NHS
Enfield
Clinical Commissioning Group

NHS Enfield CCG Operating Plan Refresh 2015-16

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Document Title	NHS Enfield CCG Operating Plan refresh 2015-16	
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0.1	Richard Young	RBY	Jan 2015	Basic document structure
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0.7	Richard Young	Graham MacDougall	18/02/15	GM amendments
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1.0	RBY / GM	Liz Wise	24/02/15	General Amendments throughout
1.1	RBY / GM / RW	Graham MacDougall	26/02/15	General amendments & PH Revision and draft Finance Plan inserted
1.2	All	Graham MacDougall	27/02/15	'Final' Draft version sent to NHSE 27/02/2015

Enfield CCG Operating Plan

NHS Enfield Clinical Commissioning Group

1.0 Introduction

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

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

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

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

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

Our Transformation Programme has six programmes supporting the delivery of the CCG Strategic Goals and Corporate Objectives as well as supporting delivery for the key priorities set out in the Joint HWB Strategy.

They are:

- Prevention and Primary Care;
- Integrated Care ;
- Planned Care and Long Term Conditions;
- Children, Young People and Maternity;
- Mental Health, Learning Disability and Continuing Healthcare;
- Unscheduled care.

Enfield CCG Operating Plan

NHS Enfield Clinical Commissioning Group

1.1 Background

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

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

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

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

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

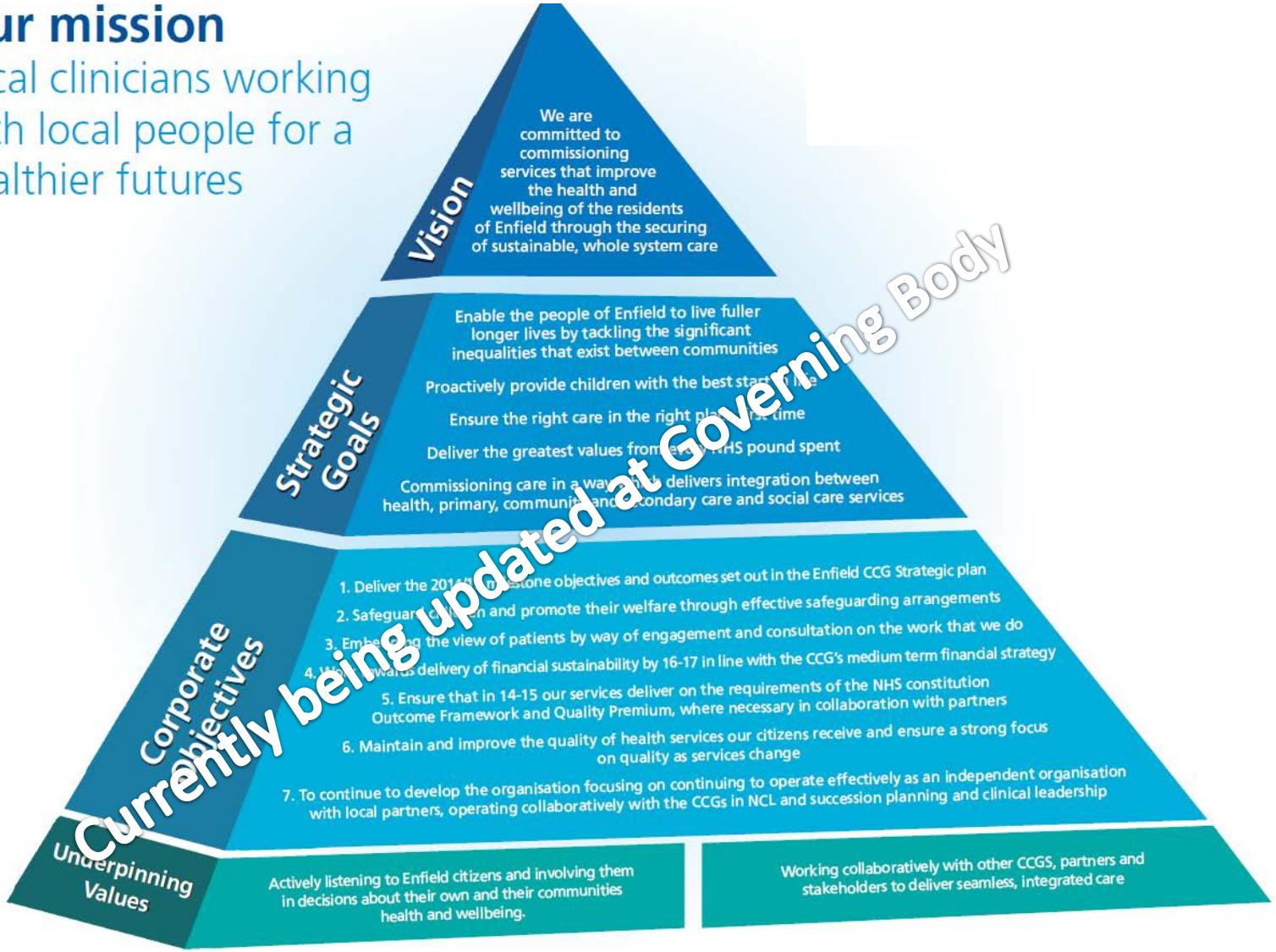
The CCG is committed to serving its population to ensure that the services it commissions meet their needs and provide value for money. We are very conscious that the financial challenge ahead of us remains significant and our focus for change is therefore on transforming services into systems that are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

