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HEALTH & ADULT SOCIAL CARE SCRUTINY PANEL

Tuesday, 6th December, 2022 at 7.00 pm in the Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

Membership:

Councillors: James Hockney (Chair), Andy Milne (Vice Chair), Nicki Adeleke, Kate Anolue, Ahmet Hasan, Nia Stevens, Emma Supple and Eylem Yuruk

AGENDA – PART 1

1. WELCOME & APOLOGIES

2. DECLARATIONS OF INTEREST

3. MINUTES OF THE PREVIOUS MEETING (Pages 1 - 6)

To approve the minutes of the meeting held on 15 September 2022.

4. NORTH CENTRAL LONDON INTEGRATED CARE SYSTEMS AND BOROUGH PARTNERSHIP PROGRAMME UPDATE (Pages 7 - 30)

The presentation from the NHS representatives provides an update on the North Central London Integrated Care Systems and Borough Partnership Programme and impact on the London Borough of Enfield.

5. ENFIELD MENTAL HEALTH COMMUNITY TRANSFORMATION (Pages 31 - 54)

A presentation from representatives of the NHS details the mental health transformations and reforms affecting the London Borough of Enfield.

6. ENFIELD COUNCIL ADULT SOCIAL CARE STATUTORY COMPLAINTS ANNUAL REPORT 2021-22 (Pages 55 - 68)

The key findings from the Adult Social Care Statutory Complaints Annual Report 2021-22, provided as a separately appendix, is summarised the officers report.

7. WORK PROGRAMME 2022/23 (Pages 69 - 72)

To note the Health and Adult Social Care Work Programme for 2022/23.

8. DATE OF NEXT MEETING

To note the dates of the future meetings as follows:

Thursday 19 January 2023
Wednesday 8 March 2023

MINUTES OF THE MEETING OF THE HEALTH & ADULT SOCIAL CARE SCRUTINY PANEL HELD ON THURSDAY, 15TH SEPTEMBER, 2022

MEMBERS: Councillors Andy Milne (Chair), Nicki Adeleke, Ahmet Hasan (Associate Cabinet Member (Enfield North)), Nia Stevens, Emma Supple and Hannah Dyson

Officers: Bindi Nagra (Director of Health & Adult Social Care), Dudu Sher-Arami (Director of Public Health), Doug Wilson (Head of Strategy & Service Development), Bharat Ayer (Safeguarding Service Manager), Sharon Burgess (Head of Safeguarding Adults & Quality), Glenn Stewart (Assistant Director of Public Health), Andrew Lawrence (Service Manager Children & Public Health Commissioning), Jayne Longstaff (Senior Public Health Service Development Manager) and Suzanne Connolly (Governance Officer)

Also Attending: Cllr Alev Cazimoglu (Cabinet Member for Health & Social Care) and Mark Tickner (Senior Public Health Strategist)

1. WELCOME & APOLOGIES

Apologies were received from the following:

Cllr James Hockney (Chair), substituted by Cllr Hannah Dyson. In the absence of the Chair, Cllr Andy Milne (Vice Chair) chaired the meeting.

Cllr Kate Anolue and Cllr Eylem Yuruk were absent.

2. DECLARATIONS OF INTEREST

There were no declarations of interest registered in respect of any items on the agenda.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 27 July 2022 were **AGREED**.

4. ANNUAL SAFEGUARDING REPORT

Cllr Alev Cazimoglu, Cabinet Member for Health & Social Care, introduced the report and extended thanks to the panel for the invitation to attend. It was noted that the report was draft, and any feedback received would be valued. There had been significant challenges, but excellent work had taken place.

Bharat Ayer, Safeguarding Service Manager, highlighted the key messages including the focus to prevent and detect issues, as well as the Modern Slavery response. There had been over 638 concerns recorded which was a

year-on-year increase, however it was felt this was positive and demonstrated increased awareness of adult abuse.

In response, members commented as follows:

1. Cllr Supple extended thanks for the informative report and asked what the plans were to prevent another case like the Josef case. Bindi Nagra, Director of Health & Adult Social Care, advised that this panel was to review adult care and issues related to children would be discussed at the Children, Young People & Education Scrutiny Panel. However, it was noted that Enfield benefits from sub committees shared between adult and child services which provides training, follow-ups, information sharing, missing children procedures and additional staff. There were some concerns about those leaving care and the transition as they approach 18. Work was taking place with the voluntary sector to improve opportunities for young people aged 18-25 in that position. Feedback from this could be shared with the panel when available.
2. Cllr Milne asked if support was back to being face-to-face and if there had been any impact of Covid. Officers advised that most face-to-face services continued throughout the pandemic.
3. There were some queries about the high number of concerns reported (3638) however Officers believed this was due to better awareness and reporting. It was suggested additional context be added to this area in the report to provide better clarification **ACTION for Bharat Ayer**.
4. It was questioned if there were any outcomes from the Joint Agency Response (JAR) meetings – Officers to explore and provide this at a later date **ACTION for Bharat Ayer**.
5. In relation to the statement on page 10 of the agenda pack regarding environmental implications and the reduced need for travel, members were concerned this meant less visits and contact with service users. Bharat confirmed this was not the case and the statement was related to strategic improvements such as online meetings. Officers to make this clearer in the report **ACTION for Bharat Ayer**.
6. Officers clarified that Enfield's Safeguarding Children's Arrangements were reviewed annually and the signing was a statutory requirement.
7. Members requested additional information, such as trend data, be added to the "highlights of what we did in 2021-22" around modern slavery **ACTION for Bharat Ayer**.
   It was noted that information in the Modern Slavery Annual Report should not be duplicated.
   It was requested that comparable trend data be added throughout the report **ACTION for Bharat Ayer**.
8. The Chair requested training on modern slavery for members **ACTION for Bindi Nagra/Governance Team**.
   Post meeting note: A member development session had been scheduled on this topic.
9. There were some concerns around the youth crime figures which were increasing – identify the drivers behind this as it was a complex area **ACTION for Bharat Ayer**.

The relocation of the Youth Justice Service would bring improvements with smaller teams working closer together.

10. Regarding the data on Hoarding, it was noted that a number of teams had been brought together to work together and provide support. Enfield was the first borough in London to have a Hoarding Database.
11. Cllr Supple asked about PainCheck, which originated in Australia to identify issues without a person having to articulate the problem. Officers were looking to widen the pilot of this within the borough.
12. Detailed records had been kept of the work that had taken place around infection control, including training and an annual report. Members requested more mapping around this – Officers to add more detail **ACTION for Bharat Ayer**.
    Bindi explained that CQC ratings did not directly link to infection control standards, however they work closely with the CQC and there was a dedicated post to focus on this.
    Dudu Sher-Arami, Director of Public Health, added that there was a dedicated officer within public health that specifically links to adult social care.
13. Cllr Adeleke asked about pressure sores in relation to the different stages and links to the safeguarding team if necessary. Officers responded by explaining the work being carried out with communities to raise awareness. It was noted that the data related to adults, not children.
14. Community Do Not Attempt CPRs was to ensure consistency and usage of the same policy by all involved.
15. It was noted that the issues around the recruitment and retention of social workers was a national issue.
16. Cllr Dyson raised queries related to care leavers and officers confirmed this was looked at and any suspicions were reported to safeguarding.
17. Throughout this item, it was recognised that due to the level of detail in the report it may be more beneficial to split the report going forward into two separate reports: one for Adults and one for Children.

Members extended thanks to officers for the detailed report and for responding to the queries.

5. PUBLIC HEALTH - PLAN TO BECOME SMOKE FREE

Alev Cazimoglu, Cabinet Member for Health & Social Care, introduced the item with the hope of the committee's full support on the issue. Dudu Sher-Arami, Director of Public Health, added that the aim was to change the culture and attitude around smoking to help stop people starting smoking in the first place.

Glenn Stewart, Assistant Director of Public Health, stated that Enfield was looking to lead the way on this issue within the London boroughs.

In response to the report, the Chair firstly voiced the absolute support of this panel on this issue. The following comments and questions were then received from members:

1. On page 108 of the report pack in the section on “purpose of this plan”, the number of years should be added as it currently stated “xxx” **ACTION for Glenn Stewart**.
2. Members raised concerns about e-cigarettes and vaping. Officers acknowledged this however stated that Public Health England had identified vaping as 95% safer than smoking. This was an ongoing topic of discussion and review. The risks of smoking tobacco were already known so the focus for now was on that.
3. Within the “Actions” table on page 110, it was noted that Jan 2022 should state Jan 2023. However, Cabinet had requested for a change to this line of activity.
4. Cllr Adeleke asked about the environmental impact of vapes. Officers to identify any data related to this **ACTION for Glenn Stewart**.
5. Cllr Stevens enquired about the link with children – work was taking place in schools and had been well received. It was part of the curriculum. It was suggested to use sufferers of COPD and lung cancer to relay the important messages.
6. There were concerns that a smoke free borough would leave people with nowhere to smoke, although it was noted that smoking in homes could not be banned. Officers relayed that it was to make people feel less comfortable to smoke.
7. Cllr Hasan raised points about hospital patients smoking. It would take time to change the culture, but officers were working with the NHS, albeit with limited resources.
8. Cllr Dyson highlighted that other substances such as “laughing gas” were not in this plan; officers would consider this **ACTION for Glenn Stewart**.
9. Cllr Supple raised potential issues around civil liberties and licensing which were noted.

Members thanked officers for the report and their work on this important issue.

6. PUBLIC HEALTH - SUBSTANCE MISUSE

Andrew Lawrence, Service Manager Children & Public Health Commissioning, introduced the item which was in response to the national drug strategy. It was a ten-year plan, however the focus at this stage was on the first 3 years.

Members thanked officers for the report and comments were made as follows:

1. The partnership work was in its early days and officers with working both within and outside of the borough, as well as with NHS services.
2. A principal area of concern was the increase in need for treatment. The guidance around drug treatment was quite prescriptive.
3. Additional capacity was required to meet the needs in the borough. Doug Wilson, Head of Strategy & Service Development, highlighted the links between issues such as drug/alcohol misuse, mental health and domestic abuse.

4. Cllr Supple asked about the common drugs 'used', to which officers stated that among adults it was heroin and alcohol, and young people cannabis and alcohol.
5. Cllr Hasan raised concerns about helium, particular with young people. Officers were aware of this and were hoping to look at this further into the plan. The challenge was to get people to make the right choices.
6. Cllr Stevens asked about the relapse rate – it was very low for young people, officers to check regarding adults **ACTION for Andrew Lawrence**.
7. Cllr Adeleke queried if the police were involved. Officers advised that they were where necessary, however the focus of the plan was on health rather than criminal activity.

7. WORK PROGRAMME 2022/23

The work programme for 2022/23 was noted.

8. DATE OF NEXT MEETING

The dates of the future meetings were noted.

The meeting ended at 9.00 pm.

