Public Document Pack

Jane Creer
Governance Officer
Direct: 020 8132 1211
e-mail: democracy@enfield.gov.uk

HEALTH & ADULT SOCIAL CARE SCRUTINY PANEL

Tuesday, 28th November, 2023 at 7.00 pm in the Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

Membership:

Councillors: James Hockney (Chair), Andy Milne (Vice Chair), Nicki Adeleke, Elif Erbil, Chris James, Doris Jiagge, Emma Supple and Kate Anolue

AGENDA – PART 1

1. WELCOME & APOLOGIES

2. DECLARATIONS OF INTEREST

Members of the Council 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 20 September 2023.

4. ENFIELD BOROUGH PARTNERSHIP UPDATE (Pages 7 - 30)

To receive the update and presentation from Stephen Wells, Head of Enfield Borough Partnership Programme, Enfield Borough Directorate, NHS North Central London ICB.

5. ADULTS SOCIAL CARE ANNUAL STATUTORY COMPLAINTS REPORT (Pages 31 - 52)

To receive the report of the Executive Director – People, presenting the annual report on Adult Social Care Statutory Complaints for 2022-23.

6. HEALTH VISITING, BREASTFEEDING AND WOMEN'S HEALTH (SCREENING) (Pages 53 - 76)

To receive the report of the Executive Director – People / Director of Public Health, providing an overview of service developments and performance within the Enfield Health Visiting Service; an update on activity to improve breastfeeding rates among Enfield residents; and highlighting uptake of women's health (breast and cervical) screening programmes and activity to increase uptake.

7. CQC INSPECTIONS UPDATE (Pages 77 - 86)

To receive the report of the Director of Adult Social Care, providing an update on the Care Quality Commission inspections of Local Authorities.

8. DRAFT JOINT LOCAL HEALTH AND WELLBEING STRATEGY (Pages 87 - 114)

To receive the report of the Director of Public Health to seek feedback from the Health and Adult Social Care Scrutiny Panel on the draft Joint Local Health and Wellbeing Strategy 2024-30.

9. WORK PROGRAMME 2023/24 (Pages 115 - 116)

To note the current Health and Adult Social Care Scrutiny Panel Work Programme for 2023/24.

10. DATES OF FUTURE MEETINGS

To note the dates of future meetings as follows:

Wednesday 28 February 2024
And 1 additional date to be confirmed.

All meetings will commence at 7:00pm and will be held in the Conference Room at the Civic Centre.

MINUTES OF THE MEETING OF THE HEALTH & ADULT SOCIAL CARE SCRUTINY PANEL HELD ON WEDNESDAY, 20TH SEPTEMBER, 2023

MEMBERS: Councillors James Hockney (Chair), Andy Milne (Vice Chair), Nicki Adeleke, Chris James, Emma Supple and Kate Anolue

Officers: Doug Wilson (Director of Health and Adult Social Care), Elspeth Smith (Team Manager – Safeguarding Adults), Bharat Ayer (Head of Safeguarding Partnerships), Glenn Stewart (Consultant in Public Health), Louisa Bourlet (Community Health Development Officer), Mark Tickner (Senior Public Health Strategist)

Also Attending: Cllr Alev Cazimoglu (Cabinet Member for Health and Social Care), Dr Fahim Chowdhury (GP and NCL ICB Clinical Lead, Enfield), Nicholas Ince (Deputy Director of Vaccination Transformation, NCL ICB), Isabelle Stones and Markela Lleshaj (Youth Council Members)

1. WELCOME & APOLOGIES

Cllr James Hockney, Chair, welcomed all attendees.

Apologies for absence were received from Cllr Doris Jiagge and Cllr Elif Erbil.

Apologies for absence had also been received from Dudu Sher-Arami, Director of Public Health, Deborah McBeal, Director of Integration, NHS North Central London ICB and Dr Riyad Karim, Assistant Director of Primary Care, Enfield.

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 8 March 2023 were **AGREED**.

4. ENFIELD SAFEGUARDING ADULTS BOARD STRATEGY 2023-28

Cllr Alev Cazimoglu, Cabinet Member for Health and Social Care, introduced the report of the Executive Director – People, in respect of the draft 5-year Safeguarding Adults Strategy for consultation. The priority areas and key projects were highlighted.

Elspeth Smith, Team Manager – Safeguarding Adults, confirmed that publishing a strategic plan was one of the duties of the Safeguarding Adults Board (SAB). Learning from previous reviews, and trends in safeguarding data were included.

Questions were invited from Members.

In response to queries around self-neglect, it was advised that this had been counted as a form of adult abuse since 2014, and that awareness had risen during the Covid-19 pandemic. High numbers of over-65 year olds lived alone and self-neglect could reach an advanced stage as no-one was aware and able to intervene. Visits from loved ones had been prevented during lockdown and this had exacerbated the problem. Hospitalisations during the pandemic also provided evidence of people not having contact with professionals, living alone and self-neglecting. The numbers of adult safeguarding concerns raised went up in 2021 and had not gone down subsequently. Hoarding was also advised to be particularly difficult to tackle. The Council had established a hoarding database. They also worked alongside London Fire Brigade. There would be recommendations on voluntary sector contracts to help with response. Trusted people and voluntary and community service (VCS) colleagues were key to better approaches to delivering assistance and communication. Longevity and continuity of the relationship was also important. Officers also commented on solutions when adults rejected intervention in their best interests.

In response to questions about support for older people for whom English was not their first language, it was confirmed that the consultation exercise would be inclusive. There had also been learning from the pandemic that people responded better to trusted voices in their communities, and these should be tapped into during this process to that those who may miss out had the opportunity to have their say. Links had been developed to all ethnic communities and there were plans to reach as many people as possible. Other communication issues in respect of literacy were discussed, and that there was liaison with colleagues in the learning disability service in respect of documentation. ‘Silo’ working was reduced during the Covid-19 pandemic. Partnership working was the way forward. A multi-disciplinary high risk advisory panel was being convened.

The Chair thanked the officers for the report and their attendance at the Panel.

The Panel **AGREED**:
I. To note the consultation and promote across the Council.
II. That updates on progress on the 2023-28 Strategy for the Enfield Safeguarding Adults Board be received by the Panel in due course.

5. SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2022/23

Cllr Alev Cazimoglu, Cabinet Member for Health and Social Care, introduced the report of the Executive Director – People, in respect of the Safeguarding

Adults Board Annual Report for noting by the Panel. The report highlighted the work undertaken to protect adults at risk in 2022-23 and achievements throughout the year. She wished to record thanks to all professionals working to safeguard adults at risk in Enfield.

Bharat Ayer, Head of Safeguarding Partnerships, highlighted the broadly positive external review by RedQuadrant, and the focus on partnership working. Recent work by the infection control team was also brought to the Panel's attention.

Questions were invited from Members.

In response to queries around assistive technology, feedback was provided regarding the trial of PainCheck, and the preventative value of SMART devices to support people.

In response to questions about the Learning Disability Learning from Lives and Deaths Programme (LeDeR) reviews, it was confirmed that notification was of deaths of all ages and regardless of circumstances and the requirement for review was brought in some years ago.

Further details were provided to Members of the support and training to care homes in respect of infection control, not just for Covid-19, and ensuring that care home residents were the priority. Further details were also given in respect of actions in extreme temperatures during summer and winter and pre-preparation.

In respect of the table of types of abuse reported, set out on page 59 of the agenda pack, it was confirmed that they showed what was reported, but there was probably under-reporting. Work needed to continue to raise awareness of how to disclose abuse, and that something can be done.

Learning from cases such as Mr K and those declining support was discussed, including the importance of professional curiosity and appropriate challenge, and assessment of mental capacity.

In response to Members' queries, it was confirmed that the Partner Updates in Appendix A of the Annual Report were expected and were produced by each partner. The Independent Chair of SAB would oversee if any action was needed on a strategic basis. In respect of the update from the National Probation Service, it was advised that people coming out of prison homeless would be provided with more than a rucksack containing a sleeping bag, and that more details could be obtained from the Service: the Panel requested a letter be sent to clarify those details.

ACTION: Elspeth Smith

In response to Members' queries regarding Deprivation of Liberty Safeguards (DoLS), further detail was provided on applications and authorisation and due diligence through the process.

The Chair thanked the officers and recorded congratulations on the team's nomination for the 2023 Local Government Chronicle Awards in recognition of modern slavery work.

The Panel **AGREED**:
I. To note the Annual Report. Noting the report at Cabinet, Scrutiny and Council enables Enfield Council to demonstrate its commitment to safeguarding adults at risk throughout the organisation. The report is a partnership document and as such is agreed at the Safeguarding Adults Board.
II. To recommend that a letter be sent on behalf of the Panel to the National Probation Service to request more details further to their Partner Update in Appendix A of the Annual Report.

6. VACCINATIONS AND IMMUNISATIONS: CHILDHOOD IMMUNISATIONS FOCUS

Glenn Stewart, Consultant in Public Health, introduced the report of the Executive Director – People / Director of Public Health, in respect of the uptake of maternity and childhood immunisations in Enfield and partnership work with the local authority and NHS being undertaken to improve the uptake.

The target uptake for immunisations worldwide was 95%. There was a lower uptake of maternity and childhood immunisations across the UK and especially in London, including Enfield. There were numerous reasons behind the lower vaccination uptake in Enfield, not all of them fully understood. A lot of work was being undertaken to raise the uptake and to rectify the high variation in uptake across Enfield. Future activity would include special focus on increasing uptake of MMR, and winter planning including for flu.

Questions were invited from Members.

In response to queries around engagement and linking with the voluntary and community sector in Enfield, it was confirmed that engagement was done at community events all the time. There had been work with schools and with faith centres, and the process was continuous. Dr Chowdhury advised that Angel Surgery had Turkish and Polish speakers, and employed a staff member just to call parents about childhood immunisations. In conjunction with North Middlesex University Hospital, ten schools had been identified for prioritisation and proactive offers for MMR alongside flu vaccinations. Work was being done involving midwives at University College London Hospital, who played a primary role in respect of messaging and immunisation support.

In response to questions about the HPV vaccinations, it was confirmed the in-school offer was now eligible for boys and girls and that from the autumn this would require one dose rather than two. For those girls who missed out on vaccination at age 12 / 13 there would be a catch up project in the new year and this vaccination was available from the NHS up to the age of 25.

Post Meeting Note: All information is detailed on the NHS website – see link below.
https://www.nhs.uk/conditions/vaccinations/hpv-human-papillomavirus-vaccine/

The good vaccination uptake during the Covid-19 pandemic was referenced, with the concerted effort and national messaging and support, and the effect of the immediate threat felt by people. NHS colleagues considered that a national effort was needed again now. They were experiencing more vaccine hesitancy and circulation of misinformation. In preparedness for the winter and anticipation of a potential measles outbreak, increased capacity for delivery of vaccinations was being planned.

Further details were provided to Members in respect of the low vaccination uptake by Gypsy / Irish Traveller ethnicity. It was difficult to put together accurate data for this group who often did not register with GPs, but an anti-vax sentiment was noted during the Covid-19 pandemic. There was some settled community in Enfield, but interaction was limited.

The Chair thanked everyone for the information, and the forthcoming communications should also be shown on the Council's social media.

The Panel **AGREED** to support the following actions:

- Write to central government to request that increased access is made to vaccination for children through pharmacies, hospital ED departments, outpatient clinics and other health care settings ensuring that all health services share responsibility for increasing immunisation.
- Consider contacting the Shadow Health Secretary to lobby government to focus on improving vaccination uptake by
  - o Tackling misinformation
  - o Improving NHS systems to collect data
  - o Making it easier for residents to see what immunisations they've received e.g. through NHS App.
  - o Providing additional resources to engage with communities with low vaccine uptake.

ACTION: To be progressed by Cllr Alev Cazimoglu, Cabinet Member for Health and Social Care, via a Motion to Council on 27 September 2023. Any other Member was also welcome to write to central government.

Post Meeting Note: The Motion (No. 14.14) in the name of Councillor Alev Cazimoglu was agreed by Council on 27 September 2023.

