# Public Document Pack

**HEALTH AND WELLBEING BOARD**

Monday, 14 September 2015 at 5.00 pm
Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

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

**MEMBERSHIP**

Leader of the Council – Councillor Doug Taylor (Chair)
Cabinet Member for Health and Social Care – Councillor Alev Cazimoglu
Cabinet Member for Public Health and Sport – Councillor Nneka Keazor
Cabinet Member for Education, Children's Services and Protection – Councillor Ayfer Orhan
Chair of the Local Clinical Commissioning Group – Dr Mo Abedi (Vice Chair)
Healthwatch Representative – Deborah Fowler
Clinical Commissioning Group (CCG) Chief Officer – Paul Jenkins
NHS England Representative – Dr Henrietta Hughes
Director of Public Health – Dr Shahed Ahmad
Director of Health, Housing and Adult Social Care – Ray James
Interim Director of Children's Services – Tony Theodoulou
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 pecuniary, non-pecuniary or other pecuniary interests relating to items on the agenda.

**3. ENFIELD CLINICAL COMMISSIONING GROUP COMMISSIONING INTENTIONS** (Pages 1 - 24)

To receive a report and presentation, for consultation on the Enfield Clinical Commissioning Group 2016/17 Commissioning Intentions.

## 4. RE-PROCUREMENT OF THE 111 OUT OF HOURS SERVICE (Pages 25 - 36)

To receive a report on the re-procurement of the 111 Out of Hours Service.

## 5. MINUTES OF THE MEETING HELD ON 14 JULY 2015 (Pages 37 - 46)

To receive and agree the minutes of the meeting held on 14 July 2015.

## 6. DATES OF FUTURE MEETINGS

To note the dates agreed for future meetings of the Health and Wellbeing Board:

- Thursday 15 October 2015, 6.15pm
- Thursday 10 December 2015, 6.15pm
- Thursday 11 February 2016, 6.15pm
- Thursday 21 April 2016, 6.15pm

To note the dates agreed for board development sessions

- Wednesday 4 November 2015, 2pm
- Wednesday 6 January 2016, 2pm
- Wednesday 2 March 2016, 2pm

## 7. 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

| MUNICIPAL YEAR 2015/2016 - REPORT NO. | |
|---|---|

| MEETING TITLE AND DATE<br><br>Health and Wellbeing Board<br>14th September 2015. | Agenda - Part: | Item: |
|---|---|---|
| | Subject:<br>NHS Enfield CCG Draft Commissioning Intentions 2015/16 | |
| | Wards: All | |
| Report of: Graham MacDougall, Director Strategy & Partnerships | Cabinet Member consulted: N/A | |
| Contact officer - Richard Young<br>Email: richard.young@enfieldccg.nhs.uk | | |

**SUMMARY:**

This report provides an update to the Health and Wellbeing Board on the development of the NHS Enfield CCG Commissioning Intentions for 2016/17. The Commissioning Intentions (CIs) for 16/17 are still under development and the attached document is at "working draft" stage.

Enfield CCG has begun its process to collate, construct and publish its commissioning intentions. In the first instance, the CCG has collated all QIPP, service redesign and contractual issues that are currently under development or already in the contract system. A final set of commissioning intentions is planned to be submitted to the CCG Executive Committee in advance of sharing with providers on 30 September 2015. A further report will be submitted to Health and Wellbeing Board at its next meeting.

Commissioning Support Unit (CSU) colleagues will utilise the final summary of CIs to produce provider specific Commissioning Intentions correspondence by 30th September.

Following the formal publication of CIs via the CSU correspondence to providers, a public facing document will be prepared for PPE and wider stakeholder engagement. Planning on this document has been recently started.

**SUPPORTING PAPERS:**

Presentation: Summary of Commissioning Intentions 16/17 (appendix 2).
(Please note that Commissioning Intentions are still under construction and is "work in progress".)

**RECOMMENDED ACTION:**

Health and Wellbeing Board is asked to NOTE the contents of this report and make comment on the draft CCG Commissioning Intentions.

## Introduction:

This report provides an update to the Health and Wellbeing Board on the development of the NHS Enfield CCG Commissioning Intentions for 2016/17.

Enfield CCG has begun its process to collate, construct and publish its commissioning intentions. In the first instance, the CCG has collated all QIPP, service redesign and contractual issues that are currently under development or already in the contract system.

The Commissioning Intentions (CIs) for 16/17 are still under development and the attached document is at “working draft” stage and is primarily intended for information only at this point. Work is currently underway on converting the contents of this document into a similar format to the one produced last year. An update will be given at the meeting.

## Commissioning Intentions

Every year, each Clinical Commissioning Group (CCG) is required to produce a list of commissioning intentions that describe to local providers how the CCG as an organisation intend to shape local healthcare services.

Commissioning intentions describe the changes we want to see to the services we commission, new services we want to commission and responding to national directives from NHS England and Government.

Some Enfield CCG commissioning intentions are CCG focussed, some are developed jointly with LBE and some developed jointly with other CCGs. Some commissioning intentions will be more contractual terms to support service change rather than all service transformation. Our commissioning intentions have to support delivery of the QIPP.

## Process

Each commissioning lead has been asked to review its commissioning intentions (CIs) from 2015/16, and engage with lead clinicians and other key stakeholders, to develop intentions for 2016/17. . The business planning process will continue with the development of full business cases / specifications by the end of October, if not already developed. Maximum use has been made of existing plans and also the ongoing discussion with providers.

The CCG is obliged to produce written correspondence to service providers on or by 30th September. This element of the process is being supported by CSU colleagues and they will utilise the final summary of Commissioning Intentions to produce provider specific Commissioning Intentions correspondence by 30th September. The attached draft timetable sets out the timeframe and key deadlines for producing the CCGs Commissioning Intentions (attached at appendix 1). When finalised, the Governing Body will be required to consider and ratify the CCG Commissioning Intentions at its meeting in October.

## North Central London and Collaborative Commissioning

At NCL level, the Contract Delivery Group (CDG) is co-ordinating the production of Commissioning Intentions. Work is progressing to collate those issues across CCGs that

may lead to collaborative Commissioning Intentions across two or more CCGs. Progress so far can be summarised as:

- The Directors of Commissioning and CCG planning leads have collectively agreed to share commissioning intentions.
- CSU are reviewing & confirming formal correspondence templates and CI summary spreadsheets
- Lead commissioners (CCGs) will co-ordinate authoring the commissioning intentions correspondence for their providers.
- Where CCGs are not leads commissioners, they will contribute to the formal correspondence through the lead CCGs.
- CSU & Planning leads to identify areas of common interest (i.e. where CCGs may have similar commissioning intentions with the same provider) and explore common approaches.
- The outputs from the Carnell-Farrar work on NCL-wide will be incorporated into Commissioning Intentions as soon as these are known and assessed.

## Patient & Public Involvement (PPI):

The CCG is planning an engagement programme for this work. In addition, each Commissioning project is subject to individual engagement.

- A major patient & public engagement event is planned to be combined with the CCG AGM
- An event will be planned to engage with providers to discuss ECCG Commissioning Intentions prior to the formal publication of commissioning intentions.
- Following the formal publication of Commissioning Intentions via the CSU correspondence to providers, a public facing document will be prepared for PPE and wider stakeholder engagement. Planning on this document has been recently started.

## Equality Impact Assessment:

There has been no EQIA on this work at this stage. Equality Impact Assessments and Quality Impact Assessments are undertaken routinely as part of each project under the CCG Transformation Programme as part of business as usual.

## Risks:

There are no risks directly arising from this report. However, several of the projects contained within the final commissioning intentions document and correspondence with providers will require further risk assessment, if commissioned.

