NHS
Enfield
Clinical Commissioning Group

Local clinicians working with local people for a healthier future

Our Commissioning Prospectus 2013-2014

Welcome from our Chair

The aim of this prospectus is to introduce you, our patients, partners and stakeholders to NHS Enfield Clinical Commissioning Group (CCG). We hope this information will help you understand more about our organisation and how we are working to improve the health of people in Enfield.

NHS Enfield CCG is a new statutory organisation created on 1 April 2013 by the Health and Social Care Act 2012. We plan, commission (buy) and monitor a wide range of health services for our patients in Enfield. This document will explain the health needs of our diverse community and our plans and ambitions for commissioning services on behalf of patients in Enfield.

Every GP practice in Enfield is a member of the CCG and we are committed to working in partnership with all healthcare professionals in Enfield to ensure that the services we commission are designed and delivered around the needs of our patients.

Our mission is: *local clinicians working with local people for a healthier future.* NHS Enfield CCG is committed to working in partnership with our stakeholders and community to achieve this. We believe that clinical leadership of commissioning will make a real difference to the health of our population and their experience of healthcare. We want to put patients at the heart of our new organisation and quality at the centre of all our commissioning decisions.

This prospectus will tell you more about our priorities and the work we will be doing in our first year as a CCG to improve local health services. As a local GP and Chair of Enfield CCG, I also encourage you to contact us to tell us your views on our prospectus and to get involved in our work to improve the health of everyone in Enfield.

Dr Alpesh Patel, Chair, NHS Enfield CCG

Our Vision

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

Our Strategic Goals

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

Joint Health and Wellbeing Strategy

We have a duty to work closely with the Enfield Health and Wellbeing Board to ensure that our plans support the delivery of the Joint Health and Wellbeing Strategy for Enfield. The strategy has five key themes. The diagram below shows how our plans will help to deliver these themes.

A Healthy Start	• Improving health for pregnant women, children and young people
Narrowing the gap: reducing Health Inequalities	•Keeping people well and preventing disease •Improving care for people with mental illness and learning disability
Healthy life styles, healthy choices	•Keeping people well and preventing disease •Improving health for pregnant women, children and young people
Healthy places	• Right care ,right time ,right place • Improving primary care
Partnerships and capacity	•Integrated care •Improving care for people with mental illness and learning disability

Our vision and strategic goals bring together our aspirations for a healthy future for Enfield with the aspirations of a national health service, and the Health and Wellbeing Strategy, our joint plan for a healthier Enfield.

Clinical Commissioning Groups: the new local leaders of the NHS

On 1 April 2013, NHS Enfield Clinical Commissioning Group became responsible for commissioning and planning local health services, replacing Enfield PCT which was abolished by the Health and Social Care Act 2012. The Department of Health has published a guide to the new NHS here: https://www.gov.uk/government/publications/the-health-and-care-system-explained

A new national body, NHS England has been set up to oversee the performance of CCGs, as well as commissioning GP services, pharmacy, opticians and dentists, and other specialised services.

A new consumer body called HealthWatch England has also been set up. Local HealthWatch bodies will replace the current Local Involvement Networks (LINks). They will promote public engagement in the NHS, comment on changes to local services, act as advocates for complaints, and deliver advice across health and social care.

NHS Enfield CCG

NHS Enfield CCG is responsible for planning and paying for services within the area. This includes: planned hospital care such as operations, rehabilitation services, urgent and emergency care and most community services. NHS Enfield CCG is also responsible for engaging with local people to ensure that the services we are paying for meet your needs.

Your GP Practice has joined NHS Enfield CCG as a member practice. All practices in Enfield have signed NHS Enfield CCG's constitution. NHS Enfield CCG is a membership organisation of 54 local GP practices. Each locality has elected two representatives to our Governing Body The Governing Body, which chaired by a GP and is made up of elected GPs who represent their localities supported by NHS managers, other health professionals and patient and partner representatives, meets regularly in public. You can find details of the meetings on our website.

Together our practices have agreed a constitution which sets out our governance arrangements and describes the way our member practices will work together. Our constitution follows the structure of the model constitution given to us by NHS England and includes certain legal requirements of the Health and Social Care Act, but our member practices have agreed some local variations.

