rates. The service provider was aiming to complete its review by the end of February 2015. To date, we still have not received the outcome of the review. This will be shared with the Health & Wellbeing Board when it is available. The CCG and Enfield Council will need to create a contingency plan in the event that the provider elects to decommission the service.

7.4 Carers

7.4.1 **The Employee Carers' Support Scheme**
Development of pages for the staff 'Enfield Eye' intranet and content is currently being developed. Development of a staff e-learning package in carer awareness has been agreed as a priority. A session in April is planned looking at the new rights for carers under the Care Act and how this can support them as working carers.

7.4.2 **Carers Week (8th June-14th June)**
Planning has begun for activities for Carers Week.

Enfield Carers Centre will be hosting a Family Fun Day outside Enfield Town Library on Saturday 13th June. This will be a combination of information stalls, entertainment and food and drink. The purpose is to raise awareness of carers issues and the Centre itself.

Enfield Carers Centre are also planning a day trip for adult carers and an activities for young and young adult carers on Friday 12th which is National Young Carers Day.

Enfield Council is planning a consultation day with carers to ask their views about the services they receive and what they would like to see developed in the future. We are also hoping to have a Question and Answer session with Ray James as this has proved very popular with carers in previous years.

7.4.3 **Enfield Carers Centre**

Due to the early meeting date for the Health and Wellbeing Board in April, we have not received the latest statistics for the services through Enfield Carers Centre as Quarter 4 (Jan-March) has not ended.

7.5 Children's Services

7.5.1 **Family Nurse Partnership (FNP)**

Enfield Family Nurse Partnership continues to progress well. Unfortunately, it is now closed to new referrals.

As this service will be transferred to Local Authorities 01 October 2015, NHS England is working with LBE to ensure that the service is being delivered according to the licence.

SCS and Public Health Commissioning have been in discussions regarding the best way forward with this service and has requested data and an analysis of the service from Public Health to ensure that (a) funding additional posts is the most appropriate way to address the demand; (b) that the borough's vulnerable young mums are part of the FNP client base, and (c) that the licence criteria is being adhered to.

7.5.2 **Health Visitors**

The campaign to recruit additional Health Visitors continues to be successful and the service is continuing to introduce a second universal check at 8-10 weeks. This is a critical point for identifying post-natal depression and other issues and will strengthen the overall early years offer to children and families in Enfield.

As more Health Visitors are recruited the programme will be further extended.
SCS and Public Health Commissioning are reviewing the current service delivery while the contract is with NHSE as responsibility for commissioning Health Visiting is due to transfer from NHS England to local authorities via the Public Health Grant - in October 2015, and are working to ensure an effective transition is in place.

7.5.3 **Maternity**

The Enfield CCG continues to monitor important quality issues in monthly meetings and through the North Central London Maternity Board. New joint services have been set up for substance misuse and maternity services. There has been steady progress in improving mental health services for pregnant women and up until their baby's second birthday (known as the perinatal period). The Tavistock & Portman Clinic is providing perinatal mental health training and 273 Enfield Social Workers, midwives, obstetricians, health visitor assistants,

Change and Challenge, Children Centre and voluntary sector staff have been trained. All health visitors have been trained.

7.5.4 **SEND/Children and Families Act Implementation**

The Children & Families Act introduces the biggest changes to the Special Educational Needs and Disability (SEND) system for 30 years for children/young people and their families,

Eight work streams have been set up to look at how different aspects of the reforms will be implemented in Enfield.

Good progress is being made with other work streams. A national video developed by Contact a Family featured Enfield Joint Service, the Voice and Enfield CCG.

7.5.5 **Paediatric Integrated Care**

A paediatric integrated care work stream was initially established to support implementation of the Barnet, Enfield and Haringey Clinical Strategy, and is now supporting the development of the Child Health and Wellbeing Networks included in the Better Care Fund submission. The new networks will enable care to be designed around the needs of children and families taking account of both their physical, social, and emotional, circumstances and providing access to expertise from across the professional spectrum, but most importantly from children and families themselves. A workshop successful looking at how the model can be further developed was held in December.

7.5.6 **Joint Enfield Council and CCG Children and Adolescent Mental Health Service (CAMHS) Strategy**

The joint strategy will set out the way in which Enfield will commission a comprehensive and integrated Emotional Wellbeing and Child and Adolescent Mental Health Service and improve outcomes for children and young people in Enfield. The Strategy is being finalised.

7.6 Drug and Alcohol Action Team (DAAT)

7.6.1 **Successful Completions (Drugs)**

Public Health England's database, NDTMS, came back on-line on the 12th March and providers have received notice that they will be given until the end of July to upload the backlog of data. Until this task is completed the DAAT remains dependent upon the local analysis generated from the Health, Housing and Adult Social Care Business Intelligence and Support Team (BIS Team). However, the reliability for the local analysis has historically proven to be extremely accurate.

The local forecast for the 12 month rolling period April 2014 to March 2015 is indicating that 974 drug users have been in treatment during the year. The BIS Team have undertaken some further analysis to determine growth rates in the system and identified that an additional 140 drug users have engaged in treatment in the past 3 months; compared to those in treatment in April 2014 (Please see Page 2 Fig 3). There has been a minor reduction in the successful treatment completion rate but Enfield still remains 3.5% above the National

average and is consistent with the last ratified NDTMS position for the London average.

7.6.2 Change in Numbers of Drug Users in Treatment

Because the numbers in treatment is calculated on a 12 month rolling basis and is influenced by the numbers successfully completing in the previous 12 month period, it is difficult to determine the actual growth rate in the numbers in treatment by just looking at Figure 1 on Page 1 of this Report. For example, if during April 2014 150 drug users were discharged successfully from treatment and yet in March 2015 an additional 200 new drug user's entered treatment, the actual growth would only be 50 people. Enfield experienced a large number of successful completions from the Dual Diagnosis Service in Feb and March 2014 which has tended to indicate there has not been much growth in the system.

The Table below provides a confirmed snapshot of the actual numbers of drug users in treatment at the start of each month for the previous 3 month period and shows the level of increase from the baseline at year start; an additional 140 drug users in treatment.

Active Caseload	Baseline 01/04/2014	01/01/2015	01/02/2015	01/03/2015
Compass	507	502	503	526
Dual Diagnosis	80	66	96	136
WDP	61	76	97	126

7.6.3 Numbers in Effective Treatment (Drugs)

The Numbers Retained in Effective Treatment Indicator is not the same measure as the Numbers in Treatment as the former relates to those drug users who are retained in treatment for 12 weeks or longer, or who are discharged drug free within the first 12 weeks. Accordingly there is always a substantial time lag in performance reporting due to the 12 week criteria being applied to this measure. As Enfield will not achieve exceeding 1068 drug users in treatment before the 31st March 2015, it is not possible to meet the trajectory target for Numbers in Effective Treatment. The DAAT are proposing to only use successful treatment completions (quality measure) and numbers in treatment (quantity measure) in 2015/16 and maintain these as the main adult drug treatment measure for all future reporting periods. This is simply because PHE no longer report on Numbers in Effective Treatment as a performance measure.

7.6.4 Numbers in Treatment and Successful Completions (Alcohol)

The alcohol performance is also moving in a positive direction with the numbers in treatment continuing to rise and the successful treatment completion rate achieving 35% for the latest 12 month rolling period April 2014 to March 2015.

7.6.5 Young People's Substance Misuse Performance

Local analysis for the number of young people in treatment has confirmed that Enfield is now reaching the previous best performance achievements under this measure, with 173 young people being in treatment during the 12 month rolling

period Feb 2014 to Jan 15. Furthermore, the Planned Treatment Exit rate has continued on the upward trend with 95% leaving in a positive way.