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Enfield Borough Partnership

Update on the NCL ICS and Borough Partnership Programme

Health Scrutiny Panel

6th December 2022

North Central London Integrated Care System

NCL ICS
Cross Borough Partnership Developments

October 2022

North Central London Integrated Care System

Where have we got to…

- Formed and arrived at agreement on Borough Partnership Decision Framework [document that sets out ambitions, accountabilities, how we'll approach resident and community engagement, resources and capability, neighbourhoods].
- Distilled priorities at place, system and in terms of population health
- Developed thinking about role of chair / leader for place – drafted role description
- Progressing work within ICS about communications and engagement and data task at place level
- Helped shape and adopted outcome framework

Highlights from Framework

North Central London Integrated Care System

Ambition / Vision

- Borough Partnerships will *reduce health inequalities through dual focus on improving quality and accessibility of health and care and tackling wider determinants*
- Strong relationships between system and place
- Spaces for regular and structured sharing between boroughs, ‘safe space’

Exec Groups

- Will take on a more formal role – joint committee / committee in common
- Overseeing delivery of shared statutory responsibilities
- Manage local risks, operational, strategic and political
- Oversee delivery of borough plan
- Oversee delivery of key transformation programmes

How we will work

- Ensure work is embedded within and informed by local communities
- Drive co-design and co-production with residents and stakeholders
- Shape and refine the operating model for place – bringing together transformation capacity over time
- Neighbourhoods as core priority, key unit for multidisciplinary working and integration on frontline
- Using data and info at neighbourhood level to enable integrated care
- Have a shared set of financial duties including: identifying and delivering efficiency, transparency of budgets and spend, oversight of shared budgets, steering use of investment to support priorities and drive improvement

Outputs

- Publish a local partnership plan, including a core set of actions and deliverables that will work for and are reflective of the local area
- Work to deliver indicators agreed through NCL outcomes framework

Priority focus areas

North Central London Integrated Care System

1 Local priorities

- ✓ Increasing the uptake of Vaccs & Imms. (Childhood Vaccs. & Imms., Flu, Covid19)
- ✓ Improving Mental Health and wellbeing
- ✓ Improving the health and wellbeing of children, young people and families
- ✓ Improving access, discharge & crisis services
- ✓ Developing neighbourhoods – and integrated models of care / pathways for delivery
- ✓ Digital inclusion, and other means of addressing social isolation
- ✓ Joining up health and care workforce development, including employment support & jobs for local people
- ✓ Tackling inequalities – via NCL inequalities fund, other local resources (e.g. community chest)

2 Outputs from population health framework

- ✓ Developing, rolling out and embedding HealtheIntent across frontline delivery
- ✓ Responding to identified priorities from current HealtheIntent analysis e.g.
  - Vaccs & Imms coverage
  - Smoking prevalence
  - Cancer screening
  - Care planning for mental health
  - Flu vaccination coverage
- ✓ Further analyses focussing on population sub-cohorts, geographical disparities

3 System-level health improvements

- ✓ Implementing outputs of strategic commissioning reviews for CYP services, Adult Community Services & Mental Health services
- ✓ Scoping and implementing a response to the Fuller report framework for action
- ✓ Local engagement in the Start Well review
- ✓ Continued vaccination programme support – including Covid19 autumn campaign, polio, and community outreach
- ✓ Embedding an integrated paediatric service model in all neighbourhoods
- ✓ Mobilising the winter plan – ED front of house, supported discharge and virtual ward scaling
- ✓ Actioning reviews around asylum seeker and homelessness health and wellbeing

Enabling functions

- ✓ Developing a more integrated approach to community and civic engagement
- ✓ A joined up approach to planning and delivering new and improved estates in response to system need
- ✓ Sharing and driving our anchor commitments around workforce

North Central London Integrated Care System

Enfield Borough Partnership:

Place Based Development – National Programme

November 2022

Contents:

Local Context - health and care challenges in Enfield

Growing Population and Deprivation

- 330,000 – 4th largest London Borough
- 30% increase in population 2001-2025
- Moved from 12th to 9th most deprived London borough
- Language barriers – 100+ languages

Increasing need impacting wider determinants of health

- 1 in 5 workers low paid
- Debt, fuel and food poverty
- 250% increase in homelessness associated with private rental market evictions
- Youth violence +27%

East/West Inequality

- Life expectancy and living in poor health
- Households in poverty & child poverty
- Adult and child obesity
- School readiness and achievement

Differential service use East/West of borough

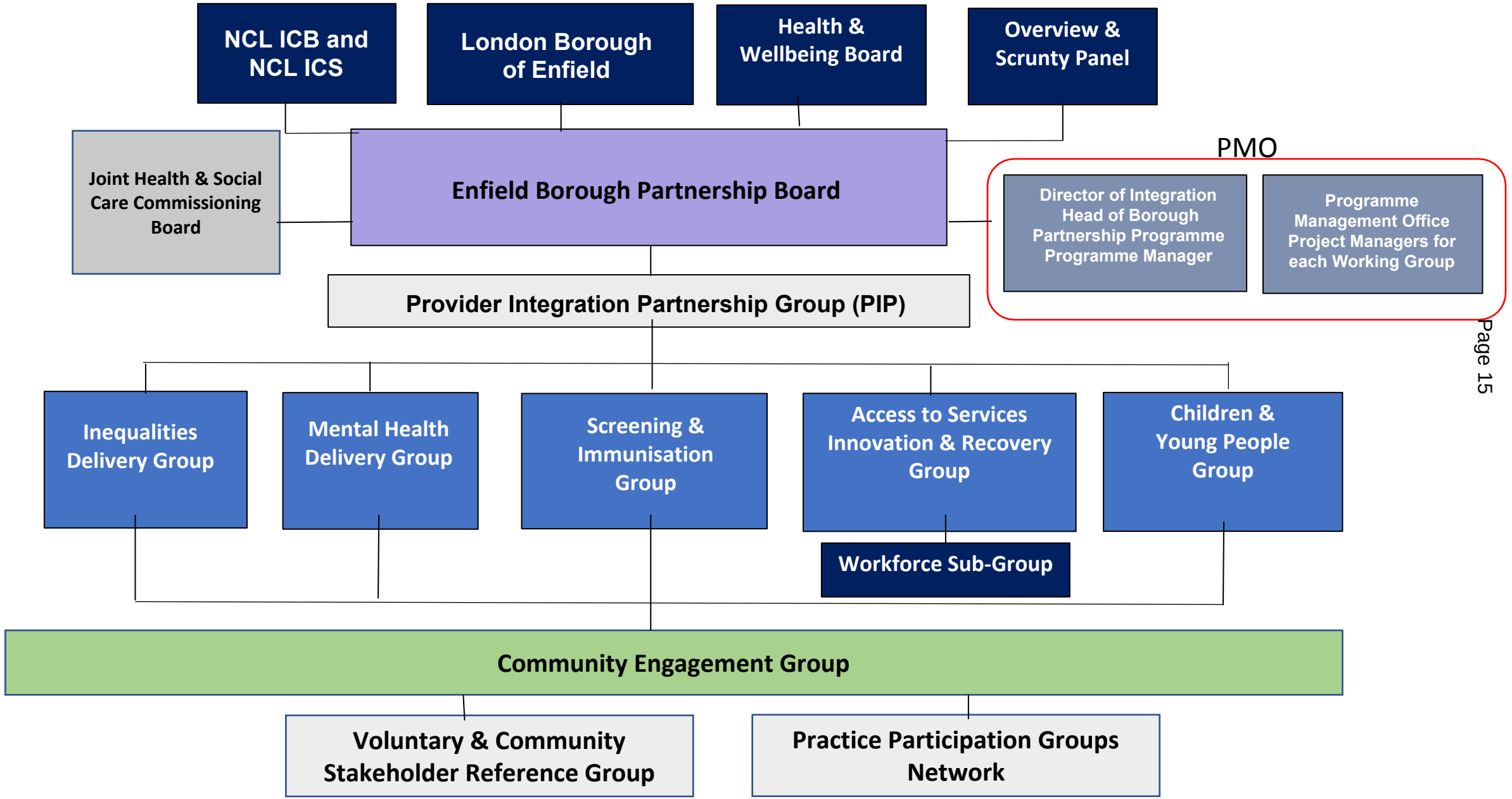
- NEL 12% and Elective 20% higher national average Edmonton Green
- 600+ attendances NMUH A&E with significant unregistered population

Differential investment

- Historic lack of investment in community and primary care services
- Significantly lower spend on community services per head of population than other NCL boroughs
- Fewer GPs and practice nurses than national average
- Austerity - Enfield Council cuts £178m since 2010 - £13m more in 2020/21. Average reduction of £800 per household for core funded services

Disadvantage generally accumulates through life **– Marmot Review**

Enfield Borough Place based Partnership - Governance Structure July 2022



Place Based Partnership Working & Programme Modules

The statutory members of our partnership are:

- London Borough of Enfield
- Enfield Borough, North Central London CCG
- North Middlesex University Hospital & Royal Free London Hospital (inc. Barnet & Chase Farm Hospitals)
- Barnet, Enfield and Haringey Mental Health Trust (inc. Enfield community Services)
- VCS organisations supporting delivery of front line services (e.g. Enfield Voluntary Action -health champions and social prescribing, Enfield Carers Trust, Age UK)
- Enfield GP Federation and 5 Primary Care Networks (PCNs)

In addition to this work:

Enfield has been working with The Leadership Centre & Traverse to drive the **Strategic Development** work required for the Enfield Borough Partnership.

We have worked hard to ensure that the Enfield Place Based Development work focuses on **Operational Delivery opportunities** and does not duplicate effort.

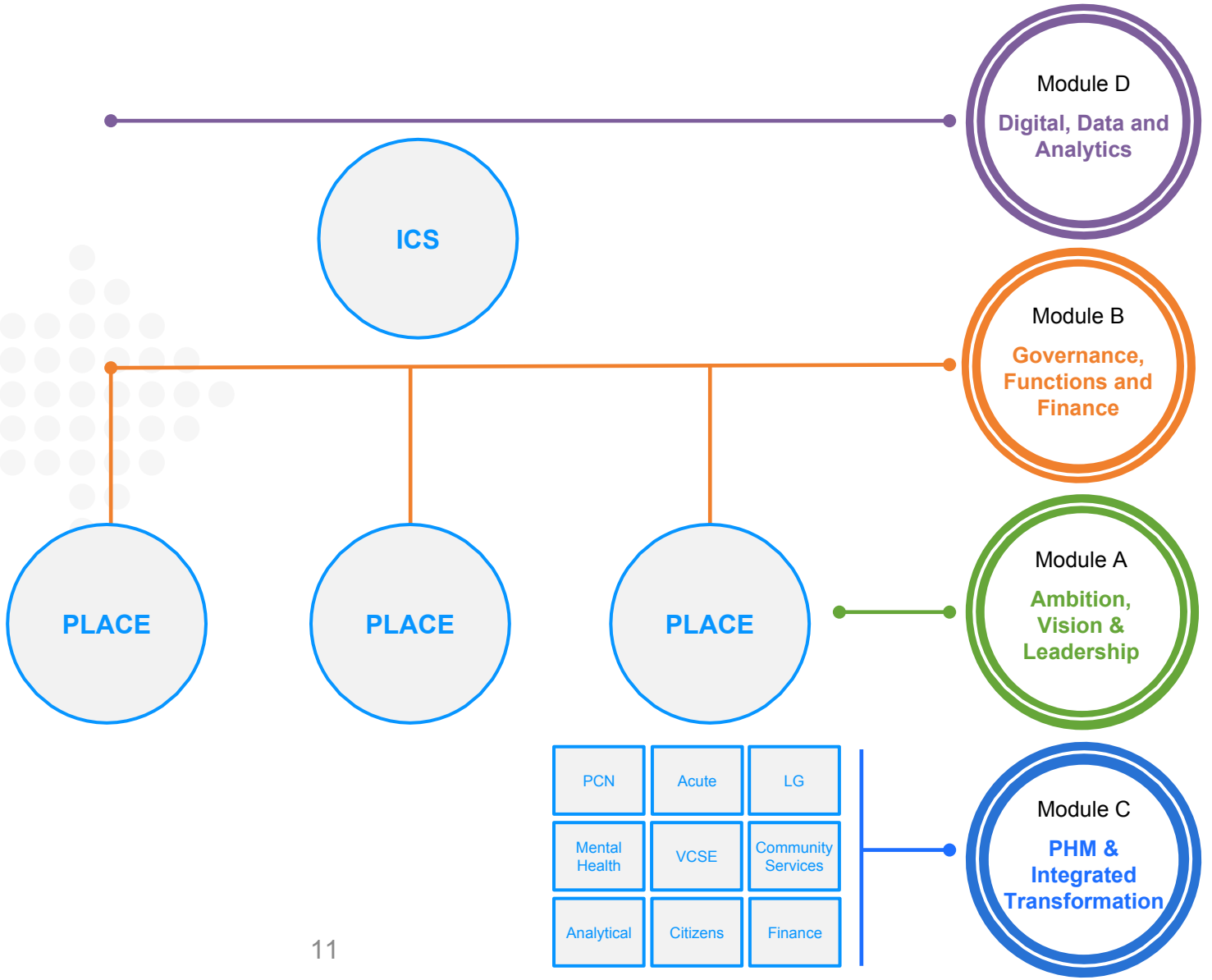
The Place Based design national offer comprises 4 Modules:

Module A - ***Leadership***	Strengthening the local vision through collaborative leadership, focused on outcomes for the population
Module B – ***Governance & Finance***	Sharing resources on a system basis while being Place & Neighbourhood focused to drive effective local decisions
Module C – ***Population Health Management***	Using this approach aims to improve the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population
Module D - ***Digital Development***	Developing a digital approach to help to improve access to health and social care services

ICS Population Health and Place Development Programme

The Programme set out to work in the following way:

- **To work in a joined up way across the different levels of an Integrated Care System.**
- **To respond to our priorities, developed through four core learning modules.**
- **Delivered online through up to 10 sessions per Module**
- **Offer of coaching and mentoring**



Four Modules

ICS Population Health and Place Development Programme

Aim of the Programme

- This has been designed to help Enfield Borough to deliver the best possible population health outcomes for its residents
- The support provided by the national offer will accelerate and embed the adoption of Population Health Management (PHM).

