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HEALTH & ADULT SOCIAL CARE SCRUTINY PANEL

Thursday, 19th January, 2023 at 7.00 pm in the Council Chamber, 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

Members of the Committee are invited to identify any disclosable pecuniary, other pecuniary or non-pecuniary interests relevant to the items on the agenda.

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

To approve the minutes of the meeting held on 6 December 2022.

4. REGULATION OF ADULT SOCIAL CARE, CQC REPORTS (Pages 7 - 38)

To receive the report of Sharon Burgess, Head of Safeguarding Adults.

5. COVID RECOVERY - VACCINATIONS, INEQUALITIES (Pages 39 - 48)

To receive the report of Louisa Bourlet, Community Health Development Officer.

6. WORK PROGRAMME 2022/23 (Pages 49 - 52)

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

7. DATE OF NEXT MEETING

To note the date of the next meeting as follows:

Wednesday 8 March 2023

8. FUTURE COMMISSIONING OF ENFIELD SEXUAL HEALTH COMMUNITY SERVICES (Pages 53 - 80)

To receive the report of Fulya Yahioglu, Senior Service Development Manager, Adult Substance, Misuse & Sexual Health.

The Health & Adult Social Care Scrutiny Panel is asked to consider and comment on the report prior to it going to Cabinet on 8 February 2023.

(This item will contain exempt information as defined in Paragraph 3 (information relating to the financial or business affairs of any particular person – including the authority holding that information) of Schedule 12A to the Local Government Act 1972, as amended.)

9. EXCLUSION OF THE PRESS AND PUBLIC

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

AGENDA – PART 2

10. FUTURE COMMISSIONING OF ENFIELD SEXUAL HEALTH COMMUNITY SERVICES

Item 8 above refers.

MINUTES OF THE MEETING OF THE HEALTH & ADULT SOCIAL CARE SCRUTINY PANEL HELD ON TUESDAY, 6TH DECEMBER, 2022

MEMBERS: Councillors James Hockney, Andy Milne, Nicki Adeleke, Kate Anolue, Nia Stevens and Emma Supple

Officers: Dudu Sher-Arami (Public Health Director), Doug Wilson (Head of Strategy and Service Development), Jon Newton (Head of Service, Integrated Care OP&PD, Adult Social Services) and Eleanor Brown (Head of Transformation, Complaints and Access to Information, Resources Department), Marie Lowe (Governance and Scrutiny Officer).

Also Attending: Councillor Nesil Caliskan (Leader of the Council), Deborah McBeal (Director of Integration, Enfield Borough Directorate, NHS North Central London Integrated Care Board) and Stephen Wells (Head of Enfield Borough Partnership Programme), Natalie Fox (Deputy Chief Executive and Chief Operating Officer, BEH and C&I), Josephine Carroll (Managing Director, BEH, Enfield Mental Health Division) and Parmjit Rai (Managing Director, BEH-CAMHS Division), Nusrath Jaku

1. WELCOME & APOLOGIES

The Chair welcomed everyone to the meeting, particularly the representatives from Council's partners from the NHS in relation to the following items on the agenda.

Item 4 - Deborah McBeal, Director of Integration, Enfield Borough Directorate, NHS North Central London Integrated Care Board and Stephen Wells, Head of Enfield Borough Partnership Programme.

Item 5 - Natalie Fox, Deputy Chief Executive and Chief Operating Officer, BEH and C&I, Josephine Carroll, Managing Director, BEH, Enfield Mental Health Division and Parmjit Rai, Managing Director, BEH-CAMHS Division.

Cllr Nesil Caliskan, Leader of the Council, was representing Cllr Alev Cazimoglu, Cabinet Member for Health and Social Care, who had given her apologies as she is unable to be present at the meeting.

Officers – Dudu Sher-Arami, Public Health Director, Doug Wilson, Head of Strategy and Service Development, Jon Newton, Head of Service, Integrated Care OP&PD, Adult Social Services and Eleanor Brown, Head of Transformation, Complaints and Access to Information, Resources Department.

Apologies for absence had been received from Cllr Eylem Yuruk.

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 15 September 2022 were **AGREED**.

4. NORTH CENTRAL LONDON INTEGRATED CARE SYSTEMS AND BOROUGH PARTNERSHIP PROGRAMME UPDATE

Deborah McBeal, Director of Integration, Enfield Borough Directorate, NHS North Central London Integrated Care Board and Stephen Wells, Head of Enfield Borough Partnership Programme spoke to the presentation which provided an update on the North Central London Integrated Care Systems and Borough Partnership Programme and impact on the London Borough of Enfield.

During the discussion which ensued and, in response to questions from the Members of the Panel, the following points were made and addressed.

The Chair expressed the view that, as he was not aware that this was part of the current governance structure, he would like to see greater involvement of elected representatives on the Integrated Care Board (ICB).

An active partnership working group were working to create a detailed plan to increase the take up of immunisations. This follows the reduction in the take up of all immunisations, but particularly polio and tuberculosis (TB). The polio virus had been recently found in a sewage works plant and was an area of concern. The plan would include an approach to work with various community groups, including schools and voluntary sector organisations, and to deliver a positive message about the benefits of immunisations.

There had been an increase in the number of reported cases of Strep A, a seasonal occurrence, which were higher this season and there were no vaccines available. The focus of the proactive work had been to inform and advise schools and partnership organisations of the preventative measures to take. Individuals with symptoms were excluded from school for 24 hours. The good relationships built up with all schools across the Borough throughout the Covid pandemic had been maintained, this had resulted in a good response from schools to the advice issued.

It was essential that work continued on smoking cessation programmes, as smoking, together with obesity, had a significant impact on health. New ways of reaching out and encouraging individuals to join the cessation programme had been found, for example there was online support through the telephone portal. Residents were made aware of the schemes available to help them to stop smoking. The partnership was working with the Council to bring together the offer in a coordinated manner.

Members acknowledged there was a huge need and work to be done across the Borough, principally around smoking (including vaping) but also adult social care and care homes. With regards to vaping the Council was responsible for the licensing of premises and the prevalence of fast-food restaurants which were contributary factors to smoking and obesity.

Work was currently underway to identify options and alternative ways of integrated working to reduce pressure on the stretched health services and to provide better outcomes for residents now and in the future.

Members welcomed the information that a further report would be brought to the Panel on the future development of Integrated Teams and the service offer available to residents across the Borough. The NCL was working to improve the long-term conditions with GPs, who were working over and above their contractual arrangements. **ACTION**

At the invitation of the Chair, Nusrath Jaku, Programme Manager, One-to-One (Enfield) raised concerns regarding patients being able to access GP services, when necessary, in a timely manner. Many patients felt frustration when trying to telephone the surgery at 8.30am to make an appointment for that day in the prescribed manner only to be told when eventually getting through to the receptionist at 9am that there were no appointments left for that day as the doctors were fully booked. On occasion the telephone had not been answered.

The Panel asked that GP representation be invited to attend the meeting when it considered access to primary care. **ACTION**

The Director of Integration, Enfield Borough Directorate, NHS North Central London Integrated Care Board recognised the difficulties experienced by patients in securing an appointment with a GP and assured the Panel that GPs were working harder than ever and that patients had alternative routes to access health care, such as urgent care centres, dialling 111. Vaccine nurses were now located within GP surgeries. The NHS were working hard with GPs and Primary Care to address the pressure faced by the NHS at this current time, where demand was greater than capacity.

A core aim of the partnership was to address health inequalities. The Public Health Director chaired the sub-group of the Inequalities Development Group, which had a wider membership, including the voluntary sector stakeholders. There were a number of factors which affected the delivery of services to residents. The recruitment and retention of staff and staff shortages had been a catalyst of the identification of new ways of working and expansion of job roles, such as pharmacists, who could now administer injections and prescribe some types of medication in order to take the pressure off GPs.

Work continued regarding the hard-to-reach communities. There was an active programme in Enfield to address food insecurities. The Council was working with the Enfield Food Alliance, a collaborative forum which involved

40 organisations. A further report for consultation would be presented to the Panel for approval, which would detail the strategic approach for the draft delivery food action plan involving the strategic groups. **ACTION**

Officers were working with the voluntary sector organisations to ensure that information was disseminated in an appropriate way to the communities in Enfield. Communication Champions were also working with Enfield Voluntary Action Faith Forum to ensure information was available and accessible by residents with English as a second language. **ACTION**

AGREED that:

1. The update on the North Central London Integrated Care Systems and Borough Partnership Programme and impact on the London Borough of Enfield be noted;

2. There should be greater involvement of elected representatives from the participant Local Authorities on the Integrated Care Board (ICB); and

3. GP representation be invited to attend the meeting when it considered access to primary care. **ACTION**

5. ENFIELD MENTAL HEALTH COMMUNITY TRANSFORMATION

Natalie Fox - Deputy Chief Executive and Chief Operating Officer, BEH and C&I, Josephine Carroll - Managing Director, BEH- Enfield Mental Health Division and Parmjit Rai - Managing Director, BEH-CAMHS Division presented the details the mental health transformations and reforms affecting the London Borough of Enfield.

Members noted and welcomed that there had been significant Government investment in mental health provision, which would enable training in and delivery of mental health services. Members supported the funding of the mental health services as the mental health of one person could destroy families.

Members also noted that there was an overlap in the provision of drug and alcohol services with mental health services. Unless funding was available specifically for the provision of mental health services there would be an unnecessary increase in patients attending other areas of the NHS, such as the Accident and Emergency Departments, which in turn impacted on other emergency services such as the Police.

At the invitation of the Chair, Nusrath Jaku, Programme Manager, One-to-One (Enfield) asked that the self-referral pathways for adults with autism through GPs be made clearer and that information for peer support groups working with adults waiting for a diagnosis and employers be made readily available. Voluntary organisations were working with employers to improve their

understanding of the needs and support for employees with autism to prevent loss of employment, which in turn may led to mental health issues.

The Programme Manager also asked that young adults with autism be encouraged to speak out, through engagement with the voluntary sector and other organisations and that their voices be heard and listened to.

The Public Health Director reported that Enfield Borough had a very low suicide rate, however during economic crises and associated pressures suicides tended to increase. The Panel Members endorsed the approach collaborative working to prevent suicides, for early intervention and to provide mental health services to patients and asked that a report detailing information regarding the number of suicides and contributory factors in the Borough be provided at a future meeting of the Panel. **ACTION**

The Deputy Chief Executive and Chief Operating Officer reported that the pathways of the adult and children were being brought together and the NHS were setting up resources so that residents did not have to wait and were supported.

The Scrutiny Panel requested that the Council's Communications Team arrange a communications update on the mental health self-referral pathways scheme including GPs and how to access the Crisis Houses and the Crisis Café. **ACTION**

At the request of Members, clarification of the acronyms contained in the presentation from the NHS would be circulated to the Scrutiny Panel and that in future presentations would be accompanied with a glossary of terms.

AGREED that:

1. The presentation of the Community Transformation programme to deliver mental and physical health support to more people in the community be noted; and

2. The Council's Communications Team arrange a communications update on the mental health self-referral pathways scheme including GPs and how to access the Crisis Houses and the Crisis Café.

6. ENFIELD COUNCIL ADULT SOCIAL CARE STATUTORY COMPLAINTS ANNUAL REPORT 2021-22

Eleanor Brown, Head of Transformation, Complaints and Access to Information, introduced the report which set out the key findings from the Adult Social Care Statutory Complaints Annual Report 2021-22 and focused on the nature of complaints and learning they provided to improve services for residents in the future.

The Head of Transformation, Complaints and Access to Information together with Jon Newton, Head of Service, Integrated Care OP&PD, Adult Social Services responded to questions from Members.

There were a number of reasons that, of the 17 complaints, referred by complainants to the LGSOC (Local Government and Social Care Ombudsman), 10 cases had been dismissed. The LGSCO could choose not to investigate a complaint for a variety of reasons, such as out of time or there was no case to answer.

The Chair and Members of the Panel, together with the Leader commended the staff in the Adult Social Care Department for their work and noted that during 2021/22, Enfield Council received 48 Adult Social Care complaints, representing 1% of the total number of contacts during that year.

AGREED that the findings and improvement actions included in the Enfield Council Adult Social Care Statutory Complaints Annual Report 2021-22 be **NOTED**.

7. WORK PROGRAMME 2022/23

AGREED that the work programme for 2022/23 be **NOTED**.

8. DATE OF NEXT MEETING

NOTED that the dates of the next scheduled meetings of the Panel were 19 January 2023 and 8 March 2023 at the Civic Centre.

The meeting ended at 9.40 pm.

London Borough of Enfield

Health and Adult Social Care Scrutiny Panel

19th of January 2023

Subject: Introduction of Care Quality Commission Inspections of Local Authorities.