8. HEALTHWATCH ENFIELD

Healthwatch Enfield has statutory responsibilities for encouraging health and social care organisations to listen to and involve their local users, and for encouraging local people to exercise their rights as 'consumers' of health and social care services. We have five staff, five Board members and around 12 volunteers.

8.1 Some recent achievements:

Provision of interpreters for GP appointments: this had been raised with us by both Deaf (BSL users) residents and by those with limited English. Some GP Practices declined to take responsibility for booking interpreters, said they didn't know how to do it or told patients to bring along a relative. The absence of interpreters risked the wrong diagnosis being made, the patient not understanding what was wrong with them and not understanding what treatment they had been given. Being told to bring a relative compromised their privacy. We raised the issue with both NHS England and the local CCG and, after many months of discussion, are pleased to report that the CCG wrote to all GP practices in February with details of how to book both foreign language and BSL interpreters. This should mean that all GP practices can easily book appropriate interpreters.

In February a **new NHS e-newsletter 'In Touch'** was launched nationally but the format chosen meant that the email could not be forwarded on to others. We raised this with the Head of Public Voice at NHS England and the second edition had a changed format. As the e-newsletter goes to thousands of recipients the change means the important information it contains can now be shared with many more people.

Access to support in making a complaint: Voiceability is the organisation contracted by LBE (via a pan-London arrangement) to provide advice and support to people wishing to make a complaint about an NHS service. We became aware that Turkish and Somali speaking residents were unaware of these services so we met with Voiceability to raise this and they have now produced material in both Turkish and Somali. We now have a supply in our office.

Blood test appointments booked via North Middlesex University Hospital (NMUH):

In January we started to receive large numbers of complaints from patients (and from GP surgery practice managers) that it was impossible to contact NMUH by phone to make a blood test appointment. This affects patients who want the test done locally at their GP practice but need to book an appointment via the hospital. There are 12 GP practices in the borough who offer this service. We checked information on the NMUH website and raised concerns with PALS and the Head of Patient Experience. The wrong phone number on the website was corrected and this information was relayed to the practice managers. However,

the situation did not improve so we have been raising our concerns with Haringey CCG (the lead commissioners) as well as with the Hospital directly. At the time of writing there are some longer-term plans to reduce pressure on the call centre and volunteers are being used to take calls at NMUH. We remain extremely concerned and remain in touch with Haringey CCG about the situation.

All of our work has a positive impact on patients and service users – whether it is provision of information, promoting patient/service user rights, ensuring the patient/service user voice is heard or securing improvements in service – some of which are highlighted in the 'You said, We did' section of our website.

8.2 Our Priorities

We are currently focusing on 5 key areas of work, identified as a result of input from our Reference Group, the wider voluntary and Community Sector, and members of the public. Our recent work under these priorities includes the following:

- **Mental Health services** – working jointly with Haringey and Barnet Healthwatch, we used our statutory powers to carry out an Enter and View visit to Oaks ward at Chase Farm hospital. We have also scheduled visits to Suffolk ward at Chase Farm and wards at St Ann's Hospital. This provides an opportunity to meet service users and patients, to hear from them about whether they have any issues with local services. We continue to meet with mental health service user groups to hear about their experiences.

- **GP access** – Our CE spoke at a meeting of GP Practice managers in January. We have just carried out an update of our ***GP Information Audit,*** checking websites and NHS choices information for all GP practices in the borough. As before, we have written to all practices where information appears to be missing to provide an opportunity for them to respond to us before we publish our report later this month.

- Access to services for people with a **sensory impairment** – We will be publishing a joint report with Enfield Disability Action, called: ***Improving Services for Deaf patients in Enfield,*** later this month and a BSL version will be available on both our websites.
  Together with 12 other HW across North Central and East London we obtained funding for a shared training project. A key element of this is to train Deaf (BSL users) people to carry out Enter and View visits and undertake mystery shopping exercises. A number of Deaf residents in Enfield have been closely involved with this.
  We remain an active member of the Enfield Vision Strategy Group.

- We continue to monitor **A&E and Urgent Care services** at NMUH and Barnet/Chase Farm hospitals and the impact of the Royal Free acquisition of Chase Farm/Barnet hospitals. Statistics are published weekly on our website.

- **Adult Social care:** in addition to our programme of Enter and View visits to care and nursing homes we are starting to focus on obtaining feedback from residents

about adult social care. We have also created a dedicated page on our website about the Care Act.

8.3 At the same time we have undertaken a range of other ongoing work:
Signposting and Information: We have ensured that our website has a full range of information about local health and social care services as well as details about complaints processes. Our website forms the basis of our signposting work and we get between 350-400 new website visitors a month. We also actively tweet information to our 570 plus followers. In addition we have dealt with 172 individual telephone/letter enquiries since April. Since the last HWB report we have published three e-newsletters and are planning a printed version for April/May so that we can reach more people.

Community Engagement: We continue to engage with service user groups and members of the public from different communities across the borough. Recent engagement activities have included focus group sessions or meetings with:

- Naree Shakti Asian Women's Group
- Enfield Asian Women's Group
- Bountagu Afternoon Tea group
- EMU mental health service users group
- NMUH Patient Representative forum
- Mental Health Resource Centre users on Park Avenue
- Enfield Vision strategy group

We have a session planned with the Enfield Chinese community.

We also hold **"pop-up" stalls** at venues across the borough (libraries, festivals, shopping centres, hospital reception areas). Since the last report we have been at:

- Enfield Civic Centre for Carers Rights Day
- Disability resource centre, Park Avenue
- Mental Health resource centre Park Avenue
- Enfield Town library, and
- Four Hills Community Centre (Chase ward)

For the coming year we have a programme of at least one pop-up stall per month, including visits to:
Chase Farm Hospital;
North Middlesex Hospital;
Southgate College;
Winchmore Hill Sainsbury's;
Trinity at Bowes community centre;
Four Hills community centre (Chase ward);
Ordnance Road, Enfield Town and Southgate Circus libraries
plus various festivals and other locations.
Some of these locations are a regular venue for us.

Enter and View: Our report on our visit to Stamford nursing centre, a BUPA home, has been published and is on our website at http://www.healthwatchenfield.co.uk/enter-view. Copies have been sent to the relevant Enfield, CQC and CCG officers. We recently carried out a visit to Hugh Myddleton House, a nursing home run by Barchester Homes, and this report is being written up. In partnership with Healthwatch Barnet we visited The Oaks ward at Chase Farm hospital and this report will be published shortly. Our next visit is on 17 March to Suffolk ward at Chase Farm hospital. We have a schedule of further visits planned – an average of one a month over the coming year.

8.4 Representation and Involvement:

BAME Health Seminar March 3rd - We continue to be involved in the Enfield Race Equality Council BAME Health and Wellbeing Focus Group, and assisted in a well-attended seminar focusing on addressing health inequalities on 3rd March. Our CE was a speaker and HW board members and volunteers helped to facilitate the workshops.

Re-commissioning of NHS 111 and Out-of-hours services: We are representing the 5 North Central London Healthwatch organisations on the Urgent Care Programme Board which is overseeing the re-commissioning of these two key services.

In addition we continue to attend a range of **partnership boards** and other meetings, to ensure that the interests of patients and service users were raised, with **36 meetings** attended since our last report to the HWB. We are told that our contributions are valued.

Since April 2014 we have **responded to 23 formal consultations** from statutory agencies. In addition we have **promoted 80 consultations**, encouraging patients and service users and their organisations to respond directly to ensure their voice was heard. We targeted particular groups, where appropriate, to ensure that they were aware of a consultation that may be particularly relevant to them.

