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THE CABINET

Wednesday, 27th April, 2011 at 7.00 pm in Room 1, Civic Centre, Silver Street, Enfield, EN1 3XA

Membership:

Councillors : Doug Taylor (Leader of the Council), Achilleas Georgiou (Deputy Leader, Public and Service Delivery), Chaudhury Anwar MBE (Cabinet Member for Community Cohesion and Capacity Building in the Third Sector), Chris Bond (Cabinet Member for Environment, Street Scene and Parks), Bambos Charalambous (Cabinet Member for Young People and Culture, Leisure, Sports and the Olympics), Del Goddard (Cabinet Member for Regeneration and Improving Localities), Donald McGowan (Cabinet Member for Older People, Health and Adult Social Care), Ayfer Orhan (Cabinet Member for Education and Children's Services), Ahmet Oykener (Cabinet Member for Housing and Area Improvements) and Andrew Stafford (Cabinet Member for Finance, Facilities and Human Resources)

NOTE: CONDUCT AT MEETINGS OF THE CABINET

Members of the public and representatives of the press are entitled to attend meetings of the Cabinet and to remain and hear discussions on matters within Part 1 of the agenda which is the public part of the meeting. They are not however, entitled to participate in any discussions.

AGENDA – PART 1

1. APOLOGIES FOR ABSENCE

2. DECLARATION OF INTERESTS (Pages 1 - 2)

Members of the Cabinet are invited to identify any personal or prejudicial interests relevant to items on the agenda. Please refer to the guidance note attached to the agenda.

DECISION ITEMS

3. URGENT ITEMS

The Chairman will consider the admission of any late reports (listed on the agenda but circulated late) which have not been circulated in accordance with the requirements of the Council's Constitution and the Local Authorities (Executive Arrangements) (Access to Information) (England) Amendment Regulations 2002.
Note: The above requirements state that agendas and reports should be circulated at least 5 clear working days in advance of meetings.

4. DEPUTATIONS AND PETITIONS

To note that no requests for deputations (with or without petitions) have been received for presentation to this Cabinet meeting.

5. ITEMS TO BE REFERRED TO THE COUNCIL

To confirm the following items for referral to the Council following consideration by the Cabinet:

1. Report No.235 – Enfield Joint Dementia Strategy 2011-2016 (agenda item 7 refers)

2. Report No.236 – Enfield Joint Intermediate Care and Re-ablement Strategy 2011-2014 (agenda item 8 refers)

6. REVENUE AND PERFORMANCE MONITORING REPORT - FEBRUARY 2011 (Pages 3 - 30)

A report from the Director of Finance and Corporate Resources is attached. This sets out the Council's revenue budget monitoring position for 2010/11 based on information at the end of February 2011. **(Key decision – reference number 3198)**

(Report No.234)
(7.10 – 7.15 pm)

7. ENFIELD JOINT DEMENTIA STRATEGY 2011-2016 (Pages 31 - 160)

A report from the Director of Health, Housing and Adult Social Care is attached. This seeks approval of the Enfield Joint Dementia Strategy 2011-2016. **(Key decision – reference number 3260)**

(Report No.235)
(7.15 – 7.20 pm)

8. **ENFIELD JOINT INTERMEDIATE CARE AND RE-ABLEMENT STRATEGY 2011-2014** (Pages 161 - 248)

A report from the Director of Health, Housing and Adult Social Care is attached. This seeks approval of the Enfield Joint Intermediate Care and Re-ablement Strategy 2011-2014. **(Key decision – reference number 3259)**

(Report No.236)
(7.20 – 7.25 pm)

9. **ASSET MANAGEMENT - POTENTIAL DISPOSAL OF COUNCIL OWNED PROPERTIES BEFORE 1 APRIL 2013** (Pages 249 - 254)

A report from the Director of Finance and Corporate Resources is attached. This seeks approval to the potential disposal of Council owned properties before 1 April 2013. **(Key decision – reference number 3218)**

(Report No.237)
(7.25 – 7.30 pm)

10. **LADDERSWOOD REGENERATION REPORT: SELECTION OF PREFERRED DEVELOPMENT PARTNER** (Pages 255 - 266)

A report from the Director of Regeneration, Leisure and Culture and Director of Health, Housing and Adult Social Care is attached. This seeks approval to the selection of the preferred bidder for the Ladderswood Place Shaping Programme. (Report No.240, agenda part two also refers) **(Key decision – reference number 3220)**

(Report No.238)
(7.30 – 7.35 pm)

11. **EXTENSION OF EXISTING SUPPORTING PEOPLE CONTRACTS** (Pages 267 - 272)

A report from the Director of Health, Housing and Adult Social Care is attached. This seeks approval to enter into supporting people contracts for a period of two years. (Report No.241, agenda part two also refers) **(Key decision – reference number 3250)**

(Report No.239)
(7.35 – 7.40 pm)

12. **ISSUES ARISING FROM THE OVERVIEW AND SCRUTINY PANEL/SCRUTINY PANELS**

No items have been received for consideration at this meeting.

13. CABINET AGENDA PLANNING - FUTURE ITEMS (Pages 273 - 276)

Attached for information is a provisional list of items scheduled for future Cabinet meetings.

14. KEY DECISIONS FOR INCLUSION ON THE COUNCIL'S FORWARD PLAN

Members are asked to consider any forthcoming key decisions for inclusion on the Council's Forward Plan.
Note: the next Forward Plan is due to be published on 17 May 2011, this will cover the period from 1 June to 30 September 2011.

15. MINUTES OF LBE/EREC - 11 JANUARY 2011 (Pages 277 - 284)

To receive, for information, the minutes of a meeting of LBE/EREC held on 11 January 2011.

16. MINUTES OF HEALTH CABINET SUB-COMMITTEE - 7 APRIL 2011 (Pages 285 - 290)

To receive, for information, the minutes of a meeting of the Health Cabinet Sub-Committee held on 7 April 2011.

17. MINUTES (Pages 291 - 308)

To confirm the minutes of the previous meeting of the Cabinet held on 9 March 2011.

INFORMATION ITEMS

18. ENFIELD STRATEGIC PARTNERSHIP FEEDBACK

To receive an oral update from members of the Enfield Strategic Partnership Board (Councillor Doug Taylor and Councillor Achilleas Georgiou).

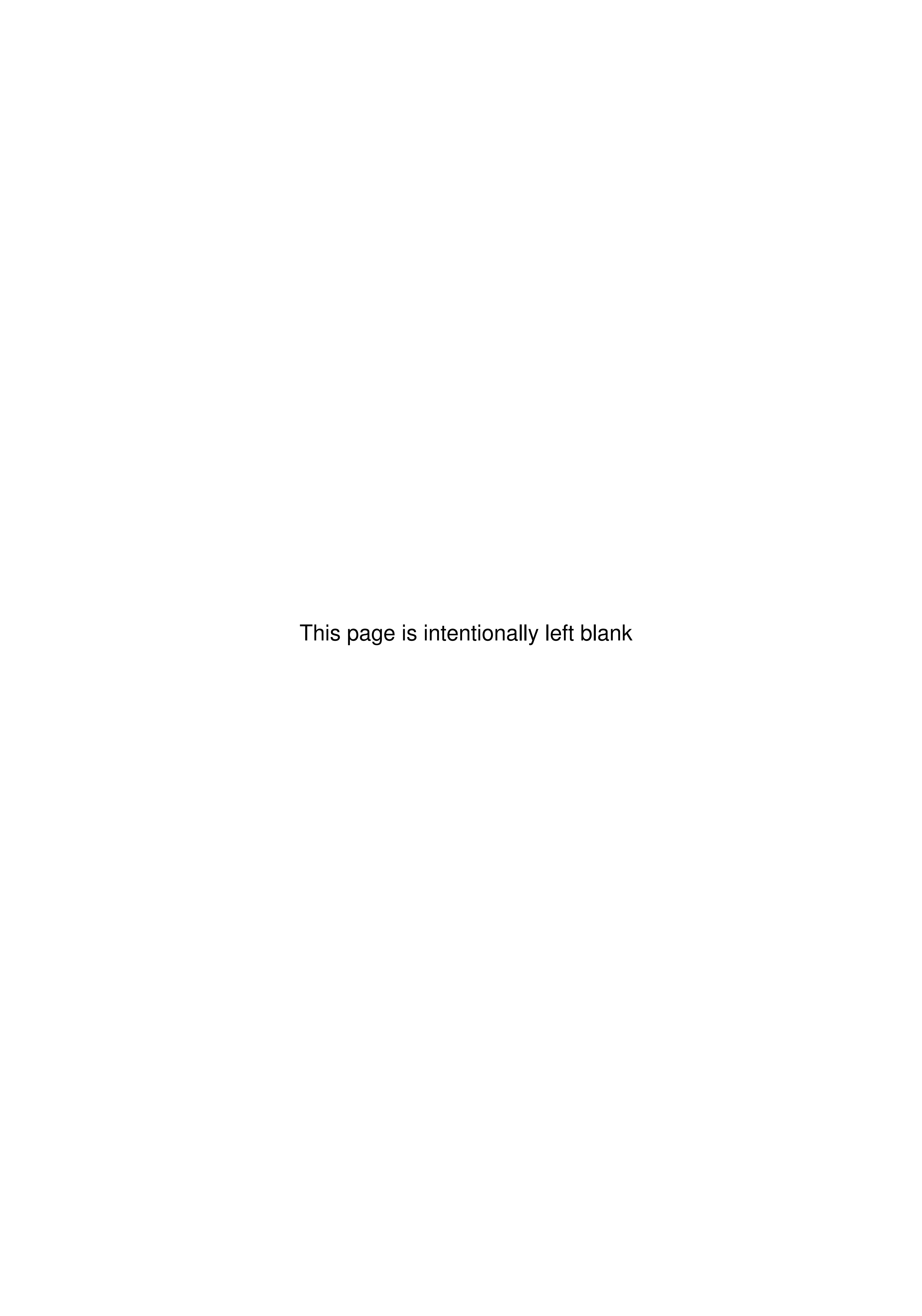
19. DATE OF NEXT MEETING

This is the last Cabinet meeting in the current municipal year. The first meeting of the Cabinet in the municipal year 2011/12 is scheduled to take place on Wednesday 25 May 2011 at 7.00 pm at the Civic Centre (subject to confirmation of the Council's calendar of meetings for the municipal year 2011/12).

CONFIDENTIAL ITEMS

20. EXCLUSION OF THE PRESS AND PUBLIC

To consider passing a resolution under Section 100A(4) of the Local Government Act 1972 excluding the press and public from the meeting for the items of business listed on part 2 of the agenda on the grounds that they involve the likely disclosure of exempt information as defined in those paragraphs of Part 1 of Schedule 12A to the Act (as amended by the Local Government (Access to Information) (Variation) Order 2006).
(Members are asked to refer to the part 2 agenda)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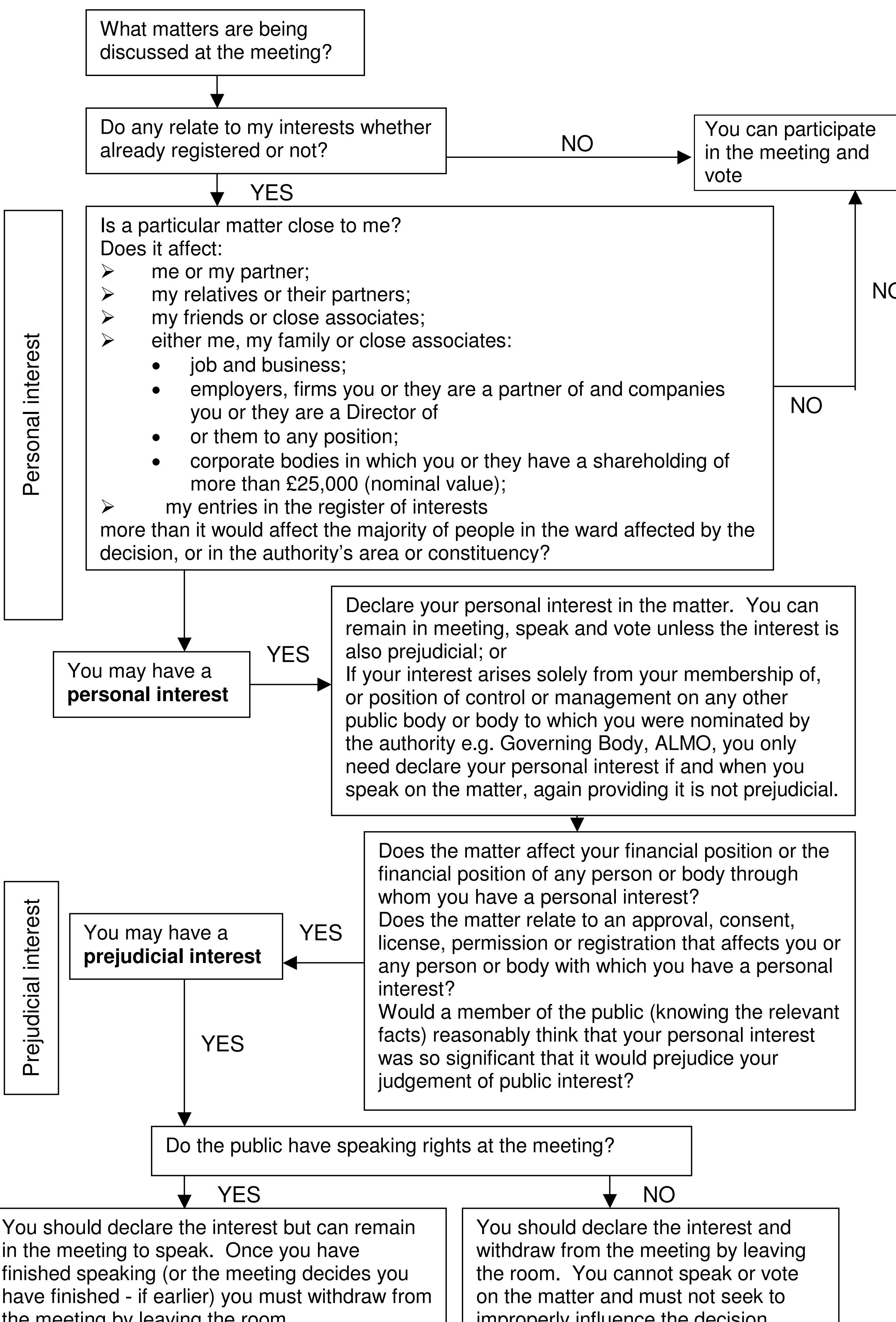
DECLARING INTERESTS FLOWCHART - QUESTIONS TO ASK YOURSELF



Note: If in any doubt about a potential interest, members are asked to seek advice from Democratic Services in advance of the meeting.

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MUNICIPAL YEAR 2010/2011 REPORT NO. 234

MEETING TITLE AND DATE:
Cabinet 27th April 2011

REPORT OF:
Director of Finance and Corporate Resources

Contact:
Isabel Brittain: 0208 379 4744

AGENDA PART 1 **ITEM 6**
Subject: Revenue and Performance Monitoring Report - February 2011
Wards: All

Cabinet Member consulted:
Councillor Andrew Stafford

1. EXECUTIVE SUMMARY

1.1 This report sets out the Council's revenue budget monitoring position for 2010/11 based on information to the end of February 2011. The report indicates a projected underspend on the General Fund of £339k in 2010/11. This figure assumes that the recommendations for carry forwards detailed below are agreed.

2. RECOMMENDATIONS

It is recommended that Cabinet:

2.1 Notes the revenue outturn projection of £339k underspend in 2010/11.

2.2 Approves the transfer of additional Performance Reward Grant to Earmarked Reserves as set out in paragraph 4.5.

2.3 Approves the list of additional spending items set out in Appendix 1 of £3.902m, funded from departmental underspends.

2.4 Approves the list of Project Carry Forwards totalling £2.706m as set out in Appendix 2.

2.5 Approves the list of Grant carry forwards totalling £7.551m as set out in Appendix 3

2.6 Delegates the final decision on the allocation of funding to each of these measures to the Leader of the Council, in consultation with the Lead Member for Finance and Resources and the Director of Finance and Corporate Resources.

2.7 Notes the recommended contribution to an invest to save reserve of £1.197m with regard to mixed garden and food waste as set out in paragraph 4.6.

2.8 Approves the use of resources of £3.026m previously set aside for the Building Schools for the Future programme as set out in paragraph 5.8.

3. BACKGROUND

3.1 The Council's revenue expenditure against budget is monitored via the regular monitoring reports to CMB and Cabinet. These reports provide a snapshot of the revenue position for each Department and for the Council as a whole, and provide details of any projected additional budget pressures and risks, or any significant underspends. The underspent funds, outlined in this report, can be appropriated in a number of ways. Appendix 1 sets out items to be considered for contributions to other funding streams, such as capital and redundancy reserves. Appendix 2 sets out for approval the schedule of project carry forward items from 2010/11. Appendix 3 sets out for consideration and approval those unspent revenue grants and contribution balances expected to be unapplied at 31st March 2011 and the proposed use of the funding in future years.

3.2 The Revenue Monitoring Report is a result of the monthly monitoring process carried out by the individual Departments, which is based on the following principles to ensure accuracy, transparency and consistency:

- Risk assessments, to enable greater emphasis to be placed on high-risk budgets throughout the year.

- Comparisons between expenditure to date, current budgets and budget profiles.

- Expenditure is predicted to the year-end, taking account of seasonal fluctuations and other determinants of demand.

- The 'Key Drivers' that affect, particularly, the high-risk budgets are monitored and reported to Department Management Teams.

- Action plans to deal with any areas that are predicting or experiencing problems staying within agreed budgets are produced.

4. FEBRUARY 2011 MONITORING - GENERAL FUND

4.1 A summary of the departmental projected outturns and variances against budget is shown in the table below:

Monitoring Statement for February 2011 - General Fund

	Original Budget	Approved Changes	Approved Budget	Projected Outturn	Projected Variation
	£000s	£000s	£000s	£000s	£000s
Chief Executive	820	1,248	2,068	1,623	(445)
Environment	40,947	942	41,889	41,879	(10)
Finance and Corporate Resources	22,143	1,220	23,363	22,561	(802)
Health, Housing &	102,507	523	103,030	102,071	(959)

Monitoring Statement for February 2011 - General Fund

	Original Budget	Approved Changes	Approved Budget	Projected Outturn	Projected Variation
	£000s	£000s	£000s	£000s	£000s
Adult Social Care					
Regeneration, Leisure & Culture	15,479	861	16,340	16,159	(181)
Schools & Children's Services	73,740	(1,922)	71,818	70,793	(1,025)
Total Department Budgets	**255,636**	**2,872**	**258,508**	**255,086**	**(3,422)**
Treasury Management	10,265	0	10,265	10,065	(200)
Contribution from Capital Financing Account	(9,759)	0	(9,759)	(9,759)	0
Contribution to Bad Debt Provision	500	0	500	500	0
Contribution to/ from Reserves	(4,451)	(2,104)	(6,555)	(5,358)	1,197
IT Fund	670	302	972	972	0
One off ICT Provision	2,401	(2,401)	0	0	0
Contingent Items	3,692	(843)	2,849	2,033	(816)
Unallocated ABG (WNF)	1,781	(217)	1,564	1,564	0
Contingency	1,000	0	1,000	0	(1,000)
Total Service Expenditure	**261,735**	**(2,391)**	**259,344**	**255,103**	**(4,241)**
Levies	9,629	0	9,629	9,629	0
Area Based Grant	(28,788)	2,391	(26,397)	(26,397)	0
Total Budget Requirement	**242,576**	**0**	**242,576**	**238,335**	**(4,241)**
Carry Forwards	**0**	**0**	**0**	**3,902**	**3,902**
Final Budget Position	**242,576**	**0**	**242,576**	**242,237**	**(339)**

4.2 The departmental underspend has increased by £2.0m on the January Monitor. This is mainly due to:

- Schools and Children's Services being able to convert £400k to grant funded expenditure in Social Work Support Teams and Care Placement and Prevention.
- Reduced costs in Housing, Health & Adult Social Care in Mental Health of £130k, Older People £100k and Housing Strategy £100k
- An increased underspend within Finance & Corporate Resources of £720k mainly due to a reduced pressure within the Revenues and Benefits Team. This is as a result of funding a £650k budget pressure from the 2009/10

Subsidy Reserve as this is not now needed, after the completion of the audit. A prudent position is assumed throughout the year until the subsidy claim audit is complete. There are also reduced utility costs, an increase in the under spend on salary costs as a result of the centralisation of Central IT functions, and reduced legal and registration costs.

- The projected overspend in Environment of £102k has been brought under control through management action across the department.

4.3 As a result of tight budget monitoring there has been a saving on the central contingency and contingent items of £1.8m in 2010/11. Appendix 1 set out a schedule of potential spend areas where the overall underspend can be applied.

4.4 £750k was transferred to revenue expenditure in Health, Housing & Adult Social Care Department (HHASC) from unapplied grant as part of the restatement of the balance sheet in accordance with new International Financial Reporting Standard guidelines. It is recommended that these funds are applied to a HHASC reserve to mitigate the risks in this area as set out in table 8a - Efficiency Proposals (Adult Social Care £1.72m) of the budget report to Council on 2nd March 2011 relating to the risks associated with the non achievement of savings in 2011/12.

4.5 The Council has recently received an additional allocation of Performance Reward Grant in respect of its performance in achieving the targets contained in the Local Area Agreement ending 31st March 2009 - this followed DCLG consideration of further performance data provided by the Council subsequent to its original LAA outturn submission.

This additional funding amounts to £270k made up of revenue (£189k) and capital (£81k). In line with previous practice in the use of PRG, it is proposed to allocate the funding to projects supported by the Enfield Strategic Partnership.

4.6 The Council is changing the outlet for the bulking and processing of the mixed garden and food waste from the North London Waste Authority (NLWA), where it is currently delivered to the London Waste site in Edmonton, and re directs this waste through Greenstar. This proposal will make significant savings in future years but due to the NLWA Levy funding mechanism an Invest to Save reserve of £1.197m will need to be set up to bridge the 2 year time lag before the NLWA levy fully reflects the reduced tonnages in 2013/14. The table above includes a proposed contribution to this reserve.

5. SERVICE AREA MONITORING INFORMATION – BUDGET PRESSURES & PROJECTED SAVINGS

5.1 Chief Executive Department

This department is currently projecting an underspend of £445k, as detailed in the table below.

CEX Service Centre	Jan 2011	Feb 2011	Notes
	£000's	£000's	
Corporate Improvement	-176	-209	Unfilled vacant posts, maternity leave not covered and staff on secondment, have resulted in savings of £101k, a further saving of £108k is due to reduced training & consultancy costs.
Agency Rebate	-332	-335	Within the Chief Executive budgets the rebate for the current agency contract is collected and then distributed to services at year end. The rebate for 2010-11 is now projected to exceed the budget by £335k.
Human Resources	229	106	There are unbudgeted one-off Capita consultation and legal costs associated with the Hay review. There is an estimated £101k of legal and consultancy fees relating to advice on single status. These are to be funded from contingency reserve. Funding for the apprenticeship & graduate trainee schemes by the Working Neighbourhoods Fund has to be finalised.
Community House	8	-17	Under recovery of income of £62k, offset by underspend on running costs £79k
Chief Exec - Other Minor Variances	8	10	Within Print & Design there is a loss of income of 15k from Enfield Homes, this is offset by projected savings of 5k from the Chief Executives department.
Total Variation – Chief Executive	**-263**	**-445**	

5.2 Environment

This department is currently projecting an underspend of £10k, as detailed in the table below.

ENV Service Centre	Jan 2011	Feb 2011	Notes
	£000's	£000's	
Highways Service	120	80	Due to the relatively clement weather experienced in January and February, the lower winter maintenance costs for this period reduces the forecast overspend from £120k to £80k. The budget pressures arising from the loss of income for skip licences and advertising hoardings have been reduced by a one-off contribution from contingency (£142k), leaving a forecast income shortfall of £47k. This and other budget pressures, including the contract indexation uplift, are being contained by favourable variances from New Roads and Street Works Act permits and Traffic Management Orders income.
Street Lighting	-408	-376	Projected underspends on the Street Lighting PFI contractor payments and energy costs are partially offset by an overspend on street lighting client expenditure.
Parking	233	148	Except during the inclement weather in December, there has been an increase in parking receipts over the past few months. Receipts are still significantly below the budget profile, due to the closure of the temporary car park at Cecil Road and better compliance with traffic regulations under the current economic climate. The shortfall on parking receipts is forecast to reduce by £65k (from £779k to £714k) due to the relatively clement weather in January and February. The shortfall in parking receipts is partly offset by savings in contractor costs (£463K), a one off saving in business rates (£93k) and some minor underspends on operating costs (10k).
Fleet Management	-67	-67	A favourable variance is forecast in this area due to the slippage of the procurement of refuse vehicles that will yield a saving of £138k on leasing

ENV Service Centre	Jan 2011 £000's	Feb 2011 £000's	Notes
			charges. This is partly offset by a shortfall on income from the MOT service.
AD - Planning & Environmental Protection	-15	-8	Savings in salary costs (£17k) are offset by a small overspend in other operating costs.
Environmental Protection	26	26	The service forecasts an overspend on employee costs.
Developmental Control	138	84	Due to a tighter control on salary, agency staff and other operational costs, the forecast adverse variance narrows by £54k to £84k. However, planning application income is likely to remain low due to property developers reassessing the viability of development schemes in light of the withdrawal of housing grants, and house owners are reluctant to spend on house extensions in the current economic climate. The number of fees earning Development Control applications is projected to be 2,059 for 2010/11
Building Control	153	172	Building Control faces the same difficult business environment as Development Control. The adverse variance consists of an income shortfall of £163k and a £9k overspend in employee costs. The number of fees earning Building Control applications is projected to be 1,149 for 2010/11
Business Regulation	-12	-29	In this area, there is a projected over achievement of income of £39k and a £10k overspend on other operating costs
AD - Waste Management	17	0	The overspend has been eliminated by management actions.
Waste & Street Scene - Operations	-97	-97	Savings are projected on vehicle maintenance and staff costs, due to the delay in the roll out of wheeled bins across the borough.
Community Safety	-75	-75	Savings have been achieved from a reduction in overtime payments to Police Community Support Officers (£30k) and keeping one post vacant (£30k). It should be noted that the budget for this post has been earmarked to address the budget pressure for an essential post in the ASB team, the grant funding for which will expire after 10/11. There is also a projected underspend of £15k on emergency planning exercises.
Resources	266	235	The biggest budget pressure continues to be on external legal costs (£155k), for which there is only a minimal budget provision (£6k). In addition, there is a projected overspend on operating costs. This is a one-off problem in 2010/11 as it has been addressed in the 2011/12 budget setting process.
Parks and Open Spaces	-71	-51	Savings are due to the cessation of the use of agency staff to cover the Head of Service post, the retirement of a finance officer and some operational posts being kept vacant.
Waste Client	-106	-7	Due to a lower than expected volume of commercial waste for disposal, North London Waste Authority recently confirmed that the final 2010/11 commercial waste disposal levy will be £961k, which is £106k lower than the budget provision, giving rise to a one off underspend. It is proposed to carry forward most of this saving to contribute to the one off costs of the roll out of the wheeled bins project.
Traffic & Transportation	0	-45	Following the inclement weather in December there has been a noticeable increase in the number of applications for temporary Traffic Management Orders, which gives rise to an over achievement of income of £45k
Total Variation – Environment	**102**	**-10**	

Environment Performance Indicators

PI Code	PI Name	Current Value	Current Target	Status	Last Update	Latest Note
NI016	Serious acquisitive crime rate - number of crimes	7,029	6,803		Feb 2011	Figures at the end of February 2011 are off target. Within the four indicators that make up this target, burglary is significantly down on last year although we have seen an increase in offending over recent months during the seasonal peak. Robbery and theft of a Motor Vehicle (MV) are showing minor reductions or are consistent with last year's performance whereas theft from a MV has seen an increase on last year. However, offending levels have fallen significantly over recent months following the introduction of various partnership initiatives. We are working as a partnership to continually reduce these crimes through groups such as our SAFE tasking process and still hope to meet our overall NI16 target.

This report shows the performance position to the end of February. For many Environment Indicators such as recycling and household waste collection, data is available on a quarterly rather than monthly basis.

Members will be updated on these indicators in the next report to show the performance data to the end of March 2011.

5.3 Finance & Corporate Resources

This department is currently projecting an underspend of £802k, as detailed in the table below.

F&CR Service Centre	Jan 2011	Feb 2011	Notes
	£000's	£000's	
Legal Services	78	-32	The projected saving is mainly due to an unexpected grant of £34k from central government to offset the loss of income following the revocation of personal searches in July 2010. The movement from January relates to the above item plus additional income from schools legal work and the Registrars / Citizenship Service.
Customer Service, Information & Transformation & Procurement	12	-16	Budgets from various departments have now been consolidated into CIT and a review of these against current staffing levels has led to this underspend. There could be further savings on third party contract payments. An unbudgeted £40k annual cost of e-marketplace has been included in this figure but is expected to be funded from council-wide savings in 2011/12.
FCR Director	0	13	This overspend is made up of a number of small items of expenditure, these are offset by savings elsewhere in the department.
Revenues & Benefits	500	13	The Housing Benefit Admin Grant has reduced, but there has been no reduction in work load. This has led to agency staff being kept on without a current source of funding, resulting in a budget pressure of £650k. However, the 2009/10 Housing Subsidy Audit is now complete and the provision of £637k set aside in the accounts as contingency against subsidy loss is not now required. It is proposed to reduce the contribution to subsidy reserve (now audited) to meet the overspend. A further provision of £722k is already accounted for in the 2010/11 budget, to mitigate the risk of the 2010/11 subsidy claim being amended.
Corporate Governance	-63	-80	There is a net £80k underspend on Democratic Services from a variety of one-off savings being made. The principal area of saving is Member's allowances.

F&CR Service Centre	Jan 2011 £000's	Feb 2011 £000's	Notes
			where no inflation increase was taken. The £28k saving from vacancies within audit & risk management is reduced by the £25k drop in income from schools for Building Schools for the Future initiative, which will not be achieved as there has been no audit involvement.
Corporate Items	-66	-86	This mainly relates to Audit commission fees that were £41k less than budgeted. There has also been a £32k rebate on the audit commission fee re transition to IFRS and a £6k saving on subscription payments. London Eye Income is £4k more than budgeted. There are other minor variances of £3k.
Accountancy & Exchequer Services	11	0	Reduced income from schools following the introduction of 'Parentpay' for school meals income has been offset by staff savings due to vacancies.
Property Services	-551	-673	The reported underspend is due largely to savings from the cost of utilities and maintenance of corporate buildings and facilities as well as from the residual budgets of vacated buildings. There are also projected savings in employee costs stemming from the delay in recruitment into some posts. The underspend is partly offset by overspends due to the accelerated rate of activities on assets disposal programme, agency costs relating to Interim Head of Property and IFRS consultant involved in creating new Asset Management System and loss of income due to voluntary groups at the Ark being unable to pay their rents. The underspend has increased due to a mixture of factors, the most significant of which were additional savings from cost of utilities and a reduction in the projected cost of R&M.
Architectural Services (Trading Account)	-1	59	The overspend is due to a retrospective reduction in fees, as tenders received in February 2011 were lower than estimated.
Total Variation – F&CR	**-80**	**-802**	

FCR Performance Indicators

PI Code	PI Name	Current Value	Current Target	Status	Last Update	Latest Note
BV010	Percentage of Non-domestic Rates Collected	95.53%	96.00%		Feb 2011	Further work has been undertaken to target high value debtors but we are not expecting to meet target this year due to system conversion interrupting our recovery programme. Not seen as long term collection issue.
BV009	% of Council Tax collected	92.54%	92.47%		Feb 2011	
NI181	Time taken to process Housing Benefit/Council Tax Benefit new claims and change events (days)	13.78	13.50		Feb 2011	Slightly below target at this stage, although better progress made than expected in processing the backlog of work due to system conversion. This will provide a much improved performance for the month of March and we will more than achieve the annual target.
BV008	% of invoices paid within 30 days for all Departments	92.5%	95%		2010/11	Year to Date for Council overall: 92.5% (106,654 within 30 days; 115,299 invoices paid in total) Monthly snapshot for Feb: 92.3%. Departments - Year to Date: PSE 95.7%; C/Ex 94%

PI Code	PI Name	Current Value	Current Target	Status	Last Update	Latest Note
						ESS 92.6%; ECSL 92% HASC 91.5%; FCR 91% *(the new Departmental structure will be reflected in 11/12 reports).*
CSC 002	Customer Service Centre enquiries dealt with at first point of contact (caller does not abandon call before connection)	95.7%	95.0%	✓	Feb 2011	Monthly snapshot for February 95.7% (30,479/31,852). Cumulative YTD 97.4% (346,598 / 355,450)
FCRF P20	Land charges income generation	£29,8900	£31,9210	⚠	Feb 2011	On target for year end (monthly targets are estimates spread across the year)

5.4 Health, Housing & Adult Social Care

This department is currently projecting an underspend of £959k, as detailed in the table below.

H,H&ASC Service Centre	Jan 2011	Feb 2011	Notes
	£000's	£000's	
Strategy and Resources	0	-71	The Training and Development Team is reporting an underspend of £126k, mainly because additional income has been received from external bodies. This underspend is offset by additional one-off costs in relation to services commissioned in 2009/10, which have only recently been resolved. Procedures are now in place to minimise this risk in future. The service has also taken on additional resources to manage a number of large procurements.
Mental Health	-270	-400	Reductions have been made in projected care packages and staffing costs and further Health funding has been obtained. The move away from residential care costs, in favour of additional support, has contributed significantly to this underspend. The movement this month arises as a result of a reduced likelihood that additional placements may have to be made.
Older People	149	54	Pressures continue within external Homecare and Care Purchasing costs. A decrease in projected staffing costs within In-House Homecare has led to a reduction in the overspend of £95k.
Learning Difficulties	16	0	The service has worked towards ensuring that the budget has a break even position at year end. The service operates an Efficiency Board which continues to oversee projects to achieve these savings through efficiencies and service reviews in 2010/11.
Physical Disabilities	11	0	A reduction in care package costs has resulted in the previously reported overspend being eliminated.
Occupational Therapy	-47	-46	Underspends as a result of reductions in staffing costs.
Total Care	-366	-338	One-off staffing costs have been funded from department contingency.

H,H&ASC Service Centre	Jan 2011 £000's	Feb 2011 £000's	Notes
Purchasing - Central Contingency			thereby reducing it. The reduction in the Social Care contingency this month is to cover enhanced pension costs of 28k.
Housing Strategy	-47	-158	The movement between months of £111k in this area is due to a reduced salary recharge from the Housing Revenue Account and various small savings.
Community Housing	0	0	There is currently an underspend of £557k projected in Community Housing. However, it is proposed that this will be added to the initiatives reserve at the end of the year. The underspend is due mainly to a reduction in the number of high cost types of temporary accommodation and the associated repair and furniture budget. There is also a reduction in staffing costs and savings in the management fees paid to Housing Associations. The Community Housing budget remains volatile.
Total Variation –Health, Housing & Adult Social Care	**-554**	**-959**	

Health, Housing and Adult Social Care Performance Indicators

PI Code	PI Name	Current Value	Current Target	Status	Last Update	Latest Note
NI135	Carers receiving needs assessment or review and a specific carer's service, or advice and information	27.00%	23.00%	✔	Feb 2011	The number of carers receiving a carer's service as a percentage of all clients receiving a community-based service is 27.00% at February 2011. This is 2,648 carers receiving support. Target is 23% this year and has now been met. This includes carers offered information & advice.
NI136	People supported to live independently through social services (all adults)	3668.0	3374.0	✔	Feb 2011	February performance for this indicator is 3668. This is above the target of 3374. This is an age standardised indicator and equates to 7715 actual clients that have been helped to live at home as at the end of February
NI130	Social care clients receiving Self Directed Support	25.12%	30.00%	⚠	Feb 11	At the end of Feb 2011, 2443 clients had received self directed support (25.12%) - 690 Clients received direct payments and 1753 clients receiving a personal budget (either via the pilot or reviewed using the self directed approach). This indicator has increased since January and further increases are being achieved during March. Target for 2010/11 is 30%.

Health Housing and Adult Social Care Performance Indicators (Housing)

PI Code	PI Name	Current Value	Current Target	Status	Last Update	Latest Note
BV072	% of urgent repairs completed within Government time limits	98.46%	98.75%		Jan 2011	Jan 11: Improved performance in January has made a positive contribution toward the achievement of year end target performance. 9,371//9,518=98.46%
BV073	Average time taken to complete non-urgent responsive repairs (days)	6.22	7.50		Jan 2011	Jan 11: This PI continues to remain on target. Current performance indicates that we will achieve median quartile performance by year end. With the exit of poorly performing contractor, it is hoped that there will be a continued steady upturn over the last quarter to push towards upper quartile. 136,011 / 21,860 = 6.22
BV212	Average time taken to re-let local authority housing (days).	27	27		Feb 2011	Feb 11: Performance in February has been adversely affected by hard to let units including sheltered housing lettings (average period for these units of 57.6 days). Strong performance in the re-letting of general needs units of 15.3 days average turnaround has absorbed this impact leading to a combined turnaround average of 26.6 days for the month and a rolling 12 month average of 26.6 days. As a result performance year to date remains within target and exceeds last years outturn
HO013	Fly-tipping & graffiti removal by Enfield Homes, within timescale	100%	100%		Feb 2011	Feb 11: Performance on the removal of reported fly tips on our estates has consistently remained on target; performance on the removal of reported graffiti on our estates has consistently remained on or near target. Access problems in January resulted in a minor dip in performance, compromising the achievement of the challenging 100% year end target. Offensive graffiti = 2/2 Non-offensive graffiti = 2/2 Fly-tipping removal by specialist contractor = none recorded 4/4=100%

5.5 Regeneration, Leisure & Culture

This department is currently projecting an underspend of £181k, as detailed in the table below.

RL&C Service Centre	Jan 2011 £000's	Feb 2011 £000's	Notes
Leisure	-110	-175	The underspend from the Leisure Centres project was due to the unknowns surrounding a Court case that meant the Council could have been exposed to extra costs. This case has now come to a conclusion and the Council are no longer at risk of suffering a financial penalty. The remaining underspend was due to a delayed programme of engagement in Cultural Services. Both underspends have been earmarked to contribute to the outstanding QEII car park and road access project.
Culture - Millfield Theatre	-27	0	The underspend in this service has been approved as a project carry forward to be utilised to fund the replacement of the main dimmer switches at Millfield Theatre.
Events	17	0	The overspend reported last month due to The Autumn Show and The New Year's Day Parade can now be covered by over achievement of income for the Dugdale Centre.
Minor Variances	3	0	This minor salaries overspend can now be covered by over achievement of income for the Dugdale Centre.
Leisure Enhanced Pensions	0	-6	This variance has arisen due to reducing retired staff costs.
Total Variation – Regeneration, Leisure & Culture	**-117**	**-181**	

The Regeneration, Leisure and Culture department was created in January 2011. Monthly PI's are being discussed and will feature in future reports.

5.6 Schools & Children's Services

This department is currently projecting an underspend of £1,025k, as detailed in the table below.

Children's Services

S&CS Service Centre	Jan 2011 £000s	Feb 2011 £000s	Notes
Education			
Continuing Professional Development Service	-175	-175	The previously reported underspend of £125k has now been substantially reduced by grant reductions to £57k. This loss in grant income is more than compensated for by a projected underspend of £130k within the Schools Improvement Service and £52k for Inclusion, Equalities & Diversity due to the freezing of staff vacancies. However, these underspends are reduced by projected income losses totalling £64k.
Early Intervention & Access			
Admissions Service	-84	-90	The school uniform grant is projecting an underspend of £90k due to a lower than anticipated take-up.
Community Access Childcare & Support	-268	-7	A net underspend is being projected across the CACS grant funded budgets mainly for employee costs plus there is an anticipated total underspend of £142k against the graduate leader fund due to the delay in recruiting staff

S&CS Service Centre	Jan 2011	Feb 2011	Notes
	£000s	£000s	
			who meet the specified criteria. This underspend has now been reduced by a transfer of eligible general fund expenditure to maximise the grant which is reflected in underspends in other service areas.
Sure Start	-47	-40	Sure Start is predicting an underspend due mainly to 2 months closure of Edmonton Green Family Centre for refurbishment plus the inability to recruit staff and general under utilisation of the Day Care Service with a resulting decrease in both employee & operating costs that has now stabilised at around £40K.
ABG Allocation for Child Poverty Action	0	-77	An ABG allocation was received late in the year, after most of the work for which the allocation was given had been completed, resulting in this projected underspend.
CAMHS/EPS	-80	-50	The underspend has resulted primarily from decreased staffing levels and increased income plus relevant costs have been identified that can be charged to the Targeted Mental Health in Schools project. The underspend has reduced by £30k in February in anticipation of a project carry-forward for sound proofing work.
Transport	-102	-140	The savings as a result of the summer re-routing exercise are now beginning to reduce as a result of increased client numbers. This has been compensated to a certain extent by reduced use of agency cover for escorts due to improved sickness levels and income from another authority for an out-borough child.
Commissioning			
Children & Families Commissioning	-39	-29	The Controlled Development budgets are projecting a £29k underspend due to staff vacancies.
Human Resources	-36	-32	H.R. has a number of small underspends, the most notable of which are enhanced pensions -£10k and C.R.B checks -£22k. The latter is due to a reduction in recruitment.
School Staff Termination of Employment	0	-65	The incidence and demographics of redundancies is schools has resulted in costs being less than budgeted.
Ladysmith Road	-51	-51	Savings will be made as a result of a Safeguarding Social work team vacating part of Ladysmith Road a year earlier than originally anticipated.
Provision for pupil transport (Academy Bus)	-83	-83	In view of the need to identify in year savings, it is felt that this earmarked provision cannot be kept to meet an uncertain need and instead should be identified as a possible future risk. The current provision of £83k is therefore reported as a saving.
Strategy, Systems and Performance	-159	-195	An underspend of £195k is reported primarily due to a 2009/10 carry-forward of £140k not being required. The Database project was completed within the available resources. The remaining £55k is the net result of an employee cost underspend of nearly £70k off-set by a loss of income relating to Schools Service agreements due to an increasing number of schools switching to alternative service providers. This months increase in underspend is due to the under-recovery of income from this year's SLA not being as high as originally anticipated.
Contact Point System Development	0	-40	As the project has now been stopped by the Government, there will be an underspend on the costs of development compared to the grant funding which was provided in 2009/10.
Asset Management & Development	73	57	The overspend is primarily due to Architects management fees of £41k on the Conditions Survey which were not anticipated and £11k for an unbudgeted payment relating to the Property Information System. £26k of the overspend is attributable to the Lettings Agency where a number of schools have withdrawn from the service.

S&CS Service Centre	Jan 2011 £000s	Feb 2011 £000s	Notes
Catering	-145	-137	The Catering Service budget is projected to underspend by approximately £137k. The phased implementation of the cashless payment system in schools has resulted in the service receiving payment for more of the meals which are provided, resulting in increased income. In addition, increased numbers of pupils in primary schools are also contributing to increased income.
Director's Office			
Directors Employee Costs	7	-32	A net underspend of £32k is primarily as a result of Neil Rousell transferring to Regeneration, Leisure & Culture group in the new year where funding for a directors post already existed.
Safeguarding Division			
Social Work & Support Teams	-131	-379	The £248k increase on the Jan underspend results mainly from the allocation of £185k from the Sure Start & Early Years grant funding to the Joint Service for Disabled Children. There have also been further reductions in the projected agency cover until the year end, however these reductions were restricted by the need to hold onto some agency staff within the Children in Need team following the recent unannounced inspection.
Care Placements & Preven-tion	370	239	Care Placements & Prevention budgets within the Safeguarding Division are now projecting a £239k overspend which is an decrease of £131k on the January projection. This is due to an allocation of £51k from the Sure Start and Early Years Grant into S17 Prevention and a further contribution of £75k from the SEN budget. There have also been further reductions within Adoption Allowances (-£24k) and Southwark 'LAC' (-£15k), which has helped offset increases within the Agency Fostering budget (+£23k).The general trend is that the numbers of Looked After Children are still increasing as the figure for February was up 11 to 300.
Youth Support Services	-180	-231	The underspend has resulted mainly from delays earlier in the year in appointing professional youth workers as part of the planned extended opening of youth centres and detached teams. The increase in the underspend this month (-£51k) is due to a further review of the Detached Team projections (-£23k) and an underspend now being reported within the Positive Activities for Young People's budget (-£28k).
External Legal Advice	420	420	The cost relating to external legal advice were reported earlier in the year as a risk on the basis that funding would be provided corporately following the centralisation of the budgets earlier in the year. In view of the other variances included in this report, the costs of external legal work can be met within available resources.
Net other minor variances - non schools	-49	-85	
Unallocated Reserve	0	-167	
Less contribution to mid year budget reduction	364	364	
Total Variation – Non Schools	**-395**	**-1,025**	

Schools Budgets

Schools Service Centre	Jan 2011 £000's	Feb 2011 £000's	Notes
Early Years- Inc Flexibility (Standards Fund)	-495	-495	The cost of introducing the early years single funding formula is projected to be £495k lower. This is largely due to the grant funding being more than required and the number and scale of early years settings which have moved to flexible provision being lower than estimated.
DSG allocation 2010-11	-115	-115	The most recent notification of our gross DSG Allocation for 2010-11 indicates an increase in income of £115k from £227.557m to £227.672m (£67k additional DSG and £48k exceptional circumstances grant)
Special Education Needs	-177	-72	The underspend is primarily due to starters & leavers within recoupment resulting in a net reduction of 19 clients. This has been partially off-set by an agreement to contribute a total of £200k for shared cost placements within Independent Residential service which would otherwise be charged to Safeguarding.
Learning Disabilities	-89	-93	The £93k underspend is due to additional grant funding of £59k, plus delays in recruiting experienced staff
Maternity Cover	43	43	The Secondary Schools Maternity budget is overspent as at the end of Dec and it is probable that the other maternity budgets will be fully spent at the year end.
Reception Classes	193	193	High demand for School placements has resulted in 5 Bulge Classes being opened in addition to the 6 classes opened earlier in the year and it is possible that a further 1 or 2 additional classes will be required in the Spring term.
Contingency General	0	-192	A balance of £192k left in general schools contingency to allow for exceptional need and nursery places in the Spring term count will not be required in 2010/11
Academies	-400	-410	Two secondary schools converted to academy status on 1 September and the closing financial balance of the predecessor schools reverts to the Authority. Both schools were initially estimated to be in deficit at the point of closure. However the latest analysis of the position indicates a projected underspend. This is due to one of the schools being in surplus rather than a deficit. Further work is being undertaken to finalise the position.
Exceptional Circumstances Grant	-603	-603	Notification has been received of an increase in Dedicated Schools Grant in both 2010/11 and 2011/12 as a result of increased number of pupils between the January and autumn 2010 pupil censuses. The amount for 2010/11 is £603k.
Area SENCO contract	-112	-112	Following the decision not to continue with the commissioning of this service there will be a projected underspend.
Schools PFI Benchmarking	0	-404	During the 25 year contract a benchmarking exercise is undertaken every 5 years by the provider on 4 specific services to determine if the charges for these are in line with market conditions. A prolonged tendering exercise has been undertaken by the provider and although the tenders have now been returned, there is no announcement on the successful bidder. Based on the returned tenders it is highly likely that there will be an underspend on the provision set aside as substantially higher costs were anticipated. Although the amount cannot be declared prior to the decision of the successful tenderers being announced.
Net Other Minor Variances - Schools	43	6	
Unallocated Reserve	0	-548	
Total Variation - Schools	**-1,712**	**-2,802**	

5.7 Schools Budget-Risk Item

There is a significant risk that the dedicated schools grant for 2011/12 will include money due to the Authority from the Department for Education in respect of 2010/11 which in effect means that the 2010/11 funding received will be £1.2m below the budget. Such a loss would result in the projected underspend being only £1.602m. If this risk crystallises, the Authority will join with other authorities to make a legal challenge against the Department for Education.

5.8 Building Schools for the Future

Previous monitors have referred to the cessation of the BSF Programme and advised that the financial implications would be reported subsequently. Previously, Council and the Schools Forum gave approval to funding for the BSF Programme amounting to £4.2m for development costs and £1.450m from the accumulated DSG reserve for expenditure on works which were not eligible to BSF funding. Expenditure on the development costs amounted to £1.950m prior to the programme being stopped, leaving £3.026m unspent up to 31 March 2011.

This is apportioned as follows:	**£,000s**
Accumulated DSG reserve	1,450
Earmarked resources from earlier years	1,419
Schools Budget underspend in 2010/11	157
Total	**3,026**

A very large proportion of this funding was derived from dedicated schools grant resources and a request was made to the Schools Forum for the above resources which are no longer needed for funding development and refurbishment of some secondary schools to be used for the primary capital programme. At its meeting on 3 February 2011, the Schools Forum gave approval to this and Cabinet is asked to give a similar approval and also approve a virement. This will reduce the costs to the Council of the Primary Capital Programme.

Schools & Children's Services Performance Indicators

PI Code	PI Name	Current Value	Current Target	Status	Last Update	Latest Note
NI062 (BV049)	Stability of placements of looked after children: number of moves	15.3%	12.0%		Feb 2011	46/300 (15.3%) of "Children Looked After" (CLA) have had 3 or more placements in the past year as at the end of February 2011 - a slight decrease on Jan 2011. The placement panel carefully monitors the moves of all children during the year. There is one child in the current cohort who will become 18 before the end of this financial year and will no longer be included in this indicator. It is widely recognised that "older" young people move more frequently than younger CLA. Of the current group of children 40% are aged 16-17 years old, and several have had moves into semi-independent living as part of their care plan, which has an impact on this indicator. The method of calculation for this indicator is very prescriptive and states that even a very short period when a child is missing from

PI Code	PI Name	Current Value	Current Target	Status	Last Update	Latest Note
						placement must be recorded as a placement change and counted for this indicator. If not included, the figure would decrease slightly. Placements continue to be scrutinised regularly by the Senior Management Team for appropriateness and stability through the placement panel process.
NI063 PAF-CF/D78	Stability of placements of looked after children: length of placement	74.4%	72.0%	✓	Feb 2011	Actual Numbers 58/78 children looked after for more than 2.5 years had been in their current placement for over two years.
NI060	Percentage of core assessments for children's social care that were carried out within 35 working days of their commencement	89.2%	83.0%	✓	Feb 2011	1216/1363= 89.2% of Core Assessments completed within 35 working days as at the end of February 2011, exceeding the end of year target of 83%.
NI117	16 to 18 year olds who are not in education, employment or training (NEET)	5.80%	6.50%	✓	2010/11	5.8% is the final figure for 2010/11. This is the average of November, December and January. This is a good performance. Enfield has had a reduction in NEETs for the last 3 years in a row. Actual Numbers: November: 488, December: 461 January: 410
NI059	Percentage of initial assessments for children's social care carried out within 7 working days of referral	87.3%	75.0%	✓	Feb 2011	1809/2164 = 87.3%. Department of Education guidance states that an Initial Assessment completed within 10 days is the new measure. For February this will be 2007/2164 = 92.7%. The NI definition is still 7 working days and will be changed when they are reviewed. Safeguarding services will report on both 7 and 10 days for this financial year.

6. OTHER GENERAL FUND ITEMS

6.1 Treasury Management – Projected underspend of £200k

There has been an increased outflow of the Council's cash balances due to an acceleration of capital expenditure and a change to housing benefit payment profile. There is however, sufficient flex within the budget to meet the impact of this increased outflow.

London Borough of Enfield Internal Investments as at 28th February 2011	Principal	Start Date	Effective Maturity	Days to Maturity	Rate	Credit Rating
HERITABLE BANK	2,392,702	28/02/11	28/02/11	-	0.00%	C
ROYAL BANK OF SCOTLAND	450,000	--	01/03/11		0.80%	A+

London Borough of Enfield Internal Investments as at 28th February 2011	Principal	Start Date	Effective Maturity	Days to Maturity	Rate	Credit Rating
				1		
SANTANDER (UK) PLC INSTANT ACCESS DEPOSIT ACCOUNT	5,000,000	--	01/03/11	1	0.70%	**AA-**
BARCLAYS BANK PLC	5,000,000	28/09/10	27/09/11	211	1.45%	**AA-**
BARCLAYS BANK PLC	5,000,000	03/12/10	03/06/11	95	1.10%	**AA-**
LLOYDS BANK PLC	7,500,000	19/10/10	18/10/11	232	1.90%	**A+**
LLOYDS BANK PLC	7,500,000	10/02/11	10/05/11	71	1.21%	**A+**
LLOYDS BANK PLC	5,000,000	03/12/10	02/12/11	277	1.95%	**A+**
Total - Internal Investments	**37,842,702**			**Average Rate**		**1.31%**
Average Investment Size	**4,730,338**			**Average Rating**		**AA-**
Time Weighted Average Days to Maturity	**137**					

7. Housing Revenue Account (HRA) – Projected £1,278k Underspend

7.1 A comprehensive review of rental income has been conducted. As a result rental income is now projected to over achieve by £858k. This is partly due to reprofiling the decanting of Ladderswood tenants, part year rent received for sheltered units and the phasing of the transfer of TFL properties to Notting Hill Housing Association.

7.2 Additional income from Highmead shops of £131k is expected in 2010-11. The Highmead shops were excluded from the estimates, a decision was taken that when the retail shops were repurchased the retailer would be encouraged to remain in the retail parade at a reduced rent, to prevent anti-social behaviour. There are also additional savings of £34k due to an increase in rental income from aerials.

7.3 An over-recovery of income of £140k in leaseholder's service charges has now been achieved. This is mainly due to an increase in income from leaseholder block repairs that was not originally budgeted.

7.4 An under-recovery of income of £112k on garage rent has been identified. This is partly due to more demolitions (budget £59k – actual £161k) than originally anticipated and partly due to a higher void rate.

7.5 When setting the budget the interest rate was 0.38%, the rate has now increased to 0.42% resulting in additional income of £20k on HRA balances.

7.6 A pressure in sheltered housing where decant costs are expected to be £40k in 2010-11. There are four tenants remaining at Tudor Crescent entitled to home loss and disturbance allowance who will be moved in 2010-11.

7.7 The tendering for the tree management survey contract was due to starting this

financial year. Due to delays in the tender process this will not start until March 2011, which has resulted in a saving of £100k. An additional saving of £31k has been identified due to savings in the arboricultural budget.

7.8 Extensive reconciliation work has been completed on the payments made to Thames Water, which has resulted in a refund of £199k.

7.9 A saving of £78k in council tax paid on void properties has been identified due to reductions in the number of long term voids.

7.10 A detailed review of housing subsidy has identified further increases to the Housing Subsidy payments. This is partly due to changes in the consolidated rate of interest (CRI), which will be offset by a decrease in Capital Charges.

7.11 A further review of the bad debt provision has been undertaken. This has resulted in the increase in variance from the £100k previously reported to £205k. This is still under review.

7.12 The managed repairs and maintenance budgets are high risk budgets. These budgets are demand-led and require close monthly monitoring. Enfield Homes is currently anticipating an underspend of £200k a decrease of £195k from last month. This is mainly as a result of a significant underspend on the painting programme. This is offset in part by additional expenditure on other areas of planned maintenance and on responsive repairs. Any underspends at year end will be transferred into the Repairs Fund. In addition, Highmead Security, Estate Improvements and Asbestos (£1.5m) costs will be funded from the Repairs Fund.

7.13 The HRA includes the £18.1m management fee paid to Enfield Homes. As agreed as part of the 2009/10 outturn, an additional £519k will be paid to Enfield Homes, for service improvements. This will be funded from HRA balances and represents a carry forward of resources allocated to Enfield Homes for 2009/10. Enfield Homes are currently reporting an underspend of £140k on their delegated budgets; this is due to savings in supplies and services budgets.

8. ACHIEVEMENT OF SAVINGS

8.1 The 2010/11 Budget Report included efficiency and other savings, and the achievement of increased income totalling £16.4m to be made in 2010/11. Overall these savings have been achieved with the projected variance in this budget report being an underspend of £339k.

8.2 The Budget Report agreed at Council on 2nd March approved savings and additional income of £34.5m in 2011/12. Work has already started on the implementation and monitoring the savings targets for 2011/12. Information on the progress in achieving these savings will form part of the 2011/12 Monitoring process to Corporate Management Board and Cabinet.

9. ALTERNATIVE OPTIONS CONSIDERED

Not applicable to this report.

10. REASONS FOR RECOMMENDATIONS

To ensure that Members are aware of the projected budgetary position for the Authority, including all major budget pressures and underspends which have

contributed to the present monthly position and that are likely to affect the final outturn.

11. COMMENTS OF THE DIRECTOR OF FINANCE AND CORPORATE RESOURCES AND OTHER DEPARTMENTS

11.1 **Financial Implications**
As the Section 151 Officer, the Director of Finance & Corporate Resources is required to keep under review the financial position of the Authority. The monthly revenue monitoring is part of this review process and this latest monitoring report confirms that there is no deterioration in the financial position of the Authority. If required, measures will be put in place to address risks identified through the monitoring process and to contain expenditure within approved budgets.

11.2 **Legal Implications**
The Council has a statutory duty to arrange for the proper administration of its financial affairs and a fiduciary duty to taxpayers with regards to its use of and accounting for public monies. This report assists in the discharge of those duties.

11.3 **Property Implications**
Not applicable in this report.

12. KEY RISKS

There are a number of general risks to the Council being able to match expenditure with resources this financial year:-

- Ability of Departments to adhere to savings targets and contain projected overspends, especially given the additional £6.89m in year target.
- State of the UK economy - which impacts on the Council's ability to raise income from fees and charges and on the provision for bad debt.
- Uncontrollable demand-led Service Pressures e.g. Adult Social Care, Child Protection etc.
- Potential adjustments which may arise from the Audit of various Grant Claims.
- Movement in interest rates
- Potential liability to fund losses incurred by the former insurance underwriter Municipal Mutual.

Risks associated with specific Services are mentioned elsewhere in this report.

13. IMPACT ON COUNCIL PRIORITIES

13.1 **Fairness for All** – The recommendations in the report fully accord with this Council priority.

13.2 **Growth and Sustainability** – The recommendations in the report fully accord with this Council priority.

13.3 **Strong Communities** – The recommendations in the report fully accord with this Council priority.

14. PERFORMANCE MANAGEMENT IMPLICATIONS

The report provides clear evidence of sound financial management, efficient use of resources.