Cabinet Member: Cllr Alev Cazimoglu
Executive Director: Tony Theodoulou

Purpose of Report

To report on the progress of the implementation of the Quality Assurance Framework and action plan. This work is in preparation for the new duty for the Care Quality Commission to assess how Local Authorities are meeting their Adult Social Care duties and how Enfield Adult Social Care are preparing for these inspections.

Background

1. On 11 February 2021, the Department of Health and Social Care (DHSC) published the White Paper, **Integration and innovation: working together to improve health and social care for all,** which set out legislative proposals for a health and care Bill. The White Paper brought together proposals that build on the recommendations made by NHS England and NHS Improvement in **Integrating Care: next steps to building strong and effective integrated care systems across England** with additional recommendations relating to the Secretary of State's powers over the system and targeted changes to public health, social care, and quality and safety matters. In recognition of the increasing numbers of people who need adult social care and the consequent need for greater oversight of the provision and commissioning of services, the White Paper proposed introduction of a new duty for the Care Quality Commission (CQC) to assess how local authorities are meeting their adult social care duties, and a new power for the Secretary of State to intervene where CQC considers a local authority to be failing to meet these duties. This entered into law as the Health and Care Act 2022.

2. CQC's new responsibilities under the Health and Care Act are twofold. Firstly, there will be a role in reviewing Integrated care Systems (ICS) and secondly a new duty is placed on CQC to assess how local authorities are meeting their social care duties under part 1 of the Care Act.

3. Under the Care Act, local authorities have duties to make sure that people who live in their areas:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
- Can get the information and advice they need to make good decisions about care and support
- Have a range of high quality, appropriate services to choose from

4. Emerging CQC scope for reviews of Adult Social Care has started to be shared. The assessment framework has been grouped into four key themes, each with several quality statements mapped to them:

- How local authorities work with people – assessing needs, care planning and review, direct payments, charging, supporting people to live healthier lives, prevention, wellbeing, information and advice.

- How local authorities provide support – market shaping, commissioning, workforce capacity and capability, integration and partnership working.

- How local authorities ensure safety – safeguarding enquiries, reviews, Safeguarding Adults Board, safe systems, pathways and continuity of care.

- Leadership – culture, strategic planning, learning, improvement, innovation, governance, management and sustainability.

  We are using a self-assessment tool developed by ADASS (the Association of Directors of Adult Social Services) to ensure that we have the desired processes in place, or are working towards them, and that we are collating the evidence for these as we go.

5. CQC will use a variety of methods to assess a Council's Adult Social Care department as follows:

   - People's Experience
   - Feedback from Partners
   - Feedback from staff and leaders
   - Observations
   - Process
   - Outcomes and performance data

6. CQC will want to speak to staff at all levels of the organisation, our partners, and those who use our services, their families and carers including:

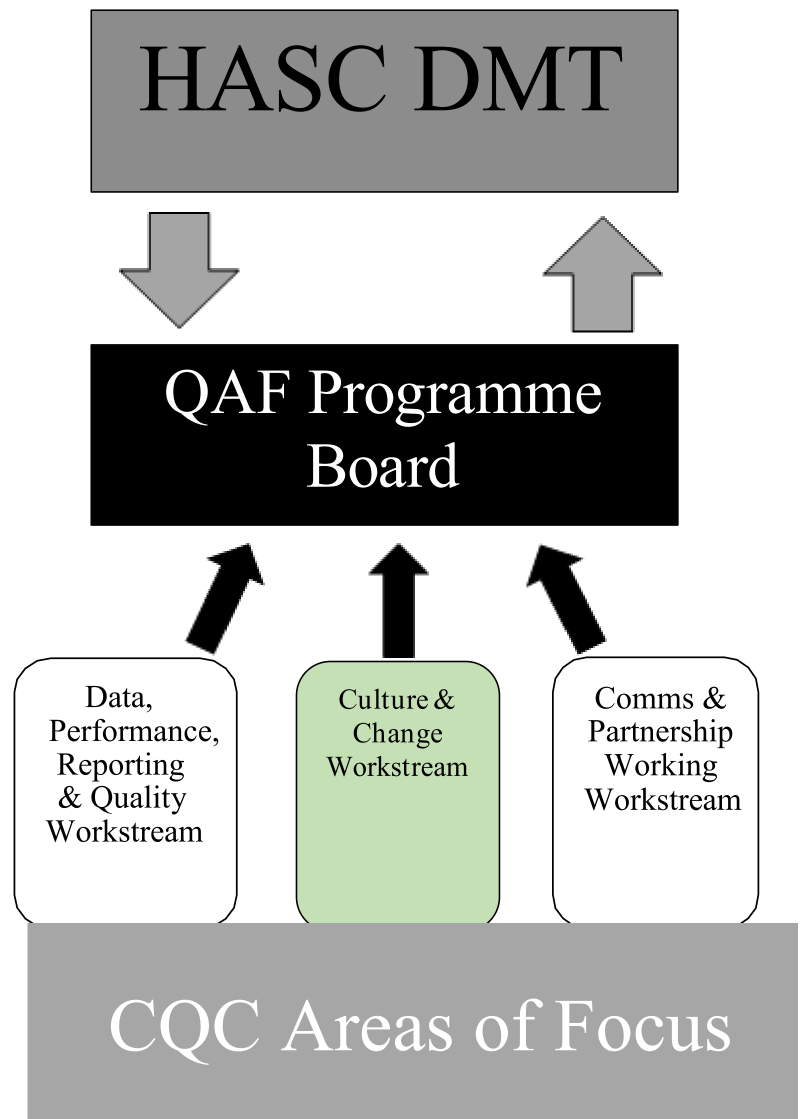
   - Operational staff
   - Social Workers
   - Principal Social Worker/Principal OT
   - Occupational Therapists
   - Assistant Team Mangers
   - Team Managers
   - Service Managers

- Heads of Service
- Directors
- Members
- Provider Organisations, including home care providers, care homes, Healthwatch, Voluntary Partners.
- Service Users, their families and carers

7. Adult Social Care (excluding regulated service provision) has not been subject to regulation of this kind for over ten years. The timetable for reviews to begin is Oct 2023. Enfield, as in other Councils, have had a period of austerity and resultant cuts in funding have forced Councils to prioritise front line service delivery, often to the detriment of other vital types of preventative services.

8. It is expected that the that the final legislation will be laid before parliament in early 2023 the expected implementation date was the 1st of April 2023 this has now been delayed until Oct 2023. In preparation for the inspections have in place a Programme Board that meets every 6 weeks. There are 3 workstreams, reporting to the programme board to identify areas where further work and development is needed and to review progress.

9. The 3 workstreams are, ‘Culture and Change’, ‘Communication & Partnership Working’ and ‘Data, Performance, Reporting and Quality’. These workstreams meet every 2 – 3 weeks to track the progress of tangible outcomes. They submit a highlight report in time for the Programme Board and report directly to the board on progress, risks and issues and any mitigating actions, as well as planned progress next reporting period. The workstream leads also take turns in submitting reports to the ASC Directors’ management team.



Here is an example of key achievements to date on each of the programme workstreams:

Culture & Change:

- Equality Diversity and Inclusion (EDI) policy being further developed in conjunction with Corporate Equalities Board for implementation across the whole council, not just ASC.
- Revised Supervision Policy finalised and being embedded.
- Strengths-based practice framework and toolkit drafted and awaiting finalisation by the strengths-based working group.
- Integration between Mental Health Trust and ASC systems being further explored in order to share best practice and learning.
- Collaboration with Employee Experience Programme.

- Developed the Anonymous Suggestion box to allow staff to ask senior management questions and to make useful suggestions. This is now up and running.
- Developed a draft etiquette policy for online meetings.
- Developed an accepted terms of reference (ToR)for Focus Group style meetings (agreed at DMT) to enable better co-production between Adult Social Care and Parents, Carers, Voluntary Organisations, Care Providers etc.
- Looking at all learning following better collaborative practice during and after COVID and what principles need to be adhered to, to continue the good on-going joint working.
- Developing plan to implement a learning culture across Adult Social Care (ASC).
- ASC workforce survey and focus groups looking at recruitment and retention completed, with results being analysed before being taken forward with staff.

Data, Performance, Reporting and Quality:

- Reports developed for both operational staff, senior management and residents (Local Account).
- Power BI reporting tool accessible from Eclipse, comms going out to staff and managers and internal online (iLearn) training available, as well as demo's to team meetings.
- Corporate customer feedback solution being considered for use in ASC, and a pilot is being developed.
- Discussions with the Mental Health Trust is on-going; some reporting included in Power BI dashboards and future solutions being considered as part of phase 2.
- Phase 2 development will focus on reporting not yet included in the Power BI dashboards, including Deprivation of Liberty Safeguards and MHT.

Comms and Partnership Working:

- Working groups on-going with Healthwatch and other partnership agencies to improve partnership working.
- Revised disclosure and barring service (DBS) policy under development.
- Internal comms framework in place, including regular updates to all ASC staff via a Principals Newsletter, updated ASC intranet page (including anonymous suggestion box) and workstream attendance at team meetings to raise awareness.
- New complaints policy, including regular reporting and learning/impact, finalised.
- Work has begun on using the SCIE integrated logic model to evaluate our progress with integration between Health and Adult Social Care.
- Co-production framework being developed by a working group, led by the Principal Occupational Therapist.
- Additional Safeguarding working group set up in order to look at processes and outcomes.

Risks

While Enfield is putting in place a range of activities to ensure inspection readiness, it is important to note the risks that the new CQC assurance regime may pose, this includes for example:

- Reputational risk for officers and politicians
- Low morale across adult social care
- Loss of confidence from residents which may impact on Safeguarding and requests for support
- Risk of Central Government intervention
- Significant financial cost, over an extended period (2 to 3 years) for example additional services and staffing
- Increased CQC assurance visits and oversight
- Loss of staff, difficulty in recruiting and retaining staff on top of current recruitment crisis
- Ratings will be published

Conclusion

A significant amount of work has been done to prepare for the return of regulatory inspections by the Care Quality Commission. Originally planned to begin at the beginning of 2022/23, delays in the development of inspection methodology and resourcing of the Care Quality Commission to deliver inspections of Councils with Adult Social Care responsibilities, have resulted in a delay until at least October 2023.

It is expected that the CQC will use a single overall rating for Local Authorities, outstanding, good, requires improvement and inadequate, although this has not yet been finalised. The evidence within the Quality Statements will be scored 1-4. The overall rating and scores for Quality statements will then be published alongside a narrative report.

The delay in implementation of the inspection regime is welcome, although it does coincide with the proposed date for implementation of the Liberty Protection Safeguards (LPS), another significant change programme of work. Nevertheless, we are confident, without being complacent, that the work done, in progress or planned will enable the Council to achieve a favourable inspection rating.

Report Author
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Date of report 16/12/2022

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Methodology and Approach

7 June 2022

Ronald Morton, April Cole, Teresa Kippax

Local Authority Assurance

CareQuality Commission

- Under the Care Act, local authorities have duties to make sure that people who live in their areas:
  - Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs
  - Can get the information and advice they need to make good decisions about care and support
  - Have a range of high quality, appropriate services to choose from

CQC's Single Assessment Framework

Our framework will assess providers, local authorities and integrated care systems with a consistent set of key themes, from registration through to ongoing assessment

Aligned with "I" statements, based on what people expect and need, to bring these questions to life and as a basis for gathering structured feedback

Expressed as "We" statements; the standards against which we hold providers, LAs and ICSs to account

People's experience, feedback from staff and leaders, feedback from partners, observation, processes, outcomes

Data and information specific to the scope of assessment, delivery model or population group

Proposed scope of LA assessments

CareQuality Commission

1. **Working with people** - assessing needs, supporting people to live healthier lives, prevention, well-being, information and advice

2. **Providing support** - markets (including commissioning), integration and partnership working

3. **Ensuring safety** - safeguarding, safe systems and continuity of care

4. **Leadership** - capable and compassionate leaders, learning, improvement, innovation

Each of the themes has several quality statements and 'I' statements within it

Choice, control and personalisation are threaded through our entire framework and approach

1. How Local Authorities **work with people**

This includes: assessing needs (including unpaid carers), supporting people to live healthier lives, prevention, well-being, information and advice

- **Assessing needs** - We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
  - ✓ *I have care and support that is coordinated, and everyone works well together and with me.*
  - ✓ *I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.*

- **Supporting people to live healthier lives** - We support people to manage their health and wellbeing so they can maximise their independence, choice and control, live healthier lives, and where possible reduce their future needs for care and support.
  - ✓ *I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.*

2. How Local Authorities **provide support**

This includes: market shaping, commissioning, workforce equality, integration and partnership working