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

- no update available for this report

10. SAFEGUARDING

10.1 Safeguarding Adults Board (SAB)

The Safeguarding Adults Board consultation is underway on the Safeguarding Adults Strategy 2015-2018. The consultation was distributed by all members of the Board and attention was given to feedback from service users, carers and patients and presented to Enfield HealthWatch. The Care Act places a requirement for the Board to have a strategy which is reviewed annually, to which Enfield SAB is well placed having had a strategy since 2009. The strategy focuses on the 6 principles of safeguarding, namely empowerment, protection, prevention, proportionality, partnership and accountability. In addition, there is an

emphasis on prevention of abuse and Making Safeguarding Personal, which shifts the focus to empowering individuals to naming their outcomes in safeguarding and support to realise these outcomes.

10.2 Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a national initiative set out by the Local Government Association and Association of Directors of Adult Social Services to improve safeguarding practice through a person centred approach. The overarching intention of MSP is to facilitate person-centred, outcome-focused responses to adult safeguarding situations. MSP records 3 levels of engagement from Bronze, Silver and Gold. Enfield aimed for Gold which included an independent evaluation of the work by a university and Bournemouth University was commissioned and agreed to undertake this evaluation. This was undertaken in January 2015 and results identified:

- LBE clearly demonstrated six principles of safeguarding set out by the DoH are being met through MSP practice
- LBE demonstrated a clear commitment to empowering service users through personalised information and advice, with service users involved in the safeguarding process
- Creative methods used to engage and support service user voice
- Key strength is the commitment to work collaboratively with external agencies
- Evidence of learning culture
- Development of IT systems and to capture outcomes

Areas for future consideration include:

- Exploring how information is presented to make the best impact
- Building on successful projects such as the Quality Checkers and committing to on-going recruitment and training of this resource
- Delivering an on-going commitment to share good practice within a learning culture promoted throughout the organisation and with partners
- Exploring new resources such as apps which can be used by practitioners to support their professional decision making and judgement in relation to risk and choice for service users

Bournemouth University supports LBE progression towards Local Government Association consideration of Gold Standard.

10.3 Safeguarding Information Panel (SIP)

An area of work for the panel is the development of a ‘dashboard’ data sheet to offer attendees an overview of the information held for providers, including number of alerts and their types and other information collected over a 12 month period. In addition to this a shared spreadsheet is now being used to enable information from the Contract Monitoring team to support the data analysis demonstration given at meetings.

10.4 Dignity in Care Panel

The Dignity in Care Panel are continuing to complete their pilot to review all services provided by the Independence and Wellbeing Services Teams focusing on Dignity and respect , the findings of the reviews are shared at a management

level along with recommendations for improvement and a timely revisit measures progress and the meeting of outcomes. A successful 'Launch' event of the panel took place on the 27th of February, Cllr Don McGowan and Ray James presented at the event along with the volunteer panel members to celebrate the significant achievements of the work of the panel and the work plan for the future. An application for the Dignity in Care Panel has been made to present at the National Children and Adults conference in Bournemouth this year.

10.5 Quality Checker Project

The Quality Checker Project has continued to visit social care providers to collect meaningful feedback from social care customers. The feedback collected is shared and heard at a strategic level to drive service improvement and highlight areas of concern for appropriate consideration and interventions if necessary. The Quality Checker Project attended and contributed at a focus group facilitated by the Bournemouth University auditing Enfield's response to the Making Safeguarding Personal agenda. The Quality Checker Project are planning a recruitment drive for more volunteers to ensure that the Quality Checkers are representative of the community that they serve.

10.5 Multi-Agency Safeguarding Hub (MASH)

10.5.1 As part of its ongoing work to transform services in Enfield Adult Social care is seeking to create a multi-agency safeguarding hub (MASH) for vulnerable adults. With a significant increase in the number of safeguarding referrals year on year and a need to respond quickly, often across multiple areas of responsibility, developing a MASH which will see the co-location of staff from adults' services, police and health makes sense. This will fit with the MASH currently in place for children.

It had previously been agreed that, as an interim solution, a joint MASH will be located within space currently in use by the children' s SPOE with additional space to be provided as part of the Enfield 2017 transformation programme. This was to be effective from 1st April 2015. Once renovation works are completed on the 9th floor of the civic centre, the service will be relocated there. It is anticipated that the move to the 9th floor civic centre will take place in September 2015. Due to the Enfield 2017 transformation programme and delays in assessing the impact and delivery of staffing reductions on available accommodation, however, the current space currently in use by the Children's SPOE may not be available for the Adult MASH. Temporary accommodation for the Adult MASH has now been agreed within the civic centre. This will be committee room 2. Work will begin soon to fit the room out in readiness for the Adult MASH go live date of 20th April 2015.

10.5.2 The group has previously received an update on the background to and need for an Adult Multi-Agency Safeguarding Hub. This update relates specifically to actions either planned or delivered to date.

The MASH steering group is chaired by the AD for Adult Social Care services and includes stakeholders from across the Council and other statutory bodies. The steering group is supported by two sub-groups, the MASH practice group and the MASH IT/infrastructure group. Progress made to date includes:

- An operating procedure for how the Adult MASH will work has been completed and tested through two desk top exercises involving all partners. This will also determine how the Adult MASH will fit with the Children's MASH already in place.
- Agreement reached on what resource will be allocated from which services to sit within the Adult MASH and what resource will be shared across both Children's and Adults MASHs
- Long term accommodation solution agreed as the 9th floor civic centre. Planned available move in date is currently September 15 once renovation works have been completed.
- Site visit completed and funding agreed for IT/re-cabling provider for the Police.
- IT System specifications to support both Children's and Adult's MASHs are complete and a system provider has been selected. System delivery for the adult requirements was scheduled for February 2015. However, there have been delays and an updated project plan is being prepared currently to take account of slippage. It is not clear at this stage whether the fully integrated solution will be available for the go live date in April 2015.
- Capital funding in place to deliver the IT solution
- Contact to be made with other councils who have already implemented joint Adult and Children MASHs across the country to learn good practice
- Information sharing protocol has been reviewed and agreed.

11 SPECIALIST ACCOMMODATION

11.1 **Department of Health Capital Funding Bid -** In October 2014, the Department of Health announced the release of £7million capital funding to support additional or improved housing and accommodation projects for people with learning disabilities, autism and/or challenging behaviour. In November 2014 a bid for £1.45 million was submitted, for the purchase and adaptation of 5 homes from the open market via the Council owned Housing Gateway. Unfortunately the bid was not successful in this instance, but work continues to look at alternative options for housing development in this area.

11.2 Work continues on the redevelopment of outdated specialist accommodation located off Carterhatch Lane and the development of wheelchair accessible homes for people with disabilities on Jasper Close (for social rent) and Parsonage Lane (for home ownership).

Commissioners are also working in partnership with the Integrated Learning Disabilities Service to re-accommodate 18 service users with learning disabilities, who are required to move having received notice to vacate premises from the property owner. Options currently being considered include purchasing homes on the market through the Housing Gateway.

12. PRIMARY CARE PREMISES STRATEGY GROUP

12.1 The 'Primary Care Premises Strategic Group' meets on a quarterly basis providing a forum for key partners to meet and supply long term strategic

oversight to current and future primary care premises developments in the borough. The purpose of this group is solely to consider the development and sustainable supply of primary care premises, in line with regeneration programmes being delivered by Enfield Council. The Group combines representatives from NHS England, NHS Enfield Clinical Commissioning Group, NHS Property and Enfield Council (various departments). The next meeting is 28th April 2015.

12.2 Reprovision Project - Elizabeth House

Planning Permission conditions have now been signed off by Planning Department. Building cost inflation is a major challenge, it is expected inflation levels will be in-line with increased levels Council faces in connection with other construction projects e.g. education building works. Current project timeline estimates show:

- Advance works beginning on site e.g. sewer rerouting on site April 2015
- Main site establishment 28th April 2015
- Major works underway 28th April 2015
- Build complete 2nd June 2016

Once the building construction has started, a competitive Tender exercise will be initiated to select and appoint a service provider to deliver care to the future resident group.

