Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 21 April 2016 at 6.15 pm
Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

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Dear All

To Follow Papers

Please find attached the following papers marked “to follow” on the agenda for the next meeting of the Health and Wellbeing Board.

Item 10 Sub Board Updates

Health Improvement Partnership Update
Joint Commissioning Board Update

Please bring these papers with you to the meeting.

If you have any queries in the meantime, please let me know, details above.

Thank you

Yours faithfully

Penelope Williams

Penelope Williams
Democratic Services

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Agenda Item 10

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **21 April 2016**	**Agenda - Part: 1** | **Item: 10a** **Subject: Health Improvement Partnership Board Update**
Contact Officer: Miho Yoshizaki Tel: 0208 379 5351 Email:	**Approved by: Dr Shahed Ahmad**

1. EXECUTIVE SUMMARY

This report summarises the work of the Health Improvement Partnership Board.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the contents of this report.

1.0 REDUCING LIFE EXPECTANCY GAP FOR THE PRIORITY WARDS

The core offer team leads on work intended to reduce health inequalities in 5 priority wards, in addition to the support to the CCG. This is undertaken by working within the communities, with patients and professionals, to improve the prevention, early recognition and effective management of long-term conditions which are a burden to patients and the local health and social care economy as a whole.

A GP registration promotion campaign was continued working with urgent care centres, walk-in centres and A&E departments. Maps with GPs and dentists were distributed with an information leaflet to patients. The map also includes walking distance to local GPs and bus routes to prevent unnecessary use of cars and to promote physical activity.

Cardiovascular disease is a major cause of life expectancy gap and there are a number of risk factors that can be modified to reduce significantly the risk of coronary events and stroke. Public Health team delivered presentation to the Enfield GPs at two of their training days around the importance to improve detection and management of blood pressure and atrial fibrillation. They were

joined by a GP with special interest in cardiovascular disease and a lecturer from Queen Mary University of London.

The next important cause of life expectancy gap is cancer, which is also a major cause of mortality across Enfield. There are some types of cancers that cannot be detected by screening such as lung cancer. “If in doubt, check it out!” campaign was delivered from March 2016 till early April 2016. A letter was sent out to the GPs to inform the key findings of cancer JSNA.

2.0 SUPPORTING PRIMARY CARE IMPROVEMENT

2.1 GP NEWSLETTER

Newsletters for local health professionals provide information about local epidemiology, health needs, evidence based practices, and variation in practices across the borough. They aim to celebrate improvement and good local practices in order to motivate and encourage improvement across Enfield. These provide additions to the information base relating to long-terms conditions such as hypertension and diabetes.

Smoking is a common cause of many killer diseases such as heart disease, most types of cancer and stroke. One venue of tackling tobacco is through dentists and oral health. A newsletter is being drafted to encourage Enfield’s dentists to give brief intervention to those who smoke and signpost to smoking cessation service.

2.2 BUSINESS CASES FOR LOCALLY COMMISSIONED SERVICES

Public health Core Offer team also supports the reduction of rising demand in long-term conditions (e.g., heart disease, stroke, diabetes, and dementia) by designing new models of care and prevention. These include atrial fibrillation recognition and management and pre-diabetes recognition and pathway. Case for change has been produced with the evidence and return on investment calculations:

- A 5-year stroke prevention scheme by managing atrial fibrillation will save every year 6 lives and 30 strokes (of which 13 disabling stroke) with net NHS recurrent savings around £350,000 per annum and social care recurrent savings around £200,000 per annum;
- A scheme to identify, recruit and provide intensive behaviour interventions to 10% of those with highest risk of diabetes can produce gross savings to the NHS from £50,000 in the first year to £750,000 in the fifth year.

3.0 ENGAGEMENT WITH DEAF COMMUNITY

As part of our efforts to ensure that our efforts in this area were of utility one of Public Health’s Senior Strategists attended the British Sign Language (BSL) drop-in session at Community House on the 18th February at which there was presentation about dementia by a BSL-trained specialist nurse.

Public Health as a team will be attending on the 21st April at the same venue to present on prevention. As part of this event members of LBE's Communications team will also be present in order to address potential issues with LBE's communications vis-à-vis the deaf community

4.0 SCRUTINY ON PHUBLIC HEALTH ENGAGEMENT WITH PRIMARY CARE

The Public Health Core Offer lead reported at scrutiny on their work in engaging local primary care to improve population health outcomes. The summary of the report can be seen below:

i. Despite improvements there remain significant health inequalities within and across the borough, and wide variation in GP outcomes related to proactive management of long-term conditions.
ii. These remain a priority within the Health and Wellbeing Strategy.
iii. These inequalities tend to be more pronounced within the 5 high-priority wards.
iv. Public Health continues to conduct activities, both focused within the 5 high-priority wards, and elsewhere to help with mitigation of these issues.
v. Primary care provides holistic healthcare of the population. High quality primary care is associated with better health outcomes and lower dependency on the acute and social care sector.
vi. Enfield GPs face a huge challenge related to the high level of long-term conditions. A supportive environment facilitated by health and wellbeing members in their own right will help improve the outcomes in health and social care economy.
vii. One of these measures is the engagement and partnership with our local GPs by public health team.

5.0 EFFICIENCY PROGRAMME (QIPP) and RIGHTCARE APPROACH

Public health core offer team supports the local CCG with strategic steer, clinical and scientific evidence, and operational support related to engagement and data to improve population health by investing according to need and evidence and allocating the resources in the right place so that patients receive the right care at the right time at the first time, while meeting its £12.5M saving target.

The team also endeavours to ensure population outcomes are improved without compromising vulnerable people or increasing health inequalities. This is undertaken in part by regularly representing Public Health, and giving expert advice in a number of regular meetings and working groups. These include the Transformation Programme and Financial Recovery Board, the Quality & Safety Group, the Clinical Reference Group, and Working Groups for diabetes, cardiology, respiratory and musculoskeletal conditions. In addition the equalities subgroup, individual funding request panel and better care fund also receive Public Health input.

Public Health Representatives also regularly attend the urgent care transformation board meetings for North Central London. This is especially

important as the admissions related to injuries, infections, common paediatric conditions, mental health issues and non-ambulatory care sensitive conditions are increasing year-on-year in Enfield.

On the other hand public health team supports the reduction of rising demand in long-term conditions (e.g., heart disease, stroke, diabetes, and dementia) by designing new models of care and prevention. These include atrial fibrillation recognition and management, pre-diabetes recognition and pathway, complex diabetes care, hypertension recognition and control, and COPD recognition and control.

It is also to be noted that NHS England chooses Enfield CCG as one of the 9 London CCGs to receive support by the national “RightCare” team. Public health Core Offer and Health Intelligence team is supporting the CCG together with the NHS England team in producing better quality outcomes with increasing efficiency by implementing “Rightcare” approach. The approach identifies the potential areas of quality and efficiency improvement by benchmark the spending and outcomes with similar CCGs.

6.0 JSNA

Maintenance and update of JSNA is progressing well. Work plan for 2016/17 will be agreed at the next steering group meeting scheduled on the 3rd May 2016.

7.0 ANNUAL PUBLIC HEALTH REPORT

Annual Public Health Report is due to be published early May. This year’s report focuses on Infant Mortality in Enfield.

8.0 REGIONAL AND NATIONAL WORK

Enfield’s DPH continues to lead for ADPH on high blood pressure and London ADPH on cancer and primary care co-leads for London ADPH on healthcare public health. The London Hypertension Leadership Group has been developed, the analytical subgroup has produced pan London analysis, and briefing papers have been produced by the detection subgroup and management subgroup. The Healthcare Public Health Consultants will be discussing cancer and hypertension at its April meeting.

8.1 LONDON HIGH BLOOD PRESSURE LEADERSHIP GROUP

London Hypertension Leadership Group aims to prevent, detect and manage hypertension to prevent further cardiac events such as stroke by supporting CCGs and Local Authorities with evidence base and tools.

As part of the Health Intelligence Work stream of this Group, Enfield Public Health produced a tool summarising opportunities derived from improving Hypertension detection and management for each London CCGs. This information is fed back to the NHS Sustainability and Transformation Plan to

improve health of the Londoners. Enfield Public Health team also contributed evidence to derive a set of measures to maintain and improve blood pressure management across London.

In addition, there is a North Central London (NCL) subgroup to produce an NCL-wide coordinated action to raise awareness, and to facilitate population and community participation in blood pressure detection and control.

