

Meeting in Public of the Enfield Clinical Commissioning Group

Governing Body

10 June 2015

2.30pm – 5pm



Clinical Commissioning Group

Millfield House
Silver Street
Edmonton
N18 1PJ

AGENDA					
		Lead	Action required	Appendices	Timing
	A private meeting will precede the Enfield CCG Public Governing Body meeting to discuss items of a confidential nature. Representatives of the press and members of the public will be excluded from this meeting. Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960.				
1.	Welcome and Apologies				
1.1	Apologies for Absence	Chair	To note	Oral	
1.1.1	Chair's Introduction and Opening Remarks	Chair	To note	Oral	
2.	Declarations of Interest <i>All Governing Body members and attendees may have interests relating to their roles. These should be declared in the register of interests. While these general interests do not need to be individually declared at meetings, interests over and above these where relevant to the topic under discussion should be declared. The Register is held on the CCG Web Site.</i>				
2.1	To declare any interests in relation to items on the agenda.	Chair	To consider	Oral	
3.	Minutes, Action Log and Matters Arising				
3.1	To approve as a correct record the Part 1 Minutes of the meeting held on 25 March 2015.	Chair	To approve	Appendix A	
3.2	Action Log	Chair	To note	Appendix B	
3.3	Matters arising	Chair	To note	Oral	
4.	Questions from the Public				
	NB: The Chair will provide a written answer to those questions relating to items on the agenda and which have been received in advance and invite questions of clarification on the answers given. There will be a further opportunity to ask questions relating to agenda items at the conclusion of the meeting.				
5.	Overview Reports				
5.1	Chief Officer's Report	Chief Officer	To note	Appendix C	
5.2	Chair's Report • Minutes of Enfield Integration Board meetings held on 18 February 2015 and 22 April 2015	Chair	To note	Appendix D	

6.	Strategy and Partnerships				
6.1	Primary Care Co-Commissioning	Director of Strategy and Partnerships	To approve	Appendix E	
6.2	2015-16 Operating Plan	Director of Strategy and Partnerships	To approve	Appendix F	
7.	Finance, Contracts and Performance				
7.1	Finance Committee Report	Chair of Finance Committee	To note	Oral	
7.2	Finance Performance as at Month 1 for 2015/16 and outturn report for 2014/15	Chief Finance Officer	To discuss	Appendix G	
7.3	Enfield CCG Financial Governance Review and Action Plan - 2014/15	Chief Finance Officer	To note and approve the action plan	Appendix H	
7.4	Integrated Performance Report for May 2015	Director of Operations	To review	Appendix I	
8.	Quality and Safety				
8.1	Quality and Safety including Committee Report	Governing Body Nurse Member/ Director of Quality and Integrated Governance.	To note	Appendix J	
9.	Governance				
9.1	Audit Committee Report	Chair of Audit Committee	To approve	Appendix K	
9.2	Board Assurance Framework and Review of Strategic Risks	Director of Quality and Integrated Governance	To review	Appendix L	
9.3	Annual Report and Accounts	Chief Finance Officer & Director of Quality and Integrated Governance	To endorse & to approve the statement	Appendix M	
9.4	Conflicts of Interest Policy, Procurement Policy and Gifts and Hospitality Policy	Director of Quality and Integrated Governance	To approve	Appendix N	
9.5	PREVENT Strategy	Director of Quality and Integrated Governance	To approve	Appendix O	
9.6	Governing Body Sub Committee Terms of Reference	Director of Quality and Integrated Governance	To approve	Appendix P	
9.7	Audit Committee Annual Report	Chair of Audit Committee	To note	Appendix Q	
10.	Patient and Public Engagement				
10.1	Patient and Public Engagement Committee Report	Lay Governing Body member and Director of Quality and Integrated Governance	To note	Appendix R	

11.	Items for Information				
11.1	Draft Health and Wellbeing Board minutes – 14 April 2015	Chair	To note	Appendix S	
12.	Any Other Business				
13.	Further questions from the public on agenda items	Chair		Oral	
14.	Meeting Evaluation Checklist	Chair	To complete	Appendix T	
15.	Date and Place of Next Meeting <i>12 August 2015 at 2.30pm at Holbrook House</i>				

DRAFT

Clinical Commissioning Group

Agenda Item: 3.1
Paper Ref: Appendix A

MINUTES

Public Meeting of the NHS Enfield Clinical Commissioning Group Governing Body

25 March 2015

Held at Dugdale Centre

Members Present:

Dr Mohammed Abedi	GP Governing Body Member and Chair
Dr Anshu Bhagat	GP Governing Body Member
Dr Hardeep Bhupal	GP Governing Body Member
Dr Fahim Chowdhury	GP Governing Body Member
Dr Janet High	GP Governing Body Member
Dr Alpesh Patel	GP Governing Body Member
Dr Ujjal Sarkar	GP Governing Body Member
Ms Angela Dempsey	Secondary Care Nurse, Governing Body Member
Professor Robert Elkeles	Secondary Care, Governing Body Member
Ms Karen Trew	Lay Vice Chair, Governing Body Member
Mr Robert Whiteford	Chief Finance Officer, Governing Body Member
Ms Liz Wise	Chief Officer, Governing Body Member

Invited Observers

Dr Shahed Ahmad	Director of Public Health Enfield
Ms Deborah Fowler	Chair, Healthwatch Enfield
Mr Bill Mackay	Enfield Patient Participation Group Representative
Ms Litsa Worrall	Enfield Patient Participation Group Representative

In attendance:

Mr Graham MacDougall	Director of Strategy and Partnerships
Ms Aimee Fairbairns	Director of Quality and Governance
Ms Jane Pike	Director of Operations
Mr David Triggs	Board Secretary
Ms Emma Casey	Executive Assistant

Apologies:

Mr Ray James	Director of Health, Housing and Adult Social Services, Enfield
Dr Teri Okoro	Lay Member, Governing Body Member
Ms Rathai Thevananth	Practice Manager Representative, Governing Body Member (belated apologies)
Dr Mike Gocman	GP Governing Body Member

1.0	WELCOME AND APOLOGIES	Action
1.1	Apologies received were noted as recorded above. Belated apologies were received from Rathai Thevananth who was unwell.	
1.1.1	<p>The Chair welcomed members of the public and Members of the Governing Body to the meeting.</p> <p>The Chair informed the meeting that questions in relation to Item 6.1 (<i>NHS 11 and Out of Hours Service</i>) and Item 9.4 (<i>Changes to the ECCG Constitution</i>) will be taken at the time that the papers are discussed. Questions relating to any other agenda item will be taken at the end of the meeting.</p>	
2	DECLARATIONS OF INTEREST	
2.1	<p>Members of the Governing Body declared the following interests in relation to items on the agenda:</p> <ul style="list-style-type: none"> • Dr Mohammed Abedi, Dr Anshu Bhagat, Dr Hardeep Bhupal, Dr Alpesh Patel, Dr Ujjal Sarkar and Dr Fahim Chowdhury declared a direct pecuniary interest in Item 6.1 (<i>NHS 111 and Out Of Hours Service</i>), Item 6.3 (<i>Primary Care Co-Commissioning</i>) and Item 9.4 (<i>Changes to the ECCG Constitution</i>). All left the room when these items were discussed and none took any part in the discussion or the voting on this item. • Litsa Worrall declared an interest in item 10.1 (<i>Patient and Public Engagement Committee Report</i>) as a candidate in the forthcoming PPG Election. 	
3	MINUTES ACTION LOG AND MATTERS ARISING	
3.1	<p>Minutes of the meeting held on 28 January 2015</p> <p>The minutes of the meeting held on 28 January 2015 were APPROVED as an accurate record of the meeting.</p>	
3.2	<p>Action Log</p> <p>The Action Log was considered and the following updates were received and noted:</p> <p>Action 30/07.10 – VBC. It was noted that it had been agreed to pause the process in order to seek greater assurance over the proposals by Haringey CCG covering Older People with Frailty. A report would in due course be considered by the Executive Committee and the Business Case for Integrated Care will continue to be developed through the Better Care Fund. This action should be closed.</p> <p>Action 28/01.21 – Extension of the NHS 111 and Out of Hours contract – discussed on agenda under Item 6.1. The Governing Body approved the business case. Closed.</p> <p>Action 28/01.24 – this could be closed as the Pharma Policy is now on the</p>	Board Sec to update

	intranet.	
4	QUESTIONS FROM THE PUBLIC	
	<p>The Chair referred to the written response to the public questions that had been circulated at the meeting.</p> <p>Hospital Performance – Stroke Network. Mr Smith clarified his question and asked if the Stroke Network was working as it should be. He felt that given what he had been advised there may be a problem in discharging patients.</p> <p>The Chief Officer responded by commenting that she was aware that there had been an issue in recent weeks around enabling patients to return to home which appeared to be more about hospitals managing capacity.</p> <p>Mr Smith agreed to raise the issue direct with the providers.</p> <p>Article around GP Practices being asked to open on Easter Saturday</p> <p>Mr Smith was looking for clarification around the Easter opening for GP surgeries/health centres over the Easter Weekend.</p> <p>It was noted that the Golders Green pharmacy is open 7 days a week. It was agreed to place this and other information around Easter opening on the CCG web site.</p> <p>NHS111 and Out of Hours Service: these were considered as part of the Out of Hours item.</p>	CCG Comms
5	OVERVIEW REPORTS	
5.1	Chief Officer’s Report	
	<p>The Chief Officer gave an update on the following:</p> <ul style="list-style-type: none"> • Future meeting dates of Enfield CCG Governing Body which have been revised in response to recommendations arising from a review of Enfield CCG’s Financial Governance; • Pathway Transformation; • A response to the joint bid submitted to the Prime Ministers’ Challenge Fund by Enfield and Barnet CCGs is expected by 27 March 2015; • NHS England Deep Dive on Domain 6 (<i>Does the CCG have strong and robust leadership?</i>): this resulted in an Assured rating for the CCG; • Conflicts of Interest Policy Update – Enfield CCG is working with neighbouring CCGs in North Central London to develop a consistent policy in relation to co-commissioning proposals and NHS England statutory guidance published in December 2015. During a discussion there was a recognition of the need to achieve a balanced approach – on the one hand ensuring clinical engagement to support developing the best possible service specifications but acknowledge that some GPs would need to withdraw from the decision making process due to them holding a direct pecuniary interest; 	

	<ul style="list-style-type: none"> • MSK Update – The timetable for this procurement is being revised following a Provider Impact Assessment, which clarified how changes in the model will affect individual providers. It was anticipated that the procurement process would commence mid May 2015; • London Statutory Participation Duty Thematic report in which Enfield CCG has been referred to as a model of good practice; • IPSOS Mori 360° Stakeholder Survey which is due to close on 3 April 2015; • Staffing changes; • An update on the following meetings <ul style="list-style-type: none"> ○ Executive Committee on 18 February 2015 and 18 March 2015 ○ Procurement Committee on 11 February 2015 <p>RESOLVED: That the Chief Officer’s report be noted.</p>	
5.2	Chair’s Report	
	<p>The Chair updated the Governing Body regarding the inaugural meeting of the Enfield Integration Board held on 18 February 2015 and attended by representatives from local providers and GP networks.</p> <p>RESOLVED: That the Chair’s report be noted.</p>	
6	STRATEGY AND PARTNERSHIPS	
6.1	NHS 111 and Out of Hours	
	<p><i>The GPs with direct pecuniary interests withdrew from the meeting room for the following item and items 6.3 and 9.4. The Lay Vice Chair acquired Chair duties. Following consultation with the Chief Officer and the Board Secretary, the Vice Chair referred to paragraph 34 of the constitution and announced a decision to revise the quorum as follows: To allow five GB Members including the Chief Officer, the Chief Financial Officer, Karen Trew (Lay GB Member & Vice-Chair), Angela Dempsey (Lay GB Member), Dr Janet High (GP Governing Body Member) and Professor Robert Elkeles (Secondary Care GB Member) as it was possible to have a quorum of 5 GB Members albeit without the normal composition that included 3 Clinical Leads.</i></p> <p>The Director of Strategy and Partnerships presented the Governing Body with the NHS 111 and GP Out of Hours (OOH) business case which details the clinical model principles and associated financial modelling of an integrated 111/OOH service across NCL. It was noted that the Governing Body meeting in private, preceding this meeting, had approved the financial case on the basis of the enhanced service.</p> <p>There are currently three contracts for 111 and OOH services across NCL and differences exist in the level of service provision. Therefore the key aims of the integrated procurement are as follows:</p> <ul style="list-style-type: none"> • A more streamlined patient pathway; • A consistent model of care across NCL; • Improved information sharing; • Improved management of workflow and staffing; 	

	<ul style="list-style-type: none"> • More streamlined contract and performance management. <p>The Director of Strategy and Partnerships offered reassurance to the Board on the following points:</p> <ul style="list-style-type: none"> • the integrated service will enable a more consistent triage service based on the clinical needs of the patient; • the integrated model should be more attractive to prospective clinicians and support a diversified skill mix; • a solid set of Key Performance Indicators will be built into the contract and monitored through a performance dashboard and routine contract monitoring procedures. <p>Deborah Fowler raised a question as to how patient experience is captured and measured. Clare Kapoor, NCL 111/OOH Programme Manager, confirmed that patient experience is currently captured through patient satisfaction surveys and reported to the 111 Clinical Quality Review Group on a quarterly basis and it is intended that this will continue with the new contract. A proposal to include this data into ECCG’s monthly Integrated Performance Report will be considered.</p> <p>RESOLVED that:</p> <ul style="list-style-type: none"> • the contents of the report be noted; • that the business case be approved. 	CK/EN																
6.2	London Transformation Project																	
	<p>The Chief Officer presented a report detailing the progress to date in agreeing London wide collaborative transformation priorities through the Commissioning System Design Group (CSDG), which was established in August 2014 as a collaborative working group between London’s CCGs and NHS England (London). The group’s remit is to develop a proposal on how extra value could be secured through working together to help deliver future transformation, and in particular to respond to the recommendations set out in the London Health Commission’s report. The NCL representatives in the group are Sarah Price (Chief Officer, Haringey CCG) and Dr Debbie Frost (Chair, Barnet CCG). There will also be input from the Strategic Planning Group.</p> <p>The group have agreed the following thirteen collaborative transformation programmes, which are consistent with NHS Enfield’s transformation priorities, and the paper provides an update on how the associated programmes are proposed to be developed further to enable commissioners to deliver change within boroughs and across Strategic Planning Group arrangements</p> <table border="1" data-bbox="289 1528 1323 1797"> <thead> <tr> <th>CLINICAL PROGRAMMES</th> <th>ENABLER PROGRAMMES</th> </tr> </thead> <tbody> <tr> <td>Urgent and emergency care</td> <td>Primary Care</td> </tr> <tr> <td>Children and young people</td> <td>Business intelligence and interoperability</td> </tr> <tr> <td>Mental health</td> <td>Estates</td> </tr> <tr> <td>Cancer</td> <td>Engagement and personalisation</td> </tr> <tr> <td>Prevention</td> <td>Payments and funding</td> </tr> <tr> <td>Homeless healthcare services</td> <td>Specialised commissioning</td> </tr> <tr> <td></td> <td>Workforce</td> </tr> </tbody> </table> <p>The Chief Finance Officer confirmed that the 0.15% factored into the plans for CCG Transformation funding in 2015/16 will be funded through the NCL Transitional Fund (formally known as the NCL Risk Share).</p>	CLINICAL PROGRAMMES	ENABLER PROGRAMMES	Urgent and emergency care	Primary Care	Children and young people	Business intelligence and interoperability	Mental health	Estates	Cancer	Engagement and personalisation	Prevention	Payments and funding	Homeless healthcare services	Specialised commissioning		Workforce	
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	<p>Members of the Board made the following comments and suggestions in relation to the project:</p> <ul style="list-style-type: none"> • The concentration of the project should be intensive and focused on specified outcomes • The programme deliverables should be absolute in order to determine success • There is lack of clarity on how the funds, which appear to be a relatively small amount of money to cover the thirteen programmes, will be effectually utilised. • A way of mapping Enfield's benefits will be required • Duplication across the thirteen programmes should be avoided <p>The Chief Officer proposed that the thirteen programme mandates be reviewed at a future meeting of the Governing Body for the Board's assurance.</p> <p>RESOLVED that:</p> <ul style="list-style-type: none"> • the thirteen priority programmes to be developed and progressed over for 2015/16 be agreed; • the interim London-wide programme governance arrangements, recognising that further proposals will be brought back to CCGs with regard to final governance arrangements be agreed; • the proposed maximum CCG transformation funding for 2015/16 of 0.15%, at this stage for planning purposes be agreed • the next steps for programme and resource development be agreed. 	LW/GM
6.3	Primary Care Co-Commissioning	
	<p><i>This item was taken following Item 6.1, whilst Governing Body members with declared conflicts of interest were absent from the room.</i></p> <p>The Director of Strategy and Partnerships updated the Governing Body that the North Central London CCGs submitted an application, including draft governance documents developed in consultation with constituents and stakeholders, to take on joint commissioning responsibility for Primary Care with NHS England on 30th January 2015. This follows guidance issued by NHS England in November 2014, CCGs were invited to submit proposals for co-commissioning that fall into one of the following categories:</p> <ul style="list-style-type: none"> • Greater involvement in Primary Care decision making • Joint Commissioning • Delegated Commissioning <p>Enfield CCG submitted proposals related to joint commissioning which will enable the opportunity to provide with greater strategic oversight and the opportunity to shape the way in which primary care develops. The CCG's Primary Care Strategy for the next five years will sit alongside the co-commissioning arrangements to deliver a clear set of outcomes for Enfield patients.</p> <p>During the discussion, the Governing Body clarified membership of the joint committee and the likely representation from each CCG. It was noted that meetings would be held in public. There was also reference to a discussion around the 5 Borough plan in October 2015 and that this would enable a</p>	

	<p>discussion on the desired health outcomes for Enfield.</p> <p>RESOLVED: That the Primary Care Commissioning proposals, including the governance documents, be approved.</p>	
6.4	2015/16 Operating Plan	
	<p>The Director of Strategy and Partnerships presented the paper to update the Governing Body on the progress of developing Enfield CCG's Operating Plan for 2015/16.</p> <p>Enfield CCG has successfully submitted the Operating Plan Narrative, Finance and Activity Plan and the UNIFY submission in accordance with the guidance and feedback is awaited from NHS England. Owing to difficulties agreeing the national tariffs, a new timetable for contracting and planning submissions has been issued.</p> <p>The Director of Strategy and Partnerships updated the Board that validation work is ongoing around the current activity in the main Acute contracts against the assumptions in the plan.</p> <p>RESOLVED: That the above report be noted.</p>	
6.5	Mental Health Transformation Board	
	<p>The Chief Officer presented a report which updates the Governing Body on the Barnet, Enfield and Haringey Mental Health Transformation Board.</p> <p>The Board was formed in December 2013 and has membership that includes representatives from BEHMHT, Barnet Enfield and Haringey CCGs and Local Authorities, the Trust Development Authority and NHS England.</p> <p>Following the Board's receipt of a report commissioned from an independent, expert organisation, 'Mental Health Strategies', the Board agreed on Terms of Reference and specific work streams as follows:</p> <ul style="list-style-type: none"> • Reduce in patient Delayed Transfers of Care (DTOC) and develop a system wide Discharge Policy • Estates review and opportunities for estate rationalisation • Crisis Service Review regarding access and exploring potential opportunities for new solutions to crisis management. • Rehabilitation Commissioning opportunities • Service and workforce redesign - Enablement <p>A question was raised around the monitoring of ensuring value for money against services delivered by BEHMHT. The Chief Officer assured the Governing Body that performance reports demonstrate value for money.</p> <p>During discussion it was noted that Haringey CCG had approved the redevelopment of the St. Ann's Hospital site.</p> <p>RESOLVED: That the above report and positive achievements be noted.</p>	

7	FINANCE, CONTRACTS AND PERFORMANCE	
7.1	Financial Recovery and QIPP Committee Report	
	<p>The Chief Finance Officer presented a summary of the items discussed by the Financial Recovery and QIPP Committee at its last two meetings on 10 February 2015 and 10 March 2015.</p> <p>The Finance Recovery and QIPP Committee had productive meetings which included the following business:</p> <ul style="list-style-type: none"> • An update on the proposed section 75 agreement with London Borough of Enfield. • An update on the month 10 financial position which, in line with month 9 and the Deloitte review, showed a £19m deficit. • An update on the contract monitoring report • A detailed run through of the CCG financial recovery plan submission of 27 February 2015 to NHSE • Update on the OOH business case • Verbal update on the Financial Governance review commenced by the CCG <p>RESOLVED: That the above report be noted.</p>	
7.2	Finance Performance as at Month 11	
	<p>The Chief Finance Officer presented the financial performance update for the period up to 28 February 2015, including progress on the QIPP programme. This report included:</p> <ul style="list-style-type: none"> • A summary of the position as at month 11 and a forecast position for the year ending 2014/15 • A contract update • A position for the QIPP <p>It was noted that the Month 11 cumulative results are a deficit of £17.6m against a planned deficit of £5.3m, £12.4m over target. The CCG forecasts a deficit of £19.0m for the year, £13.4m in excess of the control total.</p> <p>The deterioration in the CCG budget is due to an over performance on Acute contracts which currently stands at £10.8m over performance at Month 11 and £12m over performance forecast for year end. A year-end arrangement has been agreed with NMUH which removes any further risk from the forecast for that Acute contract.</p> <p>A provision of £1.2m is included in the Mental Health, Continuing Care and Learning Disabilities expenditure to allow for disputed liability cases to be determined. An improvement in cash management was noted, specifically detailing that Enfield CCG is meeting the target to pay 95% of creditors within 30 days as per the Better Payment Practice Code.</p> <p>The new format of report and improved quality of information provided was welcomed.</p> <p>RESOLVED: That the above report be noted.</p>	

7.3	Integrated Performance Report for March 2015	
	<p>The Director of Operations highlighted the key issues arising from the Integrated Performance Report for March 2015.</p> <p>North Middlesex Hospital (NMUH)</p> <ul style="list-style-type: none"> • A&E performance against 4 hour national standard deteriorated in February 2015 after four consecutive weeks of meeting the 95% target. • Ambulance turnaround-times breaches in January dropped further following the validation exercise that was carried out. Remedial actions are monitored via the SRG led by Haringey CCG. • No MRSA cases reported for this financial year. <i>C. Difficile</i> cases are under review and learning from cases attributed to lapses in care are being embedded in the organisation. • All 18 weeks RTT and cancer wait standards are being met • The proportion of positive responses from Friends and Family Test (FFT) surveys has declined in recent months although response rates continue to improve. This is managed through the Clinical Quality Review Group (CQRG). <p>Barnet Hospital & Chase Farm Hospital sites</p> <ul style="list-style-type: none"> • Barnet & Chase Farm sites of RFL Trust met the 95% performance standard for February 2015 achieving an average of 96% for the month. • One case of MRSA at BCF in January 2015 bringing the year-to-date total to 5 cases. Six new <i>C. Diff</i> cases reported in January bring YTD total to 50 against the annual ceiling of 54. There is on-going work to integrate infection control measures across all sites to minimise the risk of <i>C. Diff</i> infections. • Positive responses to FFT surveys and response rates for A&E, Inpatients and maternity services remained high in January with the exception of response rates for maternity services which continued to track below the 15% recommended. <p>Mental Health Services - BEH-MHT</p> <ul style="list-style-type: none"> • Provisional data shows improvements in IAPT access rates in January and February in line with CCG expectations for achieving the 2.5% (10% annual run rate) in Q4 of 2014-15. <p>London Ambulance Service (LAS) Performance</p> <ul style="list-style-type: none"> • 52.5% of the Category A call outs in Enfield were responded to within the 8 minutes service standard. London-wide performance has improved slightly in recent weeks but still below the 75% target. The Trust remains at REAP (Resource Escalation Action Plan) level 4 (Severe) and actions to address resource constraints continue to be monitored at weekly tri-partite meetings with commissioners, NHSE and TDA. Contributing factors for poor performance are attributed as volume of calls, vehicle availability and staffing recruitment and retention. The improvement plan is held with North West London CCG and a detailed business case on performance improvement over the next two years is awaited. <p>RESOLVED: That the above report be noted.</p>	

8	QUALITY AND SAFETY	
8.1	Quality and Safety including Committee Report	
	<p>The Governing Body received a report that updates on Enfield CCG's work to improve quality and presented key quality and safety areas within the CCG Quality Strategy and Implementation Plan.</p> <p>The Quality and Risk Sub Group met on 11 February and 4 March 2015. The Quality and Safety Committee met on the 18 February 2015 and the paper summarises papers received by the sub-committees, as well as an update on quality issues discussed through the CQRGs.</p> <p>The report provides assurance that Enfield CCG is upholding its responsibility and commitment to commission safe, high quality and value for money health services for the population of Enfield.</p> <p>Positive areas of note in the report include ECCG's commendable work with the Winterbourne View, Mental Capacity Act and Deprivation of Liberty Safeguard (MCADOLS) and the Pressure Ulcer Protocol.</p> <p>RESOLVED that:</p> <ol style="list-style-type: none"> a) the Quality and Safety report be noted; b) no issues were raised for further clarification; c) the Information Governance Policy updates summarised in section 8 of the attached report be endorsed. 	
9	GOVERNANCE	
9.1	Audit Committee Report	
	<p>The Governing Body received the report which summarised the reports reviewed at the meeting of the Audit Committee on 18 March 2015.</p> <p>The reports includes:</p> <ul style="list-style-type: none"> • Review of Committee Effectiveness for the Financial Recovery and QIPP Committee • Review of risks in the Strategy and Partnerships and Finance Directorates • Governance Review of CCG Sub-Committees • Review of reports from Internal Audit including Local Counter Fraud Service's (LCFS) update on progress and draft plan for 2015/16, CCG Assurance report and draft 2015-16 Internal Audit plan • Review of External Audit reports including 2014-15 Interim Audit Programme for CCG Accounts, External Audit Update Report and Outline Plan for Annual Report & Accounts • Review and recommendation of the Anti-Bribery & Anti-Fraud Draft Policy • Review of the Gifts and Hospitality and sponsorship register • Financial Matters reports on (a) Losses and compensation, (b) Debtors & (c) Waivers <p>The Chair of the Audit Committee advised the Governing Body that the timetable for signing off the Annual Report and Accounts meant that the Audit Committee would need to approve the Annual Report and Accounts at its meeting on 27 May.</p>	

	<p>It was noted that the Governing Body was not due to meet until 10 June 2015.</p> <p>RESOLVED that:</p> <ul style="list-style-type: none"> a) the Audit Committee report be noted; b) the Audit Committee be authorised to consider and approve the Annual Report and Accounts on behalf of the CCG Governing Body; c) the Anti-Fraud and Anti-Bribery policy be approved. 	KT/RW/ DT
9.2	2015-16 Corporate Objectives	
	<p>The Director of Operations presented the proposed 2015/16 Corporate Objectives for ECCG which have been developed through a process of analysis against National and Local requirements and reviewed with Staff, Directors and Governing Body members. A process to identify measures of success has also been undertaken.</p> <p>Regular reports on progress will be provided to the Executive Committee and Governing Body and risks to delivery will be identified and aligned with the Board Assurance Framework.</p> <p>Shahed Ahmed commented that the measures of success should make reference to health inequalities.</p> <p>RESOLVED that:</p> <ul style="list-style-type: none"> a) the 15/16 Corporate Objectives be agreed; b) the progress on the measures of success be noted. 	JP
9.3	Board Assurance Framework and review of Strategic Risks	
	<p>The Governing Body reviewed the Governing Body Assurance Framework (GBAF) which sets out the strategic risks (12+) to achieving the CCG's strategic objectives and priorities. They include risks associated with quality and safety, maximising productivity, efficiency and cost effectiveness.</p> <p>The GBAF (also known as the Board Assurance Framework or the BAF) is an important document for providing external assurance (for example to NHS England, Audit and the public) that Enfield CCG is sighted on its risks and has a robust system of internal control. The Governing Body is only properly able to fulfil responsibilities through an understanding of the principle risks facing the organisation.</p> <p>The report highlighted the key changes made to the BAF since the last Governing Body meeting of 28 January 2015.</p> <p>A query was raised as to why Risk 31 (<i>risk that Trust Development Authority (TDA) may not authorise BEHMHT to proceed to FT status</i>) does not have a corresponding risk around North Middlesex University Hospital's (NMUH) application for Foundation Trust status. The Chief Officer assured that the Board that the risk of the TDA not authorising NMUH to proceed to Foundation Trust status is perceived as a much lower possibility.</p> <p>RESOLVED that:</p> <ul style="list-style-type: none"> a) the new risks be noted; b) the extreme risks be noted; 	

	<p>c) the escalated, de-escalated and closed risks be noted;</p> <p>d) the transfer of TPG risks be noted;</p> <p>e) no comments were raised around the draft strategic risks;</p> <p>f) it was noted that the Risk & Governance Team will support Directors in describing their Departmental risks using the RMS cause and effect model, score their risks, with controls, actions and gaps for the 13 April Directors Meeting, review at the April meeting of the Executive Committee and the June meeting of the Governing Body;</p> <p>g) it was noted that the Risk & Governance Team will transfer the agreed risks to the new template, update Datix and train staff on the changes to the agreed new template;</p> <p>h) noted that the 2015/2016 BAF will be presented to the May meeting of the Audit Committee;</p> <p>i) it was noted that the Risk & Governance Team will align outstanding 2014/2015 risks to the 205/2016 strategic risks.</p>	BP/VA
9.4	Changes to ECCG Constitution	
	<p><i>This item was taken following Item 6.3, whilst Governing Body members with declared conflicts of interest were absent from the room.</i></p> <p>The Board Secretary updated the Governing Body on the proposed changes to the Enfield CCG Constitution.</p> <p>The proposed changes will enable co-commissioning of primary care services with North Central London CCGs and NHSE and is in line with NHS Guidance, “Next Steps towards Primary Care Co-Commissioning” published on 10 November 2014, which stipulates that in order to facilitate co-commissioning CCGs need to submit changes to their Constitution to NHSE by 30 January 2015.</p> <p>The proposed additional wording is detailed in paragraphs 47.3, 47.4 and 47.5 of Part 7 of the Constitution.</p> <p>RESOLVED: That the proposed changes to the Constitution are approved.</p>	
9.5	Whistleblowing Policy	
	<p>The Director of Operations introduced the Whistleblowing policy which has been updated to reflect internal staffing arrangements and to include additional resources for staff to access for further assistance.</p> <p>The policy has been amended as detailed below:</p> <ul style="list-style-type: none"> • The policy has been amended to reflect a change of internal senior staffing responsibilities in the CCG. • The policy now includes an independent Governing Body member as a contact should staff not wish to approach a line manager or other member of staff. • The policy now includes reference to alternative, available external resources. • Minor typographical errors have been removed. <p>RESOLVED: That the Whistleblowing Policy be approved.</p>	JP/JE

10	PATIENT AND PUBLIC ENGAGEMENT	
10.1	Public and Patient Engagement Committee Report	
	<p>The Governing Body considered a report that summarised the recent achievements as presented to the Patient and Public Engagement (PPE) Committee meeting held on 5 March 2015.</p> <p>The key achievements since the January report included:</p> <ul style="list-style-type: none"> • Equality Diversity System 2 (EDS2) Operational Plan progress tracker has been developed to enable the delivery of all the outcomes for the nine protected characteristics. • PPG Representative Election process – voting period from Monday 30 March to Thursday 30 April. • CCG Corporate Engagement Events held on 29 January (Public and Patient engagement and 4 March (GP member engagement). • Presentation to Enfield Heads of 6th Year concerning role of CCG; Choose Well campaign and a career in the NHS. • Lay member for Patient and Public Engagement and the Head of Communications and Engagement attended Enfield Vision meeting on 2 February 2015 to promote the Choose Well Campaign and provide information about the role of CCG. • A number of staff, including the Chair, attended the Over 50s Winter Fair, held in February, to promote a number of issues. • NHS 111/GP OOHs engagement events – a total of three events were held in February 2015. Further events are being organised. • Additional Communications and Engagement Support for the NHS 111/GP OOHs service. <p>The Governing Body noted a review of the key work areas for the next two months.</p> <p>Deborah Fowler noted the positive engagement with the public through the NHS 111/GP OOHs events.</p> <p>RESOLVED: That the above reports be noted.</p>	
11	REPORTS FROM CLINICAL LEADS	
	<p>The Governing Body received reports from individual Clinical Leads on the following disciplines:</p> <ol style="list-style-type: none"> 1. Integrated Care for older People (including Dementia) - Dr Janet High 2. Mental Health, Learning Disabilities and Continuing Healthcare - Dr Anshu Bhagat 3. Planned Care and Long Term Conditions - Angela Dempsey 4. Unscheduled/Urgent Care - Dr Hardeep Bhupal 5. Learning Disabilities and Safeguarding Adults - Dr Ujjal Sarkar 6. Maternity Children, Young People and safeguarding children - Dr Fahim Chowdhury 7. Royal Free London NHS Foundation Trust (including Barnet and Chase Farm Hospitals) contract - Dr Mike Gocman – no report. 8. Prevention and Primary Care - Dr Mo Abedi (Update on Primary Care Joint Commissioning in item 6.3) 	

	<p>9. Value Based Commissioning and North Middlesex University Hospital NHS Trust - Dr Alpesh Patel (update on contracts as part of Financial update)</p> <p>The format of the new reports was noted and the demonstration of alignment to the ECCG Operating Plan and Strategic Plan.</p> <p>RESOLVED: That the above reports be noted.</p>	
12	ITEMS FOR INFORMATION	
12.1	<p>Health and Wellbeing Board Minutes</p> <p>The meeting received and noted the minutes of the Health and Well Being Board of 12 February 2015.</p>	
13	<p>ANY OTHER BUSINESS</p> <p>No further business was cited.</p>	
14	<p>FURTHER QUESTIONS FROM THE PUBLIC ON AGENDA ITEMS</p> <p>No further questions were raised by the public in relation to items on the agenda.</p>	
15	<p>MEETING EVALUATION</p> <p>The Chair thanked everyone for their attendance and invited members of the Governing Body to complete the evaluation form attached to the agenda.</p>	
16	<p>DATE OF NEXT MEETING</p> <p>2.30pm on 10 June 2015 at Millfield House.</p>	

The Meeting commenced at 3.10pm and closed at 5.40pm.

ACTION LOG: Enfield Clinical Commissioning Group Board						
25/03/2015	25/03. 26	5.1	Conflict of Interest Policy: Amend in lieu of comments around clinical engagement	KT (Chair of Audit), AF & DT	Jun-15	The CoI Policy is on the agenda for approval. The comments around clinical engagement should be considered as part of the action plan arising from the Policy as this should influence the way in which the CCG decides to address to requirements of the NCL wide Policy and at the same time retain effective clinical engagement.
25/03/2015	25/03. 27	6.1	Consider 111 patient experience data into Integrated Performance Report	EN/CK	Sep-15	The FFT (friends and family test) is included in the IPR each month. This new data will be captured on a quarterly basis with the first report in September 2015.
25/03/2015	25/03. 28	6.2	London Transformation Project: How will Enfield's benefits be mapped?	LW	Oct-15	To review the thirteen programme mandates at the Governing Body to aid Board assurance.
25/03/2015	25/03.29	9.1	Audit Committee Report: (a) authority be given to the AC to sign off the Annual Report and Accounts. (b) Anti-Fraud and Anti-Bribery Policy. Publish approved Policy.	KT/RW/DT	29-May-15	Audit Committee approved the Annual Report and Accounts at its meeting on 27 May 2015. Anti-Fraud Policy published on the Intranet.
25/03/2015	25/03.30	9.3	BAF. To present the updated BAF to the June meeting of the Governing Body.	AF/BP/VA	10.06.15	On the agenda for this meeting
25/03/2015	25/03. 31	9.5	Whistleblowing Policy. To be published. Publish approved Policy.	JP/JE	10.06.15	Policy published on the intranet.

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE	10 June 2015
TITLE:	Chief Officer's Report
LEAD BOARD MEMBER:	Liz Wise, Chief Officer
AUTHOR & POSITION:	David Triggs, Board Secretary, on behalf of Liz Wise
CONTACT DETAILS:	Liz.wise@enfieldccg.nhs.uk

Summary:

This report updates the governing body on current matters in relation to NHS Enfield Clinical Commissioning Group not covered elsewhere on the agenda.

Recommended action:

The Governing Body is asked to note the updates contained in this report.

Objective(s) / Plans supported by this paper:

Audit Trail: None

Patient & Public Involvement (PPI): None

Equality Impact Assessment: Equality impact assessments are undertaken in relation to substantial commissioning changes and will be available where necessary in relation to individual work programmes

Risks: All risks identified are recorded on the NHS Enfield CCG risk register and board assurance framework, or available as part of individual work programmes

Resource Implications: Where relevant they are detailed, or available as part of individual work programmes

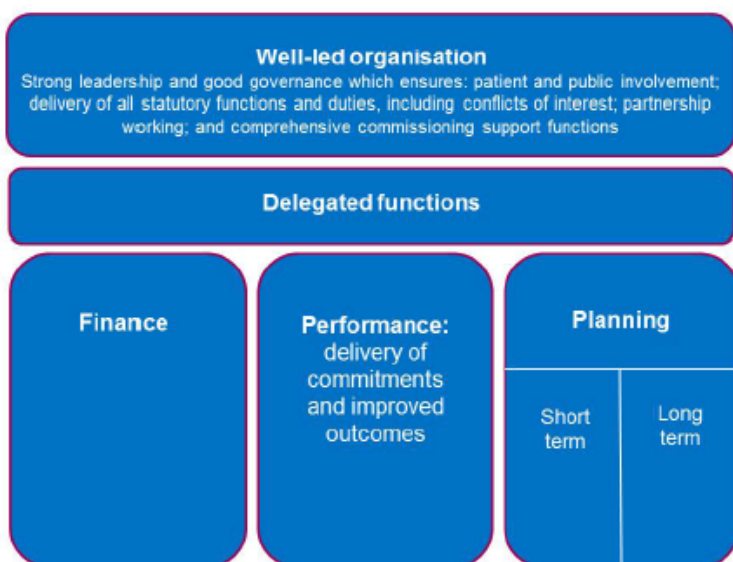
Next Steps: An updated report will be provided at each governing body meeting

NHS Enfield Clinical Commissioning Group

Chief Officer's Report

1. 2015/16 CCG Assurance Framework

NHS England has recently published the 2015/16 CCG Assurance Framework which sets their approach to CCG assurance in the this financial year. The diagram below shows the revised assurance domains, reflecting changes in the commissioning landscape and strategic direction of the NHS;



CCGs will now be assessed against the following 4 assurance categories to determine the nature of the oversight, including frequency of meetings with NHSE during the course of the year;

- **Assured as outstanding**: NHSE fully assured by CCG's performance across all 5 domains. Assurance process will be "light touch"
- **Assured as good**: Where CCG has minor concerns with performance, or has a higher level of risk but it is managing it effectively. CCG will be expected to produce their own 3-6 month improvement plans and report to NHSE. Support will be at the request of CCG.
- **Limited assurance, requiring improvement**: Where CCG has more serious performance or financial challenges and a high level of risk. CCG will be required to develop an improvement plan to recover within 12 months which will be approved and monitored by NHSE. This will include clear consequences if plans fail. CCG will be required to access additional support to ensure delivery.
- **Not assured**: Failing CCG or at risk of failing to discharge its functions. NHSE will conduct a thorough assessment to identify underlying causes and specify remedial actions for CCG.

Full operational manual manual is due to be published in late spring 2015

2. NHSE Office of London CCGs

The Office moves into its third year continuing the work of the previous years. Elections were held for all three network meetings' Chairs with both Andrew Eyres and Malcolm Hines continuing in their respective roles. Dr Marc Rowland of Lewisham CCG was elected to the role of Chair of the Clinical Leads after the retirement of Dr Howard Freeman. As one

of his first jobs, Marc organised a session with chairs to discuss a wide range of subjects including relationships with boards and members, transformation, business intelligence and devolution. The chairs were joined by senior leaders from NHS England and Local Authorities for some discussions.

The network meetings continue to run well with good attendance; and the website and newsletter are well received. The Office has also launched an app for iOS systems.

London Levies

The levies programmes finished the year in balance, despite additional work being done around the domiciliary care service specification (under the continuing care programme) and the national legal dispute with Air Liquide around home oxygen services. With support from London's CCGs, the CMC programme received national funding for a new IT system. New levies have been introduced for this financial year around mental health and the MyHealthLondon (MHL) website which transferred from NHS England (London) to the Office from 1st April 2015. The review of the MHL website has started in collaboration with Verve Communications, with plans to use the website for promotion of the transformation programmes.

Transformation Programmes

The transformation work started in September 2014, during this time the Office has formed close working relationships with the transformation team based at NHS England (London) and facilitated setting up the programme portfolio. Peter Kohn has been named Senior Responsible Officer for the Estates Programme, and Barbara O'Connor is involved in both the Homeless and Business Intelligence & Interoperability programmes.

3. MSK

The procurement for a lead provider to deliver a single integrated elective MSK system began on 11 May 2015. The current timetable means that we are looking for the new contract to commence in the autumn of 2016. The CCG is seeking a lead provider to work with all current providers of elective musculoskeletal services to ensure that the new system is effective for patients and focused on outcomes. All current MSK providers for Enfield patients, who may or may not become the lead provider, will continue to provide musculoskeletal services and will be part of the new system.

4. NHS 111 and Out of Hours Procurement

The procurement aims to bring together 111 and GP Out of Hours services to ensure the most effective pathways for patients from 111 into GP OOH with clinical triage being enhanced within the new system. The CCGs of north central London aim to procure a lead provider to commission all other providers as part of the new integrated system. There has been a pause in the process to enable further Patient and Public engagement into the development of the service specification prior to the commencement of the procurement. The procurement is expected to commence in the next few weeks.

5. Mental Health Transformation programme

Further work continues with Barnet and Haringey CCGs, the Trust, NHS England and the Trust Development Authority to develop plans as part of the sustainability of BEHMHT. An external review of BEHMHT has commenced to ensure a clear understanding of the Trust's financial position which will then be used to develop options for future sustainability. A Sustainability Steering Group has now been established which will oversee this work.

6. North Central London strategy plan update

An external review has been commenced which aims to develop the clinical and financial case for change for the health economy of north central London. The aim is to support the case for transformation across North Central London and ensure that CCGs are able to collaborate collectively in areas where it makes most sense to work together. It is expected that the review will report its initial findings and recommendations later this month.

7. IPSOS Mori – Stakeholder Survey

NHS England has again commissioned Ipsos MORI to carry out a 360° Stakeholder Survey as part of the assurance process and to support the CCG with its continuing organisational development. This survey period was carried out from 10 March 2015 to 7 April 2015. The response was higher than last year's at 68%. A preliminary review of the results shows that we need to undertake a deeper analysis to identify the actions needed to make the improvements necessary in our ongoing organisational development and relationships with the variety of our shareholders. The improvement action plan will be developed and refined following the NHS England Assurance meeting on 10 June concerning Patient and Public involvement.

8. Revalidation

Revalidation is being introduced for all Nurses and Midwives on the Nursing and Midwifery Council (NMC) register and will replace the current registration requirements. From April 1st 2016 all Nurses and Midwives will be required to Revalidate every 3 years to confirm that they meet the requirements of revalidation. Revalidation builds on the current registration standard which requires registrants to confirm that they have completed 450 hours of registered practice and 35 hours of learning activity (Continuing Professional Development) in the previous three years.

Revalidation will require the registered Nurse or Midwife to provide evidence of the following

- Practiced for 450 hours during the last three years. (No change)
- Adhered to the requirements for continuing professional development, including participatory learning. (Increase in number of hours required and change in methods of learning).
- Obtained confirmation from a third party on their continuing fitness to practise. This will be from their line manager or an NMC registrant if their line manager is not on the NMC register. (Additional requirement)
- Demonstrated how they are using practice related feedback from a variety of sources, including patients, to improve their standards of care. (Additional requirement)

To ensure that Nurses and Midwives can revalidate at the required time employers will need to ensure that their employees have access to the following

- Support in undertaking the required continuous professional development
- Peer to peer review
- Fit for purpose appraisals
- Support in gaining feedback on their clinical practice.
- A named confirmer to confirm that they meet the requirements.

The CCG employs nurses who will need to meet revalidation requirements in the following areas: Continuing healthcare (CHC), Safeguarding (Adult and Children) and the Quality team. Work is already progressing within CHC, Safeguarding and the Quality team to ensure that clinical supervision is accessible for relevant staff and the Quality team have been supporting the development of an updated policy. All Registered Nurses will recently have received the new NMC Code of Conduct and they will be required to revalidate

against the new code. Nationally there are pilots testing the revalidation model and these will inform the NMC implementation programme. The NMC website holds provisional pilot guidance on how to revalidate, guidance for confirmers and revalidations templates available for download.

There is a parallel work stream taking place to support General Practice employers and the nurses they employ to be aware of and prepared for revalidation.

Regular updates will be presented to the Executive Committee to ensure that they and the Governing Body are fully apprised of revalidation developments and CCG preparation.

8. Patient Participation Group elected Representative

We are pleased to announce that Litsa Worrall, Chair of Arnos Grove Medical Centre's PPG in the South West Enfield locality has been elected to the role of PPG representative on our Governing Body and Patient and Public Engagement Committee for a three year term.

The election process was managed externally by Electoral Reform Services and the results of this election have been independently verified.

The elected PPG candidate is the voice of our member practice's Patient Participation Groups and according to our Constitution; she is a non-voting member of the Governing Body with speaking rights only. The elected PPG representative will also sit on our Patient and Public Engagement Committee, which is the sub-committee of the Governing Body responsible for the delivery of the communications and engagement strategy and equality and diversity duties.

At committee level, the elected PPG representative will help us to ensure that our communications and engagement plans meet the needs of our diverse communities and also help us to understand how to work with and support the further development of PPGs. The elected PPG representative will also chair the PPG network meetings and work closely with PPGs all to listen to their views and help them to work collectively together.

We believe that we are the first CCG in the country to have a democratically elected PPG representative on our Governing Body. We hope that every PPG group in Enfield will take an active role in supporting and working with their chosen representative to ensure that they are representing their views at the highest level of our organisation. Further details can be found at: <http://www.enfieldccg.nhs.uk/news/AnnouncementofPPGelectionresults.html>

9. Governing Body and Staffing Changes

Dr Anshu Bhagat and Dr Mike Gocman have recently stepped down from the Governing Body and the election process has commenced with the view to filling the two vacancies that exist on the Governing Body. The CCG welcomes Mike Seitz – Interim Recovery Director, to the CCG. His role will be to oversee the CCG's delivery of the QIPP.

10. Executive Committee Report

The Executive Committee met on 22 April and 27 May 2015. The following was considered:

22 April 2015:

- Integrated Performance Report (IPR)
- Review of Executive Committee Effectiveness
- Financial Performance update on month 12

27 May 2015

- Integrated Performance Report for March 2015
- Finance Performance update on Month 1
- Update on 2015/16 Contracts
- Locality Commissioning Business Meetings
- Report from Locality Leads
- Executive Committee Workplan

11. Procurement Committee Report

The Procurement Committee met on 8 April, 6 May and 3 June 2015. At its last meeting the Committee reviewed the following:

- MSK Procurement
- GP Provider Networks
- Procurement Policy. The Procurement Policy is included as part of a later report as a recommendation from the Procurement Committee to the Governing Body to approve this Policy.

Liz Wise

Chief Officer – 10 June 2015

Minutes of the inaugural meeting of
Enfield Integration Board

Held on 18th February, 2015 at Enfield CCG, Holbrook House, Cockfosters Rd.

<u>Voting Members:</u>	
Dr Mo Abedi (MA) (Chair) CCG Chair	Eve Stickler (ES) Representing the Director of Schools and Children's Services, LBE.
Graham MacDougall (GM) Director of Strategy and Partnerships, ECCG. Also representing the CCG Chief Officer	Bindi Nagra (BN) Assistant Director Strategy and Resources – HHASC, LBE Also representing the Director of Health, Housing and Adult Social Care, LBE
Christine Whetstone (CW) Representative from Enfield Voluntary & Community Sector	Lorna Reith (LR) Healthwatch Enfield
<u>Non-Voting Members:</u>	
Lorraine Davies (LD) Assistant Director, Adult Social Care - HHASC	Robert Whiteford (RW) Chief Finance Officer, ECCG.
Maria Kane (MK) Chief Executive – Barnet, Enfield & Haringey Mental Health NHS Trust	Kim Fleming (KF) Director of Planning Representing the Chief Executive – Royal Free Hospital NHS FT
Dr Charles Boakye (CB) Primary Care Provider Representative	Mark Tickner (MT) Representing Director Public Health
Richard Gourlay (RG) Director of Operations Representing the Chief Executive – North Middlesex NHS Trust	
Richard Young (RY) Interim BCF Programme Manager	Fiona Coyne (FC) BCF Project Manager

4pm meeting opened.

1. Apologies & Welcome

Apologies – D Fowler, A Fraser, R James, V Giladi, L Wise, T Fenn

The Chair, Dr Mo Abedi, welcomed everyone to the first meeting of the Enfield Integration Board. He outlined that the dual focus of the group would be to design and drive through greater levels of integration between health and social care services within Enfield as well as manage the programme of the Better Care Fund on behalf of the Health and Wellbeing Board (HWB) within its scheme of delegation.

Declarations of Interest: The Chair highlighted that there was no opportunity on the agenda for any party to declare any interests. A debate ensued covering under what circumstances individuals or organisations were required to declare an interest. This

included organisations providing existing or (potentially) future services. It was noted that there was a clause in the draft terms of reference that attempted to deal with this issue. Members were invited to consider this and suggest any amendments back to RY.

2. Terms of Reference for the Enfield Integration Board

RY introduced the draft Terms of Reference. These were supported in principle by the Board and members were invited to send any comments directly to RY before the next Board meeting.

In addition, it was agreed that the Board would meet again in March and from April would then move to a bi-monthly meeting calendar to alternate with HWB. The Chair would then prepare a report to go to the HWB from this Board.

3. Better Care Fund Programme

GM and BN led the discussion broadly setting out the plan / vision for the Better Care Fund. It was recognised that the Board had an excellent opportunity to look beyond the Better Care Fund remit for integration across public care services.

There were questions from the meeting around how much of the £12.6m fund was set aside in the Contingency (£1.5m) and how Section 256 monies related to the national requirement for the protection of social care.

Action: RY was requested to provide a brief overview of the plan for the next meeting – outlining the programme schemes and ambitions and setting out the targets required of the BCF Plan.

The Board agreed that the focus for the group was to ensure delivery against the Plan and make sure the 'system' works at a broader level.

4. Financial Report / Overview

RW introduced the report outlining the BCF schedule within the draft section 75 agreement and the financial programme associated with it.

The Board approved the draft section 75 (this was also approved by HWB separately).

It was agreed that a three-year budget plan would be constructed and discussed at a future meeting. It was noted that there was no certainty over planning assumptions beyond 2015/16 in regards to BCF and that policy may change after the forthcoming election. However, it was also recognised that there was a genuine intention to continue this work – irrespective of policy mandate following the election result.

5. Re-setting / Confirming Emergency Admissions Reductions Target

RY introduced this paper which set out the opportunity for local partnerships to re-base the threshold and target for emergency admission reductions now that actual data was available. (Original plans were submitted on the basis of part 'actual' data and part 'planned activity'. Any new target or re-base would be required to be submitted via the CCG Operating Plan Process.

It was agreed that a further paper would be brought back to the Board but that the original target of 3.5% would be applied to the new baseline for the purposes of a planning assumption for the draft submission of the Operating Plan (due at the end of February).

6. Business Case Development

An analysis of progress with project Business Case development was shared for information. These projects would be the subject of future detailed reports. A 'benefits realisation matrix' would also be presented at a future meeting.

7. Calendar of Meetings / Forward Plan

The draft Forward plan was circulated. This would be populated over time with additional business, such as the consideration of project specific business cases.

It was agreed that the Board would meet in March or April and then move to a bi-monthly schedule, timed at least two weeks before a HWB.

8. Any Other Business

No Further AOB was discussed.

Meeting closed at 5.35pm

Minutes of the meeting of Enfield Integration Board

Held on 22 April 2015 at Enfield CCG, Holbrook House, Cockfosters Rd.

Voting Members:	
Dr Mo Abedi (MA) - Chair CCG Chair	Bindi Nagra (BN) Representing the Director of Health, Housing and Adult Social Care, LBE
Liz Wise (LW) CCG Chief Officer	Deborah Fowler (DF) Healthwatch Enfield
Eve Stickler (ES) Representing the Director of Schools and Children's Services, LBE	Apologies Representative from Enfield Voluntary & Community Sector
Non-Voting Members:	
Kim Fleming (KF) Director of Planning Representing the Chief Executive – Royal Free London NHS Foundation Trust	Richard Gourlay (RG) Director of Operations Representing the Chief Executive – North Middlesex NHS Trust
Andy Graham (AG) Executive Director of Patient Services Representing the Chief Executive – Barnet, Enfield & Haringey Mental Health NHS Trust	Dr Sanjay Patel (SP) Enfield Healthcare Alliance
Graham MacDougall (GM) Director of Strategy and Partnerships, ECCG	Robert Whiteford (RW) Chief Finance Officer, ECCG
James Rolfe (JR) Director of Finance, Resources & Customer Services, LBE	Tha Han (TH) Representing the Director of Public Health, LBE
Richard Young (RY) Interim BCF Programme Manager	Fiona Coyne (FC) BCF Project Manager, LBE
In attendance:	
Dr Eyal Lebovich Clinician Barnet, Enfield & Haringey Mental Health NHS Trust	Dr Ioana Popescu Clinician Barnet, Enfield & Haringey Mental Health NHS Trust
Paul Allen Integrated Care Programme Manager	

4pm meeting opened.

1. Welcome and Apologies

Apologies – Lorraine Davies

The Chair, Dr Mo Abedi, welcomed everyone to the second meeting of the Enfield Integration Board (EIB).

2. Declarations of Interest

None declared

3. Minutes of the Meeting Held on 18 February 2015

Agreed, but KF raised an issue that was discussed but not recorded in the minutes – i.e. resolving the issue of the beds at Chase Farm Hospital that remain open.

Action: Carry forward 'Reprovision of Chase Farm bed capacity' to next meeting.

4. Terms of Reference for Integration Board

RBV had received two comments back from members and had inserted sections on 'declaration of interests' and 'management of change processes' into draft ToR. It was **agreed** to formally adopt the EIB Terms of Reference.

Both Sub-Groups' TORs have been drafted and will come to the EIB meeting in May. For the Programme Delivery Group (PDG), the proposal is that because most of these schemes are already managed in other places and adequately governed therefore it is suggested that these schemes continue to be performance managed by the originating organisation and the PDG co-ordinates those performance management functions.

Action: circulate Draft sub-group ToR by email, obtain comments and formally agree at next meeting

Action RBV to map old Enfield Integrated Care Programme Board functions to new boards / groups appropriately. Map out, list members of each, e.g. Care Act Board. Useful to see overlaps.

5. Presentation: BCF Overview

RBV presented an overview of the BCF programme.

Action: Circulate slide pack to members with minutes.

In response to questions and comments, it was **noted** that:

- There were currently not any BCF programmes / initiatives awaiting approval (many schemes had started in 14/15 or were existing services)
- Stakeholder engagement options required
- Important to note that BCF is intended to be a catalyst for change and reshaping existing services
- Development work will take place in working groups, final decision to the EIB
- In regards to the 3.5% acute admissions reduction target, the monthly return is quite pivotal. Important that the Finance & Activity Sub Group focus on the 3.5% info. We need local, reliable data
- The primary focus of the BCF was to shift money from Acute to Social and Primary Care. The Integration Board was the vehicle to make this happen.
- Understanding the evidence around service change is going to make the difference. Developing more clinician-to-clinician conversations would be powerful

- A Performance dashboard is being developed and will be brought to a future meeting
- If reduction of emergency admissions is successful, the EIB can identify areas of further investment elsewhere
- Opportunities for acute providers to move out of traditional ways
- Business cases need to explicitly include public engagement
- A discussion on the EIB approach to stakeholder engagement would be welcome
Action Provisionally schedule to July 2015 meeting.
- **Action:** performance dashboard to every meeting, including SUS & MAR.

6. Presentation: Clinical Model for the Integrated Care Programme – Older People

GM and Paul Allen presented an overview of the Integrated Care Programme – Older People. In response to questions and comments, it was **noted** that:

- Focus on the clinical model today – full business plan at next meeting
- In the aims, include something more explicit about improving the patient experience
- The programme is a network of care for individuals. The Golden thread is the patients themselves
- Biggest challenge - cultural change for organisations and workforces
- Organisations need to invest in workforce development for staff
- Discovered opportunities for cost reduction, e.g. CHATs, reduced their costs and increased their service coverage
- Concerns were expressed that behaviours of people will frustrate these schemes, e.g. contacting 999 ambulance services rather than calling local rapid response services
- Critical to 'right-size' the teams (ILTs)
- ILTs are based on population and known patient numbers for each locality
- OPAU. The evidence suggests we may need a single unit (not at both acute hospitals)
- CHATs. Should have seen a correlation of improved quality and a reduction in safeguarding issues raised, but haven't. Suggests something is not working
- Falls programme. Concern about lack of interventions to prevent primary falls. (Fracture liaison nurse, model is about what happens after they've fallen rather than prevention)
- OP frailty. Improving dementia diagnosis is a priority and therefore important to offer more services for GPs to refer patients / carers and families to post diagnosis
- Functional mental health. Ongoing dialogue. Mental health issues for Older People has been raised
- It was noted that everyone has bought into the clinical model.

It was **agreed** that the clinical model as presented was approved – subject to some further work on some elements of the programme (**PA to Action**).

7. 2015/16 Investment Plan

Agenda item withdrawn.

8. Re-Setting / Confirming Emergency Admissions Reductions Target

Agenda item for information only (Reaffirmation of the 3.5% reduction target).

Agreed.

9. Forward Plan

It was **noted** that the May meeting had a busy agenda (**agreed** to review business scheduled for that meeting)

Agreed to send drafts around now (ToRs)

Agreed to review some of the emerging big issues from the discussions in a development session.

10. Any Other Business

None

Meeting closed at 5.50pm

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body Meeting
DATE:	10 June 2015
TITLE:	Updated North Central London Submission for Primary Care Co-Commissioning
LEAD BOARD MEMBER:	Graham MacDougall, Director of Strategy and Partnerships
AUTHOR AND POSITION:	Jenny Mazarelo, Joint Acting Assistant Director of Transformation
CONTACT DETAILS:	020-3688-2156 / Jenny.Mazarelo@enfieldccg.nhs.uk

SUMMARY:

At its meeting on 25 March 2015, the Governing Body approved the proposed submission to NHS England on 30 January 2015 for joint commissioning arrangements, in shadow form from 1 April 2015. This submission included governance documents such as the joint committee terms of reference and CCG's proposed constitutional amendment. As a result, the period from 1 April 2015 to 30 September 2015 has been deemed a development period.

The purpose of this report is to seek the Governing Body's approval to submit an updated proposal to NHS England on 24 June 2015 to establish joint commissioning arrangements from 1 October 2015. There will be further opportunity to inform the Governing Body of any additional proposed changes prior to 1 October 2015.

SUPPORTING PAPERS:

NCL submission for Primary Care Co-Commissioning report

RECOMMENDED ACTION:

The Governing Body is asked to approve the updated submission to NHS England on 24 June to establish joint commissioning arrangements from 1 October 2015.

Objective(s) / Plans supported by this paper: To work with the other CCGs in NCL, NHS England and our local GPs to commission and help support new models of primary care delivery focused on accessible care, co-ordinated care and proactive care and work towards the NCL CCGs having fully delegated commissioning of key element of primary care for 1 April 2016.

Patient and Public Involvement (PPI): PPE event on 29 January 2015

Equality Impact Analysis: Equality Impact Assessments are undertaken in relation to substantial commissioning changes and will be available where necessary in relation to individual work programmes.

Risks: As included in the Board Assurance Framework

Resource Implications: These will be made available as part of the individual work programme.

Audit Trail: NCL Primary Care Programme Board and monthly Primary Care Quality Improvement Group meetings

Next Steps: As detailed in the timeline

UPDATED NCL SUBMISSION FOR PRIMARY CARE CO-COMMISSIONING

INTRODUCTION

At its meeting on 25 March 2015, the Governing Body approved the proposed submission to NHS England on 30 January 2015 for joint commissioning arrangements, in shadow form from 1st April 2015. As a result the period from 1st April 2015 to 30th September 2015 has been deemed a development period.

The purpose of this report is to update the Governing Body on the updated submission to NHS England on 24 June 2015 to establish joint commissioning arrangements from 1 October 2015.

Progress to Date

- Dr Alpesh Patel has now assumed clinical lead responsibility for primary care, pending the appointment of a Clinical Director.
- NCL Primary Care Leads planning teleconference continuing on a fortnightly basis
- NCL Primary Care Leads planning sessions continuing on a bi-monthly basis and on a monthly basis from 19 June 2015
- NCL Collaboration Board approved £1.134m funding per CCG on 6 May in 2015/16 for implementation of NCL Primary Care Transformation Programme
- Members of the NCL Joint Committee agreed, including practice nursing representation
- NCL Joint Committee development sessions scheduled for 27 May and 15 July 2015
- NCL Access Task and Finish Group to be established on 19 June 2015 to share learning from mobilisation of Islington CCG's successful Prime Minister's Challenge Fund bid for iHub and to align implementation of 8am to 8pm seven day working models, where appropriate.
- NHS England/CCG Memorandum of Understanding core principles and Roles and Responsibilities documents issued to enable co-commissioning.

Recommendation

The Governing Body is asked to note the proposed re-submission to NHS England.

Clinical Commissioning Group

Agenda Item: 6.2
Paper Ref: Appendix F

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 June 2015
TITLE:	NHS Enfield CCG Operating Plan 2015/16
LEAD BOARD MEMBER:	Graham MacDougall, Director Strategy & Partnerships
AUTHOR:	Richard Young
CONTACT DETAILS:	richard.young@enfieldccg.nhs.uk Tel: 020 3688 2834

1. EXECUTIVE SUMMARY

This paper updates the Governing Body on NHS Enfield Clinical Commissioning Group (CCG) Operating Plan Refresh submissions.

Owing to difficulties agreeing the national tariffs, a revised timetable for contracting and planning submissions was issued. The final submission date for CCG operating plans was moved from 7th April to 14th May 2015. However, due to delays in NHS England feedback on the Operating Plan Narrative document, the submission on that part of the Operating Plan has been deferred.

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

As part of the submission on 14th May, the CCG has submitted measures for inclusion in the Quality Premium considered and approved at a previous meeting of the Governing Body.

Attached to this covering report is the latest submission for Operating Plan Narrative document (submitted to NHS England on 7th April). The Plan includes the assurances for acute activity plans to ensure commissioned activity is able to deliver the NHS constitution standards.

2. RECOMMENDATIONS

The Governing Body is asked to:

- Note the requirements of the process and the overview of the CCG submissions within the report.

1. INTRODUCTION

Each CCG has been required to undertake a “refresh” of its Operating Plan for 2015/16. However, the process undertaken by NHS England has been significantly more substantial than originally indicated.

The CCG was required to submit a ‘Full Final Plan’ of the refreshed Operating Plan 2015/16 by 14th May 2015 (This was a different deadline to that previously published – see section 3). However, the submission of the revised Narrative Document has been deferred. At the time of writing, the CCG has not had a formal notification of the new deadline.

This paper updates the Governing Body on the submissions that have been made to date; an overview the final submission of the Finance and Activity Plan and also the chosen Quality Premium Measures for 2015/16 as appendices to this report. The latest submitted Narrative document (7th April) is also attached for formal approval.

2. BACKGROUND

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

For 2015/16, each CCG must submit a one-year Operating Plan, consisting of:

- i. A Finance and Activity Plan.
- ii. A UNIFY submission covering NHS Constitution standards, performance trajectories and other requirements.
- iii. A full narrative setting out the CCG’s approach to achieving the national and local targets.

Alongside these processes has been a detailed and meticulous approach to ensure system-wide alignment of plans through a “Triangulation” process involving providers and other commissioning organisations.

3. CHANGES TO THE NATIONAL TIMETABLE

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

However, as indicated above, the submission of the revised Narrative Document has been deferred. At the time of writing, the CCG has not had a formal notification of the new deadline.

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

Enfield CCG has successfully submitted the first two elements of the Operating Plan. It is anticipated that the remaining element, the final version of the Narrative document will be submitted during June 2015.

As part of a detailed and iterative assurance process, NHSE have undertaken a forensic examination of every element of the Operating Planning submissions – frequently requiring additional information in order to assure the local health economy plans as compliant. The CCG has worked with Public Health colleagues and the Enfield Health & Wellbeing Board to complete the required returns.

The focus of this draft of the Operating Plan has been to ensure that CCGs have commissioned sufficient activity to meet the local requirements of the NHS Constitution standards (e.g. max 4 hour waits in A&E, 18 week referral to treatment times (RTT), cancer waiting times etc). Following a series of assurance exercises concerning planned levels of commissioned activity, Enfield CCG has increased the levels of activity planned to be commissioned in some areas. The key messages are:

- Increased levels of first outpatients on the basis of an 11% rise in primary care referrals in 2014/15.
- Increased levels of A&E attendances.
- Commissioned at out turn for most elective activity. This includes a substantial element of “RTT catch-up” work to reduce / eliminate waiting list backlogs. (NB: there remains an issue with establishing accurate levels of RTT waiting lists at Barnet & Chase Farm Hospitals).
- Commissioned at outturn for non-elective activity. This accommodates the significant rise in non-elective admissions at the CCG’s main providers.

QIPP reductions have then been applied to these investments which will reduce some of the levels of activity. These are set out within the CCG QIPP Plan (not attached).

This means that an average of 3.9% of activity related growth has been applied to contracted activity (NB: this does not translate into 3.9% increases in finances). Demographic growth has been applied at 1.5% across the board. (See appendix 2 for detail).

As a result, NHS England has now assured Enfield CCG 2015/16 activity plan.

Previous versions of the draft Operating Plan have been shared with the Health & Wellbeing Board (H&WBB) including a detailed consideration at one of its development sessions. Specific agreement has been given by the H&WBB in relation to areas concerning the Better Care Fund plan and the non-elective admissions reduction target. The Operating Plan refresh will actively support and delivery the Health & Wellbeing Strategy.

5. QUALITY PREMIUM

The Quality Premium is intended to reward Clinical Commissioning Groups for improvements in the quality of the services that they commission; for associated improvements in health outcomes and reducing inequalities in achieving the main objectives of the NHS Outcomes Framework and CCG Outcomes Indicator Set.

The quality premium paid to CCGs in 2016/17 – to reflect the quality of the health services commissioned by them in 2015/16 – will be based on the following measures that cover a combination of national and local priorities.

At its development meeting on 29th April, the Governing Body considered the measures for inclusion in the Quality Premium 2015/16. Alongside the mandatory requirements, the governing body approved local measures (see Appendix 3) for:

- Reducing potential years of lives lost through causes considered amenable to healthcare (10 per cent of quality premium);
- Urgent and emergency care:
 - Option 1: Reducing avoidable emergency admissions (composite measure) and
 - Option 2: Reducing NHS-responsible DToCs rates per 100k pop.;
- Mental health: Option 1: Reducing mental health- related A&E 4hr wait breaches;
- Improving antibiotic prescribing in primary and secondary care (10 per cent of quality premium);
- Two local measures:
 - (1) Further improving dementia diagnosis and
 - (2) Reducing emergency admissions from care homes.

These have been included in the CCG submission.

6. NEXT STEPS:

The CCG has submitted its plans in accordance with the original guidance and the further requirements issued by NHS England. As stated earlier, the CCG was required to submit a 'Full Final Plan' of the refreshed Operating Plan 2015/16 by 14th May 2015. However, the submission of the revised Narrative Document was deferred and the CCG has not had a formal notification of the revised deadline.

The CCG is awaiting the formal feedback on the Narrative element of the submission and then will need to respond to these queries and re-submit the narrative document.

7. RESOURCE IMPLICATIONS:

The resource implications of the operating plan are now included within the contracts agreed with providers. All of the financial implications are set out within the Finance and Activity Plan.