7. WORK PROGRAMME 2023/24

NOTED the Health and Adult Social Care Scrutiny Panel Work Programme for 2023/24.

The Integrated Care Systems topic would be submitted to Overview and Scrutiny Committee, and it would come off the Health and Adult Social Care Scrutiny Panel work programme, in order to avoid duplication.

The topics of CQC Inspections Update and the Borough Partnership Plan for consideration at the 28 November 2023 meeting were separate topics.

ACTION: Governance

8. DATES OF FUTURE MEETINGS

NOTED that the next meeting of the Health and Adult Social Care Scrutiny Panel would be on Tuesday 28 November 2023 at 7:00pm in the Conference Room, Civic Centre.

The meeting ended at 9.15 pm.

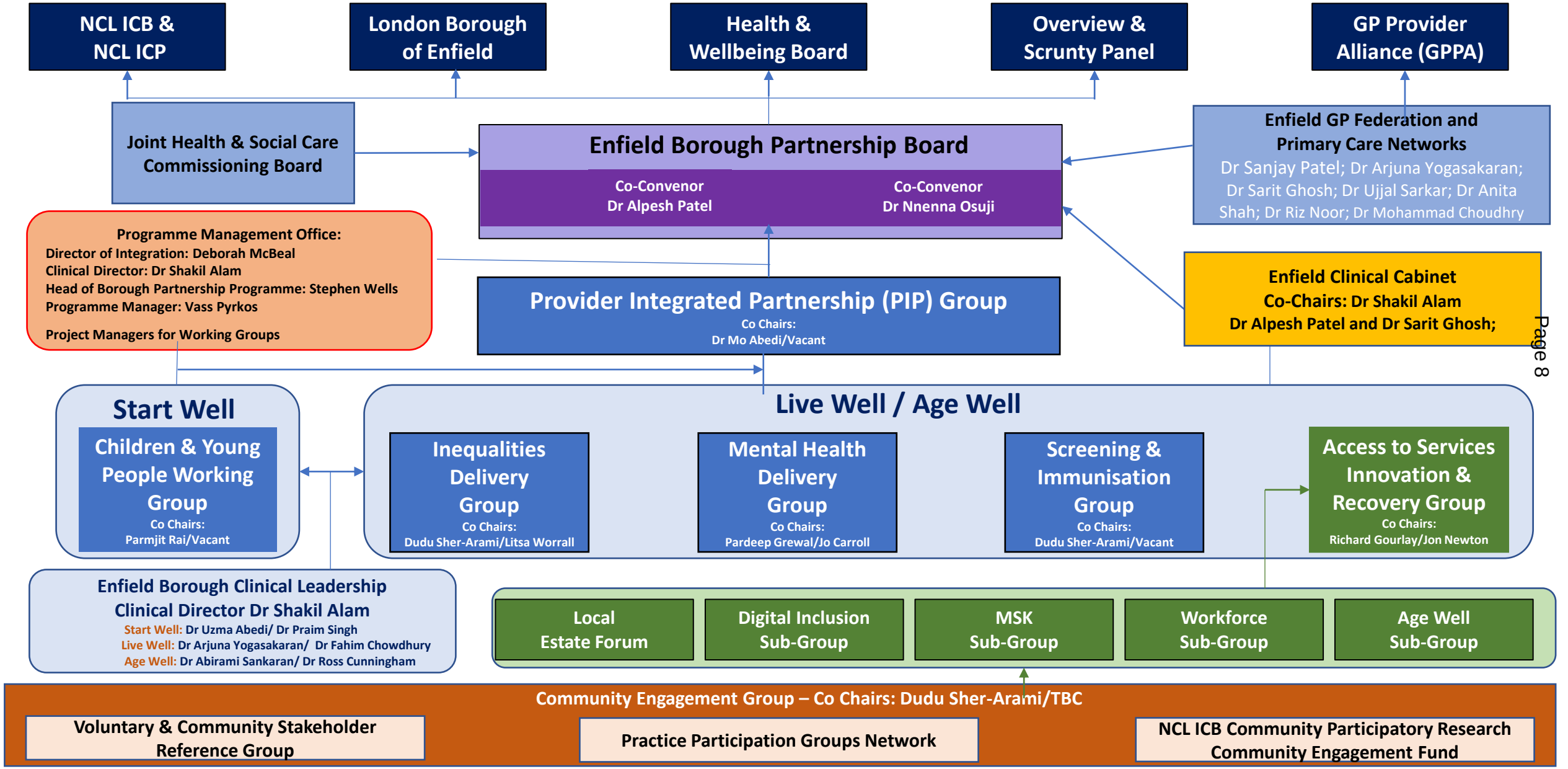
North Central London Integrated Care System

Health and Adult Social Care Scrutiny Panel

Enfield Borough Partnership Update

28th November 2023

Enfield Borough Place based Partnership - Governance structure April 2023 [Under Review]



Enfield Borough Partnership

Borough Clinical Leadership and Primary Care Clinical Cabinet

Clinical Leadership Enfield Borough

Clinical Director for Place, Enfield	**Dr Shakil Alam**
Clinical Leads for Place - Start Well / Live Well / Age Well ***[See next slide for details of the clinical lead roles]***	**Dr Uzma Abedi** **Dr Praim Singh** **Dr Fahim Chowdhury** **Dr Arjuna Yogasakaran** **Dr Abirame Sambasivan** **Dr Ross Cunningham**
Executive Director, Co-Chair, Enfield GP Federation (Co-Chair)	**Dr Alpesh Patel**
Co-Chair, Director Enfield GP Federation, Clinical Director, Enfield Unity PCN (Co Chair)	**Dr Sarit Ghosh**
Clinical Directors, Enfield Primary Care Networks (PCNs)	**Dr Sanjay Patel** **Dr Harry Grewal** **Dr Anita Shah** **Dr Sarit Ghosh** **Dr Ujjal Sarkar** **Dr Mohammad Choudhry** **Dr Riz Noor** **Dr Arjuna Yogasakaran**
Enfield GP Federation Director of Operations	**Renata Chavda**
Local Medical Committee, Enfield	**Dr Pippa Vincent**