Enfield CCG

NHS Enfield Clinical Commissioning Group

1.3 Our mission

Local clinicians working with local people for a healthier futures



Currently being updated at Governing Body

Corporate Objectives

NHS Enfield Clinical Commissioning Group

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

Collaborative Commissioning

NHS Enfield Clinical Commissioning Group

1.4 North Central London Health Economy

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

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

Our approach is:

A changed emphasis…

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

Integration of care through…

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

Patients at the centre…

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

Financial sustainability through…

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

NCL: Strategic Interventions and Enablers

NHS Enfield Clinical Commissioning Group

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

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

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

Slide taken from Draft NCL Strategy

NCL: Outcome Ambitions

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

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

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

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

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

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

NCL Target: 3.6% reduction in emergency admissions composite indicator

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

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

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

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

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

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

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

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

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

Local Planning

NHS Enfield Clinical Commissioning Group

1.6	Triangulation between Operating Plan and Joint Health & Wellbeing Strategy

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

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

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

The Enfield HWB Priorities

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

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

Local Planning

NHS Enfield Clinical Commissioning Group

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

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Better Care Fund Plan Measures

NHS Enfield Clinical Commissioning Group

1.6	Triangulation between NCL 5 Year Strategy Plan, Operating Plan and Better Care Fund Plan
Better Care Fund Emergency Admissions Reduction Target	**INITIAL BASELINE** The baseline for the initial Better Care Fund Modelling for the emergency admissions reduction target was devised using actual data from Q4 2013/14, and *projected* levels of activity for Q1-Q3 of 2014/15. The Q4 data included all Emergency admissions as defined by the nationally mandated Admission Method codes. (The data source was SUS.) The projected levels of activity for Q1-Q3 of 2014/15 was based on the same methodology used for NHS Enfield's 5 year planning intentions submitted to NHS England - to reduce the rate of admissions per 1,000 in Enfield to a phased, statistically adjusted, top quartile position in London by 2018/19. Activity was adjusted for seasonality as per the pattern of previous year's activity.
Original Submission	**INITIAL BCF MODELLING** The initial BCF modelling reduced the initial baseline activity and cost by the minimum 3.5% reduction expected nationally, which resulted in an expected reduction of **908 admissions**, at a **cost of £1,352,920**.