- **Care Provision, integration and continuity** - We understand the diverse health and care needs of people and local communities, so care is joined-up, flexible and supports choice and continuity.
  - ✓ *I have care and support that is coordinated, and everyone works well together and with me.*

- **Partnerships and communities** - We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
  - ✓ *Leaders work proactively to support staff and collaborate with partners to deliver safe, integrated, person-centred and sustainable care and to reduce inequalities.*

3. How Local Authorities **ensure safety within the system**

This includes: safeguarding, safe systems and continuity of care

- **Safe systems, pathways and transitions** - We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.
  - ✓ *When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.*
  - ✓ *I feel safe and am supported to understand and manage any risks.*

- **Safeguarding** - We work with people to understand what being safe means to them and work with them as well as our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect, and we make sure we share concerns quickly and appropriately.
  - ✓ *I feel safe and am supported to understand and manage any risks.*

4. Leadership

Scope of assessment includes: capable and compassionate leaders, learning, improvement, innovation and governance

Proposed Quality Statements:

- **Governance** - We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, Sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

- **Learning, improvement and innovation** - We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Evidence for assessments

Care Quality Commission

- People's experience
- Feedback from partners
- Feedback from staff and leaders
- Observation
- Processes
- Outcomes and performance data

Theme 1: How the LA works with people – Assessing Needs

Key question	Effective
Care Act duty	Section 1: Wellbeing principle Sections 9-13: Assessment of an adult or carers needs for care and support; eligibility criteria Section 14-17: Charging and financial assessment Section 18-20: Duty to meet needs Section 24-30: Next steps after assessment Section 31-33: Direct Payments Section 34-36: Deferred Payments (tbc) Sections 67-68 Independent advocacy support
Quality Statement	Assessing needs: ✓ I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals. ✓ We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
Evidence categories and context specific items	

People's experience	Feedback from staff and leaders	Feedback from partners
• Feedback from people who use services and unpaid carers, those close to them and their advocates. Includes existing sources (e.g. CQC Give Feedback On Care) as well as bespoke (focus groups etc) • Carers Groups – unpaid carers • Compliments/complaints •Feedback from user and carer surveys •Feedback from community groups, representative groups for people (e.g. advocacy, Healthwatch)	• Self-assessment • Interviews and focus groups • Staff surveys • Staff Carers' Network	• Healthwatch, providers, third sector • Local health partners, GPs • Health & Well-Being Board

Processes	Outcomes/performance data
• Joint Strategic Needs Assessment • Training for assessors including specialist assessors • Assessment and eligibility policy and process • Financial Assessment and Charging Policy • Better Care Fund Plan • Health and Wellbeing plan • Carers' Strategy • LA Audits • LGA Peer Review / Annual conversation	• Waiting time for assessment for (i) adults with care needs, (ii) unpaid carers • % of assessments meeting eligibility criteria for (i) adults with care needs, (ii) unpaid carers • Demographics and forecasts • No of assessments relative to demographics of local population (looking at equality of access) • Assessments and Reviews (quantitative) – numbers overdue by PSR; timeliness of assessment completion; • Assessments and reviews: number of unallocated people; size of caseloads • Number of needs assessments undertaken, number of refusals. • Number of urgent needs requests. Timescales (possibly ASCOF) • NHS England, annual Survey of Adult Carers in England (SACE) Adult Social Care Outcomes Framework:

Theme 1: How the LA works with people – Assessing Needs

- ✓ **I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and goals.**
- ✓ **We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.**

Best practice, standards and guidance

- Local authorities clearly promote wellbeing when carrying out any of their care and support functions in respect of individuals at any stage of considering health and care needs.
- The wellbeing principle is embedded throughout the local authority care and support system and is clearly promoted when carrying out all care and support functions.
- Local Authority has an eligibility framework to ensure that there is clarity and consistency around local authority determinations on eligibility.
- Local Authority has a Charging Policy which is transparent, equitable, sustainable, and promotes wellbeing, social inclusion, independence, choice and control.
- Assessment and care planning arrangements are person-centred, timely and accessible, and focus on achieving the best outcomes for people.
- Local Authority has assessors who are appropriately trained and with the experience and knowledge necessary to carry out assessments, including specialist assessments.
- Local Authority works with partner agencies to provide a holistic and integrated approach to assessment and care planning.
- People are supported to access direct payments to maximise their choice and control about how to meet their support needs.
- LA ensures a sufficient provision of high quality, accessible independent advocacy services are available and offered to facilitate the involvement of an adult or carer who is the subject of an assessment, care or support planning or review.
- LA has a clear strategic ambition and objectives in respect of improving outcomes for unpaid carers and a coherent and adequately resourced delivery plan.
- The needs of unpaid carers are equally recognized; they have access to the support required to enable them to maintain their family life and to access social, leisure, employment and education opportunities.
- Unpaid carers have access to high quality, person-centred assessments tailored to their individual current and potential future support needs including rapid access to high quality replacement care for short breaks and unplanned situations.
- Unpaid carers are provided with the information, training, support and equipment required to undertake their caring role safely and effectively.

Guidance

- Care Act Statutory Guidance, Chapters 6-13
- Supporting Adult Carers, NICE Guidance, 2021
- End of Life Care for Adults, NICE Guidance, 2019
- Decision Making and Mental Capacity, NICE Guidance, 2018
- Transition from Inpatient Mental Health Hospital to Care Home, NICE Guidance
- Older People with Care Needs and Long Term Conditions, NICE Guidance, 2015
- Learning Disabilities and Behaviours that Challenge, NICE Guidelines,
- Improving the Experience of Care and Support for people with Care and Support Needs NICE Guidelines, 2018
- Personalisation SCIE Guidance
- Personal Budgets, Minimum Process Framework, Think Local Act Personal
- Individual Service Funds and Contracting for Flexible Support, Think Local Act Personal
- Making it Real: How to do Personalised Care and Support, Think Local Act Personal
- Personal Social Services Survey of Carers in England, NHS England

Theme 3: Quality Statement descriptors

- **QS 1: Safe systems, pathways and transitions**

- Safety is a priority for everyone, and leaders embed a culture of openness and collaboration.

- There is strong awareness and monitoring of the areas with the greatest risks to people's well-being, and solutions are developed collaboratively.

- Care and support is planned and organised with people, partners, and communities in ways that improves their safety across their care journeys and ensures continuity in care, particularly when people move between different services.

- LA understands where the risks to the continuity of people's support are and it has plans to mitigate and manage them so that people's safety is maintained (eg: when moving between children and adult, hospital discharge).

Theme 3: Quality Statement descriptors

Care Quality Commission

•**QS 2: Safeguarding**

•LA has a Safeguarding Adults Board that has clear understanding of the key safeguarding risks and issues in the area and a clear, resourced strategic plan to address them.

•There is a shared understanding within the LA of the safeguarding responsibilities in respect of people with care and support needs.

•

•There is clarity on roles and responsibilities for identifying and responding to concerns. Concerns are investigated promptly so that risks to people's safety and well-being are minimised.

•People are safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination, and their liberty is protected where this is in their best interests and in line with legislation.

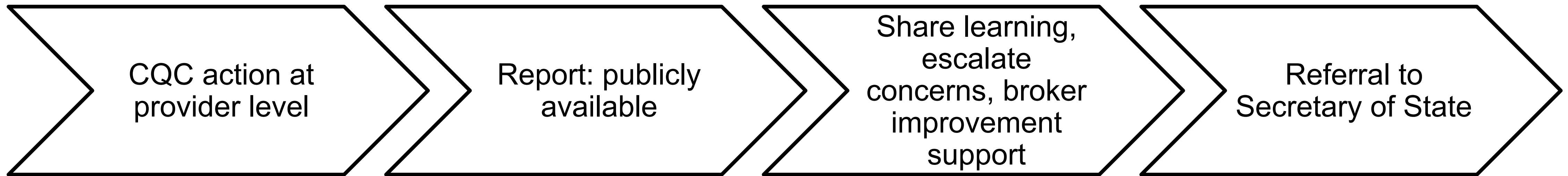
•Where people raise concerns about safety, enquiries are conducted without delay and with the person at the centre of all activity. People are supported to make choices that balance risks of harm with positive choices about their lives.

Rating and scoring

Care Quality Commission

- Early Ministerial steer is for a **single overall rating** at Local Authority level **with narrative and 'sub -ratings'** to provide granularity on the assessment and the areas for improvement.
- We would use the **four rating levels** for the overall rating: outstanding, good, requires improvement, inadequate.
- Each of the **Quality Statements would be scored, 1-4**
- **Evidence categories within the Quality Statements will also be scored**, 1-4. Scores will be aggregated to Quality Statement level. **We currently don't plan to publish this level of detail.**
- The **overall rating** and **scores for the quality statements will be published alongside a narrative report.**

Possible follow-up to reviews



High level indicative timeline

Care Quality Commission

- Throughout 2022:
  - Develop, test and iterate our approach
  - Ongoing coproduction and engagement
- Start reviews from April 2023

Coproducing our approach

- Expert Advisory Group made up of provider representatives, public groups, experts by experience, local government and system partners.

Members include ADASS, Age UK, Association of mental health providers, CPA, Carers Trust, Carers UK, Challenging Behaviour Foundation, DHSC, Disability Rights UK, Family carer, Healthwatch England, LGSCO, LGA, MHCLG, NHS Confederation, NHSE/I, NHS Providers, Ofsted, Rightful Lives, SCIE, Skills for Care, TLAP, Warwickshire County Council

- Regular updates and engagement at CQC's monthly adult social care trade association meetings, LGA sounding board, stakeholder meetings, CQC's External Strategic Advisory Group sessions and external engagement opportunities.

Future plans

- External workshops to further coproduce our approach
- Scoping potential national survey to gather views from a larger audience
- Further engagement through provider engagement sessions and local government briefings
- Invite feedback via online participation platform

Sector-led improvement and intervention

A new approach to sector improvement and support, building on sector-led improvement programme

White Paper and Health & Care Bill 2021

- Resources, training, expert advice and support provided to local authorities are valued by those who use them.
- Recognising the value of sector-led improvement, our approach remains to enable the sector to drive its own improvement.
- We will increase the scale and reach of the support offer available.
- DHSC intends to play a more proactive role in ensuring support is targeted where it is needed most, informed by data, intelligence, and the views and experience of people who draw on care and support and their carers.
- The Health and Care Bill contains new powers of intervention for Secretary of State where local authorities are failing to discharge their duties to an acceptable standard.

Developing support, improvement and intervention

- Increase in improvement funding of more than £70 million 2022-25.
- More support to local authorities, including to strengthen their market-shaping and commissioning capabilities.
- Increased DHSC/ government scrutiny of awards and drive towards competitive tendering + opportunity with increased spend to marshal skills and experience of more diverse range of organisations.
- Developing assurance and support & improvement governance for good stewardship and so that we can be more active in targeting support.
- Developing intervention regime (subject to Parliamentary approval).

Our priority is to support local authorities to lead their own improvement wherever possible, with statutory intervention considered as a last resort

Local authority unable to improve in agreed timescales. We are working through whether and how to incorporate CQC ratings here.

ocal authorities continue to lead thei own improvement, with additional oversight from CQC/DHSC

As a last resort, we will intervene using statutory powers. This may include full time improvement support, improvement panels and – where necessary - ASC commissioners. It will not include independent trusts.