APPENDIX 1

Budget Carry Forwards- 2010/11

	£000's
Schools & Children's Services	
1. £350k for additional interim children's social workers to respond to the continuing high levels of referrals and to ensure capacity for further improvements to the quality of services,	**350**
2. £300k to provide a capital budget to carry out a programme of fire prevention works in schools.	**300**
3. £65k to fully fund the rolling programme of school condition surveys in 2011/12,	**65**
4. £150k to fund the project costs of the departmental "building resilience" review that has been initiated following the recent Leaner reviews. The project will ensure that services for children, young people and their families are easy to access and use and that problems are identified and addressed as early as possible. It would also seek to deliver savings for the 2012/13 budget,	**150**
5. £100K To enable additional case workers to be appointed to the Youth Offending Service (YOS) in order to keep caseloads within the Youth Justice Board guidelines. Caseloads are currently too high and getting higher because more high-risk offenders are being supported in the community. YOS is being inspected in June 2011.	**100**
6. £150k to fund the start-up and development of a training and skills development centre, in conjunction with Regeneration, Leisure and Culture, in the premises of the former Delta City Learning Centre,	**150**
7. A new database is needed for the governor support service at a cost of £20k,	**20**
8. £17k to establish a string orchestra for children living in Edmonton, where there are currently limited opportunities for group music making. The orchestra will rehearse on a weekly basis and give regular performances. Participants and their families will have increased knowledge of the musical opportunities available locally.	**17**
Health, Housing & Adult Social Care	
1. £300k to establish a HASC Reserve to mitigate the risk of un-achieved savings through the implementation of transforming the customer pathway for 2011/12 and potential PCT creditors. The risk reserve will accommodate the assumed savings derived from assigning clients with Personal budgets, to purchase their own care, calculated through the Resource Allocation System.	**300**
Regeneration, Leisure & Culture	
The Council has previously approved funding for the restoration of the QEII stadium towards a replacement athletics track and related athletics facilities and towards the refurbishment of the Grade II listed building at the site. The stadium will become the home ground for Enfield Town FC. Planning Permission and Listed Building consent were required for the works. Listed Building consent was granted on 9 July 2010 Planning permission was granted on 20 July 2010. Planning permission was accompanied by 33 planning conditions, two of which have a significant unfunded financial impact. These two conditions relate to making improvements to Donkey lane including its widening and resurfacing and the provision of a continuous footpath and also to make improvements to the car park at the stadium. Initial estimates	**500**

	£000's
suggest that carrying out the works for these two conditions will cost £500k.	
Contribution to Sustainable Service Development Fund £1.75m was allocated to this as part of the May Monitoring Report from in year procurement savings on the IT and Leisure contracts for the purpose of creating a Sustainable Service Development Programme. £105k will top up the fund to £1.9m agreed in the May 2010 Monitoring Report.	**150**
Capital- Revenue Contribution	**800**
Redundancy Reserve	**1,000**
Total	**3,902**
Revised Underspend	**(339)**

Project Carry Forwards 2010/11			Appendix 2
Dept	**Ref**	**Item**	**£000's**
		Chief Executive	
CE	1	**I-Grasp Development**	**43**
CE		Improvements to the recruitment service for applicants who live, work and do business in Enfield. Service will also be improved for internal customers, improving the quality of candidates to fill roles and reducing time taken to fill roles. Additionally improving the service for redeployees and the principles of redeployment which is crucial for the Council's current strategy to minimise redundancies.	
CE	3	**Migration Impact Fund - Welcome pack**	**16**
CE		This is outstanding action from the Young People's Life Opportunities Commission (YPLOC). The pack will be produced by engaging a number of community who worked with the council in delivering the (YPLOC). The welcome pack will allow community to design, develop and distribute the pack. Key groups involved will be: - Parent Engagement Panel - Youth Engagement Panel - Congolese Children Association	
CE	4	**Scrutiny - North London Regional conference on reducing waste packaging**	**10**
CE		To arrange a North London regional conference on reducing waste packaging. To arrange a suitable venue, hire speakers, and commission specific targeted research on waste from food packaging. Consequences of Carry forward not being agreed would be that: • the planned regional conference would not go ahead • the initial work on Council powers and research regarding metrics would be a wasted opportunity cost • The Chairman of the Scrutiny Panel has already raised this with a number of other North London Councils (so potential reputational risk to the Council)	
CE	5	**Corporate Grant - Capacity Building Fund**	**12**
		Capacity Building small voluntary and community sector organisations to enable them to deliver their services more effectively to their communities. The project helps increase the ability of the organisations to bid for external funding. The project contributes to Aim 5 & 6 of the Council's BIP 2008-2011.	
CE	5a	To obtain Census related services and output for the period 2011-2021, via a Census Consortium consisting of the GLA and a minimum of 22 London Boroughs.	**20**
		Total Chief Executive Bids	**101**
ENV		**Environment**	
ENV	6	**Support for the Safer and Stronger Communities Board strategic priorities & targets**	**41**
ENV		In view of the sensitive nature of the activities, some delays have occurred in providing effective initiatives to deliver appropriate measures to support the objectives. If funding is not provided, this will impact on the ability of SSCB to deliver against priorities.	
ENV	7	**Crime and Disorder Fund**	**33**
ENV		To add to existing reserve of £37,271.The Crime & Disorder Fund supports activity by Community Safety that is not funded by mainstream budgets or grant funding. The reserve is needed to cover costs relating to the Strategic Assessment (now an annual requirement) upgrades for the HUB solutions database; and maintenance, repair and relocation of redeployable CCTV cameras to address anti social behaviour. For 2011/12 and each subsequent year, approximately £15,000 is required each year to support costs mentioned above.	
ENV	13	**Smart Meter Projects**	**91**
ENV		CMB authorised a roll out of SMART meters (gas and electric) on the 26th January 2010, to aid its CRC ranking energy data management to support energy reduction . SMART meters provide up to date, reliable meter information which eliminates the need for meter readers and ensures accurate billing information. Under the terms of the contract a programme is underway to install 40 SMART electricity meters in Corporate buildings, and 85 SMART electricity meters in schools and a further 40 Gas meters in Corporate buildings. It was originally envisaged that the installation programme would be complete in year 1 of the project (10/11). However, due to technical complications and additional necessary remedial works in various buildings, the project is now anticipated for completion by mid 11/12. Not installing the Smart meters will dramatically lower our position in the league. In addition the meters allow us to accurately measure energy data, reduce estimate billing, accurately predict energy purchasing and trends, accurately measure any energy savings projects and profile energy usage against property usage.	
ENV	15	**Fit for Purpose buildings to award Cemetery contract**	**10**
ENV		A new full repairing lease needs to be produced for the tender documentation, this will need to state the buildings that the contractor may use. Failure to address the condition of the buildings would increase the cost of the contract as the new contractor will add the costs, in addition to overheads, to the price of their submission. The Council has requested that the new contract comes in under the price the current one and this would put that at risk.	
ENV	16	**Health & Safety inspection and assessment for all Parks operational equipment**	**30**
ENV		To complete health & Safety inspections and assessment for all Parks operational equipment	
ENV	17	**Maintaining the apprenticeship scheme within Parks operations**	**123**
ENV		To pay and train 8 apprentices for an additional year	
ENV	19	**Waste Operations - roll out of wheeled bins project**	**320**
ENV		The roll out of wheeled bins across the rest of the Borough. If the bid were not approved then we would not be able to incur the one-off costs associated with the project, which mainly consist of route planning, training, and printing of leaflets and other information to the Public about the proposed service changes (phone lines, website updates, roadshows, etc). This will impact adversely on the delivery of the new service and is likely to result in high levels of dissatisfaction from the Public.	
ENV	20	**Proceeds of Crime Act (POCA)**	**10**
ENV		These funds are ring fenced in nature as incentivisation monies recovered **MUST** be re-invested in POCA and 'crime fighting' work/activities by the council. We are required to report to the Home Office on how these incentivisation monies have been spent for these purposes. As part of the restructure of Planning and Environmental Protections Division, we intend to use these reserves to reinvest in POCA work (ie to draw down to fund the AFI post) from 1/4/11. If the bid is not approved we will be unable to demonstrate to the Home Office that the incentivisation funds have been appropriately spent, and we will have a salary deficit for this post in 2011/12.	
		Total Environment Bids	**658**
FCR		**Finance & Corporate Resources**	
FCR	22	**IT Audits**	**28**
FCR		To undertake a number of IT reviews to enable a valid opinion on the control structure to be formed. Audits part of 2010/11 audit plan. A contractor (RSM Tenon) has been engaged to undertake this work, via an OGC framework agreement.	
FCR	23	**Galileo upgrade**	**28**
FCR		To upgrade existing Audit case management software. Grant Thornton, the Council's external auditors, made a number of recommendations relating to the recording of testing and findings – while it was agreed that these issues would be addressed, they could not be achieved without considerable investment in the existing system, or replacement with a new system. This will be achieved by the upgrade of the Galileo system	

Project Carry Forwards 2010/11			Appendix 2
Dept	**Ref**	**Item**	**£000's**
FCR	24	**LACHS Upgrade**	**18**
FCR		Software used to manage insurance claims needs to be replaced, and is the subject of ongoing project evaluation involving Serco / CIT. Currently the subject of technical evaluation, the software will enable the team to make the efficiency gains required by the service restructure.	
FCR	25	**Corporate Buildings Condition Surveys**	**30**
FCR		To undertake condition surveys of Corporate buildings to inform the asset management process. The funding is to resource the programme of condition surveys which has slipped from 10/11. Two additional surveyors will be appointed for 6 months to clear the backlog. Data is required to construct new R&M programme and to inform the Asset Register.	
FCR	26	**E-invoicing via purchase cards (1)**	**30**
FCR		Implementation of pre paid cards. This project delivers cash replacement services and reduces overheads and improved visibility of cash usage.	
FCR	27	**E-invoicing via purchase cards (2)**	**30**
FCR		Implementation of lodged or embedded cards to reduce invoices, and create more electronic invoicing.	
FCR	27	**Green Belt Farm Building Repairs**	**20**
FCR		Several repairs identified in Knight Franks Survey Report 2009/10 have not yet been undertaken or paid for. This is due to the additional repairs liability to Botany Bay Farm Cottage. This carry forward budget of £20,000 would enable repairing liabilities to be met.	
FCR	28	**Physical Move of Community Alarm Service to Claverings**	**10**
FCR		The project is to physically move the current 24/7 community alarm monitoring and mobile response service from the Control Room on the ground floor of the Civic Centre to the CCTV monitoring building based at Claverings..	
FCR	29	**Out of Hours Pan London Project**	**45**
FCR		The project is to deliver a saving to the Council of £297k by moving from the current in-house emergency out of hours call handling service to a Pan London Contract delivered by Vangent based at London Bridge. The project delivers significant savings to both the Council and Enfield Homes and both services are moving to this contract.	
FCR	30	**Citizensafe - Authentication and Verification Project**	**21**
FCR		The project is to fund the estimated volume of transactions that will require different levels of authentication for the Citzensafe to cover the external agency charges that will apply including initial verification or change of circumstances	
FCR	32	**Plan Scanner**	**10**
FCR		To provide a plan scanner to scan council drawings into our Document Management System. The current scanner is 8 years old and is now obsolete; if it were to breakdown it would be almost impossible to source parts. The scanner is used everyday and has scanned over 10,000 plans in 2010/11.	
FCR	33	**Bar Code System For Archive Storage Area**	**15**
FCR		To provide a simple, cost effective system of booking out and managing stored documents. This system will speed up our process & is 10 x faster than human input it will eliminate human error and missing documents. The system will provide more accurate data while saving both time and money.	
FCR	34	**Civic Centre car parks and loading bay - improvements to recycling/lighting/signage/road markings**	**30**
FCR		To improve recycling and health & safety	
		Total FCR Bids	**315**
HHASC		**Health, Housing & Adult Social Care**	
HHASC	39	**Assessment Suite**	**100**
HHASC		To fund the changes required for supported self assessment and the prescriber process which will ultimately give people more choice and control over the equipment they have and the way they lead their lives.	
HHASC	40	**Transformation of the Community Equipment Store (TCES)**	**90**
HHASC		The Business Change Manager post is pivotal to this high profile project – the post will coordinate and support the development of the ‘Prescription model’ for assessment and provision of equipment for disabled people in Enfield. This post will lead the period of design and implementation of this process and provide a link between the other strands of the development plan for this new service. The post holder will then be required to support the changes which will affect all assessors in Enfield – acute trusts and PCT. The post will also be involved in the development of the complex equipment process and is a pivotal position to hold the work on TCES together of the next 12 months. Additional administrative cover will also be needed for the BCM and the work of the TCES project	
HHASC	41	**CareFirst 6 Upgrade**	**25**
HHASC		To move CareFirst from version 5 to version 6 - A required upgrade for Personalisation. Carefirst 6 is required for the Personalisation agenda which is transforming Adult Social care within Enfield. Version 6 supports CareAssess (forms) and the integration with Quickheart.	
HHASC	43	**CareFirst Database Server Replacement**	**50**
HHASC		To replace the CareFirst Database Server which is now end of life, not GCSx compliant and lacking capacity for necessary upgrade plans.	
HHASC	44	**Formont Centre**	**10**
HHASC		The Formont centre is a specialised Day centre for clients with Learning disabilities. The facilitiy offers a number of responsive services to client with high levels of need. As a result the service have identified specific touch screen equipment to assist client in their communication and Learning skills	
HHASC	47	**Mental Health Carers Assessment and Support Project**	**45**
HHASC		• To meet the individual assessment and support needs of MH carers • To meet the LBE MH target PI for same • To provide information and advice to MH carers • To facilitate respite for MH carers • To ensure that those being cared for are moving towards achieving independent living.	
HHASC	48	**Employment, Training and Leisure**	**39**
HHASC		• To assist all Mental Health Dept service users to access opportunities in paid and voluntary employment, education and training, and leisure pursuits. • To assist people to pursue and move on to new interests, and to participate more fully in the local community • To provide 1:1 related advice and information sessions to Chase Farm Hospital MHU wards and day hospital, MHRC and other partner agencies. • To enable people to make appropriate and informed choices, referring to other agencies as required, inc employers, colleges, clubs and leisure centres.	
HHASC	49	**Mental Health Intensive Support and Enablement Pilot Outreach Project**	**110**
HHASC		• To provide short term intensive outreach support promoting independent living, social inclusion, well-being and choice • To offer a range of individually tailored support through personal development plans, including daily living skills and community participation	

Project Carry Forwards 2010/11			Appendix 2
Dept	Ref	Item	£000's
HHASC	50	**Mental Health Review Project**	100
HHASC		• To review residential placements and other high-costing placements with a view to facilitating step-down arrangements • To assess and review service users with a view to improving choice and independence through Personal Budgets	
HHASC	51	**N3 Connection**	20
HHASC		To provide a connection to the NHS N3 network. The connection to N3 is a vital plank in both HH&ASC and ECSL's plans for closer working with health partners. It is necessary for access to RiO and a host of other Health applications. Access will permit a more cohesive service for Enfield's service users.	
HHASC	52	**Park Avenue Empowerment and Personalisation Project**	30
HHASC		Park Avenue service provision promotes independent living skills to all service users and to support them to creatively overcome barriers and challenges that present due to chronic illness and disability. All therapies and activities focus on ability and not disability and work with service users to set and reach personal targets to improve independence and quality of life. The following project promotes the benefits of personalisation and user led services at Park Avenue, we need to continue this work to ensure the service becomes truly user led with an emphasis on health and well being and employment as follows: - Empowerment and Personalisation Project - Service user Consultation Groups - Volunteer Training - Advanced Apprenticeship post at Park Avenue	
HHASC	53	**To Continue Cost Reductions on Residential and nursing Placements for three months**	25
HHASC		To continue cost reductions on residential and nursing placements for three months to save between £25K and £30K annually.	
HHASC	54	**Quality Payments**	100
HHASC		To promote and develop a social care and health provider market in Enfield which is able the respond in ways which are innovative, creative and affordable, to increasingly personalised services which are shaped around the needs and wishes of service users	
HHASC		A substantial programme of training on Autism from basic awareness to advanced practitioner level training to meet the now statutory requirement (dec 2010) that local councils and local NHS bodies in England must improve - training for their staff / identification and diagnosis of autism in adults / planning of services for people with autism, including the transition from child services to adult services / local leadership Learning Assistant E-portfolio system- e-learning function that will support electronically the process of submitting work, assessing and verifying for the QCF programme. With the programme set to expand substantially, this will enable us to monitor and support work of candidates much more effectively and to cope with the increased demand. This increased demand will also generate	
HHASC	59	**Wireless networking of St Andrews and completion of work for the LDN Database**	24
HHASC		To carry out essential work on the LDN database, to enable both ILDS and commissioning to have a tool to provide accurate and correct information from carers and service users that have completed the LDN questionnaire. And to have wireless connections installed within the meeting rooms at St Andrews Court to enable modern working.	
HHASC		**Compulsory Purchase Orders (CPO)**	100
HHASC		To continue the rolling programme of compulsory purchase action against empty and derelict properties	
		Total HHASC	868
RLC		**Regeneration, Leisure & Culture**	
RLC	60	**Millfield Theatre Dimmer Projects**	30
RLC		To fund the replacement of the main Dimmer Switches at Millfield Theatre	
RLC	62	**Southbury Road Synthetic Pitches**	40
RLC		Renewal of a synthetic turf pitch at Southbury LC - Fusion, the new operator for the leisure centres is carrying out capital investment at the leisure centres which includes the renewal of one of the two synthetic turf pitches. The refurbishment of the second pitch will not take place until the first one is complete.	
RLC	63	**North Circular Area Action Plan**	16
RLC		Retention of specialist consultants to complete the Area Action Plan which will form part of the Council's statutory Local Development Framework.	
RLC	65	**Open space update**	18
RLC		To update the evidence base regarding future open space needs to inform the preparation of the Development Management Document and area based plans which form part of the Council's statutory Local Development Framework	
RLC	66	**Green towes decant**	24
RLC		Decant of current sessional users from Green Towers for Refurbishment of Green Towers Community Facility	
RLC	67	**Local Economic Assessment Project Officer**	31
RLC		Engagement of an Officer to undertake the research and analysis of data for the preparation of the Local Economic Assessment [LEA] The post is funded by an external grant of £65k from Govt	
		Total RLC Bids	159
SCS		**Schools & Children's Services**	
SCS	69	**SAFE Team - Acoustics (improvement to soundproofing at St Andrew's Court)**	65
SCS		To improve the soundproofing between a number of rooms at St Andrews Court on the second floor. These rooms are used by the Service for Adolescents & Families in Enfield (SAFE) and by the Alliance Outreach Team.	
SCS	70	**School meals service developments**	155
SCS		To continue the upgrading of school kitchens resulting in an improvement to the efficiency and quality of meals produced.	
SCS	71	**South Street Campus Development**	137
SCS		The South Street area of Ponders End is one of the Council's priority areas for regeneration, and part of this is the building of an all-through academy on the former gas holder site. Funding was agreed for project management costs and as the project is spread over three financial yeas, the remaining portion of funding needs to be carried forward	
SCS	72	**Ponders End Youth Centre works - Carry Forward**	158
SCS		To maintain the fabric, facilities and equipment of the Ponders End Youth Centre in line with service plans and objectives	
SCS	73	**Schools Condition Surveys**	90
		To fund the provision of surveys on the condition of schools as well as the provision of up to date computer aided design plans.	
		Total SCS Bids	605
		Total Departmental Bids	2,706

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Grant Carry Forward Requests 2010/11 **APPENDIX 3**

Ref	Grant Carry Forward Request	Brought Forward 1 April 2010 (Restated)	Net Revenue Movement 2010/11	Project Carry Forward 31 March 2011
	Chief Executive	**£'000**	**£'000**	**£'000**
1	**Migration Impact Fund** Government grant from CLG aimed at engaging new and emerging communities in activities that will build capacity and provide opportunities for integration into wider civic life. The projects within the programme contribute to putting Enfield First by being specifically aimed at our most excluded communities, bringing them into contact with local services and integrating them more fully into life in the Borough	**0**	135	**135**
	Total Chief Executive Bids	**0**	**135**	**135**
	Environment			
2	**Anti Social Behaviour Improvement Grant** Ringfenced grant funding provided by Communities and Local Government. The funding must be spent on delivering targeted interventions to address anti social behaviour. However, funding is not time limited. Balance of funding to be carried forward to 2011/12. Contract being arranged with Parkguard, a private security company, to work in Enfield's parks and open spaces to combat the growing problem of irresponsible dog ownership. Contract start date 1 April 2011.	**0**	44	44
3	**Grant funding to enable training and support for residents to tackle anti social behaviour** Ringfenced grant funding provided by Communities and Local Government. The funding must be spent on delivering training and providing support to residents to address anti social behaviour, and to support the community to develop minimum standards	**0**	12	**12**
4	**Grant funding for Faith Narrative Book** Completion of project planned for 2011/12. DCLG funding to Enfield Council (as lead authority) to work in partnership with Haringey and Barnet Councils to develop a Faith Narrative Booklet and to deliver workshops in schools and colleges in each Borough. Part of targeted funding to counteract the extremist	**0**	19	**19**
5	**Grant funding for North London Regional Alcohol Pilot** Ringfenced grant. Balance of funding required in 2011/12 to complete project and comply with terms of Memorandum of Understanding to deliver a pilot programme in North London to 'look at' alcohol misuse in the workplace and to provide effective training. Memorandum of Understanding completed with Department of Health. Grant held on YJ1131; Spend on CS0059.	**0**	26	**26**
6	**Grant funding for the preparation of off-site reservoir flood plans** Ringfenced grant funding of £67,497 provided by DEFRA to Enfield Council as the lead authority to work with partner organisations to develop specific off-site reservoir emergency flood plans, to deliver emergency exercises and to inform the public. DEFRA has provided the funding as they have identified one reservoir in Enfield as a high priority. 3 year funding 2010/13. Spend to be incurred over the life of the 3 year project.	**0**	67	**67**
7	**Smoke Free Grant** The reserve is ring-fenced grant money provided by the Department of Health to Enfield Council for project work on supporting smoke free work place environments. Enfield Council now chairs the Enfield Tobacco Control Alliance, which has been set up to deliver a number of key objectives	**68**	0	**68**
8	**Housing & Planning Delivery Grant** Under B/S code 82526 there is £76,000 allocated under the HPDG grant (now ceased). The HPDG grant is awarded to Councils in order to fund improvements to the planning process. As part of the Development Management FSR there was a recommendation that the back office applications system needs to be reviewed and a document management system be set in place. As a result this £76,000 has been earmarked to fund the necessary improvement to the back office system and is due to be implemented by December 2011. The consequence of the carry over not being agreed is that the necessary improvements to the back office system as recommended by the FSR will not be delivered.	**76**	0	**76**
	Total Environment Bids	**144**	**168**	**312**
	Health, Housing & Adult Social Care			
9	**Homelessness grant added on** To assist Local Authorities to deal with homelessness issues arising from the changes to the Housing Benefit regulations due to be implemented in April 2011.The finance is a grant from the CLG	**0**	300	**300**
10	**Aids Support Grant (ASG)** The purpose of ASG is to help local authorities with social services responsibilities with the costs of providing HIV related personal social services to people with HIV/AIDS and, where appropriate, their partners, carers and families.	**67**	89	**156**
11	**Carers Grant** Implementing national and local carers strategies. Providing services to carers. Delayed commissioning of carers centre and production of carers RAS. 3 year programme to deploy carry forward to develop Carers RAS	**0**	700	**700**
12	**Learning Disabilities Development Fund** The LDDF has been made available to support the implementation of the Gov't white paper Valuing People in 2002 and Valuing People Now in 2009. The grant was originally received by Enfield Primary Care Trust and was only paid if the funds were contained within a Pooled Budget under the Section 31 of the Health Act (1999). This agreement between the Local Authority and Enfield Primary Care Trust has been in place since the financial year 2002/03. From April 2008, the LDDF (revenue) grant was delivered to local authorities through the Department of Health's contribution to the new Area Based Grant. However, the Local Authority Social Services Letter LASSL(DH)(2007)2 sets out the expectation that this component of the Area Based Grant will be used to support local authorities in delivering the key outcomes for people with learning disabilities. As an un-ringfenced grant, there are no restrictions on carry forward between financial years.	**691**	(208)	**483**
13	**Mental Capacity Act and Deprivation of Liberty Safeguards** To implement statutory requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards	**80**	20	**100**
14	**Stroke Grant** To develop stroke services, to implement national and local strategies, to improve services	**96**	26	**122**
15	**Supporting People** Carry forward for Supporting People to support the budget in 2011/12 allowing for a programme of budget reduction exercises and re-tendering.	**1,705**	(889)	**816**

Grant Carry Forward Requests 2010/11 **APPENDIX 3**

Ref	Grant Carry Forward Request	Brought Forward 1 April 2010 (Restated)	Net Revenue Movement 2010/11	Project Carry Forward 31 March 2011
16	**Grow Your Own Social Work Scheme** To provide ongoing funding for the grow your own social work programme which offers HHASC staff the opportunity to retrain as a qualified social worker through completion of a three year degree or two year masters programme. This programme will reduce dependency on agency staff, develop new social work talent within the department and provide development opportunities for staff within the entire directorate. It is a rolling programme with two additional placements planned for the next two years. There will be two new intakes of two trainees in each year from 2011/12 taking us up to 2015 so the carry forward will fund the scheme over the next 4 years. Total gyo funding required over the next 4years will be 560k.	**0**	440	**440**
17	**Capacity Pressures Funding** To facilitate seamless care for patients on discharge from hospital and to prevent avoidable hospital readmissions. To invest in social care services to benefit health and to improve overall health and social care outcomes (to be transferred under Section 256 (NHS Act 2006))	**0**	540	**540**
	Compulsory Purchase Order Grants Brought Forward	**251**	0	**251**
18	**Compulsory Purchase Order Grants 2010/11**	**0**	103	**103**
	Total HHASC	**2,890**	**1,121**	**4,011**
	Schools & Children's Services			
19	**Local Safeguarding Children's Board Fund** The Local Safeguarding Children's Board is a statutory body and the Children's Act requires each local authority to establish one. The LSCB Fund holds contributions from partners such as Health, Police and Probation and income raised from training events. The Council acts as lead authority and makes payments incurred by or purposes connected with the role of the LSCB.	**13**	31	**44**
20	**Central Council for Education and Training in Social Work Fund** The CCETSW Training Fund holds contributions and grants from various bodies such as Middx University which are used to support and supplement the training of children's social workers in Enfield. The funding will not be fully spent in 2010/11 due mainly to the academic year running until the end of the summer term. Social work training is also an ongoing activity and lasts over a number of years.	**42**	(13)	**29**
21	**Youth Offending Team Development Fund** The Youth Offending Team Development Fund was created to hold contributions from various partner agencies e.g. Police, Probation and Health which can then be used to support the YOT in Enfield. At present this fund has not needed to be accessed as levels of funding have been sufficient. However in 2011/12 the government grant funding from the Youth Justice Board and other external sources has reduced. This fund will now be used as a cushion for one year only whilst the long term options are considered. This funding will be used to maintain staffing during this transitional period and as the service deals with growing new demands (ISSP)	**185**	33	**218**
	Schools & Children's Services	**240**	**51**	**291**
	Grant Brought Forward 1.4.2010 fully applied in 2010/11	**2,587**	**(2,587)**	**0**
	Total Departmental Bids for Carry Forward	**5,861**	**(1,112)**	**4,749**
	Dedicated Schools Grant	**2,232**	570	**2,802**
	Total All Bids for Carry Forward	**8,093**	**(542)**	**7,551**

Agenda Item 7

MUNICIPAL YEAR 2010/2011 REPORT NO. 235

MEETING TITLE AND DATE:

Cabinet Meeting 27 April 2011

REPORT OF:
Ray James - Director of Director of Health, Housing and Adult Social Care

Agenda – Part: 1	**Item: 7**
Subject: Enfield Joint Dementia Strategy 2011 - 2016 **Wards: ALL**	
Cabinet Member consulted: **Councillor Don McGowan**	

Contact officer and telephone number:

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1. EXECUTIVE SUMMARY

1.1 This report proposes the agreement of an Enfield Dementia Strategy jointly with NHS Enfield.

1.2 The Strategy is attached **[Annex 1]** and has been prepared and been subject to a 3 month period of consultation with key partner agencies and the voluntary sector. The Strategy has been considered at the Older People's Partnership Board and the Mental Health Partnership Board.

1.3 Dementia is a progressive, terminal organic brain disease. Symptoms include memory loss, mood changes, a decline in reasoning and communications skills as well as a gradual loss of skills needed to carry out daily living functions. It is estimated that the number of people in Enfield with late onset dementia (i.e in people aged over 65) is 2706 and this is set to increase by 44% by 2030.

1.4 The strategy sets out how Enfield will develop and deliver health and social care services to better meet the needs of people with dementia and their carers over the next 5 years (2011 -16). It outlines 11 key strategic objectives that were developed in consultation with local stakeholders. Each objective is aligned with the National Dementia Strategy and each is supported by a robust rationale.

2. RECOMMENDATIONS

2.1 Cabinet is asked to:

i) note the contents of this report; and

ii) approve the Enfield Joint Dementia Strategy 2011-16.

3. BACKGROUND

3.1 The Joint Dementia Strategy has been developed as a local response to the National Dementia Strategy. It recognises the projected increase in demand for services in Enfield as a result of a 44% increase in those with late onset dementia by 2030. The strategy also helps to ensure resources are used efficiently and effectively, to improve quality and to provide a framework for a more integrated approach to the delivery of health and social care services.

3.2 Living Well with Dementia, the national dementia strategy, was published in February 2009 and aims to improve dementia services across 3 key areas: improved awareness, early diagnosis, and a high quality of care. Other key policy documents include: "Putting People First" which describes a vision for health and social care services which help people to remain healthy and independent and maximise individual choice and control. NICE/SCIE clinical guidelines 2006, The National Carers Strategy (2008) and the End of Life Strategy (2008) are all relatively recent policy drivers which recommend areas to improve services for people with dementia and their carers.

3.3 Consultation on Strategy

3.4 Formal public consultation on the draft dementia strategy was undertaken over a 3 month period from 1 November 2010 to 28 January 2011. A total of 37 questionnaires were completed and a further 11 written responses were received. In addition, verbal feedback was received at several live consultation meetings.

3.5 A summary of submissions received in response to the consultation on the draft Joint Dementia Strategy (2011 – 2016) is attached **[Annex 2].** The document also sets out the Council and NHS Enfield response to the comments and suggestions that were received. As a result a number of revisions to the strategy were made including an on-going commitment to the development of day opportunities and respite care.

3.6 Current and Future Funding

3.7 There is no comprehensive local data on the current combined health and social care costs of dementia services. People with dementia commonly access a wide range of services provided by the NHS, Council and a multitude of private and not-for-profit providers.

3.8 The Alzheimer Society (2007) found that the average cost of caring for someone with dementia in the UK was £25,472 per year (including costs of health, social and informal care). Applying these figures to Enfield would mean that the current cost of late-onset dementia in Enfield is an estimated £68.9 million per year, and that by 2030 the annual cost of dementia in Enfield will have increased to over £99.5 million. These costs are estimated sums that include the unfunded contribution of carers and families and are not intended to represent the cost to health and social care budgets.

3.9 Whilst we acknowledge the need to improve our understanding of current dementia resources, we do know a number of things and these are summarised below:

Service	Cost 2009/10
Mental Health services, including dementia, are commissioned from the Barnet, Enfield and Haringey Mental Health Trust.	£10.5m
Enfield Councils gross spend on older people's health and social care services.	£56.7m
Adult Social Care spend on services for people with dementia.	£14.1m
Approximate spend on residential care services for people with dementia.	£10.65m
Approximate spend on home care for services for people with dementia.	£2.07m
The cost of day opportunities for people with dementia.	£536k
Direct payments for people with dementia.	£539k
2 years pilot dementia adviser programme funded by the Department of Health.	£165k

In addition to the costs detailed in the table above, a substantial proportion of Acute Sector costs can be attributed to dementia.

3.10 To support the implementation of the national strategy, £60m of notional additional baseline funding was made available to PCTs nationally for 2009/10 and an additional £90m in 2010/11 within the overall baseline. No ring fencing has been applied in respect of Dementia, and no actual funds allocated by the PCT.

3.11 The Department of Health expects implementation to be mostly funded through efficiency savings from the acute and long term care sectors. It is expected that these savings will largely be met through reducing unnecessary use of acute hospital beds and delaying entry to care homes through improving early diagnosis and intervention. This is supported by the National Audit Office report that concluded that services are not currently delivering value for money. Spending was late with diagnosis, and early intervention was not widely available. Better value for money can be obtained through earlier diagnosis. Also services in the community are not delivering consistently or cost-effectively to support people to live as independently as possible.

3.12 An implementation plan with indicative resource implications for implementing this strategy over the next 3 years has been developed **[Annex 3]**. Many of the commissioning intentions set out in the strategy are cost neutral and will be delivered through reprioritised activity and more efficient use of existing resources. Some of the costs of implementation will be met through a developing partnership with primary care services. Funding is available through re-ablement budgets which allow service improvements to be delivered without additional costs to the Council. Implementing this strategy allows significantly improved management of the forecast increase in demand for dementia services going forward. Where implementing the strategy may require additional resources, this will be addressed through the Councils annual budget setting process. Dedicated project management resource will be required to deliver this strategy.

3.13 Enfield Joint Dementia Strategy 2011-16.

3.14 The Strategy sets out how Enfield will develop and deliver health and social care services to better meet the needs of people with dementia and their carers over the next 5 years (2011-16). It outlines 11 key Strategic objectives as follows:

STRATEGIC OBJECTIVES:

Priority	**Rational**
1. IMPROVE PUBLIC AND PROFESSIONAL AWARENESS OF DEMENTIA AND REDUCE STIGMA	*Raising awareness and understanding of dementia will encourage people to engage with services earlier and lead to improved outcomes and quality of life.* *Improving the cerebrovascular health of our population may contribute to preventing or minimising vascular dementia.*

2. IMPROVE EARLY DIAGNOSIS AND TREATMENT OF DEMENTIA	*Research suggests that early identification and treatment of dementia is effective in terms of quality of life and overall cost effectiveness.*
3. INCREASE ACCESS TO A RANGE OF FLEXIBLE DAY, HOME BASED & RESIDENTIAL RESPITE OPTIONS	*Support for carers plays a significant role in reducing admissions to residential care and enabling people with dementia to live in the community for as long as possible.*
4. DEVELOP SERVICES THAT SUPPORT PEOPLE TO MAXIMISE THEIR INDEPENDENCE.	*Good-quality, flexible home care services contribute significantly to maintaining people's independence, reducing social isolation, preventing admissions to care homes and hospitals, and supporting carers.*
5. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE	*Lack of understanding of dementia in the workforce – whether in mainstream or specialist services can lead to care practices that can make the situation worse for both the person with dementia and their carer.*
6. IMPROVE ACCESS TO SUPPORT AND ADVICE FOLLOWING DIAGNOSIS FOR PEOPLE WITH DEMENTIA AND THEIR CARERS	*The need for improved access to support and advice has been identified as a priority by local stakeholders and is a key objective of the National Dementia Strategy.*
7. REDUCE AVOIDABLE HOSPITAL & CARE HOME ADMISSIONS AND DECREASE HOSPITAL LENGTH OF STAY	*People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation.*
8. ENSURE THAT THE NEEDS OF YOUNGER PEOPLE WITH DEMENTIA ARE ADDRESSED	*It is estimated that there are approximately 64 people in Enfield with early onset dementia and it is more prevalent amongst people with learning disabilities.*
9. IMPROVE THE QUALITY OF DEMENTIA CARE IN CARE HOMES & HOSPITALS	*There is a high level of inappropriate prescribing of anti-psychotic drugs for people with dementia who are living in care homes.* *Stays in acute general hospitals affect people with dementia badly – increasing their confusion and speeding up deterioration.*
10. IMPROVE END OF LIFE CARE FOR PEOPLE WITH DEMENTIA	*Evidence suggests that people with dementia receive poorer end of life care than those who are cognitively intact.*
11. ENSURE THAT SERVICES MEET THE NEEDS OF PEOPLE FROM BLACK AND MINORITY ETHNIC GROUPS	*Early-onset dementia is more common amongst black and minority ethnic groups and the number of people with late onset dementia is set to rise sharply.*

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 The Strategy sets out the case for change and the rational for the priorities chosen and supported by local stakeholders. It proposes an approach to commissioning Dementia Services that is consistent with national policy drivers and is in line with existing Council and NHS Enfield strategies.

5. REASONS FOR RECOMMENDATIONS

5.1 The strategy is intended to meet the government's key objectives for the delivery of services to meet the needs of people with dementia and ensure that the best possible services are provided for our residents in Enfield for the next five years.

6. COMMENTS OF THE DIRECTOR OF FINANCE AND CORPORATE RESOURCES AND OTHER DEPARTMENTS

6.1 Financial Implications

The financial impact of each of the objectives of the strategy is set out in Annex 3. The majority of the proposed actions can be met from within existing budgets. However, the annex shows that additional expenditure of £1.3 million will be required over the next 3 years jointly across the NHS and Council.

Although the proposed funding streams are indicated, it is imperative that, if Cabinet agree to the recommendations set out in this report, the Council works closely with Health colleagues to refine the proposals and ensure that clear agreements are in place around the funding streams, and the value for money reasons for investment, prior to any additional expenditure being incurred.

6.2 Legal Implications

This Strategy has been developed following publication of the National Dementia Strategy by the Department of Health. The emphasis is on providing locally delivered quality outcomes and local accountability.

6.3 Property Implications

Not applicable.

7. KEY RISKS

7.1 There are no significant risks identified as a result of this strategy.

7.2 Implementation of service changes will be managed and considered in the context of proper risk management arrangements.

7.3 A dementia strategy is essential to mitigate against failure to meet the Government's key objectives for the delivery of

services and meet the needs of Enfield residents over the next five years and to meet strategic objectives.

7.4 The strategy should help reduce the risk of health inequalities and assist in making an early diagnosis.

7.5 It should also encourage systems that act on and minimise risk of abuse and neglect of vulnerable adults.

8. IMPACT ON COUNCIL PRIORITIES

8.1 Fairness for All

- A key priority of the strategy is to reduce inequalities.
- Awareness raising will target Black and Minority Groups and the more deprived wards of the Borough.
- The strategy sets out a commitment to better understanding the needs of Black and Minority Groups and younger people with dementia.

8.2 Growth and Sustainability

- The strategy sets out a commitment to partnership working with care home providers.
- Market development is a key strand of the strategy.
- The voluntary and community sector will be key partners in implementation of the strategy.

8.3 Strong Communities

- The strategy is intended to enhance access to services by the whole community.
- The strategy has been informed by the views of local residents who responded to the consultation.
- We will engage local communities to gain advice on the best way to raise awareness and spread the prevention message within their communities.

9. PERFORMANCE MANAGEMENT IMPLICATIONS

9.1 The Care Quality Commission have a range of indicators as part of the Performance Assessment Framework for PCTs and Councils with an Adult Social Services Department which are directly relevant to the commissioning strategies for people with mental health problems. Performance is routinely monitored on a monthly basis.

9.2 There are a number of indicators within the New Local Area Agreement relevant to Health and Adult Social Care. In particular the following are most significant:

- Number of Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets)
- Carers receiving needs assessment or review and a specific carer's service, or advice and information.
- People supported to live independently through social services
- Number of Delayed Discharges from Acute Hospitals.

10. HEALTH AND SAFETY IMPLICATIONS

No Health and Safety Implications arising directly from this report.

Background Papers

- Forget Me Not: 2000 Audit Commission
- National Service Framework for Older People(2001) (NSF):
- Who Cares Wins (2005):
- Everybody's Business – Integrated mental health services for older adults: a service development guide (2005):
- NICE/SCIE Clinical Guideline (2006):
- Dementia UK Report (2007):
- The National Audit Office value for money study (2007):
- The Carers' Strategy (2008):
- The End of Life Strategy (2008):
- Updated Intermediate Care Guidance (2009):

ANNEX 1

ENFIELD JOINT DEMENTIA STRATEGY 2011 – 2016

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1. Executive Summary

- Dementia has a major impact on the lives of people with dementia and on their families. Family members who care for people with dementia are often old and frail themselves, with high levels of depression and physical illness, and a diminished quality of life.

- Dementia is a term for a range of progressive, terminal organic brain diseases. Symptoms include loss of memory, mood changes, a decline in reasoning and communication skills as well as a gradual loss of skills needed to carry out daily functions and activities. Alzheimer's disease is the most common form of dementia and age is the main risk factor in dementia. Vascular dementia is the second most common form of dementia and can develop following a stroke or if there is blood vessel damage that interrupts the supply blood to your brain.

- Dementia is a terminal condition and people generally live with it for 7–12 years after diagnosis. There are however a number of different psychological treatments that can be used to help people cope with the symptoms of dementia and slow down the symptoms. In addition, medication can be used to treat dementia. Early diagnosis is therefore important in managing the disease and assists in getting appropriate support.

- Living a healthy lifestyle that protects cardiovascular health has been shown to reduce the risk of developing dementia.

- It is estimated that the number of people in Enfield with late onset dementia (ie in people aged over 65) is 2706 and that this is set to increase by 44% in the next 20 years. This presents a significant and urgent challenge to health and social care in terms of both the growing numbers of people affected by dementia and the increasing cost of providing good quality services to enable people with dementia and their carers to live well.

- The Alzheimer Society (2007)[1] found that the average cost of caring for someone with dementia in the UK was £25,472 per year (including costs of health, social and informal care). Applying these figures to Enfield would mean that the current cost of late-onset dementia in Enfield is an estimated £68.9 million per year, and by 2030 the annual cost of dementia in Enfield will have increased to over £99.5 million.

- In 2009 the Department of Health published *Living Well with Dementia: A National Dementia Strategy* which aims to ensure that significant improvements are made to dementia services across three key areas:

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[1] Alzheimer's Society (2007). *Dementia UK.*

improved awareness, earlier diagnosis and intervention, and a higher quality of care.

- This strategy sets out how Enfield will develop and deliver health and social care services to better meet the needs of people with dementia and their carers over the next 5 years (2011-16). It outlines 11 key strategic objectives that were developed in consultation with local stakeholders. Each of the objectives is aligned with the National Dementia Strategy and each is supported by a robust rationale.

- This strategy has been developed in the context of an extremely challenging financial environment. Councils are being asked to reduce their budgets year on year, and NHS organisations are working hard to improve their financial positions and reduce their deficits. The Department of Health expects implementation of the National Dementia Strategy to be mostly funded through efficiency savings from the acute and long term care sectors. It is expected that these savings will largely be met through reducing unnecessary use of acute hospital beds and delaying entry to care homes through improving early diagnosis and intervention. Any new investment in local dementia services will necessarily be funded through efficiency savings and/or reconfiguration of existing resources.

STRATEGIC OBJECTIVES:

1. IMPROVE PUBLIC AND PROFESSIONAL AWARENESS OF DEMENTIA AND REDUCE STIGMA

Raising awareness and understanding of dementia will encourage people to engage with services earlier and lead to improved outcomes and quality of life.

Improving the cerebrovascular health of our population may contribute to preventing or minimising vascular dementia.

Develop a targeted local awareness campaign that aims to raise public and professional understanding of dementia and the stigma associated with it. The awareness campaign will focus on encouraging people to seek early diagnosis and care and increasing people's knowledge of how to reduce their risk of developing dementia through making healthy lifestyle choices.

Engage with local employers of public-facing staff to gain advice on how best to develop staff awareness including access to local resources for staff.

Dementia awareness will be included in all induction training for employees within the NHS, Council and partner organisations working with adults and older people.

Link with existing health promotion activities and awareness campaigns to improve awareness of the link between healthy lifestyles and reduced risk of vascular dementia.

Develop and implement a local dementia care pathway, spanning early diagnosis to the end of life and ensure that people with dementia, carers and health and social care professionals are aware of this pathway

2. IMPROVE EARLY DIAGNOSIS AND TREATMENT OF DEMENTIA

Research suggests that early identification and treatment of dementia is effective in terms of quality of life and overall cost effectiveness.

Reconfigure the current Memory Treatment Clinic model in line with NICE guidance to enable it to have a greater role in early diagnosis and to better manage existing and future demand, including the capacity to meet the needs of the growing population of older people with dementia from Black and Minority Ethnic groups. This will include exploring the option of direct referral to the clinic from primary care and assessing the benefits of providing assessment and treatment as part of the service.

Establish processes to ensure that GP practices are notified when one of their patients is admitted to hospital with a diagnosis of dementia.

3. INCREASE ACCESS TO A RANGE OF FLEXIBLE DAY, HOME BASED & RESIDENTIAL RESPITE OPTIONS

Support for carers plays a significant role in reducing admissions to residential care and enabling people with dementia to live in the community for as long as possible.

Allocate additional funding for the development of increased flexible day opportunities and respite care that is responsive to individual needs including the needs of carers.

Implement *Putting People First* personalisation changes to enable the development of more innovative, flexible day, home based and residential respite services to better meet the needs of people with dementia and their carers.

Through review, promote local initiatives to make more effective use of existing resources currently invested in day opportunities to provide increasingly flexible responses to peoples expressed needs.

Ensure that the need for respite is an integral part of people's assessment and care package and that the rights of carers to an assessment of needs are upheld.

Provide funding to support the development of a peer support group for carers of people with dementia that will enable carers to support each other, share information and advice, give carers a stronger voice and provide a forum for training.

4. DEVELOP SERVICES THAT SUPPORT PEOPLE TO MAXIMISE THEIR INDEPENDENCE.

Good-quality, flexible home care services contribute significantly to maintaining people's independence, reducing social isolation, preventing admissions to care homes and hospitals, and supporting carers.

Increase investment in assistive technology to support people to remain in their own homes and ensure that appropriate housing related support is available to people with dementia.

Commission a range of housing options that better meet the specialist needs of people with learning difficulties and dementia.

Ensure that a range of high quality, affordable local services providing therapeutic, cognitive and social stimulation for people with dementia are available to help maintain their well being. These services will be appropriate for people at different stages of the disease.

Commission training for carers on caring for someone with dementia.

5. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE

Lack of understanding of dementia in the workforce – whether in mainstream or specialist services – can lead to care practices that can make the situation worse for both the person with dementia and their carer.

Develop a local dementia workforce plan that links to, and complements, the identified national workforce development initiatives.

Ensure that all services specify dementia training and core competencies that include, but are not limited to, the national minimum standards.

Ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from Community Mental Health Teams.

6. IMPROVE ACCESS TO SUPPORT AND ADVICE FOLLOWING DIAGNOSIS FOR PEOPLE WITH DEMENTIA AND THEIR CARERS

The need for improved access to support and advice has been identified as a priority by local stakeholders and is a key objective of the National Dementia Strategy.

Enfield is piloting a new service - the Enfield Dementia Demonstrator Pilot programme – which provides information, advice and support to people with

dementia and their carers. If evaluation of the pilot shows that it is achieving the desired outcomes then we will continue to commission the service.

We will ensure that dementia information materials and resources are available for all people with dementia and their carers.

7. REDUCE AVOIDABLE HOSPITAL & CARE HOME ADMISSIONS AND DECREASE HOSPITAL LENGTH OF STAY

People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation.

Review the Hospital Mental Health Liaison Service with a view to expanding the role of the service to include responsibility for general hospital staff dementia training and education.

Ensure that people with dementia are able to access Intermediate care services by providing all Intermediate Care staff with core training in dementia and access to advice and support from specialist mental health staff. In addition we will increase the capacity of Intermediate Care to provide in-reach to care homes in order to reduce avoidable hospital admissions.

Review the appropriateness of current arrangements for assessing people with dementia in general hospitals, including the appropriateness of current assessment environment.

Review the quality, range and provision of services for people who require continuing healthcare.

8. ENSURE THAT THE NEEDS OF YOUNGER PEOPLE WITH DEMENTIA ARE ADDRESSED

It is estimated that there are approximately 64 people in Enfield with early onset dementia and it is more prevalent amongst people with learning disabilities.

Ensure that health and social care staff working with people with learning disabilities and other younger people at risk of dementia receive training in dementia awareness.

Ensure that people with learning disabilities and those supporting them have access to specialist advice and support for dementia.

Explore the potential of jointly commissioning services for younger people with dementia with our neighbouring boroughs of Barnet and Haringey.

9. IMPROVE THE QUALITY OF DEMENTIA CARE IN CARE HOMES & HOSPITALS

There is a high level of inappropriate prescribing of anti-psychotic drugs for people with dementia who are living in care homes.

Stays in acute general hospitals affect people with dementia badly – increasing their confusion and speeding up deterioration.

Commission specialist older peoples mental health teams to provide in-reach service to support primary care in its work in care homes.

Commission primary care and pharmacy in-reach services to ensure more appropriate use of anti-psychotic medication.

Ensure distribution, promotion and implementation of the ‘good practice resource pack’ that is being developed by the National Dementia Strategy Implementation Team.

Develop collaborative partnerships with care home providers to encourage the development of local leaders who can demonstrate excellence in provision of services.

Identify a senior clinician within Chase Farm Acute Trust to take the lead for quality improvement and training in dementia care in hospital.

Review the current care pathway for the management and care of people with dementia in hospital, led by that senior clinician.

Explore the potential use of the commissioning for quality and innovation (CQUIN) payment framework, to incentivise general hospital providers to improve quality and innovation.

10. IMPROVE END OF LIFE CARE FOR PEOPLE WITH DEMENTIA

Evidence suggests that people with dementia receive poorer end of life care than those who are cognitively intact[2].

Ensure that people with dementia have the same access to palliative care services as others.

Develop local end of life care pathways for dementia consistent with the Gold Standard Framework as identified by the National End of Life Care Strategy.

Introduce quality payments to care homes that achieve the Gold Standard for End of Life Care.

[2] Living Well with Dementia: A National Dementia Strategy (DH 2009)

Commission a Gold Standard Framework Facilitator to work with care homes to assist them to implement the Gold Standard Framework.

Raise awareness of the Mental Capacity Act among health and social care professionals in order to increase the number of people who are enabled to plan for their end of life care while they have the capacity to do so.

11. ENSURE THAT SERVICES MEET THE NEEDS OF PEOPLE FROM BLACK AND MINORITY ETHNIC GROUPS

Early-onset dementia is more common amongst black and minority ethnic groups and the number of people with late onset dementia is set to rise sharply.

We will review current service provision to assess whether it is meeting the needs of Black and Minority Ethnic groups and engage with the Black and Minority Ethnic community to gain a better understanding of their needs and current gaps in service provision.

2. Introduction

Dementia is a term for a range of progressive, terminal organic brain diseases. Symptoms include decline in memory, reasoning and communication skills, and ability to carry out daily activities, and loss of control of basic bodily functions caused by structural and chemical changes in the brain. Alzheimer's disease is the most common form of dementia and age is the main risk factor in dementia. There are also a number of modifiable risk factors including smoking, excessive alcohol consumption and obesity.

The impact of dementia on people with the disease and on their families is profound. Family members who care for people with dementia are often old and frail themselves, with high levels of depression and physical illness, and a diminished quality of life.

The number of people in Enfield with late onset dementia is set to increase by 44%, from 2706 to 3906, in the next 20 years. This presents a significant and urgent challenge to health and social care in terms of both the growing numbers of people affected by dementia and the increasing cost of providing good quality services to enable people with dementia and their carers to live well. In order to meet the current and future needs of people with dementia we need to take a strategic approach to developing and redesigning the way that we provide services to people with dementia and their carers.

The major growth in the predicted prevalence of dementia and associated increase in the cost of service provision is not the only important issue for commissioners of dementia care. The quality of care for people with dementia and their carers has come under considerable scrutiny over the past decade. Key issues that have been highlighted by the National Audit Commission and voluntary sector include poor diagnosis of dementia, lack of early intervention, and a paucity of support in the community. Lack of public and professional awareness and the stigma associated with dementia are also considered to be key contributors to neglect and under-diagnosis of the condition.

Dementia care is delivered through a range of providers, with diagnosis and medical support provided primarily by health services, and longer-term care delivered by the social care and third sector, as well as private companies providing care homes and domiciliary care. It is the intention that this strategy provides a vehicle for encouraging integration and collaboration across the range of health and social care services.

This strategy sets out the local direction for dementia services from 2010/11 - 2015/16. It is evidence based, built on an analysis of current and predicted future need and has been guided by input from local stakeholders who have contributed to our understanding of the priorities for improving services for people with dementia and their carers in Enfield.

A 3 month period of consultation on the strategy was carried out and revisions to the strategy were made in response to the feedback that we received. A summary of submissions and the response to these submissions is set out in a separate document: *Enfield Joint Dementia Strategy 2011-2016 – A Summary of Submissions Received in Response to the Consultation*. The feedback will also be used to inform the implementation of the strategy, particularly with regard to developing our priorities for the first year of implementation.

The strategy is underpinned by the National Dementia Strategy, which aims to improve dementia services across 3 key areas: improved awareness, early diagnosis, and a higher quality of care; and is set in the context of the vision for transforming the adult health and social care system from one which intervenes at the point of crisis to one which helps people to remain healthy and independent and maximises individual choice and control.

The strategy development has been led by the Older People's Mental Health Group, which is a sub-group of the Older People's Partnership Board (a Thematic Action Group of the Enfield Strategic Partnership[3]). It has been developed in collaboration with key stakeholders, including carers and service users, who provided advice and expertise on the priorities for developing services in Enfield. A full list of people who have contributed to the development of this strategy through participation in stakeholder workshops or individual discussions is included in Appendix 4.

The strategy will be regularly reviewed and progress on implementation will be monitored by the Older People's Mental Health Group who will have a remit to monitor implementation and make recommendations for further developments.

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[3] The Enfield Strategic Partnership is a mature partnership and brings together organisations, businesses and the third sector.

3. National and Local Guidance and Research

National Guidance and Policy Context

There is a national drive towards enabling patient choice and developing services that are responsive to individual needs (or 'personalised'). This agenda is outlined in the Department of Health White Paper *Our Health, Our Care, Our Say* (2006) which sets out a fundamental change in the way services are delivered. Of relevance to the development of dementia services are the objectives of shifting resources into preventative services; providing care closer to home; further development of joint commissioning; and encouraging innovation through direct payments and individual budgets.

Following on from this, the Department of Health Published *Putting People First* (2008), which outlines a radical reform of the way that health and social care services are delivered. The requirements set out in this document build on *Our Health, Our Care, Our Say* (2006) and describe a vision for transforming the adult health and social care system from one which intervenes at the point of crisis to one which helps people to remain healthy and independent and maximises individual choice and control.

Improving the delivery of services to people affected by dementia is a key national and local priority. *Living Well with Dementia*, the national dementia strategy, was published in February 2009 and aims to improve dementia services across 3 key areas: improved awareness, early diagnosis, and a higher quality of care. The strategy sets out 17 objectives, the majority of which require implementation at a local level.

There are a number of other important national publications containing findings and recommendations regarding the development of dementia services that have directly influenced the development of our local strategy. They are summarised in Appendix 1: National Policy Context.

Local Guidance

In January 2009, Enfield published *A Future for All*, a joint social care and health document which set out the joint commissioning intentions for older people's mental health services (2009 – 2012). This document included a commitment to the development of services for people with dementia and their carers.

This strategy builds on the priority intentions outlined in *A Future for All* and aims to ensure that our strategic objectives and commissioning intentions are underpinned by a robust evidence based approach and informed by the priorities identified in the Joint Strategic Needs Assessment and Local Area Agreement. The priorities identified in these documents include:

- Reducing health inequalities

- Early intervention and prevention for people with long term conditions
- Improving outcomes for people with dementia
- Focusing on healthy lifestyles and improved cardiovascular health
- Improving access to health and wellbeing information
- Giving people increased choice and control
- Maximising independence and enabling people to remain in their own homes for as long as possible
- Strengthening the Voluntary and Community Sector and developing their capacity to deliver services.

Enfield is also developing a number of other joint commissioning strategies that will sit alongside the dementia strategy and will contribute to achieving the strategic objectives outlined in Section 6 of this strategy. They include:

- Prevention and Early Intervention
- End of Life Care
- Intermediate Care and Re-ablement
- Carers
- Mental Health; and
- Accommodation

All of the strategies are being developed as part of a wider local work programme to develop personalised services and take forward the recommendations outlined in *Putting People First*. This is an ambitious work programme to transform local services and will make a significant contribution to achieving the strategic objectives for dementia set out in this strategy. It includes a commitment to:

- Local authority leadership accompanied by authentic partnership working with NHS Enfield, other statutory agencies, third and private sector providers, users and carers and the wider local community to create a new, high quality care system which is fair, accessible and responsive to the individual needs of those who use services and their carers
- Agreed and shared outcomes which should ensure people, irrespective of illness or disability, are supported to:
    - live independently;
    - stay healthy and recover quickly from illness;
    - exercise maximum control over their own life and, where appropriate, the lives of their family members;
    - sustain a family unit which avoids children being required to take on inappropriate caring roles;
    - participate as active and equal citizens, both economically and socially;
    - have the best possible quality of life, irrespective of illness or disability;
    - retain maximum dignity and respect
- System-wide transformation, developed and owned by local partners covering the following objectives:

- Commissioning which incentivises and stimulates quality provision offering high standards of care, dignity and maximum choice and control for service users.
- Universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding.
- A common assessment process of individual social care needs with a greater emphasis on self-assessment. Social workers spending less time on assessment and more on support, brokerage and advocacy.
- Person centred planning and self directed support to become mainstream and define individually tailored support packages.
- Telecare to be viewed as integral not marginal.
- Personal budgets for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision.
- Direct payments utilised by increasing numbers of people, as defined by our Local Area Agreement targets.
- Family members and carers to be treated as experts and care partners other than in circumstances where their views and aspirations are at odds with the person using the service or they are seeking to deny a family member the chance to experience maximum choice and control over their own life. Programmes to be supported which enable carers to develop their skills and confidence.
- Systems which act on and minimise the risk of abuse and neglect of vulnerable adults, supported by a network of "champions", including volunteers and professionals, promoting dignity in local care services.
- Local workforce development strategies focussed on raising skill levels and providing career development opportunities across all sectors.

The NHS Enfield Operating Plan for 2009/2010 notes the need to work towards implementation of the National Dementia Strategy. NHS Enfield has also adopted a ten year Primary Care Strategy in 2009 which aims to increase the range of services available in the community, and locate these services together. Existing GPs will be grouped together in upgraded premises with the aim of achieving better outcomes and improving patient choice. The establishment of service hubs and the range of services available are currently being worked up[4] within the Coalition Government's outline Programme. Services for people with dementia should be advanced within this model, allowing for greater multi-disciplinary contact, awareness raising and sharing of evidence that will support early diagnosis and support.

Finally, NHS Barnet, Enfield and Haringey have developed a joint commissioning strategy for Adult Mental Health Services (2009 – 2014). This

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[4] Current at May 2010

strategy recognises a number of common issues regarding the delivery of dementia services across the 3 boroughs, including:

- o The current approach is primarily medically based and there is often a lack of expertise in non-pharmacological approaches
- o Social inclusion for people with dementia is not well supported
- o The number of referrals back from care homes to acute wards is high

As a result the strategy commits to focusing on:

- o Developing person centred care
- o Supporting independence through social inclusion and whole systems approaches
- o Training for health and social care staff, family members and carers

This strategy builds on the priorities outlined in Barnet, Enfield and Haringey commissioning strategy for Adult Mental Health Services and sets out how we intend to address the issues at a local level. In addition, we have formed a local commissioning forum across the 3 Boroughs to develop collaborative approaches, share best practice and explore the opportunities for joint commissioning. One of the areas that the 3 Borough forum will focus on initially is the commissioning of services for younger people with dementia and the opportunities for developing a joint approach to this.

Research

There is considerable evidence to support good practice in dementia care. Some of the key research findings that have informed the development of this strategy are summarised below:

- Early diagnosis and interventions for dementia is cost-effective and improves the quality of life of people with dementia and their carers (Department of Health 2007)[5]

- Only around 30% of people with dementia have a formal diagnosis made, or contact with specialist service at any time in their illness (National Audit Office 2007)[6]

- Providing people with diagnosis, decreases their level of anxiety and depression. (Carpenter *et al* 2008)[7]

- Early diagnosis and intervention have positive effects on the quality of life of people with dementia (Banerjee *et al.* 2007)[8]

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[5] Department of Health, Transforming the Quality of Dementia Care – Appendix 4, the Clinical and Health Economic Case for Early Diagnosis and Intervention Services in Dementia (2008)

[6] National Audit Office (2007). *Improving services and support for people with dementia*. London: TSO.

[7] Carpenter, BD, Xiong, C, Porensky, EK, Lee, MM, Brown, PJ, Coats, M, Johnson, D and Morris, JC (2008). 'Reaction to a dementia diagnosis in individuals with Alzheimer's disease and mild cognitiveimpairment.' *Journal of the American Geriatrics Society*, 56, 405–12.

- Services that enable early intervention have positive effects on the quality of life of family carers (Mittelman *et al.* 2007)[9]

- People wait up to three years before reporting symptoms of dementia to their doctor. (Alzheimer Society 2002)[10]

- Lack of understanding of dementia in the workforce – whether in mainstream or specialist services – can lead to care practices that can make the situation worse for both the person with dementia and their carer. (Ballard *et al* 2002)[11]

- Early provision of support at home for people with dementia can reduce institutionalisation by 22%. (Gaugler *et al* 2005)[12]

- A brief programme of carer support and counselling at diagnosis alone has been demonstrated to reduce care home placement by 28%. (Mittelman *et al.* 2007)[13]

- People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation but this is not widely appreciated by clinicians, managers or commissioners. (Royal College of Psychiatrists 2005)[14]

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[8] Banerjee, S, Willis, R, Matthews, D, Contell, F, Chan, J and Murray, J (2007). 'Improving the quality of dementia care – an evaluation of the Croydon Memory Service Model.' *International Journal of Geriatric Psychiatry*, 22, 782–8.