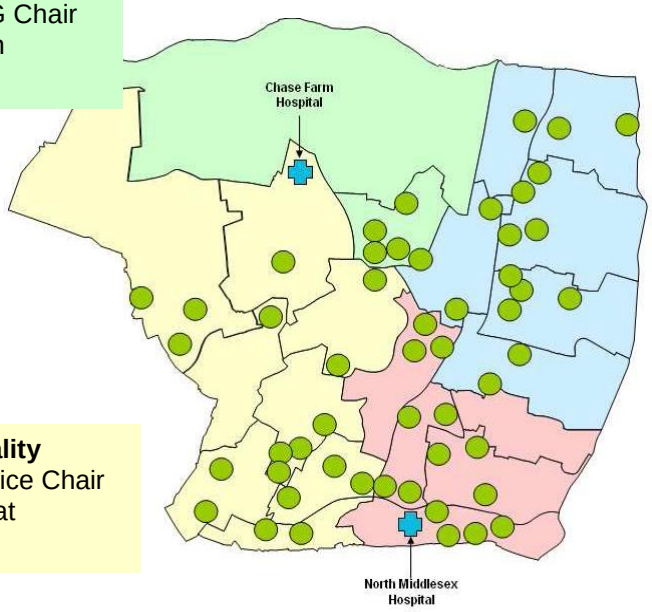
You can read our constitution on our website www.enfieldccg.nhs.uk.

The specific reference for this is http://www.enfieldccg.nhs.uk/Downloads/Policies/Enfield%20CCG%20Constitution%2031.03.2013.pdf.

Our localities and GP representatives

North West Locality
Dr Alpesh Patel – CCG Chair
Dr Mike Gocman

North East Locality
Dr Ujjal Sarkar
Dr Raj Mazumder



South West Locality
Dr Janet High – CCG Vice Chair
Dr Anshu Bhagat

South East Locality
Dr Tim Fenn
Dr Parvan Sardana

Our local population and their health needs

We are responsible for commissioning health services for a population of around 310,000 people. Enfield is a diverse London borough and some of the key health challenges we face are:

- Between 2008-2010 our infant mortality rate was the third highest in London
- Childhood obesity rates in Enfield are amongst the highest in the country
- Cardiovascular disease and cancers remain our biggest killers and survival rates are lower than neighbouring boroughs
- One in three adults in Enfield over 55 have a limiting long term illness
- There is a large gap in life expectancy in Enfield, greater for women than men
- People in the more deprived parts of the borough tend to experience worse health than the rest of the population
- 1% of people in Enfield have a mental health disorder and 7.5% are reported as having depression

We are committed to improving the health of local people and reducing health inequalities.

Transforming healthcare in Enfield: Our priorities

We know that too many people use hospital services for conditions that could be better managed in primary care or through a team of health and social care professionals based in the community, closer to patients' homes. We also know that there are significant financial challenges, locally and nationally.

NHS Enfield CCG has six transformational programmes that will each work to redesign services and deliver clinically effective and safer care, improve patient experience and better value for every NHS pound spent in our local healthcare economy.

PREVENTION	PRIMARY CARE	INTEGRATED CARE	CLINICAL AND COST EFFECTIVENESS	CHILDREN AND YOUNG PEOPLE	MENTAL HEALTH
Helping people to stay well and identifying those who are unwell early.	Improving access to and reducing variations in the quality of care and patient experience	Joining up health and social care to support older people and people with long term conditions	Delivering more care locally and helping people to stay out of hospital through improving planned and unplanned care services	Joining up health and social care to support pregnant women, children and young people	Delivering better care for people with mental health needs
Clinically effective and safe services					
Patient centred – a good patient experience					
Most effective use of NHS services					

Our Partners

We will deliver good healthcare in Enfield by working with our partners to:

- build strong and lasting relationships,
- deliver effective commissioning,
- manage risk and;
- deliver our statutory obligations towards patients and the public and Health and Wellbeing Board.

Our main commissioning partners are:

- NHS England
  www.england.nhs.uk Tel: 0300 311 2233
- London Borough of Enfield
  www.enfield.gov.uk Tel: 0208 379 1000
- Other local Clinical Commissioning Groups especially Barnet, Haringey, Islington and Camden CCGs.