## Resource Implications:

The resource implications of the CI process are not yet finalised.  However, all of the implications contained within the final commissioning intentions document and correspondence with providers will require to be aligned with the CCG Financial Plan, if commissioned.

## Next Steps:

- Health and Wellbeing Board is asked to note progress, approve the outline time table and note the initial summary of ECCG Commissioning Intentions;
- ECCG to share Commissioning Intentions with NCL partners (and identify areas of common interest);
- Quality check all Commissioning Intentions submitted to date;
- Strategically review all Commissioning Intentions, sift out any that are not viable and identify any omissions or gaps;
- Planning for public engagement event has commenced;
- The CCG will continue to develop and finesse ECCG Commissioning Intentions in conjunction with LBE, CSU and NCL partners.

**Commissioning Intentions: Timetable to 1st October** **Appendix 1**

| Date | Action Required | Lead |
|---|---|---|
| 29/07/15 | Commissioning Intentions Group established (alternate with CMG) | RBY |
| 31/07/15 | Re-establish NCL Planning Leads Group & share Commissioning Intentions | RBY |
| 31/07/15 | Commissioning / Projects leads to complete summary CI template | Commissioning Leads |
| 03/08/15 | Collate Commissioning Intentions | RBY |
| 10/08/15 | NCL DoCs to circulate draft CI's (to data) | GMac |
| 12/08/15 | ECCG GB – Advise GB of Commissioning Intentions & Process | C/O Report |
| 26/08/15 | ECCG Exec Cttee – Agree Draft Set Of Commissioning Intentions | GMac |
| Aug / Sept | Finalise Service Specifications And Activity Finance Plans, Etc | Project Leads |
| 02/09/15 | ECCG GB Seminar– Draft Commissioning Intentions & Process | GMac / RBY |
| 09/09/15 | Stakeholder & Public Engagement Event – Focussing On Commissioning Intentions. | L Andrews / RBY / GMac |
| 14/09/15 | EIB / HWBB Development Session | GMac / RBY |
| 23/08/15 | ECCG Provider Event (TBC) | GMac / RBY |
| 30/09/15 | ECCG Exec Cttee – Agree Final / Published Commissioning Intentions | RBY (GMac on A/L) |
| 30/09/15 | Publish CI Document And Formal Letters To Providers (Incl Contract Notices) | CSU / RBY |

**Commissioning Intentions: Timetable October – March 16**

| Date | Action Required | Lead |
|---|---|---|
| 14/10/15 | ECCG GB – Agree Final / Published Commissioning Intentions | GMac |
| 15/10/15 | H&WBB– Agree Final / Published Commissioning Intentions | RBY / GMac |
| 30/10/15 | Commissioning / Projects Leads To Complete Detailed Activity & Finance Changes | Commissioning / Project Leads |
| Nov 15 | Finance / Contracts To Model Impact Of Changes – Draft Finance Plan? | Finance / Contracts |
| Nov / Dec | Detailed Activity / Finance / Specification Changes To Providers | Finance / Contracts |
| Late Dec | NHSE Planning Round Guidance | NHSE |
| Nov 15 - Jan 16 | Detailed Activity / Finance Modelling | Finance / Contracts / CSU |
| Jan 16 | Detailed Activity / Finance / Specification Changes To Providers | Finance / Contracts / CSU |
| Jan- March | Contract Negotiation | Contracts / CSU |
| **31/03/16** | **Final Date For Agreement / Sign Contracts For 16/17** | **CSU / Contracts** |
| **01/04/16 ?** | **Publish ECCG Operating Plan /Public Prospectus** | **RBY / GMac** |

NHS
Enfield
Clinical Commissioning Group

# Commissioning Intentions 2016/17

Graham MacDougall

# Local Clinicians Working With Local People for a Healthier Future

NHS Enfield
*Clinical Commissioning Group*

**Our Vision**

We are committed to commissioning services that improve the health and wellbeing of residents of Enfield borough through the securing of sustainable whole system care

**Our Strategic Goals**

1. Enable the people of Enfield to live longer fuller lives by tackling the significant health inequalities that exist between communities
2. Provide children with the best start in life
3. Ensure the right care in the right place, first time
4. Deliver the greatest value for money for every NHS pound spent
5. Commission care in a way which delivers integration between health, primary, community and secondary care and social care services

**Our Corporate Objectives 2015/16**

1. Deliver the Milestone objectives and outcomes set out in the Enfield CCG Strategic Plan
2. Deliver the requirements of the NHS Constitution with our partners
3. Embed the views of patients and citizens in all of our work
4. Deliver improvements in the quality of local health services
5. Deliver effective safeguarding arrangements for those who are vulnerable
6. Deliver financial sustainability
7. Develop our organisation and ensure effective collaboration with our partners.

# What are Commissioning Intentions?

NHS Enfield Clinical Commissioning Group

- Every year we produce commissioning intentions that describe to local providers how we as an organisation intend to shape local healthcare services.
- Commissioning intentions describe the changes we want to see to the services we commission, new services we want to commission and responding to national directives from NHS England and Government.
- Our commissioning intentions are both CCG focussed, some developed jointly with LBE, some developed jointly with other CCGs.
- Some commissioning intentions will be more contractual terms to support service change rather than all service transformation
- Our commissioning intentions have to support delivery of the QIPP

# Key Achievements of 2015/16 Commissioning Intentions

NHS
Enfield
Clinical Commissioning Group

1. Implemented Integrated Locality Teams
2. Developed new models of care for older / frail people
3. Re-commissioned OPAU at NMUH (to an Ambulatory Unit)
4. Delivered and assured Better Care Fund investment plan
5. Improved IAPT access and recovery rates
6. Improved dementia diagnosis in Primary Care
7. Implemented Care Homes Assessment Teams
8. Reducing unplanned admissions for over 65's (-8%)
9. Liaison Mental Health services on both acute sites 24/7
10. Implemented on-line support networks for IAPT, CBT and 1-1 counselling (Big White Wall / Silver Cloud / IESO)
11. Continued impact of Community Intervention Service for our learning disability patients
12. Commissioning 2 urgent primary care hubs
13. Early booking research with East London University
14. Co-located IAPT and substance misuse services with maternity servicers to improve perinatal mental health

# Service Reviews 2015/16

NHS
Enfield
Clinical Commissioning Group

1. Crisis Resolution Home Treatment Teams: part of review of adult emergency care pathway
2. Liaison Mental Health Services: reviewed with NCL CCGs to review models across NCL. National requirement for 24/7 LMHS by April 2017
3. Recovery Houses as part of BEHMHT procurement
4. Community and inpatient rehabilitation services
5. District Nursing services
6. PACE and TREAT
7. OPAU
8. Integrated Locality Teams
9. Memory Clinics as part of dementia review/prevalence
10. PAU and paediatric urgent and emergency care pathways

# Our Local Challenges

Enfield
Clinical Commissioning Group

## 1. Key Performance Issues

1. RTT
2. Urgent and Emergency Care Flows, Emergency admissions
3. Primary care variability
4. Access to diagnostics

## 2. National Directives

1. Parity of Esteem: funding, waiting times, mental health liaison, CAMHS
2. NHS Constitution, Quality Premium, Urgent and Emergency Care System

## 3. Financial Challenge And Value For Money

1. Delivery of QIPP
2. Value for money from all current contracts
3. Managing demand

## 4. Commissioning In New Ways

1. New models of care – integrating service delivery
2. New financial models
3. New contract forms

# Timetable for Commissioning Intentions

NHS Enfield
Clinical Commissioning Group

| Date | Action Required | Lead |
|---|---|---|
| 29/07/15 | Commissioning Intentions Group established (alternate with CMG) | RBY |
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# The Transformation Programme