[9] Mittelman, MS, Roth, DL, Clay, OJ and Haley, WE (2007). 'Preserving health of Alzheimer caregivers: impact of a spouse caregiver intervention.' *American Journal of Geriatric Psychiatry*, 15, 780–9.

[10] Alzheimer's Society (2002). *Feeling the pulse*. A report for Alzheimer's Awareness Week 2002. London

[11] Ballard, C, Powell, I, James, I, Reichelt, K, Myiut, P et al (2002). 'Can psychiatric liaison reduce
neuroleptic use and reduce health service utilization for dementia patients residing in care facilities.' *International Journal of Geriatric Psychiatry*, 17, 140–45. Turner, S (2005). 'Behavioural symptoms of dementia in residential settings: A selective review of non-pharmacological interventions.' *Aging and Mental Health*, 9 (2), 93–104.

[12] Gaugler, JE, Kane, RL, Kane, RA and Newcomer, R (2005). 'Early Community-Based Service Utilization and Its Effects on Institutionalization in Dementia Caregiving.' *The Gerontolog*ist, 45, 177–85.

[13] Mittelman, MS, Roth, DL, Clay, OJ and Haley, WE (2007). 'Preserving health of Alzheimer caregivers: impact of a spouse caregiver intervention.' *American Journal of Geriatric Psychiatry*, 15, 780–9.

[14] Royal College of Psychiatrists (2005). *Who cares wins: Improving the outcome for older people admitted to the general hospital*. London: RCPsych.

A national evidence base on the effectiveness of preventative services is beginning to develop through the Partnership for Older People Projects (POPP). POPP was funded by the Department of Health to develop services for older people, aimed at promoting their health, well-being and independence and preventing or de
laying their need for higher intensity or institutional care. The evaluation found that a wide range of projects resulted in improved quality of life for participants and considerable savings, as well as better local working relationships. These included pilots focusing on people with dementia.

Consultation

Formal public consultation on the draft dementia strategy was undertaken over a 3 month period from 1 November 2010 to 28 January 2011.

A total of 37 questionnaires were completed and a further 11 written responses were received; most representing the views of organisations or networks of organisations. In addition, verbal feedback was received at several live consultation meetings.

Over 80% of respondents who completed the questionnaire agreed with the proposed direction that is set out in the strategy.

A number of revisions to the strategy were made as a result of the feedback that was received, including a commitment to allocate additional funding to support the development of increased flexible day opportunities and respite care; and the development of peer support groups for carers. In addition, feedback on the consultation will assist us in setting the priorities for the first year of strategy implementation.

4. Current and Future Demand

Current and future demand for services for people with dementia and their carers has been estimated by undertaking an assessment of the needs of the Enfield population. The assessment of need is based on a balance of national and local data and consists of demography, incidence and prevalence, risk factor data and local and service user data.

What is Dementia?

Dementia is the term used for a range of progressive, terminal organic brain diseases. The symptoms of dementia include:

- Loss of memory – for example, forgetting the way home from the shops, or being unable to remember names and places, or what happened earlier the same day.
- Mood changes – particularly as parts of the brain that control emotion are affected by disease. People with dementia may also feel sad, frightened or angry about what is happening to them.

- Communication problems – a decline in the ability to talk, read and write.

In the later stages of dementia, the person affected will have problems carrying out everyday tasks, and will become increasingly dependent on other people.

There are several diseases and conditions that cause dementia. These include:

- **Alzheimer's disease:** accounts for 62% of dementia in England. It changes the chemistry and structure of the brain, causing the brain cells to die.

- **Vascular dementia**: caused by problems with the supply of oxygen to the brain following stroke or small blood vessel disease and accounts for 30% of dementia. Conditions that blood circulation to the brain, such as hypertension can contribute to vascular dementia.

- **Dementia with Lewy Bodies**: is caused by protein deposits that develop inside nerve cells in the brain and interrupt its normal functioning. It accounts for 4% of dementia.

- **Fronto-temporal dementia:** is a rare form dementia and affects 2% of people with Dementia in England. It often affects the under 65s, affecting their behaviour and personality rather than their memory in the early stages.

Dementia is a terminal condition and people generally live with it for 7–12 years after diagnosis. There are a number of different psychological treatments that can be used to help people cope with the symptoms of dementia and slow down the symptoms. These include cognitive stimulation, behavioural therapy, reality orientation therapy, multi-sensory stimulation and exercise therapy. In addition, medication can be used to treat dementia. The most common medications are acetylcholinesterase inhibitors (AIs) which are widely used to treat Alzheimer's disease. Antipsychotic medication also may also be used in cases where there are severe symptoms of challenging and disruptive behaviour.

Local Needs Assessment

This section highlights key facts from the needs assessment that have informed the development of this strategy (the full needs assessment is included in Appendix 2).

- The number of people aged 65yrs & over living in Enfield is 38,000. This is projected to increase to 40,800 in 5 years and 53,500 in 20 years.
- The number of people aged 85yrs & over living in Enfield is 5,200. This is projected to increase to 5,700 in 5 years and 8,500 in 20 years.

- Enfield has the 8th highest percentage of people aged 65yrs & over in London.
- In 2001, 8.5% of people in Enfield were from Black and Minority Ethnic groups. This is projected to increase to 24% by 2021.
- There are currently 1026 people 65 yrs and over living in a care home. This is projected to increase to 1,113 in 5 years and to 1,537 in 20 years.
- 74% of people with dementia who are receiving social care services are female
- 87.5% of people with dementia who are receiving social care services are over 75 years, and 47% are over 85 years.
- It is estimated that there are approximately 2706 people with late-onset dementia living in Enfield. This is projected to increase to 2978 by 2015; 3446 by 2025; and 3906 by 2030 - an increase of nearly 44% in 20 years.
- Enfield has the 5th highest number of people with late-onset dementia in London (however prevalence rate is the same as the London Average of 7.3%).
- Of the 31 London PCTs, Enfield is ranked amongst the top 12 with the largest number of people with early-onset dementia. It is estimated that there are approximately 64 people with early onset dementia (2007) living in Enfield.
- Early onset dementia is more prevalent among Black and Minority Ethnic groups.[15]
- There is a significantly higher projected increase in late onset dementia among Black and Minority Ethnic groups than in the general population.[16]
- Of the current estimated 2706 people in Enfield with late onset dementia it is estimated that:
    - 1480 have mild dementia
    - 874 have moderate dementia
    - 351 have severe dementia
- Compared to London, Enfield has the:
    - 8th highest prevalence rate for stroke or TIA (mini stroke)
    - 5th highest number of people on the obesity register
    - 7th highest number of smokers
    - 5th highest prevalence rate for hypertension

5. Market Analysis

A market analysis has been undertaken to assist us to build a picture of existing local services and their use, as well as a wider picture of the market and an assessment of current gaps in service availability or performance.

Map of Services

As part of the preparation to inform this strategy a mapping exercise was undertaken to provide a comprehensive understanding of the range of health and social care services that are currently being provided in Enfield for people

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[15] Dementia UK 2007 report

[16] London Dementia Needs Assessment

with dementia and their carers. It is an evolving description of services based on our current market intelligence and it is acknowledged that there may be more services that provide support to people with dementia and their carers. As part of the ongoing development of our strategic approach to the commissioning of services we will continue to develop our understanding of the services that people with dementia and their carers are accessing in Enfield. Following is a brief overview of the range of services that are available in Enfield (a detailed map of services is provided in Appendix 3):

Specialist NHS dementia care is primarily provided by Barnet, Enfield and Haringey Mental Health Trust. They provide a memory treatment clinic, in-patient care, day hospital, continuing care, mental health liaison and community mental health teams. Community Psychiatric Nurses support an Alzheimer's Society weekly drop-in session. In patient beds for assessment and long stay, along with day hospital/treatment service is provided at Chase Farm Hospital.

Specialist care is also provided by general practitioners who provide diagnosis and ongoing management. As peoples dementia progresses they may need help at home, for example, domiciliary care and, in the later stages, residential or nursing home care. These services are commissioned by Enfield Council and are provided by both the council and the independent sector. A number of older people are also supported with care packages at home or in Nursing Homes through NHS Continuing Healthcare funding.

People with dementia and their carers also access a wide range of services provided by the third sector, including respite care, day opportunities and information and advice.

General Hospital services are primarily provided by Chase Farm and North Middlesex Hospitals.

New Initiatives:

1. Dementia Demonstrator Pilot

In 2009, Enfield Council, in partnership with the Alzheimer's Society, NHS Enfield and the Barnet , Enfield and Haringey Mental Health Trust were successful in securing funding of £165,000 (over 2 years) from the Department of Health to pilot a new dementia service – the Dementia Demonstrator Pilot.

The new service is being managed by the Alzheimer's Society and provides the following services:

- An introduction call to all people and their carers who have received a diagnosis of dementia
- Sign posting offered for immediate needs and assistance to access services if required.
- The development of a local information pack and fact sheets
- A dedicated helpline

- Adviser ‘surgery’ appointments offered for face to face meetings if requested.
- Facilitate local connections and access to peer support networks.

The service is run by a dementia advisor, supported by a team of voluntary staff. Funding from the Department of Health is for 2 years only however NHS Enfield and Enfield Council have made a commitment to continue to commission the service if, after evaluation of the pilot, it is shown to be effective and valued.

<u>2. Unique Care Pilot</u>
A pilot based on Practices in Enfield North West is starting in autumn 2010 to better support people with long term conditions in their own homes. People on GPs’ Dementia Registers will be included in this pilot which aims to:

- Deliver patient centred coordinated care, a single assessment point and improved quality care
- Reduce unnecessary hospital admissions and excess bed days in the over 65s through extra case management resource
- Identify high risk patients and initiate packages of care by additional Community Matrons and Social Workers to avoid hospital admission, carrying out in-reach services to acute trusts where admissions do occur.

NHS Enfield adopted a ten year Primary Care Strategy[17] in 2009 with the aim of increasing the range of services available in the community, and locating those services together. It is planned that existing GPs will be grouped together in upgraded premises with the aim of achieving better outcomes and improving patient choice. The establishment of service hubs and the range of services available are currently being worked up within the Coalition Government’s outline Programme[18]. Services for people with dementia should be advanced within this model, allowing for greater multi-disciplinary contact, awareness raising and sharing of evidence that will support early diagnosis and support.

A review of medicines management in care homes for older people has recently been carried out for the Department of Health. A review by the Care Quality Commission of health services into all care homes is currently in progress[19]. The outcome of these reviews will be taken into account in planning to meet dementia needs and will be used to inform the development of the strategy implementation plan. A Pharmacy Needs Review to be completed by February 2011 is also underway and will assist in our understanding of dementia needs.

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[17] Making Enfield Better - NHS Enfield Primary Care Strategy (2009)

[18] Current as at May 2010
[19] Current as at May 2010

Service Quantity

This part of our market analysis aims to identify any known under or over supply of services and comment on current service utilisation, including waiting times.

Acute Trust: Chase Farm & North Middlesex Hospitals

A considerable number of patients are admitted to hospital with a diagnosis of dementia. In 2008/09, Chase Farm and North Middlesex Hospitals admitted 71 people with a primary diagnosis of dementia, of which over 78% were emergency admissions. These admissions utilised 860 bed days. Based on a bed day cost of £223, this equates to over £191,780.

Expanding this analysis to the first three diagnostic positions, there were 420 admissions which utilised 4,856 bed days. Based on a bed day cost of £223, this equates to over £7.8 million.

With the correct model of diagnosis and treatment, it should be possible to reduce the number of costly admissions to hospital thereby freeing up resources to be used more cost effectively.

Primary Care

NHS Enfield has 922 patients on general practice dementia registers. This equates to approximately only 1/3 of the expected numbers based on the estimated current prevalence. Issues impacting upon this may include GPs' caution where screening or diagnosis is difficult at early stages, lack of confidence in outcomes of any intervention, coupled with the perception that responses should be social rather than medically driven.

Of the 922 patients on the dementia register, 850 were eligible for review, and 677 of these patients had their care reviewed in the previous 15 months. The register is largely dependent upon correspondence with secondary care where a primary or additional diagnosis may have been made; GPs' attention is also drawn to those cases where referral may not be appropriate and diagnosis may be based on their clinical judgement and knowledge of the patient. Reviews should involve communication and co-ordination from secondary care and be a face to face review of physical and mental health needs, and include carers' support needs.

Memory Treatment Clinic

The memory treatment clinic in Enfield was set up to provide prescribing and monitoring of anti-dementia medications, working to the current NICE guidelines for monitoring and prescription.

It has never been a diagnostic service; a diagnosis is made in other parts of the mental health services in Enfield, or by other mental health services or neurology services, but all referrals to the memory treatment clinic come from the psychiatric staff within the Enfield Older People's Mental Health Service who are, in effect, monitoring the referrals. This is different to other areas

where memory assessment and treatment services are combined and can therefore lead to some confusion and duplication.

When referrals are accepted, patients are seen four times during the first 6 months, and thereafter every 6 months. For the first 6 months, the medication is prescribed by Mental Health Trust staff; after that, general practitioners take over prescribing. If patients live alone, it is a requirement of their treatment that a care package is instituted to ensure they take the medication. Carers are also seen, inline with NICE guidelines.

New referrals to the Enfield memory treatment clinic:

- Between Jan 2006- Dec 2006 -119
- Between Jan 2007- Dec 2007 - 138
- Between Jan 2008 - Dec 2008 – 160
- Between Jan 2009-Dec 2009-182

The rise in numbers of new referrals is particularly significant as up until October 1st 2007, patients from the Cheshunt/Waltham Cross area of Hertfordshire were seen in the clinic but were transferred out through 2007.

In 2006, using the NICE costing template, Barnet, Enfield and Haringey Mental Health Trust projected that 80 new patients with moderate dementia would be referred to the clinic in 2008. In reality, double these numbers were referred.

In January 2010 there were 455 patients in the memory treatment clinic and 18 on the waiting list. There has been an increase in the waiting time for access to the clinic from 36 days in 2008 to the current waiting time of 12 weeks.

<u>Hospital Mental Health Liaison Service</u>

Specialist Mental Health liaison is provided to general acute hospital wards at Chase Farm by one full time nurse with consultant input.

<u>Continuing Care</u>

Continuing healthcare is fully NHS funded care for patients who are

- physically frail
- have a long term mental illness as a result of a physical change in the brain, for example dementia, or
- need end-of-life (palliative) care

Continuing healthcare is provided in independent sector nursing homes that are part of a London Framework agreement. The framework agreement is intended to improve and standardise the prices paid for care, while maintaining the quality of care.

- Continuing care is also provided in The Oaks and Silver Birches inpatient wards. These wards provide an assessment and continuing care service for older people who are suffering from the effects of a chronic degenerative mental health condition (dementia/cognitive impairment). The wards provide specialist inpatient mental health care where there are significant psychological and behavioural symptoms of dementia.

Social Care

Enfield Council commission and provide a range of social care services for people with dementia and their carers. These include assessment and review, residential and nursing care, support in the home, extra care housing, respite care, support for carers, assistive technology and information and advice.

Key facts on social care activity:

- 125 Mental Health assessments were recorded as dementia (2006/07)
- The number of service users receiving a review increased from 240 in 2005/06 to 480 in 2008/09
- The number of people receiving a service package increased from 260 in 2005/06 to 600 in 2008/09
- Approximately 50% of people who received a service were in a residential or nursing placement.
- Support was provided to 680 carers aged 65+ (2008/09), of these, 137 were caring for people with dementia.
- The number of people with dementia who are receiving social care funded residential or nursing care has increased from 209 in 2005/06 to 343 in 2009/10. This can be broken down as follows:
    - The number of people with dementia living in general nursing care homes has increased from 24 in 2005/06 to 51 in 2009/10.
    - The number of people with dementia living in dementia registered nursing care homes has increased from 7 in 2005/06 to 16 in 2009/10.
    - The number of people with dementia living in general residential care homes has increased from 140 in 2005/06 to 174 in 2009/10.
    - The number of people with dementia living in dementia registered residential care homes has increased from 38 in 2005/06 to 102 in 2009/10.

There are 6 dementia nursing care homes in Enfield with a total capacity of 335 places. A spot check of vacancies as at May 2010 indicated that there were 22 vacancies available, only 1 of these vacancies was with a block contracted provider.

There are 33 residential care providers in Enfield who are registered to provide dementia care. They have a total capacity of 1138 places. A spot check of vacancies as at May 2010 indicated that there were 23 vacancies, of these only 4 were under a block contract.

This would suggest that there is currently an adequate supply of nursing and residential care services for people with dementia in the short term however with the significant predicted increase in the number of people with dementia over the next 20 years this is unlikely to be sufficient in the medium to long term.

Stakeholders have identified an undersupply of services for carers and poor access to good information and support following diagnosis as well as a gap in the provision of respite within nursing care homes.

Service Quality

Care Homes

This section provides information on what we know about the quality of current services.

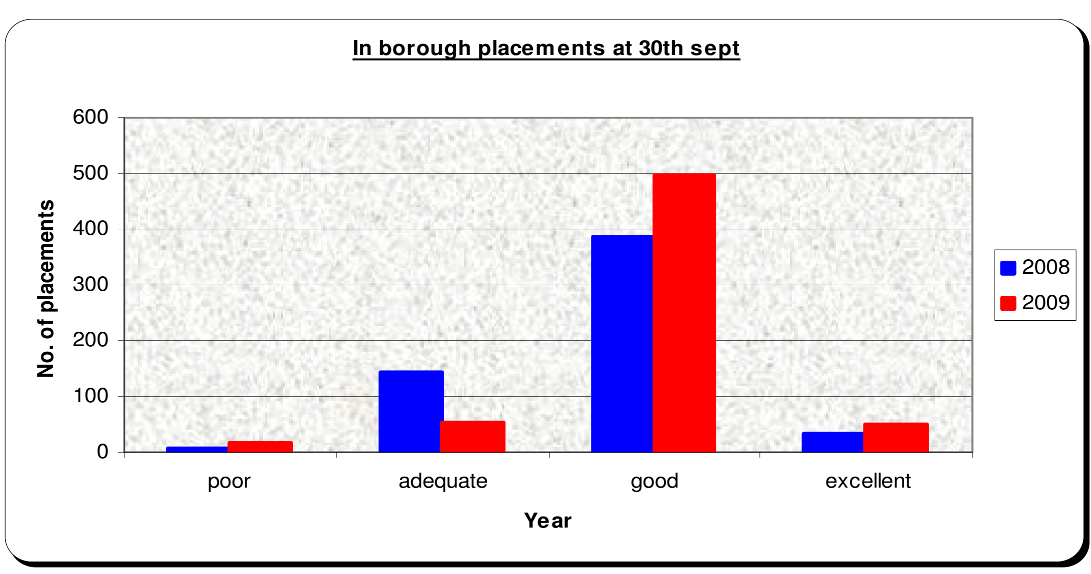
Enfield has 33 residential care homes registered to provide dementia care. Of these 3 are rated as excellent (3 star); 28 are rated as good; and 2 are rated as adequate (1 star).

The Care Quality Commission (CQC) created the ‘CRILL’ tool (Capturing Regulatory Information at Local Level) to link Councils purchasing data (residential, nursing & domiciliary care) with performance on Key National Minimum Standards (KNMS) by provider establishment. Details of Enfield commissioned services are sent to CQC for analysis. The Commission check the information provided and populate it with information from their database which illustrates a percentage of placements/places in services that meet or exceed 80% of KNMS.

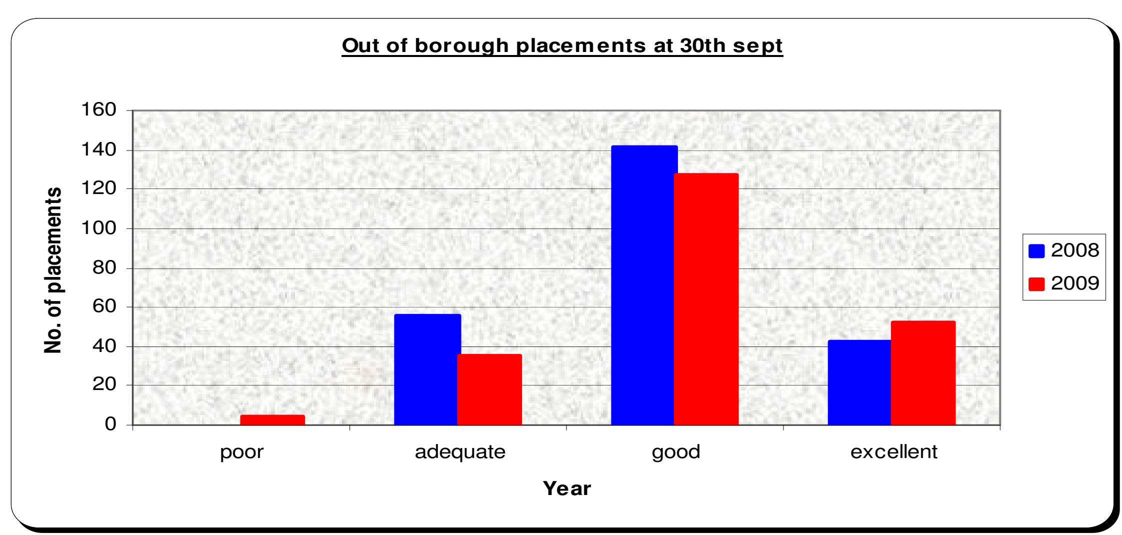
Overall there has been a positive improvement in the quality of residential placements and domiciliary care service provision both available and commissioned in Enfield when comparing 2009/10 with 2008/09. In order to continue to improve quality, Enfield has:

- Introduced quality payments to providers achieving a 3 star rating
- Reduced admissions to poor/adequate providers
- Supported the domiciliary care market through routine monitoring and engagement

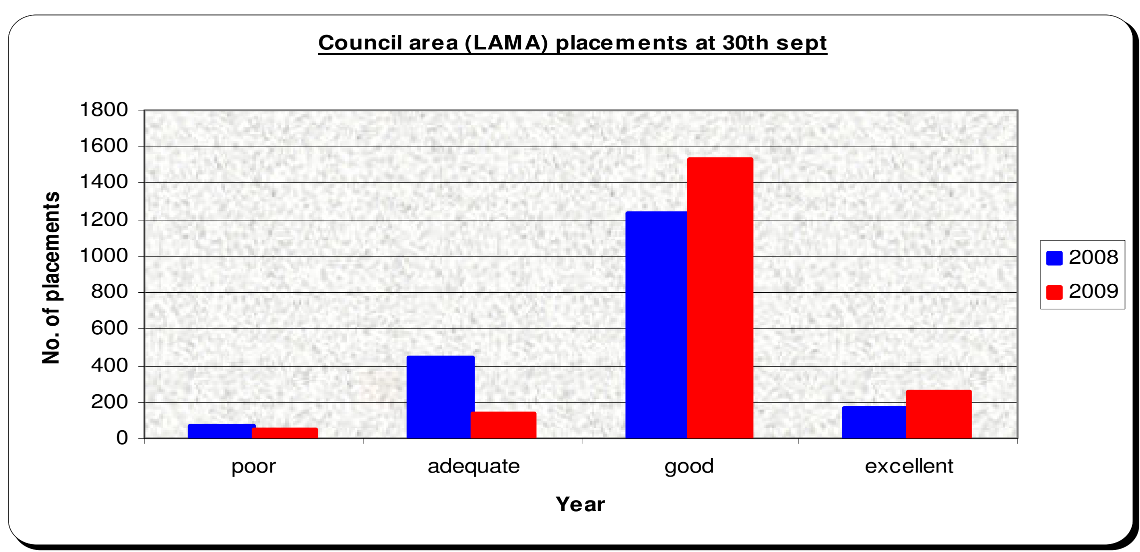
The following 3 graphs show the change in CQC ratings between 2008 and 2009.



The number of in borough placements made by the LA as at 30th September 2009 shows a decrease in the number ranked as adequate, from 25% of all placements in 2008 to 9% in 2009. There has been an increase in the number recorded as Good, from 68% of placements in 2008 to 81% in 2009. Excellent ranked placements in 2008 were 6% of the total; in 2009 they increased to 8%.



For out of borough placements made by the LA the percentage of placements in adequate providers has decreased from 23% in 2008 to 15% in 2009, whilst numbers in good providers have also decreased from 59% in 2008 to 53% in 2009. This is due to the increase in the numbers placed with providers ranked as excellent which have risen from 42 to 52, or 18% in 2008 to 22% in 2009 of all placements.



There has been a large increase in good placements in Enfield, rising from 64% in 2008 to 78% in 2009, similarly numbers in excellent placements have risen from 168 in 2008 to 258 in 2009, an increase from 9% to 13%. Placements in providers ranked as adequate decreased, from 23% in 2008 to 7% in 2009.

All of the 6 nursing care homes in Enfield that are registered to provide dementia care are rated as good (2 star).

Primary Care
Of an estimated prevalence of 2706 people in Enfield with dementia, only 922 are recorded on G.P dementia registers. Issues impacting upon this may include GPs' caution where screening or diagnosis is difficult at early stages, lack of confidence in outcomes of any intervention, coupled with the perception that responses should be social rather than medically driven.

Carers Views
In a recent carers survey, carers of people with dementia said the following regarding their satisfaction with social care services received in the past year:

- 2 were extremely satisfied
- 6 were very satisfied
- 10 said they were fairly satisfied
- 1 was very dissatisfied

(a further 5 either didn't respond or were neither satisfied or dissatisfied)

When asked about the care and support that the person that they cared for received in the past year:

- 17 said it had made things easier for them
- 1 said it had made things more difficult
- 1 said it had made little difference
- 1 said the person they care for received no support but it would have helped if they did

(a further 3 did not respond to this question)

Contracting Arrangements

This section describes the contractual arrangements that are currently in place and any strengths or weaknesses in the arrangements.

Service	Contract type	Strengths	Weaknesses
Domiciliary care	Providers agree to provide services for a fixed fee regardless of volume and agree provision on a stand-by basis.	No waste, services are purchased as and when they are needed.	Unpredictability of placing numbers may discourage providers from investing in services
Residential, nursing and extra care	Block contracts	Simplifies administration – an agreed price for an agreed service Provides value for money due to the volume they are purchased in Stable types of contract that run for an agreed time – this allows provider to invest in their service Can help to manage unpredictability in service demand Costs are guaranteed & known in advance	Inflexible – contract is for a fixed time & service level Not realistic for the future with the increase forecast in the take up of Direct Payments and Individual Budgets. Can create a perverse incentive to fill places in order to secure cheaper rates
Respite, day opportunities and other services provided by the 3rd sector	Grant Funded	Innovation and links to local community	Not market tested for quality or price

Specialist dementia services are commissioned from Barnet, Enfield and Haringey Mental Health Trust within a block contract.

Continuing health care is funded by NHS Enfield through a framework agreement which is designed to improve and standardise the prices paid for care, while maintaining the quality of care.

Finance and Funding

This section is intended to give a picture of the financial resources available now and potentially over the period of the strategy.

The strategy includes a number of commissioning intentions which will require various levels of financial investment. In order to be successful, commitment to implementing this Strategy will require some level of direct and in-direct investments in both people and services by the NHS and Council and other providers of care. The approach that has been taken is an 'invest to save' approach that is premised on the view that if we don't make significant changes to the way services are currently delivered, we will find it increasingly difficult to meet the growing demand for services. As set out earlier in the strategy, the number of people with late onset dementia in Enfield is set to increase by 44% in the next 20 years. It is clear that without changes to the way services are developed, costs will continue to rise significantly putting huge pressure on health and social care budgets.

Through implementation of this strategy we aim to improve the quality of services for people with dementia and their carers, whilst at the same time using resources efficiently and effectively to ensure continued affordability.

Current Funding

There is no comprehensive local data on the current combined health and social care costs of dementia services. People with dementia commonly access a wide range of services provided by the NHS, Enfield Council and a multitude of private and not-for-profit providers. Psychiatric services for dementia are commissioned from Barnet, Enfield and Haringey Mental Health Trust within a block contract, and there is no national "payment-by-results" tariff for costing mental health activities. In addition, as people often do not have a diagnosis of dementia, they may be recorded as accessing services for other reasons.

The Alzheimer Society (2007)[20] found that the average cost of caring for someone with dementia in the UK was £25,472 per year (including costs of health, social and informal care). The cost varied according to the level of progression of dementia, with further progressed cases requiring more intensive and complex care and thus costing more. The figure provided is an average of people at various stages of their illness.

[20] Alzheimer's Society (2007). *Dementia UK.*

Applying these figures to Enfield would mean that the current cost of late-onset dementia in Enfield is an estimated £68.9 million per year, and by 2030 the annual cost of dementia in Enfield will have increased to over £99.5 million. Whilst these estimates give us an indication of the increasing financial impact of dementia, they should also be treated with caution as they are indicative of service provision, the cost of which differs from borough to borough. In addition, we should not interpret this to mean that the cost of £25,472 per person is optimal – the optimal figure may be more or less than this.

Whilst we acknowledge the need to improve our understanding of current dementia resources, we do know a number of things and these are summarised in the table below:

Service	**Funding 2009/10**
Mental Health services (including dementia) commissioned from Barnet, Enfield and Haringey Mental Health Trust.	£10.5m
Enfield Councils gross spend on older peoples health and social care services.	£56.7m
Adult Social Care spend on services for people with dementia.	£14.1m
Approximately spend on residential care services for people with dementia.	£10.65m
Approximately spend on home care for services for people with dementia.	£2.07m
The cost of day opportunities for people with dementia.	£536k
Direct payments for people with dementia.	£539k
2 years pilot dementia adviser programme.	£165,000

Future funding to support the implementation of the strategy

The Department of Health estimates that it will cost £1.9 billion to implement National Dementia Strategy over 10 years. To support the implementation, £60m of notional additional baseline funding was made available to PCTs nationally for 2009/10 within the overall baseline. No ring fencing has been applied in respect of Dementia, and no actual funds allocated. The NHS Enfield Board holds responsibility for allocation of funds locally, and needs to balance local and national priorities. An additional £90m of notional additional baseline funding will made available to PCTs nationally in 2010/11 within the overall baseline.

The Department of Health expects implementation to be mostly funded through efficiency savings from the acute and long term care sectors. It is expected that these savings will largely be met through reducing unnecessary use of acute hospital beds and delaying entry to care homes through improving early diagnosis and intervention.

In their report, the National Audit Office[21] concluded that services are not currently delivering value for money. Spending was late with diagnosis, and early intervention was not widely available. Also services in the community are not delivering consistently or cost-effectively to support people to live as independently as possible.

Enfield, like the rest of the UK, is facing a significant rise in its older population. There is a choice to continue with the same modes of treatment, but prepare for an increased volume, or to radically adjust how services are delivered. This latter ‘spend to save’ option is the preference put forward in the National Dementia Strategy and supported by the NAO and Public Accounts Committee.

[21] Improving Dementia Services in England, National Audit Office (2010)

6. Gap Analysis and Design of Future Provision

The following table sets out our key strategic objectives for the development of local dementia services and our associated commissioning intentions. This is the nub of the strategy and describes what we intend to do to improve services over the next 5 years for people with dementia and their carers.

The strategic objectives and associated commissioning intentions were developed in partnership with key stakeholders. They are aligned with the aims and objectives of the National Dementia Strategy and are underpinned by a robust evidence base which includes the research, needs assessment and market analysis described in the preceding sections.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
1. IMPROVE PUBLIC AND PROFESSIONAL AWARENESS OF DEMENTIA AND REDUCE STIGMA.	Objective 1: Improving public and professional awareness and understanding of dementia.	Advice from local stakeholders that raising awareness and understanding of dementia will encourage people to engage with services earlier; increase early diagnosis and intervention thereby reducing cost by delaying admission to hospital and long term care; reduce prevalence of vascular dementia; and improve quality of life. 3rd sector providers report low referrals from primary care. People currently wait up to 3 years before reporting symptoms of dementia to their doctor.[22] 70% of carers report being unaware of the symptoms of Dementia before diagnosis.[23]	Develop a local awareness and social marketing campaign that supports the planned national awareness campaign by targeting the following groups: • People aged 50 + • Carers of people with dementia • Black and minority ethnic groups • People with learning disabilities and their carers • Major employers whose workforce has significant interaction with the public e.g Police, transport, post office workers etc.

[22] Alzheimer's Society (2002). *Feeling the Pulse*. London: Alzheimer's Society.
[23] Easai Inc/Pfizer (2004). *Facing Dementia Survey*. London: Easai Inc and Pfizer.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		In Enfield the estimated number of people with dementia is approximately 2770 (64 with early onset dementia)[24] however only 922 people are recorded on G.P registers as having a formal diagnosis. A pilot awareness campaign carried out by the Alzheimer's Society in 2007 achieved positive results with 78% of G.Ps believing that such a campaign would lead to people reporting symptoms earlier.[25] The current evidence base suggests that up to 50% of dementia cases may have a vascular component (ie vascular dementia or mixed dementia).[26] We can therefore postulate that improving the cerebrovascular health of our population will lead to a decrease in the prevalence of dementia. The number of people over 65 yrs in Enfield with a BMI of 30 or more is approximately 9,900.[27] This is predicted to increase to 13,707 by 2030. Enfield has the 5th highest number of people (aged 16+) on the obesity register in London and the 7th highest number of smokers in London. These figures give reason to assume that the proportion of people with vascular dementia in Enfield may be even higher	• People living in the more deprived wards of the Borough • People at risk of poor cerebrovascular health • Schools Explore potential to link with existing campaigns and services, for example: • Existing health promotion campaigns • Carers health checks • Health trainers programme • Learning Disability services Address the promotion of healthier lifestyles through exercise and diet through the Prevention strategy. Consult with local employers of public-facing staff to gain advice on how best to develop staff awareness including access to local resources for staff. Include dementia awareness in all

[24] Data source: Healthcare for London Dementia Needs Assessment (2007)
[25] Alzheimer's Society (2008). Worried about your memory. London: Alzheimer's Society.
[26] Living Well: The National Dementia Strategy (DH, 2009)
[27] Data source: POPPI
[28] Improving Dementia Services in England (NAO)

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		than regional averages. A May 2009 survey found 28 per cent of people still thought (wrongly) that dementia was a 'natural part of ageing'; and 22 per cent thought (again wrongly) there was no way to reduce the risk of dementia.[28]	induction training for employees within the NHS, Council and partner organisations working with adults and older people. Ensure awareness raising is coordinated with the development of services to ensure that any additional demand that is created through improved awareness is able to be responded to. Develop and implement a local dementia care pathway, spanning early diagnosis to the end of life, and ensure that people with dementia, carers and health and social care professionals are aware of this pathway

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
2. IMPROVE EARLY DIAGNOSIS AND TREATMENT OF DEMENTIA	Objective 2: Good-quality early diagnosis and intervention for all.	Research suggests that early identification and treatment of dementia is effective in terms of quality of life and overall cost-effectiveness.[29] The benefits of early diagnosis are recognised by the National Service Framework (NSF): 'If dementia is not diagnosed early, carers can become demoralised due to lack of recognition and support and having to cope with apparently unexplained behavioural changes[30]. Currently only about one-third of people with dementia receive a formal diagnosis at any time in their illness.[31] When diagnoses are made, it is often too late for those suffering from the illness to make choices. Further, diagnoses are often made at a time of crisis; a crisis that could potentially have been avoided if diagnosis had been made earlier. In Enfield only 1/3 of the estimated number of people with dementia are recorded on G.P registers which suggests significant under diagnosis.	Reconfigure the current Memory Treatment Clinic model to enable it to better manage existing and future demand, including the capacity to meet the needs of the growing population of older people with dementia from BME groups. Explore the option of direct referral to the clinic from primary care; and consider the benefits of developing the service to provide assessment and treatment. Cross Borough options for development and remodelling will be explored through the Haringey, Barnet and Enfield Dementia Commissioning Forum. Model the impact of increasing early diagnosis on other services. People diagnosed early are likely to receive pharmaceutical and therapeutic interventions that will help them live active lives for longer therefore reducing hospital admissions and delaying the need for long

[29] Banerjee, Sube and Wittenberg, Raphael (2009) Clinical and cost effectiveness of services for early diagnosis and intervention in dementia. *International journal of geriatric psychiatry*, 24 (7). pp. 748-754. ISSN 0885-6230

[30] National Service Framework, Department of Health (2001)

[31] *Improving services and support for people with dementia.* National Audit Office (2007). London: TSO.

[32] *Transforming the quality of dementia care: consultation on a National Dementia Strategy*, Department of Health (2008)

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		The 2007 National Audit Office report *Improving services and support for people with dementia* estimated that re-engineering systems for dementia could yield £6.5 million of acute trust savings per year. The National Dementia Strategy consultation document *Transforming the quality of dementia care*[32] includes an appendix on the clinical and health economic case for early diagnosis and intervention services for people with dementia. The economic case demonstrates how, over 10 years, reductions can be made in admissions to long-term institutional care thus releasing revenue to invest in prevention and early intervention. NICE has published a commissioning guide on memory assessment services which describes the potential benefits of commissioning effective memory assessment services, which include: • Providing a cost effective way of increasing the number of people seen for early diagnosis and intervention; • reducing total care expenditure by delaying the time to nursing home admissions and other costly outcomes; • reducing the stigma of dementia and barriers to recognition and diagnosis; • improving the quality of life of people with dementia and their carers by promoting and maintaining their independence; • reducing inequalities and improving access to appropriate treatment and support;	admissions and delaying the need for long term residential care. However it is likely that pressures will be felt by other parts of the health and social care economy as more people are referred for diagnosis, treatment and support. Establish formal processes to ensure that people who are admitted to hospital with a diagnosis of dementia are notified to the appropriate GP practice to ensure that the patient is placed on the dementia register. Shift resources from the point of crisis to prevention and early intervention services that help people to maintain their independence and prevent or delay the need for high cost care (this will be implemented through the Enfield Prevention Strategy).

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		• increasing patient choice, improving partnership working, patient experience and engagement; and • Achieving better value for money. The local Memory Treatment Clinic is provided by Barnet, Enfield and Haringey Mental Health Trusts. It receives referrals from Older People's Mental Health Services (who provide assessment and diagnosis) and provides prescribing and monitoring of anti dementia medications. This is different to most memory clinic models where assessment and treatment services are combined and referrals are accepted directly from GPs. There is increasing demand for services with new referrals increasing each year and waiting times growing (refer to Section 5: Market Analysis for further details).	
3. INCREASE ACCESS TO A RANGE OF FLEXIBLE DAY, HOME BASED & RESIDENTIAL RESPITE	Objective 6: Improved community personal support services. Objective 7:	Approximately 2/3 of people with dementia are cared for in the community. According to the 2001 census, 4298 people in Enfield aged 65+ were providing informal support. In 2008/09 support was provided to 680 carers aged 65+ (unfortunately we are unable at this stage to identify how many of these were	Allocate additional funding for the development of increased flexible day opportunities and respite care that is responsive to individual needs including the needs of carers. Implement *Putting People First*

[33] Dementia UK report
[34] Living well with Demenit: The National Dementia Strategy (2009). Department of Health
[35] Banerjee et al 2003, *Predictors of institutionalisation in people with dementia,* Journal of Neurology, Neurosurgery and Psychiatry 74, 9 1315-1316

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
RESPITE OPTIONS.	Implementing the Carers' Strategy for people with dementia.	caring for people with dementia) The development of more flexible, person centred respite options was identified as a key priority by local stakeholders during workshops to develop this strategy. It is estimated that 53% of people aged over 65 years with 'dependency problems' were supported by unpaid carers only, 34% received both informal and formal care, 9% formal care only and 3% were unsupported.[33] Support for carers can play an important role in reducing admissions to residential care and enabling people with dementia to remain in the community for as long as possible.[34] Co-residence of a carer is a strong predictor of a person with dementia remaining living in the community and avoiding entry to institutional care.[35] The White Paper "Our health, Our care, Our say", the NICE/SCIE guideline and the New Deal for Carers all emphasise the importance of short breaks as part of a spectrum of care to enable people to remain in the community.	personalisation changes to enable the development of more innovative, flexible day, home based and residential respite services to better meet the needs of people with dementia and their carers. Through review, promote local initiatives to make more effective use of existing resources currently invested in day opportunities to provide increasingly flexible responses to peoples expressed needs. Ensure that the need for respite is an integral part of people's assessment and care package; and that if respite is include in the care package they are able to access flexible respite using Direct Payments. Where the person is entitled to it, they should also be able to access the Independent Living Fund to add to the resources available to fund respite. Ensure that the rights of carers to an assessment of needs are upheld. Engage in discussions with the market regarding their ability to respond to the personalisation agenda in the provision of

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
			flexible and responsive respite services. Ensure that the needs of carers of people with dementia are addressed through the Enfield Carers Strategy. Provide funding to support the development of a peer support group for carers of people with dementia that will enable carers to support each other, share information and advice, give carers a stronger voice and provide a forum for training.
4. DEVELOP SERVICES THAT SUPPORT PEOPLE TO MAXIMISE THEIR INDEPENDENCE.	Objective 6: Improved community personal support services. Objective 10: Considering the potential for	Approximately 2/3 of people with dementia live in their own homes.[36] During workshops to develop this strategy, local stakeholders identified the development of more person centred home care services as a key priority that will significantly contribute to improving outcomes for people with dementia and their carers.	Implement *Putting People First* personalisation changes to enable the development of more innovative, flexible home care services to better meet people's needs. This will include the development of self-directed care and individual budgets to increase individual choice and control over the services that they receive.

[36] Living Well: National Dementia Strategy (DH, 2009)
[37] 35 CSCI (2006). *Time to Care?* London: TSO.
[38] *Evaluation of the Individual Budgets pilot programme* Personal Social Services Research Unit 2008

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
	potential for housing support, housing-related services and telecare to support people with dementia and their carers.	The Commission for Social Care Inspection (CSCI) has found that good-quality, flexible home care services contribute significantly to maintaining people's independence, reducing social isolation, preventing admissions to care homes and hospitals, and supporting carers.[37] The evidence so far shows that older people are least likely to make use of the opportunities afforded by personal budgets.[38] The number of people in Enfield aged 45+ who have a learning disability is 2345. This is projected to increase by 26% by 2030. People who have learning difficulties have a higher prevalence of dementia compared with the general population. 20% of people with a learning disability aged 65 years and over will develop dementia. About 20 per cent of people with learning difficulties have Down's syndrome, and people with Down's syndrome are at particular risk of developing early onset dementia.	Ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from Community Mental Health Teams. Invest in assistive technology to support people to remain in their own homes. Ensure that Enfield's Supporting People Programme offers appropriate housing related support to people with dementia. Commission a range of housing options that better meet the specialist needs of people with learning difficulties and dementia. Ensure that a range of high quality, affordable local services providing therapeutic, cognitive and social stimulation for people with dementia are available to help maintain their well being. These services will be appropriate for people at different stages of the disease.

http://www.pssru.ac.uk/pdf/IBSEN.pdf

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
			Commission training for carers on caring for someone with dementia.
5. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE	Objective 13: An informed and effective workforce for people with dementia.	Among those aged 65+ living in Nursing Homes, the estimated prevalence of dementia is 66% & 50% in residential care homes.[39] A third of care homes specialising in dementia do not adequately train staff according to a Laing Buisson's market survey of UK care homes[40]. 30 Enfield providers of residential care are registered to provide dementia (EMI) care. Of these, CQC rate 10 as adequate,18 as good, and 2 as excellent. Research carried out by MacDonald et al (2003)[41] suggests that most cognitive impairment in non-specialist nursing homes appeared to be unrecognised.	The Department of Health has commissioned Skills for Care and Skills for Health to map the training needs of the workforce and the training currently available across all sectors, identifying the gaps. The mapping exercise will conclude in March 2010 and make recommendations to inform the Department's workforce action plan. Following development of the national action plan, we will develop a local dementia workforce plan that links to, and complements, the identified national workforce development initiatives.

[39] Dementia UK report
[40] Care of Elderly People UK Market Survey 2009. Laing Buisson.

[41] The recognition of dementia in 'non EMI' nursing home residents in South East England. MacDonald, A.J.D. and Carpenter, G.I. (2003) *The recognition of dementia in 'non EMI' nursing home residents in South East England.* International Journal of Geriatric Psychiatry, 18 (2). pp. 105-108. ISSN 0885-6230 .

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		Only 31% of GPs believe they have received sufficient basic and post-qualification training to diagnose and manage dementia, a decrease since the same question was asked in for the Forget Me Not report11 eight years ago.[42] Lack of understanding of dementia in the workforce – whether in mainstream or specialist services – can lead to care practices that can make the situation worse for both the person with dementia and their carer. (Ballard et al 2002)[43] The need for improved training is a priority that runs across all themes in the National Strategy and was highlighted by local stakeholders as a priority area for development.	We will ensure that all commissioned services include service specifications that specify dementia training and core competencies that include, but are not limited to, the national minimum standards. We will ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from Community Mental Health Teams. All community based health and social care staff will receive core training in dementia.

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[42] Living Well with Dementia: A national Dementia Strategy (DH 2009)

[43] Ballard, C, Powell, I, James, I, Reichelt, K, Myiut, P et al (2002). 'Can psychiatric liaison reduce neuroleptic use and reduce health service utilization for dementia patients residing in care facilities.' *International Journal of Geriatric Psychiatry*, 17, 140–45. Turner, S (2005). 'Behavioural symptoms of dementia in residential settings: A selective review of non-pharmacological interventions.' *Aging and Mental Health*, 9 (2), 93–104.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
6. IMPROVE ACCESS TO SUPPORT AND ADVICE FOLLOWING DIAGNOSIS FOR PEOPLE WITH DEMENTIA AND THEIR CARERS	Objective 3: Good-quality information for those with diagnosed dementia and their carers. Objective 4: Enabling easy access to care, support and advice following diagnosis. Objective 5: Development of structured peer support and learning networks.	Better access to information is a key component that has been identified in local stakeholder events. Approximately half of the carers of people with dementia who responded to the recent carers survey said that they would like more information. The need for a key contact who can provide ongoing advice and support for people who are stable and have been therefore been discharged from health and social care services has been identified as a key priority in discussions with local stakeholders.	Undertake an evaluation of the Enfield Dementia Demonstrator Pilot programme for dementia advice in order to inform future commissioning decisions regarding this service. Ensure that dementia information materials and resources are available for all people with dementia and their carers. Ensure that the needs of carers of people with dementia for support and advice are included in the Enfield Carers Strategy.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
7. REDUCE AVOIDABLE HOSPITAL & CARE HOME ADMISSIONS AND DECREASE HOSPITAL LENGTH OF STAY	Objective 8: Improved quality of care for people with dementia in general hospitals. Objective 9: Improved intermediate care for people with dementia.	Of 202 new residential & nursing home admissions In Enfield in 09/10, 126 (or 62%) came directly from hospital. There is currently no specialist dementia assessment ward therefore people with dementia are assessed in general medical wards which may not be conducive to conducting accurate assessment due to the chaotic and challenging environment. A considerable number of patients are admitted to hospital with a diagnosis of dementia. In Enfield in 2008/09, there were 420 admissions with a diagnosis of dementia. These admissions utilised 4856 bed days which equates to a cost of over £7.8m. Up to 70% of acute hospital beds are currently occupied by older people and up to a half of these may be people with cognitive impairment, including those with dementia and delirium. People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation[44]. There is minimal mental health input to Enfields current Intermediate Care Service (1 specialist mental health nurse in hospital discharge team). Updated DH guidance for Intermediate Care recommends	Hospital Mental Health Liaison Service: Collate and analyse current data and review existing model of service provision in order to develop an 'invest to save' business case for expanding the role of the current liaison service. This would include exploring the benefits of expanding the service to include responsibility for general hospital staff dementia training and education. Ensure that people with dementia are able to access Intermediate care services by providing all Intermediate Care staff with core training in dementia and access to advice and support from specialist mental health staff. In addition we will increase the capacity of Intermediate Care to provide in reach to care homes in order to reduce hospital admissions. (To be implemented as part of the Intermediate Care Strategy). Review the appropriateness of current arrangements for assessing people with dementia in general hospitals, including appropriateness of current assessment

[44] Living Well with Dementia: A national Dementia Strategy (DH 2009)

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		that: - All older people at risk of entering care homes should be able to access Intermediate Care - No one should be directly transferred from an acute ward to long term residential care (unless exceptional circumstances) - Intermediate care should be able to meet the needs of people with dementia or mental health needs.	environment. Implement and evaluate the Unique Care Pilot described in Section 5. Agree local targets for a reduction in inpatient admissions and length of stay and increase in the number of patients on dementia registers. Review the quality, range and provision of services for people who require continuing healthcare.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
8. ENSURE THAT THE NEEDS OF YOUNGER PEOPLE WITH DEMENTIA ARE ADDRESSED		Early-onset dementia (dementia that affects people aged under 65) affects approximately 1 in 40 people in England. Enfield had between 46.2 and 47.7 people per 100,000 with early-onset dementia in 2007. Of the 31 London PCTs, this ranks Enfield amongst the top 12 with the largest number of people with early-onset dementia. The actual number of people with early-onset dementia in 2007 was 64. This is a prevalence rate of 1.6% of the population of people aged 30 years and over in Enfield which is higher than the London average of 1.4%. The number of people in Enfield aged 45+ who have a learning disability is 2345. This is projected to increase by 26% by 2030. About 20 per cent of people with a learning disability have Down's syndrome, and people with Down's syndrome are at particular risk of developing early onset dementia.	Ensure that health and social care staff working with people with learning disabilities and other younger people at risk of dementia receive training in dementia awareness. Ensure that people with learning disabilities and those supporting them have access to specialist advice and support for dementia. Explore the potential of jointly commissioning services for younger people with dementia with our neighbouring boroughs of Barnet and Haringey. This will be taken forward by the newly formed 3 Borough Dementia Commissioning Group.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
9. IMPROVE THE QUALITY OF DEMENTIA CARE IN CARE HOMES & HOSPITALS	<u>Objective 11:</u> Living well with dementia in care homes. <u>Objective 8:</u> Improved quality of care for people with dementia in general hospitals.	An independent review which had been commissioned by the Department of Health reported in November 2009 that up to 150,000 people with dementia are inappropriately prescribed anti-psychotic drugs, contrary to clinical guidelines. This may contribute to 1,800 additional deaths each year. The Department set out an action plan to reduce the use of these drugs, including an audit to establish definitive prescribing figures for each PCT. The key recommendation for PCTs is to commission from local specialist older people's mental health services an in-reach service that supports primary care in its work in care homes. This extension of service needs the capacity to work routinely in all care homes where there may be people with dementia and may be aided by regular pharmacist input into homes. People with dementia in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation.[45] The NAO has estimated the excess cost to be more than £6 million per year in an average general hospital.[46] Stays in acute general hospital affect people with dementia badly – increasing their confusion and speeding up deterioration.	We will commission our specialist older peoples mental health team to provide in-reach service to support primary care in its work in care homes. We will commission primary care and pharmacy in reach services to ensure more appropriate use of anti-psychotic medication. We will ensure distribution, promotion and implementation of the 'good practice resource pack' that is being developed by the National Dementia Strategy Implementation Team. We will enter into collaborative partnerships with care home providers to encourage the development of local leaders who can demonstrate excellence in provision of services. Identify a senior clinician within Chase Farm Acute Trust to take the lead for quality improvement and training in dementia care in hospital.

[45] 38 Royal College of Psychiatrists (2005). *Who Cares Wins: Improving the outcome for older people admitted to the general hospital*. London: RCPsych.
[46] NAO (2007). *Improving services and support for people with dementia*. London: TSO.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
			Review the current care pathway for the management and care of people with dementia in hospital, led by that senior clinician. Explore the potential use of the commissioning for quality and innovation (CQUIN) payment framework, to incentivise general hospital providers to improve quality and innovation.

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
10. IMPROVE END OF LIFE CARE FOR PEOPLE WITH DEMENTIA	Objective 12: Improved end of life care for people with dementia.	For a given disorder, people with dementia have 4–6 times the mortality than the cognitively intact. There is strong evidence to suggest that people with dementia receive poorer end of life care than those who are cognitively intact in terms of provision of palliative care. For example, few people with dementia have access to hospice care.[47] End of life planning needs to take place whilst the person still has the capacity to make decisions about their end of life care and where these decisions can be recorded.	Ensure people with dementia have the same access to palliative care services as others. Ensure that end of life care is included in the local pathway for dementia and is consistent with the Gold Standard Framework as identified by the National End of Life Care Strategy. Continue quality payments to care homes that achieve the Gold Standard for End of Life Care. Commission a Gold Standard Framework Facilitator to work with care homes to assist them to implement the Gold Standard Framework. Continue to raise awareness of the Mental Capacity Act among health and social care professionals in order to increase the number of people who are enabled to plan for their end of life care while they have the capacity to do so. Enable people with dementia and their

[47] Living Well with Dementia: A national Dementia Strategy (DH 2009)

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
			carers the opportunity and support to discuss and document advance care plans. Ensure that care home staff are trained and supported so that they feel more confident in adhering to advance care plans.
11. ENSURE THAT SERVICES MEET THE NEEDS OF PEOPLE FROM BLACK AND MINORITY ETHNIC GROUPS	Objective 14: A joint commissioning strategy for dementia.	Early-onset dementia is more common amongst black and minority ethnic groups with 6.1% of all people with early-onset dementia being from black and minority ethnic groups compared with 2.2% of all groups.[48] This may be due to some groups that are more prone to hypertension and cardiovascular disease. Number of people with dementia in black and minority ethnic groups is set to rise sharply. In Enfield it is projected that 642 people from black and minority ethnic groups will have late-onset dementia by 2021 compared to an estimate of 231 people in 2001. This is a 178% increase which is higher than the London average of 123%.[49] These significant projected	Review current service provision to assess whether it is meeting the needs of Black and Minority Ethnic groups. Engage with the Black and Minority Ethnic community to gain a better understanding of their needs and current gaps in service provision. Ensure that the needs of Black and Minority Ethnic groups are taken into account during the implementation of all strategic objectives.

[48] *Dementia UK 2007 report*

[49] *London Dementia needs assessment*

Strategic Objective	Link to National Strategic Objectives	Rationale	Commissioning Intentions
		increases are due to first generation migrants from the 1950's to the 1970's reaching the age groups most at risk of dementia.	

7. Implementation and Monitoring Arrangements

The implementation and monitoring of the strategy will be overseen by the Older Peoples Mental Health Group, which is a sub-group of the Older Peoples Partnership Board (a Thematic Action Group of the Enfield Strategic Partnership[50]).

A detailed 5 year implementation plan will be developed in partnership with NHS Enfield; the Local Borough of Enfield; Barnet, Enfield and Haringey Mental Health Trust and key local stakeholders. This will be agreed by the Older Peoples Mental Health Group who will monitor implementation to ensure that the strategy is shaping services in the way intended. A lead commissioner from NHS Enfield and the Local Borough of Enfield will be identified and they will be tasked with delivering the implementation and reporting progress and issues to the Older Peoples Mental Health group.

The Older Peoples Mental Health Group will also have a lead role in the development of a communication and engagement plan that will set out:

- how implementation of the strategy will be communicated to key stakeholders and members of the public; and
- how stakeholders will be engaged throughout the implementation.

[50] The Enfield Strategic Partnership is a mature partnership and brings together organisations, businesses and the third sector.

Appendix 1: National Policy Context

Forget Me Not: In 2000 the Audit Commission published its *Forget Me Not* report; key findings included:

- Only one half of general practitioners (GPs) believed it important to look actively for signs of dementia and to make an early diagnosis.
- Less than one half of GPs felt that they had received sufficient training.
- There was a lack of clear information, counselling, advocacy and support for people with dementia and their family carers.
- There was insufficient supply of specialist home care.
- Poor assessments and treatment with little joint health and social care planning and working.

They found little improvement when reviewing change two years later.

National Service Framework for Older People(2001) (NSF): Describes eight standards for improvement in services to older people including a specific standard on mental health in older people which aims to promote good mental health and to treat and support those older people with dementia and depression. The NSF advocates early diagnosis and intervention and recommends that the NHS and local councils should review arrangements for health promotion, early detection and diagnosis, assessment, care and treatment planning, and access to specialist services.

Who Cares Wins (2005): This report was published by the Royal College of Psychiatrists and highlights the neglected clinical problem of mental disorder affecting older people admitted to general hospitals. Based on evidence from pilots and the success of liaison psychiatry for adults under 65 years old, it calls for the development of specialist mental health liaison services for older people.

Everybody's Business – Integrated mental health services for older adults: a service development guide (2005): This guide sets out the essentials for a service that works for older people's mental health in general, including memory assessment services to enable the early diagnosis of dementia for all and integrated community mental teams whose role includes the management of people with dementia with complex behavioural and psychological symptoms.

***NICE/SCIE Clinical Guideline (2006)*:** This guideline recommends several key areas that should be developed in order to improve services for people with dementia and their carers. Recommendations include:

- integrated working across all agencies;
- provision of memory assessment services as a point of referral for diagnosis of dementia;
- assessment, support and treatment (where needed) for carers;
- assessment and treatment of non-cognitive symptoms and behaviour that challenges;
- dementia-care training for all staff working with older people; and

- improvement of care for people with dementia in general hospitals.

Dementia UK Report (2007): Published by the Alzheimer's Society, recommends making dementia an explicit national health and social care priority, and improving the quality of services provided for people with dementia and their carers.

The National Audit Office value for money study (2007): This report was critical about the quality of care received by people with dementia and their families. It found that the size and availability of specialist community mental health teams was extremely variable, and that confidence of GPs in spotting the symptoms of dementia was poor and lower than it had been in 2000. They also commented on deficiencies in carer support. The report concluded that overall services are not currently delivering value for money to taxpayers or people with dementia and their families; that spending is late – too few people are being diagnosed or being diagnosed early enough; and that early intervention is needed to improve quality of life. Finally it concluded that services in the community, care homes and at the end of life are not delivering consistently or cost effectively against the objective of supporting people to live independently as long as possible in the place of their choosing. The NAO advocated a 'spend to save' approach, with upfront investment in services for early diagnosis and intervention, and improved specialist services, community services and care in general hospitals resulting in long-term cost savings from prevention of transition into care homes and decreased hospital stay length.

Public Accounts Committee report (2007):
The National Audit Office report was submitted for consideration by the House of Commons Public Accounts Committee (PAC), and at the committee's public hearing on 15 October 2007 the NHS Chief Executive and others from the Department of Health were questioned on the NAO's criticisms and recommendations. As is normal practice, following the hearing the PAC subsequently published its own report on dementia services in January 2008. The Committee's comments and recommendations (available at www.publications.parliament.uk/pa/cm200708/cmselect/cmpubacc/228/22802.htm) were consistent with those of the NAO report and with earlier reports on the changes that were needed.

The Government's response to the PAC report is available at www.official-documents.gov. uk/document/cm73/7323/7323.pdf. The response accepted virtually all the conclusions and recommendations of the Committee, emphasising that their findings would be fully addressed in the National Dementia Strategy

The Carers' Strategy (2008):
Half a million family members who care for people with dementia provide over £6 billion a year of unpaid care. A far-reaching consultation of carers contributed to the development of the Carers' Strategy and its implementation will ensure a 10-year plan that builds on the support for carers and enables them to have a life outside caring.

The End of Life Strategy (2008):
This strategy highlights the fact that end of life care for people with dementia is an under-developed area and recommends it be given specific attention.

Updated Intermediate Care Guidance (2009):
This guidance builds on the 2001 guidance on intermediate care and recommends renewed emphasis on those at risk of admission to residential care and inclusion of people with dementia.

Appendix 2: Dementia: Joint Needs Assessment

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Enfield's Population

Population Projections
Accommodation Status Projections
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Dementia

Current Early-Onset Dementia Prevalence Rates
Current Late-Onset Dementia Prevalence Rates
Prevalence by Age Band and Sex
Dementia Type
Prevalence by Ethnic Group
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Length of Stay in a Care Home
Admissions to Hospital
Carers

Population Projections

Table 1:Population aged 65 and over, in five year age bands, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-69	10,300	12,100	11,500	13,700	16,100
People aged 70-74	9,400	9,000	10,700	10,200	12,200
People aged 75-79	7,600	8,100	7,800	9,300	9,000
People aged 80-84	5,500	5,900	6,500	6,400	7,700
Total population 65 and over	**38,000**	**40,800**	**43,000**	**47,200**	**53,500**

Data Source:POPPI

There is a projected 41% population increase by 2030. The largest increase will be in the 65-69 bracket (56% increase).