8. EQUALITY IMPACT ANALYSIS:

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

9. RISKS:

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

10. PATIENT & PUBLIC INVOLVEMENT (PPI):

There has limited direct PPI on this document. However, many of the individual elements of the Plans (including commissioning intentions for 2015/16) have been the subject of extensive engagement.

11. RECOMMENDATIONS

The CCG Governing Body is asked to note the 2015/16 Operating Plan requirements and submissions to date within the report.

Revised Contracting and Planning Submission Timetable

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

Summary Bridging Analysis for Planned Activity in 2015/16

		ACTIVITY TYPE (e.c denotes technical guidance code - SUS data to be used unless specified otherwise)								
NHS ENFIELD CCG	All Trusts	Non-elective spells - all specialities (E.C.23)	Daycase Elective Spells - all specialities (E.C.32)	Ordinary Elective Spells - all specialities (E.C.21)	Total - all spec elective spells (E.C.22)	All First Outpatient Attendances - all specialities (E.C.24)	All subsequent outpatient attendances - all specialities (E.C.6)	A&E attendances all types (E.C.8)	GP Written Referrals for a first outpatient appointment - G&A (E.C.9) (MAR DATA)	
2013-14 Out-Turn										
M10 SUS FOT		34,359	35,288	6,146	41,434	124,099	269,479	151,715	58,233	
Seasonality		0	0	0	0	0	0	0	0	
Other (POD Remapping)		0	0	0	0	0	0	0	0	
Remove non-recurrent activity		997	2,540	1,771	4,311	0	0	0	0	
Restated FOT		33,362	32,748	4,375	37,123	124,099	269,479	151,715	58,233	
Pop Growth (1.5%)		515	529	92	622	1,861	4,042	2,276	873	
Non-Demographic Growth		996	423	74	497	13,651	3,638	5,538	6,406	
Service developments (Pathway Design)		0	0	0	0	0	0	0	0	
Other (Other)		997	0	0	0	0	0	0	0	
Other (Reversals Metrics & Challenges)		0	0	0	0	0	0	0	0	
Less QIPP		0	(514)	0	(514)	(5,450)	(318)	(2,500)	(4,814)	
Less BCF		0	0	0	0	0	0	0	0	
Plus RTT		0	2,876	2,014	4,890	0	0	0	0	
Net Adjustments		2,509	3,315	2,180	5,495	10,062	7,362	5,313	2,465	
2015/16		35,871	36,062	6,555	42,618	134,161	276,841	157,028	60,698	
Revised year on year growth (%)										
Growth in 2014/15 (%)		6.1%	13.3%	1.6%	3.2%	11.8%	3.5%	10.2%	11.3%	
Growth in 2015/16 (%)		4.4%	2.2%	6.7%	2.9%	8.1%	2.7%	3.5%	4.2%	

2015-16 Quality Premium- Enfield CCG

Quality Gateway

No cases of serious quality failures at a local provider where CCG is not considered to have made appropriate, proportionate response with its partners to resolve failures. Payments will be discretionary and subject to CCG assurance process criteria in relation to quality failures where gateway is not

Financial Gateway

Operate in a manner consistent with Managing Public Money; does not incur unplanned deficit in 2015/16, or require unplanned support to avoid unplanned deficit; and does not incur a qualified audit report in respect of 2015/16.

National Measures	Target	% Allocation	Maximum Available	Reporting Frequency	
Reducing Potential Years of Life Lost (PYLL) through causes considered amenable to healthcare over time	No less than 1.2%	10%	£162,423	Annual	
Urgent & Emergency Care Option 1: Reducing avoidable emergency admissions (composite measure)	at least 0% change over 4 years; or rate of less than 1k per 100k pop. (ISR)	30%	£487,268	Monthly	
Urgent & Emergency Care Option 2: Reducing NHS-responsible DTocS rates per 100k pop.	Less than 2014/15 Rate			Monthly	
Mental Health Option 1: Reducing mental health- related A&E 4hr wait breaches	% mental health breaches no greater than average for all patients; OR less than 5%	30%	£487,268	Monthly	
Improving antibiotic prescribing in primary and secondary care:	(i) Reducing the number of antibiotics prescribed in primary care	Reduction from 1.144% to 1.133%	5%	£81,211	Quarterly
	(ii) reducing the proportion of broad spectrum antibiotics prescribed in primary care	Reduction from 12.5% to 11.3%	3%	£48,727	
	(iii) secondary care providers validation their total prescription data	Compliance at RFL and NNUH (providers with 10% or more of their activity commissioned by CCG)	2%	£32,485	

Proposed Local Measures	Target	Adjustment Value	Maximum Available	Reporting Frequency
Emergency admissions from care homes	6% Reduction	10%	£162,423	Monthly
Dementia Diagnosis Rates	66.7%	10%	£162,423	Monthly
Sub total		100%	£1,624,225	

Constitutional Measures	Target	Potential % Adjustment	Potential Adjustment	Reporting Frequency
18 Week RTT (Admitted Pathway)	90%	-10%	-£162,422.50	Monthly
18 Week RTT (Non-Admitted Pathway)	95%	-10%	-£162,422.50	Monthly
18 Week RTT (Incomplete Pathway)	92%	-10%	-£162,422.50	Monthly
A&E waits (CCG mapped from HES provider data)	95%	-30%	-£487,267.50	Monthly
Cancer waits - 14 days (Urgent GP referral for Suspected Cancer)	93%	-20%	-£324,845	Monthly
Cat A red 1 ambulance calls (LAS performance)	75%	-20%	-£324,845	Monthly

Grand Total**-100%**

NHS Enfield CCG

Operating Plan Narrative

to Support Operational Planning, 2015/16




Context

Supplementary information for commissioner planning, 2015/16 asks that a full narrative detail of commissioners' operating plans must be available locally to be shared with partners and stakeholders including NHS England.

The key elements of CCG operating plans to be covered in a full narrative are set out in the following template. **The template asks that you outline any recovery or action plans where performance is not in line with trajectory. When detailing these, please provide specific actions, measurable ambitions and timeframes for delivery.**

The template should be completed and submitted **in draft by Tuesday 7th April**. The narrative will be reviewed alongside CCG activity data, financial planning data and UNIFY submissions.

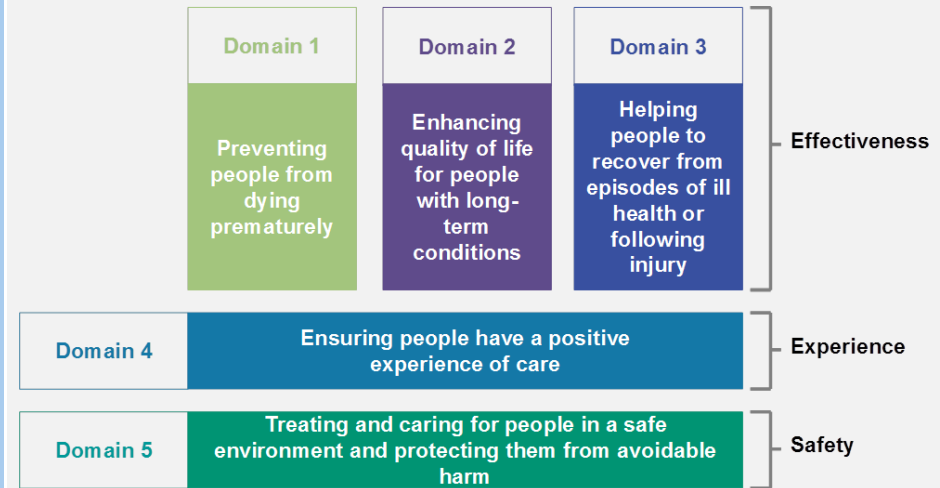
CCG:	NHS Enfield CCG
Date:	7th April 2015
CO signature:	 Liz Wise – Chief Officer

Delivery Across the Five Domains and Seven Outcome Measures

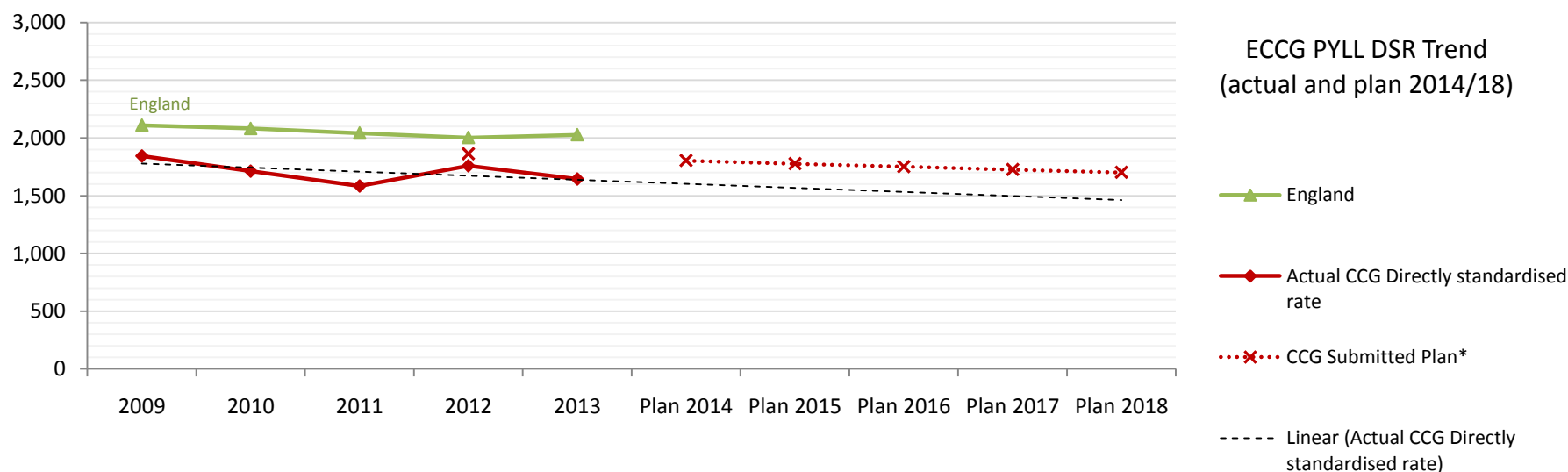
Your understanding of your current position on outcomes as set out in the NHS Outcomes Framework

The following slides in this section set out the latest understanding of the CCG performance against the relevant trajectories and targets.

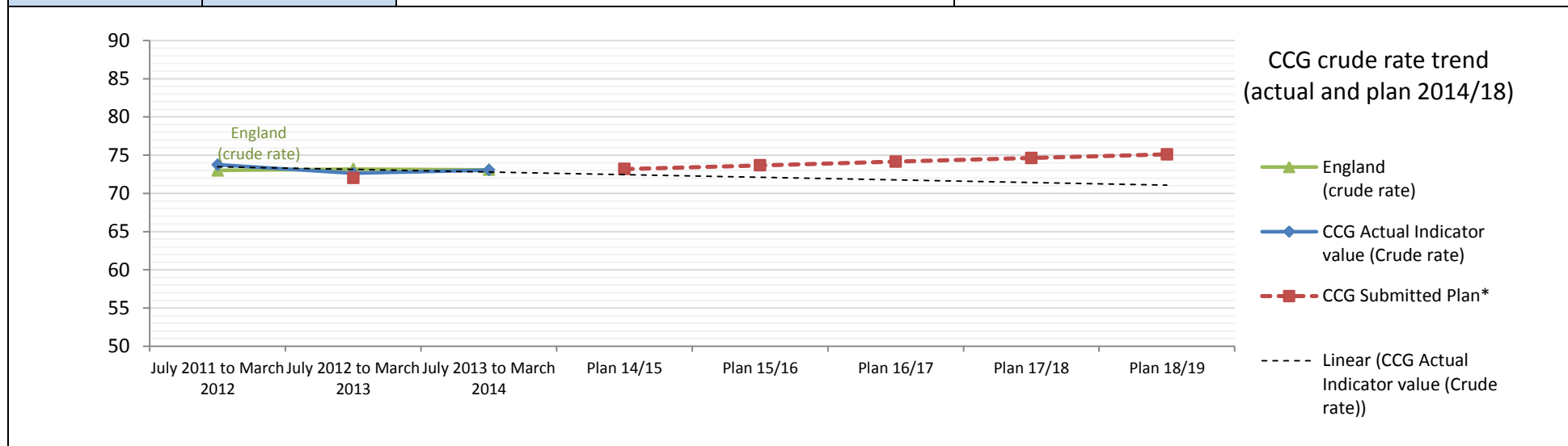
The slides setting out a detailed commentary on the performance position and (where appropriate) setting out actions required to improve upon current performance.



	Baseline measure to set a quantifiable ambition	Are you meeting the trajectory that was submitted as part of your 2014/15 operating plan? Please provide your 2014/15 ambition and performance to date.	If you are not meeting the trajectory, what actions are you taking in 2015/16 to recover? Please provide specific actions, measureable ambitions and timeframes for delivery.
<p>Securing additional years of life for your local population</p>	<p>E.A.1 (annual) - Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare</p>	<p>The CCG has performed strongly against this target and aims to continue to improve in this area.</p> <p>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%.</p> <p>As noted in the draft NCL Strategy, all CCGs 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.</p>	<p>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.</p>

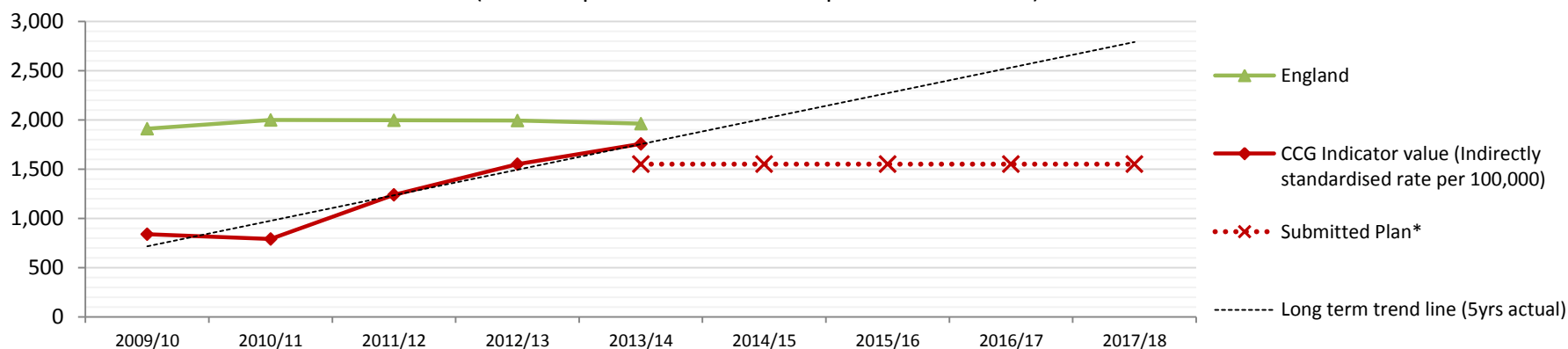


	Baseline measure to set a quantifiable ambition	Are you meeting the trajectory that was submitted as part of your 2014/15 operating plan? Please provide your 2014/15 ambition and performance to date.	If you are not meeting the trajectory, what actions are you taking in 2015/16 to recover? Please provide specific actions, measureable ambitions and timeframes for delivery.
<p>Improving the health related quality of life for people with long-term conditions, including mental health conditions</p>	<p>E.A.2 (annual) - Health related quality of life for people with long-term conditions</p>	<p>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.</p> <p>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.</p>	<p>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.</p> <p>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.</p>



	Baseline measure to set a quantifiable ambition	Are you meeting the trajectory that was submitted as part of your 2014/15 operating plan? Please provide your 2014/15 ambition and performance to date.	If you are not meeting the trajectory, what actions are you taking in 2015/16 to recover? Please provide specific actions, measureable ambitions and timeframes for delivery.
<p>Reducing the amount of time people spend avoidably in hospital</p>	<p>E.A.4 (quarterly) - Quality Premium Composite measure on emergency admissions</p>	<p>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%</p>	<p>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.</p> <p>In addition, the CCG is working collaboratively with NCL partners through the Urgent & Unscheduled Care work programme to direct patients to an unscheduled care service that signposts patients to the appropriate care setting, based on the principles of right care, right place, right time.</p>

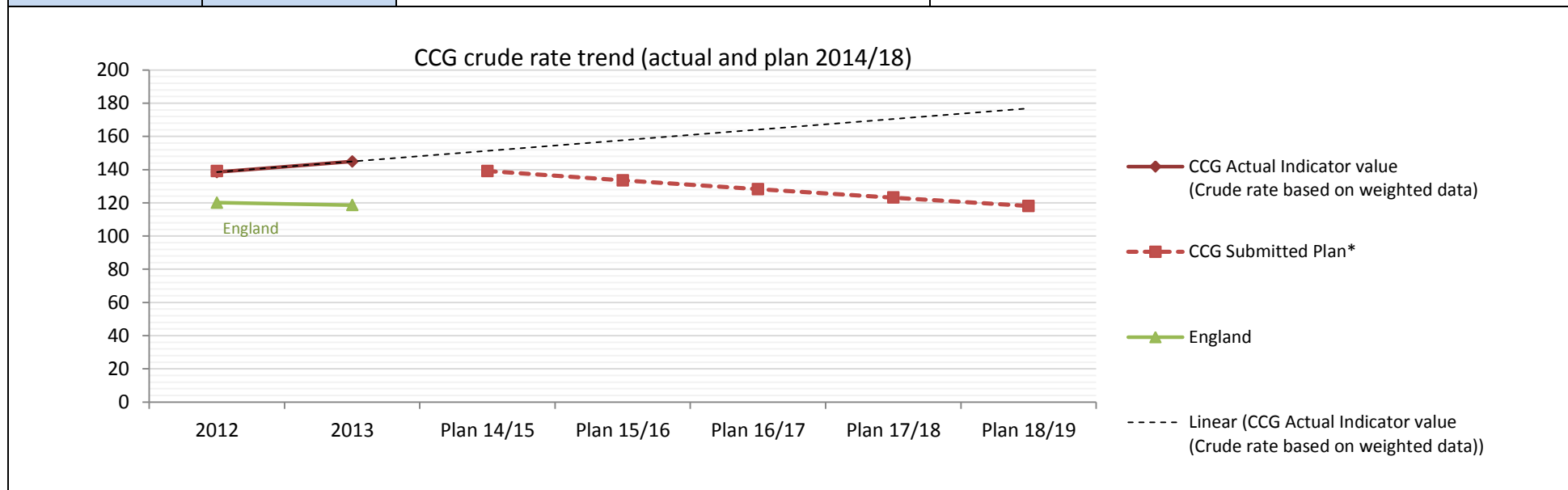
CCG Avoidable admissions Trend (national published actual and plan 2014 to 2018)



	Baseline measure to set a quantifiable ambition	Are you meeting the trajectory that was submitted as part of your 2014/15 operating plan? Please provide your 2014/15 ambition and performance to date.	If you are not meeting the trajectory, what actions are you taking in 2015/16 to recover? Please provide specific actions, measurable ambitions and timeframes for delivery.
Increasing the proportion of older people living independently at home following discharge from hospital	E.A.S.3 (annual) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	<i>Note: as CCGs are not required to submit data against this measure, please include details of the ambition set in your Better Care Fund plan and any improvements against baseline.</i>	

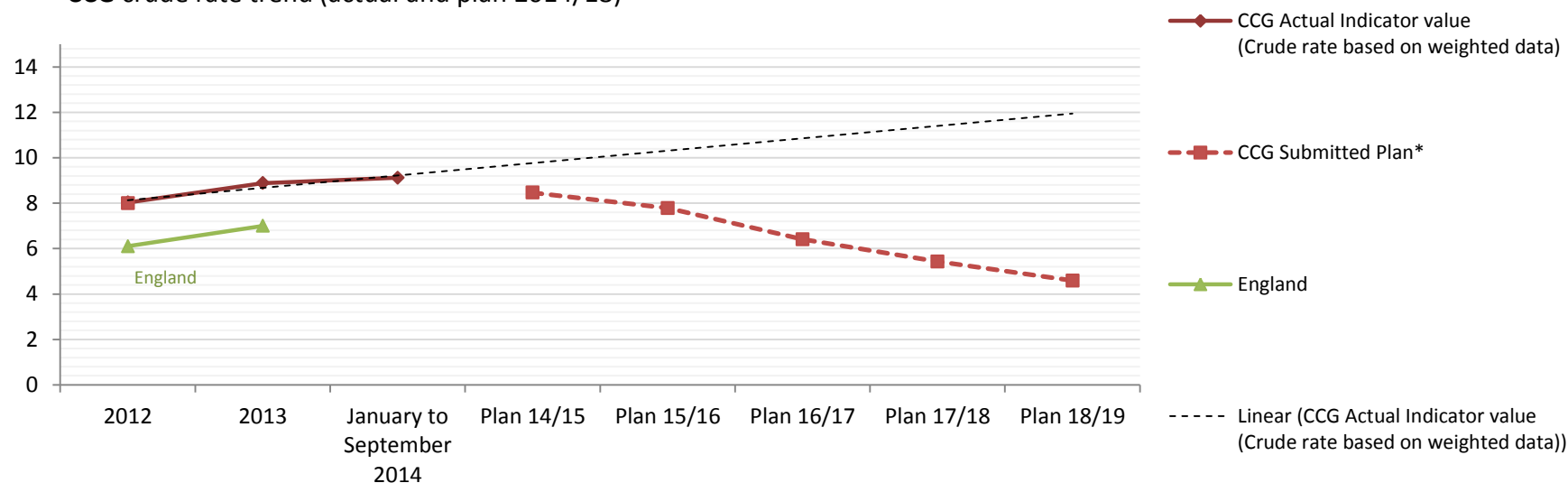
Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Actual (Performance)	Awaiting data	Awaiting data	Awaiting data
	Target (Annual %)	82.3	88.1	88.1
	Numerator	205	229	229
	Denominator	250	260	260

	Baseline measure to set a quantifiable ambition	Are you meeting the trajectory that was submitted as part of your 2014/15 operating plan? Please provide your 2014/15 ambition and performance to date.	If you are not meeting the trajectory, what actions are you taking in 2015/16 to recover? Please provide specific actions, measureable ambitions and timeframes for delivery.
<p>Increasing the number of people having a positive experience of hospital care</p>	<p>E.A.5 (annual) – Proportion of people having a positive experience of hospital care</p>	<p>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.</p>	<p>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.</p>



	Baseline measure to set a quantifiable ambition	Are you meeting the trajectory that was submitted as part of your 2014/15 operating plan? Please provide your 2014/15 ambition and performance to date.	If you are not meeting the trajectory, what actions are you taking in 2015/16 to recover? Please provide specific actions, measurable ambitions and timeframes for delivery.
<p>Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community</p>	<p>E.A.7 (annual) – Proportion of people having a positive experience of care outside hospital, in general practice and the community</p>	<p>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.</p>	<p>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.</p>

CCG crude rate trend (actual and plan 2014/18)



	Baseline measure to set a quantifiable ambition	Are you meeting the trajectory that was submitted as part of your 2014/15 operating plan? Please provide your 2014/15 ambition and performance to date.	If you are not meeting the trajectory, what actions are you taking in 2015/16 to recover? Please provide specific actions, measureable ambitions and timeframes for delivery.
Making significant progress towards eliminating avoidable deaths in our hospitals	E.A.8 (annual)	<i>Note: Indicator in development, this should be available for measuring a national ambition in Autumn 2015 and local ambitions in 2016/17. For the purpose of your 2015/16 operating plan, please outline any local measures currently in use and any improvements against baseline.</i>	N/A

The CCG has a clear process from learning from never events, and participates in a monthly panel meeting with other CCGs to review serious incidents and ensure that learning where avoidable death is deemed to have occurred is appropriately embedded.

The CCG also uses its contractual arrangements with providers, through monthly Clinical Quality review Groups, for assurance on seven day services which ensure that clinically appropriate escalation procedures are in place for deteriorating, high-risk patients.

Where other investigations identify learning, especially where not solely associated with hospital care, the CCG takes steps to embed this with its member practices through clinical education. An example is a recent Health Service Ombudsman report into the death in Devon of a three year old child from sepsis.

Improving Health: Your Planned Outcomes From Taking The Five Steps Recommended In The “Commissioning For Prevention” Report

	Commentary
What Analysis Have You Undertaken Of Key Health Problems?	<p>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.</p> <p>As a point of note, national benchmarking with peers shows Enfield is the best performing CCG among its peers in ‘Living for Longer’ analysis.</p>
Based On This Analysis, What Are Your Priorities And Common Goals?	<p>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).</p> <p>The HWB target of reducing the difference in female life expectancy between the worst and best wards to 10 years has already been achieved.</p>
Have You Identified Your High Impact Programmes?	<p>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).</p> <p>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.</p>

<p>What Are Your Plan Resources?</p>	<p>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.</p> <p>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.</p>
<p>How Will You Measure Progress?</p>	<p>Outcome & process metrics are in place to measure progress on of each HWB priority.</p> <p>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.</p> <p>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.</p>

Reducing Health Inequalities

Which groups of people in your area have the worst outcomes and experience of care? How are you planning 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 variations within the borough. These areas with worst outcomes are identified through Enfield JSNA, APHR and various health needs assessment.

Successive reports on health inequalities in Enfield has found that people from poorer socio-economic backgrounds, people from BME backgrounds and people suffering from mental Health issues have the poorest outcomes.

We identified five electoral wards with where there are high concentrations of these groups of people. Across these geographical areas, these communities experience the worst life expectancy outcomes (Upper Edmonton, Jubilee, Ponders End, Chase and Lock) and the CCG, public Health and the Council are working with other partners at the Health and Wellbeing Board to close the gap. A joint plan will be discussed at the Health and Wellbeing Board meeting in summer.

Specific Initiatives include:

- 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.

Does this include implementation of the five most cost-effective high impact interventions recommended by the NAO report on health inequalities?

Yes. The CCG is committed to implement most cost-effective high impact interventions identified in NAO Report on health inequalities, and the Public Accounts Committee Report into Tackling Inequalities in life expectancy. These are:

- a. To increase prescribing of blood pressure drugs: Health Kiosks that measures blood pressure and BMI, hypertension campaigns, initiatives that ensures control of both hypertension and cholesterol among those diagnosed (aka Hilo), integrated strategy (being designed) for primary care diagnosis and early treatment of long-term conditions and risk factors

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.

- b. To increase prescribing of drugs to reduce cholesterol: initiatives that ensures control of both hypertension and cholesterol among those diagnosed (aka Hilo), integrated strategy (being designed) for primary care diagnosis and early treatment of long-term conditions and risk factors and promoting NHS Healthcheck.

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.

- c. To increase smoking cessation rates: text-message reminders, making every contact count by front line practice staff, campaigns targeting parents at schools and pharmacies

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.

- d. To increase anticoagulant therapy in atrial fibrillation: we have a pilot to detect atrial fibrillation using primary care database in the deprived Southeast locality and anti-coagulant service hubs throughout Enfield; integrated strategy (being designed) for primary care diagnosis and early treatment of long-term conditions and risk factors.

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.


- e. To improve blood sugar control: integrated strategy for primary care diagnosis and early treatment of long-term conditions and risk factors is being designed which includes improving the early recognition of

	<p>diabetes and the management blood sugar in primary care.</p> <p>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.</p> <p>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.</p>
<p>How are you planning to reduce health inequalities for Looked After Children and people with a Learning Disability and offenders?</p>	<p>Enfield Council's children's services were recently rated as good by Ofsted. Strong partner agency support, the good work of the Looked After Children health team including CAMHS, and the effectiveness of Kratos, the children in care Council, were all noted. Working with the Council, the CCG will build on this work; ensure that outcomes for Looked After Children are monitored on an ongoing basis, and necessary action taken to reduce health inequalities.</p> <p>Enfield does not host any prison services.</p> <p>However, the CCG participates in the local Community Safety and Crime Reduction Forum and works with other partners such as the Probation service, Police and Drug & Alcohol Action Team.</p>

<p>What progress have you made in implementing Equality Delivery System (EDS2)?</p>	<p>The first Workforce Race Equality Standard (WRES) requires NHS organisations employing almost the entire 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.</p>	
	<p>Enfield CCG compares well against the first NHS Workforce Race Equality Standard:</p> <p>continues to monitor , report and publish its workforce data</p> <p>This includes race equality information about governing body members, existing workforce, recruitment and leavers</p>	<p>The CCG has already analysed its data as part of the EDS2 self-assessment. In 2015-16 the CCG will:</p> <p>Update equality information of all staff and governing body members</p> <p>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.</p> <p>Implement the EDS2 action plan which includes specific actions relating to workforce equality.</p>
	<p>Implementing EDS2:</p> <p>The CCG is committed to implement EDS2 by:</p> <p>Conducting a self-assessment and reviewing the grades on an annual basis;</p> <p>Engaging the key stakeholders including Healthwatch and the local authority;</p> <p>Working closely with providers;</p> <p>Publishing the grades in the CCGs annual equality information report in January;</p> <p>Developing actions to deliver equality objectives; and</p> <p>Revising equality objectives</p>	<p>Examination of how the organisation compares against the first NHS Workforce Race Equality Standard:</p> <p>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:</p> <p>Update equality information of all staff and governing body members;</p> <p>Produce staff equality information by using the WRES metrics;</p> <p>Implement the EDS2 action plan which includes specific actions relating to workforce equality;</p> <p>Monitor providers' equality performance against the WRES (and EDS2) through contract monitoring.</p>

Quality - Responding to Francis, Berwick and Winterbourne View

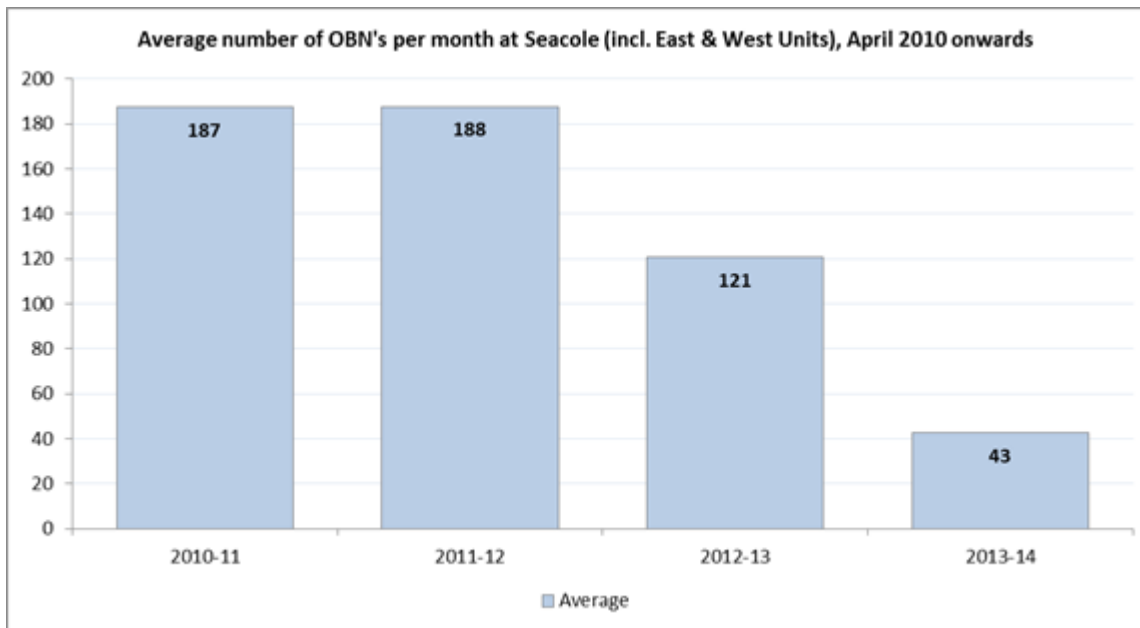
	What quantifiable progress has been made in 14/15?	What quantifiable ambitions are in place for 2015/16? What action plans are agreed to deliver this and over what timeframe?	Supporting documents / references
<p>What is your ambition for quality improvement in response to Francis, Berwick and Winterbourne View</p>	<p>Our plans have reflected the key findings of the Francis, Keogh, Berwick and Winterbourne View reports:</p> <ul style="list-style-type: none"> • We worked with the integrated learning disabilities service to transition patients (identified as the winterbourne cohort) under the MHA to appropriate clinical environments that were closer to home. We then developed personalised move on plans with individual patients and their advocates / carers with a view to discharging back to the community. • We diverted funding from learning disabilities specific assessment & treatment services to establish a community intervention service with the ambition to reduce admissions to our in borough assessment & treatment service • We funded a PBS community nurse post to provide interventions, training and support to services for people with complex needs and behaviour that can prove challenging at times. • We provided awareness training to primary care 	<p>The CCG has committed to:</p> <ul style="list-style-type: none"> • Continue to invest in community intervention models of healthcare for people with learning disabilities and reduce unavoidable admissions to assessment and treatment services • Embed all that we have achieved in 14/15 as standard practice and constantly look for ways to improve the quality, safety and efficiency of services for people with learning disabilities • We will work with the local authority to continue to develop community options for people with learning disabilities in the local community • We will work with partnership organisations and agencies (e.g. MAPPA) to ensure that risk management plans are in place. • We will work with the Local Authority to ensure that our Market Position Statement includes a needs assessment and gap analysis for people with 	

	<p>through PLT sessions this was to increase awareness of the needs of people with learning disabilities and to promote health checks for people with learning disabilities</p> <ul style="list-style-type: none"> • We worked with the local authority to ensure that the needs of people with learning disabilities sectioned under the MHA were included in the procurement exercise to award IMHA, IMCA and DoLs contracts to the independent sector. • Our lead psychiatrists have been working with complex needs and challenging behaviour services to work in a holistic way with a view to reducing the use of medication. • We have regularly monitored and reported 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. • Specific escalations have been included in a Quality and Safety Report to every Governing Body 	<p>learning disabilities. This will be completed by July 2015.</p> <p> Patient Safety Improvement Plan EN</p> <ul style="list-style-type: none"> • Recommendations have informed the design of quality indicators that form part of provider contractual arrangements monitored through Clinical Quality Review Groups. These indicators will be monitored at each meeting throughout the coming year.
<p>What is your ambition for reducing the number of inpatients beds for people with a</p>	<p>Analysis undertaken in the year of 2011/12 indicated that on average there were 9 people with learning disabilities admitted to our in-borough assessment & treatment services at any given time.</p> <p>Due to investment in our learning disabilities community intervention and intensive resettlement service, we have drastically reduced this to 1 admission with no new planned admissions identified in the community at</p>	<p>The CCG intends to achieve this by:</p> <ul style="list-style-type: none"> • 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

<p>learning disability and improving the availability of community services for people with a learning disability?</p>	<p>present.</p> <p>The CCG have:</p> <ul style="list-style-type: none"> • Reduced the number of admissions to our in borough assessment & treatment service provided by CNWLFT. The extent of this reduction in numbers over the last year has meant that our local provider has raised issues in terms of the medium to long term viability of the service. • We have diverted funding from assessment & treatment services to community intervention models of healthcare. • We have developed a range of bespoke housing and specialist support services for people with complex needs and behaviour that can prove challenging at times. This has enabled us to transition people under the winterbourne cohort back to the community. • We worked in partnership with the local authority to bid for DH capital funding to purchase properties suitable for adaption on the local market and to develop a respite and recovery centre that will enable the Community Intervention Service to support people with learning disabilities in crisis who require a period of intense intervention in a place other than their own home. Unfortunately, this bid was unsuccessful. We will continue to bid for capital funding to develop community provision. 	<p>move people on to community settings that are closer to home.</p> <ul style="list-style-type: none"> • 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. • 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 •
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Please see table below for an 'at a glance' overview of activity:

As indicated in the table above the CIS has significantly reduced assessment & treatment admissions over the last 6 months. The service has also made good use of alternative community un/ planned provision (Respite beds at NTec, Bycullah Road and Shelly Lodge residential care) and improves outcomes for patient / service users by offering holistic and personalised treatment options that promote patient / service user and parent / carer choice and control. It is evidenced in many research findings on the subject matter that when patients / service users feel that they are more in control of their own healthcare and are part of the decision making process then this can have a positive impact on health & wellbeing outcomes and how the patient responds to treatment (QS15 NICE Patient experience in adult NHS services dated Feb 2012). The table demonstrates that the community intervention service not only promotes wellbeing benefits for people with learning disabilities but also offers a holistic, personalised home treatment centred approach that is a viable alternative to traditional hospital style services. FR&Q at its meeting on 12th of November 2014 endorsed the recommendation to fund the CIS on a reoccurring basis.



Quality – Patient Safety

How are you addressing the need to understand and measure the harm that can occur in healthcare services?

For example, duty of candour, HCAI and CQC themes and action reports related to providers from 2014/15.

Monthly monitoring of compliance with relevant indicators 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 and for assurance following CQC inspection visits.

How are you increasing the reporting of harm to patients, particularly in primary care with a focus on learning and improvement?

Working 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

Reviewing and discussing 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.

<p>How are you tackling sepsis and acute kidney injury?</p>	<ul style="list-style-type: none"> • 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 numbers 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. • Negotiations anticipated with providers on two new national CQUIN indicators, to be led by the Commissioning Support Unit and the lead commissioners for those providers (Barnet CCG for Barnet and Chase Farm/Royal Free London and Haringey CCG for North Middlesex Hospital)
<p>How are you improving antibiotic prescribing in primary and secondary care and how?</p>	<ul style="list-style-type: none"> • 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.

Quality – Patient Experience

Have you set measureable ambitions to reduce poor experience of inpatient care and poor experience in general practice. How will you deliver against your ambitions?

Suggestions include FFT, PPG development – reference to CQC and action reports.

In its corporate objectives, the CCG has set out its overarching measures of success to deliver improvements in the quality of local health services. These are:

- Improve our performance against the Friends & Family Standards taking previous year as a baseline
- Deliver improvements in the Mental Health services in 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
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We will do this by:

- The CCG is currently in the process of reviewing final assurance on outputs and learning associated with the Friends and Family Test (FFT) in 2014/15, which will inform ambitions for 2015/16.
- We are aiming to ensure our commissioned providers deliver the highest level of quality including numbers of Healthcare Acquired Infections (HCAI's) within expected levels.
- We are already monitoring on a monthly basis provider compliance with relevant indicators 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).
- This also includes 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 patient feedback obtained through the CCG website.
- We will continue to utilise 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.

	<p>We will ensure this happens through:</p> <ul style="list-style-type: none"> • Monthly monitoring of provider compliance with relevant indicators 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.
<p>How will you assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for patients?</p> <p><i>Suggestions include CQC reports, care homes and domiciliary care.</i></p>	<ul style="list-style-type: none"> • Methods to monitor patient experience through acute hospitals and General Practice 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. • We will continue to work with local borough and nursing homes (e.g. on pressure ulcer trends) 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. <p>Specifically in relation to Learning Disabilities:</p> <p>In collaboration with colleagues in joint commissioning and the Local Authority, the CCG completes Self-assessment frameworks (SAFs) internally which are signed off through Quality and Safety Committee (QSC). The actions are sent to NHSE for compliance monitoring. The CCG self-assessment frameworks completed in 2014/15 for learning disability and safeguarding have been reviewed through QSC, and updates sent to NHS England to demonstrate improvements and compliance where actions were required. SAFs for 15/16 are currently being developed for completion. There is additionally a SAF for autism in 15/16.</p> <p>SAFs are also presented by providers at the CQRG meetings for review. The gaps are addressed through action plans and the improvements are monitored Locally.</p>

	<p>Specifically in relation to Older People and Care Homes:</p> <p>The Care Homes Action Team (CHAT) has developed a care home staff feedback survey as a method of collating user experience. There are challenges with having a direct user experience at Care Homes as the vast majority of residents have cognitive impairments, visual or communication difficulties or unable to write, document their views.</p> <p>Falls and pressure sores were a major concern in specific care homes and CHAT devised a falls clinic with BEH-MT physiotherapists and has seen a 50% reduction of falls since this development in those homes including an overall reduction in falls requiring hospital attendances. This clinic is been rolled out to other homes with predominantly residents with dementia and supported by training from ECS physiotherapists on falls prevention, bone health etc to all CHAT covered Care Homes.</p> <p>CHAT have improved quality by assisting and supporting those homes without managers or short of staff, homes with safeguarding or provider concerns with weekly visits to offer training, nursing functions etc but have also proactively raised SIP forms highlighting safeguarding issues to the Enfield delegated Safeguarding Boards and contacts.</p> <p>By working with those homes closely with quality provider concerns, those homes have subsequently been listed by HealthWatch as homes that provide greater quality of care with no concerns for CQC reports and safeguarding concerns subsequently.</p> <p>CHAT routinely assists CH staff with identifying needs and developing individualised care plans with the residents at the centre of any recommendations.</p>
<p>How will you demonstrate improvements from FFT, complaints and other feedback?</p>	<ul style="list-style-type: none"> • Monthly monitoring of provider compliance with relevant indicators 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.

<p>How will you ensure that all the NHS Constitution patient rights and commitments to patients are met?</p>	<ul style="list-style-type: none"> • 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.
<p>How will you ensure that the recommendations of the Caldicott Review relevant to patient experience are implemented?</p>	<ul style="list-style-type: none"> • 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

Quality – Compassion in Practice

<p>How will you ensure that local providers are delivering against the six action areas of Compassion in Practice?</p>	<ul style="list-style-type: none"> • As part of the Enfield CCG Francis Action plan, all providers are expected 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.
<p>How are you working with providers to ensure the roll out 6C's across all staff groups?</p>	<ul style="list-style-type: none"> • 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.

Quality – Staff Satisfaction

What is your understanding of the factors affecting staff satisfaction in the local health economy and how staff satisfaction locally benchmarks against others?

Suggestions include FFT for staff, annual staff surveys, care homes and domiciliary care.

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 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 will you ensure measureable improvements in staff experience in order to improve patient experience?

Suggestions include London BME standards, linkage to patient staffing surveys.

- 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.
- As the CCG is lead commissioner for Barnet, Enfield and Haringey Mental Health Trust, it has particularly noted poor staff FFT results and is assured that an action plan in place, including establishment of a Staff Engagement Task Group to consider analysis of survey data and progress in delivering its initiatives, together with a proposal to introduce a staff council.

Seven Day Services

How will you make significant progress in 2015/16 to implement at least 5 of the 10 clinical standards for seven day working, supported by a Service Delivery and Improvement Plan (SDIP) with providers?

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.

Safeguarding: Adults and Children

How do you plan to meet the requirements of the Accountability and Assurance Framework for protecting vulnerable people (adults and children)?

Suggestions include the Care Act Implementation, Prevent, FGM and CSE.

We are working with the local authority to implement the requirements of the Care Act to ensure that vulnerable people are appropriately safeguarded. Enfield has been praised by Ofsted and other regulatory bodies on safeguarding work around children. This includes:

- 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).

What is the ambition for quality improvement in child and adult safeguarding?

Suggestions include the identification of a baseline including preventing harm (minimisation of SCRs for adult and children through integration with the Local Authority and early help and domestic violence agenda)

The CCG is working to ensure that the number of events requiring an SCR is minimised.

- The CCG recognises its statutory duties and responsibilities to safeguard children, young people and adults at risk, including ensuring clear CCG and provider policies are in place to set out approaches to safeguarding including training, recruitment practices and dealing with allegations.
- Currently the effectiveness of the children and young people safeguarding system is assured and regulated in a number of ways, which includes:
 - Enfield Safeguarding Children Board Section 11 Audit
 - External joint inspections Ofsted and Care Quality Commission (CQC)
 - Quarterly Returns of Metrics and annual reports from providers, together with supervision with named nurses.
 - Quarterly provider Board Reports that will be spoken to twice a year at the Quality and Risk Committee within the CCG.

<p>How will improvement be achieved in the application of the Mental Capacity Act (House of Lords Recommendation 2014)?</p> <p><i>Please take into account Cheshire West (DOLS) and Commissioning for Compliance.</i></p>	<ul style="list-style-type: none"> • We have organised 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 requires a quarterly provider return on the application of the Mental Capacity and Deprivation of Liberty Safeguards.
<p>What improvements will be made through the Implementation of the Care Act from April 2015?</p> <p><i>Please take into account statutory requirements including the Statutory Duty to Cooperate with the Local Authority and widening of scope of safeguarding to include Human Trafficking, Domestic Violence and Modern Slavery, self-neglect.</i></p>	<ul style="list-style-type: none"> • All CCG staff and Governing Body have been trained in care act principles by a nationally regarded expert. • Care Act summary as part of April Safeguarding Training for the CCG Governing Body, together with a review in progress of additional capacity needs within the CCG to ensure it meets its statutory requirements. • Enfield Local Authority Safeguarding Department have proposed to turn over all nursing investigations to NHS Enfield Clinical Commissioning Group; a vacant nurse assessor post has now been re-recruited.
<p>How will you measure the requirements set out in plans in order to meet the standards in the prevent agenda (taking into account Tier 1-3 priority areas)?</p>	<ul style="list-style-type: none"> • The CCG has a PREVENT lead in post • All CCG staff have attended training workshops on PREVENT. • Enfield CCG requires provider staff have had PREVENT training • The CCG requires 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. • The Governing body will receive training in PREVENT in April 2015

Workforce

What are the workforce implications from your 2015/16 operational plans and how will these be addressed?

This is under development

Enfield CCG has commissioned **Integrated Locality Teams** across health & social care. The ILTs are a multi-disciplinary team formed from community clinicians and social care professionals and their development is supported by a significant training programme from HENCEL.

As part of the development of an NCL 5 Year Strategy Plan 2014/19. CCGs are focussing on Workforce Development to ensure the right people with the right skills are in place at the right time to enable high-quality patient care to be delivered using new pathways. The CCGs aim to create a culture of continuous improvement through investment in workforce development, training, education and shared learning. A programme will established in 2015/16 to:

- Audit existing primary care capacity and project future workforce requirements, identifying gaps in current and future capacity e.g. Plan for dealing with GP practice nurses, A&E and district nurses.
- Develop an integrated workforce strategy
- Liaise with 'learning and development services' to align training packages/programmes with business requirements under new pathways e.g. Development of Physician Associates.
- Job plans to be reviewed / restructured to provide dedicated CPD time.
- link with Community Education Provider Networks within NCL to conduct training and shared learning needs analysis to identify what training is required available in primary / secondary care
- For training that is available ensure staff have access; where there is no training currently available, design and organise the delivery of shared education between primary /community care
- Review the workshop outputs and identify training needs such as 'all diagnostics are performed appropriately and reports written to a minimum operational standard to include the whole report and image'
- Set up a monitoring systems to ensure all staff training needs are identified and delivered
- Design and organise the delivery of shared learning between primary /secondary care

How are you developing a workforce that is able to work across acute and community boundaries?

5. Constitution Standards – RTT, A&E, Cancer, Mental Health

Plans should demonstrate the commissioning of sufficient services, based on robust demand planning, to deliver the NHS Constitution rights and pledges for patients on access to treatment as set out in Annex B of the planning guidance and how they will be maintained during busy periods. Where standards have not been met in 2014/15, details should be provided of specific steps being taken to ensure improvement this year, measureable ambitions for improvement and timelines for delivery.

RTT and Diagnostics

Does your provider have residual RTT backlogs - patients waiting over 18 weeks on either admitted or non-admitted pathways - who will need to be treated in 2015/16 in order to support sustainable delivery of the RTT standards?

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.

For all providers **EXCEPT Barnet & Chase Farm**, Enfield CCG plans to achieve the standards each month in 2015-16. The projection takes into account recent improvements in performance and also recognises on-going challenges in sustaining performance. Trajectory is based on 1.5% ONS estimated population growth on 2014-15 and an average 2.2% for increase in demand. Further adjustment for the impact demand management initiatives will be applied to the final submission after further analyses is completed.

Barnet & Chase Farm sites of Royal Free London FT have not reported their RTT position since September 2013. An RFL/BCF RTT Programme Board (including commissioners from Barnet, Herts and NHS) was established to address and oversee the issues that resulting to in suspension of reporting. The Trust is yet to provide accurate figures on residual backlog as the validation process is still ongoing.

Other main providers who account for approximately 50% of CCG activity do not have residual RTT backlog.

The CCG has picked up risks in relation to endoscopy capacity which is impacting on CCG diagnostic wait standard. The provider has an action plan in place and this will form the basis of an agreed recovery action plan.

<p>If yes, have you agreed an additional activity profile with that provider (which is likely to be above and beyond BAU activity) to manage those backlogs?</p>	<p>Enfield CCG plans include substantial amounts of capacity included in 14/15 contracts and rolled over into 15/16 contracts. The CCG plans are based on M1-9 2014-15 FOT which includes the additional £3.7M RTT funding as best estimated of additional activity profile required in 2015-16 to manage RTT backlog. This includes additional activity commissioned at alternative providers in 14/15 (BMI) and this has also been rolled forward and included in our 15/16 plans.</p> <p>By using the M1-9 FOT, CCG is also commissioning additional diagnostic activity to make up the recent shortfall.</p>
<p>Have you agreed the timeline required for this additional activity –ensuring that patients are treated as quickly as possible?</p>	<p>RFL is currently sourcing additional capacity to ensure patients identified from the data validation exercise are treated within waiting time standards. The additional capacity will continue to be in place in 2015-16, with additional capacity to be secured depending on the outcome of the validation exercise.</p> <p>To address the shortfall in endoscopy capacity, provider actions are in place to address shortfall. This includes “insourcing” of additional capacity, increase in clinic sessions from 2 to 3 sessions a day, and procurement of additional equipment. The CCG is also scoping out options for additional activity from other providers.</p>
<p>Have you agreed performance trajectories based on the profile of backlogs and the timeline required to clear them?</p> <p>I.e. managing backlogs is likely to mean that the performance measures may not be achieved until they are managed back to a sustainable level.</p>	<p>It has not been possible to agree performance trajectories at this stage because of the lack of reliable quantifiable data from RFL / BCH.</p> <p>Depending on the progress of the RFL / BCF RTT Programme Board in ascertaining the scale of the RTT issue at RFL / BCH, we expect to have these trajectories in place by early summer 2015.</p>
<p>Have you and the provider agreed a RTT recovery plan based on the above information?</p>	<p>The RFL / BCF RTT Programme Board is managing the process of returning RFL to reporting status and ensuring that provider plans to achieve compliance are credible.</p>

<p>Has your provider(s) completed detailed demand and capacity modelling at speciality level for non-admitted and admitted activity – and have they shared this with you?</p>	<p>The RFL / BCF RTT Programme Board is managing the process of returning RFL to reporting status and ensuring that provider plans to achieve compliance are credible.</p>
<p>Has this been used to calculate elective capacity and activity for 2015/16?</p>	<p>Elective capacity and activity for 2015-16 has been based on 2014-15 outturn which included additional activity undertaken with the additional RTT funding. Commissioners and provider have agreed this approach to give best estimates of demand to assess capacity.</p>
<p>Does the Trust have sufficient capacity to meet demand or will alternative providers need to be identified and agreed?</p>	<p>For RFL / BC, this is not clear for the reasons set out above and is part of the on-going work of the Programme Board.</p> <p>As part of the RTT Programme RFL have plans in place to increase their capacity when the true size of the RTT backlog is identified from the operational validation exercise.</p>
<p>If the Trust(s) has backlogs to clear in 2015/16 have these been profiled against BAU demand and capacity/run rates?</p>	<p>Not at this stage. As indicated previously, the size and scale of the issue is not yet clear.</p> <p>In the meantime, CCG plans have assumed 14/15 outturn (including substantial additional RRT capacity rolled over into 15/16). Therefore, estimates of backlog have been profiled against BAU until more accurate figures on backlogs are confirmed.</p>
<p>Does the Trust(s) have sufficient capacity to deliver both BAU run rates and clear backlog or will alternative providers need to be identified to support the backlog activity and ensure that patients are treated as quickly as possible?</p>	<p>See above.</p> <p>RFL is reviewing capacity on an ongoing basis as part of the RTT work programme. Provider will consider all options including further outsourcing to increase capacity when backlog figures are confirmed.</p> <p>In the meantime, within the auspices of patient choice, Enfield CCG has actively sought to direct patients to alternative provision where appropriate and has developed alternative pathways away from Chase Farm in order to not further exacerbate the pressure on RTT backlogs. This activity has been included in 15/16 baselines for all those providers.</p>

A&E Waits

By each A&E provider, provide your performance against the 4 hour standard for each quarter of 2014/15. How did this vary from your planned trajectory?

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 are expected to sustain the recent improvements. Chase Farm ran an improvement week in March. This produced a number of themes which will be reviewed by the SRG.

	Q1 -2014-15	Q2 2014-15	Q3 2014-15	Q4 QTD 2014-15
Performance	95.2%	95.5%	92.2%	92.2%

A&E Performance – NMUH

The CCG will be working with Haringey CCG and other leads to work with NMUH. 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.

	BCF	RFL (inc BCF)	RFL (inc BCF)	RFL (inc BCF)
	Q1 -2014-15	Q2 2014-15	Q3 2014-15	Q4 QTD 2014-15
Performance	95.9%	95.6%	94.5%	93.5%

<p>Where 4 hour performance did not meet trajectory, have the major factors affecting performance been identified?</p>	<p>Yes. Key factors affecting performance at both RFL and NMUH Trusts are:</p> <ul style="list-style-type: none"> • Increase in demand for A&E services, • Bed management • Staff shortages. • Emergency & Urgent Care Pathways.
<p>What are the proposed mitigating actions to recover / maintain progress against your trajectory for 2015/16?</p>	<p>Proposed mitigating actions include</p> <ul style="list-style-type: none"> • Implementation of Urgent Care Model at NMUH with additional GP hours to meet demand. • Comprehensive recruitment plan and retention has been enacted successfully at NMUH with Trust all establishments now filled. • Enhance ward rounds are in place to facilitate timely discharges • Additional are working on plans to deliver more step down beds and nursing home placements to ensure medically fit patients are discharged in a timely manner. • Reducing referrals from outpatient clinics • Development of an ambulatory care model
<p>Has your plan taken into account the impact of various schemes and investment? E.g. QIPP, NETA, BCF</p>	<p>Yes, A&E performance and activity plans takes into account wider CCG plans to reduce A&E attendances, emergency admissions and readmissions which is expected to reduce demand and reduce pressure on beds.</p>

Cancer waits – 62 day	
By each provider, what is current performance against 2014/15 plan?	<p>NMUH Q3 2014/15: 92.4% vs 85% Standard</p> <p>RFL Q3 2014/15: 78.3% vs 85% Standard</p>
Where performance is not meeting trajectory, has a comprehensive action plan and recovery date been agreed with the provider?	RFL has provided a remedial action plan and a trajectory which is being reviewed by commissioners including NHSE.
How will you work with the provider to sustain improvement in 2015/16 to meet your trajectory?	The RAP is being monitored through Performance Review Group and Contract Management Group. This includes identifying and mitigating risks associated with the action plan. CCGs will also work with providers in identifying areas where primary care education on referral pathways and thresholds are required.

Mental Health	
<p>IAPT: By April 2016, at least 75% of adults should have had their first treatment session within six weeks of referral, with a minimum of 95% treated within 18 weeks. How are you working with providers to achieve new waiting time standards for people entering a course of treatment in adult IAPT services?</p> <p>Please confirm your trajectory for meeting this standard by April 2016 and the actions you are taking to deliver it.</p>	<p>Issue</p> <p>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.</p> <p>Provisional activity figures for March 2015 show that BEHMHT IAPT service achieved the 15% access rate for 2014-15 and, in March 2015, the 50% recovery rate (actual recovery rate for March 2015 was 52%)</p> <p>Planning Assumption:</p> <p>The planning assumption for access (15%) is:</p> <p>Q1 – 3.25%</p> <p>Q2, 3 and 4 – 3.75% (which reflect a 15% run rate)</p> <p>The planning assumption for the Recovery Rate is maintenance of the 50% target throughout the year</p> <p>Waiting times: current monitoring information shows that the service already meets the target of 75% of adults having their first treatment session within six weeks of referral. Information regarding the number of people treated within 18 weeks will be collected and monitored with effect from 1st April 2015 to ensure this target is also being met.</p> <p>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.</p>

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.

The CCG has required detailed provider staffing and recruitment plans.

Monthly IAPT performance meetings are in place to monitor action plans with provider. CCG is also undertaking marketing exercises to increase referrals.

In addition, the CCG is exploring the use of alternative providers (including voluntary / independent sectors).

Trajectory for Achieving New Mental Health Waiting Times

		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%

Early intervention in psychosis (EIP): By April 2016, it is expected that more than 50% of people experiencing a first episode of psychosis will receive treatment within two weeks. This will require dedicated specialist early intervention-in-psychosis services. How are you working with local secondary mental health providers to ensure this waiting time standard is met?

Please confirm your trajectory for meeting this standard by April 2016 and the actions you are taking to deliver it.

During January to March 2015 the CCGs funded a project within BEHMHT (using Crisis Concordat monies) to establish working practices which ensured service users experiencing a first episode of psychosis reach their destination care pathway within two weeks. The CCGs will be working with BEHMHT to monitor performance during 2015-2016 to ensure this standard is maintained.

A review of the EIS service (links with CAMHS and fidelity to NICE guidance) is just about to produce its report – issues identified appear to be:

- Current approach is primarily **post diagnosis treatment and support** for FEP which is one of the accepted approaches within the model; however, the EIS does not focus resources on reducing the earlier prodromal phase of presentation, another key approach within the model.
- Caseloads are currently running at 16-25 clients per care co-ordinator compared with the model ratio of 15 (NHS Mental Health Policy Implementation Guide 2003).
- Across the three boroughs, only 43% of EIS service users access psychological therapies.
- Lack of employment and support workers in Enfield and Haringey
- The Trust's RIO data collection system is unable to easily and readily confirm the volume of 14-18 year olds referred to AOT, BAS and SAFE with symptoms of psychosis and time between referral to assessment.
- The collection and reporting of clinical and functioning outcome measures (e.g. GAF-F, GAF-D, HONOS) is inconsistent

As yet there has not been any work commenced on a baseline or trajectory. This will be developed during 15/16.

<p>Have you agreed a Service Delivery and Improvement Plan (SDIP) as part of contracts with mental health providers? Does this plan set out how providers will prepare for and implement the new standards for EIP and IAPT during 2015/16 and achieve them on an on-going basis from 1st April 2016?</p>	<p>The CCG has a draft SDIP with the provider and these are part of the on-going contractual discussions.</p> <p>IAPT and EIS standards are referred to in the current SDIP. See below:</p> <table border="1" data-bbox="689 323 2011 1094"> <thead> <tr> <th data-bbox="689 323 1003 448">Description of Scheme</th> <th data-bbox="1003 323 1435 448">Milestones</th> <th data-bbox="1435 323 1659 448">Timescales</th> <th data-bbox="1659 323 2011 448">Expected Benefit</th> </tr> </thead> <tbody> <tr> <td data-bbox="689 448 1003 1094"> <p>(1) Implementation of robust arrangements to deliver against national targets for 50% of people experiencing a first episode of psychosis being treated with a NICE approved care package within two weeks of referral.</p> </td> <td data-bbox="1003 448 1435 1094"> <p><u>End of Q1</u> Report on Trajectory towards 50% target</p> <p><u>End of Q2</u> Report on Trajectory towards 50% target</p> <p><u>End of Q3</u> Report on Trajectory towards 50% target</p> <p><u>End of Q4</u> 50% target met for mainstreaming in 2016-17 contract</p> </td> <td data-bbox="1435 448 1659 1094"> <p>Target achieved by end March 2016</p> </td> <td data-bbox="1659 448 2011 1094"> <p>Parity of esteem and early intervention (linked to enablement)</p> </td> </tr> </tbody> </table>	Description of Scheme	Milestones	Timescales	Expected Benefit	<p>(1) Implementation of robust arrangements to deliver against national targets for 50% of people experiencing a first episode of psychosis being treated with a NICE approved care package within two weeks of referral.</p>	<p><u>End of Q1</u> Report on Trajectory towards 50% target</p> <p><u>End of Q2</u> Report on Trajectory towards 50% target</p> <p><u>End of Q3</u> Report on Trajectory towards 50% target</p> <p><u>End of Q4</u> 50% target met for mainstreaming in 2016-17 contract</p>	<p>Target achieved by end March 2016</p>	<p>Parity of esteem and early intervention (linked to enablement)</p>
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<p>Have you ensured the provision of mental health support as an integral part of NHS 111 services? If not, what do you currently have in place instead? Do you have plans to build this into future procurement specifications?</p>	<p>Referral to mental health services within the NHS 111 service is currently facilitated via the Directory of Services. This will continue within the new service however, there will also be the addition of clinical staff with the appropriate mental health training and knowledge, who will assess patients who call the 111 service with a mental health related problem</p>								

<p>In commissioning mental health services and working towards meeting new standards, have you developed robust demand and capacity plans? Please provide details of these.</p>	<p>Not at this stage. This remains work in progress.</p>
<p>How are you working with other local commissioners to invest in community child and adolescent mental health services?</p>	<p>Barnet, Haringey and Enfield CCGs have a tri-borough approach to mental health – including CAMHS.</p> <p>In addition, there is a well-established Joint Commissioning Group for CAMHS with the local authority in Enfield which is responsible for the development and implementation of a Joint CAMHS strategy, and for optimising use of resources. Investment in CAMHS is an element of the Better Care Fund.</p>

6. Operational Resilience

Have you extended all of your operational resilience schemes from 2014/15 into April 2015 and beyond?

Yes. All schemes have been extended into April 2015. SRGs are reviewing the effectiveness and efficiency of all resilience schemes with a view to recommending schemes to continue into 2015/16.

NHS Enfield CCG Participates in two System Resilience Groups; Barnet Covering the Royal Free System and Haringey which covers the NNUH 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 Group works 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

The group takes a strategic overview of patient pathways, capacity and emergency provision through appropriate monitoring and evaluation of:

- actual/planned activity
- hospital discharge arrangements
- delayed transfer of care
- bed utilisation
- hospital admission avoidance
- targeted special initiatives

and commissions work to advance those issues. Ensuring appropriate distribution of targeted monies to maximize effectiveness in respect of the delivery of all key services across Enfield.

The aim of the System Resilience Groups is to manage extra demand and capacity which may be required during surges in demand. Its objectives are:

- Achieve a co-ordinated multiagency response
- Establish a framework for escalating capacity shortfalls between partners
- Identify needs that need to be (re)commissioned.

	<p>The aim of the initiatives developed will ensure that patients are treated promptly with fewer delays in A&E and will create alternative capacity, to avoid A&E attendances and emergency admissions and improve the discharge of patients from hospital and provide effective on-going support in the community and their own homes. Thus improving patient flow and freeing up capacity in the acute setting for patients that need to be there.</p>
<p>If no and where you are stopping specific schemes, has this been approved by your SRG? Are you assured there will be no impact on performance?</p>	<p>N/A</p>

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 June 2015
TITLE:	Finance Report – Month 1
LEAD BOARD MEMBER:	Robert Whiteford, Chief Financial Officer
AUTHOR:	Robert Hudson, Deputy Chief Financial Officer
CONTACT DETAILS:	robert.whiteford@enfieldccg.nhs.uk

SUMMARY:

This report updates the Governing Body on our financial performance. NHSE do not require CCGs to produce a finance report at month 1 and we are somewhat unusual in doing so. However in view of our financial position we have produced what we are able to with limited data. The distribution of funds from the Transitional Investment Fund in 2015/16 is also presented in this paper.

SUPPORTING PAPERS:

No additional supporting papers.

RECOMMENDED ACTION:

Members of the Committee are asked to note the report.

Objective(s) / Plans supported by this paper: Measure performance against our financial targets

Patient & Public Involvement (PPI): N/A

Equality Impact Analysis: N/A.

Risks: The risks inherent in this paper are recorded on the Enfield CCG Risk Register and Board Assurance Framework. Specific risks are referenced in the text.

Resource Implications: Specific resource implications are detailed in the paper where relevant.

Audit Trail: The Finance Report sets out performance against our statutory financial duties.

Next Steps: This report will be further developed in conjunction with key recipients.

1. Year to date and forecast

Table 1 sets out our financial performance for the year so far along with a projection of our likely year end position.

Table 1 Financial Position– Month 1 Year to Date and Forecast Outturn

	£m	£m	£m	£m	£m	£m
	Annual Plan	Budget YTD	Actual YTD	Var YTD	FOT M12	FOT Var
Allocation	354.7	29.3	29.3	0.0	354.7	0.0
Primary Care	2.4	0.2	0.2	(0.0)	2.4	(0.0)
Prescribing	39.8	3.3	3.3	0.0	39.8	0.0
Acute Care	225.3	19.0	19.2	0.2	226.1	0.8
Mental Health	45.0	3.7	3.7	(0.0)	45.1	0.1
Learning Disabilities	3.0	0.3	0.2	(0.0)	2.9	(0.1)
End of Life care	1.3	0.1	0.1	0.0	1.3	0.0
Community Services	25.9	2.2	2.2	0.0	25.9	0.0
Continuing Care	18.8	1.6	1.3	(0.2)	18.6	(0.1)
Running Cost Allowance	7.0	0.6	0.5	(0.1)	7.0	(0.0)
Other Programme Costs	14.5	1.2	1.3	0.1	16.5	2.0
Reserves	5.1	0.0	0.0	(0.0)	2.3	(2.8)
(Surplus)/Deficit	33.4	2.8	2.8	(0.0)	33.4	0.0
In year (Surplus)/Deficit	14.4	1.2	1.2	(0.0)	14.4	0.0

Note that as the 2014/15 overspend of £18.9m is automatically deducted from our 2015/16 Resource Allocation the Cumulative Deficit is forecast at £33.4m. The in-year forecast deficit is £14.4m.

The CCG is showing an on target position both for month 1 and forecast outturn. There is minimal acute activity data available, so acute contracts have been forecast at contract value where agreed. Where not agreed we have forecast using the contract envelope adjusted for QIPP we have not been able to negotiate into contracts.

Appendix 1 provides a more detailed breakdown of this information.

2. Run Rate

Table 2 shows the aggregate expenditure from months 1-11 of 2014/15, the actual expenditure in month 12 and then month 1 of 2015/16.

Table 2 Run Rate

	£m	£m	£m	£m	£m	£m	£m
	M1-M11	M12	M1	Average forecast m2 to m12	FOT	Target	Variance
Allocation	320.5	28.8	29.3	29.6	354.7	354.7	0.0
Primary Care	3.3	0.0	0.2	0.2	2.4	2.4	(0.0)
Prescribing	35.2	3.4	3.3	3.3	39.8	39.8	0.0
Acute Care	207.2	17.8	19.2	18.8	226.1	225.3	0.8
Mental Health	39.0	4.3	3.7	3.8	45.1	45.0	0.1
Learning Disabilities	2.3	0.2	0.2	0.2	2.9	3.0	(0.1)
End of Life care	1.1	(0.0)	0.1	0.1	1.3	1.3	0.0
Community Services	20.1	2.1	2.2	2.2	25.9	25.9	0.0
Continuing Care	15.7	1.9	1.3	1.6	18.6	18.8	(0.1)
Running Cost Allowance	6.9	0.6	0.5	0.6	7.0	7.0	(0.0)
Other Programme Costs	8.8	0.8	1.3	1.4	16.5	14.5	2.0
Reserves	(1.4)	(1.1)	0.0	0.2	2.3	5.1	(2.8)
(Surplus)/Deficit	17.6	1.2	2.8	2.8	33.4	33.4	0.0

Month 1's spend is marginally below the expected monthly spend for the rest of the year, £32.1m compared to £32.4m. This reflects the expected deployment of reserves later in the year.

The overspend on other programme costs will be removed when the relevant budgets are issued from reserves.

It must be stressed these are provisional numbers based on very limited data at this stage in the year.

3. Contracts

Table 3 shows a breakdown of our acute contracts by provider.