NHS
Enfield
Clinical Commissioning Group

- The Programme is organised into six overarching Programmes which are:
  1. Primary Care and Prevention
  2. Integrated Care for Older People
  3. Urgent and Emergency Care
  4. Planned care and Long-term conditions
  5. Children, Young People and Maternity
  6. Mental Health, Continuing Healthcare and Learning Difficulties

- Each Programme has a Clinical Lead and a Management Lead who are responsible for strategic leadership and a Programme Manager who actively manages the development and delivery of that Programme

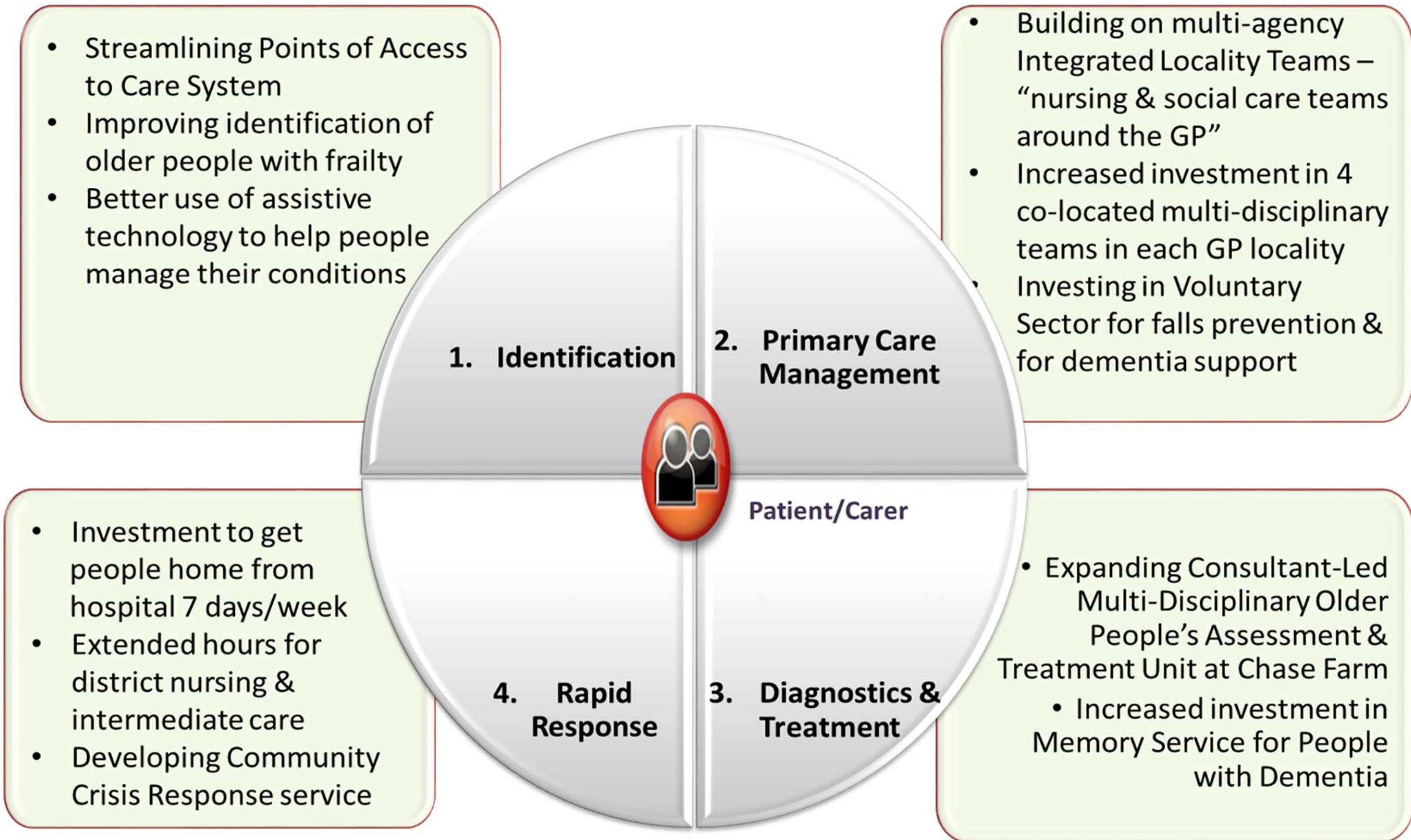
# Primary Care and Prevention

NHS
Enfield
Clinical Commissioning Group

- GP Provider Networks
  - Provision of integrated services by emerging GP Provider Network to practice registered pan-Enfield population
  - To provide extended, integrated models of care to locality/pan-Enfield populations.
- Co-Commissioning of Primary Care
  - To create a joined up, clinically-led commissioning system which delivers seamless, integrated out of hospital services based around the needs of local populations in terms of accessible, co-ordinated and proactive care.
- Primary Care Urgent Access
  - To enable delivery of an urgent care model linked to the integrated 111/OOH service, A&E and Urgent Care Centres as we move towards integrating urgent primary care services into a 24/7 urgent care system.
- Long Term Conditions Management
  - Provision of integrated diabetes, respiratory and heart failure services by emerging GP Provider Network to practice registered pan-Enfield population

# Integrated Care for Older People

NHS
Enfield
*Clinical Commissioning Group*



# Urgent and Emergency Care

NHS Enfield Clinical Commissioning Group

- **NCL NHS 111 and GP Out-of-Hours Re-procurement**
  - Ensure right care, first time
  - The five NCL CCGs (Barnet, Camden, Enfield, Haringey and Islington) will procure a single, integrated NHS 111 and GP Out-of-Hours (OOH) service for their collective population.
- **NCL Urgent and Emergency Care Review**
  - To deliver the best possible health care and outcomes to patients requiring it on an urgent basis, at any time of the day or night, within available resources.
  - North Central London CCGs have agreed to undertake a joint review of system wide urgent and emergency care provision for the populations they are responsible for across the boroughs.
- **NCL Urgent and Emergency Care Network**
  - Connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.
  - Ensure best possible outcomes, safety and experience for patients and a fulfilling working environment for staff, through the consistent delivery of U&EC services 24-hours a day, seven days a week.

# Planned Care and Long-Term Conditions

NHS
Enfield
Clinical Commissioning Group

## 1. Long Term Conditions:

Provision of integrated diabetes, respiratory and heart failure services by emerging GP Provider Network to practice registered pan-Enfield population.

## 2. Elective Care:

Still being worked through as commissioning intentions…

1. Integrated Community Dermatology Service
2. Improving access to day case cataract surgery
3. Community Sleep Apnoea Service
4. Community TB contact tracing service
5. Community Cardiac Rehabilitation Service
6. Community Phlebotomy Services
7. Direct Access to MRIs
8. Enfield Referral Service IT improvement
9. Locality Commissioning Plan 2016/17
10. Community Urology Service
11. Choose and Book - Clinical Advice and Guidance
12. Access to tQUEST Review at NMH

# Children, Young People And Maternity Services

NHS Enfield Clinical Commissioning Group

- **Early Years**
  - Work with the Local Authority on redesign of an early help model
  - Implementation of an integrated care pathway for perinatal mental health
- **School Aged Children**
  - Ongoing work with the Local Authority to deliver the Healthy Child Programme
  - Review Speech and Language Therapy Services with a view to delivering a whole school approach
- **Mental Health And Emotional Wellbeing**
  - National priority for transformation with additional investment
  - Implementation plans to be submitted 16th October 2015, with a focus on transparency, improved access, early identification and intervention, working with vulnerable groups, and workforce development
- **Children With Disabilities**
  - Ongoing work with the Local Authority and other partners to continue to implement the Children and Families Act
  - Implementation of an integrated pathway for the diagnosis of children with autism
- **Children Who Are Ill**
  - Implement the recommendations from the review of urgent care and paediatric assessment unit pathways