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

BCF Measures

NHS Enfield Clinical Commissioning Group

1.6	Triangulation between NCL 5 Year Strategy Plan, Operating Plan and Better Care Fund Plan
6.3 Revised Baseline	**REVISED BASELINE** In light of the known increase in Accident & Emergency attendances and resultant Non-Elective admissions nationally in the last 12 months, NHS England sent a survey to all CCGs on 22nd January 2015 to gauge the potential for local areas to revise their non-elective admissions reduction ambition. As a result, work was done within NHS Enfield CCG to re-calculate a new baseline of non-elective admission from the most up to date actual activity. The new baseline therefore covers Q4 2013/14 to Q3 2014/15, and includes all Emergency admissions as defined by the nationally mandated Admission Method codes. The new baseline shows significantly increased levels of activity to the initial baseline. (Data source = SUS.)
Revised Submission	**REVISED BCF MODELLING** The H&WB Integration Board agreed an option is to keep the minimum expected 3.5% reduction, and apply it to the revised baseline. This has increased the expected level of activity and cost savings, due to the increased activity in the revised baseline. The new target reduction is **1,065 admissions**, at a **cost of £1,586,850**. The increase can be absorbed within the existing Contingency Fund within the BCF Plan.

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

Operating Plan Measures

Supporting Narrative for UNIFY Submission

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

Operating Plan Measures

Supporting Narrative for UNIFY Submission

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

Operating Plan Measures

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

Operating Plan Measures

Supporting Narrative for UNIFY Submission

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

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

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

Operating Plan Measures

Supporting Narrative for UNIFY Submission

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

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

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

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

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

Specific initiatives include:

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

Our new Trajectory for 2015/16:

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

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

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

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

Actions

CCG is implementing recommendations from the National IAPT IST and has committed additional resource to the service in 2015-16 to meet expected demand and target. Monthly IAPT performance meetings are in place to monitor action plans with provider. CCG is also undertaking marketing exercises to increase referrals.

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

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

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

Actions

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

Operating Plan Measures

Supporting Narrative for UNIFY Submission

NHS Enfield Clinical Commissioning Group

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

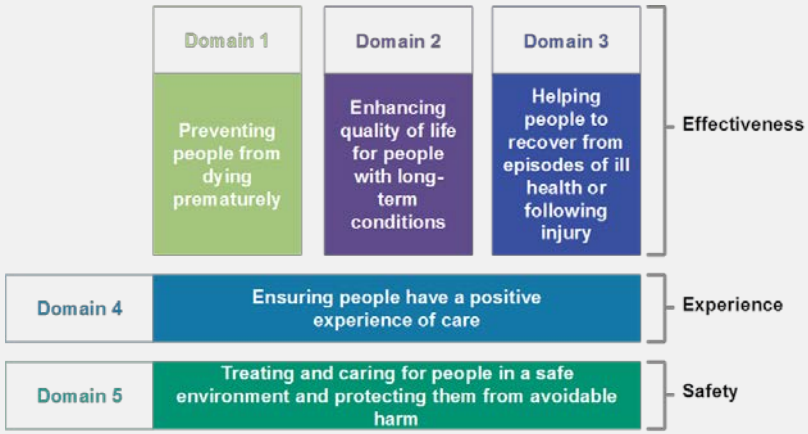
Annex A: Enfield CCG Planning Submission 2015/16