Why is Place based working so important?

- Breaks down institutional silo's and draws together support and services around people and the local population
- Best utilises the shared resources and assets of a Place
- Helps to tackle local problems, drawing on creativity of people from across the Place
- Emphasises the importance of community and citizen involvement in the design/delivery/evaluation of services and support

What role can PHM play in Place based health and wellbeing?

- Considers the wider determinants of health and inequalities, not just health and care
- Improving health inequalities by taking action
- Using data-driven insights and evidence of best practice to inform targeted, proactive interventions to improve the health & wellbeing of specific populations & cohorts
- Making informed judgements - clinical, public health and analysts working together
- Making best use of collective resources – workforce and incentives - to have the best impact
- Acting together – the NHS, local authorities, public services, the VCS, communities, activists & local people. Creating partnerships of equals
- Achieving practical tangible improvements for people & communities

Leadership & PHM Workshops

Priorities from the borough partnership PHM analyses it was agreed to focus on:

- ❑ Preventing & Reducing Tobacco Dependence - vaping vs. tar based
- ❑ Preventing & Reducing Overweight People from becoming Obese

Definitions of Population Health & Population Health Management discussed:

Population Health…
… is an approach aimed at improving the health of an entire population.

It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies.

Population Health Management…
…improves population health by **data driven planning and delivery of proactive anticipatory care to achieve maximum impact within collective resources**.

It includes **segmentation, stratification** and impactability modelling to identify local 'at risk' cohorts - and, in turn, designing and **targeting interventions to prevent ill-health** and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.

Following in-depth discussions of the partner members, it was agreed:

- ○ **The population cohort we should focus on is:**
  - ❖ **18 – 40 year age group – who smoke and who are obese or at risk of becoming obese**
  - ❖ **Living in the 20% most deprived areas**
  - ❖ **Other determinants of health to be considered , including cost of living crisis and poverty, social deprivation, education, access to fresh food, and access to green spaces**
- ○ **Partner members would identify operational leads to drive the development of the borough delivery plan in their respective organisations**

North Central London Integrated Care System

'Place-based partnerships should centre their work around a clear, shared vision of what the partnership is trying to achieve for local people and communities. The development of new structures and governance arrangements is secondary to this and must not become the principal focus. (The King's Fund)'

Case for Change:

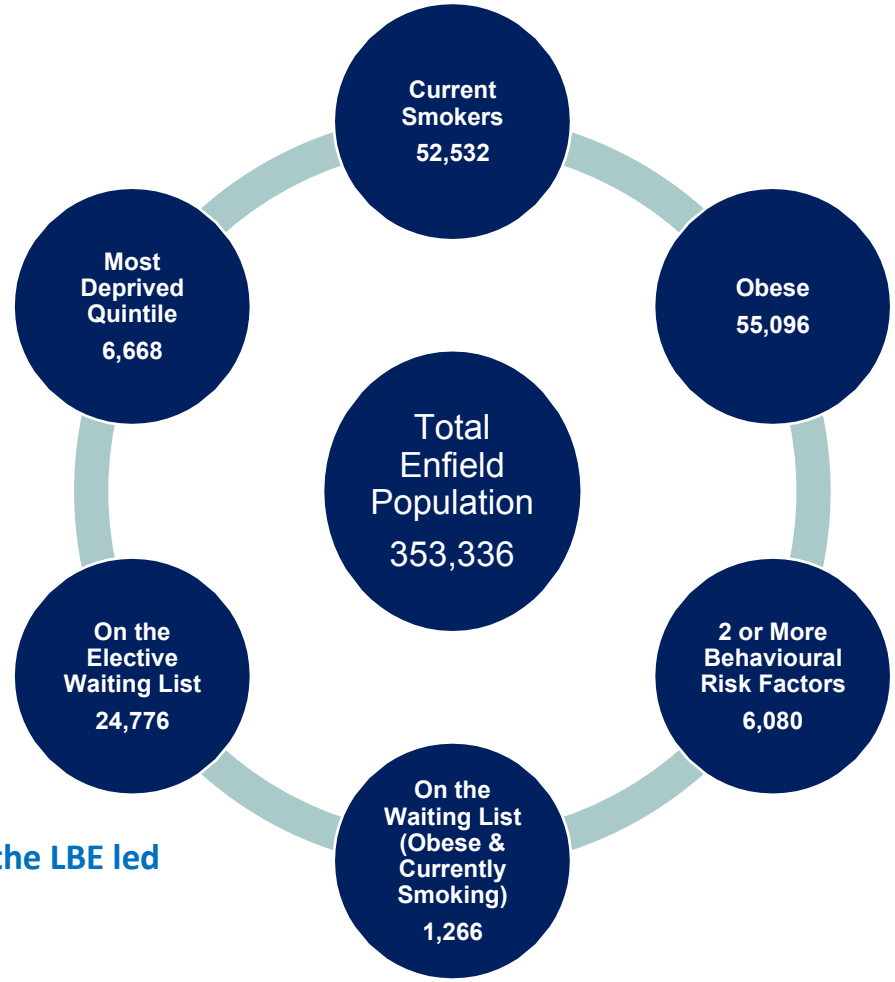
- 55,107 (20.5%) patients are reported as obese
- Obesity is high in the most deprived quintile and age 65yr
- 52,612 (19.6%) patients are current smokers
- Smoking prevalence is highest in:
  - the most deprived areas of the borough
  - The Turkish, Polish and Irish community groups

Wider determinants of health to consider:

- Unemployment / poverty
- Access to healthy food
- Access to green spaces

Aspects to consider during intervention design:

- Language, English / Turkish / Polish / Other
- Children in the household and childhood obesity
- Cultural co-production
- Use of social media/community spaces (e.g. libraries, building synergies with the LBE led work including development of community hubs



North Central London Integrated Care System

Local Priorities

- ❑ **Preventing & Reducing Tobacco Dependence - vaping vs. tar based**
- ❑ **Preventing & Reducing Overweight People from becoming Obese**

Last 100 Days

The following progress has been made to date:

- Have started to articulate a good case for change
- Have gathered evidence to inform and influence the ICB, particularly to secure further resources to help deliver at borough level
- Have reached out to staff on the ground who engage with our patients
- Have engaged with colleagues who's work focuses on our target groups of smoking and obesity
- Agreed the need to develop a standardized approach to access services, and a definitive directory of available resources to aid signposting.

Next 100 Days

As we start to shape our plan for the next 100 days:

- We recognise the scale of the challenge
- Consider how to take forward the learning that emerged in the first 100 days Look at the longer term future
- Use intelligence to help us define intervention
- Ensure local incentives are appropriately aligned to ICS level priorities
- Ensure sufficient infrastructure and capacity supports delivery
- Develop a model in order to track and monitor the impact over time, including metrics and indicators for each outcome.

Looking at holistic interventions that will lead to positive change:

In the short to medium term:

- Work will include looking at wider determinants of health
- Quantified quit rates within a measured time frame
- Looking at eating habits to support the cohort signposting
- Reduce smoking, and the use of tar based products based on NICE recommendations
- Explore the effects of vaping
- Reduce the impact of second-hand smoke on children and families

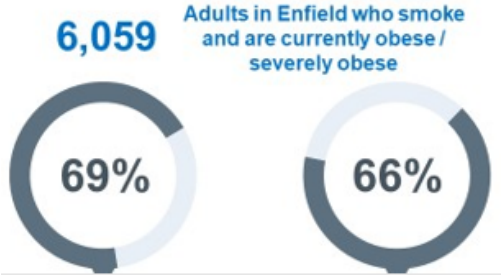
In the long term:

- Individuals in the cohort will be engaged in their own health care and well-being
- Looking for long term reduction rates of associated co-morbidities such as CBD hypertension, Cancer, COPD etc.
- Reduction in smoking prevalence and obesity.

Local Population Health Improvement priorities in 2022/23

North Central London Integrated Care System

Population characteristics of individuals who smoke and are currently obese/severely obese



- Data is not currently readily available at a level of granularity that allows us to look at the demographic characteristics of individuals aged 19-40 living in the 40% most deprived areas
- We estimate that between 2,767 and 4,170 19 to 49 year olds in Enfield who smoke and are currently obese / severely obese
- The upper bound is the total number of individuals living in the 40% most deprived LSOAs
- The lower bound is 66% of the total
- However, people living in the most deprived areas are more likely to be young; therefore, it is safe to assume that the size of the cohort is closer to ~4,000.

NCL Population Health Improvement Strategy: Enfield Borough

Borough:	**Enfield**	**Where/who PHI Strategy & OF have been socialised:**	• Borough Partnership (PIP/Board) • Health and Wellbeing Board • VCSRG • PCN/Clinical Director Forum
Borough view on outcomes/ focus areas for NCL:	• Addressing Inequalities – Core 20 Plus 5 • Smoking – reducing harm from tobacco • Obesity – Diet, physical activity, environment • Physical & Mental Wellbeing • Wider determinants of health – isolation, debt, housing, employment, education, cost of living, food poverty • Climate change/social responsibility • Integrated workforce, working across organisational boundaries • System cost analysis.	**Borough view on outcomes/ focus areas for Boroughs:**	• Obesity – reducing the risk of people who are overweight from becoming obese • Smoking – reducing harm from tobacco • Inequalities • Access to Services, Recovery & Innovation – to include workforce • Screening & Immunisation • Mental Health (including Community Services Review) • Children & Young People • Communication & Engagement – Community Fund, to improve health literacy and involve local residents to inform local priorities.
Next steps to support population health improvement delivery (over next 12 months): (e.g. further socialisation, programme mapping, deep dive analytics, etc.)		**Suggestions/requirement from NCL to assist with next steps & onward delivery:**	
• Socialisation of the Population Health Strategy • Identification of key actions by groups • Deep dive analytics and interpretation • VCS – Community Participatory Research		• Programme management support • Additional PHM analytics and ICB analytical support – develop borough dashboards for health and care service provision • Shared intelligence, systems and data	

Function	Functions needed at Place level in Enfield		
	For Smoking (& reducing harm from tobacco)	**For Obesity**	**Discussion on Developing Place**
Strategy & Planning	• Lead engagement with local people/residents • Lead the development of a local strategy • Manage the co-production with residents & partners • Identify best practice approaches	• Lead engagement with local residents and HWBB • Appoint a local Obesity Champion and a Food Quality Champion • Focus on obesity and health outcomes at a whole population scale • Define what success looks like for obesity	**KEY POINTS** • Involving wider stakeholders in the Partnership's decision-making • Articulating role and functions, and how they fit with those of the ICB • Confirming and socialising the functions • Considering what this means for how we organise and govern our work **RESOURCES** **Resources we have across the partnership include**: • A borough partnership office with a programme support team • Pooled funding e.g. Community Engagement Fund • Sufficient workforce pan-borough to support priority initiatives • Use residents as a resource & influencers e.g. faith group & networks • Consolidate "Healthy Intent" and other evidence of what has worked • Significant physical assets across organisations • Strong relationships / trust formed across the ICS. **What resources do we need?** • Political will and power to implement these ambitious strategies • All ICS partners being willing to be educated and understand how the ICS impacts them • VCS organisations must see themselves as part of solution • Enfield NHS commissioners must support the development of emerging business cases **How could we close the gap? (including by stopping things…)** • Financial resources /funding need to be unlocked • Identify commissioner skills to support development of business cases • Consolidate evidence to demonstrate the case for change • Clear communications & engagement strategy needed to explain how ICS impacts different groups • Work with head teacher forums to develop avenues into partnership working with schools.
Service Design & Delivery	• Identify innovative initiatives & models to tackle tobacco • Design services & initiatives to prevent young people becoming addicted to tobacco	• Focus on changing behaviours/prevention • Align capacity requirements with service design • Collate local population health data • Signpost obesity services to residents	
Collaborate with Partners	• Lead the development of a local partner collaboration strategy • Collaborate across partners to support delivery of initiatives • Support partners to drive tobacco/smoking cessation through engagement • Collate local intelligence to inform where/how efforts are best targeted • Establish joint working groups to tackle tobacco • Manage engagement with senior stakeholders of organisations	• Collaborate with partners to provide better food options • Develop proactive information based campaign for engaging with partners • Coordinate development of a comprehensive obesity strategy and plan • Drive up advocacy amongst local partners & facilitate exchange of information • Develop an anti Obesity Charter for partners to sign up to • Drive behaviour change in anchor organisations to act as role models • Develop common terminology around obesity	
Performance & Finance	• Develop performance models • Ensure resources are aligned to deliver • Ensure full involvement of holders of community wellbeing council contracts • Define realistic outcome-based targets within the available resources • Monitor performance against targets	• Develop a sustainable regime for reporting performance/finances to the system • Set realistic performance targets • Monitor/report on delivery against obesity initiatives • Disaggregate information/data from system level to more local level • Consolidate information to measure success	
Quality & Risk	• Ensure quality & risk management are aligned to patient/resident experience/stories • Manage escalation/communication on quality/risk to the ICB.		