# Mental Health

NHS
Enfield
Clinical Commissioning Group

## Crisis Pathway

1. Implementation of Crisis Concordat Action Plan
2. Individual Crisis Prevention Planning
3. Improve consistent access to the Crisis Service
4. Meet waiting times for IAPT and new waiting time for first episode of psychosis
5. Commission co-created integrated mental health and wellbeing service with LBE that integrates primary care, VCS provision, LBE enablement service, housing etc to provide system recovery with less need for referral to mental health secondary care
6. Embed patient and carer voice into the co-creation of services
7. Recovery and enablement principles embed all interactions with patients and service users across all service areas and systems
8. Continue to progress parity of esteem

# Medicines Management

NHS
Enfield
Clinical Commissioning Group

1. **Increasing Antibiotic Resistance:**
   GPs will continue to reduce antibiotic prescribing. Patient's should not expect antibiotics when they have colds, coughs, sore throats and ear infections.
2. **Self Care and Treatment For Minor Ailments**
   e.g. hay fever, cough and cold remedies-patients will be expected to visit a pharmacy and buy medicines or may be able to receive free medicines from pharmacy as part of minor ailments scheme. This improves access to GP appointments.
3. **Stopping Prescribing Of Vitamins**
   where there is no evidence of clinical benefit would save £70k pa which could be used to provide other services.
4. **Working with Hospitals**
   to ensure they use most cost effective medicines to enable maximum number of patients to be treated.

# Quality

**The CCG has a Quality Strategy which sets our ambitions for clinically led continuous improvement.**

**We measure quality of providers through the domains of quality; safety, effectiveness and experience.**

- We must ensure that quality and safety are central to everything we do to fulfil our statutory responsibilities in improving local healthcare and outcomes.
- Our performance and quality indicators, which are set to address the key issues within the local health community, are to: improve access to primary care, diagnosis of dementia and reduce hospital readmissions. Reports on these are reviewed at every Governing Body meeting.
- We also ensure that service developments do not adversely affect quality through clinical scrutiny of their specifications and assessments of potential impact.

# Key Issues for Consideration

NHS
Enfield
Clinical Commissioning Group

- Commissioning Intentions development mainly bottom up
- Awaiting to see where NCL Strategic Planning work will land
- Need to c-heck "Big Ticket" priorities and Key Messages

## Draft Key Messages…?

- £10m QIPP challenge for 2016/17.
- Mental Health Transformation.
- Urgent and Emergency Care Transformation.
- Provider sustainability and partnerships.
- Develop collaborative commissioning with LBE and other CCGs where currently practicable.

## What are Our Future Approaches to…

- New Models Of Care ?
- New Financial And Contractual Models ?
- Outcomes Based Commissioning ?

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**MUNICIPAL YEAR 2015/2016**

| MEETING TITLE AND DATE | Agenda - Part: 1 | Item: 3 |
|---|---|---|
| **Health and Wellbeing Board**<br>**14 September 2015** | **Subject:**<br>**Proposed procurement of an integrated NHS 111/out-of-hours service across north central London – engagement report**<br>**Wards: All** | |
| | **Cabinet Member consulted:** | |
| Clare Kapoor, NCL Urgent Care Programme Manager, 0203 688 2181Contact officer and telephone number:<br>E mail: **clare.kapoor@enfieldccg.nhs.uk** | **Approved by: Graham MacDougall, Director of Strategy, Enfield CCG** | |


## Summary

This report updates the Health and Wellbeing Board on the planned procurement of an integrated NHS111 and GP Out of Hours service across the North Central London area. It outlines the rationale for service proposals, the extensive engagement undertaken and updates the Board on the current timetable. National guidance from NHS England on the commissioning of NHS111 and GP Out of Hours services is due at the end of September; national thinking is in line with the preferred approach being taken by the North Central London CCGs and we do not anticipate this will significantly alter our plans or intentions.


## Recommendations

1. **That the Committee notes the proposal to procure an integrated NHS 111/out-of-hours service across Barnet, Camden, Enfield, Haringey and Islington.**

## 1. WHY THIS REPORT IS NEEDED

1.1 This report provides Members with an update on the planned procurement of an integrated NHS 111/OOH service across Barnet, Camden, Enfield, Haringey and Islington.

1.2 NHS 111 and the out-of-hours services work very closely together, with OOH seeing by far the majority of referrals from NHS 111. It is vital to make sure they work in a co-ordinated way to support the patient's journey and deliver high quality, safe patient care.

1.3 Currently the CCGs in north central London commission three different organisations to deliver separate NHS 111 and out-of-hours services to patients in north central London.

- The NHS 111 service is provided by one provider for all five CCGs in North Central London – *London Central and West Unscheduled Care Collaborative (LCW),* a GP-led not for profit organisation.
- The GP out-of-hours service for Barnet, Enfield and Haringey is provided by *Barndoc Healthcare* Ltd. and the service for Camden and Islington is provided by *Care UK*.

1.4 The contracts for both of these services were set to expire in March 2015, but these have been extended to allow the Clinical Commissioning groups (CCGs) to refresh and improve the service and consider commissioning a combined NHS 111 and out-of-hours (OOH) service across the five boroughs.

1.5 Enfield CCG, along with the other CCGs in north central London think it therefore makes sense to commission NHS 111 and OOH as a single contract, with a single specification, so that patients would receive a more joined-up service with fewer transfers between medical staff and better information-sharing.

1.6 A single contract, does not, however, mean that a single provider would be commissioned to provide the service. Our proposal is to develop a single contract, where a lead provider(s) would coordinate the work with all the local providers (which could include NHS trusts, GP collaboratives or private and voluntary sector providers), making sure they are working together to deliver the best possible outcomes and care for patients – they would be held

accountable by CCGs for delivering those outcomes and care, with a detailed and clear specification for the service. We believe this would be the right model because it matches how patients actually access these services.

1.7 Evidence published on the NHS England website[1] shows that 86% of our patients said they were fairly or very satisfied with their NHS 111 experience. However, we also know from complaints, incidents and feedback that some patients have had a poor experience, and this needs to be improved.

1.8 Because the current contracts for these services are all drawing to an end, the CCGs are legally required to undertake a formal procurement process.

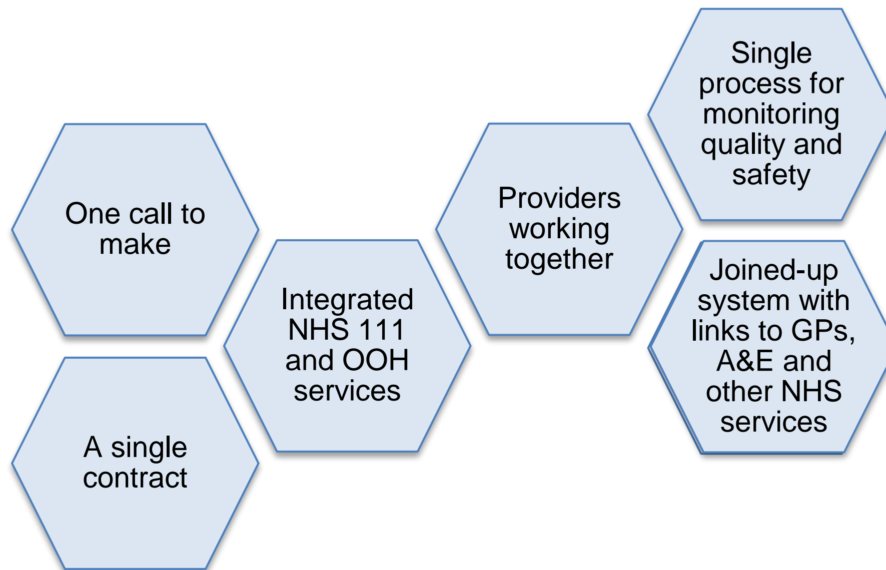
1.9 By commissioning a service across NCL, doctors believe it would mean the NHS could develop better systems and infrastructure which would be more flexible and reactive to patients' needs; for example, we want the service to employ a skills-mix of health professionals – including pharmacists and paramedics as well as GPs and nurses – so that patients have access to health advice and treatment that matches their needs, all from a single point of contact via NHS 111 – and this would be the same for our patients, wherever they live.