Enfield Borough Clinical Leads – Start Wells, Live Well, Age Well

Clinical Director	Start Well	Live Well	Age Well
Dr Shakil Alam	Dr Uzma Abedi Dr Praim Singh	Dr Fahim Chowdhury Dr Arjuna Yogasakaran	Dr Abirame Sambasivan Dr Ross Cunningham

23/24 focus

- Chair ICB clinical leads monthly meetings
- ICB leadership at the Enfield primary care clinical cabinet
- Rotational chair at the Pan NCL Thursday GP webinar,
- Enfield ICB clinical representative at the Primary care clinical cabinet and the HWBB
- Enfield ICB clinical representative at the NMUH Primary & Secondary Interface Steering Group Meeting.
- Attend Clinical Directors/CMO/CNO /Deputies meetings.
- Supporting 6 Enfield clinical leads across the Start Well/ Live Well and Age well portfolios with regular touch points.
- Enfield ICB clinical representative at the Enfield Borough partnerships PIP meeting.
- Enfield ICB clinical representative at the Enfield Borough partnership meetings.
- Paediatric Low Acuity NMUH Attendance
- Supporting with Clinical DOS sign off from a clinical governance perspective for NHS 111.
- Providing Clinical leadership over the mobilisation of the NCL NHS 111 contract.

- NCL Clinical leads and Commissioners Integration Improvement
- Development of Hospital @ Home pilot
- NCL Integrated Paediatric Steering Group & Asthma Network
- Enfield Primary Care Clinical Cabinet
- Mental Health Partnership Board Steering Group & Enfield Mental Health & Children's Commissioner
- Individual Placement support (IPS) for people on the SMI QOF Register
- Enfield SEND Action Plan overview
- Enfield IPS T&F group (stakeholders from LBE, Early help, Asthma nurses, Mental health etc)
- CAMHS referral / one contact discharges.
- Enfield ASTHMA / Development of LCS
- Clinical Directors and Clinical Leaders ICB Clinical and Care Leadership
- Paediatric Low Acuity NMUH Attendance
- NCL Royal Free Interface Steering Group Meeting

- Improve patient access to PC
- Work with secondary care teams to review and manage referrals
- Clinical guidance on the Enfield Single Offer
- Contribute to planning NCL primary care development workflows obo Enfield Borough
- Chair the NCL ICP Inequalities Workshop
- Work with local trust to improving access and pathway communications and integration.
- Provide clinical advice & guidance to long-term care homes planning & implementation.
- Contribute to the development of learning needs for Enfield GPs
- Attend the NMUH Primary & Secondary Interface Steering Group Meeting
- Ensure readiness for service delivery start date of Oct 2023 by providing clinical & digital advice on: Service specifications, indicators/outcomes; Training Spec/support materials: Support GP practices in prep. period; LCS mobilisation; Development of LTC LCS GP IT infrastructure Chairing of regular NCL GP IT infrastructure meetings – bringing a wider number of stakeholders across NCL together and ensuring progression along agreed timelines

- Clinical leadership to the development of care pathways, improving clinical outcomes & service delivery; GP practice training; engage with Community Matrons; inform development of local Neighbourhood model
- Meet with the Borough Head of PC to provide programme and operational clinical updates/escalate any risks and mitigations
- Clinical leadership to the development of services for older people (incl. falls prevention; urgent care response)
- Attend ICB Frail Elderly Group and LBE older people partnership board; and meetings with Providers, Social Care and VCS partners i.e. Age UK, Dementia UK, Healthwatch Enfield
- Co-chair /clinical leadership to the NCL ICB CVD Prevent Network; and to pathway developments (Heart Failure, Cardiology, BP@Home; input to the GP website
- Attend NMUH A&E Delivery Board & HIU Users Group, and inform the clinical leadership to the ICB Urgent Care Review

Access to Services, Innovation & Recovery Working Group

Co-Chairs: Richard Gourlay, Director of Strategic Development, NMUH and Jon Newton, Director of Integration, Older People & Physical Disabilities, LBE

- To ensure access to health care, social care, and VCSE services for the residents of Enfield, engaging with all local stakeholders to inform the delivery of agreed local priorities
- Ensure we are looking at innovation and measures that support commitment to change the way we deliver services and make a real difference the patient's experience
- Ensure resident views and patients experience is feeding into the work of the group i.e. access to services, development of MSK services, etc.
- We recognise as a group we represent a range of different providers/ settings/ capacity, and we must ensure we have an open culture that builds trust, openness and respect to enable everyone to contribute, respect their and to encourage genuine contribution to shape the way we can work effectively by collaboration
- To make best use of effort, resources etc. and ensuring that each partner plays it part to maximise the success of the Borough Partnership
- To accept that each stakeholder has different drivers, targets and frameworks, and acknowledging how these can complement each other, enabling services to go forward in a different way

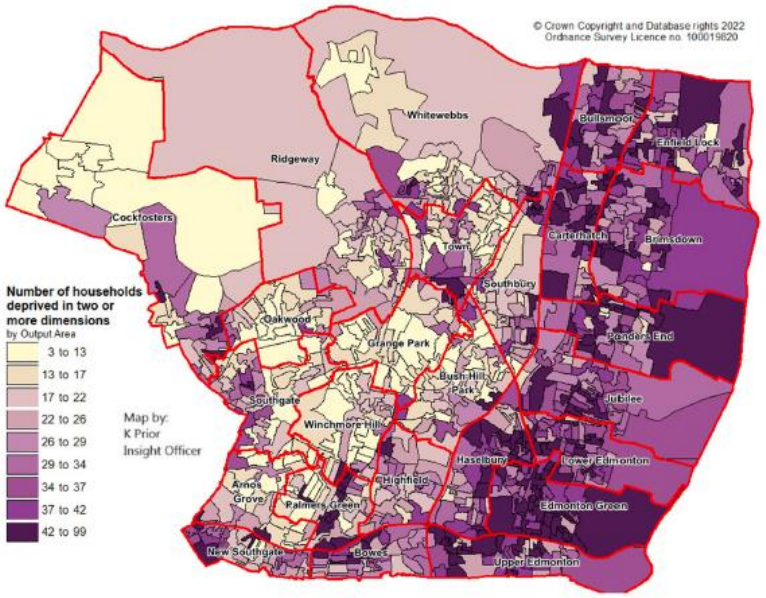
The priority areas of the group include:

- Access to services, System resilience and enhanced access (primary care)
- Development of Lifestyle Hubs (as part of joint work with LBE Public Health, RFL Public Health and the borough partnership local priorities of smoking and obesity
- MSK on the High Street – working with RNOH, to pilot an enhanced community MSK service delivered in partnership with RFL, NMUH, BEH and RNOH to improve local access by those with MSK conditions in our most deprived communities
- Review and co-develop the implementation plans following the NCL strategic services reviews of Community Services (inc. CYP) and Mental Health services reviews
- Development of Social Prescribing working with VCSE partners
- Future development of Neighbourhoods (informed by work in NCL ICB with borough partnerships, GP Fed/ PCNs).