13. SECTION 75 AGREEMENT FOR ADULTS

The Council and NHS Enfield Clinical Commissioning Group have had a Section 75 Agreement for commissioned services for adults since 2011. The mid-year review concluded that the partnership arrangements are continuing to work effectively. As a result, both the Council and Enfield Clinical Commissioning Group has confirmed the intention to continue the agreement, however some amendments are required for 2015-16 in order to facilitate the inclusion of the Better Care Fund pooled budget and support further effective collaborative working across health and social care.

14. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

14.1 Learning Difficulties Partnership Board (LDPB)

14.1.1 The Learning Disabilities Partnership Board met on the 23rd February. The Big Issues for this meeting were the Implications of the Care Act for Safeguarding, Information, Advice & Advocacy, and Care Charging.

14.1.2 Helen Tapfumaneyi (Team manager – Safeguarding Adults) gave a presentation on ‘Making Safeguarding Personal’. The board were pleased with the person centred approach to safeguarding, but were concerned that many people with learning disabilities still found the process difficult to understand. Board members will send Chris O’Donnell (person centred planning coordinator) links to accessible information and he will discuss with Helen how these may be referred to from the council website.

14.1.3 Michael Sprossen (Service Manager – Procurement) updated the board on progress with information, advice and advocacy in light of the Care Act. The board were pleased to see progress being made. However, many board members found information on the council's website hard to find. They also noticed that much of the accessible information 'signed off' by the board was still waiting to go on the site. Chris will work with members on possible 'Easy Access' sites that could work alongside the council's webpage.

14.1.4 Suzanne Hutchinson (Acting Performance manager) and Tracey Owen (Acting Income Assessment Team Leader) gave a presentation on care charging as part of the consultation on the draft care charging policy. The board had the following feedback, which they will contribute to the consultation –

- People living on their own are often financially disadvantaged by current care charging policy. The board noted the examples in the policy showed significant discrepancies in disposable income people are left with, i.e., and person with learning disability living on their own had a minimum income guarantee of £56 less than an elderly person in the same situation, and only £4 more than a person with a learning disability living with their family.

- The board is also aware of a separate consultation regarding charges for transport services, which will not be completed until after this consultation closes. The board felt strongly that the results of this consultation should not be included in this year's charging policy, but implemented in April 2016.

- The board also noted that Disability Related Expenses (DRE) are poorly understood for people with learning disabilities. Both by the Income Assessment Team and people with learning disabilities would benefit from an easy read guidance on DRE.

14.2 Carers Partnership Board (CPB)

The Board has held its first meeting using the new structure for 2015 with longer, quarterly meeting instead of 6 shorter meetings a year. The next meeting will take place on the 22nd April and will be the annual away day focusing on the Care Act, development of carers services and the review of the Carers Strategy which will be need renewing in 2016.

It has also been agreed to review the structure of the sub-groups that sit underneath the Carers Partnership Board for effectiveness. One priority for 2015 is to strength the voice of the Carers Hub – the forum for VCS organisations who work with carers.

14.3 Physical Disabilities Partnership Board (PDPB)

Update: 23rd March PD Board – following our successful 'new members' campaign at Christmas, the Board was well attended and included new members. We have a number of 'virtual' members, who are unable to attend quarterly, but wish to be kept informed and will attend when possible. This is a very positive step forward; our new members include carers and young people.

The meeting spent some time getting to know each other. The Board were informed of the Safeguarding Adults Strategy consultation which generated

helpful discussion and comments. We had a presentation from the Chair of the LD Partnership Board - as it is a successful Board and we are a relatively new cohort of members, it was helpful to understand their format and why it is successful.

Following this, the Board agreed the outline ToR and general work plan for the year. This will include themed Board meetings to be agreed at the next meeting.

14.4 Sexual Health Partnership Board (SHPB)

14.4.1 The inaugural meeting of the Enfield Sexual Health Partnership Board took place on 10 February 2015 with representation from CCG, Teenage Pregnancy Team, Public Health, Commissioning, Consultant and management from the current Reproductive and Sexual Health community services providers (BEH MHT)

14.4.2 The members reported on:

- the co-ordination of the teenage pregnancy strategy with a focus on prevention [Teenage Pregnancy team]
- the high number of unintended pregnancies in the borough with more than 90% of terminations are for pregnancies less than 10 weeks. Enfield has the high rates of termination of pregnancy and the 4th highest rate of repeat abortions terminations in London [CCG]
- the ongoing sexual health campaign to coincide with Valentine's Day [Public Health]
- all sexual health contracts:
    - LARC contract with GPs
    - HIV secondary prevention contract with Embrace to be extended to 30 September 2015 and then go out to tender to invite interest from the voluntary sector. LBE has to the responsibility for primary prevention, which means more testing
    - Enfield is a member of the London Collaborative, which is reviewing sexual health services starting with GUM
    - The procurement programme for RaSH community services

14.4.3 The Terms of Reference were agreed

14.5 Safeguarding Adults Board (SAB)

14.5.1 Please note separate submission, which outlines the Safeguarding Adults Board Strategy 2015-18 Consultation and the draft Strategy

14.5.2 The Safeguarding Adults Board met on 9th March 2015 and data was presented for Q3 2014-2015. Some key points of note include:

- There were 732 alerts raised from Q1-3 2014-2015, which is a 1% increase from the previous year. The Board noted that number of alerts appears to be plateauing as compared to much higher increases seen in previous years

- For the second quarter running Mental Health reported decrease in number of referrals reported for 18-64 year olds. This was noted as a 32% decrease.

Information reported to the SAB confirmed that this decrease was caused by late data returns from specific teams, which have now been addressed.

- Most alerts relate to Multiple Abuse (36%) and Neglect (28%). Neglect is higher when compared to 2013/14 which has seen a 23% increase (167 to 206).

- 42% referrals are in relation to alleged abuse in the Adult at Risk's own home and 29% are in a residential/nursing home. Referrals where the location of abuse is 'MH inpatient setting' is lower when compared to 2013/14, which has seen a reduction from 47 to 19 alerts. (47 to 19).

- There is an 11% increase in the number of adults at risk whom have a nominated advocate involved (344 to 382) since 2013/14. The type of advocacy is set by the request or requirement of the adult at risk and can include family members, friends, or paid advocate for example.

- 40% of closed cases were substantiated or partially substantiated (49% in Q3 2013/14). The outcome in 34% of referrals concludes 'The allegation has not been substantiated' this is an increase from 2013/14 with 22%.

In line with the Care Act and a focus on wellbeing, the Safeguarding Adults Board scope has widened. At the last meeting a presentation was facilitated by the Metropolitan Police on Human Trafficking and the Board is now considering actions it can take to identify potential victims. These are recognised as issues which cross over with safeguarding children and steps have been taken to complete more joined up working, such as the Strategic Safeguarding Adults Team to sit on the Task and Finish Group for Female Genital Mutilation.

The Board was kept updated on the development of the **Enfield Multi-Agency Safeguarding Hub**. The purpose of the Multi Agency Safeguarding Hub (MASH) is to provide a single gateway for safeguarding vulnerable adult's referrals for Enfield Council, which will share information, within agreed protocols, to protect and safeguard vulnerable adults who are, or could be, at risk of harm.

This will be achieved through enhanced communication in a multi-agency environment and the early identification of risk and harm to make timely, co-ordinated and proportionate interventions to keep vulnerable people safe. Central to this, are the needs and desired outcomes of the service user.

The MASH is a collaborative, partnership approach to safeguarding adults with the aim of gathering and analysing information to inform decision making, which includes the expressed outcomes of the service user. MASH will comprise of partners from a number of agencies, some are co-located and full time and others will attend on a part time or virtual basis. The 3 key agencies are Police, Health and Adult Social Care.