The Fuller Stocktake Report sets out a vision for integrating primary care

At the heart of this report is a new vision for integrating primary care, improving the access, experience and outcomes, which centres around three essential offers:

- **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it**

- **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to, those with multiple long-term conditions

- **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

The new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations.

- **Neighbourhoods of 30-50,000**, incorporating teams from
  - across primary care networks (PCNs),
  - wider primary care providers,
  - secondary care teams,
  - social care teams, and
  - domiciliary and care staff

- **Working together** to:
  - share resources and information and
  - form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and
  - tackling health inequalities.

- **PCNs have already enabled many neighbourhoods to progress** – but limited by lack of infrastructure / support.

The report also highlights the need to build integrated teams in every neighbourhood

Integrated neighbourhood 'teams of teams'

- **Integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks** (PCNs), and be rooted in a sense of shared ownership for improving the health and wellbeing of the population.
- **They should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.**
- **Cultural shifts needed to enable this**:
  - Move towards a more psychosocial model of care that takes a more holistic approach to supporting the health and wellbeing of a community;
  - Realignment of the wider health and care system to a population-based approach – for example, aligning secondary care specialists to neighbourhood teams.
- **Leadership is also a key ingredient** – fostering an improvement culture and a safe environment for people to learn and experiment

Delivering integrated neighbourhood teams of teams

Requires a step-change in progress, with a **systematic cross-sector realignment to form multi-organisational and sector teams working in neighbourhoods.** This will unlock improvements in patient care and help individual PCNs and teams to better manage demand and capacity, building resilience and sustainability. For example:

- **full alignment of clinical and operational workforce from community health providers to neighbourhood 'footprints'**, working alongside dedicated, named specialist teams from acute and mental health trusts, particularly their community mental health teams
- **making available 'back-office' and transformation functions for PCNs,** including HR, quality improvement, organisational development, data and analytics and finance – for example, by leveraging this support from larger providers (e.g. GP federations, supra-PCNs, NHS trusts)
- **a shared, system-wide approach to estates**, including NHS trust participation in system estates reviews, with organisations co-locating teams in neighbourhoods and places.

Community Hubs:

Creating a 'bridge' between the Council's Early Help for All Strategy and a range of targeted support for residents in need

Four Pillars – current support & referral pathways

Health & Wellbeing	Jobs & Skills	Housing Stability	Money
• Food Pantries (Appendix 2) • ABC Parents • Enfield Community Psychological team • Age UK • NHS Digital First Programme • NMUH Midwifery Service • Enfield Food Alliance • EVA • NMUH Health & Wellbeing Hub	• Local Employment Team (New) • 50+ Job club • Informed Families/ • Training • EVA • Community Development Team	Housing & Immigration Service Street Homeless service Floating Housing Team Link to Homelessness Team	• Welfare & Debt Advice • CAB • Informed Families • Enfield Connections

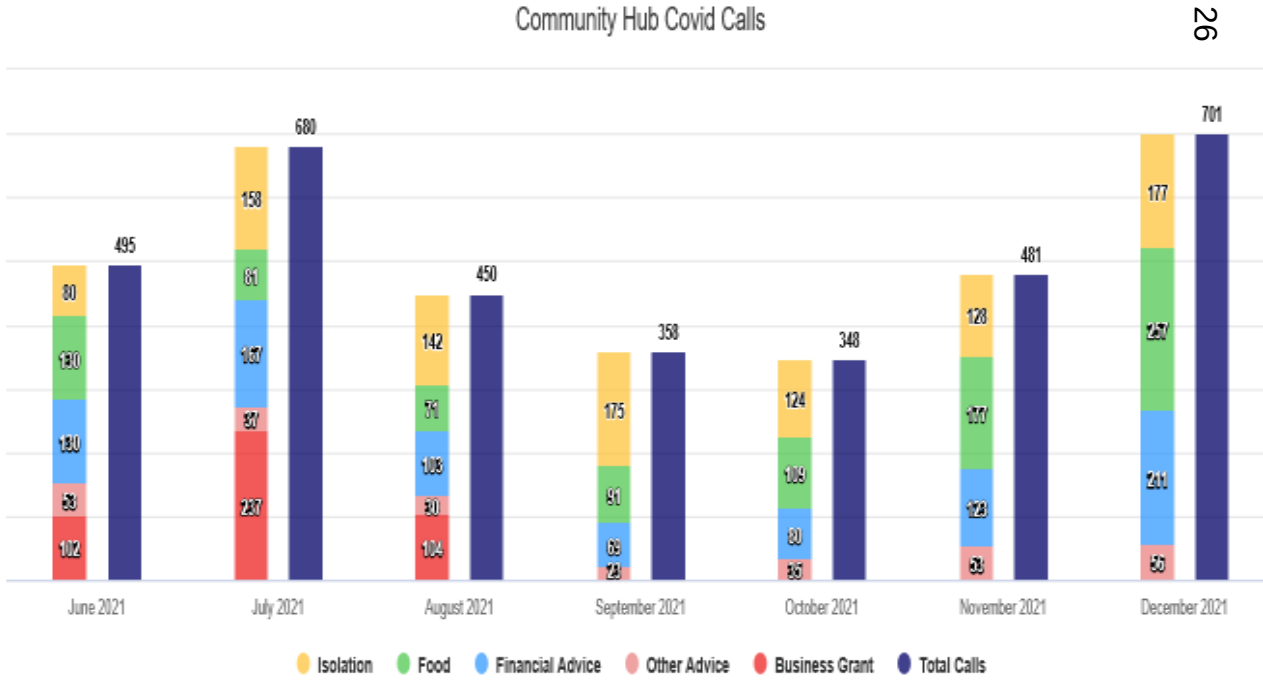
Community Hubs contact with customers 2021/22

Our Community Pantry

- **Strictly a referral-based model, with bespoke customer action plans.**
- **Provision by Enfield Foodbanks, Felix Project and ASDA so far…**
- **Cheaper and healthier alternatives to mainstream shopping for people who are in poverty.**
- **Promoting self-esteem**

Lead by the creation of a Food Action Plan for Enfield to ensure that all families have access to healthy food as per Enfield Poverty Inequality Plan 2020.

Our community-led model; with community volunteers operating the pantry, nudges people who can self-help, away from complete dependency on food banks, so those in most need can access the support.



Community Powered Edmonton

Partnership: NCL Integrated Care Board, Edmonton Community Partnership, Healthwatch Enfield, and New Local

What we did

- Three workshop discussions bringing together residents, VCSE groups, and public sector (NHS and local authority) led by New Local
- A showcase event led by ECP and involving Platinum Performing Arts, allowing young people and residents from GRT Bulgarian and Roma communities to share their lived experience and stories through music, poetry, dance, film and panel discussions, captured by a graphic scribe.
- A series of focus groups and a survey led by Healthwatch Enfield, capturing the perspectives of particular communities (e.g. mental health service users, Turkish women's group)

Living a healthy life in Edmonton – what do we know

- This workshop discussed what helps people and communities in Edmonton to live a healthy life, and what gets in the way of their health and wellbeing.

Talking and listening to improve health and wellbeing

- Public sector staff and residents in Edmonton engaged in a community conversation to better understand what matters to local communities, so that local public service providers can listen to ideas and co-design changes.

Taking action to address health inequalities

- Bringing together residents, VCSE organisations, and public sector organisations to focus on practical actions which could be taken to work more collaboratively to address health inequalities in Edmonton.

What we heard

Biggest issues affecting people & communities' health & wellbeing in Edmonton:

- **Safety:** for young people and the wider community
- **Poverty:** facing financial hardship which has a negative impact on health, wellbeing and feelings of exclusion
- **Social isolation:** even though community, friends, and family are highly rated factors to support health and wellbeing locally
- **Mental health:** an issue affecting many communities, heightened in some due to stigma or mistrust of treatment options e.g. Bulgarian
- **Language barriers & lack of knowledge and confidence:** to access services
- **Digital exclusion:** not always being IT literate to be able to access available information and support

Blocks to effective collaboration between communities and service providers:

- **Lack of trust:** because the time hasn't been taken to build relationships, or people feel 'let down' by the system
- **Knowledge and awareness:** people don't always know where to go or what services exist (e.g. if different in their host country)
- **Language barriers:** limits understanding and communication
- **Engagement skills:** professionals need to be supported to collaborate well with people and communities
- **Lack of personalisation:** people and communities will need different things, sometimes the system doesn't allow for this
- **Lack of safe spaces for collaboration:** not enough bringing together of the public sector with people and communities

North Central London Integrated Care System

Next Steps

Summary of Key Actions/Priorities

1.	**Winter Community Resilience Forum**	We will drive this via the Access to Services, Innovation & Recovery Group, and through other meetings across the borough partnership.
2.	**Data and information**	To be used to understand trends and think about how we work collectively as a place partnership to make change happen, not just for 6 months, but for ongoing resilience as a place, and as part of the Integrated Care Board, Integrated Care System.
3.	**Strengthen our relationships**	In order to cement our structures
4.	**Think about our resources**	What additional resource do we have within the Borough Partnership programme. We have established new Children & Younger People Group, and due to set up the Enfield BP Engagement & Communication Group
5.	**Convener and clinical director roles**	How they will help us develop our leadership model for Enfield
6.	**Leadership around population health**	Including the LTC programme across NCL and work we're doing locally, and ensure we get the right level of support for Enfield.
7.	**Next 100 Days**	As we shape the care model, articulate what we must do in the short > medium > long term
8.	**Develop a lifestyle network**	Model based around a population health perspective, by resource mapping (in the next three months), and establishing a Task & Finish Group to shape and drive this work in partnership with our residents.
9.	**Become a Core20Plus5 Accelerator Site**	Take forward this opportunity to gain further resource to help us take this programme of work forward.
10.	**Develop our Digital Inclusion work**	Via the Access Group. Consider the ICB Digital Inclusion Plan & the challenges our residents have in terms of accessing solutions.
11.	**Governance**	• Crucial to have sufficient support to manage this programme of work: 18+ projects currently in the programme of work that must be managed; including taking stock of what our inequalities programme of work is achieving and establish strategic oversight. • Source analytical support around population health, and build on collaborative partnership working with public health • Work with the GP Federation and PCN clinical directors to look at our Borough Partnership governance, and our neighbourhood based multidisciplinary structures going forward, between now and April next year.
12.	**Embed the VCS into all aspects of this programme**	Consider how we resource them, in terms of our leadership model and our financial model, and how we ensure they have time to meaningfully participate and contribute to this important work.

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Enfield Council Health & Adult Social Care Scrutiny Panel

Transformation
What is the Impact on Enfield residents?

Natalie Fox - Deputy Chief Executive and Chief Operating Officer, BEH and C&I
Josephine Carroll - Managing Director, BEH- Enfield Mental Health Division
Parmjit Rai - Managing Director, BEH-CAMHS Division

Content
Context
Partnership working with Enfield Council and Integration
Adults Mental Health Transformation
Programme Workstreams
• Community Transformation Outcomes ➢ Outcome 1: More people receiving support ➢ Outcome 2: See people quickly ➢ Outcome 3: Higher quality care
Young People Mental Health Transformation

Context

The aim of the Community Transformation programme is to deliver mental and physical health support to more people in the community with SMI by ensuring all parts of the primary and secondary health and social care system, including VCSE organisations, work together.

An integrated care model will bring all the agencies that support people with different mental health needs closer to develop new services which help keep people safe and able to contribute and participate in their local communities to create or fulfil hopes and aspirations in line with individual wishes. This is part of delivering Person-centred approaches that have an evidence-base in improving whole-life outcomes for people.