1.10 This is also an opportunity to redevelop the NHS 111 and OOH service as an integral part of the health system across north central London, and ensure that it works intuitively with other aspects of primary care and emergency care.

1.11 In developing our proposals we have considered a number of options for the future of NHS 111 and OOH services in north central London. These options include commissioning the services in the same way as at the moment, or commissioning the services separately for each individual borough. The CCG's preferred option is to commission an integrated service across all five boroughs – there would be a lead provider, but services might be delivered by a combination of providers.

[1] [1] http://www.england.nhs.uk/statistics/statistical-work-areas/nhs-111-minimum-data-set/

1.12 The proposed model would look like this:




1.13 Callers to NHS 111 are often not near their registered GP practice when they call, but are usually somewhere within the NCL area, so it makes sense for NHS 111 to be able to refer them to healthcare services near to where they actually are at the time of their call. Combining the two services would make this easier.

1.14 Deaf service users and those with learning difficulties also sometimes experience a poor service, and we want to develop systems to improve this. This is achievable if we commission at a five borough scale, and would be much less viable if we commissioned separate services.

1.15 Current model vs proposed model:

| | Current model | Proposed model |
|---|---|---|
| **Contract** | One organisation providing NHS 111 for all of north central London (Barnet, Camden, Enfield, Haringey and Islington).<br><br>Two organisations providing OOH services for north central London (one in Barnet, Enfield and Haringey; one in Camden and Islington) | A single contract with responsibility for all NHS 111 and OOH services in north central London. This may be delivered by a single organisation or (more likely) by a group of organisations working together. A single contract, with a clearly designed specification, would make it easier for CCGs to hold providers to account for delivering the right outcomes and care for patients. |
| **Clinical support** | Heavily reliant on GPs for clinical support. Recruitment of GPs is increasingly difficult as there is a shortage of GPs nationally. | A range of clinical skills is available (nurses, paramedics, pharmacists and GPs) who could be used flexibly to provide clinical support. This means callers would be directed to the most appropriate clinician for what they need. |
| **Assessment** | People who require a GP urgently have to speak to at least two people (typically more) before they can get definitive clinical advice or an appointment. | People would be directed to the most appropriate service; usually by the first person they speak to. |
| **Appointments** | Some direct bookings – but patients usually need to hang up and call a different number to make an appointment with the appropriate service | Direct bookings for OOH appointments, including home visits. Direct bookings available for most other services. |
| **Medical history** | Services have limited access to special patient notes for people with complex health and/or social care needs, and no access to routine medical | Those involved directly in patient care would have consistent access to special patient notes and routine medical history for patients using the service |

| | Current model | Proposed model |
|---|---|---|
| | history for NHS 111 or OOH | |
| **Equity of access** | Access to OOH services is different depending on where people live in north central London | Access to OOH services would be the same, regardless of where people live in north central London – and patients would have more choice |

1.16 The CCGs believe that investing in an integrated NHS 111/out-of-hours service would provide numerous benefits for patients and residents of north central London:

- Patients would be more likely to be seen by the right clinician, earlier in the process
- There would be fewer transfers as the patient progresses through the system – you should only have to give your information once
- Patients would no longer be bound by administrative barriers (eg residents in West Haringey could be directed to the OOH base at the urgent care centre at the Whittington hospital, rather than travel across the borough to the North Middlesex hospital) – you would be able to choose the services most convenient to you
- The skills mix model, combined with more timely access to a GP, would help support the urgent care system – you would be directed to the most appropriate service that meets your medical needs and this should mean you are less likely to have to wait around at a busy A&E
- The integrated service would have flexibility to redeploy staff to where they are most needed to meet changes in patient use throughout the day and year
- Clinicians would be able to prescribe without the need for duplication or unnecessary referral
- All contracts would be rigorously monitored, as is the case today; providing assurance that the service is safe and of a high quality. Providers would be accountable for delivering the outcomes and care that patients need
- NHS 111 call advisers would be able to book patients directly to appointments with OOH and other services
- Commissioning at this scale would allow the development of systems and infrastructure that are more flexible and reactive to patients' needs – for example online tools to enable you to assess your own health needs, and systems for deaf service users.

## 2. REASONS FOR RECOMMENDATIONS

2.1 The report is an update on the planned procurement of an integrated NHS 111/OOH service across Barnet, Camden, Enfield, Haringey and Islington.

## 3. ALTERNATIVE OPTIONS CONSIDERED AND NOT RECOMMENDED

3.1 In further developing our proposals we have considered a number of options for the future of NHS 111 and OOH services in north central London. These options include commissioning the services in the same way as at the moment, or commissioning the services separately for each individual borough. Our preferred option is to commission an integrated service across all five boroughs – there would be a lead provider, but services might be delivered by a combination of providers. The following table outlines the advantages of each option:

✓ = the option partially offers this advantage

✓✓ = the option fully offers this advantage

| | Patients get clinical advice quickly from the right person, without calling a different number | Reduces pressure on A&E by making sure patients get treatment early on | Equal access to services wherever you live in north central London | Fewer transfers from one adviser to another | Can adapt to deal with pressure at peak times | Service provided by local clinicians | Contracts can be rigorously monitored | Could develop new systems – e.g. for deaf service users – that are better at meeting patients' needs |
|---|---|---|---|---|---|---|---|---|
| **Option 1 – Commission one NHS 111 and two GP OOH providers – No change** | ✓ | ✓ | | | ✓ | ✓[2] | ✓✓ | ✓ |
| **Option 2 – Each CCG to commission its own NHS 111 and GP OOH providers** | ✓ | ✓ | | | | ✓[2] | ✓✓ | |
| **Option 3 – Commission one lead provider for NHS 111 and GP out-of-hours across five boroughs – our preferred option** | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓[2] | ✓✓ | ✓✓ |

3.2 The initial idea to commission NHS 111 and OOH services as a single service across NCL was developed based on extensive feedback from service users

[2] * The current national shortage of GPs means it can be difficult for OOH services to recruit local doctors. We couldn't guarantee, regardless of how we commission these services; that they would employ local doctors – but we do want to make sure that the local service is an attractive career option that good local clinicians would want to take part in.

and clinicians. In particular, the Review of Urgent Care carried out in Camden and Islington in 2013/4, in which the CCGs spoke to hundreds of patients, which recommended a more joined-up approach to commissioning urgent care and specifically NHS 111 and OOH services.

3.3 There was also an independent review by the Primary Care Foundation which showed how reducing transfers between NHS 111 and OOH would speed up the clinical care patients received and improve their experience.

## 4. IMPLICATIONS OF DECISION

### 4.1 Corporate Priorities and Performance

The key projects described in this report are closely aligned to the remit of the HWBB as it relates to key leaders from the health and care system working together to improve the health and well-being of local communities through local commissioning of health care, social care and public health; informed by the Joint Strategic Needs Assessment (JSNA) and Health and Wellbeing Strategy. There is also close alignment with the strategic aims of the other four CCGs for the delivery of high-quality health and health care services for the residents of north central London.

### 4.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

None in the context of this report.

### 4.3 Legal and Constitutional References

4.3.1 The Council's Constitution sets out the Terms of Reference for the Health and Well-Being Board. These responsibilities include:
None in the context of this report.