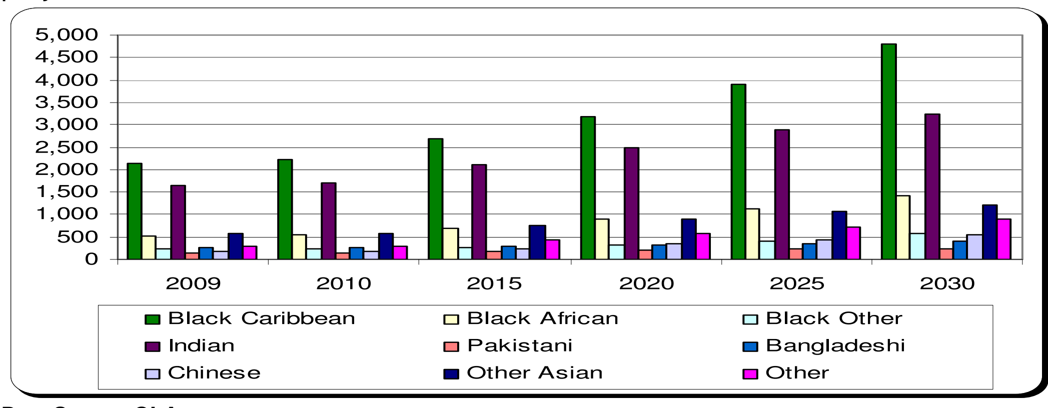
Table 2:Population aged 65 and over, in five year age bands, by gender, projected to 2030

	2009	2015	2020	2025	2030
Males aged 65-69	4,900	5,700	5,500	6,800	8,100
Males aged 70-74	4,500	4,200	5,000	4,800	6,000
Males aged 75-79	3,400	3,700	3,600	4,300	4,200
Males aged 80-84	2,200	2,600	2,900	2,800	3,400
Males aged 85 and over	1,700	2,200	2,700	3,300	3,800
Total males 65 and over	**16,700**	**18,400**	**19,700**	**22,000**	**25,500**
Females aged 65-69	5,400	6,400	6,000	6,900	8,000
Females aged 70-74	5,000	4,800	5,700	5,400	6,200
Females aged 75-79	4,200	4,300	4,200	5,100	4,800
Females aged 80-84	3,300	3,300	3,600	3,600	4,300
Females aged 85 and over	3,500	3,500	3,700	4,300	4,700
Total females 65 and over	**21,400**	**22,300**	**23,200**	**25,300**	**28,000**

Data Source:POPPI

In 2009 the male/female split is 44% male 56% female. It is projected that there will be a slightly higher proportion of males by 2030 (48%).

Figure 1: BME Population projections aged 65 and over, in five year age bands, projected to 2030



Data Source:GLA

The highest population increases are Black Caribbean (6% in 2009 to 11% in 2030) and Indian (4% in 2009 to 7% in 2030). The White population is projected to decrease from 84% to 71%.
8.5% of the 2001 Enfield PCT population of people aged 65+ was BME. It is projected that this will increase to 23.7% by 2021[1].

1 *This is from the Healthcare for London Dementia Needs Assessment*

Table 4: Population aged 45 and over, in five year age bands to 2030, projected to have a learning disability

	2009	2015	2020	2025	2030
People aged 45-54 predicted to have a learning disability	924	1,048	1,012	956	972
People aged 55-64 predicted to have a learning disability	635	689	813	883	858
People aged 65-74 predicted to have a learning disability	427	454	482	515	610
People aged 75-84 predicted to have a learning disability	261	280	287	318	339
People aged 85 and over predicted to have a learning disability	98	109	125	148	167
Total population aged 45 and over predicted to have a learning disability	**2345**	**2580**	**2719**	**2820**	**2946**

Data Source:POPPI & PANSI

The Enfield population of people aged 45+ is projected to increase by 25.6% by 2030.
The age bracket with the largest percentage increase in population is the 85+ group. This is projected to increase by 70%. In actual numbers the 55-64 age group will increase the most (223 increase in people).

Accommodation Status Projections

Table 5: Numbers of population aged 65 and over, in five year age bands, by gender and living alone, projected to 2030

	2009	2015	2020	2025	2030
Males aged 65-74 predicted to live alone	1,880	1,980	2,100	2,320	2,820
Males aged 75 and over predicted to live alone	2,482	2,890	3,128	3,536	3,876
Females aged 65-74 predicted to live alone	3,120	3,360	3,510	3,690	4,260
Females aged 75 and over predicted to live alone	6,710	6,771	7,015	7,930	8,418
Total population aged 65-74 predicted to live alone	**5,000**	**5,340**	**5,610**	**6,010**	**7,080**
Total population aged 75 and over predicted to live alone	**9,192**	**9,661**	**10,143**	**11,466**	**12,294**

Data Source:POPPI

In 2030 19,374 people are predicted to be living alone compared to 14,192 in 2009. Though this is a 36.5% increase in the number of people predicted to be living alone, as a percentage of the projected population this is actually a slight decrease in the proportion of the projected population living alone. In 2009 it is predicted that 37% of

the total 65+ population lives alone compared to 36% of the total 65+ population in 2030.

Table 6: Percentage of population aged 65 and over, in five year age bands, by gender and living alone, projected to 2030

	2009	2015	2020	2025	2030
%age of Males aged 65 and over predicted to live alone of total 65+ population	30.7%	32.5%	33.2%	33.5%	34.6%
%age of Females aged 65 and over predicted to live alone of total 65+ population	69.3%	67.5%	66.8%	66.5%	65.4%

Table 6 indicates that a higher proportion of the 65+ population will be male by 2030. Life expectancy in Enfield is 77.9 for males and 81.9 for females[2]. This is higher than the England average (77.3).

[2] *This is from the JSNA Dec 2008*

Table 7: Numbers of population aged 65 and over, in five year age bands, living in a care home, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-74 living in a LA care home with or without nursing	7	8	8	9	10
People aged 75-84 living in a LA care home with or without nursing	35	37	38	42	45
People aged 85 and over living in a LA care home with or without nursing	56	61	70	81	91
People aged 65-74 living in a non LA care home with or without nursing	100	107	113	122	144
People aged 75-84 living in a non LA care home with or without nursing	295	315	322	354	376
People aged 85 and over living in a non LA care home with or without nursing	533	584	666	778	871
Total population aged 65 and over living in a care home with or without nursing	**1,026**	**1,113**	**1,217**	**1,386**	**1,537**

Data Source:POPPI

It is projected that 511 more people aged 65+ will be in a care home in Enfield by 2030. The 2009 population projection of people living in a care home is 2.7% of the total population. By 2030 it is projected that 2.9% of the total 65+ Enfield population will be living in a care home.

Health Projections

Table 8: Numbers of population aged 65 and over, in five year age bands, predicted to have a longstanding health condition caused by a stroke, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-74 predicted to have a longstanding health condition caused by a stroke	388	412	434	472	565
People aged 75 and over predicted to have a longstanding health condition caused by a stroke	486	534	568	642	695
Total population aged 65 and over	**874**	**946**	**1,003**	**1,115**	**1,261**

predicted to have a longstanding health condition caused by a stroke					

Data Source:POPPI

It is predicted that from 2009 to 2030 there will be an additional 387 people with a longstanding health condition caused by stroke.

In 2008/09 3351 people within Enfield PCT were on the Stroke or TIA (Transient Ischaemic Attack) register which is a 1.1% prevalence of these conditions[3]. Enfield has the 8th highest prevalence rate for stroke or TIA in London.

[3] *This information is taken from the 2008/09 QoF and is all ages. The prevalence rate is calculated by the number of people on the register divided by the number of people registered with a GP.*

Table 9: Numbers of population aged 65 and over, in five year age bands, predicted to have a longstanding health condition caused by a heart attack, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-74 predicted to have a longstanding health condition caused by a heart attack	881	935	987	1,074	1,286
People aged 75 and over predicted to have a longstanding health condition caused by a heart attack	977	1,051	1,111	1,256	1,354
Total population aged 65 and over predicted to have a longstanding health condition caused by a heart attack	**1,859**	**1,985**	**2,098**	**2,330**	**2,639**

Data Source:POPPI

It is predicted that from 2009 to 2030 there will be an additional 780 people with a longstanding health condition caused by a heart attack.

In 2008/09 1615 people within Enfield PCT were on the Heart Failure register which is a 0.5% prevalence of these conditions[2] and 37952 people (all ages) were on the GP's hypertension register which is a prevalence of 12.7%. Enfield has the 5th highest prevalence rate for hypertension in London - the London average is 10.8%.

Table 10: Numbers of population aged 65 and over, in five year age bands, predicted to have a BMI of 30 and more, projected to 2030

	2009	2015	2020	2025	2030
People aged 65-69 with a BMI of 30 or more	3,252	3,822	3,630	4,317	5,070
People aged 70-74 with a BMI of 30 or more	2,715	2,574	3,060	2,916	3,480
People aged 75-79 with a BMI of 30 or more	1,932	2,024	1,974	2,382	2,274

People aged 80-84 with a BMI of 30 or more	1,166	1,234	1,357	1,340	1,610
People aged 85 and over with a BMI of 30 or more	835	885	973	1,147	1,273
Total people aged 65 and over with a BMI of 30 or more	**9,900**	**10,539**	**10,994**	**12,102**	**13,707**

Data Source:POPPI

It is predicted that from 2009 to 2030 there will be an additional 3807 people with a BMI of 30 or more. Though this is a 38.5% increase in the number of people predicted to be obese by 2030, as a percentage of the projected population this is actually a slight decrease in the proportion of the projected population with a BMI of 30 or more. In 2009 it is predicted that 26% of the total 65+population has a BMI of 30 or more compared to 25.6% of the total 65+ population in 2030.

The highest proportion of the 65+ population with a BMI of 30+ is the 65-69 age band (approx 35%). The 85+ age band has the lowest numbers of people predicted to have a BMI of 30+ (approx 9%).
Enfield has the 5th highest number of people (aged 16+) on the obesity register in London.

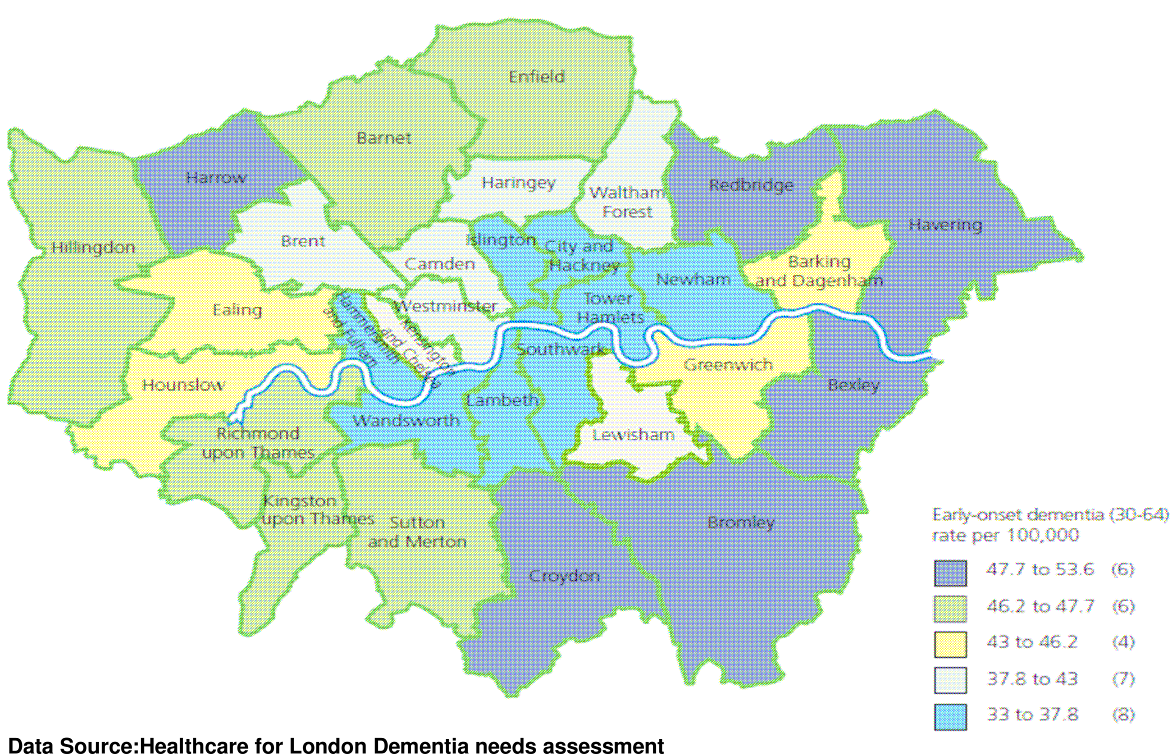
Enfield has the 7th highest number of smokers (who are registered with a GP) in London.

Current Early-Onset Dementia Prevalence Rates

Early-onset dementia (dementia that affects people aged under 65) affects approximately 1 in 40 people in England. Enfield had between 46.2 and 47.7 people per 100,000 with early-onset dementia in 2007. Of the 31 London PCT's, this ranks Enfield amongst the top 12 with the largest amount of people with early-onset dementia.

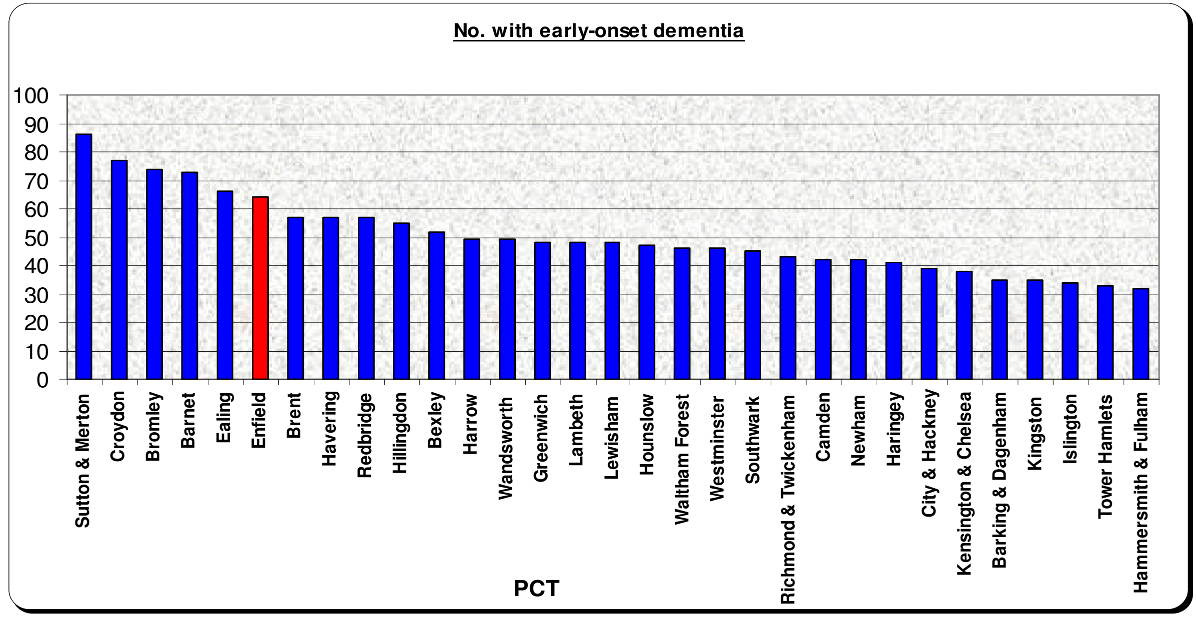
The actual number of people with early-onset dementia in 2007 was 64.

Figure 2: Estimated prevalence of early-onset dementia by PCT, 2007



Data Source:Healthcare for London Dementia needs assessment

Figure 3: Number of people aged 30-64 with early-onset dementia by PCT, 2007



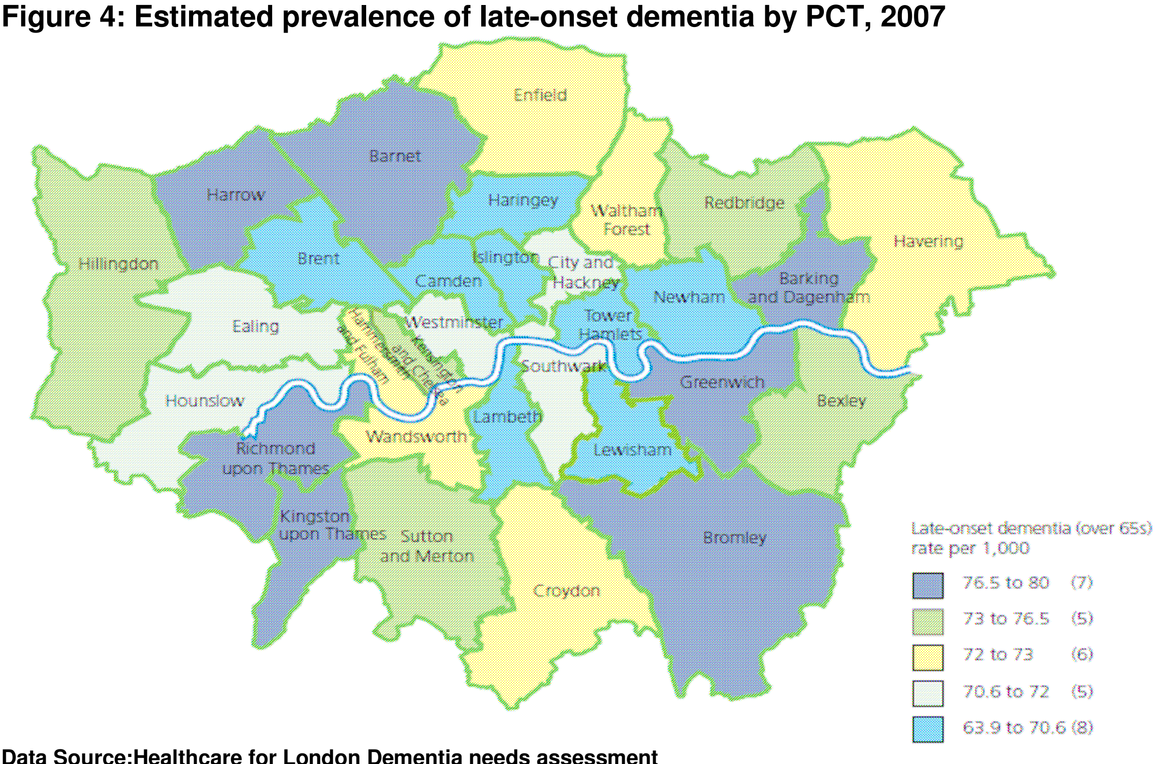
Data Source:Healthcare for London Dementia needs assessment

Current Late-Onset Dementia Prevalence Rates

Late-onset dementia (dementia that affects people aged 65 plus) affects 7.3% of London's population. Enfield had between 72 and 73 people per 1000 with late-onset dementia in 2007.

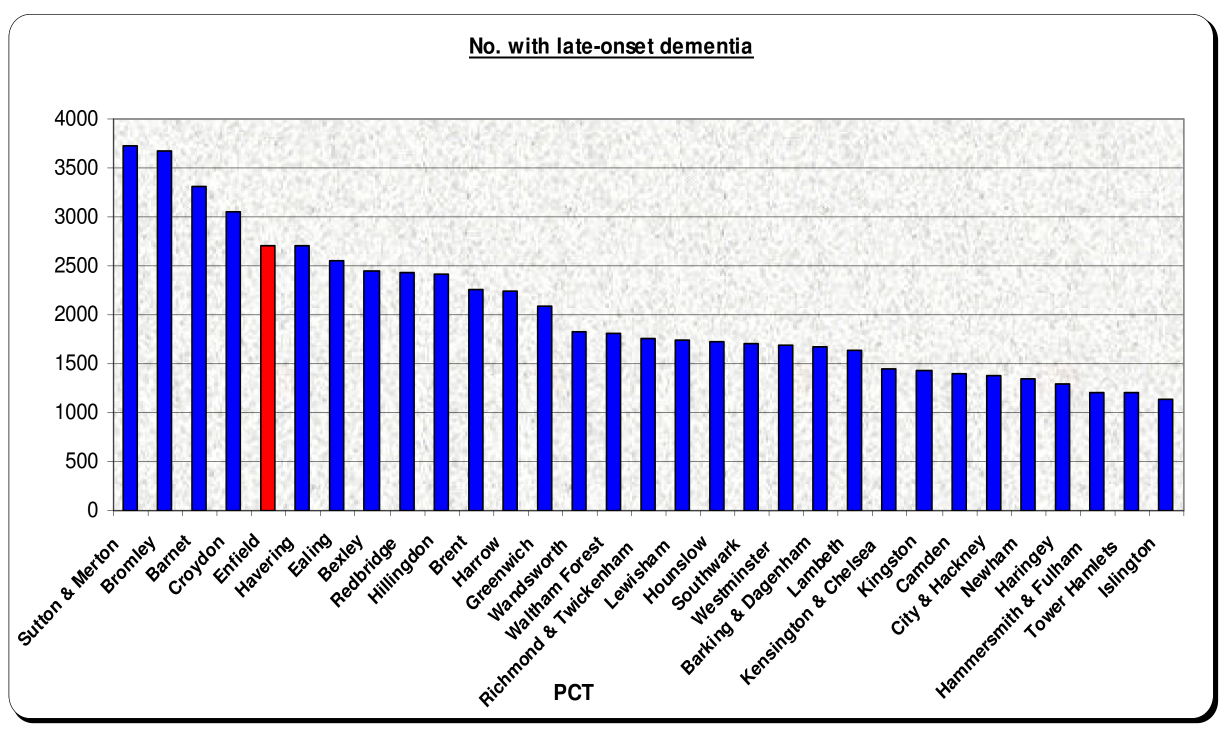
The number of people with late-onset dementia in 2007 was 2706. This is a prevalence rate of 7.3% for Enfield which is the same as the London average.

Figure 4: Estimated prevalence of late-onset dementia by PCT, 2007



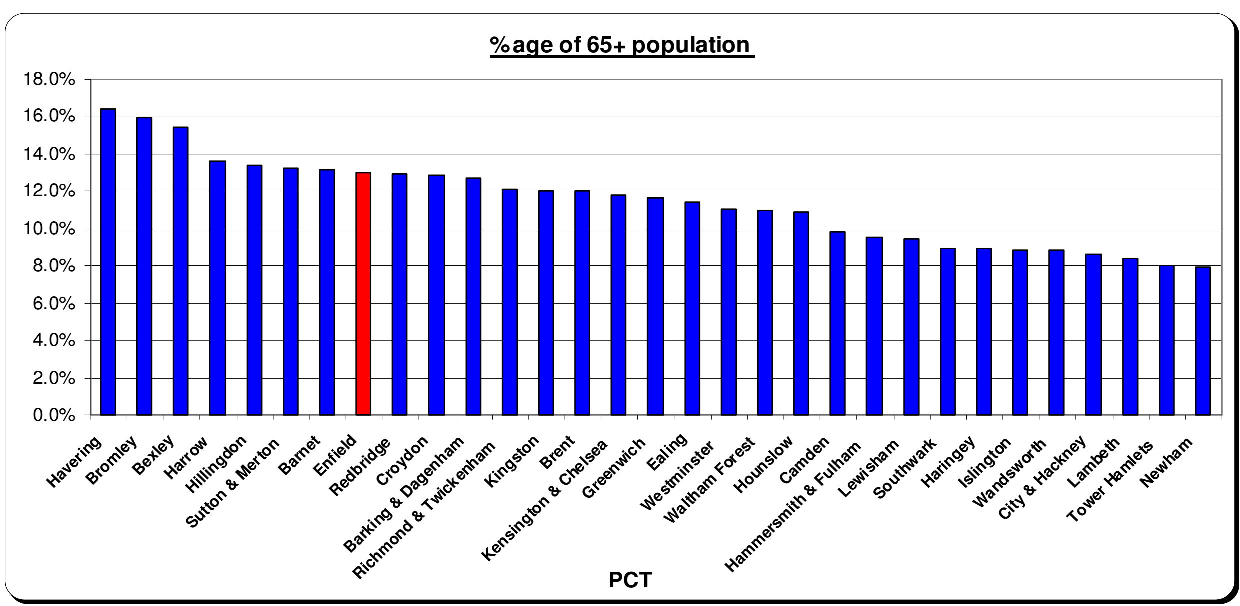
Data Source:Healthcare for London Dementia needs assessment

Figure 5: Number of people aged 65+ with late-onset dementia by PCT, 2007



Data Source:Healthcare for London Dementia needs assessment

Figure 6: Percentage of population aged 65+ by PCT, 2007



Data Source:Healthcare for London Dementia needs assessment

Figure 6 shows the percentage of each PCT's population that is aged 65+. 13% of Enfields population is 65+ compared to a London average of 11.4%.
Figure 6 shows that the reason there are fewer people in inner London boroughs with dementia is due to there being a lower proportion of the population being aged 65+. Enfield PCT has the 8th highest percentage of people aged 65+ and the 5th highest number of people with late-onset dementia in London.

Applying the current prevalence rates for late-onset dementia in Enfield with the projected population figures for older people would indicate that Enfield will have the following amount of people diagnosed with dementia in future years.

Table 11: Numbers of population aged 65 and over, in five year age bands, predicted to have late-onset dementia, projected to 2030

	2009	2015	2020	2025	2030
Projected number of people with late-onset dementia	2774	2978	3139	3446	3906

Data Source:Healthcare for London Dementia needs assessment

Though it is estimated that 2769 people have dementia in 2007 only 905 were registered with a GP as having dementia. This means that approximately two thirds of people in Enfield with dementia have not been registered as such with their GP. It is likely that the majority of these people have mild dementia. This number of people in Enfield on the GP dementia register in 2008 has risen slightly to 922. Of the 922 patients on the dementia register, 850 were eligible for review. 677 of these patients had their care reviewed in the previous 15 months[4]. This gives Enfield a performance of 79.6% which is similar to the London average of 79.7%.

Of the 2706 estimated prevalence of people with late-onset dementia in 2007 it is estimated that 1480 have mild dementia, 874 with moderate dementia and 351 with severe dementia [5]. This is a split of 54.7% mild, 32.3% moderate and 13% severe.

The prevalence rate of early and late onset dementia is 1.6% for Enfield which is higher than the London average of 1.4%.

[4] *This is from the 2008/09 QoF*
[5] *This is from the Healthcare for London Dementia Needs Assessment*

Prevalence by Age Band and Sex

The prevalence of dementia varies between age groups and gender. The prevalence rate of dementia is higher amongst the female population from 30 until 45 when the male population then shows a higher prevalence rate. This trend continues until the 75 age group when the shift changes back to females.

Figure 7: Prevalence of early-onset dementia in the UK by age and sex

Age	Female rate per 100,000 population	Male rate per 100,000 population
30-34 years	9.5	8.9
35-39	9.3	6.3
40-44	19.6	8.1
45-49	27.3	31.8
50-54	55.1	62.7
55-59	97.1	179.5
60-64	118.0	198.9

Data Source:Healthcare for London Dementia needs assessment

Figure 8: Prevalence of late-onset dementia in the UK by age and sex

Age	Female (%)	Male (%)
65-69 years	1.0	1.5
70-74	2.4	3.1
75-79	6.5	5.1
80-84	13.3	10.2
85-89	22.2	16.7
90-94	29.6	27.7
95+	34.4	30.0

Data Source:Healthcare for London Dementia needs assessment

Dementia Type

The most common form of dementia is Alzheimer's which affects nearly two-thirds of all people with dementia in the UK. Figure 9 shows the estimated breakdown of the London population by dementia type.

Figure 9: Breakdown of the population of London with dementia by type, 2007

Type of dementia	Proportion of people with dementia	Estimated number in London
Alzheimer's disease	62%	40,150
Vascular dementia	17%	11,009
Mixed (AD and VD)	10%	6,476
Dementia with Lewy bod-ies	4%	2,590
Frontotemporal dementia	2%	1,295
Parkinsons' dementia	2%	1,295
Other	3%	1,943
Total	**100%**	**64,759**

Data Source:Healthcare for London Dementia needs assessment

The distribution of dementia type varies between male and female. Women are more prevalent to Alzheimer's (67%) than men (55%) and men are more likely to have a vascular dementia/mixed dementia (31% men compared to 25% in women).

Prevalence by Ethnic Groups

Early-onset dementia is more common amongst BME groups with 6.1% of all people with early-onset dementia being from BME groups compared with 2.2% of all groups[6]. This could be due to some groups that are more prone to hypertension and cardio vascular disease.

It is projected that 642 people from BME groups will have late-onset dementia by 2021 compared to an estimate of 231 people in 2001. This is a 178% increase which is higher than the London average of 123%[7]. These significant increases are due to first generation migrants from the 1950's to the 1970's reaching the age groups most at risk of dementia.

[6] *From the Dementia UK 2007 report*
[7] *From the London Dementia needs assessment*

Social Care Assessments, Reviews, Services

In Enfield 4.5% of MH assessments were recorded as a percentage of dementia prevalence in 2006/07 which is higher than the London average of 2.4%. This equates to 125 mental health assessments recorded as dementia.

Table 12: Numbers of service users with dementia receiving a review from 2005/06 to 2008/09

	2005/06	2006/07	2007/08	2008/09
Number of Services Users reviewed in the year	240	420	490	480
London Average	166	177	281	223

Data Source:RAP A1

Table 12 shows the number of clients who have received a social care service and a review in the year. Enfield has performed above the London average each year.

Table 13: Numbers of service users with dementia, ages 18+, receiving a service package from 2005/06 to 2008/09

	2005/06	2006/07	2007/08	2008/09
Number of Services Users with dementia receiving services in the year	260	380	485	600
London Average (excluding Bromley as anomaly with figures)	183	182	189	180

Data Source:RAP P1

The number of service packages provided to clients has continued to increase each year. On average 95% of the clients receiving services are age 65+. The number of clients that Enfield social services provides support to is significantly above the London average.

Table 14: Numbers of service users with dementia, ages 18+, receiving a service package from 2005/06 to 2008/09

	2005/06	2006/07	2007/08	2008/09
Received a community based service in the year	135	240	275	400
Received a residential service in the year	140	180	235	295
Percentage of clients who have received a residential service in year of total clients receiving services	53.8%	47.4%	48.5%	49.2%
London Average of dementia clients	44.9%	45.6%	45.1%	50.8%

receiving a residential service				

Data Source:RAP P1

Please note that in table 14 the sum figures for community based clients and clients in a residential placement will differ from table 13 as some clients would have received both types of service in the year.

Approximately 50% of Enfield clients who received services were in a residential/nursing placement. The London average shows that there is a steady increase in the proportion of clients with dementia being placed in a residential setting rather than being supported in the community. As the number of people projected to have dementia increases there will be a greater demand for dementia registered homes in Enfield. In 2005/06 in Enfield there were 1.8 places (per 100 people) in homes registered to older people [8].

[8] *Information from Healthcare for London Dementia needs assessment*

Length of Stay in a Care Home

Table 15: Length of stay of residential with dementia and nursing with dementia placements, from 2005/06 to 2008/09

Financial Year	**2005/06**			**2006/07**			**2007/08**			**2008/09**		
Service Type	starts	deaths	avg los (wks) deaths	starts	deaths	avg los (wks) deaths	starts	deaths	avg los (wks) deaths	starts	deaths	avg los (wks) deaths
Nursing Older with Dementia	10	13	108	25	28	78	11	15	69	14	14	81
Residential Older with Dementia	36	12	88	36	23	90	41	38	81	53	29	113
Grand Total	**46**	**25**	**105**	**61**	**51**	**105**	**52**	**53**	**92**	**67**	**43**	**90**

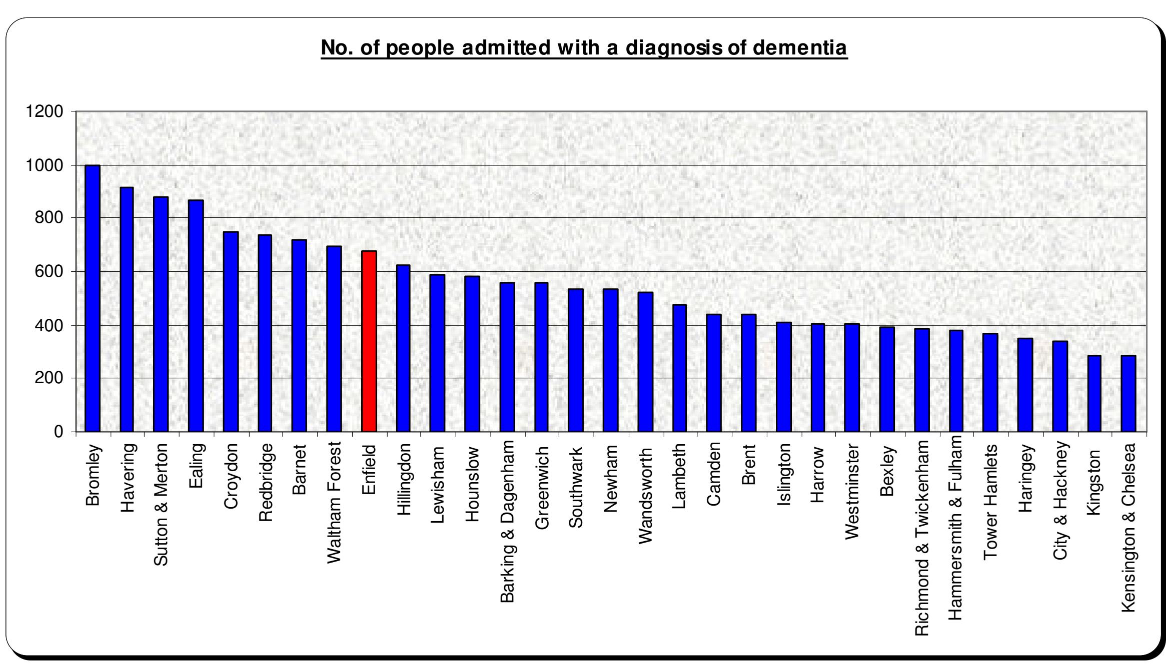
Data Source: HASC Performance Team

Table 15 shows the length of stay for clients who have died whilst in a residential/nursing placement with dementia placed by Health & Adult Social Care. Over the last 4 years the average length of weeks for a client in a nursing home with dementia is 84 weeks and 93 weeks for a residential placement.

Admissions to Hospital

In 2007/08 680 people with any diagnosis of dementia were admitted into hospital. This is above the London average of 552.

Figure 10: Number of people admitted to hospital with any diagnosis of dementia, by PCT, 2007

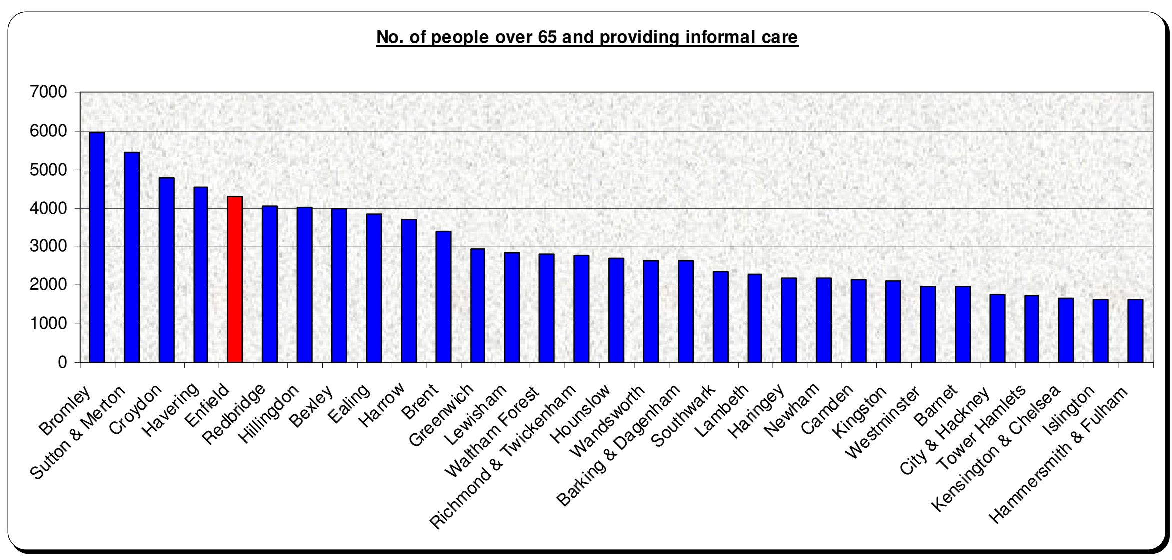


Data Source:Healthcare for London Dementia needs assessment

Figure 10 shows that Enfield had the 9th highest number of people with dementia admitted to hospital in London.
The number of people admitted into hospital with a primary diagnosis of dementia was significantly lower, only 47 people. This is much lower than the London average of 75 people admitted. Enfield was the 5th lowest performing PCT in London in this area.

Carers

Figure 11: Number of people 65+ providing informal support

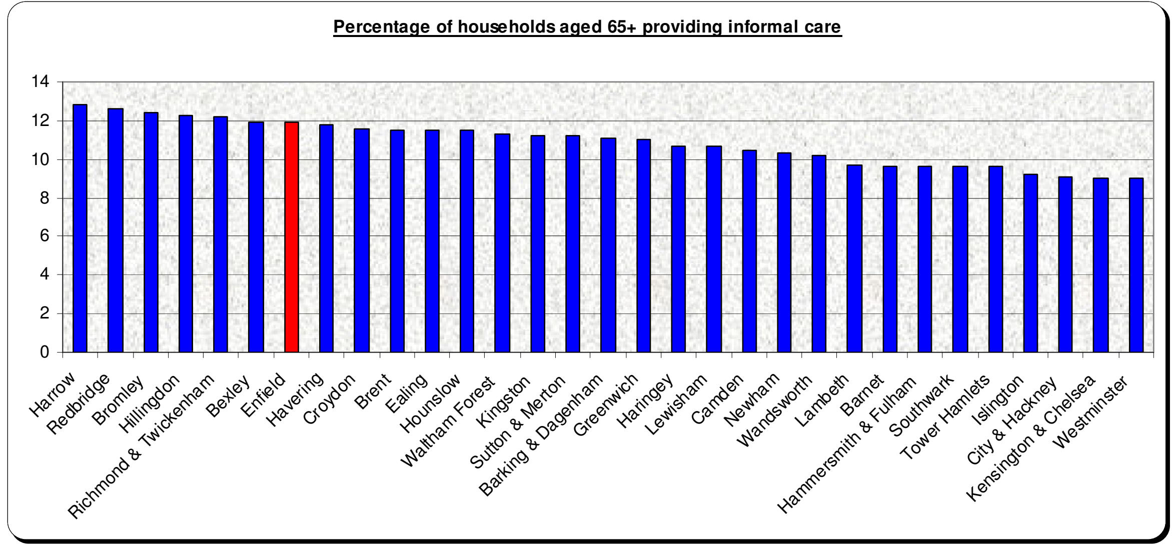


Data Source:Healthcare for London Dementia needs assessment

The 2001 census stated that 4298 people aged 65+ provided informal support. This is higher than the London average of 2998 clients.

In relation to the number of households aged 65+, 11.9% of these households provide informal care. This is above the average of 10.85%.
Please note that this information is now 9 years out of date therefore could have significantly changed.

Figure 12: Number of people 65+ providing informal support



Data Source:Healthcare for London Dementia needs assessment

Enfield LA provided support to 680 carers aged 65+ in 2008/09[9]. This was above the London average of 446. Enfield was the 7th highest performing LA in London in this area.

[9] *RAP 2008/09*

Appendix 3: Map of Local Services

Service	Provider	Description
Cornwall Villa - acute admission ward for older people with mental health needs	BEHMHT	Provides in-patient care for older people, usually 65+, who are suffering acute mental illness and need to be in hospital care for a period of observation and assessment to help the care team decide on the best course of treatment.
Continuing Care In-Patient Wards ○ The Oaks ○ Silver Birches ○ Bay Tree House	BEHMHT	The Oaks and Silver Birches provide an assessment and continuing care service for older people who are suffering from the effects of a chronic degenerative mental health condition (dementia/cognitive impairment). The wards provide specialist inpatient mental health care where there are significant psychological and behavioural symptoms of dementia, which may include: • Persistent threatening behaviour, aggression or violence • Recent history of self harm • Persistent unwillingness to accept services which are necessary to maintain independent living • Persistent wandering Bay Tree House provides a similar service for older people with a functional illness
Older Peoples Community Mental Health Team (Refuge House)	BEHMHT	The OPCMHT offers community-based services for older people with severe and enduring mental health needs and dementia. Teams offer a person-centred approach, based on individual assessment, in order to support service users in achieving their personal goals, and where possible retaining their place in the community. CMHTs are multi-disciplinary teams of nurses, social workers, psychiatrists, clinical psychologists and occupational therapists. In most cases teams offer a multi-disciplinary assessment and management plan and in some cases they also provide follow-up and a review of treatment plans.
Memory Treatment Clinic	BEHMHT	The memory treatment clinic in Enfield provides prescribing and monitoring of anti

Service	Provider	Description
(Refuge House)		dementia medications, working to the current NICE guidelines for monitoring and prescription.
Clinical Psychology	BEHMHT	Provides specialist dementia assessment & support to memory clinic.
Day Hospital ○ The Elms (dementia and cognitive impairment ○ The Hawthorns (functional illness) Both delivered from the Warwick Centre, Chase Farm site	BEHMHT	Provide multi-disciplinary specialist day services for people aged 65 and over with organic and long-standing functional mental health problems, sometimes with substance misuse problems. The service provides: • Assessment, including a memory assessment service • Diagnosis • Management plans Support is provided to support people in their own home through step-up/step-down services, psychological support, developing social skills and new coping strategies and additional services are offered such as occupational therapy, advocacy, bereavement counselling, outreach services, sign-posting
MH liaison	BEHMHT	Specialist MH liaison to general acute hospital wards provided by a full time nurse with consultant input. (Note: This is not a commissioned service)
Day opportunities	Age Concern	The Parker Centre in Edmonton provides a caring and safe environment for people with dementia, which allows their carer to have more time for themselves. The Centre offers activities such as reminiscence work, arts and crafts, singing, indoor bowling, board games, quizzes, group work, cookery, poetry, gentle exercise and day outings. Also offers support for carers about dementia, how to care for their loved ones and how to adapt to changing needs.
	LBE	Rose Taylor is a 15 place day centre for older people with dementia which is based in a residential care home offering a range of social activities. It is open 7 days per week and also offer home made meals that are prepared on site.

Service	Provider	Description
	Enfield Asian Welfare Association	EAWA provides a preventative and high need day opportunities centre for Asian Elders, including those with dementia. EAWA are also starting a new service which is designed to help new carers of Older People on discharge from hospital; to engage with a Carers Assessment; and to be sign posted to access the services they need to support them in their caring role.
Nursing & Residential Homes	There are a large number of nursing and residential care providers in Enfield. A complete list can be found in the Enfield Older Peoples Care Directory.	The majority of residential homes for older people provide service for people with dementia and 30 care homes are registered specifically to provide dementia care. There are 5 nursing homes in the Borough contracted to provide specialist nursing dementia care. Nursing homes also provide continuing healthcare which is funded by the NHS.
Extracare Schemes	Alcazar Court Skinners Court	Extracare schemes provide domiciliary care and housing related support. These are not specifically for people with dementia however people with dementia use these services.
Respite & Carers Services	LBE	Respite care provided from a residential setting, day opportunities setting, or personal care and assistance at home to give a carer a break. There are dedicated respite units for people with Dementia at Coppice Wood Lodge (5 places) and Bridge House (8 places).
	Crossroads Care Enfield	Provides care at home, including for people with dementia, to enable carers to have a break.

Service	Provider	Description
	Alzheimer's Society	Two Carers support groups – information, education and support. Information drop-ins where you can call in without appointment for advice and information, or just for a chat. A community psychiatric nurse is available to all carers for a one-to-one consultation. Purchases respite care from Age Concern and Crossroads
	Age Concern Enfield	'Time-out' home based respite for carers of people aged 50 years and over with dementia. Day opportunities service in Edmonton provides a range of therapeutic and cognitively stimulating activities 6 days per week.
	Nursing homes	Respite is purchased from nursing care providers through spot purchasing arrangements.
	Carers UK	Campaigns to raise awareness of the needs of carers, provides information and advice and helps them become more aware of their own role and status in the community. They also run Carers Line, a free phone helpline offering information and support to carers.
	Enfield Carers UK	The Enfield branch of Carers UK supports, informs and represents carers in the borough of Enfield. A monthly meeting is held in Edmonton. They also hold a monthly drop-in where taster sessions of complimentary therapies are offered.
	Enfield Mental Health Carers	Provides information, advice, training, advocacy, respite, emergency respite, befriending and group support to carers of people with mental health difficulties.
	Asian Carers Consortium	This organisation aims to provide a culturally and linguistically appropriate home based sitting and home care service to Asian carers (including carers of those with dementia) living in Enfield.
	Dazu Young Carers	Dazu supports children and young people who are under 18 years of age and who have caring responsibilities within their families (including caring for family members with dementia).

Service	Provider	Description
Information & advice	Age Concern	Information/Signposting Service provides a one-stop shop providing independent information on a wide range of subjects affecting older people.
	Greek & Cypriot Association	Provides information and advice to people with dementia and their carers.
	G.Ps	922 people on G.P registers.
Home Care	LBE	Provides help with personal care, eating and drinking, and supervising medication.
Home Care	External Providers	Approximately 8-9 external providers regularly provide homecare to people with dementia.
	Enfield Mental Health User Group	Monthly drop-in for older people who receive mental health services.

Appendix 4: Stakeholder Participation

The London Borough of Enfield and NHS Enfield would like to thank those that gave up their time to contribute to the development of the strategy, including:

- Dr. Janet Carrick, Consultant Psychiatrist, Barnet, Enfield and Haringey Mental Health Trust
- Jacqui Wood, Alzheimer's Society
- Anne Taylor, Age Concern
- Kate Holmes, Enfield Mental Health Users
- Julia Brownlie, Barnet, Enfield and Haringey Mental Health Trust
- Jack Williams, Carer
- Steve Tall, Barnet, Enfield and Haringey Mental Health Trust
- John Hancock, Private Sector Housing
- Elaine Yeo, Clinical Director, NHS Enfield
- Gwennie Oakley, Manager Older Peoples Mental Health Team, Barnet, Enfield and Haringey Mental Health Trust
- Pauline Waldron, Anchor Trust Housing Association
- Lisa Doherty, Alzheimer's Society
- Jenny Murtagh, Homecare, London Borough of Enfield
- Needyanand Raya, Care Home Manager
- Glynis Vaughn, Older Peoples Mental Health Team Manager, Barnet, Enfield and Haringey Mental Health Trust
- Cathy McMahon, Age Concern, Enfield
- Shetna Shah, Enfield Asian Welfare Association
- Tosque Dnovo, Alcazar Court
- Hinnah Gill, Enfield Mental Health Carers

ANNEX 2

Enfield Joint Dementia Strategy 2011-2016:

A Summary of Submissions Received in Response to the Consultation

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INTRODUCTION

This document provides a summary of submissions received in response to public consultation on the draft dementia strategy. It also sets out the Council and NHS Enfield response to the comments and suggestions that were received.

In addition to the public consultation on the strategy, stakeholder input was sought during the development of the draft strategy. Two stakeholder workshops were held to develop the strategic objectives and commissioning intentions and these were well attended by service user representatives, carers, voluntary and community sector providers, primary care, Mental Health Trust, Health, Social Care and Housing.

CONSULTATION PROCESS

Formal public consultation on the draft dementia strategy was undertaken over a 3 month period from 1 November 2010 to 28 January 2011.

Stakeholder and public views on the strategy were sought through the following means:

- A e-questionnaire on the Enfield Council website
- Live consultation events with:
  - Carers (2 events involving over 40 carers)
  - Over 50's Forum
- Health and Social Care Partnership Boards
- Health and Social Care Scrutiny Panels

The consultation was publicised through the following means:

- 192 posters distributed to GP surgeries, libraries, health and social care providers and voluntary sector services.
- An advertisement in the Enfield Independent.
- Letter to all carers on the carers register and all carers of people who use the Age Concern Parker Centre services.
- A notice in EVAeNews (the electronic newsletter of the Enfield Voluntary Association).
- An email to staff in NHS Enfield, Health and Adult Social Care staff, acute trusts, voluntary and community sector providers, and independent and private providers.
- A notice in Enfield Staff Matters.

RESPONSES

A total of 37 questionnaires were completed either online or in writing. A further 11 written responses were received; most representing the views of organisations or networks of organisations, including submissions from:

- Barnet, Enfield and Haringey Mental Health Trust
- Barnet and Chase Farm Hospital Trust
- LINKS
- Enfield Disability Action
- Enfield Asian Welfare Association
- The Alzheimers Society

In addition verbal feedback was received at consultation meetings, including:

- Two events for carers
- Over 50's forum
- Health and Social Care Partnership Board meetings
- Health and Social Care Scrutiny Panel meetings

The majority of respondents who completed the questionnaire agreed with the proposed direction that is set out in the strategy.

Strategic Objectives

- 81% of respondents either agreed or strongly agreed with the strategic objectives
- 6.3% of respondents neither agreed or disagreed with the strategic objectives
- 12.5 % disagreed with the strategic objectives

Commissioning Intentions

- 79% of respondents either agreed or strongly agreed with the commissioning intentions
- 9.1% of respondents neither agreed or disagreed with the commissioning intentions
- 9.1 % disagreed with the commissioning intentions

SUMMARY

The collation process involved reading each of the narrative responses that were received. On reading the responses, a number of key themes emerged and comments were allocated to one or more theme headings. A lengthy and wide ranging response will have been allocated to a number of theme headings while shorter 5responses and comments have been allocated to just one or two theme headings. The groupings are useful indicators of where there is common ground with the following themes being most prominent in the responses received:

- Awareness and Prevention
- Day Opportunities
- Workforce
- Support for Carers
- Continuing Care
- Early Diagnosis
- General Hospital Quality
- Access to information, advice and guidance
- Home Care
- End of Life Care and advance planning
- Services for younger people
- Diversity
- Funding and Implementation

A number of comments did not easily fit under any of these themes and are summarised under 'additional comments'.

What follows is a summary of responses collated under each theme heading, followed by a response from the Council and NHS ENFIELD.

1. Awareness and Prevention

A number of respondents commented on the importance of raising awareness amongst both health and social care professionals and the general public. Along side this, it was felt that there are good resources available, for example, from the Alzheimer's Society, but that these could be made better use of. Increasing awareness amongst GPs was seen as particularly important and it was suggested that GPs need a clear pathway to provide information on when, where, and to which services they should refer.

Awareness raising for the general public should include awareness of the needs of people with dementia and also of the services that are available.

Several respondents stated that there should be more emphasis in the strategy about prevention and the link between healthy lifestyles and a reduced risk of vascular dementia. It was suggested that leisure services and

the voluntary sector should be supported in offering opportunities for people to stay fit and healthy, and that awareness of current opportunities, for example, walking groups, should be increased.

Response:

The strategy makes a commitment to increasing both awareness of dementia and availability of local services. It also commits to increasing people's knowledge of how to reduce their risk of developing vascular dementia through making healthy lifestyle choices, including linking with existing health promotion activities and awareness campaigns. Further detail will be developed during the implementation of the strategy and comments received during the consultation will inform this work.

The following additional commissioning intention has been added to the strategy as a result feedback received:

'Develop and implement a local dementia care pathway, spanning early diagnosis to the end of life, and ensure that people with dementia, carers and health and social care professionals are aware of this pathway.'

2. Day Opportunities and Respite Care

There were many responses about the need to increase the provision of good quality day opportunities and respite care. As well as increased provision, a number of respondents commented on the need for services to be more flexible and responsive to individual needs, choices and preferences. Specific gaps that were highlighted include night sitters, increased opening hours to support working carers, transportation problems, and greater geographical spread of services across the borough.

Respondents were very clear about the value of good quality day care and respite in both supporting carers and providing a better quality of life for people with dementia. Respondents also highlighted the importance of these services in keeping people out of residential/nursing care for longer and in reducing the number of avoidable hospital admissions.

Day opportunities should include structured activities, cognitive stimulation, behavioural therapy, multi-sensory stimulation and exercise therapy.

Response:

The need for more flexible day opportunities and respite services that are responsive to individual needs is recognised as a key priority within the strategy. These services not only enhance people's quality of life and reduce

pressures on family carers, they also play an important role in reducing admissions to residential care and hospital care.

Enfield is committed to the development of more and better services that support people to remain in the community for as long as possible. As a result of the research and consultation undertaken in the development of this strategy, the following additional commissioning intention has been added to the strategy:

'Allocate additional funding for the development of increased flexible day opportunities and respite care that is responsive to individual needs including the needs of carers.'

"Through review, promote local initiatives to make more effective use of existing resources currently invested in day opportunities to provide increasingly flexible responses to peoples expressed needs."

3. Workforce

It is apparent from the number of comments regarding the workforce that this is a key concern for a number of respondents. Several respondents expressed concerns regarding the skills and competencies of home care staff, and one respondent suggested that a specialist dementia care agency should be commissioned. It was recognised that low pay and status of home care workers, as well as high turn over, make improving skills difficult. However it was also stated that training for home care workers is vital if inappropriate hospital admissions are to be reduced. It was also suggested that there needs to be a greater awareness of the Mental Capacity Act and that all staff should understand how to undertake capacity assessments.

It was evident that respondents thought that a greater emphasis should be put on workforce development and training for all health and social care staff, including GPs, A&E staff, general hospital staff, ambulance staff, care homes staff, home care staff, and related agencies, for example, police, and it was suggested that a comprehensive local workforce commissioning plan be developed.

Response:

The strategy gives priority to improving the skills and competencies of the workforce and sets out a number of associated commissioning intentions, including the development of a local dementia workforce plan and ensuring that commissioned providers of services deliver appropriate dementia training to their staff.

Due to the large number of responses that reinforced the importance of improving the skills and competencies of the workforce, development of the workforce will be a key priority for implementation in year one of the strategy.

4. Support for Carers

Two consultation events were held for carers and were attended by over 40 people who provided feedback both verbally and in writing. Carers were enthusiastic about the direction set out in the strategy but also expressed a general feeling of frustration, distress and anxiety regarding the lack of support to them in their caring role.

Key issues that carers articulated included:

- More support is required to enable people to stay in their own homes however there are no additional proposals in the strategy.
- Carers are often very old themselves and get very little respite from their 24 hr caring role.
- Carers need training at the time of diagnosis.
- Support should also be available for carers of people living in care homes.
- The needs of disabled carers should be recognised.
- How will younger carers be supported?
- Need to include training for carers in dysphasia and risks of aspiration
- There is a lack of appreciation of the role of carers and of the high proportion of cost that is borne by carers.
- Carers need support to look after their own health.
- Carers need to be informed of their rights.
- Support groups and mentoring would be beneficial
- A closer focus on the experience of people with dementia and their carers, recognising their diversity and the contribution they make to their own wellbeing and that of the community, would strengthen the strategy

Another key issue that carers raised concerned the planned closure of the Continuing Care In-Patient Wards at Chase Farm Hospital (The Oaks and Silver Birches) and this summarised separately below under 'Continuing Care'

Response:

The need for further development of flexible respite and day opportunities to enable carers to better support their loved ones at home is addressed in point 2. above where a commitment to additional funding has been made. In addition, the following commissioning intention has been added to the strategy as a direct result of feedback from carers:

'We will provide funding to support the development of a peer support group for carers of people with dementia that will enable carers to support each other, share information and advice, give carers a stronger voice and provide a forum for training.'

5. Continuing Care

A number of carers expressed concern at the potential reprovision of the Continuing Care In-Patient Wards at Chase Farm Hospital. Specifically, carers spoke of the high level of stress and anxiety that they were experiencing due to the lack of communication regarding the closure, the timeframes for closure, and the lack of information on proposed alternative service provision.

Carers expressed concern that the potential reprovision of these services was not referenced in the strategy and that there were no plans outlined for the development of services to meet the needs of the growing number of people with dementia who have significant psychological and behavioural symptoms of dementia.

Reassurance was sought regarding the financial impact of transferring patients to the community where there would be a financial assessment of service user contributions to the cost of their care and where continuing care is fully funded by the NHS.

Response:

Continuing joint work with Enfield NHS will seek to ensure that there is open and urgent communication with those people who live in Continuing Care In - Patient Wards, and with their families and carers, to clarify the future intentions about these three sites and the services provided.

6. Early Diagnosis

There was general support for making diagnosis easier and earlier and comments on the long waiting list for diagnosis from the Memory Clinic. There was also comment that earlier diagnosis would increase the need for support services and that this needed to be accounted for in the strategy.

It was suggested that as home care staff come into contact with many people who have some level of dementia that is not formally diagnosed, they could be provided with training to recognise the signs and refer people for treatment.

Response:

The benefits of early diagnosis are clear and the strategy identifies earlier diagnosis as a key priority. The strategy makes a commitment to developing the Memory Treatment Clinic model in line with NICE guidance to enable it to have a greater role in diagnosis and to better manage existing and future demand. It also recognises the impact that an increase in the number of people who are diagnosed at an earlier stage in their illness will have on the

demand for treatment and support services and the need to account for this in our planning.

With regard to training for home care staff, this will be included in the development of our plan to improve the skills and competencies of the workforce.

7. General Hospital Quality

An issue that featured in a number of responses concerned the poor quality of services for people with dementia in general hospital settings.

Respondents identified a lack of awareness, understanding and empathy around dementia and gave examples of the difficulties that have arisen because of this. Specific suggestions about how to address this issue included:

- More dementia specialists in general hospitals
- Speech and Language Therapy input
- Dementia training for general hospital staff, including appropriate use of medication

This theme should be read in conjunction with the comments included under the Workforce theme as training was suggested by many respondents as a key mechanism for improving quality.

Response:

We are committed to improving the quality of care provided to people with dementia in general hospital settings and will work with our local hospitals to do this. A key focus will be on working with hospitals to improve quality through training and specialist support for staff and we will ensure that general hospital staff are included in our local workforce development planning.

8. Access to Information, Advice and Guidance

One issue that came up frequently was the need to improve access to information, advice and guidance. There was comment regarding the lack of information, particularly when someone is first diagnosed, and that carers have to research this for themselves. Other issues included difficulty contacting services and the lack of advice and information for self funders.

There were a number of suggestions to how the provision of information could be improved, including:

- Running regular surgeries
- Ensuring that staff who come in to contact with people with dementia have access to information
- Give people a named contact person/support worker
- Advice on how to choose respite and residential care
- A clear Dementia Care Pathway should be made available
- More funding to voluntary organisations, for example the Alzheimer's Society and Age Concern
- Provide hard copies of information
- Care Homes to advertise which ones are suitable for people with dementia

Several respondent s commented on the pilot dementia adviser services, suggesting that a face-to-face service is preferred. It was also suggested that the dementia advisor service should be linked in with other information and advice agencies to ensure choice and multiple access points. One respondent wanted to know what alternative provision would be put in place if it was decided, as a result of evaluation, not to continue commissioning this service. Other respondents commented on the need for counselling and advocacy services.

Response:

We are committed to improving access to the provision of information, advice and guidance, through both this strategy and through a wider programme of work within the Council that is transforming the way that services are provided.

A new information and advice module has been developed for the Enfield website. It is simple to use and covers all aspects of adult social care. In addition, a new Health and Adult Social Care Access Team is being established. This will provide a single point of access for people who want to speak to someone to get information, advice and guidance.

Further to this, the Council is also reviewing the role of the voluntary and community sector and plans to develop a greater role for the sector in terms of information, advice and guidance.

Finally, we will continue to develop the dementia adviser service to ensure that it can meet the need for information and guidance of people who have recently been diagnosed and their carers. This will include exploring the potential for the service to provide face to face support.

GPs also have a key role in the provision of advice and guidance and we will work to improve this through the implementation of an agreed dementia pathway.

The planned development of carer support groups will also play a key role in improving access to information, advice and guidance.