The Trust has designed our new service model and care pathways through co-production and co-design with stakeholders, partners and service users and carers. Enfield Council officers are a key partner and members of the programme. The investment is enabling the Trust to increase the size and skill mix of the workforce whilst providing training to help them to work differently. One example is the introduction of Dialog+ to create co-produced personalised care plans which focus on holistic health and social needs for all service users. The ICB and ICS has invested in joint commissioning arrangements with the Council.

The goals for the Community Transformation are to realise the following outcomes:

- Outcome 1: More people receiving support
- Outcome 2: See people more quickly
- Outcome 3: Provide higher quality care

Partnership working with Enfield Council and Integration

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In Enfield, we have strong and long standing Partnership Arrangements and ways of working in an integrated way that benefit our residents. A few examples of these are below.

The Enfield Mental Health Community Transformation and core offer delivery is being implemented under the auspices of Enfield Partnership Board Mental health sub-group with updates provided to the HWBBs Mental Health Partnership Board, Joint Health and Social Care Commissioning Board and other health, care and support system stakeholder forums.

The Enfield Partnership Board and its sub-groups are co-chaired and / or well attended by key Members of the Council, such as, the Director of Adult Social Care (DASS), Director of PH services, Service development leads, commissioners and contract leads within the Council.

ICB and BEHMHT have worked with Enfield council to deliver a broad range of mental health services under the transformation programme through joint commissioning arrangements. E.g.: Joint contracting of the Working Well Trust specialist Employment services for people with MH needs, the Autism Hub provided by a VCSE Enfield one-2-one.

The Enfield Crisis Café was established under a system steering group and the crisis case finder is employed by the Council via Section 75 arrangements, s.256 MH Prevention funding of £360k via Section the Partnership Agreement held between NCL ICB and Enfield Council.

BEHMHT and Enfield Council hold a Section 75 Partnership Agreement to ensure the delivery of integrated teams across health, care and support system and models. Integrated services have a proven evidence base in providing positive outcomes for people with Mental health needs as this approach ensures person centred care and support is delivered.

Enfield Borough Place based Partnership Governance structure July 2022

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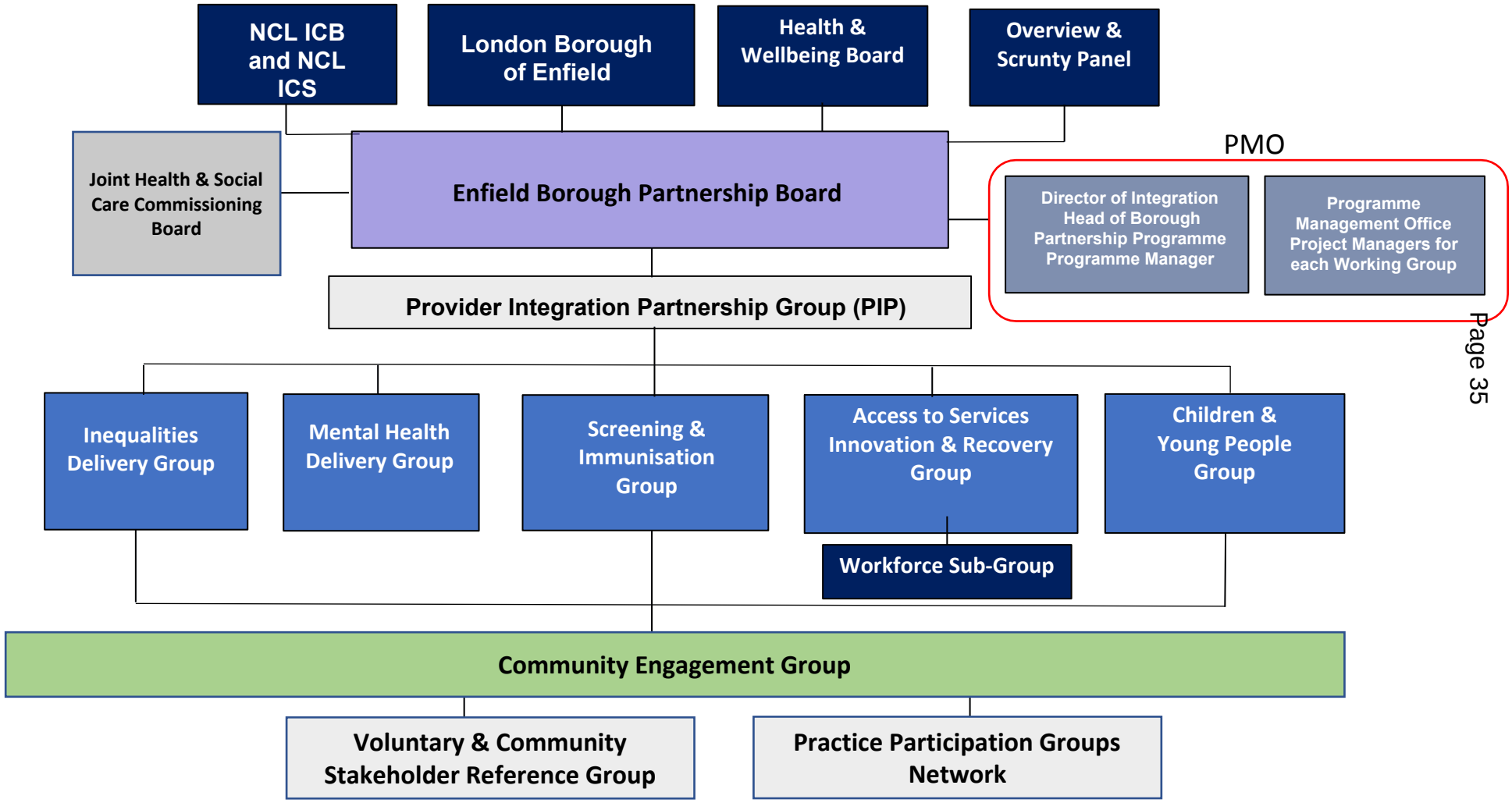

Community Transformation Engagement Event
30th Sept 2022

Programme Workstreams

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Deliverables by 2023/24

- An integrated model of primary and community mental health working alongside VCS and Social Care
- Additional clinicians to reduce number of admissions and keep more people with SMI in their communities
- Case-finding to address inequalities in accessing mental health support
- Rapid access to MH services providing treatment within 4 weeks
- Holistic personalised care plans for all service users
- Physical health support for people with SM

Trust Strategic Aims

Excellence for service users *(Patient experience care in areas that matter most to them)*	Empowerment for Staff *(Staff are valued and developed.)*
Partnership with others *(Least intensive and clinically appropriate care closer to home)*	Innovation in Services *(Support more people with SMI in our communities)*

Community Transformation Outcomes

Key changes and areas to measure quality impact and outcomes

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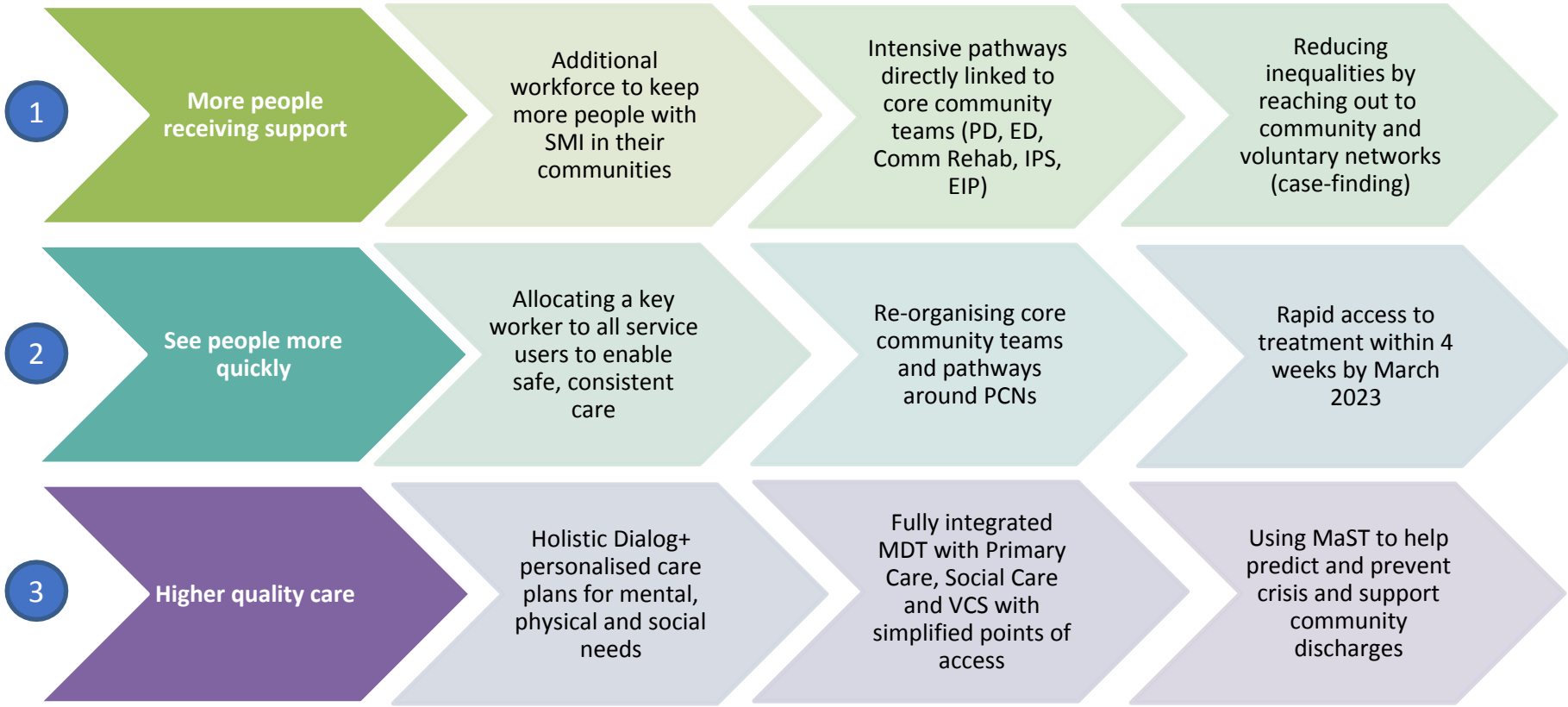

Outcome 1

More people receiving support: Intensive pathways

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Older Adults
- Increasing capacity through specialist education to support to core teams.
- Strengthened Intensive Support Teams with Psychology groups commenced (Saheli Womens', wellbeing group)

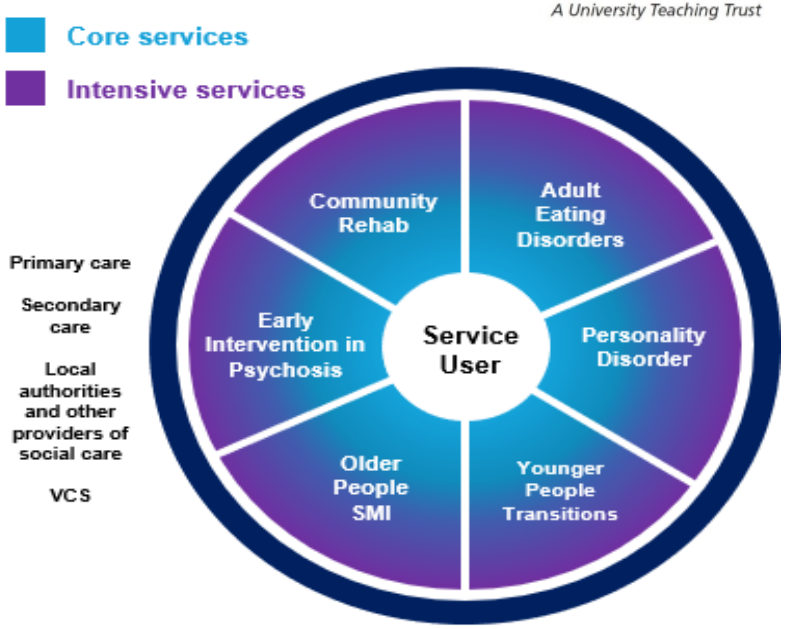
Early Intervention in Psychosis
- Enfield now **achieving Level 3** standard
- Enfield achieved nearly **100%** for Physical Health