8.2 COMMISSIONING FOR PREVENTION IN LONDON

Mayor's office and Healthy London Partnership a piece of work to review the economic case of prevention programmes that can be useful for all CCGs and local authorities (LAs) across London. Enfield Public health representatives contributed to the priority setting and the methodology of the economic review. Ten key areas were short-listed by key stakeholders:

1. Alcohol
2. Obesity
3. Physical activity
4. Smoking
5. Circulatory diseases
6. Diabetes
7. Hypertension
8. Mental Health
9. Musculoskeletal conditions (e.g., falls, back pain)
10. Workplace Health

Enfield public health team continues to take part in the on-going discussion so that the needs of Enfield will be represented and to scrutinise the quality of work. The results will be presented to CCGs and LAs in a way to include both the size and pace of return on investment made to health and social care economy.

9.0 SMOKING

There will be a conference on smoking in the Turkish community on 21st May. A new smoking contract is being negotiated following budget cuts to the PH budget. The new contact will focus on the Turkish community, pregnancy and post-natal women, long-term conditions and schoolchildren. As smoking prevalence has fallen much more than might be expected given the number of quitters we have gained through meeting the four week quitter target it is expected that this will enable us to continue to reduce our smoking prevalence (currently 8th lowest in London). PH is attending GP meetings to explain the new contract and its reasoning.

9.1 TRADING STANDARDS

Trading Standards are working across the sector to plan a series of coordinated raids on establishments potentially selling illegal / illicit tobacco and alcohol. This will be followed up with press releases emphasising that illegal tobacco helps

children to start smoking and that even smokers believe that ‘something should be done’ about the sale of illicit / illegal tobacco.

9.2 SMOKING TARGET

At the end of Q3 Enfield had achieved 1030 four week quitters against a target of 920.

10.0 HEALTH CHECKS

The contract was suspended in February. An end of year figure is still to be finalised. February projections were that we had already achieved the yearly target.

11.0 HEALTH TRAINER SERVICE

The health trainer service has now left the Angel in Edmonton and is operating from the Civic saving accommodation costs of £7.5k per year.

12.0 HEALTHY WEIGHT STRATEGY

A learning meeting was held with other boroughs re childhood obesity at the end of February. Enfield actions included promoting sugar free days, apps for physical activity and developing a physical activity care pathway. Actions will be taken forward this quarter.

13.0 CYCLE ENFIELD CONFERENCE

The cycle Enfield conference was held on the 8th April. It was attended by approximately 60 people including Cllrs Anderson and Pite. Following this a response to the Dept for Transport Walking and Cycling investment strategy has been written for consideration by the relevant Cabinet member.

Health and Wellbeing Board – 21 April 2016

Agenda – Part: 1	**Item: 10b**
Subject: Joint Commissioning Board Report	
Date: Thursday 21st April 2016	

REPORT OF:

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1. EXECUTIVE SUMMARY

1.1 This report provides an update on the work of joint commissioning across health and social care in Enfield

1.2 Updates for all key commissioning areas are included, as are relevant updates on commissioning activity from Partnership Boards

1.3 This report notes:

- The borough's Health & Adult Social Care Market Position Statement (MPS) local market facilitation tool has been drafted [p.3]

- An end of year review of 2015/16 Section 75 Agreement is underway. Discussions continue regarding 2016/17 amendments [p.3]

- Specialist Housing [p.3/4]:
  - The opening of Desmond Court
  - Jasper Close has been identified for wheelchair accessible family homes
  - The Parsonage Lane shared ownership pilot project is now near completion
  - The approval of a pilot project with the Housing Gateway to purchase accommodation from the open market to meet the specific needs of adults with disabilities wishing to live independently in the community
  - The initiation of a Joint Workforce Development Project to provide front line housing staff with public health training

- Partnership working between NHS Enfield CCG, LBE and Enfield Community Service forming Integrated Locality Teams (ILT) to deliver a multi-disciplinary approach to supporting GPs as Lead Accountable Professionals
  The CCG also collaborates with NHSE offering a GP Local Incentive Scheme to work with ILTs and Care Homes Assessment Team (CHAT) [p.4]

- The function of Rapid Response, which includes a range of services to help people return home safely after hospital or providing crisis management response in the community to avoid hospitalisation [p.5]

1. EXECUTIVE SUMMARY (CONTINUED)

- Public Health services summary [p.6]
- Learning Disabilities [p.8]:
  - Enfield is the lead commissioner for development and delivery of the NCL Transformation Plan
  - Enfield Council has submitted a bid to the Municipal Journal Local Government Achievement Awards 2016. Results will be announced in May 2016
  - Collaborative contract framework – Waltham Forest, Hackney and Enfield – for people with LD who require support to live independently
  - Learning Disability Assessment & Treatment Unit [Appendix 1]
- Implementation of the Joint Strategy for people with Autism, working with a local voluntary and community sector provider to implement the strategy [p.9]
- Feedback from the workshops organised by HHASC in partnership with Enfield Voluntary Action [p.15]
- Safeguarding Quality Checker update on [p.16-19]:
  - The successful recruitment and Training of Quality Checkers that reflect the diversity of the community
  - Awareness of the needs of the LGBT community
  - Volunteers have now received training and will commence a series of visits in Care Homes from April 2016
- Carers [p.20]:
  - The contract for the young carers service delivery has been awarded to DAZU
  - 6th June: Carers' Week. Them being 'Creating Carer Friendly Communities
  - 7th June: Ray James Q&A session
  - 11th June: Family Fun Day, outside Enfield Town Library
  - 11th June: Training session on supporting young carers in schools
- Partnership Board updates [p.21-26]
  - Safeguarding Adults Board [p.21]
  - Carers Partnership Board [p.23]
  - Sexual Health Partnership Board [p.23]
  - Learning Difficulties Partnership Board [p.24-26]

2. RECOMMENDATIONS

2.1 It is recommended that the Health & Wellbeing Board note the content of this report (with appendices).

3. INTEGRATED & PARTNERSHIP WORKING

3.1 MARKET POSITION STATEMENT

Following engagement events with service users, carers and local providers, Enfield's Health & Adult Social Care Market Position Statement (MPS) has now been drafted. The MPS is a local market facilitation tool. It aims to:

- set out the local authority's **direction of travel** including strategic and legislative drivers that are influencing change;
- provide **information** to the social care market on population needs, service demands, commissioning priorities and resource availability, to facilitate the effective planning and development of services to meet the needs of our residents
- encourage **understanding** and provide a basis for **constructive and creative dialogue** with stakeholders and providers
- set out **opportunities for market development** and encourage the development of a quality adult social care market that is innovative, flexible, affordable, sustainable and diverse - offering a true choice for local people.
- set out how providers can **work in partnership** with the Council to deliver change

The MPS is a 3 year document, to be reviewed annually in partnership with service users, carers and providers.

3.2 SECTION 75 AGREEMENT FOR ADULTS

The partnership continues to work well, facilitating collaborative and effective working between Enfield Council and Enfield Clinical Commissioning Group. Discussions continue regarding the 2016/17 amendments, including the Better Care Fund plan which is due to be submitted by April 25th. Work is also underway to complete an end of year review of 2015/ 16 agreement and this will be shared with both parties once complete.

4. SPECIALIST HOUSING

4.1 A newly developed specialist Extra Care Accommodation Service for adults with learning disabilities has now opened, providing 14 accessible homes for older adults with learning disabilities and dementia. Named '**Desmond Court'** the new service provides much improved, fully accessible accommodation with communal lounge, activity rooms, and 24 hour on site support for older people with disabilities who wish to live independently within the community.

4.2 Referrals are now being identified for wheelchair accessible family homes that are being developed for social rent on **Jasper Close**. These new homes, funded through monies secured from the Mayor's Care and Support Specialist Housing Fund, will enable adults with disabilities, who require high level support, including 24 hour care, to move out of residential care placements to live in the community. It will also provide accessible accommodation to enable people with disabilities to return to live with their family in an accessible environment.

4.3 The **Parsonage Lane** shared ownership pilot project is now near completion. The pilot will enable people with long term disabilities who are not in work to secure a mortgage and part purchase a newly developed and suitably adapted home in the borough. Potential benefits of this pilot project are cross cutting, including opportunities to support people who are placed in local authority housing or residential placements to purchase an accessible home of their own.