9. End of Life Care and Advance Planning

There were a number of responses that highlighted the need for support to enable people to plan their care in advance, with one respondent suggesting that advance care planning should be part of the pathway of early diagnosis and support. It was suggested that carers need to be given advice on how to obtain Power of Attorney and that the cost of applying for Power of Attorney can be prohibitive.

It was suggested that all care providers should be required to have End of Life policies and that providers who implement the Gold Standard Framework should be offered higher rates.

Response:

Based on the feedback that we received regarding end of life care, we have strengthened the commissioning intentions regarding the dementia pathway and advance planning. They now include a commitment to:

Ensuring that end of life care is included in the local pathway for dementia.

Ensuring that people are given information on advance planning, at an early stage.

Ensuring that care home staff are trained and supported so that they feel more confident in adhering to advance care plans.

These developments will be implemented through the continued roll-out of the Gold Standard Framework for end of life care. We will commission a facilitator to support care home and primary care providers to implement the framework, and care homes will continue to receive quality payments for achieving the Gold standard.

Sharing of information and support for carers will also be enhanced through the planned development of peer support groups.

10. Diversity

The overall theme with regard to diversity was that everyone has unique, individual needs and that services need to be able to meet these needs.

It was suggested that meeting the needs of BME Groups should be incorporated throughout the strategy rather than a separate objective. Comment was made that there are a wide variety of ethnic groups in Enfield who are culturally, socially and economically diverse and that the strategy should include breakdowns of Greek and Turkish speakers as language is important in dementia. For example, the standard memory test is designed for people with English as a first language. Many people revert to their first language when they have dementia.

A number of respondents emphasised the importance of services that are tailored to people's specific, individual needs, particularly those who have other disabilities such as sensory impairment, mental health needs or learning difficulties.

Response:
Our aim is to commission services that are able to respond to people's individual needs, including their cultural needs.

It was not the intention of the strategy to limit our approach to BME groups to just one strategic objective however due to the predicted increase of dementia in BME goups over the next 10 years we do think that a separate objective is needed. We agree that we need to be more explicit about the needs of BME groups being taken into account in implementation of all the objectives and have revised the strategy accordingly.

The needs assessment has been revised to include more a more detailed breakdown of BME groups.

There is a national drive towards enabling patient choice and developing services that are responsive to individual needs (or 'personalised'). This strategy has been developed as part of a wider local work programme to develop personalised services and take forward the recommendations outlined in *Putting People First* which includes a commitment to Person centred planning and self directed support.

11. Funding and Implementation

Many respondents expressed concern about the ability to implement the strategy in the current economic environment and with the lack of ring fencing for dementia funding. There was also concern about the commitment to

implementation with the move to a single management structure across the 5 North London PCTs and the planned devolvement of health commissioning to GP consortia. Respondents stressed the importance of ensuring that implementation of the strategy links in with other local developments such as the Barnet, Enfield and Haringey Mental Health NHS Trust's consultation on 'Improving services for people with Dementia and Cognitive Impairment'.

Questions were asked regarding when the strategy would be implemented and how progress will be monitored and it was suggested that there should be carer involvement in monitoring and feedback.

Response:

We recognise the concerns that people will have regarding the challenges that we face in implementing this strategy in a time of unprecedented change to the NHS and in the context of an extremely challenging financial environment.

Health and social care commissioners are committed to the implementation of the strategy and to working in partnership to achieve this. Discussion and engagement with the emerging Enfield GP consortia has already begun and the Council and its Health partners governance arrangements will continue to provide leadership in implementing the strategy.

In response to the feedback we have received, we have now made a commitment to explore options for making the most effective use of resources to support the development of carer support and increased flexible day opportunities and respite care.

The strategy will be implemented over a 5 year period from 2011-2016 and feedback from the consultation will assist us in developing priority actions for the first year of implementation. As set out in the strategy, implementation will be overseen and monitored by the Older Peoples Mental Health Group which includes carer representation and stakeholders will be involved in implementation planning. The Older Peoples Mental Health Group will also be responsible for developing a communication and engagement plan that will set out how stakeholders will be informed and engaged throughout the implementation.

12. Additional Comments

- There are few/no services for younger people with dementia and a pathway is needed. Are there any plans to provide day care for younger people?

Response:
We recognise that there are gaps in the provision of services for people with dementia and also gaps in our knowledge of what is needed now and in the

future. As there are only very small numbers of younger people with dementia in Enfield, we plan to explore the potential of jointly commissioning services for younger people with dementia with our neighbouring boroughs of Barnet and Haringey. The first step in the commissioning process will be to undertake a joint assessment of the needs of younger people with dementia in order to plan appropriate services to meet those needs.

- Improve Intermediate Care Provision for people with dementia

Response:
Updated DH guidance for Intermediate Care recommends that Intermediate care should be able to meet the needs of people with dementia or mental health needs.

The strategy makes a commitment to ensuring that people with dementia are able to access Intermediate Care services by providing all Intermediate Care staff with core training in dementia and access to advice and support from specialist mental health staff.

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ANNEX 3
JOINT DEMENTIA STRATEGY: DRAFT IMPLEMENTATION PLAN

The following table sets out the draft implementation plan and indicative estimated resource implications for the first 3 years of the 5 year strategy. Following approval of the strategy, more detailed work on the plan will be carried out in partnership with stakeholders and definitive yearly resource allocations will be agreed through the usual financial approvals process and as part of the Councils annual budget setting process.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
1. IMPROVE PUBLIC AND PROFESSIONAL AWARENESS OF DEMENTIA AND REDUCE STIGMA	Develop a local awareness and social marketing campaign that supports the planned national awareness campaign by targeting the following groups: • People aged 50 + • Carers of people with dementia • Black and minority ethnic groups • People with learning disabilities and their carers • Major employers whose workforce has significant interaction with the public e.g Police, transport, post office workers etc. • People living in the more deprived wards of the Borough • People at risk of poor cerebrovascular health • Schools	£0	£0	£0	Resourced from within existing commissioning and public health budgets and through partnership working with the voluntary sector, and ongoing communication and community engagement activities.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Explore potential to link with existing campaigns and services, for example: • Existing health promotion campaigns • Carers health checks • Health trainers programme • Learning Disability services	£0	£0	£0	Within existing budget through incorporating key messages into existing programmes and services. For example, health promotion and healthy lifestyles campaigns, community engagement events, and health checks.
	Address the promotion of healthier lifestyles through exercise and diet through the Prevention strategy.	£0	£0	£0	As above.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Consult with local employers of public-facing staff to gain advice on how best to develop staff awareness including access to local resources for staff.	£0	£0	£0	Within existing resources as part of ongoing development of local partnerships. Potential to tap into corporate social responsibility programmes. In partnership with voluntary sector and utilising national information and awareness resources and materials.
	Include dementia awareness in all induction training for employees within the NHS, Council and partner organisations working with adults and older people.	£0	£0	£0	Cost neutral through inclusion in existing induction programmes for NHS and Council staff. Through contract specifications with external providers.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Ensure awareness raising is coordinated with the development of services to ensure that any additional demand that is created through improved awareness is able to be responded to.	£0	£0	£0	Additional demand for services will be closely monitored and considered during annual budget setting. It is important to note that over the longer term improving early access to services will reduce pressures on care home and hospital budgets.
2. IMPROVE EARLY DIAGNOSIS AND TREATMENT OF	Develop and implement a local dementia care pathway, spanning early diagnosis to the end of life, and ensure that people with dementia, carers and health and social care professionals are aware of this pathway.	£0	£0	£0	Within existing resources - work to be carried out by commissioners in partnership with providers who are part of the care pathway.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
TREATMENT OF DEMENTIA	Reconfigure the current Memory Treatment Clinic model to enable it to better manage existing and future demand, including the capacity to meet the needs of the growing population of older people with dementia from BME groups. Explore the option of direct referral to the clinic from primary care; and consider the benefits of developing the service to provide assessment and treatment. Cross Borough options for development and remodelling will be explored through the Haringey, Barnet and Enfield Dementia Commissioning Forum.	£0	To be determined		Need to develop NHS 'invest to save' business case. (Rationale: Investment in early diagnosis and treatment will reduce total care expenditure by delaying the time to nursing home admission and reducing hospital admissions)

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Model the impact of increasing early diagnosis on other services. People diagnosed early are likely to receive pharmaceutical and therapeutic interventions that will help them live active lives for longer therefore reducing hospital admissions and delaying the need for long term residential care. However it is likely that pressures will be felt by other parts of the health and social care economy as more people are referred for diagnosis, treatment and support.	£0	£0	To be determined	See Objective 3 setting out commitment to increasing funding for day opportunities and respite. Monitor impact of increasing early diagnosis on other services and consider during annual budget setting process.
	Establish formal processes to ensure that people who are admitted to hospital with a diagnosis of dementia are notified to the appropriate GP practice to ensure that the patient is placed on the dementia register.	£0	£0	£0	Acute trust in partnership with G.Ps.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Shift resources from the point of crisis to prevention and early intervention services that help people to maintain their independence and prevent or delay the need for high cost care (this will be implemented through the Enfield Prevention Strategy).	£0	£0	£0	Reconfiguration of existing resources through community and voluntary sector review. Re-ablement grant for investment in assistive technology as detailed in Objective 3.
3. INCREASE ACCESS TO A RANGE OF FLEXIBLE DAY, HOME BASED & RESIDENTIAL RESPITE OPTIONS.	Allocate additional funding for the development of increased flexible day opportunities and respite care that is responsive to individual needs including the needs of carers.	£75k	£150k	£150k	NHS re-ablement funding for social care.
	Implement *Putting People First* personalisation changes to enable the development of more innovative, flexible day, home based and residential respite services to better meet the needs of people with dementia and their carers.	£0	£0	£0	Moving to self directed care options with potential for more efficient use of resources.
	Through review, promote local initiatives to make more effective use of existing resources currently invested in day opportunities to provide increasingly flexible responses to peoples expressed needs.	£0	£0	£0	No cost. Will be resourced within existing day opportunities funding.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Ensure that the need for respite is an integral part of people's assessment and care package; and that if respite is include in the care package they are able to access flexible respite using Direct Payments. Where the person is entitled to it, they should also be able to access the Independent Living Fund to add to the resources available to fund respite.	£0	£0	£0	Cost neutral.
	Ensure that the rights of carers to an assessment of needs are upheld.	£0	£0	£0	Within existing budget for carers assessment.
	Engage in discussions with the market regarding their ability to respond to the personalisation agenda in the provision of flexible and responsive respite services.	£0	£0	£0	Cost neutral
	Ensure that the needs of carers of people with dementia are addressed through the Enfield Carers Strategy.	£0	£0	£0	Implemented as part of carers strategy.
	Provide funding to support the development of a peer support group for carers of people with dementia that will enable carers to support each other, share information and advice, give carers a stronger voice and provide a forum for training.	£5k	£10k	£10k	NHS re-ablement funding for social care.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
4. DEVELOP SERVICES THAT SUPPORT PEOPLE TO MAXIMISE THEIR INDEPENDENCE.	Implement *Putting People First* personalisation changes to enable the development of more innovative, flexible home care services to better meet people's needs. This will include the development of self-directed care and individual budgets to increase individual choice and control over the services that they receive.	£0	£0	£0	Cost neutral.
	Ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from Community Mental Health Teams.	£0	£0	£0	Within existing resources.
	Invest in assistive technology to support people to remain in their own homes.	£75k	£75k	£75k	Existing telecare budget.
	Ensure that Enfield's Supporting People Programme offers appropriate housing related support to people with dementia.	£0	£0	£0	Cost neutral
	Commission a range of housing options that better meet the specialist needs of people with learning difficulties and dementia.	£0	£0	£0	No additional cost. Implementation through review of services at Caterhatch, retendering of extra care housing, and internal sheltered accommodation.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Ensure that a range of high quality, affordable local services providing therapeutic, cognitive and social stimulation for people with dementia are available to help maintain their well being. These services will be appropriate for people at different stages of the disease.	£0	£0	£0	No additional cost. Within review of day opportunities and re-ablement funding allocation in Strategic Objective 3 above.
	Commission training for carers on caring for someone with dementia.	£0	£0	£0	Rolling programme of quarterly workshops facilitated through the carers centre funded through reprioritisation of existing carers resource.
5. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE	Develop a local dementia workforce plan that links to, and complements, the identified national workforce development initiatives.	£0	£0	£0	Within existing resources.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
WORKFORCE	We will ensure that all commissioned services include service specifications that specify dementia training and core competencies that include, but are not limited to, the national minimum standards.	£0	£0	£0	Within existing resources through procurement team.
	We will ensure that home care services specify core competencies and training in dementia care for all staff and that home care staff have access to specialist dementia input from Community Mental Health Teams.	£0	£0	£0	Within existing resources through procurement team.
	All community based health and social care staff will receive core training in dementia.	£0	£0	£0	Within existing training budgets.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	**Y2**	**Y3**	
6. IMPROVE ACCESS TO SUPPORT AND ADVICE FOLLOWING DIAGNOSIS FOR PEOPLE WITH DEMENTIA AND THEIR CARERS	Undertake an evaluation of the Enfield Dementia Demonstrator Pilot programme for dementia advice in order to inform future commissioning decisions regarding this service.	£55k	£165k	£165k	2011/12 funds to be met from carry forward of DH grant. Potential financial impact in 2012/13 when DH funding for pilot ceases. Note, commitment made jointly by PCT, MH Trust and Council to continuation of funding subject to evaluation of pilot. Council contribution from within existing voluntary sector funding.
	Ensure that dementia information materials and resources are available for all people with dementia and their carers.	£0	£0	£0	Cost neutral. Access national resources.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Ensure that the needs of carers of people with dementia for support and advice are included in the Enfield Carers Strategy.	£0	£0	£0	Cost neutral.
7. REDUCE AVOIDABLE HOSPITAL & CARE HOME ADMISSIONS AND DECREASE HOSPITAL LENGTH OF STAY	Hospital Mental Health Liaison Service: Collate and analyse current data and review existing model of service provision in order to develop an ‘invest to save’ business case for expanding the role of the current liaison service. This would include exploring the benefits of expanding the service to include responsibility for general hospital staff dementia training and education.	£0	To be determined		Develop an ‘invest to save’ business case for consideration in 2012/13 annual budget setting process.
	Ensure that people with dementia are able to access Intermediate care services by providing all Intermediate Care staff with core training in dementia and access to advice and support from specialist mental health staff. In addition we will increase the capacity of Intermediate Care to provide in reach to care homes in order to reduce hospital admissions. (To be implemented as part of the Intermediate Care Strategy).	£0	£0	£0	Resource implications addressed with Intermediate Care and re-ablement strategy implementation plan.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Review the appropriateness of current arrangements for assessing people with dementia in general hospitals, including appropriateness of current assessment environment.	£0	£0	£0	Resource implications to be reconsidered on completion of review.
	Implement and evaluate the Unique Care Pilot described in Section 5.	£0	£0	£0	Within existing resources in partnership with G.Ps.
	Agree local targets for a reduction in inpatient admissions and length of stay and increase in the number of patients on dementia registers.	£0	£0	£0	Cost neutral. Potential acute savings to be reinvested in prevention and early intervention.
	Review the quality, range and provision of services for people who require continuing healthcare.	£0	£0	£0	Resource implications to be reconsidered on completion of review.
8. ENSURE THAT THE NEEDS OF YOUNGER PEOPLE WITH DEMENTIA ARE ADDRESSED	Ensure that health and social care staff working with people with learning disabilities and other younger people at risk of dementia receive training in dementia awareness.	£0	£0	£0	Cost neutral.
	Ensure that people with learning disabilities and those supporting them have access to specialist advice and support for dementia.	£0	£0	£0	Cost neutral.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Explore the potential of jointly commissioning services for younger people with dementia with our neighbouring boroughs of Barnet and Haringey. This will be taken forward by the newly formed 3 Borough Dementia Commissioning Group.	£0	£0	£0	No cost – undertake needs assessment and service mapping as part of core commissioning business. Needs assessment and review of gaps to inform recommendations.
9. IMPROVE THE QUALITY OF DEMENTIA CARE IN CARE HOMES & HOSPITALS	We will commission our specialist older peoples mental health team to provide in-reach service to support primary care in its work in care homes.	£0	£0	£0	Within existing budgets.
	We will commission primary care and pharmacy in reach services to ensure more appropriate use of anti-psychotic medication.	£0	£0	£0	Within existing budgets.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	We will ensure distribution, promotion and implementation of the ‘good practice resource pack’ that is being developed by the National Dementia Strategy Implementation Team.	£0	£0	£0	No cost.
	We will enter into collaborative partnerships with care home providers to encourage the development of local leaders who can demonstrate excellence in provision of services.	£0	£0	£0	No cost.
	Identify a senior clinician within Chase Farm Acute Trust to take the lead for quality improvement and training in dementia care in hospital.	£0	£0	£0	No cost. Acute Trust lead.
	Review the current care pathway for the management and care of people with dementia in hospital, led by that senior clinician.	£0	£0	£0	No cost. Acute Trust lead.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Explore the potential use of the commissioning for quality and innovation (CQUIN) payment framework, to incentivise general hospital providers to improve quality and innovation.	To be determined			Resource implications to be determined. Any additional costs would be health funded and require approval by North Central London Sector.
10. IMPROVE END OF LIFE CARE FOR PEOPLE WITH DEMENTIA	Ensure people with dementia have the same access to palliative care services as others.	£0	£0	£0	Implementation and resourcing through the End of Life strategy.
	Ensure that end of life care is included in the local pathway for dementia and is consistent with the Gold Standard Framework as identified by the National End of Life Care Strategy.	£0	£0	£0	Implementation and resourcing through the End of Life strategy.
	Continue quality payments to care homes that achieve the Gold Standard for End of Life Care.	£20k	£40k	£60k	Funded through commissioning budget to develop the market in Enfield.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Commission a Gold Standard Framework Facilitator to work with care homes to assist them to implement the Gold Standard Framework.	£25k	£50k	£50k	NHS re-ablement funding for social care. Target: reduction in emergency hospital admissions from care homes.
	Continue to raise awareness of the Mental Capacity Act among health and social care professionals in order to increase the number of people who are enabled to plan for their end of life care while they have the capacity to do so.	£0	£0	£0	Through DolS Office work programme.
	Enable people with dementia and their carers the opportunity and support to discuss and document advance care plans.	£0	£0	£0	Through Mental Health Trust supported by voluntary and community sector services.
	Ensure that care home staff are trained and supported so that they feel more confident in adhering to advance care plans.	£0	£0	£0	Implemented as part of workforce planning and through GSF implementation.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	INDICATIVE RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
11. ENSURE THAT SERVICES MEET THE NEEDS OF PEOPLE FROM BLACK AND MINORITY ETHNIC GROUPS	Review current service provision to assess whether it is meeting the needs of Black and Minority Ethnic groups.	£0	£0	£0	No cost. Core commissioning business to ensure access for hard to reach groups.
	Engage with the Black and Minority Ethnic community to gain a better understanding of their needs and current gaps in service provision.	£0	£0	£0	No cost. Core commissioning business to ensure access for hard to reach groups.
	Ensure that the needs of Black and Minority Ethnic groups are taken into account during the implementation of all strategic objectives.	£0	£0	£0	No cost. Core commissioning business to ensure access for hard to reach groups.
PROJECT MANAGEMENT	In order to ensure effective implementation of the strategy, investment in additional project management support for 1 year spanning 11/12 – 12/13 is required.	£30k	£30k	£0	Funding options will include GP consortium early delegated responsibility; existing project management resource; or new re-ablement funding.
Total:		**£285k**	**£520k**	**£510k**	

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ANNEX 4

Predictive: assessing proposed changes to services and policies

Enfield Council

Predictive Equality Impact Assessment

JOINT DEMENTIA STRATEGY

Proposed change to service / policy	**Enfield Joint Dementia Strategy**
Officer completing the assessment	**Michael Sprosson / Kate Charles**
Extension Number	**3961**
Team	**Commissioning &Procurement**
Department	**Housing, Health & Adult & Adult Social Care**
Date impact assessment completed	**22/2/2011**

Section 1 – About the service, policy and proposed change

Q1. Please provide a brief description of the service and / or related policy / policies

The strategy sets out how Enfield will develop and deliver health and social care services to better meet the needs of people with dementia and their carers over the next 5 years (2011-16). It outlines 11 key strategic objectives that were developed in consultation with local stakeholders. Each of the objectives is aligned with the National Dementia Strategy and each is supported by robust rationale.

Q2. Please provide a brief description of the proposed change(s) to the service and/or related policy / policies

Strategic Objectives are set out within the strategy under eleven domains :

- Improve public & professional awareness of dementia & reduce stigma
- Improve early diagnosis & treatment of dementia
- Increase access to a range of flexible day, home based & residential respite options
- Develop services that support people to maximise their independence
- Improve the skills & competencies of the workforce
- Improve access to support & advice following diagnosis for people with dementia & their carers
- Reduce avoidable hospital & care home admissions & decrease hospital length of stay
- Ensure that the needs of younger people with dementia are addressed
- Improve the quality of dementia care in care homes & hospitals
- Improve end of life care for people with dementia
- Ensure that services meet the needs of people from Black & Minority Ethnic Groups

Q3. Does equalities monitoring of your service show that the beneficiaries in terms of the recipients of the service or policy, include people from the following groups?

R	All members of the community will have access to the services set out in the strategy. Monitoring of the effect of the strategy to be carried out post implementation – see Q17.
D	
G	
A	
F	
S	

Q4. If you answered 'no' to any of the groups listed in Q3, please state why?

Not applicable

Q5. How will the proposed change eliminate discrimination, promote equality of opportunity, or promote good relations between groups in the community?

All members of the community will have access to the services set out in the strategy

Section 2 – Consultation and communication

Q6. Please list any recent consultation activity with disadvantaged groups carried out in relation to this proposal	
R	Formal public consultation on the draft dementia strategy was undertaken over a 3 month period from 1 November 2010 to 28 January 2011. Stakeholder and public views on the strategy were sought through the following means: • A e-questionnaire on the Enfield Council website
D	
G	
A	
F	

<table>
<tr><td>S</td><td>

- Live consultation events with:
  - Carers (2 events involving over 40 carers)
  - Over 50's Forum
- Health and Social Care Partnership Boards
- Health and Social Care Scrutiny Panels

The consultation was publicised through the following means:

- 192 posters distributed to GP surgeries, libraries, health and social care providers and voluntary sector services.
- An advertisement in the Enfield Independent.
- Letter to all carers on the carers register and all carers of people who use the Age Concern Parker Centre services.
- A notice in EVAeNews (the electronic newsletter of the Enfield Voluntary Association).
- An email to staff in NHS Enfield, Health and Adult Social Care staff, acute trusts, voluntary and community sector providers, and independent and private providers.
- A notice in Enfield Staff Matters.

A total of 37 questionnaires were completed either online or in writing. A further 11 written responses were received; most representing the views of organisations or networks of organisations, including submissions from:

- Barnet, Enfield and Haringey Mental Health Trust
- Barnet and Chase Farm Hospital Trust
- LINKS
- Enfield Disability Action
- Enfield Asian Welfare Association
- The Alzheimers Society

In addition verbal feedback was received at consultation meetings, including:

- Two events for carers
- Over 50's forum
- Health and Social Care Partnership Board meetings
- Health and Social Care Scrutiny Panel meetings

</td></tr>
<tr><td colspan="2">Q7. Please state how you have publicised the results of these consultation exercises</td></tr>
<tr><td>R</td><td rowspan="6">Responses are in the process of being collated and summarised ready for presentation along with the final version of the strategy to the Cabinet Meeting in April 2011.

We plan to publish the results on the Council's website alongside the final strategy once approved by Cabinet & also notify people who attended events and provide hard copies if required.</td></tr>
<tr><td>D</td></tr>
<tr><td>G</td></tr>
<tr><td>A</td></tr>
<tr><td>F</td></tr>
<tr><td>S</td></tr>
<tr><td colspan="2">Q8. How have you consulted, or otherwise engaged with, all relevant staff in this activity / process?</td></tr>
</table>

Staff & stakeholder workshops, team meetings, staff newsletter

Section 3 – Assessment of impact

Q9. Please describe any other relevant research undertaken to determine any possible impact of the proposed change
The strategy contains a section on the research carried out and sources of information from national guidance, analysis of current and future demand and needs assessment The strategy was informed by research with regard to best practice , much of which contained within national guidance and strategy and as published by the National Institute of Clinical Excellence (NICE) .

Q10. Please list any other evidence you have that the proposed change may have an adverse impact on different disadvantaged groups	
R	None identified
D	None identified
G	None identified
A	None identified
F	None identified
S	None identified

Q11. Could the proposal discriminate, directly or indirectly, and if so, is it justifiable under legislation? Please refer to the guidance notes under the heading, *7. Useful Definitions*
Not envisaged, given equality of access to services to the whole community.

Q12. Could the proposal have an adverse impact on relations between different groups? If so, please describe
Not envisaged

Section 4 – Service delivery

Q13. How could this proposal affect access to your service by different groups in the community?	
R	
D	
G	Positive. The strategy is intended to enhance access to services by the

A	whole community
F	
S	
Q14. How could this proposal affect access to information about your service by different groups in the community?	
R	The strategy sets out enhanced access to information and services
D	
G	
A	
F	
S	

Section 5 – Miscellaneous

Q15. Do you plan to publicise the results of this assessment? Please describe how you plan to do this
This assessment will be placed on the Council's website. The assessment will be listed on the Council's Equality and Diversity Annual Report and the full assessment will be made available on request.
Q17. How and when will you monitor and review the effects of this proposal?
The implementation and monitoring of the strategy will be overseen by the Older Peoples Mental Health Group, which is a sub-group of the Older Peoples Partnership Board (a Thematic Action Group of the Enfield Strategic Partnership50). A detailed 5 year implementation plan will be developed in partnership with NHS Enfield; the Local Borough of Enfield; Barnet, Enfield and Haringey Mental Health Trust and key local stakeholders. This will be agreed by the Older Peoples Mental Health Group who will monitor implementation to ensure that the strategy is shaping services in the way intended. A lead commissioner from NHS Enfield and the Local Borough of Enfield will be identified and they will be tasked with delivering the implementation and reporting progress and issues to the Older Peoples Mental Health group. The Older Peoples Mental Health group will also have a lead role in the development of a communication and engagement plan that will set out: how implementation of the strategy will be communicated to key stakeholders and members of the public; and how stakeholders will be engaged throughout the implementation. The new strategy will also be reviewed as part of the next retrospective equality impact assessment of Commissioning & Procurement that is due to be undertaken in 2011/12.

ANNEX 4

11. Action plan template for proposed changes to service or policy *To be completed post receipt & analysis of consultation responses.*

Proposed change to, or new, service or policy: **Joint Dementia Strategy**

Team: **Commissioning & Procurement & Adult Social Care** Department: **Health , Housing**

Service manager: Shaheen Mughal (Commissioning Manager)

Issue	Action required	Lead officer	Timescale	Costs	Comments
Publication of final strategy & consultation results	Publish on Council's website & provide hard copies / other accessible formats as required	Kate Charles	Post April 2011 Cabinet	To be determined	
Strategy Implementation	Development of implementation plan. See response to Q17.	Shaheen Mughal	5-year implementation plan 2011-16	To be determined	
Monitoring implementation of strategy	Continuous monitoring of implementation and its impact – to be developed. See response to Q17.	Shaheen Mughal	5-year implementation plan 2011-16	To be determined	

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Agenda Item 8

MUNICIPAL YEAR 2010/2011 REPORT NO. 236

MEETING TITLE AND DATE:
Cabinet – 27 April 2011

REPORT OF:
Ray James - Director of Director of Health, Housing and Adult Social Care

Agenda – Part: 1	**Item: 8**
Subject: Enfield Joint Intermediate Care and Re-ablement Strategy 2011 - 2014 **Wards: ALL**	
Cabinet Member consulted: **Councillor Don McGowan**	

Contact officer and telephone number:
Bindi Nagra – Assistant Director Health Adult Social Care
E mail: Bindi.nagra@enfield.gov.uk

1. EXECUTIVE SUMMARY

1.1 Intermediate Care and Re-ablement services are a key priority within the overarching Personalisation agenda. The development of Intermediate Care, and its integration with social care Re-ablement, is seen as essential to the transformation of health and social care and to maximising people’s independence.

1.2 This report proposes the agreement of an Enfield Intermediate Care and Re-ablement Strategy jointly with NHS Enfield. The Strategy is attached **[annex 1]** and has been prepared and been subject to a 3 month period of consultation with key partner agencies and the general public. The direction of travel set out in the strategy has been endorsed by the Older People’s Partnership Board.

1.3 Intermediate Care services are aimed at helping people avoid prolonged hospital stays or inappropriate admission to acute in-patient care, long-term social care or continuing NHS in-patient care. They feature comprehensive assessment and outcome-focused rehabilitation aimed at maximising independence and enabling people to resume normal living. They are time-limited, usually between 1-6 weeks.

1.4 Re-ablement describes the use of timely and focused intensive therapy and care in a person’s home to improve their choice and quality of life, so that people can maximise their long-term independence.

1.5 The strategy sets out how Enfield intends to commission Intermediate Care and Re-ablement services over the next 3 years (2011 - 2014) in order to improve the quality, effectiveness and efficiency of current service provision. It outlines 6 key strategic objectives that were

developed in consultation with local stakeholders. Each objective is aligned with national policy and guidance and each is supported by robust rationale.

1.6 As part of the Council transforming social care programme, a new Health and Adult Care Services structure will be in operation from 11 April 2011. The new structure includes an integrated ‘enablement service’ which combines Intermediate Care, Hospital Social work and In-house home care. These developments are in line with the proposals set out in the strategy and are the first step towards the development of a fully integrated health and social care service as described in the strategy.

1.7 The key anticipated outcomes that the strategy aims to achieve are:

- A reduction in avoidable hospital admissions
- A reduction in hospital readmissions
- A decrease in post-hospital transfer to long-term care
- A reduction in the use of ongoing home care packages
- Increased user and carer satisfaction

1.8 Implementation of the strategy will result in an estimated saving across health and social care of approximately £1.34 million over 3 years while at the same time provide higher quality, person-centred services.

2. RECOMMENDATIONS

2.1 Cabinet is asked to:

i) Note the contents of this report; and

ii) Approve the Enfield Joint Intermediate Care and Re-ablement Strategy 2011-14.

3. BACKGROUND

3.1 In April 2008, Enfield published *Getting Personal*[1] a joint social care and health document which set out the commissioning intentions for older people’s services (2008 – 2011). This document included a

[1] London Borough of Enfield – *Getting Personal - 2008*

commitment to the development of Intermediate Care Services in the Borough.

3.2 This strategy builds on the intentions outlined in *Getting Personal* and aims to ensure that the strategic objectives and commissioning intentions are underpinned by robust evidence based approach and informed by the priorities identified in the Joint Strategic Needs Assessment.

3.3 The strategy also helps to ensure resources are used efficiently and effectively, to improve quality and to provide a framework for a more integrated approach to the delivery of health and social care services.

3.4 The strategy sets out a commitment by NHS Enfield and Enfield Council to investing in a unified Intermediate Care and Re-ablement framework across Enfield that :

- Promotes faster recovery from illness;
- Prevents unnecessary acute hospital admission;
- Prevents premature admission to long-term residential care;
- Supports timely discharge from hospital;
- Maximises independent living;
- Facilitates timely hospital transfer;
- Ensures re-admissions to hospital are avoided as appropriate;
- Is 'joined up' across health and social care with clear and easy to recognise access points and care pathways;
- Increases access to those with complex needs including those with dementia;
- Ensures the focus is on achieving outcomes for individuals;
- Makes optimum use of Telecare and Telehealth;
- Is of a high quality and based on best practice and research;
- Has a robust performance management framework;
- Works within an agreed governance framework.

3.5 The strategy is in line with a number of key national policy drivers, including the national drive towards enabling patient choice and developing personalised services outlined in the Department of Health White Paper "*Our Health, Our Care, Our Say"* (2006). Of relevance to the development of Intermediate Care services are the objectives of shifting resources into preventative services; providing care closer to home; further development of joint commissioning; and encouraging innovation through direct payments and individual budgets. Following on from this, the Department of Health published *"Putting People First"* (2008), which describes a vision for transforming the adult health and social care system from one which intervenes at the point of crisis to one which helps people to remain healthy and independent and maximises individual choice and control.

3.6 One of the key aims of this strategy is to ensure that Intermediate Care and Re-ablement services are commissioned effectively in order to maximise independence, reduce unnecessary use of costly acute hospital beds and delay entry to long-term residential and nursing care.

3.7 As part of the Council transforming social care programme, a new Health and Adult Care Services structure will be in operation from 11 April 2011. The new structure includes an integrated 'enablement service' which combines Intermediate Care, Hospital Social work and In-house home care. These developments are in line with the proposals set out in the strategy and are the first step towards the development of a fully integrated health and social care service as described in the strategy.

3.8 Consultation on Strategy

3.9 Formal public consultation on the draft Intermediate Care and Re-ablement strategy was undertaken over a 3 month period from 1 November 2010 to 28 January 2011. The consultation was widely publicised and people were invited to respond either to an online questionnaire or in writing.

3.10 A summary of submissions received in response to the consultation on the draft Intermediate Care and Re-ablement Strategy (2011 – 2014) is attached **[Annex 2]**. The document also sets out the Council and NHS Enfield response to the comments and suggestions that were received.

3.11 Current and Future Funding

3.12 Over £6.5 million is currently invested in a range of health and social care commissioned Intermediate Care and re-ablement services in Enfield. This is detailed in the table below:

Intermediate Care Service	Provider	Commissioner	Annual Budget
Magnolia Unit-Residential Rehabilitation	NHS Enfield	NHS Enfield	£2.186 million (Continuing Care component is £0.729m)
Hospital Avoidance Service	NHS Enfield	NHS Enfield	£870,183
Greentrees Unit Step-down beds.			£951,241 (agreed estimated cost for 2010-11. Includes

	NHS Haringey	NHS Enfield	provision of Stroke Rehabilitation)
Finchley Memorial Hospital Step-down beds.	NHS Barnet	NHS Enfield	£873,000 (spot purchased)
Finchley Memorial Stroke Rehabilitation beds.	NHS Barnet	NHS Enfield	£212,354 (cost per case provision)
Total NHS Enfield:			**£5,092,778**
Re-ablement Service (including Intermediate Care hospital discharge)	LBE	LBE	£1.5 million
Home from Hospital Service	Age Concern	LBE	£46,920
Total LBE:			**£1,546,920**
TOTAL:			**£6,639,698**

3.13 One of the key aims of the strategy is to ensure that Intermediate Care and Re-ablement services are commissioned effectively in order to reduce unnecessary use of costly acute hospital beds and delay to long-term residential and nursing care.

3.14 A review of services indicated that there is spare capacity within the current service to address future need and considerable potential for redesign to increase productivity and to achieve maximum efficiency.

3.15 By decommissioning hospital based Intermediate Care Services provided in neighbouring Boroughs and further investing in the development of services provided in Borough, it is estimated that we will save approximately £800k per annum while at the same time provide higher quality, person-centred services.

3.16 Further savings are anticipated through a reduction in inappropriate hospital admissions, timely discharge from hospital, a decrease in the number of people admitted to long term care, and a reduction in the use of ongoing home care.

3.17 Enfield Joint Intermediate Care and Re-ablement Strategy 2011-14

3.18 The strategy sets out how Enfield intends to commission Intermediate Care and Re-ablement services over the next 3 years (2011 - 2014) in order to improve the quality, effectiveness and efficiency of current service provision. It describes 6 key strategic objectives as follows:

Priority	Rationale
1. PREVENT AVOIDABLE ADMISSIONS TO HOSPITAL AND SUPPORT TIMELY DISCHARGE	*Individuals will receive their care in the right place, at the right time.* *We will reduce the cost of acute hospital care and manage increasing projected demand.*
2. DECREASE THE NUMBER OF PEOPLE UNNECESSARILY ADMITTED TO LONG TERM CARE FOLLOWING A HOSPITAL STAY	*Assessment and decision making about peoples long term care needs will be made only after they have had the opportunity for rehabilitation, recuperation and recovery.*
3. IMPROVE QUALITY AND MAXIMISE INDEPENDENT LIVING	*Increase patient satisfaction and maximise people's potential to live as independently as possible in their chosen community.*
4. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE	*Investing in workforce development will allow the current services to support people with more complex needs thereby reducing hospital admissions, admissions to care homes and home care hours.*
5. DELIVER MORE COST EFFECTIVE SERVICES IN ORDER TO MEET CURRENT AND FUTURE DEMAND WITHIN EXISTING RESOURCES	*Within the current and future financial and political climate, both health and social care economies are tasked to provide best value services for the local population, within agreed budgetary constraints.*
6. ROBUST PERFORMANCE MANAGEMENT AND GOVERNANCE	*Monitoring and evaluating quality and performance will provide robust information to ensure the strategy is achieving desired outcomes and inform future commissioning intentions.*

4. IMPLEMENTATION AND MONITORING

An implementation plan which includes indicative resource allocations has been drafted and is attached **[annex 3]**. On approval of the strategy, this plan will be further developed in partnership with NHS Enfield; the Local Borough of Enfield; and key local stakeholders.

The implementation and monitoring of the strategy will be overseen by the Older Peoples Partnership Board.

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 The Strategy sets out the case for change and the rationale for the priorities chosen and supported by local stakeholders. It proposes an approach to commissioning Intermediate Care and Re-ablement Services that is consistent with national policy drivers and is in line with existing Council and NHS Enfield strategies.

5. REASONS FOR RECOMMENDATIONS

5.1 The strategy is intended to meet the government's key objectives for the delivery of personalised services that maximise people's independence and provide choice and control. It aims to ensure that services are commissioned efficiently and effectively in order to ensure that we can continue to meet projected increases in demand as a result of Enfield's growing population of older people. The strategy is also intended to provide a framework for more integrated approach to the delivery of health and social care services.

6. COMMENTS OF THE DIRECTOR OF FINANCE AND CORPORATE RESOURCES AND OTHER DEPARTMENTS

6.1 Financial Implications

The financial implications of undertaking the proposed actions arising from the strategy are set out in Annex 3. The annex shows that savings will be realised from year 1 onwards. The actions that require funding or produce savings relate mainly to NHS budgets and expenditure, and not the Council. However, the benefits realisation relies on both working in partnership to achieve the desired outcomes.

It is therefore imperative that, if Cabinet agree to the recommendations set out in this report, the Council works closely with Health colleagues to refine the proposals and ensure that clear agreements are in place around the funding streams before additional expenditure is incurred.

6.2 Legal Implications

The Strategy is the Councils response to the initiatives set out in the various Central Government Guidance referred to in this report and commensurate with the statutory duties and powers of the Council.

6.3 Property Implications

Not applicable.

7. KEY RISKS

7.1 There are no significant risks identified as a result of this strategy.

7.2 Implementation of service changes will be managed and considered in the context of proper risk management arrangements.

7.3 In addition to mitigating the risk of non-compliance with national guidelines, the Intermediate Care and Re-ablement Strategy should help to reduce the risk of longer term stays as well as reducing financial demands through encouraging people to live at home wherever possible.

8. IMPACT ON COUNCIL PRIORITIES

8.1 Fairness for All

- Improved services will benefit all residents of Enfield by enhancing people's independence and ability to remain at home rather than being admitted to hospital.

8.2 Growth and Sustainability

- Not applicable

8.3 Strong Communities

- The strategy is intended to enhance access to services by the whole community.
- The strategy has been informed by the views of local residents who responded to the consultation.

9. PERFORMANCE MANAGEMENT IMPLICATIONS

9.1 The Care Quality Commission have a range of indicators as part of the Performance Assessment Framework for PCTs and Councils with an Adult Social Services Department which are directly relevant to the commissioning of Intermediate Care and Re-ablement services. Performance is routinely monitored on a monthly basis.

9.2 There are a number of indicators within the New Local Area Agreement relevant to Health and Adult Social Care. In particular the following are most significant:

- Number of Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets)
- People supported to live independently through social services
- Number of Delayed Discharges from Acute Hospitals.

10. COMMUNITY IMPLICATIONS

9.1 The strategy aims to promote peoples recovery from ill health and maximise their independence and therefore is for the benefit of all people in Enfield.

9.2 A Predictive Equality Impact Assessment has been completed and is attached **[annex 4]**

11. HEALTH AND SAFETY IMPLICATIONS

No Health and Safety Implications arising directly from this report.

11. PUTTING ENFIELD FIRST

Delivering Fairness, Growth and Sustainability is fundamental to the delivery of the Enfield Joint Intermediate Care and Re-ablement Strategy. Improving peoples quality of life and maximising their independence will support the Council's ambition of Fairness, Growth and Sustainability.

Background Papers

- Department of Health: Intermediate Care – Halfway Home 2009

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JOINT INTERMEDIATE CARE AND RE-ABLEMENT STRATEGY 2011 – 2014

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1. EXECUTIVE SUMMARY

- This strategy has been developed jointly by NHS Enfield and Enfield Council. It is a joint health and social care strategy which specifies how Enfield intends to commission Intermediate Care and Re-ablement services over the next 3 years (2011 - 2014) in order to improve the quality, effectiveness and efficiency of current service provision.

- Commissioners from Health and Adult Social Care have worked with the local Intermediate Care and re-ablement service to analyse the current picture of service provision and develop strategic objectives and evidence based commissioning intentions. We have been guided by local and national policy and guidance and by the priorities set out in Enfield's Joint Strategic Needs Assessment.

What is Intermediate Care?

- The term 'Intermediate Care' covers a wide array of services which are characterised by the following features:-

  - They are aimed at helping people avoid prolonged hospital stays or inappropriate admission to acute in-patient care, long-term social care or continuing NHS in-patient care.

  - They feature comprehensive assessment and outcome-focused rehabilitation aimed at maximising independence and enabling people to resume normal living.

  - They typically comprise multi-professional, multi-agency working.

  - They are time-limited, usually between 1-6 weeks.

- These services are central to the delivery of a number of key national policies, including the National Service Framework for Older People, management of long-term conditions, and avoiding acute hospital admission.

- Of equal importance, effective Intermediate Care services are very popular with patients, particularly older people who value their independence and ability to remain at home rather than being admitted to hospital.

What is Reablement?

- The term 'Re-ablement' describes the use of timely and focused intensive therapy and care in a person's home to improve their choice and quality of life, so that people can maximise their long-term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on re-abling people within their homes so they achieve their optimum, stable level of independence with the lowest appropriate level of ongoing support care.

- Evidence shows that timely bursts of social care Re-ablement can either prevent hospital admission or post-hospital transfer to long-term care, or appropriately reduce the level of ongoing home care support required. Re-ablement complements Intermediate Care services and the benefits include:-

- ➢ maximised independence;
- ➢ minimised whole life cost of care[1].

The Picture in Enfield Today

- Enfield's Intermediate Care service comprises a mix of multi-disciplinary community teams providing home-based care; nurse consultant led community hospital care for acute admission avoidance; and consultant led hospital care purchased from neighbouring Boroughs to facilitate timely discharge from acute care.

- Whilst there is considerable expertise and enthusiasm at managerial and operational level across the range of commissioned services, there is evidence of some duplication of service provision and gaps in the services available.

- Enfield Council operate a Home Care team providing long-term support with a range of personal and domestic tasks to assist people to remain in their homes for as long as it is reasonable to do so.

- The strategic direction for modernising adult social care services means that Home Care teams need to change the way in which they work in order to provide services which promote independence. For Enfield, this means integrating the current in-house Home Care team with the hospital discharge component of the Intermediate Care service and creating a dedicated Re-ablement Service; work on this has already commenced and the new service will become fully operational on 11 April 2011.

- The changes to Enfield Councils home care and Intermediate care services are part of a wider programme of service redesign and the development of a new operating model for social care services. This is in response to the governments personalisation agenda and aims to benefit service users by:

  - ➢ Providing a single point of access;
  - ➢ providing a more responsive service by ensuring that requests for assistance are processed in a way that is proportionate to the persons circumstances and needs;
  - ➢ Embedding of re-ablement within the customer pathway to deliver timely interventions to maximise a persons opportunity to regain skills, confidence and independence; and
  - ➢ Increased flexibility delivering choice and control enabling people to self direct the support to achieve the outcomes required to meet their needs.

Finance and Funding

- This strategy has been developed in the context of an extremely challenging financial environment. Councils are being asked to reduce their budgets year on year, and NHS organisations are working hard to improve their financial position and reduce their deficits. One of the key aims of this strategy is to ensure that Intermediate Care and Re-ablement services are commissioned effectively in

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[1] CSED website: http://www.dhcarenetworks.org.uk/csed/homeCareReablement/

order to reduce unnecessary use of costly acute hospital beds and delay entry to long-term residential and nursing care.

- Approximately to £6.6 million per annum is currently invested in the range of health and social care commissioned Intermediate Care and Re-ablement services in Enfield.

- A review of services in 2010 indicated that there was spare capacity within the current service to address future need and considerable potential for redesign to increase productivity and to achieve maximum efficiency.

- By decommissioning hospital based Intermediate Care Services provided in neighbouring Boroughs and further investing in the development of services provided in Enfield, it is estimated that, across health and social care, savings of approximately £1.34 million can be made while at the same time provide higher quality, person-centred services.

- In order to achieve these savings, additional funding of £1.24 million over 3 years (2011/12 – 2013/14) will be invested in Intermediate Care and Re-ablement services. This additional funding will be allocated from the NHS Support for Social Care: 2010/11 – 2012/13 allocations set out in the 2011/12 NHS Operating Framework.

- Further savings are anticipated through a reduction in inappropriate hospital admissions, timely discharge from hospital, a decrease in the number of people admitted to long term care, and a reduction in the use of ongoing home care.

Strategic Objectives

1. PREVENT AVOIDABLE ADMISSIONS TO HOSPITAL AND SUPPORT TIMELY DISCHARGE
Individuals will receive their care in the right place, at the right time.   ***We will reduce the cost of acute hospital care and manage increasing projected demand.***   Identify a Single Point of Access (SPA) for Intermediate Care services across Enfield which is readily identifiable and accessible to all referrers and which is promoted widely.   Develop an integrated health and social care I.T system.   Commission an increased provision of the full range of step down and admission avoidance Intermediate Care beds within Enfield.   Decommission out of borough Intermediate Care beds and develop agreements to spot-purchase from alternative hospital and community based providers where demand exceeds local capacity.   Increase the capacity of Intermediate Care to provide in-reach to care homes.

Develop clear care pathways

Develop the capacity of the current rapid response component of the Intermediate Care Hospital Avoidance team to provide urgent community based assessment and immediate intervention in people's homes.

Develop the ability of the Intermediate Care service to deliver intravenous therapy at home.

2. DECREASE THE NUMBER OF PEOPLE UNNECESSARILY ADMITTED TO LONG TERM CARE FOLLOWING A HOSPITAL STAY

Assessment and decision making about peoples long term care needs will only be made only after they have had the opportunity for rehabilitation, recuperation and recovery

Ensure that no one is transferred directly from an acute ward to long term residential care (unless in exceptional circumstances) without being offered a period of Intermediate Care and Re-ablement.

Implement a unified assessment process, trusted by all with appropriate information shared between partners.

Adjust the time limited criteria currently in place across Intermediate Care, to ensure that individuals with more complex needs have equity of access for assessment and rehabilitation, prior to decisions being made about their longer-term needs.

Determine a clear Re-ablement pathway that links Re-ablement with the self-directed support processes.

3. IMPROVE QUALITY AND MAXIMISE INDEPENDENT LIVING

Increase patient satisfaction and maximise people's potential to live as independently as possible in their chosen community.

Integrate Re-ablement into the customer journey by reconfiguring the provision of in-house Home Care and ensuring an integrated continuum of service provision.

Develop a person centred 'menu based' approach to service provision.

Ensure a dedicated care management service to the Intermediate Care step down and admission avoidance beds to ensure that people are able to move through the whole system in an appropriate and timely manner.

Integrate the health and social care Intermediate Care teams to ensure that the full needs of the client can be met by the service.

Invest in Assistive Technology to support people to remain in their own homes.

Transfer management of people with Chronic Obstructive Pulmonary Disease to Primary Care.

Address the absence of a Community Therapy service, ensuring that this links with

the service redesign programme currently underway in Enfield.

Continue to commission low level Re-ablement Services from the 3rd sector.

4. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE

Investing in workforce development will allow the current services to support people with more complex needs thereby reducing hospital admissions, admissions to care homes and home care hours.

Ensure there is ready access to the specialist skills required to enable Intermediate Care to support people with long-term conditions, including those individuals with dementia and mental health needs.

All Intermediate Care staff will receive core training in dementia, and appropriate access to professional support.

5. DELIVER MORE COST EFFECTIVE SERVICES IN ORDER TO MEET CURRENT AND FUTURE DEMAND WITHIN EXISTING RESOURCES

Within the current and future financial and political climate, both health and social care economies are tasked to provide best value services for the local population, within agreed budgetary constraints.

Ensure cost effective service delivery and monitor outcomes of Intermediate Care and Re-ablement service to ensure that the service meets the desired outcomes of the individual and their carers.

Ensure there is a robust financial monitoring framework which links service delivery to ensure that the service is delivered within the defined budget.

Commission a longitudinal study to track the impact of the redesign of Intermediate Care services on;

- admissions to long term care
- hospital readmissions
- home based packages of care
- self care
- user and carer satisfaction
- Cost.

6. ROBUST PERFORMANCE MANAGEMENT AND GOVERNANCE

Monitor and evaluate quality, provide accurate reporting data and to inform future commissioning intentions.

Develop and implement a robust performance management framework to ensure that future Intermediate Care provision meets identified needs and achieves desired outcomes.

Ensure that Intermediate Care has a robust governance framework.

2. INTRODUCTION

NHS Enfield and Enfield Council have identified Intermediate Care and Re-ablement services as a key priority within the overarching Personalisation agenda. The development of Intermediate Care, and its integration with social care Re-ablement, is seen as essential to the transformation of health and social care and to maximising people's independence.

NHS Enfield and Enfield Council are committed to investing in a unified Intermediate Care framework across Enfield and have agreed to commission jointly a service for the population of Enfield that:-

- Promotes faster recovery from illness;
- Prevents unnecessary acute hospital admission;
- Prevents premature admission to long-term residential care;
- Supports timely discharge from hospital;
- Maximises independent living;
- Facilitates timely hospital transfer;
- Ensures re-admissions to hospital are avoided as appropriate;
- Is 'joined up' across health and social care with clear and easy to recognise access points and care pathways;
- Increases access to those with complex needs including those with dementia;
- Ensures the focus is on achieving outcomes for individuals;
- Makes optimum use of Telecare and Telehealth;
- Is of a high quality and based on best practice and research;
- Has a robust performance management framework;
- Works within an agreed governance framework.

This strategy describes how each of these elements will be achieved and progress monitored over the next three years.

3. NATIONAL AND LOCAL GUIDANCE AND RESEARCH

National Guidance and Policy Context

There is a national drive towards enabling patient choice and developing services that are responsive to individual needs (or 'personalised'). This agenda is outlined in the Department of Health White Paper "*Our Health, Our Care, Our Say"* (2006) which sets out a fundamental change in the way in which services are delivered. Of relevance to the development of Intermediate Care and Re-ablement services are the objectives of shifting resources into preventative services; providing care closer to home; further development of joint commissioning; and encouraging innovation through direct payments and individual budgets.

Following on from this, the Department of Health published *"Putting People First"* (2008), which outlined a radical reform of the way that health and social care services are delivered. The requirements set out in this document build on *"Our Health, Our Care, Our Say*" (2006) and describe a vision for transforming the adult health and social care system from one which intervenes at the point of crisis to one which helps people to remain healthy and independent and maximises individual choice and control.

The Department of Health published its original Intermediate Care guidance in 2001[2] which was incorporated within the *"National Service Framework (NSF) for Older People"* 2001[3] . Since 2001, there have been numerous policy developments and considerable investment in the whole health and social care economy and in July 2009 the updated guidance, "Intermediate Care – Halfway Home"[4] was published.

The *"Intermediate Care – Halfway Home"*, July 2009 guidance informs local health and social care economies to ensure that:-

- Intermediate Care is widely available to support a diverse range of service users to promote their independence in the community.
- Lean thinking methodology is used to develop pathways which ensure timely transfers from acute settings.
- There is an effective alternative to avoidable hospital admissions.
- There is the widest access to Intermediate Care, underpinned by a collaborative approach
- Assessment and decision making of an individual's longer term care needs is undertaken outside of an acute setting, in a rehabilitative and re-enabling environment.
- The number of individuals requiring readmission to hospital is minimised.
- There is a reduction in the number of service users requiring formalised care.
- That assessment for, and delivery of Assistive Technology, is an integral part of Intermediate Care provision.

The *"Personal Care at Home Act"* (2010)[5] which amends the 2003 Act and introduces the provision of free personal care at home is also relevant to this strategy. The Act includes a new provision that gives local authorities the power to make a person's eligibility for free personal care conditional on the person undergoing a process designed to maximise the person's ability to live independently. This could include a short period of intensive and focused Re-ablement to maximise the person's independent living skills.

In May 2010, the Secretary of State indicated that Health and Social Care economies must be influenced by the following emerging priorities:

- Patients must be at the heart of everything, not just as beneficiaries of care, but as participants, in shared decision-making. As patients, there should be no decision about them, without them.
- The focus for Health and Social Care should be to seek to achieve continuously improving outcomes. Not simply measuring inputs or constant changes to

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[2] Department of Health *Intermediate Care* 2001 Health Service / Local Authority Circular HSC 2001/001

[3] Department of Health *National Service Framework for Older People* 2001

[4] Department of Health *Intermediate Care – Halfway Home* 2009

[5] Department of Health *Personal Care at Home Act - 2010*

structures, but a consistent, rigorous focus on outcomes which achieve results for patients.

- Professionals are empowered to deliver. This is the only way we can secure the quality, innovation, productivity and safe care, all of which are essential to achieving those outcomes.
- As a society, focus should concentrate on improving the health and well-being and of preventing ill-health more effectively, of families and communities. This will result more in the overall health outcomes being sought, not just good health services but good population-wide health outcomes, and reduce the inequalities in health, which so blight our society.
- Health and social care should be more integrated. Whether provided by their families, by carers, by support workers or by health professionals, all are part of a spectrum of care for those in need. There is a need to reform social care alongside healthcare, so that we can support and empower people – not least as individuals – to be more safe and secure and, themselves, to be able to exercise greater control over their care.

In November 2010, the Care Services Minister Paul Burstow launched "A vision for adult social care: Capable communities and active citizens ". The Vision sets out how the Government wishes to see services delivered for people; a new direction for adult social care, putting personalised services and outcomes centre stage.

Alongside the launch of the new vision for social care, the Government is supporting an expansion of re-ablement across the NHS and social care, with £70m in new resources in 2010/11 and up to £300m a year earmarked for re-ablement in the next Spending Review period. In addition to this, the 2011/12 NHS Operating Framework provides details of separate PCT allocations for social care, totalling £648m in 2011/12 and £622m in 2012/13.

The Health and Social Care Bill 2011

The Health and Social Care Bill was introduced into Parliament on 19 January 2011. The Bill is a crucial part of the Government's vision to modernise the NHS so that it is built around patients, led by health professionals and focused on delivering world-class healthcare outcomes.

The Bill takes forward the areas of Equity and Excellence: Liberating the NHS (July 2010) and the subsequent Government response Liberating the NHS: legislative framework and next steps (December 2010), which require primary legislation. It also includes provision to strengthen public health services and reform the Department's arm's length bodies.

Of relevance to the successful implementation of this strategy, is the development of GP consortia who will become responsible for the commissioning of health services.

Definition of Intermediate Care

The original guidance described Intermediate Care as a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, prevent premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

The definition included services that met the following criteria:-

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long-term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are developing care plans that are person-centred and reflect the individual's outcomes. The timescales for reviews are incorporated into these.
- They involve cross-professional working, with a single assessment.
- Inclusion of adults of all ages, such as young disabled people managing their transition to adulthood.
- Renewed emphasis on those at risk of admission to residential care.
- Inclusion of people with dementia or other mental health needs.
- Flexibility over the length of the time-limited period.
- Integration with mainstream health and social care services.
- Timely access to specialist support as needed.
- Joint commissioning of a wide range of integrated services to fulfill the intermediate care function, including social care re-ablement.
- Governance of the quality and performance of services.
- Clarity on where decision-making falls.

Providers of Intermediate Care

"Halfway Home" states that the services that might contribute to the Intermediate Care function include:-

- Rapid response teams to prevent avoidable admission to hospital for patients referred from Primary Care, Accident and Emergency or other sources, with short-term care and support in their own home;
- Acute care at home from specialist teams, including some treatment such as administration of intravenous antibiotics;
- Residential rehabilitation in a setting such as a residential care home or community hospital, for people who do not need 24-hour consultant-led medical care but need a short period of therapy and rehabilitation, ranging from one to about six weeks;
- Supported discharge in a patient's own home, with nursing and/or therapeutic support, and home care support and community equipment where necessary, to allow rehabilitation and recovery at home. The arrangements may work well in specialist accommodation such as extra care housing;
- Day rehabilitation for a limited period in a day hospital or day centre, possibly in conjunction with other forms of intermediate care support.

Arrangements for providing local authority home care, day care and residential care free to the user, where they are an integral part of an Intermediate Care package, remain unchanged from the guidance issued in 2001.

The core service should generally be provided in community-based settings or in the person's own home, but a range of services is likely to be needed, including beds in residential settings, some with nursing care. It may include a rapid response team to provide assessment and immediate intervention in people's homes (or care home, if this is where they live), to reduce inappropriate admissions to hospital. It could also include more intensive support and treatment in the person's home to avoid admission or to facilitate discharge, sometimes described as 'hospital at home'. Part of the service should be available on a 24-hour, seven days a week basis, with access to assessment.

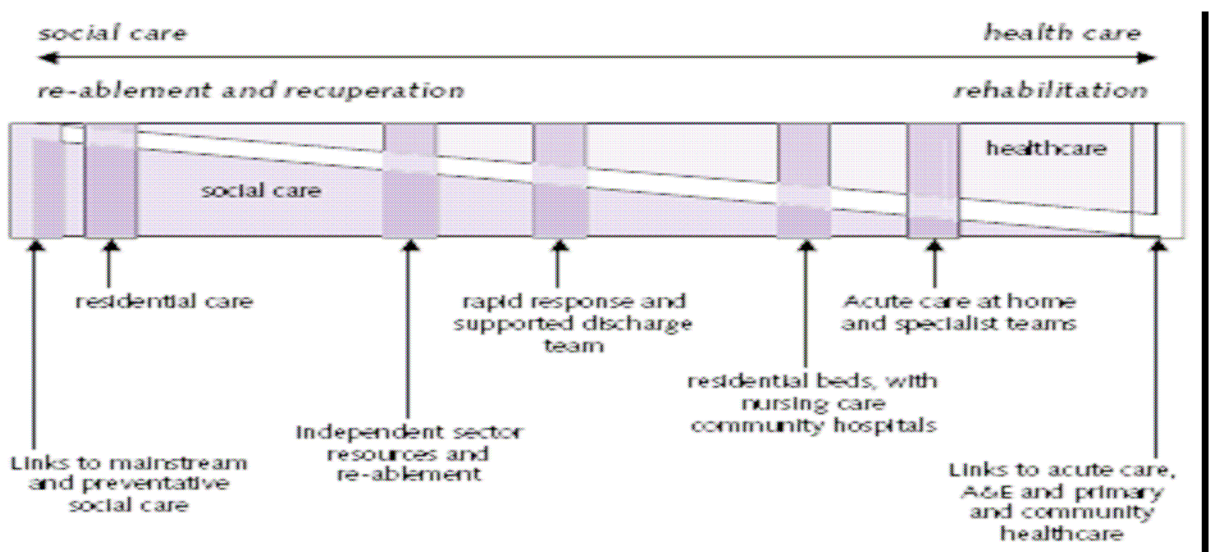
Some services make greater use of residential beds, while others provide more care at home or in day care settings or resource centres, with therapies available. In some areas, the service might be able to manage with fewer beds if it employed more 24-hour community-based staff. Some beds may be provided in care homes, possibly linked to long-term placements, but the Intermediate Care function should be distinct and be related to short-term goals.