CQC assessment identifies serious/persistent risk to people's wellbeing

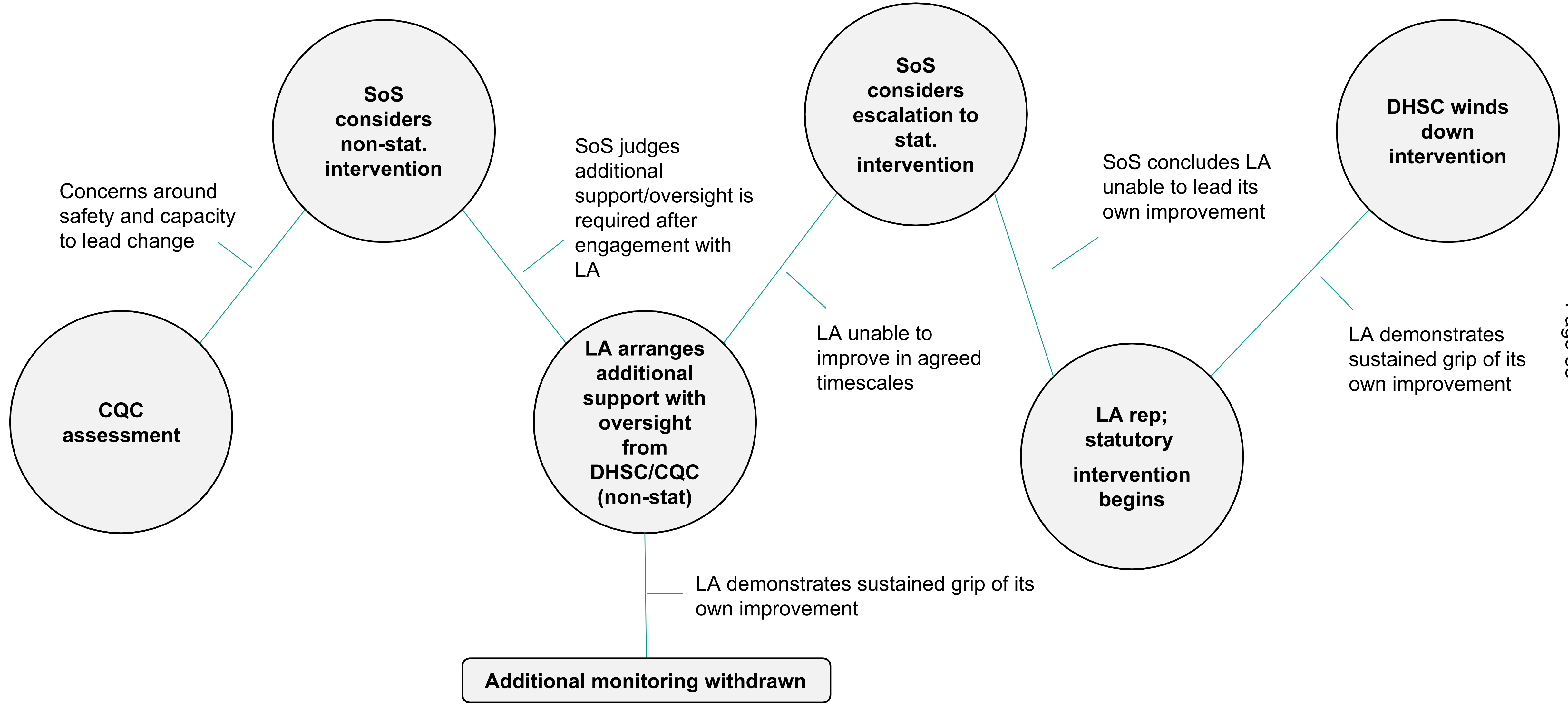
Local authorities lead their own improvement, including through drawing on national improvement offer

Local authorities will be expected to produce a robust improvement plan, and arrange for additional support, with oversight from DHSC

DHSC and sector partners work to share good practice

All LAs will be able to draw on improvement offer as required

The improvement/intervention journey envisages a strong voice for local authorities and an ongoing role for sector-led improvement



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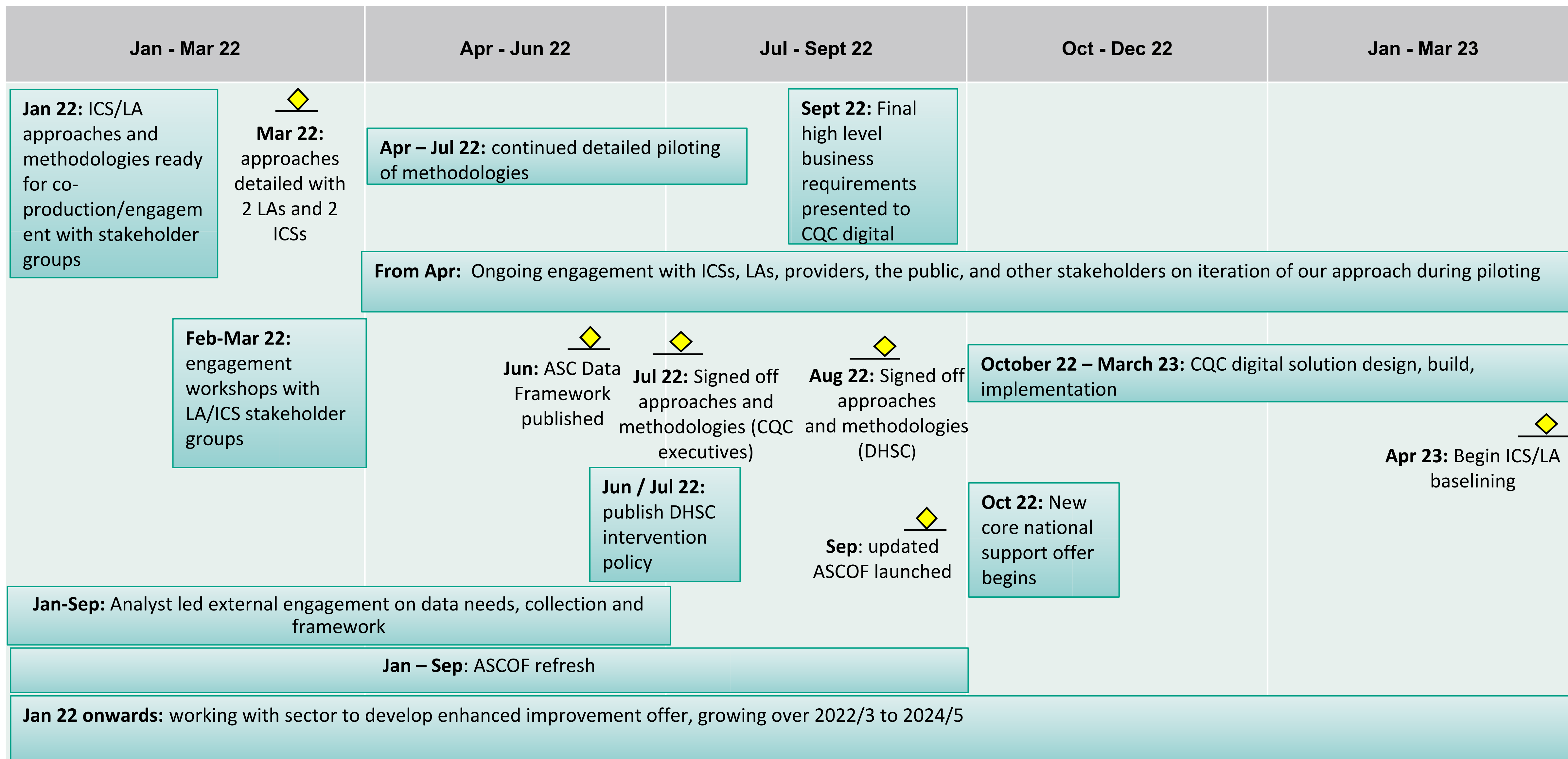
Indicative high-level timeline

Enhanced Assurance – Key Milestones



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London Borough of Enfield

Health and Adult Social Care Scrutiny Panel, 19th January 2023

Subject: Covid Recovery – vaccinations, inequalities

Cabinet Member: Cllr Cazimoglu
Executive Director: Tony Theodoulou

Purpose of Report

1. To inform the panel of vaccination uptake across Enfield, focusing on the disparities in uptake.

2. To inform the panel about the Community Vaccine Champions scheme in Enfield. This follows the award of £485k through Public Health to LBE from the Department for Levelling Up, Housing and Communities (DLUHC).

3. To inform the panel about the development of an immunisation action plan.

Relevance to the Council Plan

4. This scheme links into the "Safe, Healthy and Confident communities" chapter in the Council Plan. A key theme of this is to address health inequalities. During the pandemic it became apparent that the communities with lowest uptake of vaccines were often those most at risk from the virus.

Background

Successful Public Health intervention

5. Vaccine programmes are one of the most cost-effective Public Health interventions and have helped to control deadly diseases and save millions of lives worldwide. Vaccination saw the eradication of smallpox (responsible for some 300 million deaths in the 20th century) and in a reduction in serious illnesses such as polio, measles and meningitis.

Role of the Public Health team

6. The use of Public Health Intelligence data provided the evidence and rationale behind the strategies used to engage with communities. The data identified the community groups with the lowest uptake, as well as additional information such as the wards, language spoken, and age of

residents where uptake for immunisations is lower. Having this level of intelligence allows for a highly tailored approached to engagement. The Public Health team provided leadership across health and social care and managed the day to day running and strategic oversight of the vaccine champions scheme. The governance for immunisations has sat with the ICS Immunisations and Screening group, co-chaired by the Director of Public Health and ICS Clinical Lead.

COVID-19 vaccine inequalities

7. Uptake of the first dose of the COVID-19 vaccine demonstrates inequalities in the borough, with the east of the borough having lower uptake and higher deprivation rates. As shown on the map below, uptake in Upper Edmonton was 22.7% lower than in Town ward.

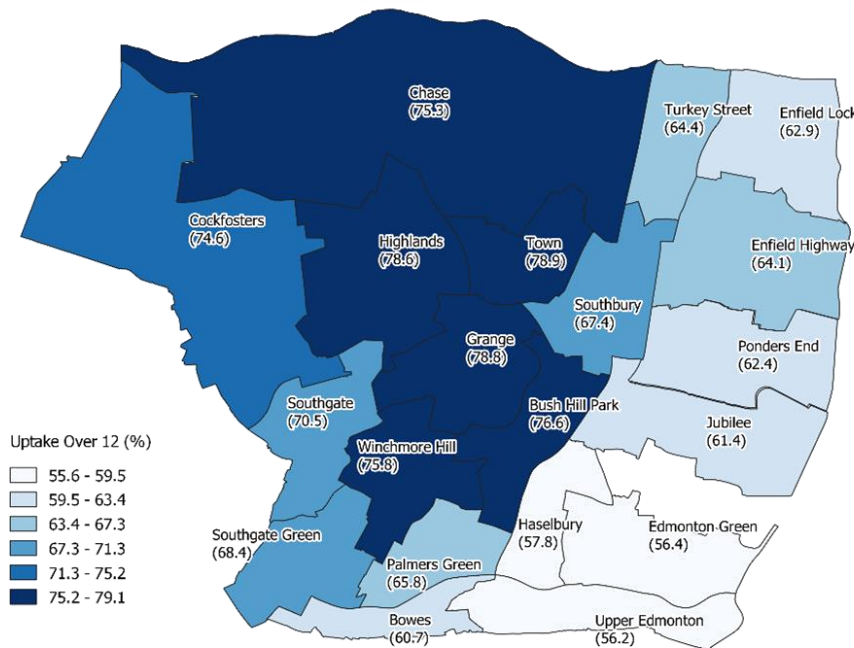

Figure 1: Percentage uptake first dose of COVID-19 vaccination in all above 12 years by ward

Other adult immunisations

8. There are similarities in trends for the flu vaccine. As seen on the map below, flu vaccination uptake is also lowest in the east of the borough with uptake of 55.4% in Lower Edmonton compared to 78.7% in Town ward.

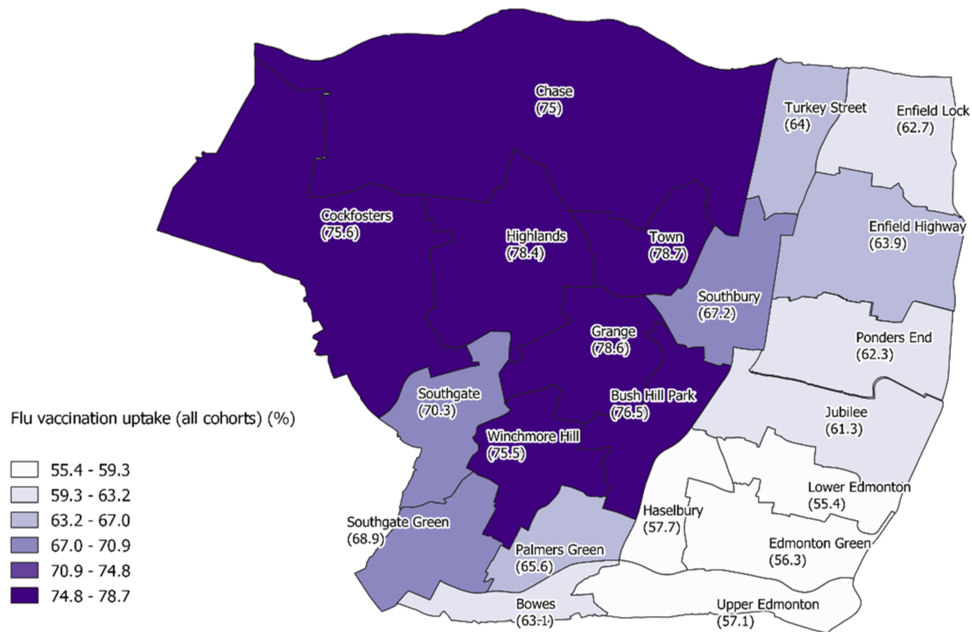

Figure 2: Percentage flu uptake by ward in all cohorts

9. Vaccination uptake is monitored at the fortnightly Enfield Immunisation and Screening group, co-chaired by the Director of Public Health and the Integrated Clinical Partnership Clinical Lead at the NCL Integrated Care Board (Enfield). This group provides governance and strategic leadership on immunisations and the intersection with inequalities. This group guides vaccine interventions and provides system collaboration to address inequalities in uptake.