The MASH will be operational from 28th April 2015. Operating manual has been completed in draft form and is currently being taken to appropriate groups for agreement. Temporary accommodation has been secured to allow partners to be

co-located, with permanent location to be available once refurbishment in the Enfield Civic Centre has been completed.

The Single Point of Entry in Children's Services use a system called 'Maisy', which is currently being developed for use with adults. This will help to ensure that information from partners can be accessed which are then held centrally in the MASH, allowing only appropriate information (in line with information sharing guidance) to be shared.

The Care Act statutory guidance encourages partners to make a resource contribution to recognise the corporate partnership accountability and to ensure the SAB can carry out its functions. A paper was presented to the Safeguarding Adults Board which set out expected cost for 2015-2016 and request was made for partner contributions to this cost. To date, some partners have responded with financial contributions to the running of the Board.

MUNICIPAL YEAR 2014/2015

MEETING TITLE AND DATE **Health and Wellbeing Board** **14 April 2015**	**Agenda - Part: 1** **Item: 7c** **Subject: Primary Care Strategy for Enfield** **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 work to date to implement the Primary Care Strategy across the borough of Enfield.

2. RECOMMENDATIONS

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

3. UPDATE

As the current Primary Care Strategy Programme reaches its conclusion on 31st March 2015 and the five NCL CCGs commence a six month development process on 1st April 2015 to assume responsibility for joint (co-)commissioning arrangements with NHS England from 1st October 2015, the six key areas of primary care transformation are reflected in the table below
:

	SPG Lead	Joint Lead	CCG Lead
Quality improvement of general practice			✓
Implementing co-commissioning arrangements		✓	
Implementing the Primary Care Strategic Commissioning			

Framework for London → accessible, co-ordinated and proactive care		✓	
Development of federated care networks			✓
IT interoperability			✓
Development of an estates strategy		✓ with NHS England and LBE	
Development of a programme of workforce development		✓ With SPG and CEPN	

In addition to the above, both the aims of the Five Year Forward View and the CCG are based upon a local primary care landscape that is of high quality, sustainable and delivered to locality populations. The CCG needs to build upon its existing Enhancing Access, Locality Commissioning, Network Development, Clinical Improvement Leads and GP IT workstreams as a means of delivering these aims.

The Primary Care Strategy Implementation Board met for the last time on 17th March 2015 and the governance for the six key areas will be as follows:

- Quality Improvement currently reporting to the Primary Care Quality Improvement Group
- Implementation of effective joint commissioning arrangements currently reporting to the Joint NCL Committee
- Implementation of the Strategic Commissioning Framework for London currently reporting to Joint NCL Committee
- Development of federated care networks across 100% of CCGs in NCL currently reporting to Network Development Steering Group
- Interoperability between practices across NCL currently reporting to Barnet, Enfield, Haringey & Islington IT Working Group
- Development of an estates strategy currently reporting to LBE Strategic Primary Care Premises Group
- Development of a programme of workforce development currently reporting to Community Education Provider Network

These transitional arrangements will become the responsibility of the CCG/LBE Transformation Board, although the detail of this is yet to be established.

4. CONCLUSION

This report provides an update on progress of the Primary Care and Prevention programme.

MUNICIPAL YEAR 2014/2015 - REPORT NO.	

MEETING TITLE AND DATE **Health and Wellbeing Board** **April 2015.**	**Agenda - Part:1** | **Item: 7d** **Subject:** **Report From** **Enfield Integration Board** **Wards: All**
Report of the Chair of Enfield Integration Board	**Cabinet Member consulted:**
Contact officer - Richard Young **Email:** richard.young@enfield.gov.uk **Email**: richard.young@enfieldccg.nhs.uk	

1. EXECUTIVE SUMMARY

- The inaugural meeting agreed the Sub-Boards Terms of Reference in principle – allowing opportunity for detailed study and comment before being finalised at the next meeting.
- The draft section 75 schedule for the BCF programme was considered and approved
- The BCF Plan Emergency Admissions Reduction Target was considered and it was agreed that a formal paper would be brought to the next meeting to form the basis of the recommendation to the Health & Wellbeing Board. It was agreed to support the original target of a 3.5% reduction as applied to the revised baseline.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to receive the report.

3. BACKGROUND PAPERS

- Enfield Integration Board Terms of Reference
- BCF Schedule of Draft Section 75 Agreement
- Emergency Admissions Reductions Target

Report from Enfield Integration Board

Meeting date 18th February, 2015.

1. Apologies & Welcome

Apologies – D Fowler, A Fraser, R James, V Giladi, L Wise, T Fenn

The Chair, welcomed everyone to the first meeting of the Enfield Integration Board and outlined that the dual focus of the group would be to design and drive through greater levels of integration between health & social care services within Enfield as well as manage the programme of the Better Care Fund on behalf of the Health & Wellbeing Board (HWB) within its scheme of delegation.

Declarations of Interest: The Chair highlighted that there was no opportunity on the agenda for any party to declare any interests. Members were invited to consider this and suggest any amendments. This would be a regular agenda item in future.

2. Terms of Reference for Integration Board

These were supported in principle by the Board and members were invited to send any comments directly to officers before the next Board meeting. It was agreed that members would be able to nominate deputies to attend on their behalf in advance of meetings.

It was agreed that the Board would move to a bi-monthly meeting calendar to alternate with the Health & Wellbeing Board. The Chair would then prepare a report to go to the HWB from the Enfield Integration Board.

3. Better Care Fund Programme

GM and BN led the discussion broadly setting out the plan / vision for the Better Care Fund. It was recognised that the Board had an excellent opportunity to look beyond the Better Care Fund remit for integration across public care services.

A brief overview of the plan would be provided for the next meeting – outlining the programme schemes and ambitions and setting out the targets required of the BCF Plan.

The Board agreed that the focus for the group was to ensure delivery against the Plan and make sure the ‘system’ works at a broader level.

4. Financial Report / Overview

The BCF schedule within the draft section 75 agreement and the financial programme associated with it was considered and agreed.

It was also agreed that a three-year budget plan would be constructed and discussed at a future meeting. It was noted that there was no certainty over planning assumptions beyond 2015/16 in regards to BCF and that policy may change after the forth coming election. However, it was also recognised that there was a genuine intention to continue this work – irrespective of policy mandate following the election result.

5. Re-setting / Confirming Emergency Admissions Reductions Target

BCF Partnership Areas have an opportunity to re-base the threshold and target for emergency admission reductions now that actual data was available. (Original plans were submitted on the basis of part 'actual' data and part 'planned activity'). Any new target or re-base will be required to be submitted via the CCG Operating Plan Process.

It was agreed that a further paper would be brought back to the Board but that the original target of 3.5% would be applied to the new baseline for the purposes of a planning assumption for the draft submission of the Operating Plan (due at the end of February).

6. Business Case Development

An analysis of progress with project Business Case development was shared for information. These projects would be the subject of future detailed reports. A 'benefits realisation matrix' would also be presented at a future meeting.

7. Calendar of Meetings / Forward Plan

The draft Forward Plan was circulated. This would be populated overtime with additional business – such as the consideration of project specific business cases.

8. Any Other Business

No Further AOB was discussed.

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Terms of Reference

Integration Board

Purpose

The Integration Board will act as the key management body for the BCF and Integrated Care programmes and will operate with delegated powers from the HWB. Any decisions outside the terms of the delegated authority will require a formal decisions being subject to ratification by the HWB.

The HWB will set the annual budget and programme for the Integration Board (and in particular the Better Care Fund, its pooled budget and programme) at the start of the financial year. The Integration Board will manage the business of the HWB Integration programme and the Better Care Fund Pooled budget and programme within the annual limits set by the HWB.

Authority to Act

The Integration Board is a formal sub-board of the HWB and will have delegated powers to manage the programmes within the budget and programme limits set by the HWB up to a financial value of £250,000. Any decisions above this limit will require to be referred to the HWB. In addition, any new schemes added to the programme will require the approval / ratification of the HWB.