Table 3 Acute Contract Performance by provider

Provider	Annual Contract	Budget M1	Actual M1	Var M1	YTD Budget	YTD Actual	YTD Var	FOT	FOT var
	£m	£m	£m	£m	£m	£m	£m	£m	£m
The North Middlesex Hospital NHS Trust	92.4	7.7	7.8	0.1	7.7	7.8	0.1	93.0	0.6
Royal Free London NHS Foundation Trust (BCF site)	64.3	5.4	5.5	0.1	5.4	5.5	0.1	64.6	0.2
University College London Hospitals NHS Foundation Trust	14.8	1.2	1.2	0.0	1.2	1.2	0.0	14.8	0.0
Royal Free London NHS Foundation Trust (Hampstead site)	10.5	0.9	0.9	0.0	0.9	0.9	0.0	10.5	0.0
The Whittington Hospital NHS Trust	3.8	0.3	0.3	0.0	0.3	0.3	0.0	3.8	0.0
Moorfields Eye Hospital NHS Foundation Trust	3.6	0.3	0.3	0.0	0.3	0.3	0.0	3.6	0.0
Royal National Orthopaedic Hospital NHS Trust	2.1	0.2	0.2	0.0	0.2	0.2	0.0	2.1	0.0
BMI	4.2	0.4	0.4	0.0	0.4	0.4	0.0	4.2	0.0
Great Ormond Street Hospital For Children Foundation Trust	0.8	0.1	0.1	0.0	0.1	0.1	0.0	0.8	0.0
Total in sector	196.4	16.4	16.6	0.2	16.4	16.6	0.2	197.2	0.8
Barts and The London NHS Trust	4.1	0.3	0.3	0.0	0.3	0.3	0.0	4.1	0.0
Homerton Foundation Trust	1.7	0.1	0.1	0.0	0.1	0.1	0.0	1.7	0.0
Guy's and St Thomas' NHS Foundation Trust	1.3	0.1	0.1	0.0	0.1	0.1	0.0	1.3	0.0
Imperial College Healthcare NHS Trust	0.8	0.1	0.1	0.0	0.1	0.1	0.0	0.8	0.0
The North West London Hospital Trust	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.0
Princess Alexandra Hospital NHS Trust	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0
Chelsea and Westminster Hospital NHS Foundation Trust	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.0
Kings College Foundation Trust	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0
Royal Brompton and Harefield NHS Foundation Trust	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.0
Barking Havering & Redbridge NHS Trust	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
The Royal Marsden NHS Foundation Trust	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
St George's Healthcare NHS Trust	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Oxford Radcliffe NHS Trust	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Total out of sector	10.6	0.9	0.9	0.0	0.9	0.9	0.0	10.6	0.0
Acute Ambulance	11.2	0.9	0.9	0.0	0.9	0.9	0.0	11.2	0.0
Specific acute reserves	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
Non-Contract Activity	2.8	0.2	0.2	(0.0)	0.2	0.2	(0.0)	2.8	0.0
Acute Winter Pressures	1.7	0.3	0.3	0.0	0.3	0.3	0.0	1.7	0.0
Emergency Re-admissions	1.7	0.1	0.1	0.0	0.1	0.1	0.0	1.7	0.0
Acute In Health	0.8	0.1	0.1	0.0	0.1	0.1	0.0	0.8	0.0
Total acute spend	225.3	19.0	19.2	0.2	19.0	19.2	0.2	226.1	0.8

No acute data has been received as yet for 2015/16 so all figures are estimates based on agreed contracts or current contract envelopes as described above. These have been adjusted where QIPPs within contracts have not yet started, and where QIPP has not been negotiated into the contract.

The forecast overspends on Royal Free and NNUH are as a result of potential delays in QIPP scheme development.

4. Risks & Mitigations

NHSE does not require a non-isfe report for month 1.

Internally however the Financial Governance Review has highlighted the importance of transparency of key risks being communicated to the Finance Committee as soon as possible. The main ones are below:

- The CCG has “spare” reserves of only £1.9m. This represents less than 1% of acute budgets. We have planned on realistic levels of activity in 2015/16, but further unplanned growth is a material risk.
- QIPP must deliver £12.5m in order for the CCG to achieve its control total. At present risk adjusted plans total £6.8m.
- There is a risk of £0.4m on the Whittington contract. This was a block in 2014/15 and our PbR activity was £0.4m in excess of plan. The proposed block recommended by the lead commissioner is £0.2m in excess of our plan. Update: This contract has now been settled at £0.2m in excess of plan, which represented the best available deal for the CCG.
- BEHMHT “stabilisation” may cost the CCGs in excess of the available funds.
- Cash Envelopes for RFL and BCF are £10.5m and £63.9m respectively. Latest offers were £10.3m and £63.4m, so we are very close to our envelopes. Our risk is whether £1.7m will cover the RTT backlog in 15/16, and the outcome of the contract dispute on productivity measures.
- The Transitional Investment Fund has made only £6.0m available for Primary Care investment – this may impact on our ability to deliver QIPP. This was the maximum possible based on the revised funds available. The total funds may increase later in the year. There remains a possibility these funds will not be available at all, but this appears increasingly unlikely.
- Continuing Healthcare is budgeted at 2014/15 outturn plus growth. However this is a low volume high cost area and as such is at high risk of overspend in year.

5. Better Payment Practice Code

The CCG paid 98% of invoices by value and 86% by number for NHS creditors. For non-NHS creditors we achieved 96% and 94% respectively. This represents excellent performance in this area.

6. QIPP

There is no activity data for month 1 as yet so the full QIPP report cannot yet be produced. The financial plan has a QIPP target of £12.5m. Of this there are plans for £9.8m, which is risk adjusted to £6.8m. It is imperative that QIPP delivers to target in 2015/16.

7. Statement of Financial Position

This is included at Appendix 5. Accruals have increased partially because contracts have yet to be agreed. Invoicing therefore does not yet match current contracts or envelopes and some providers have yet to invoice for 15/16.

8. Cash Flow

A detailed cash flow forecast is included at Appendix 6.

9. Transitional Investment Fund

Following agreement at the NCL Collaboration Board the following was agreed as initial usage of the TIF.

Table 3 Transitional fund

North Central London CCGs Risk Share & Transformation Investment Fund

	Barnet £'000	Camden £'000	Enfield £'000	Haringey £'000	Islington £'000	Total £'000
Sources of Funding						
Non Recurrent Funding	6,000	3,400	5,400	3,253	3,100	21,153
Contingency Contributions (as currently agreed)	1,200	900	800	626	500	4,026
Retention of Non-Recurrent Funding as per NHSE	(6,000)		(5,200)			(11,200)
Additional contributions		15,300				15,300
CCG Contributions	1,200	19,600	1,000	3,879	3,600	29,279
Applications						
<u>Contractually Committed:</u>						
RFH/BCF Transaction Costs	3,300		4,000	2,500		9,800
BEH CS Transaction Costs	3,800					3,800
London wide transformation		510	540	490	470	2,010
Carnell/Farrar Fees		600				600
Sub Total	7,100	1,110	4,540	2,990	470	16,210
Balance						13,069
<u>Other Priority Areas:</u>						
Primary Care Strategy						6,000
TSDO support						650
Mental Health Transformation Fund						1,769
Value Based Commissioning						650
Risk-Share Fund						4,000
Total						13,069
<u>Unfunded Commitments:</u>						
Contributions to national CHC Risk Pool	500	500	500	500	500	2,500
1516 LAS Cost Pressure	743	623	704	603	550	3,223
RFH/BCF PMO Team	400					400
Urgent and ambulatory care	500	500	500	500	500	2,500
CIDR rollout		500				500
CCAS rollout		500				500
Mental Health - Rapid Access Interface Discharge	500	500	500	500	500	2,500
Total						12,123

It is key to note that £16.2m out of the available £29.3m is already committed on non-discretionary expenditure. Of the remainder £6.0m is provided for primary care and £4.0m for in year risks, along with £1.8m to address Mental Health stabilisation as below.

This may be updated and supplemented during the course of the year.

Recommendation

Members are asked to note the report, including the current distribution of the Transitional Investment Fund.

Robert Hudson
Deputy Chief Finance Officer
02/06/15

Appendix 1 – Income and Expenditure Position

Trust / Service		Month					YTD					Full Year				
		Budget £'000	Actual £'000	Variance £'000	Variance %	Rating	Budget £'000	Actual £'000	Variance £'000	Variance %	Rating	Budget £'000	Forecast £'000	Variance £'000	Variance %	Rating
Revenue Resource Limit	Confirmed	(29,348)	(29,348)	0	0.0%		(29,348)	(29,348)	0	0.0%		(354,719)	(354,719)	0	0.0%	
	Anticipated	0	0	0			0	0	0			0	0	0		
Revenue Resource Limit Total		(29,348)	(29,348)	0	0.0%		(29,348)	(29,348)	0	0.0%		(354,719)	(354,719)	0	0.0%	
CCG Delegated Budgets																
Acute & Integrated Care Providers	Acute & Integrated Care NHS SLA - In Sector	16,366	16,606	240	1.5%		16,366	16,606	240	1.5%		196,394	197,208	814	0.4%	
	Acute & Integrated Care NHS SLA - Out of Sector	883	883	0	0.0%		883	883	0	0.0%		10,593	10,593	0	0.0%	
	SLA Exclusions	17	17	0	0.0%		17	17	0	0.0%		201	201	0	0.0%	
	SLA Reserve	0	0	(0)			0	0	(0)			0	0	(0)		
	Acute Re-admissions & Threshold	143	143	0	0.0%		143	143	0	0.0%		1,721	1,721	0	0.0%	
	Acute LAS	930	930	0	0.0%		930	930	0	0.0%		11,158	11,158	0	0.0%	
	Acute InHealth	66	66	0	0.0%		66	66	0	0.0%		795	795	0	0.0%	
	Acute Winter Pressures	320	320	0	0.0%		320	320	0	0.0%		1,709	1,709	0	0.0%	
	Non Contracted Activity	230	230	(0)	0.0%		230	230	(0)	0.0%		2,755	2,755	0	0.0%	
Acute & Integrated Care Total		18,955	19,195	240	1.3%		18,955	19,195	240	1.3%		225,327	226,141	814	0.4%	
Non Acute	Mental Health	3,749	3,712	(37)	-1.0%		3,749	3,712	(37)	-1.0%		44,994	45,139	145	0.3%	
	Learning Disabilities	250	237	(14)	-5.4%		250	237	(14)	-5.4%		3,004	2,921	(83)	-2.8%	
	Continuing Care	1,564	1,349	(215)	-13.7%		1,564	1,349	(215)	-13.7%		18,763	18,636	(127)	-0.7%	
	End of Life care	107	107	0	0.0%		107	107	0	0.0%		1,286	1,286	0	0.0%	
	Community Services	2,161	2,161	0	0.0%		2,161	2,161	0	0.0%		25,933	25,933	0	0.0%	
	Other Commissioning	0	0	(0)			0	0	(0)			0	0	0		
	Primary Care - QOHs, 111 & LESs	199	199	0	0.0%		199	199	0	0.0%		2,382	2,382	0	0.0%	
	Primary Care - Prescribing	3,316	3,316	0	0.0%		3,316	3,316	0	0.0%		39,790	39,790	0	0.0%	
	Primary Care - GPIT	0	0	(0)			0	0	(0)			0	0	(0)		
	Sexual Health	58	58	0	0.0%		58	58	0	0.0%		700	700	0	0.0%	
	Strategic Investments	849	881	32	3.8%		849	881	32	3.8%		10,185	10,161	(24)	-0.2%	
Non Acute Total		12,253	12,020	(233)	-1.9%		12,253	12,020	(233)	-1.9%		147,039	146,950	(90)	-0.1%	
Programme Corporate Costs Total	Programme Corporate Costs	454	322	(132)	-29.1%		454	322	(132)	-29.1%		5,054	5,050	(4)	-0.1%	
	QIPP	(169)	0	169	-100.0%		(169)	0	169	-100.0%		(2,033)	0	2,033	-100.0%	
		285	322	37	13.0%		285	322	37	13.0%		3,021	5,050	2,029	67.2%	
Total Commissioning Expenditure		31,493	31,537	44	0.1%		31,493	31,537	44	0.1%		375,386	378,140	2,754	0.7%	
Corporate Costs	CCG Running Cost (Excl CSU)	378	320	(57)	-15.2%		378	320	(57)	-15.2%		4,533	4,532	(1)	-0.0%	
	CCG Running Cost (CSU)	207	207	(0)	-0.1%		207	207	(0)	-0.1%		2,486	2,486	0	0.0%	
Corporate Costs Total		585	527	(58)	-9.9%		585	527	(58)	-9.9%		7,019	7,018	(1)	0.0%	
Estates Costs Total	CCG Non Running Cost (PropCo)	53	53	0	0.1%		53	53	0	0.1%		633	633	0	0.0%	
		53	53	0	0.1%		53	53	0	0.1%		633	633	0	0.0%	
Reserves and Contingencies Total	Reserves	0	0	(0)			0	0	(0)			5,081	2,329	(2,752)	-54.2%	
		0	0	(0)			0	0	(0)			5,081	2,329	(2,752)	-54.2%	
Total Expenditure		32,131	32,117	(14)	0.0%		32,131	32,117	(14)	0.0%		388,119	388,120	1	0.0%	
Unadjusted Surplus / (Deficit)	Deficit	(2,783)	(2,769)	(14)	0.5%		(2,783)	(2,769)	(14)	0.5%		(33,400)	(33,400)	1	0.0%	

Appendix 2 – QIPP Performance

To be produced in month 2

Appendix 3 Statutory Duties

	£m Month 1	£m YTD	£m Forecast	£m Plan
Capital Expenditure	NIL	NIL	NIL	NIL
Cash Drawdown	28.99	28.99	348.42	n/a
BPPC by number nhs	86%	86%	n/a	n/a
BPPC by value nhs	98%	98%	n/a	n/a
BPPC by number non nhs	94%	94%	n/a	n/a
BPPC by value non nhs	96%	96%	n/a	n/a

Appendix 4 Statement of financial position

	£m	£m
	Month 1	Movement in year
NHS Debtors	(0.0)	(0.3)
Non NHS Debtors	1.6	(0.4)
Bad Debt Provision	(2.4)	0.0
Prepayments & Accrued Income	3.7	0.4
VAT	0.1	0.0
Cash	2.5	2.5
Total Assets	5.4	2.2
NHS Creditors	(16.5)	(0.2)
NHS Accruals	(6.6)	(2.9)
Non NHS Payables	(7.0)	2.6
Family Health Services (FHS) Payables	(9.6)	(3.3)
Non NHS Accruals and Deferred Income	(4.1)	(1.8)
Tax	(0.1)	0.0
Other	(0.3)	0.2
Total Current Liabilities	(44.1)	(5.3)
Assets/(Liabilities) Employed	(38.6)	(3.1)
General Fund	£m	£m
Opening balance	(35.5)	0.0
Cash Drawdown	29.0	29.0
Net Expenditure	(32.1)	(32.1)
Taxpayers Equity	(38.6)	(3.1)

Appendix 5 Aged Debtors report

Debtor	Days overdue	0-30	31-60	61-90	91-120	121-180	181-360	>360 days	Total due
		£	£	£	£	£	£	£	£
ENFIELD LONDON BOROUGH COUNCIL		565,908	-	-	2,174	128,026	-	777,697	1,473,805
HEALTH EDUCATION ENGLAND		100,000	-	-	-	-	-	-	100,000
NHS HARINGEY CCG		-	45,878	-	-	-	-	-	45,878
BARNET ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST		6,472	7,713	-	-	-	5,764	-	19,949
NHS BARNET CCG		-	10,000	-	-	-	-	-	10,000
WINCHMORE PRACTICE		-	3,499	-	-	-	-	-	3,499
FOREST ROAD GROUP PRACTICE		-	1,504	-	-	-	-	-	1,504
OTHERS		2,279	6,433	-	-	983	-	1,104	10,799
Total		674,659	75,027	-	2,174	129,009	5,764	778,801	1,665,435

Appendix 6 Cash Flow

Enfield CCG													
Cash position and forecast													
Position as at 30th April 2015													
	April 2015 Actual	May 2015 Forecast	June 2015 Forecast	July 2015 Forecast	August 2015 Forecast	September 2015 Forecast	October 2015 Forecast	November 2015 Forecast	December 2015 Forecast	January 2016 Forecast	February 2016 Forecast	March 2016 Forecast	Total
RECEIPTS													
Balance b/w/d	184	3,061	937	321	325	279	234	189	144	99	54	109	184
BACS	516	100	100	100	100	100	100	100	100	100	100	100	1,616
NCB Drawdown	28,986	28,986	28,744	29,344	29,044	29,045	29,045	29,045	29,045	29,045	29,045	29,045	348,419
RFTs	304	100	100	100	100	100	100	100	100	100	100	100	1,404
Other	148	100	100	100	100	100	100	100	100	100	100	100	1,248
Risk Pool Funding													-
Prescribing - BSA Topslice (2 mths behind)	2,901	3,345	3,345	3,345	3,345	3,345	3,345	3,345	3,345	3,345	3,347	3,347	39,700
TOTAL	33,039	35,692	33,326	33,310	33,014	32,969	32,924	32,879	32,834	32,789	32,746	32,801	392,571
PAYMENTS													
Creditors NHS	21,733	26,585	25,085	25,085	25,085	25,085	25,085	25,085	25,085	25,085	24,985	25,149	299,132
Creditors BACS	4,877	4,390	4,140	4,140	3,890	3,890	3,890	3,890	3,890	3,890	3,890	3,890	48,667
Creditors CHAPS													-
Salary CHAPS													-
Cleared Payable Orders	28	30	30	10	10	10	10	10	10	10	10	10	178
Salaries & Wages	235	221	221	221	221	221	221	221	221	221	221	221	2,666
Pensions	71	71	71	71	71	71	71	71	71	71	71	71	852
Tax & NI	133	113	113	113	113	113	113	113	113	113	113	113	1,376
Standing Orders/Direct Debits													-
Foreign Payments													-
Other													-
Risk Pool Expenditure													-
Prescribing - BSA Topslice (2 mths behind)	2,901	3,345	3,345	3,345	3,345	3,345	3,345	3,345	3,345	3,345	3,347	3,347	39,700
TOTAL	29,978	34,735	33,005	32,985	32,735	32,735	32,735	32,735	32,735	32,735	32,637	32,801	392,571
BALANCE CFWD	3,061	937	321	325	279	234	189	144	99	54	109	-	-

MCD 388,119

Prescribing -39,700

Remaining Cash 348,419

Clinical Commissioning Group

Agenda Item: 7.3
Paper Ref: Appendix H

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 th June 2015
TITLE:	Financial Governance Review
LEAD BOARD MEMBER:	Robert Whiteford, Chief Financial Officer
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SUMMARY:

Following the deterioration in the CCGs financial position in 2014/15, the CCG jointly commissioned a Financial Governance Review with NHS England.

The review and the recommendations, together with the management response, are presented in this paper.

SUPPORTING PAPERS:

1. Financial Governance Review
2. Recommendations and Management Response

Note that appendix A of item 1 is the action plan and management response at the time of issue of the final report. It is superseded by supporting paper 2, which includes the same recommendations with updated CCG actions.

RECOMMENDED ACTION:

Members of the Committee are asked to note the Financial Governance Review and to approve the recommendations and management response.

Objective(s) / Plans supported by this paper: To ensure a robust system of Financial Governance is in place.

Patient & Public Involvement (PPI): N/A

Equality Impact Analysis: N/A.

Risks: There are no specific risks as the review deals with risk management in general. The risk of not implementing the measures recommended is that the Governing Body may not become aware of the CCG financial position in a timely manner.

Resource Implications: There are no specific resource implications.

Audit Trail: The Financial Governance Review, recommendations and management response have been presented to the Finance and Audit Committees.

Next Steps: Recommendations due for implementation by 30th June and 30th September respectively to be reported to the August and October meetings respectively.

NHS Enfield CCG

Financial Governance

Review 2014/15

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17 April 2015



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Executive summary

Introduction

Deloitte LLP ('Deloitte') was appointed in February 2015 by Enfield Clinical Commissioning Group ('the CCG') and NHS England to undertake a review of the CCG's financial governance structure and arrangements, in accordance with our engagement letter, dated 13 February 2015. Our review considers financial governance at the CCG between April 2014 and 20 February 2015.

2014/15 – Factual context

Outlined below are the key elements of the CCG's financial position and risk reporting throughout 2014/15:

Reported forecast deficit

The CCG reported a £5.6m forecast deficit between months 1 and 8. This was in line with the planned financial position agreed with NHS England.

- At month 8, the CCG forecast a deterioration in the financial position of £10m, due to a £6.2m adverse variance on acute expenditure and a £4m adverse variance on non-acute expenditure. A provisional balance of £10m of income from the risk share arrangement was recognised which offset the deterioration in the forecast position. The CCG agreed with NHS England (in December 2014) not to report the deterioration in financial forecast position at month 8 until more work was done to confirm the deterioration in the financial position.
- In month 9, the CCG revised its reported forecast deficit to be £19m, and reported this to NHS England and internally in January and February 2015 (respectively).
- The key elements of the deterioration in reported forecast deficit (£13.4m) are presented in Figure 2.4.1. The most significant items are:
 - £6.2m acute over-performance;
 - £4.7m (net) due to recognition of a financial risk in the financial forecast in relation to RTT expenditure;
 - £1.2m due to continuing healthcare payments, which the CCG was not expecting to be required to pay; and
 - £1.1m forecast QIPP non-delivery (against a QIPP plan of £12m).

Financial risk

- In months 2 and 3, the CCG reported a net financial risk of £1.8m. Between months 4 and 7, the CCG reported equal financial risks and financial opportunities and therefore no net risk to its forecast financial position.
- In month 8 the CCG included £10m of provisional risk share income in its forecast financial position. The CCG recognised a financial risk of the same value. The CCG agreed this treatment with NHS England.
- In month 9 both the £10m provisional income and associated financial risk were removed. The worst case scenario forecast deficit reported in month 9 (including the gross value of financial risk) was a deficit of £24.8m. This position was reported to the FR&Q on 10 February 2015.

Scope of this review

As agreed in our engagement letter, dated 13 February 2015, the scope of our review was to perform an assessment of the financial governance arrangements in place at the CCG during 2014/15 financial year, through the following key procedures:

- Review of key documents, including financial reports and minutes of meetings, between the period April 2014 to 20 February 2015;
- Observation of the meetings of the following committees held in February and March 2015: Financial Recovery and QIPP (FRQ) committee; the Transformation Programme and Financial Recovery Group; and the Audit Committee;
- Interviews with key members of the leadership team, including the Chief Officer, CFO, Chair of the CCG, Chair of the FRQ and Chair of the Audit Committee (details of further interviews held are included in Appendix B); and
- Meetings with the Director of Finance (London Region) at NHS England, and review of relevant information provided by NHS England.

Fuller details of our scope of work are included in Section 1 of this report along with information on the the limitations of our report (Section 1.6) and use of the report (Section 1.7).

Executive summary

Key findings and recommendations

Outlined on the following pages are the key findings and recommendations that have been identified within this review.

Area	Findings and recommendations	Reference to relevant area in the report
<p>2014/15 Financial planning</p>	<ul style="list-style-type: none"> • The CCGs financial planning processes for 2014/15 were underdeveloped. The key reasons for this are: <ul style="list-style-type: none"> • The CCG’s commissioning contracts changed from block contract to activity-based PbR in 2014/15. These contracts were set too low. It is understood that at the time of 2014/15 planning the CCG had limited capacity of finance team members with strong PbR experience; • The impact of seasonality on acute contracts was not represented fully in the planned levels of expenditure; and • Optimism in the ability to deliver the full QIPP target, despite £6m of £12m target being unidentified at the time of planning. • Key risks that were noted to the 2014/15 financial plan at the time of planning were not fully quantified or estimated, and were not stated overtly in relation to their potential impact on the financial position. • The impact of this is that the CCG commenced 2014/15 with an optimistic planned financial position, without a clear awareness of the worst case financial position should the financial risks that were identified materialise. • Financial planning for 2015/16 should be more accurate due to the CCG having the experience of a year of activity-based PbR contracts to base its planning on. The CCG has recruited an experienced and permanent Chief Finance Officer and is seeking a permanent Deputy Chief Finance Officer. CCG management has sought to increase the level of contracting experience, for example through the appointment of a Deputy Director of Contracts. <p>Recommendations</p> <ul style="list-style-type: none"> • A full financial risk assessment should be performed alongside 2015/16 planning, including quantification of identified risks and presentation of these to the CCG’s committees, in order to: <ul style="list-style-type: none"> • Increase transparency around the assumptions included and treatment of these risks in the financial position, as well as to communicate the potential for variance against the planned position should these risks materialise; and • To obtain approval from the committees for the 2015/16 financial plan and treatment of financial risks. • Identified financial risks should be reported regularly to the FR&Q and the Executive Committee, with clear details of the latest position and estimate of financial impact, as well as the change from the previous month. 	<p>Section 3 - Finding D3</p>

Executive summary

Key findings and recommendations (continued)

Area	Findings and recommendations	Reference to relevant area in the report
Financial risk and financial information	<ul style="list-style-type: none"> • Through a review of financial information reported between month 1 and month 9 2014/15, we identified weaknesses in the quality and style of financial information produced by the CSU and CCG, and reviewed by committees. These include: <ul style="list-style-type: none"> a) Financial risk <ul style="list-style-type: none"> • Throughout 2014/15, financial risks and opportunities have been presented in the Finance Reports presented to the FR&Q, mostly in equal proportions, therefore presenting no net unmitigated risk (as presented in Figure 2.4). • Presentation of a worst case scenario through presenting the financial forecast and financial risks together would have helped to expose earlier in the year the potential extent of the deterioration in the financial position. • The majority of the drivers for the deterioration in the financial position had been identified as financial risks and reported previously by the CCG internally and to NHS England. The CCG was optimistic about the likelihood of the receipt of funding to mitigate these risks, as well as its ability to delivery unidentified QIPP savings. Mitigations were not removed until their non-receipt was fully certain. b) Financial information <ul style="list-style-type: none"> • The underlying financial position and run rate is not clearly presented in the Finance Report throughout 2014/15, particularly in months 1 to 4 where reserves were applied to manage the financial position, making it difficult to understand and observe trends in the true underlying financial position. • The CCG does not report best or worst case scenarios for the financial position, and it therefore does not expose the potential range in the financial position effectively. • Committees are not supported and directed in their review and response to financial information. For example, the CSU provides detailed reports on the underlying financial and activity performance at a provider level. These reports contain detailed information, and are not appropriately focused to draw out the key messages and any concerns for the committees they are issued to. • The Finance Report does not communicate clearly changes month on month in the financial position and the risks, making it difficult to understand what has happened and the direction of travel. • The timing of the TP&FRG and FR&Q committee meetings means that these are committees reviewing information that is out of date, often relating to the financial period 2 months before the committee date. <p>Recommendations</p> <ul style="list-style-type: none"> • Improvements are required to the CCG's financial information, for example to include presentation of the best and worst case scenarios, details of the underlying position and run rate, and clarity on the month on month change in the financial position (particularly noting the latest position on key financial risks). We note that this recommendation has been partially addressed through the production of an improved Finance Report that was presented to the Executive Committee in February 2015. • Financial information needs to be presented to committees with clarity around the reason for its presentation, the key focus areas, and the response required from the committee. • Actions taken to manage the financial position, for example the application of reserves or mitigations to the position, should be presented transparently to expose the underlying financial position and the impact of the actions taken. 	Section 3 - Findings D1, D2, D4 and D5

Executive summary

Key findings and recommendations (continued)

Area	Findings and recommendations	Reference to relevant area in the report
<p>Committee effectiveness</p>	<ul style="list-style-type: none"> Throughout 2014/15, the number of members of the FR&Q with financial experience has been low – with only the Chief Executive and CFO being finance qualified. The CCG has struggled to recruit to the role of external finance member, and the Chair of the FR&Q (who was in place until January 2015) did not have a financial background. There is limited evidence of challenge noted in the minutes of the FR&Q before and at the time of the reporting of the deterioration in the financial position, <i>particularly in December 2014 and January 2015 meetings when the significant deterioration in the financial position came to light.</i> The purpose and alignment of committees with a financial remit is unclear, and not fully supported by clear Terms of Reference. Internal Audit reviews have been understandably focused in financial areas; there is a risk that broader risks are not given sufficient attention. CCG management has made attempts to increase the level of financial experience on the FR&Q; the Chair of the FR&Q was changed in January 2015, and the Chair of the Audit Committee, a chartered accountant, is acting in the role of the external finance member since January 2015. Evidence of challenge around financial matters and accountability has been noted in the February 2015 meeting. <p>Recommendations</p> <ul style="list-style-type: none"> To continue urgent efforts to recruit to the post of external finance member for the CCG. Perform a review of the alignment and purpose of the committees in relation to finance, particularly the TP&FRG, FR&Q and Executive Committee. Re-emphasise the purpose of these committees and the responsibilities of the members. Urgently revise the timing of the committees (particularly the FR&Q), to ensure that the committee are able to review the most recent financial information available. NHS Enfield CCG management inform us this has since been implemented. To ensure that the remit of the Audit Committee is clear and adhered to, so that the risk of duplication of the remit of other committees or the Governing Body is effectively managed. To ensure that Internal Audit plans maintain sufficient breadth of focus to cover the CCG's key strategic risks. 	<p>Section 3 - Findings B1 and C2</p>
<p>Financial capability and capacity</p>	<ul style="list-style-type: none"> The CCG (and former PCT) has experienced significant difficulty in recruiting substantively to senior positions, particularly in Finance. The person filling the CFO has changed 3 times, while the Deputy CFO has changed twice, since April 2013. The CCG recruited substantively to the post of the CFO in November 2014; the Deputy CFO role is currently filled on an interim basis. Instability in the financial leadership at the CCG is expected to have resulted in a lack of strategic financial leadership throughout 2014/15. The CCG finance team demonstrated optimism bias, for example through reporting risk and mitigations at equal value, throughout the majority of 2014/15, and rarely reporting the worst case position should financial risks materialise. <p>Recommendations</p> <ul style="list-style-type: none"> Continue efforts to recruit substantively to the post of the Deputy CFO. CCG management has engaged a recruitment consultant to assist in this. Improvements to financial reporting noted on the previous page will help to reduce the level of optimism bias in the reporting of the financial position and financial risks. Development sessions should be planned and delivered for the Governing Body and Executive Committee. These should focus on finance, and particularly on financial forecasting, planning and reporting in an NHS CCG context. 	<p>Section 3 - Finding B2</p>

Executive summary

Key findings and recommendations (continued)

Area	Findings and recommendations	Reference to relevant area in the report
CSU financial information and service performance	<ul style="list-style-type: none"> Through interviews performed, it has been noted that there is a perception that performance of the CSU has been weak in certain areas. Financial reports produced by the CSU generally contain a high level of detail, with limited analysis or summarisation of key points. 'Deep dives' have been performed in the year by the CSU, which contain analysis and clearer messages. However, these have been noted through interviews and review of committee minutes as reactive to requests rather than produced as standard. The 5 CCGs have agreed to a service improvement plan with the CSU. <p>Recommendations</p> <ul style="list-style-type: none"> A review of the financial information the CSU (or other CSUs) produces for other CCGs may help to identify examples that are more suited to the CCG's requirements. The CCG should seek to identify and implement methods to ensure the regular production of financial information that suits its needs. For example, through specific agreement with the CSU on the style and content of CSU produced financial information. The CCG should ensure that its own requirements are clearly reflected in the CSU service improvement plan that has been agreed amongst the 5 CCGs and include a quarterly review of progress in this area. 	<p>Section 3 – Finding D2</p>

Next steps

CCG management has already implemented a number of actions in response to this review, as detailed in section 2, and has developed a management response and action plan (as detailed in Appendix A).

The next steps that should be taken in response to this report are:

- CCG management to present and agree the findings of this report with the Governing Body;
- The CCG's Governing Body to approve the management response and action plan (as included in Appendix A);
- CCG management to meet with NHS England to agree the findings, the management response and action plan;
- CCG management to produce and agree a Financial Recovery Plan, as outlined below; and
- CCG management to report progress against implementation of remaining recommendations in this report to both NHS England and to the CCG's Governing Body, at the end of quarter 1 and quarter 2 in 2015/16.

Financial Recovery Plan

CCG management has agreed with NHS England to produce a Financial Recovery Plan, covering a 5 year period. The following has been agreed between the CCG and NHS England:

- Plan production:** A revised 5 year plan, meeting business rules by the end of the 5 year period, will be produced for the 14th May 2015;
- Governance:** This plan to be then taken to the CCG Governing Body on the 10th June 2015, and to be subject to specific discussion and sign off by NHS England between the 14th May and the 10th June 2015.

We would like to thank management for the support and cooperation received during this review.

1. Scope and approach

1.1 Introduction

Deloitte LLP ('Deloitte') was appointed in February 2015 by Enfield Clinical Commissioning Group ('the CCG') and NHS England to undertake a review of the CCG's financial governance structure and arrangements, in accordance with our engagement letter, dated 13 February 2015. Our review considers financial governance at the CCG between April 2014 and 20 February 2015.

This section of the report sets out the scope of work, and the approach taken.

1.2 Scope of our work

In line with our signed engagement letter, our scope of work is to review the financial governance arrangements in place at the CCG, over the period April 2014 to 20 February 2015, through carrying out the following procedures:

a) Financial governance arrangements

- Examine the process for review and monitoring of CSU reporting and develop an understanding of the quality of this reporting.
- Review minutes of the following committees for meetings held in 2014/15, in order to develop an understanding of the financial governance structures and processes in place at the CCG, and the quality of debate and challenge in relation to financial matters:
 - Governing Body;
 - Executive Committee;
 - Financial Recovery and QIPP Committee;
 - Transformation Programme and Financial Recovery Group; and
 - Audit Committee.
- Review the Terms of Reference for the following committees, in order to understand and provide comment on their financial responsibilities:
 - Financial Recovery and QIPP Committee;
 - Transformation Programme and Financial Recovery Group; and
 - Audit Committee.
- Attend a sample of the following key committees and provide comment on their operation and the quality of decision making, and execution against their Terms of Reference:
 - Financial Recovery and QIPP committee;
 - Transformation Programme and Financial Recovery Group; and
 - Audit Committee.

- Interview key past and present members of the Governing Body (including the Audit Committee Chair), members of the finance team and CSU to develop an understanding of the process for assurance of reported monthly and year end positions.
- Review all Audit Committee papers for meetings held in 2014/15 for evidence of discussion, challenge and actions on reported monthly and year end positions.
- Review the Financial Risk Register and associated governance processes to evidence understanding and mitigation of financial risks.
- Carry out a focused range of additional procedures as required and as summarised in the Deliverable.

b) Monthly reporting processes

- Develop an understanding of processes for reporting of performance against key contracts and the nature of any adjustments made to reported activity data.
- Develop an understanding of the assumptions used to determine forecast outturn and the method used to identify and report key risks and mitigations to the financial position.
- Test consistency of reporting of financial expenditure (year to date and forecast), as well as financial risks and opportunities, reported in the CCG's internal monthly Finance Reports, and the CCG's finance returns to NHS England, to the CCG's general ledger.

We performed our scope of work between the period of 3 February 2015 and 20 February 2015.

1.3 Our approach

Our step by step approach to performing the agreed procedures is outlined in Figure 1.3 on the following page.

1. Scope and approach

1.3 Our approach (continued)

Approach to the review

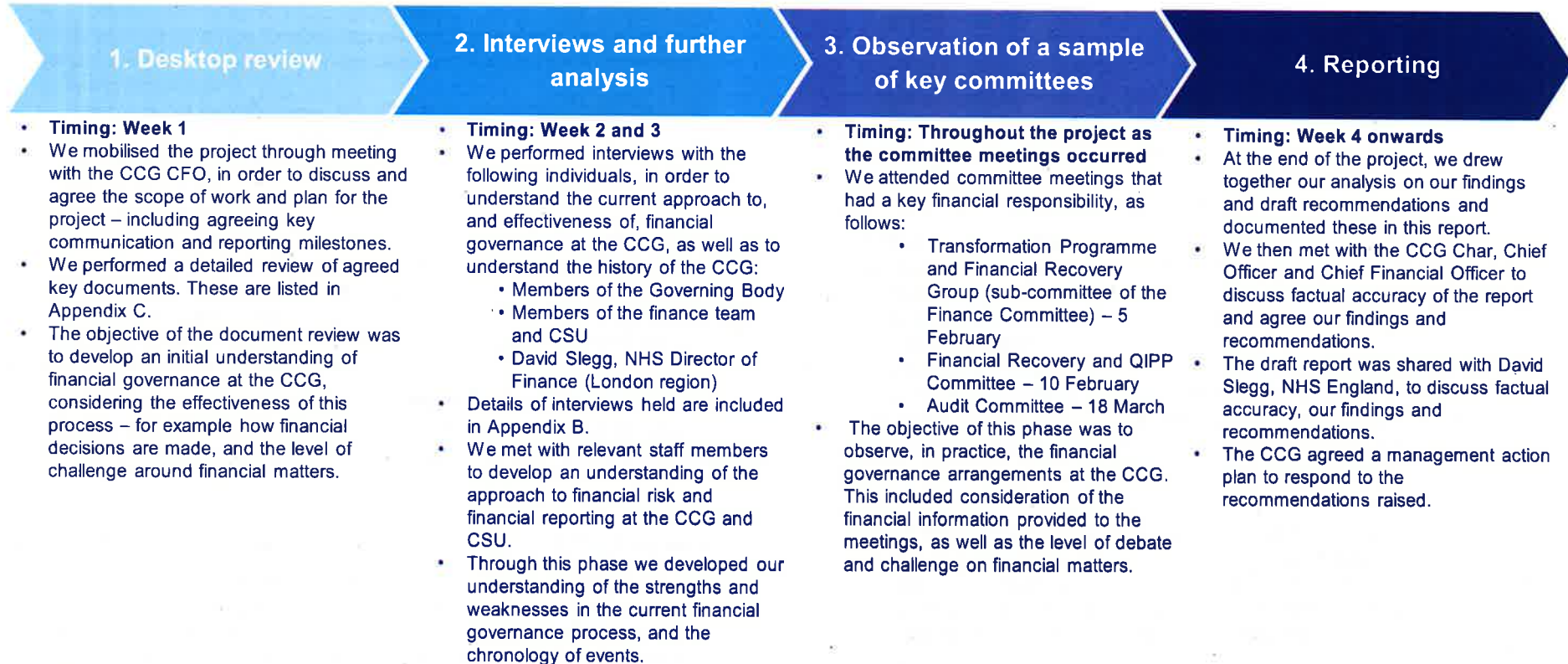


Figure 1.3: Approach to the review

1. Scope and approach

1.4 Framework for the review

Deloitte has performed a number of Foundation Trust reviews under the Monitor “Well-Led” approach. Through its supporting guidance, “Well-led framework for governance reviews: guidance for NHS foundation trusts”, the Well-Led approach outlines a framework for assessors to follow in performing assessments of a Trust’s governance arrangements. Although this framework is intended primarily for Trusts, we consider this to be a useful framework to use to structure the analysis of the project.

As illustrated in Figure 1.4, the Well-Led approach is organised around 4 key core capabilities:

1. Strategy
2. Capability and culture
3. Structures and processes
4. Measurement

The approach covers broad areas of governance, that are beyond the remit of financial governance. The principles within the framework are useful, however, as a reference and basis for a review of any type of governance.

In performing our scope (as set out in Section 1.2) we have not attempted to perform a Well-Led governance review, however we have referred to the Well-Led principles where appropriate, particularly to structure and communicate our findings. The scope outlined in Section 1.2 fits mostly into capabilities 3 and 4, with a limited element of the scope aligning to capabilities 1 and 2.

Our findings (as presented in Section 3) are presented in alignment with the 4 core capabilities.



Figure 1.4: The Monitor “Well-Led” review framework

1. Scope and approach

1.5 Structure of our report

This report is structured around the following key sections:

- **Section 2** – Context of the review
- **Section 3** – Detailed findings and recommendations
- **Section 4** – Next steps for management to consider
- **Appendices** – Including supporting information for our review, and outputs including:
 - Summary of interviews held
 - Summary of documents reviewed
 - Details of committee meetings observed in this review
 - The CCG's committee structure and relevant details
 - Results of detailed testing performed
 - NHS Enfield CCG Management response and action plan

1.6 Limitations of our report

Our Report is provided in accordance with our engagement letter, dated 13 February 2015.

You are responsible for determining whether the scope of our work as set out in the engagement letter and in Section 1.2 of this Report is sufficient for your purposes. We make no representation regarding the sufficiency of these procedures for your purposes. If we were to perform additional procedures, other matters might come to our attention that would be reported to you.

The procedures we performed did not constitute an audit of any kind. We did not subject the information contained in our Report or given to us to checking or verification procedures, except to the extent expressly stated. This is normal practice when carrying out such a review, but contrasts significantly with, for example, an audit. The procedures we performed were not designed to and are not likely to reveal fraud.

This document should not be taken to supplant any other enquiries and procedures that may be necessary to satisfy your requirements. The Report is based solely on the information provided. To the extent that the final terms and circumstances differ from those presented, it may be necessary for you to seek an updated view on the information originally provided.

This review was performed on the CCG's financial governance arrangements. The review did not involve consideration of the financial governance arrangements or associated financial processes, or any aspect of the internal control environment at NHS England.

As deemed necessary to develop a high level understanding of the CCG's financial governance and financial reporting procedures, we liaised with the North East London Commissioning Support Unit (CSU) staff as required. We did not, however, perform a review of the financial governance structures and arrangements in place at the CSU, or any element of the CSU internal control environment; this was considered to be outside the scope of this engagement.

As part of this review, we did not speak directly to any of the CCG's previous CFOs. Particularly, we did not speak directly to the interim CFO who is the predecessor to the current CFO, who was in post between July and October 2014.

1.7 Use of this document

Our document is prepared solely for CCG and NHS England exclusive use. Our document is not to be used for any other purpose, recited or referred to in any document, copied or made available (in whole or in part) to any other person except as required by law without our prior written express consent. To the fullest extent permitted by law we accept no duty, responsibility or liability to any other party in connection with this document or this engagement.

2. Context of the review

2.1 Introduction

This section of the report outlines the context for the review, including:

- Details of the CCG and its financial history since formation in April 2013;
- Background to planning of the financial position in 2014/15;
- Reporting of the financial position over the 2014/15 financial year, both internally and to NHS England; and
- Changes to the financial leadership at the CCG over the period April 2013 to February 2015.

2.2 Wider context in the NHS

During 2014/15, a number of challenges have arisen for the NHS, in relation to both financial and operational performance. These have been widely reported by NHS England and the media.

Many organisations across the NHS have experienced unprecedented patient demand, coupled with deteriorating financial positions. There has been a significant increase in the number of Trusts missing the A&E 4 hour wait target, as well as targets relating to wait times for cancer treatment and hospital operations.

The pressure on NHS organisations is increasing, as measures to control or redirect patient demand fail to be as effective as planned, while the government simultaneously acts to control spending in the sector.

Overall, Clinical Commissioning Groups (CCGs) are reporting an aggregate £6m surplus for 2014/15 (NHS England Board paper, January). However, there are a number of CCGs that are forecasting a deficit position - 22 of the 211 are forecasting a year end deficit (HFMA).

In 2015/16, the NHS budget will continue to increase overall in real terms, to a budget of £115bn. However, the challenges experienced in 2014/15 look set to continue; the King's Fund has calculated that at least a further £2bn of funding is required in the coming financial year, in order to avoid further increases to patient waiting times and potential decreases in quality of care.

2.3 Background to the CCG

2.3.1 CCG background

NHS Enfield CCG was formed on 1 April 2013, under the directions of the Health and Social Care Act 2012. The CCG commissions healthcare services for the Enfield borough from a number of providers. The core providers for the CCG are North Middlesex University Hospital NHS Trust (NMUH) and Barnet and Chase Farm NHS Trust (B&CF, part of the Royal Free London NHS Foundation Trust from July 2014).

The CCG was authorised with 7 conditions, including the following which have a direct governance and financial relevance (Governing Body minutes, March 2013):

- The CCG needs to clearly set out how it will achieve financial balance and manage within its management allowance and other required constraints.
- Further evidence is required to demonstrate that the risk-sharing arrangements has been agreed with neighbouring CCGs.
- Further support is needed to ensure that the capacity of the senior leadership team is developed to sufficiently address the CCG's strategic issues.

Enfield CCG inherited a challenging financial position from the former Enfield Primary Care Trust (PCT). As at the end of 2011/12, the PCT's recurrent deficit reached £39.2m; in 2012/13 improvements were made to the financial position and the underlying run rate improved significantly, an in-year underspend against Revenue Resource Limit of £2.8m was achieved.

Year	2011/12 (PCT) £m	2012/13 (PCT) £m	2013/14 (CCG) £m
In year surplus / (deficit) against RRL	(17.2)	2.8	0.4

Table 2.3: Historical in year surplus or deficit position

Source: Enfield PCT accounts 11/12, Enfield CCG accounts 13/14

2. Context of the review

2.3 Background to the CCG (continued)

At the start of 2013/14, the CCG agreed a financial recovery plan, with the objective of achieving recurrent financial balance over a two year trajectory from the inherited recurrent run rate deficit of £19.2m. The plan forecast the achievement of a breakeven position in 2013/14, mainly through reducing the recurrent deficit and the application of non-recurrent measures including the release of the CCG's 2% reserve, as well as £6m funding from the risk share arrangement. The CCG achieved a small surplus position in 2013/14.

The CCG commenced 2014/15 with a planned deficit of £5.6m. In December 2014, the CCG advised NHS England of a potentially deteriorating financial position. An external review of the forecast outturn position was commissioned, and this indicated a likely outturn position of £19m deficit. The CCG reported this revised financial forecast to its Governing Body and NHS England in month 9, having previously reported up to that point that it would achieve its financial plan.

2.3.2 Financial planning for 2014/15 and contracting

The CCG performed its financial planning in late 2013/14 and early 2014/15. As at July 2014, the CCG had agreed contracts with a number of its main providers. Contract negotiations with B&CF and UCLH, however, continued into August 2014.

As noted from the CCG's 2014/15 financial planning documentation and through interviews held, the following are understood to be key elements of the 2014/15 financial plan:

- A planned deficit of £5.6m was agreed with NHS England, as submitted in plans to NHS England 20 June 2014. It is understood that this financial position broadly assumed that acute contracts and non-acute contracts would be delivered at planned levels; the planned overspend is understood to be related to the transfer of specialised commissioning services to NHS England (the impact of this transfer of funding in 2013/14 had a net impact of £5.7m adverse);
- Planned QIPP was included at £12m; however, at the time of planning in June 2014 £6m of this QIPP target remained unidentified;
- 2014/15 was the first year that the CCG agreed activity-based Payment by Results (PbR) contracts with its main providers. In 2013/14, the CCG had agreed block contracts with all providers except UCLH; and

- The key financial risks for 2014/15 were identified as over performance on acute contracts (particularly noting the risk of 2014/15 as the first year for activity-based contracts) as well as the achievability of the QIPP target. Estimates for the financial impact of these risks were not included in the CCG's financial plan or deficit calculation.

2.3.4 The NCL CCG Risk Share arrangement

There are five CCGs within the North Central London (NCL) area, these are:

- Barnet
- Camden
- Enfield
- Haringey
- Islington

The 5 CCGs have in place a risk share agreement, that requires each CCG to contribute an agreed level of funds to the risk share pool. Funds are then made available to fund joint investments and unexpected expenditure at each CCG, awarded through a business case submission and voting process. In 2014/15, the total funds contributed to the risk share pool are £16.9m; the most significant contribution of £6.9m is from Camden CCG. Enfield CCG contributed £1.7m to the risk share pool in 2014/15 (as reported to the FR&Q in November 2014).

The proposed application of the funds in 2014/15 covers a number of areas, the most significant being £8m for Primary Care Strategy and £6.3m for Barnet, Enfield and Haringey (BEH) Clinical Strategy. The provisional allocation of funds to Enfield CCG is £2.3m for 2014/15, with £2m of this awarded in relation to the Primary Care Strategy (FR&Q, November 2014). In 2013/14, the CCG received £6m from the risk share in relation to acute over performance and the impact of changes to specialist commissioning.

It is understood that there hasn't been a strong culture of cross-working amongst the 5 CCGs. A cross-CCG financial leadership position has not been established in this region of London.

The CFOs of each of the 5 CCGs meet weekly to discuss financial matters. Options are being considered to establish cross-CCG strategic financial leadership, similar to that in place in other parts of the London region.

2. Context of the review

2.3 Background to the CCG (continued)

2.3.5 The Commissioning Support Unit (CSU)

The CCG commissions the following key support services from the North East London CSU (NELCSU):

<ul style="list-style-type: none">• Corporate: Finance, Legal, HR and payroll;<ul style="list-style-type: none">• Financial governance, monthly financial reporting, financial accounting, finance planning to support annual contract negotiations; and• Cash management, AP, AR.
<ul style="list-style-type: none">• Quality and provider management;
<ul style="list-style-type: none">• Procurement and market management;
<ul style="list-style-type: none">• Support for commissioning/QIPP planning and service redesign; and
<ul style="list-style-type: none">• Business intelligence information technology and informatics.

The CSU maintains the financial infrastructure for the CCG, including the general ledger, and takes a key role in reporting financial information for the CCG. The CSU produces monthly reports for the CCG, which include financial information, as well as contract management and activity information. Throughout the year, the CSU has been requested by the CCG to provide “deep dive” reviews into areas of increasing activity and expenditure, for example A&E and outpatient activity as reported to the FR&Q in October 2014.

The CSU produces monthly management account information for the CCG. The CCG feeds into the process by communicating specialised operational knowledge and challenging the basis for estimation and the level of accruals. The key steps for the production of the monthly financial position are:

- The CSU analyses provider activity information to provide an estimate to forecast expenditure on acute and non-acute activity and running costs. Some of this is done in advance of the end of the month and the CCG will feed in specialised knowledge;
- The CSU analyses provider activity data to issue financial challenge and uses performance metrics to manage CCG contracts with providers;

- There is a pre-ledger closure meeting between the CSU and CCG finance team on working day 4. The objective of this meeting is to:
 - understand the financial management information;
 - understand the adjustment to the ledger position for activity forecast and contractual challenges with providers;
 - challenge information and agree the ledger position; and
 - identify any further analysis required.
- General ledger closes on working day 7;
- The CSU provides a hard close trial balance and management information report to the CCG;
- The CCG use this to send budget statements to budget holders; and
- Monthly financial performance reports are produced for CCG committees by working day 10.

The month-end process has changed part-way through the year to enable involvement of the CCG earlier in the process.

The 5 CCGs (as defined in 2.3.4) have agreed a service improvement plan with the CSU in response to identified areas of weaker performance.

2.3.6 Committee structure

The CCG's committee structure, including details of membership, terms of reference and information considered by the committee, is presented in Appendix G. The most important committees in the CCG's financial governance structure are:

- The Governing Body;
- The Executive Committee;
- The Audit Committee;
- The Financial Recovery and QIPP Committee (FR&Q); and
- The Transformation Programme and Financial Recovery Group (TP&FRG, sub-committee of the FR&Q. This was formed from the merger of two previous committees during 2014/15 – The Transformation Programme Group and the Financial Recovery Group.)

2. Context of the review

2.3.6 Committee structure (continued)

It is understood that during the establishment of the CCG, a number of organisational development sessions were held with the Governing Body and the Executive Committee. These included financial sessions, including basic sessions on finance in the NHS.

The key members of the Executive Committee with a financial background are the Chief Officer, the Chief Financial Officer and the Chair of the Audit Committee, all of which are qualified accountants.

2.4 Chronology of the reported financial position in 2014/15

Figure 2.4 on the following page illustrates the financial position reported by the CCG throughout 2014/15. It shows the reported forecast deficit (reported both internally and to NHS England), as well as the risks and opportunities as stated in the CCG's Finance Report. The key messages from this include:

Reported forecast deficit

- The CCG reported a £5.6m forecast deficit between months 1 and 8. In month 9, the CCG revised its reported forecast deficit to be £19m.
- At the time of publication, we understand from CCG management the latest year-end position forecasts the achievement of the £19m revised deficit position. However, it is noted the year-end position is yet to be finalised.
- The key elements of the deterioration in reported forecast deficit (£13.4m) are presented in Figure 2.4.1. The most significant items are:
 - £6.2m acute over-performance;
 - £4.7m (net) due to recognition of a financial risk in the financial forecast in relation to RTT expenditure;
 - £1.2m due to continuing healthcare payments, which the CCG was not expecting to be required to pay; and
 - £1.1m forecast QIPP non-delivery (against a plan of £12m).

Financial risk

- In months 2 and 3, the CCG reported a net financial risk of £1.8m. Between months 4 and 7, the CCG reported equal financial risks and financial opportunities and therefore no net risk to its forecast financial position.
- In month 8 the CCG included £10m of provisional risk share income in its forecast financial position. The CCG recognised a financial risk of the same value. The CCG agreed this treatment with NHS England.
- In month 9 both the £10m provisional income and associated financial risk were removed. The worst case scenario forecast deficit reported in month 9 (including the gross value of financial risk) was a deficit of £24.8m. This position was reported to the FR&Q on 10 February 2015.

It is understood (through interviews held) that the Chief Officer had received assurances from the interim Chief Financial Officer that mitigations would be sufficient to offset financial risks throughout 2014/15, up until October (month 7). This assumption was reported in the CCG's finance reports until (and including) month 7.

Figure 2.4.1 overleaf illustrates the key items that bridge the CCG's financial position, between the £5.6m planned deficit position and the £19m forecast deficit position reported in February 2015.

2. Context of the review

2.4 Chronology of the reported financial position in 2014/15 (continued)

Reserves

The CCG identified within its annual plan specific reserves of £4.5m in acute & integrated care and £1.7m general reserves.

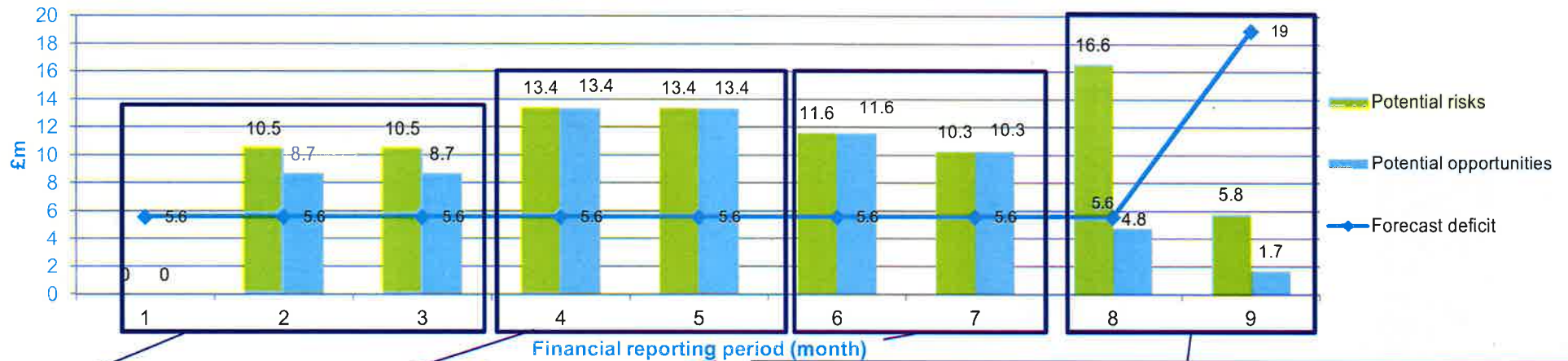
The key releases to non-acute services from the acute and integrated care reserve (£4.5m) are:

- £1.3m continuing health care; and
- £1.8m integrated care programme.

The remaining £1.4m acute and integrated care reserve has been allocated to support adverse in-year performance on acute SLA contracts and QIPP.

Funds held within general reserves set at £1.7m have been allocated to manage the financial position.

Figure 2.4: Forecast deficit, risks and opportunities reported throughout 2014/15



Months 1 to 3

- The CCG commenced the year with a planned £5.6m deficit
- Reporting on the month 2 and 3 position identified a net risk to the financial position of £1.8m (month 2 and 3 reported to FR&Q in July and August 2014, respectively).

Months 4 and 5

- The reported value of both financial risk and opportunity increased for month 4 and 5.
- Key financial risks included £8.4m for the financial impact of Trusts performing activity to meet the RTT target.
- Overall no net risk reported as opportunities are equal in value to reported risks. Reported forecast deficit remained £5.6m.

Months 6 and 7

- The reported value of financial risks and opportunity vary in months 6 and 7. They remain similar in nature, with no net risk reported.
- Reported forecast deficit remained £5.6m

Month 8 (Reported to FR&Q January 2015)

- The expenditure forecast deteriorated by £10m, mostly due to acute forecast deterioration of £6.2m as a result of an external review performed. Through review of the run rate and forecast, this identified the need to increase the forecast acute expenditure level and factor in the impact of greater seasonality.
- Non-acute activity forecast deteriorated by £4m which primarily arises from recognising a £1.2m liability for continuing care and £1.3m in relation to primary care strategy (explained further at Figure 2.7).
- The CCG maintained a reported forecast deficit position of £5.6m, through balancing the position by including an un-agreed provisional £10m drawdown from the North Central London Risk Share. This was also included as a financial risk. The CCG agreed this treatment with NHS England.
- £5.6m forecast deficit, as well as the position on financial risk and opportunity, reported to NHS England through monthly returns.

Month 9 (Reported to FR&Q February 2015)

- The reported forecast outturn deteriorated to £19m, an adverse variance to planned deficit of £13.4m. This deterioration is shown in Figure 2.4.1.
- The CCG included RTT expenditure of £6.6m in its position for the first time in month 9; in previous months this had been removed from the forecast outturn and held as a financial risk.
- The provisional £10m drawdown from the NCL risk share was removed from the forecast and from financial risks.
- £19m forecast deficit, as well as the position on financial risk and opportunity, was reported to NHS England through monthly returns.
- A further net risk of £4.1m was reported.

Figure 2.4: Forecast deficit, risks and opportunities reported throughout 2014/15
 Source: All information taken from CCG Finance Reports presented to the FR&Q throughout 2014/15

2. Context of the review

2.4 Chronology of the reported financial position in 2014/15 (continued)

Figure 2.4.1: Bridge between planned deficit position and month 9 reported forecast position

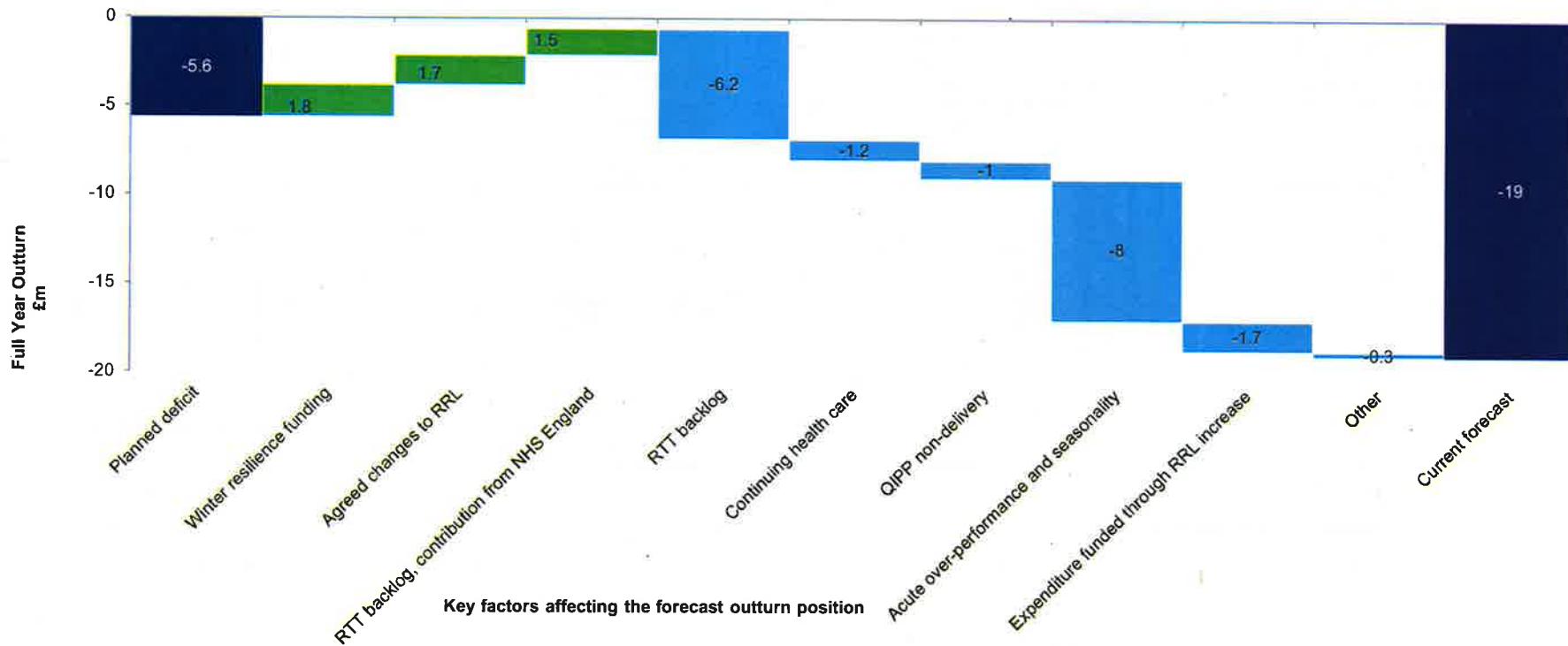


Figure 2.4.1: Bridge between planned deficit position and month 9 reported forecast position

Source: CCG Finance Reports presented to the FR&Q throughout 2014/15, CCG management information and discussions with the CCG finance team.

2. Context of the review

2.4 Chronology of the reported financial position in 2014/15 (continued)

The following table details the financial reporting throughout 2014/15 both internally in the CCG and to NHS-England, including the forecast financial position.

The column on the left outlines the financial reporting month, while the column on the right includes the date that the position for relevant financial reporting month was reported to the CCG committees and to NHS England.

There is, in general, a delay of 5 or 6 weeks from the month end to reporting the financial position to the FR&Q. There is also a lag in the receipt of activity information which means that the reported financial position includes an estimate for 1 month of activity information.

Financial reporting month	Key chronology	Reporting (Including date reported)
April (1)	<p>Committee reporting</p> <ul style="list-style-type: none"> Update on 2014/15 planning presented. A deficit of £5.6m was been calculated and stated. Includes assumption of a £12m QIPP achievement. Key risks to 2014/15 outlined as over performance on acute contracts and failure to meet QIPP targets (£6.5m unidentified at this point) <p>NHS England reporting</p> <ul style="list-style-type: none"> Not prepared 	<p>Committee reporting</p> <ul style="list-style-type: none"> FR&Q (7/5/14)
May (2)	<p>Committee reporting</p> <ul style="list-style-type: none"> A deficit of £5.6m is stated as the planned and forecast position. £6m of planned QIPP remains unidentified. The month 2 Finance Report reports: <ul style="list-style-type: none"> A deficit of £986k against a planned deficit of £933k (£53k adverse variance); Potential risks of £10.5m, the most significant being £5m acute over performance and £5.0m unidentified QIPP; and Potential opportunities of £8.7m, the most significant being £5.0m "Recommendation from McKinsey review". A net risk of £1.8m is therefore reported. <p>NHS England reporting</p> <ul style="list-style-type: none"> £5.6m deficit reported; and Net risk reported to within the non-IFSE return is £1.8m; risk £10.5m and mitigation £8.7m. 	<p>Committee reporting</p> <ul style="list-style-type: none"> FR&Q (2/7/14) <p>NHS England reporting</p> <ul style="list-style-type: none"> Working day 8, June 2014
June (3)	<p>Committee reporting</p> <ul style="list-style-type: none"> A deficit of £5.6m remains the planned position. "£5m to £6m" of planned QIPP remains unidentified. The month 3 Finance Report reports: <ul style="list-style-type: none"> A deficit of £1,258k against a planned deficit of £1,264k (£6k favourable variance). £0.9m of reserves and unused budgets are supporting the position. Potential risks of £10.5m, the most significant being £5m acute over performance and £5.0m unidentified QIPP; and Potential opportunities of £8.7m, the most significant being £5.0m "Recommendation from McKinsey review". A net risk of £1.8m is therefore reported. <p>NHS England reporting</p> <ul style="list-style-type: none"> £5.6m deficit reported; Net risk reported to within the non-IFSE return is £1.8m; risk £10.5m and mitigation £8.7m; and Q1 Assurance Meeting (Occurred September 2014) – Reported forecast achievement of financial plan. Also reported risks around significant over performance on acute contracts, and that £5m of the £12m QIPP target is unidentified. <p>Change in financial leadership (CFO) – Simon East was replaced by Ian Winning in July 2014 (interim CFO role).</p>	<p>Committee reporting</p> <ul style="list-style-type: none"> FR&Q (6/8/14) Governing Body (30/07/14) <p>NHS England reporting</p> <ul style="list-style-type: none"> Working day 8, July 2014 Q1 assurance meeting 2 September 2014

2. Context of the review

2.4 Chronology of the reported financial position in 2014/15 (continued)

Financial reporting month	Key chronology	Reporting
July (4)	<p>Committee reporting</p> <ul style="list-style-type: none"> • A deficit of £5.6m remains the planned position. • £5.1m of planned QIPP remains unidentified. • The month 4 Finance Report reports: <ul style="list-style-type: none"> • A deficit of £1,862k against a planned deficit of £1,867k (favourable variance of £5k). £1.5m of reserves and unused budgets are supporting the position; • Potential risks of £13.4m, the most significant being £8.4m for RTT (which has been removed from the forecast) and £3.1m Continuing healthcare risk; and • Potential opportunities of £13.4m, the most significant being £5.7m income expected from the NCL CCGs risk share and £5.0m savings calculated by the Financial Recovery Group. • No net risk is therefore reported. <p>NHS England reporting</p> <ul style="list-style-type: none"> • £5.6m deficit reported; and • Net risk reported to within the non-IFSE return is £1.9m; risk £10.6m and mitigation £8.7m. 	<p>Committee reporting</p> <ul style="list-style-type: none"> • FR&Q (3/9/14) <p>NHS England reporting</p> <ul style="list-style-type: none"> • Working day 8, August 2014
August (5)	<p>Committee reporting</p> <ul style="list-style-type: none"> • A deficit of £5.6m remains the planned position. • £5.1m of planned QIPP remains unidentified. £10.9m of QIPP delivery forecast for the full year. • The month 5 Finance Report reports: <ul style="list-style-type: none"> • A deficit of £2,328k against a planned deficit of £2,333k (£5k favourable variance). This position includes full utilisation of the acute reserve and SLA exclusion budgets; • Potential risks of £13.4m, the most significant being £8.4m for RTT (which has been removed from the forecast) and £2.9m Continuing healthcare risk; and • Potential opportunities of £13.4m, the most significant being £5.9m savings calculated by the Financial Recovery Group, and £3.1m income expected from the NL CCGs risk share. • No net risk is therefore reported. <p>NHS England reporting</p> <ul style="list-style-type: none"> • £5.6m deficit reported; and • Net opportunity reported to within the non-IFSE return is £1.2m; risk £15.0m and mitigation £16.2m. 	<p>Committee reporting</p> <ul style="list-style-type: none"> • FR&Q (8/10/14) • Executive Committee (10/09/14) • Governing Body (24/09/14) <p>NHS England reporting</p> <ul style="list-style-type: none"> • Working day 8, September 2014

2. Context of the review

2.4 Chronology of the reported financial position in 2014/15 (continued)

Financial reporting month	Key chronology	Reporting
September (6)	<p>Committee reporting</p> <ul style="list-style-type: none"> A deficit of £5.6m remains the planned position. £4.8m of planned QIPP remains unidentified. £9.8m of QIPP delivery forecast for the full year. The month 6 Finance Report reports: <ul style="list-style-type: none"> A deficit of £3,390k against a planned deficit of £3,398k (£8k favourable variance). This position includes full utilisation of the acute reserve and SLA exclusion budgets; Potential risks of £11.6m, the most significant being £7.7m for RTT (which has been removed from the forecast) and £2.9m Continuing healthcare risk; and Potential opportunities of £11.6m, the most significant being £5.9m savings calculated by the Financial Recovery Group, and £2.0m income expected from NHS England in relation to RTT (2nd contribution). No net risk is therefore reported. <p>NHS England reporting</p> <ul style="list-style-type: none"> £5.6m deficit reported; Net risk reported to within the non-IFSE return is £0m; risk £11.6m and mitigation £11.6m; and Q2 Assurance Meeting (Occurred November 2014) – Reported forecast achievement of financial plan, but that over performance on acute had been mitigated through use of reserves. Also reported risks around significant over performance on acute contracts, and that the Financial Recovery Group were tasked with reviewing schemes to address the gap in the 2014/15 QIPP plan. 	<p>Committee reporting</p> <ul style="list-style-type: none"> FR&Q (12/11/14) Executive Committee (15/10/14) <p>NHS England reporting</p> <ul style="list-style-type: none"> Working day 8, October 2014 Q2 Assurance Meeting – 19 November 2014
October (7)	<p>Committee reporting</p> <ul style="list-style-type: none"> A deficit of £5.6m remains the planned position. £4.8m of planned QIPP remains unidentified. £10.0m of QIPP delivery forecast for the full year. The month 7 Finance Report reports: <ul style="list-style-type: none"> A deficit of £3,653k against a planned deficit of £3,656k (£3k favourable variance). This position includes full utilisation of the acute reserve and SLA exclusion budgets; Potential risks of £10.3m, the most significant being £7.3m for RTT (which has been removed from the forecast) and £1.1m Continuing healthcare risk; and Potential opportunities of £10.3m, the most significant being £4.3m savings calculated by the Financial Recovery Group, and £2.1m income from the NCL CCG risk share. No net risk is therefore reported. <p>NHS England reporting</p> <ul style="list-style-type: none"> £5.6m deficit reported; and Net risk reported to within the non-IFSE return is £0m; risk £10.3m and mitigation £10.3m. <p>Change in financial leadership (CFO) – Ian Winning (Interim CFO) was replaced by Rob Whiteford (Substantive CFO) in November 2014.</p>	<p>Committee reporting</p> <ul style="list-style-type: none"> FR&Q (10/12/14) Executive Committee (19/11/14) Governing Body (26/11/14) <p>NHS England reporting</p> <ul style="list-style-type: none"> Working day 8, November 2014

2. Context of the review

2.4 Chronology of the reported financial position in 2014/15 (continued)

Financial reporting month	Key chronology	Reporting
November (8)	<p>Committee reporting</p> <ul style="list-style-type: none"> A deficit of £5.6m remains the planned position. £4.8m of planned QIPP remains unidentified. £10.2m of QIPP delivery forecast for the full year. The month 8 Finance Report reports: <ul style="list-style-type: none"> A deficit of £4,145k against a planned deficit of £4,145k. Potential risks of £16.6m, comprised of £10.0m for provision income from the risk share arrangement, and £6.6m for RTT; Potential opportunities of £4.8m, the most significant being £3.1m savings calculated by the Financial Recovery Group £11.8m net risk therefore reported. <p>NHS England reporting</p> <ul style="list-style-type: none"> 5.6m deficit reported; and Net risk reported to within the non-IFSE return is £0m; risk £16.9m and mitigation £16.9m. Although it was understood at this point that the CCG was unlikely to meet the £5.6m planned deficit, it was agreed with NHS England that the CCG would report a forecast outturn of £5.6m deficit until further work was performed to confirm the forecast outturn position. The key reasons for the deterioration in the month 8 position are included in Figure 2.4. 	<p>Committee reporting</p> <ul style="list-style-type: none"> FR&Q (14/01/15) Executive Committee (19/12/14) <p>NHS England reporting</p> <ul style="list-style-type: none"> Working day 8, December 2014
December (9)	<p>Committee reporting</p> <ul style="list-style-type: none"> The month 9 report states a deficit of £19m is forecast for the year, against the planned deficit of £5.6m (£13.4m adverse variance). Deterioration attributed to: <ul style="list-style-type: none"> £12m over performance on acute contracts; £1.9m reduction in RTT funding; and £1.2m recovery scheme now assessed as unachievable. £4.7m of planned QIPP noted as unidentified. QIPP savings forecast for the full year to be £10.9m against a plan of £12m (£1.1m adverse variance). Potential risks of £5.8m noted, including £2.0m for potential impact of acute seasonality and £1.7m in relation to RTT funding from Barnet CCG. Potential opportunities of £1.7m noted, which relates solely to funding from NHS England in relation to RTT. Net risk is therefore £4.1m. <p>NHS England reporting</p> <ul style="list-style-type: none"> £19m deficit reported; and Net risk reported to within the non-IFSE return is £4.7m; risk £6.4m and mitigation £1.7m. 	<p>Committee reporting</p> <ul style="list-style-type: none"> FR&Q (10/02/15) <p>NHS England reporting</p> <ul style="list-style-type: none"> Working day 8, January 2015

2. Context of the review

2.5 Reported financial position – Worst case

The Figure 2.5 below summarises the CCG's reported forecast deficit, along with the financial worst case. The worst case is presented as the reported forecast deficit position with the full value of reported financial risks (therefore assuming reported financial opportunities do not materialise).