Our main acute hospital partners locally are:

- Barnet and Chase Farm Hospitals NHS Trust
  www.bcf.nhs.uk Tel: 0845 111 4000
- North Middlesex University Hospital NHS Trust
  www.northmid.nhs.uk Tel: 020 8887 2000

Our main community and mental health services partner is:

- Barnet, Enfield and Haringey Mental Health Trust
  www.beh-mht.nhs.uk Tel: 020 8702 3000

We also aim to work closely with partners in the voluntary sector and with patients and the public including:

- HealthWatch Enfield
  www.enfield.gov.uk/healthwatch

For information about how to make a complaint or give feedback on services NHS Enfield CCG commissions, please visit

http://www.enfieldccg.nhs.uk/advice-complaints-compliments.htm

Keeping people well and preventing disease

We need to help people stay healthy and prevent them from becoming acutely unwell. This means that we should help people have healthy lives and where they do become ill, to manage their own care and be cared for at home by primary and community health services for as long as possible.

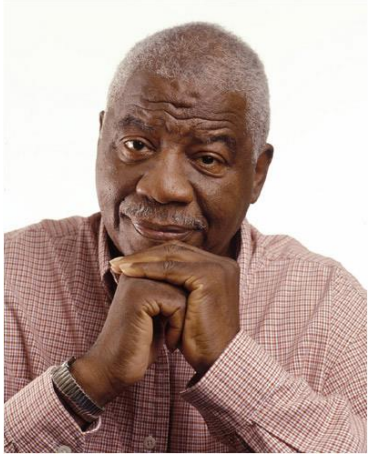
We are proud of what we have achieved so far working closely with colleagues in the London Borough of Enfield (LBE):

- More people have stopped smoking than ever before
- More children are being immunised
- We have active screening programmes for cardiovascular disease (NHS HealthChecks) and for breast, cervical and bowel cancer.

However there is still more to do.

During 2013 -14, and working with LBE, we will

- **Help more children receive immunisations helping them to stay healthy and to prevent serious diseases spreading**
- **Help more pregnant women to access maternity services as soon as possible and certainly within 12 weeks and 6 days**
- **Help more people to stop smoking**
- **Offer all people life-style advice and support, particularly for smoking and obesity.**
- **Deliver more NHS HealthChecks to screen people for heart and circulatory disease**
- **Encourage more people to take up bowel, breast and cervical cancer screening especially from our most vulnerable communities.**



Improving Care Example: Preventing Heart Disease

Mr F is 72. At a recent NHS HealthCheck, he mentioned that his father had died of heart disease at a similiar age. His blood pressure was checked and found to be high. An appointment was booked with his GP.

The GP discovered that Mr F had hypertension (high blood pressure) and was able to start him on suitable medication to reduce his risk of heart disease. Mr F was also advised to have a flu jab at the start of winter to help him to stay well.

Improving Primary Care

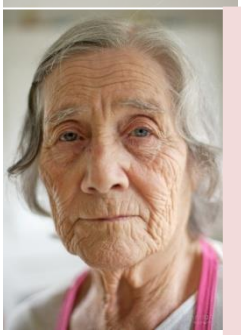
Primary Care includes general practice (GPs), dentistry, pharmacists and optometrists (opticians) and over 90% of people's access to the NHS starts with these services.

We have worked hard during 2012-13 to improve local primary care services.

- We have established four primary care networks, groups of GPs who share best practice and learn from each other to improve care for patients.
- We have delivered 4,700 NHS HealthChecks, checking patients for early signs of heart and circulatory disease.
- We have multi-disciplinary teams working with patients with long term conditions to set up individual care plans. These plans ensure that patients to get the care they need locally or in their own homes, helping them to stay independent.

By the end of 2013-14

- **There will be blood pressure machines in every practice so that patients can measure their blood pressure without having to see a doctor**
- **There will be an extra 47,000 appointments in general practice with both GPs and practice nurses**
- **Patients will be able to get more advice from local pharmacies through the Minor Ailments Scheme**
- **More patients with long term conditions such as heart disease and COPD will receive local care, helping them to stay out of hospital**



Improving Care Example: Managing lung disease better

Mrs B is 75 and has chronic obstructive pulmonary disease (lung disease). It's a Friday in December and she has had a poor night's sleep with an increase in wheezing. She knows from past experiences that the cold weather along with these symptoms means that she could start to feel ill quickly, so calls her practice for an appointment. A triage nurse takes the call from reception and then books an appointment with a COPD nurse specialist in a network practice.

Mrs B attends the appointment later that morning and is prescribed simple steroids for her to take should she start to feel unwell. The nurse notices that Mrs B hasn't had a flu jab. She makes an appointment for the next clinic at Mrs B's own practice in two weeks when she will be well enough to have it.