Sheltered or extra care housing can be part of Intermediate Care, providing a range of options with input from the core team. Rapid care and repair services can also enable people to move back home who might otherwise have remained in hospital or a residential setting. Technology such as Telecare can also enable people to remain at home safely and independently who might otherwise have needed either residential care or more intensive home care.

Types of Intermediate Care provision

Intermediate Care is a function rather than a discreet service, so it can incorporate a wide range of different services, depending on the local context of needs and other facilities available. It should support anyone with a health-related need through periods of transition, operating between other service units, so will need to adapt in response to any changes in the surrounding services. It is part of a continuum, as illustrated below, spanning acute and long-term care, linking with social care re-ablement.

Figure 1: The continuum of Intermediate Care (adapted from Brophy 2008)



Since the components of the Intermediate Care service vary, depending on the context of other local services, it should provide the function of linking and filling gaps in the local network. For example, a crisis response service for older people who fall, resulting in minor injury, might be provided by the Intermediate Care service in some areas, but in others it might be provided by primary care or by the Ambulance Service. What is important is that the service is available and all agencies know about it.

Intermediate Care should also encompass a wider preventative role, aiming to promote confidence building and social inclusion, thus avoiding the need for institutional care or intensive home care at a later date. It should link closely with social care Re-ablement, acute or urgent healthcare (including out of hours primary care services), Accident and Emergency, community health services and management of long-term conditions, primary health care, domiciliary social care, day care and residential or nursing care homes.

Effective links are necessary so that potential users are referred into the service from any of these services as soon as the need arises. It can be useful to have some staff located close to Accident and Emergency. General Practitioners in particular need to be well informed about the service, as well as acute trusts.

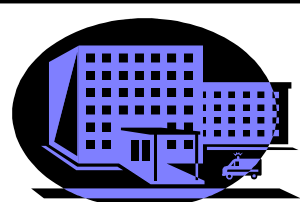
The Intermediate Care function should be managed in an integrated way. Integration can and should exist at several levels – strategic, operational and performance management. This might be best achieved with a single manager, although it may consist of a number of multi-agency teams and facilities.

The following diagram (Figure 2) details the journey of a person through Intermediate Care from the identification of their need to access services to the maximisation of their skills and independence.

Figure 2: Step Up / Down Care Pathways

Individual becomes unwell. Primary / DN / ECP / SW / A&E attendance. Contact Single Point of Access. Assessment < 2 hours. Intervention as required: • Nursing • Therapy • Support Worker Timely diagnosis by: • GP Specialist input by: • Community Geriatrician • Community diagnostics • Rapid access Clinic	If too unwell to be cared for at home, step up to community facility. History / Examination/ Diagnostics. GP or Nurse Consultant review within 24 hours. MDT input with principle of care delivery at home when appropriate.	If too unwell to be cared for in a community facility, admit to acute hospital for comprehensive assessment. Transfer to community facility or home when medically stable and fit for transfer.

Level of acute need

		
Timely comprehensive assessment by: • Clinician • Therapist • Social Worker • Nurse Rehabilitative need identified. Referral to Intermediate Care Single Point of Access. Individual is medically stable and fit for transfer. Individual transferred to the appropriate setting: • Own home • Community based step-down facility	If the individual requires more care than can be delivered at home, step down from acute hospital to community facility. Regular MDT and GP / Nurse Consultant review with principle of step down to care at home to continue rehabilitation when appropriate.	Majority of users of intermediate care to receive their episode of care at home. MDT driven Re-ablement to optimise recovery and promote independence.

Level of need during recovery

The Department of Health published *"Living Well with Dementia: A National Dementia Strategy"* in 2009.[6] The Strategy identifies 17 key objectives which, when implemented, largely at a local level, should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia. The following objectives are relevant to Intermediate Care:

- **Improved community personal support services**

An appropriate range of services to support people with dementia and their carers, living at home. Access to flexible and reliable services, ranging from early intervention to specialist home care services, responsive to the personal needs and preferences of each individual taking into account their broader family circumstances. These services should be accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services.

- **Improved Intermediate Care for people with dementia**

Intermediate Care which is accessible to people with dementia and which meets their needs.

- **Considering the potential for housing support, housing-related services and Telecare to support people with dementia and their carers**

The needs of people with dementia and their carers should be included in the development of housing options, Assistive Technology and Telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.

- **Effective national and regional support for implementation of the Strategy**

The appropriate national and regional support to be available to advise and assist local implementation of the Strategy. Good-quality information to be available on the development of dementia services, including information from evaluations and demonstrator sites.

Improved Intermediate Care for people with dementia is part of the vision of jointly commissioned services along a defined care pathway to enable people to live well with dementia.

The National Stroke Strategy (2007)[7] must also be considered in relation to the further development of Intermediate Care services. It identifies the importance of the provision of high quality rehabilitative support. It documents that intensive rehabilitation immediately after stroke, operating across a seven day week, can limit disability and improve recovery. Specialised rehabilitation needs to continue across the transition to home or care home ensuring that health, social care and voluntary services together provide the long-term support people need.

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[6] Department of Health, *Living Well with Dementia: A National Dementia Strategy - 2009*

[7] Department of health – *The National Stroke Strategy - 2007*

Homecare Re-ablement

Evidence shows that timely bursts of social care Re-ablement can either prevent hospital admission or post hospital transfer to long term care, or appropriately reduce the level of ongoing home care support required. Re-ablement complements intermediate care services and the benefits include:

- maximised independence;
- minimised whole life cost of care[8].

The Department of Health's definition of Re-ablement is:

'The use of timely and focused intensive therapy and care in a person's home to improve their choice and quality of life, so that people can maximise their long term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on re-abling people within their homes … so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing support care'.

The philosophy behind a Re-ablement Service is that people want to be independent and that means being able to do things themselves rather than having people do things for them. Often when people have had a crisis, such as a fall or illness, or they just get to the stage where they feel that they can't manage anymore without help, they need someone to work with them to regain lost skills or, perhaps even more importantly, to regain confidence in their own abilities.

A Re-ablement Service offers support that is designed specifically for the client, taking into account all the elements that are important to independence, such as making sure they have the right equipment, that they have any modern aids and gadgets that might assist with improving their independence. In addition it takes into consideration, carers and their role, providing help so that they can practice daily living skills in a positive and supportive way. There is a growing body of evidence that an effective Re-ablement Service results in a reduction of the need for ongoing traditional home care type services.

Local Guidance and Policy Context

In April 2008, Enfield published *Getting Personal*[9] a joint social care and health document which set out the commissioning intentions for older people's services (2008 – 2011). This document included a commitment to the development of Intermediate Care Services in the Borough.

This strategy builds on the intentions outlined in *Getting Personal* and aims to ensure that our strategic objectives and commissioning intentions are underpinned by robust evidence based approach and informed by the priorities identified in the Joint Strategic Needs Assessment and Local Area Agreement. The priorities identified in these documents include:

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[8] CSED website: http://www.dhcarenetworks.org.uk/csed/homeCareReablement/

[9] London Borough of Enfield – *Getting Personal - 2008*

- Reducing health inequalities;
- Early intervention and prevention for people with long term conditions;
- Improving outcomes for people with dementia;
- Focusing on healthy lifestyles and improved cardiovascular health;
- Improving access to health and wellbeing information;
- Giving people increased choice and control;
- Maximising independence and enabling people to remain in their own homes for as long as possible;
- Strengthening the Voluntary and Community Sector and developing their capacity to deliver services.

Enfield Council and NHS Enfield are also developing a number of other joint health and social care commissioning strategies that will sit alongside the Intermediate Care and Re-ablement Strategy and will contribute to achieving the strategic objectives outlined in Section 6 of this document. They include:

- Prevention and Early Intervention
- End of Life Care
- Dementia
- Stroke
- Carers
- Learning Disability
- Mental Health
- Accommodation

All of the strategies are being developed as part of a wider local work programme to develop personalised services and take forward the recommendations outlined in *Putting People First (*2007)[10]. This is an ambitious work programme that aims to transform local services and will make a significant contribution to achieving the strategic objectives for Intermediate Care and Re-ablement that are set out in this strategy. It includes a commitment to:

- Local Authority leadership accompanied by authentic partnership working with NHS Enfield, other statutory agencies, third and private sector providers, users and carers and the wider local community to create a new, high quality care system which is fair, accessible and responsive to the individual needs of those who use services and their carers.

- Agreed and shared outcomes which should ensure people, irrespective of illness or disability, are supported to:
    - live independently;
    - stay healthy and recover quickly from illness;
    - exercise maximum control over their own life and, where appropriate, the lives of their family members;
    - sustain a family unit which avoids children being required to take on inappropriate caring roles;
    - participate as active and equal citizens, both economically and socially;
    - have the best possible quality of life, irrespective of illness or disability;

[10] Department of Health – *Putting People First - 2007*

- retain maximum dignity and respect.

- System-wide transformation, developed and owned by local partners covering the following objectives:
    - Commissioning which incentivises and stimulates quality provision offering high standards of care, dignity and maximum choice and control for service users.
    - Universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding.
    - A common assessment process of individual social care needs with a greater emphasis on self-assessment. Social workers spending less time on assessment and more on support, brokerage and advocacy.
    - Person-centred planning and self directed support to become mainstream and define individually tailored support packages. Telecare to be viewed as integral not marginal.
    - Personal budgets for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision.
    - Direct payments utilised by increasing numbers of people, as defined by our Local Area Agreement targets.
    - Family members and carers to be treated as experts and care partners other than in circumstances where their views and aspirations are at odds with the person using the service or they are seeking to deny a family member the chance to experience maximum choice and control over their own life. Programmes to be supported which enable carers to develop their skills and confidence.
    - Systems which act on and minimise the risk of abuse and neglect of vulnerable adults, supported by a network of “champions”, including volunteers and professionals, promoting dignity in local care services.
    - Local workforce development strategies focussed on raising skill levels and providing career development opportunities across all sectors.

Implementing Personalisation in Enfield

Enfield Council is undertaking a programme of work to implement the government’s agenda to achieve a shift in resources from the point of crisis to early intervention and prevention. This will be achieved by developing an effective Re-ablement Service within existing resources available (existing homecare and Re-ablement Services) as well as developing our preventative approach to customers, including the mixture of service delivery models across the market (voluntary sector and private provision). Consideration will be given as to the placement of preventative and Re-ablement Services within the customer pathway for the future.

The strategic approach to the development of preventative services will be set out in a Prevention and Early intervention strategy that is currently under development. The development of Re-ablement Services and their integration with Intermediate Care is set out in this strategy and the local approach is described below.

The Re-ablement Service is intended to maximise independence and promote well-being by helping people to gain or regain the skills and confidence they need to live at home. The service is often needed following hospital discharge, bereavement or a crisis in the community or a general deterioration in ability to live safely at home.

National information indicates that a Re-ablement Service should provide a home based intensive period of close working with people (typically up to six weeks but in assessed circumstances up to twelve). Typical tasks could include, teaching a person to use a microwave, enabling them to prepare a meal for themselves or helping them to relearn the skills required to wash, get dressed, make their own bed, do the laundry, use transport or organise shopping. However, a Re-ablement Service is very different from a home care service in that it aims to work alongside clients to help them to do as much as they can for themselves working towards goals agreed at the start of the service.

The philosophy behind a Re-ablement Service is that people want to be independent and that means being able to do things themselves rather than having people do things for them. Often when people have had a crisis (such as a fall or illness) or they feel that they can't manage without help, they may benefit from someone working with them to regain skills or to build confidence in their own abilities.

A Re-ablement Service offers support that is designed specifically for the client. This takes into account all the elements that are important for independent living such as making sure they have the right equipment (including Telecare). As well as assisting with improving their independence it is important to take into consideration carers and their crucial role. This may involve providing support to the client so that they can practice their daily living skills in an un-pressurised and supportive way. There is evidence that an effective Re-ablement Service is likely to lead to a reduction in the need for ongoing traditional home care services.

Continual assessment of a client's needs and progress will take place throughout the provision of Re-ablement. This will identify the potential for ongoing improvement in function and ability. However, there may be for some people a need for longer-term help with personal care type tasks. The core principals of Re-ablement should then continue within any further package of support.

Enfield Council is in the process of developing an effective in-house Re-ablement Service by transforming the existing in-house homecare provision and other Re-ablement Services. It is important to recognise that evidence from national pilots confirm that Re-ablement Services are most effective when delivered jointly by health and social care working closely together with a mixture of skills available (e.g. Social Work, Occupational Therapy, Physiotherapy, Nursing and Care Support Workers) and therefore consideration will be given to the skill mix required within the service to maximise effectiveness for people in Enfield.

Research

Intermediate Care

Intermediate Care is now considered a mainstream activity and many different models have developed across the country. Whilst the evidence base to support the effectiveness of Intermediate Care is mixed, it has been shown to reduce acute hospital admissions in some areas and to enable people to regain skills and abilities in daily living, thus enhancing their quality of life. A comprehensive review of the available research findings is summarised in Intermediate Care – Halfway Home, the Department of Health's updated guidance on Intermediate Care.

Home-care Re-ablement
Building on evidence contained within an earlier discussion document[11], a retrospective longitudinal study was commissioned by Care Services Efficiency Delivery[12] with the Social Policy Research Unit, at the University of York.

Examining the experiences of four councils and schemes, three of which were highlighted in the original Care Services Efficiency Delivery discussion document, the retrospective longitudinal study shows that in three of the four schemes:

- 53% to 68% left Re-ablement requiring no immediate homecare package;
- 36% to 48% continued to require no homecare package two years after Re-ablement;
- In the fourth service, which operated on a selective basis, the results were significantly higher.

Of those that required a homecare package within the two years after Re-ablement:

- 34% to 54% had maintained or reduced their homecare package two years after Re-ablement;
- In the fourth service, which operated on a selective basis, the results were higher.

Of those aged over 65 years that required a homecare package within two years after Re-ablement:

- In three of the four schemes the number that had reduced their package was higher after 24 months than after three months;
- This was even more noticeable in two of the schemes for those aged over 85 years.

National pilot studies evidence a reduction in the life costs of care (table below). However, the anticipated growth in numbers will require further investment in preventative and Re-ablement Services in the longer term.

Homecare Package at First Review *			
Care package req'd post 1st review (6 wks)	Matched service users (control group)	Re-ablement Pilot (selective)	Re-ablement Roll-out (intake)
Discontinued	5%	62%	58%
Decreased	13%	26%	17%
Maintained	71%	10%	17%
Increased	11%	2%	8%
Total	100%	100%	100%

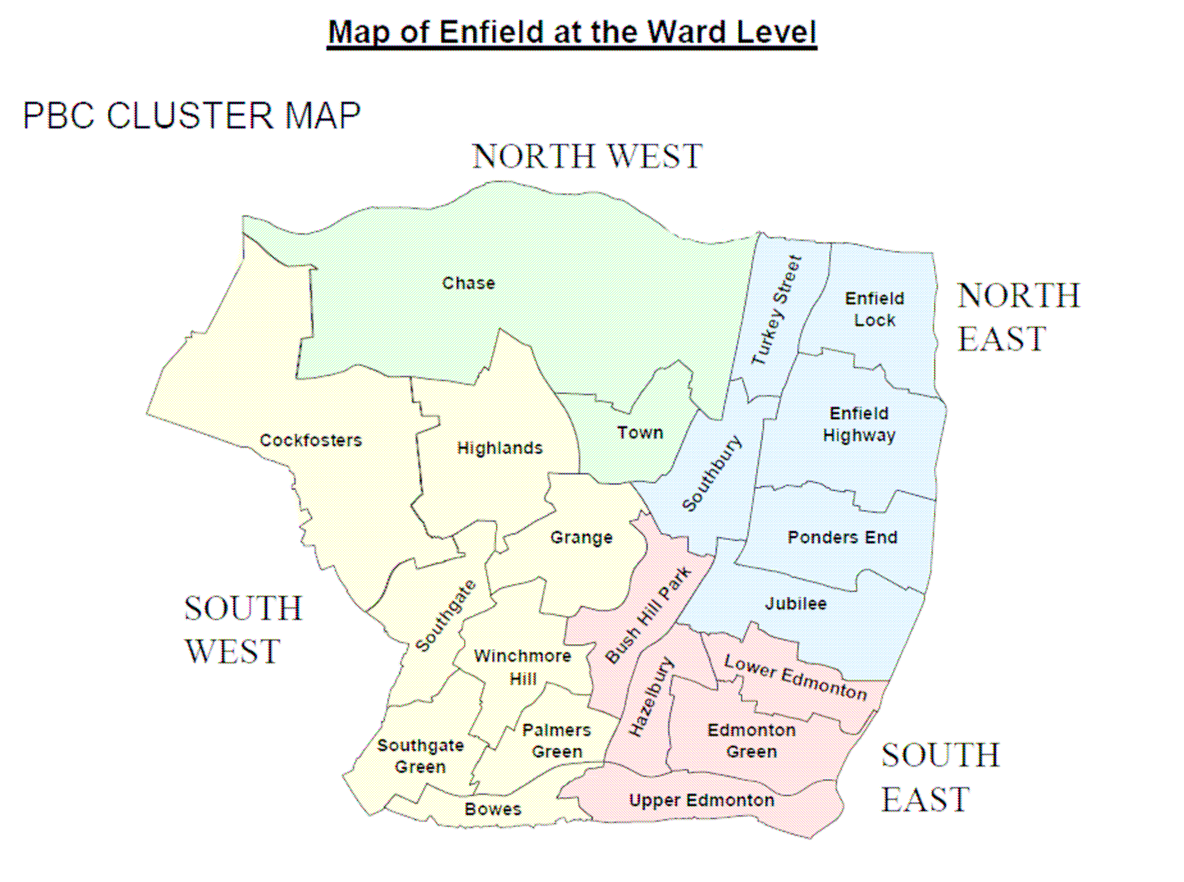
Leicestershire De Montfort Study 2000

[11] Care Services Efficiency Delivery Homecare Re-ablement Discussion Document January 2007

[12] Care Services Efficiency Delivery is a part of the Department of Health that helps councils to identify and develop more efficient ways of delivering adult social care.

4. CURRENT AND FUTURE DEMAND

The map below demonstrates the distribution of wards within the London Borough of Enfield. It also demonstrates the four cluster areas as supported by NHS Enfield.



Estimating the current and future demand for Intermediate Care Services is a complex exercise as it very much depends on how you define Intermediate Care and what services are included. It also requires mapping of the needs of those individuals who are not currently accessing health and social care services, as well as those who are already known to service providers. In addition, Intermediate Care services are accessed by people with a wide range of different conditions, at different levels of need, and across all ages.

For the purpose of this strategy, current and future demand for Intermediate Care services has been estimated by undertaking an assessment of the needs of the Enfield population. The assessment of need is based on a balance of national and local data and consists of demography, incidence and prevalence, risk factor data and local and service user data.

This section highlights key facts that have informed the development of this strategy[13].

- 287,000 people live in the Borough of Enfield and of these, 220,900 are over the age of 18 years.
- The current number of people aged 65 years and over living in Enfield are 38,000. This is projected to increase to 40,800 in 5 years and 53,500 in 20 years.
- The current number of people aged 85 years and over living in Enfield is 5,200. This is projected to increase to 5,700 in 5 years and 8,500 in 20 years.
- Enfield has the 8th highest percentage of people aged 65 years and over in London.
- In 2001, 8.5% of people in Enfield were from Black and Minority Ethnic groups. This is projected to increase to 24% by 2021.
- There are currently 1096 people 65 years and over living in residential care. This is projected to increase to 1,145 by 2013 and 1,240 by 2020.
- In 2009/10 there were 202 new admissions to long-term nursing and residential care. Of these, 126 people (62%) where admitted to long-term care directly from hospital (55 to nursing care and 71 to residential care). The number of new long term care placements has decreased from 2008/09 when 238 new placements were made, however the number being admitted directly from hospital has remained constant.
- Of the 202 new admissions to long-term residential or nursing care in 2009/10, 138 had a community based support package prior to admission and 66% of these had packages valued at £300 or less per week.
- Compared to London, the population of Enfield has relatively poor health. Enfield has the:
    - 8th highest prevalence rate for stroke or Transient Ischemic Attack
    - 5th highest number of people on the obesity register
    - 7th highest number of smokers
    - 5th highest prevalence rate for hypertension

There is a high level of inequality in health status in the borough and reducing this is one of the key priorities identified in the *Joint Strategic Needs Assessment* (2009)[14]. Inequality in health outcomes mirrors the patterns of deprivation seen within the borough. The differences are so significant that it is judged essential to have this as a priority – albeit one that is reflected across all other areas. Life expectancy at birth in Enfield over the past 15 years has been higher than London or national averages for both males and females. However there is a significant life expectancy gap between deprived and more affluent wards within the borough, and there is evidence that this gap is widening for both men and women.

The highest life expectancies for both men and women are reported in the South West Wards. The main causes of death within Enfield, identified as contributing to existing inequalities are circulatory disease, cancer and respiratory disease, and in particular stroke occurring in women. Diabetes is also known to contribute by increasing the risk of developing co-morbidity for long-term conditions.

[13] Data sourced from: Enfield Joint Strategic Needs Assessment (2009); POPPI & PANSI (2009); and LBE social care performance data.

[14] Department of Health – *Joint Strategic Needs Assessment - 2007*

In the North East Cluster, Ponders End has one of the lowest female life expectancy rates in Enfield. In the *Joint Strategic Needs Assessment*, models for the early identification of long-term conditions indicate that a large number of patients remain undiagnosed for chronic conditions where early identification and treatment is critical to health and the reduction of emergency admissions and mortality rates. The North West Cluster has the second lowest life expectancy for the Borough especially in the Chase Ward.

Enfield's population of older people are more heavily concentrated in the Western half of the Borough, particularly in Cockfosters, Southgate and Winchmore Hill, however, some of the fastest increases for 2006-11 are projected in some Eastern wards.

In summary, Enfield has a growing population of older people and a population with relatively poor health status. There are significant inequalities in health status across the Borough which mirrors the pattern of deprivation. Older people and people with poor health are more likely to develop long-term conditions which lead them to require health and social care services. People with long term conditions account for a significant and growing amount of health and social care resources. We need to plan to manage this increased demand and put in place services that enable people to maximise their independence and decrease their reliance on costly acute and social care services.

In planning Intermediate Care and Re-ablement Services, it is important to be mindful of the differing health status and age profile of people living in the Borough and aim to locate services in areas where need is greatest.

Almost two thirds of admissions to long term residential care in 2009 to 2010 were made directly from hospital. This would suggest that there may be scope for services to further develop their capacity to meet the needs of this group of people with the aim of reducing the number of admissions to long term care. Good practice dictates that no one should be admitted directly into long-term care from hospital (unless there are exceptional circumstances) without first being offered a period of Intermediate Care and/or Re-ablement.

5. MARKET ANALYSIS

Map of Services: Intermediate Care

Intermediate Care in Enfield currently consists of the following components.

The Magnolia Unit

The Magnolia Unit is managed by NHS Enfield Community Services, and provides Intermediate Care admission avoidance beds on the St Michael's Care Centre site within Enfield. This is a Nurse Consultant led unit. The multidisciplinary team provides specialist nursing care, occupational therapy, physiotherapy and social work. It also has the facility to receive ad-hoc input from other clinicians. Medical cover at evenings and weekends is provided by Barndoc[15] with week day morning GP medical cover.

[15] After hours GP service

The unit currently provides a admission avoidance beds offering short-term care (approximately 2 weeks).

The building is able to support the use of 28 beds, however, currently 18 are used for Intermediate Care and two additional beds are used for continuing care patients. Staffing levels are in place to support 20 beds. If diagnostics are required, patients are transferred to the Acute Trust.

Referrals are made into the unit from Primary Care, Accident and Emergency and the Ambulance Service. In order to be eligible, patients must:-

- Be registered with an Enfield GP.
- Have a medical condition that has the potential to improve following a short-term period of rehabilitation with clearly defined goals.
- A medical condition that is stable and can be safely managed within the unit.
- Patients requiring diagnostics should have these completed prior to admission.

Currently, 18 admission avoidance beds (and 2 additional beds used for continuing care), are commissioned within the Magnolia Unit by NHS Enfield, the number of beds commissioned, having reduced by of total of 8 beds during the previous two years.

Figures collected during 2008/09 demonstrated average bed occupancy of 75.5%. The numbers of bed days available were 5597, of which 4084 were used. However, the bed occupancy for 2009/10 reduced. The numbers of bed days available were 6178, of which 3270 were used. It should be acknowledged that during this period Intermediate Care saw its budget reduced accordingly as the 8 beds were removed. There is potential to increase the provision to 28 beds and to increase the bed occupancy rate.

See Appendix 1 and 2 for details of Bed Occupancy and Establishment.

Intermediate Care Team - Hospital Avoidance Service
This NHS Enfield service provides a nursing, therapy and support role to individuals as an alternative to inappropriate hospital admission. The service is divided into three geographical areas across Enfield. It provides seven day a week assessment and appropriate intervention to assist individuals to rehabilitate at home. The service operates between 08.30 to 22.00 hours. There is no cover provided outside of these hours.

Criteria for the patient to use the service:
- The patient is a resident of Enfield or is registered with an Enfield GP.
- The patient has been diagnosed with an acute short-term medical condition requiring nursing, or therapy intervention in order to prevent a hospital admission.
- The GP must agree to provide medical cover as needed.
- The team can safely manage the patient’s medical condition.
- Expected duration of input should be 1 to 2 weeks in most cases and should not exceed 6 weeks.
- Patients and main carers must agree to admission to the service, and the patient must have the potential to improve from their current condition.

- Home circumstances are suitable and have adequate facilities to maintain the patient at home in a safe environment.
- There are no known risk factors for staff to provide care in the patient's own home.
- The Intermediate Care Team has the capacity and resources to admit the patient.

Referrals are received from primary care, Accident and Emergency and the Ambulance Service.

Map of Services: Re-ablement

Reablement Team (Previously called the Hospital Discharge Team).
This service is provided by Enfield Council to facilitate a safe and successful discharge from hospital and to prevent admission or re-admission. The service provides short-term reablement support and the recovery of independence to individuals. Provision is normally for between two to three weeks and provided to a maximum of six weeks. The operating hours are from 8am to 10pm, seven days a week.

Care Support workers, co-ordinated by a Manager and Assistant Managers work in close partnership with the social care and health professionals within the wider Intermediate Care service. People access this service by referral from the hospital social work team. The eligibility criteria are as follows:-

- the person has the potential for full recovery within a maximum period of 6 weeks (with some room for flexibility); and
- the person does not have an existing care package in place.

People are also able to access the service if they have been discharged from hospital with no support services and within 14 days from discharge it is clear that they require support to avoid a re-admission.

Additionally, where a primary carer has been admitted to hospital, the team will provide support to the cared for person.

See Appendix 2 for details of the establishment.

Out of Borough Intermediate Care Provision

Greentrees Unit
This out of Borough Unit operated by NHS Haringey provides step down beds for up to 32 patients who reside in Haringey and Enfield. This is a consultant led unit and has nursing, therapy and social work input. Predominantly, patients admitted to the North Middlesex Hospital for their acute care, requiring step down Intermediate Care services will be referred to the unit. The average length of stay is approximately 35 days. The average cost per occupied bed day for 2009/10 was £323.55.and the number of occupied bed days were 2653. (This includes the bed days used for 22 stroke patients).The proportion of the service used for Enfield patients is funded by NHS Enfield.

Finchley Memorial
This service is operated by NHS Barnet and is situated out of borough at Finchley Memorial Hospital. It is a 56 bedded unit which is consultant led and has nursing,

therapy and social work input. Patients requiring step down Intermediate Care from Barnet and Chase Farm Hospital Trust are referred into the service in the absence of step down beds in Enfield. The average length of stay is approximately 35 days. The average cost per occupied bed day for 2009/10 was £239.56, the number of occupied bed days were 3645. This figure excludes the stoke rehabilitation function. The proportion of the service used for Enfield patients is funded by NHS Enfield.

In addition, Enfield patients requiring Stroke Rehabilitation are able to access specialist in-patient services at Finchley Memorial Hospital. The cost per day in 2009/10 was £258.97 and a total of 820 bed days were recharged to NHS Enfield.

Service Performance and Contractual Arrangements

A scoping exercise was undertaken between February and April 2010. It should be noted that a significant amount of work has already been undertaken to develop Intermediate Care, particularly with regards to the development of the re-ablement agenda, and the Intermediate Care and Reablement strategy will complement this important and high profile development.

There is significant Intermediate Care investment annually across the partner organisations, which provides considerable opportunities for innovative re-design.

There is considerable expertise and enthusiasm at managerial and operational level to refresh the current services in line with guidance.

There are a broad range of Intermediate Care services, with a knowledgeable workforce in place across Enfield, but there is some evidence of a lack of joined up thinking regarding how these services interact. In addition, there is evidence of differing time-limiting criteria across the three components of Intermediate Care in Enfield, as referred to previously.

There is evidence of some duplication of service provision and consequently evidence of gaps in the services available, which gives potential for service users with more complex long-term needs to be excluded.

There are a relatively high number of admissions to long term residential / nursing care directly from the acute hospital setting. In the financial year 2009/10, 62% of new residential admissions came directly from hospital. There is no current facility for these individuals to have the assessment and decision making of their longer term care needs carried out within an Intermediate Care facility. This is particularly the case if the person has an identified element of dementia.

Intensive community support, providing specialist support over 6-12 weeks to older people with mental health problems who were considered to be at risk of admission to hospital or institutional care was cited as an example of good practice in Bradford

in the updated Intermediate Care guidance[16]. The evaluation indicated that 26% of the service users were prevented from being admitted to a care home, 13% had a hospital admission prevented or delayed and the home care hours needed were reduced by 26%. The net savings were estimated at more than £0.5m per year.

The health components of Intermediate Care in Enfield (the Hospital Avoidance Service and the Magnolia Unit beds) are predominantly dedicated to support individuals from the community, rather than timely hospital transfer. The recent one-day audit across the services identified a degree of spare capacity, but also, significant numbers of patients whose needs could be met in less supported environments.

NHS Enfield has a cost and volume contract for Intermediate Care step-down beds with NHS Haringey. This is provided at Greentrees on the St Anne's Hospital site. The contract is based on the previous year's activity and multiplied up by the bed day price. Identified Enfield patients access the facility following their acute care at North Middlesex Hospital.

NHS Enfield also has a cost per case contractual arrangement with NHS Barnet. This relates to the provision of general and orthopaedic rehabilitation within the 56 beds at Finchley Memorial Hospital and to a much lesser extent, 37 beds at Edgware Hospital. NHS Enfield also has a separate contractual arrangement with NHS Barnet to provide Stroke rehabilitation

Intermediate Care in Enfield is used to supplement the absence of some other mainstream services, i.e. the lack of a Community Occupational Therapy service, the absence of a Phlebotomy service, the supplementation of District Nursing and long-term conditions management. This severely affects the ability of the health components of Intermediate Care in Enfield to function proactively as is encouraged by the updated Intermediate Care guidance.

There is an Avoidance of Admission service which operates out of the Accident and Emergency Department of the North Middlesex Hospital. This service has good liaison links with the Intermediate Care health based services in Enfield. There is no equivalent service operating from within Chase Farm Hospital. That has reflected in the number of referrals to Intermediate Care as an alternative to admission. Hence, individuals who attend Accident and Emergency at Chase Farm or North Middlesex Hospital do not have comparable access to Intermediate Care as an alternative to hospital admission.

[16] Intermediate Care – Halfway Home, Update Guidance for the NHS and Local Authorities (DH, 2009)

Previous evidence from figures available from 2008 to 2009 show that 79 patients were referred from the Accident and Emergency department at the North Middlesex hospital to Intermediate Care, compared to only 10 patients referred from the Accident and Emergency at Chase Farm during the same period.

There appears to be limited links between Intermediate Care and the discharge planning arrangements within the two acute hospitals in Enfield, predominantly, because of the admission avoidance function of the current health services and the limited access to step-down beds, except during periods of acute bed pressure.

There are limited links between Intermediate Care in Enfield and the Ambulance Service to signpost appropriate individuals to any services other than an acute Accident and Emergency episode.

There is no single point of access to Intermediate Care across Enfield and thence referrers could be unclear of the pathway and therefore not adhere to it.

There is limited access to Intermediate Care, particularly the health component of home based care, out of hours, and at week-ends. This limits its potential to function at its optimised capacity.

There is some evidence to suggest that Intermediate Care in Enfield is service driven rather than person-centred, in that, individuals who are likely to have more complex needs and, therefore, need a longer period of Intermediate Care, are less likely to be considered for inclusion.

There is limited use of a unified assessment, some evidence of duplication of assessment and a lack of trust in the assessment of referrers to the service, all of which contribute to a potential for delay and the unnecessary usage of resources.

There is an inconsistent approach to goal setting and outcome measurement, as demonstrated in the Hospital Avoidance service where individuals have the potential to receive an ongoing maintenance service rather than one which is time limited and outcome based. It is acknowledged that this is mainly due to the lack of ongoing provision in Enfield.

There is limited understanding of the potential for the use of Telecare and Telehealth as part of assessment and the management of risk within Intermediate Care.

There is a lack of Interim Care provision for those individuals whose longer term needs are unlikely to be met in an Intermediate Care environment and who currently are likely to be delayed in hospital inappropriately.

Home from Hospital Service

Age Concern provides a home based Re-ablement Service for people discharged from hospital with low to medium care needs. It provides short-term practical support to facilitate rehabilitation after a hospital stay for a period of up to 6 weeks, for example, help with shopping, paying bills and housework.

This service received £46,920 per annum from the Enfield Council. In 2008 to 2009, 84 people accessed the service, giving a unit price of £559 per person.

In-House Home Care Team

The purpose of the In-House Home Care Team is:

- To provide long-term support with a range of personal and domestic tasks to assist people to remain in their homes for as long as it is reasonable to do so. The service is primarily provided to older people with dementia but also service users with learning difficulties, physical disabilities and mental health support needs.
- To provide an Out-of-Hours service during evenings and weekends to respond to the need for emergency home care in the community and to support home carers working at these.

Help is provided with the following:

- Washing
- Dressing
- Toileting needs
- Eating and drinking
- Assistance with medication
- Assistance with housework, shopping, laundry and with everyday financial matters may be provided to people who are already receiving help with personal care, either provided by the Council or by family or friends.

The strategic direction for modernising adult social care services means that home care teams need to change the way in which they work in order to provide services which promote independence. For Enfield, this means integrating the current in-house home care team with the intermediate care service and creating a dedicated Re-ablement Service.

All people requiring social care services will be offered a period of Re-ablement during which time comprehensive assessment of their potential for independence can be assessed by therapists and home carers. Occupational Therapists and Home Care services are experienced in supporting people in their own home and their skills can be used to good effect when they focus on enabling people to be self-caring. This dispenses with the need for the traditional ‘doing for’ model of care.

The use of Assistive Technology (Telecare) and other equipment aids, together with a Re-ablement programme if required, allows many people to achieve full

independence. For those who people who need ongoing support following assessment and the development of an agreed support plan, they will be offered an individual budget from which to purchase any required support.

It has been demonstrated by a number of other authorities who have already fully introduced Re-ablement Services, that this form of provision is more effective and efficient than traditional in-house home care services and that it is valued by Service Users.

Health and Adult Social Care: New Customer Pathway

The new Re-ablement service will be operational from 11 April 2011 as part of the redesigned Social Care customer pathway.

The key features of the new structure are described below:

- A ‘single point of access’ for all enquiries about health and adult social care;
- A re-ablement service to deliver timely interventions to maximise a persons opportunity to regain skills, confidence and independence;
- Non-complex cases being assessed and support planned following a period of re-ablement for cases where ongoing needs have been identified;
- A complex service dedicated to those where the identified needs are high and more in-depth assessment and support planning is required as well as dealing with complex safeguarding cases;
- A brokerage team responsible for arranging the services identified within the support plan.

The new re-ablement service will provide short-term interventions to maximise someone’s ability to live independently in the community. The re-ablement service will make an assessment of need and identify the types, levels and expected timeline of interventions required to improve the person’s independence. This may also include the provision of equipment.
Once an individual has reached their goals and prior to the point of the intervention ceasing, the re-ablement team will to take the person through the Resource Allocation System to identify their personal budget.

Assistance with support planning will also take place but only for those that are straight forward and non-complex in nature. Professionals within the team will be called upon to support the process as required. Those with complex needs will be directed on to the Complex Service for assessment and support planning.

The Re-ablement Service has three parts:

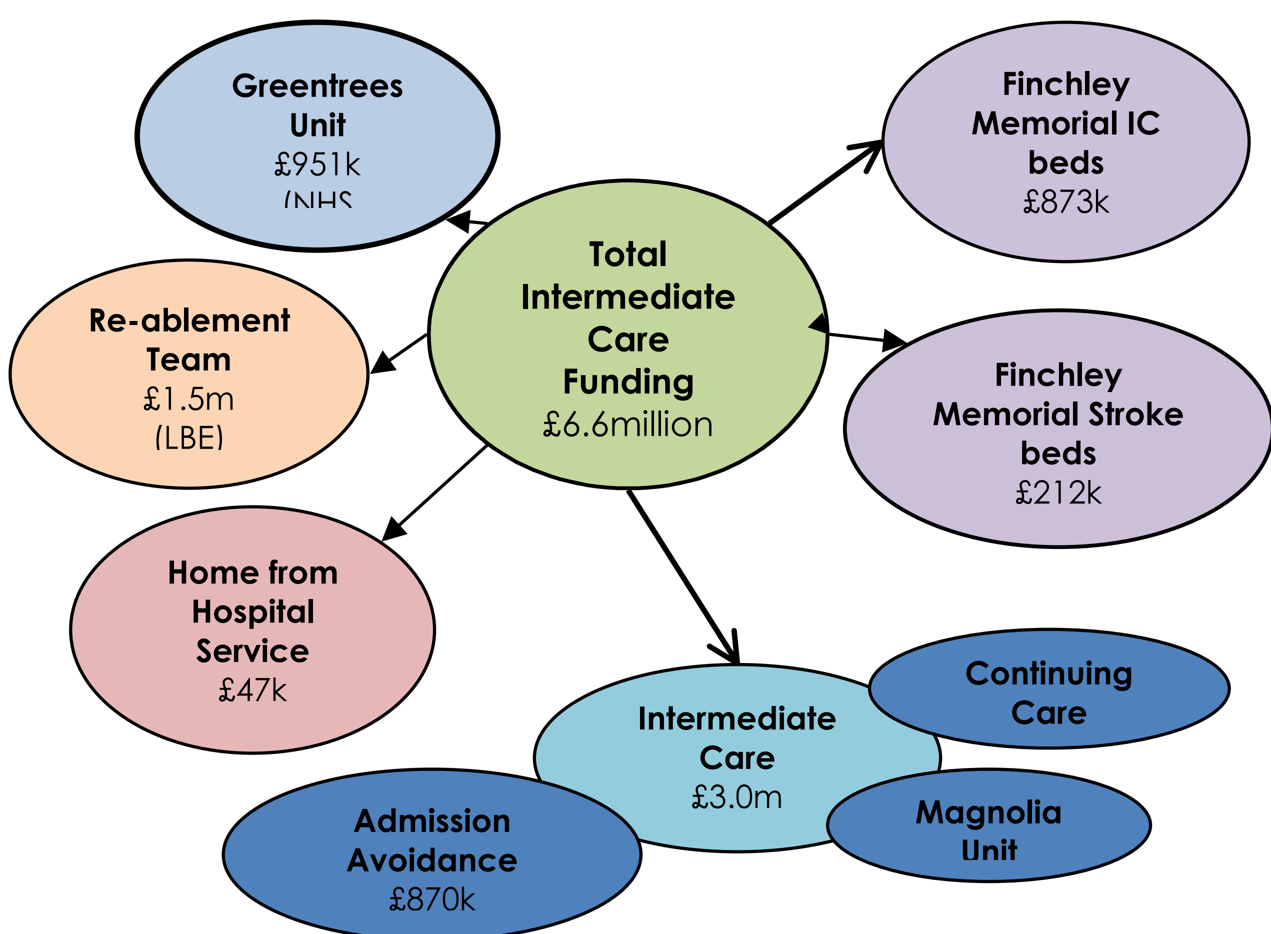
- Hospital Social Work team will complete 4-6 week reviews where placements are made directly.
- Re-ablement team, which will include re-ablement care workers, occupational therapy assistants, homecare officers / managers, social workers, occupational therapists and physiotherapists.
- Health Intermediate Care, which is a Health service to support hospital avoidance (Magnolia Unit). Social Care professionals within the Re-ablement Service will

support the unit particularly in relation to those being discharged and returning back into the community.

Finance and Funding

The figure below shows the current elements of the Intermediate Care and re-ablement service in Enfield and also the annual spend by the Enfield Council and NHS Enfield on these services.

Figure 2: Intermediate Care Financial Model



Please note the organisations detailed above are the providers of each service. The commissioners of each service are detailed in Table 1 below along with details of the specific funding arrangements.

Table 1: Providers of Intermediate Care

Intermediate Care Service	Provider	Commissioner	Annual Budget
Magnolia Unit-Residential Rehabilitation	NHS Enfield	NHS Enfield	£2.186 million (Continuing Care component is £0.729m)
Hospital Avoidance Service	NHS Enfield	NHS Enfield	£870,183
Greentrees Unit Step-down beds.	NHS Haringey	NHS Enfield	£951,241 (agreed estimated cost for 2010-11. Includes provision of Stroke

			Rehabilitation)
Finchley Memorial Hospital Step-down beds.	NHS Barnet	NHS Enfield	£873,000 (spot purchased)
Finchley Memorial Stroke Rehabilitation beds.	NHS Barnet	NHS Enfield	£212,354 (cost per case provision)
Total NHS Enfield:			**£5,092,778**
Re-ablement Service	LBE	LBE	£1.5 million
Home from Hospital Service	Age Concern	LBE	£46,920
Total LBE:			**£1,546,920**
TOTAL:			**£6,639,698**

Bed based provision analysis

It can be demonstrated, based on the recent one day audit of Patients / Service Users receiving Intermediate Care in Enfield, which the auditors were informed was a typical representation of usage, that there is spare capacity within the current service to address future need and considerable potential for redesign to increase the throughput and to achieve maximum re-configuration.

Table 2: Bed based provision analysis

Service Provider	Type of Provision	Type of Contract	Capacity	Available Bed Days (annual)	Occupied Bed Days (annual)	Average Length of Stay (days)	Cost per Day	Occupancy (people)
NHS Enfield Magnolia Unit	Admission avoidance beds	Cost and volume	20 beds (18 Intermediate Care + 2 CHC)	5,992	3,688	12.89	£295	168
NHS Barnet Finchley Memorial Hospital	Step down beds	Cost per case	56 beds (not all available to Enfield patients)	3,645 – General Orth 820 – Stroke	3,645 – General Orth 820 – Stroke	35	£239.36	86
NHS Haringey Greentrees Unit	Step down beds	Cost and volume	32 beds (12 stroke)	2,653 – Gen & stroke	2,653 – Gen & stroke	35.35	£369.23	72 (estimated)
TOTAL				**12,290 (excl. Stroke)**	**9,986**			326

Current capacity and usage
The current and future demand and capacity for the beds has been calculated as shown below.

- Demand per year for Intermediate Care beds by Enfield residents (including stroke) for 2009 / 2010 = 326 patients
- Available bed days to Enfield in 2009 / 2010 (from all providers) = 12,290
- Occupied bed days for Enfield patients in 2009 / 2010 (at all sites) = 9,986
- Unoccupied bed days in 2009 / 2010 = 2,304
- In 2010 – 2011 Magnolia Unit is able to provide (based on 20 beds) = 7,280
- Capacity available based on 2009 2010 usage = 7,280 – 3,688 (bed days used) = 3,592 days spare capacity

Therefore, even if the beds were no longer commissioned at Finchley Memorial Hospital and at Greentrees Unit there would be capacity in the system. Previously there has been no single point of access to Intermediate Care in Enfield and it relied on referrers to signpost to the most appropriate type of Intermediate Care provision for their patient. Hence it can be argued that there are patients in the system referred to the bed based facility, when a home based package of care might have been more appropriate.

Similarly, in the absence of step-down access for patients requiring a more complex assessment and rehabilitation programme of care, patients were automatically referred out of Borough.

Even at its maximum reported beds days used in 2009 -2010 capacity was only at 79% in Magnolia Unit and demonstrated spare capacity within the Hospital Avoidance Service. Using the rationale demonstrated in Figure 2 (page 14). Therefore there is at least 20% spare capacity based on the current configuration. Additional capacity can also be found where inappropriate usage is prevented.

Future capacity and usage
Magnolia Unit has the potential to increase the amount of beds available for Intermediate Care by 8 beds to a total of 28 beds. This would give additional capacity within Enfield of 2,920 bed days and making a total of **10,200** available bed days. The estimated cost for the provision of those extra days would be £531.440. (Forecast provided by NHS Enfield - Community Services).

By shifting the focus of Magnolia Unit to provide step down as well as step up Intermediate Care provision and by altering the contracts with NHS Haringey and NHS Barnet to a cost per case contract, it is possible to demonstrate enough capacity in the system and to make a gross cost reduction of approximately £1.5 million per annum.

The Market
It is considered that the Intermediate Care services currently provided are specialist in nature and as such are most appropriately commissioned from expert providers.

Current providers of step down residential care for NHS Enfield include Finchley Memorial Hospital, North Middlesex Hospital (Greentrees Unit), and St Michaels Care Centre site, (Magnolia Unit). Any of these providers, as well as other acute trusts, could potentially provide residential step down services for Enfield. In addition, we have a number of nursing care home providers from whom we could consider commissioning step down residential care with support provided from the Intermediate Care team.

The current development of an Over 65's Admission Avoidance Programme will have the effect of reducing Accident and Emergency and unplanned hospital admissions through the proactive identification, assessment and support of high risk patients over 65 years. This programme is being piloted initially in the Enfield Town area and will be delivered through Community Matrons, GP's and Social Workers who will be closely aligned to work collaboratively with identified individuals. If successful the programme will be mainstreamed throughout all areas of Enfield within three years. Intermediate Care will be a key partner in the delivery of short-term support for these individuals using clearly defined pathways.

Enfield is working closely with the London Ambulance Service (LAS) to strengthen the falls pathway and to ensure timely and appropriate access to Intermediate Care and other falls services over a 24 hour period. This takes effect from October 2010.

The hospital discharge/social care Re-ablement component of the Intermediate Care service is currently provided by the Enfield Council. This ensures good links with social care and health services and access to specialist expertise. It is conceivable however that this service could be commissioned from the voluntary or independent sector, however there may be a risk that links with the Hospital Avoidance Service would weaken and access to specialist expertise could become problematic.

Similarly, the Hospital Avoidance component of the Intermediate Care service is provided by NHS Enfield. However, there may be potential to consider looking to the voluntary or independent sector to provide this service.

Further to this, it is considered that in the short-term, we are not sufficiently confident that the voluntary or independent sector have the expertise and capacity to deliver a localised, integrated Intermediate Care service and that the risks inherent in going to the market to commission this service are too high at present. However, the market can be explored and capacity built over time. For example, this could involve capacity building within the third sector, the private sector or other health and social care providers.

The market for providers of home care is relatively competitive, with a large number of providers who are able to provide domiciliary support. Consequently, there is more choice for Service Users and commissioners, as well as increased cost effectiveness. Enfield Council has recently run a tender for the provision of home care services and has entered into contracts with four independent service providers. Service Users are now offered a choice of providers and are able to use individual budgets to purchase this support. There is potential that in the future, Re-ablement Services could be commissioned from external providers however in the short to medium term it is considered that the Council is best placed to provide the service.

6. GAP ANALYSIS AND DESIGN OF FUTURE PROVISION

The following table sets out our key strategic objectives for the development of Intermediate Care services and our associated commissioning intentions. This is the nub of the strategy and describes what we intend to do over the next three years to improve services.

The strategic objectives and associated commissioning intentions are aligned with the aims and objectives of the national guidance on Intermediate Care and are underpinned by a robust evidence base which includes the research, needs assessment and market analysis described in the preceding sections.

Strategic Objective	Rationale	Commissioning Intentions
1. PREVENT AVOIDABLE ADMISSIONS TO HOSPITAL AND SUPPORT TIMELY DISCHARGE	Individuals will receive their care in the right place, at the right time and will be able to optimise their potential for recovery and recuperation.	Identify a Single Point of Access (SPA) for Intermediate Care services across Enfield which is readily identifiable and accessible to all referrers and which is promoted widely.
	Reduce cost of acute hospital care and manage increasing projected demand.	Regular communication with all GP's on all aspects of the service ensuring familiarity with the referral process and availability.
	The current provision of admission avoidance and step down beds is fragmented, costly and inefficient.	Regular reporting from the service to highlight use and non-use by specific GP's and to tailor assertive marketing to those areas.
		Develop an integrated health and social care I.T system.
	Currently, 18 step up beds (+ 2 used for continuing care), are commissioned within the Magnolia Unit. There is potential to increase the provision to 28 beds. Figures collected during 2009/10 demonstrated that the Unit was not being utilised to its full potential.	Commission an increased provision (to 28 beds) at the Magnolia Unit, of the full range of step down and admission avoidance Intermediate Care beds within Enfield which will also be used to meet the needs of people with more complex needs including those with Mental Health

Strategic Objective	Rationale	Commissioning Intentions
	Currently, step down beds are commissioned out of borough which does not align with the principles of providing care closer to home for residents of Enfield. There is spare capacity and in addition the potential to utilise a further eight currently unused beds within the bed based Intermediate Care service currently provided by NHS Enfield within the Magnolia Unit. Currently the Rapid Response element of the Intermediate Care team in Enfield provides an immediate service to prevent avoidable admission to the two acute hospitals. There are	needs. Further invest in the medical support to complement the existing GP and Nurse Consultant to ensure that the patients receive appropriate and timely intervention. Decommission Cost and Volume contract out of borough Intermediate Care step-down beds currently purchased from NHS Haringey. Commission Cost per case contractual arrangements with NHS Barnet and NHS Haringey demand exceeds capacity within Enfield Intermediate Care bed provision. Monitor the ongoing requirement for spot purchasing in order to inform future commissioning requirements and consider the potential for spot purchasing from Independent Sector residential care providers with support provided by the Intermediate Care Team. Increase the capacity of Intermediate Care to provide in-reach to care homes. Develop clear care pathways; • from the two acute hospitals in Enfield and out of borough acute hospitals, • via the Ambulance Service, • From Primary Care, to access Intermediate Care thereby ensuring that individuals move through the system in a

Strategic Objective	Rationale	Commissioning Intentions
	good links with the “front of House” at the A&E department at the North Middlesex Hospital where there is a dedicated assessment facility to identify people who could be returned to primary care. The facility at Chase Farm Hospital is less defined and the pathways to divert people to Intermediate Care are patchier. Very limited use is made of Intermediate Care by the Out of Hours Service during the evenings and weekends, even though Intermediate Care is available. Therefore, increasing the potential for individuals to be admitted to Acute care during these periods. Despite the marketing of the service to GPs and the Out of Hours Service, there still exists, a perception that Intermediate Care in Enfield is a week day only service. There is potential to extend the access to Intermediate Care to prevent avoidable admission by further strengthening the links with Acute care at both the North Middlesex and Chase Farm Hospitals and by the assertive and ongoing marketing with GP’s and the Out of Hours service. Community Nurses have a valuable role in raising the awareness within general practice.	timely and appropriate way. Develop the capacity of the current rapid response component of the Intermediate Care Hospital Avoidance team to provide urgent community based assessment and immediate intervention in people’s homes (or care home, if this is where they live), to reduce inappropriate admissions to hospital. Develop the ability of the Intermediate Care service to deliver intravenous therapy at home in line with the developing expectations of a rapid response service which has the necessary skills that enable people to be treated in their own homes rather than to be admitted to hospital.

Strategic Objective	Rationale	Commissioning Intentions
2. DECREASE THE NUMBER OF PEOPLE UNNECESSARILY ADMITTED TO LONG TERM CARE FOLLOWING A HOSPITAL STAY	There is currently a high level of admissions to long term residential and nursing care directly from hospital. In 2009/10 almost 2/3 of new admissions to long term care came directly from hospital. There is currently no facility for people to have the assessment and decision making regarding their longer term care needs carried out within an Intermediate Care facility. Reduce cost of long term residential and nursing care and manage increasing projected demand for these services. Halfway Home, the Department of Health guidance on Intermediate Care (2009) states that people should not be transferred directly to long-term residential care from an acute hospital ward unless there are exceptional circumstances. For example, those judged to have had sufficient previous attempts at being supported at home (with or without Intermediate Care support). Individuals will have their assessment and decision making of their longer term care needs only after they have had the opportunity to optimise their independence in an Intermediate Care environment.	We will ensure that no one is transferred directly from an acute ward to long term residential care (unless in exceptional circumstances) without being offered a period of Intermediate Care and Re-ablement. We will provide Intermediate Care services to an individual which ensure the patient experience is of the highest quality. Establish targets and a trajectory for the reduction of numbers of patients who are admitted directly to long-term care from and Acute setting. We will ensure that assessment, review and decision making takes place in an Intermediate Care environment, rather than in an acute setting, following the opportunity for rehabilitation, recuperation and recovery. The effect of this intention will be to reduce the current number of individuals who are admitted to long term bed based care, directly from hospital. It will also have the potential to reduce the ongoing financial requirement of statutory organisations.

Strategic Objective	Rationale	Commissioning Intentions
	Unified Assessment will be key to the delivery of Intermediate Care in Enfield, taking into account, medical, nursing, therapy, mental health and social care needs and respecting the identified priorities for the individual. The national guidance encourages Intermediate Care to accommodate for the needs of people with more complex needs whose rehabilitation to reach an optimum level may require an extended time limited episode of care.	We will ensure there is a unified assessment process, trusted by all with appropriate information shared between partners. We will adjust the time limited criteria currently in place across Intermediate Care, to ensure that individuals with more complex needs have equity of access for assessment and rehabilitation, prior to decisions being made about their longer term needs. We will determine a clear Re-ablement pathway that links reablement with the self-directed support processes.
3. IMPROVE QUALITY AND MAXIMISE INDEPENDENT LIVING	Whole systems approach to the R-eablement, recuperation, rehabilitation journey for the individual to their maximum benefit. Increase patient satisfaction and maximise people's potential to live as independently as possible in their chosen community. Ensure a proactive care management component to support patients who use the Magnolia Unit.	Integrate Re-ablement into the customer journey by reconfiguring the provision of in-house home care and ensuring an integrated continuum of service provision. Develop a person centred 'menu based' approach to service provision. Ensure a dedicated care management service to the Intermediate Care step down and admission avoidance beds to ensure that people are able to move through the whole system in an appropriate and timely manner. Integrate the health and social care Intermediate Care teams to ensure that the full needs of the client can be met by the service.

Strategic Objective	Rationale	Commissioning Intentions
	Telecare has considerable potential to assist in the assessment of risk for identified individuals and manage the risks associated with independent living. It is estimated nationally, that 80% of GP consultations relate to a long-term condition, and that 60% of hospital bed usage is by people with a long-term condition Telehealth has the potential to support independent living, promote patient self-management and reduce the need for repeat hospital admissions.	Invest in Assistive Technology to support people to remain in their own homes and ensure that Telecare and Telehealth become an integral component of the rehabilitative and re-ablement processes. Ensure that the management of the Chronic Obstructive Pulmonary Disease (COPD) patients currently monitored within Intermediate Care are proactively reassessed and managed within Primary Care. Use Telehealth within the COPD service, rather than as an add-on service to Intermediate Care to assist in the support towards self-management. There would be an initial outlay of equipment costs associated with the development of this additional component and staff will require training. We will address the absence of a Community Therapy service, ensuring that this links with the service redesign programme currently underway in Enfield. Continue to commission low level Re-ablement Services from the 3rd sector.

Strategic Objective	Rationale	Commissioning Intentions
4. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE	Enable the Intermediate Care service to support people with more complex needs. For example, evidence suggests that providing intensive specialist support to people with mental health problems can reduce hospital admissions, reduce admissions to care homes and reduce home care hours. Intensive community support, providing specialist support over 6-12 weeks to older people with mental health problems who were considered to be at risk of admission to hospital or institutional care was cited as an example of good practice in Bradford in the updated Intermediate Care guidance[17]. The evaluation indicated that 26% of the service users were prevented from being admitted to a care home, 13% had a hospital admission prevented or delayed and the home care hours needed were reduced by 26%. The net savings were estimated at more than £0.5m per year.	Ensure there is ready access to the specialist skills required to enable Intermediate Care to support the needs of people with long-term conditions including those individuals with dementia and mental health needs. All Intermediate Care staff will receive core training in dementia, and appropriate access to professional support.
5. DELIVER MORE COST EFFECTIVE	Within the current and future financial and	Ensure cost effective service delivery and

[17] Intermediate Care – Halfway Home, Update Guidance for the NHS and Local Authorities (DH, 2009)

Strategic Objective	Rationale	Commissioning Intentions
SERVICES IN ORDER TO MEET CURRENT AND FUTURE DEMAND WITHIN EXISTING RESOURCES	political climate, both health and social care economies are tasked to provide best value services for the local population, within agreed budgetary constraints.	monitor outcomes of Intermediate Care and reablement service to ensure that it meets the desired outcomes of: the individual and their carers. Ensure there is a robust financial monitoring framework which links service delivery to ensure that the service is delivered within the defined budget. Commission a longitudinal study to track the impact of the redesign of Intermediate Care services on; • admissions to long term care • hospital readmissions • home based packages of care • self care • user and carer satisfaction • Cost.
6. ROBUST PERFORMANCE MANAGEMENT AND GOVERNANCE	To monitor and evaluate quality, provide accurate reporting data and to inform future commissioning intentions.	Develop and implement a robust performance management framework to ensure that future Intermediate Care provision in Enfield meets the requirements as directed by the Intermediate Care strategy. To ensure that Intermediate Care in Enfield has a detailed governance framework. This ensures that the governance arrangements are adhered to and are transparent.

7. MONITORING ARRANGEMENTS

The implementation and monitoring of the strategy will be overseen by the Older People's Partnership Board (a Thematic Action Group of the Enfield Strategic Partnership[18]).

A detailed three year implementation plan with associated targets for a reduction in avoidable admissions to hospital and long term care will be developed in partnership with NHS Enfield; the Enfield Council; and key local stakeholders. The plan and targets will be agreed by the Older People's Partnership Board who will monitor implementation to ensure that the strategy is shaping services in the way intended. A lead commissioner from NHS Enfield and the Enfield Council will be identified and they will be tasked with delivering the implementation and reporting progress and issues to the Older People's Partnership Board.