The CCG does not report the worst case in its own Finance Reports; instead, the value of any financial risks and opportunities are reported together, with a net unmitigated value. Throughout the majority of 2014/15 the CCG reported financial risks and opportunities of equal value. The month 9 position was reported to the FR&Q in February 2015.

Figure 2.5 shows that for the majority of 2014/15, the CCG reported (to the FR&Q and to NHS England) a forecast deficit of £5.6m, and therefore forecast achievement of its planned position. Inclusion of the CCG's financial risks show a worst case financial position of between £15.9m (month 7 and 8) to £24.9m (month 9).

Presentation of the worst case using this method illustrates that while the CCG maintained a reported forecast deficit of £5.6m throughout the majority of the financial year, **a more significant deficit outturn could be foreseen from early in the financial year in the worst case scenario.** It is noted, however, that the monthly return to NHS England does include a formula to calculate the worst case scenario based on the risk information reported.

Figure 2.5: Reported forecast deficit and worst case

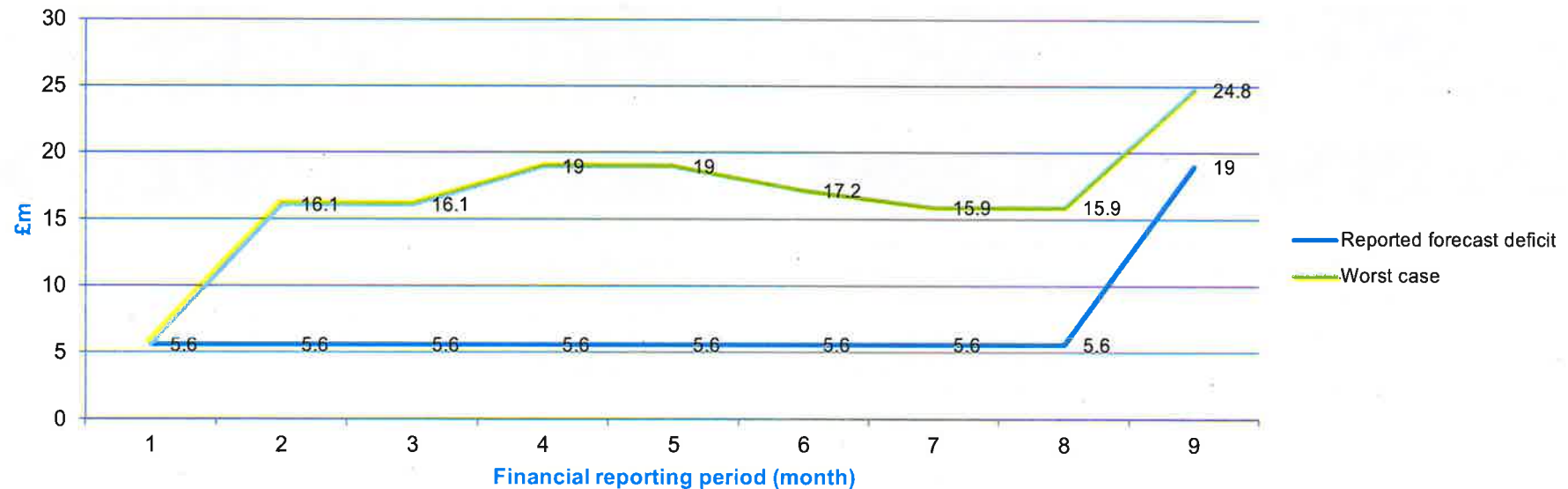


Figure 2.5: Reported forecast deficit, and the potential worst case

Source: All information taken from CCG Finance Reports presented to the FR&Q throughout 2014/15

2. Context of the review

2.6 Changes in the CCG financial leadership

2.6.1 Financial leadership

The CCG financial leadership has been through a period of instability through 2013/14 and 2014/15. There has been a requirement to fill vacancies at the CFO and Deputy CFO level on an interim basis throughout the period. The Figure 2.6 below outlines the history of financial leadership at the CCG between the period from late 2013/14 to the present. Table 2.6 below details some of the relevant background and experience of each of the CFOs in post throughout the period.

2.6.2 Recruitment

The CCG has experienced significant difficulties in attracting suitable candidates to fill senior management roles. The CCG has responded to this through agreeing with NHS England the payment of a payment of a premium (beyond nationally agreed rates), for example for the Chief Officer and CFO role.

The finance team has traditionally had a number of interims in post, as shown in Figure 2.6 below. Prior to the authorisation of the CCG in 2013, there was a shared finance director across 5 north-central London PCTs including Enfield.

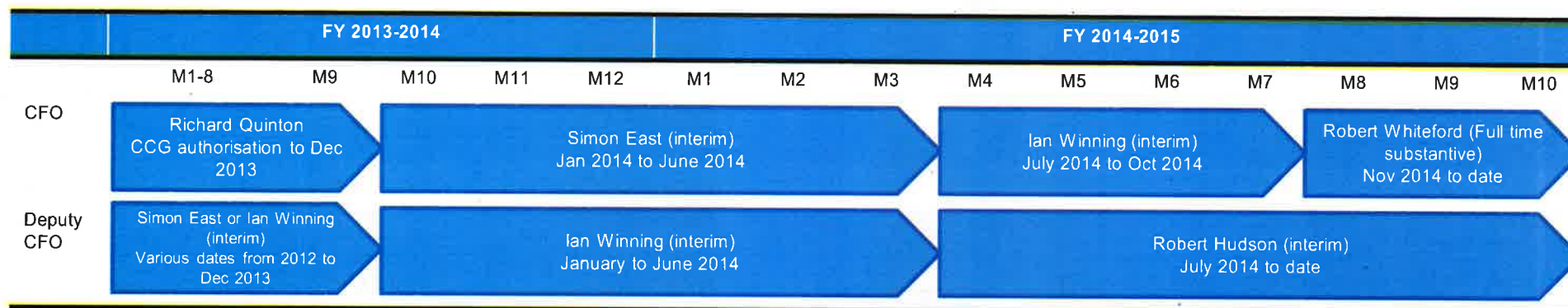


Figure 2.6: History of financial leadership at the CCG between month 9 2013/14 and present.

Source: NHS Enfield CCG HR Business Partner

Name	Post	Period in post	Relevant background
Richard Quinton	CFO	CCG authorisation to December 2013	<ul style="list-style-type: none"> Experience since 2003: Acute Trust experience: interim Finance Director, project management, Foundation Trust applications. PCT experience: Interim Finance Director and cluster Deputy Director; Ambulance Trusts, and Strategic Health Authorities. Professional Accountancy Qualification: FCA
Simon East	CFO (interim)	January 2014 to June 2014	<ul style="list-style-type: none"> Recent experience (past 5 years): PCT Director of Finance/ Resources NHS experience: 34 years prior to joining NHS Enfield CCG (not considering breaks in employment) Professional Accountancy Qualification: CIPFA 1984
Ian Winning	CFO (interim)	July 2014 to October 2014	<ul style="list-style-type: none"> Recent experience (past 5 years): CCG & PCT Head of Finance, PCT Assistant Director Financial Management / Reporting, Deputy Director of Finance Community Services, interim roles as Deputy Director of Finance at PCTs and programme management NHS experience: 23 years prior to joining NHS Enfield CCG (not considering breaks in employment) Professional Accountancy Qualification: CIPFA
Rob Whiteford	CFO	November 2014 to present	<ul style="list-style-type: none"> Recent experience: Director of Finance at Epsom and St Helier hospitals having spent two years previously as Deputy Director of Finance NHS experience: NHS career spans 21 years, and has worked in senior roles within commissioning, community services and acute hospitals. Graduated in Accountancy and Economics from Strathclyde University, is a Fellow of the Association of Chartered Certified Accountants

Table 2.6: Relevant background of the CFO at NHS Enfield CCG. **Source:** NHS Enfield CCG HR Business Partner and personal CVs

2. Context of the review

2.7 Analysis of key budget movements

2.7.1 Key budget changes in 2014/15

- We have analysed the CCG's key budget movements in year to understand the primary reasons for these budget adjustments and the authorisation process required to make these adjustments to the general ledger. We selected material budget changes to select a sample of 16 budget changes to test. The results of this work are presented in Appendix H.
- Figure 2.7 below outlines budget changes by top level expenditure type for CCG budgets and where there has been a change to the revenue resource limit throughout 2014/15.

Figure 2.7: Analysis of key budget movements in-year

CCG Delegated Budgets	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Total
Acute & Integrated Care Total	(£3,175)	£356	£0	(£314)	£1,831	£80	£352	(£358)	(£1,228)
Non Acute Total	£4,275	(£464)	£238	(£947)	£834	£2,000	£0	£305	£6,240
Programme Corporate Costs Total	(£319)	£108	£0	£0	£0	£0	£0	£0	(£211)
Corporate Costs Total	£17	£0	£0	£0	£0	£0	£0	£0	£17
Estates Costs Total	£0	£0	£0	£0	£0	£0	£0	£0	£0
Reserves and Contingencies Total	£0	£0	£0	£647	(£834)	(£1,382)	£288	£0	(£1,281)
Revenue Resource Limit Total	(£798)	£0	(£238)	£614	(£1,831)	(£698)	(£640)	£54	(£3,537)

Initial ledger balances loaded in May 2014 (Month 2).

Month 3

- The CCG transferred £3.1m of specific reserves from the acute and integrated care reserve to non-acute budget in month 3 for:
 - £1.3m continuing health care; and
 - £1.8m integrated care programme.
- The revenue resource allocation increased by £0.8m for GPIT allocation from NHS England.

Month 7

- £1.8m winter resilience money was received from NHS England and included in the forecast with the corresponding increase in revenue resource limit.
- £0.8m was transferred from reserves to fund community nursing services that had not been budgeted at the full contract level within the initial plan.

Month 8

- £0.6m increase in the RRL for funding from the risk share and transformation fund.
- £1.4m was required to be transferred from reserves into non-acute, in relation to Primary Care Strategy (PCS) budget.
- A debtor had been incorrectly recognised in relation to funding for PCS. This funding had already been received and was therefore double counted, and required a reversal. A transfer from reserves was required to offset the impact.

Figure 2.7: Analysis of key budget movements in-year. Figures stated are in £'000s.

Source: Hard close ledger reports, budget virement vouchers and explanation from the NHS Enfield CCG finance team

2. Context of the review

2.8 Improvements identified and implemented by the CCG

CCG management has implemented a number of improvements and changes throughout 2014/15, and since the recommendations included in this report were presented to management. Actions to date include:

- **Amendments to the membership of the FR&Q** including changing the Chair and Chair of the Audit Committee acting in the role of the external finance member (both since January 2015);
- **Improvements to the monthly Finance Report** prepared by the CCG finance team have been agreed, and presented to the Executive Committee in February 2015. Positive feedback on this improved report has been noted amongst the senior team;
- **The CFO post has been permanently occupied** since November 2014. The CCG has been working to appoint substantively to the Deputy CFO role, and is proposing to use a recruitment consultant to assist in the identification of a suitable candidate;
- **The CCG has prepared a recovery plan**, and appointed external advisors to assist in the identification and quantification of savings and cost improvements;
- **Improvements to the relationship and interaction between the CSU finance team and CCG finance team** have been implemented, for example closer working between the two teams has developed from the working day 4 meeting which was established in autumn 2014;
- **A service improvement plan** has been agreed between the 5 CCGs and the CSU;
- **The contracting team within the CCG has been expanded**, for example to include the Deputy Director of Contracts (joined in January 2015);
- **An internal review of the governance arrangements and committee structure at the CCG is being performed**. It is understood that the outcome of this is to be reported to the Audit Committee in March;
- **Review and revision of Terms of Reference** for key committees has taken place;
- **Reporting to key committees has been improved**, through clearer and leaner agendas, as well as a clearer focus on the key discussion points for committees to consider;
- **Guidance in relation to budget virements has been produced**, including delegation limits, approval and evidence retention, as well as the process for reserve management and tracking; and
- **Revised dates for all meetings within the committee structure have been agreed, including the Governing Body**, these revised dates align to the financial reporting timetable at the CCG.

Implementation of the improvements noted above have not been subject to audit or verification, and therefore reflect the views of CCG management.

3. Detailed findings and recommendations

3.1 Introduction

In this section of the report we draw together our observations from the work completed in this focused review, using the framework outlined in Section 1.4 of the report.

For each area considered we summarise our observations, the impact of those and our recommendations for action. Our observations are drawn from the following:

- Interviews held (as summarised in Appendix B)
- Review of key documents (as summarised in Appendix C)
- Observation of key committees (as summarised in Appendix D)
- Work performed around review of budget changes (included in Appendix H);
- Work performed around agreement of financial reporting to NHS England, to committee reports and to the ledger (included in Appendix E and F).

As noted in Section 1.4, we have structured our findings around the Well-Led framework capabilities:

- Strategy
- Capability and culture
- Structures and processes
- Measurement

Our scope of work, as agreed with you, is focused mostly into capabilities 3 and 4. We do not have findings to report against capability 1 – Strategy, given the defined nature and scope of our work.

CCG management has produced a management response and action plan in response to our findings and recommendations. This is included in Appendix A of this report.

Rating of findings

Our findings have been rated, as defined in Table 3.1.





Rating key	Definition
	Significant weakness in financial governance – expected to have been influential in the late reporting of the financial deterioration in 2014/15
	Moderate weakness in financial governance – may have been influential in the late reporting of the financial deterioration in 2014/15
	Low level weakness in financial governance – unlikely to have been influential in the late reporting of the financial deterioration in 2014/15

Table 3.1: Definition of ratings applied to findings in this report


3. Detailed findings and recommendations

B. Capability and culture

Area	Observations	Impact	Recommendations	Rating
<p>B1 Committee effectiveness</p>	<ul style="list-style-type: none"> Until 2015, the Chair of the FR&Q was the CCG's Practice Manager Member. The CCG has struggled to recruit to an external finance role, and therefore this member of the FR&Q was not in place throughout most of 2014/15. As noted in Finding B2, there has been change in the person in the CFO role as well over the same period. The level of financial experience across FR&Q committee members, and particularly independent financial experience, was therefore lower than would have otherwise been the case. Financial information provided to the FR&Q does not provide a clear and focused view on the financial position, and the key areas of risk or concern (see Finding D1). This limits the committee's ability to understand and challenge the financial position and financial risk. There is limited evidence of challenge or the requirement for mitigating actions noted in the minutes of the FR&Q around the financial position, particularly in December 2014 and January 2015 meetings when the significant deterioration in the financial position came to light. The CCG had appointed external consultants to support on producing an accurate forecast. An update on the month 8 financial position was presented to the Executive Committee on 17 December 2014. Mitigating actions were presented to the committee. CCG management has made attempts to increase the level of financial experience on the FR&Q; the Chair of the Audit Committee, a chartered accountant, is acting in the role of the external finance member since January 2015. It was noted through observation that the level of challenge in relation to financial information was strong at the February 2015 FR&Q meeting. Particularly there were a number of actions required to answer questions in relation to the financial position. The majority of the challenge was from the Chief Officer and the Chair of the Audit Committee, who joined the FR&Q in January 2015. <i>Continued on the following page.</i> 	<ul style="list-style-type: none"> The level of financial expertise on the FR&Q, particularly external financial expertise, was insufficient to enable effective challenge of the financial position. The financial information provided to the FR&Q does not present a full analysis of the financial position and financial risk. Important financial risk items and underlying trends in the financial position were not presented and therefore went un-noted or unchallenged. The level of challenge at the FR&Q and Executive Committee in relation to the deterioration was low. Clear actions were not requested, for example in relation to understanding and presenting the clear underlying financial position. 	<ul style="list-style-type: none"> CCG management should seek to recruit to the post of the external finance member. (CCG management has confirmed this as completed – Appendix A). It should be ensured that financial information presented to the FR&Q is focused, and highlights the key areas of risk and concern for the committee to focus on. This could be achieved, for example, through better use of the Contract Monitoring Group to review detailed financial information and escalate key areas to the FR&Q. (CCG management has confirmed this as completed – Appendix A). It should be re-emphasised to committee members that one of the objectives of the FR&Q is to ensure the financial position is fully understood, and that the committee should require specific actions to be taken where this is not the case. 	


3. Detailed findings and recommendations

B. Capability and culture

Area	Observations	Impact	Recommendations	Rating
<p>B1 Committee effectiveness</p>	<ul style="list-style-type: none"> The Audit Committee, observed in March 2015, was chaired effectively with a full summary for each agenda item. The Audit Committee in March had 16 agenda items, many with up to 3 sub-sections. A small number of papers had been received the night before the committee meeting. This was given due attention during the meeting by the chair, with report owners urged to ensure adequate review time for future reports. It was noted at the Audit Committee that some discussions and topics related to consideration and review of the overall strategy of the CCG, rather than the assurance in place around this. Understandably, the Audit Committee is working to ensure that Internal Audit has sufficient focus on reviews of a financial nature, through increasing the number of financial reviews. 	<ul style="list-style-type: none"> While late papers presented to the Audit Committee were, correctly, not approved at the meeting as a result of insufficient review time, the late provision of information will have a longer-term negative impact for the CCG, for example through the late review of important information by the committee. There is a risk the Audit Committee focuses on topics outside its remit, duplicates the efforts of other committees and the Governing Body. There is a risk that due to the focus of Internal Audit being moved into financial areas, other important areas are overlooked and not given sufficient focus. 	<ul style="list-style-type: none"> Efforts should be made to ensure that papers required for the Audit Committee meetings are made available with sufficient time for a full review by the committee. Where this is not possible, the item should be moved to the next committee agenda, or where the item is urgent alternative arrangements should be made in order to ensure appropriate consideration of the item, as well as any required decision, occurs within the required timescale. The Audit Committee and Internal Audit should work to ensure that the Internal Audit plan continues to be appropriately focused to manage the breadth of key strategic risks at the organisation. 	


3. Detailed findings and recommendations

B. Capability and culture

Area	Observations	Impact	Recommendations	Rating
<p>B2 Financial capability, capacity and culture</p>	<ul style="list-style-type: none"> As noted in Section 2.6, there has been instability in the financial leadership at the CCG over 2013/14 and 2014/15. Over this period, the person filling the CFO role has changed 3 times, and the Deputy CFO has changed twice. The substantive CFO role was successfully recruited to in November 2014. CCG management is currently working to recruit substantively to the Deputy DFO role, and is expecting to use a recruitment consultant to assist in this as the first attempt did not attract any appropriate candidates. The people who filled the posts over this period appear to have appropriate CVs for the role, including significant NHS and finance experience. Although it is difficult to evidence, it is expected that the instability in financial leadership over this period affected strategic financial leadership of the finance team. As 2014/15 was the first year that the CCG had agreed activity-based PbR contracts with its providers, it has been noted in interviews that there was a lack of capacity in relation to team members with a knowledge of PbR contracts at the time of contract negotiations and 2014/15 planning. The CCG has sought to expand its contracting team, for example through the appointment of the Deputy Director of Contracts in January 2015. As noted in Finding D1, the CCG's Finance Reports demonstrate a level of optimism bias, for example through presenting a balanced picture in relation to financial risks and opportunities for the majority of the year, as well as communicating the best or mid case, and rarely the worst case scenario. Financial practice around reserves and contingencies held centrally does not clearly indicate when reserves have been committed. Reserves committed to Primary Care Strategy were not allocated by budget transfer in-year and were used to mitigate acute contract overspends. No documentation, from the sample of budget adjustments, was available to evidence that budget holders had approved the general ledger postings for budget transfers. 	<ul style="list-style-type: none"> Leadership and strategic direction of the finance team over 2013/14 and 2014/15 was disrupted by the frequent change in CFO and Deputy CFO. Insufficient capacity of team members with PbR experience at the time of contract negotiation and 2014/15 is likely to have contributed towards issues in 2014/15 planning noted in Finding D3. An optimism bias (as noted in observations) means that the extent of the potential financial deterioration was not exposed throughout the majority of 2014/15. A £2m debtor accrual relating to Primary Care Strategy had been incorrectly set up during the year; the impact was that this amount was double counted as it had already been included in reserves. At a corporate level this understated the adverse variance to the financial position until it was corrected in the month 8 position. Budget holders may not be aware of changes to their resource allocation. 	<ul style="list-style-type: none"> It is recommended that the CCG aim to ensure long-term stability of the financial leadership, through retention of senior finance staff and substantive recruitment of the Deputy CFO (see below). Improvements to reserves and contingency management are required. A tracking of the value of contingencies and reserves held and the purpose of reserves should be developed. This should be reconciled to the expenditure these have been committed against. NHS Enfield CCG management inform us this has since been implemented. (CCG management has confirmed this as completed – Appendix A). Develop and implement a process for approval by budget holders for budget transfers. (CCG management has confirmed this as completed – Appendix A). It is recommended that a number of development sessions are planned and delivered for the Governing Body and Executive Committee. These should focus on finance, and particularly on financial forecasting, planning and reporting in an NHS CCG context. The CCG should consider the benefits of performing a Governing Body effectiveness review, considering financial capability, but also wider Governing Body responsibilities where value in performing this is identified. This effectiveness review should be used to inform the nature and focus of the development sessions noted above. <p>Wider consideration</p> <ul style="list-style-type: none"> In other regions of London, a cross CCG strategic finance role has been established. It is recommended that the CCG explore the opportunity for this in their region. Where there is disruption in financial leadership at a CCG level, a cross CCG finance leader would help to ensure strategic financial leadership is maintained. 	


3. Detailed findings and recommendations

C. Structures and processes

Area	Observations	Impact	Recommendations	Rating
<p>C1 Timing of committee meetings</p>	<ul style="list-style-type: none"> Through review of minutes, observation of committee meetings, and interviews held, it is clear that the timing of key committees requires urgent review. "The timing of the FR&Q doesn't make sense – it's been known for a while that it needs to change." (Interview quotation). The FR&Q and TP&FRG are in most cases held in the first or second week of the month. Financial information is not ready for reporting until around working day 7. The FR&Q frequently reviews financial information that relates to 2 months before the date of the committee meeting, for example the FR&Q meeting on 3 September 2014 (month 6) was presented with month 4 financial results. This issue is further exacerbated due to the lag in timing of activity information; financial information presented relates to activity recorded for the previous month, with an estimate included for the most recent month (i.e. financial information presented for month 3 is based on month 2 activity information with an estimate for month 3). It is noted that this issue is not unique to the CCG. Due to the timing of the Governing Body meetings (usually the last week of the month), the Governing Body is often the first committee to receive and review the CCG's Finance Report (in advance of the FR&Q, which would receive the report in the following month). Through observation of the TP&FRG meeting in February, it was noted that information on financial performance of QIPP schemes was not available for the committee to review. This is understood to be due to a mixture of data issues, and due to the timing of the TP&FRG committee being out of sync with the financial reporting timetable. Refer to Section 2.4 for details of the timing of committee meetings held in 2014/15 and the financial information presented at these meetings. The CCG management is already aware of the need to amend the timing of committee meetings held throughout the year – this has been discussed in committee meetings and in interviews held. 	<ul style="list-style-type: none"> Review of information that is considered to be out of date, limiting the ability to effectively challenge and request effective mitigation or response. Duplication of effort, as the Governing Body, Executive Committee and FR&Q are reviewing the same Finance Report, drawing similar points and asking similar questions. Ineffective review of financial information and escalation of issues, as the Governing Body are reviewing the Finance Report before the FR&Q (in the months when the Governing Body meeting is held). 	<ul style="list-style-type: none"> CCG management should urgently review the timing of meetings for committees that have a financial remit, and revise these in line with the financial reporting timetable. The aim should be to ensure that the FR&Q are able to review more recent financial information, and in advance of other more senior committees. NHS Enfield CCG management inform us this has since been implemented. (CCG management has confirmed this as completed – Appendix A). Implementation of revised timings for these committees will require consideration of the wider committee structure; revisions to the timing of other committees is likely to be needed. (CCG management has confirmed this as completed – Appendix A). It needs to be ensured that the flow of financial information is aligned to the committee structure – refer to Finding D3. (CCG management has confirmed this as completed – Appendix A). 	


3. Detailed findings and recommendations

C. Structures and processes

Area	Observations	Impact	Recommendations	Rating
<p>C2 Focus and remit of the committees</p>	<ul style="list-style-type: none"> Similar financial information is presented to different committees. It is not always clear what the committees' responsibilities are in relation to the information, the outcome they are expected to achieve and hence the lens through which they should be reviewing the information. "Different committees see the same financial information, review it in a similar way and ask similar questions" (Interview quotation). From review of the Terms of Reference of the TP&FRG and FR&Q, there is overlap and lack of clarity in relation to financial remit of each committee. Both committees have stated responsibilities in relation to achievement of the CCG's control total and management of the financial position, however, it is not clear how the responsibility of each committee differs or aligns on this. Through observation of the recently merged TP&FRG and through interviews held, the remit of this committee is not understood to be to review and manage the overall financial position. The committee do not receive information on the overall financial position of the CCG. There is a misalignment between the committees responsibilities in practice and its Terms of Reference. This is likely to be as a result of the recent merger of the TPG and FRG. The Terms of Reference for the FR&Q committee state duties in relation to areas that would be considered beyond the remit of a finance committee, for example "to review and develop services and integrated pathways across health and social care". It is noted, however, that this was challenged at February FR&Q meeting. There was a significant amount of discussion at the FR&Q around the purpose of the committee and how this has been documented in the Terms of Reference. The CCG has been working to review its committee and governance structure since October 2014, to review alignment of committees and with the objective to reduce the number of committees. This has led to, for example, the combination of the Transformation Programme Group and the Financial Recovery Group into one committee. At the Audit Committee meeting there was a proposed future focus on the organisation's strategy and the risks themselves rather than a review of the effectiveness of risk management processes. There is a risk that the Audit Committee seeks to operate outside of its remit; it is the latter that should be the remit of an Audit Committee. 	<ul style="list-style-type: none"> There is a risk of duplicated effort where the same financial information is presented to multiple committees, without clarity around the purpose or required response. There is also a risk that, as responsibility and remit of the committees is unclear, a committee assumes incorrectly that responsibility for a specific area falls to another committee. The alignment and difference in remit between different committees with a financial responsibility is not clear. Committee hierarchy is not clear, for example, how and when the TP&FRG should take action in relation to the financial position and financial risks, or when this is the FR&Q committee's responsibility. There has been change in the financial governance structure at the CCG, for example the combining of committees – this is yet to establish and embed fully. There is significant discussion and focus at committees on the remit and responsibility of the committee at the expense of focusing on committee matters. There is a risk the Audit Committee focuses on topics outside its remit, duplicates the efforts of other committees and the Governing Body. 	<ul style="list-style-type: none"> To review and align the committee structure to ensure that the responsibility of each committee is clear, including the alignment and boundary between each committee with a financial remit. (CCG management has confirmed this as completed – Appendix A). Ensure that the responsibilities stated in the Terms of Reference are appropriate and relevant for the committee. (CCG management has confirmed this as completed – Appendix A). To document this clearly in the Terms of Reference for the committee, and re-emphasise the purpose of committees to ensure that all committee members understand and agree to this. (CCG management has confirmed this as completed – Appendix A). Review, in connection with the Terms of Reference, the financial information presented to each committee – in order to understand and define why this information is relevant for the committee, and how each committee is expected to use and respond to the information presented (see also Finding D4). Perform a short effectiveness review at the end of each committee meeting that refers back to the purpose of the committee and the agenda and concludes whether or not they have achieved this. This would be enabled by a clear agenda for each meeting and a clear list of the decisions needed, the work commissioned by the committee, and the confirmations they should be giving (for example, having review available information the committee is content that their currently reported financial position adequately reflects the impact of reasonably likely risks and opportunities). NHS Enfield CCG management inform us this has since been implemented. It should be ensured that the remit of the Audit Committee is clear and adhered to, and that agenda items align to this, in order to prevent the risk of the committee acting outside of its remit. 	


3. Detailed findings and recommendations

D. Measurement

Area	Observations	Impact	Recommendations	Rating
<p>D1 Financial information and financial risk reporting</p>	<ul style="list-style-type: none"> The key report on the financial position is the monthly Finance Report, prepared by the finance team and presented by the CFO to the FR&Q, and also to the Governing Body (and at times, other committees). The Finance Report has not consistently been presented to the Executive Committee throughout 2014/15. The committee meets monthly and the Finance Report was not presented to the following 4 meetings: 9/4/14; 14/5/14; 11/6/14; and 16/7/14. The report format is mostly narrative, with some tables in the appendices. A table is included with details of financial risks and opportunities. For most of 2014/15, financial risks and opportunities were presented in the Finance Report at equal value, therefore with no net overall impact (as presented in Section 2.4). Detailed reporting of financial performance to the FR&Q did not commence in 2014/15 until July 2014 (month 4), when the results for month 2 were presented. Through the majority of 2014/15, the forecast financial position was presented as on plan, at £5.6m deficit. Reported information did not communicate a potential range in value, or a best or worst case scenario. While financial risks were quantified and reported, these were not added to the financial position to expose the potential worst case position. As explained in Finding D5, amendments were made to the financial position through the release of reserves and removal of the impact of financial risks, for example in relation to acute expenditure relating to the clearing of RTT backlog. Limited information is reported in the CCG Finance Report on the underlying run rate. The Finance Report does not clearly indicate the change in the financial position since the prior month, and the main causes. Testing performed of risk and mitigation values reported monthly to NHS England and to CCG committees identified a number of differences in the value reported. These differences are detailed in Appendix F. 	<ul style="list-style-type: none"> The presentation format is not easy to understand as most of the information is presented in narrative rather than using graphical presentation or tables. The potential for a significantly adverse financial position was not presented to the FR&Q until month 9. While management may have expected the value of financial opportunities to fully mitigate any risks, the presentation of a clear worst case scenario and potential range in the financial position in the Finance Report would have assisted in developing an understanding that the position may deteriorate. Management were transparent in the Finance Report each month about the application of reserves in the financial position, particularly to balance the acute position. Had reserves not been applied in this way throughout the year, the deterioration in the underlying financial position may have been more overt earlier in the financial year. From the Finance Report, it is difficult to understand the change in the underlying financial position month on month, and the key drivers for this. Values of risks and mitigations reported internally to CCG management and to NHS England are not always consistent. 	<ul style="list-style-type: none"> The finance team have performed work to improve the Finance Report for month 10. Key changes include: <ul style="list-style-type: none"> Inclusion of tables amongst the narrative; Information on the underlying run rate, and how this compares to forecast; and Balance sheet information, including aged debtors and cashflow. Further improvements are recommended to the finance report: <ul style="list-style-type: none"> Inclusion of information on best and worst case scenarios, particularly exposing the range in the financial position and the potential worse position; Details of the risk adjustment or probability applied to financial opportunities and risks; Clarity on changes in the financial position between months, for example a waterfall chart to bridge the forecast position in the current and previous month; Clarity in movements in key financial risks, explaining the latest position and what has been included in the forecast; Further presentation of the underlying run rate and financial position, for example presenting this in a line chart with projected future position; and Further balance sheet analysis, for example trend analysis in activity accruals and other significant balance sheet items. It is recommended that at the start of the financial overview session at the FR&Q the CFO gives a high level review of the 3-5 key messages, risks and decisions required. (CCG management has confirmed this as completed – Appendix A). A dashboard or scorecard style of reporting could be employed, to present the latest position on key metrics and risks in an understandable and accessible format. The CCG finance team should investigate the differences noted between the value of risks and mitigations reported to CCG management and to NHS England, in order to identify the reason for these differences and to ensure there was appropriate approval in place to report different values. (CCG management has confirmed this as completed – Appendix A). 	


3. Detailed findings and recommendations

D. Measurement

Area	Observations	Impact	Recommendations	Rating
<p style="text-align: center;">D2 CSU Financial information</p>	<ul style="list-style-type: none"> A view is held amongst some of those interviewed that the CSU has performed insufficiently. Particularly this is noted in relation to the financial information provided by the CSU, and the level of analysis and explanation that accompanies this. Financial reports prepared by the CSU and presented to the FR&Q regularly contain high amounts of detailed data, with limited focus into the key messages (noted through review of papers presented to the FR&Q throughout 2014/15). Through interviews, examples were noted where the CSU had produced analysis which contained inaccuracies or inaccurate interpretation of data, for example around increases in GP referrals. It is unclear to what extent this is attributable to poor performance from the CSU, or from poor contract and supplier management at the CCG. The CSU has agreed to a service improvement plan with all of the 5 CCGs. There are a number of discussions at Board level in the CSU as to the future of the relationship and contract between the CCG and CSU, and how this could be altered in the future to drive improvement. CCG management has implemented measures to improve the relationship and interaction between the CSU and the CCG finance teams, for example joint meetings and closer working. 	<ul style="list-style-type: none"> The financial information routinely produced by the CSU and provided to the CCG does not meet the requirements of the CCG. Important trends and analysis in relation to the CCG's financial position are not routinely performed and therefore do not support the understanding of the financial position and identification of financial risk. 	<ul style="list-style-type: none"> A review of the financial information the CSU (or other CSUs) produces for other CCGs may help to identify examples that are more suited to the CCG's requirements. Once this has been clearly understood, the CCG should seek to identify and implement methods to ensure the regular production of financial information that suits its needs. For example, through specific agreement with the CSU on the style and content of CSU - produced financial information. (CCG management has confirmed this as completed - Appendix A). The CCG should ensure that its own requirements are clearly reflected in the CSU service improvement plan that has been agreed amongst the 5 CCGs and include a quarterly review of progress in this area. (CCG management has confirmed this as completed - Appendix A). 	


3. Detailed findings and recommendations

D. Measurement

Area	Observations	Impact	Recommendations	Rating
<p>D3 2014/15 financial planning</p>	<ul style="list-style-type: none"> 2014/15 was the first year the CCG agreed activity-based PbR contracts with its providers. In 2013/14 block contracts had been agreed. The key details of the 2014/15 financial planning are outlined in Section 2.3. It is understood that the overall financial deficit of £5.6m was produced by assuming break even position on acute and non acute contracts, with the deficit being caused by the net impact of transfer of specialised commissioning budgets to NHS England in 2013/14 (from interviews held and the 2014/15 Financial Planning update presented to FR&Q between April and June 2014). Risks to the financial position were noted as unidentified QIPP schemes (£6m of a planned £12m at the time of 2014/15 planning) and over performance on acute contracts. These risks were not built into the financial position beyond nationally required headroom contingency (2014/15 Financial Planning update presented to FR&Q between April and June 2014). CCG management has noted that the setting of baselines for 2014/15 PbR contracts was compromised the following: <ul style="list-style-type: none"> The need to reflect the impact of a significant service reconfiguration which occurred in November and December 2013; Poor quality data from Barnet and Chase Farm Hospital Trust (a key provider for the CCG); and The acquisition of Barnet and Chase Farm Hospital by Royal Free London NHS Foundation Trust in July 2014. CCG management has concluded that the high level of over performance at Barnet and Chase Farm Hospital was most likely due to setting the baseline for the contract too low. The CCG should be in a better place to produce a robust financial plan for acute expenditure in 15/16, based on PbR contract performance experienced in 2014/15. 	<ul style="list-style-type: none"> Overly optimistic or unrealistic budget setting for 2014/15 may have occurred, coupled with optimistic reporting of the position until month 8 (see Finding D1). Insufficient headroom was built into the plan for probable risks such as QIPP delivery failure for unidentified schemes. There was insufficient capacity of staff in the CCG finance team with experience of PbR and activity-based contracts at the time of planning. 	<ul style="list-style-type: none"> It is recommended that the CCG performs a full risk assessment when producing the 2015/16 financial plan – in order to identify and quantify potential financial risks that may impact the position, and how to reflect these in the financial position. (CCG management has confirmed this as completed – Appendix A). These financial risks should be communicated to the Audit Committee, FR&Q, Executive Committee and Governing Body. Approval should be sought from the committees that the quantification and treatment of financial risks in the 2015/16 financial plan is agreed. These identified risks should then be reported regularly during the financial year, as described in Finding D1. 	


3. Detailed findings and recommendations

D. Measurement

Area	Observations	Impact	Recommendations	Rating
<p style="text-align: center;">D4 Flow and focus of financial information</p>	<ul style="list-style-type: none"> Financial information presented to committees is rarely tailored to the specific committee. For example, the monthly Finance Report is presented to the FR&Q and Governing Body – the same report is presented, with no tailoring in relation to the key items for each committee to focus on, or what action is required by either committee. The CSU produce a monthly Finance & Activity report. This includes detailed information on the latest activity and financial position across the CCGs providers. It includes a number of detailed tables, graphs and charts. There is a summary at the start of the report – however, this does not highlight the key areas of concern nor does it state what the committee is asked to focus on or consider. "We are probably asking the same questions as the Contract Monitoring group" (Committee observation quotation). "So, what are the key messages I am meant to be taking from this report?" (Committee observation quotation). A report was produced by the Contract Monitoring Group for the August FR&Q – this was useful for identifying the key areas of concern in the CSU report and actions and mitigations taken as a result. This hasn't been prepared for other FR&Q meetings. Committees receive a significant number of items that are classified as "to note" rather than for consideration and action. The agenda for the FR&Q does not reflect the priority of information. The most significant time allocation in the February FR&Q meeting was 20 minutes for "Administration items"; 4 reports, including the month 9 Finance Report, were allocated 10 minutes in total and were last on the agenda. It has been noted, however, by the CFO that it was agreed with the Chair shortly prior to the FR&Q meeting that the discussion around the financial position should be given greater time allocation. It has also been agreed with the FR&Q Chair that the financial position will feature earlier in the agenda for future meetings. 	<ul style="list-style-type: none"> Duplication of effort is likely, due to repeated multiple committees reviewing the same information. The time spent by committees on reviewing financial information is sub-optimal, due to a lack of upfront consideration of the focus and key messages for the committee. The prioritisation of the agenda in relation to ordering and time allocation does not drive the focus of committee meetings into the most significant areas. Significant time is spent by committee members reviewing data in order to try and identify the message and any concerns, rather than discussing the key areas and agreeing action as a result. The flow of financial information between the different committees is not clear. 	<ul style="list-style-type: none"> In connection with Findings C1 and C2, a review of the financial information presented to the committees should be performed to ensure this aligns clearly to the responsibilities of the committee. (CCG management has confirmed this as completed – Appendix A). The flow and focus of information between committees should be reviewed and improved. For example, it is recommended that the CSU Finance & Activity report is reviewed by the Contract Monitoring group, and key concerns and actions identified, before reporting this to the FR&Q. (CCG management has confirmed this as completed – Appendix A). Financial information presented to the committees should be presented with clear advice noting the key areas for consideration, and the response or action required from the committee on specific items. (CCG management has confirmed this as completed – Appendix A). Agendas should be designed to support the prioritisation of key items - the time allocation and ordering should reflect the most important items on the agenda. (CCG management has confirmed this as completed – Appendix A). It is recommended that the Finance Report and the key messages from the CFO are stated early in the FR&Q meeting as these will set the context for the discussion of remaining items, before moving onto detailed reports and other items. It is understood that this has already been agreed between the CFO and Chair of the FR&Q for future meetings. (CCG management has confirmed this as completed – Appendix A). 	<p style="text-align: center;"></p>

3. Detailed findings and recommendations

D. Measurement

Area	Observations	Impact	Recommendations	Rating
<p>D5 Management of financial position</p>	<ul style="list-style-type: none"> During 2014/15, the CCG released £4.5m of reserves into acute and non-acute budgets to balance the financial position (as noted in the Finance Reports presented throughout the year). In month 8, the CCG recognised a £10m balance of provisional and un-agreed income from the risk share, in order to balance the position and report an on plan deficit position (as noted in the month 8 Finance Report). The CCG agreed this treatment with NHS England. The CCG calculated an estimate for the impact of RTT backlog, and recognised both expenditure and expected income, therefore removing the impact of this from the financial position. This was shown as a financial risk, until month 9 when the majority of the expected income was removed from the financial position due to the expectation of non-receipt. As shown in Figure 2.5, if a worst case scenario had been presented by the CCG (by totalling the financial deficit and gross financial risks), management could have been more aware of the potential for significant deterioration in the financial position earlier in the financial year. 	<ul style="list-style-type: none"> The examples of the methods used by the CCG to manage the financial position were clearly reported in the CCG's Finance Report throughout 2014/15. The impact of these items is that the underlying deterioration in the financial position was not fully exposed in financial reporting, and therefore not fully understood by CCG management until late in the financial year. 	<ul style="list-style-type: none"> Where the CCG wishes to continue management of the financial position in this way, management should identify a means to report more clearly the underlying financial position, for example the variance against planned position had the reserves not been applied (in conjunction with Finding D1). (CCG management has confirmed this as completed – Appendix A). As noted in Finding D1, the CCG should report scenarios and particularly the worst case scenario, in order to communicate the potential for variance around the forecast position. 	

4. Recommended next steps in response to this report

The next steps that should be taken in response to this report are:

- CCG management to present and agree the findings of this report with the Governing Body;
- The CCG's Governing Body to approve the management response and action plan (as included in Appendix A);
- CCG management to meet with NHS England to agree the findings, the management response and action plan;
- CCG management to produce and agree a Financial Recovery Plan, as outlined below; and
- CCG management to report progress against implementation of remaining recommendations in this report to both NHS England and to the CCG's Governing Body, at the end of quarter 1 and quarter 2 in 2015/16.

Financial Recovery Plan

CCG management has agreed with NHS England to produce a Financial Recovery Plan, covering a 5 year period. The following has been agreed between the CCG and NHS England:

- **Plan production:** A revised 5 year plan, meeting business rules by the end of the 5 year period, will be produced for the 14th May 2015;
- **Governance :** This plan to be then taken to the CCG Governing Body on the 10th June 2015, and to be subject to specific discussion and sign off by NHS England between the 14th May and the 10th June 2015.

Appendices

Appendix A: NHS Enfield CCG Management response and action plan

CCG management has developed an action plan in response to the findings and recommendations presented in section 3 of this report. The management response and action plan, due date and responsibility have been completed by CCG management as at 10th April 2015 and have not been reviewed by Deloitte for evidence of implementation, therefore reflect the views of management only.

B. Capability and culture

Area	Recommendation	Management response and action plan as at 08/04/2015	Due date and responsibility
<p>B1 Committee effectiveness</p>	<ul style="list-style-type: none"> CCG management should seek to recruit to the post of the external finance member. 	<ul style="list-style-type: none"> The Chair of the Audit Committee (a qualified accountant) has agreed to fulfil this role. 	<ul style="list-style-type: none"> Completed
	<ul style="list-style-type: none"> It should be ensured that financial information presented to the FR&Q is focused, and highlights the key areas of risk and concern for the committee to focus on. This could be achieved, for example, through better use of the Contract Monitoring Group to review detailed financial information and escalate key areas to the FR&Q. 	<ul style="list-style-type: none"> Agreed. The Finance Committee agenda is now focussed on key high level information, with a brief presentation on performance of key contracts. 	<ul style="list-style-type: none"> Completed
	<ul style="list-style-type: none"> It should be re-emphasised to committee members that one of the objectives of the FR&Q is to ensure the financial position is fully understood, and that the committee should require specific actions to be taken where this is not the case. 	<ul style="list-style-type: none"> Revised Terms of Reference prepared and this point is included. Robert Whiteford will present a verbal reminder (to be minuted) at the start of the Finance Committee of 22/04/15. 	<ul style="list-style-type: none"> Robert Whiteford – 22/04/15
	<ul style="list-style-type: none"> Efforts should be made to ensure that papers required for the Audit Committee meetings are made available with sufficient time for a full review by the committee. Where this is not possible, the item should be moved to the next committee agenda, or where the item is urgent alternative arrangements should be made in order to ensure appropriate consideration of the item, as well as any required decision, occurs within the required timescale. 	<ul style="list-style-type: none"> Noted and Agreed. 	<ul style="list-style-type: none"> Rob Whiteford 27/5/15 (Date of next audit Committee)
	<ul style="list-style-type: none"> The Audit Committee and Internal Audit should work to ensure that the Internal Audit plan continues to be appropriately focused to manage the breadth of key strategic risks at the organisation 	<ul style="list-style-type: none"> Noted. Agreed by Enfield CCG. Will be discussed with Internal Audit for implementation when this report is released. 	<ul style="list-style-type: none"> Rob Whiteford 27/5/15

Appendix A: NHS Enfield CCG Management response and action plan

B. Capability and culture

Area	Recommendation	Management response and action plan as at 08/04/2015	Due date and responsibility
<p style="text-align: center;">B2</p> <p>Financial capability, capacity and culture</p>	<ul style="list-style-type: none"> It is recommended that the CCG aim to ensure long-term stability of the financial leadership, through retention of senior finance staff and substantive recruitment of the Deputy CFO (see below). 	<ul style="list-style-type: none"> We agree with this recommendation. The CCG now has a substantive CFO, and is using a recruitment agency to recruit a permanent Deputy CFO. We should note however, recruitment and retention difficulties and the CCG is not alone in struggling to attract and retain quality candidates in permanent roles. The CCG has taken additional measures to strengthen its finance department, specifically in contracting. 	<ul style="list-style-type: none"> Robert Whiteford – 30/09/15 for start date for Deputy CFO.
	<ul style="list-style-type: none"> Improvements to reserves and contingency management are required. A tracking of the value of contingencies and reserves held and the purpose of reserves should be developed. This should be reconciled to the expenditure these have been committed against. NHS Enfield CCG management inform us this has since been implemented. 	<ul style="list-style-type: none"> This is now implemented. 	
	<ul style="list-style-type: none"> Develop and implement a process for approval by budget holders for budget transfers. 	<ul style="list-style-type: none"> Implemented. Revised Virement Policy shared with Deloitte FRG team and internally. 	
	<ul style="list-style-type: none"> It is recommended that a number of development sessions are planned and delivered for the Governing Body and Executive Committee. These should focus on finance, and particularly on financial forecasting, planning and reporting in an NHS CCG context. 	<ul style="list-style-type: none"> Agreed. Governing body seminars will be used to deliver the development sessions. The governing body seminar of 25/02/15 considered in detail the Financial Plan for 2015/16. The CCG financial position will be discussed separately at every Governing Body Seminar. 	<ul style="list-style-type: none"> Robert Whiteford – to end by 30/09/15. Suggest two 3 hour sessions.
	<ul style="list-style-type: none"> The CCG should consider the benefits of performing a Governing Body effectiveness review, considering financial capability, but also wider Governing Body responsibilities where value in performing this is identified. This effectiveness review should be used to inform the nature and focus of the development sessions noted above. 	<ul style="list-style-type: none"> The CCG will consider with NHSE how best to implement this recommendation. 	<ul style="list-style-type: none"> Liz Wise & Mo Abedi 30/4/15
<p>Wider consideration</p>	<ul style="list-style-type: none"> In other regions of London, a cross CCG strategic finance role has been established. It is recommended that the CCG explore the opportunity for this in their region. Where there is disruption in financial leadership at a CCG level, a cross CCG finance leader would help to ensure strategic financial leadership is maintained. 	<ul style="list-style-type: none"> This recommendation will be discussed with David Slegg at NHSE. 	<ul style="list-style-type: none"> Rob Whiteford 10/4/15 – for the discussion with NHS England. A further target date will be set dependent upon on the discussion with NHS England.

Appendix A: NHS Enfield CCG Management response and action plan

C. Structures and processes

Area	Recommendation	Management response and action plan as at 08/04/2015	Due date and responsibility
<p>C1 Timing of committee meetings</p>	<ul style="list-style-type: none"> CCG management should urgently review the timing of meetings for committees that have a financial remit, and revise these in line with the financial reporting timetable. The aim should be to ensure that the FR&Q are able to review more recent financial information, and in advance of other more senior committees. NHS Enfield CCG management inform us this has since been implemented. Implementation of revised timings for these committees will require consideration of the wider committee structure; revisions to the timing of other committees is likely to be needed. It needs to be ensured that the flow of financial information is aligned to the committee structure – refer to Finding D3. 	<ul style="list-style-type: none"> Agreed. The date of the finance committee is now in the 3rd or 4th week of the calendar month, enabling a full report to be presented to the finance committee for the previous calendar month. Noted and implemented. Agreed. Revised Terms of Reference, refocused agendas, time spent on key items and financial information relevant to the group in question have all been addressed. 	<ul style="list-style-type: none"> Completed. Completed. Completed, but will be kept under review for effectiveness – Robert Whiteford – review 30/09/15.
<p>C2 Focus and remit of the committees</p>	<ul style="list-style-type: none"> To review and align the committee structure to ensure that the responsibility of each committee is clear, including the alignment and boundary between each committee with a financial remit. Ensure that the responsibilities stated in the Terms of Reference are appropriate and relevant for the committee. To document this clearly in the Terms of Reference for the committee, and re-emphasise the purpose of committees to ensure that all committee members understand and agree to this. Review, in connection with the Terms of Reference, the financial information presented to each committee – in order to understand and define why this information is relevant for the committee, and how each committee is expected to use and respond to the information presented (see also Finding D4). Perform a short effectiveness review at the end of each committee meeting that refers back to the purpose of the committee and the agenda and concludes whether or not they have achieved this. This would be enabled by a clear agenda for each meeting and a clear list of the decisions needed, the work commissioned by the committee, and the confirmations they should be giving (for example, having review available information the committee is content that their currently reported financial position adequately reflects the impact of reasonably likely risks and opportunities). NHS Enfield CCG management inform us this has since been implemented. It should be ensured that the remit of the Audit Committee is clear and adhered to, and that agenda items align to this, in order to prevent the risk of the committee acting outside of its remit. 	<ul style="list-style-type: none"> Terms of Reference for the Finance Committee and the Transformation Programme and Financial Recovery Group have been revised and clearly state the remit and authorisation level of each. See above. Clear and succinct purpose of each committee now stated in Terms of Reference. Agreed. We will deliver tailored financial information to Executive Committee and full financial information to the Finance Committee and the Governing Body. This needs to be reviewed for effectiveness on an ongoing basis. This is already in place through a paper based process but could be improved by verbal feedback at the end of the meeting. I will trial this on the 22/04/15 - Robert Whiteford Agreed. The CCG will review the Audit Committee Terms of Reference and ensure it acts within its remit. 	<ul style="list-style-type: none"> Completed Completed. Completed Robert Whiteford – review effectiveness ongoing and formally by 30/09/15. In place but trial "verbal" feedback – Robert Whiteford – finance committee meeting on 22/04/15. Rob Whiteford & Karen Trew 27/5/15

Appendix A: NHS Enfield CCG Management response and action plan

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Due date and responsibility
<p style="text-align: center;">D1 Financial information and financial risk reporting</p>	<ul style="list-style-type: none"> • The finance team have performed work to improve the Finance Report for month 10. Key changes include: <ul style="list-style-type: none"> ○ Inclusion of tables amongst the narrative; ○ Information on the underlying run rate, and how this compares to forecast; and ○ Balance sheet information, including aged debtors and cashflow. • Further improvements are recommended to the finance report: <ul style="list-style-type: none"> ○ Inclusion of information on best and worst case scenarios, particularly exposing the range in the financial position and the potential worse position; ○ Details of the risk adjustment or probability applied to financial opportunities and risks; ○ Clarity on changes in the financial position between months, for example a waterfall chart to bridge the forecast position in the current and previous month; ○ Clarity in movements in key financial risks, explaining the latest position and what has been included in the forecast; ○ Further presentation of the underlying run rate and financial position, for example presenting this in a line chart with projected future position; and ○ Further balance sheet analysis, for example trend analysis in activity accruals and other significant balance sheet items. <ul style="list-style-type: none"> • It is recommended that at the start of the financial overview session at the FR&Q the CFO gives a high level review of the 3-5 key messages, risks and decisions required. • A dashboard or scorecard style of reporting could be employed, to present the latest position on key metrics and risks in an understandable and accessible format. • The CCG finance team should investigate the differences noted between the value of risks and mitigations reported to CCG management and to NHS England, in order to identify the reason for these differences and to ensure there was appropriate approval in place to report different values. 	<ul style="list-style-type: none"> • The CCG recommend that known quantifiable risks (and certainly where they are liabilities) are included in the reported base financial position, with the variation in best/likely/worst scenarios kept to an absolute minimum. Risks not included in the financial position are articulated clearly in the finance report text, which has a section dedicated to risks and opportunities. We would welcome the opportunity to discuss the best way in which to practically implement this, as we recognise its value as an early warning sign. • The revised Finance report clearly and succinctly sets out the month on month changes. • The revised finance recovery plan sets out key risks and quantifies them where possible. For example the risk (now materialised) on LAS was included in the previous plan. • Information is now included in the revised finance report. This is clear and the CFO has explained to the finance committee and governing body how to interpret it. • Agreed. The value of this is limited by the nature of CCG cash drawdown (i.e. liabilities always far exceed assets). Nevertheless changes to key balances require explanation and this will be incorporated. • Initiated with effect from March Finance Committee. • Noted. • Agreed. These risks are identical in the 2015/16 plan and the intention is for them to remain so, notwithstanding differences in the reporting mechanism. The CCG will clearly report unmitigated risk. 	<ul style="list-style-type: none"> • Best/Likely/Worst forecasts to be prepared from Month 6 onwards, when meaningful trends are established. Clearly any risks impacting on our ability to achieve our control total will be included in our position immediately. – Robert Whiteford – by 3rd week of October. From Month 1 each finance committee meeting will discuss risks and opportunities as part of the finance report. • Completed. • Completed for the Recovery Plan, but required for ongoing Finance Reports in 2015/16. Robert Whiteford - first by the 3rd week of May. • Robert Whiteford – first by 3rd week of May and ongoing • Robert Whiteford – by 3rd week of July (to allow for trends to become evident) • Implemented (but ongoing) • Robert Whiteford with Deloitte – by 3rd week of May. • Implemented with immediate effect.

Appendix A: NHS Enfield CCG Management response and action plan

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Due date and responsibility
<p style="text-align: center;">D2 CSU Financial information</p>	<ul style="list-style-type: none"> • A review of the financial information the CSU (or other CSUs) produces for other CCGs may help to identify examples that are more suited to the CCG's requirements. • Once this has been clearly understood, the CCG should seek to identify and implement methods to ensure the regular production of financial information that suits its needs. For example, through specific agreement with the CSU on the style and content of CSU produced financial information. • The CCG should ensure that its own requirements are clearly reflected in the CSU service improvement plan that has been agreed amongst the 5 CCGs and include a quarterly review of progress in this area. 	<ul style="list-style-type: none"> • Across NCL an improvement group led by the CO of Haringey has resulted in improved and standardised reporting. • This has taken place. The CSU is limited in that it must adopt a "factory" based approach to maintain economies of scale. We work closely with the CSU on site to ensure good communication of local financial information. • Agreed and this has taken place. 	<ul style="list-style-type: none"> • Remains in progress – Jane Pike by 30/6/15 • Completed- Robert Whiteford. • Completed – the CCG now works in close contact with the CSU to share all relevant information prior to production of monthly contract and finance information.

Appendix A: NHS Enfield CCG Management response and action plan

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Due date and responsibility
<p>D3 2014/15 financial planning</p>	<ul style="list-style-type: none"> It is recommended that the CCG performs a full risk assessment when producing the 2015/16 financial plan – in order to identify and quantify potential financial risks that may impact the position, and how to reflect these in the financial position. 	<ul style="list-style-type: none"> The CCG has considered the risks and opportunities in the plan very carefully. The plan contains a section on risks and opportunities, the previous version containing London Ambulance, Mental Health and the risk of over activity on acute contracts. These are then included in the financial position when they crystallise, e.g. London Ambulance is now included within our revised plan. The risk of over activity was in part mitigated by useful challenge sessions with NHSE on the amount of growth assumed in the plan, and whether this was realistic. This resulted in increased growth being included. 	<ul style="list-style-type: none"> Implemented – but the risks require to be monitored continually. – Robert Whiteford
	<ul style="list-style-type: none"> These financial risks should be communicated to the Audit Committee, FR&Q, Executive Committee and Governing Body. 	<ul style="list-style-type: none"> Agreed and they will form part of the report received by these Committees. 	<ul style="list-style-type: none"> Robert Whiteford from 3rd week in May for April reports
	<ul style="list-style-type: none"> Approval should be sought from the committees that the quantification and treatment of financial risks in the 2015/16 financial plan is agreed. 	<ul style="list-style-type: none"> Noted. We would welcome the opportunity to discuss this further with the Deloitte team. 	<ul style="list-style-type: none"> Rob Whiteford with Deloitte. 30/4/15.
	<ul style="list-style-type: none"> These identified risks should then be reported regularly during the financial year, as described in Finding D1. 	<ul style="list-style-type: none"> Agreed. 	<ul style="list-style-type: none"> Robert Whiteford by the 3rd week in May for April reporting.

Appendix A: NHS Enfield CCG Management response and action plan

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Due date and responsibility
<p style="text-align: center;">D4 Flow and focus of financial information</p>	<ul style="list-style-type: none"> In connection with Findings C1 and C2, a review of the financial information presented to the committees should be performed to ensure this aligns clearly to the responsibilities of the committee. 	<ul style="list-style-type: none"> Agreed and covered above. 	<ul style="list-style-type: none"> Robert Whiteford – completed.
	<ul style="list-style-type: none"> The flow and focus of information between committees should be reviewed and improved. For example, it is recommended that the CSU Finance & Activity report is reviewed by the Contract Monitoring group, and key concerns and actions identified, before reporting this to the FR&Q. 	<ul style="list-style-type: none"> Agreed and already implemented. 	<p>Robert Whiteford – the CSU reports are summarised and locally interpreted before presentation to the Finance Committee.</p>
	<ul style="list-style-type: none"> Financial information presented to the committees should be presented with clear advice noting the key areas for consideration, and the response or action required from the committee on specific items. 	<ul style="list-style-type: none"> Agreed and already implemented. Agendas are much shorter with "updates", "for info" and discussion items largely removed. Reports are presented highlighting key points and then leaving time for meaningful discussion and questioning. 	<p>Implemented - ongoing by nature – Robert Whiteford</p>
	<ul style="list-style-type: none"> Agendas should be designed to support the prioritisation of key items - the time allocation and ordering should reflect the most important items on the agenda. 	<ul style="list-style-type: none"> See above. Finance committee agenda now much shorter with tight control of items not critical. 	<p>Implemented – can be tested with Finance Committee agenda for 22/4/15.</p>
	<ul style="list-style-type: none"> It is recommended that the Finance Report and the key messages from the CFO are stated early in the FR&Q meeting as these will set the context for the discussion of remaining items, before moving onto detailed reports and other items. It is understood that this has already been agreed between the CFO and Chair of the FR&Q for future meetings. 	<ul style="list-style-type: none"> Agreed and implemented. 	<p>Implemented – can be tested 22/04/15.</p>

Appendix A: NHS Enfield CCG Management response and action plan

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Due date and responsibility
<p style="text-align: center;">D5 Management of financial position</p>	<ul style="list-style-type: none"> Where the CCG wishes to continue management of the financial position in this way, management should identify a means to report more clearly the underlying financial position, for example the variance against planned position had the reserves not been applied (in conjunction with Finding D1). As noted in Finding D1, the CCG should report scenarios and particularly the worst case scenario, in order to communicate the potential for variance around the forecast position. 	<ul style="list-style-type: none"> The CCG does not seek to manage the position in this way in future. See comments above. The CCG agrees on the importance of this and would welcome views on how best to implement it in practice. We feel it is important to recognise as much as possible within the base financial forecast, with minimum movement around unforeseen or indeterminate events. The key point is that the CCG will report unmitigated risks in a clear way. 	<ul style="list-style-type: none"> Not applicable – implemented by default. Robert Whiteford – 3rd week in May for April reporting.

Appendix B: Interviews requested and held as part of this engagement

Interview held with	Job title	Date held
Robert Hudson	Interim Deputy CFO	5 February 2015
James Colledge	Deputy Director of Contracts	5 February 2015
Keith Spratt	Head of Acute Contracting	5 February 2015
Robert Whiteford	Chief Finance Officer and Director of Contracts	9 February 2015
Jane Pike	Director of Operations	10 February 2015
Dr. Alpesh Patel	Chair of FR&Q	11 February 2015
Karen Trew	Lay Member (finance) and Vice Chair of GB	11 February 2015
Dr. Mo Abedi	CCG Chair	12 February 2015
Paul Woodhead and Joseph Szymanski	NEL CSU Management Accountants	12 February 2015
Liz Wise	Chief Officer	20 February 2015
Aimee Fairbairns	Director of Service Quality & Integrated Governance	20 February 2015
David Slegg	Director of Finance (London Region), NHS England	12 February 2015 and 23 March 2015

Appendix C: Documents reviewed as part of this engagement

Key documents reviewed
Transformation Programme & Financial Recovery Group Terms of Reference
Transformation Programme & Financial Recovery Group committee papers and minutes (for the period April 2014 to January 2015)
Financial recovery and QIPP Committee Terms of Reference
Financial recovery and QIPP Committee papers and minutes (for the period April 2014 to January 2015)
Audit Committee Terms of Reference
Audit Committee papers and minutes (for the period April 2014 to January 2015)
Executive Committee Terms of Reference
Executive Committee papers and minutes (for the period April 2014 to January 2015)
Governing Body Committee papers and minutes parts 1 and 2(for the period April 2014 to January 2015)
Committee structure
Corporate risk register
Finance risk register
Business case template and monitoring templates, and project initiation documents
CCG finance report month 2 to month 10
CSU estimate of Barnet and Chase Farm Hospitals RTT backlog estimate month 8
NHS Enfield CCG non-ISFE return May 2104 to December 2014
NHS Enfield CCG month-end hard close reports April 2014 to December 2014
NHS Enfield key budget adjustment vouchers
CFOs in 14/15 CVs.
14/15 budget sign-off sheets
Draft financial management information reporting template
Appendix B to the service level agreement between NEL CSU and Enfield CCG. List of services core and additional

Appendix D: Committee meetings and key operational meetings observed as part of this engagement

Committee Meeting	Meeting Date
Transformation Programme & Financial Recovery	5 February 2015
Working day 4 soft close meeting	5 February 2015
Financial Recovery and QIPP committee	10 February 2015
Audit Committee	18 March 2015

Appendix E: Comparison of general ledger balances reported by NHS Enfield CCG to CCG committees and to NHS England within the non-ISFE return

For the 14/15 financial year we have assessed the balances reported by NHS Enfield CCG in their internal reporting to their committees and in their external reporting to NHS England.

Table D.1 below presents the results of the test of the YTD net expenditure balance per the general ledger at each reporting period to the CCG committee papers (finance reports) and to the non-ISFE return to NHS England. The year-to-date net expenditure reported by the CCG at each period agrees to the trial balance, with the exception of the finance papers prepared at month 2 for CCG committees.

Table D.2 below presents the results of the test of the forecast net expenditure balance per the general ledger at each reporting period to the CCG committee papers (finance reports) and to the non-ISFE return to NHS England. No exceptions were noted in this test.

YTD net expenditure	Non-ISFE return	Committee papers	Trial balance
Financial reporting period	£m	£m	£m
1	Not prepared	Not prepared	£28.3
2	£56.8	£58.4	£56.8
3	£87.6	£87.7	£87.6
4	£117.0	£117.0	£117.0
5	£146.3	£146.3	£146.3
6	£176.5	£176.5	£176.5
7	£205.6	£205.6	£205.6
8	£236.2	£236.2	£236.2
9	£275.0	£275.0	£275.0

Table D.1: Reconciliation for YTD net expenditure balance reported within the non-ISFE return to NHS England, NHS Enfield CCG committee papers and NHS Enfield general ledger trial balance.

Source: Non ISFE returns, committee papers and general ledger download

Forecast net expenditure	Non-ISFE return	Committee papers	Trial balance
Financial reporting period	£m	£m	£m
1	Not prepared	Not prepared	£350.2
2	£350.2	£350.2	£350.2
3	£351.0	£351.0	£351.0
4	£351.0	£351.0	£351.0
5	£351.3	£351.3	£351.3
6	£350.7	£350.7	£350.7
7	£352.5	£352.5	£352.5
8	£353.2	£353.2	£353.2
9	£367.2	£367.2	£367.2

Table D.2: Reconciliation for forecast net expenditure within the non-ISFE return to NHS England, NHS Enfield CCG committee papers and NHS Enfield general ledger trial balance.