4.4 A pilot project with the **Housing Gateway** to purchase accommodation from the open market to meet the specific needs of adults with disabilities wishing to live independently in the community has now been approved by the Housing Gateway Board. The pilot will enable the purchase of up to 10 homes to provide secure, affordable and appropriate accommodation options for people with disabilities. This will enable us to meet the exacting property requirements of some people with disabilities, for whom alternative properties cannot be secured, as acquisitions can be tailored to meet specific needs of individuals requiring care.

4.5 A **joint workforce development project** to provide front line housing staff with public health training has been initiated. Funded by Enfield Community Education Practice Network (CEPN) in 2016/17, the training will also provide 'in focus' workshops on key areas of need, including promoting healthy lifestyle messages and issues such as dementia, with the view to increase early intervention and prevent avoidable escalation of health related needs. As part of this programme, information shall also be made available to health staff, including nurses, on local housing pressures, processes and options.

5. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

5.1 **Identification and Primary Care Management**

Working in partnership between NHS Enfield CCG, London Borough of Enfield and Enfield Community Service, Integrated Locality Teams were formed comprising of social workers, community matrons & therapists, to deliver a multi-disciplinary, approach to supporting GPs as Lead Accountable Professionals in their practices. Phase II Plans are in advanced development between Enfield CCG, BEHMHT and LBE to develop 4 jointly managed, co-located ILTs by Q3 2016/17 led by a joint manager of service, with the 4 ILTs having 200+ staff.

The CCG is also in collaboration with NHS England offered a GP Local Incentive Scheme for Jan – Mar-16 to primary care practices to support GPs to work with ILTs and CHAT to manage the more complex cases on their caseload. Plans are being developed to continue this GP LIS for 2016/17 – 40 practices signed up to the LIS in 2015/16.

The Care Homes Assessment Team (CHAT) fulfils a similar role for care home residents and is a nurse-led team with geriatrician input to manage the individual cases of older residents in homes, help develop lasting nursing staff skills in these homes and engage with GPs of residents. CHAT now covers all older people's residential & nursing care homes in the Borough. It continues to have a positive impact on quality of care and the care system more generally: of those

care home patients who died in CHAT covered homes, all did so in their preferred place of death (predominantly the home), whilst there was a 9% decrease in the number of emergency hospital admissions between 2014/15 and 2015/16 in the 32 homes which CHAT covered on 1st Apr-15. CHAT is also working with Alcazar Court Extra Care scheme to support care staff in the scheme. North Central London's Joint Health Overview & Scrutiny Committee recently commended the CHAT scheme.

The CCG and LBE have also recently invested in 2 voluntary sector services, one to enable post-diagnostic support for dementia, the other to promote falls prevention, aligned to the new partnership approach to working with the sector. Age UK Enfield and its partners were awarded both services following a competitive tender process open to all voluntary sector organisations. The falls service is being mobilised for Apr-16, whilst the post-diagnostic support for dementia has now started and is developing partnerships with other voluntary sector organisations, including those representing black & ethnic minority communities.

5.2 **Rapid Response**

This function includes a range of services with a focus either on time-limited help for people to return home safely after hospital or providing a crisis management response in the community to help people avoid hospitalisation 7 days a week.

Part of this service includes an out-of-hours Community Crisis Response Team (5pm-2am), a nurse prescriber team to respond to crisis situations in the community or in care homes within 20 minutes–2 hours in which individuals would otherwise attend A&E unnecessarily. A Task & Finish Group developed an operational policy and mobilised this service, linked to all other care & support community out-of-hours, including Barndoc, 111, LAS and Safe & Connected. The service started on 18th Jan-16. The number of cases is growing gradually, e.g. the number of call outs increased from 30 to over 50 between Feb- and Mar-16, with Barndoc and care homes forwarding more and more referrals to the service. The target for the number of call outs is 120 per month.

Rapid response includes time-limited community rehabilitation, and a draft Service Specification incorporating hospital & community bed-based and home-based rehabilitation has been developed, including an analysis of the likely need for fast- and slow-stream rehabilitation beds. A commissioner-led review of the existing intermediate care at home and enablement is planned, which has been agreed with providers, with a view to inform further development of the Integrated Locality Teams in 2016/17.

6. PUBLIC HEALTH

6.1 **Smoking**

There will be a conference on smoking in the Turkish community on 21st May fronted and headed by the Cabinet member for Public Health and the Turkish community.

A new smoking contract is being negotiated following budget cuts to the PH budget. The new contact will focus on the Turkish community, pregnancy and post-natal women, long-term conditions and schoolchildren. As smoking prevalence has fallen much more than might be expected given the number of quitters we have gained through meeting the four week quitter target it is expected that this will enable us to continue to reduce our smoking prevalence (currently 8th lowest in London). PH is attending GP meetings to explain the new contract and its reasoning.

Trading Standards
Trading Standards are working across the sector to plan a series of coordinated raids on establishments potentially selling illegal / illicit tobacco and alcohol. This will be followed up with press releases emphasising that illegal tobacco helps children to start smoking and that even smokers believe that 'something should be done' about the sale of illicit / illegal tobacco.

Smoking target
At the end of Q3 Enfield had achieved 1030 four week quitters against a target of 920.

Contract
A new model will be piloted in 2016/17 that will target:
- The Turkish Community
- Pregnant women
- Postnatal women
- Long Term Conditions
- School Students

The model has been designed in response to the reduced budget and the identified prevalence with these residents.

6.2 **Healthchecks**
A Steering Group has been created with membership from the CCG, GPs, LMC, the link Councillor and Council officers to redesign the service delivery plan.

An end of year figure is still to be finalised. February projections were that we had surpassed the annual target.

6.3 **Health Trainer service**
The health trainer service has now left the Angel in Edmonton and is operating from the Civic saving accommodation costs of £7.5k per year.

6.4 **Healthy weight strategy**
A learning meeting was held with other boroughs re childhood obesity at the end of February. Enfield actions included promoting sugar free days, apps for physical activity and developing a physical activity care pathway. Actions will be taken forward this quarter.

6.5 **Cycle Enfield conference**

The above was held on 8th April. It was attended by approximately 60 people including Cllrs Anderson and Pite. Following this a response to the Dept for Transport Walking and Cycling investment strategy has been written for consideration by the Cabinet member for CE.

7. SERVICE AREA COMMISSIONING ACTIVITY

7.1 **Older People – Dementia**

NHS Enfield CCG has been working with GPs to identify those patients with a formal diagnosis of dementia who need to be added to individual GPs Dementia Registers, as well as those individuals who may need to be assessed for a formal diagnosis from the Memory Service. The Review indicated an improvement area was post-diagnostic support for people with dementia, and a voluntary sector service linked to the Memory Service is being mobilised (see Integrated Care).

The post-diagnostic service will support Enfield to increase the proportion of older people likely to have dementia in Enfield (estimated at around 3,000) who were known to be on GPs' Dementia Registers to increase. There was a gradual long-term improvement in the proportion of people with dementia with a formal diagnosis from 45% to 68% (the BCF Plan target for Mar-16) between Jun-14 and Nov-15.

7.2 **Mental Health**

7.2.1 The CCG has appointed a Head of Mental Health Commissioning Officer who commences in June 2016.

7.2.2 An updated National Mental Health Crisis Care Concordat (MHCCC) has been developed and will continue to focus on the four pillars of the Crisis Care Concordat

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well

Next Steps – Continue to work with all stakeholders across the health and social care system to ensure that clinical pathways, timescales and social/housing pathways are aligned to ensure appropriate and effective communication processes to develop solutions to enable timely and sustainable discharge from inpatient beds.

7.3 **Learning Disabilities**

7.3.1 Transforming Care for adults with learning disabilities (Winterbourne View)

Enfield continues to be one of the leading areas in terms of implementation of the Transforming Care programme and the Concordat.

All age health and care Commissioners from the North Central London (NCL - Barnet, Enfield, Haringey, Islington and Camden) area are working together to develop the NCL Transforming Care Plan for people with learning disabilities.

The aim of the transformation plan is to develop a sustainable system and new model of service delivery for the NCL area that is focussed on supporting people with learning disabilities to remain healthy and well in the community and reduce avoidable admissions to assessment and treatment and inpatient services. The NCL commissioners have worked together to set a baseline for assessment and treatment and inpatient activity and we have developed key objectives that outline how we intend to reduce activity by 50% in line with the new national service delivery model. The key aims of the new national service model are:

- more choice for people and their families, and more say in their care;
- providing more care in the community, with personalised support provided by multi-disciplinary health and care teams ;
- more innovative services to give people a range of care options, with personal budgets, so that care meets individuals' needs;
- providing early more intensive support for those who need it, so that people can stay in the community, close to home;
- but for those that do need in-patient care, ensuring it is only for as long as they need it.