Integrated Care

Integrated Care means that everyone involved in your care talks to each other about your care and works together to plan your care with you. This includes people working within health, social care and voluntary services. We will make sure that integrated care is available to older people and people with long term conditions in Enfield.

We have already made a start on this work. In 2012-13

- we have improved the care for many of our residents living in care homes by introducing health and social care teams
- we have a health and social care forum in North East Enfield supporting older people to stay well without the need for them to be admitted to hospital

In 2013-14 we will

- **create health and social care forums for south east, south west and north east Enfield**
- **develop older people's assessment units (OPAU) at Chase Farm and North Middlesex hospitals. This means that more people will be able to access assessment and care planning more quickly from teams including doctors, nurses, physiotherapists, social workers and others**
- **Ensure that more than half the people having the illness are diagnosed in the early stages of dementia**

By the end of 2013-14 older people will be able to get a rapid assessment of their needs from the right teams of people. More people will be cared for at home without having to stay in hospital meaning that 19% fewer people over 65 years will be admitted to hospital as an emergency.

Improving Care Example: Helping people to stay at home when they are ill

Mrs S is 86 years old and has a number of medical issues that are usually well managed by her GP and community matron. Mrs S also has some help from social care to live at home. Mrs S has begun to feel unwell and is visited by her community matron. There appears to be a number of things making it difficult for Mrs S to manage and it is agreed that she would benefit from coming into the OPAU. Transport is arranged and she is seen by the team the same day. She has a chest infection and is given antibiotics. The social worker is able to increase the help that she is having at home and the community matron will visit the following day to assess how she is getting on. Mrs S is able to go home and doesn't have to stay in hospital.

Right care, right place, first time - Planned care

We know that planning care properly leads to better clinical outcomes for patients and reduces the cost of health services. We are working hard to ensure that more patients receive care locally, closer to their homes without having to attend hospital.

We have already successfully set up community services for a range of specialties including gynaecology, ophthalmology and dermatology. Patients needing these services can be referred by their GP to clinics closer to home, rather than needing to attend hospital.

During 2013-14 we will open new community services clinics for people with

- **chronic pain management**
- **for respiratory illness**
- **ear, nose and throat (ENT)**
- **cardiology, and**
- **urology.**

Through these changes

- patients can choose to attend outpatient appointments close to home
- GPs and hospital doctors will work together to improve care locally
- NHS resources are directed to where they will make the most difference

Improving Care Example: Care Closer to Home

Mrs C has suffered from chronic pain in her back for many years. She has been seen many times by her GP, within A&E and by many health professionals. She recently saw her GP and was referred to the new Chronic Pain Management Service. Mrs C was seen within a local GP practice by a group of clinicians and joined the Pain Management Programme. Mrs C attended a set of eight sessions run by a pain psychologist and a physiotherapist where she was taught how to cope with her pain as well as being given a direct link to the team when she needed

Unplanned Care (Emergency and Urgent Care)

Many people will continue to have or believe they have emergency or urgent needs for healthcare. These needs are met through unscheduled care services such as NHS 111, accident and emergency (A&E), pharmacies, general practice and urgent care centres.

During 2012-13 we have helped to establish NHS 111 locally. This means that the access to all urgent care services is streamlined through a single telephone number and patients can be directed to the best care. We have also co-located the GP Out of Hours Service with the Urgent Care Centre at Chase Farm Hospital so that Enfield residents have 24 hour access to urgent care.

During 2013-14 we will ensure

- **we will have more GPs and primary care nurses at the Urgent Care Centre at Chase Farm Hospital seeing and treating patients between the hours of 9am to 9pm seven days a week.**
- **'patient navigators' in the urgent care centres, to help people find their way around the system**
- **a GP out of hours service based from Chase Farm offering out of hours support to Enfield residents from 6.30pm to 9am seven days per week.**
- **the national 111 service offering 24/7 support to residents**

By the end of 2013-14 patients with urgent care needs will

- find it easier to see a GP either through the Out of Hours service or at an urgent care centre as we will have 24 hour primary care cover locally
- be seen quickly for urgent care assessment and treatment

Improving Care Example: Better Care Urgently

Mr R had been feeling unwell all day with a persistent cough and high temperature. He rang the new NHS 111 service at 7pm and after explaining his symptoms was advised to attend a local Urgent Care Centre based at the hospital. He attended, was seen by a GP working there, given medication and advised to make an appointment with his own GP in a few days. Mr R was not registered with a GP and was supported by the staff at the Urgent Care Centre to register. An appointment was made in advance with the GP practice for him.