Inequalities Delivery Group

Co-Chairs: Dudu Sher-Arami, Director of Public Health, LBE and
Litsa Worrell, Chair, Enfield PPG Network

- Enfield is a diverse borough with over 150 languages spoken and the census data 2021 has seen large increases in Albanians and Bulgarians and is now home to the largest populations nationally.
- Barnet is the 10th least deprived borough in London. This hides pockets of deprivation in the borough where around 12,000 people lived in the 20% most deprived parts of England.
- In Enfield, 28.7% of residents were estimated to be earning below the Living Wage in 2021 This was worse than the average London Borough.



Work In Progress

- 21 Inequalities Projects including community participatory research funded by NCL ICB in Enfield, in 2022/23 and 2023/24
- CORE 20 PLUS 5 –CORE 20 PLUS 5 Accelerator site (1 of 7 in England funded by NHS England and Institute of Healthcare Improvement) looking at improving the uptake of Targeted Lung Health Checks (working with NCL Cancer Alliance) in 20% most deprived areas of Enfield.
- Community Engagement - Empowering Community Engagement in Edmonton – to identify new approaches through co-production to engage with local communities and improve relationships with partner organisations and local community groups
- Neighbourhood Development – inform the work with local PCNs and GP Federation to develop a neighbourhood model that improves same day access to services and develop proactive care approaches to address health inequalities.

Enfield Inequalities Fund: List of Enfield Projects

Project number	Project title
9	Black Health Improvement Programme (BHIP)
10	Enhanced Health Management of People with Long-Term Conditions (LTC) in Deprived Communities
11	Community Hubs Outreach
12	Supporting People with Severe & Multiple Disadvantage who are High Impact Users in Healthcare Services
13	ABC Parenting Programme
14	Divert and Oppose Violence in Enfield (DOVE)
15	Smoking cessation (Enfield GP Federation)
48	Social and Emotional support to recover from the COVID pandemic
49	Addressing childhood obesity through community led activity
50	Increasing access to healthier food and financial support in community settings
51	Analysis – system costs, PH analysis
52	Diversity Living Services Programme
53	Enfield 0-2 Years' Speech and Language (SLT) Early Identification and Intervention Service
54	Interestelar Twalking Challenge
55	Enfield paediatric asthma nursing service – Healthy London Partnership asthma-friendly schools pilot
56	Community Powered Edmonton -Drop in events
57	Enfield Patient Participation Network (PPG)
59	#WhatIf Project Wellbeing Connect & Edmonton Partnership
NCL projects	
35	Enfield Homelessness LCS
36	(NCL scheme) Cancer community development project
37	Community Mentoring Programme

North Central London Integrated Care System

CORE20PLUS5 A FOCUSED APPROACH TO TACKLING HEALTH INEQUALITIES

NCL ICB Enfield Borough Partnership A Core20PLUS Accelerator Site (1 of 7 sites in England)

NHS England & Institute of Healthcare Improvement Core20Plus 5 Accelerator sites in England 2023/24:

Core20Plus Region Themes, Aims & Objectives

Cornwall	Early cancer diagnosis rates among the GRT community in Cornwall
Humber & North Yorkshire	Develop an assessment, planning and care co-ordinated model, for integrated neighbourhoods, supported by a practice culture that is teamwork orientated and person centred.
Mid & South Essex	Increase life expectancy for people with Severe Mental Illness (SMI) in South Essex
North Central London (Enfield)	To help improve early diagnosis of lung cancer by identifying key insights into the reasons for low uptake of the Targeted Lung Health Checks amongst deprived communities in Enfield by 2027, with a view to designing targeted activities, to help meet the programme's national target of 50%. This contributes towards the national ambition of diagnosing 75% of cancers at stage 1 or 2 by June 2028.
Surrey Heartlands	Increase cancer screening uptake and coverage for those with learning disabilities. Test within the cervical screening programme in the Guildford and Waverley place of Surrey Heartlands
Nottingham	Proportion of people dying early due to CVD in the most deprived areas of Nottingham and Nottinghamshire will be more similar to those in the least deprived areas
Lancashire & South Cumbria	Improve access to cancer screening and earlier care with the aim of achieving 75% of cancers identified at stage 1 and stage 2 in specified cancers by 31st October 2023.

CORE20 PLUS 5
NCL ICS Enfield Borough

Enfield Targeted Lung Health Checks: Timeline

North Central London Integrated Care System

COHORT GROUP	**Age:** 55 – 74 years	**Smoking Status:** Current & previous smokers	**Ethnicity:** Black African (Black/Caribbean), Turkish, Bulgarian, Bangladeshi	**Post Code:** From areas of greatest deprivation in Enfield (East of the Borough)

Key Note: The target cohort for the Enfield TLHC project broadly mirrors that of the similar NCL programme, so the initiatives developed as a result of the local project will likely be suitable to be upscaled pan NCL and National