Enfield is the lead commissioner for development and delivery of the NCL Transformation plan and we have been sharing good practice with our NCL partners.

We received feedback from NHS England on the draft plan that was submitted on 8th of February 2016. We have closed gaps and provided additional information with a view to submitting the final version of the plan on Monday 18th of April 2016.

Municipal Journal (MJ) Local Government Achievement Awards 2016
Enfield Council has submitted a bid to the Municipal Journal (MJ) Local Government Achievement Awards 2016. We have outlined our approach to delivering the Transforming Care Programme for people with learning disabilities and have entered the "Delivering Better Outcomes" category. We have been shortlisted and have attended the interview panel on the 14th of April 2016. We will find out at the beginning of May if we are finalists for an award.

7.3.2 Collaborative contract framework for people with learning disabilities
Waltham Forest, Hackney and Enfield have commenced procurement and agreed a collaborative contract framework for people with learning disabilities who require health, care and support to live independently.

The tender commenced in October and closed at the beginning of November. Commissioners from Waltham Forest, Hackney and Enfield have evaluated all the 24 bids that were submitted and shortlisted to 12 organisations. We are currently developing internal processes with a view to start drawing off of the contract framework by the end of April 2016. Experts by Experience (Parent / Carers and people with learning disabilities) were supported to take part in the procurement and the interview process, and actively contributed towards evaluation.

The aim of the contract framework is to diversify the local supported living market and improve quality, safety and efficiency outcomes for people with learning disabilities who meet the eligibility criteria for specialist health and care. Enfield CCG will be able to utilise this contract framework also.

Islington has expressed an interest to join the contract Framework. Enfield has arranged to present an overview of the contract framework to the NCL learning disabilities commissioners at a workshop set up to deliver the Transforming Care Programme on 28th of April 2016.

7.3.3 New developments

Commissioning is currently working in partnership with the Council's Housing Gateway to develop a process for accessing accommodation through this means. We are also in communication with the Housing Policy team to ensure that people with learning disabilities can access housing and housing advice, advocacy and support where necessary.

7.3.4 Implementation of the Joint Strategy for People with Autism

Commissioning is working with a local voluntary and community sector provider - One-2-One - to implement the strategy for adults with autism.

a. Enfield Council and NHS Enfield CCG sponsored One-to-One to host Enfield's Autism Conference "Let's Make Enfield Autism Friendly" which was held on 6th of April to raise awareness of the needs of people with autism and celebrate World Autism Week (4th – 10th of April 2016). The event was co-produced and facilitated by people with autism. The programme for the day was designed to be interactive and involved presentations from self advocates, carers, clinicians, professionals and experts by experience and a guest speaker – Robyn Steward – who is an autism trainer, author and mentor and is a member of the National Autism Strategy implementation group. The day ended with a lively discussion about how to improve our diagnostic pathway. The event was attended by over 140 people and we were operating a waiting list for the event. Feedback has been overwhelmingly positive so we have already booked another event for next year at a much bigger location.

b. We are developing a set of standards and principles for practitioners to work towards when supporting someone with autism. Membership includes: ILDS, BEHMHT, Royal Free London, Social care workforce, Children's and young people clinicians and experts by experience.

c. The Peer Support Group network that is jointly facilitated by One-to-One and the National Autistic Society (NAS) now have over 50 members. The peer support group is arranging drop in sessions across Enfield and an event that is funded by Enfield Council's Autism Innovation fund where self- advocates will be testing technology and apps that are designed to support people with autism to self- manage and prevent episodes of low level anxiety and depression. The peer support group are aiming to prepare an overview of this research in a report that summarises their views of how effective this technology is. This report will be transposed into accessible formats and will be shared with the Council and MH Trusts and special interest groups with a view to contributing towards providing information about the different options and assistive technology available to support people with autism to remain healthy and well in the community.

d. Commissioners from across Barnet, Enfield and Haringey are working together to identify existing demand, access, trends, activity and expenditure for people with autism. This information will inform pathway redesign with a commitment to commissioning more local provision for diagnosis and post-diagnostic support.

7.4 **Children's Services**

7.4.1 Joint Enfield Council and CCG Strategy for Emotional Wellbeing and Child and Adolescent Mental Health for 0-18 year olds in Enfield
Implementation of the plan is being progressed through the CAMHS Partnership Group, which is in in turn accountable to the Joint Commissioning Board.

The majority of work is to improve crisis intervention, neurodevelopment work and to expand Children and Young People's admin. BEHMHT is recruiting staff members.

7.4.2 Strengthening the Team Around You (STAY) (formerly the Enhanced Behaviour Support Service)
STAY was approved at the 13 October 2015 BCF Management Group meeting. The new service aims to avoid residential accommodation for (approximately) four children/young people per year through a combination of timely and intensive therapeutic support and the provision of regular, planned short breaks. This service will work closely with adult and transition services and follows the success of a similar model in Ealing. BEH Mental Health Trust have struggled to recruit to posts but an interim solution is being sought. The STAY team is a key element of the local response for children and young people of Transforming Care: A national response to Winterbourne View Hospital.

This service will work closely with the Joint Disability Service, education services, adult and transition services and follows the success of a similar model in Ealing. BEH Mental Health Trust is re-advertising posts.

7.5 DRUG AND ALCOHOL ACTION TEAM (DAAT)

7.5.1 Performance for Drug Users in Treatment

The latest NDTMS ratified data for the 12 month rolling period February 2015 to January 2016 is confirming that Enfield has seen 1065 Drug Users in Treatment during the year; 51 more than the minimum end of year target. The Successful Treatment Completion Rate remains positive at 25.8%. This is 6.3% above the London average, 10.6% above the National average and 10.12% above our PHE Comparator LA's. Our London raking for Successful Treatment Completions for All Drug Users has improved to 6th.

The Numbers of Drug Users in Treatment and the Successful Treatment Completion rate for Enfield DAAT is summarised in Fig.1 below:-

Fig. 1: Successful Completions All Drug Users (Partnership)

Partnership	Apr 2014 to Mar 2015 Baseline	Dec-14 to Nov-15	Jan-15 to Dec-15	Feb-15 to Jan-16	Apr 2015 to Mar 2016 Target
Number of Successful Completions	177	259	268	275	**217**
Numbers in Treatment	977	1069	1064	1065	**1014**
% Successful Completions	**18.1%**	**24.20%**	**25.20%**	**25.80%**	**21.4%**
% London Average	19.6%	**19.60%**	**19.80%**	**19.50%**	
% National Average	15.8%	**15.20%**	**15.20%**	**15.20%**	

7.5.2 Numbers of Alcohol Users in Treatment

The Alcohol performance has remained good with 349 Users in Treatment for the latest ratified NDTMS period February 2015 to January 2016. There has been a marked improvement in quality from the Baseline with Alcohol Successful Treatment Completions now at 49.6%. This is well above the London and National averages. The London ranking now stands at 7th for this measure.