NHS Enfield Clinical Commissioning Group

Section 3	Annex A

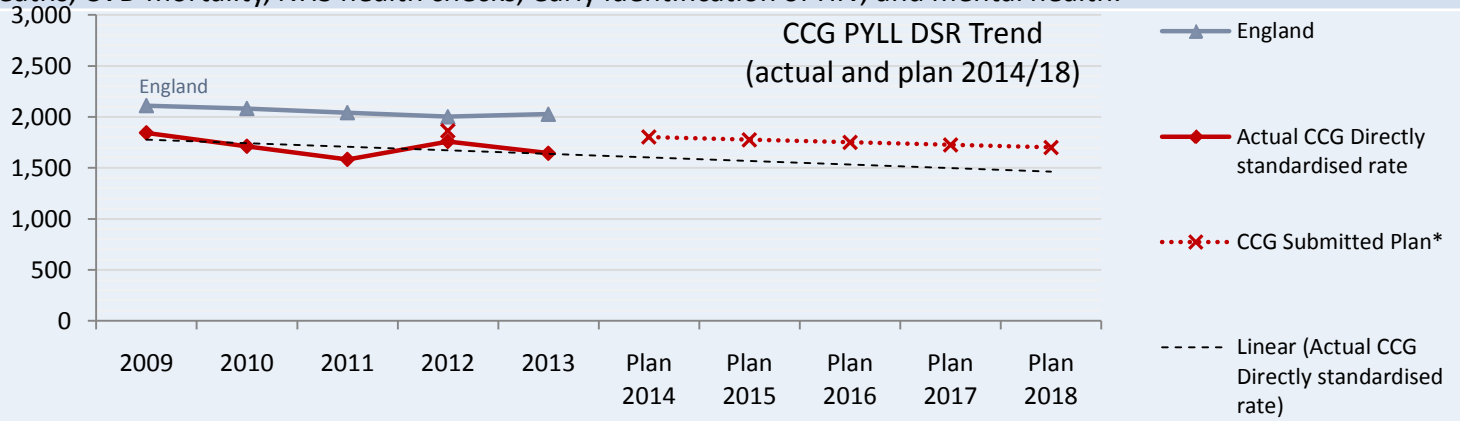
The following Slides (section 3) are based around the headings found in the "**Annex A**" template within the *Forward view into Action – supplementary Information for Commissioner Planning 2015/16*.

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

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

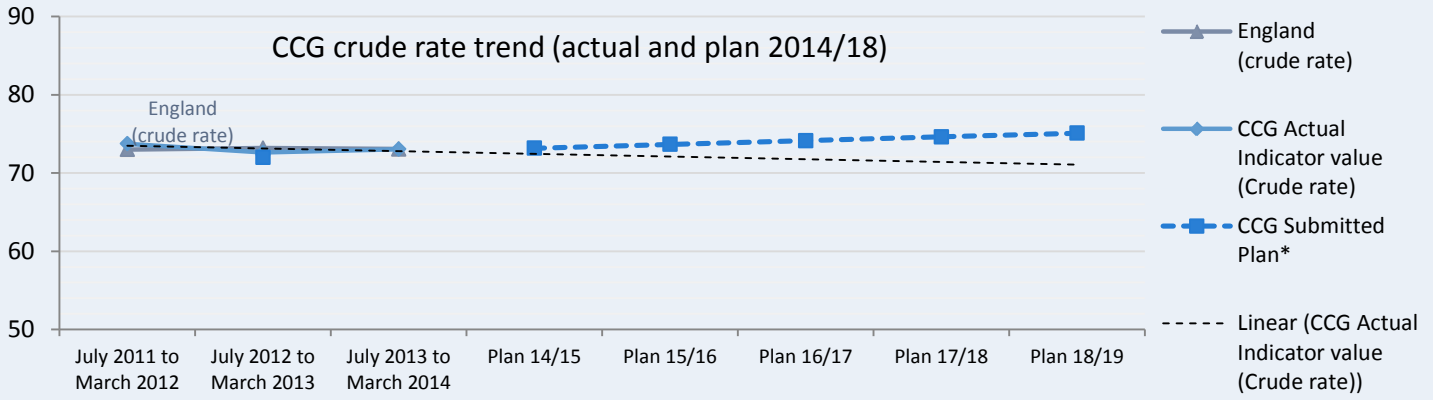
Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.2	Delivery Across The Seven Outcome Measures (3)
The actions you need to take to improve outcomes	**Ambition 3: Reducing Emergency Admissions** This trajectory is also a Better Care Fund indicator and it has recently been agreed with the Council, following the recalculating of the baseline on actual data, to align the BCF trajectory based on 3.5% reduction of emergency admissions for both the BCF and Operating Plans. The long term trend line in the graph below illustrates the position the CCG will be in if no actions are taken. Our current ambition is to ensure that emergency admissions remain flat following the reduction by 3.5% To support delivery we have a number of initiatives: long term conditions, integrated care for older people, value based commissioning, mental health liaison, and audits of emergency admissions in both main acute providers. The CCG and LBE have an ambitious plan for the development of integrated care for older people which will prevent a significant number of avoidable admissions. We are currently reviewing emergency and urgent care pathway for our two main acute providers to ensure that those pathways support alternatives to admission. In addition, the CCG is working collaboratively with NCL partners through the Urgent & Unscheduled Care work programme to direct patients to an urgent and unscheduled care service that signposts patients to the appropriate care setting, based on the principles of right care, right place, right time.
Enfield CCG is currently in the second best quintile [2013/14 HES data], but was in the best quintile for 2012/13. **Lower values are better**	CCG Avoidable admissions Trend (national published actual and plan 2014 to 2018) 3,000 2,500 2,000 1,500 1,000 500 0 2009/10 2010/11 2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 England CCG Indicator value (Indirectly standardised rate per 100,000) Submitted Plan* Long term trend line (5yrs actual)