Improving care for pregnant women, children and young people

We know that helping children to have the best start in life helps to improve their outcomes for health, education and employment. Working with Enfield Council and our other partners we want to achieve this, regardless of where any child lives in Enfield.

In 2013-14 we will

- **promote physical exercise and healthy weight amongst children and young people to help them to stay healthy**
- **help implement the Family Nurse Partnership which provides support to young mothers**
- **work with local hospitals to ensure children and young people with diabetes receive the very best care**
- **ensure children who are ill get the right care in the right place first time by improving access to services in primary care**
- **open a paediatric assessment unit at Chase Farm Hospital**

Improving Care Example: Family Nurse Partnership

K is 16 years old and is pregnant for the first time. She is referred by her midwife to the Family Nurse Partnership, and meets the nurse who will support through regular visits and a structured programme through her pregnancy and up to her child, T, second birthday. At the end of the programme T is doing well. They both have a good group of friends and K is returning to college to start an access course.

Improving Care Example: Keeping Children Healthy

Mr A visits his GP with H his 6 years old son. The GP notices that they are both overweight and suggests they attend a weight management programme with other families at a local surgery. The programme looks at simple lifestyle changes that can be made and at the end of the programme. On-going support is available from the practice nurse.

Improving Care Example: Keeping Children Out of Hospital

M is 8 and has asthma and has been admitted to hospital several times with breathing difficulties. He has now been seen by paediatrician working in a community clinic, who has agreed a new plan with M, his parents and his GP. M is booked in for regular appointments with his GP or specialist nurse, and his parents know that he will be seen by the paediatrician if needed.

Improving Care for People with Mental Illness and Learning Disability

People with Mental Health Needs

In recognising the importance of mental wellbeing and ensuring that that a full a range of approaches provided for the population of Enfield, we will:

- listen to people who use the services and encouraging people to have their say on what is needed for Mental Health, working closely with the Enfield Mental Health Partnership Board
- help more people with anxiety and depression get the support and treatment they need to lead a more fulfilling life.

During 2013-4 we will

- **plan better services for people with autism**
- **improve care and support in primary care for people with mental illness**
- **provide better support to carers**
- **more people will be able to attend psychological therapies, increasing access by 10%**

Improving Care Example: Psychological Care

S started to feel depressed a few months ago when her back pain became very bad. She was under a lot of pressure at work at the time and started to worry everyday about small things. By the time she came home she was exhausted and short-tempered. Over time, she stopped seeing her friends and did less and less. She was referred to a Psychological Wellbeing Practitioner who helped her to get back into being more active at a pace that suited her. Learning these skills helped her confidence improve and she now worries less.

People with a Learning Disability

We would like to see more of our residents with learning disabilities having their care close to home, in Enfield. During 2012-13 we reviewed the individual needs of people in placements outside Enfield to make sure they were receiving best care, and really needed to live away.

We are making good progress in changes for the better in light of the Winterbourne Review. We have provided intensive support to service users and carers locally when they need it to reduce the number of hospital admissions that may be a result of challenging behaviours. Working with our key stakeholders within the local authority and health we are reviewing the current care pathway for users of learning disability services.

Ensuring quality and safety: Putting patients at the heart of everything we do

We measure quality in three ways.

Safe service

The right staff, correctly trained, learning from experience

Effective service

Evidence based, right care, right place, first time

Good experience

Service users feel valued and cared for

Our objectives

- to work with people to improve their health and well-being
- to make sure health services are safe, high quality, efficient and effective
- to make sure that services are delivered within available resources
- to work in partnership with health and social care colleagues
- to have strong clinical leadership and learn from experience to deliver the best care
- for everyone delivering care to be well trained and well supported
- to take action when we are not receiving high quality, efficient and effective health services