### 4.4 Risk Management

4.4.1 None in the context of this report.

### 4.5 Equalities and Diversity

4.5.1 The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies **to have due regard** to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

4.5.2 The broad purpose of this duty is to integrate considerations of equality into day business and keep them under review in decision making, the design of policies and the delivery of services.

4.5.3 Health partners as relevant public bodies must similarly discharge their duties under the Equality Act 2010 and consideration of equalities issues should

therefore form part of their reports. Proposals are therefore assessed for their impact on equality and diversity.

4.5.4 The current service configuration results in an access inequality between boroughs. The proposed service will reduce this inequality by offering consistent access and availability of services across NCL. The NHS 111 and OOH Patient and Public Reference Group has been involved in the service development which informed the equality analysis. A number of engagement events have been held with patient groups such as those with hearing difficulties or learning difficulties with useful feedback on current services.

4.6 **Consultation and Engagement**

4.6.1 The CCGs have undertaken a substantial engagement programme across NCL over the past six months, which has included:

- Individual CCGs discussing NHS 111 and OOH proposals at local events, including discussions with hundreds of individual service users and meetings with community and voluntary groups
- Presentations at the regular meetings with GPs across NCL to ensure local doctors understand what is proposed and how they could be involved
- Two phases of focused engagement events held at venues across NCL and advertised through local newspapers and CCG websites, which were attended by hundreds of interested service users and encouraged in-depth discussion of the proposals. In Barnet, these took place in March, April and May.
- An online survey to find out the views of stakeholders and service users on our commissioning proposals.
- The setting-up of a Patient and Public Reference Group, involving service users from all five boroughs and Healthwatch representation – this is looking in detail at the proposed service specification and has had a fact-finding visit to the current NHS 111 provider. Members who have expressed an interest are being invited to participate in the Procurement Panel when it goes ahead.
- Market events with local and national providers, letting them know what we are proposing so they can decide whether to bid for the new contract.
- Presentations to the joint health overview and scrutiny committees.

4.6.2 We have had very useful feedback from many service users and local campaign groups, with considerable support for joining up NHS 111 with the GP out-of-hours service to improve patients' experience. That a future service would mean fewer handoffs between services has been particularly welcomed, as have the improvements proposed in the clinical model such as the opportunity to talk to other NHS services (dentists, pharmacists, mental health workers) and earlier access to clinicians including pharmacy, repeat prescriptions and direct access into GP appointments.

4.6.3 There were concerns and anxieties too, so in July, a focused piece of engagement took place, sharing further with residents and service users, exactly why the CCGs are proposing to commission an integrated NHS 111/OOH service. Despite wide communications highlighting the engagement document and its survey, there was a very small response to the engagement, of those that did respond Option 3 was the most favoured option.

4.6.4 The draft service specification for the proposed integrated service has been under development since Spring 2015, with input from the programme's clinical sub-group, whose members are clinical leads from Barnet, Camden, Enfield, Haringey and Islington CCGs. The Patient and Public Reference Group and Healthwatch organisations have had the opportunity to discuss the specification and make line-by-line comments. Additionally, the draft specification was published on the websites of all five CCGs from 21 July to 19 August, and circulated to same stakeholder list as the engagement document, inviting comments which will be fed back to the drafting team before the final specification is produced for discussion by CCGs in September.

4.6.5 In July, CCG Chief Officers, with other NHS leads, received a letter from Dame Barbara Hakin, National Director of Commissioning Operations for NHS England, informing of proposals for 'commissioning a functionally integrated urgent care access, treatment and clinical advice service.' This letter notes that NHS England is developing new commissioning standards for an integrated NHS 111 and OOH service, and asks commissioners to suspend procurements of these services until the end of September 2015. This is already in line with the timetable to which CCGs in north central London (NCL) are working – our procurement is planned to start in October, allowing time for a further period of engagement and communication with our local communities.

## 5. Timetable

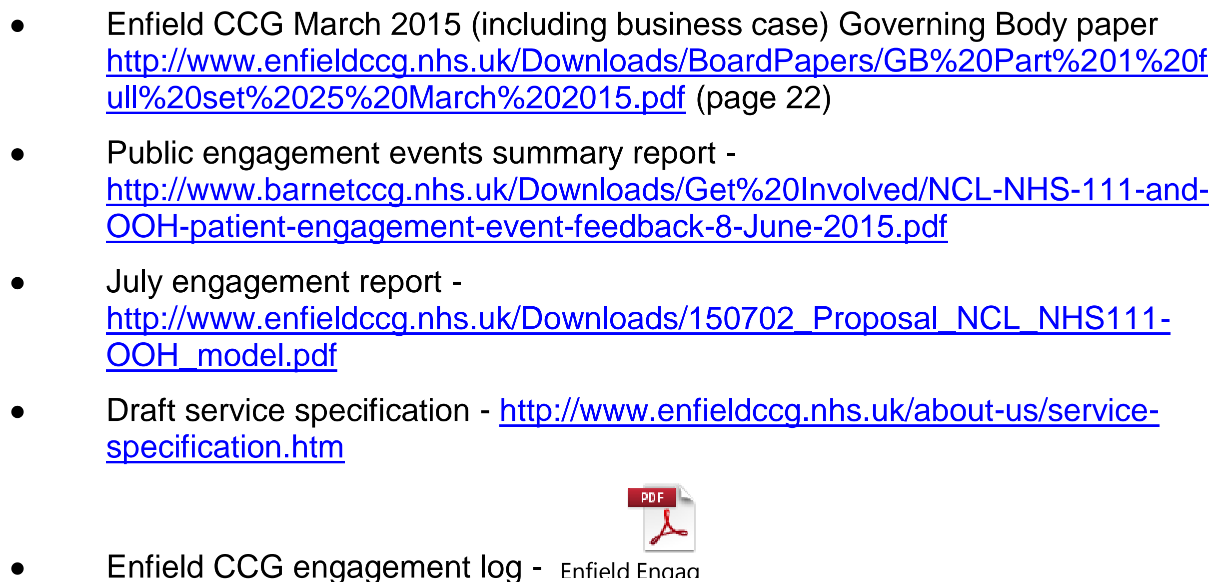
Key dates in the current timetable are as follows:

- September 2016 – service specification finalised
- October 2015 – procurement starts
- March 2016 – procurement ends
- April 2016 – contract awarded to successful provider
- October 2016 – new service starts, allowing 6 months for smooth transition.

## 6. Conclusion

This report updates the Board on the planned procurement of the integrated NHS111 and GP out-of-hours service across the north central London area. The Board is asked to note the service proposals as well as the extensive engagement that has underpinned this work. Work on developing the service specification continues whilst we await national guidance although, as outlined, it is unlikely our plans will change significantly as these are already congruent with national thinking.