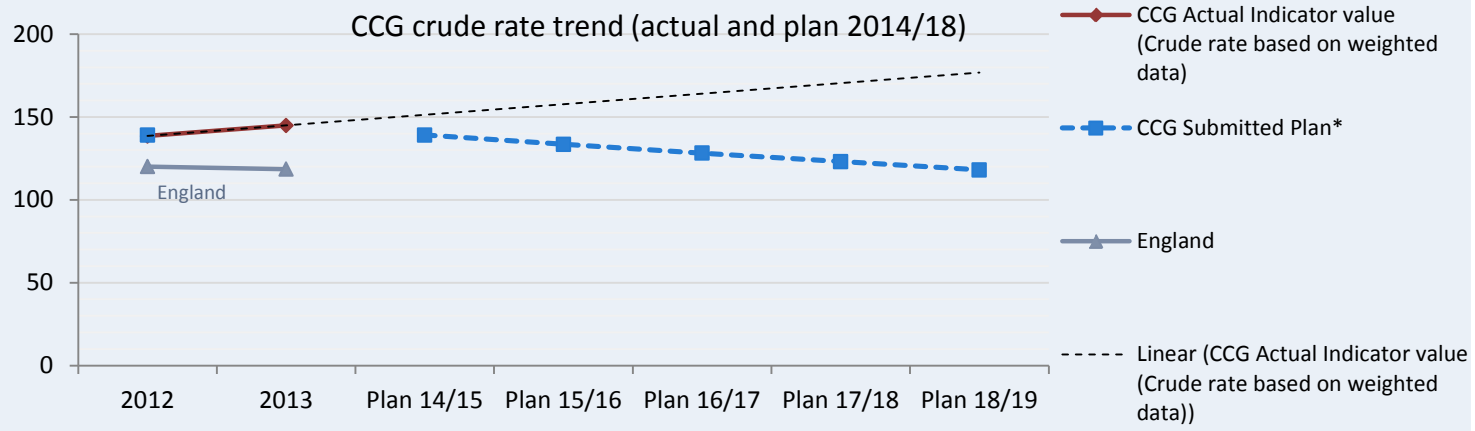
Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