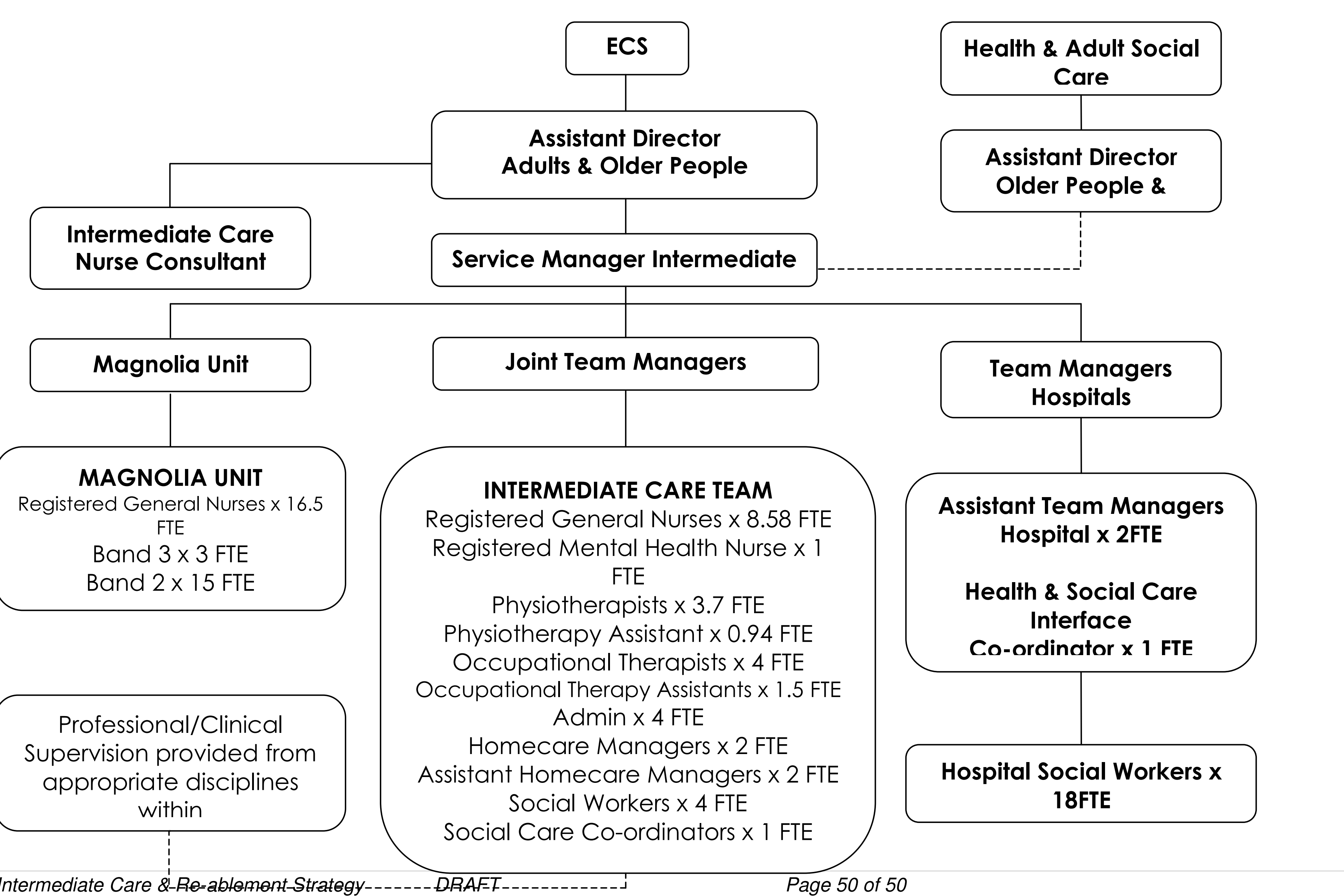
Successful implementation of the strategy will require a strong partnership approach across all commissioning partners, including the Council, PCT, Emerging GP Consortium and North Central London Sector.

[18] The Enfield Strategic Partnership is a mature partnership and brings together organisations, businesses and the third sector.

Appendix 1: Magnolia Unit Occupancy – 2009-10

Magnolia Unit Occupancy - 2009-2010	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Available Beds	16	16	16	16	16	20	20	20	20 (17+3)	20 + (8)	20 (17+3)	20 (18+2)
New episodes (NE) Vev numbers	10	13	10	11	16	10	11	11	21	21	15	19
Actual activity (AA) count on data base (OBDs2009-2010 2)	11	17	18	21	18	23	18	26	33	34	26	32
Available Bed Days (ABD)	(16x30) 480	(16x31) 496	(16x30) 480	(16x31) 496	(16x31) 496	(16x30) 480	(16x31) 496	(16x30) 480	(17x31) 527	(17x31) 527 (8x19)=152 =713	(17x28) 476	(18x31) 558
Occupied Bed Days (OBDs 2009-2010 3)	111	196	210	234	239	339	302	296	414	561	355	431
OBD/AA =LOS	10.09	11.52	11.6	11.1	13.2	14.7	15.1	11.4	12.5	16.5	14	13
% Occupancy OBDx100/ABD	23%	41%	43.8%	47.1%	48.1%	71%	61%	62%	79%	79%	75%	77.2%

Appendix 2: Current Intermediate Care Service Structure Chart



Enfield Joint Intermediate Care and Re-ablement Strategy 2011-2014:

A Summary of Submissions Received in Response to the Consultation

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INTRODUCTION

This document provides a summary of submissions received following public consultation on the draft Intermediate Care and Re-ablement Strategy. It also sets out the Council and Enfield NHS response to the comments and suggestions that were received.

In addition to the public consultation on the strategy, Commissioners from Health and Adult Social Care have worked with the local Intermediate Care and Re- ablement Service during the development of the strategy to analyse the current picture of service provision and gain their views on how services could be developed to better meet identified needs. We have also been guided by the priorities set out in Enfield's Joint Strategic Needs Assessment which was widely consulted on.

CONSULTATION PROCESS

Formal public consultation on the draft strategy was undertaken over a 3 month period from 1 November 2010 to 28 January 2011.

Stakeholder and public views on the strategy were sought through the following means:

- An e-questionnaire on the Enfield Council website
- Invitation to submit written responses
- Health and Social Care Partnership Boards
- Health and Social Care Scrutiny Panels

The consultation was publicised through the following means:

- 192 posters distributed to GP surgeries, libraries, health and social care providers and voluntary sector services.
- An advertisement in the Enfield Independent.
- A notice in EVAeNews (the electronic newsletter of the Enfield Voluntary Association).
- An email to staff in NHS Enfield, Health and Adult Social Care staff, acute trusts, voluntary and community sector providers, and independent and private providers.
- A notice in Enfield Staff Matters.

RESPONSES

Reponses were received from the following groups:

- The Mental Health Trust
- Enfield Disability Action (EDA)
- Enfield Local Involvement Network (LINk)

- The Physical Disability Partnership Board

In addition, six questionnaires were submitted. Of the questionnaires received, there was no response to questions two and four.

Questionnaire responses:

To what extent do you agree or disagree with the strategic objectives that have been identified?

Answer	No. of respondents
Strongly Agree	1
Agree	4
Neither agree nor disagree	1
Disagree	0
Strongly disagree	0

To what extent do you agree or disagree with the commissioning intentions (actions) that have been identified?

Answer	No. of respondents
Strongly Agree	1
Agree	3
Neither agree nor disagree	2
Disagree	0
Strongly disagree	0

Some responses related to the changes already in place in terms of reconfigured care pathways but are nonetheless worthy of note.

- Timely bursts of re-ablement are seen as beneficial and will be promoted for disabled people for self referral
- De-commissioning of services will be aligned with the development of local capacity to develop specialist treatment, for example for stroke patients, This is intended to reduce delay in people receiving treatment
- Listening to service users and their carers is central to the implementation of the strategy and we will learn from, for example, the Expert Patients Programme which has promoted a self management approach

The key points emerging from the consultation responses are listed below.

Strategic Objectives

These were generally welcomed, however:

- Whilst the high priority given to services that promote independence is welcomed, assurance is needed that there is capacity locally to develop specialist treatment within required time frames
- Its important that the emphasis should not solely be on making the best use of resources but it should be on enabling people to continue to do what matters to them in the settings they prefer, thus improving lives
- Suggestions have been made that more emphasis be placed on “the need for hospital staff to access education and training in understanding, attitudes and skills to support them to work effectively with services outside the hospital setting”. The same would also apply to GPs. The Strategy should identify that collaboration between hospital and community health and social care services is a major area for development.
- Objective 6 – should include gathering, analysing and learning from user and carer feedback.

Step down and admission avoidance

- Clear protocols would need to be in place for accessing the service (use of step down and admission avoidance intermediate care beds). The Mental HealthTrust would wish to be involved in the development of this proposal.

IV Therapy at home

- Previous research by the Trust has shown that IV Therapy at home would only be appropriate for a small number of people. It is suggested that this is considered further
- There is concern that there will not be enough capacity in the community to end the practice of patients being transferred directly from an acute ward to long term residential care without intermediate care and re-ablement.

Information and Advice, Advocacy and Brokerage

- It is seen as important that service users are given choice and independent service provision regarding information and advice, advocacy and brokerage.

Resources & Funding

- The Strategy should be linked to other community Health and Wellbeing initiatives, as many existing opportunities (e.g. gym classes, sports facilities) are not affordable or accessible – consideration needs to be given to subsidising opportunities for exercise

- Concerns were raised about what will happen to the funding when NHS funding devolves to an Enfield GP Consortium. Concern also about how much of the funding will remain in Enfield?
- Concern about resourcing is increased in light of planned budget reductions in Enfield NHS and within the Council's service.

Staff training & development

- Comprehensive Disability Awareness Training for staff is worthy of consideration. Staff need to understand physical and sensory impairment, learning disabilities, brain injury and other neurological conditions
- The strategy would benefit from a more specific emphasis on the need for hospital staff "to access education and training understanding, attitudes and skills to support them to work effectively with services outside the hospital setting"
- Education and learning for those planning and providing services is considered to be of key importance and as such should be mentioned in the Strategy. In addition, patient and carer involvement is essential in planning and designing services

Eligibility

- It is questionable whether the potential to make a full recovery is a fair indicator of eligibility. Many people would benefit from a short period of enablement, therefore should they be excluded? For those with ongoing support needs, it is suggested that re-ablement should be built into their care plan
- Exclusion of existing clients from the service is thought to be problematic. Existing recipients of social care were anxious that a review when 'well' could result in insufficient support when 'unwell'. A number of people would like to engage in re-ablement services and would welcome a reduction in social care services, therefore the decision to limit the service to existing clients is thought to be unjustified. These concerns need to be addressed
- EDA suggest the inclusion of the following criteria from Intermediate Care:
  "Patients and main carers must agree to admission to the service, and the patient must have the potential to improve from their current condition.
  Key factors for support include home circumstances which are suitable and have adequate facilities to maintain the patient at home in a safe environment and that there are no known risk factors for staff to provide care in the patient's own home".

The Market

- There are secondary needs that might still be best met by the independent providers, which could include advocacy and supporting service user feedback and enablement.

General Points

- Re-ablement should not be treated as an opportunity to cut services
- Its important that the Strategy recognises the diversity of the needs and wishes of Enfield residents and avoids a "one size fits all" approach
- Its important that strategy implementation is monitored so that the information can be collected and monitored effectively
- Need to ensure a co-ordinated approach that links in with other strategies and involvement initiatives in Enfield and in other boroughs. One suggestion is that a recommendation of the Independent Reconfiguration Panel report (2008) on the Barnet, Enfield and Haringey Clinical Strategy be considered:
  "The panel supports the proposal to develop the provision of intermediate care beds on the Chase Farm Hospital site and wish to see this as part of an integrated strategy for rehabilitation"
- As people in need of intermediate care or re-ablement often have multiple impairments, special effort should be made to adapt systems to suit varied communication needs to ensure the document is accessible e.g. distributing an audio version in Enfield's talking newspaper
- The strategy is lacking reference to the needs of people who require a longer period of re-ablement e.g. 12-18 months
- It is recommended that an Equality Impact Assessment be undertaken
- Clarity regarding the scope is required – where does specialist rehabilitation (e.g. for spinal injury) fit in? How does this link to intermediate care and the re-ablement service?
- Should the Strategy consider longer term independent living skills?
- Reference to the 'complex re-ablement' part of the customer pathway would add value
- The language used could be re-phrased in parts, as terminology has been "medicalised" for example the use of the word 'patient' in a reablement context
- The Strategy has little mention of carers and their role in hospital admission & being able to cope when their cared for is released from hospital.

RESPONSE FROM THE COUNCIL AND NHS

These thoughtful responses to the process of consultation are to be welcomed. Many of the responses relate to matters of detail which will be taken up within the plan to implement this strategy as it now begins to be drafted. A number of comments relate to the increasing focus on personalised services and it will be in this context that choice and control, access to and the availability of a range of services which seek to meet the expressed needs of service users and patients, will meet the diversity of individual need.

It is worth noting that the strategy remains the single and most robust evidence of a jointly agreed position with the Council's health partners. As the scale of change within the administration and management of Enfield NHS becomes clear and as a GP Consortium begins to emerge in Enfield, the significance of a jointly agreed strategy for the PCT and its successors becomes ever more important.

In addition, where demand for health and social care services is increasing and resources to meet that need come under increasing pressure, then a jointly agreed strategy becomes the instrument for planning services which in turn provide a coherent thread to the allocation of resources as the financial expression of those service plans. This applies as much to the allocation of resources currently invested in services as to where new investment may be made available in future.

At the same time, it has been appropriate to anticipate the outcomes from implementation of this strategy, to make changes to service provision in the interests of improved outcomes for service users or where early opportunity may be taken to use resources more effectively. As an example, action has been taken to build local capacity to seek to end the practice of patients being transferred directly from hospital to long term care. An additional 8 beds are now available at the Magnolia Unit as an interim measure and commissioners are considering spot purchasing intermediate care from nursing homes if additional capacity is still required.

In the final version of the strategy, changes will be made to incorporate the following comments and suggestions:

- Clear links will be made to the development of the new customer pathway, to the work to develop a range of services providing information and advice and to plans to provide choice for service users in brokerage services available both within the Councils service and to be further developed within the voluntary and community and independent sectors.
- Reference will be made to the developing relationship with the GP Consortium in Enfield, particularly to their role in terms of preventing avoidable admissions
- Note has been taken of comment made about specialist rehabilitation services being available to meet the needs of people with longer term

needs for re-ablement specifically in the context of spinal injuries. Whilst outside the scope of this strategy account will be taken of these comments where appropriate.
- Where comments made relate to the needs of carers reference will be made to the Joint Carers Strategy which is currently being drafted.

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ANNEX 3
COMMISSIONING INTENTIONS AND INDICATIVE RESOURCE ALLOCATION

The following table sets out the draft implementation plan and indicative estimated resource implications for the 3 year strategy. Following approval of the strategy, more detailed work on the plan will be carried out in partnership with stakeholders and definitive yearly resource allocations will be agreed through the usual financial approvals process and as part of the Councils annual budget setting process.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
1. PREVENT AVOIDABLE ADMISSIONS TO HOSPITAL AND SUPPORT TIMELY DISCHARGE	Identify a Single Point of Access for Intermediate Care services across Enfield which is readily identifiable and accessible to all referrers and which is promoted widely.	£0	£0	£0	Within existing operational budgets.
	Regular communication with all GP's on all aspects of the service ensuring familiarity with the referral process and availability.	£0	£0	£0	Team manager's responsibility in partnership with GP Consortium.
	Regular reporting from the service to highlight use and non-use by specific GP's and to tailor assertive marketing to those areas.	£0	£0	£0	Team manager's responsibility in partnership with GP Consortium.
	Develop an integrated health and social care I.T system.	£0	£0	£0	Costs met through implementation of corporate IT strategy.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Commission an additional 8 beds at the Magnolia Unit, of the full range of step down and admission avoidance Intermediate Care beds within Enfield which will also be used to meet the needs of people with more complex needs including those with Mental Health needs.	£443k	£531k	£531k	Funded through decommissioning of out of borough NHS beds and in borough hospital based provision. Planned implementation from 1 June 2011.
	Further invest in the medical support to complement the existing GP and Nurse Consultant to ensure that the patients receive appropriate and timely intervention.	£0	£0	£0	To be developed as part of the planned service redesign of Magnolia unit and in partnership with the GP consortium.
	Decommission Cost and Volume contract out of borough Intermediate Care step-down beds currently purchased from NHS Barnet and NHS Haringey.	-£1,113,750	- £1,485,000	- £1,485,000	Gross NHS full year saving of £1.485 million.
	Commission Cost per case contractual arrangements with NHS Barnet and NHS Haringey demand exceeds capacity within Enfield Intermediate Care bed provision.	£0	£0	£0	Potential cost of this contingency plan will be met through identified savings.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Monitor the ongoing requirement for spot purchasing in order to inform future commissioning requirements and consider the potential for spot purchasing from Independent Sector residential care providers with support provided by the Intermediate Care Team.	£0	£0	£0	Cost neutral as routine commissioning activity.
	Increase the capacity of Intermediate Care to provide in-reach to care homes.	£0	£0	£0	Cost neutral. Increased capacity through integration of intermediate care and re- ablement teams and refocusing of current resources.
	Develop clear care pathways; • from the two acute hospitals in Enfield and out of borough acute hospitals, • via the Ambulance Service, • from Primary Care, to access Intermediate Care thereby ensuring that individuals move through the system in a timely and appropriate way.	£0	£0	£0	Cost neutral.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Develop the capacity of the current rapid response component of the Intermediate Care Hospital Avoidance team to provide urgent community based assessment and immediate intervention in people's homes (or care home, if this is where they live), to reduce inappropriate admissions to hospital.	£50k	£50k	£50k	Funded from re-ablement crisis response provision.
	Develop the ability of the Intermediate Care service to deliver intravenous therapy at home in line with the developing expectations of a rapid response service which has the necessary skills that enable people to be treated in their own homes rather than to be admitted to hospital.	£0	£0	£0	No additional cost. Implementation through development of rapid response team as detailed above.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
2. DECREASE THE NUMBER OF PEOPLE UNNECESSARILY ADMITTED TO LONG TERM CARE FOLLOWING A HOSPITAL STAY	We will ensure that no one is transferred directly from an acute ward to long term residential care (unless in exceptional circumstances) without being offered a period of Intermediate Care and Re-ablement. We will ensure that assessment, review and decision making takes place in an Intermediate Care environment, rather than in an acute setting, following the opportunity for rehabilitation, recuperation and recovery. The effect of this intention will be to reduce the current number of individuals who are admitted to long term bed based care, directly from hospital. It will also have the potential to reduce the ongoing financial requirement of statutory organisations.	£400k	£400k	To be determined	Health re-ablement funding
	We will provide Intermediate Care services to an individual which ensure the patient experience is of the highest quality.	£0	£0	£0	Within existing budget and refocusing of services.
	Establish targets and a trajectory for the reduction of numbers of patients who are admitted directly to long-term care from and Acute setting.	£0	£0	£0	Routine monitoring to be built into redesigned service,

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	We will ensure there is a unified assessment process, trusted by all with appropriate information shared between partners.	£0	£0	£0	Within existing budget and refocusing of services.
	We will adjust the time limited criteria currently in place across Intermediate Care, to ensure that individuals with more complex needs have equity of access for assessment and rehabilitation, prior to decisions being made about their longer term needs.	£0	£0	£0	Within existing budget and refocusing of services.
	We will determine a clear Re-ablement pathway that links reablement with the self-directed support processes.	£0	£0	£0	Within existing budget and refocusing of services.
3. IMPROVE QUALITY AND MAXIMISE INDEPENDENT LIVING	Integrate Re-ablement into the customer journey by reconfiguring the provision of in- house home care and ensuring an integrated continuum of service provision.	£0	£0	£0	Within existing budget and refocusing of services.
	Develop a person centred 'menu based' approach to service provision.	£0	£0	£0	Within existing budget and refocusing of services.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	Ensure a dedicated care management service to the Intermediate Care step down and admission avoidance beds to ensure that people are able to move through the whole system in an appropriate and timely manner.	£0	£0	£0	Within existing budget and refocusing of services.
	Integrate the health and social care Intermediate Care teams to ensure that the full needs of the client can be met by the service.	£0	£0	£0	Within existing budget and refocusing of services.
	Invest in Assistive Technology to support people to remain in their own homes and ensure that Telecare and Telehealth become an integral component of the rehabilitative and re-ablement processes.	£75k	£75k	£75k	Funded from decommissioning of out of borough beds as described above.
	Ensure that the management of the Chronic Obstructive Pulmonary Disease (COPD) patients currently monitored within Intermediate Care are proactively reassessed and managed within Primary Care. Use Telehealth within the COPD service, rather than as an add-on service to Intermediate Care to assist in the support towards self-management. There would be an initial outlay of equipment costs associated with the development of this additional component and staff will require training.	£0	£0	£0	Within existing budget and refocusing of services. Telehealth costs to be met from decommissioning of out of borough beds as described above.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
	We will address the absence of a Community Therapy service, ensuring that this links with the service redesign programme currently underway in Enfield.	£0	£0	£0	Delivered through health led service redesign.
	Continue to commission low level Re-ablement Services from the 3rd sector.	£0	£0	£0	Within existing budget allocations.
4. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE	Ensure there is ready access to the specialist skills required to enable Intermediate Care to support the needs of people with long-term conditions including those individuals with dementia and mental health needs.	£0	£0	£0	Within existing resources of community mental health teams.
	All Intermediate Care staff will receive core training in dementia, and appropriate access to professional support.	£0	£0	£0	Agreement required with Mental Health trust for them to deliver training and support.
5. DELIVER MORE COST EFFECTIVE SERVICES IN ORDER TO MEET	Ensure cost effective service delivery and monitor outcomes of Intermediate Care and reablement service to ensure that it meets the desired outcomes of: the individual and their carers.	£0	£0	£0	Requires joint monitoring framework to be established by commissioners in line with newly specified service description.

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
CURRENT AND FUTURE DEMAND WITHIN EXISTING RESOURCES	Ensure there is a robust financial monitoring framework which links service delivery to ensure that the service is delivered within the defined budget.	£0	£0	£0	Requires joint monitoring framework to be established by commissioners in line with newly specified service description.
	Commission a longitudinal study to track the impact of the redesign of Intermediate Care services on: • admissions to long term care • hospital readmissions • home based packages of care • self care • user and carer satisfaction • cost.	£0	£0	£0	No cost. Requires commissioning leadership.
ROBUST PERFORMANCE MANAGEMENT AND GOVERNANCE	Develop and implement a robust performance management framework to ensure that future Intermediate Care provision in Enfield meets the requirements as directed by the Intermediate Care strategy.	£0	£0	£0	Core commissioning business.
	To ensure that Intermediate Care in Enfield has a detailed governance framework. This ensures that the governance arrangements are adhered to and are transparent.	£0	£0	£0	Core commissioning business.
PROJECT	In order to ensure delivery of targeted savings of	£30k	£30k	£0	Funded from

STRATEGIC OBJECTIVE	COMMISSIONING INTENTIONS	RESOURCE IMPLICATIONS			COMMENTS
		Y1	Y2	Y3	
MANAGEMENT	£1 million and to improve access to services, this challenging agenda will require investment in additional project management support over the 3 year period.				decommissioning of out of borough beds as described above.
TOTAL:		**- £115,750**	**- £399,000**	**- £829,000**	Total savings realised from year 1.

Predictive: assessing proposed changes to services and policies

Enfield Council

Predictive Equality Impact Assessment

JOINT INTERMEDIATE CARE & RE-ABLEMENT STRATEGY

Proposed change to service / policy	**Joint Intermediate Care & Re-ablement Strategy**
Officer completing the assessment	**Michael Sprosson / Kate Charles**
Extension Number	**3961**
Team	**Commissioning & Procurement**
Department	**Housing, Health & Adult Social Care**
Date impact assessment completed	**22/2/2011**

Section 1 – About the service, policy and proposed change

Q1. Please provide a brief description of the service and / or related policy / policies	
The strategy has been developed jointly by NHS Enfield and Enfield Council. It is a joint health and social care strategy which specifies how Enfield intends to commission Intermediate Care and Re-ablement services over the next 3 years (2011-2014) in order to improve the quality, effectiveness and efficiency of current service provision. Commissioners from Health and Adult Social Care have worked with the local Intermediate Care and re-ablement service to analyse the current picture of service provision and develop strategic objectives and evidence based commissioning intentions. We have been guided by local and national policy and guidance and by the priorities set out in Enfield's Joint Strategic Needs Assessment.	
Q2. Please provide a brief description of the proposed change(s) to the service and/or related policy / policies	
Strategic Objectives are set out within the strategy under six domains : • Prevent avoidable admissions to hospital & support timely discharge • Decrease the number of people unnecessarily admitted to long term care following a hospital stay • Improve quality & maximise independent living • Improve the skills & competencies of the workforce • Deliver more cost effective services in order to meet current & future demand within existing resources • Robust performance management & governance	
Q3. Does equalities monitoring of your service show that the beneficiaries in terms of the recipients of the service or policy, include people from the following groups?	
R	All members of the community will have access to the services set out in the strategy. Monitoring of the effect of the strategy to be carried out post implementation – see Q17.
D	All members of the community will have access to the services set out in the strategy. Monitoring of the effect of the strategy to be carried out post implementation – see Q17.
G	All members of the community will have access to the services set out in the strategy. Monitoring of the effect of the strategy to be carried out post implementation – see Q17.
A	All members of the community will have access to the services set out in the strategy. Monitoring of the effect of the strategy to be carried out post implementation – see Q17.
F	All members of the community will have access to the services set out in the strategy. Monitoring of the effect of the strategy to be carried out post implementation – see Q17.
S	All members of the community will have access to the services set out in the strategy. Monitoring of the effect of the strategy to be carried out post implementation – see Q17.

Q4. If you answered 'no' to any of the groups listed in Q3, please state why?

Not applicable

Q5. How will the proposed change eliminate discrimination, promote equality of opportunity, or promote good relations between groups in the community?

All members of the community will have access to the services set out in the strategy

Section 2 – Consultation and communication

<table>
<tr><th colspan="2">Q6. Please list any recent consultation activity with disadvantaged groups carried out in relation to this proposal</th></tr>
<tr><td>R</td><td rowspan="6">Stakeholder and public views on the strategy were sought through the following means:

• An e-questionnaire on the Enfield Council website
• Invitation to submit written responses
• Health and Social Care Partnership Boards
• Health and Social Care Scrutiny Panels

The consultation was publicised through the following means:
• 192 posters distributed to GP surgeries, libraries, health and social care providers and voluntary sector services.
• An advertisement in the Enfield Independent.
• A notice in EVAeNews (the electronic newsletter of the Enfield Voluntary Association).
• An email to staff in NHS Enfield, Health and Adult Social Care staff, acute trusts, voluntary and community sector providers, and independent and private providers.
• A notice in Enfield Staff Matters.

Reponses were received from the following groups:
• The Mental Health Trust
• Enfield Disability Action (EDA)
• Enfield Local Involvement Network (LINk)
• The Physical Disability Partnership Board</td></tr>
<tr><td>D</td></tr>
<tr><td>G</td></tr>
<tr><td>A</td></tr>
<tr><td>F</td></tr>
<tr><td>S</td></tr>
<tr><th colspan="2">Q7. Please state how you have publicised the results of these consultation exercises</th></tr>
<tr><td>R</td><td rowspan="6">Responses are in the process of being collated and summarised ready for presentation along with the final version of the strategy to the Cabinet Meeting in April 2011.

We plan to publish the results on the Council's website alongside the final strategy once approved by Cabinet & also notify people who attended events and provide hard copies if required.</td></tr>
<tr><td>D</td></tr>
<tr><td>G</td></tr>
<tr><td>A</td></tr>
<tr><td>F</td></tr>
<tr><td>S</td></tr>
</table>

Q8. How have you consulted, or otherwise engaged with, all relevant staff in this activity / process?
Staff & stakeholder workshops, team meetings, staff newsletter

Section 3 – Assessment of impact

Q9. Please describe any other relevant research undertaken to determine any possible impact of the proposed change
The strategy contains a section on the research carried out and sources of information from national guidance, analysis of current and future demand and needs assessment. The strategy was informed by research with regard to best practice , much of which contained within national guidance and strategy and as published by the National Institute of Clinical Excellence (NICE) .

Q10. Please list any other evidence you have that the proposed change may have an adverse impact on different disadvantaged groups	
R	None identified
D	None identified
G	None identified
A	None identified
F	None identified
S	None identified

Q11. Could the proposal discriminate, directly or indirectly, and if so, is it justifiable under legislation? Please refer to the guidance notes under the heading, *7. Useful Definitions*
Not envisaged, given equality of access to services to the whole community.

Q12. Could the proposal have an adverse impact on relations between different groups? If so, please describe
Not envisaged

Section 4 – Service delivery

Q13. How could this proposal affect access to your service by different groups in the community?	
R	Positive. The strategy is intended to enhance access to services by the whole community
D	Positive. The strategy is intended to enhance access to services by the whole community
G	Positive. The strategy is intended to enhance access to services by the whole community

A	Positive. The strategy is intended to enhance access to services by the whole community
F	Positive. The strategy is intended to enhance access to services by the whole community
S	Positive. The strategy is intended to enhance access to services by the whole community
Q14. How could this proposal affect access to information about your service by different groups in the community?	
R	The strategy sets out enhanced access to information and services
D	The strategy sets out enhanced access to information and services
G	The strategy sets out enhanced access to information and services
A	The strategy sets out enhanced access to information and services
F	The strategy sets out enhanced access to information and services
S	The strategy sets out enhanced access to information and services

Section 5 – Miscellaneous

Q15. Do you plan to publicise the results of this assessment? Please describe how you plan to do this
This assessment will be placed on the Council's website The assessment will be listed on the Council's Equality and Diversity Annual Report and the full assessment will be made available on request.
Q17. How and when will you monitor and review the effects of this proposal?
A detailed three year implementation plan with associated targets for a reduction in avoidable admissions to hospital and long term care will be developed in partnership with NHS Enfield; the Enfield Council; and key local stakeholders. The plan and targets will be agreed by the Older People's Partnership Board who will monitor implementation to ensure that the strategy is shaping services in the way intended. A lead commissioner from NHS Enfield and the Enfield Council will be identified and they will be tasked with delivering the implementation and reporting progress and issues to the Older People's Partnership Board. The new strategy will also be reviewed as part of the next retrospective equality impact assessment of Commissioning & Procurement that is due to be undertaken in 2011/12.

11. Action plan template for proposed changes to service or policy –

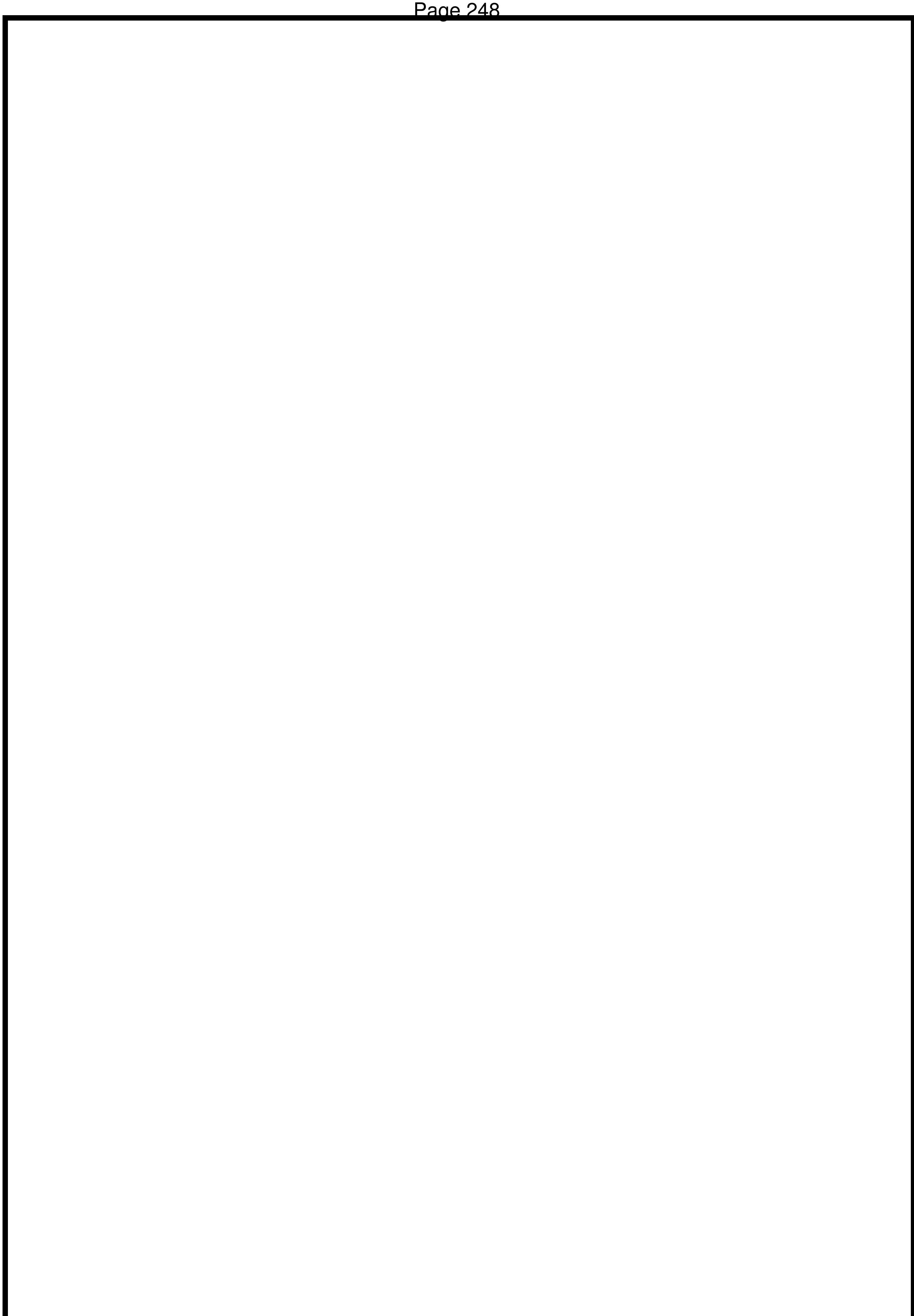
Proposed change to, or new, service or policy:…… **Joint Intermediate Care & Re-ablement Strategy**

Team: **Commissioning & Procurement** Department: **Health, Housing and Adult Social Care**

Service manager: Shaheen Mughal (Commissioning Manager)

Issue	Action required	Lead officer	Timescale	Costs	Comments
Publication of final strategy & consultation results	Publish on Council's website & provide hard copies / other accessible formats as required	Kate Charles	Post April 2011 Cabinet	To be determined	
Strategy Implementation	Development of implementation plan. See response to Q17.	Shaheen Mughal	3-year implementation plan 2011-14	To be determined	
Monitoring implementation of strategy	Continuous monitoring of implementation and its impact – to be developed. See response to Q17.	Shaheen Mughal	3-year implementation plan 2011-14	To be determined	

Please insert additional rows if needed



Agenda Item 9

MUNICIPAL YEAR 2010/2011 REPORT NO. 237

MEETING TITLE AND DATE:
Cabinet – 27 April 2011
REPORT OF:
The Interim Assistant Director of Property Finance and Corporate Resources

Contact officer and telephone number:
Brian Smart (ext 4101)

E mail:
brian.smart@enfield.gov.uk

Agenda: Part 1 **Item:** 9

Subject: Asset Management – Potential disposal of Council owned properties before 1 April 2013.

Wards: All

Cabinet Members consulted: Cllrs Doug Taylor, Achilleas Georgiou and Andrew Stafford

1. EXECUTIVE SUMMARY

1.1. The drive to increase funds includes an ongoing study of all freehold and leasehold property owned by the Council.

1.2. Properties that seem suitable for disposal before 1 April 2013 are listed at Appendix 1. Investigations regarding each property are underway and the list is subject to review.

1.3. This report seeks authority to delegate decisions as stated in Paragraph 2

1.4. An update to the report of December 15th 2010 is provided advising on progress of the disposal programme.

2. RECOMMENDATIONS

That Cabinet:

2.1. Authorises the disposal of properties property shown at Appendix 1 and delegates to the relevant Cabinet Member (in conjunction with the Cabinet Member for Finance, Facilities and Human Resources) and the relevant Director the final agreement of terms for individual disposals:

2.1.1. Providing the property is shown in Appendix 1

2.1.2. Or, in the unlikely event that alternative property is identified (not shown in Appendix 1) which is introduced to the programme necessitating an urgent transaction decision then the transaction and reasons for the urgent action is reported at the next Cabinet Meeting.

2.2. Notes that:

2.2.1. Investigations are taking place regarding the potential of each property shown at Appendix 1

2.2.2. As the results of investigations become more apparent, the list of properties will be reviewed and changed as appropriate

2.3. Future reports will list further properties to be added to the Disposal Programme.

3. BACKGROUND

3.1. The drive for increased funds includes a study of all freehold and leasehold properties owned by the Council.

3.2. Properties that seem suitable for disposal before 1 April 2013 have been grouped into the list shown as Appendix 1. Investigations continue and include:

3.2.1. Evaluating the need for the Council to own such property
3.2.2. Due diligence checks regarding covenants, planning issues, rent reviews etc
3.2.3. Ascertaining the net income loss, if any, resulting from a disposal. Net income is calculated by deducting from gross income such costs as repair, maintenance and management
3.2.4. Consideration of the rent received by the Council against the net proceeds of disposal (rate of return)
3.2.5. Consideration of the best time to sell e.g. sale proceeds may be maximised by selling the property after the completion of a rent review or after planning permission has been obtained
3.2.6. Consideration of the Council's liability for immediate and future repairs
3.2.7. Opportunities such as assembling larger sites with adjoining owners and/or partner organisations.
3.2.8. Opportunities to sell a capital asset and replace it with a cheaper alternative.

3.3. All disposals will be in accordance with the Council's Property Procedure Rules as revised by Council decision dated 6 April 2011. Most will be sold by auction or tender.

3.4. This is a key decision in the forward plan as the values for the programme will exceed £250,000 and implications are borough-wide.

3.5. It may be useful to note that the release of the Carterhatch and Melling Drive depot sites will depend upon the reprovision of existing functions as needed. In addition the release will be subject to the satisfactory selection and agreement for an alternative depot site that satisfies the GLA approvals for planning use.

3.6. Part only of the Glyn Road car park has been identified for release subject to facilitating access for such authorised residential parking as may exist.

3.7. The ongoing review of the sheltered housing portfolio is likely to bring forward some sites for consideration later this year.

4. ALTERNATIVE OPTIONS CONSIDERED

4.1. Continuing to own the existing property estate and not dispose of property. Such a strategy will not deliver the much needed capital receipts.

4.2. Borrowing more money is considered to be a less favourable option that disposing of property.

5. REASONS FOR RECOMMENDATIONS

5.1. Property disposal is necessary to enable the Council to achieve its objectives.

6. COMMENTS OF THE DIRECTOR OF FINANCE AND CORPORATE RESOURCES AND OTHER DEPARTMENTS

6.1. Financial Implications

6.1.1. Appendix 1 of the report contains a list of proposed disposals. Each disposal will be evaluated using the criteria outlined in paragraph 3.2 to determine whether the disposal offers value for money.

6.1.2. The proceeds from disposals will be one off and used to fund the capital programme. The alternative method for funding the programme would be to borrow and the current cost of borrowing is estimated at 9.5% p.a.

6.1.3. The costs associated with disposals can be offset against the receipt. This is capped at 4% of each disposal for general fund disposals. The expenditure will be closely monitored to ensure that all appropriate costs are offset against the capital receipts.

6.1.4. The costs of HRA disposals are not capped at 4% so any reasonable cost can be offset against the receipt. However HRA receipts are subject to capital pooling regulations. Under these regulations 50 % of the receipt would be paid over to the government unless the council can demonstrate that it has spent an equivalent amount on affordable housing. (The Council has always managed to demonstrate this, however this will depend on the level of capital receipts.) This rule may change when HRA self financing is introduced.

6.2. Legal Implications

6.2.1. In accordance with the Council's Property Procedure Rules the inclusion of property on the disposals programme requires

approval either by the appropriate Cabinet member or by Cabinet itself.

6.2.2. All disposals should be made on a competitive basis, as required by the Property Procedure Rules. This will demonstrate that the Council are achieving the best price reasonably obtainable for each property, as required by Section 123 of the Local Government Act 1972.

6.3. Property Implications

As stated in this report.

7. KEY RISKS

7.1. Risks as yet unidentified may be discovered by the due diligence investigations.

7.2. Property values may decline.

8. IMPACT ON COUNCIL PRIORITIES

8.1. Fairness for All

The release of surplus property or the prospective disposal of sites to alternative providers is intended to generate receipts to protect essential services. Equality impact assessments will be completed for individual property disposals if deemed appropriate.

8.2. Growth and Sustainability

Several properties listed for disposal should attract investment and funding such as business or residential development.

New schemes should achieve enhanced green technology solutions.

8.3. Strong Communities

The generation of capital receipts from property disposals will help the Council's objectives to deliver strong communities.

9. PERFORMANCE MANAGEMENT IMPLICATIONS

The overall rationalisation should optimise the use of council accommodation.

10. HEALTH AND SAFETY IMPLICATIONS

The review has had regard to the likely future cost of retaining and sustaining those premises that are not efficient to run and to optimise use of those premises where cost effective management controls can best support the health and well being of employees and visitors.

Background Papers
None.

APPENDIX 1

Disposal Programme
Properties targeted for Disposal before 1 April 2013

Address			**Legal interest**	**Fund**
321/323 and 321A and 323A Plus land to north	Baker Street	EN1 3LF	Freehold	General Fund
Land to west of Baptist Church	Cecil Road	EN2 6TG	Freehold	General Fund
59-65	Cecil Road	EN2 6TJ	Freehold	General Fund
Carterhatch depot	Melling Drive	EN1 4LF	Freehold	General Fund
Melling Drive depot	Melling Drive	EN1 4LF	Freehold	General Fund
Part of car park	Glyn Road	EN2	Freehold	General Fund
Car park	Sydney Road	EN4 0PY	Freehold	General Fund
24	Cyprus Road	N9 9PG	Freehold Ground Rent	General Fund
Land East of Highfield primary school	Highfield Road	N21 3HE	Freehold	General Fund
1 Flat+shop investment 2 vacant shops Office Flat	Whitefields Road Cheshunt	EN8 0EL	Freehold investment	HRA
Depot	Whitefields Road Cheshunt	EN8 0EL	Freehold	General fund

MUNICIPAL YEAR 2010/2011 REPORT NO. 238

MEETING TITLE AND DATE:
Cabinet – 27th April 2011

JOINT REPORT OF:
Ray James, Director of Health, Housing and Adult Social Care and Neil Rousell, Director of Regeneration, Leisure and Culture.

Contact officer and telephone number:

Neil Vokes, 020 8379 1781

E mail: neil.vokes@enfield.gov.uk

Agenda – Part: 1	**Item: 10**

Subject: Ladderswood Regeneration Report: Selection of a preferred Development Partner and authorisation to enter into a Development Agreement with the preferred Ladderswood Development Partner

Cabinet Members consulted:

Cllr Doug Taylor, Cllr Andrew Stafford, Cllr Achilleas Georgiou, Cllr Del Goddard

1. EXECUTIVE SUMMARY

1.1 Ladderswood is a regeneration project of key strategic importance to the Council. The regeneration of the estate and the neighbouring industrial estate will see new homes, new streets, new commercial spaces, new employment and training opportunities, new community facilities and new open spaces provided. The vision is to create a truly attractive, enjoyable and sustainable place for people to live and work. The Ladderswood regeneration will contribute to key deliverables within the Sustainable Community Strategy for Enfield 2009 – 2019, 'Enfield's Future' by improving the New Southgate and North Circular Road area.

1.2 This report marks an important milestone in the project's life cycle; the selection of a preferred Development Partner, pursuant to a Competitive Dialogue Procedure (in accordance with the Public Contracts Regulations 2006) and the recommendation for the Council to enter into a Development Agreement with the preferred Development Partner.

1.3 This report provides a detailed summary of the competitive dialogue process delivered by the Council, including a summary of the consultation and engagement of residents and key stakeholders.

2. RECOMMENDATIONS

2.1 Note the detailed summary of the competitive dialogue process delivered by the Council.

2.2 Note the consultation and community engagement carried out as part of the Ladderswood redevelopment.

2.3 Note the outcome of the legal, financial and design evaluations of the Bids submitted by the two short-listed Bidders at the final tender stage.

2.4 Appoint Bidder A as the Council's preferred Development Partner for the Ladderswood regeneration and then enter the Development Agreement with the preferred Development Partner.

2.5 Authorise the Council's Legal Services to obtain all the necessary statutory consents and to exchange contracts in respect of the Development Agreement and all other associated legal documentation that the Council is obligated to complete to comply with the Development Agreement including those agreements that will govern the relationship between the preferred Development Partner and the Council.

2.6 Note the actions still required by the Council post contract closure.

2.7 Note the position on the adoption of roads and public realm areas in Ladderswood.

2.8 Delegate authority to the Authorised Officer within legal services to sign the Development Agreement and all other associated legal documentation that the Council is obligated to complete to comply with the Development Agreement including those agreements that govern the relationship between the preferred Development Partner and the Council.

3. BACKGROUND

3.1 The redevelopment of the Ladderswood Way estate and the adjoining New Southgate Industrial estate is a project of major strategic importance for the Council and its regeneration ambitions. Set within the context of the recently adopted New Southgate Masterplan, the project aims to transform this part of the Borough into a vibrant and sustainable neighbourhood by providing a mixture of new homes, new streets, new commercial spaces, new employment and training opportunities, new community facilities and new open spaces.

3.2 Council officers have been dialoguing with the two shortlisted Bidders (Mulalley partnered with One Housing and Higgins partnered with Notting Hill Housing Trust) to ensure that the Bids, submitted at the final tender stage, achieve the vision and aspirations for Ladderswood as set out below.

3.3 The vision for Ladderswood has been drawn up with the residents of the Ladderswood Way estate and is set out in Section 3 of the *Ladderswood Way Estate – Design Guidance Report 2009,* produced by Shepherd Epstein and Hunter and endorsed by Cabinet in November 2009. The vision sets out the following aspirations for the area:

- The regeneration of the Ladderswood Way Estate should enable the residential area to maximise opportunities for a diverse and integrated community, with design which provides choice through a varied mix of residential unit types and sizes including family dwellings. The proposals should also respond to local needs by including more ground floor properties with private external spaces than exists at present. The design should result in a distinctive and understandable space with a clear image, which is easy to understand; currently the estate has a confused image of a residential area and an industrial estate which contributes to a feeling of isolation in this residential corner of New Southgate.

- There should be improvements to existing roads and provision of new links and routes, with intersections and landmarks to help wayfinding around and through the estate and enhanced connections to wider residential areas.

- Increased neighbourhood vitality helping to create a sense of community should be an important consideration as part of the Ladderswood Way proposals, including the creation of active residential streets, increasing the area’s liveliness and providing the opportunity for more active community spaces.

3.4 The resident’s design panel, which was consulted as part of the indicative scheme, produced by Shepherd Hunter and Epstein, were keen that any redevelopment design for their estate includes improved

amenity space and community facilities, something which is lacking in this area of New Southgate. The residents see a new amenity space and community facility as key considerations for any future development.

Procurement process of the preferred development partner

3.5 In November 2009, the Cabinet of the Council approved the development strategy for the Ladderswood Regeneration Programme (Key decision reference: 2952) as part of the wider regeneration strategy for regenerating the area; as set out in the New Southgate Masterplan.

3.6 The strategy required the Council to procure a development partner pursuant to a Competitive Dialogue procedure in accordance with the Public Contracts Regulations 2006; upon selection, the Council would enter into a Development Agreement with the preferred development partner. The procurement consisted of four stages:

- Stage 1: Pre-Qualification Questionnaire
- Stage 2: Invitation to Participate in Competitive Dialogue
- Stage 3: Invitation to Submit Detailed Solutions
- Stage 4: Final Tenders

3.7 The timetable below sets out the procurement process delivered by the Council. Stages 1, 2 and 3 are set out in detail in the 25th November 2010 *Ladderswood Place Shaping Report: Detailed update on the Ladderswood Place Shaping Programme and outcome of the decision to short-list Bidders* (Key decision reference: 3128). Stage 4: Final Tender, is described in this report.

Ladderswood Procurement Timetable	
Task	**Start / Completion Date**
Stage 1: Pre-Qualification Questionnaire	
OJEU issued	15th January 2010
Pre-Qualification Questionnaire issued	20th January 2010
Suppliers' Event	4th February 2010
PQQs received	26th February 2010
PQQs evaluated and 3 Bidders short-listed	16th April 2010
Stage 2: Invitation to Participate in Competitive Dialogue	
Invitation to Participate in Competitive Dialogue (ITPD)	17th June 2010
Pre-submission meeting with 3 shortlisted bidders	24th June 2010
Interim Solution submitted	7th July 2010
Dialogue meetings	21st July to 19th August 2010
Stage 3: Invitation to Submit Detailed Solutions	
Invitation to Submit Detailed Solutions	23rd August 2010
Detailed solutions submitted	10th September 2010
Evaluation of Bids	10th Sept to 29th Sept 2010
Cabinet authorise delegated authority to short list	13th Oct 2011
Delegated decision to shortlist from 3 to 2 Bidders	27th Oct 2010
Detailed Dialogues	**9th Nov to 15th Dec 2010**
Stage 4: Final Tender	
Invitation to Submit Final Solutions	23rd December 2010
Bidders submit Final Tenders	28th Jan 2011
Evaluation of Bids	28th Jan to 23rd Feb
Cabinet agree preferred Development Partner	27th Apr 2011
Bidders and Residents informed subject to Cabinet call in	6th May 2011
Alcatel standstill period	May to 2011
Award decision published	May 2011
LBE enters into a Development Agreement with the preferred Development Partner	May / June 2011
Planning Application submitted	6 months after DA is signed

3.8 On the 13th October 2010, the Cabinet of the Council delegated authority to short-list the Bidders from 3 to 2 at Detailed Solutions stage to the Leader of the Council, the Cabinet Member for Regeneration and Improving Localities and the Cabinet Member for Finance, Facilities and Human Resources. The same report also authorised additional funds to continue the leasehold buy back programme and for the buyback programme to expand beyond the original scope of the November 2009 report, to now include buybacks from Betspath House.

3.9 The decision to short list the two consortia (Mulalley partnered with One Housing and Higgins partnered with Notting Hill) was announced on the 27th October 2010. The two consortia were then invited to dialogue further before submitting their Final Tenders on the 28th January 2011.

3.10 The requirements of each Bid are set out in detail in the Invitation to Submit Final Tenders which was issued to the Bidders on the 23rd

December 2010. The Bids submitted on the 28th January 2011 meet the minimum scheme requirements of the Council.

3.11 As with the evaluation of the Detailed Solutions, the Final Tender Bids were evaluated against Legal, Financial and Quality / Design criteria. The criteria are set out in the Invitation to Submit Final Tenders. The consortium who submitted the highest scoring Compliant Bid is being recommended to Cabinet as the preferred Development Partner for Ladderswood.

3.12 The procurement of the preferred Development Partner has been delivered to timetable.

3.13 In accordance with the Public Contracts Regulations 2006, there has been genuine competition at the Final Tender stage with two Bids from credible Bidders.

Consultation and Community Engagement

3.14 The Council has made a clear commitment to putting residents at the heart of the Ladderswood Regeneration Programme. The Ladderswood Resident Panel has been instrumental in conveying the desires and aspirations of the residents to both the Council and the Bidders. The Panel has recently appointed an Independent Tenant and Leasehold Advice service to support the Panel as well as providing impartial and independent advice to residents.

3.15 The table below sets out the history of the consultation and engagement on Ladderswood since the November 2009 Cabinet report. Considerable effort has been made to enable residents to feed into the procurement process of the development partner and the Final Tenders have responded to considerable resident input; this includes input around internal flat layouts, massing and building heights, external design and storage issues and location of private and affordable housing. Another key area where residents have affected change in the bids is around an increase in the number of dual aspect properties and in the number of houses.

3.16 The Ladderswood Resident Panel has appointed an Independent Tenant and Leasehold Advisor to provide independent and impartial advice to residents and also to support the Ladderswood Resident Panel.

3.17 The Council envisages that the Ladderswood Resident Panel will continue to play a central role in the regeneration of the area; their terms of reference set out the desire;

(a) to act as a forum whereby the Council and the chosen development partner must consult and obtain views of the tenants and leaseholders on the estate;

(b) to work with the Council to ensure the Ladderswood regeneration programme delivers a high quality development which meets the needs of the existing community whilst also contributing to the wider needs of the Borough;

(c) to assist the Council in effectively communicating and consulting with residents on the Ladderswood estate, the commercial tenants on the New Southgate Industrial estate and residents in the wider New Southgate area;

(d) to be consulted on any documentation issued to residents;

(e) to determine future management arrangements for the estate.

(f) to monitor progress in the regeneration of the Ladderswood regeneration programme

(g) to participate with the Housing Association on the redevelopment of Social Housing.

(h) to represent the residents and the Ladderswood Resident Panel at key council meetings where decisions are to be taken in regards to the Ladderswood regeneration programme

Consultation Session	Date	Description
Ladderswood Resident Panel	First Tuesday of every month	The Ladderswood Resident Panel consists of residents living on the Ladderswood Estate who wish to work with the Council in taking forward the regeneration of the area.
New Southgate Industrial Estate meetings	Initially meetings held every two months and now email updates	The Council facilitated bi-monthly meetings with the commercial tenants; these are being reviewed to ensure they remain effective tools for communicating updates to the tenants. Regular one-to-one meetings with LBE Property Services continue.
Woodberry Down site visit	6th April 2010	Ladderswood Resident Panel taken to see the Woodberry Down development; opportunity to discuss redevelopment issues with the Chair of the Woodberry Down Community Organisation (WDCO). The Chair of WDCO then attended the first of the site visits.
Tenants and	21st June 2010	Tenants and Leaseholders invited to resident

Leaseholder Re-housing event		event to discuss the re-housing programme.
Site visits	17th July, 31st July and 14th August 2010	The 3 bidders organised individual visits to various developments across London to demonstrate to residents, Councillors and officers examples of similar developments completed elsewhere.
Bidder and Resident Panel sessions	3rd, 4th, 5th August 2010	Each bidder was invited to meet with the Resident Panel on an individual basis to discuss their detailed solutions
Bidder and New Southgate Industrial Tenants sessions	27th, 28th, 29th July 2010	Each bidder was invited to meet the New Southgate Industrial Tenants
Bidder and Garfield Primary School sessions	27th July 2010	The Council organised meetings between the bidders and the local Primary School.
Bidder and Millennium Green Trustees sessions	18th August 2010	Each bidder was invited to meet the Millennium Green trustees and then again in December 2010 to agree works and services.
Lorne and Roberts consultation	18th August 2010	Consultation event with residents of Lorne and Roberts House to clarify the status of the two blocks.
Scheme exhibition	22nd September 2010	Residents and businesses in the New Southgate area were invited to a public exhibition of the 3 bidding schemes.
New Southgate Festival	25th September 2010	Model and scheme information presented at the New Southgate Festival.
Door knocking	13th October 2010	The Project Manager and the Re-housing officer door knocked Lorne and Roberts House to discuss the development.
Lorne and Roberts feedback session	3rd November 2010	Opportunity for LBE officers to feed back the findings of the consultation.
Assured Tenancy event	7th December 2010	Event held for all residents to discuss what it means to be a Housing Association tenant.
Lorne and Roberts feedback session	10th February 2011	Opportunity for residents to have their comments heard before the March Cabinet meeting.
No 10	4th April 2011	Void flat refurbished and now opened as a community hub; providing information, advice and guidance on a range of services from housing to health.

3.18 Going forward the emphasis on consultation and engagement will increase. A resident website will be established to keep them up to date on the latest developments on Ladderswood. Residents will be involved in discussions around the ongoing and long term management and maintenance of the estate. This will include discussions over what services the Housing Association will deliver and how this will affect the service charge. There will be opportunities for residents to discuss the proposed tenancy agreement and they will be supported by the Independent Advisor in all negotiations.

3.19 It is envisaged that a resident Design Panel will be set up and they will play an important role in the development of the detailed planning application to be submitted no later than 6 months after the signing of the Development Agreement.

3.20 A key element of the scheme is the inclusion of a community centre and residents will be heavily involved in deciding what services are delivered from the centre and how it is managed.

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 In November 2010 the Government circulated a consultation paper, A Fairer Future for Social Housing. The paper includes a number of key policy proposals which will impact on Ladderswood. These proposals include the potential move to the new affordable rent model. To take account of these proposals the option was available to the Council to extend the period of dialogue at the final tender stage to such time in the future when there is greater clarity as to whether the new initiatives proposed in A Fairer Future for Social Housing would be taking affect.

4.2 This option had several risks attached. Firstly, it is unclear as to when there would be sufficient clarity over these policy issues not only from Government but also from the Council to close the procurement. This would push back the date for contract close, increase bidder costs, lose momentum built up over the last 9 months and ultimately delay the selection of a development partner and the start of the development itself.

4.3 As a contingency the Development Agreement contains a number of clauses which allow the Council to benefit should the affordable rent model be adopted by the Council.

5. REASONS FOR RECOMMENDATIONS

5.1 To enable the Council to select a preferred Development Partner, to agree the final form of the documentation and to then enter into contract to deliver the regeneration of the Ladderswood Estate and the New Southgate Industrial Estate.

6. COMMENTS OF THE DIRECTOR OF FINANCE AND CORPORATE RESOURCES AND OTHER DEPARTMENTS

6.1 Legal Implications

6.1.1 The Ladderswood procurement process has been conducted in accordance with the Competitive Dialogue procedure under the Public Contracts Regulations 2006, and Councils Constitution, in particular the Contract Procedure Rules. Continued compliance will ensure value for money in accordance with the Best Value principles under the Local Government Act 1999.

6.1.2 The Council is empowered to dispose of housing land under Section 32 of the Housing Act 1985. However, an open market sale of the housing land at Ladderswood will require the specific consent of the Secretary of State. An application will need to be made and the consent will need to be secured prior to the exchange of the development agreement

7. KEY RISKS

A detailed risk register has been maintained for the Ladderswood Regeneration Programme. Risks are monitored on a regular basis by the Ladderswood Project Team and then reported to CMB on a weekly basis.

Where required, the Council has commissioned external consultants with specialist procurement, financial and legal expertise to meet the needs of the project and to minimise the risk of challenge.

The Council does not have the flexibility under Competitive Dialogue to negotiate changes to final bids. Therefore the challenge for the contracting authority is to balance the legal requirements with the need to achieve contract signature in an environment where change can occur between the closure of the dialogue phase and contract signature. At the final tender stage only fine tuning and clarification requests can be made.

8. IMPACT ON COUNCIL PRIORITIES

8.1 Fairness for All

The Ladderswood Regeneration Programme contributes to this aim by tackling inequality and access to social housing by providing new homes, a mix of tenure and employment opportunities in the New Southgate Masterplan area.

Through the dialogue process the Council has protected tenants' rents and existing residents on Ladderswood, on moving into their new property on Ladderswood, will remain on their LBE rent level, subject to the standard annual increases.

8.2 Growth and Sustainability

The Ladderswood Regeneration Programme contributes to this priority by building strong and sustainable futures for our residents. The scheme attracts investment from the private sector, empowers the voluntary and community sector and promotes business growth by re-providing B1 commercial space. It is the flagship project in the New Southgate Masterplan and is the first step towards delivering the planned regeneration of the New Southgate Priority Area, and housing growth, as set out in the Masterplan and the Core Strategy.

8.3 Strong Communities

The Ladderswood Resident Panel plays a central role in driving forward change and regeneration in the local area to create a stronger community in the New Southgate Masterplan area. The Panel has nominated three representatives who will be part of the scoring panel, evaluating the Bidders submissions.

9. PERFORMANCE MANAGEMENT IMPLICATIONS

This report does not recommend a change of service of implementation of new practices and therefore Performance Management Implications are not required.

10. HEALTH AND SAFETY IMPLICATIONS

Not applicable.

Background Papers

None

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MUNICIPAL YEAR 2010/11 REPORT NO. 239

MEETING TITLE AND DATE: Cabinet 27th April 2011 **REPORT OF:** Director of Health, Housing & Adult Social Care	**Agenda – Part: 1**	**Item: 11**
	Subject: Extension of existing Supporting People contracts **Wards: ALL**	
	Cabinet Member consulted: Cllr Don McGowan	

Contact officer and telephone number: Pauline Kettless Ext 4725

E mail: Pauline.Kettless@enfield.gov.uk

1. EXECUTIVE SUMMARY

The purpose of this report is to allow for a decision to be made on entering into Supporting People contracts for a period of 2 years. The summary below provides the main rationale for entering into the contracts with additional information found in the main body of this report:

- In 2006 Cabinet agreed to issue Steady State Contracts to support services which had successfully completed their Service Review in accordance with the Quality Assessment Framework.
- The expectation was that providers attain at least a ‘C’ in the Quality Assessment Framework and work has been ongoing since 2006 to ensure that has been achieved.
- Although existing contracts are coming to an end there has been considerable uncertainty about Supporting People funding. In 2009 the Government removed the ring fencing and in 2010/11 apart from the overall grant reduction, Supporting People also had £267,000 grant removed.
- To ensure market stability, providers are requesting steady state contracts to ensure ongoing investment into their services for the coming two years.
- Supporting People have already negotiated a 3% year on year reduction in funding to providers based upon the reassurance of a 1 year plus 1 year contract. Resulting in initial savings of £188,000 and £105,000 in each respectively.
- As the majority of services are tied with the provision of accommodation, the steady state contracts will provide reassurance and reduce an element of risk of providers removing accommodation and effectively making customers homeless.
- The best way forward is to provide a period of time to undertake a programme of consultative, collaborative re-modelling and re-tendering of services. The aim to provide increased integration of services and generate further savings of at least £500,000.