At its meeting on 11th December 2014, the Health & Wellbeing Board (HWB) agreed the governance structure required going forward for the performance management and implementation of the joint BCF plan as well as for the financial governance, under Section 75, of the pooled BCF monies. Appendix 1 sets out the governance structure agreed by the Health & Wellbeing Board.

For the Better Care Fund, the management of the Pooled Budget is set out in schedule of the section 75 Agreement between Enfield CCG and LBE.

Final authority remains with the Enfield Health and Wellbeing Board as the Accountable Body.

Management of Change Process

Where the Integration Board is minded to approve a change to the finances or the programmes agreed by HWB, it shall be able to do so without recourse to the HWB if the financial value is within the scheme of delegated authority.

However, if the change is a substantial deviation in service delivery, policy or is a financial value in excess of the delegated authority, the Integration Board should consider the matter in detail and then recommend a specific course of action to HWB at the next appropriate meeting of the HWB.

Key Responsibilities of the Integration Board

- Managing the BCF and Integrated Care Programmes.
- Delivering and owning the Vision for integrated care.
- Communicating the Vision for integrated care.
- Defining and owning the blueprint for change.
- Responsibility for defining and managing the overarching risk framework.
- Managing, by exception, the identified Critical Success Factors, benefits and Milestones of the BCF Programmes as reported or escalated from the Programme Delivery Group (PDG).
- Providing 'whole system' leadership in the oversight & development of integrated care.
- Providing Financial, Quality and Risk Management leadership (subject to delegated authority from the HWB).
- Owning the 'desired outcomes' (end states), benefits and value for Enfield's people and monitoring them in light of safeguarding and quality of care considerations.
- Providing regular reporting and monitoring information to the HWB Board particularly where there are perceived high level risks and issues for delivery.
- Monitoring the benefits realisation and delivery milestones, via highlight reports, within the Better Care Fund programme and Integrated Care Programmes.
- Leading the programme of work through facilitating and developing a positive culture across organisations for improved service integration for those populations identified through the joint Better Care Fund plan
- Individually and jointly communicating key messages across staff partners / people - including supporting the communications campaign and strategy.
- Identifying and ratifying quick and sustainable opportunities for further integration of services across Enfield.
- Unblocking of any actual or potential barriers to success in partner organisations.
- Jointly engaging with stakeholders (both internal and external) in development and implementation of the Programme to ensure awareness and ownership.
- Ensuring that appropriate community engagement is taking place and feedback is captured and acted upon swiftly.

Formal Sub-Groups

A *Programme Delivery Group* (PDG) has been established beneath the integration Board to operationally manage the constituent programmes. The terms of reference for this group are attached at appendix 2. [Not Attached]

A *Finance & Activity Sub-Group* has been established to manage finance and performance against agreed metrics. The terms of reference for this group are attached at appendix 3. [Not Attached]

Membership of the Integration Board

The Board will comprise of a mixture of representatives from NHS and Local Authority commissioning and provider organisations. However, in line with the HWB constitution, Provider representatives shall be members of the Board but not have voting rights.

Chair of the Integration Board

The Chair of the Integration Board will be the Chair of the CCG. The Chair will provide regular updates to the HWB.

Voting Members

Title	Organisation
CCG Chair (Chair)	ECCG
Director of Health, Housing and Adult Social Care	LBE
CCG Chief Officer	ECCG
Chair	Healthwatch Enfield
Director of Schools and Children's Services	LBE
Representative from Enfield Voluntary & Community Sector	VCS

Non-Voting Members

Title	Organisation
Chief Executive – Royal Free Hospital NHS FT	NHS
Chief Executive – North Middlesex NHS Trust	NHS
Chief Executive - BEH-MHT	NHS
Primary Care Provider Representatives (X2)	NHS
Assistant Director, Adult Social Care - HHASC	LBE
Assistant Director Strategy and Resources - HHASC	LBE
Director of Strategy and Partnerships	ECCG
Chief Finance Officer	ECCG
Director of Finance	LBE
Director / Asst Dir Public Health	LBE
Integration Programme Director (BCF Programme Manager)	CCG/LBE

Voting

The integration Board will endeavour to reach a consensus agreement on any matters under consideration where ever possible. However, should a vote be required to make any decisions, only voting members (as indicated above) will be eligible to participate in the vote. Voting members of the Board shall have one vote. Decisions will be made by the majority.

Any voting member can invoke the right to refer any decision to the Health and Wellbeing Board for Consideration.

Quoracy

Quoracy for the Integration Board will be no less than one-third of full membership (i.e. 6 members present) – including 3 voting members (where there is at least one voting representative from each of Enfield CCG and LBE).

Members of the Board can nominate a named deputy to attend on their behalf. This includes voting members delegating authority to vote to the named deputy.

Reporting

The Integration Board will receive updates from the Programme Delivery Board (which is chaired by the Integration Programme Director) and, in turn, will provide updates to the HWB.

Individual members will be responsible for updating their own organisations on progress.

The Board will establish individual Working Groups to drive forward key programmes and engage providers and stakeholders where appropriate.

Declarations of Interest

Any member that perceives that they may have an interest to declare should do so at any meeting where that interest / matter is considered. It is recognised that all providers currently providing services will have a standing interest in those services. These interests need not be declared at every meeting.

However, where a specific service is being considered for investment / disinvestment or service change, any party that may have a financial or service interest in that service (now or in the future) is advised to declare that interest.

Conflicts of Interest

Given the stated aim of integrated services, it is essential that the perspectives, experience and expertise from all parties is welcomed and encouraged during discussions. However, in some cases, members of the Integrated Board will have a conflict of interest. In such cases it is proposed that:

- Where there is a direct interest (or Direct Pecuniary Interest) then the board member should declare that interest and take no further part in the discussion.

- Where there is an interest which is not a direct financial or contractual interest, e.g. a non-pecuniary interest, then the board member should declare that interest and is permitted to remain in the meeting and participate in the discussion.

Review

The Terms of Reference and governance structure will be reviewed after three months of operation. (July 2015.)

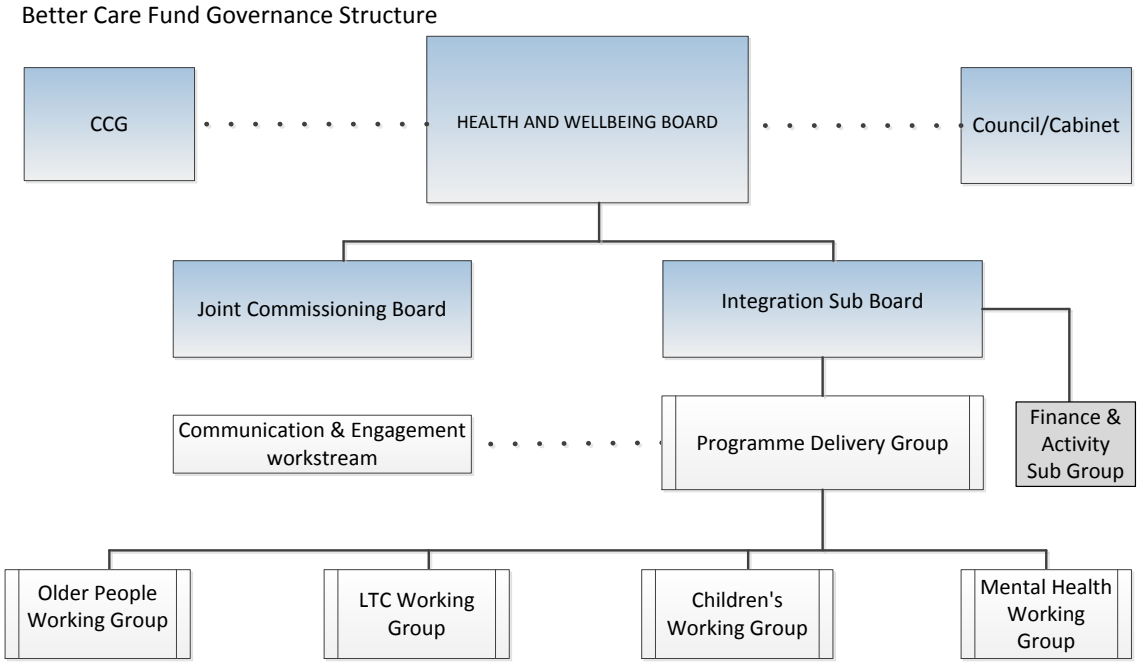
DRAFT Version 1.2 (updated 29 01 15)