**Background Papers**

- Enfield CCG March 2015 (including business case) Governing Body paper http://www.enfieldccg.nhs.uk/Downloads/BoardPapers/GB%20Part%201%20full%20set%2025%20March%202015.pdf (page 22)
- Public engagement events summary report - http://www.barnetccg.nhs.uk/Downloads/Get%20Involved/NCL-NHS-111-and-OOH-patient-engagement-event-feedback-8-June-2015.pdf
- July engagement report - http://www.enfieldccg.nhs.uk/Downloads/150702_Proposal_NCL_NHS111-OOH_model.pdf
- Draft service specification - http://www.enfieldccg.nhs.uk/about-us/service-specification.htm
- Enfield CCG engagement log - 

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# MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY, 14 JULY 2015

**MEMBERSHIP**

**PRESENT** Shahed Ahmad (Director of Public Health), Deborah Fowler (Enfield HealthWatch), Liz Wise (Clinical Commissioning Group (CCG) Chief Officer), Vivien Giladi (Voluntary Sector), Ayfer Orhan, Alev Cazimoglu, Doug Taylor (Leader of the Council), Nneka Keazor, Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust), Tony Theodoulou (Interim Director of Children's Services) and Lance McCarthy (Deputy Chief Executive North Middlesex University Hospital NHS Trust)

**ABSENT** Ian Davis (Director of Environment), Ray James (Director of Health, Housing and Adult Social Care), Dr Henrietta Hughes (NHS England), Kim Fleming (Director of Planning, Royal Free London, NHS Foundation Trust) and Julie Lowe (Chief Executive North Middlesex University Hospital NHS Trust)

**OFFICERS:** Allison Duggal (Public Health Consultant), Richard Young (Interim Strategic Planning Programme Manager), Sharon Burgess (Head of Service - Safeguarding Adults, Complaints and Quality Assurance) and Doug Wilson (Head of Strategy, Performance and Policy) Penelope Williams (Secretary)

**Also Attending:** Marian Harrington (Chair of the Adult Safeguarding Board)

## 1
## WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies for absence were received from Ray James, Dr Henrietta Hughes, Councillor Alev Cazimoglu, Julie Lowe (Chief Executive North Middlesex University Hospital NHS Trust) and Kim Fleming (Royal Free London NHS Trust).

## 2
## DECLARATION OF INTERESTS

There were no declarations of interests.

## 3
## CHANGE TO THE HEALTH AND WELLBEING BOARD CABINET MEMBERSHIP

Members noted the changes to the membership of the Health and Wellbeing Board terms of reference, relating to the cabinet members on the Board.

## 4
## CHANGE IN THE ORDER OF THE AGENDA

Members agreed to change the order of the agenda so that Item 6 was taken after Item 3 and followed by Item 7. The minutes reflect the order of the original agenda.

## 5
## SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014/15

The Board received the Adult Safeguarding Annual Report 2014/15.

### 1. Presentation of Report

Marian Harrington (Chair of the Adult Safeguarding Board) presented the report to the Board highlighting the following:

- This was the first year that it had been a statutory requirement to produce an annual report.
- Key achievements include the work of the Quality Checkers and the Dignity in Care Panel which has looked in depth at the quality of service provided by the Council.
- Also the link with Healthwatch, encouraging good user care involvement, and the establishment of the first multi-agency safeguarding adults' hub.
- Enfield has a large number of care homes, compared to other boroughs, of which the Board has oversight.
- The Safeguarding Board co-ordinates information on safeguarding and promotes good practice.
- Marion Harrington said that she would welcome help to encourage the greater involvement of partnership members in the board's sub groups.

### 2. Questions/Comments

2.1 Sub groups include: learning and development, policy, procedure and practice, service users, carers and patients, quality safety and performance and the joint safeguarding adults and safeguarding children group. The membership of the sub groups had declined due to changes in personnel and shrinking numbers of staff. There had been some consideration given to consolidating the current groups, where possible, but groups numbers have already been cut down to 4.

2.2 This year the focus had been on prevention.

2.3 There has been a 780% increase in referrals under mental capacity and deprivation of liberty standards.

2.4 The huge increase in referrals from North Middlesex was likely to be because of increased awareness, as well as an increase in the number of incidents. The numbers in 2013/14 were low, which could be due to a lack of reporting in that year.

**AGREED** to note the progress being made in protecting vulnerable adults in the Borough, as set out in the annual report of the Safeguarding Adults Board.

**6**
**HEALTHWATCH REPORT - COMPLAINTS HANDLING**

The Board received a report from Healthwatch concerning the adoption of a recognised approach to complaints-handling.

**1. Presentation of the Report**

1.1 Deborah Fowler, Chair of Healthwatch, presented the report to the board highlighting the following:

- A learning organisation is a listening organisation. Well run organisations welcome feedback and complaints.
- The Care Quality Commission has recognised the importance of listening to people and has adopted a new framework for complaints handling in “Complaints Matter”.
- Healthwatch would like the Health and Wellbeing Board and its members to sign up to the scheme, to endorse a focus on improving the ease with which people can raise complaints, to encourage local organisations to move towards implementation of the new complaints framework and to incorporate it into service contracts.

1.2 Nicholas Foster, Complaints Manager, Health, Housing and Adult Social Care, reported that he had been involved with the development of the user led vision which the local authority had already adopted in part. A piece of work had been undertaken to make sure that they would be fully compliant and to establish assurance looking at the 5 parts of the complaints journey, working out what systems and processes needed to be put in place. Social Care already uses an on line complaints form, which could be expanded for use across the authority.

**2. Questions/Comments**

2.1 GPs were unaware of the new framework. It was recommended that this was a framework for all, and they as well as other health and social care organisations, should be made aware of it and encouraged to sign up.

2.2 The Council’s Social Care Annual Report outlines the lessons learned over the year.

2.3 A further report would be made to the Board later in the year to enable it to monitor progress in implementing the framework.

**AGREED**

1.1 To note the user-led complaints framework published jointly by the Local Government Ombudsman (LGO), Healthwatch England and the Parliamentary and Health Service Ombudsman (PHSO) and adopted by the Care Quality Commission (CQC) for use in its inspection regime.

1.2 To ask commissioners from the CCG, NHS England and local authority to consider adopting the new complaints framework, as appropriate, in their provider contract specifications relating at least to health and social care, to achieve a consistent approach across Enfield;

1.3 To ask that, in monitoring existing contracts, the CCG, NHS England and local authority commissioners are informed by the new complaints framework and encourage their providers to improve their existing complaints systems.

1.4 To note that NHS England has assured the LGO, Healthwatch England and PHSO that it will use the new user-led complaints framework as a performance management tool to be built into the NHS Outcomes Framework;.

1.5 To resolve that, as part of its role in promoting and reviewing integrated care arrangements, the HWB will consider and review how well the user experience of complaints-handling matches the expectations set out by the CQC.

1.6 To note that when reviewing complaints-handling in provider organisations, Healthwatch Enfield will adopt the user-led complaints framework.

**7**
**NHS ENGLAND: ANTE NATAL IMMUNISATION AND SCREENING IN ENFIELD**

The Board received a report reviewing ante-natal, new born immunisation and screening programmes in Enfield 2015 from Joanne Murfitt, Head of Public Health, Health in the Justice System and Military Health, (London Region, NHS England).

Joanne Murfitt presented the report to the board highlighting the following:

- The report provided an overview of the universally provided immunisation and screening programmes.
- Enfield had a young population and it was felt to be particularly important to focus on antenatal and new born programmes.

- NHS England wanted to promote early antenatal booking and screening so that any issues could be detected and addressed at an earlier stage.
- The data provided was based on Barnet and Chase Farm Hospital Trust before amalgamation with the Royal Free.
- Pertussis (whooping cough) was an area of concern as it had recently caused 3 baby deaths. NHS England was offering a service level agreement to increase take up of the pertussis vaccine.
- There had been anxieties created by the press campaign about the ineffectiveness of last year's flu virus but this had only been one strain, vaccines had been effective against two other strains. Work was needed to counteract the bad press and to make sure uptake of the vaccine was kept up.
- Increasing uptake of antenatal hearing tests was also a priority.
- Two new vaccines were being introduced: the Meningococcal ACWY to replace the Men C from September 2014 for Year 8 girls, with a catch up in years 12 and 13: and Meningitis B for babies.
- The majority of vaccines are provided through GP surgeries which is putting a strain on their services. Also the offer is now incredibly complicated. NHS England were keen to find ways to make the delivery easier, to improve uptake and increase coverage, particularly to vulnerable people whose lives are often already chaotic.
- Consideration was being given to offering the HPV vaccine given to 12-13 year old girls, to boys as well.
- There was a lot of effort being made on increasing the vaccination of 70 and 79 year olds against shingles.
- Flu vaccinations were doing reasonably well – 36 out of 60 local pharmacists were now offering them.
- A major push was also on to increase vaccine uptake amongst people with long term conditions especially liver and respiratory disease.
- Flu vaccinations were now being offered to school age children. Special Schools in Enfield had not taken up the offer. Help to encourage these schools to do so would be appreciated.
- The immunisation and screening programme for Enfield was quite generic and more work was needed to make sure that it was adapted to the borough's specific circumstances and to enable NHS England to provide help and training where it was most needed.