10. An extensive report to the HASC Scrutiny on the COVID vaccination rollout was received in March 2022.

Childhood immunisations

11. There are several immunisations available to babies and children that are part of the routine immunisation schedule (Appendix 1). Babies and children are vaccinated at an early age to protect them from illnesses that can be particularly serious at their age (or later).

12. Table 1 show the uptake of immunisations from age 1 to age 10. This shows that uptake varies by vaccination offered. “All Vaccinations” denotes the Enfield average for all vaccinations that a child would be given by that specific age.

Vaccine	Age	Current uptake Enfield
6-in-1 (dose 1, 2, 3)	1 Year	86%
6-in-1 (dose 1, 2, 3, 4) polio catch-up campaign	1 Year	28%
PCV (dose 1)	1 Year	89%
Rotavirus (dose 1 & 2)	1 Year	82%
Men B (dose 1 and 2)	1 Year	85%
All vaccinations	1 Year	79%
6-in-1 (dose 1, 2, 3, 4) polio catch-up campaign	2 Years	29%
PCV (completed dose)	2 Years	81%
MMR (dose 1)	2 Years	81%
Men B (dose 3)	2 Years	76%
Hib/MenC	2 Years	81%
6-in-1 (dose 1, 2, 3)	2 Years	86%
All vaccinations	2 Years	74%
6-in-1 (dose 1, 2, 3, 4) polio catch-up campaign	3 Years	6%
4-in-1 Booster (dose 1 & 2) polio catch-up campaign	4 Years	30%
4-in-1 Booster (dose 1 & 2) polio catch-up campaign	5 Years	32%
MMR (dose 2)	5 Years	70%
MMR (dose 1)	5 Years	87%
Hib/MenC	5 Years	86%
6-in-1 (dose 1, 2, 3)	5 Years	87%
4-in-1 Booster	5 Years	72%
All vaccinations	5 Years	66%
3-in-1 polio catch-up campaign	6 Years	25%
4-in-1 Booster (dose 1 & 2) polio catch-up campaign	6 Years	6%
3-in-1 polio catch-up campaign	7 Years	28%
3-in-1 polio catch-up campaign	8 Years	25%
3-in-1 polio catch-up campaign	9 Years	23%
3-in-1 polio catch-up campaign	10 Years	5%

Table 1: Uptake of routine childhood immunisations

13. Figure 3 similarly shows a link between lower vaccine uptake and deprivation.

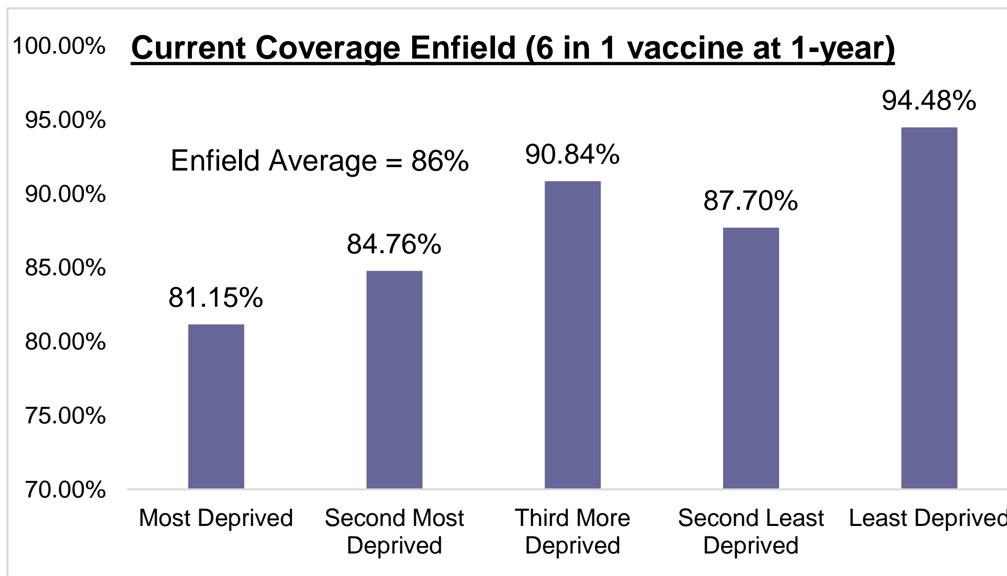

Figure 3: 6 in 1 vaccine at 1-year uptake by deprivation

Immunisations plan

14. The immunisation workplan is a live document that is used to collate and monitor the projects and activities across the borough that aim to improve the uptake of immunisations. Areas that are captured in this plan are, commissioning and performance management, early years and children

and working with the Voluntary ad Community Sector (VCS). For example, work is ongoing to reduce the variation in immunisation between GP practices, improve the uptake for school aged children and provide training for early years staff, health visitors and midwives. The plan will be presented and agreed at the ICS Immunisations and Screening group by February 2023.

Localised approach

15. North Central London boroughs were awarded funding by the NHS to address inequalities in uptake of the flu and COVID-19 vaccine. The first phase (January 2022) of the hyperlocal plan included:

- Increase staff capacity for walk-in services at Evergreen Surgery
- Pop-up vaccination clinics at North Middlesex hospital for pregnant women
- Targeted call/re-call for parents of 12-15-year olds
- Behavioural science research project to identify reasons for low/no consent/returns for school aged immunisations led by Barnet, Enfield, Haringey Mental Health Trust (BEHMHT)
- Enhanced communications for the GRT outreach programme

Phase Two (December 2022) projects include:

- Youth Health engagement project by Revival Christian church
- PCN initiative to call/re-call patients over 65.
- Complex Case Learning Disability Vaccination Service
- Extension of Eastern European health outreach workers at Edmonton Community Partnership
- Additional staff to support the school-aged immunisations team at BEHMHT

Vaccine champions scheme

16. Following a funding bid by Public Health in January 2022, Enfield Council was awarded £485,000 by the Department for Levelling Up Housing and Communities (DLUHC) to reduce inequalities in vaccine uptake.

17. The initial ask from the DLUHC was for funding to be allocated by March 2022 and for a reasonable level of implementation by July 2022. Following representation this was subsequently extended to March 2023.

18. The key outcomes of this programme prescribed by the DLUHC were:

    Short-term:

    - Increased vaccine uptake rates in target communities.
    - Increased visibility/activity of Community Vaccine Champions within local areas and on social media, with target communities.
    - Increased awareness of Community Vaccine Champions within the local area.

- Increased interaction with Community Vaccine Champions or local authority by disproportionately impacted groups.

Medium-term:

- Increased reach of, and reported trust in, official public health messaging amongst target communities.
- Increased reported confidence in challenging misinformation around vaccine safety amongst target communities.
- Evidence of behaviour change, within the targeted communities, especially with regards to protective health behaviour such as vaccine uptake and challenging misinformation around vaccine uptake.

Long-term:

- Reduced COVID-19 transmission in the long-term.
- Increased access to guidance and awareness of local services through outreach and practical tools which could lead to improved health and wellbeing of target cohorts and their families.
- Increased coordination and dialogue with public health providers by participating local authorities with the aim to create cohesive and trusted local messaging.
- Reduced inequality and disparity in health outcomes between different groups.

Work undertaken

19. The groups identified as having lower than average uptake were:
    - Gypsy Roma Traveller (GRT)
    - Black African and Caribbean
    - Eastern European including Bulgarian, Romanian and Polish
    - School-aged children

20. The project activities were designed and delivered in ways that meet the needs of different target communities. Initial proposals were submitted to Public Health and subsequently refined before being approved by the DLUHC.

21. A summary of projects included:

    - Delivery of critical thinking workshops on misinformation and “fake news” to over 160 young people through theatre in education (TIE) by Chickenshed Theatre company
    - The employment of 2 family liaison officers (FLOs) with a specific remit to work with the Gypsy Romany Traveller (GRT) community
    - The use of Covid marshals to signpost and escort people to vaccine centres
    - The establishment of a community grants programme administered by Enfield Voluntary Action (successful applicants shown in Appendix 2)

- Q&A sessions delivered by the Kongolese Children's Association with local healthcare professionals
- Health workshops with the Somali community delivered by Samafal, with support from healthcare professionals
- Monthly health & wellbeing "Town Hall" events hosted by Revival Christian Church with local healthcare professionals
- Recruitment of additional Eastern European outreach workers to conduct health workshops

Increases in vaccination

22. The actual number of COVID-19 first dose administered are compared in the table below before the scheme started up to November 2022.

Ethnicity	September 2021 (%)	November 2022 (%)	Number Vaccinated (September 2021)	Number Vaccinated (November 2022)	Difference
Gypsy, Roma, Traveller (GRT)	30	32.7	176	207	31
Black African	51	57	10,848	14,485	3,638
Black Caribbean	49	53	4,907	5,551	644
Bulgarian	20.4	21.6	745	840	94
Romanian	26.8	25.2*	896	986	90
Polish	38.2	41.3	1,590	1,726	136
Borough Average	62.3	68.1	183,248	198,635	15,387

**A decrease in percentage uptake was due to a change in population size following campaigns to increase the number of GP registrations.*

23. As the scheme formally ends in March 2023, we will continue to build on the close working relationship with the VCS groups and will engage with them on other health topics. The council will also signpost to relevant funding opportunities for VCS groups. A short survey was shared with delivery partners to get their feedback on their key learnings and insights; this will be used to guide future engagement with underserved communities.

Main Considerations for the Panel

24. Key learning from the early COVID-19 vaccination programme have been transferred into other adult and childhood vaccination programmes such as engaging with local community leaders and trusted members and producing culturally competent communications.

25. Learning from the vaccine programmes is relevant to engaging with underserved communities around cancer screening and other preventative health care provision.
26. The scheme was led by Public Health through a steering group including the VCS (Enfield Voluntary Action (EVA), Samafal, Edmonton Community

Partnership, Revival Christian Church, The Kongolese Children's Association, Chickenshed) and other LBE teams including communications, customer services and the LBE GRT lead. PH are also working alongside the behavioural science project team at Barnet Enfield and Haringey Mental Health Trust who are researching the reasons for low and non-consenters to immunisations at school.

27. Organisations and teams were asked to submit proposed schemes of work to Public Health who then liaised with the DLUHC on an initially weekly and then monthly basis. All funded proposals were approved by the DLUHC. Funding was allocated to voluntary and community groups and council departments based on the proportionate need by vaccine rates.

28. EVA ringfenced £75k in funding to administer a grants programme for voluntary sector groups to undertake projects addressing health inequalities in the borough. The successful applicants were all from the target communities and demonstrated robust plans to engage on health issues.

29. Throughout, consideration was given to what the longer-term impacts of the funding might be. The emphasis was on building relationships, trust and capacity for these messages to be supported and received well by communities.

30. It is evident from local and national intelligence that the wider determinants of health influence vaccine uptake. Whilst the vaccine champions programme has resulted in increased uptake in the COVID-19 vaccination, there remains significant and entrenched inequalities in the uptake of vaccines within communities.

Conclusion

31. Immunisation remains one of the most important and cost-effective Public Health interventions throughout the life course. Enfield is developing a multi-faceted approach to address inequalities in vaccine uptake and ensuring that the most vulnerable residents are protected from serious illness. The Council is working closely with Primary Care, the Integrated Care System, the VCS and other partners to address this.

32. Significant work has been undertaken through the vaccine champions scheme which has been used to both increase vaccine uptake and to increase capacity in the VCS. With funding allocated through EVA, the impact will be ongoing. The learning from this programme will be utilised to continue working with underserved groups and will continue to inform the immunisation work plan.

33. In summary, whilst the wider determinants of health affect vaccine uptake, the Vaccine Champions scheme has successfully increased COVID-19 vaccine uptake amongst underserved groups.