1. Devise approach and agree cohort group	• Market researchers to identify volunteer participants (using social media and those signed up) • Devise the insights tests documentation (schedule and focus group questions) • Map out insights test process, draft schedule and questions for focus groups • Meet with local partners to identify cohort group	May 2023
2. Insights Test	• Undertake insights test of at least 20 participants, plus volunteers from local community, faith and Public and Patient group (5th to 19th June) • Analyse insights test, draft and share report (by end June)	June 2023
3. Solutions	• Devise solutions to incentivise cohort population uptake of TLHC (incl. forums in community/faith centres, leaflets in target languages etc.) – informed by insights test findings • Agree pilot initiatives	July 2023
4. Rollout	• Commence roll-out of initiatives to improve uptake of TLHC	August 2023
5. Impact analysis and upscale	• Undertake 3-month impact analysis of the initiatives to increase the uptake of TLHC • Identify barriers to improving care delivery in cohort population that need could be upscaled • Work with the NCL TLHC team to Identify new pathways and solutions to reducing inequalities in the cohort population for the uptake of TLHC to share at NCL and National level	October 2023
Demonstrate initial improvement in the uptake of TLHC in the cohort population		December 2023

North Central London Integrated Care System

Enfield Healthy Communities Zone

November 2023

1. Purpose of a Healthy Communities Zone (HCZ)

North Central London Integrated Care System

Aims

To build on the success of the Inequalities Fund schemes in Haringey and Enfield by the creation of a Healthy Communities Zone in wards around NMUH

- Funding: £300k across Enfield and Haringey (£150k / year / borough)

To act as a demonstrator site for the regional Anti-Racism Framework (Kevin Fenton)

To bring an equity lens to wider system performance, spend and outcomes, in order to illustrate how making health inequalities everyone's business is more cost effective for the system as a whole

To demonstrate that the involvement of local communities in identifying needs and co-designing solutions improves cost effectiveness

To act as a magnet for new investment (repurpose/ refocus / prioritise activity) and to broaden the number of stakeholders involved in promoting economic and social gain – for example through working closely with Royal Free Charity to gain input from local business and third sector organisations

To act as a delivery vehicle for the Population Health Improvement Strategy / Health and Wellbeing Strategy

Hypotheses

Impact of Community Empowerment That additional investment led to an improvement in the following:

a. Reported social connectiveness to a community
b. Being in control over your life and/or condition
c. Being better able to manage my own and my families physical and mental wellbeing

Impact on Crisis reduction That additional investment led to a reduction in the number of people from the defined community reaching crisis. This may be expressed as:

a. A&E admissions
b. A&E attendances
c. Self reported crisis

Improving planning and resource allocation A focus on the data underpinning disproportionate outcomes by deprivation and ethnicity improves system understanding and enables better planning and use of resource – e.g. system / place conversations about where resource is currently placed and how we work together to change this

To maximise limited resources there will be a focus on particular segments of the population, in particular young children, underserved ethnic communities, severe multiple disadvantage (including working age), and older people

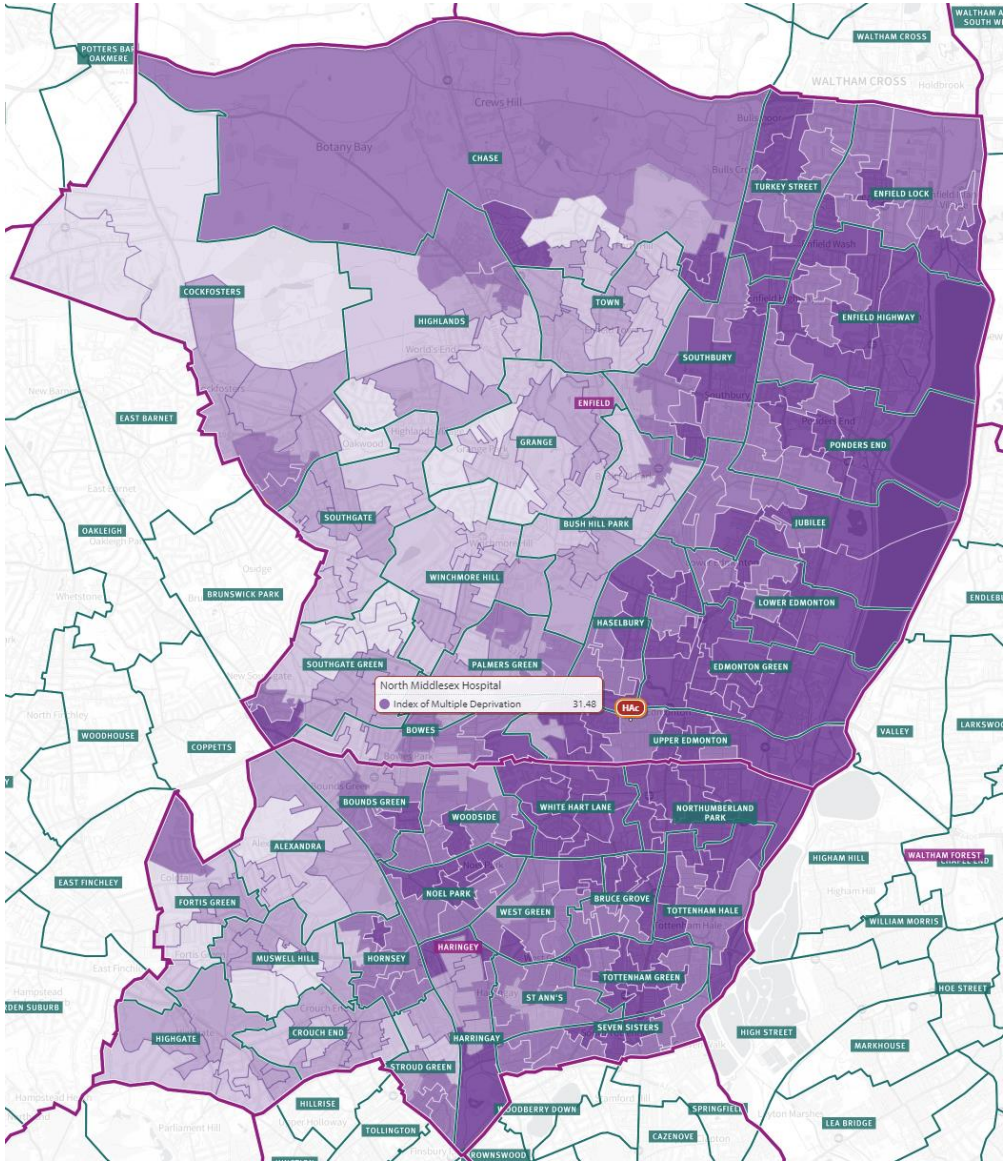
2. Healthy Community Zone Wards

North Central London Integrated Care System

Wards which are included within the Healthy Community Zones are those across Enfield and Haringey which are made up of the 20% most deprived LSOAs as defined by the IMD (2019)