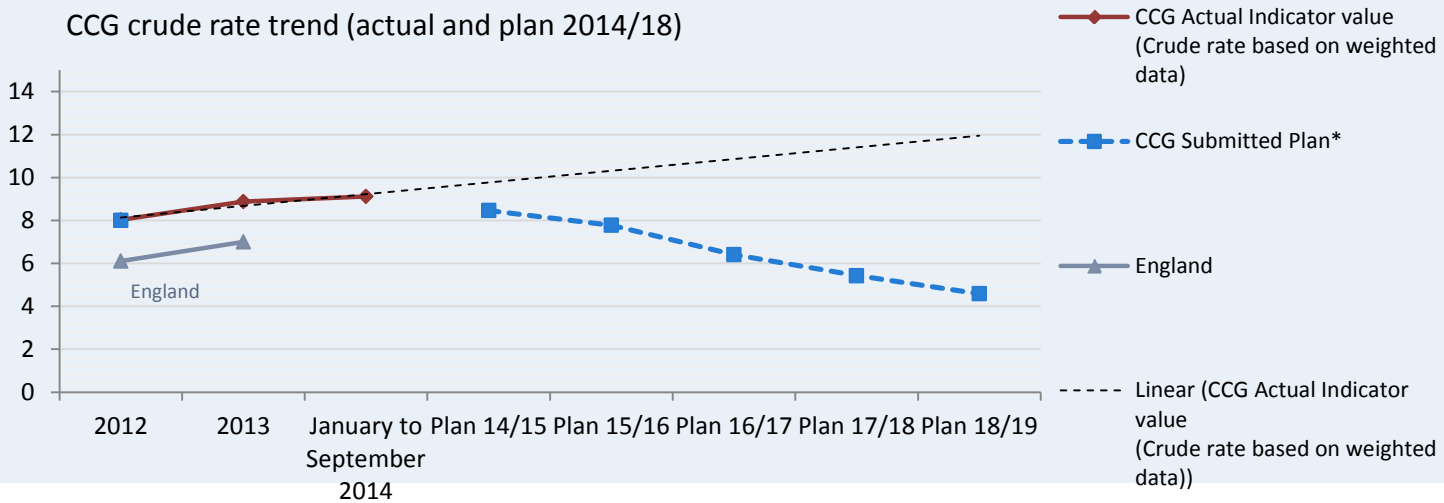
Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.3	Improving Health (1)

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

The Enfield HWB Priorities are:

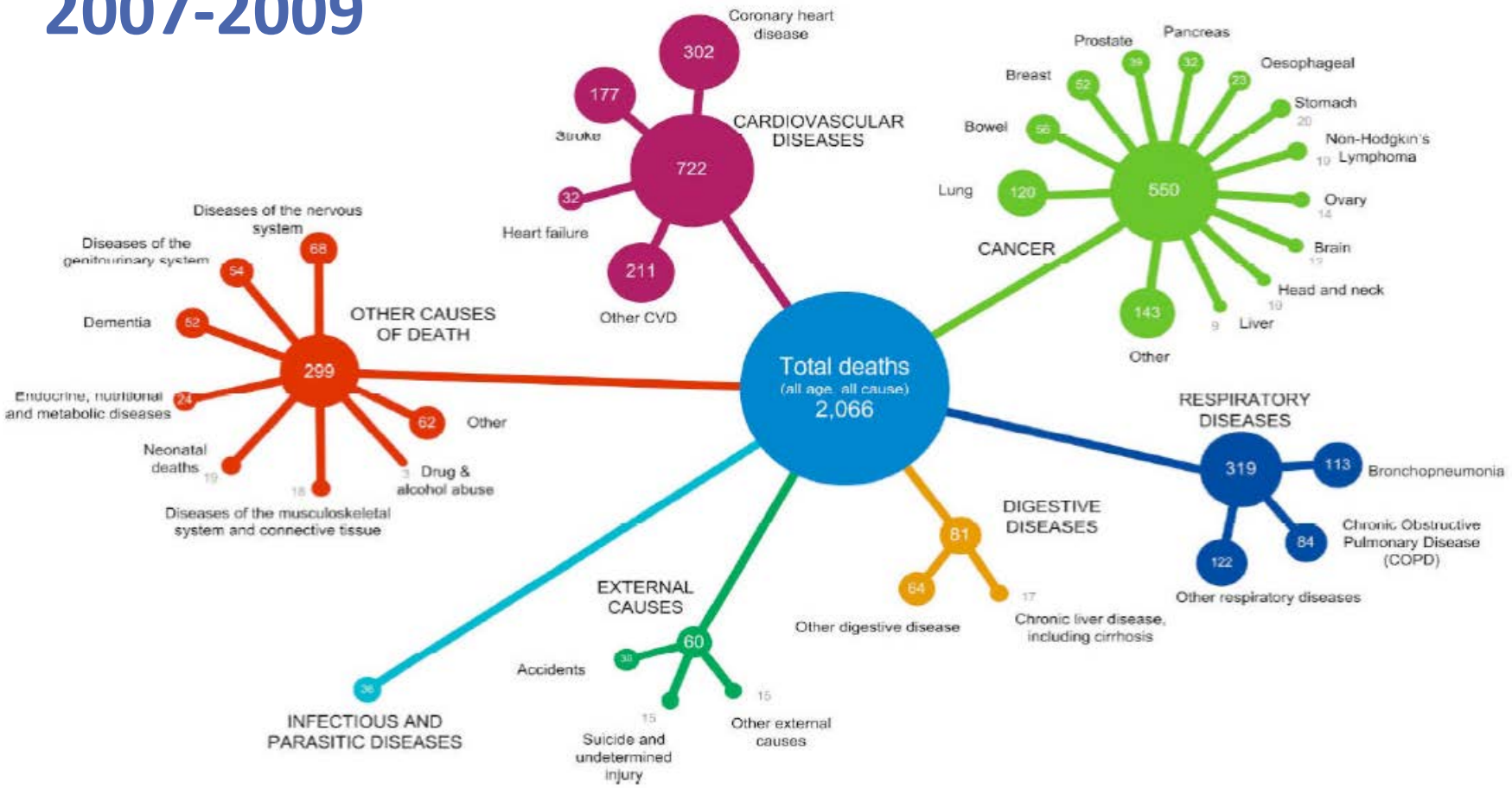
- Ensuring the best start in life
- Enabling people to be safe, independent and well and delivering high quality health and care services
- Creating stronger, healthier communities
- Reducing health inequalities – narrowing the gap in life expectancy
- Promoting healthy lifestyles and making healthy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

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

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

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

NHS Enfield Clinical Commissioning Group



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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

3.4	Reducing Health Inequalities (2)

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

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Outcomes

NHS Enfield Clinical Commissioning Group

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

Annex A: Access

NHS Enfield Clinical Commissioning Group

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

Annex A: Access

NHS Enfield Clinical Commissioning Group

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

Annex A: Access

NHS Enfield Clinical Commissioning Group

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

Annex A: Quality

NHS Enfield Clinical Commissioning Group

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

Annex A: Quality

NHS Enfield Clinical Commissioning Group

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

Annex A: Quality

NHS Enfield Clinical Commissioning Group

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

Annex A: Quality

NHS Enfield Clinical Commissioning Group

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

Annex A: Quality

NHS Enfield Clinical Commissioning Group

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

Annex A: Quality

NHS Enfield Clinical Commissioning Group

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

Annex A: Quality

NHS Enfield Clinical Commissioning Group

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

Annex A: Quality

NHS Enfield Clinical Commissioning Group

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

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

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

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

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

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

Annex A: Quality

NHS Enfield Clinical Commissioning Group

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

Annex A: Innovation

NHS Enfield Clinical Commissioning Group

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

Annex A: Innovation

NHS Enfield Clinical Commissioning Group

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

Annex A: Delivering Value

NHS Enfield Clinical Commissioning Group

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

Financial Plan

NHS Enfield Clinical Commissioning Group

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

Activity Trajectories

NHS Enfield Clinical Commissioning Group

4.2	Activity Trajectories

Referrals

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

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

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

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

Risk Register

NHS Enfield Clinical Commissioning Group

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

Enfield CCG Operating Plan Conclusion

NHS Enfield Clinical Commissioning Group

5.0 CONCLUDING REMARKS

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

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

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

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

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

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

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