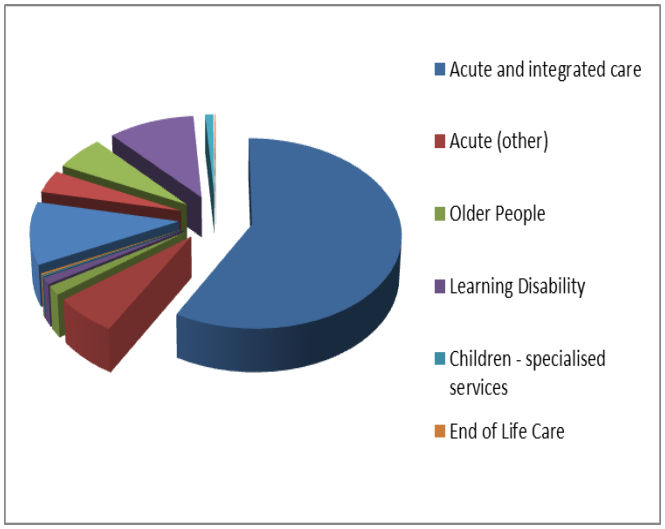
Our resources

We recognise that we are working within a challenging financial context. Based on spending by Enfield PCT last year, the CCG begins the financial year with a run-rate deficit of £19.2m. In order for us to invest in health services locally, we must first achieve financial balance without impacting on the quality and safety of patient care, and where possible, improving it. It is our ambition and intention to achieve financial balance and we have a plan to reduce the spending gap in 2013/14 to £8m and a recurrent breakeven position in 2014/15.

We will spend our money wisely on high quality services and through our Transformation Programme we will invest in more care closer to home. This will help us to reduce our spending on acute hospital care, which currently takes the largest part of our budget. Our Transformation Programme (QIPP) is a key enabler in ensuring best value for NHS resources and in maintaining quality across the patient pathway. It has already achieved savings of £13.5m in 2012/13 and we plan to deliver a further £15.4m in 2013/14 through review of patient pathways, implementing best practice and ensuring better productivity and efficiencies across the health system.

We have been allocated approximately £341.4 million to commission health services for Enfield. The diagram below shows how we will spend our money on healthcare during 2013-14.

Our Health Resources



Budget Line	% CCG Commissioning Spend
Acute and integrated care (all ages)	58%
Acute (other)	6.5%
Older people	1.5%
Learning disability	1.1%
Children's specialist services	0.2%
End of life care	0.3%
Mental health	11%
Continuing healthcare	4%
Community	6%
Prescribing	10.5%
Primary Care	1%
Public health	0.1%

We know that our aspirations for 2013/14 are challenging and are placed at risk through both acute spend and by the completion of the transfer of funds for specialised commissioning to NHS England.

Getting involved and contacting us

Your views as residents of Enfield and users of our services are important to us and we also want to share our ideas with you.

How we will engage with our local population and how you can give us feedback

We will**:**

- Use our website www.enfieldccg.nhs.uk to publish information about NHS Enfield CCG and the local services available to our patients. We will also use our website to gather feedback from patients. The website will be inclusive and use technologies that will help us engage and communicate with people with disabilities.
- Use social media to extend the reach of our website. We will use a number of interactive methods such as Twitter, blogging and forums.
- Work with the local, national and trade media to help journalists and the public understand more about NHS Enfield CCG.
- Publish information about NHS Enfield CCG including newsletters, leaflets, strategic and operating plans and annual reports. We will regularly publish materials electronically and make hard copies available on request. Wherever possible, we will produce plain English summaries of our key documents.
- Hold at least six Governing Body meetings in public a year including an Annual General Meeting (AGM) to review our financial position and work during the previous financial year. We will ensure we hold a meeting in each of our localities once a year.
- Support health campaigns on a variety of topics. Some of these will be targeted at health issues in Enfield and others will be national campaigns
- Have three public engagement events a year to involve patients in our commissioning cycle and strategic plans.

You can**:**

- Get involved with your GP practice's patient participation group (PPG) - ask at reception to see if your practice has a group.
- Send us your comments through our website: www.enfieldccg.nhs.uk
- Take part in consultations or surveys about local health services.
- Speak to Healthwatch Enfield to tell them what you think about local health and social care services in Enfield.
- Come along to one of our Governing Body meetings which are held in public to hear how we make decisions: www.enfieldccg.nhs.uk/about-us/ccg-board-meetings.htm
- Volunteer to be a patient or carer representative and help us to redesign NHS services around the needs of local patients.

- Join our CCG engagement email list by contacting communications@enfieldccg.nhs.uk

You can contact us or find out more at:

Address: Communications Team, Holbrook House, Cockfosters Rd, Enfield EN4 0DR
Phone: 0203 688 2840
E-mail: communications@enfieldccg.nhs.uk
Website: www.enfieldccg.nhs.uk

If you require this document in another format (e.g. large print or braille) or another language please contact communications@enfieldccg.nhs.uk