Enfield
Bowes
Chase
Edmonton Green
Enfield Highway
Enfield Lock
Haselbury
Jubilee
Lower Edmonton
Ponders End
Southbury
Southgate Green
Turkey Street
Upper Edmonton

Haringey
Bounds Green
Bruce Grove
Harringay
Hornsey
Noel Park
Northumberland Park
Seven Sisters
Tottenham Green
Tottenham Hale
West Green
White Hart Lane
Woodside



3. All schemes in HCZ

North Central London Integrated Care System

- The Enfield and Haringey Healthy Community Zone consists of schemes across both boroughs which covers five health inequalities programme areas

Category	Address Wider Health Determinants	Building Community Power	Adopt Healthy Lifestyles	Health Inclusion of Vulnerable Groups	Promote Active Health Management
Aim	**Address Social Issues in Under-Served Communities** work to improve social, working & living conditions affecting health outcomes & life chances.	**Enabler to Build Social Capital** engage with people, groups & communities to 'have their say' & co-design solutions or understand their needs.	**Engaging with People to Promote Public Health** encourage people, including those at risk, to adopt behaviours to improve physical or mental health and well-being.	**Work with Vulnerable Groups in Under-Served Areas** to improve access to health and social & health outcomes and improve life changes.	**Proactive LTC Screening/Diagnosis and its Management to Avoid Crises** work with people receive early diagnosis & help with active condition management.
Example	Projects associated with preventing serious youth violence & mentoring into employment opportunities.	Examples include Community Powered Edmonton scheme; Haringey Healthy Neighbourhoods.	Projects include ABC Parenting, Somali Mental Health.	Projects which support people at risk of homelessness, those with complex multiple disadvantage, Gypsy and Traveller community, sickle cell.	In both Boroughs screening, diagnosing & helping patients with specific physical and mental health LTCs, including those in Core20Plus5

Impact Size

Likelihood of Immediate Impact on Healthcare Utilisation

Likelihood of Longer-Term **impact** on Population Health Inequalities & Future Healthcare Utilisation

Screening & Immunisation Working Group

Co-Chairs: Dudu Sher-Arami, Director of Public Health, LBE and
Riyad Karim, NCL ICB, Assistant Director of Primary Ccare (Enfield)

Ensures the delivery of adult and childhood national Immunisation programmes, in Primary Care and schools is supported, planned, monitored and evaluated in collaboration with all local partners; and local screening programmes. It supports the planning of immunisation delivery in General Practices, Schools, Pharmacies, Care Homes and other community settings; co-ordinates comms to support immunisation uptake and informs partners of the communications needed in their respective settings; and develops specific services to increase uptake amongst vulnerable and targeted population's such At Risk Groups, Over 65s and Pregnant Women.

Of note: the group carefully oversaw the rollout of COVID vaccinations, is driving and monitoring Polio, MMR and Whooping Cough vaccination campaigns. The group is actively embarking on the 23/24 winter flu planning; as well as focusing on cervical, breast cancer screening and targeted lung health checks screening (as part of the NHS England Core 20 Plus5 accelerator site). work).

Key Focus of the Group is to:

- **To improve the uptake of national cancer screening programmes and Adult and Childhood immunisations by Enfield residents**
- **Ensure we are looking at innovation and measures that support commitment to change the way we deliver services and make a real difference the patient's experience**
- **Ensure resident views and patients experience is feeding into the work of the group informed by work undertaken by other working groups**
- **We recognise as a group we represent a range of different providers/ settings/ capacity, and we must ensure we have an open culture that builds trust, openness and respect to enable everyone to contribute, respect their and to encourage genuine contribution to shape the way we can work effectively by collaboration**
- **To make best use of effort, resources etc. and ensuring that each partner plays it part to maximise the success of the Borough Partnership**
- **To accept that each stakeholder has different drivers, targets and frameworks, and acknowledging how these can complement each other, enabling services to go forward in a different way**