Community Mental Health Rehabilitation
- Reduce reliance on inpatient provision and as part of the wider new model, Council partners are fully involved
- Four workstreams have been formed across NCL with multi partner collaborations

Physical Health
- Pilot new delivery models relating to physical and MH care especially for BAME service users
- Supporting uptake of Annual Health Checks

Personality Disorders
- Continue to deliver against the 60% waiting time standard and improve links to the core offer

Eating Disorders
- Aligned to core model, embed Experts by Experience, No barriers to access e.g. BMI or weight thresholds, offering early intervention model

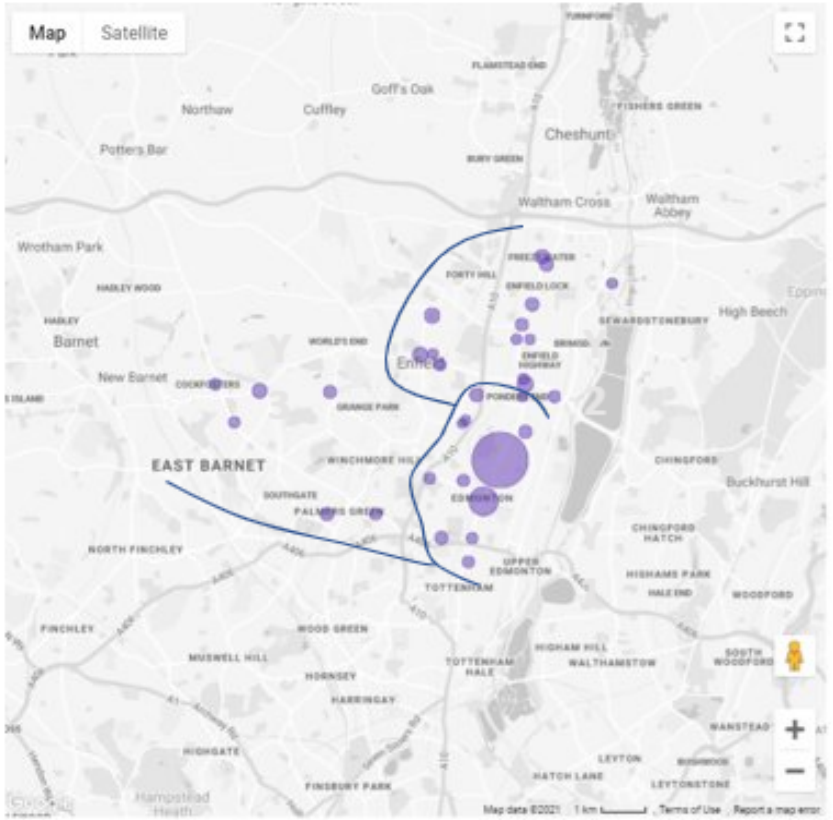


Key actions
- Community Transformation investment, including a range of new roles, is supporting multi-disciplinary core community teams integrated with PCNs, Social Care, Employment staff, and the VCS sector
- With Yr1 and Yr2 investment plans are to increase the workforce by 68wte new roles.
- Investment in Peer Support and Community Engagement roles directly employed by Voluntary and Care sector organisations
- 50% match funding with Primary Care Networks to introduce GP three Advanced MH Practitioner roles in GP Surgeries.

Outcome 2
See people quickly

- Community Mental Health teams are now aligned around Primary Care Networks (PCN's)
- Enfield have engaging with the Primary Care Networks resulting in clustering around PCN neighbourhoods/GP practices (47 practices in total) – **see map example**
- Capacity in Multi-disciplinary teams has increased with clinical and non-clinical staff, including **new roles, VCS and GP-based MH practitioners**, to work closely with psychological therapy, and intensive support pathways

Re-organisation of Enfield Teams around Neighbourhood Clusters (PCN sub-level)



N.B. Size of circle reflects % of SMI on list combined by GP group practices

Improving access to treatment – first episode Psychosis

Key data and findings

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- ✓ 42% of clients are black or black British, an increase from 26% the previous year
- ✓ 57% of clients male, and 43% are female
- ✓ 2 week wait for commenced treatment met 100%
- ✓ High levels of service user/carer satisfaction
- ✓ 15% of clients transferred to longer term mental health teams
- ✓ 85% of patients discharged back to their GP
- ✓ 100% clients on the caseload are within 3 years of treatment
- ✓ 68% of the clients have had annual physical health checks.
- ✓ 92% referral to treatment rate met

Outcome 3

Higher quality care: Holistic Dialog+ personalised care plan

Status

- Dialog+ is an outcomes-based intervention using a questionnaire to assess a Service Users quality of life and experience of care received, in a structured way, and enabling a personalised holistic care plan to be created
- Initial reporting is looking at # of users trained, # of users active, # of DIALOG assessment completed.
- Organisational Development Plan includes DIALOG+ for teams

Key next steps

- Continuing our journey to shift away from CPA and manage this transition through a phased approach:
- The trajectory for teams using Dialog+ is expected to reach **78%** by end of Mar 23

Outcome 3

Higher quality care: Personalised holistic care plan

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Dialog + Service User and Community Team Feedback

"Using DIALOG+ was brilliant, it helped me to identify, for the first time, the specific areas of my life where I was stuck and needed help. By breaking my challenges into manageable parts, I was able to identify actions and potential solutions. It has changed my life for the better."
Service user

''A young non-engaging female has been with me since last November, I using Dialog+ regularly. She went from being as low as one can be, less than 9 months later she is now a volunteer and applying for a university to study mental health! She has blossomed into a rose right before my eyes."
Community team member

"In my appointment, I talked about my challenging areas, I identified small actions to take before the next meeting…I agreed to contact a local recruitment agency who could help me update my CV and prepare for job interviews. This opened new doors."
Service user

Outcome 3

Higher quality care: PCN/GP Surgery based clinicians

Enfield's Advanced Clinical Practitioner feedback

Feedback from Evelair Piper, Enfield Advanced Clinical Practitioner

"I am based at Forest Road Group Practice Tue-Thur and provide face to face, video and telephone consultations to service users with complex MH problems, who often also have several physical health conditions.

I also serve as a point of access for direct consultation and advice, as well as training and support for other practitioners on issues around mental health/illness.

ACPs manage clinical care in partnership with individuals, families and carers and other care providers, by analysing and processing complex health and social problems and work with the service user to find innovative solutions to enhance their experience and improve outcomes.

The ACP role is pivotal in that it supports the aims and vision of the Trust. Another aspect of my role include attending and contributing to collaborative Primary Care Network Multi-Disciplinary Team and Trust meetings, work closely with senior management and partners to promote and influence positive changes in policy across the service.

I'm looking forward to bringing the skills and knowledge I have developed during my career, to this exciting new role that will make real and positive change to people's lives''

Outcome 3

Higher quality care: Voluntary and Care Sector support

- A 59 year old client had been under locality team for several years. The client accessed our Service presenting with anxiety and severe depressive episodes, EUPD and alcohol dependence. He was experiencing social withdrawn, self neglect, and missing medical appointment appointments. The multiple conditions he was experiencing led the client to aggravate his presenting condition and accessing crisis support services on a regular basis.

- The VCS staff member supported client to prioritise and attend GP and other medical appointments and to re-engage with alcohol management support. They identified other social needs e.g. new furniture with items within the house, and helped the client to secure those via the Enablement Team. Client reported bad eating and self care habits, so they were referred to courses on Healthy Eating and supported to go Grocery shopping to start building positive habits.

- VCS applied for Freedom Pass to enable the client to attend community activities, and they use this to regularly attend groups including Hearing Voices and LGBT specialist support groups and counselling. Client has not reported a crisis for over a year.

"I just wanted my thanks and appreciation noted. My son has had mental health problems for many years. Since VCS support worker has been appointed key worker, there has been a positive impact on my sons mental health. He understands, and for the first time my son relates to his worker. He has started to venture out with some confidence and looks forward to seeing him. Coming from despair, for the first time in many years hope has been given to us. He has insight and a buoyant personality which is improving my sons self-worth and motivation. This has not happened in many years."

Community Engagement Practitioner

"I love being able to use my own personal experience to support somebody else and see them going through positive change. It is challenging but when somebody starts to make changes and feel better it makes it worthwhile."

Peer Engagement Practitioner

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Enfield Council Health & Adult Social Care Scrutiny Panel

CAMHS Transformation Update

Parmjit Rai

Managing Director

November 2022

CHILDREN AND YOUNG PEOPLE MENTAL HEALTH – LTP Priorities for Enfield			
Priority	**Description of LTP Priority**	**Deliverables in 22/23**	**Outcomes**
1. LTP 24/7 CYPMH Crisis Response	• Provision of 24/7 Crisis Services to CYP across NCL	• 24/7 Crisis Line for all ages with CYP specialists • A&E diversion Hub with Enfield available from 09:00 -24:00 hrs • Crisis Liaison service mobilised into North Middlesex Hospital A&E and Paediatric Department..	• Enfield CYP access to 24/7 Crisis Services.
2. Community CYP MH services, early intervention and prevention offers and pathways	• Reduce Waits • Increase school based services • Removing unwarranted MH treatment access gaps for in-borough Looked after children (LAC*) • Address inconsistency and gaps in community based universal and early intervention offers. • Develop integrated delivery models and partnership working in the core offer delivery not just clinical pathway/model.	• Appropriate allocation of SDF funding to community CAMHS to manage waits and local variation in capacity and service gaps, including achievement of planned access and wait times trajectories. £700K to Enfield Division for 21/23 and 22/23 • Additional MHSTS in Enfield	• Reduction in waiting times • Increase in school based services
3. LTP Eating Disorders targets and Disordered Eating and ARFID support pathway	• Increase capacity in Eating Disorders pathway to achieve and maintain LTP targets for urgent and routine waits • Mobilise pilot Community Disordered Eating and ARFID support and pathways • Strengthen community CAMHS and ASD links to support multi-agency planning for co-morbidities e.g.. ASD, self-harm.	• Uplift into specialist Eating Disorder Services in NCL • Mobilisation of Community Disordered eating disorder service in Enfield • LD/ ASD Keyworker project roll out in Enfield for 23/24	• Disordered eating service clinician embedded in Enfield CAMHS. • LD/ASD Keyworker project implementation in 22/23.

CHILDREN AND YOUNG PEOPLE MENTAL HEALTH : LTP Priorities for Enfield			
Priority	**Description of LTP Priority**	**Deliverables in 22/23**	**Outcome**
4. MH Support Teams in Schools	• Increase number of schools accessing Mental Health Support Teams aligned to national trajectory	• Waves 7 and 9 MH Support Teams in Schools bring the total teams to 14 in NCL (45% coverage for NCL)	• Enfield has 50/96 schools with provision. Further wave 9 investment will extend to all schools in the Borough.
6. Central Point of Access	• Implement NCL wide Thrive model including integrated front doors with system partners.	• Planning for integration of front doors	• Deliver multi-agency models in 23/24
7. Crisis Services and Adolescent assessment and interventions including psychosis	• Extend provision of 24/7 Crisis Provision in line with National guidance for CYP.	• 24/7 Crisis Line implemented • Crisis Liaison Service at NMUH for Enfield CYP • A&E Diversion hub set up with key worker in Enfield to respond to 4hr response time • DBT service to mobilise in Jan 23 • Home Treatment Team mobilise in March 23	• CYP have access to 24/7 crisis support.
8. CYP LD, autism and ADHD	• Achieve ambitions of Transforming Care agenda to offer better care closer to home and improved assessment and treatment pathways.	• Implement 22/23 ASD/ADHD waiting list recovery plan – 40 CYP in Enfield being offered assessments via NCL with a further 60 offered via digital provider. • LD/ ASD keyworker pilot implemented in 22/23. •	• Reductions in assessment waits anticipated byQ4 23/24

YOUNG ADULTS (18-25) – LTP Priorities for Enfield			
Priority	**Description of LTP Priority**	**Deliverables in 22/23**	**Outcomes**
1. Student and young adult wellbeing support	• Increase support for students and young adult wellbeing support.	NCL residents will benefit from increased capacity and new models of care for YA, inc; • proactively reach out into community settings and partner providers incl. Local Authority Services (YOS and LAC and the VCS , bridging young people into services as required. Focus on vulnerable groups specifically BAME, care leavers (incl. people seeking asylum) and young offenders • offer developmentally appropriate pan-diagnostic assessment, formulation intervention and be a resource, supporting colleagues to do the same • develop and roll out training for Adult MH staff in specialist services on adolescence and transitioning, including trauma impact on developmental delay. • Transition champions will work across age and intensive team boundaries, proactively identifying CAMHS users requiring AMHS. Offering highly specialist psychological and systemic assessment, formulation and care planning as appropriate for young adults and families, and bridge YA into the most appropriate AMHS service. Offer leadership, consultation, training, supervision within AMHS • Transition workers (primarily Expert by Experience) will help YA access signposted services and support care planning activities. They will offer containment and coordination, build a therapeutic relationship using a person-centered recovery approach and provide psychologically informed interventions. • Enhanced delivery to reach YP at risk of serious youth violence	• Phase one transition teams embedded in core teams in Enfield and working across Adult and CYP services.
2. Adolescent and Young Adult Mental Health Service	• Improve provision for YA accessing services by providing flexible and integrated care with focus on CYP who are accessing services for the first time and vulnerable groups such as Care Leavers and UASC.		
3. Transition MDT (case discussion) and transitions champions	• Ensure that all young people have transition plans and access to a transition service that is NICE Compliant and in which they feel their care is improved,.		