Appendix 1

The graphic below sets out the governance structure agreed by the Health & Wellbeing Board, which includes:

- An *Integration Board* has now been established as a Sub Board of the HWB, operating with delegated powers from the HWB Board, to take forward the BCF Plan and Integrated Services across health and social care in Enfield.
- A *Programme Delivery Group* (PDG) will be established beneath the integration Board to operationally manage the programmes.
- A *Finance & Activity Sub-Group* will be established to manage finance and performance against agreed metrics.
- Final authority remains with the Enfield Health and Wellbeing Board and as the Accountable Body and the HWB will approve the budget and BCF programme.

Better Care Fund Governance Structure



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Appendix 2

Terms of Reference

Programme Delivery Group

Under construction

Appendix 3

Terms of Reference

Finance & Activity Group

Under construction

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 12 FEBRUARY 2015

MEMBERSHIP

PRESENT Shahed Ahmad (Director of Public Health), Ian Davis (Director of Environment), Deborah Fowler (Enfield HealthWatch), Liz Wise (Clinical Commissioning Group (CCG) Chief Officer), Donald McGowan, Rohini Simbodyal, Doug Taylor (Leader of the Council), Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Kim Fleming (Director of Planning, Royal Free London, NHS Foundation Trust) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust), Lance McCarthy (Deputy Chief Executive North Middlesex University Hospital NHS Trust)

ABSENT Andrew Fraser (Director of Schools & Children's Services), Ray James (Director of Health, Housing and Adult Social Care), Litsa Worrall (Voluntary Sector), Vivien Giladi (Voluntary Sector), Dr Henrietta Hughes (NHS England), Ayfer Orhan and Julie Lowe (Chief Executive North Middlesex University Hospital NHS Trust)

OFFICERS: Bindi Nagra (Joint Chief Commissioning Officer), Glenn Stewart (Assistant Director, Public Health), Jemma Gumble (Strategic Partnerships Development Officer), Graham MacDougal (Director of Strategy and Performance - Enfield Clinical Commissioning Group), Pragati Somaia (Public Health Programme Manager), Richard Young (Better Care Fund - Interim Programme Manager) and Jill Bayley (Principal Lawyer - Safeguarding) Penelope Williams (Secretary)

Also Attending: Councillors Vicki Pite, Alev Cazimoglu, Ozzie Uzoanya, Daniel Anderson, Christiana During, Jane Johnson (Borough Commander - Metropolitan Police), and Les Bowman (Borough Commander – Fire Brigade), and 3 members of the public.

1
WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. He gave a special welcome to the Borough Commanders for Fire and the Police who were attending the meeting, as observers, for the first time.

Apologies for absence were received from Councillor Ayfer Orhan, Henrietta Hughes, Ray James, Andrew Fraser, Vivien Giladi and Litsa Worrall.

2

DECLARATION OF INTERESTS

There were no declarations of interest.

3
PROPOSALS FOR CHASE FARM HOSPITAL

The Board received a presentation on the new proposals for the Chase Farm Hospital site from Maggie Robinson, Head of Property and Angela Bartley, Assistant Director of Public Health at the Royal Free London, NHS Foundation Trust.

Copies of the presentation slides are attached to the agenda.

1. Key Points of the Presentation

1.1 Maggie Robinson, Head of Property highlighted:

- The current buildings on the site were in a poor state of repair and would not be suitable for future health care needs. Therefore it had been decided that the best solution was a wholescale site redevelopment.

- An outline planning application had been submitted and was due to be considered by the Council's Planning Committee on 12 March 2015.

- If the application was approved, a reserved matters application will be submitted in summer 2015.

- The masterplan includes, for the 39 acres of the site, a new hospital campus (17 acres), residential units (18 acres) and a new school (4 acres).

- Clinical services proposed were set out on the slide. Further detail would be provided on request.

- Consultation had been taking place and feedback on a number of areas received. All feedback would be considered, responses to queries made and adjustments incorporated.

- The consultation period had been extended to allow more time for the Royal Free to respond, to allow for greater clarity and further detail. Two weeks of consultation remain.

1.2 Angela Bartley, Assistant Director of Public Health, highlighted:

- The Royal Free was unusual in having a public health section. Its role is to support and complement local community initiatives and it had been involved in the early development of plans for the Chase Side site.

- Deprivation and health were linked and it was the role of the service to do what it could to improve health, to reduce the life expectancy gap and address health inequalities.

- Research had been carried out into outpatients to identify reasons behind the life expectancy gap and to work out how to shift resources to the most deprived areas.

- They were plans to create a health promoting clinical and community environment on the site which would include support for work around cycling, enforcing no smoking regulations and providing and promoting healthy food options.

- Every contact would be used to try and prevent ill health, starting with maternal and child health. In Enfield 54% of under 16's are growing up in areas that are amongst the most deprived communities in England.

- The Royal Free had had success at increasing referrals as part of a domestic violence initiative. They would look to introduce a similar initiative at Chase Farm

- Providing opportunistic immunisations on the spot to those who had missed them was an example of successful practice.

2. Questions/Comments

2.1 Enfield was the tenth most physically inactive borough in the UK. It was suggested that the Royal Free could link into Council initiatives such as the provision of free exercise in parks which had been recently launched. A similar project in Birmingham had revealed that for every £1 invested £26 cost savings were made.

2.2 Local hospitals would also need to be involved in the council's key priority, reducing child poverty.

2.3 More detail on the clinical services could be provided on another occasion. At this meeting they had focussed on public health. The Royal Free wanted to know what else they could do to support local initiatives.

2.4 Concerns were expressed about the lack of availability of borough level and site specific data. It was felt that this data would provide greater clarity on the quality of clinical services provided.

2.5 Conversations had started to see how contractors could be encouraged to employ local residents and to offer mentoring and work experience placements. Local people would also be employed to deliver services as part of the Social Value Act.

2.6 There had been a large amount of public involvement and engagement at the start of the process but concern was expressed that but this had tailed off recently. In response there had been a large amount of local stakeholder and resident engagement around at the start of the process and around the planning application which was continuing. Two more consultation/engagement events were planned towards the end of March. In addition, a temporary building had been placed in front of the Clock Tower which would house a facility containing information about the proposals and there would be people will be on hand to answer queries. Comments were always welcome. Details of ne initiatives would be sent to Deborah Fowler to add to the Healthwatch website.

2.7 The majority of the proposed public health initiatives would be provided as part of the trust's normal services, from the trust's own resources, but others would depend on alternative sources of funding.

2.8 This twenty first century facility was welcomed by local GPs but questions were asked about how the local population would be segmented to help address some of the wider determinants of health. The Royal Free would work with Public Health officers to work out what was needed.

2.9 A fine balance would be made, when setting parking charges, between what was fair and reasonable, as well as being aware that this could be a means of encouraging people to cycle or use public transport. The plans included a reduction in car parking spaces from about 1,200 to 900.