The Numbers of Alcohol Users in Treatment and the Successful Treatment Completion rate for Enfield DAAT is summarised in Fig. 2 below:-

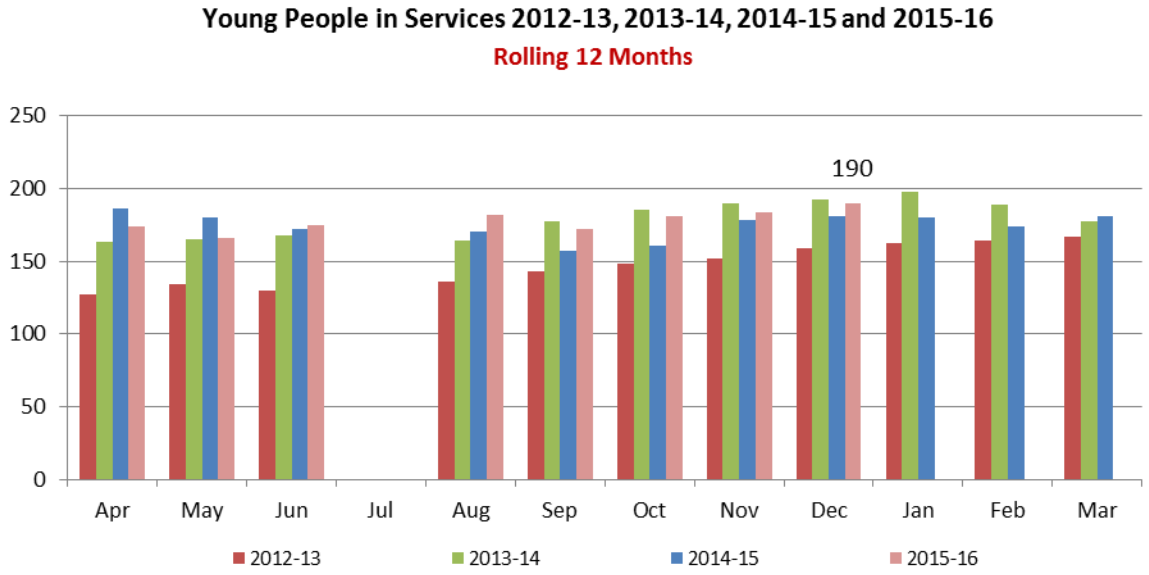
Fig. 2: Enfield Successful Completions Alcohol (Partnership)

Partnership	Apr 2014 to Mar 2015 Baseline	Dec-14 to Nov-15	Jan-15 to Dec-15	Feb-15 to Jan-16	Apr 2015 to Mar 2016 Target
Number of Successful Completions	113	170	174	173	**122**
Numbers in Treatment	326	358	354	349	**326**
% Successful Completions	**34.7%**	**47.50%**	**49.20%**	**49.60%**	**37.4%**
% London Average	39.3%	**41.90%**	**41.80%**	**41.60%**	
% National Average	39.2%	**39.10%**	**39.30%**	**39.20%**	

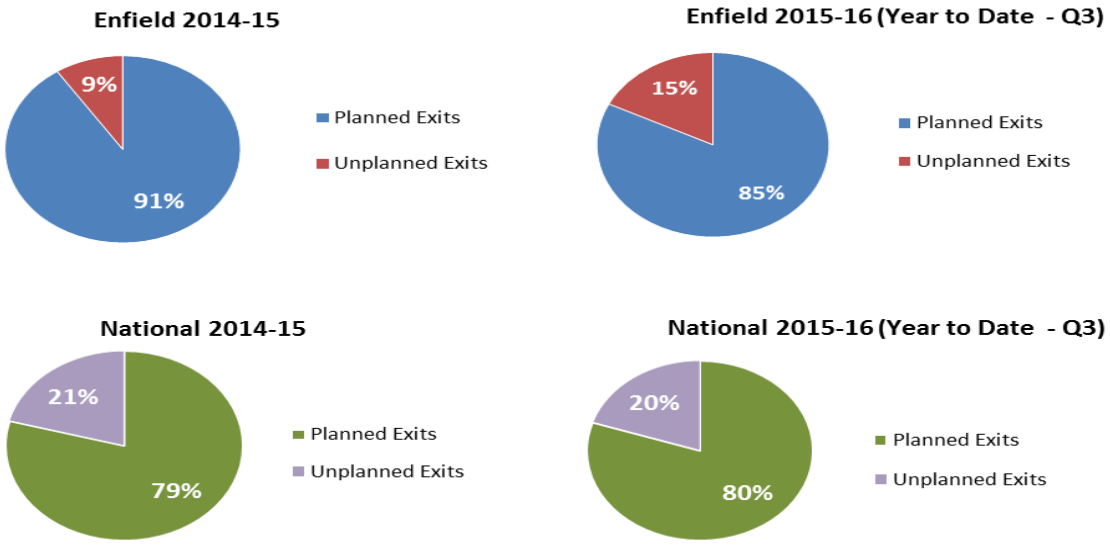
7.5.3 Number of Young People in Substance Misuse Treatment

The PHE National Drug Treatment Monitoring System (NDTMS) ratified data for the Number of Young People In Drug or Alcohol Treatment for Q3 2015/16 has increased to an all-time high of 190. This growth corresponds to a 4% improvement while nationally the Number of Young People in Treatment has declined in the same period by 6%. The Planned Treatment Exit rate has slightly decreased to 85% but this is still 5% above the national average which shows acceptable progress in young people's substance misuse provision.

The Numbers of Young People in Treatment and the Planned Treatment Exit Rate for Enfield DAAT is summarised below:-



DAAT Young People Planned Treatment Exits



7.5.4 DAAT Substance Misuse Crime Reduction Recovery Performance

7.5.4.1 There are three revised targets under the amended 2015/16 Mayor's Office for Police And Crime (MOPAC) Grant Agreement which are as follows:-

(i) The key target is the Percentage of Drug Offenders with Reduced Offending and Q4 has shown that Enfield achieved 40.5% (40.476%) against a target of at least 20%;

(ii) The target for Drug and Alcohol Successful Treatment Completions has to be above the London average of 19.5% and Enfield has achieved 37%; this is 17.5% above the minimum target required.

(iii) The target for the Numbers of Drug and Alcohol Users in Treatment was based upon the 2013/14 Baseline of 149 with a 40% minimum growth factored in to equal 208. Enfield has achieved 297 for the latest 12 month rolling period to year end; 89 more than the minimum required target.

7.5.4.2 It was agreed that Enfield would continue to report on the Total Number of Convictions and maintain an ambition to ensure these did not exceed the 2013/14 Baseline. Q4 confirmed the forecast made in the previous quarter of remaining below the end of year target of 221 was correct, as the total number of convictions at the end of 2015/16 is 124 against a target of <221.

Enfield MOPAC Q4 Re-offending Report 2015-16

MOPAC Re-Offending Cohort: 42	2013-2014 BASELINE				2015-2016 FINAL					
Period	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**YtD**	**TARGET**
Total Number of Convictions	62	33	75	51	21	48	35	20	**124**	**<221**
Cumulative Number of Convictions	62	95	170	221	21	69	104	**124**	**124**	**<221**
Clients with Increased Conviction Rate YTD	N/A	N/A	N/A	N/A	6	12	8	2	**2**	**N/A**
Clients with Static Conviction Rate YTD	N/A	N/A	N/A	N/A	17	19	21	23	**23**	**N/A**
Clients with Decreased Conviction Rate YTD	N/A	N/A	N/A	N/A	19	11	13	17	**17**	**>8**
IMPROVED MOPAC TARGET % of Cohort Achieving Reduced Offending Behaviour	**N/A**	**N/A**	**N/A**	**N/A**	**45.2%**	**26.2%**	**31%**	**40.5%**	**40.5%**	**>20%**
DIP NDTMS Successful Completions 12 Month Rolling	N/A	N/A	N/A	N/A	**28.3%**	35.1%	33.7%	37%	**37%**	**>19.6%**
DIP NDTMS In Treatment Drug/Alcohol 12 Month Rolling	N/A	N/A	N/A	N/A	**329**	319	323	297	**297**	**>208**

7.5.5 Young People Substance Misuse MOPAC Measures

Enfield also receives funding from MOPAC for Young People's Drug and Alcohol Crime Reduction performance measures and it is pleasing to report that the end of year data has confirmed all targets have been exceeded.

Young People DAAT MOPAC Measures:-

MOPAC Measures (Year to date) – 2015/16 End of Q4	
MOPAC Measure 1 - 35 young people will attend the structured one to one work (Year to date by Q4 2015/16)	73 young people have received services from Compass and were referred by the Youth Justice Services.
MOPAC Measure 2 - 19% will be free from dependency at the end of the programme (by Q4 2015/16)	30% of young people referred from Youth Justice Services left drug free.
MOPAC Measure 3 - 25% will reduce their substance misuse (Year to date by Q4 2015/16)	39% of young people referred from Youth Justice Services left as an occasional user.
MOPAC Measure 4 - 50% of those who engage who are known to the Youth Offending Service will not re-offend following completion of the substance misuse programme	61% of young people who were known to the Youth Offending Service did not go on to re-offend post completing their substance misuse treatment.

8. REPROVISION PROJECT

8.1 Building works continue on the build of a new 70 bed care home on the former Elizabeth House site in eastern Enfield. Morgan Sindall is now in week 35 of the build programme - over halfway through the programme. The steel to all floors has been completed and this month sees the concrete slab being poured and installation of 3rd floor planks.

8.2 Communication and Engagement activities continue:

- The topping out ceremony has been scheduled for 12th May.