New Investment & Impact

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Enfield secured £224k in 21/22 and recurrently in 22/23 of the overall North Central London Mental Health investment into Community CAMHs provision (32% of £700k), delivering the following impact:

The additional investment increased the generic Community CAMHs workforce by 10.2wte posts across a range of disciplines and introduction of new skilled workforce

Introduction of a new Crisis Liaison team at North Middlesex Hospital - 184 CYP seen in 6 months
Continuation of 24/7 Crisis Line and Crisis Hub to CYP and families in Enfield
Disordered Eating Service implemented across NCL with clinician based in Enfield

Enfield Transition team embedded in core adult team to support 18–25
NCL wide DBT service to go live in Jan 23
Enfield CYP to access Home Treatment Team service March 23

New Investment & Impact

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Mental Health Support Team invest in Enfield since 2019 to support the roll out of delivering emotional support within school settings

Mental Health Support Team MYME
Investment in 2019/20 and 21/22 to extend school-based offer in Enfield (50 schools out 96)
Further investment in wave 9 (23/24) will extend the coverage to nearly all schools in the borough

MHSTs deliver three core functions:
Evidence-based interventions for mild to moderate mental health and emotional wellbeing concerns (e.g. anxiety and low mood)
Support to senior mental health leads in schools to develop a whole-school approach to mental health and wellbeing
Timely advice and signposting to schools, to ensure children and young people receive the right support at the right time, and to support effective collaboration between education, specialist CAMHS, and other agencies.

Waiting List Improvements

Following the additional investment into community CAMHS, improvements in the following areas:

Waits for 1st appointment decreased from 235 in August to 196 in September and no cases waiting over 41 weeks for 1st appointment or contact

Group sessions offered to support timely access to services

Offering a digital platform for both supported and unsupported guided help for anxiety and CBT

Weekend clinics commenced in May 22 with additional staffing capacity to offer appointments to patients waited the longest for specialist assessments

Welfare checks embedded within the service, to keep in touch with families on waiting lists

Digital platform offer for both supported and unsupported guided help for anxiety and CBT

Enfield division achieved significant reduction in waiting times and waiting lists

There has been a 44.5% reduction of children and young people wating for specialist assessment and treatment from 1357 in September 2021 to 747 in October 2022

Targeted work to improve triage, discharges resulting in reduced number of waits

Key Challenges and Next Steps

Key Challenges	• Longest waits for Neurodevelopmental pathway - waits of over 52 weeks. • Further development with system Partners , Thrive model in the borough of Enfield to strengthen VCS offer.
Next Steps	• Opportunities to support and collaborate with Enfield Council with the developments and the Family Hub • Strengthened, collaboration with borough partners to support priority commissioning • Further recovery in the NDS pathway • Developing a sustainable workforce strategy • Maintaining local staff wellbeing initiatives • Strengthening QI within the service to improve flow and patient experience • Evaluating the impact and success of new roles developed • Building on the Co-Production work in Enfield

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London Borough of Enfield

Health & Adults Social Care Scrutiny Panel

6th December 2022

Subject: Enfield Council Adult Social Care Statutory Complaints Annual Report 2021-22

Cabinet Member: Cllr Alev Cazimoglu

Executive Director: Tony Theodoulou

Key Decision: N/A

Purpose of Report

1. To summarise the findings of the Adult Social Care Statutory Complaints Annual Report 2021-22. The report focuses on the nature of complaints and learning they provide to improve services in the future.

Proposal(s)

2. Note the findings and improvement actions included in the Annual Report.

Relevance to the Council's Corporate Plan

3. Analysing Adult Social Care complaints and compliments on an annual basis provides valuable insight into customer experience. This learning informs Enfield Council's future approach to service improvement.

Background

4. This annual report covers the period of 1st April 2021 to 31st March 2022. It focuses on the nature of complaints received by the Council, handling performance and learning elicited to shape future service improvements.

5. The report content has changed compared to previous years to provide improved insight such as multiple year trend analysis and greater granularity regarding nature of complaints. Also included is improvement actions based on learning from these complaints.

6. Recent technology improvements (new case management system) will provide further detailed insight for 2022/23 report.

7. Between 1st April 2021 and 31st March 2022, Enfield Council's Adult Social Care services supported over 4,500 clients to access long term care. 2,100 assessments and 2,500 reviews were undertaken. 3,300 carers were supported, and teams responded to over 3,600 safeguarding concerns.

Main Considerations for the Council

8. This section summarises the key findings from Annual Report which is provided as an appendix to this covering Health & Adult Social Care Scrutiny Panel paper.

Findings

9. During 2021/22, Enfield Council received 48 Adult Social Care complaints, representing 1% of the total number of contacts during that year.

10. When comparing 3 year-trends, the volume has increased slightly from the previous year (37 received in 20/21) but remains lower than 19/20 (55).

11. The majority of complaints related to disagreement regarding fees and dissatisfaction with service quality received.

12. 17 complaints were referred by complainants to the LGSOC (Local Government and Social Care Ombudsman) reflecting a marginal increase compared to the previous year. Of these, LGSOC investigated 7, resulting in 5 decisions made (3 were upheld and 2 were not upheld).

Improvement Actions

13. Learning from the complaints surfaced a number of improvement actions for the service areas as well as for individual cases. These fell into three categories:
    - Remedial action for individual complaints
    - Improving social work or occupational therapy practice and delivering training
    - Establishing or changing existing processes and policies.

14. Remedial action for individual complaints included agreeing a change in social worker and offering a reassessment of either a care package or finances.

15. In order to improve practices actions are underway to ensure clearer information and advice is provided regarding care and support packages. Issues are being addressed directly with social workers and/or managers, for example returning telephone calls promptly and completing assessments accurately.

16. Application of processes and policies are also being revised including advising clients of potential wait times for assessments and improving information included in financial charging documentation.

Financial Implications

17. No Financial implications

Legal Implications

18. No Legal implications

Workforce Implications

19. There are no workforce implications

Property Implications

20. There are no property implications

Other Implications

21. There are no other implications

Options Considered

22. Not applicable as this report is to note the findings from the Adult Social Care Statutory Complaints Annual Report 2021-22.

Conclusions

23. During 1st April 2021 to 31st March 2022, over 4,500 people were supported by Adult Social Care.

24. Given the complex nature of this work, the number of complaints received are relatively low. There has been a slight increase in volumes compared to the previous year both received by the Council and referred to the Ombudsman by complainants.

25. Whilst there were specific improvement actions taken at an individual level, learning from complaints demonstrates the need to ensure policies and processes are fully understood and enacted by staff. Addressing gaps in service provision through staff training and supervision is underway. Other improvement actions include ensuring that information regarding financial payments for care/support packages, as well as changes to financial charging, are clearly communicated to clients.

Report Authors:
Bindi Nagra, Director of Adult Social Care
&
Eleanor Brown, Head of Transformation & Complaints and Access to Information Services

Date: 23/11/2022

Appendix: Annual Adult Social Care Statutory Complaints Report 2021-22 (attached separately).

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Enfield Council

Adult Social Care
Statutory Complaints Annual Report
2021 - 2022

ENFIELD Council

Contents

Executive Summary

Introduction

Between 1st April 2021 and 31st March 2022, Enfield Council supported over 4,500 clients to access long term care. We also undertook over 2,100 assessments and 2,500 reviews, supported over 3,300 carers and responded to over 3,600 safeguarding concerns.

Findings

During this period, the organisation received 48 complaints regarding Adult Social Care. The volume received increased slightly from the previous year, although remained lower when compared to 2019/20.

The majority of complaints related to disagreement regarding fees and dissatisfaction with service quality received.

17 complaints were referred by complainants to the Ombudsman (a marginal increase compared to the previous year). Of these, 7 were investigated further by the Ombudsman with 5 decisions made (3 were upheld and 2 were not upheld).

Improvement Actions

Learning from the complaints surfaced a number of improvement actions for the service areas as well as for individual cases. In terms of service improvements, actions are designed to improve social work practice through training and communications. The application of policies and procedures are also being reviewed regarding assessment waiting times and changes to financial charging.

1. Introduction

The purpose of this report is to provide an overview of complaints made about Enfield Council's Adult Social Care services during 2021-22, in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The report provides information about all statutory complaints made between 1st April 2021 and 31st March 2022.

2. Overview of the Adult Social Care Statutory Complaints Process

The Department of Health defines a complaint as "*an expression of dissatisfaction or disquiet about the actions, decisions or apparent failings of a Council's adult social care provision which requires a response*".

Anyone who has received, is currently receiving, or is seeking an adult social care service from Enfield Council can make a complaint. A family member, carer or formal representative may also complain on a service user's behalf.

Services provided by an external provider acting on the Council's behalf are also included. In such instances, complaints can be submitted directly to the provider or the Council.

The Adult Social Care statutory complaints process is comprised of one stage. The regulations stipulate that all complaints must be responded to, in writing, within six months of receiving the complaint. However, in Enfield we aim to complete our complaint responses within 20 working days, which is similar to many local authorities.

If the complainant remains dissatisfied with the Council's response, they have the right to refer their complaint to the Local Government and Social Care Ombudsman (LGSCO). The LGSCO is an independent organisation empowered to review or investigate where it appears the Council's own investigations may not have resolved the complaint or handled it appropriately.

3. Adult Social Care Service Users

In order to provide some context in relation to the complaints submitted, Enfield Council's Adult Social Care received over 4,660 contacts and enquiries from residents in 2021-22, alongside supporting over 4,500 clients to access long term care during the year. We also undertook over 2,100 assessments and 2,500 reviews, supported over 3,300 carers and responded to over 3,600 safeguarding concerns.