2. RECOMMENDATIONS

2.1 That the content of this part 1 report and its part 2 appendix is noted.

2.2 That approval is given for the Council to enter into 1 year + 1 year contracts with the providers set out in the Appendix to part 2.

3. BACKGROUND

3.1 In April 2006 Cabinet approved a report of the Director of Community Housing and Adult Social Services and the Director of Finance and Corporate Resources; which gave authority to issue Steady State Contracts to all service providers who had completed a satisfactory Service Review.

3.2 Since the inception of Supporting People in 2003 there has only been one inflationary up-lift of, on average, 2%. This has meant that providers have improved quality whilst effectively receiving a 22% reduction in funding since 2003[1].

3.3 Supporting People team delayed the process of issuing Steady State Contracts after the Cabinet approval. This provided time to respond to the Personalisation Agenda and to consider the outcomes, due in 2011, of the Supporting People element of the Right to Control pilots run under the Welfare Reform Act.

3.4 Using the Communities for Local Government Quality Assessment Framework (QAF) there was an expectation that Providers would achieve at least a 'C' standard. As some of the Providers were inherited from a time pre-Supporting People a need was quickly identified for the Contract and Review Officers to work closely with Providers and improve standards across the QAF in order for them to achieve the Council's minimum requirements. This process has been ongoing as there have been several changes to the QAF and the need to work with smaller community providers; through the use of Action Plans and regular reviews in order to meet and maintain the required standard.

3.5 As there is an expectation that there will be periods of time of under utilisation of services, and therefore a void saving, Supporting People had created total contract values exceeding budget to maximise spend and deliver Value for Money. In the current economic climate this is no longer sustainable and there is a requirement to deliver budget reductions. These proposed reductions have left the Providers market

[1] Source Office for National Statistics: annual index of retail prices 1948-2009

uncertain and many are requiring a level of security in order to maintain investment in their service.

3.6 In April 2009 the ring fencing was removed from the Supporting People budget and the funding was transferred to the Area Based Grant, this potentially means that Supporting People funding may be reduced in line with overall Council savings. In 2010/11 an amount of £267,000 was specifically removed from Supporting People funding. The response from Supporting People is to propose a comprehensive re-tendering of services. These are being developed to achieve the efficiencies required to meet the new budget.

3.7 A programme of decommissioning, re-design and re-tendering of services is planned on a sector-by-sector basis from 2011 to 2013, in order to develop more efficient services that meet the forecast budget reductions and address the changing policy environment. The 2 year time allowance to procure new contracts will allow for:

- Remodelling of services to ensure they meet current and future requirements,
- Appropriate consultation with all stakeholders,
- Identifying opportunities to deliver services in conjunction with:
    - Care,
    - Local providers
    - Third Sector
    - and other local authorities.

3.8 To make short-term savings, Providers were asked to agree a 3% reduction for 2010/11 (£188,000) and another 3% for 2011/12 (£105,000). In order to stabilise the market and provide security and an incentive for these savings, Providers have requested to receive a 2 year Steady State Contract.

3.9 The updated Steady State Contracts also require Providers to:

- Utilise the Capita Support IT system that Supporting People has developed to facilitate effective referrals, and contain clauses to ensure greater financial efficiency through limiting back-payment and granting greater powers to recoup funding to services with low utilisation.
- Make explicit the requirements for Providers to be compliant with data security in line with the requirements of N3.
- The QAF is more explicitly tied into the new contract, consequently providing a quality standard that Providers will need to meet.

3.10 The services indicated in the Part 2 report have met the SP quality standards, and have negotiated a reduced price. It is therefore proposed to issue a Steady State Contract, promoting stability and transparency.

3.11 A Waiver from the Council's Contract Procedure Rules has been granted by the Director of Finance and Corporate Resources.

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 The alternative option would be to delay issuing contracts until a tender process has taken place. Tendering for all Supporting People services in a short period of time would present considerable resource implications for the Council and Providers, would destabilise the market, and possibly affect client care. A phased tendering approach will take time, and contracts are required for services until such time that tendering takes place to ensure that the Council is not at risk not having a written contract in place.

5. REASONS FOR RECOMMENDATIONS

5.1 The issuing of new contracts allows the Council to achieve the necessary cost savings, to introduce improved contract clauses to our benefit, to reduce risks in the case of potential disputes, and to ensure certainty by having a written contract in place.

6. COMMENTS OF THE DIRECTOR OF FINANCE AND CORPORATE RESOURCES AND OTHER DEPARTMENTS

6.1 Financial Implications

The Supporting people budget was reduced by £637k in 2010/12 for savings. A further £150k of savings has been offered in 2011/12.

As a result of the budget pressures on Supporting People resources, projects have been identified and plans developed to resolve the budget gap and implement savings proposals. This has involved incentivising the market to meet the savings requirement of 3% in 2010/11 and 3% in 2011/12 by offering steady state contracts for 2 year period.

The impact of the 3% savings in 2010/11 (£188k) has had a positive effect on the Supporting people budget position. However further work is still required to ensure that the service reduce the volume of provisions over the 3 year spending period.

6.2 Legal Implications

6.2.1 The Council has the power to provide accommodation and care under section 21 of the National Assistance Act 1948. Section 26 of the National Assistance Act allows the Council to discharge this function by making arrangements with individuals, companies or voluntary organisations.

6.2.2 The contract must be in a form approved by the Assistant Director of Legal Services.

6.2.3 A waiver of the Council's Contract Procedure Rules, as set out in the Constitution, has been obtained.

6.3 Procurement Implications

Exemption to the contract procedure rules (CPR's) in tendering Supporting People contracts has been granted. This will facilitate the formalisation of Steady State contracts with those suppliers listed in Appendix A. The two-year period covered by the exemption will provide sufficient time for HHASC to produce a suitable procurement strategy for tendering the required services by 31 March 2013.

7. KEY RISKS

7.1 Not having up-to-date contracts in place exposes the Council to risk, particularly if there are disputes.

7.2 The issuing of contracts gives some security to providers, which helps them manage their strategic risks and plans.

7.3 Risk of legal challenge to issuing contracts is limited as Providers understand that comprehensive re-tendering is expected in a phased approach.

7.4 Re-tendering of contracts over the next two years reduces the risk of accommodation and support being removed from vulnerable customers without adequate support arrangements in place.

8. IMPACT ON COUNCIL PRIORITIES

8.1 Fairness for All

This aim is about tackling inequality; providing excellent services, targeted to meet the needs of each area; and understanding the needs of all our communities

The extension of the contracts will allow time for the remodelling of services to meet the requirements of some of our most vulnerable customers. Without this extra time the risk would increase as accommodation and support maybe withdrawn without appropriate support arrangements being in place.

8.2 Growth and Sustainability

This aim is about helping Enfield reach its full economic potential; supporting local businesses, attracting investment; increasing jobs and business growth; supporting and empowering the voluntary and community sector; and building strong and sustainable futures for our residents, environment and the economy

The contract extension will allow time for local providers to work with the Council in helping shape the market for different care groups. For any

providers unsuccessful in a re-tendering process it will provide time for the authority to work with them in seeking opportunities for still providing local services through personalisation.

8.3 Strong Communities

This aim is about listening to the voices and needs of Enfield's diverse communities and creating opportunities for residents to lead local improvement and be involved in decision making.

The extension of the contracts provides opportunity for wider consultation with the community in the modelling of these services.

9. PERFORMANCE MANAGEMENT IMPLICATIONS

9.1 Issuing of contracts stabilises the services and ensures that the provision of quality housing related support continues. It also ties in the QAF closer with the contract and allows the Council to recoup under utilisation. Fixed term contracts also provide both the Council and the Providers with the opportunity to forecast and plan future service requirements and resource implications

Background Papers

Cabinet Report - 6th April, Report No. 332, Key Decision number 988

THE CABINET

List of Items for Future Cabinet Meetings
(NOTE: The items listed below are subject to change.)

MUNICIPAL YEAR 2011/2012

MAY 2011

1. **Extra Care Housing Environment, Alcazar Court, Edmonton** Ray James

   This will seek to secure provision of care and support services in an Extra Care Housing environment at Alcazar Court, Edmonton. (Part 1) **(Key decision – reference number 3248)**

2. **Membership of Cabinet Sub-Committees for the municipal year 2011/12**

   To agree the membership of the Cabinet Sub-Committees for the municipal year 2011/12.

3. **Biodiversity Action Plan** Ian Davis

   This will seek approval to the adoption of the Biodiversity Action Plan. (Part 1) **(Key decision – reference number 3176)**

4. **Food Strategy** Neil Rousell

   This will seek approval of the Council's Food Strategy which has been out for consultation from 28 July to 22 October 2010. (Part 1) **(Key decision – reference number 3180)**

5. **Adoption of the Business Accord** Neil Rousell

   This will explain the progress to date on developing an Accord to improve communications with businesses in Enfield and propose its formal adoption by the Council. (Part 1) **(Key decision – reference number 3256)**

6. **Housing Related Support Services** Ray James

   This will seek approval to enter into single provider negotiation for the procurement of three Housing Related Support Services for young people aged 16-22. (Parts 1 and 2) **(Key decision – reference number 3276)**

7. **Ordnance Road Surgery** Ray James

   This will seek approval to the proposed site for the development of a Health Centre. (Part 1) **(Key decision – reference number tbc)**

JUNE 2011

1. Cemeteries Grounds Maintenance Ian Davis

This will seek approval to award the contract for the Cemeteries Grounds Maintenance in Enfield. (Part 1) **(Key decision – reference number 3254)**

2. Local Economic Assessment Neil Rousell

This will ask Members to note the completion of the Local Economic Assessment which will provide the basis for the preparation of the Regeneration Strategy and the Inward Investment Strategy. (Part 1) (Non key)

3. Sheltered Housing Blocks Ray James

This will seek authority to procure a demolition contractor to demolish vacant sheltered housing blocks. (Part 1) **(Key decision – reference number 3184)**

4. Highways and Engineering Works Contract Ian Davis

This will seek approval to award the Highways and Engineering Works Contract to the recommended contractor following the selection and evaluation process. (Parts 1 and 2) **(Key decision – reference number 3272)**

5. Regeneration of 188-216 Ponders End High Street - Strategy Paper Neil Rousell

(Part 1) **(Key decision – reference number tbc)**

6. Inter Authority Agreement Ian Davis

This will seek approval of the Inter Authority Agreement (IAA) 1st Schedule information to support the procurement process for the replacement of the main waste disposal contract for the seven North London boroughs. (Part 1) **(Key decision – reference number 3277)**

7. Development of the First Floor of Thomas Hardy House Neil Rousell

This will propose the development of a conference facility on the first floor of Thomas Hardy House. (Part 1) **(Key decision – reference number 3249)**

8. Right to Buy Leases Ray James

This will seek approval to adopt regulations to be included in the current Right to Buy leases held by 4,500 current LBE leaseholders. (Part 1) **(Key decision – reference number 3273)**

9. Enfield Residents' Survey – Departmental Action Plans Rob Leak

This will provide information on the key actions being undertaken by departments in response to the findings from the 2010 Enfield Residents Survey. (Part 1) (Non key)

10. Review of the Preliminary Flood Risk Assessment Ian Davis

This will review the forthcoming Preliminary Flood Risk Assessment for Enfield and determine whether it is fit for purpose in meeting the requirements of the Flood Risk Regulations 2009. (Part 1) **(Key decision – reference number 3247)**

11. Council Tax Rebate James Rolfe

This will seek agreement to a scheme to offer a £100 council tax rebate to low income pensioner households not eligible for council tax benefit. (Part 1) **(Key decision – reference number 3265)**

JULY 2011

1. Enfield Joint Stroke Strategy 2011-2016 Ray James

This will seek approval of the Enfield Joint Stroke Strategy 2011-2016. (Part 1) **(Key decision – reference number 3269)**

2. Debt Write-Offs James Rolfe

This will seek agreement to write off uncollectable council tax debt identified within quarter 1 (11/12) for combined debts over £2,500 totalling above £250,000. (Part 1) **(Key decision – reference number 3266)**

3. Repairs and Maintenance Contract Ray James

This will seek approval to allow the current repairs and maintenance contract to expire on 30 July 2012 and agree to re-procure a new repairs and maintenance contract to commence on 31 July 2012. (Part 1) **(Key decision – reference number tbc)**

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MINUTES OF THE MEETING OF THE LONDON BOROUGH OF ENFIELD/ENFIELD RACIAL EQUALITY COUNCIL HELD ON TUESDAY, 11 JANUARY 2011

COUNCILLORS

PRESENT	Donald McGowan (Chairman), Eric Jukes and Ingrid Cranfield
OFFICERS:	Martin Garnar (Equalities Officer), Christine Cox (Benefits Performance Manager) and Peter Lister (Interim Head of Health and Adult Social Care Commissioning and Procurement) Elaine Huckell (Secretary)

ENFIELD RACIAL EQUALITY COUNCIL (EREC)
Bevin Betton (Co-Chairman) (part), Chandra Bhatia, Roger Hallam, Suhas Khale and Ken Allen

1
APOLOGIES

Apologies for absence were received from Councillor Simbodyal, Councillor Zetter, and Sam Bell.

2
DECLARATION OF INTERESTS

There were no declarations of interest

3
MINUTES OF THE PREVIOUS MEETING (7:30PM)

AGREED that the minutes of the 9 November 2010 be confirmed except under item on Personalisation in Enfield – the following to be included
“Over 6000 questionnaires were sent out to service users and carers. A total of 1562 questionnaires were received. A full report of the consultation findings will be available on the Enfield Council website soon.”

4
MATTERS ARISING FROM THE PREVIOUS MEETING

Abolition of Slave Trade Plaque
Martin Garnar confirmed that the artist, Les Johnson, had been advised of changes required to the sculpture and a new version would be available in March. An unveiling ceremony would be organised and Martin Garnar would discuss the possible format of this event with an officer who organised a similar ceremony in Waltham Forest. He asked if Bevan Betton would confirm the name of the officer, as he had been unable to locate him.

'Improving Health Project'
At a previous meeting it was asked that consideration be given to the continued funding of this project. Councillor McGowan stated that he had asked officers in Health & Adult Social Care to look into this matter and would respond back.

Audit of Recruitment Activity
It was confirmed that at the next meeting Olive Jones would provide an update on recruitment processes for agency staff, and also on the Council's apprenticeship scheme

Enfield Homes Equalities Monitoring Report
It had been requested that a member of staff from Enfield Homes be requested to attend the Hate Crime Forum Case Management Panel. Martin Garnar would update S Khale on if this had taken place.

Personalisation in Enfield
Martin Garnar would respond back to Roger Hallam on details of which communities had been consulted on the Personalisation Programme. Members emphasized the need for us to engage with hard to reach groups and to encourage people to respond.

Engagement with BME Communities.
At the last meeting Martin Garnar referred to the Enfield Strategic Partnership engagement toolkit and framework that gave names and organisation contacts. It included a section on engagement with hard to reach groups, Martin Garnar and Chandra Bhatia would examine this further.
It was thought a review would be undertaken on the Enfield Observatory which, it was hoped, would make it more user friendly.

5
MEETING THE NEEDS OF THE BME ELDERLY POPULATION (7:45PM)

Peter Lister, (Interim Head of Commissioning and Procurement), Health and Adult Social Care presented a report on Health and Social Care Needs of BME Elderly population in response to a paper submitted to the November meeting of this Group by EREC.

The report aimed to answer the 12 questions put forward by EREC which requested information relating to the population profile of BME elderly people, the services provided to them and their current and future needs. It had been hoped that a working group would meet in December to discuss the issues raised, however, this had not been possible. Feedback had been provided instead by EREC to an initial report and their comments were also answered in this report.

The following issues were highlighted:

- That the Enfield Joint Strategic Needs Assessment 2010-12 had been used to provide information about the health and wellbeing needs from NHS Enfield, Enfield Council and key stakeholders. Information had also been supplied by the Office for National Statistics “The Older Peoples Profile” Sept 2007.
- The next census was due to be completed in 2011 which would provide more accurate and up-to-date data on the Enfield population.
- That it was necessary to engage with the Enfield community to ensure that any gaps in service provision were addressed

Members raised the following issues:

- The monitoring of the quality of service provided to BME groups - Peter Lister confirmed that this was carried out in a number of different ways that included the setting down of clear standards in contracts and careful monitoring by performance teams.
- Feedback from BME elders who use the services. Peter Lister stated that questionnaires were being used as a means of obtaining information to gauge the perception of the service provided. He would present findings relating to BME elders to this Group.
- (Para 4) It was confirmed that the proportion of older people in Enfield (29%) was higher than London (25.6%) but lower than the England average of 33%.
- (Para 4)That of the 1067 people aged 65 and over that live in a care home, only 11% were from BME communities. It was thought this may be because a larger proportion received personal care in their home. Of the 1,800 elderly people who received personal care in their homes 787 were BME elders i.e 44%.
- (Para 4) It was questioned whether the figures indicated that the BME community was ‘shouldering more of the burden’ in providing care at home, or that the experience of being in a care home was perceived differently for BME elderly people.
- (Para 8) It was confirmed that the LBE Citizens Panel which was used as a means of providing consultation/ research information was weighted to reflect the equality strands of the Enfield population.
- (Para 8) Martin Garnar stated that he would be able to provide an update on the Citizens Panel to a future meeting of this Group if required.
- (Para 8) Cllr McGowan thought it would be useful if EREC would carry out informal discussions with organisations that provide facilities for the BME elderly. This may include informal clubs, day care centres, home care etc and could provide information on whether the service was suited to the needs of the BME elderly. An example of this may relate to different dietary requirements or cultural needs. It was thought this information could build on the work undertaken as part of the Personalisation agenda.

- (Para 8)Census research/ analysis information was necessary to ascertain the needs of the BME elderly, and therefore the census should be promoted to ensure everyone takes part.
- (Para 10) The Council was currently undertaking a review of Third Sector organisations including luncheon clubs, day care etc. Peter Lister said it would be useful for EREC to be involved and have an input into this.
- (Para 11) As part of the personalisation programme, direct payments would be made to give individuals direct control of purchasing the services they required.
- (Para 12) A working group would be established to take forward issues raised by this report.

AGREED A working group be established between LBE and EREC to take forward issues raised by this report.

Peter Lister, Brigitte Shallow and Shaheen Mughal from Health and Adult Social Care were thanked for the report.

6
IMPACT OF HOUSING BENEFIT CHANGES (8:15PM)

Christine Cox (Benefits Performance Manager) gave a presentation on the Benefits Service changes that are to be introduced as part of the Government's changes to welfare benefits. She circulated a leaflet "Benefits Service challenges ahead – A briefing paper – Welfare Reform Changes announced by the Government" which set out the changes that would come into effect from 1st April 2011.

The following issues were highlighted:

- That a report detailing the full impact of changes for Enfield was being prepared and would be ready in March 2011, the numbers of people affected could then be reported back to this meeting.
- Changes from April 2011 would affect tenants who were renting privately and receive Local Housing Allowance (LHA). The maximum room entitlement would be capped to the 4 bedroom rate. It was thought this would greatly affect inner London boroughs, and that many inner London tenants may therefore move to outer London Boroughs where rents were cheaper.
- That the Local Housing Allowance rate would be set at 30% of average rent in the Enfield area rather than the 50% given at present.. The rent excess whereby a tenant could receive up to £15 a week if rent was lower than the LHA amount set by the Government would cease. It was mentioned that the incentive for a tenant to find a cheaper rented property may cease as a result of this.
- 52 families were thought to be affected by the 4 bedroom capping rate in Enfield. Each case has an annual review meeting, and there would

be a 9 month transitional protection period. However there would only be limited discretionary payments available from the hardship fund.

- Forums would be held in January to discuss changes with private landlords. The new rules would enable payments to be made directly to a landlord where a local authority considers that it would help to secure or retain a tenancy for a claimant.
- There were also changes relating to the Shared Room Rate and also all new and existing claims were eligible to include an extra bedroom for a non-resident carer.
- Universal Credit would be introduced from 2013 that aims to create a leaner system administered by a single government department, and which would be focused on the Government idea that "work always pays"

Members raised the following issues

- Councillor Jukes and Christine Cox would discuss the issue of disregards, where an Authority previously had discretion in calculating benefit in relation to war widows' pensions.
- It was asked whether a person getting less housing benefit and unable to afford the rent would be able to apply for discretionary hardship funds. It was confirmed that there were very limited funds available.
- It was confirmed that the new legislation did not consider a situation resulting in inappropriate housing i.e the sharing of accommodation for different genders as a result of a move to a property with fewer bedrooms.
- An impact assessment should determine how the legislation would affect Enfield, It was felt it may have a significant effect on BME families who may have larger families and would be in need of more bedrooms.
- That the local authority would need to ensure there would be sufficient social housing in the Borough and this should cover provision for larger families.

A 'Toolkit for Communication' had been prepared by the Department for Work and Pensions and it was confirmed that some families may be affected by more than one change to the benefits system. As some Boroughs have more than one housing benefit rate, it was thought this would probably result in people moving within a Borough i.e to the cheaper rental area before moving out of the Borough completely.

Letters would be sent to the 52 families who are affected by the 4 bedroom capping rule and leaflets would be prepared for tenants for information.

AGREED That details showing the full impact of changes for Enfield, as a result of the Welfare Reform benefit legislation, should be reported back to this Group when available.

Christine Cox was thanked for her informative presentation

7
EQUALITY FRAMEWORK UPDATE (8:45PM)

Martin Garnar, Equalities Officer presented a briefing paper on the Equality Framework for Local Government. He highlighted the following points:

- The Council had previously measured its equalities performance against the Equality Standard for Local Government and had reached level 4 out of 5 levels of performance. In 2009 this had been replaced by the Equality Framework for Local Government
- An informal assessment meeting had been arranged for the 12.1.11 when interviews would be held with representatives from LBE including the Leader of the Council, the Chief Executive, and Corporate Equalities Group and other council officers to determine if the Council was ready to go forward for a more formal detailed assessment in March.
- The formal assessment on 22nd and 23rd March 2011 would include interviews with partners from the voluntary and community sector including EREC and other public sector partners
- The briefing paper set out the characteristics that an authority would be required to demonstrate in order to achieve the excellent standard and it was felt that the authority met these requirements.

Members raised the following issues:

- When asked if service users would be interviewed, Martin Garnar explained that, as part of the formal assessment, interviews would take place with community groups where they would be looking at the community engagement processes that were in place and would check that the correct outcomes had been reached.
- Martin Garnar confirmed that the lead assessor was appointed by a Government agency, Local Government Improvement and Development.
- Chandra Bhatia asked if an 'excellent' assessment would be of advantage to the authority and enable them to obtain government grants. Martin Garnar replied that whilst it would not entitle the authority to any government grants, it would be a prestigious award which may attract staff and would give the Council a higher profile. He stated that regardless of the outcome the authority would be continually looking to improve its performance.

8
DATE OF NEXT MEETING

The next meeting would be held at 7:30pm on Tuesday 26th April 2011

AGREED that the following item would be considered at the next meeting:
- Updates on Recruitment Processes for Agency Staff, and the Council's Apprenticeship Scheme
- Equality Monitoring of Services 2009/10
- Housing Benefit changes update
- New health commissioning arrangements
- Enfield Residents Priority Fund.

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MINUTES OF THE MEETING OF THE HEALTH CABINET SUB-COMMITTEE HELD ON THURSDAY, 7 APRIL 2011

COUNCILLORS

PRESENT Donald McGowan (Cabinet Member for Older People and Adult Social Services) (Chairman), Ayfer Orhan (Cabinet Member for Education and Children's Services) and Doug Taylor (Leader of the Council)

ABSENT Andrew Stafford (Cabinet Member for Finance, Facilities and Human Resources)

OFFICERS: Andrew Fraser (Director of Schools & Children's Services), Ray James (Director of Health, Housing and Adult Social Care) and Bindi Nagra (Joint Chief Commissioning Officer), Dr Shahed Ahmad (Director of Public Health), Jacqui Hurst (Secretary)

Also Attending: One Member of the public

1
APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Andrew Stafford (Cabinet Member for Finance, Facilities and Human Resources) and Rob Leak (Chief Executive).

2
DECLARATIONS OF INTEREST

There were no declarations of interest from members of the Sub-Committee.

Dr Shahed Ahmad (Director of Public Health) advised Members that his wife had recently been appointed to a joint post covering Barnet and Chase Farm Hospitals and University College Hospital.

3
URGENT ITEMS

NOTED that the reports listed on the agenda had been circulated in accordance with the requirements of the Council's Constitution and the Local Authorities (Executive Arrangements) (Access to Information) (England) Amendment Regulations 2002. These requirements state that agendas and reports should be circulated at least 5 clear days in advance of meetings.

4
BARNET, ENFIELD AND HARINGEY (BEH) CLINICAL STRATEGY REVIEW UPDATE

Councillor Don McGowan (Cabinet Member for Older People, Health and Adult Social Care) introduced the report of the Director of Health, Housing and Adult Social Care (No.223) providing an update on the review of the Barnet, Enfield and Haringey Clinical Strategy.

NOTED the content of the report and the following issues in particular,

1. the outcome from the meeting with the Secretary of State on 10 March 2011 for the Council to lead on the development of alternative proposals to the closure of the 24 hour A & E and maternity unit at Chase Farm Hospital;

2. the range of communication channels to seek views, new ideas and alternatives within Enfield;

3. the timescale for response to the Secretary of State for Health and the final decision resting with the Secretary of State;

4. Ray James (Director of Health, Housing and Adult Social Care) provided Members with a comprehensive summary of the actions and engagement activities which had taken place, as detailed in the report, and following the report's publication. The issues covered included the following:

    - The Council had set up an on-line BLOG which had received approximately 76 comments
    - Comment boxes in libraries had resulted in 60 responses
    - All comments received were currently being collated and analysed
    - A stakeholder meeting had taken place with 45 representatives from local groups being in attendance
    - A public meeting had been held at Kingsmead School which had been attended by approximately 140 people, providing an opportunity for public views to be fully expressed.
    - A number of conversations and meetings had taken place with clinicians, GPs and health experts to gather views.
    - A meeting of the Health and Wellbeing Board had taken place earlier today.
    - The full range of data received was now being gathered and would help to form the Council's submission to the Secretary of State. It was noted that the original deadline for response of 7 April had now been extended to 19 April 2011 but the Council aim to have the submission made by early next week.
    - In response to questions from Members, Ray James summarised the views which had been expressed by local GPs

and Clinicians on the future provision of services in the Borough both in regard to maternity services and A & E provision.

- The funding arrangements in place for junior doctors' training programmes.
- The recognised need for improvement in primary care services and health service provision within the community.

5. that the Sub-Committee was asked to delegate responsibility for signing off the final submission to the Secretary of State for Health to the Leader of the Council and the Cabinet Member for Older People, Health and Adult Social Care), the decision below refers:

6. the written submission which had been received from the Save Chase Farm Group commenting on Report No.223. In response to the comments received it was noted that the clinicians in attendance at the public meeting, held at Kingsmead School, had been asked to allow maximum time for public views to be expressed, and therefore did not speak.

Alternative Options Considered: None stated, report for information.

DECISION: The Health Cabinet Sub-Committee agreed to delegate responsibility for signing off the final submission to the Secretary of State for Health to the Leader of the Council and the Cabinet Member for Older People, Health and Adult Social Care.

Reason: To advise the Sub-Committee of the progress of the review of the Barnet, Enfield and Haringey Clinical Strategy.
(Non-key)

5
HEALTH SERVICES TRANSITIONAL ARRANGEMENTS UPDATE

Councillor Don McGowan (Cabinet Member for Older People, Health and Adult Social Care) introduced the report of the Director of Health, Housing and Adult Social Care (No.224) providing an update on progress with the transformation of local health structures.

NOTED

1. the progression of the overarching section 75 Partnership Agreement, the update on the recruitment to the post of Joint Chief Commissioning Officer and Borough Director and the development of the Enfield GP Consortium; and

2. the initial list of key priorities for the Chief Joint Commissioning Officer as set out in paragraph 5.3 of the report and the proposal to use the funding currently being transferred by the NHS to the Council for 2011/12 to support these priorities;

3. an update on the development of the Health and Wellbeing Board;

4. the proposed new governance arrangements for approval of joint strategies, by the council as detailed in paragraph 9 of the report;

5. the Risk Assessment of the transitional arrangements;

6. Bindi Nagra (Joint Chief Commissioning Officer) outlined for Members' consideration the detail of the report and drew attention to the following issues:

   - The update provided on the recruitment to the post of Enfield Borough Director as set out in section 4 of the report;
   - Bindi Nagra had been appointed to the post of Joint Chief Commissioning Officer, as detailed in section 5 of the report. Members' attention was drawn to the key priorities for the future, referred to in paragraph 5.3 of the report.
   - The future of the Health and Wellbeing Board as set out in section 5 of the report. Further information would be presented to a future meeting of the Sub-Committee for consideration. Forthcoming legislation could change current expectations. In response to a question from Members, the structure and membership of the current Board was outlined.
   - With regard to the GP Consortium, section 7 of the report, it was noted that the application to become a pathfinder pilot had been successful. Members noted the funding that would be forthcoming for development and training provision.
   - The development of Section 75 Partnership Agreements as set out in section 8 of the report.
   - Members discussed the proposed future governance arrangements for the approval of joint commissioning strategies as set out in section 9 of the report. Any changes required to the Council's Constitution would need to be agreed by the Governance Review Group and full Council.

7. that the joint commissioning arrangements also included an element of Children's Services which should have been addressed within the report. Members were assured of the joint work which was being undertaken with Children's Services and in particular the safeguarding issues which had been addressed with the Primary Care Trust. Further joint work would continue;

8. the current and future role of the Health and Wellbeing Board as detailed above. Further discussions would be required at future appropriate meetings to determine the way forward. There were still a number of issues to be debated.

Alternative Options Considered: None stated.

DECISION: The Health Cabinet Sub-Committee agreed to

1. approve the initial list of key priorities for the Chief Joint Commissioning Officer as set out in paragraph 5.3 of the report and, agree the use of funding currently being transferred by the NHS to the Council for 2011/12 to support these priorities;

2. approve the proposed new governance arrangements for approval of joint strategies, by the Council as detailed in section 9 of the report.

Reason: Use of the Health Act flexibilities to establish integrated commissioning and joint services and senior posts would facilitate a number of issues, as set out in section 11 of the report.
(Non-key)

6
UPDATE ON PUBLIC HEALTH PRIORITIES

Councillor Don McGowan (Cabinet Member for Older People, Health and Adult Social Care) introduced the report of the Director of Public Health (No.225) providing an update on Public Health changes and identifying the key priorities for the Public Health Function.

NOTED

1. the content of the report and the priorities and reports listed in paragraphs 4.1 and 4.2 of the report;

2. that the Borough's breast screening rates had risen to 69%. Enfield was now the best performing Borough in North Central London. Now that targets were being met, consideration would also be given to promoting early awareness of breast cancer;

3. that the Public Health Department had now moved to the Civic Centre, paragraph 4.4 of the report referred;

4. the current situation with regard to the ring fenced public health budget for 2012/13 and the public health budget for 2011/12 as detailed in paragraphs 4.5 and 4.6 of the report. It was noted that historically Enfield had not received a generous allocation;

5. in response to Members' questions, the role and responsibilities of Locality Boards in the Borough, paragraph 4.7 referred, were discussed in detail. There were 3 locality boards based in Edmonton Leeside, North East Enfield and South West Enfield. The Boards would be considering public health priorities and delivery mechanisms. Joint working and engagement with relevant agencies would be sought to encourage local service delivery. Further development work would continue;

6. the proposed key priorities and proposed delivery targets for the coming year as detailed in paragraphs 4.9 and 5 of the report. The priorities represented realistic and achievable targets;

7. a discussion took place on further potential targets and priorities, which would be dependant on the budget allocation received by Enfield. Such issues included awareness raising for prostrate and bowel cancer and for cancer in general. The continuation of child health issues such as obesity, infant mortality and teenage pregnancy. Targeting adult obesity through increased physical activity. Further discussions would take place and joint work would continue.

Alternative Options Considered: None.

Reason: Priorities and targets based on the Joint Strategic Needs Assessment and performance monitor of activity during 2010/11.
(Non-key)

7
MINUTES

AGREED that the minutes of the previous meeting of the Health Cabinet Sub-Committee held on 16 February 2011 be confirmed and signed by the Chairman as a correct record.

8
DATE OF NEXT MEETING

NOTED that the date of the next meeting of the Health Cabinet Sub-Committee was to be confirmed and would be subject to the approval of the Council's calendar of meetings for the new municipal year 2011/12.

MINUTES OF THE MEETING OF THE CABINET HELD ON WEDNESDAY, 9 MARCH 2011

COUNCILLORS

PRESENT	Doug Taylor (Leader of the Council), Achilleas Georgiou (Deputy Leader, Public and Service Delivery), Chris Bond (Cabinet Member for Environment, Street Scene and Parks), Bambos Charalambous (Cabinet Member for Young People and Culture, Leisure, Sports and the Olympics), Del Goddard (Cabinet Member for Regeneration and Improving Localities), Donald McGowan (Cabinet Member for Older People and Adult Social Services), Ayfer Orhan (Cabinet Member for Education and Children's Services), Ahmet Oykener (Cabinet Member for Housing and Area Improvements) and Andrew Stafford (Cabinet Member for Finance, Facilities and Human Resources)
ABSENT	Chaudhury Anwar MBE (Cabinet Member for Community Cohesion and Capacity Building in the Third Sector)
OFFICERS:	Rob Leak (Chief Executive), James Rolfe (Director of Finance and Corporate Resources), Andrew Fraser (Director of Schools & Children's Services), Neil Rousell (Director of Regeneration, Leisure & Culture), Ian Davis (Director of Environment), Ray James (Director of Health, Housing and Adult Social Care), Asmat Hussain (Assistant Director Legal), John Austin (Assistant Director - Corporate Governance), Geoff Waterton (Head of Collection Services), Suzanne Linsey (Press Officer), Nathalie Boateng (Principal Lawyer), Julie Mimnagh (Head of HR Operations), Alison Trew (Head of Corporate Policy and Performance) and Neil Vokes (Project Manager) Jacqui Hurst (Secretary)
Also Attending:	Councillor Henry Lamprecht.

1
APOLOGIES FOR ABSENCE

An apology for absence was received from Councillor Chaudhury Anwar (Cabinet Member for Community Cohesion and Capacity Building in the Third Sector).

An apology for lateness was received from Councillor Ayfer Orhan (Cabinet Member for Education and Children's Services).

2
DECLARATION OF INTERESTS

There were no declarations of interest.

3
URGENT ITEMS

NOTED that the reports listed on the agenda had been circulated in accordance with the requirements of the Council's Constitution and the Local Authorities (Executive Arrangements) (Access to Information) (England) Amendment Regulations 2002. These requirements state that agendas and reports should be circulated at least 5 clear days in advance of meetings.

4
DEPUTATIONS AND PETITIONS

NOTED that there were no deputations or petitions to be received at this meeting.

5
REVENUE MONITORING REPORT DECEMBER 2010

Councillor Andrew Stafford (Cabinet Member for Finance, Facilities and Human Resources) introduced the report of the Director of Finance and Corporate Resources (No.201) setting out the Council's revenue budget monitoring position for 2010/11 based on information to the end of December 2010.

NOTED

1. a correction to paragraph 1.1 of the report, the underspend including schools budgets is £1.434m, not £1.080m as stated in the report;

2. the revenue outturn projection of £399k underspend in 2010/11;

3. the identified pressures on the revenue budget as set out in the report;

4. the information provided with regard to Section 106 funding agreements, as set out in paragraph 6.3 of the report. A full review of all outstanding Section 106 obligations was being carried out and a detailed analysis would be available next month;

5. the detailed risk analysis outlined in the report. There had been no deterioration in the financial position of the Authority.

Alternative Options Considered: Not applicable to this report.

DECISION: The Cabinet agreed that Departments reporting pressures should continue to take actions to ensure that they remain within budget in 2010/11.

Reason: To ensure that Members were aware of the projected budgetary position for the Authority, including all major budget pressures and underspends which had contributed to the present monthly position and that were likely to affect the final outturn.
(Key decision – reference number 3196)

6
CAPITAL PROGRAMME MONITOR THIRD QUARTER DECEMBER 2010 - BUDGET YEAR 2010-11

Councillor Andrew Stafford (Cabinet Member for Finance, Facilities and Human Resources) introduced the report of the Director of Finance and Corporate Resources (No.202) informing Members of the current position regarding the Council's 2010 to 2015 capital programme taking into account the latest monitoring information on the progress of the schemes.

NOTED that a full review of all capital schemes had taken place and the capital programme had been re-profiled. This process had resulted in over £12m of schemes being stopped, saving the Council over £1m in ongoing revenue costs. The report showed that the overall expenditure was projected to be £116.6m which was in line with the re-profiled budget.

Alternative Options Considered: None stated.

DECISION: The Cabinet

1. agreed the forecast outturn detailed in Appendix A of the report, with spend to date as set out in Appendix B of the report;

2. agreed the revisions to the budget of £47.021m as set out in Table 1 of the report.

Reason: To review and monitor the Council's capital programme.
(Key decision – reference number 3245)

7
EMPTY PROPERTY COMPULSORY PURCHASE ORDERS (CPO VI)

Councillor Ahmet Oykener (Cabinet Member for Housing and Area Improvements) introduced the report of the Director of Health, Housing and Adult Social Care (No.203) seeking authorisation to make compulsory purchase orders on three empty residential properties whose owners had proved un-responsive to attempts by Officers to bring them back into residential use.

NOTED the considerable amount of work which had been undertaken by Officers to date in seeking to bring the properties concerned back into residential use, as detailed in the report.

Alternative Options Considered: All attempts to negotiate with, and assist the owners of these properties to return them back into use had been exhausted. The other option the Council might pursue was to do nothing (section 4 of the report referred).

RECOMMENDED TO COUNCIL to authorise

1. the making of three compulsory purchase orders (Orders) in respect of the following properties under Section 17 of the Housing Act 1985 and the Acquisition of Land Act 1981 (as amended by the Planning and Compulsory Purchase Act 2004): 11 St John's Terrace, EN2 9AQ, 35 Kingsway, EN3 4HS, and 42 Lion Road, N9 9DW, as shown on the plans (appendices 1 – 3 of the report);

2. the preparation of Orders, and supporting documentation and the taking of all necessary steps (including the conduct of a Public Inquiry if necessary) to obtain confirmation of the Orders by the Secretary of State;

3. the acquisition of the properties (either compulsorily or by agreement) following confirmation of the Orders, the payment of compensation and statutory interest and the instituting or defending of proceedings where necessary; and

4. the disposal of the properties in accordance with the Property Procedure Rules.

Reason: The compulsory purchase of the above properties, and their subsequent onward sale, would produce a quantitative and qualitative gain to the borough's housing stock, would assist in the achievement of the Council's housing strategies and would turn existing eyesores into much needed homes. They would address the Council's strategic supply, regeneration and sustainability objectives, together with the Mayor of London's expectations cited in the report.
(Key decision – reference number 3228)

8
2010/11 QUARTER 3 PERFORMANCE OUTTURN REPORT

Councillor Achilleas Georgiou (Deputy Leader, Public and Service Delivery) introduced the report of the Chief Executive (No.204) presenting the overview of performance information for the third quarter of 2010/11.

NOTED

1. the progress made towards delivering the identified key priority indicators for Enfield;

2. that the majority of indicators were performing well. Members noted the current position and that some areas required further improvement.

Alternative Options Considered: None.

Reason: To update Cabinet on the progress made against all key priority performance indicators for the Council and Enfield Strategic Partnership.
(Key decision – reference number 3193)

9
SETTING UP THE COUNCIL'S TRADING COMPANY

Councillor Andrew Stafford (Cabinet Member for Finance, Facilities and Human Resources) introduced the report of the Director of Finance and Corporate Resources (No.205) proposing the establishment of the Council's trading company, wholly owned by the London Borough of Enfield, to commence trading in April 2011.

NOTED

1. that Section 95 of the Local Government Act 2003 permits local authorities to trade commercially in their normal functions with the mechanism of a trading company, as detailed in the report;

2. that the London Borough of Enfield provided a range of high quality services with a reputation for excellence in the public and private sectors such as Community Alarm and Enfield Public Safety Centre;

3. the rationale for setting up a trading company as set out in section 3.2 of the report. The proposed name for the Company was New River Services Ltd. The company would raise income for the Council, provide greater opportunities for staff, help to protect jobs and share services in other authorities;

4. the proposals for the trading company outlined in section 3.3 of the report, including governance arrangements, services, staffing, legal issues and service level agreements. The cost for setting up the trading company would be approximately £85k.

Alternative Options Considered: NOTED that there were many options open to Councils to sell their services, develop staff and raise income, as detailed in section 4 of the report.

RECOMMENDED TO THE COUNCIL that

1. the Council's Trading Company is established following Council approval in April 2011;

2. the Trading Company is registered under the name New River Services Ltd.

3. the transfer of services to the Trading Company is agreed by the Trading Company's management board and the relevant Cabinet Members in accordance with the Council's Scheme of Delegation.

4. the governance and legal structures of the Trading Company – including the day to day management of performance and budgets and the structure and membership of the Management Board – are established as outlined in the body of the report (paragraph 3.3 of the report referred). Cabinet would agree the third member to serve on the Board (paragraph 3.3.1 of the report referred).

   Cabinet agreed to nominate the third member prior to the full Council meeting.

Reason: The full reasons for the recommendations were set out in section 5 of the report.
(Key decision – reference number 3190)

10
APPROVAL OF THE INTER AUTHORITY AGREEMENT STATEMENT OF PRINCIPLES BETWEEN THE NORTH LONDON WASTE AUTHORITY AND ENFIELD COUNCIL

Councillor Chris Bond (Cabinet Member for Environment, Street Scene and Parks) introduced the report of the Director of Environment (No.206) setting out the 12 key principles forming the basis for an Inter Authority Agreement (IAA) between the North London Waste Authority (NLWA) and its seven constituent Boroughs, of which Enfield is one.

NOTED

1. that all of the other Boroughs involved, with the exception of Barnet, had already signed up to the Principles. Barnet had indicated that they would be supporting the Principle of Agreement;

2. that further key decisions relating to the Inter Authority Agreement would be presented to the Cabinet in due course.

Alternative Options Considered: NOTED the alternative options considered as set out in section 4 of the report.

DECISION: The Cabinet

1. agreed to adopt the 12 principles set out in Appendix 1 (principles 4 and 8 as amended in the report) and to delegate authority for approval of any minor amendments to the Cabinet Member for Environment, Street Scene and Parks;

2. agreed that further key decisions relating to the IAA as it develops would be brought back to the Cabinet;

3. agreed to delegate authority to the Cabinet Member for Environment, Street Scene and Parks in consultation with the Cabinet Member for Finance, Facilities and Human Resources in consultation with the Director of Environment, to approve the tonnage projections for the new contract to inform the procurement process ahead of June 2012;

4. noted that the fully developed IAA would be agreed by full Council prior to financial close.

Reason: The full reasons for the recommendations were as set out in section 5 of the report.
(Key decision – reference number 3129)

11
LONDON LIVING WAGE

Councillor Doug Taylor (Leader of the Council) introduced the report of the Chief Executive (No.207) seeking approval to adopt the London Living Wage for all Council employees and that the London Living Wage is promoted in the letting of all future Council contracts.

NOTED

1. that Members supported the implementation of the London Living Wage for all Council employees. The majority of all directly employed permanent staff were paid a rate above the London Living Wage and this change would only affect a small group of staff, as detailed in the report. This proposal supported the Council priority of Fairness for All;

2. the position with regard to agency workers, as set out in the report.

Alternative Options Considered: None.

DECISION: The Cabinet agreed to support the establishment of the London living wage, set at a level calculated by the Living Wage Unit (currently £7.85 per hour) to avoid poverty wages being paid within the capital. All Council employees (not on a training contract) should receive at least the London Living Wage. Where appropriate the Council would promote the adoption of the concept of the London Living Wage amongst its contractors and suppliers.

Reason: To demonstrate the Council's commitment to the London Living Wage. The potential benefits had been described in the main body of the report.
(Non-key)

12
LOCAL IMPLEMENTATION PLAN 2011/12 - SETTLEMENT AND PROGRAMME OF WORKS

Councillor Chris Bond (Cabinet Member for Environment, Street Scene and Parks) introduced the report of the Director of Environment (No.208) giving details of the settlement for Enfield from TfL, announced in December 2010, for transport related spending within the Local Implementation Plan for 2011/12 and outlining the Council's proposed programme of transport schemes.

NOTED

1. the significant programme of works for 2011/12 and the level of flexibility built into the programme. Members noted the schemes, as set out in the report, including Smarter Travel and the introduction of 20mph zones. The schemes were covering both the East and West of the Borough;

2. the major schemes detailed in table 6 of the report.

Alternative Options Considered: None. The LIP was a statutory requirement arising from GLA Act 1999. The allocations detailed in section 5 were confirmed by TfL in response to Enfield's submission of funding requests, in October 2010. The programmes of work detailed in section 6 of the report correspond to the priorities stated by Enfield in the draft consultation version of the LIP submitted to TfL in December 2010.

DECISION: The Cabinet agreed to approve the following

1. the expenditure of £780,000 the programme and schemes for the Principal Road Renewal and Maintenance for 2011/12 as given in Table 2 in section 6 of the report;

2. the proposals submitted for works on Bridges in 2011/12 as given in Table 3 in Section 6 of the report;

3. the expenditure of £2,860,000, the programme and schemes for Corridors and Neighbourhoods for 2011/12 as given in Table 4 in section 6 of the report and associated consultation and Traffic Management Orders subject to agreement with the Cabinet Member for Environment, Street Scene and Parks;

4. the expenditure of £390,000, the programme and schemes for Smarter Travel for 2011/12 as given in Table 5 in section 6 of the report;

5. the expenditure of £1,310,000 for the three (Area Based) Major Schemes Programme for 2011/12 allocated by TfL in December 2010, given in Table 6 in section 6 of the report;

6. noted the provision for the expenditure of £100,000, the programme and schemes for local transport expenditure for 2011/12. This had not been allocated against any programme and could be spent as the Council wishes providing that the scheme(s) remain in accordance with the Mayor's transport priorities;

7. delegation of authority to the Cabinet Member for Environment, Street Scene and Parks to agree variations to the approved programme of works and the areas of expenditure for the above.

Reason: To give details of the settlement for transport related spending within the Local Implementation Plan (LIP) for 2011/12 and outlines the implications for the Council's programme of transport schemes. It seeks the necessary financial and other approvals so that work can start in April 2011.
(Key decision – reference number 3222)

13
AREA FORUM REVIEW

Councillor Achilleas Georgiou (Deputy Leader, Public and Service Delivery) introduced the report of the Director of Finance and Corporate Resources (No.209) dealing with a review of the Council's Area Forums.

NOTED

1. that the proposals had previously been considered by the Governance Review Group at its meeting on 15 February 2011;

2. that the review and consultation undertaken had sought ways in which the Area Forums could be used more effectively and to encourage increased and wider attendance at the meetings;

3. the feedback received during the consultation had been taken into consideration when drawing up the proposals for the future. Residents had indicated that they wished to have a greater level of engagement with their local Ward Councillors;

4. the responses which had been received from individual Councillors, as advised by Councillor Georgiou;

5. in recommending the following options to Council, Members also indicated the need for some flexibility within the individual Area Forums to meet their particular needs, for example, the preferred seating

arrangements, venues and attendees. A greater level of engagement with Ward Councillors would be encouraged through, for example, by dividing the meeting into individual Wards for part of the Area Forum meeting.

Alternative Options Considered: As detailed in the body of the report.

RECOMMENDED TO THE COUNCIL that the following options are adopted:

1. **Developing Role of Area Forums** – Option 3 in Table 1 of the report. This would allow the Council to retain elements of the current format of the meeting but adding issues such as developing links with CAPEs, attendance by Enfield Homes and Youth Area Forums.

2. **Structure of Area Forums** - Option 3 in Table 2 of the report. This would allow retention of 3 wards per Area Forum across the Borough but would permit the clusters to be changed to reflect views received from residents and Members.

3. **Frequency and Location of Area Forums** - Option 4 in Table 3 of the report. This would allow the Area Forums to continue to meet 4 times a year but additional venues would be sought where practical.

4. **Format Including Seating and Provision of Information**. Option 3 in Table 4 of the report is favoured. This provides for a change to allow information to be provided in advance. The seating would also change to a style that allows round table discussion.

Reason: As detailed in full in section 6 of the report.
(Key decision – reference number 3236)

14
BUSINESS RATE HARDSHIP RATE RELIEF

Councillor Andrew Stafford (Cabinet Member for Finance, Facilities and Human Resources) introduced the report of the Director of Finance and Corporate Resources (No.210) setting out a revised proposal for a Business Rate Hardship Relief scheme in the light of proposed changes to business rate administration set out in the Localism Bill and published on 13 December 2010.

NOTED that given the changes detailed in the report, the rate relief scheme previously agreed in November 2010 had been amended to introduce a more representative pilot scheme. The comments which had been received had been taken into consideration and the scheme had been simplified. The revised scheme complied with the Localism Bill.

Alternative Options Considered: The report sets out a pilot scheme to monitor the application of rate relief in the borough's poorest area where there is the greatest concentration of need amongst small businesses, with a view to its extension after a year, if successful. The Council could not justify extending the scheme borough-wide without monitoring and evaluating the impact of an initial pilot scheme.

DECISION: The Cabinet agreed

1. the proposed Hardship Rate Relief scheme as set out in Appendix 1 of the report;

2. the financial assessment criteria to be used to evaluate applications detailed in Appendix 2 of the report;

3. the pilot scheme evaluation criteria set out in Appendix 3 of the report;

4. the proposed pilot ward based on the index of multiple deprivation as recommended in paragraph 3.5 of the report.

Reason: To help local businesses and the local community. To enhance the additional Government rate relief to small businesses which also recognises the importance of business to the whole community.
(Key decision – reference number 3237)

15
LADDERSWOOD PLACE SHAPING PROGRAMME: THE INCLUSION OF LORNE HOUSE AND ROBERTS HOUSE IN THE LADDERSWOOD REDEVELOPMENT

Councillor Del Goddard (Cabinet Member for Regeneration and Improving Localities) introduced the report of the Director of Health, Housing and Adult Social Care and Director of Regeneration, Leisure and Culture (No.211) considering whether to retain Lorne House and Roberts House or whether to include them in the redevelopment plans for the area.

NOTED

1. that Enfield Homes had confirmed that 31 of the 35 homes in Lorne House and Roberts House were non decent and would require works to bring them up to standard. Funding for the four year Decent Homes programme had recently been announced. The Council had a significant shortfall in funding to bring the Borough's stock up to the Decent Homes standard (paragraphs 3.10 and 3.11 of the report referred);

2. that extensive discussions had taken place with residents and a full consultation exercise had been implemented. Should Lorne House and Roberts House be included in the redevelopment, the Council would make a number of commitments to the secure tenants, as detailed in paragraph 3.22 of the report;

3. that there were a number of vulnerable residents living within the two blocks, their particular needs would be taken into account and appropriate support provided to them;

4. the number of tenants in favour of the inclusion of the blocks in the redevelopment, paragraphs 3.40 and 3.41 of the report referred. The Council had also ensured that the consultation process followed had been fair and accurate; an independent tenant and leasehold advisor had been employed to check and confirm this;

5. that the Council would continue to work with residents to meet their individual needs and ensure a smooth transition for them;

6. that the Council had approached both bidding Development Partners to secure a further commitment that a specific apartment block within the new development could be identified at an early stage for re-housing residents from Lorne House and Roberts House who wished to remain close to their neighbours (paragraph 3.26 of the report referred);

7. that Councillor Taylor had received an email from Mr Weeks, a resident leaseholder, a block representative for Lorne House and a member of the Ladderswood Resident Panel. Mr Weeks was opposed to the inclusion of the blocks in the redevelopment of Ladderswood. Councillor Taylor acknowledged the points which had been raised. Mr Weeks was provided with a written response to the issues stated in the e mail and was invited to consider the response and if he wished, to make any further comments in writing which could then be responded to appropriately;

8. that the consultation exercise had been extensive and every effort had been made to seek options for the benefit of all concerned;

9. Councillor Goddard informed Cabinet that an Independent Tenant and Leasehold Advisor had been commissioned to appraise the effectiveness and appropriateness of the consultation and engagement programme carried out by the Council;

10. a sample survey, which included at least 30% of the residents who had indicated their position as in favour of the inclusion of the two blocks and 30% of the residents who were not in favour, was completed. In summary, out of the 10 people surveyed who were recorded as in favour, 9 confirmed that to be their position whilst 1 had changed to against. Of the 3 people surveyed who were recorded previously as against, 2 continued to be against whilst the third was now in favour;

11. the independent survey indicated that 77% of respondents believed that they had enough information to make an informed choice and 85% felt that the level of consultation was appropriate.

Councillor Goddard extended his thanks and appreciation to all those who had been involved in the consultation work to date.

Alternative Options Considered: NOTED the alternative options which had been considered as set out in section 4 of the report.

DECISION: The Cabinet

1. agreed to include Lorne House and Roberts House in the Ladderswood redevelopment;

2. agreed to endorse the commitments to Lorne House and Roberts House residents as set out in 3.22 of the report;

3. agreed to authorise Property Service to agree terms for the purchase for the leasehold properties included in Lorne House and Roberts House on behalf of the Council and to authorise Legal Services to complete the purchases;

4. agreed to authorise the issuing of Ground 10 and Demolition Notices under the Housing Act 1985 in respect of tenanted properties on the Ladderswood Estate which consist of Lorne House and Roberts House;

5. agreed to the decant of secure tenants from Lorne House and Roberts House.

Reason: To respond to the majority of residents living in Lorne House and Roberts House. To enable the regeneration of Ladderswood to achieve its vision of creating a truly attractive, enjoyable and sustainable place for people to live and work. To enable the Council to close the procurement of a preferred development partner for Ladderswood. To mitigate the risk that cuts to the Decent Homes budget results in the refurbishment works to kitchens and bathrooms not being carried out.
(Key decision – reference number 3219)

16
LADDERSWOOD PLACE SHAPING PROGRAMME: COMPULSORY PURCHASE ORDER AND SHARED EQUITY OPTION REPORT

Councillor Del Goddard (Cabinet Member for Regeneration and Improving Localities) introduced the report of the Director of Health, Housing and Adult Social Care and Director of Regeneration, Leisure and Culture (No.212) recommending the making of the Ladderswood and New Southgate Industrial estate compulsory purchase order 2011.

NOTED

1. that Report No.213 also referred, as detailed in Minute No.27 below:

2. that the Compulsory Purchase Orders would only be required should the Council fail to reach negotiated settlements on the properties concerned.

Alternative Options Considered: An alternative option considered was for the Council not to make a CPO for Ladderswood and the New Southgate Industrial estate. The development partner would then lead on leasehold buybacks. Two major risks with this approach are that firstly, the development partner may have to pay above market rate to complete negotiations with individual leaseholders and secondly, that there will remain a high risk that negotiation with all the remaining leaseholders might not be successful and vacant possession cannot be secure.

RECOMMENDED TO COUNCIL

1. to note the statement of reasons attached to the report which set out the justification for making the Ladderswood and New Southgate Industrial estate CPO 2011;

2. to note the indicative timeline for the CPO process for the Ladderswood and New Southgate Industrial Estate CPO 2011 attached to the report;

3. to agree to approve the making of the Ladderswood and New Southgate Industrial Estate CPO 2011 under section 226(1)(a) of the Town and Country Planning Act 1990 as amended by the Planning and Compulsory Purchase Act 2004 (the “1990 Act”);

4. to agree to authorise the Director of Health, Housing and Adult Social Care to take all the necessary steps consequent to the making of the Ladderswood and New Southgate Industrial Estate CPO 2011;

5. to agree to authorise the inclusion of a limited number of shared equity properties in the development as an alternative purchase option for leaseholders on the Ladderswood Estate.

Reason: To provide the Council with a legal option to ensure that vacant possession of the site could be achieved to enable the regeneration of the area could take place, as detailed in section 5 of the report.
(Key decision – reference number 3166)

17
ISSUES ARISING FROM THE OVERVIEW AND SCRUTINY PANEL/SCRUTINY PANELS

There were no issues arising.

18
ITEMS TO BE REFERRED TO THE COUNCIL

AGREED that the following items be referred to the Council:

1. Report No.203 – Empty Property Compulsory Purchase Orders (CPO VI)

2. Report No.205 – Setting Up the Council's Trading Company

3. Report No.209 – Area Forum Review

4. Report Nos 212 and 213 – Ladderswood Place Shaping Programme: Compulsory Purchase Order and Shared Equity Option Report

NOTED that in future this item would appear at the beginning of the Cabinet agendas and would indicate which reports should be referred up to full Council.

19
CABINET AGENDA PLANNING - FUTURE ITEMS

NOTED the provisional list of items scheduled for future Cabinet meetings. This list was subject to further change.

20
KEY DECISIONS FOR INCLUSION ON THE COUNCIL'S FORWARD PLAN

NOTED that the next Forward Plan was due to be published on 15 March 2011, this would cover the period from 1 April to 31 July 2011.

21
MINUTES OF LOCAL DEVELOPMENT FRAMEWORK CABINET SUB-COMMITTEE - 8 FEBRUARY 2011

NOTED the minutes of a meeting of the Local Development Framework Cabinet Sub-Committee held on 8 February 2011.

22
MINUTES OF HEALTH CABINET SUB-COMMITTEE - 16 FEBRUARY 2011

NOTED

1. the minutes of a meeting of the Health Cabinet Sub-Committee held on 16 February 2011;

2. that the date of the meeting with the Secretary of State, referred to in Minute No.4 (2), had been changed and was now due to take place on 10 March 2011;

3. that an appointment had recently been made to the post of Joint Commissioner. This post would work closely with the Enfield Borough Director, when an appointment had been made. The appropriate location for the officers concerned was currently under consideration.

23 MINUTES

AGREED that the minutes of the previous meeting of the Cabinet held on 9 February 2011 be confirmed and signed by the Chairman as a correct record.

24 ENFIELD STRATEGIC PARTNERSHIP FEEDBACK

NOTED that there had been no recent meeting of the Enfield Strategic Partnership.

25 DATE OF NEXT MEETING

NOTED that the next meeting of the Cabinet was scheduled to take place on Wednesday 27 April 2011 at **7.00pm** at the Civic Centre.

The meeting previously scheduled to take place on Wednesday 30 March 2011 had been cancelled.

26 EXCLUSION OF THE PRESS AND PUBLIC

RESOLVED in accordance with Section 100A (4) of the Local Government Act 1972 to exclude the press and public from the meeting for the item of business listed on part 2 of the agenda on the grounds that it involves the likely disclosure of confidential information as defined in Part 1 of Schedule 12A to the Act (as amended by the Local Government (Access to Information) (Variation) Order 2006).

27 LADDERSWOOD PLACE SHAPING PROGRAMME: COMPULSORY PURCHASE ORDER AND SHARED EQUITY OPTION REPORT

Councillor Del Goddard (Cabinet Member for Regeneration and Improving Localities) introduced the report of the Director of Health, Housing and Adult Social Care and Director of Regeneration, Leisure and Culture (No.213) containing commercially sensitive information with regard to the Compulsory Purchase Order.

NOTED

1. that Report No.212 also refers, as detailed in Minute No.16 above;

2. the additional commercially sensitive information with regard to the compulsory purchase order programme and in support of the decisions detailed in Minute No.16 above;

3. in response to a question raised by Councillor Ayfer Orhan, the processes adopted with regard to considering the human rights of individuals affected by potential compulsory purchase orders were outlined for Members' information.

Alternative Options Considered: As detailed in Report No.212, Minute No.16 above refers.

Reason: As detailed in Report No.212, Minute No.16 above refers.
(Key decision – reference number 3166)

(Exempt information as defined in Paragraph 3 (information relating to the financial or business affairs of any particular person (including the authority holding that information)) of Schedule 12A to the Local Government Act 1972 as amended).

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