- Morgan Sindall attended a construction career day and breakfast careers event at College of Haringey, Enfield and North East London.
- In addition, they are working with the Business and Economic Development department to progress recruitment of 7 apprentices for the project.

9. VOLUNTARY & COMMUNITY SECTOR STRATEGIC COMMISSIONING FRAMEWORK (VCSSCF)

Further to the update provided in the last report:

In partnership with Enfield Voluntary Action, the Council's Health, Housing and Adult Social Care function (HHASC) organised two workshops in January 2016 to engage a range of stakeholders in the co-design of prevention services for the borough. Each workshop was attended by representatives of the voluntary community sector, social service commissioners and frontline practitioners and well as representatives from Enfield CCG. The aim of the workshops was to harness the experience, knowledge, community insight and creativity of a cross sector, multidisciplinary group to help inform and shape the prevention interventions HHASC will commission through a grant aid process later in 2016. The co-production model is at the heart of the Council's approach to commissioning, recognising that all partners and service users should inform the design of services commissioned on their behalf.

In total 73 people attended both workshops, representing 50 individual organisations and service user groups. A key strength of the workshop attendance profile was the coverage of communities engaged across all the diversity strands. This adds value to the intervention ideas generated through the workshops as the needs of large sections of the communities fed into the process.

The intention is to commission intervention services, jointly with the Enfield CCG to meet all needs from all communities. Commissioners will be looking at how to spend the limited resources available in order to achieve the greatest impact. This will require collaborative and joined up working from the voluntary and community sector in order to meet the requirements of the commissioning process. As well as prevention services, HHASC is also exploring additional opportunities to commission services that support the strategic voice of the differing age groups in the borough as well as disabled communities. The concept of a Mental Health Hub (physical or virtual) is being explored as a joint venture with the Enfield CCG which may be staffed by VCS organisations whom we grant fund. Additional opportunities for the VCS include brokerage, support planning and provision of Personal Assistants. These services will be commissioned separately to the prevention services and will not be grant aided.

A report summarising the outcomes of the workshops has been prepared. Commissioners are reviewing the findings and preparing commissioning priorities. A follow up event for those organisations that attended is being arranged for later in April 2016 to feedback and plan key next steps.

10. SAFEGUARDING

10.1 Quality Checker Project Update

Recruitment and Training

The Quality Checker project has worked through a program of targeted recruitment to successfully recruit Quality Checkers that reflect the diversity of the community of Enfield using the following methods:

- Adverts in a range of BME community organisation newsletters
- Information and advice and attendance at volunteer recruitment fairs
- Information and advice and attendance at the Town Show
- Information and advice at the EMU Mental Health Conference
- Presentations at community organisation group Drop In services
- 4 timely adverts placed in the local press.

This has enabled the project to recruit several new Quality Checkers with personal experiences and skills regarding social care services that will benefit the project to review social care services, identify areas for improvement and drive service improvements. In addition the Quality Checker Project has raised awareness of the work of the project and formed links with a number of key community organisations in the borough.

Whilst the uniqueness of the project is that all volunteers have first-hand experience of using or caring for a person using social care service, it is important that the Quality Checker volunteers receive appropriate training to fulfil their role. This offers them the opportunity to relate their own experiences to others with a range of social care needs and be made aware of significant changes in social care practices, including the councils obligation determined by legislation and updates and development in policy and procedures. Most recent training delivered to the Quality Project volunteers has been;

- Meaningful Activities in Care Homes
- Mental Health Basic Awareness
- LGBT Awareness

The training has prepared the Quality Checker volunteers to undertake future visits and develop reviews of services currently operating; this has included making recommendations for improvements and providing the council with direct service user and carer feedback collected by a ‘critical friends’.

LGBT Project

The Quality Checkers have now completed the 20 visits to a range of care homes across the borough to explore the providers’ awareness and consideration of the needs of the LGBT community and of their ability to meet these identified needs. This alongside service user and carer views is being used to develop a full and detailed report of the findings and recommendations from these visits entitled ‘Staying Out of The Closet,’ which is being presented at the Quality Improvement Board on the 6th of April.

Activities in Care Homes

The Quality Checker Volunteers involved in this project have now received training and a full briefing detailing the scope of this project and will be starting a series of visits from April 2016 . It is envisaged that this detailed piece of work could take 3-4 months to complete, at which time a full and detailed report will be developed of the projects finding and recommendations.

Hydration Visits

As an action from the multi-disciplinary Hydration Working group the Quality Checkers will be making a further 20 visits to care homes across the borough to collect information on providers methods and ability to ensure residents with dementia and who are non-verbal are kept adequately hydrated with food and drink of their choice. This feedback will be shared with the working group to support the ongoing activities to reduce the number of residents of care homes presenting at A&E dehydrated.

Safeguarding visits

The Quality Checkers continue to make visits to providers in response to quality issues raised with the council and feedback is given at a range of forums to support the councils safeguarding processes.

Health & Wellbeing of Volunteers

The Quality Checker volunteers are a valued asset of the council and their health and wellbeing is important to ensure they are happy and supported in their role and continue to work with the project. The Quality Checkers Volunteer Co-ordinator has implemented a number of strategies to support the volunteers including the following:

- Regular networking sessions for peer group support and project information and updates
- Debrief sessions after every visit to capture feedback and identify any issues and concerns
- Safeguarding training for all volunteers to have awareness of process and criteria for safeguarding
- Open door policy to discuss concerns

To further support the project volunteers a Support and Wellbeing framework has been developed, consulted on and agreed with the project volunteers. This clearly sets out the options of support available and has resulted in the Quality Checker volunteers receiving a monthly relaxation and wellbeing session offered at Park Avenue to promote feelings of wellbeing and reduce stress.

10.2 **Safeguarding Information Panel Update**

The Safeguarding Information Panel continues to meet regularly to discuss issues and concerns relating to providers across the borough. A number of improvements have been made and are in progress to streamline the data collection and analysis required to monitor the safeguarding concerns received. Regular meetings now take place with the Performance, Multi Agency Safeguarding Hub and Strategic Safeguarding team to ensure that the information presented at the SIP meetings is accurate and captures the

information required for meaningful discussion. A map is being created so that monitoring of providers performance, number of beds and incidences of provider concerns processes can be identified in the areas that they operate. This offers the SIP an opportunity to identify themes and trends of issues and concerns that may occur due to issues that exist in a particular area and or ward.
These issues may include the following:

- Areas with higher crime rates that present difficulties in recruiting staff
- The size of care home impacting on the quality of service provided
- Identification of providers who are regularly on the Provider Concerns process.

This information will support the work in progress to prevent safeguarding concerns and be able to identify providers failing at an early stage to offer timely support and interventions to prevent lengthy provider concerns processes being required which are costly and resource intensive.

10.3 **New London Multi Agency Adult Safeguarding Policy and Procedures**
On December 23rd, 2015 all partners on the Board were shared the final version of the London Multi-Agency Adult Safeguarding Policy and Procedures. The launch of this across London was undertaken on February 9th 2016 and Enfield Partners delivered one of the workshops at this event focused on the development of outcomes for safeguarding. Policy was agreed by the Board to be implemented from April 1, 2016. Some of the key changes from previous are as follows:

- Collaborative and collegiate approach - all organisations not just local authority responsibility.
- Risk Management – spells out that adult safeguarding about shared risk from all partners with the adult
- Co-operation and information sharing – joint accountability/ prevention and links to Health and Wellbeing Board and Community Safety Partnerships
- Incorporates sections 6,7,45 of Care Act about co-operation and information sharing (helps stop using Data Protection Act as a barrier) uses DPA as a positive means of protection and links to Human Rights
- Clear link to wellbeing of individual and the wellbeing principles in the Care Act
- Focus on prevention of abuse
- More detail on statutory Safeguarding Adult Reviews
- Good Adult Safeguarding Practice**,** which includes the key areas of mental capacity and consent, advocacy and support, managing risk, record keeping and organisational learning.
- Only four stages in the adult safeguarding procedures, with making safeguarding personal running through
- Focus on the provider concerns process and working with providers; differentiating between poor care and abuse

10.4 The Adult **Multi-Agency Safeguarding Hub (MASH)**

10.4.1 Staffing **–** full complement of staff recruited and in place. Senior management provided by the Service Manager of the care management service, Roxine Harris and Head of Service Niel Niehorster.