2.10 Encouraging the payment of the London living wage would be something which would be kept in mind.

2.11 The suggestion was made that interventions would need to be targeted at specific communities. Smoking levels amongst the general Enfield population was about 15.8%, but this was 50% in the young Turkish population.

2.12 Local Authority land had been set aside within the proposals for a reasonable sized NHS GP practice.

2.13 Measuring blood pressure was seen as a very important preventative measure.

2.14 The question was asked as to how many more patients had presented at North Middlesex following the changes to Chase Farm.

4
SECTION 75 AGREEMENT INCLUDING GOVERNANCE OVER BETTER CARE FUND FOR 2015/16

The Board received a report from Bindi Nagra, Assistant Director Strategy and Resources, on the revisions to Enfield Council and the Enfield Clinical Commissioning Group's Section 75 Agreement (Adults) 15-16.

Bindi Nagra introduced the report highlighting the following:

- The agreement worked well in 2014/15 and it was proposed to continue the agreement with some amendments, including incorporating the Better Care Fund provisions.

- The revised agreement will be made up of six schedules: Better Care Fund, Mental Capacity Act and Deprivation of Liberty, Safeguards, Joint Commissioning Team, Integrated Community Equipment Service, Integrated Learning Disability Service and Public Health.

- The voluntary and community sector wheelchair service and personal budgets for health schedules have been incorporated within the Better Care Fund Schedule.

- The Better Care Fund is made up of £20m worth of existing money.

- Any changes to the Better Care Fund will need to be authorised by the Health and Wellbeing Board.

- The agreement complies with the best practice in managing pooled budgets.

Questions/Comments

1. The chart showing the links to the partnership bodies on page 27 of the report is the current arrangement. The dotted link to HealthWatch indicates co-operation. There are no immediate plans to make any changes. Some of the bodies work better than others. Deborah Fowler agreed to feed her concerns direct to Bindi Nagra.

AGREED

1. To note the proposed changes to the financial contributions to the Section 75 Agreement Adults for 2015/16.

2. To recommend that the Section 75 Agreement go forward to be signed and sealed by Enfield Council and the NHS Enfield Clinical Commissioning Group.

5
CCG OPERATING AND FINANCIAL PLAN

The Board received a report from Graham MacDougal, Enfield Clinical Commissioning Group, Director of Strategy and Performance.

Graham MacDougal introduced the report to members highlighting the following:

- Reviewing the operating plan was part of the annual cycle of review.
- NHS England had asked each Clinical Commissioning Group to refresh the plan for 2015/16, agreed as part of last year's 2 year plan (2014/16). The refresh had turned out more substantial than originally envisaged.
- The report updates the Board on the progress being made. Substantial work has been done on reviewing trajectories and current performance.
- Submission dates include 13 January (for initial headline plan) 27 February (full draft plan), 10 April 2015 (final submission).
- The plan is made up of three elements: finance and activity which includes the financial recovery plan for financially challenged CCGs such as Enfield's: targets both local and national with trajectories over the year: and a full narrative on how to approach delivery on both local and national levels.
- In 2015/16 it is hoped to obtain a quality premium for one off uses in 2015/16.
- More guidance is awaited for medication errors.
- Primary Care access and access to psychological therapies were key focusses.
- The 2014/15 plan had been based on Nicholson's 7 ambitions.
- Work was continuing with Public Health to make sure trajectories are aligned and match those of the Health and Wellbeing Strategy.
- New areas of work will include mental health targets and reducing the wait for psychological therapies to 18 weeks.
- There will be a new emphasis on how the CCG works with the Borough.
- Prevention and reducing health inequalities were also key.

AGREED

1. To note the requirements and progress set out in the report.
2. That the plan would be discussed in more detail at the next board development session in March 2015.

6
SUB BOARD UPDATES

1. Health Improvement Partnership Board

The Board received the sub board update from the Health Improvement Partnership Board.

1.1 Glenn Stewart, Deputy Director of Public Health, presented the report to the board, highlighting the following:

- Public Health continued to work closely with the Enfield Clinical Commissioning Group (CCG).
- Locality practice profiles had been completed.
- The procurement specification is being finalised for the School Nursing and Health Visitor Contracts 2015/16.
- The procurement process for the Reproductive and Sexual Health (RASH) service is underway.
- A successful child poverty conference had been held in November, following which an action plan was produced and a project manager employed to implement it.
- Breastfeeding support has been successful.
- The Pharmaceutical Needs Assessment is out for consultation.
- Work on Female Genital Mutilation (FGM) continues and Public Health has now taken over the chair of the Safeguarding Board's FGM task and finish group.
- Public health officers have been trained to enable them to screen licensing applications.
- The Child Death Overview Panel is holding a learning event for stakeholders.
- Media campaigns are running for World Aids Day to encourage people to get tested, as well as on sexual health, antibiotics and hypertension.
- Quitting smoking targets are being exceeded. An event is being held on 16 February, focussing on the Turkish community, who have high numbers of smokers. Preparations for No Smoking day on the 11 March 2015 are in hand.
- Health checks are on target.

- Individual Funding Requests are up to date.

- Public Health has launched the stepjockey scheme at the Civic Centre to encourage people to use the stairs rather than the lifts. A Healthy Weight website has also been launched.

1.2 Questions/Comments

a. Providing information including placing posters in GP practices would help raise public awareness of public health issues. GP's would be happy to help.

b. Dementia memory clinics waiting times had increased, but these had now gone down.

c. Late presenting of people with AIDs was a problem in Enfield, but it is worth noting that Inner London boroughs where the figures are higher have put in much more resources and spent significantly more money on raising awareness of the issue.

AGREED to note the content of the report.

2. Joint Commissioning Sub Group Update

The Board received a report from Bindi Nagra, Assistant Director of Strategy and Resources (Health, Housing and Adult Social Care).

Bindi Nagra presented the report to the Board highlighting the following:

- A large amount of time has been spent preparing for the implementation of the Care Act 2014, which takes effect from the 1 April 2015. As a Council he felt that we are well placed to deal with the changes.

- The Better Care Fund has now been fully approved in terms of submission. The Council continues to receive guidance on implementation. NHS has asked the council to review certain targets to check whether they are consistent with original benchmarks and whether they are sustainable.

- Work is continuing on providing support to integrated care for older people.

- Consideration of how to commission the Reproductive and Sexual Health services is underway. Market testing is planned for February 2015

- The Mental Health Strategy has now been approved by all partners and an implementation group set up.

- The Council is putting together a self-assessment framework for learning disabilities. A joint action plan has been developed in response to the Winterbourne View Concordat.

- Planning permission has now been granted for a new 70 bed care home on the old Elizabeth House site. Pictures and plans were attached to the report.

2.2 Questions/Comments

a. The review of the Better Care Fund targets will take account of the current trends and expectations, particularly in the light of current winter pressures. Revision and review will be taking place in the week following the meeting. Formal submission of the revised targets would form part of the CCG operating plan. It would be approved by the Integration Sub Board and reported back to the full Health and Wellbeing Board. Further discussion would be possible when the operating plan is considered at the development session.

b. Bindi Nagra confirmed that there would be no changes to the grant funding arrangements to the voluntary and community sector without 6 months notice having been given.

c. Concern was expressed about the current system for allocating Council housing through the online portal. This route was acknowledged to be unsatisfactory for some niche groups and alternatives were being considered in specific cases.

AGREED to note the content of the report.

3. **Improving Primary Care Board**

No update was provided for this meeting as the board had been updated at the recent development session.

7
MINUTES OF MEETING HELD ON 11 DECEMBER 2014

The minutes of the meeting held on 11 December 2014 were received and agreed as a correct record.

8
DATES OF FUTURE MEETINGS

The Board noted the date agreed for future meetings:

- Tuesday 14 April 2015

The Board noted the date agreed for future development sessions:

- Thursday 12 March 2015

Next municipal year’s provisional dates will be circulated when available.