**2. Questions/Comments**

2.1 Mo Abedi felt that it would be useful if good practice, particularly in working with different populations, could be shared across GP's in Enfield: a tailored approach was needed.

2.2 More children were likely to have been immunised than official figures suggested, as not all vaccinations were documented. In Hammersmith and Fulham research had been done and found that the real figures were actually 10% higher that the documented figures.

2.3 Enfield used to have a full time co-ordinator dedicated to working in the borough, now there is only one co-ordinator for 5 boroughs. Joanne Murfitt said that there were fewer resources and this was challenging, but in these circumstances it was essential to share good practice and take a more co-ordinated and targeted approach working closely with partners. There was a hope and an expectation that they would be able to promote, publicise and support initiatives, including making sure that initiatives were included in contracts. An immunisation action plan was being putting in place to ensure more could be done.

2.4 Persuading mothers to present at 10 weeks was even more difficult when very late presentation was already a problem in parts of the borough. Many believed that they did not need to present until 12 weeks. Currently, 84.4% of women in Enfield, presented by 12 weeks and 6 days. There was a big job to be done to change this perception and to persuade mothers of the need to present earlier. Information was being provided through NHS England and through a poster campaign but this needed more specific targeting. The possibility of providing information at the point of sale for pregnancy tests in pharmacies was being explored.

2.5 Work was being done through the Change and Challenge Programme and through the family nurse partnership.

2.6 The recent confusion over the issue of the shingles vaccination offer to 70 and 79 year olds was highlighted. It was unfortunate but a targeted message will help to address any confusion.

2.7 Concern was expressed about the decrease in immunisation rates among over 65's in Enfield and across London. NHS England were not concerned as the decrease was small and they were intending to focus on those with long term conditions and pregnant women.

2.8 The number of people accessing the flu vaccine via pharmacists, although only 5% of the total, had increased.

2.9 Joanne Murfitt thanked everyone for their support and helpful comments and emphasised the will to work in partnership with the Board, the CCG, as well as schools, care contractors and staff.

**AGREED** to note and support the work of NHS England (London) are doing to increase screening and vaccination coverage and screening and immunisation uptake in Enfield.

**8**
**CLINICAL COMMISSIONING GROUP OPERATING PLAN 2015/16**

The Board received a report from Graham MacDougal, Director of Strategy and Partnerships Enfield Clinical Commissioning Group on the Enfield Clinical Commissioning Group Operating Plan 2015/16.

**1. Presentation of the Report**

1.1 Richard Young (Interim Better Care Fund Programme Manager – Enfield Council / Interim Strategic Planning Programme Manager- Enfield clinical Commissioning Group) presented the report to the Board, highlighting the following:

- The report represented the culmination of all previous board discussion on the operating plan including the work in the development sessions.
- A quality premium will be paid to the CCG in 2016/17 based on the measures agreed by the Board at their development session in April.
- These were reducing potential years of lives lost through causes considered amenable to healthcare, urgent and emergency care (reducing avoidable emergency admissions and reducing NHS responsible delayed transfer of care rates), further improving dementia diagnosis and reducing emergency admissions from care homes.

1.2 Liz Wise (Chief Officer Enfield CCG) reported that NHS England had recently assured the non-financial activity of the Enfield CCG. The financial activity was not assured.

**2. Questions/Comments**

3.1 The plans submitted had been revised to take account of increased accident and emergency hospital admissions. Two contracts with the trust providers had been signed and one agreed, but still to be signed.

3.2 So far the activities of the current year were aligned with the plan.

**AGREED**

1. To note the requirements of the process and the overview of the Clinical Commissioning Group submissions within the report.

2. To endorse the NHS Enfield Clinical Commissioning Group Operating Plan 2015/16

**9**
**SUB BOARD UPDATES**

The Board received the following sub board updates:

**1. Health Improvement Partnership Board**

**1.1 Report Presentation**

Shahed Ahmad, Director of Public Health, presented the report to the Board highlighting:

- News received after the report was written included, a Central Government announcement of a 7.4% in year reduction in Public Health Spending. If this were to be applied uniformly, to each individual local authority, Enfield would lose about £1m from this year's budget.
- Enfield has achieved excellent standard in the GLA Healthy Work Place accreditation.
- Immunisation data had been discussed earlier in the meeting.
- The HiLo project had been successful in reducing blood pressure and lowering cholesterol levels.

**1.2 Questions and Comments**

1.2.1 Grave concern was expressed about the government proposed reduction to the amount of money allocated to public health. Enfield was already historically underfunded in contrast to richer London boroughs such as Kensington and Chelsea. Members agreed that all organisations should respond to the formal consultation on the issue and that there should also be a co-ordinated response from the Health and Wellbeing Board. As well as lobbying local MPs. The suggestion should be put forward that richer areas that already received more funding should receive a greater reduction than areas like Enfield which received less.

1.2.2 It was felt that the water companies should be encouraged to add fluoride to the water in Enfield. In the past it had been argued that all London boroughs needed to agree to enable this, but it was felt that it must be possible to segment the supply in some way to enable Enfield to be fluoridised more quickly.

1.2.3 Detail on outcomes as well as activity was requested.

1.2.4 A strategy on childhood obesity was being put together. Opportunities for sharing experience and good practice were being explored. As well as better ways of making use of Children's Centres to help manage obesity.

**AGREED** to note the report.

**2. Joint Commissioning Board**

There were no comments.

**AGREED** to note the report.

**3. Primary Care Update**

There were no comments.

**4. Enfield Integration Board**

### 4.1 Report Presentation

Richard Young presented the report to the Board.

NOTED

1. The current better care fund plans are coming to an end, so the board had decided that it would be useful to hold some facilitated sessions to enable them to set out a plan for how to achieve the overall integration strategy, in the future. It was agreed that all board members would receive an open invitation to the sessions.

**AGREED** to

1. Approve the plans for a short facilitated development programme for the Integration Board.
2. Approve the quarterly Better Care Fund data return, attached as an appendix to the report.

## 10
## MINUTES OF THE MEETING HELD ON 14 APRIL 2015

The Board received and agreed the minutes of the meeting held on 14 April 2015.

## 11
## FUTURE ITEMS

The Board noted the items agreed for the October meeting.

Richard Young reported that the Clinical Commissioning Group would like to bring an item on their commissioning intentions for 2016/17 to the September meeting. A short extra meeting of the full board would be held after the development session on the 14 September 2015 to enable the board to discuss these.

## 12
## DATES OF FUTURE MEETINGS

The Board noted the dates agreed for future full board meetings:

- Thursday 15 October 2015
- Thursday 10 December 2015
- Thursday 11 February 2016
- Thursday 21 April 2016

All full board meetings will begin at 6:15pm unless otherwise indicated.

The Board noted the dates agreed for board development sessions:

- Monday 14 September 2015
- Wednesday 4 November 2015
- Wednesday 6 January 2016
- Wednesday 2 March 2016

All development sessions will begin at 2pm unless otherwise indicated.

A short full board meeting will be held after the development session on Monday 14 September 2015 at 5pm to discuss the CCG Commissioning Intentions 2016 /17.