10.4.2 Referrals **–** The MASH continues to receive between 270 and 300 per month and within its first year of operation the MASH received 3084 referrals an average of around 60 per week. On any given day each social worker will be carrying a caseload of between 13-17 cases.

Initial delays with police and London Ambulance risk assessments and batched deliveries of these referrals have been resolved but continue to be reviewed.

10.4.3 Partner Agencies **–** inter-agency work is generally working well. Where there are issues with response times, this continues to be monitored. Police attendance at strategy meetings has improved but MASH staff are still having to ring 101 to share information with police – this was the case at the time of the last update and is still the case. Where there are more complex cases these are discussed directly with named individual officers. Around half of the referrals received have been police risk assessments. There is duplication in the process currently where risk assessments will already have been actioned before receipt by the MASH. Liaison with operational and police services will continue to improve the process. Capacity and expertise around admin support including minute taking has proved challenging but the MASH is working with the Head of Service responsible for the business support function to address and new working arrangements have been agreed.

10.4.4 Technology and Location **-** There is limited access to RIO (Mental Health Client information system) for business support staff but not for professionals with in the MASH. The matter has been escalated again to the Council's IT support company SERCO and the Mental Health Trust. The MASH is now co-located on the 7th floor of the civic centre with the SPOE (single point of entry) service within children's. This has improved significantly communication and partnership working arrangements.

10.4.5 Post Implementation Review of the MASH – this will be led by the Head of Safeguarding and Quality and the Head of the Integrated Learning Disability Service. An update on findings and recommendations will be included within the next update.

10.4.6 Interface Meetings – these meetings have been established in order to discuss cases, address process issues or delays and agree case responsibility with:

- North Middlesex hospital
- Receiving teams (to pursue enquiries)

11. CARERS

11.1 The Care Act and Carers Assessments

Work has been ongoing to delegate authority for standalone Carers Assessments to Enfield Carers Centre. Enfield Carers Centre will undertake a one year pilot project to undertake standalone Carers Assessments and have employed two members of staff to undertake these. This contract began on the 1st December 2015. The newly appointment Officers have now undergone all their training and shadowing and starting undertaking assessment in January 2016. By the end of February 63 assessments had been completed. Monthly monitoring meetings have been arranged to look at the arrangements, the impact on carers and how to ensure the pilot is a success. As a result of these assessments 15 carers have received a direct payment, the others having their needs met through information, advice and preventive services available through the voluntary sector.

11.2 Young Carers and Transition

Joint work between Adults and Children's Services has been ongoing in terms of the Children and Families Act and the new duties to Young carers and transition. The contract for the young carers service delivery has just been awarded to DAZU following a tender exercise.

Work continued to develop a pathway for young carers in transition and the look at options in terms of young carers assessments. New Young Carers Assessment forms and paperwork are currently being designed and young carers will be consulted on the design and content.

11.3 Carers Week (6 to 12 June)

Carers Week will take place in the week beginning 6th June this year. The theme this year is 'Creating Carer Friendly Communities'.

Enfield Carers Centre will undertake their usual outreach work in local supermarkets and shopping centres throughout the week. This is to increase the public awareness of carers and to fundraise.

Enfield Carers Centre will also host their annual Family Fun Day on Saturday 11th June outside Enfield Town Library. There will be the usual entertainments, stalls and activities.

Enfield Council will be hosting an event on the afternoon of Tuesday 7th June with Ray James speaking and a question and answer session.

A training session on supporting young carers in schools will be held for school governors and DAZU are hosting an awareness raising event on Saturday 11th June in Edmonton Green.

The Council, Enfield Carers Centre and North London Hospice are also planning a wellbeing event at the Winchmore Hill NLH site just details are to be confirmed.

11.4 Enfield Carers Centre

Statistics are from Quarter 4 – January –March 2016

The Centre now has 4529 carers on the Carers Register. In addition, 1002 carers hold a Carers Emergency Card. In this quarter the Centre registered 266 new carers.

The Carers Centre respite programme has allowed 286 carers to receive a break between January-March

In the Jan-March quarter, 70 carers received benefits advice from the ECC Benefits Advisor. This has highlighted the real need for benefit advice specifically for carers and is an excellent addition to the range of support the Centre provides.

The Hospital Liaison Worker continues to work on the wards at North Middlesex, Chase Farm and Barnet Hospital. Leaflets and posters are distributed and supplies kept topped up throughout all hospitals. Barnet Hospital has also a permanent pop up banner advertising Enfield Carers Centre near the lifts next to the outpatients department. In the quarter of January-March 2016 the Hospital Worker identified 60 new carers.

The Advocacy Worker has been taking up cases and has continued to promote the services within the VCS and with practitioners. In this quarter they provided support to 76 carers.

The newly established Transition project for young carers and young adult carers is running well, although funding is currently being sought to continue this work. In this quarter of operation the Young Adult Carer Project has identified 22 young adult carers.

The Centre's training programme has seen 157 carers attend a training sessions over this quarter. A further 24 carers have received one to one counselling during this period.

12. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

12.1 Safeguarding Adults Board (SAB)

The Safeguarding Adults Board met in March 2016. Performance data was reviewed and it was noted that there had been a significant reduction in concerns meeting section 42 criteria across a range of adult care and mental health teams; further work is being done to explore how initial work with adults at risk is reducing the need for complex enquiries and contributing to this reduction. Multiple abuse and neglect continue to be reported most often, with abuse happening predominantly in people's own home and in care homes. It was noted that we have now added ethnicity of the adult at risk to our reporting, which has highlighted that majority of alerts are for white British and not representative of the demographics in Enfield. In response, the Council's Strategic Safeguarding Adults Service have focused upcoming event with BME communities, such as eighty women at a Naree Shakti event. It was positive to note that there continues to be good use of nominated advocates in safeguarding to support adults at risk. Data presented at the Board is now being integrated with partner

submissions and included provider information from the Care Quality Commission and Police data on Adults Coming to Notice.

The Boards strategy action plan continues to be monitored and it was noted many actions have progressed well. For example, domestic abuse training was delivered jointly across adults and children's, learning and development options for safeguarding adults in 2016-2017 have been set out, and an audit of safeguarding adults practice has been completed by an external author and will be reported on in the Boards annual report. The Board has consulted on actions to be undertaken in the coming year and will present a revised action plan in June.

The Board received a presentation on the outcome of a Safeguarding Adults Review by an independent author following the death of an adult at risk. There were a number of recommendations which will now be monitored via the Safeguarding Adults Board and we are seeking consent with the family to publish and share learning. Some of the recommendations include

- Pre-admission to care settings to include that checks that people are discharged with sufficient stock of medication
- Meeting to be convened with local hospitals, nursing and residential care providers to set out protocols for improving discharge from hospitals and admission to care settings
- Transfer letters to hospitals from care settings to clearly detail the reason for contacting acute medical services and highlight if there is a repeat concern
- Clinical Commissioning Group to quality assure discharge planning in local hospitals

The Enfield Clinical Commissioning Group presented their Joint Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards Nursing Home Policy. This covers Barnet, Enfield and Haringey CCG and has been adopted by NHS England (London) for pan London implementation. This policy is supported by the CCG Commissioning Strategic Plan to ensure quality services and improve patient safety, while being linked to the CCG corporate objective to safeguard Children and Adults at risk. The Board agreed and ratified this Policy.

The Board received a collaborative partnership document on the management of self-neglect and hoarding under safeguarding. The policy represents how cases of self-neglect and hoarding involving adults at risk may be managed in line with the principles of making safeguarding personal, either via single agencies and when it can be escalated under safeguarding. There is a clear risk assessment process involved which can inform decision making. The emphasis is on balancing right to self-determination with the duty to safeguard adults at risk. It provides a framework for when it may be necessary and proportionate under safeguarding to intervene, particularly where required for safety of individuals or others, or where the person lacks mental capacity for a decision as to what is in their best interest. The Board ratified this Policy and has set out a plan for implementation.

12.2 Carers Partnership Board (CPB)

The Carers Partnership will now be chaired by Doug Wilson, Head of Strategy and Commissioning going forward.

The Carers Partnership Board met on the 20th January and a number of issues were discussed. The Terms of reference for the Board was refreshed and membership revised and updated. The Board is keen to recruit more Carer representatives for 2016 and recruitment will begin shortly.