Source: Non ISFE returns, committee papers and general ledger download

Appendix F: Comparison of risks and mitigations reported by NHS Enfield CCG to CCG committees and to NHS England within the non-ISFE return

For the 14/15 financial year we have reviewed the financial risk and mitigation balance reported by NHS Enfield CCG in their internal reporting to their committees and in their external reporting to NHS England.

Tables E.1, E.2., E.3 below presents the results of the test to verify the value of financial risk and mitigation (non-risk adjusted) at each reporting period within the CCG committee papers (finance reports) and in the non-ISFE return to NHS England.

A number of variances were noted in the tests performed, as noted in the variance column of the tables below. The greatest differences in the value of risks and mitigation reported internally and to NHS England are:

- Month 4: A greater net risk of £1.9m was reported to NHS England than in CCG committee papers;
- Month 5: A net risk reported to NHS England of £1.2m lower than that included in CCG committee papers; and
- Month 8: A net risk reported to NHS England of £11.8m lower than that included in CCG committee papers.

in month 4, where £1.9m greater net risk is stated in the non-ISFE return than the committee papers, and month 8 where the net risk stated in the NHS England reporting is £11.8m less than in committee papers. These most significant differences are noted to be due to:

Risk	Non-ISFE return	Committee papers	Variance
Financial reporting period	£m	£m	£m
1	Not prepared	Not prepared	-
2	10.5	10.5	0
3	10.5	10.5	0
4	10.6	13.4	2.8
5	15.0	13.9	-1.1
6	11.6	11.6	0
7	10.3	11.6	1.3
8	16.9	16.6	-0.3
9	6.4	5.8	-0.6

Table E.1 Reconciliation for level of financial risk reported (not-risk adjusted) within the non-ISFE return to NHS England and NHS Enfield CCG committee papers.

Source: Non ISFE returns, committee papers

Mitigation	Non-ISFE return	Committee papers	Variance
Financial reporting period	£m	£m	£m
1	Not prepared	Not prepared	-
2	8.7	8.7	0
3	8.7	8.7	0
4	8.7	13.4	4.7
5	16.2	13.9	-2.3
6	11.6	11.6	0
7	10.3	11.6	1.3
8	16.9	4.8	-12.1
9	1.7	1.7	0

Table E.2: Reconciliation for level of financial mitigation reported (not-risk adjusted) within the non-ISFE return to NHS England and NHS Enfield CCG committee papers.

Source: Non ISFE returns, committee papers

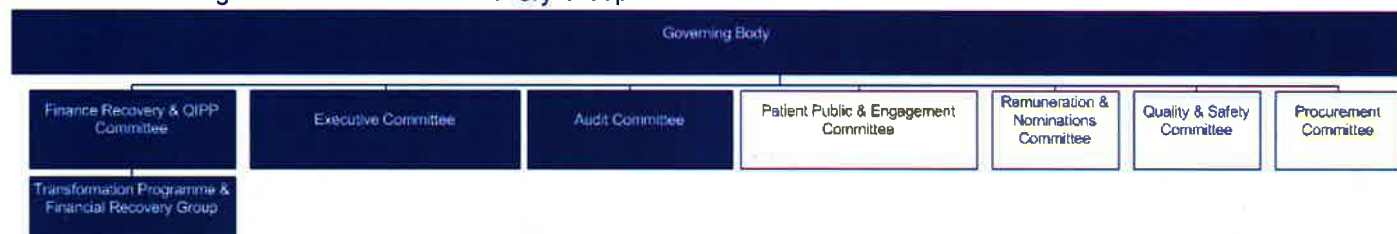
Net Risk	Non-ISFE return	Committee papers	Variance
Financial reporting period	£m	£m	£m
1	Not prepared	Not prepared	-
2	1.8	1.8	0
3	1.8	1.8	0
4	1.9	0	1.9
5	-1.2	0	-1.2
6	0	0	0
7	0	0	0
8	0	11.8	-11.8
9	4.7	4.1	0.6

Table E.3: Reconciliation for level of financial net risk reported (not-risk adjusted) within the non-ISFE return to NHS England and NHS Enfield CCG committee papers.

Source: Non ISFE returns, committee papers

Appendix G: NHS Enfield CCG Governing Body and sub-committees

The CCG's constitution and authorisation process included the approval of the following Committee Terms of Reference: Audit Committee, Remuneration & Nominations Committee, Finance Recovery & QIPP Committee, Patient Public & Engagement Committee and Quality & Safety Committee. In 2014 two more sub-committees were established and added to the CCG's constitution: the Executive Group and Procurement Committee. The TORs of sub-committees were reviewed at the July 2014 Governing Body meeting. The committees in scope for the financial governance review are the: Governing Body, Executive Group, and Finance Recovery & QIPP Committee with its sub-committee the Transformation Programme & Financial Recovery Group.



Source: NHS Enfield CCG Governing Body Papers July 2014

Key items from the TOR	Membership	Frequency	Purpose	Key financial information presented to the committee
Audit Committee	<ul style="list-style-type: none"> Chair (The Lay Member of the Governing Body with responsibility for governance) Two further lay members (one a member of the Governing Body and one external). At least two other Governing Body members, one of whom must be a general practitioner. 	<ul style="list-style-type: none"> At least 6 times per annum 	<ul style="list-style-type: none"> Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of CCG's activities, both clinical and non-clinical, that supports the achievement of its objectives. Internal audit External audit 	<ul style="list-style-type: none"> Board assurance framework Corporate risk register Losses and compensation report Debtors report Waivers report Financial reporting Relevant items on the forward plan, internal audit work plan and external audit work plan.
Executive Committee	<ul style="list-style-type: none"> Chair – Chief Officer Vice Chairs Chief Finance Officer Director of Quality and Integrated Governance Medical Director Director of Strategy and Partnerships Head of Performance Locality lead from each locality 	<ul style="list-style-type: none"> Monthly 	<ul style="list-style-type: none"> Ensure effective co-ordination of the Governing Body, Committees' and CCG's corporate business and organisational development, and support the senior management team responsibilities 	<ul style="list-style-type: none"> Monthly financial performance report Monthly contracts report Specific funding requests CSU performance report

Table F.1: NHS Enfield CCG committee details

Source: NHS Enfield CCG committee terms of reference

Appendix G: NHS Enfield CCG Governing Body and sub-committees

Key items from the TOR	Membership	Frequency	Purpose	Key financial information presented to the committee
Finance Recovery & QIPP Committee	<ul style="list-style-type: none"> Chair Chief Officer Accountable Officer Chief Financial Officer Director of Quality and Integrated Governance Two Governing Body members Qualified Finance member (external) 	<ul style="list-style-type: none"> Monthly 	<ul style="list-style-type: none"> Review and scrutinise the performance of the CCG against its financial targets. 	<ul style="list-style-type: none"> Monthly financial position Monthly activity report QIPP monitoring Financial recovery plan Business cases Risk reports and financial risk share
Transformation Programme & Financial Recovery Group	<ul style="list-style-type: none"> Chief Officer (CHAIR) Medical Director Chief Finance and Director of Contracting (VICE CHAIR) Director of Quality Services and Integrated Governance Director of Strategy and Partnerships Director of Operations GB Member and Clinical Lead GB Member and Secondary Care Consultant Joint Acting Assistant Director of Transformation Joint Acting Assistant Director of Transformation Head of Acute Contracting Head of Medicines Management Financial Modelling Manager Transformation Programme Office Manager Interim NCL POD Deputy Director (CSU) - (Enfield MDT) Assistant Director of Contracts (CSU) – (Enfield MDT) Director of Public Health (LBE) 	<ul style="list-style-type: none"> Monthly 	<ul style="list-style-type: none"> To generate potential solutions which may deliver efficiencies and innovation Provide planning, scrutiny and challenge role to ensure the achievement of QIPP targets, Recovery Plans, and future delivery of the CCG's financial control total. To generate potential solutions which may deliver efficiencies and innovation 	<ul style="list-style-type: none"> Monthly financial position Monthly activity report QIPP monitoring Financial recovery plan Business cases Service improvements

Table F.1: NHS Enfield CCG committee details

Source: NHS Enfield CCG committee terms of reference

Appendix H: Assessment of in-year budget changes

- For the 14/15 financial year we performed a test of significant budget changes processed within 2014/15. We sampled the most significant budget changes based on value; this resulted in a sample of 16 in-year budget changes. We assessed each budget change to test evidence of authorisation, and to gain an understanding of the reason for the change in budget.
- Are results are presented in Table G.1 below. Key findings are:
 - All budget journals had been approved by the Deputy CFO;
 - None of the budget journals we sampled had been approved by a budget holder; and
 - It is understood that there is no formal policy in place at the CCG for the approval of budget changes.
- The initial ledger balances were loaded in May 2014 and have been adjusted through the year for contract values as contracts have been agreed.

Item	Budget Journal Number from voucher	NHS Enfield CCG Journal description	Posting date	Number of lines	Largest line value £	Authorised by budget holder	Authorised by	Reason for budget journal
1	1012141/21888116	BUDGET UPLOAD Budget - Upload GBP 85045	27/06/2014	39	2,410,500	-	Ian Winning	Update to a large number of cash envelop budgets. Greatest adjustments to budgets for: CHC, Barnet and Chase Farm RTT and thresholds & readmissions.
2	1008150/21806788	Updating for Cash envelope Budget - Upload GBP 85045	25/06/2014	44	2,200,000	-	Ian Winning	Update to a large number of cash envelop budgets.
3	1301905	Winter pressures funding to be allocated to programmes Budget - Upload GBP 85045	30/10/2014	2	1,831,000	-	Robert Hudson	Increasing revenue resource limit and planned expenditure for winter resilience funding 14/15.
4	1384432	RISK POOL ADJUSTMENTS Budget - Upload GBP 85045	27/11/2014	6	1,382,000	-	Robert Hudson	Allocation of reserves for primary care strategy and increase to revenue resource limit for money drawn from the risk share and transformation fund.
5	1251380	Reduce integrated care budget Budget - Upload GBP 85045	06/10/2014	2	947,000	-	Robert Hudson	Reduce integrated care budget and transfer excess budget to reserves.
6	1017928/22034273	GPIT BUDGET UPLOAD Budget - Upload GBP 85045	30/06/2014*	2	797,862	-	Robert Hudson	Increasing revenue resource limit and planned expenditure for GPIT funding.
7	1326975	Enhanced Nursing costs Budget - Upload GBP 85045	11/07/2014	2	586,864	-	Robert Hudson	Increasing expenditure budget for nursing costs that were not included in the initial budget upload.
8	1242466/25704809	CEOV and non-rechargeable services allocation adjustment Budget - Upload GBP 85045	02/10/2014	2	314,000	-	Robert Hudson	Decreasing revenue resource limit and planned acute non contracted activity expenditure.
9	999569/21621658	Corporate Budget Adjustment Budget - Upload GBP 85045	20/06/2014	35	302,620	-	Ian Winning	Budget virement to match the structure of the CSU
10	-	BCF RF transfer transaction costs Budget - Upload GBP 85045	25/09/2014	14	300,000	-	Robert Hudson	Decreasing revenue resource limit and planned expenditure for BCF RF transfer transaction costs.
11	1327359	BCF HOT Reconciliation Budget - Upload GBP 85045	11/07/2014	2	208,257	-	Robert Hudson	Reduce acute care budget for Barnet and Chase Farm hospitals and transfer excess budget to reserves.
12	1028837/22172736	Programme share of CSU costs Estimated Budget - Upload GBP 85045	03/07/2014*	2	202,870	-	Robert Hudson	Transfer between CSU running costs and programme corporate costs.
13	1034638/22226796	Medicine Management Budget adjustments Budget - Upload GBP 85045	04/07/2014*	4	107,695	-	Robert Hudson	Budget adjustment for medicines management 14/15 planned expenditure.
14	1049662/22422800	Running cost adjustment Budget - Upload GBP 85045	09/07/2014*	2	98,159	-	Robert Hudson	Budget realignment for the Whittington Hospital running costs
15	1025857/22137096	Reverse duplicate Prop cost to Programme Budget - Upload GBP 85045	02/07/2014*	2	94,489	-	Robert Hudson	Budget realignment for the CCG running costs
16	1042769/22331593	Reversing Budget adj for Paul Gouldstone Budget - Upload GBP 85045	07/07/2014*	2	24,000	-	Robert Hudson	Reversing transfer of salary costs for medicines management.

Table G.1 Information about in-year budget virements assessed as part of our sample. *Robert Hudson joined NHS Enfield CCG 09/07/2014 and reviewed and signed after the period end ledger closure.

Source: NHS Enfield general ledger and budget virement forms



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NHS ENFIELD CCG MANAGEMENT RESPONSE AND ACTION PLAN

UPDATED 14th May 2015 –
VERSION – 7

Emma Casey to hold master copy;
please ensure Emma is aware of any
changes.

VERSION CONTROL SHEET

Version	Date	Updated by
Version 4	15 th April 2015	Jane Pike
Version 5	7 th May 2015	Rob Whiteford
Version 6	14 th May 2015	Rob Whiteford
Version 7	14 th May 2015	Emma Casey (formatting only)

Appendix H: NHS Enfield CCG Management response and action plan

Following the production and presentation to the Trust of the draft Deloitte report the Trust has prepared a draft management action plan in response to the findings and recommendations. The management response and action plan, due date and responsibility have been completed by NHS Enfield Clinical Commissioning Group as at 08/04/2015 and have not been verified/audited by Deloitte and therefore reflect the views of management only.

B. Capability and culture

Area	Recommendation	Management response and action plan as at 08/04/2015	Lead	Due Date	RAG
B1 Committee effectiveness	<ul style="list-style-type: none"> CCG management should seek to recruit to the post of the external finance member. 	<ul style="list-style-type: none"> The Chair of the Audit Committee (a qualified accountant) has agreed to fulfil this role. Update from 22/4/15 Finance committee from RW – above agreed as full time plus additional finance lay person to be recruited. 	Jonathan Elwood	In post end of August	Amber
	<ul style="list-style-type: none"> It should be ensured that financial information presented to the FR&Q is focused, and highlights the key areas of risk and concern for the committee to focus on. This could be achieved, for example, through better use of the Contract Monitoring Group to review detailed financial information and escalate key areas to the FR&Q. 	<ul style="list-style-type: none"> Agreed. The Finance Committee agenda is now focussed on key high level information, with a brief presentation on performance of key contracts. Update from 22/4/15 Finance committee from RW - Revised reporting format presented and welcomed. Limited number of key items discussed at length including this report. 		Completed	Green
	<ul style="list-style-type: none"> It should be re-emphasised to committee members that one of the objectives of the FR&Q is to ensure the financial position is fully understood, and that the committee should require specific actions to be taken where this is not the case. 	<ul style="list-style-type: none"> Revised Terms of Reference prepared and this point is included. Robert Whiteford will present a verbal reminder (to be minuted) at the start of the Finance Committee of 22/04/15. Update from 22/4/15 Finance committee from RW – clear verbal statement to committee at outset and checked that members understood the 2015/16 plan and M12 position. 	Robert Whiteford	22/04/15	Amber
	<ul style="list-style-type: none"> Efforts should be made to ensure that papers required for the Audit Committee meetings are made available with sufficient time for a full review by the committee. Where this is not possible, the item should be moved to the next committee agenda, or where the item is urgent alternative arrangements should be made in order to ensure appropriate consideration of the item, as well as any required decision, occurs within the required timescale. 	<ul style="list-style-type: none"> Noted and Agreed. Update from 29/4/15 Audit Committee from RW – papers submitted on time with the pre-planned exception of the draft annual accounts, which were available on the 23/4/15. 	Rob Whiteford	27/5/15 (Date of next audit Committee)	Amber
	<ul style="list-style-type: none"> The Audit Committee and Internal Audit should work to ensure that the Internal Audit plan continues to be appropriately focused to manage the breadth of key strategic risks at the organisation 	<ul style="list-style-type: none"> Noted. Agreed by Enfield CCG. Will be discussed with Internal Audit for implementation when this report is released. Update from RW 29/4/15 – internal audit plan agreed. Will cover progress against this report as a key component. 	Rob Whiteford	27/5/15	Amber

Appendix H: NHS Enfield CCG Management response and action plan, continued.

B. Capability and culture

Area	Recommendation	Management response and action plan as at 08/04/2015	Lead	Due Date	RAG
<p>B2 Financial capability, capacity and culture</p>	<ul style="list-style-type: none"> It is recommended that the CCG aim to ensure long-term stability of the financial leadership, through retention of senior finance staff and substantive recruitment of the Deputy CFO (see below). 	<ul style="list-style-type: none"> We agree with this recommendation. The CCG now has a substantive CFO, and is using a recruitment agency to recruit a permanent Deputy CFO. We should note however, recruitment and retention difficulties and the CCG is not alone in struggling to attract and retain quality candidates in permanent roles. The CCG has taken additional measures to strengthen its finance department, specifically in contracting. 	Robert Whiteford	30/09/15 for start date for Deputy CFO.	Yellow
	<ul style="list-style-type: none"> Improvements to reserves and contingency management are required. A tracking of the value of contingencies and reserves held and the purpose of reserves should be developed. This should be reconciled to the expenditure these have been committed against. NHS Enfield CCG management inform us this has since been implemented. 	<ul style="list-style-type: none"> Update from RW 7/5/15 – Hays Executive running campaign, advert out and interested parties contacted for initial screening by Hays. Note that response to date is disappointing. This is now implemented. Update from RW 7/5/15 – This was implemented in April 2015. Complete. 			Green
	<ul style="list-style-type: none"> Develop and implement a process for approval by budget holders for budget transfers. 	<ul style="list-style-type: none"> Implemented. Revised Virement Policy shared with Deloitte FRG team and internally. 	Robert Hudson		Green
	<ul style="list-style-type: none"> It is recommended that a number of development sessions are planned and delivered for the Governing Body and Executive Committee. These should focus on finance, and particularly on financial forecasting, planning and reporting in an NHS CCG context. 	<ul style="list-style-type: none"> Agreed. Governing body seminars will be used to deliver the development sessions. The governing body seminar of 25/02/15 considered in detail the Financial Plan for 2015/16. The CCG financial position will be discussed separately at every Governing Body Seminar. Update from RW 7/5/15 – Governing Body Seminar dates scheduled as follows: 10am to 2pm 8 July 2015 and 9am to 1pm 2 September 2015. Content and presentation to be confirmed. 	David Triggs	To end by 30/09/15. Suggest 2 X 3 hour sessions.	Yellow
	<ul style="list-style-type: none"> The CCG should consider the benefits of performing a Governing Body effectiveness review, considering financial capability, but also wider Governing Body responsibilities where value in performing this is identified. This effectiveness review should be used to inform the nature and focus of the development sessions noted above. 	<ul style="list-style-type: none"> The CCG will consider with NHSE how best to implement this recommendation. Update from LW – TBC 	Liz Wise & Mo Abedi	30/4/15	Yellow
<p>Wider consideration</p> <ul style="list-style-type: none"> In other regions of London, a cross CCG strategic finance role has been established. It is recommended that the CCG explore the opportunity for this in their region. Where there is disruption in financial leadership at a CCG level, a cross CCG finance leader would help to ensure strategic financial leadership is maintained. 	<ul style="list-style-type: none"> This recommendation will be discussed with David Slegg at NHSE. Update from RW 7/5/15 – RW discussed with David Slegg. He has measures in place to address this recommendation. Carnall Farrar, including the former cluster DoF Bev Evans are also actively assisting us to operate more effectively in finance as a health economy. 	Ian Boyle	10/4/15	Yellow	

Appendix H: NHS Enfield CCG Management response and action plan, continued.

C. Structures and processes

Area	Recommendation	Management response and action plan as at 08/04/2015	Lead	Due Date	RAG
C1 Timing of committee meetings	<ul style="list-style-type: none"> CCG management should urgently review the timing of meetings for committees that have a financial remit, and revise these in line with the financial reporting timetable. The aim should be to ensure that the FR&Q are able to review more recent financial information, and in advance of other more senior committees. NHS Enfield CCG management inform us this has since been implemented. 	<ul style="list-style-type: none"> Agreed. The date of the finance committee is now in the 3rd or 4th week of the calendar month, enabling a full report to be presented to the finance committee for the previous calendar month. Update from RW 7/5/15 – Implemented w.e.f 22/4/15 (note date of Finance Committee). Dates in 3rd or 4th week of the month set for the rest of the year. Closed. 		Completed	Green
	<ul style="list-style-type: none"> Implementation of revised timings for these committees will require consideration of the wider committee structure; revisions to the timing of other committees is likely to be needed. 	<ul style="list-style-type: none"> Noted and implemented. Update from RW 7/5/15 – Executive Committee timings changed to accommodate Finance Committee where necessary. Closed. 		Completed	Green
	<ul style="list-style-type: none"> It needs to be ensured that the flow of financial information is aligned to the committee structure – refer to Finding D3. 	<ul style="list-style-type: none"> Agreed. Revised Terms of Reference, refocused agendas, time spent on key items and financial information relevant to the group in question have all been addressed. Update from RW 7/5/15 – Evidenced by short focussed agenda for the Finance Committee of the 22nd April. Revised ToRs for the Finance Committee were agreed in this meeting. Keep under review – do not close. 	Robert Whiteford	Completed, but will be kept under review for effectiveness — review 30/09/15.	Green






Appendix H: NHS Enfield CCG Management response and action plan, continued.

C. Structures and processes

Area	Recommendation	Management response and action plan as at 08/04/2015	Lead	Due Date	RAG
C2 Focus and remit of the committees	<ul style="list-style-type: none"> To review and align the committee structure to ensure that the responsibility of each committee is clear, including the alignment and boundary between each committee with a financial remit. 	<ul style="list-style-type: none"> Terms of Reference for the Finance Committee and the Transformation Programme and Financial Recovery Group have been revised and clearly state the remit and authorisation level of each. Update from RW 7/5/15 –Committees of the Board are all clear on Terms of Reference, which have been agreed or recommended to the Governing Body by the relevant Committee. Following the start of the Recovery Director ToRs for the Transformation Programme and Financial Recovery Group are being re-written. This is not a Board Committee. 		Completed for Board Committees, TPG outstanding.	Yellow
	<ul style="list-style-type: none"> Ensure that the responsibilities stated in the Terms of Reference are appropriate and relevant for the committee. 	<ul style="list-style-type: none"> See above. 		Completed	Green
	<ul style="list-style-type: none"> To document this clearly in the Terms of Reference for the committee, and re-emphasise the purpose of committees to ensure that all committee members understand and agree to this. 	<ul style="list-style-type: none"> Clear and succinct purpose of each committee now stated in Terms of Reference. 		Completed	Green
	<ul style="list-style-type: none"> Review, in connection with the Terms of Reference, the financial information presented to each committee – in order to understand and define why this information is relevant for the committee, and how each committee is expected to use and respond to the information presented (see also Finding D4). 	<ul style="list-style-type: none"> Agreed. We will deliver tailored financial information to Executive Committee and full financial information to the Finance Committee and the Governing Body. This needs to be reviewed for effectiveness on an ongoing basis. Update from RW 7/5/15 – This will be trialled with Month 1 information in May Committees. 	Robert Whiteford	Review effectiveness ongoing and formally by 30/09/15.	Yellow
	<ul style="list-style-type: none"> Perform a short effectiveness review at the end of each committee meeting that refers back to the purpose of the committee and the agenda and concludes whether or not they have achieved this. This would be enabled by a clear agenda for each meeting and a clear list of the decisions needed, the work commissioned by the committee, and the confirmations they should be giving (for example, having review available information the committee is content that their currently reported financial position adequately reflects the impact of reasonably likely risks and opportunities). NHS Enfield CCG management inform us this has since been implemented. 	<ul style="list-style-type: none"> This is already in place through a paper based process but could be improved by verbal feedback at the end of the meeting. I will trial this on the 22/04/15 - Robert Whiteford Update from RW 7/5/15 – verbal assurance (to be minuted) sought at the end of presenting each paper to ensure understanding. Agenda streamlined and focussed discussion on key issues. Keep open for review do not close. 	Robert Whiteford	Completed but review for effectiveness ongoing.	Green
	<ul style="list-style-type: none"> It should be ensured that the remit of the Audit Committee is clear and adhered to, and that agenda items align to this, in order to prevent the risk of the committee acting outside of its remit. 	<ul style="list-style-type: none"> Agreed. The CCG will review the Audit Committee Terms of Reference and ensure it acts within its remit. Update from RW 7/5/15 – Agenda on 29/4/15 completely aligned to ToRs. The audit chair does not consider the Committee has acted outside of its remit and manages it effectively ensuring it continues to do so. RW to clarify reason for recommendation with Richard Mott – outstanding action for RW. 	Rob Whiteford & Karen Trew	27/5/15	Yellow

Appendix H: NHS Enfield CCG Management response and action plan, continued.

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Lead	Due Date	RAG
<p>D1 Financial information and financial risk reporting</p>	<ul style="list-style-type: none"> The finance team have performed work to improve the Finance Report for month 10. Key changes include: <ul style="list-style-type: none"> Inclusion of tables amongst the narrative; Information on the underlying run rate, and how this compares to forecast; and Balance sheet information, including aged debtors and cashflow. Further improvements are recommended to the finance report: Inclusion of information on best and worst case scenarios, particularly exposing the range in the financial position and the potential worse position; 	<ul style="list-style-type: none"> The CCG recommend that known quantifiable risks (and certainly where they are liabilities) are included in the reported base financial position, with the variation in best/likely/worst scenarios kept to an absolute minimum. Risks not included in the financial position are articulated clearly in the finance report text, which has a section dedicated to risks and opportunities. We would welcome the opportunity to discuss the best way in which to practically implement this, as we recognise its value as an early warning sign. RW update 7/5/15 - Known risks and opportunities not provided for in the base position are now clearly articulated in both the Monthly Finance Reports and the Recovery Plan. 	Robert Whiteford	Best/Likely/Worst forecasts to be prepared from Month 6 onwards, when meaningful trends are established. Clearly any risks impacting on our ability to achieve our control total will be included in our position immediately. By 3rd week of October. From Month 1 each finance committee meeting will discuss risks and opportunities as part of the finance report.	  
	<ul style="list-style-type: none"> Details of the risk adjustment or probability applied to financial opportunities and risks; Clarity on changes in the financial position between months, for example a waterfall chart to bridge the forecast position in the current and previous month; Clarity in movements in key financial risks, explaining the latest position and what has been included in the forecast; 	<ul style="list-style-type: none"> The revised Finance report clearly and succinctly sets out the month on month changes. The revised finance recovery plan sets out key risks and quantifies them where possible. For example the risk (now materialised) on LAS was included in the previous plan. RW update 7/5/15 - a further plan submission on the 14th May will build on the key risks and opportunities presented in previous versions. This has been and will remain very clear in its presentation. 		<p>Completed</p> <p>Completed for Recovery Plan, but required for ongoing Finance Reports 2015/16; first by the 3rd week of May.</p>	 

Appendix H: NHS Enfield CCG Management response and action plan, continued.

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Lead	Due Date	RAG
<p style="text-align: center;">D1 Financial information and financial risk reporting</p>	<p><i>Continued from previous page:</i></p>				
	<ul style="list-style-type: none"> Further presentation of the underlying run rate and financial position, for example presenting this in a line chart with projected future position; and 	<ul style="list-style-type: none"> Information is now included in the revised finance report. This is clear and the CFO has explained to the finance committee and governing body how to interpret it. RW update 7/5/15 – agreed at Finance Committee to leave 2014/15 numbers in run rate table to enable comparison of the run rate in each month. 	Robert Whiteford	First by 3rd week of May and ongoing	
	<ul style="list-style-type: none"> Further balance sheet analysis, for example trend analysis in activity accruals and other significant balance sheet items. 	<ul style="list-style-type: none"> Agreed. The value of this is limited by the nature of CCG cash drawdown (i.e. liabilities always far exceed assets). Nevertheless changes to key balances require explanation and this will be incorporated. 	Robert Whiteford	By 3rd week of July (to allow for trends to become evident)	
	<ul style="list-style-type: none"> It is recommended that at the start of the financial overview session at the FR&Q the CFO gives a high level review of the 3-5 key messages, risks and decisions required. 	<ul style="list-style-type: none"> Initiated with effect from March Finance Committee. RW update 7/5/15 – and carried on with delivery of key messages in the Finance Committee of 22/4/15. Keep open for review. 		Implemented but ongoing	
	<ul style="list-style-type: none"> A dashboard or scorecard style of reporting could be employed, to present the latest position on key metrics and risks in an understandable and accessible format. 	<ul style="list-style-type: none"> Noted. RW Update 7/5/15 - The format of the finance report has been revamped and has received positive feedback from the Finance Committee and the Governing Body. Closed. 	Robert Whiteford w/ Richard Mott	By 3rd week of May.	
	<ul style="list-style-type: none"> The CCG finance team should investigate the differences noted between the value of risks and mitigations reported to CCG management and to NHS England, in order to identify the reason for these differences and to ensure there was appropriate approval in place to report different values. 	<ul style="list-style-type: none"> Agreed .These risks are identical in the 2015/16 plan and the intention is for them to remain so, notwithstanding differences in the reporting mechanism. The CCG will clearly report unmitigated risk. 		Implemented with immediate effect.	

Appendix H: NHS Enfield CCG Management response and action plan, continued

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Lead	Due Date	RAG
<p style="text-align: center;">D2 CSU Financial information</p>	<ul style="list-style-type: none"> A review of the financial information the CSU (or other CSUs) produces for other CCGs may help to identify examples that are more suited to the CCG's requirements. 	<ul style="list-style-type: none"> Across NCL an improvement group led by the CO of Haringey has resulted in improved and standardised reporting. 	Jane Pike	Remains in progress – by 30/6/15	
	<ul style="list-style-type: none"> Once this has been clearly understood, the CCG should seek to identify and implement methods to ensure the regular production of financial information that suits its needs. For example, through specific agreement with the CSU on the style and content of CSU produced financial information. 	<ul style="list-style-type: none"> This has taken place. The CSU is limited in that it must adopt a “factory” based approach to maintain economies of scale. We work closely with the CSU on site to ensure good communication of local financial information. RW update 7/5/15 - CSU finance staff are incorporated into our team and attend all team meetings. This has assisted in achieving more locally focussed interpretation of CCG information provided by the CSU, notably the contract monitoring report. 	Robert Whiteford	Completed	
	<ul style="list-style-type: none"> The CCG should ensure that its own requirements are clearly reflected in the CSU service improvement plan that has been agreed amongst the 5 CCGs and include a quarterly review of progress in this area. 	<ul style="list-style-type: none"> Agreed and this has taken place. 		Completed – the CCG now works in close contact with the CSU to share all relevant information prior to production of monthly contract and finance information.	

Appendix H: NHS Enfield CCG Management response and action plan, continued

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Lead	Due Date	RAG
<p style="text-align: center;">D3 2014/15 financial planning</p>	<ul style="list-style-type: none"> It is recommended that the CCG performs a full risk assessment when producing the 2015/16 financial plan – in order to identify and quantify potential financial risks that may impact the position, and how to reflect these in the financial position. 	<ul style="list-style-type: none"> The CCG has considered the risks and opportunities in the plan very carefully. The plan contains a section on risks and opportunities, the previous version containing London Ambulance, Mental Health and the risk of over activity on acute contracts. These are then included in the financial position when they crystallise, e.g. London Ambulance is now included within our revised plan. The risk of over activity was in part mitigated by useful challenge sessions with NHSE on the amount of growth assumed in the plan, and whether this was realistic. This resulted in increased growth being included. RW update 7/5/15 – completed for previous plan iterations and risks and opportunities are clearly set out in the accompanying Financial Recovery Plan. 	Robert Whiteford	Implemented – but the risks require to be monitored continually.	
	<ul style="list-style-type: none"> These financial risks should be communicated to the Audit Committee, FR&Q, Executive Committee and Governing Body. 	<ul style="list-style-type: none"> Agreed and they will form part of the report received by these Committees. RW update 7/5/15 – risks very clearly communicated to the Finance Committee on 22/4/15. The Financial Recovery Plan setting out risks has been approved by the Governing Body and taken to the Executive Committee. 	Robert Whiteford	From 3rd week in May for April reports	
	<ul style="list-style-type: none"> Approval should be sought from the committees that the quantification and treatment of financial risks in the 2015/16 financial plan is agreed. 	<ul style="list-style-type: none"> Noted. We would welcome the opportunity to discuss this further with the Deloitte team. RW update 7/5/15 - The Financial Recovery Plan setting out risks has been approved by the Governing Body. Quantification and treatment is discussed in the Finance Committee. 	Rob Whiteford with Richard Mott.	30/4/15.	
	<ul style="list-style-type: none"> These identified risks should then be reported regularly during the financial year, as described in Finding D1. 	<ul style="list-style-type: none"> Agreed. 	Robert Whiteford	By the 3rd week in May for April reporting.	

Appendix H: NHS Enfield CCG Management response and action plan, continued

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Lead	Due Date	RAG
<p>D4 Flow and focus of financial information</p>	<ul style="list-style-type: none"> In connection with Findings C1 and C2, a review of the financial information presented to the committees should be performed to ensure this aligns clearly to the responsibilities of the committee. 	<ul style="list-style-type: none"> Agreed and covered above. 	Robert Whiteford	Completed	Green
	<ul style="list-style-type: none"> The flow and focus of information between committees should be reviewed and improved. For example, it is recommended that the CSU Finance & Activity report is reviewed by the Contract Monitoring group, and key concerns and actions identified, before reporting this to the FR&Q. 	<ul style="list-style-type: none"> Agreed and already implemented. 	Robert Whiteford	The CSU reports are summarised and locally interpreted before presentation to the Finance Committee.	Green
	<ul style="list-style-type: none"> Financial information presented to the committees should be presented with clear advice noting the key areas for consideration, and the response or action required from the committee on specific items. 	<ul style="list-style-type: none"> Agreed and already implemented. Agendas are much shorter with "updates", "for info" and discussion items largely removed. Reports are presented highlighting key points and then leaving time for meaningful discussion and questioning. RW update 7/5/15 – This can be evidenced by both the Finance and Audit Committee agendas from the 22nd and 29th April respectively. 	Robert Whiteford	Implemented - ongoing by nature –	Green
	<ul style="list-style-type: none"> Agendas should be designed to support the prioritisation of key items - the time allocation and ordering should reflect the most important items on the agenda. 	<ul style="list-style-type: none"> See above. Finance committee agenda now much shorter with tight control of items not critical. RW update 7/5/15 – This can be evidenced by both the Finance and Audit Committee agendas from the 22nd and 29th April respectively. Both short and targeted. 		Implemented – can be tested with Finance Committee agenda for 22/4/15.	Green
	<ul style="list-style-type: none"> It is recommended that the Finance Report and the key messages from the CFO are stated early in the FR&Q meeting as these will set the context for the discussion of remaining items, before moving onto detailed reports and other items. It is understood that this has already been agreed between the CFO and Chair of the FR&Q for future meetings. 	<ul style="list-style-type: none"> Agreed and implemented. RW update 7/5/15 – actioned by RW in the Finance Committee meeting of 22/4/15. 		Implemented – can be tested 22/04/15.	Green

Appendix H: NHS Enfield CCG Management response and action plan, continued

D. Measurement

Area	Recommendation	Management response and action plan as at 08/04/2015	Lead	Due Date	RAG
<p>D5 Management of financial position</p>	<ul style="list-style-type: none"> Where the CCG wishes to continue management of the financial position in this way, management should identify a means to report more clearly the underlying financial position, for example the variance against planned position had the reserves not been applied (in conjunction with Finding D1). 	<ul style="list-style-type: none"> The CCG will not manage the position in this way in future. RW update 7/5/15 – closed. Changed w.e.f from 1/4/15. 		Implemented	Green
	<ul style="list-style-type: none"> As noted in Finding D1, the CCG should report scenarios and particularly the worst case scenario, in order to communicate the potential for variance around the forecast position. 	<ul style="list-style-type: none"> See comments above. The CCG agrees on the importance of this and would welcome views on how best to implement it in practice. We feel it is important to recognise as much as possible within the base financial forecast, with minimum movement around unforeseen or indeterminate events. The key point is that the CCG will report unmitigated risks in a clear way. RW update 7/5/15 – the CCG will recognise known quantifiable assets and liabilities in its base position, with a clear articulation of risk and opportunity in the accompanying text. 	Robert Whiteford	3rd week in May for April reporting.	Yellow

Clinical Commissioning Group

Agenda Item: 7.4
Paper Ref: Appendix I

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE	10 June 2015
TITLE:	Integrated Performance Report
LEAD BOARD MEMBER:	Jane Pike - Director of Operations
AUTHOR:	Ed Nkrumah - Head of Performance & Informatics
CONTACT DETAILS:	edmund.nkrumah@enfieldccg.nhs.uk

SUMMARY:

The purpose of this report is to provide an update on the CCG's performance against operational plans, NHS constitutional measures and other corporate activities. The report also includes benchmark information and actions where performance is below standard. The key areas to highlight this month are;

North Middlesex Hospital (NMUH)

NMUH did not achieve the 95% A&E 4 hour wait standard in April reporting 94.4%. Bed management and staff shortages remain the key drivers of the underperformance which is being addressed through the on-going recruitment drive and a more focused monitoring of delayed transfers of care and patients suitable for discharge following the completion of an acute medical intervention. All 18 weeks RTT and cancer wait standards were met for the year.

There has been no MRSA cases for this financial year and *C. Difficile* cases are being reviewed. Learning from cases attributed to lapses in care are being embedded in the organisation.

The proportion of positive responses from Friends and Family Test (FFT) surveys in March were comparable to previous months. The Trust is taking steps to improve both satisfaction and response rates. These actions are being monitored through the Clinical Quality Review Group (CQRG).

Royal Free London Hospitals (including BCF)

Barnet & Chase Farm sites of RFL Trust met the 95% performance standard for April 2015 achieving an average of 96.7% for the first 5 weeks of the financial year. Work is ongoing identify the most effective resilience schemes to roll out in 2015/16. The RTT programme Board is continuing its validation work with the Trust expected to return to reporting in the coming months. Action plans are also in place to address underperformance in 62-day referral to treatment wait and 6 week diagnostic wait standards currently being reported by the Trust.

One MRSA cases were reported in March which leaves the year-to-date total to 6 cases. No new *C. Diff* cases were also reported in March leaving the full year total at 58 cases against the annual ceiling of 54. There is on-going work to integrate infection control measures across all sites to minimise the risk of *C. Diff* infections. CCG action plans are also in place to address community/ care homes – acquired cases.

The positive responses to FFT surveys and response rates for A&E, Inpatients and maternity services remained high in March with the exception of response rates for maternity services where implementation issues have been identified. These are being addressed and monitored through the CQRG.

Mental Health Services - BEH-MHT

Enfield CCG achieve the 10% IAPT access target in 2014/15 and continues to work towards meeting the national target of 15% by the end of 2015/16. The new mental health targets relating to waiting times and Early Intervention in Psychosis are also being implemented with CCG expecting to meet the targets by the end of the financial year. Dementia diagnosis rate target of 59% by the end of 2014/15 was also met.

London Ambulance Service (LAS) Performance

LAS continue to underperform against key targets including the response times to Category A calls. In March 65.5% of call outs were responded to within the 8 minutes service standard, up 2.4% points on previous month. The Trust remains at REAP (Resource Escalation Action Plan) level 4 (Severe) and actions to address resource (staffing/ equipment) constraints continue to be monitored at weekly tri-partite meetings with commissioners, NHSE and TDA. Improvements have been in 2014/15 and further work is required to return to compliance.

SUPPORTING PAPERS:

Attached

- Integrated Performance Report
- Integrated Performance & Quality Report – Detailed Pack

RECOMMENDED ACTION:

The Executive Committee is asked to:-

- Note the content of the report

Objective(s) / Plans supported by this paper: NHS Forward View and Operating Plan 2014-15

Patient and Public Involvement PPI:

Equality Impact Analysis: Equality Impact Assessments are undertaken in relation to substantial commissioning changes and will be available where necessary in relation to individual work programmes.

Risks: All risks identified are recorded on the Enfield risk Register and board Assurance Framework, or available as part of individual work programmes

Resource Implications: Where relevant these are detailed or available as part of individual work programme.

Audit Trail: IPR report is provided to each Executive Committee and Governing Body

Next Steps: An updated report will be provided to each Executive Committee

INTEGRATED PERFORMANCE REPORT

ENFIELD CLINICAL COMMISSIONING GROUP

May 2015

1. Introduction

This report provides an update on the key performance measures for Enfield CCG including remedial actions where standards have not been achieved. More detailed information in graphical format, including benchmark information across London, is also included in the Appendix.

2. North Middlesex University Hospital (NMUH) Performance

A&E Performance

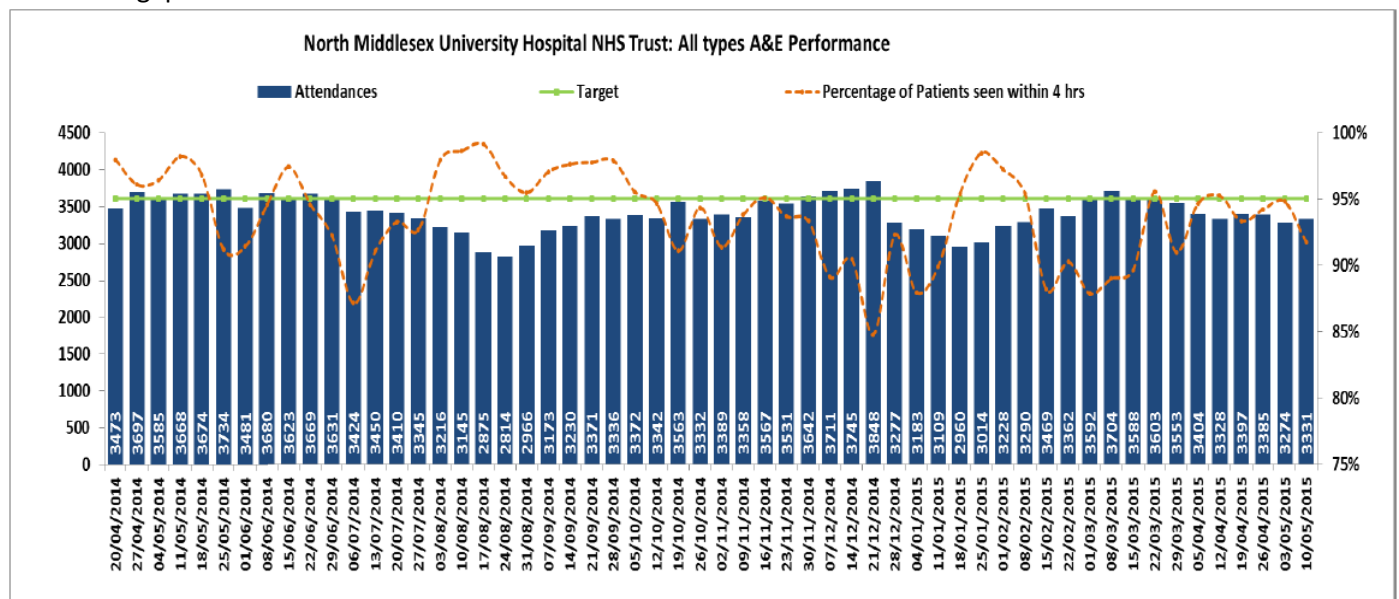
NMUH did not meet the 95% A&E 4 hour wait standard in April 2015 achieving 94.4% for the period. Performance for the week ending 3rd May 2015 was 94.8% representing five consecutive week of underperformance in 2015/16.

The average weekly A&E attendance numbers for the period was 3,358 compared to 3,612 in March 2015. The key reasons for breaches of the 4 hour target remain bed management issues (approximately 40%) and staff shortages in the emergency department (approximately 40%).

NMUH reported 113 '30 minute' and 3 '60 minute' ambulance arrival to handover wait breaches in March 2015.

Key Actions

- Trust is monitoring delayed transfers of care (DTocS) and patients who may be suitable for discharge following acute medical intervention completion (AMICs) on a daily basis.
- Work is ongoing to introduce an extended UCC model with additional GP hours to meet demand.
- Trust is also improving access clinical support services on weekends *e.g.* pharmacy, therapy and radiology which currently operate reduced hours on weekends. This is aimed at improving discharges and throughput during weekends.
- The recruitment drive, which extended to overseas and included Open Days, resulted in a number of substantive appointments expected to start in the next few months. Agency and bank staff are being used to cover gaps in the interim.



Health Care Associated Infections (HCAI)

The Trust maintained the zero tolerance for MRSA throughout the 2014/15 financial year and reported 4 *C. Difficile* cases in March 2015 bringing the annual figure to 46 which is above the annual ceiling of 21 cases. 35 cases for the period April to December 2014 have been reviewed via RCA of which 10 were considered to involve lapses in care (28%). Q4 cases are yet to be reviewed.

The objective set by NHSE for 2015/16 is a maximum of 34 cases. The Trust is therefore progressing with actions to reduce rates of infection including regular audits of cleanliness of all clinical areas and weekly audits of hand hygiene in all clinical areas. Trust is also reviewing their antimicrobial guidance to address inappropriate antibiotic prescribing. This will be closely monitored in 2015/16 through the Clinical Quality Review Group (CQRG).

18 Weeks RTT & Cancer Standards

The validated 18 Weeks RTT data from NNUH for February 2015 indicates the Trust has remained compliant with all 3 RTT standards for the fifth consecutive month;

- Admitted adjusted 94.9% (90%)
- Non – admitted 97.5% (95%)
- Incomplete pathways 96.0% (92%)

The Trust also met all cancer wait standards in-month and year-to-date (February 2015).

Friends & Family Test (FFT)

The satisfaction rates for A&E services improved in March to 69% compared to 53% in February. In general performance appears to be impacted by Trust's performance against the 4 hour access target which has been below national standard since October 2014.

Satisfaction rates for inpatient services remained stable in March at 92%, up 2% points on February. Response rates have also stabilised at 31%, double the minimum standard of 15% and following recent improvements in data collection equipment. Satisfaction rates for maternity services (births) were comparable to previous months at 85%. FFT performance is being reviewed regularly by the Trust to ensure prompt actions are taken to address any issues reported through the survey. The CQRG also reviews performance on a monthly basis.

3. Royal Free London Hospitals (including BCF sites) Performance

A&E Performance

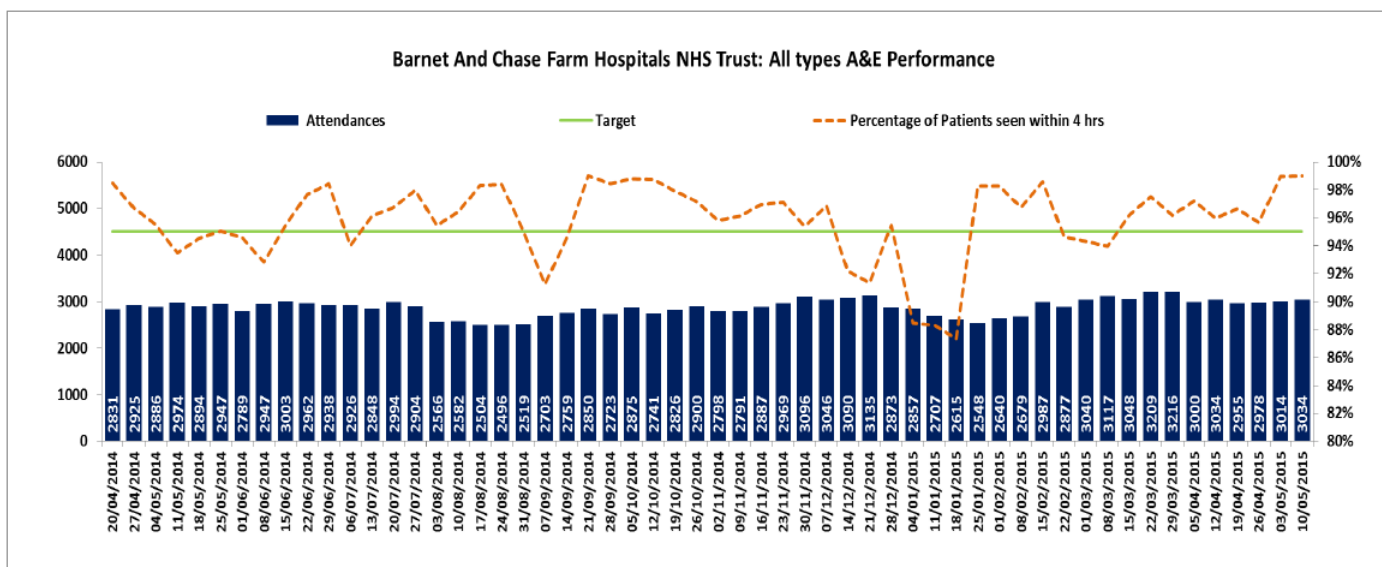
Royal Free London Trust achieved the 95% A&E 4 hour wait standard in April 2015. 96.7% of patients were treated and discharged or admitted within 4 hours of arrival. This represents 3 consecutive months of above target performance. The Trust met the target for each of the first 5 weeks of the financial year. Recent analysis of A&E activity patterns across the Trust have indicated that demand remains significantly higher than previously expected. A more detailed root cause analysis is being undertaken to inform resilience planning for 2015/16.

The Trust's Barnet Hospital site reported 144 '30 minute' and 24 '60 minute' breaches in March 2015. Actions to improve A&E waits performance are expected to impact on ambulance arrival to handover waits at the hospital. The Trust is reporting that a postcode switch between Barnet Hospital and Northwick Park Hospital has resulted in a significant increase in conveyances to the hospital which needs to be addressed. The lead commissioner is looking into this.

Key Actions

To maintain the recent strong performance the Urgent Care Summit has now been restructured to System Resilience Group with 2 operation subgroups (urgent and emergency, and planned care) reporting into the group.

Commissioners are also working on system resilience funding and schemes for 2015/16 ahead of the SRG meeting in June. Six schemes deemed to have had positive impact on patient flows are now being considered by CCGs.



Health Care Associated Infections (HCAI)

One MRSA case was reported in March, bringing the total number of cases assigned to the Trust in 2014/15 to six. No *C. Difficile* cases were reported in March, leaving the total number of cases apportioned to the Trust at 58 cases against an annual ceiling of 54 cases. 44 cases have so far undergone RCAs; 26 at BCF with 18 care lapses identified; and 18 cases at RFH with only 3 lapses.

In addition to the Trust's action plan to address infection rates, commissioners have developed a detailed action plan to address infection acquired from the community and care homes as well. The plans include reductions in antibiotic prescribing. Sustained improvements are expected from Q1 of 2015/16.

18 Week RTT

RFL continues not to report on 18 Weeks RTT performance for BCF sites due to data quality issues. The Trust has advised that the technical and operational validation exercises that began shortly after their acquisition of the former BCF NHS Trust are nearing completion. In accordance with NHS England guidance on resuming RTT reporting in cases where it had been suspended for technical reasons, the RTT Programme Board is expected to agree a timetable with the Trust Board for resuming national reporting.

Although not a member of the RTT Programme Board, Enfield CCG has been more sighted on the validation work being undertaken by the board since March 2015 when the lead commissioner was able to share weekly unvalidated data with Enfield CCG. This has been an important step in providing Enfield CCG the needed assurance on progress of work.

The CCG has also been fully engaged with the clinical harm review process, one of six work streams of the RTT Programme Board.

Diagnostic Tests 6 week Standard

The proportion of patients waiting less than 6 weeks for a diagnostic test has dropped below the 99% national standard in recent months due to reduced endoscopy capacity. The Trust is implementing an action plan to address the shortfall which includes outsourcing, change of work patterns from 2 to 3-sessions a day and the procurement of additional equipment. The CCG is also exploring commissioning options to mitigate the delays. This is being led by CCG transformation team, with support from contracting and performance teams.

Cancer Standards

RFL is also making progress on their remedial action plans to address the underachievement of the 62 day cancer wait in recent months which has been primarily due to delays in diagnostics for patients on the urology pathway. There is a risk that the Trust will not be able to return to compliance by the end of Quarter 1 of 2015/16 as earlier indicated due to the volume of existing backlog of patients yet to be seen. Provider action plans are being closely monitored by commissioners at the monthly performance review group.

The Chair of the CCG has notified all GPs about the issues pertaining to RTT non-reporting, cancer and diagnostic waits, and the actions being taken to address them. Advice to patients in relation to potential delays at BCF for elective care remains in place to inform patients' choices.

Friends & Family Test (FFT)

The proportion of patients who responded positively to the A&E FFT fell slightly from 86% in February to 84% in March. Response rates remained significantly above the recommended 15% in March, at 49%.

Response rate for inpatient services was 42% in March, with 87% saying they would recommend the service. The Trust reported a response rate for the birth-related FFT survey of 3%, which is well below the 15% percentage minimum required for drawing meaningful conclusions from the data. The Trust has identified issues with the survey methodology in maternity services. This is being addressed and monitored at the monthly Clinical Quality Review Group (CQRG).

4. Mental Health Performance (BEHMHT)

IAPT – Access Rates

During 2014/15, 10% of Enfield’s estimated population with depression received psychological therapies, in line with plan. To achieve the 15% target set for 2015/16, the CCG has made additional investments in the service to ensure adequate capacity is in place to meet expected increase in demand. Enfield CCG is also working with various stakeholders to increase awareness of the IAPT service which should result in an increase in referrals (GP and self) into the Service. This is part of a wider action plan currently being monitored weekly. New waiting time targets have been introduced for the first time in 2015/16 requiring 75% of patients to be seen within 6 weeks of referral and 95% within 18 weeks by the end of the financial year. These will also be monitored on a regular basis.

Early Intervention in Psychosis (EIP)

Enfield CCG is also committing to improving access for patients experiencing their first episode of psychosis from 2015/16, in-line with the national NHS ambition. By April 2016, at least 50% of people experiencing a first episode of psychosis will be expected to be treated with a NICE approved care package within two weeks of referral. The CCG is working with BEHMHT, with support from the CSU, to ensure that plans are in place to deliver against the national target before the end of the financial year.

Dementia Diagnosis

Enfield CCG met the year-end target of 59% dementia diagnosis rate for 2014/15. 59.73% of the estimated prevalence in Enfield was reported on primary care disease registers at the end of March 2015. The CCG has plans in place to ensure the national target of 66.7% is achieved by the end of March 2016. This indicator has also been selected as a local quality premium measure to highlight its importance to the CCG.

Friends & Family Tests (FFT)

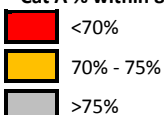
FFT was rolled out to providers of community and mental health services to NHS patients on 1st January 2015. The results are likely to be published as national official statistics from June following a review process.

5. London Ambulance Service (LAS) Trust Performance

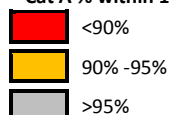
LAS continues to underachieve on response time targets for Enfield and across London as a whole. Category A response times in the week ending 10th May declined from the previous week for Enfield (62.53% to 59.76%, against the target of 75%).

CCG	Week Ending 10/05/2015				YTD Performance			
	Category A			Category C	Category A			Category C
	Incidents	% reached in 8 mins	% reached in 19 mins	Incidents	Incidents	% reached in 8 mins	% reached in 19 mins	Incidents
Barnet	355	52.39%	92.68%	372	2129	56.46%	92.58%	2324
Enfield	415	59.76%	91.08%	352	2286	60.15%	93.35%	2154
Haringey	289	60.90%	95.50%	255	1759	57.93%	94.71%	1755
Camden	294	73.13%	93.54%	287	1789	73.34%	93.35%	1892
Islington	286	67.48%	94.06%	286	1484	66.71%	93.53%	1643
North Central	1639	62.11%	93.17%	1552	9447	62.43%	93.46%	9768

Cat A % within 8 mins



Cat A % within 19 mins



On a monthly basis, performance has improved at Trust level (covering all commissioners);

- Red 1 (8 minute) performance was also below the 75% standard at 65.5%, 2.4% points improvement on previous month.
- Red 2 (8 minute) performance was below the 75% standard at 64.7%, 6% points improvement on previous month

- Category A19 performance (19 minutes) was below the 95 % standard at 94.3%, 2.4% points improvements on previous month

The Trust continues to provide weekly tri-partite updates to lead Commissioner, NHSE and the TDA. LAS has recently conducted an assessment centre in Ireland which resulted in 9 jobs offers, with 4 starting in April. The remaining 5 are due to start by end of June. The graduate pipeline currently stands at 155. The Trust has also completed their 2015/16 international recruitment drive and made a total of 225 offers of employment.

London CCGs are making a total of about £32.2m additional investments into the service in 2015/16, about £20.8m of which will be recurrent. Contract negotiations are still ongoing to agree risk share arrangements and the performance monitoring framework. In addition to the monthly contract management group meetings between provider and lead commissioner, there will be quarterly monitoring meetings which will be open to all associate commissioners to provide further assurance on provider performance.

Enfield CCG Integrated Performance & Quality Report

May 2015

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- 9 – Serious Incident Reporting Royal Free London Hosp.
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London Benchmarking [16]

- 17 – A & E 4 Hour Standard – All Types
- 18 – A & E 4 Hour Standard – Type 1
- 19 – MRSA Dashboard
- 20 – *C. Difficile* Dashboard

Financial Performance

INDICATORS	YTD Performance	Trend	Forecast to Qtr end	Forecast to year end
Financial Balance	£18.9m deficit		£19.0m deficit	£19.0m deficit
Debtors>90 days exceed 5% of total debtor balances	-		-	-
Creditors paid within 30 days, by number (Target 95%)	91.88%		91.88%	91.88%
Creditors paid within 30 days, by value (Target 95%)	97.52%		97.52%	97.52%
Cash Flow within agreed quarterly forecast	£32k		£32k	£32k

FINANCIAL COMMENTARY

The month 12 cumulative results are a deficit of £18.9m against a planned deficit of £5.6m, £12.4m in excess of the control total.

The major overspend of £10.4m is in secondary care, driven by higher than planned activity on our Payment by Results contracts.

The QIPP achieved savings of £10.6m, £1.4m below target. This number relies on activity from providers (as do the PbR contracts themselves), and may change for M12 based on final year-end figures when agreed for 2014/15.

All risks and mitigations are included in the Month 12 position

Cash Flow - The CCG had a balance of £32k cash at the end of March 2015, within the NHSE target.

Better Payment Practice Code - The CCG is meeting the 95% target by value to pay all its creditors within 30 days (97.52%), however by number of invoices only 81.47% of NHS and 94.17% of non NHS invoices are paid within the period. The former is due to the large number of small value non contractual referral invoices. The later reflects the time taken to process the high volume of relatively low value community care invoices.

QIPP Performance 2014-15

Enfield CCG QIPP Performance 2014/2015

Month 12 (March 2015)

QIPP Scheme	A	B	A + B	C	D	E	D + E	(D + E) - C	From Last Month
	Gross QIPP	Plan Investment	Net QIPP	Plan	Saving	Year to Date Investment	Net	Variance	
Transformational									
Anti-coagulation	-8,328	0	-8,328	-8,328	-8,328	0	-8,328	0	↔
Integrated care	-3,187,930	2,439,931	-748,000	-748,000	-1,914,012	1,847,000	-67,012	680,988	↓
ENT	-83,380	0	-83,380	-83,380	-396,587	0	-396,587	-313,206	↑
Urology	-40,800	0	-40,800	-40,800	0	0	0	40,800	↔
Respiratory	-162,949	0	-162,949	-162,949	0	0	0	162,949	↔
Cardiology	-375,000	0	-375,000	-375,000	-646,691	0	-646,691	-271,691	↑
Gastroenterology	-112,629	21,646	-90,983	-90,983	-17,629	21,646	4,017	95,000	↓
Diabetes	-30,000	0	-30,000	-30,000	0	0	0	30,000	↔
Integrated MSK Services	-209,000	113,000	-96,000	-96,000	0	113,000	113,000	209,000	↔
Primary Care Paediatrics	-94,234	0	-94,234	-94,234	0	0	0	94,234	↔
UCC - North Middlesex	-262,000	0	-262,000	-262,000	0	0	0	262,000	↔
BCF - Ambulatory Emergency Care	-253,374	0	-253,374	-253,374	0	0	0	253,374	↔
NMH - Ambulatory Emergency Care	-413,911	0	-413,911	-413,911	0	0	0	413,911	↔
Maternity	-317,000	0	-317,000	-317,000	-987,000	0	-987,000	-670,000	↔
Transformational QIPP Total	-5,550,535	2,574,577	-2,975,959	-2,975,958	-3,970,246	1,981,646	-1,988,600	987,358	↑
Transactional									
Primary Care Medicines Management	-1,097,190	0	-1,097,190	-1,097,190	-1,685,685	0	-1,685,685	-588,495	↑
Seacole and Learning Disabilities	-110,000	0	-110,000	-110,000	-110,000	0	-110,000	0	↔
Acute Medicines Management	-148,000	0	-148,000	-148,000	-355,500	0	-355,500	-207,500	↔
Acute Productivity	-1,713,223	0	-1,713,223	-1,713,223	-1,343,223	0	-1,343,223	370,000	↔
Direct Access Pathology	-130,000	0	-130,000	-130,000	-130,000	0	-130,000	0	↔
Corporate	-1,050,000	0	-1,050,000	-1,050,000	-1,050,000	0	-1,050,000	0	↔
Unidentified	-4,775,628	0	-4,775,628	-4,775,629	-4,148,000	0	-4,148,000	627,629	↔
Transactional QIPP Total	-9,024,041	0	-9,024,041	-9,024,042	-8,822,409	0	-8,822,409	201,634	↑
Total QIPP	-14,574,576	2,574,577	-12,000,000	-12,000,000	-12,792,654	1,981,646	-10,811,008	1,182,992	↑

NHS Constitution Standards - Enfield CCG

NHS CONSTITUTION INDICATORS - Enfield CCG

Indicator Type	Target	Date of Previous Data	Date of Most Recent Data	Previous Month	Current Month	Trend		2014/15 YTD
Access								
18 Weeks Referral to Treatment (RTT) - Admitted	90%	Feb-2015	Mar-2015	92.9%	93.7%	↑		91.2%
18 Weeks Referral to Treatment (RTT) - Non-Admitted	95%	Feb-2015	Mar-2015	96.4%	96.4%	→		95.2%
18 Weeks Referral to Treatment (RTT) - Incomplete Pathways	92%	Feb-2015	Mar-2015	94.7%	94.0%	↓		92.2%
Diagnostic Tests - Waiting less than 6 Weeks	99%	Feb-2015	Mar-2015	97.6%	97.6%	→		98.5%
RTT - 52 Week Waiters	0	Feb-2015	Mar-2015	0	0	→		21
A & E 4 Hour Waits	95%	Feb-2015	Mar-2015	91.3%	92.1%	↑		94.3%
Cancer Waits								
Cancer Waits: 2 Week GP Referral-to-Appointment	93%	Jan-2015	Feb-2015	94.4%	96.2%	↑		94.5%
Cancer Waits: 2 Week Breast Symptomatic Target	93%	Jan-2015	Feb-2015	93.1%	95.1%	↑		93.8%
Cancer Waits: 31 Days Diagnosis to Treatment	96%	Jan-2015	Feb-2015	98.8%	96.4%	↓		98.9%
Cancer Waits: 31 Days Diagnosis to Treatment (Subsequent Surgery)	94%	Jan-2015	Feb-2015	96.6%	94.1%	↓		97.3%
Cancer Waits: 31 Days Diagnosis to Treatment (Subsequent Drug Treatment)	98%	Jan-2015	Feb-2015	100.0%	100.0%	→		99.7%
Cancer Waits: 31 Days Diagnosis to Treatment (Subsequent Radiotherapy)	94%	Jan-2015	Feb-2015	100.0%	95.2%	↓		99.2%
Cancer Waits: 62 Days Referral to Treatment	85%	Jan-2015	Feb-2015	77.8%	62.5%	↓		79.3%
Cancer Waits: 62 Days Referral to Treatment (from Screening)	90%	Jan-2015	Feb-2015	100.0%	100.0%	→		96.1%
Cancer Waits: 62 Days Upgrade	No Target	Jan-2015	Feb-2015	94.4%	92.3%	↓		92.1%
Mixed Sex								
Minimise Breaches	0	Feb-2015	Mar-2015	2	0	↓		25
Hospital Acquired Infection								
MRSA Reported Cases	0	Feb-2015	Mar-2015	0	0	→		4
<i>C.Difficile</i> Reported Cases	76 (Annual)	Feb-2015	Mar-2015	8	4	↓		88
Ambulance Response (LAS Trust)								
Category A Calls: Response within 8 Minutes (RED1)	75%	Feb-2015	Mar-2015	67.1%	62.7%	↓		67.2%
Category A Calls: Response within 8 Minutes (RED2)	75%	Feb-2015	Mar-2015	58.7%	59.1%	↑		59.7%
Category A Calls: Response within 19 Minutes	95%	Feb-2015	Mar-2015	91.8%	92.2%	↑		91.9%

NHS Operational Standards – North Middlesex Hosp.

NHS CONSTITUTION INDICATORS - North Middlesex Hospital								
Indicator Type	Target	Date of Previous Data	Date of Most Recent Data	Previous Month	Current Month	Trend		2014/15 YTD
Access								
18 Weeks Referrral to Treatment (RTT) - Admitted	90%	Jan-2015	Feb-2015	95.4%	94.9%	↓		92.9%
18 Weeks Referrral to Treatment (RTT) - Non-Admitted	95%	Jan-2015	Feb-2015	97.7%	97.5%	↓		97.0%
18 Weeks Referrral to Treatment (RTT) - Incomplete Pathways	92%	Jan-2015	Feb-2015	95.0%	96.0%	↑		92.8%
Diagnostic Tests - Waiting less than 6 Weeks	99%	Jan-2015	Feb-2015	99.0%	99.9%	↑		99.4%
RTT - 52 Week Waiters	0	Jan-2015	Feb-2015	0	0	→		0
A & E 4 Hour Waits (Type 1)	95%	Feb-2015	Mar-2015	90.4%	91.2%	↑		93.6%
A & E Waits (All Types)	95%	Feb-2015	Mar-2015	90.4%	91.2%	↑		93.6%
Waits from 'Decision to Admit' to 'Admission' over 12 Hours	0	Feb-2015	Mar-2015	0	0	→		0
Cancer Waits								
Cancer Waits: 2 Week GP Referral-to-Appointment	93%	Jan-2015	Feb-2015	95.1%	97.7%	↑		94.5%
Cancer Waits: 2 Week Breast Symptomatic Target	93%	Jan-2015	Feb-2015	98.5%	98.0%	↓		94.2%
Cancer Waits: 31 Days Diagnosis to Treatment	96%	Jan-2015	Feb-2015	100.0%	97.9%	↓		99.2%
Cancer Waits: 31 Days Diagnosis to Treatment (Subsequent Surgery)	94%	Jan-2015	Feb-2015	100.0%	100.0%	→		100.0%
Cancer Waits: 31 Days Diagnosis to Treatment (Subsequent Drug Treatment)	98%	Jan-2015	Feb-2015	100.0%	100.0%	→		100.0%
Cancer Waits: 31 Days Diagnosis to Treatment (Subsequent Radiotherapy)	94%	Jan-2015	Feb-2015	97.6%	96.4%	↓		99.6%
Cancer Waits: 62 Days Referral to Treatment	85%	Jan-2015	Feb-2015	88.2%	91.3%	↑		90.1%
Cancer Waits: 62 Days Referral to Treatment (from Screening)	90%	Jan-2015	Feb-2015	100.0%	100.0%	→		100.0%
Cancer Waits: 62 Days Upgrade	No Target	Jan-2015	Feb-2015	89.4%	93.1%	↑		96.2%
Ambulance Handover Times								
Ambulance Handovers: 30 mins wait	0	Feb-2015	Mar-2015	103	113	↑		868
Ambulance Handovers: 60 mins wait	0	Feb-2015	Mar-2015	7	3	↓		32
% of Data Recorded Electronically	90%	Feb-2015	Mar-2015	87.7%	87.5%	↓		89.9%
Mixed Sex Accommodation								
Number of MSA Breaches	0	Feb-2015	Mar-2015	0	0	→		0
Hospital Acquired Infections								
MRSA Reported Infections	0	Feb-2015	Mar-2015	0	0	→		0
<i>C. Difficile</i> Reported Infections	21 (Annual)	Feb-2015	Mar-2015	3	4	↑		46
Cancelled Operations								
Urgent Operations cancelled for the second time	0	Feb-2015	Mar-2015	0	0	→		0
Cancelled operations on or after day of admission for non clinical reasons offered another binding date within 28 days	0	Q2 2014/15	Q3 2014/15	0	0	→		0

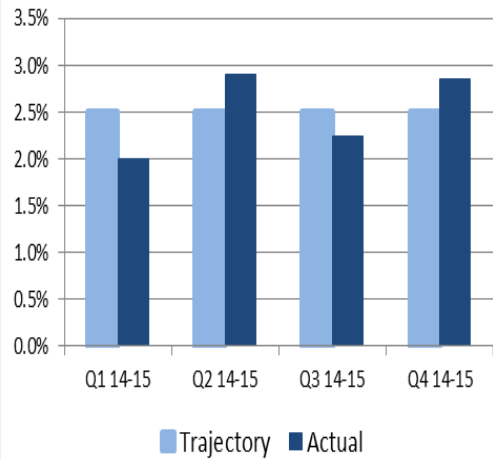
NHS Operational Standards – Royal Free Hosp.