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0208 078 2808

Date of report 19th January 2022

Appendices

1. Routine immunisation schedule for children

Immunisation	Dose	Due	Time interval for vaccination to be considered in schedule	Report date
6-in-1 (DTap/IPV/Hib/Hep B)	1	8 weeks	8 weeks – 1 year	1 year
6-in-1 (DTap/IPV/Hib/Hep B)	2	12 weeks	12 weeks – 1 year	1 year
6-in-1 (DTap/IPV/Hib/Hep B)	3	16 weeks	16 weeks – 1 year	1 year
Rotavirus	1	8 weeks	8 weeks – 1 year	1 year
Rotavirus	2	12 weeks	12 weeks – 2 years	2 years
MenB	1	8 weeks	8 weeks - 51 weeks and 6 days	1 year
Men B	2	16 weeks	16 weeks – 1 year	1 year
Men B (booster)	3	1 Year	1 year – 2 years	2 years
Pneumococcal (PCV) vaccine	1	12 weeks	12 weeks – 1 year	1 year
Pneumococcal (PCV) vaccine	2	1 Year	1 Year – 2 years	2 years
Hib/Men C	1	1 Year	1 Year – 2 years	2 years
MMR	1	1 years	1 Year – 2 years	2 years
MMR	2	3 years and 4 months	3 years and 4 months – 5 years	5 years
4-in-1 (Diptheria, Tetanus, Pertussis and Polio)	1	3 years 4 months	3 years and 4 months – 5 years	5 years

2. VCS groups who were awarded “Trusted Voices” grants

Large grants (£10,000-£15,000)	Small grants (£500)
Polish Saturday School	Nigerian Catholic Community
Edmonton Community Partnership	Community Aid
Skills and Training Network	Poverty Concern
Bulgarian Centre for Social Integration	Success Club
Dalmar	Nigerian Catholic Community

Background Papers

The following documents have been relied on in the preparation of this report:

1. Community Vaccine Champions Prospectus

<u>**Health & Adult Social Care Scrutiny Panel Work Programme**</u>

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	Tony Theodoulou/ Bindi Nagra	Cllr Cazimoglu	Updates required on changes and impact on LBE	
	Mental Health Transformations/Reforms	Natalie Fox	Tony Theodoulou/ Bindi Nagra	Cllr Cazimoglu	Concerns about services provided	
	Adult & Children's Social Care Annual Statutory Complaints Report	Eleanor Brown	Fay Hammond	Cllr Cazimoglu	Requested by officers and OSC	
19th January 2023	Regulation of Adult Social Care, CQC reports	Bindi Nagra	Tony Theodoulou	Cllr Cazimoglu	Updates required on changes and	

					impact on LBE	
	Covid Recovery – vaccinations, inequalities	Dudu Sher-Arami	Tony Theodoulou	Cllr Cazimoglu	National issue and how LBE is taking forward	
	~~Public Health – Obesity~~	~~Dudu Sher-Arami~~	~~Tony Theodoulou~~	~~Cllr Cazimoglu~~	~~To reduce obesity rates~~	Dudu proposed delay – results awaited. Agreed by the Chair
	Future Commissioning of Enfield Sexual Health Community Services	Fulya Yahioglu	Tony Theodoulou	Cllr Cazimoglu	Pre Cabinet consultation	Report Author to confirm if going to this meeting before Cabinet on 8 Feb 23.
8th March 2023	Primary Care Access	Deborah McBeal	Tony Theodoulou/ Bindi Nagra	Cllr Cazimoglu	Concerns about access issues with GPs, dentists	GP Representation at meeting
	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	
	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.	
To be determined	Suicides in the Borough		Tony Theodoulou	Cllr Cazimoglu	Information, reason and statistics on suicides in the Borough and the impact of the cost-of-living crisis	

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London Borough of Enfield
Cabinet Meeting

8th February 2023

Subject: Future Commissioning of Enfield Sexual Health Services

Cabinet Member: Cllr Alev Cazimoglu
Executive Director: Tony Theodoulou

Key Decision: KD5531

Purpose of Report

1. This report seeks approval from Cabinet to enter into a partnership agreement between Enfield Council and North Middlesex University Hospital NHS Trust (NMUH) for the provision of Enfield Integrated Sexual Health Community Services in accordance with Section 75 of the National Health Service Act (2006).

2. To outline to Cabinet that entering into a Section 75 partnership agreement will facilitate the continued delivery of mandated sexual health provision in Enfield consisting of Family Planning & Contraception, Level 3 Genitourinary Medicine (GUM) for the testing & treatment of sexually transmitted infections (STis) , sexual health outreach and service support to young people. NMUH is the local NHS Trust currently delivering sexual health services in Enfield since Nov 2015.

3. To inform Cabinet that a Section 75 agreement between Enfield Council and NMUH will enhance partnership working allowing for service development and redesign, provide better integration with community services to support the sexual health and reproductive needs of the most vulnerable, improve the local service offer to residents, deliver value for money and improve performance and quality.

4. To advise Cabinet that a Section 75 Partnership Agreement already exists between LBE and NMUH through the recommissioning of the 0-19 Service in 2019 and that local Governance arrangements have been established between LBE and NMUH against this agreement.

Proposal(s)

5. Cabinet is asked to approve:

(i) This proposal to enter into a Section 75 Partnership Agreement between Enfield Council and NMUH for the delivery of the Enfield Integrated Community Sexual Health Services consisting of Family Planning & Contraception, STi testing and treatment, sexual health outreach and services to support to young people.

(ii) A separate schedule for the Enfield Integrated Sexual Health Community Service within the current Section 75 agreement held with NMUH for the 0-19 Service and utilise the existing governance structures for the delivery of this service.

(iii) The delegation of authority to the Director of Public Health, in consultation with the Director of Law and Governance, to finalise and agree this Section 75 Partnership Agreement for the Enfield Integrated Sexual Health Community Services and to make any variations during the term of the Agreement.

Reason for Proposal(s)

6. The current contract for the delivery of sexual health services in Enfield is due to end on the 31st March 2023 when the final 2-year extension of this contract comes to an end.

7. NMUH has been delivering clinic based sexual health services since November 2015 when the contract for the Enfield Integrated Community Sexual Health Services was awarded after full competitive tender process.

8. Sexual Health is a statutory function and under the Health and Social Care Act 2012 local authorities have a duty to secure the provision of open access services for contraception and testing and treatment of STIs for their residents. This is a mandatory function and entails the key principles of providing services that are free, confidential, open access and not restricted by age.

9. Sexual health is an on demand and open access service that delivers specialist clinical care to individuals, their partners and young people to support the sexual health and reproductive needs of the local population.

10. Sexual health services in Enfield form part of an integrated system working with community services for the delivery of accessible clinical sexual health provision for all residents of the borough. The service offers a range of sexual health provision locally being one of the clinics within North Central London (NCL) that provide access to Level 3 GUM services locally for the treatment of complex patients including access to microscopy, ultrasound, insertion and removal of complex Long Acting Reversible Contraception (LARC), Pre-Exposure Prophylaxis (PrEP) clinic service for men wo have sex with men (MSM) and psychosexual counselling.

11. Since the contract commenced in Nov 2015 the Service has continued to provide key sexual health provision in Enfield, this has included Level 1-3 services including prevention and support as well providing access to GUM provision in clinical settings for complex cases.

12. Service delivery has continued to be maintained during COVID-19 pandemic and Monkeypox outbreaks with clinic sites remaining open for STI treatment, complex LARC, psychosexual counselling and young people's provision as well as services to MSM for PrEP provision. Focus

continues to be on patient access for the most vulnerable including young people, MSM, BAME groups, sex workers and those who are homeless.

13. Uptake in sexual health service provision in Enfield is good and has steadily increased with performance being sustained throughout the term of the contract. This has been complemented by a reduction in Enfield residents attending clinics out of the borough with the implementation of the Hub and spoke mode of delivery in 2018.

14. Placing sexual health provision under a Section 75 agreement between Enfield Council and NMUH will better enhance partnership working allowing for service development and redesign as well as innovation in delivery with the use of digital technology as presented during the Covid-19 pandemic. It will allow for better integration with community services, a key objective for the Council and NMUH, to support the sexual health and reproductive needs of the most vulnerable and marginalised, improve the local service offer to residents, deliver value for money and improve performance and quality.

15. The Section 75 partnership arrangements in the National Health Service Act 2006 (formerly Section 31 of the Health Act 1999 – Health Act Flexibilities) were developed to give local authorities and NHS bodies the ability to respond effectively to improve services, either by joining up existing services or developing new, co-ordinated services. Section 75 agreements can be agreed for one or more of the following:

    - Pooled funds - the ability for partners each to contribute agreed funds to a single pot, to be spent on agreed projects for designated services

    - Lead commissioning - the partners can agree to delegate commissioning of a service to one lead organisation

    - Integrated provision - the partners can join together their staff, resources, and management structures to integrate the provision of a service from managerial level to the front line.

16. Experience shows us that joining up health and care is important in improving experience and outcomes for patients. It is by working together that the Council and NHS can best ensure we optimise the use of our shared resources and deliver the most impact.

17. The use of a Section 75 Partnership Agreement will facilitate strong joint working arrangements across the partnership and between system partners. The transformation of the service will be therefore be subject to a change management programme overseen by Enfield Council and NMUH.

18. The proposal will allow for improved adaptation to meet the changing needs of the Enfield population. It will allow NMUH, our current provider to innovate at pace and also raise opportunity for specific collaboration in the form of joint commissioning through a system-wide budget to realise a

more stable local sexual health system and growth with a relevant services commissioned by the ICB and/or NHS England.

19. Greater innovation and opportunity towards collaboration will result in:

- Increased partnership working opportunities as a system, without the challenges of multiple commissioner/provider splits.
- A gain in efficiencies of scale.
- More capacity (time and money) to re-invest in elements of care that need this most.
- Further development and alignment with Council and other NHS services to support new pathway development across services associated with sexual health to best meet need, especially for those most at risk. An example of this would be increased working between sexual health provision and substance misuse services as well as children's services.
- Greater transparency in activity and outcomes against investment, creating further flexibility and responsiveness to need Ultimately a Section 75 agreement will enable the Council and its partners to work together more cohesively to manage future turbulence within the sexual health system and enact savings at a faster pace as necessary.

20. A Section 75 agreement offers an opportunity for efficiencies as one party provides functions on behalf of another, or functions are shared, through a pooled budget arrangement. Pooled budgets result in more seamless and efficient services for the population, but also realise savings from shared administration and reduced back office costs. Savings can then be utilised to deliver service improvement to better meet the needs of the local population.

Relevance to the Council Plan

Good homes in well-connected neighbourhoods

21. Sexual health services currently operate within a Hub and Spoke model of service delivery. The Hub at Silverpoint is based in Upper Edmonton, N18 in an area of high health need whilst the Spoke in the Town Clinic in EN2 continues to provide accessible health interventions in the heart of Enfield with particular focus on young people's access.

22 The Section 75 partnership agreement will ensure continuity of service provision, providing residents with access to high class quality service provision in the Borough to address the sexual health and reproductive needs of the local population.

23. The clinic locations, currently under review with the potential to increase satellite provision across the borough through the partnership agreement. will aim to provide local residents with increased access to sexual health service provision in a choice of settings to improve their sexual health in more appropriate and cost-effective community settings.

Safe, healthy and confident communities

24. Integrated Sexual Health Community Services will continue to support and expand multi-agency working. Silverpoint clinic is currently co-located with a GP practice ensuring that each service is working to support the health needs of the local population. This provision will be maintained in the short-term.

25. The Hub and Spoke model across the two sites of Enfield Town and Upper Edmonton offers residents and those from across the border access to specialist sexual health provision in the Borough. The seven-day service through utilisation of a telephone triage/ appointment system and use digital technology will increase accessibility for new patients and to those that are highly vulnerable continuity of access through face to face clinics.

26. The remodelling of the service through the Section 75 agreement will aim to increase joint work with local partners including Pharmacists, Community HIV support Services at Alexander Pringle Centre, Drug and Alcohol Services, Homeless Outreach Team, other GP practices and young people's services including those working with gang members. Targeted outreach support to sex workers within the Fore Street corridor will be maintained with rapid access to treatment and engagement through specialist referral pathways to clinical services at Silverpoint.

An economy that works for everyone

27. The Section 75 agreement and development of the service beyond 31st March 2023 will ensure the most vulnerable in the community including black and minority ethnic (BAME) patients, men who have sex with men (MSM), the homeless and sex workers, have access to integrated sexual health treatment in a more appropriate and cost effective community setting.

28. Improving the health of these vulnerable groups as well as young people will prevent a range of longer-term negative health outcomes including mental and physical ill health. Furthermore, improving health outcomes will increase the number of people who are able to work and reduce sickness rates. The Wanless Report was clear that a healthy population is a productive population.

Background

National Policy

29. The Government has set out a number of key priorities in relation to Sexual and Reproductive Health (SRH) since 2013, which include:

30. The Framework for Sexual Health Improvement in England (2013) which sets out ambitions for improving sex and relationship wellbeing across the life-course.