A number of issues of particular interest were raised at the meeting, notably improvements required in terms of hospital discharge, finding appropriate residential and nursing care and how to reach and identify hidden carers particularly within the minority ethnic communities in Enfield. The next meeting will be the away day where a work plan for 2016/7 will be produced.

12.3 Sexual Health Partnership Board (SHPB)

Notes from 25 Feb Board:

- NMUH gave a detailed service update:
  Existing BEH MHT staff has been TUPE'd across to NMUH. There is a staff consultation currently taking place which is based on new ways of working and staff structures. The consultation is due to be completed mid-March. NMUH wish to create more capacity in the team; the proposals include allowing HCAs to take on more responsibility, changing working hours to cover weekend opening, redefining care support worker roles to allow them to conduct outreach work for one session/day a week. This will enable outreach nurses to do joint visits with band 3 care support workers instead of another band 7 nurse.

- NMUH is planning to commission prevention work from the VCS. This has resulted in a steep organisational learning curve in writing tender documents etc. Tender documents will be ready to share to review. NMUH will be encouraging VCS organisations to bid in groups/collaborates. Whittington Health have been asked to continue to act as provider of sex worker services until this is re-tendered and a provider is awarded the contract.

- NMUH is in advanced discussions with a GP network who are interested in being a sub-contractor to provide SH services on behalf of NMUH. It is envisaged that the GP network will use NMUH IT systems.

- NMUH commissioned Resonant to complete two patient consultations, one for self-reported heterosexual men, and one for self-reported homosexual men. The cohort used was a good representation of both groups and gave very honest and frank feedback. NMUH are awaiting the final report from Resonant.

- NMUH attended a GP training event in the west of the borough. GPs were very interested in the service and are keen to support. NMUH will be attending another GP training event in the east in April. GPs need to be encouraged to collaborate between themselves as it was evident at the training that some practices were not aware that each other were offering LARC, and did not know

how to refer to one another instead of referring to SH clinics. LBE will complete an audit on GPs to ascertain who is accredited / qualified to administer LARC. NMUH consultant is an accredited LARC trainer and will offer one-to-one training sessions for any interested GP.

12.4 Learning Difficulties Partnership Board (LDPB)

The LDPB last met on the 22nd of February.

- The Big Issue for this meeting the 'prevention agenda'. Mark Tickner (senior public health strategist) attended and presented to the board.
- The Board were pleased that the life expectancy (median age at death) for people with learning disabilities in Enfield was 62. This is higher than the national figure. However, the overall figure for Enfield is 83 – so people with learning disabilities are still likely to die 20 years younger than everyone else.
- The Board has been aware of health promotions for some time, and thought it was important to acknowledge the good work already underway. This includes things like –
    - Organised walks in the park.
    - Partnership work with slimming world
    - Providing healthy living drop ins
    - The healthy eating group
    - The diabetes drop-in, amongst others.
- The Board acknowledged that One-to-One are key partners in promoting healthy lifestyles. The board were concerned that One-to-One's core funding had been cut. New funding will be available, but there will be a gap. One-to-One have sufficient resources for about 18months before services would be at risk.
- Additional actions that will help further promote healthy lifestyles include –
    - Supporting people with 'e-health' at the healthy living drop ins, where they are not able to access the technologies on their own.
    - Improving the quality, as well as the number, of annual health checks.
    - Offer training and support for carers and support staff, so that the good work done by One-to-One becomes part of people's everyday lives.
    - Invite G.P's to healthy living drop in sessions
    - Check the accessibility of leisure facilities.

- Georgina Diba consulted with the Board on the Safeguarding Adult's Strategy Review. The Board had the following comments:
    - The Board thought there should be more focus on 'Mate Crime'.

- The Board thought that the images in the easy read leaflet were vague. Georgina said that this was co-produced with Barnet and in the process for being updated.
- The Board felt we could make better use of video resources. The Hate Crime sub group will do a review of video resources currently available on line.
- Board members pointed out that part of the definition of institutional abuse included people not being able to go out when they wanted to, and expressed a concern that reductions in budgets could result in more incidents of Institutional abuse.
- The Board thought the Quality Checkers could be used more widely. With permission, they could check the quality of supported housing services as well as residential.

- Soobhash Ramphul (Community Nurse) presented to the board on the Health Sub groups top priorities for this year.
  - Increase the number and quality of annual health checks. Last year performed approximately 500 annual health checks. Feedback has been that some were done very well, but other less so. This year we will increase the number of checks, and are working with the CCG on an ‘outcomes sheet’ to track referrals generated by the checks.
  - Increase uptake of health screening. The health sub group is working with the CCG to deliver ‘cancer screening events’ to help people with learning disabilities attend.
  - Ensure people have accessible information about their health and services, through using ‘Easy Heath’ literature, and locally produced information, including a poster to publicise Annual health Checks.
  - Promote healthy lifestyles, through healthy living drop-ins and ‘get health’ event.
  - Increase awareness of wider health services, like opticians and pharmacists.
  - Improve joint working between acute and primary health services, including making sure everyone has a hospital passport this year. The health sub group will work with the carers centre to deliver a workshop for carers on completing hospital passports.
  - Improve support in hospitals, including using the now established ‘flagging systems’ at the Royal Free hospitals and North Middlesex Hospital. These prompt hospital staff to ask for hospital passports, and provide a method of recording reasonable adjustments. Paulette Blackwood (ALN) is also working with the North Middlesex Hospital on improved waiting areas for people with learning disabilities.
- The Board discussed the current financial situation. Board members were concerned that a recent cabinet report had suggested people with expensive packages of care may need to move to cheaper accommodation, possibly out of borough. Family members had written to senior council officers and

received a reply. The Board also drafted a response to this report, and have made the ‘Financial Situation’ a big issue for the next Board. The Board have invited Bindi Nagra to attend.

- The Board were very pleased that One-to-One have been successful in their Big Lottery Fund bid for funding for the Learning Disability Council. The council will have 10 elected members, 2 of which will be specifically for people with Autism. This will also be a Big Issue for our May meeting.

Appendix 1

LEARNING DISABILITY ASSESSMENT AND TREATMENT UNIT – update for the HWBB

Our local delivery of the national Transforming Care programme (Winterbourne View) over the last few years has significantly improved the lives of people with learning disabilities and autism in Enfield. NHS Enfield CCG and Enfield Council jointly reviewed health and care resources attached to our admission and treatment pathway. We reconfigured our resources to concentrate on providing personalised care and support in the community; to improve health and wellbeing with the ambition of reducing avoidable hospital admissions. Everything we do, collectively, focusses on supporting people with learning disabilities to remain healthy and well, and connected to their community.

In 2013 /14, we invested in a nurse–led community intervention service that has been successful in reducing avoidable admissions to our specialist learning disabilities Assessment and Treatment Service – Seacole which is located within the Chase Farm Hospital site. The community intervention service offers holistic, personalised home treatment support for people with learning disabilities who are at risk of falling into crisis. Since the service was set up we have seen a significant reduction in admissions to ATU services; from 10 people at any given time to 2 people being admitted on average. This is a significant achievement.

Central and North West London Foundation Trust (CNWLFT) is our local provider of specialist ATU provision for people with learning disabilities. This service is called Seacole and is located at the Chase Farm Hospital site. Due to a significant reduction in admissions over the last couple of years, CNWLFT conducted a viability assessment of the service in 2015 and CNWLFT's Board of Trustees endorsed plans on the 17th of February to decant the remaining 6 beds to a comparable specialist learning disabilities Assessment and Treatment service in Kingswood in Brent in order to continue to provide good quality and safe services.

NHS Enfield CCG will continue to commission 1.8 beds per annum from CNWLFT at the Kingswood service. This is to ensure that people with learning disabilities from Enfield will continue to have access to good quality, safe and efficient assessment and treatment services in a crisis when needed. Our community intervention team and the CCG's nurses will continue to attend weekly ward rounds at Kingswood to ensure that we operate within the same partnership arrangements with CNWLFT as we do currently and that treatment and discharge remains focussed. The Kingswood service is 19 miles away from Enfield and is 20 minutes away by vehicle. Public transport links are available.

We will be working with mainstream mental health services to ensure that services are accessible for people with learning disabilities especially those with mild to moderate needs.

Engagement with patients, individual families , carers and staff has already started. CNWLFT has offered assurance that discharge plans, transition and resettlement plans have been co-produced with patients and their parent / carers. Engagement with Commissioners from Enfield and other areas has already started too. CNWL has advised that they will aim to decant the service fully by the beginning of May 2016.

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