NHS CONSTITUTION INDICATORS - Royal Free London Foundation Trust (reporting inclusive of Barnet & Chase Farm Hospitals Trust)

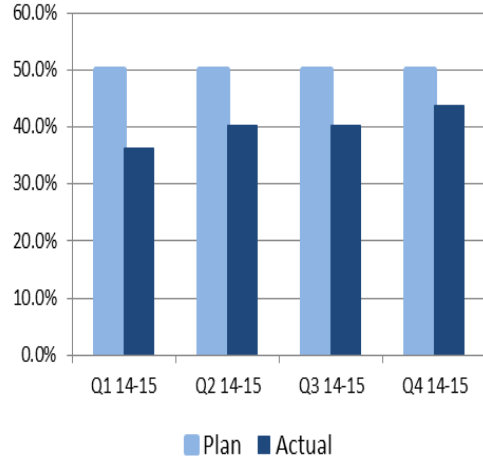
Indicator Type	Target	Date of Previous Data	Date of Most Recent Data	Previous Month	Current Month	Trend		2014/15 YTD
Access								
18 Weeks Referrral to Treatment (RTT) - Admitted	90%	Jan-2015	Feb-2015	90.2%	90.6%	↑		90.9%
18 Weeks Referrral to Treatment (RTT) - Non-Admitted	95%	Jan-2015	Feb-2015	96.8%	96.7%	↓		97.2%
18 Weeks Referrral to Treatment (RTT) - Incomplete Pathways	92%	Jan-2015	Feb-2015	92.2%	92.0%	↓		92.2%
Diagnostic Tests - Waiting less than 6 Weeks	99%	Jan-2015	Feb-2015	95.6%	95.9%	↑		97.2%
RTT - 52 Week Waiters	0	Jan-2015	Feb-2015	0	0	→		13
A & E 4 Hour Waits (Type 1)	95%	Feb-2015	Mar-2015	95.8%	94.8%	↓		94.1%
A & E Waits (All Types)	95%	Feb-2015	Mar-2015	96.4%	95.7%	↓		94.8%
Waits from 'Decision to Admit' to 'Admission' over 12 Hours	0	Feb-2015	Mar-2015	0	0	→		0
Cancer Waits								
Cancer Waits: 2 Week GP Referral-to-Appointment	93%	Jan-2015	Feb-2015	95.4%	96.3%	↑		95.6%
Cancer Waits: 2 Week Breast Symptomatic Target	93%	Jan-2015	Feb-2015	91.1%	94.7%	↑		95.2%
Cancer Waits: 31 Days Diagnosis to Treatment	96%	Jan-2015	Feb-2015	100.0%	100.0%	→		98.7%
Cancer Waits: 31 Days Diagnosis to Treatment (Subsequent Surgery)	94%	Jan-2015	Feb-2015	98.0%	100.0%	↑		98.7%
Cancer Waits: 31 Days Diagnosis to Treatment (Subsequent Drug Treatment)	98%	Jan-2015	Feb-2015	100.0%	100.0%	→		100.0%
Cancer Waits: 31 Days Diagnosis to Treatment (Subsequent Radiotherapy)	94%	Jan-2015	Feb-2015	97.6%	100.0%	↑		99.7%
Cancer Waits: 62 Days Referral to Treatment	85%	Jan-2015	Feb-2015	72.1%	76.3%	↑		80.1%
Cancer Waits: 62 Days Referral to Treatment (from Screening)	90%	Jan-2015	Feb-2015	100.0%	89.2%	↓		90.9%
Cancer Waits: 62 Days Upgrade	No Target	Jan-2015	Feb-2015	90.5%	91.3%	↑		89.1%
Ambulance Handover Times (Barnet Hospital)								
Ambulance Handovers: 30 mins wait	0	Feb-2015	Mar-2015	73	144	↑		902
Ambulance Handovers: 60 mins wait	0	Feb-2015	Mar-2015	10	24	→		131
% of Data Recorded Electronically	90%	Feb-2015	Mar-2015	91.4%	94.2%	↓		92.4%
Mixed Sex Accommodation								
Number of MSA Breaches	0	Feb-2015	Mar-2015	5	9	↑		36
Hospital Acquired Infections								
MRSA Reported Infections	0	Feb-2015	Mar-2015	0	1	↑		6
<i>C. Difficile</i> Reported Infections	54 (Annual)	Feb-2015	Mar-2015	7	0	↓		58
Cancelled Operations								
Urgent Operations cancelled for the second time	0	Feb-2015	Mar-2015	0	0	→		0
Cancelled operations on or after day of admission for non clinical reasons offered another binding date within 28 days	0	Q2 2014/15	Q3 2014/15	3	4	↑		8

IAPT Performance Enfield CCG

IAPT - Access 2014-15



IAPT - Recovery Rates 2014-15



Issues

Performance for Q4 now confirmed as 2.85% (11.4% run rate). CCG was therefore exactly on target with 10.0% performance across the year against the 10% target.

Recovery Rate for the quarter was 44%, below 50% target. The monthly data, however, shows significant improvements during the course of Q4;

- Jan 15 – 37%
- Feb 15 – 43%
- Mar 15 – 52%

Key issue to be addressed in 2015/16 is low referral rates. There has been significant improvements in waiting times and recovery rates during the latter part of last year.

Weekly provisional data from provider indicate provider is on track to deliver 3.1% target for Q1.

Mitigating Actions

Total investment increased to £2.2M in 2015/16 to deliver 15% across the year.

Monthly IAPT Performance Review meetings and weekly teleconference updates providing focus for developing IAPT opportunities, marketing monitoring and progress performance of the service, including waiting times. This complements work by Contract Management Group and Contract Technical Groups meetings.

Revised action plan in place and being monitored internally and with the provider. Update provided in the next 3 slides. CCG is on track with key milestones.

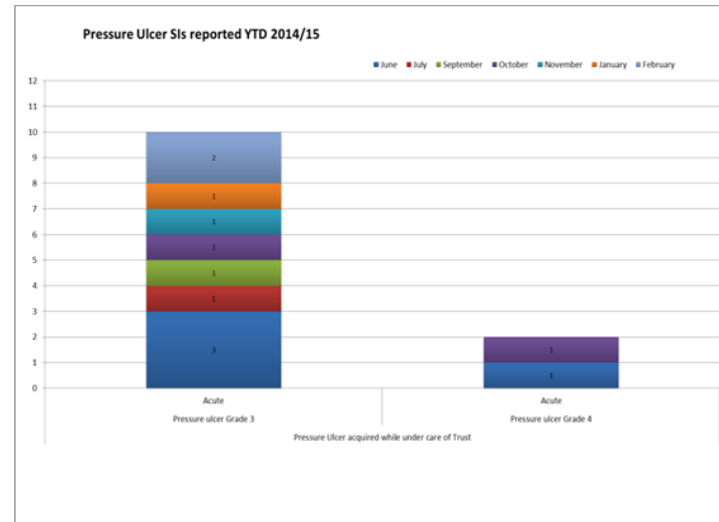
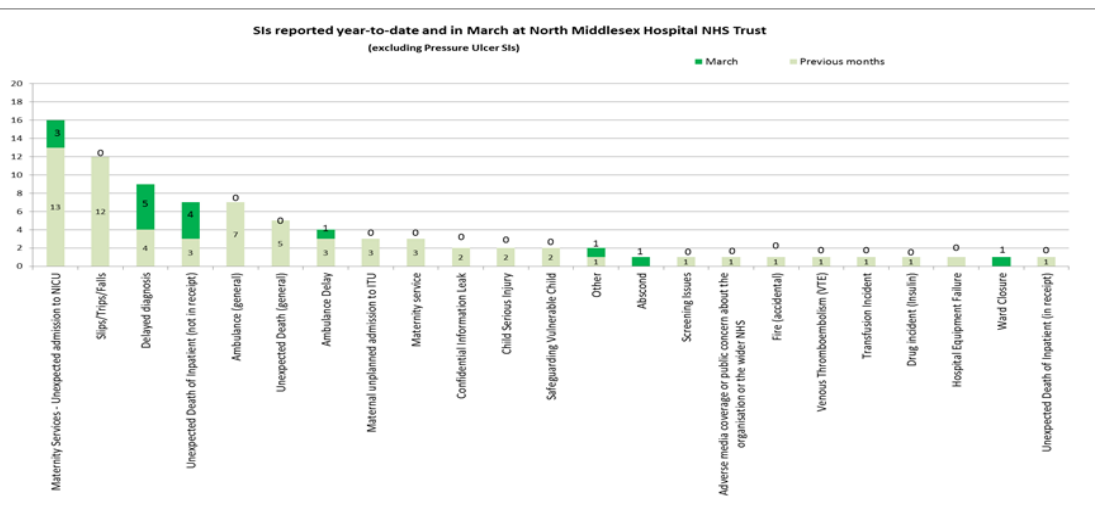
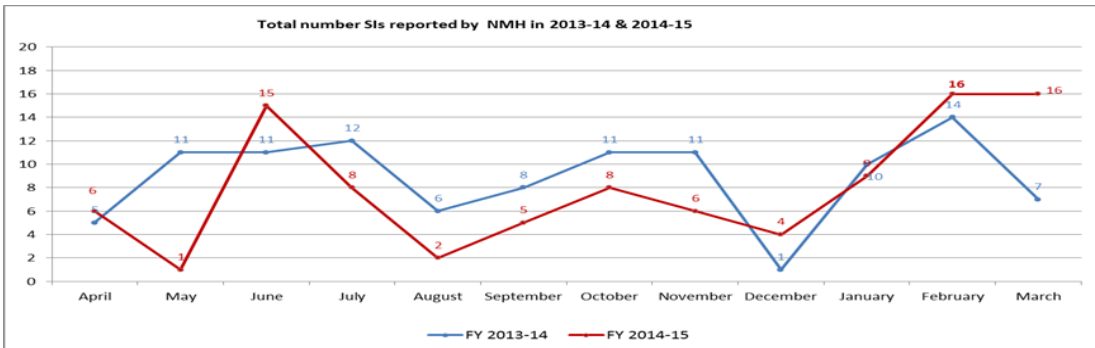
Plans include securing additional capacity from a second provider in anticipation of increase in referrals.

2015/16 Operating Plan

CCG will revise plans to deliver 15% Access Rate and 50% Recovery Rate across 2015-16 as follows;

	Access	Recovery
Q1	3.10%	50%
Q2	3.75%	50%
Q3	4.00%	50%
Q4	4.15%	50%

Serious Incidents – North Middlesex Hospital



Grade 2 SIs reported in March 2015 (including Never Events & Maternal Deaths) None Reported

Never Events reported in March 2015 None Reported

Grade 2 SIs reported 2014/15 YTD = 0 (None reported)

Grade 0 SIs reported in March 2015 None Reported

NRLS Reporting - Patient safety incident report uploads to NRLS have been completed by the Trust in the following months (March 2015 data not yet available from NHSE):

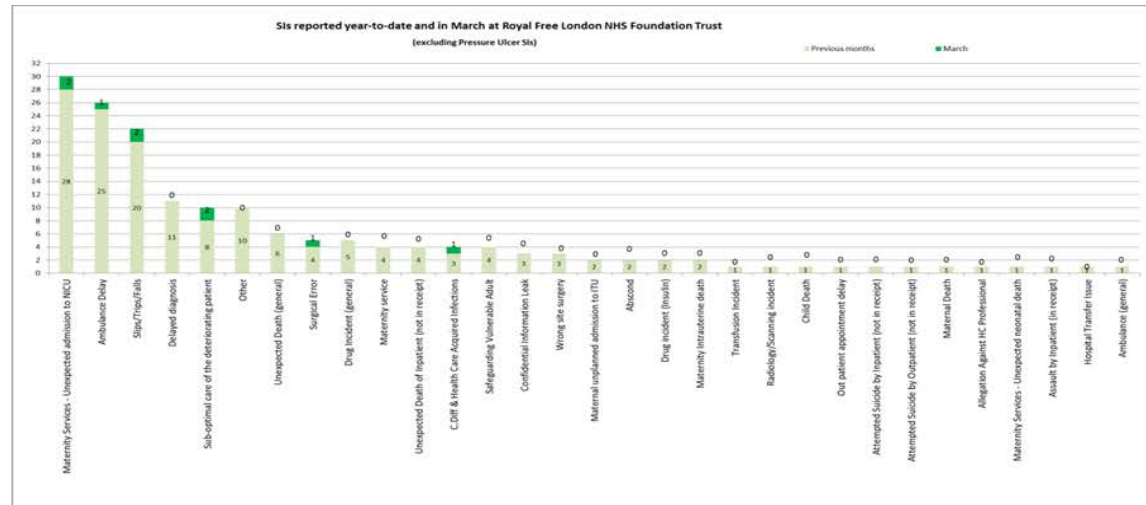
Key points to note

- The significant increase in the monthly SI reporting rate noted in February has continued, with 16 SIs reported in March.
- 5 'Delayed Diagnosis' SIs were reported, one in a patient attending A&E and the remaining 4 in other specialties
- 4 'Unexpected Death of Inpatient' SIs were reported, one had occurred in January, two in February and one in March.
- 3 SIs were reported in the category 'Maternity Services - Unexpected Admission to NICU'.
- 'Maternity Services - Unexpected Admission to NICU' is the most frequently reported type of SI reported by the Trust in 2014/15 YTD.
- No pressure ulcer SIs were reported in March. The Trust has not reported any Type A pressure ulcer SIs on StEIS since January 2014.

SI Report Status

2014/15	Mar	Feb	Jan	Dec	Nov	Oct
No. reports due	8	9	3	7	4	4
Reports received (regardless of due date)	11	16	3	2	6	6
No. reports closed	0	4	1	1	4	5
Type A Pressure Ulcers closed	0	0	0	0	0	0
No. reports overdue	2	6	12	12	9	9

Serious Incidents – Royal Free London



Reporting of Grade 2 and Grade 0 SIs

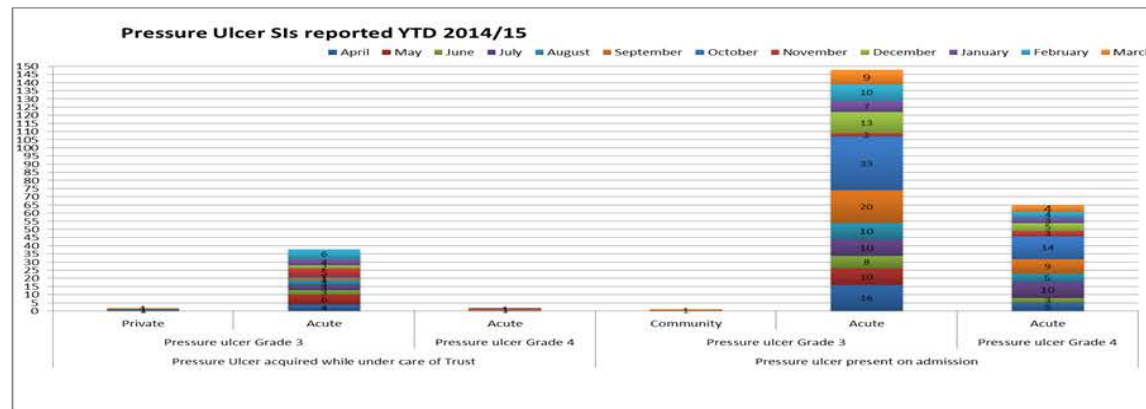
Grade 2 SIs reported in March 2015 (including Never Events & Maternal Deaths) = 1
 SI 2015/9911 – Surgical Error, subsequently downgraded to Grade 1 in March. Grading and Never Event (NE) status currently under discussion with commissioners.

Grade 1 SIs Upgraded to Grade 2 in March 2015
 SI 2015/6964 Delayed diagnosis – reported as Grade 1 SI in February upgraded to Grade 2 SI in March
 SI 2014/39342 Other (retained swab/tampon) - upgraded to Grade 2 Never Event SI in March following review of investigation report

Never Events reported in March 2015 = SI 2015/9911 – NE status to be confirmed (see above)
 SI 2014/39342 Other (retained swab/tampon) - upgraded to Grade 2 Never Event SI in March following review of investigation report

Grade 2 SIs 2014/15 YTD = 7
 SI 2014/40020 – Other - Administration Issue
 SI 2014/39343 – Never Event (Wrong Site Surgery)
 SI 2014/23092 - Never Event (Surgical Error)
 SI 2014/32677 – Never Event (Wrong Site Surgery)
 SI 2014/25711 - Maternal Death
 SI 2015/6964 - Delayed diagnosis (upgraded to Grade 2 this month)
 SI 2014/39342 Other - retained swab/tampon (upgraded to Grade 2 this month)

Grade 0 SIs reported in March 2015 = None reported



SI Report Status						
2014/15	Mar	Feb	Jan	Dec	Nov	Oct
No. reports due	20	24	21	16	16	19
Reports received (regardless of due date)	18	22	17	23	12	20
No. reports closed	14	25	18	3	16	10
Type A Pressure Ulcers closed	29	1	13	9	3	36
No. SI reports overdue	15	12	13	11	16	11

NRLS Reporting - Patient safety incident report uploads to NRLS have been completed by the Trust in the following months. March 2015 data not yet available from NHSE.

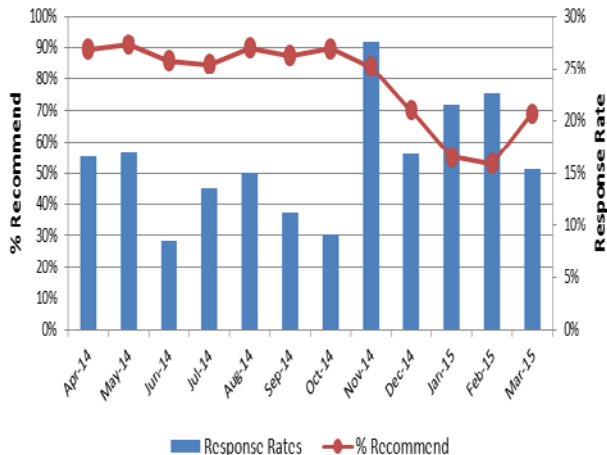
2014				2015	
Sep	Oct	Nov	Dec	Jan	Feb
Yes	Yes	Yes	Yes	Yes	Yes

Key points to note

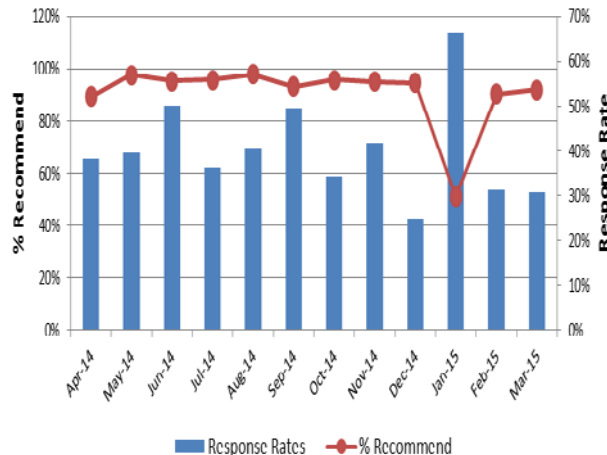
- Two Grade 1 SIs reported in previous months were upgraded to Grade 2 SIs in March, one of which was upgraded to a Grade 2 Never Event (see Grade 2 section of slide for details)
- One SI reported in March as a Never Event was subsequently downgraded to a Grade 1 SI. The grading of this SI is currently under discussion with the commissioners.
- 29 Type A pressure ulcer SIs were closed for Trust in March 88

Friends & Family Test – North Middlesex Hospital

NMUH - A&E FFT Postive Responses & Response Rates



NMUH - Inpatient FFT Postive Response & Response Rates



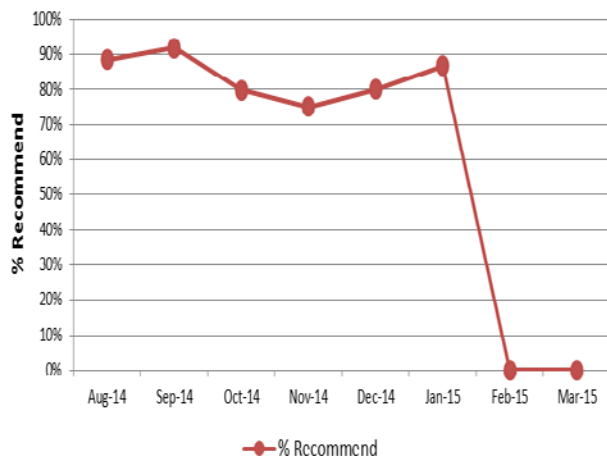
NMUH are reporting response rates above the recommended minimum of 15%.

Maternity: Scores remain lower than England average for touch-points 2 and 3 in Mar 2015. Feedback shows patient dissatisfaction with staff attitude, clinical care and giving formation.

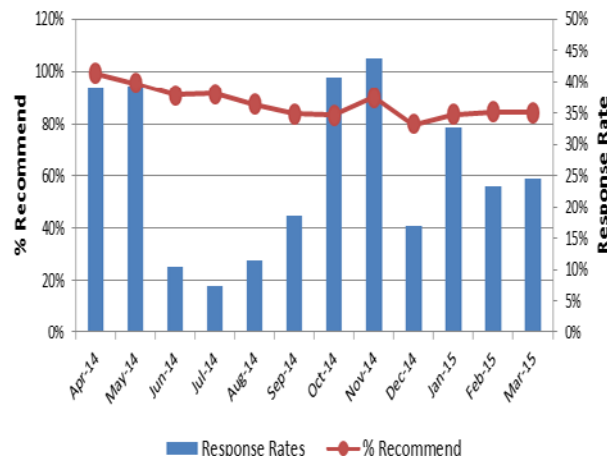
A&E: FFT score has improved to 69% in Mar 2015 from 53% in Feb, but remains lower than England average of 87%.

Low response rate to the antenatal survey make the results statistically unreliable. FFT issues are discussed at the monthly Clinical Quality Review Group meetings.

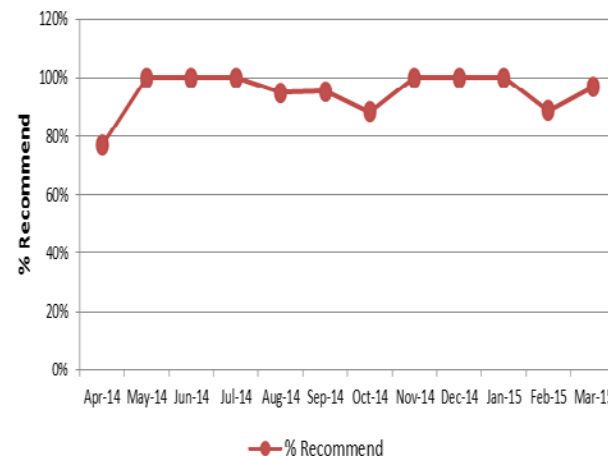
NMUH - Antenatal FFT Postive Response Rate



NMUH - Birth FFT Postive Response & Response Rates

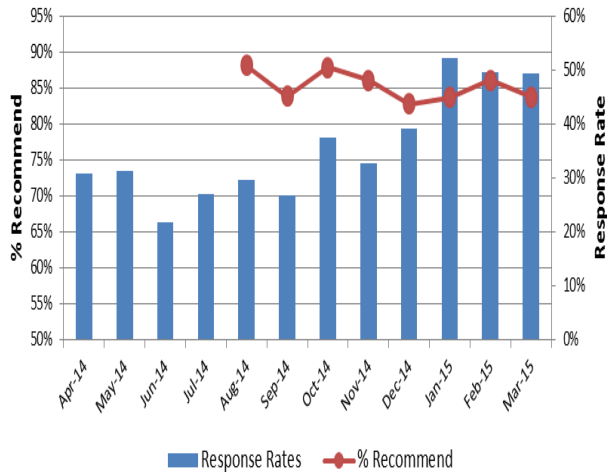


NMUH - Postnatal FFT Postive Response Rate

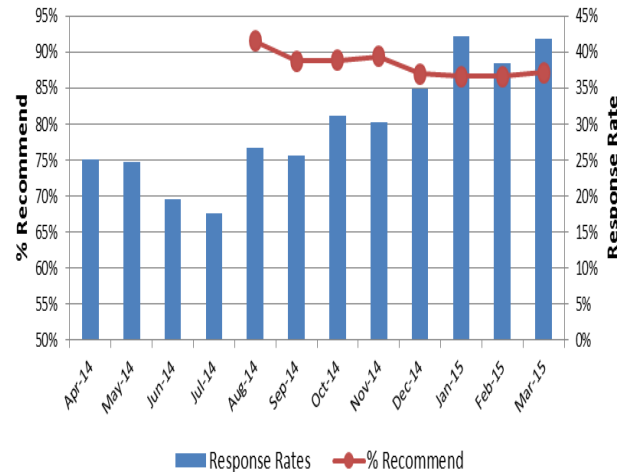


Friends & Family Test – Barnet & Chase Farm Hospitals

Barnet Hosp. - A&E FFT



Barnet & Chase Farm Sites - Inpatient FFT

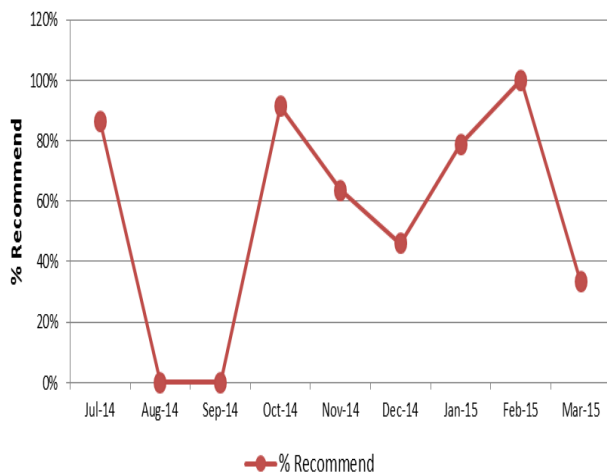


Response rates are reasonably stable, except for birth services at Barnet hospital which also remain well below the recommended 15%. This is partly due to changes to the collection system to ensure uniformity across all sites.

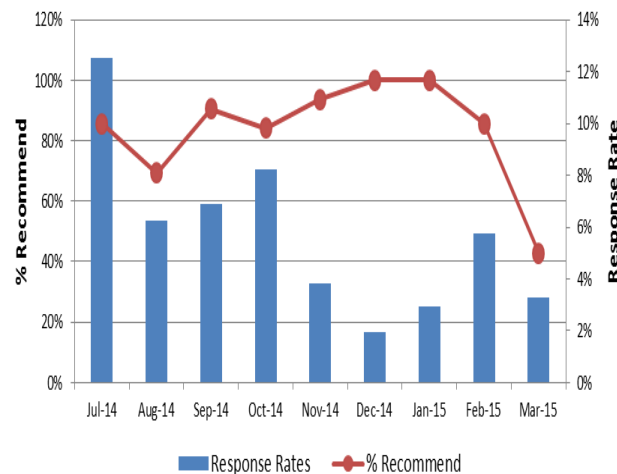
The number of patients responding positively to the survey remains high for the services covered, except for maternity. Maternity services to be reviewed at May CQRG.

RFL is focused on encouraging frontline staff to review patient feedback and implement changes where needed.

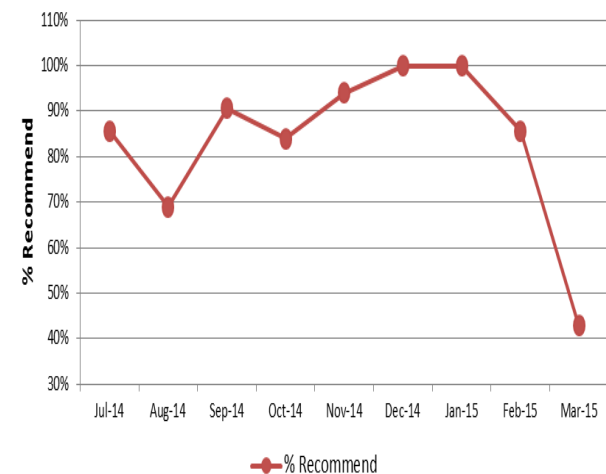
Barnet Hosp - Antenatal FFT



Barnet Hosp - Birth FFT

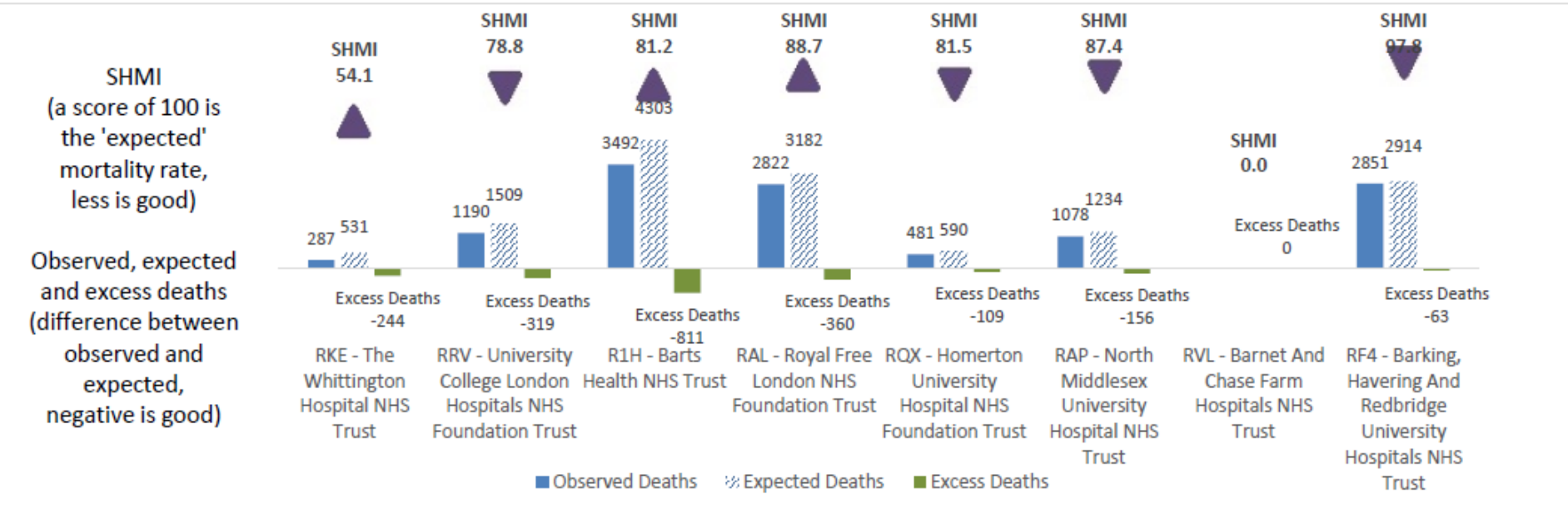


Barnet Hosp - Postnatal FFT



Summary Hospital-Level Mortality Indicator (SHMI)

July 2013 to June 2014



Data Source: HSCIC SHMI Indicator, publication January 2015. The next quarterly data (September 2014) will be published in May 2015

NHS 111 - NCL Provider Performance

LCW - Barnet CCG, Enfield CCG, Haringey CCG, Islington, Camden CCG

Indicator	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	England (April 2013)	England (February 2015)
Total Number of Calls Received	9,983	11,934	12,676	13,620	12,176	11,763	11,970	12,006	13,356	14,300	16,214	14,421	13,041	not available	n/a
Abandoned Calls as Percentage of Calls Offered (%)	2.3%	1.6%	1.3%	1.3%	0.9%	0.7%	0.8%	0.8%	0.3%	0.3%	0.6%	0.7%	0.2%	1.6%	1.7%
Percentage of Calls Answered within 60 Seconds (%) *National quality standard of 95%	91%	93%	94%	92%	94%	96%	95%	96%	96%	98%	96%	98%	98%	94%	93%
Percentage of Calls Not Requiring 111 (%)	0.00	0.00	0.00	0.00	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Total Triaged Calls	9,390	11,351	11,697	12,835	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Triaged Calls as Percentage of Calls Answered (%)	98%	98%	99%	99%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	84%	84%
Percentage Calls Backs in Under 10 Minutes (%)	43%	43%	45%	47%	56%	54%	61%	56%	51%	53%	45%	46%	43%	49%	49%
Percentage of Calls Directed to 999 for Ambulance Dispatch (%)	21.8%	18.6%	13.4%	12.8%	14.5%	15.1%	14.7%	14.2%	13.4%	11.3%	11.8%	10.2%	9.8%	9.1%	9.3%
Percentage of Ambulance Dispatches that were Conveyed (%)	70%	73%	51%	63%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Average Call Times (Episode) (minutes)	15.16	15.35	13.50	13.41	13.02	13.14	12.43	13.13	13.46	13.21	13.47	13.34	12.54	14m:14s	14:28
Average Call Times (Clinician) (minutes)	9.76	9.77	9.99	10.63	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Average Call Times (Health Advisor) (minutes)	8.55	8.47	8.86	8.66	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a

ELC - City and Hackney CCG, Tower Hamlets CCG, Newham CCG

Indicator	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	England (April 2013)	England (February 2015)
Total Number of Calls Received	7,716	9,170	10,217	10,290	9,468	9,605	9,340	9,882	11,273	10,999	12,047	13,298	9,786	not available	n/a
Abandoned Calls as Percentage of Calls Offered (%)	5.5%	5.1%	4.3%	4.2%	5.4%	4.5%	2.2%	2.0%	2.0%	3.3%	4.7%	3.3%	3.8%	1.6%	1.7%
Percentage of Calls Answered within 60 Seconds (%) *National quality standard of 95%	95%	96%	97%	96%	95%	96%	99%	98%	98%	96%	95%	96%	95%	94%	93%
Percentage of Calls Not Requiring 111 (%)	24.59	23.50	27.36	27.31	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Total Triaged Calls	4,969	6,087	6,545	6,612	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Triaged Calls as Percentage of Calls Answered (%)	68%	70%	72%	71%	70%	70%	70%	68%	69%	79%	77%	81%	79%	84%	84%
Percentage Calls Backs in Under 10 Minutes (%)	70%	70%	71%	68%	64%	61%	66%	66%	77%	70%	61%	51%	45%	49%	49%
Percentage of Calls Directed to 999 for Ambulance Dispatch (%)	11.9%	11.8%	9.6%	9.3%	9.9%	9.5%	9.5%	10.2%	10.9%	9.8%	8.8%	9.5%	9.3%	9.1%	9.3%
Percentage of Ambulance Dispatches that were Conveyed (%)	0'	0'	0'	0'	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Average Call Times (Episode) (minutes)	7.62	7.51	11.43	11.49	11.07	11.53	11.27	11.20	11.17	11.30	12.39	13.50	15.13	14m:14s	14:28
Average Call Times (Clinician) (minutes)	8.14	7.89	7.40	7.40	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Average Call Times (Health Advisor) (minutes)	7.32	7.25	7.15	7.17	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a

i Please note that there were no Ambulance Conveyance numbers reported by PELC from May onwards. This is due to a LAS access issue.

ONEL - Waltham Forest CCG, Havering CCG, Redbridge CCG, Barking and Dagenham CCG

Indicator	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	England (April 2013)	England (February 2015)
Total Number of Calls Received	20,277	23,377	19,691	21,618	20,471	20,062	19,595	19,126	21,299	21,641	26,067	22,007	20,044	not available	n/a
Abandoned Calls as Percentage of Calls Offered (%)	4.2%	7.7%	3.2%	3.5%	3.7%	3.3%	1.5%	1.8%	1.7%	2.7%	3.5%	2.6%	3.3%	1.6%	1.7%
Percentage of Calls Answered within 60 Seconds (%) *National quality standard of 95%	95%	96%	96%	96%	95%	96%	98%	98%	97%	95%	94%	96%	94%	94%	93%
Percentage of Calls Not Requiring 111 (%)	22.74	20.36	15.08	15.38	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Total Triaged Calls	13,980	15,002	15,478	16,771	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Triaged Calls as Percentage of Calls Answered (%)	72%	70%	84%	84%	79%	79%	76%	79%	78%	86%	84%	85%	87%	84%	84%
Percentage Calls Backs in Under 10 Minutes (%)	77%	70%	70%	68%	68%	68%	67%	70%	74%	74%	62%	54%	50%	49%	49%
Percentage of Calls Directed to 999 for Ambulance Dispatch (%)	11%	12%	9%	10%	10%	10%	10%	11%	11%	10%	9%	9%	10%	9%	9.3%
Percentage of Ambulance Dispatches that were Conveyed (%)	0'	0'	0'	0'	0'	0'	0'	0'	0'	0'	0'	0'	0'	not available	n/a
Average Call Times (Episode) (minutes)	7.72	7.56	11.08	10.55	10.46	11.16	11.05	10.45	10.45	11.00	12.03	13.13	14.08	14m:14s	14:28
Average Call Times (Clinician) (minutes)	8.15	7.92	7.37	7.36	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a
Average Call Times (Health Advisor) (minutes)	7.32	7.22	7.03	7.01	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	not available	n/a

i Please note that there were no Ambulance Conveyance numbers reported by PELC from May onwards. This is due to a LAS access issue.

Operating Plan Performance 2014-15

Delivery against milestones	Baseline	Current	Plan 14/15	Frequency	Date of current data	RAG	Comments
Section 1 Self Certification							The CCG self certified as 'NO' because of the Referral to Treatment issue at Barnet and Chase Farm (BCF).
Section 2 Ambitions for Improving Outcomes							
Ambition 1. Securing additional years of life from conditions considered amenable to healthcare PYLL (Rate per 100,000 population)	1862.6	1643.8	1802.9	Annual	2013		HSCIC has changed methodology. 2012 baseline now shown as 1758.8. 6.5% fall in 2013. NHSE Ambitions Atlas updated to 2013.
Ambition 2. Improving the health related quality of life for people with long term conditions Average EQ- 5D score for people reporting having one or more long-term condition	72.24 (crude) 73.6 (dir std)	72.94 (crude) 74.0 (dir std)	73.18 (crude)	Annual (from bi-annual survey)	2013/14		Baseline is 2012/13 figure. Complex calculation. Ambitions Atlas is now updated with 13/14. Only crude rates available for planning round.
Ambition 3. Reducing avoidable emergency admissions Emergency admissions composite indicator	1551	1848	1551	Quarterly	2014/15 Q1 (Year to)		All component rates increased in 2013/14 (see Quality Premium - Slide 5)
Ambition 5. Proportion of people having a positive experience of hospital care The proportion of people reporting poor patient experience of inpatient care	138.5	144.9	139.1	Annual	2013		Baseline figure is from 2012. Some deterioration in 2013 was assumed in plan.
Ambition 6. Increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community The proportion of people reporting poor experience of General Practice and Out-of-Hours Services	8.03	8.88	8.46	Bi-Annual	2013/14		Published July 2014. Both components have seen more poor experience reported. Ambitions Atlas updated in December 2014
Section 3 Quality Premium Measures (Quality Premium update on next page)							
Section 4 Quality Premium Local Priorities (Quality Premium update on next page)							
Section 5 Other Measures							
4.1 Number of C. Difficile infections in 2014/15	67	88	76	Monthly	Mar 15 YTD		Baseline is 13/14. Source: HCAI website. 4 cases in Mar.
4.2 Dementia diagnosis - 2014/15	44.9%	59.73%	59%	Monthly	Mar 15		Baseline is 12/13. Source: Dementia Prevalence Calculator website. Lowest diagnosis rate in NCL
4.3 IAPT recovery rate - 2014/15	37.5%	43.3%	50%	Monthly / Quarterly	Q4		Q4 rate is higher than Q3 (40.3%)

Quality Premium 2014-15

Indicators	Threshold	Current Data	YTD	Comment
National Measures				
CCG satisfies the financial expectations and does not incur an unplanned financial deficit				Premiums will only be paid if this is met
18 week referral to treatment - incomplete pathways	92%	94.0% - M12	92.22%	Monthly A&E-to-CCG mapped figure difficult to produce accurately from weekly Sitreps.
A & E 4 hour waits	95%	92.1% - M12	94.32%	
8 minute responses for Category A Red1 ambulance calls ^a	75%	62.7% - M12	67.22%	
Cancer 2 week waits	93%	96.2% - M11	94.54%	
Quality Measure				% of Quality Premium
1. Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people				
Potential years of life lost from causes considered amenable to health care - adults, children and young people	Reduction by minimum of 3.2% between baseline and 2014 (calendar years)	2013 data shows decrease of 6.5%	2014 data available Sep 2015	15%
2. Improving access to psychological therapies				
Improving access to psychological therapies - IAPT access levels	10% (The CCG has not commissioned to meet 15% target in 14/15)	10.2% (Apr-Mar) 2.9% (Q4)	11.5% (Q4 x 4)	15%
3. Avoidable emergency admissions				
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	Baseline 660.2 (Reduction or 0% change)	13/14 shows increase of 6.9%	2014 data available Sep 2015	13/14 Composite Measure, received 5 th Nov, shows 13.3% increase (highest in NEL area)
Unplanned hospitalisation for asthma, diabetes and epilepsy in children	Baseline 215.0 (Reduction or 0% change)	13/14 shows increase of 5.8%	2014 data available Sep 2015	
Emergency admissions for acute conditions that should not usually require hospital admission	Baseline 949.9 (Reduction or 0% change)	13/14 shows increase of 11.1%	2014 data available Sep 2015	
Emergency admissions for children with lower respiratory tract infection	Baseline 232.0 (Reduction or 0% change)	13/14 shows increase of 31.9%	2014 data available Sep 2015	
4. Addressing issues identified in the 2013/14 Friends and Family Test				
Patient experience of hospital care as measured by CQC Inpatient Survey - Average number of negative responses per 100 patients	Baseline 138.5 (4% relative improvement per year required to reach 118.1 by 2018/19)	2013 Survey 144.9	2014 Survey published on 21 st May 2015	15%
5. Improved reporting of medication-related safety incidents				
Recording of incidents by providers on National Reporting & Learning System (NRLS) (agreement on increased reporting of 15% at BEH MHT – subject to contractual amendment for in-year monitoring)	Reporting increase of 15% on NRLS	NRLS data available in Sep 2015	NRLS data available in Sep 2015	15%
6. Local Measure				
Emergency readmissions within 30 days	Ambition 13% or below	12.1% - M11	12.9%	15%

^a The 8 minute responses for Cat A Red1 Quality Premium is measured against the London LAS performance and not the CCG one

LONDON BENCHMARKING

4 hour standard A & E – all types

4 hour standard A & E – type 1

MRSA Dashboard

C – Difficile Dashboard

London A&E Performance (All type)

	w-e 12 Apr 15	w-e 19 Apr 15	w-e 26 Apr 15	w-e 03 May 15	4 weeks average	Quarter 4 2014-15	Quarter 1 2015-16	Estimated average required to meet standard in Quarter 1			
Chelsea and Westminster	94.96%	94.63%	96.65%	96.38%	95.65%	96.46%	95.84%	94.47%	Top 5 QTD Trusts		
Hillingdon	93.20%	95.48%	96.41%	95.83%	95.22%	93.64%	94.88%	95.08%		Moorfields	98.26%
Imperial	93.03%	92.97%	92.99%	93.23%	93.06%	92.00%	92.51%	96.56%		UCLH	97.77%
London North West Healthcare	88.99%	90.35%	90.45%	90.85%	90.15%	88.57%	90.05%	98.09%		Royal Free London	96.70%
West Middlesex	95.25%	95.96%	96.97%	93.28%	95.35%	93.50%	95.59%	94.63%		Chelsea and Westminster	95.84%
North West London Trusts	93.96%	94.58%	95.00%	94.66%	94.54%	93.62%	94.41%	95.37%	West Middlesex	95.59%	
Moorfields	97.34%	97.85%	98.96%	99.76%	98.50%	99.58%	98.26%	92.96%	Bottom 5 QTD Trusts		
North Middlesex	95.25%	93.35%	94.21%	94.81%	94.40%	91.87%	94.45%	95.34%		King's College	87.83%
Royal Free London	96.16%	96.22%	96.59%	97.67%	96.66%	94.25%	96.70%	93.94%		Bart's Health	88.59%
UCLH	98.14%	97.17%	97.25%	97.73%	97.57%	95.07%	97.77%	93.27%		Croydon Health Services	88.82%
Whittington	94.20%	96.01%	95.13%	97.43%	95.75%	94.01%	94.68%	95.20%		London North West Healthcare	90.05%
Barking, Havering & Redbridge	92.04%	93.79%	94.34%	90.75%	92.74%	88.79%	92.19%	96.76%	Kingston	90.72%	
Bart's Health	87.35%	87.97%	89.38%	89.26%	88.49%	88.30%	88.59%	99.01%			
Homerton	95.82%	95.63%	94.56%	92.44%	94.61%	95.34%	94.80%	95.12%			
North and East London Trusts	93.91%	94.17%	94.70%	94.39%	94.29%	92.98%	94.22%	95.49%			
Guy's & St Thomas'	96.47%	94.55%	94.41%	94.75%	95.01%	93.94%	95.03%	94.98%			
King's College	86.24%	86.33%	92.34%	88.46%	88.39%	85.82%	87.83%	99.48%			
Lewisham & Greenwich	92.88%	88.87%	89.47%	93.61%	91.19%	87.63%	91.34%	97.29%			
Epsom & St. Helier	93.95%	96.81%	95.98%	95.90%	95.66%	94.76%	95.22%	94.86%			
Kingston	86.63%	92.19%	94.07%	95.34%	92.14%	91.47%	90.72%	97.67%			
Croydon Health Services	84.73%	85.07%	93.09%	92.98%	88.91%	91.92%	88.82%	98.86%			
St. George's	94.10%	90.83%	92.82%	92.89%	92.64%	88.39%	92.25%	96.72%			
South London Trusts	92.33%	91.73%	93.82%	93.77%	92.91%	91.29%	92.65%	96.47%			
Total London Performance	93.42%	93.49%	94.50%	94.27%	93.92%	92.63%	93.77%	95.77%			

London A&E Performance (Type 1)

	Last 4 Weeks Sitrep				4 Wk Avg w-e 03 May 15	Quarterly performance	Quarterly Performance	Estimated weekly average to meet 95% standard in Q1
	w-e 12	w-e 19	w-e 26	w-e 03		2014-15	2015-16	
	Apr 15	Apr 15	Apr 15	May 15		2014-15 Q4	2015-16 Q1	
Chelsea & Westminster	94.96 %	94.63 %	96.65 %	96.38 %	95.65%	96.46 %	95.84 %	94.47%
Hillingdon	81.66 %	87.52 %	89.27 %	88.50 %	86.65%	82.63 %	85.72 %	100.80%
Imperial	87.04 %	84.73 %	83.44 %	83.98 %	84.78%	81.70 %	83.40 %	102.25%
West Middlesex	89.70 %	90.94 %	93.41 %	84.97 %	89.71%	85.14 %	90.15 %	98.03%
London North West Healthcare	71.18 %	74.88 %	75.27 %	77.63 %	74.75%	71.27 %	74.42 %	107.86%
North West London	84.55 %	85.59 %	86.43 %	85.91 %	85.61%	83.07 %	85.23 %	101.11%
North Middlesex	95.25 %	93.35 %	94.21 %	94.81 %	94.40%	91.87 %	94.45 %	95.34%
Royal Free London	95.38 %	95.46 %	95.94 %	97.21 %	96.00%	93.18 %	96.05 %	94.35%
UCLH	98.14 %	97.17 %	97.25 %	97.73 %	97.57%	95.07 %	97.77 %	93.27%
Whittington	94.20 %	96.01 %	95.13 %	97.43 %	95.75%	94.01 %	94.68 %	95.20%
Barking, Havering & Redbridge	90.61 %	92.55 %	93.30 %	88.96 %	91.36%	86.76 %	90.75 %	97.66%
Bart's Health	82.06 %	83.38 %	85.43 %	85.56 %	84.13%	83.74 %	84.20 %	101.75%
Homerton	95.82 %	95.63 %	94.56 %	92.44 %	94.61%	95.34 %	94.80 %	95.12%
North East London	91.56 %	91.92 %	92.63 %	92.22 %	92.08%	90.08 %	92.00 %	96.88%
Guy's & St Thomas'	95.57 %	92.85 %	92.68 %	93.06 %	93.52%	92.20 %	93.64 %	95.85%
King's College	80.97 %	80.63 %	89.22 %	84.53 %	83.89%	80.26 %	83.12 %	102.42%
Lewisham & Greenwich	91.49 %	87.00 %	87.40 %	92.31 %	89.52%	85.41 %	89.71 %	98.31%
Epsom & St. Helier	93.75 %	96.69 %	95.83 %	95.75 %	95.51%	94.55 %	95.05 %	94.97%
Kingston	85.54 %	91.28 %	93.43 %	94.85 %	91.33%	90.67 %	89.80 %	98.25%
Croydon Health Services	79.76 %	77.89 %	89.86 %	89.01 %	83.93%	87.49 %	84.81 %	101.37%
St. George's	93.45 %	90.06 %	92.02 %	92.10 %	91.88%	87.12 %	91.45 %	97.22%
South London	89.16 %	88.17 %	91.09 %	91.32 %	89.94%	87.47 %	89.62 %	98.36%
London	89.46 %	89.46 %	91.01 %	90.82 %	90.19%	87.90 %	89.97 %	98.15%


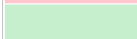

Top 5 QTD Trusts	
UCLH	97.77%
Royal Free London	96.05%
Chelsea & Westminster	95.84%
Epsom & St. Helier	95.05%
Homerton	94.80%

Bottom 5 QTD Trusts	
London North West Healthcare	74.42%
King's College	83.12%
Imperial	83.40%
Bart's Health	84.20%
Croydon Health Services	84.81%

Trauma Centres in blue

London MRSA Cases

Trust Name	Number of cases		Number of cases so far this		2015-16 YTD	2015-16 YTD	2014-15 YTD
	Total for last 12 months	Total for last 3 months	last month (March 2015)	month (April 2015)	Position to 29th April 2015	Position to 6th May 2015	position to the end of April 2014
Barking, Havering and Redbridge Hospitals NHS Trust	6	0	0	0	0	0	0
Barts Health Trust	9	1	1	0	1	1	1
Great Ormond Street Hospital For Children NHS Trust	0	0	0	0	0	0	0
Homerton University Hospital NHS Foundation Trust	2	1	1	0	1	1	1
North Middlesex University Hospital NHS Trust	0	0	0	0	0	0	0
Royal Free NHS Foundation Trust	5	0	0	0	0	0	0
Royal National Orthopaedic Hospital NHS Trust	0	0	0	0	0	0	0
University College London Hospitals NHS Foundation Trust	3	1	0	0	0	0	0
Whittington Hospital NHS Trust	2	0	0	0	0	0	0
NEL TOTAL	27	3	2	0	2	2	2
Chelsea And Westminster Hospital NHS Foundation Trust	0	0	0	0	0	0	0
Hillingdon Hospital NHS Trust	1	0	0	0	0	0	0
Imperial College Healthcare NHS Trust	6	1	1	0	1	1	1
London North West Healthcare NHS Trust	2	0	0	0	0	0	0
Royal Brompton And Harefield NHS Trust	0	0	0	0	0	0	0
West Middlesex University NHS Trust	3	0	0	0	0	0	0
NWL TOTAL	12	1	1	0	1	1	1
Croydon Healthcare Services NHS Trust	1	1	1	0	1	1	0
Epsom And St Helier NHS Trust	6	2	0	0	0	0	0
Guy's and St Thomas's NHS Foundation Trust	4	1	0	0	0	0	0
King's College Hospital NHS Trust	5	0	0	0	0	0	1
Kingston Hospital NHS Trust	0	0	0	0	0	0	0
Lewisham and Greenwich NHS Trust	3	0	0	0	0	0	0
Royal Marsden NHS Foundation Trust	1	0	0	0	0	0	0
St George's Healthcare NHS Trust	7	3	2	0	2	2	0
SL TOTAL	27	7	3	0	3	3	1
LONDON	66	11	6	0	6	6	4

 Trust above 0 threshold
 Trust achieving 0 threshold
 Trust YTD position increased from previous week

London C. Difficile Cases

Trust Name	Total for last 12 months	Total for last 3 months	Number of cases last month (March 2015)	Number of cases so far this month (April 2015)	Number of cases from 1st April 2015 - 29th April 2015 (Provisional)	Number of cases from 1st April 2015 - 6th May 2015 (Provisional)	Year to date Trajectory to 6th May 2015	Annual Trajectory	2014-15 YTD number of cases to end April 2014
Barking, Havering And Redbridge Hospitals NHS Trust	32	7	2	0	2	2	2.8	30	2
Barts Health Trust	89	16	5	0	2	5	7.8	82	6
Great Ormond Street Hospital For Children NHS Trust	13	0	0	0	0	0	1.4	15	0
Homerton University Hospital NHS Foundation Trust	6	2	1	0	1	1	0.7	7	1
North Middlesex University Hospital NHS Trust	39	6	1	1	1	2	3.2	34	3
Royal Free NHS Foundation Trust	45	0	0	0	0	0	6.2	66	7
Royal National Orthopaedic Hospital NHS Trust	2	0	0	0	0	0	0.2	2	0
University College London Hospitals NHS Foundation Trust	114	29	19	0	12	19	9.2	97	4
Whittington Hospital NHS Trust	11	2	1	0	1	1	1.6	17	2
NEL TOTAL	351	62	29	1	19	30	33.0	350	25
Chelsea And Westminster Hospital NHS Foundation Trust	3	0	0	0	0	0	0.7	7	2
Hillingdon Hospital NHS Trust	19	3	2	0	2	2	0.8	8	0
Imperial College Healthcare NHS Trust	65	9	0	0	0	0	6.5	69	7
London North West Healthcare NHS Trust	34	4	0	0	0	0	3.5	37	3
Royal Brompton And Harefield NHS Trust	23	2	0	0	0	0	2.2	23	0
West Middlesex University NHS Trust	7	2	1	0	0	1	0.8	9	1
NWL TOTAL	151	20	3	0	2	3	14.5	153	13
Croydon Healthcare Services NHS Trust	13	1	0	0	0	0	1.5	16	1
Epsom And St Helier NHS Trust	40	3	3	0	3	3	3.6	39	2
Guy's and St Thomas's NHS Foundation Trust	45	8	4	0	3	4	4.8	51	5
King's College Hospital NHS Trust	70	13	7	0	4	7	6.8	72	6
Kingston Hospital NHS Trust	15	0	0	0	0	0	0.8	9	1
Lewisham and Greenwich NHS Trust	38	10	4	0	4	4	3.7	39	1
Royal Marsden NHS Foundation Trust	34	5	0	0	0	0	2.9	31	0
St George's Healthcare NHS Trust	35	7	3	0	3	3	2.9	31	3
SL TOTAL	290	47	21	0	17	21	27.1	288	19
LONDON	792	129	53	1	38	54	74.6	791	57

Note – The 2015/16 weekly C.diff. numbers are aggregated at provider level but not attributed to the Trusts, therefore to avoid giving an inaccurate position we have omitted any comparison to plan and associated RAG rating.

Clinical Commissioning Group

Agenda Item: 8.1
Paper Ref: Appendix J

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 June 2015
TITLE:	Quality and Safety Update Report
LEAD BOARD MEMBER:	Aimee Fairbairns, Director of Quality and Governance
AUTHOR & POSITION:	Karen Keane, Head of Clinical Quality
CONTACT DETAILS:	Karen.keane@enfieldccg.nhs.uk

SUMMARY:

This paper updates the Enfield Clinical Commissioning Group Governing Body on Enfield CCG's work to improve quality and brings together key quality and safety areas within the CCG Quality Strategy and Implementation Plan.

The paper provides an update on quality issues discussed through the Clinical Quality Review Groups (CQRG) and provides assurance that Enfield CCG is upholding its responsibility and commitment to commission safe, high quality and value for money health services for the population of Enfield.

The Governing Body quality and safety report usually provides detail of areas discussed at the preceding Quality and Safety Committee and Quality and Risk Sub Group meetings for assurance but due to the change in timing of the governing body meeting, this has not been possible on this occasion. The order of meetings has been altered to overcome this for future reports. The outputs from the May Quality and Risk Sub Group and July Quality and Safety Committee will inform the August Governing Body report.

SUPPORTING PAPERS:

- See audit trail below

RECOMMENDED ACTION:

- Note and discuss the Quality and Safety report
- Raise any issues that require further clarification

Plans supported by this paper: This paper supports the Enfield Clinical Commissioning Group's (CCG) strategic plan to achieve a robust governance framework and to ensure there is continuous service quality improvement with service providers.

Patient & Public Involvement (PPI): Enfield Clinical Commissioning Group wishes to involve patients and the public at all levels within the CCG and will be working with its Patients and Public Engagement Committee to determine the most effective way to achieve this.

Equality Impact Assessment: Not required.

Risks: Capacity, development, and duplication are all risks to quality and safety and are reflected in the CCG's corporate risk register.

Resource Implications: None at this stage.

Audit Trail:

Minutes of the 22nd April RFH CQRG

Minutes of the 24th April NMUH CQRG

Minutes of the 16th April BEH CQRG

Agenda of the 27th May RFH CQRG

Agenda of the 29th May NMUHT CQRG

Agenda of the 21st May BEH CQRG

Quality and Safety Update Report

1. Barnet Enfield and Haringey Mental Health Trust (BEHMHT)

1.1 Extended Round Table

Three extended round table meetings have taken place since 2014 with BEHMHT. Enfield CCG has worked with the Trust to agree a comprehensive annual work plan. The final work plan was agreed at the Clinical Quality Review Group (CQRG) in January 2015 and the work plan has been aligned with the Trust governance meetings schedule where possible. The enhanced work plan reflects the CQC Quality Domains as well as the Quality Schedule (Schedule 4) of the BEHMHT 2014/15 Contract. Each element of the work plan is fully auditable providing assurance that actions are delivered as scheduled or where this has not happened that mitigation actions are recorded via Clinical Quality Review Group minutes.

The most recent extended round table meeting took place in May 2015 with stakeholders agreeing that there was sufficient assurance for the extended round table meetings to be stood down but that they could be re-instated if required for system wide assurance.

1.2. Serious Incidents (SI's)

The Trust continues to work to strengthen serious incident (SI) investigation reports submitted to the NCL SI panel for closure.

The introduction of a new national SI Framework in April offers the opportunity to introduce changes to the management of the SI process and is anticipated to strengthen processes and reduce variability in the quality of reports submitted for closure.

1.3. Focus on Forensic Services

The Clinical Quality Review Group received a presentation focussing on Quality in Forensic Service. The presentation provided assurance on risk assessments, staffing and an in depth discussion on patient experience.

BEHMHT Forensic Services are part of a network that takes part in peer review audits. In the most recent peer review the auditor spent two days in the Trust as part of the peer review audit and the Trust report positive feedback from the review. Forensic Services are part of a network that undertakes peer review audits. The auditor met front line staff and service users on a 2 day visit. The Trust received positive feedback in the Peer Review.

Next Steps – BEHMHT

- Continue to robustly monitor the quality of services via the monthly CQRG meetings.
- Work with the Trust to ensure Serious Incident investigations and reports provide assurance that where incidents occur they are investigated and learning from incidents is used to continually improve the quality of services.

2. North Middlesex University Hospital Trust (NMUH)

2.1 Withdrawal of Anaesthetic trainees at North Middlesex Hospital.

Following Health Education North East and North Central (HENCEL) decision to withdraw anaesthetic trainees from North Middlesex University Hospital commissioners have participated in meetings and weekly teleconference calls, chaired by the Trust Development Authority (TDA), aimed at ensuring risks were mitigated.

Enfield CCG work closely with Haringey CCG and will report from CQRG meetings to Enfield CCG Quality and Safety Committee.

2.2. Annual Staff Survey 2014

The Clinical Quality Review Group received a report addressing the findings of the annual staff survey in which the Trust detailed both the most and least favourable benchmarked outcomes. Metrics for which NMUH compares most favourably with other acute trusts/ in the best 20% of all acute trusts include

- Staff motivation at work
- % of staff who agree feedback from patients is used to inform decisions in their unit
- % of staff who agree they would feel safe raising concerns about unsafe clinical practice

Metrics for which NMUH compares least favourably with other acute trusts/in the bottom 20% of all acute trusts

- % of staff receiving job-relevant training and development in the last 12 months
- Work pressure felt by staff

An action plan has been developed by the Trust in response to the annual staff survey and other staff feedback it receives, including the staff friends & family test. Updates will be presented at 6 monthly intervals.

2.3 Patient Experience

Both the Friends and Family Test and the Trust's internal patient experience metrics are showing improvement following renewed focus from the Trust. Taking into account the challenge improving these metrics present to all organisations, the Trust is to be commended for this. The Clinical Quality Review Group (CQRG) meetings will continue to receive regular updates.

2.4 CQC Improvement plan

The Clinical Quality Review meeting received assurance that all the actions from the CQC Improvement Plan have been completed. The Trust confirmed any on-going actions from the plan have been placed on the Trust's Risk Register for monitoring.. The Trust Development Authority acknowledged the progress on the CQC Improvement Plan and the clear and robust nature of the assurance process. Commissioners will be monitoring performance to ensure levels of service improvement are maintained and sustained.

2.5 Complaints

CQRG received details of the Trust actions to improve the complaints process in the organisation. There has been a focus on triangulating information from complaints, clinical harm, incidents and serious incidents. The Trust confirmed improvements have been made in 2015 and additional resource invested in the complaints team.

A further update is expected and will be reported in the next Quality and Safety report.

Next Steps – NMUH

- Continue to monitor Anaesthetic risks and mitigating actions via CQRG meetings to monitor effectiveness of Trust plan to improve patient experience.

3. Royal Free Hospital Foundation Trust – Barnet and Chase Farm (BCF) site

3.1 Referral to Treatment (RTT) and Clinical Harm

The Royal Free London Hospital Foundation Trust reports progress on the clinical harm review through the monthly CQRG meetings and Clinical Harm remains a substantive item for assurance on each CQRG agenda.

The Clinical Harm report in April confirmed that 64 patients (affected by RTT before 1st July 2014) are still to be treated but this is expected to be completed by the end of the summer. The Enfield CCG Director of Quality and Integrated Governance confirmed at the external Clinical Harm Steering Group, that it was noted that the trust needs to maintain sight of the cohort of patients affected from 1st July 2014 until the time of reporting and any potential harm needs to be flagged; the Trust confirmed that this is being done.

The Trust confirmed that information will be presented to the next CQRG meeting on RTT trend lines. A paper on lessons learnt presented to CQRG was noted as providing a useful review.

The Quality and Safety Committee will continue to receive the minutes of the External Clinical Harm Steering Group.

3.2 The Cancer 62 days standard.

The Trust breached the Cancer 62 day from GP referral indicator in quarter three and forecast a planned fail in quarter four 2014/15. The quarter four planned fail is part of a managed backlog clearance trajectory in order to return to compliance with the national standard during quarter one 2015/16.

A recovery plan is in place, but to support a quarter one 2015/16 return to compliance, the focus is on the five tumour sites contributing the greatest volume of breaches which include Urology, Skin, Lower Gastrointestinal, Gynaecology and Lung.

The implementation of the plan will be overseen by a delivery group meeting bi weekly and comprised of all 11 tumour sites, all relevant diagnostic modalities and outpatient/inpatient administrative booking teams. The delivery group is chaired by the trusts Chief Operating Officer with tumour sites represented by Divisional Directors, Divisional Directors of Operations as well as Clinical Leads and senior Operations managers. Regular updates will be presented to CQRG with the CCG performance team also monitoring progress and escalating appropriately.

3.3 Infection Control

In Q4 there were 2 MRSA bacteraemia reported, 1 in the Royal Free hospital and 1 at Chase Farm Hospital. Post Infection reviews took place following both cases with learning identified. Implementation of the learning identified will be monitored at the Infection Control Meeting with assurance provided to the Quality and Safety Committee.

There were 25 attributable Clostridium Difficile (C Diff) cases for Royal Free hospital against a trajectory of 38 for the year (13 below trajectory). At Barnet and Chase Farm hospital there were 33 attributable cases against a trajectory of 16 for the year, (17 above trajectory). Work continues with the Trust to ensure it meets its infection target. An expert, external review of the BCF service was undertaken in July 2014. The actions from the recommendations from this review have been amalgamated into the overarching Trust C. difficile action plan.

Compliance is monitored regularly at Infection Control meeting at which the CCG is represented.

Next Steps - Royal Free London Foundation Trust

- To continue to monitor RTT clinical harm.
- To monitor timeliness of satisfactory completion of serious incidents investigations reported as a result of the RTT Clinical Harm review.
- To monitor infection control metrics, particularly clostridium difficile rates at the BCF site and the overarching Trust C. difficile action plan.
- To monitor delivery of 62 day cancer standard.

4. Enfield CCG Infection Control Clostridium Difficile Plan.

There has been a reduction in rates of hospital acquired Clostridium Difficile cases but an increase in community acquired infection rates recently. There is evidence from the Health Protection Agency that Clostridium Difficile is present in the guts of up to 3% of healthy adults (Health Protection Agency, 2012). People at risk of contracting Clostridium Difficile infection include those being treated with broad-spectrum antibiotics, people with serious underlying illnesses and older people. More than 80% of all Clostridium Difficile infections occur in people aged over 65, with most deaths occurring in the over-85 population.

NHS England hosted a national conference in March 2015 and indicated that a whole system approach is required to reduce the burden of Clostridium Difficile infection. Only through reducing the circulation of pathogens, across both hospital and community will the burden be reduced.

As a direct result of the identified increase in community acquired infections the CCG has developed a pan organisational action plan with the aim of reducing rates of clostridium difficile infection. Organisations involved in the development of the action plan include acute providers, NHS England, Local Authority Health Protection teams, and Public Health England. All those involved have expressed their support and commitment to working with us to deliver the action plan.

Regular communication is taking place with stakeholders. The Quality and Safety Committee will receive the plan formally at the next meeting and regular updates on delivery against milestones will be submitted.