31. Governments ambitions to improve SRH outcomes and wellbeing by taking a life course approach which is demonstrated in the Sexual Reproductive Health (SRH) Strategy & HIV Action Plan. This was developed in response to the Health Select Committee report on Sexual Health and includes a new HIV Action Plan to meet the target of zero new HIV transmissions in England by 2030. The strategy also covers system working, workforce, health inequalities and information and education across three main areas: reproductive health, sexually transmitted infections (STIs) and human immunodeficiency virus (HIV);

32. Relationships Education being made compulsory in 2020 in all primary schools in England and Relationships and Sex Education compulsory in all secondary schools; and

33. Confirmation of routine commissioning of HIV pre-exposure prophylaxis (PrEP) included in the Public Health Grant in 2021.

Local Context

34. Enfield ranks as the 9th most deprived London Borough and 74th most deprived in England. Levels of deprivation vary considerably across the borough and there is a clear east-west divide. Wards in the east of the borough, such as Edmonton Green, Upper Edmonton and Lower Edmonton rank in the 10% most deprived wards in England. Overall, more than half of Enfield’s wards fall within the most deprived 25% in England.

35. Economic deprivation has been associated with an increase in the risk of various health conditions, these include increased risk of mental health conditions, obesity, diabetes, heart disease and poor sexual health.

36. Deprivation is also associated with a number of hazardous behaviours such as smoking, substance misuse, risky sexual activity, teenage pregnancy, social isolation and poor diet.

37. Under the Health and Social Care Act 2012 local authorities have a duty to secure the provision of open access services for contraception and testing and treatment of STIs for their residents. This is mandatory and entails the key principles of providing services that are free, confidential, open access and not restricted by age.

38. The Council is mandated to ensure provision of open access sexual health services to protect the health of the local population and end ensure appropriate access to sexual health services which include the provision of:

- Contraception
- Testing and treatment of sexually transmitted infections (STIs)
- Sexual health aspects of psychosexual counselling, and,
- Sexual health specialist services including young people’s services, outreach, HIV prevention and sexual health promotion.

39. The open access nature of sexual health services means that there are significant cross-boundary flows of residents using services across London with sexual health services of this type delivered in a clinical setting by hospital trusts. Sexual health therefore represents one of the most significant challenges to local public health services.

40. In 2015 a competitive tender process was undertaken to select a suitable provider to deliver the Integrated Sexual Health Community Service contract in Enfield. This service provides Family Planning & Contraception, Level 3 genitourinary medicine (GUM) provision including STI testing and treatment and Sexual Health Outreach Nurse provision to young people.

41. In July 2015 the Cabinet approved the award of contract for Integrated Sexual Health Community Services in Enfield to North Middlesex Hospital NHS Trust.

42. The contract commenced on the 1st November 2015 for an initial period of three years and five months with two consecutive options to extend for a further 24-months subject to satisfactory performance. This final contract extension commenced on 1 April 2021 and is set to expire on 31 March 2023.

43. The annual contract value of the Enfield Integrated Sexual Health Community Service is £2.372 million. As part of the contract negotiations for the first extension in 2019, the GUM element of the contract was reduced by £200k per annum.

44. Current payment for sexual health services is under a ‘block arrangement’ covering all Enfield residents who access services commissioned by LB Enfield and is capped at the annual contract value.

Current Service Provision

45. The provision of clinical sexual health services for Enfield residents is through an open access contract with NMUH through a Hub and Spoke model. The Hub currently being based at Silverpoint in Upper Edmonton N18 close to the Haringey border and the Spoke in Enfield Town at the Town Clinic, EN2.

46. The council pays for sexual health services delivered by NMUH on a block contracted basis providing Level 1-3 GUM services for testing and treatment, contraception and reproductive health, young people peoples service and support for vulnerable client groups with poor sexual health outcomes including but not exclusively to BAME, MSM and sex workers.

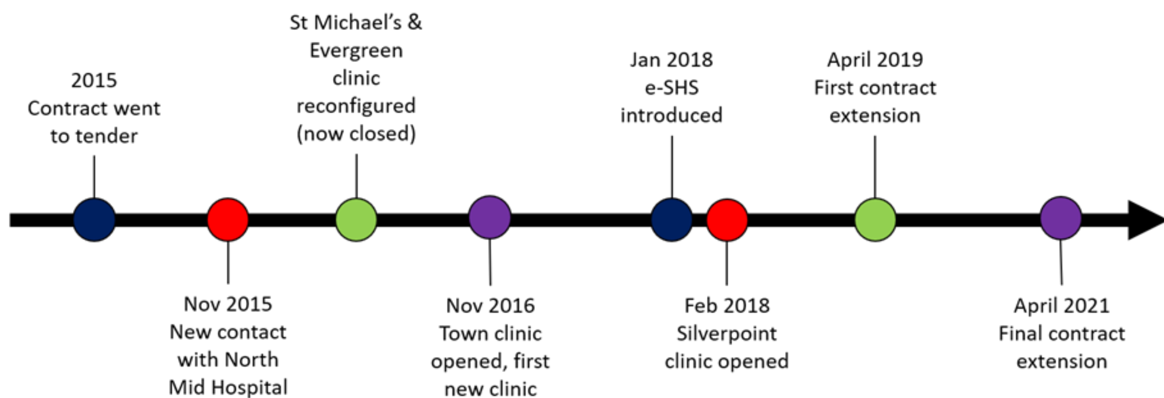
47. Residents also have open access to all sexual health services (out of borough) across the country under the Depart of Health national directive as part of a cross charging agreement. Clients accessing services out of borough (OOB) services are paid for on an activity basis only. These costs are absorbed by the Council through the Public Health Grant.

48. As part of the London Sexual Health Transformation Programme in 2017, Enfield entered into a Pan-London Agreement with Sexual Health London (SHL) to provide access to STI testing including Chlamydia, Gonorrhoea, Syphilis and HIV for asymptomatic patients through the online E-Service. The cost of providing this service is additional to the main Integrated Sexual Health Community Services contract.

49. Equalities monitoring of SHL activity in Enfield over the 12-month period from April 2020– March 2021 revealed an increasing proportion of service users self-reporting as female, being a young person, or of Black ethnicity compared to the rest of London. This trend has continued into 2021/22.

50. Sexual health services are also delivered in community settings through direct contracts with Primary Care for the fitting and removal of Long Acting Reversible Contraception (LARC) by trained GPs across 21 practices within the borough and the provision of Emergency Hormonal Contraception (EHC) across 20 Pharmacies within Enfield.

51. An overview of the local landscape since 2015 is depicted below:



52. Overall sexual health services in Enfield form part of an integrated system working with community services to deliver accessible clinical sexual health provision for all residents of the borough.

53. Since 2015, the landscape of sexual and reproductive health services has changed and there have been a number of advancements (some triggered by the Covid-19 pandemic) that have since been incorporated into GUM and Sexual Health Services locally and across London.

Proposed Model of Service Delivery in Enfield

54. As part of the recommissioning process of the current contract a service review of sexual health provision was conducted between 2021/22. The outcome from this review identified areas of good practice together with key themes where the existing model needed adaption and improvement through service development and redesign to enhance service quality and provision.

55. Under the Section 75 partnership agreement a collaborative approach to the commissioning process will allow for innovation and adaptation, ensure high quality and cost-effective provision adapted to the needs of the local population.

56. Following on from the service review there has been ongoing discussions with NMUH to adapt and develop a model which meets the needs of the Enfield population and manages demand as well as increasing case complexity. The proposed model of delivery will be subject to consultation and review and will include:

(i) Remodelling of the current Hub and spoke model in Enfield with potential clinic sites in community settings including primary care and family hubs;

(ii) Increased opening hours and access through the 7-day service with longer opening hours with the aim of reducing OOB attendances by increasing access to clinic provision locally, improving appointment and walk-in access by employing an effective triage system developing a robust partner notification pathway and actively promoting on-line services across the borough.

(iii) Shifting the majority of clinic activity to complex GUM and LARC patients with the aim of moving the majority of routine non-complex LARC and EHC to primary care and channel shifting asymptomatic patients and those with mild symptomatic symptoms to the SHL E-Service for STI testing and treatment;

(iv) Improving Partner Notification systems through reconfiguring of the staffing complement to include results co-ordination;

(v) Expansion of non-complex with GP primary care services and Emergency Hormonal Contraception (EHC) in Pharmacies;

(vi) Increasing access to psychosexual counselling and developing pathways with Community Gynaecology and Maternity Services;

(vii) Development of specialist clinics for women, sex workers, MSM and those using ChemSex;

(viii) Increasing investment in sexual health promotion and outreach for young people in school settings and maintaining YP Sexual Health Clinic access at the Town Clinic.

(ix) Increasing the use of digital technologies to offer better choice and access locally including expansion of online consultations, video conferencing and a robust booking system;

(x) Increasing Condom distribution from Pharmacies and GP practices.

57. The proposed model of service delivery will be part of future service development and redesign of sexual health provision in the borough and will be costed for estates, service demand, staffing and incorporation of new technologies under the Section 75 agreement.

58. Through remodelling of current services as part of the recommissioning process a potential efficiency in OOB costs could be achieved through increased access and improved quality in service provision locally.

59. The review of clinic estates will also aim to provide reduction in costs to the contract with a negotiated reduction of cost at Silverpoint (the current lease ends in March 2023) through the potential for short-term sub-letting arrangements with the termination of the lease. This again will be subject to review.

60. By avoiding potential overlaps in commissioning and moving towards a new activity based model of delivery for future provision will result in efficiency both in the amount spent on STI testing and the cost of payments by clients seeking sexual health consultations outside of the borough, activity that is currently also being covered under the existing block contract.

61. The overall aim of recommissioning and remodelling of service delivery will be to realign a reduction in costs/savings from both the current service contract value and future budget arrangements, and this will be re-invested to support and broaden the wider Public Health improvement offer.

Main Considerations for the Council

62. An options paper detailing the future recommissioning of the Enfield Integrated Community Sexual Health Service was presented to the Strategic Development in Dec 2021. The Board endorsed the option to enter into a Section 75 partnership agreement with NMUH from 1st April 2023, when the current contract comes to an end.

63. To support the options for the future recommissioning of sexual health service provision, a service review was conducted which highlighted key recommendations for service improvement to enhance quality and access for the local population. The proposed model has been highlighted in the previous section.

64. Following on from the review and in line with the requirements to progress with a Section 75 agreement Enfield Council will be undertaking a consultation with key stakeholders including GPs, Pharmacists together with members of the Enfield Sexual Health & Teenage Pregnancy Partnership Board (ESHTPPB) on the proposed model and those affected by this Section 75 agreement.

65. Robust joint governance and management arrangements have already been established as part of this agreement under the recommissioning of the 0-19 Service. A Sexual Heath Governance Board with two working

subgroups has been implemented to oversee the transfer of the Enfield Integrated Community Sexual Health Service to a Section 75 partnership agreement, subject to Cabinet approval.

66. Feedback from consultation on the proposed service model will be incorporated into the service specification for this agreement and will take into account user feedback. A service user consultation exercise undertaken in 2020/21 has also been used to inform the new model of delivery.

67. Enfield Council is also gathering feedback from the two subgroups of the Sexual Health Governance Board overseeing the current Section 75 agreement. This feedback will also be incorporated into the agreement and service specification for the future delivery of the Enfield Integrated Sexual Health Community Services.

68. As part of the new proposed model of service delivery, user involvement and staff consultation will be key and vital component of future service improvements and enhancements.

69. The Section 75 agreement will build on the good service that is currently delivered by NMUH and would mitigate any future risk on performance due to re-procurement.

70. The Council already has a section 75 agreement in place for the provision of services for people aged 0 to 19 with NMUH, with existing mechanisms of policy, partnership and service delivery with the same provider established.

71. The Section 75 agreement for sexual health provision will be separate schedule from the current 0-19 Service, however utilising the existing organisational methods. This will be least disruptive in terms of organisational change to progress the better integration of services and care across public health and Sexual Health services.

72. Overall the Section 75 Agreement will allow greater flexibility and provide an opportunity to provide services across an entire integrated sexual health pathway. This will improve the patient experience for individuals, their partners and young people and bring health benefits to the community.

Other considerations

73. Since the contract commenced in Nov 2015 the Service has continued to provide key sexual health provision in Enfield, including access to Level 3 GUM provision for complex cases as well as maintaining service delivery during the COVID-19 pandemic with clinic sites remaining open for STI treatment, complex LARC and young people's provision. Focus has continued to be on the most vulnerable of patients with the highest burden of sexual health including young people, MSM, sex workers and those who are homeless.

74. Pathways have been developed and maintained with key partner agencies in Enfield with a telephone triage system being implemented, as per the British Association for Sexual Health and HIV (BASHH) guidelines, in response to the Covid-19 pandemic and Monkeypox outbreak. This has allowed the service to maintain service provision and support patients whilst social distancing was implemented during lockdowns.