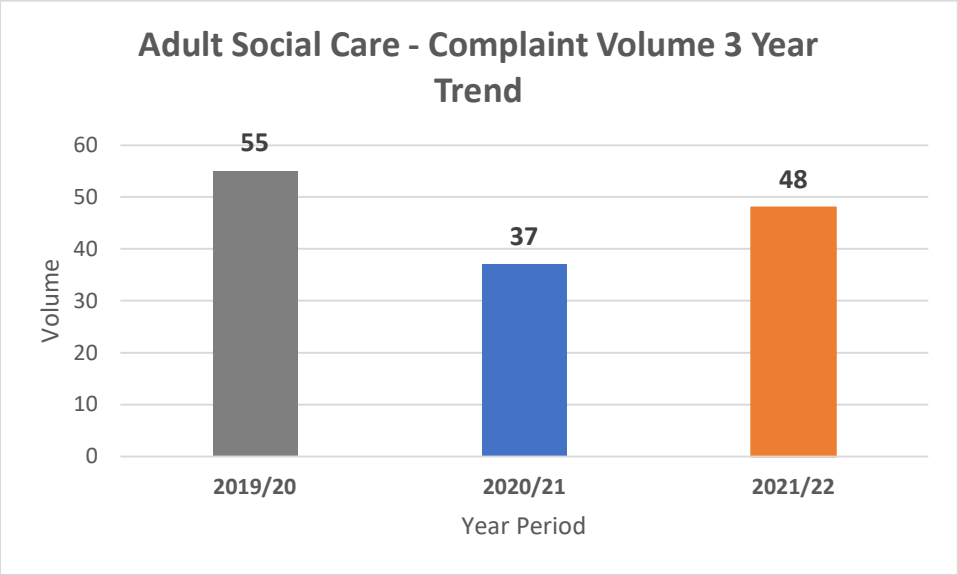
During this period:

- 1,131 service users were assessed as Care Act (2014) eligible for services of which 465 received community-based support and 196 went into a care home
- Over 9,000 pieces of equipment were provided to service users and over 2,800 received some form of adaptation to their home

4. Complaints

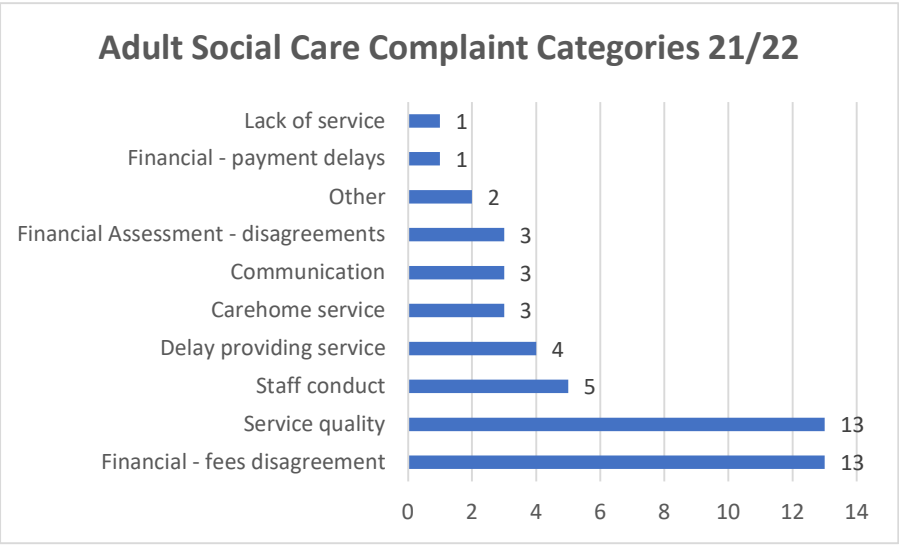
4.1 Overview

During 2021/22, Enfield Council received 48 Adult Social Care statutory complaints. This represents 1% of the total number of contacts during that year.



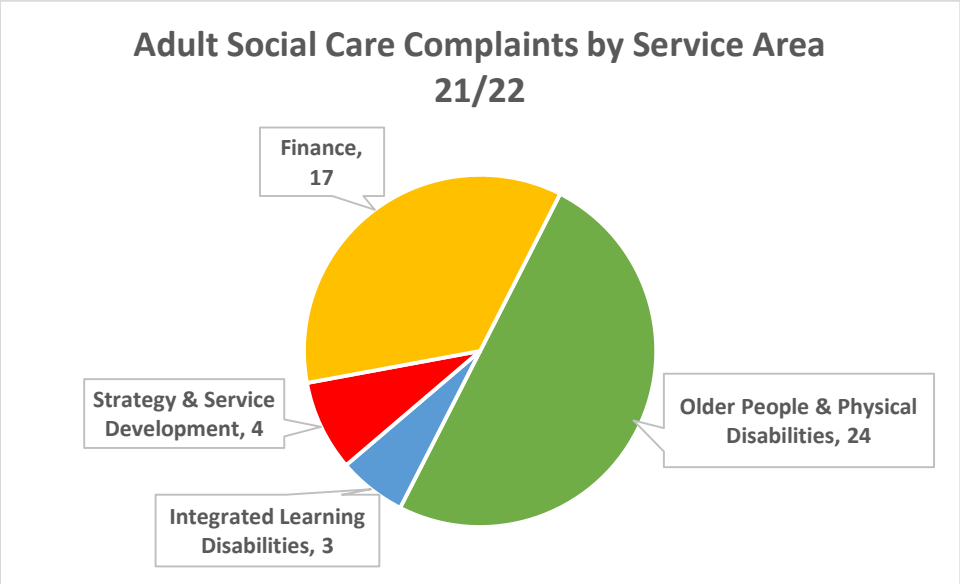
As per the graph above, there was a slight increase in complaints compared to the previous year, although still lower when compared to 2019/20. In terms of service contacts, 2021/22 was a busier year than 2020/21.

4.2 Nature of Complaints



In terms of the types of complaints received during 21/22, the largest volumes related to disagreement regarding fees and dissatisfaction with service quality received.

4.3 Complaints by Service Area



Service areas within Adult Social Care differ in size and their roles may differ. Therefore, comparing total complaint numbers for each service provides limited insight. As such, this section provides further detail on the types of complaints received per service area.

The Older People and Physical Disabilities Service, as the largest service, receives the highest number of complaints. In 2021/22 complaints including:

- Service quality: 10 complaints
- Delays in providing services: 4 complaints
- Staff conduct: 4 complaints

The Integrated Learning Disability Service's complaints related to

- Service quality
- Staff conduct
- Delays in financial payment

Strategy & Service Development complaints related to

- Service quality
- Communication

Finance Complaints consist of complaints about financial assessments, fees and payment delays for Adult Social Care Services. Complaints about finance consist of 35% of all complaints.

4.4 Complaint Response Timescales

All complaints were responded to on time within the regulations 6 months target. With regard to the local 20 working day target, 6 complaints took longer than 20 working days to respond to with the longest taking 26 days to complete.

4.5 Ombudsman Complaints

In 2021/22, 17 complaints were referred to the LGSCO (an increase of 6 compared to 2020/21). Upon review, the Ombudsman elected to investigate 7 of these complaints. The LGSCO can choose not to investigate for a variety of reasons. Our remaining complaints were dismissed primarily because they were premature or there was insufficient evidence of fault was identified by the Ombudsman.

Of the 7 investigated, LGSCO made 5 decisions.

- 2 confirmed Enfield Council was not at fault.
- 3 identified that Enfield Council was at fault due to delays in care and financial assessments.

In its decisions, the LGSCO did not request that Enfield reconsider its procedures, indicating that after investigation, they were satisfied with these.

5. Learning & Improvement Action

Learning from complaints provides valuable opportunities to gain wider understanding and ensure improvements are realised. This section outlines the improvement actions identified during 2021/22.

Improvement actions arising from 2021/22 complaints fall into three main categories:

- Remedial action for individual complaints
- Improving social work or occupational therapy practice and delivering training
- Establishing or changing existing processes and policies.

Examples of these improvement actions are summarised below:

Remedial action for individual complaints

- Apology to a complainant where complaints were upheld or partially upheld.
- Agreed a change of social worker.
- Offered a reassessment of either a care package or finances.

Improving social work practice and delivering training

- Ensuring that clearer information and advice is provided around paying for care and support packages.

- Addressing issues directly with social workers and/or managers in supervision. Themes included returning telephone calls promptly, or completing assessments accurately

Reflection on application of processes and policy

- Agreement to inform people about potential waiting times for assessments
- Alterations to financial charging information documents

6. Compliments

Managers are encouraged to log the compliments they receive as learnings are derived from positive feedback, as well as negative.

During 2021-22, 58 compliments were logged centrally regarding Adult Social Care, an increase of 14 compared to 2020/21. The majority of compliments related to members of staff.

Below are some examples of compliments received:

"*I wanted to express my heartfelt gratitude and sincerest thanks for all the help, care and support we have received from X and the Occupation Therapy Services at Enfield Council. Thank you so much for the attention, care, compassion and hard work you have provided during this process. You were kind and understanding and assessed my mothers' needs extremely well. The recommendations you made were things we would never have thought of on our own and will be life changing for her*."

"*Thank you for the especially fast service and hard work delivering everything so quickly. X came for a home visit under difficult conditions during a pandemic in a matter of days and went above and beyond. Thank you from the bottom of our hearts*."

"*X arranged a suitable care home placement for my mother at really short notice and was reassuring and helpful. X took our preferences into account and kept us well informed throughout the process. The information provided on costs and funding options was clear and straightforward*."

"*I am writing to you to let you know what a wonderful person you have working for you in Social Care assessment – X. X was so kind and compassionate and gave us good advice how to proceed*."

"*Very helpful and quick, X did help a lot not just with the case but made me feel positive and fresh start to the day. Many thanks*"

"*I would like to thank you for all the help you have given my Mother. She was adamant that she did not need any help but now that she has the aids that you suggested she loves them and doesn't know how she managed without them. Thank you again*"

"*Thank you so much for all your help, support & information. You have been amazingly prompt in everything and we as a family are so very grateful to you. I can't begin to tell you the amount of stress it relieves from our end*."

"Thank you so much X for your help. It's so nice being helped by professionals who really understand the system and how to help individuals. Keep up the great work."

7. Conclusion

During 1st April 2021 to 31st March 2022, over 4,500 people were supported by Adult Social Care. Given the complex nature of this work, the number of complaints received are relatively low. There has been a slight increase in volumes compared to the previous year both received by the Council and referred to the Ombudsman by complainants.

Whilst there were specific improvement actions taken at an individual level, learning from complaints demonstrates the need to ensure policies and processes are fully understood and enacted by staff. Addressing gaps in service provision through staff training and supervision is underway. Other improvement actions include ensuring that information regarding financial payments for care/support packages, as well as changes to financial charging, are clearly communicated to clients.

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Health & Adult Social Care Scrutiny Panel Work Programme – Cllr Adeleke 26.10.22

Date of meeting	Topic	Lead Officer	Executive Director/ Director	Lead Members	Reason for the proposal	Other Committee/Cabinet/Council approvals ?
27th July	Work Planning					
15th September 2022	Annual Safeguarding Report	Bharat Ayer/Sharon Burgess	Tony Theodoulou	Cllr Cazimoglu	The Annual report is brought to this Panel for discussion.	Children's Scrutiny 27th Sep Cabinet 12th Oct Council 16th Nov
	Public Health – smoking/vaping	Glenn Stewart	Tony Theodoulou/ Dudu Sher-Arami	Cllr Cazimoglu	Local priority to reduce smoking & vaping	
	Public Health – substance misuse	Andrew Lawrence	Tony Theodoulou/ Dudu Sher-Arami	Cllr Cazimoglu	Local priority to reduce drug misuse	
6th December 2022	Integrated Care Systems/NCL	Deborah McBeal Deborah McBeal, Director of Integration Enfield Borough Directorate NHS North Central	Tony Theodoulou/ Bindi Nagra	Cllr Cazimoglu	Updates required on changes and impact on LBE	

		London Integrated Care Board				
	Mental Health Transformations/Reforms Josephine Carroll, Managing Director for the borough adults and Paramjit Rai Managing Director for CAMHS	Natalie Fox (Barnet, Enfield and Haringey Mental Health NHS Trust	Tony Theodoulou/ Bindi Nagra	Cllr Cazimoglu	Concerns about services provided	Levels of mental health in the borough Is there a Crisis helpline? How many patients moved outside Enfield?
	Adult & Children's Social Care Annual Statutory Complaints Report	Eleanor Brown	Bindi Nagra	Cllr Cazimoglu	Requested by officers and OSC	Additional report
19th January 2023	Regulation of Adult Social Care, CQC reports	Bindi Nagra	Tony Theodoulou	Cllr Cazimoglu	Updates required on changes and impact on LBE	OSC Work Planning meeting minute Care Quality Commission (CQC) inspections challenges were around having the right systems in place to meet the needs of adult social care required. Significant changes ahead

						including funding which are unclear at this stage. There is a budget gap, which will increase as interest rates increase.
	Covid Recovery – vaccinations, inequalities	Dudu Sher-Arami	Tony Theodoulou	Cllr Cazimoglu	National issue and how LBE is taking forward	Vaccine hesitancy champions update
	Public Health – Obesity	Dudu Sher-Arami	Tony Theodoulou	Cllr Cazimoglu	To reduce obesity rates	Details of campaigns; social prescribing; liaising with NHS/GPs
8th March 2023	Primary Care Access	Deborah McBeal	Tony Theodoulou/ Bindi Nagra	Cllr Cazimoglu	Concerns about access issues with GPs, dentists	
	Women's Health – cervical cancer motion, access to family planning, pregnancy packs, health visitor drop-ins	Dudu Sher-Arami	Tony Theodoulou	Cllr Cazimoglu	Update requested by panel members	Period poverty
	Safeguarding Enfield strategy consultation	Bharat Ayer	Tony Theodoulou	Cllr Cazimoglu	The Safeguarding Adults Board currently has a strategy which	

					the SAB will be reviewing and updating in 2023. As with the annual reports, we will be developing a joint strategy that covers adults and children's safeguarding.	