End of Report

Clinical Commissioning Group

Agenda Item: 9.1
Paper Ref: Appendix K

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 June 2015
TITLE:	Audit Committee – meetings held on 29 April and 27 May 2015
LEAD BOARD MEMBER:	Karen Trew, Audit Committee Chair
AUTHOR:	David Triggs Board Secretary
CONTACT DETAILS:	David.triggs@enfieldccg.nhs.uk

SUMMARY:

The purpose of this paper is to outline matters discussed by the Audit Committee at its meetings held on 29 April 2015 and 27 May 2015 and to highlight those matters that are recommended by the Committee to the Governing Body for its approval/review

Audit Committee Meeting held on 29 April 2015. The following was considered:

- Internal Audit. Local Counter Fraud Plan for 2015/16
- 2014/15 Draft Annual Report and Annual Accounts. This was also reviewed by the Committee at its May meeting.
- Internal Audit Progress Reports for Enfield CCG and the CSU
- Draft Head of Audit Opinion
- **Prime Financial Policies.** The Policies form part of the CCG Constitution and are therefore recommended for approval by the Governing Body. The only change proposed by the Audit is to remove the Committee terms of reference which are currently appended to the Prime Financial Policies. The document is located on the web site <http://www.enfieldccg.nhs.uk/document-library.htm> as Annex 6 to the Constitution and hard copies are available on request.
- Financial Governance Review and Action Plan (this is the subject of a separate paper on the agenda).
- Waivers Report
- Committee Effectiveness review of the Quality & Safety Committee

Audit Committee Meeting held on 27 May 2015

- **Governing Body Assurance Framework.** The Committee reviewed the BAF, it welcomed the new format, suggested that one of the existing high level risks could be amalgamated into a broader risk area and suggested a more detailed review of a high level risk at each future meeting of the Committee (this is the subject of a separate report).
- **2014/15 Draft Annual Report and Accounts.** These were approved by the Committee under the delegated authority of the Governing Body. The Governing Body is asked to (a) endorse the Annual Report and Accounts and (b) to approve the statement set out in the recommendations.
The following were also discussed as part of approving the Annual Report and Accounts:

- Review of the CCG as a Going Concern
 - Financial Statements Letter from Audit Committee
 - Audit Findings Report
 - Head of Internal Audit Opinion
 - Annual Governance Statement (part of the Annual Report)
- **NCL Conflicts of Interest Policy.** The Governing Body is recommended to approve the draft NCL Conflicts of Interest Policy localised to apply to Enfield CCG and this is the subject of a separate covering paper.
 - **Gifts and Hospitality Policy.** The Governing Body is recommended to approve the amended Policy. The key changes to the revised Policy include removing reference to Declarations of Interest as these are now covered by the Conflicts of Interest Policy and merging the threshold for Gifts and Hospitality so these are both set at £25. The Policy is available on the web site and hard copies are available on request.
 - **Procurement Policy.** A revised Policy is being reviewed by the Procurement Committee at its meeting on 3 June and will be the subject of a recommendation to the Governing Body. The draft Policy will be made available on the web site with hard copies available on request. [Note: although this was not a matter reviewed by the Audit Committee this together with Conflicts of Interest and Gifts and Hospitality Policy are all documents that have been reviewed following the issue of NHSE Statutory Guidance for CCG's and should be seen as a suite of policies].
 - **Audit Committee Annual Report.** This is attached as a separate paper and the Governing Body are asked to receive this Report.
 - Committee Effectiveness Review of the Audit Committee
 - Internal Audit - CSU Assurance Report
 - Debtors Report & Waivers Report. These reports were received and noted.

SUPPORTING PAPERS:

- There are no supporting papers

RECOMMENDED ACTION:

The Governing Body is recommended to:

- (a) Review the Governing Body Assurance Framework (*attached as a separate report*);
- (b) Endorse the Annual Report and Accounts for 2014/15 as approved by the Audit Committee at its meeting on 27 May 2015 (*this is the subject of a separate report*);
- (c) Approve the following declaration:

“The Governing Body is not aware of any relevant audit information that has been withheld from the CCG’s external auditors, and members of the Governing Body take all necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.”

- (d) Approve the NCL Conflicts of Interest Policy as localised for Enfield CCG and for submission to NHSE as part of the application to move to the next stage of co-commissioning (*this is the subject of a separate report*);
- (e) Approve the Procurement Policy as recommended by the Procurement Committee at its meeting on 3 June 2015 (*this is the subject of a separate report*);
- (f) Approve the revised Enfield CCG Gifts and Hospitality Policy (*this is the subject of a separate report*);
- (g) Approve the Prime Financial Policies that have no changes other than to remove the appendices that detail the committee terms of reference.

Objective(s) / Plans supported by this paper: The Audit Committee Annual Report applies to all Enfield CCG objectives

Patient and Public Engagement (PPE): Audit Committee membership includes lay members. The PPE Committee also reports annually to the Audit Committee on its performance

Equality Impact Analysis: This is conducted in line with agenda items.

Risks: As outlined in the CCG's assurance framework and risk register

Resource Implications: None identified

Audit Trail: None

Clinical Commissioning Group

Agenda Item: 9.2
Paper Ref: Appendix L

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 June 2015
TITLE:	Proposed new BAF for 2015/16
LEAD BOARD MEMBER:	Aimee Fairbairns, Director of Quality and Integrated Governance
AUTHOR:	Bridget Pratt, Associated Director of Quality, Governance and Risk Vivienne Ahmad, Risk and Governance Manager
CONTACT DETAILS:	vivienne.ahmad@enfieldccg.nhs.uk

SUMMARY:

- **Governing Body Assurance Framework**

The Governing Body Assurance Framework (GBAF) sets out the strategic risks (12+) to achieving the CCG's strategic objectives and priorities. They include risks associated with quality and safety, maximising productivity, efficiency and cost effectiveness.

The GBAF (also known as the Board Assurance Framework or the BAF) is an important document for providing external assurance (for example to NHS England, Audit and the public) that Enfield CCG is sighted on its risks and has a robust system of internal control.

The Governing Body is only properly able to fulfil responsibilities through an understanding of the principle risks facing the organisation.

Chronological changes to the current BAF reporting template

- The CCG's 2014/2015 corporate objectives were refreshed at the February Governing Body Seminar and approved at the March Governing Body.
- Following feedback from the Audit Committee and Internal Audit (Baker Tilly) on the need to moderate on risk scores and review the number of red risks, the CCG agreed a different approach to BAF level risk in 2015/2016.
- Baker Tilly also facilitated a risk identification session at the February Board seminar using intelligence from other CCG BAFs and came up with key BAF level risks highlighted and agreed with Governing Body members.
- For 2015/2016, the BAF will contain composite strategic risks 12+ which impact on the CCG's corporate/strategic objectives.
- 2014/2015 BAF risks have either been aligned to these new composite BAF risks or will be closed as recommended by a GB Committee.
- Some Directors retained existing BAF level risks; merged new risk with 2014/2015 risks as indicated, created new risks or recommended risk for closure.
- As the 2014/2015 BAF template was felt to have too many fields and not user friendly, for 2015/2016, the CCG adopted Tower Hamlet's CCGs BAF template as agreed at the Directors meeting.

Summary of key updates discussed at the Audit Committee meeting on 28 May 2015

The Audit Committee reviewed the BAF and the following comment was made:

- The Committee welcomed the new BAF and recommended further review of an operational quality risk which has been actioned.

Total Number of Risks on the new proposed BAF (12+)

There are currently 9 open BAF - level risks.

New Risks

There are seven new risks as follows:

- **Risk No 1:** Risk to the delivery of transformational change programmes in line with programme timescales.
- **Risk No 2:** Risk to delivery of Co-Commissioning model across North Central London CCGs.
- **Risk No 3:** Inability to hold providers to account for their performance may impact on the quality of the services we commission for Enfield residents. Specific areas of concern include: RTT, Demand Management and A&E Performance.
- **Risk No 4:** CCG fails to demonstrate positive change on behalf of patients and residents in Enfield leading to stakeholder disillusionment, poor engagement and reputational damage.
- **Risk No 5:** Failure to ensure a safe and high quality service is commissioned from and delivered by our providers with particular reference to: 1: Quality Monitoring following RFL acquisition of BCF. 2. Underperformance of the CSU's quality assurance of provider contracts, 3, Delays in Referral to Treatment at BCF. 4. Limited Provider cost improvement plan assurance, 5.Serious and specific concerns relating to the quality and safety of the anaesthetic service at NMUH submitted by a trainee to HENCEL on 23 January 2015. 6.Risk to patient safety and poor personalised care at Murrayfield Residential Home caused by lack of qualified staff due to staff turnover
- **Risk No 6:** Failure to maintain long-term financial sustainability through an inability to deliver on key financial imperatives including: QIPP, Payment by Results costs in line with contracts/SLAs; Maintenance of sound financially sustainable partners within the health economy; Outcomes from the Better Care Fund and having realistic assumptions and achievable plans.
- **Risk No 9:** CSU's inability to deliver key CCG functions in line with CCG performance and SLA.

Aligned / merged risks

There is one aligned / merged risk as follows:

- **Risk No 7:** Failure to achieve intended commissioning outcomes of effective collaboration arising from conflicts of interest. (Related to 2014/15 BAF Risk 13)

Extreme risks (15+)

There are three extreme risks with 15 or above with a current risk rating:

- **Risk No 1:** Risk to the delivery of transformational change programmes in line with programme timescales
- **Risk No 3:** Inability to hold providers to account for their performance may impact on the quality of the services we commission for Enfield residents.
- **Risk No 6:** Failure to maintain long-term financial sustainability through an inability to deliver on key financial imperatives including: QIPP; Payment by Results costs in line with contracts/SLAs; Maintenance of sound financially sustainable partners within the health economy; Outcomes from the Better Care Fund and Having realistic assumptions and achievable plans.

De-escalate Risk to Corporate Risk Register

Three risks are recommended for de-escalation as follows:

- **Risk No 5:** Failure to ensure a safe and high quality service is commissioned from and delivered by our providers. **The following risk areas are recommended for de-escalation:**
 1. Risk to quality monitoring from the RFH acquisition of BCF: RFL CQRG established. Barnet CCG is the lead Commissioner for RFL and Enfield CCG is represented at the RFL CQRG. Business as usual. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register
 2. CSU: SLA amendments were suggested during 2015/2016 contract negotiations. These are being monitored via the Director of Operations and NCL CSU Improvement Group. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register
 3. Provider CIP assurance: Regular monitoring via the CQRG & Quality & Safety Committee. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register
 4. NMUH Anaesthetic: Weekly risk teleconference has been stood down as there is a measure of assurance in the system. Monitoring and oversight continues via the NMUH CQRG. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register
- **Risk No 7:** Failure to achieve intended commissioning outcomes of effective collaboration arising from conflicts of interest. Recommend de-escalation from 12 to 8 with monitoring via the Corporate Risk Register.
- **Risk No 8:** Inability of the CCG to report accurately and make effective decisions due to poor data quality. Recommend de-escalation from 12 to 9 with monitoring via the Corporate Risk Register.

2014/2015 risks recommended for closure:

Datix ID 31: Risk that the Trust Development Agency (TDA) may not authorise BEH MHT to proceed to FT (Foundation Trust) status. Relevant new risk to be created.

SUPPORTING PAPERS:

- Appendix 1: Risk Tracker
- Appendix 2: Risk Map
- Appendix 3: Full Board Assurance Framework

RECOMMENDED ACTION:

The **Governing Body Meeting** is asked to:

- REVIEW the BAF and note the new risks
- Note the extreme risks
- Note aligned/merged risks
- Note the de-escalated and closed risks
- Note that the Risk & Governance Team will update Datix and train staff on the changes to the agreed new template

Objective(s) / Plans supported by this paper: The BAF applies to all plans related to services commissioned by the CCG

Patient and Public Involvement (PPI): Enfield CCG aims to involve patients and the public in implementing its corporate objectives. No specific involvement on BAF issues.

Equality Impact Analysis: This is conducted in line with commissioning intentions.

Risks: There is a notable risk associated with Risk Leads not providing BAF updates for some risk areas or not complying with update request in a timely manner

Resource Implications: Staff capacity to review and update risks

Audit Trail:

- 27 April - Directors Meeting
- 11 May - Directors Meeting
- 27th May - Audit Committee

Next Steps:

- Datix to be updated with new 2015/2016 risks
- Risk and Governance team to provide training to risk champions, risk owners and leads on the changes

			2015/16												Progress	Target Risk Rating	Key changes/updates since last review
Risk No	Datix ID	Risk description	Q1			Q2			Q3			Q4					
			APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR			
1	Datix Risk ID: TBC (Related to 2014/15 BAF Risk: New Risk)	Risk to the delivery of transformational change programmes in line with programme timescales	15	15											→	10	
2	Datix Risk ID: TBC (Related to 2014/15 BAF Risk: New Risk)	Risk to delivery of Co-Commissioning model across North Central London CCGs	12	12											→	8	
3	Datix Risk ID: TBC (Related to 2014/15 BAF Risk: 247)	Inability to hold providers to account for their performance may impact on the quality of the services we commission for Enfield residents. Specific areas of concern include: • RTT • Demand Management • A&E Performance	20	20											→	10	
4	Datix Risk ID: TBC (Related to 2014/15 BAF Risk: N/A)	CCG fails to demonstrate positive change on behalf of patients and residents in Enfield leading to stakeholder disillusionment, poor engagement and reputational damage.	12	12											→	8	20/04/15 - C2. Comments received and toolkit adapted. Awaiting confirmation that this is finalised and can be re-circulated. C5. Engagement log circulated with deadline of 24 April; to be updated and forwarded to PPE Committee for consideration. C7. Development of leaflets e.g. Choose well leaflets; currently Enfield Vision reviewing CDs of Choose Well Campaign to confirm suitability for the partially sighted and or blind C8. Continue to participate in events organised by other organisations e.g. Schools Career Event on 22 April 2015.
5	Datix Risk ID: TBC (Related to 2014/15 BAF Risk: 55,236,237,286)	Failure to ensure a safe and high quality service is commissioned from and delivered by our providers with particular reference to: 1. Quality Monitoring following RFL acquisition of BCF. 2. Underperformance of the CSU's quality assurance of provider contracts. 3. Delays in Referral to Treatment at BCF. 4. Limited Provider cost improvement plan assurance. 5. Serious and specific concerns relating to the quality and safety of the anaesthetic service at NMUH submitted by a trainee to HENCEL on 23 January 2015. 6. Risk to patient safety and poor personalised care at Murrayfield Residential Home caused by lack of qualified staff due to staff turnover	16	12											↘	8	19/05/15 - Current risk rating downgraded from 16 to 12 given significant progress made in the following key areas: 1. Risk to quality monitoring from the RFL acquisition of BCF: RFL CQRG established. Barnet CCG is the lead Commissioner for RFL and Enfield CCG is represented at the RFL CQRG. Business as usual. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register 2. CSU: SLA amendments were suggested during 2015/2016 contract negotiations. These are being monitored via the Director of Operations and NCL CSU Improvement Group. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register 3. RTT: Regular monitoring continues via the CQRG. Risk remains on BAF view 4. Provider CIP assurance: Regular monitoring via the CQRG & Quality & Safety Committee. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register 5. NMUH Anaesthetic: Weekly risk teleconference has been stood down as there is a measure of assurance in the system. Monitoring and oversight continues via the NMUH CQRG. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register 6. Murrayfields: Regular monitoring of the recruitment process via the provider concerns meeting. Lead: Assistant Director of Safeguarding. Deadline: 30/06/15 Risk to remain on BAF view. Remains a BAF level risk
6	Datix Risk ID: TBC (Related to 2014/15 BAF Risk: 15,307,188,198,149,150,294)	Failure to maintain long-term financial sustainability through an inability to deliver on key financial imperatives including: • QIPP • Payment by Results costs in line with contracts/SLAs • Maintenance of sound financially sustainable partners within the health economy • Outcomes from the Better Care Fund • Having realistic assumptions and achievable plans	16	16											→	12	
7	Data Risk ID: TBA (Related to 2014/15 BAF Risk: 13)	Failure to achieve intended commissioning outcomes of effective collaboration arising from conflicts of interest	8	8											→	8	19/05/15 - NCL Conflicts of Interest (COI) Policy written following NHSE statutory guidance (December 2014) for approval by Governing Body on 10 June 2015. Procurement policy to be updated following the issue of statutory guidance and approval of the COI Policy. 19/05/15 - Following the above update and the related 2014/15 BAF risk 13, recommend de-escalation from 12 at the BAF level down to 8 with monitoring via the Corporate Risk Register.
8	Data Risk ID: 69 (related 2014/15 BAF Risk: 196 (duplicate))	Inability of the CCG to report accurately and make effective decisions due to poor data quality.	9	9											→	6	19/05/15 - Following the related 2014/15 BAF risk 196, recommend de-escalation from 12 at the BAF level down to 9 with monitoring via the Corporate Risk Register.
9	Data Risk ID: 5	CSU's inability to deliver key CCG functions in line with CCG performance and SLA	8	8											→	8	

Enfield CCG Board Assurance Framework New Risk Map (NB: Now 12-25)

(See Risk Tracker for full risk description)

Likelihood	5					
	4			Risk No 2	Risk No 6	Risk No 3
	3			Risk No 8	Risk No 4 Risk No 5	Risk No 1
	2				Risk No 7 Risk No 9	
	1					
		1	2	3	4	5
		Consequence				

Appendix 3: Proposed Full BAF (Risks to the strategic / Corporate Objectives) for 2015/16

Objective 1: Deliver the milestones in the Enfield CCG Strategic Plan - Risk 1

Datix Risk ID: TBC (related 2014/2015 BAF risk: New risk)	Risk Description	Risk Caused by?	Effect of Risk	Controls: (what are we currently doing about the risk?)	Assurances	GAPS		Risk Ratings	
					Documentation	Control	Assurance	Likelihood x Severity	
	Risk to the delivery of transformational change programmes in line with programme timescales.	1.Readiness of GP Network Providers to deliver commissioned services.	1.Delayed roll out of primary care model across full patient population. 2.Impact on procurement timescales, diabetes and urgent care for October 2015 3. Lead GP Network provider will face delays in subcontracting services from other Enfield GP Network. 4. Practice disengagement	C1. Clear process and timelines for the assurance process in place and engagement with the emerging Networks throughout the process. C2. Plan B options worked through involving lead provider negotiation with local providers and/or competitive procurement C3. Review of commissioning plans C4. Monitoring and risk management through Network Development Steering Group	A1. Project documentation; Procurement Committee minutes A2. Business cases for respiratory, cardiology and diabetes. A3. Finance, Recovery & QIPP Committee. Transformation Programme Group A4. Network Steering Group Minutes	C1a. Assurance process in progress, and one Network has been assured with effect from 01/04/15. However, potential for second Network to not be fully assured or commissionable.	A1a Clear escalation of risks through Network Steering Group to ECCG risk register	Initial	4x5 = 20
		2.Capacity and resilience of primary care providers to deliver reductions and variations across localities in A&E activity, outpatient admissions, emergency admissions and primary care medicines management.	1. Challenge in reducing activity in acute setting. 2. Variations across locality in A&E activity, outpatient admissions, emergency admissions, and primary care medicines management. 3. Disengagement of primary care practices	C1-C3 Working closely with GP commissioning leads to develop locality commissioning plans. C2 Allocation to help reduce emergency admissions of the over 65's. C3 Appointment of a Demand Management post. C4. Monitoring and risk management through Locality Commissioning Steering Group and TP&FRG. C5. Monthly monitoring of practice progress by Locality Managers to Steering Group.	A1. Locality Business meetings. A2. Regular practice meetings A3. Regular practice visits A4. TP&FRG Performance Sub-Group Minutes.	C1b. All practices in each locality have signed up to deliver the Locality Commissioning Plan, but no contractual lever exists for non-engagement	A1b. Inaugural Steering Group meeting scheduled for 15/04/15.	Current	3x5 =15
								Target	2x5 =10
Date last reviewed	New risk	Actions: (What more should we do?) (State Lead and action completion date)							
Governing Body Lead	Liz Wise	Actions			Key changes since the last review (including date of update)				
Director Lead	Graham MacDougall	C1a-A1a To continue working with practices and network leads to develop commissioning assurance, to escalate risks associated with GP network provider model through the risk management function of the Transformation Programme Group. Lead: Joint Acting Assistant Director of Transformation (JM) Deadline: July 2015 C1b. Clear process of escalation to the Locality GP Lead and the Chair for practices refusing to engage. Lead: Demand Management Programme Manager. Deadline: May 2015							
Lead Committee	Executive Committee								
Rationale for current risk score									
Rationale for appetite									

Objective 1: Deliver the milestones in the Enfield CCG Strategic Plan - Risk 2

Data Risk ID: TBC (related 2014/15 BAF risk: New Risk)	Risk Description			Controls: (what are we currently doing about the risk?)	Assurances	GAPS		Risk Ratings	
		Risk Caused by?	Effect of Risk		Documentation	Control	Assurance	Likelihood x Severity	
	Risk to delivery of Co-Commissioning Model across North Central London CCGs	1. Potential conflict of interest in the commissioning of services from member practices.	1.Reputational risk to the CCGs and member practices.	C1. Establishment of a Shadow Joint Committee	A1 Minutes of the Joint Committee and Terms of Reference	C1a Clear robust and agreed framework for managing conflicts of interest.	A1a Agreed Operating Framework A2a Agreed Terms of Reference A3a Agreed Joint Committee membership	Initial	4x4 = 16
		2. Potential conflict of interest in commissioning decisions relating to outer practices.	1. Reputational risk to the CCGs and member practices. 2. Lack of trust and engagement in the commissioning model.	C1. Shadow Joint Committee governance C2. Part two confidential agenda	A1 Minutes of the Joint Committee and Terms of Reference A2 Part two minutes	C1b Clear robust and agreed framework for managing conflicts of interest.	A1 bAgreed Operating Framework A2b Agreed Terms of Reference A3b Agreed Joint Committee membership	Current	4x3 = 12
		3. Possible resource and capacity issues in delivering new commissioning model	1. Challenge in delivering co-commissioned services. 2. Pressure on resourcing other commissioned services and CCG functions. 3.Challenge to resource intensive primary care commissioning issues	C1. Core contracting staff to remain as central team for 1 year. C2 Review of resources required after 1 year. C3.Locality engagement	A1 - 2 Joint Committee A3 Locality business meeting and practice visits	C1c Financial modelling	A1c Agreed financial assumptions	Target	4x2 = 8
		4. Challenges in agreeing governance relating to the decision making arrangements of the Joint Committee	1. Delay to the implementation of co- commissioning. 2. Impact on success of shadow arrangements	C1 Development of an operating framework outlining governance arrangements C2 Mobilisation timeline in place C3 Shadow Joint Committee	A3 Shadow Joint Committee	C1d Signed off and agreed Governance arrangements	A1d Agreed Operating Framework A2d Agreed Terms of Reference A3d Agreed Joint Committee membership		
Date last reviewed	New risk	Actions: (What more should we do?) (State Lead and action completion date)							
Governing Body Lead	Liz Wise	Actions			Key changes since the last review (including date of update)				
Director Lead	Graham MacDougall	C1a,b & d A1a,b&d. Continue to engage with NHS England relating to the governance of the Joint Committee and its decision making functions until operating framework, ToR and Committee membership are agreed. Lead: Joint Acting Assistant Director of Transformation (JM). Deadline: October 2015 C1c-A1c. Work with NHS England to agreed financial support to deliver on additional CCG function of co-commissioning. Lead: Joint Acting Assistant Director of Transformation (JM). Deadline: October 2015							
Lead Committee	Executive Committee								
Rationale for current risk score									
Rationale for appetite									

Objective 2: Deliver on the requirements of the NHS Constitution - Risk 3

Datix Risk ID: TBC (related 2014/2015 BAF risk: 247)	Risk Description	Risk Caused by?	Effect of Risk	Controls: (what are we currently doing about the risk?)	Assurances	GAPS		Risk Ratings		
					Documentation	Control	Assurance	Likelihood x Severity		
	<p>Inability to hold providers to account for their performance may impact on the quality of the services we commission for Enfield residents. Specific areas of concern include:</p> <ul style="list-style-type: none"> • RTT • Demand Management • A&E Performance 	<p>1. RTT Backlog at Royal Free & Barnet Hospitals 2. Overperformance on Acute Contracts in 14/15 3. Increased demand for A & E combined with developing system response</p>	<p>1.Long waits in A&E 2.Waits for beds 3.Delayed transfers of care 4.Cancelled elective procedures 5. Lack of Capacity Nursing Home Delays in placements. 6. Lack of Neuro Rehab Capacity Delays in Transfers of Care 7. Barnet system is a net importer for intelligent Conveyancing impacting on performance.</p>	<p>System Resilience: C1. SRG & ORGs in place for both the North Middlesex System and the Royal Free and Barnet System C2. Action Plans in place developed from 'breaking the cycle weeks' monitored through SRGs C3. System response to DTOCs on a daily/weekly basis C4. Collaborative work with LA to assure Nursing Home Capacity and leverage through block bookings C5. Development of case for Neuro Rehab Capacity C6. Monitoring of key KPIs to understand performance and system to focus on root causes and minimise impact on elective capacity C7. Investment in increased capacity through resilience schemes which have been extended through April 15.</p> <p>Demand Management : C8. Increased ECGG Contract capacity to secure improved contract management C9. Demand Management Project established within the QIPP to invest in primary care and develop plans with Localities to improve demand management on 4 key areas which include Emergency Attendances. C10. RTT - Collaborative working with Barnet CCG & NHSE to secure expeditious resolution to 'backlog' and resumption of formal reporting. Programme Board in place and specific performance meeting with the Trust established focusing on RTT.</p>	<p>A1. Minutes of SRGs and ORGs A2. Contract management Reports and minutes of Contract Management Group A3. Minutes of TPG & Financial Recovery A4. Integrated performance reports A5. Minutes of performance meeting with Royal Free & Barnet with BCCG A6. Minutes of the Programme Board with Royal Free on RTT Recovery A7. CQRG Minutes</p>	<p>C1. Limited data on out of area ambulance and flows into local systems C2. Royal Free not reporting data on RTT</p>	<p>None identified</p>	<p>Initial 4x5=20</p>	<p>Current 4x5=20</p>	<p>Target (Appetite) 2x5=10</p>
Date last reviewed	New risk									
Governing Body Lead	Liz Wise	Actions:			Key changes since the last review (including date of update)					
Director Lead	Jane Pike	<p>C1. Develop System Resilience groups and continue cycle of meetings throughout year C2. Develop robust commissioning plans and agree contracts to ensure the right capacity C3. Ensure focused monitoring of contractual variances and utilise appropriate contract levers & challenges to assure performance to plan C3. Develop robust resilience schemes to assure increased capacity during 'winter period' C4. Develop robust monitoring of QIPP schemes and prioritise demand management</p>								
Lead Committee	Executive Committee									
Rationale for current risk score	National Constitution Standards									
Rationale for appetite	Significant controls in place									

Objective 3: Embed the views of patients and citizens in all of our work - Risk 4

Datix Risk ID: TBC (related 2014/2015 BAF risk: N/A)	Risk Description	Risk Caused by?	Effect of Risk	Controls: (what are we currently doing about the risk?)	Assurances	GAPS		Risk Ratings	
					Documentation	Control	Assurance	Likelihood x Severity	
	CCG fails to demonstrate positive change on behalf of patients and residents in Enfield leading to stakeholder disillusionment, poor engagement and reputational damage.	1. Limited CCG staff engagement with the patients and residents 2. Limited engagement of GP members	1. Non compliance with the Communications & Engagement strategy 2. CCG's inability to deliver its statutory duties to consult and engage	C1. TPG/PMO assurance on engagement workstreams reported to the steering groups C2. Consultation and engagement toolkit developed by Patient and Public Engagement Manager and piloted C3. Protected Learning Time in place for member practices C4. Annual workplan of engagement events in place C5. CCG engagement log used to collate all CCG engagement C6. Facilitating the PPG Network; developed section on ECCG website for PPG members; email distribution list of PPG chairs and some members C7. Developing material leaflets, CDs etc C8. Increasing opportunities for gaining views of patients and citizens by not only carrying out 3 PPE events a year, but also attending events organised by voluntary groups e.g. Over 50s Forum; Enfield Vision; Carers Centre; Edmonton Summer festival and Enfield Town Show.	A1. 360 Survey report A2. PPE & Executive Committee Minutes and Reports A3. Locality Meetings minutes A4. Documents held on website and twitter used for communications	C2. Staff & member practice engagement requires improvement	None identified	Initial	3x4=12
								Current	3x4=12
								Target (Appetite)	2x4=8
Date last reviewed	New risk	Actions: (What more should we do?) (State Lead and action completion date)							
Governing Body Lead	Terri Okoro	Actions			Key changes since the last review (including date of update)				
Director Lead	Aimee Fairbairns	C2. Share the communications and engagement toolkit developed and piloted. Circulated January 2015 with 3 March deadline for responses Lead: PPE Manager. Deadline 30/04/15			20/04/15: C2. Comments received and toolkit adapted. Awaiting confirmation that this is finalised and can be re-circulated.				
Lead Committee	PPE Committee	C2. Outcome base specification to be commissioned. Lead: Director of Strategy & Partnership. Deadline: To be agreed			C5. Engagement log circulated with deadline of 24 April; to be updated and forwarded to PPE Committee for consideration.				
Rationale for current risk score	See risk cause				C7. Development of leaflets e.g. Choose well leaflets; currently Enfield Vision reviewing CDs of Choose Well Campaign to confirm suitability for the partially sighted and or blind				
Rationale for appetite	Anticipated progress with deliverable actions				C8. Continue to participate in events organised by other organisations e.g. Schools Career Event on 22 April 2015.				

Objective 4: Deliver improvements in the quality of local health services - Risk 5

Datix Risk ID: TBC (related 2014/2015 BAF risk: 55, 236, 237, 286)	Risk Description	Risk Caused by?	Effect of Risk	Controls: (what are we currently doing about the risk?)	Assurances	GAPS		Risk Ratings	
					Documentation	Control	Assurance	Likelihood x Severity	
	Failure to ensure a safe and high quality service is commissioned from and delivered by our providers with particular reference to : 1: Quality Monitoring following RFL acquisition of BCF. 2. Underperformance of the CSU's quality assurance of provider contracts, 3, Delays in Referral to Treatment at BCF. 4. Limited Provider cost improvement plan assurance, 5. Serious and specific concerns relating to the quality and safety of the anaesthetic service at NMUH submitted by a trainee to HENCEL on 23 January 2015. 6.Risk to patient safety and poor personalised care at Murrayfield Residential Home caused by lack of qualified staff due to staff turnover	1. Changes to healthcare provision and organisational restructure (Risk to quality monitoring from the RFH acquisition of BCF)	Increased likelihood of poor quality of care, poor patient experience and delivery of poor clinical outcomes	C1. Clinical Quality Review Group established C2. Quality and Safety Committee reporting C3. Performance reporting through to the Governing Body C4. Integrated Performance Report (IPR) developed encompassing quality metrics. C5. Maintain an effective working relationship with Barnet CCG as Lead CCG. C6: Working with CSU to ensure a robust Integrated Quality Report is produced. C7. Integrated Quality & Performance Report now includes full reporting against BEH quality metrics.	A1. Quality and Safety Committee Report and minutes A2. Governing Body oversight and scrutiny A3. NHS England external clinical assurance Reports A4. CQRG Minutes	None identified	None identified	Initial	4x4 =16
2. Underperformance of CSU's quality assurance of provider contracts and CSU's leadership of Quality Assurance work and recruitment capacity.		1. Lower assurance: inability to identify poor practice/trends 2. Negative impact- reputational risks 3. Reports not delivered in a sufficiently timely manner, leading to ineffective quality assurance of contracts. 4. CCG's ability to assure itself and NHSE that contractual expectations are being met.	C1. Agreed SLA in place, considered sufficiently tightly worded. C2. Some KPIs in place. C3. NCL collaborative work on improvement plan. C4. CSU Steering Group operating with issues escalated to CSU Lead C5. CSU has monthly meetings with Quality Leads at NCL. C6. CSU Quality Improvement Plan monitored through Q&S Ctte. C7. CSU organisational changes: existing single QA team to be split to form a team for each CCG. C8. CSU reports to Q&R, Q&S.	A1. Integrated CSU Report to every Quality & Safety Committee. A2. Internal Audit Clinical Governance Review Report of services commissioned from the CSU. A3. CSU Improvement Plan monitored at NCL wide improvement group	C1. Improved Client/Customer relationship. C2. Limited KPIs within SLA.	None identified			
3. Delays in treatment (RTT) at BCF, leading to reduced pt experience, and potential for clinical harm.		Provider non-compliance with Constitution will lead to weak performance ratings, and reputational damage which will transfer to CCG. 2. Potential increase in patient complaints. Potentially negative financial implications . 3. Impact on patient experience and quality and poor clinical effectiveness	C1. Pt experience reporting to CQRG and Q&R, Q&S as Integrated Quality Performance Reports ("IPQR") C2. Regular review at the External Clinical Harm Steering Group C3. The CCG has part-funded with Barnet CCG a programme manager who will provide reports as basis for assurance.	A1. CQRG minutes. A2. Governing Body minutes. A3. Routine NHSE Assurance Visits Reports A4. NHSE Clinical Harm Steering Group Minutes	C1. Improving pt experience remains a priority for the Trust. C1. Discussions continue with the CSU to improve content, detail and timeliness of IQPR. C3. Delays to established reporting since acquisition .	A1&2. Degree of uncertainty over extent and strength of new providers (Royal Free) assurances while new governance arrangements at BCF bed in following acquisition.	Current	3x4 =12	
4. Limited provider Cost Improvement Plan(CIP) assurance		1. Compromise/poor delivery of patient care and impact on the quality and safety of patient care 2. Adverse/negative publicity	C1. Regular Monitoring at the CQRG C2: Regular Monitoring the Quality & Safety Committee	A1. Report to CQRG January 2015 A2. Report to Quality & Safety Committee	C1. Recent staff proposal document does not demonstrate the Trust has undertaken a Quality Impact Assessment	None identified			

		<p>5. Serious and specific concerns relating to the quality and safety of the anaesthetic service at NMUH submitted by a trainee to HENCEL on 23 January 2015.</p>	<p>1. Trust will be unable to provide a high quality safe anaesthetic service and fail to deliver sustained performance against key requirements.</p> <p>2. The increased dependence on locum anaesthetists (in the absence of trainees) and a failure to deliver the changes needed will impact on the Trust's ability to deliver responsive high quality service to departments dependent on the anaesthetic service.</p>	<p>C1. CCG Director of Quality membership of the Trust Comprehensive Review Panel overseeing investigation into the specific concerns raised by the trainee.</p> <p>C2. Haringey CCG (HCCG) as Lead Commissioner is assured that the Trust CEO and Medical Director have acted on the advice of the TDA to ensure the necessary clinical leadership is in place to ensure essential anaesthetic rotas are covered, immediate quality issues are addressed and the programme of transformation for this department is progressed at pace.</p> <p>C3. HCCG Chair and the Executive Nurse and Director of Quality and Integrated Governance (on behalf of the Chief Officer) are members of the intelligence and planning meetings with the Trust. The purpose of these meetings is to receive assurance that the current risks to service provision have been identified and appropriate plans are in place to mitigate these risks.</p> <p>C4. HCCG Chair and Executive Nurse and Director of Quality and Integrated Governance attended the Risk Summit convened on 17.3.15 by the Medical Director</p>	<p>1a - Minutes of the panel and internal briefing sent by the Executive Nurse and Director of Quality and Integrated Governance to HCCG Chair, Chief Officer and CQRG Clinical lead.</p> <p>1b. Minutes of the intelligence meeting convened by HENCEL on 2.2.15 and the planning meetings chaired by NHSE Medical Director on 18.2.15 and 26.2.15.</p> <p>2. Minutes of the Risk Summit</p> <p>3. Contingency plan and dashboard received and approved (subject to adding metric to monitor staff feedback) at Risk Summit on 17.3.15.</p> <p>4. Notes of the CCG Directors Meeting</p>	None identified	A1. Assurance yet to be received	Target (Appetite)	2x4=8
		<p>6. Risk to patient safety and poor personalised care at Murrayfield Residential Home caused by lack of qualified staff due to staff turnover. Lack of qualified staff due to staff turnover</p>	<p>1. Compromise of quality and safety and patient care</p>	<p>C1. Regular provider concerns meetings attended by Assistant Director of Safeguarding</p> <p>C2. Assistant Director of Safeguarding audits homes</p> <p>C3. Provider improvement plan in place. C4. Local Authority & CCG monitoring on a regular basis</p>	<p>A1. Regular provider concerns minutes</p>	<p>C1. Ongoing challenges with retaining staff in nursing homes in general</p>	No gaps identified		
Governing Body Lead	Angela Dempsey	Actions			Key changes since the last review (including date of update)				
Director Lead	Aimee Fairbairns	<p>1: C1 & A1: Work with the CSU to ensure site specific reporting to enable sufficient assurance to the Governing Body. Lead: Head of Clinical Quality. Deadline: 30/04/15. Completed and business as usual.</p> <p>2: C1 & C2. Director of Operations attends CSU SLA Monitoring Group which will also review KPIs and other monitoring metrics. Lead: Director of Operations. Deadline: Ongoing.</p> <p>3: C1: CCG monitoring Trust Pt Experience reports on regular basis via CQRG. Lead: Karan Keane. Deadline: As workplan</p> <p>C1: CSU Improvement Plan reported to Q&R, Q&S. Lead: Aimee Fairbairns. Deadline: 31st December 2014. Work ongoing</p> <p>A1&2: Providers Transitional Risk Register regularly monitored at CQRG. Lead: Aimee Fairbairns. Deadline: Ongoing</p> <p>Work ongoing</p> <p>C3. Monitoring through Royal Free Programme Board via BCF. Lead: Karen Keane. Deadline: Ongoing.</p> <p>C3. Collaborative commissioning and contract management within NCL CCGs to strengthen reports. Lead: Head of Quality. Deadline: Ongoing</p> <p>4: C1 & A1: CQRG to request QIA on staff consultation & proposal for management restructure. Lead: Head of Clinical Quality. Deadline: Completed</p> <p>+D132 C1&.A1: Director of Quality & Safety to raise with Trust Executive Director of Nursing and lead for Quality. Lead: Director of Quality & Governance. Deadline: 31/11/14. Completed</p>			<p>19/05/15 - Current risk rating downgraded from 16 to 12 given significant progress made in the following key areas:</p> <p>1. Risk to quality monitoring from the RFH acquisition of BCF: RFL CQRG established. Barnet CCG is the lead Commissioner for RFL and Enfield CCG is represented at the RFL CQRG. Business as usual. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register</p> <p>2. CSU: SLA amendments were suggested during 2015/2016 contract negotiations. These are being monitored via the Director of Operations and NCL CSU Improvement Group. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register</p> <p>3. RTT: Regular monitoring continues via the CQRG</p> <p>4. Provider CIP assurance: Regular monitoring via the CQRG & Quality & Safety Committee. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register</p> <p>5. NMUH Anaesthetic: Weekly risk teleconference has been stood down as there is a measure of assurance in the system. Monitoring and oversight continues via the NMUH CQRG. Recommend de-escalation from BAF view and monitoring via the Corporate Risk Register.</p> <p>6. Murrayfields. The recruitment process has commenced and will be monitored via the Provider concerns</p>				
Lead Committee	Quality & Safety Committee								
Rationale for current risk score									
Rationale for appetite									

Objective 5: Deliver effective safeguarding arrangements - There are no BAF level risks against this objective

Objective 6 : Deliver financial sustainability - Risk 6

Datix Risk ID: TBC (related 2014/2015 BAF risk: 15, 307, 188, 198, 149, 150, 294)	Risk Description			Controls: (what are we currently doing about the risk?)	Assurances	GAPS		Risk Ratings	
		Risk Caused by?	Effect of Risk		Documentation	Control	Assurance	Likelihood x Severity	
	<p>Failure to maintain long-term financial sustainability through potential inability to deliver on key financial imperatives including:</p> <ul style="list-style-type: none"> • QIPP • Payment by Results costs in line with contracts/SLAs • Maintenance of sound financially sustainable partners within the health economy • Outcomes from the Better Care Fund • having realistic assumptions and achievable plans 	<p>1. Unavoidable Cost Pressures for commissioners and providers</p> <p>2. Under delivery of QIPP</p> <p>3. Activity and population growth exceeding funding levels.</p> <p>4. Staffing shortages & recruitment difficulties</p>	<p>1. Reputational damage</p> <p>2. Unable to invest as desired to improve patient care</p> <p>3. Damage to the CCG financial position and subsequent failure to achieve "balanced success"</p>	<p>C1. Scheme of Delegation to control expenditure</p> <p>C2. Improved contracting function to negotiate improved contracts with major providers</p> <p>C3. Appointment of a Delivery Director</p> <p>C4. Working with Deloitte to enhance QIPP and develop a robust recovery plan</p> <p>C5. Development of the NCL Transformation programme with colleague CCGs and Carnall / Farrar</p> <p>C6. Use of TPG to recommend investments and monitor QIPP progress.</p> <p>C7. Audit Chair now Finance Lay member of Finance committee</p> <p>C8. Implementing recommendations from the financial governance review including timing of key committees.</p>	<p>A1. Minutes of relevant meetings.</p> <p>A2. Revised finance Board Report</p> <p>A3. Contract Monitoring Report</p> <p>A4. External Audit Reports</p> <p>A5. Internal Audit Reports</p> <p>A6. Business Cases in agreed format with minuted outcomes</p> <p>A7. Signed contracts with providers</p> <p>A8. Detailed Operating Plan signed off by Governing Body (25/2/15)</p>	<p>C1. Activity data is a month behind current month financial reporting</p> <p>C2. Unmet demand causes use of PbR contracts even if QIPP schemes have delivered successfully.</p>	<p>A1. Further improvement to content of Board Report required</p> <p>A2. Provider RTT information is incomplete and not reported</p>	<p>Initial</p>	<p>5x4=20</p>
								<p>Current</p>	<p>4x4=16</p>
								<p>Target (Appetite)</p>	<p>3x4=12</p>
Date last reviewed	New risk	Actions: (What more should we do?) (State Lead and action completion date)							
Governing Body Lead	Liz Wise	Actions			Key changes since the last review (including date of update)				
Director Lead	Rob Whiteford, Graham MacDougall	C1, C2, A1 & A2: Level of unidentified QIPP represents significant risk to CCG position in 2015/16 . Work with lead commissioner (Barnet CCG) to ensure 3 speciality areas included in contract for 2015/16. Lead: Joint Acting Assistant Director of Transformation (CW) Deadline 31/03/15.							
Lead Committee	Executive Committee	Financial Recovery Plan Drafted and Financial Recovery Group (FRG) established ON-GOING Year End offers to Acute Providers. Lead: Chief Finance Officer.							
Rationale for current risk score									
Rationale for appetite									

Objective 7: Develop our organisation and ensure effective collaboration with our partners - Risk 7

Datix Risk ID: TBC (related 2014/15 BAF Risk: 13)	Risk Description			Controls: (what are we currently doing about the risk?)	Assurances		GAPS		Risk Ratings	
		Risk Caused by?	Effect of Risk		Documentation	Control	Assurance	Likelihood x Severity		
	Failure to achieve intended commissioning outcomes of effective collaboration arising from conflicts of interest	1. Potential conflicts of interest in commissioning decisions arising from Clinical commissioners being both providers and commissioners of services	1. Potential for legal challenge to Commissioning decisions 2. Reputational damage 3. Potential conflicts of interest in commissioning decisions 4. Potential negative impact on patient care 5. Negative impact on decision making which could impact overall direction of organisation	C1. Conflicts of Interest Policy in place C2. OD and training available to all ECCG staff. C3. Declarations of Interests is a standing agenda item on all Governing Body and Sub Committee agendas. C4. Dialogue developed with interested members of the public and community representatives. C5. Governing body business has been managed to exclude those declaring a relevant interest from discussion and involvement in decision making. C6: Register of interests extended to non governing body GPs involved in commissioning decisions and service redesign. C7. Reminder of the conflicts on interest policy and gifts and hospitality policy sent to all staff on 13/06/14. C8. Procurement Policy covering conflicts of interest approved by the Governing Body. C9.A1. Publish enhanced and updated conflict interest registers. Individual updates incorporated in register as advised by members.	A1. Approved Conflict of Interest Policy on the internet A2. Refreshed Register of Interests published for the 28 Jan 2015 public governing body meeting A3. Evidence of OD on Conflicts of Interest A4. Internal Audit Review Report on Governance & Conflict was considered by Audit Committee Six month review by Board Secretary. A7. Regular review by CCG internal auditor	C1: Review current CCG Conflicts of Interest and Procurement Policy in light of recent NHSE statutory Conflicts of Interest Guidance	A1: On-going process to enhance level of detail and transparency of Register of Interests	Initial	3x4=12	
								Current	2x4=8	
								Target (Appetite)	2x4=8	
Date last reviewed	New risk merged with existing risk	Actions: (What more should we do?) (State Lead and action completion date)								
Governing Body Lead	Liz Wise	Actions			Key changes since the last review (including date of update)					
Director Lead	Aimee Fairbairns	C1: Conflicts of Interest Action Plan updated following NHSE statutory guidance and adoption of COI Policy. Lead: Board Secretary. Deadline: 31 September 2015.			19/05/15 - NCL Conflicts of Interest (COI) Policy written following NHSE statutory guidance (December 2014) for approval by Governing Body on 10 June 2015. Procurement policy to be updated following the issue of statutory guidance and approval of the COI Policy.					
Lead Committee	Executive Committee	A1. Review development of Networks and managing of conflicts of interest. Lead: Board Secretary. Deadline 31 September 2015 .			19/05/15 - Following the above update and the related 2014/15 BAF risk 13, recommend de-escalation from 12 at the BAF level down to 8 with monitoring via the Corporate Risk Register.					
Rationale for current risk score										
Rationale for appetite										

Objective 7: Develop our organisation and ensure effective collaboration with our partners - Risk 8

Datix Risk ID: 69 (related 2014/15 BAF Risk: 196) (duplicate)	Risk Description	Risk Caused by?	Effect of Risk	Controls: (what are we currently doing about the risk?)	Assurances	GAPS		Risk Ratings	
					Documentation	Control	Assurance	Likelihood x Severity	
	Inability of the CCG to report accurately and make effective decisions due to poor data quality.	Delayed and/or incomplete RTT information from Royal Free/BCF.	Unable to plan how much activity we are required to purchase	Contract Requirements for data provision, RTT reporting mechanism through NHSE	A1. Regular reporting of activity performance under PBR, work undertaken by RFL to validate RTT position	None identified	A1. Provider unable to formally report as yet	Initial	4x3=12
								Current	3x3=9
								Target (Appetite)	2x3=6
Date last reviewed	26/02/2015	Actions: (What more should we do?) (State Lead and action completion date)							
Governing Body Lead	Liz Wise	Actions			Key changes since the last review (including date of update)				
Director Lead	Rob Whiteford	A1. Close working with CSU and Trusts in ensuring better quality and timely data to the Governing Body. Lead. Head of Performance. Deadline Ongoing.			19/05/15 - Following the related 2014/15 BAF risk 196, recommend de-escalation from 12 at the BAF level down to 9 with monitoring via the Corporate Risk Register.				
Lead Committee	Executive Committee								
Rationale for current risk score									
Rationale for appetite									

Objective 7: Develop our organisation and ensure effective collaboration with our partners - Risk 9

Datix Risk ID: 5	Risk Description	Risk Caused by?		Controls: (what are we currently doing about the risk?)	Assurances		GAPS		Risk Ratings	
			Effect of Risk		Documentation	Control	Assurance	Likelihood x Severity		
	CSU's inability to deliver key CCG functions in line with CCG performance and SLA	Capacity and capability within the CSU	1. Gaps in additional service areas 2. Failure of CCG to deliver or meet its statutory responsibilities 3. Damage to the organisation's reputation 4. Potentially negative impact suffered by staff and patients	C1. Agreed SLA between CCG and CSU for core and additional services. C2. GB agreed updated SLA with KPIs between CCG and CSU for core and additional services 22 January 2013. C3. Monthly SLA meetings with the CSU in place. C4. NCL collaborative work on a recovery improvement plan ongoing C5. CCG and CSU collaboratively working through issues identified in new commissioning requirements. C6. CSU have changed structure to ensure alignment to CCG corporate teams and appointment of POD Director C7. Issues Log jointly maintained and reviewed for resolution/escalation actions. C8. Clear service specifications and amendments to services to be agreed by 31/12/2014. C9. Internal Audit Review of CSU Services C10. SLA in order with KPIs in place	A1. Minutes of NCL CSU Improvement Group A2. Executive Committee minutes A3. KPI & Improvement Plan reports	None identified	None identified	Initial	3x4=12	
								Current	2x4=8	
								Target (Appetite)	2x4=8	
Date last reviewed	New risk	Actions: (What more should we do?) (State Lead and action completion date)								
Governing Body Lead	Liz Wise	Actions			Key changes since the last review (including date of update)					
Director Lead	Jane Pike	C1. Contributing to the development of an interim CSU SLA improvement plan, covering the period April to Sept 15. This will address operating/process improvements needed across the CSU and five CCGs. Lead: HCS. Deadline 01/04/15 C2. Contributing to the production of a single joint SLA covering NCL CCGs -restructured from the current ECCG SLA and introducing a new set of measurable KPIs and risk share, incentives. Lead: Director of Operations. Deadline: 31/03/2015. C2-C3 : Letter from CSU 08/08/14 setting out proposed core/bespoke and decommissioned services, plus a schedule of prices for 14/15 to be reviewed and agreed. Formal response to CSU required. Lead: HCS Deadline revised from 31/12/14 to 31/04/15								
Lead Committee	Executive Committee									
Rationale for current risk score										
Rationale for appetite										

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 June 2015
TITLE:	2014/15 Annual Report and Accounts
LEAD BOARD MEMBER:	Karen Trew, Audit Committee Chair
AUTHOR:	David Triggs Board Secretary
CONTACT DETAILS:	David.triggs@enfieldccg.nhs.uk

SUMMARY:

The purpose of this paper is to present the **2014/15 Annual Report and Accounts** as approved by the Audit Committee at its meeting on 27 May 2015. These were uploaded onto the CCG web site and submitted to NHSE by the deadline of noon on 29 May 2015. The Governing Body is asked to review the Annual Report and Accounts and approve the declaration set out below.

Copies of the Annual Report and Accounts are on the CCG web site:

<http://www.enfieldccg.nhs.uk/about-us/annual-report-and-accounts-2014-15.htm>

Hard copies will be available on request.

As part of its consideration of the 2014/15 Draft Annual Report and Accounts the following documents were discussed:

- Review of Going Concern Assumption from Chief Finance Officer
- Financial Statements Letter from Audit Committee Chair to Grant Thornton
- Audit Findings Report
- Head of Internal Audit Opinion
- Annual Governance Statement (part of the Annual Report)

Audit Opinion: The Audit Committee asks that the Governing Body notes the following:

- (a) The External Auditors (Grant Thornton) have issued an unqualified audit opinion in relation to the CCG's financial statements;
- (b) The External Auditors have issued a qualified opinion on whether the CCG has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources (the Value for Money Conclusion) – this relates to the deficit of £18.9m for 2014/15 and the CCG's planned deficit of £14.4m for 2015/16 and therefore breaching its statutory duty under the NHS Act 2006, amended by the Health and Social Care Act 2012 to break even on its commissioning budget;
- (c) The External Auditors issued a report to the Secretary of State under Section 19 of the Audit Commission Act 1998 on 21 May 2015. This relates to the deficit of £18.9m for the year and the fact that the failed to comply with its statutory duty to break even;
- (d) The External Auditors referred to the CCG's financial governance review conducted by Deloitte which identified weaknesses with the CCG arrangements for financial planning, financial control and financial governance. It notes the positive response to the recommendations with many actions already completed and all recommendations due for completion by 30 September 2015.

SUPPORTING PAPERS:

- There are no supporting papers

RECOMMENDED ACTION:

The Governing Body is recommended to:

- (a) Endorse the Annual Report and Accounts for 2014/15 as approved by the Audit Committee at its meeting on 27 May 2015

- (b) Approve the following declaration:

“The Governing Body is not aware of any relevant audit information that has been withheld from the CCG’s external auditors, and members of the Governing Body take all necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.”

Objective(s) / Plans supported by this paper: The Audit Committee Annual Report applies to all Enfield CCG objectives

Patient and Public Engagement (PPE): Audit Committee membership includes lay members. The PPE Committee also reports annually to the Audit Committee on its performance

Equality Impact Analysis: This is conducted in line with agenda items.

Risks: As outlined in the CCG’s assurance framework and risk register

Resource Implications: None identified

Audit Trail: None

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 June 2015
TITLE:	NCL Conflicts of Interest Policy, Enfield CCG Gifts, Hospitality and Sponsorship Policy and revised ECCG Procurement Policy
LEAD BOARD MEMBER:	Aimee Fairbairns, Director of Quality and Integrated Governance
AUTHOR:	Bridget Pratt, Assistant Director Quality Governance and Risk David Triggs, Board Secretary
CONTACT DETAILS:	Bridget.pratt@enfieldccg.nhs.uk David.triggs@enfieldccg.nhs.uk

SUMMARY:

The **purpose of this report** is to invite the Governing Body to consider recommendations from

- (a) The Audit Committee (meeting on 27 May 2015) to approve the NCL Conflicts of Interest (Col) Policy and the Gifts, Hospitality and Sponsorship Policy;
- (b) The Procurement Committee (meeting on 3 June 2015) to approve the revised Procurement Policy.

Background: Members of the Governing Body will be aware that on 18 December 2014 NHSE issued statutory Guidance for CCGs on the subject of ‘Managing Conflicts of Interest’.

The introduction within the NHSE Statutory Guidance refers to the fact that this is issued:

- (a) in recognition of the fact that effective handling of conflicts of interest is crucial for the maintenance of public trust in the commissioning system; and
- (b) in recognition that with CCGs being given the opportunity to take on increased responsibility for the commissioning of primary care through co-commissioning this is seen to expose CCGs to a greater risk of conflicts of interest.

Enfield CCG submitted initial proposals for the co-commissioning of primary care services as part of a wider NCL proposal on 29 January 2015 and these were subsequently endorsed by the Enfield Governing Body at its meeting on 18 March 2015. Alongside these proposals NCL CCGs are now required to submit a Conflicts of Interest Policy. The deadline for this submission is 24 June 2015 as part of proposals for NCL CCGs to move to the next stage i.e. launching co-commissioning with effect from October 2015.

It was subsequently agreed that rather than each CCG write its own Col policy (i.e. five different Col policies) NCL CCGs should engaged Baker Tilly to draft an NCL policy.

This draft **NCL Conflicts of Interest Policy** has been reviewed by the Audit Committee. The proposed document addresses those areas raised in the NHSE Statutory Guidance, it has been localised to apply to Enfield CCG and meet with the ECCG Constitution. The proposed Col Policy is available on the CCG web site and hard copies are available on request.

As the proposed Policy is part of a joint NCL submission to go to NHSE by 24 June it may be necessary to seek minor changes before the deadline of 24 June. The Governing Body is asked to authorise the Chair to authorise such minor changes prior to the submission date.

The **Gifts, Hospitality, Sponsorship and Declarations of Interest** (GHS&DoI) Policy was reviewed and approved by the Governing Body in July 2015. It has been reviewed in the light of the proposed NCL Col Policy. At its last meeting the Audit Committee endorsed the proposal to remove reference to Declarations of Interest as this exists in the Col Policy. The other main change is to remove the £10 threshold for Gifts in favour of a common £25 threshold for both Gifts and Hospitality. The proposed Col Policy is available on the CCG web site and hard copies are available on request.

The NHSE Statutory Guidance makes many references and proposals linked to procurement and it is for this reason that the Procurement Committee has been asked to review the **Procurement Policy**. In addition to the Statutory Guidance there have been changes to EU Regulations around procurement. It is for these reasons that the Governing Body is asked to approve the revised Policy but note that it is intended to review the Policy again before the end of the year ahead of new EU Regulations being implemented. The proposed Procurement Policy is available on the CCG web site and hard copies are available on request.

SUPPORTING PAPERS:

- Managing Conflicts of Interest: Statutory Guidance for CCGs – (NHSE dated 18 December 2014
<http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf>
- NCL Conflicts of Interest Policy (see Enfield CCG Web Site)
- Gifts, Hospitality, Sponsorship and Declarations of Interest Policy (see Enfield CCG Web Site)
- Draft Procurement Policy (see Enfield CCG Web Site)

RECOMMENDED ACTION:

The Governing Body is Recommended to:

- i. Approve the NCL Conflicts of Interest Policy as localised for Enfield CCG;
- ii. Authorise the Chair of the CCG to make any minor changes to the Policy ahead of submission to NHSE on 24 June 2015;
- iii. Approve the revised Enfield CCG Gifts, Hospitality and Sponsorship Policy;
- iv. Approve the revised Procurement Policy.

Objective(s) / Plans supported by this paper: The NCL proposals for Co-Commissioning.

Patient and Public Engagement (PPE): this will be an integral part of Co-Commissioning.

Equality Impact Analysis: This will be part of the Col Policy.

Risks: As outlined in the CCG's assurance framework and risk register

Resource Implications: No significant implications. However, this assumes that CSU will provide support for the joint committee and that the reference to members is deleted on the top left box of appendix 5.

Audit Trail: Indicated on the policy coversheet for each document.

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 June 2015
TITLE:	PREVENT Strategy
LEAD BOARD MEMBER:	Aimee Fairbairns, Director of Quality and Integrated Governance
AUTHOR:	Carole Bruce-Gordon, Assistant Director for Safeguarding
CONTACT DETAILS:	Carole.bruce-gordon@enfieldccg.nhs.uk

SUMMARY:

NHS Enfield Clinical Commissioning Group PREVENT strategy document.

PREVENT is part of the Government's counter-terrorism strategy CONTEST, that requires strong support from the health sector. The CONTEST strategy was created to protect the UK from international terrorism and is led by the Office for Security and Counter Terrorism at the Home Office. There are four strands to the strategy:

- PREVENT - to stop people becoming terrorists or supporting terrorism
- Protect - strengthening our borders, infrastructure and public spaces from attacks
- Prepare - where we cannot stop an attack, to reduce its impact by responding effectively
- Pursue - to disrupt or stop terrorist attacks

The aim of the **PREVENT** strategy is to focus on working with individuals and communities who may be vulnerable to the threat of violent extremism and terrorism. The overall principle of **PREVENT is to safeguard vulnerable individuals.**

The key challenge for the healthcare sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the healthcare worker can interpret those signs correctly, is aware of the support which is available and is confident in referring the person for further support.

Preventing someone from becoming a terrorist or supporting terrorism is substantially comparable to safeguarding in other areas, including child abuse or domestic violence.

There is a clear need to support the counter-terrorism strategy due to recent high profile cases associated with the NHS, as well as the vulnerability of the people we come in to contact with. PREVENT is also part of the NHS Contract which states that all staff in the NHS should be trained appropriately.

It is important NHS Enfield Clinical Commissioning Group fulfils its obligations in helping minimise risks by identifying and supporting staff, vulnerable adults and children who may be susceptible to exploitation or influence from violent extremism by following the **PREVENT** objectives.

Enfield Clinical Commissioning Group are working to deliver PREVENT, to support 'Member Practices' through Protected Learning Time (PLT).

SUPPORTING PAPERS:

NHS Enfield CCG PREVENT strategy.

RECOMMENDED ACTION:

- | |
|---|
| <ol style="list-style-type: none">1) The Governing Body approve the report and the PREVENT Strategy2) The Governing Body endorse the proposal that the PREVENT strategy should be adopted by all NHS Enfield CCG staff |
|---|

Objective(s) / Plans supported by this paper:

This paper is supported by the CCG Commissioning Strategic Plan to ensure quality services and improve patient safety

Patient & Public Involvement (PPI): There is PPI involvement via the various quality domains

Equality Impact Analysis: Impact to be determined

Risks: All quality risks are reflected on the CCG Corporate Risk Register

Resource Implications: None identified at present

Audit Trail: 1st paper

PREVENT STRATEGY

(Enfield CCG Operational Policy)

1	SUMMARY	The purposes of this document is to encourage a consistent and proportionate approach to raising awareness of PREVENT as part of the wider safeguarding agencies. This guidance describes how NHS Enfield CCG will implement the PREVENT agenda.			
2	RESPONSIBLE PERSON:	Assistant Director of Safeguarding			
3	ACCOUNTABLE DIRECTOR:	Director of Service Quality and Integrated Governance			
4	APPLIES TO:	All staff employed within ECCG			
5	GROUPS/ INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS POLICY:	Amelia Howard, NHS England PREVENT Lead Aimee Fairbairns – Director of Quality and Integrated Governance. Quality & Risk Sub Group			
6	GROUPS WHICH WERE CONSULTED AND HAVE GIVEN APPROVAL:	Directors Meeting Executive Committee Governing Body Workshop			
7	EQUALITY IMPACT ANALYSIS COMPLETED:	Policy Screened	Yes	Template completed	Yes
8	RATIFYING COMMITTEE(S) & DATE OF FINAL APPROVAL:	Governing Body			
9	VERSION:	1.1			
10	AVAILABLE ON:	Intranet	X	Website	X
11	RELATED DOCUMENTS:	Safeguarding Children & Adults Policies			
12	DISSEMINATED TO:	All staff in ECCG			
13	DATE OF IMPLEMENTATION:	June 2015			
14	DATE OF NEXT FORMAL REVIEW:	April 2017			

Document Control

Date	Version	Action	Author
April 2015	1	Drafted	Carole Bruce-Gordon, Assistant Director for Safeguarding
April 2015	1.1	Quality Assured	Amelia Howard, NHS England PREVENT Lead

PREVENT STRATEGY
(Enfield CCG Operational
Policy)

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1. Introduction

The Government's PREVENT strategy focuses on stopping people becoming terrorists or supporting terrorism. It is part of the Government's counter terrorism strategy CONTEST, which is led by the Home Office. As PREVENT is about recognising when vulnerable individuals are being exploited for terrorist-related activities, the guidance is about PREVENT being integrated into our safeguarding structures. PREVENT addresses all forms of terrorism but prioritises these according to the threat they pose to our national security. PREVENT is delivered in partnership by a wide range of organisations including the police service. Together we recognise that the best long term solution to preventing terrorism is to stop people becoming terrorists in the first place.

CONTEST, which is primarily organised around four key principles/programmes, each with a specific objective:

- **PURSUE** To stop terrorist attacks.
- **PREVENT** To stop people becoming terrorists or supporting terrorism.
- **PROTECT** To strengthen our protection against a terrorist attack.
- **PREPARE** To mitigate the impact of a terrorist attack.

NHS Health Care Organisation is a key partner in the PREVENT principle of this strategy, in line with all part of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients. It refers to anyone (staff, patients or visitors).

PREVENT has 3 national objectives:

- Objective 1: respond to the ideological challenge of terrorism and the threat we face from those who promote it.
- Objective 2: prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support. Channel is a key part of the Governments work to prevent terrorism and is a multi-agency approach to identifying and supporting vulnerable individuals.
- Objective 3: work with sectors and institutions where there are risks of radicalisation which we need to address.

Enfield Clinical Commission Group focuses primarily on all 3 objectives.

Terrorism is a very real threat to all our communities and terrorist seeks to exploit those who are most vulnerable. That is why it is vital that we all work together to support those who are at risk of being drawn into terrorism as a consequence of radicalisation – regardless of faith, ethnicity or background.

Enfield is one of 30 local authorities identified as being at higher risk for radicalisation (Ofsted 2015).

2. Purpose of the policy

The purposes of this document is to encourage a consistent and proportionate approach to raising awareness of PREVENT as part of the wider safeguarding agencies.

This guidance describes how NHS Enfield CCG will implement the PREVENT agenda.

The PREVENT agenda will ensure that:

- NHS Enfield CCG staff have adequate training and know how to safeguard and support vulnerable individuals, whether service users or staff, who they feel may be at risk of being radicalised by extremists.
- Appropriate systems are in place for staff to raise concerns if they think this form of exploitation is taking place.
- NHS Enfield CCG promotes and operates safe environments where extremists are unable to operate.

3. How does PREVENT affect you in your work?

The Government is committed to the prevention of radicalisation where there is a risk of drawing people into terrorism, as an integral part of the counter-terrorism strategy. The PREVENT strategy addresses all forms of terrorism and focuses work to prevent radicalisation on three key objectives:

- a. Respond to the ideological challenge of terrorism and the threat we face from those who promote it;
- b. Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support; and
- c. Work with sections and institutions where there are risks of radicalisation we need to address.

PREVENT is a national programme that is prioritised at a local level according to the risks we face. **Section 26 of the 2015 Counter Terrorism and Security Act places a duty** on certain bodies to have 'due regard to the need to prevent people from being drawn into terrorism'. **Any community** can be affected by the threat from terrorism but the nature and extent of the threat will vary across the country; local responses need to be appropriate and proportionate to local circumstances.

The principles of the PREVENT strategy apply equally to all communities who may be the focus of attention from terrorist and radicalisers. This includes those at risk from groups supporting international terrorism, far right extremist ideologies and other forms of terrorism.

4. Safeguarding

Safeguarding and promoting the welfare of vulnerable children and adults is the responsibility of all members of NHS Enfield CCG. It is a key requirement for NHS Enfield CCG as well as the voluntary sector, parents and carers and the wider community to ensure that vulnerable children, young people and adults are protected from harm.

Local authorities have a lead role in coordinating work to safeguard adults. Under the Care Act 2015, local authorities have established Adult Safeguarding Boards in their areas. These boards provide strategic

leadership to the work of the local authority, and partner agencies, on the development of policy and practice in relation to safeguarding adults at risk.

All local authorities also have Local Safeguarding Children Boards with an equivalent strategic leadership role in relation to partners involved in safeguarding children locally. The Working Together to Safeguard Children (2015) guidance, and guidance on safeguarding adults, is relevant in England in this context.

PREVENT referrals should be considered by the local authority and other partners as part of their work to safeguard vulnerable individuals.

Safeguarding vulnerable people who may be at risk of being drawn into terrorism is an essential part of the PREVENT strategy. Terrorism is a real and serious threat to us all because terrorists actively seek to harm us, to damage community relations and to undermine the values we share. Throughout the country there is now a duty on certain bodies to “have due regard in the exercise of its functions, to the need to prevent people from being drawn into terrorism”.

5. What might make you concerned that an individual maybe becoming/is radicalised?

- Reports of unusual behaviour, friendships or actions and request for assistance
- Reports could come from family, parents or colleagues
- Patients or staff accessing extremist material online
- Use of extremist or hate terms to exclude others or incite violence
- Artwork or literature promoting violent extremist messages or images

You will need to use your own judgement in determining the significance of changes in their behaviour.

6. Contact with radicalisers

It is generally more common for vulnerable individuals to become involved in terrorist-related activity through the influence of others. Initial contact may be via peers, siblings, other family members or acquaintances, with the process of radicalisation often being a social one. Such social interaction takes place in a range of unsupervised environments such as gyms or cafes, in private homes and via the internet. Staff need to be mindful of booking meeting rooms/public areas/seminar rooms etc which may be used for terrorist activities.

Access to extremist material is often through leaflets and local contact. However, the internet plays an important role in the communication of extremist views. It provides a platform for extremists to promote their cause and encourage debate through websites, internet forums and social networking and is a swift and effective mechanism for disseminating propaganda material. Healthcare organisations should be aware of anyone making frequent visits to websites showing images such as armed conflict around the world and providing speeches and access to material from those involved in the radicalising process and be aware of any inappropriate canvassing/leafleting.

7. Use of extremist rationale (often referred to as 'narrative')

Radicalisers usually attract people to their cause through a persuasive rationale contained within a storyline or narrative that has the potential to influence views. Inspiring new recruits, embedding the beliefs of those with established extreme views and/or persuading others of the legitimacy of their cause is the primary objective of those who seek to radicalise vulnerable individuals.

8. Process of exploitation

It is suggested that there is no single profile or indication of a person who is likely to become involved in terrorist-related activity. To date, there is no universally accepted view of why vulnerable individuals become involved.

The factors surrounding exploitation are many and they are unique to each person. The increasing body of information indicates that factors thought to relate to personal experiences of vulnerable individuals affect the way in which they relate to their external environment. In this sense, vulnerable individuals may be exploited in many ways by radicalisers, who target individuals for their vulnerability. Contact with radicalisers is also variable and can take a direct form, i.e. face to face, or can happen indirectly through the internet, social networking or other media. More commonly this will occur through a combination of the above.

9. Requests for information about an individual raised by another organisation

Generally requests for information **should be in writing**, justifying the grounds for disclosure. Concerns relating to Preventing individuals from becoming drawn into terrorism sharing information may become routine. The seriousness of the crime and the risk of harm to the individual may outweigh the need to maintain confidentiality.

Note that the **Crime and Disorder Act 1998** does not in itself constitute a statutory requirement for NHS organisations to disclose patient information to other agencies. This should be determined on a case by case basis with the informed PREVENT Lead for each organisation.

If a NHS PREVENT Lead is asked to share information for the purposes of preventing an individual from being drawn into terrorism the following question should be considered:

- By sharing the information, is the intention to protect the individual from criminal exploitation, grooming (being drawn into terrorism) or self-harm?
- In sharing information, is a serious crime being prevented or detected?
- Is the information that has been requested appropriate to the risk of the serious crime of exploitation to the individual who may be drawn into supporting terrorism?
- In being drawn into terrorism does this individual pose harm to themselves or the wider public?

- Can the public interest justification be clearly stated?

(If in doubt, seek legal advice)

10. Confidentiality, information sharing and disclosure

Organisation staff or other workers providing services on behalf of the organisation must ensure they share information appropriately both professionally and legally when there is a safeguarding concern and in-line with HM Governments Information Sharing Guidance and Confidentiality: NHS Code of Practice, and the relevant local information sharing protocols.