75. Sexual Health Services in Enfield have maintained service delivery minimising the impact of the pandemic through use of digital, telephone and online technology as directed by BASHH. The use of a telephone triage system, promotion and referral to online STI testing with treatment and support at local clinic sites, provision of complex LARC & contraception and access for young people have all been maintained due to the good work undertaken by the service. The lockdown measures have also provided Enfield Council with an opportunity to reduce out of borough patient attendances due to social distancing restrictions and subsequently there has been increased referrals into local services and a reduction in out of borough presentations.

76. Enfield Council's Gold Emergency Planning Team identified the Integrated Sexual Health Community Services as priority one service regarding the COVID-19 pandemic. Throughout the COVID-19 pandemic period of lockdowns and recovery, the sexual health clinics have provided uninterrupted service provision in the borough, being one of the few clinics in London providing clinic access.

77. Enfield Sexual health services continue to provide open access on demand services across the two clinic sites delivering sexual health and reproductive support to patients and their partners, supporting those with psychosexual issues through specialist counselling and providing much needed support for PrEP access and support to MSM.

78. The service since its last extension in April 2021 has seen an increase in demand and diversity within its clinics particularly those with complex needs. Young people's access remains consistent and the service has maintained open access provision to young people through the pandemic and recovery ensuring clinic slots for those young people who are most vulnerable.

79. Given the current sexual health landscape and the level of need with the borough and challenges that this presents in terms of increasing STIs and complex cases, it will be crucial to provide a stable and consistent service to support local residents over the next 12-18 months.

Performance overview

80. Please refer to the Confidential Annex of this report.

Safeguarding Implications

81. NMUH has in place the necessary safeguarding protocols, in line with Council Policy and applies the Frazier Guidelines and Gillick Competency where a young person is under 16.

82. The Service is registered with CQC and adheres to NICE Clinical guidelines, BASHH and FRSH guidelines and Trust governance arrangements.

Public Health Implications

83. Good sexual health is an important part of people's lives, fundamental to the health and wellbeing of the individual and has obvious implications for the society. It requires a positive and respectful approach to sexuality and sexual relationships. Good service provision supports this through control of fertility and of sexually transmitted infections.

84. Sexual ill health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions, with the highest burden borne by women, men who have sex with men, teenagers, young adults and BAME. Similarly, HIV infection in the UK disproportionately affects MSM and Black Africans. Some groups at higher risk of poor sexual health face stigma and discrimination, which can further influence their ability to access services.

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85. Evidence shows that every £1 invested in sexual health services results in £11 of wider savings across health and social care due to the prevention of disease and unintended pregnancies.

Equalities Impact of the Proposal

86. The proposal is for the continuation of the existing service arrangement under a Section 75 Partnership agreement and therefore will not result in any change in Equalities impact.

87. A full Equalities Impact Assessment was undertaken in 2015 as part of the recommissioning of sexual health service provision in the borough. This analysis demonstrated positive impacts in maintaining access to STi testing and treatment to ensure key outcomes can be met, especially for those at risk of poor sexual health – young people, BAME communities and MSM.

88. The remodelling of service provision under this Section 75 partnership agreement will have a positive impact on equality groups that share a protected characteristic such as BAME, LGBT individuals and those with gender reassignment, young people, men, women, those with disabilities and some religious groups. The positive benefits identified include improved access to a full range of contraceptive services, STI testing and treatment, reduction in unplanned pregnancy including teenage pregnancy, referral to maternity, community gynaecology and abortion service, a reduction in STi prevalence and HIV incidence and late diagnosis.

89. An updated Equality Impact Assessment will be conducted prior to the endorsement of the new proposed model of service delivery. The service specification will include a requirement to identify and provide services that meet the needs of protected groups, especially those most at risk of sexual ill health. The service is thus required to target population groups, young people, MSM and BME communities, which are vulnerable to risk taking behaviour, bear the burden of sexual ill health and/or less likely to engage with sexual health services. The services as part of its KPIs monitors the use of its services by these groups.

90. The service is required to provide universal STi testing, treatment and prevention to all residents of Enfield.

Environmental and Climate Change Considerations

91. The continuation of the existing service under a Section 75 Partnership Agreement will have no significant impact on environmental and climate change considerations.

92. The increased use of telephone triage and digital technology through booking of online appointments and virtual consultations, which were highly effective during the Covid-19 pandemic will continue to reduce the Borough's carbon footprint with patients accessing STI testing online or attending clinics locally rather than going out of borough.

Risks that may arise if the proposed decision and related work is not taken

93. Given the specialist and clinical nature of sexual health services maintaining continuity of service provision will be critical ensuring that residents of Enfield have to access treatment and support for their sexual and reproductive health needs.

94. As there are no further extension to this existing service contract and that sexual health services are mandated, if the proposed decision and related work is not undertaken the following risks are likely. These include:

- Potential loss and disinvestment of NMUH, our local NHS provider
- Loss of crucial clinical provider staff if stability within the contract is not maintained;
- Disengagement of patients if there is any disruption to the service delivery;
- Deterioration of referral pathways impacting on access to and the provision of treatment;
- Increased 'out of borough' costs with residents accessing sexual health provision outside of Enfield;
- Increase in STIs and teenage pregnancy rates due to lack of local provision;
- Reputational risk as local authorities are mandated to provide open access services for contraception and testing & treatment of sexually transmitted infections for their local residents.

95. The recommendations to enter into Section 75 agreement will enable service innovation and redesign to support those communities most at risk of sexual ill health. The partnership agreement will ensure that sexual health services are fit for purpose for all communities of Enfield, ensuring continuity of service provision maintaining quality and value for money.

Risks that may arise if the proposed decision is taken and actions that will be taken to manage these risks

96. The risks that may arise if the related work is undertaken is that Performance may initially reduce as the Provider moves to the Section 75 Partnership Agreement and service development commences with review of estates, staffing and the move to an adapted hub and spoke model. To mitigate this risk regular contract review meetings will be conducted as well as the ongoing service review meetings to identify performance and operational issues as well as issues in relation to contracting beyond 2023. The existing Strategic Governance Board for the 0-19 Service will also include the Sexual Health Service ensuring that risks to service delivery are highlighted through the partnership as quickly as possible with mitigating actions.

97. As the service moves to a model of delivery where focus will be on complex patients, there will be potential for a greater channel shift to online STI testing for asymptomatic and mild symptomatic patients as the service enters into the new partnership agreement period. Mitigations will include regular monitoring of online STI testing data on Preventx data system and ongoing discussions with the London Sexual Health Partnership Board (LSHPB) to ensure increases are managed accordingly and are reflected across London.

98. A review of estates may impact on the continuation of the Hub and spoke model of delivery. This may lead to capacity issues and demand management with a potential increase in our out of borough costs as well as reduction in income stream to the partnership for those out of borough residents accessing Enfield services. This will be mitigated through operational meetings and through robust governance and partnership arrangements will be implemented as part of this Section 75 agreement.

Financial Implications

99. The Public Health Grant for Enfield in 2021/22 is £17.531m, this being a slight increase of £241k or 1.4% from 2020/21.

100. The Public Health Grant is ringfenced and is designed to cover expenditure incurred in delivering the Public Health function, which covers mandated (statutory) services and non-mandated (non-statutory) services.

101. Sexual Health is a mandated function and requires each local authority to provide, or secure the provision of, open access sexual health services in its area including: preventing the spread of sexually transmitted

infections (STIs); treating, testing and caring for people with STIs and partner notification.

102. Local authorities should provide contraceptive services including advice on, and reasonable access to, a broad range of contraceptive substances and appliances; advice on preventing unintended pregnancy.

103. The cost of this service and funding are set out in the confidential annex.

Legal Implications

102. To be completed.

Workforce Implications

103. There are no workforce implications for Enfield Council as the report outlines entering into a Section 75 Partnership Agreement with the existing provider with the continuation of Sexual Health Service provision in the borough.

Property Implications

104. The service currently operates through a Hub and spoke model across two clinic sites in Enfield, the Town Clinic at Units 4&5 Burleigh Way in Enfield Town and Silverpoint, Fore Street in Upper Edmonton. The leases for these properties are held by the Council and will terminate at the end of the current contract on 31st March 2023.

105. To maintain service stability and manage demand the Hub and spoke model will be retained within these two clinic sites as part of the Section 75 Partnership Agreement.

106. LBE Operational Estate Management and NHS Estates are working with Commissioners to maintain a presence at these sites. This will include the renewal of the current lease at the Town Clinic at Burleigh Way and the possibility of a short-term sub-let arrangement at Silverpoint, this will be subject to review.

Other Implications

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107. To be completed.

Options Considered

Option 1: Recommission through a Section 75 Agreement – Recommend

108. Nationally a number of councils have directly awarded contracts to a preferred provider without undertaking a full competitive tender process using a Section 75 Agreement. This has included the provision of sexual health services with the aim of remodelling existing provision.

109. A direct award using a Section 75 Agreement would enable commissioners and the provider to collaborate on a new integrated model of delivery for sexual health provision in Enfield with a view to sustainable service delivery and improvements within a flexible legal framework.

110. The Section 75 agreement would also allow for joint ownership of the development of a specification of a newly reshaped service model to meet public health priorities, include new technologies and prioritise early intervention and prevention.

111. It would also ensure service transformation starts immediately, with benefits realised in-year as changes are rolled out allowing for local and London specialist clinical and technological expertise to inform the development of the new specification' and a shared focus on efficiency between the Council and NMUH.

112. The recommendation is for Enfield Council to enter into a Section 75 partnership agreement with NMUH, for the continued delivery of Enfield Integrated Community Sexual Health Service.

Option 2: Tender for a new service with a new service specification – Not recommended

113. This is the standard model for the delivery of Sexual Health Services in the current marketplace offering competition in tendering.

114. Competitive sexual health procurements in London are extremely complex utilising payment by activity utilising integrated sexual health tariffs (ISHT). The process is therefore both time consuming and requires large amounts of specialist commissioning input. A new provider will need to mobilise across the borough, providing on-the ground specialist clinics within primary care services. These take time to build to the correct clinical requirements.

115. Furthermore, the market is currently limited, unsettled and restricted to a small number of NHS trusts and private providers, In London the number of experienced providers within the marketplace being limited to the following London NHS Trusts NHS Trusts NMUH, CNWL, ChelWest, Barts Health, Homerton and GSST with most London procurements to date based on contractual agreements.

116. In Enfield the option to retender this service within a new service model, specification and draft contract would be unfeasible due to the current time constraints and would not allow us enough time to follow the governance process for the Council. Time constraints would also not allow us to develop a detailed specification with the proposed new model of delivery embracing new digital and medical technologies whilst still ensuring the service could provide an effective universal testing and treatment offer.

117. Bidders will also expect Councils to identify and secure sites however due to the review of estates with a potential move to a one clinic model of

delivery this may not be possible – securing accommodation sites can be both time-consuming and expensive.

118. This is a high value contract and will need to go to full Cabinet for the decision to award. An external competitive tender process will need time and capacity and may not necessarily result in a better NHS Trust winning the award.

Option 3: In house provision – Not recommended

119. The council does not currently have the clinical expertise or governance to deliver clinical GUM services in-house.

120. The council could decide to deliver this directly or set up a Community Interest Company to provide these services. However, this would require the council to transfer clinical teams and make appropriate training, equipment, and premises available for them to operate from.

121. This model would require a significant capital investment and would need to give due consideration to workforce issues.

Option 4: Cease to deliver the service – Not recommended

122. As outlined above the Council is mandated to provide open-access, accessible and confidential contraceptive and sexually transmitted infections (STIs) testing & treatment services for all age groups in the borough.

123. Decommissioning services will result in further investment being required in relation to health and social care costs associated with unplanned pregnancies and the more expensive provision of care for those with long term health conditions such as HIV.

Conclusions

124. Following review of the available options and the various considerations detailed within this report it is concluded that the safest and most effective way forward is to recommission the Enfield Integrated Sexual Community Service through a Section 75 partnership agreement with NMUH. This will ensure ongoing availability of effective and specialist clinical services to residents of Enfield for their sexual and reproductive health needs.

125. Furthermore, it will ensure continuity of care, testing & treatment for STis to patients at a time when we anticipate an increase in need and complexity for those at risk of poor sexual health including young people, BAME communities and MSM.

126. The recommissioning of this provision under a Section 75 partnership agreement will allow for ongoing delivery of effective and accessible services, an opportunity for service development and redesign of the sexual health offer to residents which will improve quality and offer value for money.

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Date of report 28th November 2022

Appendices

Confidential Annex

Background Papers

The following documents have been relied on in the preparation of this report:

Sexual Health Review

https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

https://www.gov.uk/government/publications/sexual-and-reproductive-health-and-hiv-strategic-action-plan

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By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
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