PREVENT is based on the active engagement of the vulnerable individual and is at a pre-criminal stage, therefore appropriate consent should be obtained from the individual involved prior to a referral, both to comply with the Code of Practice on Confidentiality and to establish an open relationship with the vulnerable individual at the start of the process. However, in exceptional circumstances, where seeking consent prior to referral would cause immediate significant harm to the vulnerable individual and/or where the vulnerable person lacks capacity to give consent, a referral may be made without consent in their best interests.

Additionally agencies may share limited and proportionate information prior to consent in exceptional cases where this is immediately required to establish whether the case should be managed under PREVENT or as a Counter Terrorism case.

Please note: Where there is concern or evidence that an individual is actually engaged in the planning or undertaking of terrorist acts, then consent is not required to share any information that may be required to assess and manage the risk of a serious criminal offence occurring. In these cases the individual should not be informed that information is being shared without multi agency agreement of what is required to ensure the safety of others.

If staff are not sure on information sharing or consent issues, they should seek advice from the Safeguarding Adult or Children lead or Caldicott Guardian. All information shared must comply with all Caldicott Principles.

Any disclosures or discussions on information sharing or consent should be recorded in the records.

11. Guidance for raising concerns

Concerns that an individual may be vulnerable to radicalisation do not mean that you think the person is a terrorist, it means that you are concerned they are prone to being exploited by others and so the concern is a safeguarding concern:

- The nature of the issue
- The vulnerability of the service user
- The influencing party
- The degree of harm

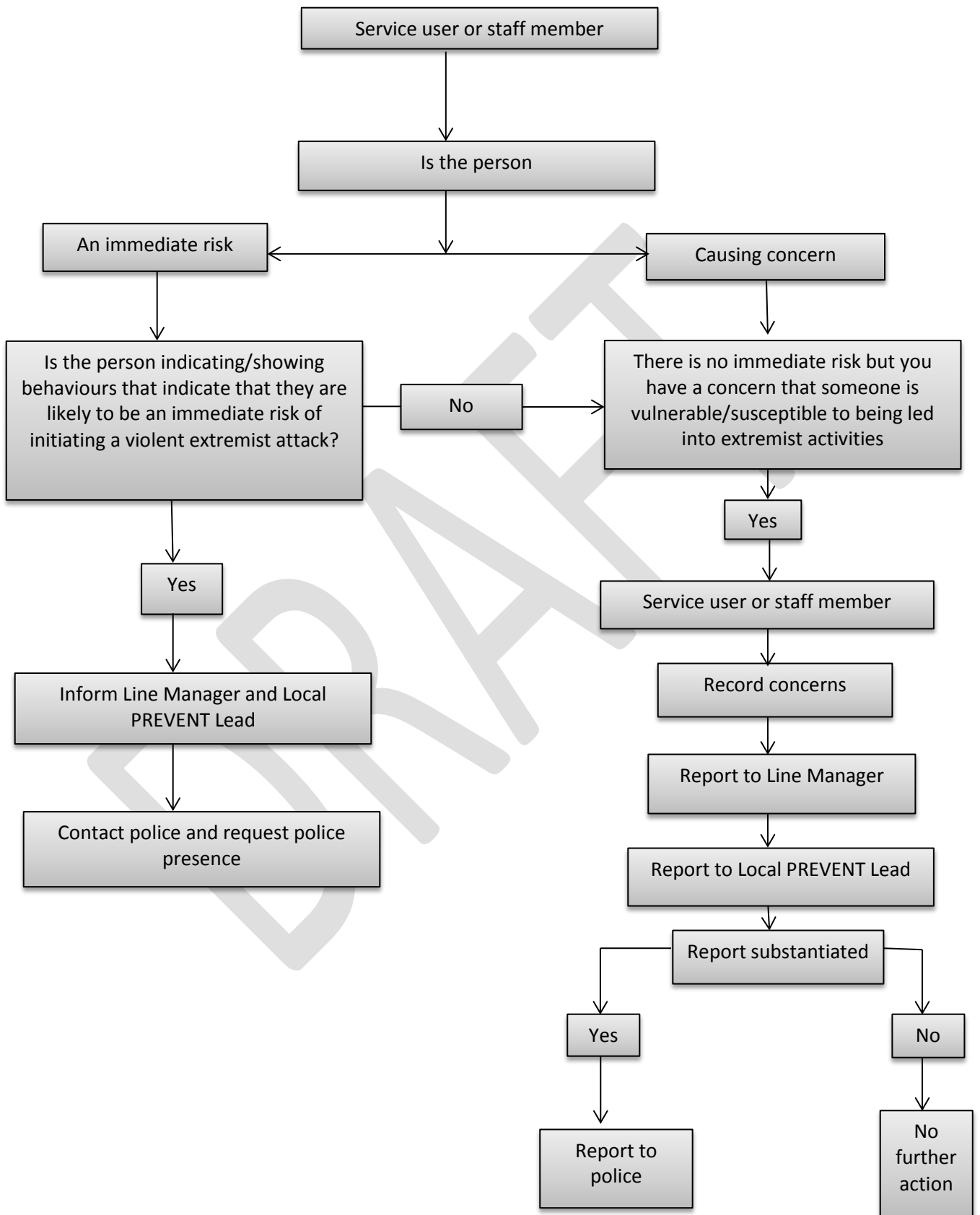
Intervention must include the individual's consent (Code of Practice on Confidentiality) where possible and the local Caldicott Guardian may be notified.

If you have concerns you MUST raise them in accordance with PREVENT Leads as soon as possible or any of the key contacts in the CCG, the police or crime stoppers. All contact details are at the back of this policy.

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12. Reporting flow chart or raising concerns

Action to take if you suspect an individual is being radicalised/self-radicalised into extremist activities:



13. PREVENT training

The PREVENT Training and Competencies Framework has been developed in draft by NHS England (2015) to provide clarity on the level of training required for healthcare workers; it defines staff groups that require basic PREVENT awareness and those who have to attend Workshops to Raise Awareness of PREVENT (WRAP).

It is the role of NHS Enfield Clinical Commissioning Group to hold their providers to account on PREVENT which is in the NHS Standard Contract. The PREVENT Training and Competencies Framework has been developed in conjunction with the safeguarding children and young people: roles and competences for health care staff (Intercollegiate Document, 2014) in order to ensure a consistent approach to training and provide parity between the expectations to safeguard both children and adults with care and support needs.

Basic PREVENT Awareness Training – Level 1 & 2

Staff Groups

All staff working in NHS Enfield CCG

Competencies

Knowledge:

- The objectives of the PREVENT strategy and the health sector contribution to the PREVENT agenda;
- What professional responsibilities are in relation to the safeguarding of vulnerable adults, children and young people;
- Understand vulnerability factors that can make individuals susceptible to radicalisation or a risk to others; and
- Who to contact and seek advice from if they have concerns that a vulnerable individual is being groomed into terrorist activity.

Skills:

- Able to recognise potential indicators that an individual might be vulnerable to radicalisation or at risk of involvement in acts of terrorism;
- Understand the impact of influence on vulnerable individuals (direct or internet);
- Know what action to take if they have concerns, including to whom you should refer your concerns and from whom to seek advice; and
- Have an understanding of the importance of sharing information (including the consequences of failing to do so).

Criteria for Assessment:

- Demonstrates an awareness and understanding of indicators of risk relating to vulnerable individuals being radicalised;
- Demonstrates an understanding of appropriate reporting mechanisms in own organisation i.e. knows who to contact (organisation's PREVENT Lead), where to access advice within the organisation and policies and how to make a referral;

- Is aware of PREVENT aims to tackle all forms of terrorism and the health sector contribution operates in pre-criminal space.

Training delivery and training compliance targets

Workshops to Raise Awareness of PREVENT (WRAP) should be completed within 12 months of starting in a role requiring this level of training.

The training compliance target for organisations at this level is 85% over 3 years or as agreed locally by the NHS Standard Contract holder.

Only a WRAP Facilitator registered with NHS England and the Home Office can deliver WRAP. WRAP can be delivered to staff in a single organisation, on a partnership basis between organisations, or on a multi-agency basis.

DRAFT

14. Key contacts in Enfield CCG and the community

Adult Safeguarding lead

Ext 2809

NHS Enfield Clinical Commissioning Group

Holbrook House

Cockfosters Road

Barnet

Herts EN4 0DR

Designated Nurse Child Protection

Ext: 2810

NHS Enfield Clinical Commissioning Group

Holbrook House

Cockfosters Road

Barnet

Herts EN4 0DR

PREVENT Police Officer for Enfield CCG

Mobile: 07887 546395

Metropolitan Police: 999

Crime Stoppers (anonymous)

0800 789321

Clinical Commissioning Group

Agenda Item: 9.6
Paper Ref: Appendix P

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 th June 2015
TITLE:	Proposed Amendments to the Terms of Reference for (a) Quality and Safety Committee (b) Financial Recovery and QIPP Committee (c) Executive Committee
LEAD DIRECTOR/MANAGER:	Aimee Fairbairns, Director of Quality & Integrated Governance
AUTHOR:	David Triggs, Board Secretary
CONTACT DETAILS:	David.triggs@enfieldccg.nhs.uk

SUMMARY:

The CCG's governance processes require regular review and this report highlights proposed amendments recommended by three of the Governing Body Committees. The proposed terms of reference are attached at appendices 1, 2 and 3 and the main changes are highlighted below:

- **Quality & Safety Committee.** Recommendation from the Committee meeting held on 18 February 2015. The following changes were proposed:
 - Chief Finance Officer (CFO) or Deputy CFO to be invited as required and not a member
 - Local Authority Social care representation invited as required
 - Assistant Director of Quality, Governance & Risk (amendment from previous title)
 - Frequency of meetings changed to five times per year (at least) to account for holiday periods
 - To amend the quorum from five members (three clinical) to four members (two clinical)
- **Finance Recovery & QIPP Committee.** Recommendation from the Committee meeting held on 22 April 2015. The key changes proposed are as follows:
 - To change the name of the Committee to 'Finance Committee'
 - Revise the Committee membership to 6 members - there remains one Governing Body member vacancy
 - Remove the QIPP reference to feature as part of terms of reference for the Transformation Programme and Financial Recovery Group
 - to include an overview of the Committees' remit as part of the introduction
 - a role of the Committee should be to provide to the Governing Body assurance in respect of the CCG finances
 - the Committee to receive assurance in respect of expenditure from pooled budgets overseen by NCL Integration Board into the Finance Committee
 - the Committee to receive assurance of the NCL Transitional Investment Fund via the CFO's monthly Financial Report
- **Executive Committee.** Recommendation from the Committee meeting held on 22 April 2015. The key changes proposed are as follows:
 - Reference to "the Clinical Reference Group" be removed

- The Committee should have a high level overview of finance with the financial assurance being obtained through the Finance Committee
- The Committee to have responsibility for overseeing Performance and Estates

SUPPORTING PAPERS:

Subcommittee Terms of Reference for:

- Quality & Safety Committee (appendix 1)
- Finance Recovery & QIPP Committee (appendix 2)
- Executive Committee (appendix 3)

RECOMMENDED ACTION:

The Governing Body is recommended to approve the amended terms of reference of the three Committee's as attached.

Objective(s) / Plans supported by this paper: ECCG Constitution

Audit Trail: Regular, at least annual, review of the Committee Terms of Reference.

Patient & Public Involvement (PPI): As outlined in the Terms of Reference

Equality Impact Assessment: Will be considered in line with subcommittee duties and responsibilities

Risks: Regular review of the Terms of Reference will reduce the risk of new developments being excluded from review by the Committee

Quality and Safety Committee

Terms of Reference

1. GENERAL

2. The Quality and Clinical Risk committee is established in accordance with NHS Enfield Clinical Commissioning Group's Constitution, Standing Orders and Scheme of Delegation. These terms of reference set out the membership, remit responsibilities and reporting arrangements of the Committee

3. CONSTITUTION

The Quality and Safety Committee (the Committee) is a committee of the Governing Body.

4. MEMBERSHIP

- 4.1 The Committee comprises ten members appointed by the Governing Body as follows:

- 4.1.1 Chair – the Registered Nurse on the Governing Body;
- 4.1.2 One GP Locality Lead (Vice Chair) and Chair of Quality & Risk Sub Group;
- 4.1.3 Director of Service Quality and Integrated Governance;
- 4.1.4 Clinical Director;
- 4.1.5 Head of Performance and Informatics;
- 4.1.6 One Lay Member;
- 4.1.7 CCG Secondary Care Doctor
- 4.1.8 Public Health Representative.
- 4.1.9 Head of Clinical Quality

5. QUORUM

the quorum for the Committee will be four members, two of whom must be clinical members.

6. DECISION MAKING

Each full member of the Committee has one vote. In the event of a tie vote the chair or the person chairing the meeting has a casting vote

7. ATTENDANCE

The following will be in attendance at all meetings:

CSU Quality and Safety representative

Assistant Director of Quality, Governance & Risk

Head of Engagement

Head of Safeguarding

Head of Prescribing

- 7.1 Other CCG GP Members or Members of the Governing Body should be invited to attend when the Committee is discussing areas of risk or operation that are their responsibility. These will include the Safeguarding leads for adults and children, and medicines management. If unable to attend in person, the relevant person will nominate a suitable deputy to attend in their place. Other individuals will be invited to attend if specific specialist advice is required, e.g. Chief Finance Officer, Local Authority – social care representation
- 7.2 Other colleagues from supporting organisations including Commissioning Support Unit, Public Health, NHS England etc. will be invited to attend where appropriate and with their agreement.

8. FREQUENCY OF MEETINGS

The Committee will meet at least five times a year. The chair of the Committee may call additional meetings as necessary.

9. PURPOSE

The Committee is responsible for ensuring the quality and safety of all commissioned services. It will keep under review providers' compliance with contracts relating to quality and safety, whilst taking into account patient experience which is a quality marker ensuring patients have a positive experience of services. Particular emphasis relates to CCG statutory responsibilities for quality in accordance with the Health and Social Care Act.

10. DUTIES

- 10.1 The duties of the committee will be driven by the priorities for NHS Enfield clinical commissioning group and any associated risks or areas of quality improvement. The committee will operate to a programme of business, agreed by the Committee that is flexible to new and emerging priorities and risks.
- 10.1.1 To assure the Governing Body that quality and safety is integral to the commissioning function, by providing an overview of quality assurance and clinical governance;

- 10.1.2 To ensure the quality and safety of commissioned services, working with the CSU Quality and Contracts Team to keep under review providers compliance with terms and conditions of contracts relating to clinical quality, and taking account of patient experience, reporting quality issues regularly to the Governing Body
- 10.1.3 To oversee the development of local quality key performance indicators and metrics in order to ensure continuous improvement of the services that it commissions including improving patient experience;
- 10.1.4 To provide the Governing Body with a clear and comprehensive summary of quality, safety and effectiveness of commissioned services, with a focus on improving these as well as the patient experience;
- 10.1.5 To ensure a robust Clinical Quality Review (CQR) process is in place for commissioned services and regular reports are received from the CSU Safety Team ;
- 10.1.6 To ensure CQR oversight and that appropriate remedial action(s) is in place, where areas of poor performance are identified for commissioned services; work with the CSU to ensure compliance with the Health and Social Care Act 2012 including Quality Accounts;
- 10.1.7 Receive assurances from within the organisation and providers that areas relating to clinical quality and safety are implemented Ensure that the quality agenda leads to improvements in productivity and prevention through innovation and to develop a robust process for ensuring patient safety is paramount in commissioning decisions
- 10.1.8 To receive quarterly patient safety incident and Serious Incidents reports from the CSU Safety Team relating to NHS and service providers that identify themes and trends and recommend areas for change in practice through the commissioning process. Review exception reports in respect of clinical risks including serious incidents and investigations of poor quality care/patient safety issues where appropriate to identify organisational learning
- 10.1.9 To liaise with the Chief Finance Officer and CSU Contracts Team to ensure appropriate contractual notices are issued, where appropriate;
- 10.1.10 To review remedial action taken by providers in relation to breaches in quality standards;
- 10.1.11 To review any notification, advice or instruction issued by regulators;
- 10.1.12 To ensure that the quality agenda in relation to Quality, Innovation, Productivity and Prevention (QIPP) is advocated and supported;
- 10.1.13 To engage with other committees as appropriate to ensure appropriate oversight of quality across all services;
- 10.1.14 To review reports as appropriate to ensure oversight of quality across all services, work with the CSU to review reports from providers on

progress against existing Quality Account work plans, and to review new work plans;

- 10.1.15 To provide oversight and receive reports from the CSU Individual Funding Request (IFR) Team on the work of the IFR and PoLCE panels where it is appropriate to do so;
- 10.1.16 To advise the Governing Body following national inquiries, and national and local reviews undertaken by regulators for commissioned services, and to monitor the implementation of action plans;
- 10.1.17 To advise the Governing Body in relation to compliance with quality and safety aspects of the Health and Social Care Act 2012;
- 10.1.18 To receive minutes from the Clinical Reference Group with delegated responsibility for clinical leadership and to feedback to the Clinical Reference Group, as appropriate;
- 10.1.19 To receive minutes from the Quality & Risk Sub Group with delegated operational responsibility for quality and safety and to feedback to the sub group as appropriate
- 10.1.20 To receive minutes from the Medicines Management Committee with delegated operational responsibility for medicines management and to feedback to the Medicines Management Committee as appropriate
- 10.1.21 To review quality and safety risks and ensure appropriate mitigation is in place, with relevant advice to the Governing Body;
- 10.1.22 To receive Safeguarding (adults and children) assurance reports that identify areas of compliance, themes and trends and recommend appropriate actions, advising the Governing Body appropriately;
- 10.1.23 To approve the annual Safeguarding (adults and children) reports;
- 10.1.24 To oversee the development of a Quality Strategy and Plan, for approval by the Governing Body and to ensure oversight of the implementation plan in relation to this;
- 10.1.25 To receive patient experience reports (both qualitative and quantitative) from the CSU Complaints Team on a quarterly basis, including Patient enquiries reports and complaints reports, that identify themes and trends and recommend areas for change in practice through the commissioning, advising the Governing Body appropriately;
- 10.1.26 To review trends in complaints received in relation to services
- 10.1.27 Work with the CSU to monitor the performance of providers against CQUINs and support development of local CQUINs;
- 10.1.28 To review and agree an audit plan with commissioned services to ensure continuous improvements in quality, safety, effectiveness and patient experience reviewing summarised results of audits previously undertaken

10.1.29 To oversee the quality of commissioned services and primary care services including the quality of services provided by general practitioners with specialist interests, where appropriate, in liaison with the NHS England;

10.1.30 To ensure Quality and Safety advice in relation to the redesign of clinical pathways;

10.1.31 The Committee may discharge appropriate quality and safety monitoring and reporting requirements through other groups; Clinical Quality Review, Contract Meetings (in liaison with Commissioning Support Unit). However, the Quality and Safety Committee will retain accountability for assuring the Governing Body of the quality and safety of all commissioned services.

11. REPORTING

The Committee will report to the Governing Body after each meeting.

12. MONITORING ARRANGEMENTS AND REVIEW DATE

12.1 The Committee's performance will be monitored annually via agreed Key Performance Indicators to ensure its effectiveness in discharging its duties against the Terms of Reference.

12.2 The Committee's Terms of Reference will be reviewed annually.

Last approved: 26 November 2014 - Governing Body – next approval scheduled GB on 10 June 2015

Last reviewed 18 February 2015 Quality & Safety Committee

FINANCE COMMITTEE
TERMS OF REFERENCE

1. GENERAL

- 1.1 The Finance Committee (the Committee) is established by resolution of the Governing Body with the decision-making powers specified in these terms of reference.

Membership

- 1.2 The Committee comprises 6 members appointed by the Governing Body. The membership is as follows:
- 1.2.1 Chair (a member of the Governing Body)
 - 1.2.2 Accountable Officer;
 - 1.2.3 Chief Finance Officer;
 - 1.2.4 Two Governing Body members one of who is a non-executive clinical member;
 - 1.2.5 Qualified Finance member (external).

Quorum

- 1.3 The quorum for the Committee will be three members at least one of whom will be a non- executive clinical member.

Attendance

- 1.4 Other senior management are invited to attend when the Committee is discussing areas of risk or operation that are their responsibility.

Frequency of meetings

- 1.5 The Committee will meet monthly during the 3rd or 4th working week of the month. The Chair of the Committee may call additional meetings as necessary.

2. DUTIES

- 2.1 The overall purpose of the Committee is
- 2.1.1 to review and understand CCG performance against its financial duties including forecasting in each month.
 - 2.1.2 To review and understand the major financial risks facing the CCG.
 - 2.1.3 to authorise investments and business cases in line with the Scheme of Delegation.
 - 2.1.4 to monitor CCG delivery of the QIPP and Investment Programme, including the consideration of update reports from the Transformation and Recovery Group.

- 2.1.5 to monitor activity and financial performance on key contracts.
- 2.1.6 to provide assurance to the Governing Body in respect of financial performance.
- 2.1.7 to authorise capital investments in line with the scheme of delegation.
- 2.1.8 To receive assurance in respect of expenditure from pooled budgets overseen by the Integration Board. To receive updates on the NCL Transformation Investment Fund

3. REPORTING

- 3.1 The Committee will report to the Governing Body after each meeting. The report will set out the main matters discussed and any decisions taken. It will also draw the attention of the Governing Body to any matters requiring disclosure to them, or requiring its approval.

4. MONITORING ARRANGEMENTS AND REVIEW DATE

- 4.1 The Committee's performance will be monitored annually via a review of effectiveness considered by the Audit Committee. This will consider how the Committee discharges its duties against the Terms of Reference.
- 4.2 The Committee's Terms of Reference will be reviewed annually.

It is proposed that these revised terms of reference be considered at the Finance Committee meeting on 22 April 2015 and recommended to the Governing Body for approval.

Note the previous terms of reference were last approved by the Governing Body at its meeting on 26 November 2014.

22 April 2015 Version 5

EXECUTIVE COMMITTEE TERMS OF REFERENCE

1. General Context

- 1.1 The Executive Committee (the Committee) is established in accordance with NHS Enfield Commissioning Group's (the CCG's) constitution (section 23, Delegation). These terms of reference set out the membership, remit responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the constitution.
- 1.2 The Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any Member, officer or employee who are directed to co-operate with any request made by the Committee.

2. Membership

- 2.1 The Committee shall be appointed by the CCG as set out in the CCG's constitution and may include individuals who are not on the Governing Body.
- 2.2 The Chief Officer or their nominee is the chair of the Committee.
- 2.3 Other members to include:
- Chair of the Governing Body
 - Lay Vice Chair of the Governing Body
 - Clinical Vice Chair of the Governing Body
 - Chief Finance Officer
 - Director of Quality and Integrated Governance
 - Clinical Director
 - Director of Strategy and Partnerships
 - Director of Operations
 - Locality lead from each locality

In attendance: all meetings:

- The Board Secretary (or other secretary to the group)

- 2.4 Other Governing Body members, staff, stakeholder representatives and partners will be invited to attend as relevant to the agenda.

3. Quorum

- 3.1 A minimum of 3 members including the Chief Officer or a Director and the Chair or another GP Locality Lead.

4. Secretary

- 4.1 The secretary will provide administrative support and advice. The duties of the secretary in this regard include but are not limited to:
- 4.1.1 Agreement of the agenda with the Chair and attendees together with collation and distribution of papers;

4.1.2 Taking the minutes and keeping a record of matters arising and issues to be carried forward;

4.1.3 Providing advice on best practice, national guidance and other relevant documents.

5. Frequency of meetings

The Committee will meet monthly.

6. Remit and responsibilities of the Committee

6.1 The Committee will ensure timely scheduling and effective co-ordination of the Governing Body committees and the CCG corporate business and organisational development, consistent with the Constitution.

In particular to ensure and support the following responsibilities:

- To receive and act upon performance reports on behalf of the Governing Body, reporting to the Governing Body;
- To discharge a high level overview of financial issues;
- To have responsibility for overseeing Performance;
- To incorporate a locality lead from the four localities and receive locality group minutes or formal reports
- Implementing the (commissioning strategy and operational) business plan within the constraints of the financial plan;
- Helping to ensure that the organisation remains healthy, safe and legal;
- To have oversight of the CCG's Estates function;
- Managing day to day risks and issues as they arise;
- Securing and aligning the necessary managerial and clinical resources to bring about reform and improve quality in line with the CCG management procurement strategy;
- To take a lead in the oversight of Emergency Planning within the CCG;
- To take a lead in the oversight of Human Resources policies for the CCG

6.2 To ensure implementation of the CCG's Organisational Development Plan and Programme and oversee the effectiveness of the CCG's management structure. This will include assurance that the CCG's current and future Commissioning Support requirements are met within the CCG's allocated management cost budget and strategic programme funding.

6.3 To consider the establishment of Advisory Groups, including changes to Locality Groups, committees or collaborative boards with a direct line of accountability to the Governing Body. This will support effectiveness of the CCG's Governance Framework;

6.4 To have the remit to review and where necessary remove those groups, and committees that are below the level of the Governing Body committees and are not referred to in the

Enfield CCG Constitution. The Committee will review the Governance Framework at least annually.

- 6.5 Governing Body Committees remain responsible for their sub-group and collaborative arrangements within the scheme of delegation and as reported to the Governing Body.

7. Relationship with the Governing Body

- 7.1 The minutes of meetings shall be formally recorded.
- 7.2 A summary report of the actions being undertaken by the Executive Committee will be presented through the appropriate Committee and/or the Chairs or Chief Officers Reports to the Governing Body. Where there are recommendations from the Executive Committee appropriate supporting information will be provided to the Governing Body.
- 7.3 The action log will be used to manage the Group's work and any delegated responsibilities from the Governing Body.

8 Review of Terms of Reference

- 8.1 The terms of reference shall be reviewed by the Committee at least annually and any changes sent to the Governing Body for approval.

9. Monitoring Arrangements

- 9.1 The Committee's performance will be monitored annually via agreed Key Performance Indicators to ensure its effectiveness in discharging its duties against the Terms of Reference.

Last review:
Executive Committee 19 November 2014
Governing Body 26 November 2014

Clinical Commissioning Group

Agenda Item: 9.7
Paper Ref: Appendix Q

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 June 2015
TITLE:	Audit Committee Annual Report
LEAD BOARD MEMBER:	Karen Trew, Audit Committee Chair & Lay Vice Chair
AUTHOR:	Bridget Pratt, Assistant Director of Quality, Governance & Risk
CONTACT DETAILS:	bridget.pratt@enfieldccg.nhs.uk

SUMMARY:

This Annual Report describes the work of the Enfield Clinical Commissioning Group's Audit Committee during the year 2014/15 within the context of the organisation's integrated governance arrangements.

The Audit Committee is established under Governing Body delegation with approved terms of reference that is aligned with the NHS Audit Committee handbook published by Healthcare Financial Management Association (HFMA) and the Department of Health.

The Committee consists of two lay members (one of whom is chair), and one GP from the Governing Body. The Committee has met 7 times during the financial year and has discharged its responsibilities for scrutinising the management of risk and controls which affect all aspects of the organisation's business.

In order to discharge this function the Audit Committee prepares an annual report for the Board and Accounting Officer. This report includes information provided by Internal Audit, External Audit and other assurance providers.

SUPPORTING PAPERS:

- There are no supporting papers

RECOMMENDED ACTION:

The Governing Body is asked to:

- Note the report approved by the Audit Committee as an accurate record of its work during 2014/15

Objective(s) / Plans supported by this paper: The Audit Committee Annual Report applies to all Enfield CCG objectives

Patient and Public Engagement (PPE): Audit Committee membership includes lay members. The PPE Committee also reports annually to the Audit Committee on its performance

Equality Impact Analysis: This is conducted in line with agenda items.

Risks: As outlined in the CCG's assurance framework and risk register

Resource Implications: None identified

Audit Trail: None

ENFIELD CLINICAL COMMISSIONING GROUP

Audit Committee Annual Report 2014/15

1. INTRODUCTION

The Audit Committee's chief function is to advise the Governing Body on the adequacy and effectiveness of the organisation's systems of internal control and its arrangements for risk management, control and governance processes, and securing economy, efficiency and effectiveness (value for money).

The main duties of the Committee are set out in the Terms of Reference which are reviewed annually. The Terms of reference were last reviewed by Audit Committee on 12 November and approved by the Governing Body on 26 November 2014. Minor changes and corrections were made.

In order to discharge its function the Audit Committee prepares an annual report for the Governing Body and Accounting Officer. This report includes information provided by Internal Audit, External Audit and other assurance providers.

1.1. FINANCIAL CHALLENGES IN 2014/2015

All CCGs have a duty to deliver both financial and other statutory duties. The CCG is expected to manage its business within the resources allocated to it:

- Expenditure should not exceed the Revenue allocation
- The CCG will manage its cash flow to target
- Running costs not to exceed £25 per head of population

The CCG successfully managed its cash flow to target and kept its running costs within £25 per head of population.

However it was not able to maintain expenditure within its Revenue Allocation.

In 2014/15, a planned deficit budget of £5.6m was agreed with NHS England, reflecting a number of pressures including a specialist commissioning adjustment originating late in 2013/14. Due to the increased pressures in 2014/15 the CCG acknowledged it would not achieve its original control total, and in Month 9 the CCG amended its forecast to a deficit of £19.0m. The annual accounts show a deficit of £18.9m.

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

- Acute activity rose significantly in 2014/15, including a headline 20% on Non Elective Admissions.
- GP Referral rates increased by c12% in the same time period, causing an increase in first outpatient appointments.
- Daycase and Inpatient elective activity rose by 8.5% in 2014/15, which was largely attributable to addressing one off waiting list reductions.
- The 2014/15 QIPP programme did not deliver savings to the level expected from service redesign. The total QIPP programme savings were £10.6m of which half are transactional and non-recurrent in nature. The QIPP target was £12.0m and was underachieved by £1.4m.

The CCG has undertaken a review of PMO and QIPP structures, processes and documentation to support improved delivery. The CCG has also worked extensively with external consultants to support its recovery plan and have appointed a Recovery Director reporting directly to the Chief Officer.

The CCG also jointly commissioned a Financial Governance Review with NHS England.

In summary the Report recommended that a full risk assessment should be performed as part of our 2015/16 planning, including quantification of risks presented to the appropriate committees. This has been implemented.

The CCG has already implemented many of the other more detailed practical measures recommended by the review. The CCG will implement all of the recommendations by the 30th September 2015 and this will be monitored by the Audit Committee.

The review also recommended that the CCG produce a Recovery Plan and agree it with NHS England. This Recovery Plan, which covers a five year period, is being finalised and will be taken to Governing Body for scrutiny and approval.

Enfield CCG forecast an in year deficit of £14.4m in 2015/16. This plan is 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 and that our PbR acute contracts will overspend our budgets.

To mitigate these risks the CCG have commissioned external help to support building a robust recovery plan. The terms of reference for this work were signed off jointly with NHS England. Whilst the remit covered contracting, monitoring and reporting the main focus is to build and implement the QIPP programme for 2015/16.

2. MEMBERSHIP OF THE COMMITTEE AND ATTENDEES

The membership comprises

- Mrs Karen Trew Lay Member and Committee Chair
- Dr Parvan Sardana, GP governing Body member until 31 July 2014
- Dr Ujjal Sarkar, GP Governing Body member from 1 October 2015
- Mrs Rathai Thevananth, Practice Manager Member
- Teri Okoro, Lay Member
- Mr Adam Sharples, External Lay Member

The Committee is appointed by the Governing Body and consists of a chair (the Lay Member of the Governing Body with responsibility for governance) and two Governing Body members, with a quorum of two. The Chair of the Governing Body and the Chief Finance Officer may not be members of the Committee.

The Committee is supported by the Board Secretary.

The following are normally in attendance at the meetings of the Audit Committee:

- Chief Finance Officer
- Director of Service Quality and Integrated Governance
- Director of Quality Governance & Risk
- Assistant Director of Quality, Governance & Risk
- Internal Auditor, Baker Tilly
- External Auditor, Grant Thornton
- Local Counter Fraud Specialist, Baker Tilly
- Board Secretary

In addition, during 2014/15, the Chief Officer, a number of directors and senior managers of the CCG, have attended meetings of the Audit Committee.

In 2014/2015, the Committee met 7 times in line with its Terms of Reference.

3. PRINCIPAL REVIEW AREAS

This annual report reflects the following key duties of the Committee as set out in its terms of reference:

- Governance, risk management and internal control
- Internal Audit
- External Audit
- Management
- Annual Accounts
- Effectiveness of the Audit Committee

4.1. GOVERNANCE, RISK MANAGEMENT AND INTERNAL CONTROL

In order to fulfil this duty the committee has undertaken the following:

- Scrutiny of the CCG independent Financial Governance Review and monitoring progress on recommendations. Review will look at CCG meetings, focusing on the number of internal meetings attended by staff, areas of duplication, reporting arrangements, terms of Reference and Work plan for all CCG committees and groups.
- The Internal Audit Plan. In addition, all twelve CCGs worked with North East London Commissioning Support Unit to gain assurance on the process of this significant outsourcing operation that Enfield CCG (along with the other 11 CCGs) relies on.
- Reviewed the Annual Governance Statement to ensure that it reflects the committee's view on the CCG's system on internal control. It has sought assurance from the Head of Internal Audit Opinion, External Audit opinion and other appropriate independent assurances in order to gain a view of the CCGs system of internal control.
- Reviewed the Governing Body Assurance Framework and Corporate Risk Register at every meeting. The Committee made recommendations on the need for Directors to moderate on the number of red risks and reviewed evidence to support this.
- Reviewed Directorate Risk Registers on a rotational basis. In 2014/2015, each Director attended the Audit Committee to discuss their risk registers and provide assurance on the management of their respective risks.
- Received effectiveness reports from the Chairs of the Quality & Safety Committee, Remuneration and Nominations Committee, Executive Committee and Finance, Recovery & QIPP Committee. A report is on this June 2015 Audit Committee agenda to review the effectiveness of the Audit Committee and is expected to come to the next Committee meeting from the Patient & Public Engagement Committee and the Procurement Committee established in June 2014.
- Reviewed the completeness of the risk management system and the extent to which it is embedded throughout the organisation. The Committee believes that while adequate systems for risk management are in place, more work is required to ensure that these are embedded throughout the whole organisation. The Committee's opinion is that this issue requires continuing executive management focus and support.
- Reviewed the Counter Fraud Plan, which has reviewed CCG's systems as well as supported by proactive awareness work as part of the agreed Plan

- Reviewed the External Audit Plan, which has included the review of the Annual Report and Accounts from which an evaluation of the process and value for money review take place
- Considered and agreed an anti-fraud and bribery policy
- Considered delegated limits and financial process arrangements, which had been approved by the Governing Body
- Considered the management of service provider contracts with the Commissioning Support Unit, seeking assurance as to the way these had been monitored and progressed as well as acknowledging the complexities when several CCGs were party to the contract with the provider
- Approval of the Gifts & Hospitality Policy and review of the Gifts & Hospitality Register
- Approval of the Policy for working in conjunction with the pharmaceutical industry
- Review of the Committee's own Terms of Reference
- Completed a meetings evaluation checklist at the end of every meeting

4.2 INTERNAL AUDIT

Throughout the year the Committee has worked effectively with internal auditors (Baker Tilly) to strengthen the CCG's internal control processes. The Committee has also in year:

- Received and considered the external audit review of the effectiveness of internal audit and considered the provision of the internal audit service sufficient in supporting the Committee in fulfilling its role
- Reviewed and approved the internal audit operational plan and more detailed programme of work
- Considered the major findings of internal audit and are assured that management have responded in an appropriate manner.
- Worked effectively with Internal Audit to strengthen the CCG's internal control processes.
- Considered the Internal Audit annual plan, and received regular progress reports and an annual report.
- Undertook a tender for Internal Audit services across 12 NELC CCGs for 15/16 onwards

4.2.1. HEAD OF INTERNAL AUDIT OPINION

The Internal Auditors issued the organisation with a draft Head of Internal Audit Opinion (HIAO) and this has been used to assist the organisation in preparing its Annual Governance Statement **as** part of its accounts submission for 2014/15. Internal audit concluded that:

Based on the work undertaken in 2014/15, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses have been identified.

The month 9 cumulative results were showing a deficit of £13.5m against a planned deficit of £4.5m, £9.0m over target. The CCG is forecasting a deficit of £19.0m for the year, £13.4m in excess of the control total. The major factor was a worsening position on the acute contract over-performance exacerbated by the move to primarily payments by results contracts as opposed to block contracts as in 2013/14

The CCG has had external support from Deloitte in reviewing the financial out-turn. We are planning to deliver a detailed Financial Governance review early in the 2015/16 financial year.

We also identified one review where we could only provide some assurance. We issued an Amber RED opinion for the Procurement review. We found instances where the procurement process and value for money could not be evidenced due to a lack of supporting documentation. However it should be noted that these issues related to contracts let early in the CCG's life and more recent contracts procured were found to be supported by stronger evidence, demonstrating significant improvements in the procurement processes at the CCG.

Internal Audit has been able to deliver substantial or reasonable assurance in all other areas reviewed.

The Committee would like to thank Clive Makombera, Nick Atkinson and their team, for delivering the Internal Audit programme which is closely aligned to the CCG's objectives

4.3 EXTERNAL AUDIT

Grant Thornton were appointed by the Audit Commission as auditors to Enfield CCG for 2014/15. The Committee reviewed and agreed the external audit plan and received regular reports as well as ensuring timely implementation of any actions recommended.

From their audit findings -

“Key audit and financial reporting issues

Financial statements opinion

Subject to completion of our testing, we have so far identified no adjustments affecting the CCG's comprehensive net expenditure position of £368.2m. We have suggested a small number of adjustments to improve the presentation of the accounts.

The key messages arising from our audit of the CCG's financial statements are:

- given the tight timescale for preparation of financial statements the CCG and CSU responded well and prepared materially accurate financial statements
- the annual report and financial statements have been prepared to satisfy the requirements of NHSE guidance.

Subject to completion of our work, we would propose to issue an unqualified audit opinion on the CCG's financial statements

Regulatory Opinion

As well as an opinion on the accounts, our auditors are required to give a regularity opinion on whether expenditure has been incurred 'as intended by Parliament'. Failure to meet statutory financial targets automatically results in a qualified regularity opinion.

Our review of the CCG's expenditure has highlighted the following issue which will give rise to an except for regularity opinion. The CCG incurred a deficit of £18.9m for the year, and therefore it failed to comply with the statutory duty to break even. We issued a report to the Secretary of State under Section 19 of the Audit Commission Act 1998 on 21 May 2015.

Value for money conclusion

Our review of the CCG's arrangements to secure economy, efficiency and effectiveness has highlighted the following issues which will give rise to an adverse qualified VFM conclusion:

- the CCG reported a deficit of £18.9 million in its financial statements for the year ending 31 March 2015, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, to break even on its commissioning budget
- the CCG has set a deficit budget for the year ending 31 March 2016 and is anticipating an overspend of £14.4 million against its revenue resource limit for that year
- in February 2015 the CGG and NHS England appointed Deloitte LLP to undertake a financial governance review which identified weaknesses with the CCG's arrangements for financial planning, financial control and financial governance. Management has responded positively to all the recommendations contained in the report, many of which have already been implemented, with all outstanding actions having an implementation date no later than 30 September 2015.

The Committee would like to thank Paul Hughes and his team for their work and expert and independent advice throughout the year.

It should be noted that for 2015/16 the CCG's external auditors will be BDO.

4.4. MANAGEMENT

The Committee has continually challenged the assurance process when appropriate and has requested and received assurance reports from CCG management and various other sources both internally and externally throughout the year.

As part of its workplan, the Committee requested a governance review of CCG meetings focusing on the number of internal meetings attended by staff, areas of duplication, reporting arrangements, terms of Reference and Work plan for all CCG committees and groups. This review is still ongoing and the outcome and action plan will be monitored by the Audit Committee.

The committee has also been monitoring the performance of the commissioning support service provided by North East London Commissioning Support Unit and has been seeking assurance from management that improvements in service delivery has been experienced.

The Committee has challenged the assurance process during the year and has received presentations from management on a range of major risks during the year including issues around provider capacity, CSU and contract management.

The Committee has also continued to monitor the development of integrated governance within the organisation where good progress has been made.

4.5. ANNUAL ACCOUNTS

The Committee has reviewed the process and controls the CCG have put in place to achieve its financial obligations throughout the year. Although final accounting guidance came out very late from NHS England, the CCG has been able to fulfil its statutory accounting requirements within the national deadlines.

The Committee reviewed the draft annual accounts and financial statements for 2014/15 and also the final draft of the CCG's annual report at its April 2015 meeting.

4.6. EFFECTIVENESS OF THE AUDIT COMMITTEE

The Committee has been active during the year in carrying out its duty in providing the CCG Governing Body with assurance via a report to every Governing body Meeting that effective internal control arrangements are in place.

4.6.1. MEETING SELF EVALUATION CHECKLIST

A meeting evaluation checklist is completed by all meetings attendees after every meeting and feedback is analysed and reviewed at the subsequent meeting to ensure learning. The checklist covers timeliness of papers, hospitality, chairing of meetings and areas for improvement. There were no key themes highlighted from the analysed meeting evaluation checklist in 2014/2015.

4.6.2. ANNUAL MONITORING OF COMMITTEE EFFECTIVENESS

An effectiveness/self-assessment review has been completed by all members and the outcome will be presented to the June 2015 Audit Committee meeting. Any key actions identified will be monitored by the Audit Committee.

4.6.3. ANNUAL AUDIT COMMITTEE PROGRAMME

An annual plan was continued which has been helpful in managing the Audit Committee's business. This is a live document which is reviewed and revised at regular intervals.

5. OTHER KEY ACTIVITIES OF THE AUDIT COMMITTEE DURING THE YEAR

5.1. ASSURANCE FROM OTHER COMMITTEES

The other main Committees providing assurance to the Audit Committee include the:

- Quality and Safety Committee
- The Finance, Recovery & QIPP Committee
- Remuneration & Nominations Committee
- Executive Committee

The Audit Committee has received reports about the activities of the above Committees from the Chairs of these Committees in 2014/2015.

5.2. GOVERNING BODY ASSURANCE FRAMEWORK

The priority for 2014/15 was to develop the Governing Body Assurance Framework (GBAF) further so that it was more focused and streamlined.

In 2014-15, following feedback from the Audit Committee, the Board Assurance Framework (BAF) and Risk Register was overhauled with the

support of Baker Tilly. The Audit Committee recommended a moderation exercise on the number of extreme risks scores to ensure that the BAF reflects the key strategic risk facing the CCG. The Committee also felt there was a significant amount of operational risks on the BAF which required review. The CCG Executive Committee considered the Audit Committee recommendations and agreed an amendment to the Risk Management Strategy so that the BAF reflects not just strategic extreme risk graded 15 and above but strategic high risks graded 12+.

In 2014/2015, two Governing Body risk workshops were facilitated by Baker Tilly on risk management as well as a deep dive into existing risks on the BAF. The second session involved a review of our 2015/2016 objectives and associated high level strategic risks. As part of this work, the existing risks on the Enfield CCG Board Assurance Framework were reviewed and either refreshed or closed down as appropriate. Updated risks, along with any newly-identified risks, were then migrated or aligned to a new and more easily digestible template to reflect feedback from the Governing Body and staff.

Internal Audit also carried out a review of the CCG's Governance Framework. It was noted that there is a much improved GBAF, but there was a low level recommendation for the CCG to ensure Controls and assurances documented on the Board Assurance Framework are described in sufficient detail including frequency of meetings and reports, names and dates of reports.

5.3. LOCAL COUNTER FRAUD SPECIALIST (LCFS) REPORTS

The Committee approved the LCFS's annual plan and has received regular progress reports through the year and an annual report. The LCFS's main activities were:

- Creating an anti fraud culture – through counter fraud awareness training, input to staff induction, publishing a regular newsletter, and organising road shows. The uptake of training during the year has continued to improve.
- Deterring fraud – a risk assessment was carried out which two proactive reviews were programmed.
- Preventing fraud – through effective policies.
- Detecting fraud – participation in national Counter Fraud and Security Management Service (CFSMS) proactive reviews.
- Investigating fraud – following up on allegations of fraud. As in previous years, a selective approach has been taken to investigating and following up frauds, 'filtering' those which are more appropriately dealt with managerially or through disciplinary procedures.
- Reviewing the Gifts & Hospitality Policy

5.4 CHIEF OFFICER'S ANNUAL GOVERNANCE STATEMENT

The Committee discussed the draft Annual Governance Statement at its April meeting and will approve the final version along with the annual report and accounts at its June meeting.

5.5 OTHER ROUTINE MATTERS

The Committee received a report at each meeting dealing with waivers and losses and compensation.

5.6 BRIEFING MECHANISMS

During the year, both the External and Internal Auditors have kept the Committee apprised of developments and key issues and developments in areas such as regulation and data protection. These updates have been circulated to the Committee and other directors where relevant and ensure that the Committee is kept up to date and made aware of key issues.

6. CONCLUSION

The Audit Committee is fully established as part of the CCG's integrated governance framework. It is able to apply independent scrutiny to the CCG's management and provide a focus for improvements across a wide range of activities.

For 2014/2015, Enfield CCG failed to achieve its statutory duty in regard to financial performance in 2014/15.

The (CCG) budget for the 2014-15 financial year was a £5.6m deficit. After a thorough review involving external objective opinion the CCG indicated a likely deficit of £19.0m at the end of the financial year and subsequently recorded a deficit of £18.9m. This was caused by increased activity in both emergency and planned care under Payment by Results.

Enfield CCG is currently finalising a recovery plan with the aim of returning to financial balance as soon as possible.

The Committee is assured that robust measures are in place to support financial recovery and governance arrangements include:

- Monthly Finance Committee receiving improved and comprehensive information
- Monthly Transformation Programme Group (TPG) to oversee development of the three year Transformation Programme as well as in between fortnightly meetings focusing on performance.
- The appointment of a Recovery Director reporting directly to the Chief Officer
- Implementation of the recommendations included in the Financial Governance Review

The Committee is of the opinion that this annual report is consistent with the annual governance statement, Head of Internal Audit opinion, and that there are no matters that the Committee is aware of at this time that has not been disclosed appropriately.

Karen Trew
Chair
Audit Committee

May 2015

Clinical Commissioning Group

Agenda Item: 10.1
Paper Ref: Appendix R

MEETING:	NHS Enfield Clinical Commissioning Group Governing Body
DATE:	10 June 2015
TITLE:	Enfield Clinical Commissioning Group Patient and Public Engagement (PPE) Committee's Report
LEAD BOARD MEMBER:	Teri Okoro, Lay member for Patient and Public Engagement & Aimee Fairbairns, Director of Quality and Integrated Governance
AUTHOR & POSITION:	Laura Andrews, Patient and Public Engagement Manager
CONTACT DETAILS:	Laura.andrews@enfieldccg.nhs.uk

SUMMARY:

This Patient and Public Engagement (PPE) report provides an update about 7 May 2015 meeting of the PPE Committee.

The key achievements for Patient and Public Engagement since March 2015 report :

- **PPG Representative Election process-** Litsa Worrall was elected to sit on the Governing Body. The PPG network meeting was held on 21 May to introduce Litsa Worrall to the PPGs and for PPGs to agree how they would work together in the future
- **Annual Report and Accounts 2014-15-** The Annual Report and Accounts were completed and forwarded to NHS England on Friday 29 May as required. This is on the website: <http://www.enfieldccg.nhs.uk/about-us/annual-report-and-accounts-2014-15.htm>
- **Engagement Events –**
NHS 111/GP OHHs Over 50s engagement event attended by the Project Manager and Head of Communications and Engagement to explain the proposals was well received by members.
Enfield Carers Centre – Carers event attended by Dr Ujjal Sarkar and Patient and Public Engagement Manager.
- **Health and Care Careers Information Event on 22 April 2015-** Nurse Member for the Governing Body and Head of Communications and Engagement provided information on careers in the NHS for 4 schools in Enfield as well as supplying information concerning Choose Well Campaign. The students who attended felt it was very useful and asked that this be made an annual event

SUPPORTING PAPERS:

None.

RECOMMENDED ACTION:

The Governing Body is asked to:

- Note the contents of the rest of the report.

Objective(s) / Plans supported by this paper: This paper supports the Enfield Clinical Commissioning Group's (CCG) communications and engagement plan and the equality and diversity plan, both of which the PPE Committee is responsible for delivering and monitoring.

Patient and Public Involvement (PPI): Enfield CCG's PPE Committee will take a strategic lead in embedding patient and public involvement at all levels within the CCG and is planning how the organisation can best achieve this through continuous development and review of the PPE workplan.

Equality Impact Analysis: This paper indicates how the CCG is working to fulfil both its statutory obligations under the Equality Act 2010 and embed patient and public involvement in the CCG.

Risks: Risks identified by the PPE Committee will be recorded in the corporate risk register

Resource Implications: Not applicable

Audit Trail: This paper is a summary of the CCG's PPE Committee meeting on 7 May 2015 and is a regular Governing Body paper. It also includes wider engagement activities.

Next Steps:

Equality and Diversity System (EDS2):

- The establishing of an Equality and Diversity Staff Forum which aims to provide a safe and supportive space for staff to talk about issues and to plan activities that promote equality, diversity and inclusion.
- Equality Task and Finish Group continues to work on achieving the Equality Objectives

Patient Participation Groups (PPG):

- PPGs have developed a workplan with the newly appointed elected representative
- PPG s continued to work together in developing their Network

Patient and Public Engagement Events:

- An update on the Patient and Public Engagement Event held on 3 June will be provided at the next Governing Body meeting

Patient and Public Engagement Annual Report: NHS England have provided the draft template for the Patient and Public Engagement Annual Report which will be developed in the coming months and presented to the Governing Body meeting in September 2015 for approval.

Patient and Public Engagement Update Report

1. Mental Health commissioning priorities

The interim Tri-Borough Mental Health Programme Manager advised committee members that the two main commissioning priorities were:

- Individual access to Psychological therapies (IAPT) – early intervention
- Choice in Mental Health Care

It was confirmed that a range of IAPT services was being provided by Barnet, Enfield and Haringey Mental Health Trust to different communities and these services were available to Enfield GP registered patients as well as unregistered patients.

There are also a new range of digital IAPT services that are being evaluated. The CCG is working closely with BEH MHT on the evaluation of these digital options and also to support marketing and targeting of IAPT services across different communities and age groups.

Barnet, Enfield and Haringey CCGs have also worked together to produce a local crisis concordat action plan. This has now been uploaded and shared with all stakeholders.

2. PPG representative election process

The PPE Committee welcomed the appointment of Litsa Worrall as the elected Patient Participation Group representative. This completes a democratic process that was carefully planned through the PPE Committee with delegated responsibility from the Governing Body.

As part of her new role, Litsa will attend the PPE Committee and the Governing Body as a non-voting member where she will represent the views of patients at member practices. She will also chair the PPG network meetings and will work closely with PPGs across Enfield.

Litsa was previously the interim Patient Participation Group representative and this post was shared with Bill Mackay. Bill was thanked for all his hard work over the past year. The two patient volunteers from PPGs in Croydon and Haringey on the interview panel were also thanked.

The other election candidate Lorraine Eytel has been invited to be vice chair of the PPG network and will take an important role moving forwards in supporting Litsa.

3. Communications and Engagement Strategy

The CCG's Communications and Engagement Strategy was approved on the 9 January 2014 and is a three year strategy. An annual review opportunity was included to give the CCG the opportunity to update the strategy with any developments, for example new methods of engagement.

The Strategy is an overarching and comprehensive corporate document that provides a broad overview of the way the CCG communicates and engages with the public and is complemented by bespoke plans for CCG work programmes and projects.

No changes to the Strategy were agreed but it was recognized that Healthwatch provided a comprehensive response to this agenda item.

4. Equality and Diversity update

NHS England has published a new EDS2 monitoring template. Our approach to EDS2 has been agreed by the Governing Body and the information will be transferred to the new template and published.

The EDS2 task and finish group met on 27 May.

5. Healthwatch update

Healthwatch published two reports in March 2015:

- Improving the health of deaf patients in Enfield
- GP audit report

Healthwatch have also carried out two acute adult mental health ward visits:

- Suffolk Ward at Chase Farm Hospitals
- Downhills Ward at St Ann's Hospital

The joint visit with Healthwatch Barnet to The Oaks mental health ward and to Hugh Myddelton House nursing home will be published shortly.

In the coming months Healthwatch are planning to visit care homes specialising in care for younger people with disabilities, including learning disabilities.

Engagement has also taken place with the Chinese and Turkish communities, Enfield Homes Access to Services forum, the Over 50s and a range of other pop-up stalls.

6. Update from Public Health

Dr Tha Han will present on social prescribing and a planned GP registration campaign at the next PPE meeting.

END OF REPORT

**MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD
HELD ON TUESDAY, 14 APRIL 2015**

MEMBERSHIP

PRESENT Shahed Ahmad (Director of Public Health), Deborah Fowler (Enfield HealthWatch), Liz Wise (Clinical Commissioning Group (CCG) Chief Officer), Vivien Giladi (Voluntary Sector), Donald McGowan, Ayfer Orhan and Doug Taylor (Leader of the Council)

ABSENT Ian Davis (Director of Environment), Andrew Fraser (Director of Schools & Children's Services), Ray James (Director of Health, Housing and Adult Social Care), Litsa Worrall (Voluntary Sector), Dr Henrietta Hughes (NHS England), Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Kim Fleming (Director of Planning, Royal Free London, NHS Foundation Trust), Julie Lowe (Chief Executive North Middlesex University Hospital NHS Trust) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

OFFICERS: Bindi Nagra (Joint Chief Commissioning Officer), Sharon Burgess (Head of Service - Safeguarding Adults, Complaints and Quality Assurance), Allison Duggal (Public Health Consultant) and Richard Young (Interim Programme Manager) Penelope Williams (Secretary)

Also Attending: Bindi Nagra (Assistant Director Strategy and Resources, Health Housing and Adult Social Care) standing in for Ray James. Lance McCarthy (Deputy Director of North Middlesex University Hospital NHS Trust) standing in for Julie Lowe.

1

WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies for absence were received from Mo Abedi (Chair of the Enfield Clinical Commissioning Group), Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust), Kim Fleming (Royal Free London NHS Trust), Andrew Fraser (Director of Schools and Children's Services), Ray James (Director of Health, Housing and Adult Social Care), Julie Lowe (North Middlesex University Hospital NHS Trust).

Bindi Nagra (Assistant Director Strategy and Resources, Health Housing and Adult Social Care) was standing in for Ray James.

Lance McCarthy (Deputy Director of North Middlesex University Hospital NHS Trust) was standing in for Julie Lowe.

2

DECLARATION OF INTERESTS

There were no declarations of interests.

3

CLINICAL COMMISSIONING GROUP (CCG) OPERATING PLAN 2015/16 - DRAFT SUBMISSION (6:35-6:50PM)

The Board received a report on the draft submission of the Enfield Clinical Commissioning Group (CCG) Operating Plan 2015/16 from Graham MacDougall, Director of Strategy and Performance.

1. In Graham MacDougall's absence the report was presented by Liz Wise (CCG Chief Officer) and Richard Young (Interim Better Care Fund Programme Manager/Interim Strategic Planning Programme Manager). The following points were highlighted:
 - Detailed discussion on the Operating Plan had taken place at the Board's last development session.
 - An initial submission had been made on 7 April 2015: the final submission was due on 14 May 2015.
 - The final format has had to be changed to meet new guidance from NHS England including more detail and greater granularity. However the content will be substantially the same.
 - Strategic interventions and issues discussed at the development session would be taken forward by the Integration Sub Board.

2. Questions/Issues Raised by the Board

- 2.1 The key changes were in the detail, setting out the underpinning calculations and the figures around accident and emergency admissions. The principles and the discussion still stand.
- 2.2 Some concern was expressed about the proposals for patient and public involvement. It was felt that many of the GP patient groups were not fully developed and as a result too few candidates had been put forward to take part. Richard Young agreed to pick up on this issue and talk to Vivien Giladi outside of the meeting.
- 2.3 The Better Care Fund was reflected in the Operating Plan.
- 2.4 Liz Wise agreed to organise a seminar to explore the financial issues in more detail and to explain how she would be working with the other 4 North Central London CCGs to develop five year plans.

- 2.5 Working with the other CCGs will enable a more holistic and integrated approach, highlighting the gaps in social care and areas in need of transformation.
- 2.6 After the general election, it is likely that the strategic plans will need to be looked at again.

AGREED

1. To approve the 2015/16 Operating Plan in principle as in the draft attached to the report.
2. To delegate the final plan sign off, to the Chair, who will sign the final submission, on behalf of the board.

4

PHARMACEUTICAL NEEDS ASSESSMENT (6:50-7:10PM)

The Board received the report on the Pharmaceutical Needs Assessment (PNA)

Allison Duggal (Public Health Consultant) presented the report to the Board highlighting the following:

- The PNA has been designed to enable an understanding of current and future pharmaceutical needs. This is the final version.
- It is a statutory requirement that it is published in April 2015.
- The production of the assessment has been overseen by a multiagency steering group.
- A 60 day consultation period taken place and all comments received incorporated in the final document.

2. Questions/Comments

- 2.1 It was suggested that the PNA be retitled for the 3 years it covers: 2015-18.
- 2.2 If there were changes in the future, supplementary statements could be issued.
- 2.3 When the assessment has to be renewed, after three years, it should be a much smoother and less expensive process, due to the work put in this time.
- 2.4 Members appreciated the consultation process that had taken place. A summary of the responses has been included as an appendix. The full version could be available if necessary.

- 2.5 Members welcomed the resource and praised the excellent work that had been done by Alison Duggal and her team.
- 2.6 It was suggested that it would have been helpful to have included percentages in the table on page 32 of the assessment.
- 2.7 The finding that the rate of community pharmacies per population in Enfield is below average for England and that providers in Enfield currently dispense more prescriptions compared with the average community pharmacy in England was telling. Any future gaps in provision would be addressed through additional statements. The NHS will take the PNA into account when looking at extra provision.
- 2.8 Liz Wise felt that the pharmacists could potentially provide an even wider range of health services particularly in the areas such as urgent care and long term illnesses. The pharmacies were an important part of primary care.
- 2.9 Some concern was expressed about the limited range of opening hours in some areas. There were a number of pharmacies that stayed open up until midnight, but none were open 24 hours a day in Enfield.

AGREED that

1. The Board approves the publication of the new Pharmaceutical Needs Assessment attached as appendix 1 to the report.
2. Takes into consideration the statutory requirement to meet its obligation to publish the PNA by April 2015.

5

ADJUSTMENTS TO THE BETTER CARE FUND PLAN REDUCING EMERGENCY ADMISSIONS TARGET (7:10-7:25PM)

The Board received a report setting out adjustments to the Better Care Fund Plan Reducing Emergency Admissions Target.

Richard Young presented the report to the Board highlighting the following:

- NHS England has issued guidance that the ambition for the level of improvement agreed by CCGs and Councils in Better Care Fund plans should be reviewed in the light of the current increased level of emergency hospital admissions.
- In order to achieve the original target of 3.5% (a reduction of 908 from a total of 25,965 admissions) the required reduction would be 18% of an outturn of 30,463 admissions.

- Two options were considered: to recalculate the activity baseline and generate a new admissions reduction target at 3.5%: to maintain the existing reduction target generating a new percentage target reduction of 1065.

2. Questions/Comments

- 2.1 There had been a step change in the numbers of accident and emergency admissions across the country which was difficult to understand. It was unclear whether this was a rectification of clinical behaviour or a new phenomenon. This was not accounted for by the increasing number of people attending accident and emergency departments.
- 2.2 The change had occurred in Autumn 2013 with a 20% rise in the conversion rate. It was noted that this was a national phenomenon and that these figures were not true of North Middlesex University NHS Hospital which has one of the lowest conversion rates in the country.
- 2.3 Enfield is suffering from the same pressures as elsewhere in London and nationwide. More people are presenting at accident and emergency departments, this however is a separate phenomenon, but which also adds to the impact of the target in Enfield.
- 2.4 The reality of the 3.5% target means a reduction of 7% to maintain the levels in the current system and finances, partly due to the growth in the local population and changing demographics.
- 2.5 As part of the CCG planning process, the Health and Wellbeing Board have been asked to agree to revising the target connected to the performance of the Better Care Fund. The choice is to maintain the existing target or deviate from it.
- 2.6 The question was asked that as we did not meet the target last year, why should we meet it this year.
- 2.7 The question had been discussed at length by the Integration Sub Board and they felt that if the target was altered it would also mean making changes to other plans which would be more difficult. Some of the initiatives that had been started as part of the Better Care Fund were having an impact.
- 2.8 The risk of not meeting the target will be managed.

AGREED to approve the recommendation from the Integration Sub Board to agree to Option 1 – a new target reduction of 1,065 admissions, based on the existing percentage 3.5% reduction target.

6

ADULT SAFEGUARDING STRATEGY (7:25-7:45PM)

The Board received a report on the draft Adult Safeguarding Strategy.

1. Presentation of the Report

Sharon Burgess, Head of the Safeguarding Adults, Quality, Improvements and Complaints presented the report to the Board highlighting the following:

- The Care Act which came in on 1 April 2015 requires all local authorities to publish annually an adult safeguarding strategy. Enfield has had a strategy since 2009.
- Key elements of the strategy were that it is free from jargon and written in Plain English.
- The aims of the strategy were to prevent abuse from occurring, to ensure adequate support where dignity is respected and to provide support which is person centred once harm occurs.
- The strategy and its action plan related to the 6 key principles set out by the Government and included in the Care Act.
- The strategy has been developed with partners and those who use the services.
- It has been developed within the “Making Safeguarding Personal in Enfield” agenda and has achieved the gold standard for the partnership work with Bournemouth University and Enfield’s quality checkers.

2. Questions/Comments

- 2.1 The service was congratulated on receiving the gold award.
- 2.2 Adults were working together in partnership with Children’s Services and were aware of the need to address the transition gap between the two safeguarding services.
- 2.3 It was felt that it would be helpful to include some higher level actions between the preamble and the tables in the strategy to make a smoother link.
- 2.4 The targets were long term. It was felt that it would be better to make sure that they were achievable and that they could be embedded along with the other measures being bought in by the Care Act.
- 2.5 Enfield was one of the first authorities to adopt a strategy and this had been developed using a successful team based approach which had been widely praised.

- 2.6 The current strategy had been a refresh of the earlier one including actions over 1,2 and 3 years and incorporating the new safe standards.

AGREED to note the content of the strategy and action plan.

7

SUB BOARD UPDATES (7:45-8:25PM)

1. Health Improvement Partnership Board Sub Board Update

The Board received the report updating them on the work of the Health Improvement Partnership Board.

1.1 Presentation of the Report

Allison Duggall presented the report to the Board, highlighting the following:

- Work was continuing to address health inequalities, working in partnership in the five key priority wards using a spectrum of different measures to ensure health outcomes are maximised and health inequalities not widened.
- Healthy lifestyles were being promoted, addressing long term conditions, encouraging more physical activity, healthy eating and not smoking. Key initiatives include Cycle Enfield, Active and Creative Enfield, Step Jockey and a bid to Sports England.
- Public Health officers, following training, are now inputting into licensing applications.
- A pilot project providing information and advice in pharmacies is planned, starting in May 2015.
- Work on child poverty is being carried out by Public Health with Price Waterhouse Coopers and the Enfield 2017 team. An action plan had been put in place to address the issues.
- A successful conference on Female Genital Mutilation (FGM) was held on 20 March 2015.
- An assessment of sexual health needs has been carried out which will lead to procurement of the service and a refresh of the strategy.
- Two notable achievements: Ofsted had judged safeguarding services in Enfield as good and Enfield had been awarded excellent by the Greater London Authority as a healthy workplace.

1.2 Questions/Comments

- 1.2.1 Members congratulated officers on their excellent work in this area.

- 1.2.2 Measures were in place to ensure that the child sexual exploitation work being carried out by the Children's Safeguarding Board would be taken account of in commissioning services.
- 1.2.3 The Public Health Team had four statutory duties: those that support the CCG are now based in Holbrook House, approximately 8 officers. Ten other members of staff are embedded in services across the council.
- 1.2.4 Enfield is the only authority in London which has been graded good for child protection services.
- 1.2.5 A new sexual exploitation task group has been set up to look at this area of work. They will be scrutinising all work carried out both internally and externally. This task group is the only one of its kind in London and will ensure that robust procedures are in place to prevent child sexual exploitation taking place in Enfield.
- 1.2.6 The granting of the Healthy Workplace Award to the Council is important for encouraging other employers to become healthy work places.
- 1.2.7 The outcome of the Sports England bid is not yet known.
- 1.2.8 An 8% reduction in hospital admissions has been achieved by the Care Homes Assessment Team as part of the larger Integrated Care target.

AGREED to note the content of the report.

2. Joint Commissioning Board Update

The Board received an update report from the Joint Commissioning Board Sub Board.

2.1 Bindi Nagra (Assistant Director Strategy and Resources – Health, Housing and Adult Social Care) presented the report to the Board and asked for questions.

2.2 Questions/Comments

2.2.1 Various reviews had been undertaken on both commissioning and procurement linked to the information and advice requirements of the Care Act and with work being done by Enfield 2017. The front end access point is the Council website. Key is wellbeing in its wider sense.

2.2.2 The Council was considering the best approach to the provision of the work of the Family Nurse Partnership and Health Visitors once the transfer to the Council due in October 2015 has occurred. The Family Nurse Partnership

had not taken on any new referrals due to the illness of one of the members of staff.

2.2.3 Concern about the growth of the use of Laughing Gas (Nitrous Oxide) by young people was an issue that could be considered by the Drug and Alcohol Action Team and would be referred to them.

AGREED that the Board note the content of the report.

3. Improving Primary Care Sub Board Update

The Board received an update report from the Improving Primary Care Sub Board.

3.1 Liz Wise, Enfield CCG Chief Officer, introduced the report to the Board:

- The current three year primary care strategy programme ended on the 31 March 2015. From 1 April 2015 a new way of working is being developed by the five North Central London CCGs for joint co-commissioning arrangements with NHS England, to take effect from October 2015. A shadow period will operate between April and October 2015.

3.2 Questions/Comments

3.2.1 Local Government is involved in the proposals for co-commissioning. The CCG's are currently looking at the best way to engage them and this was discussed at the last meeting of the CCG governing body. Crucial work is taking place on estates and regeneration.

3.3 The aim is that the primary care commissioning framework becomes more proactive, accessible and consistent.

3.4 The CCG is assessing where we are locally and will then look to fill the gaps. Where more services are needed, they will work with NHS England to provide them.

3.5 The benefits of working with Camden and Islington are more than the dis-benefits.

3.6 Some of the Enfield initiatives are being carried forward including the Minor Ailments Scheme, the work with University College London and the IT improvements.

3.7 It was important to take forward what was right for Enfield. The first 6 months will provide an opportunity for a local refresh.

AGREED to note the contents of the report.

4. Integration Board Update

The Board received an update from the Integration Board.

4.1 Richard Young (Interim Better Care Fund Programme Manager/Interim Strategic Planning Programme Manager) presented the report to the Board:

- Much of the information about integrated care had been discussed elsewhere on the agenda.
- The business case for integration was discussed at the first meeting and the clinical case will be discussed at the next meeting.
- The old programme board has now been disestablished and replaced by the new board structures.

4.2 Questions/Comments

4.2.1 The Older People Working Group will be reformed as part of the programme delivery group. Their work will not be lost, but will be bought in to develop the new group.

4.2.2 Concern was expressed that not all interests were represented on the Integration Board: there was little representation from the secondary care sector. The Sub Board membership had been agreed at the last board meeting with only members of the full board given voting rights. The terms of reference will be reviewed in 3 months. Named substitutes were permitted in the current terms of reference.

AGREED to note the report.

8

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

The minutes of the meeting held on 12 February 2015 were agreed and signed as a correct record.

9

DATES OF FUTURE MEETINGS

Members noted that dates for next year will be agreed at Annual Council on 13 May 2015.

Clinical Commissioning Group

Agenda Item: 14
Paper Ref: Appendix T

Governing Body Meeting Checklist

10 June 2015

Meetings of the audit committee	Yes	No
1. Were papers received in a timely manner?		
2. Did everyone feel welcomed and valued?		
3. Was prime time given to planning further action on important issues and/or projects?		
4. Did the meeting begin and end on time?		
5. Was each member of the group treated with respect?		
6. Are there any suggestions for improvement?		