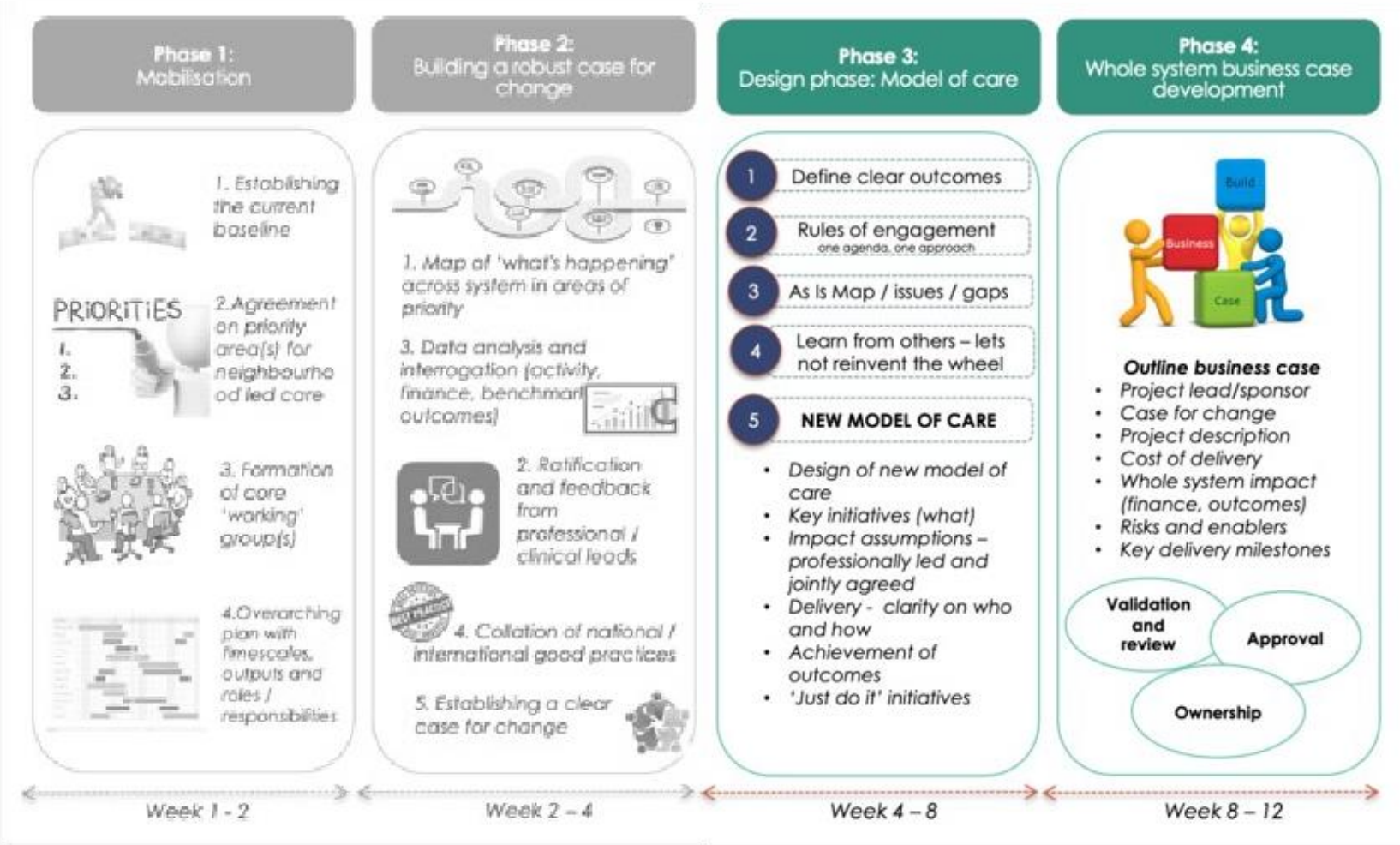
Enfield Borough Partnership

Putting Fuller into Practice
Neighbourhood Development

Roadmap to deliver the model of care

Proactive Anticipatory Care & Same Day Access

1. Co-design the model
2. Demand and capacity model to understand movement in activity and capacity
3. Trigger a business case with clear KPIs
4. Develop an implementation plan
5. Trigger quality improvement (QI) cycles



Case studies: same day access

How is the ability to access care impacting our population?

CASE	NEEDS	KEY ISSUES	HOW CAN FULLER HELP?
	**Marina, 33** - Migrated from Poland - English as second language - 3 young children - 2 year old is sick and she wants him to be seen - Can not afford OTC meds	• Likely to have 6-8 touchpoints a year • Deprivation level, digital exclusion • No network of support for reassurance • Language barrier + extended consultations • Understanding of where to access help • Positive reinforcement at UCC (meds received) • Positive reinforcement at GP (meds received)	• Utilise social prescribing and voluntary care sector for support groups in native language to reinforce good behaviours • Family hubs with health visitor, co-located near pharmacy to access appropriate care • A dedicated line to call for advice and guidance
	**Hassan, 28** - Turkish young male from high deprivation ward - Heavy smoker (20-30/day) - Has asthma & hypertension Does not attend LTC reviews - Overusing salbutamol and poor inhaler technique	• Likely to have 2-3 A&E attendances a year • Reactively seeking support for LTCs • Symptoms deteriorate before accessing primary care, poor management • Lack of understanding for proactively managing care, does not use brown inhaler • Positive reinforcement at A&E (bloods, x-rays, nebuliser vs spacer in General Practice) and relays to family and friends.	• Fuller hub means access is there, in a similar way to A&E, where you can turn up and wait • Time spent on technique and proactive management through targeted support • Education groups with similar age group and ethnicity through community-based health coaches
	**Tony, 53** - Works as a locksmith, so moving around daily - Water feels like it 'passes straight through him' so he avoids hydrating all day - Has a mark on skin he is worried is cancer	• Repeatedly told no availability, and therefore deprioritises his health • Constantly dehydrated as unable to drink water through the day, and worried about his prostate and potentially diabetes • Was told to take a picture of skin mark and send to surgery, and told it is fine • Feels lack of reassurance and nowhere to turn	• A dedicated line to call for advice and guidance to ensure better understanding of why teledermatology is a new way of working and how to re-access care if he still has concerns • A drop-in environment means that access is there and provides a face to face which in some cases is invaluable where reassurance is an underlying issue.

Case studies: proactive care

How is the the gap in proactive care impacting our population?

CASE	NEEDS	KEY ISSUES	HOW CAN FULLER HELP?

	**Joan, 77**
	- Lives alone and due to leg wound has found it more challenging to leave the house.
	- Has been ordering more magazine subscriptions which she enjoys, and are in piles across her home –which has turned into hoarding.
	- She is a diabetic and is becoming more forgetful when it comes to taking her medication, including her antibiotics.
	- She does not like to bother anyone with her problems, which then become urgent and she has to seek emergency treatment.
		• Needs multiagency multidisciplinary support.
		• Frequent infections of a leg wound in a diabetic patient, high risk of complications.
		• Hoarder, who is socially isolated.
		• Memory decline, and possible dementia.
		• Loss of trust in health professionals
		• Reactively accessing emergency care
		• Likely to need intensive social care package if she continues to decline.
			• PCN integrated teams provide relationship and continuity, including RRT and community matrons.
			• Mental Health care coordinator to build trust with Joan. She is then linked in with:
			  • Social services for hoarding
			  • Memory clinic
			  • MH support for mood.
			• Social isolation support through social prescribing to Age Concern.
			• Could have a SPA that could link into all the services that Joan will need. This will prevent future episodes, and support her wellbeing.
			• Better diabetes control via PCN & community diabetes team, and her wound heals.

	**Nigel, 65** - Afro-Caribbean - Has been urinating more at night, and felt dizzy and collapsed one night - Ended up at Chase Farm UCC where they did a urine dipstick which was clear and the patient is not diabetic. - Outcome micturition, discharged to GP - Has UTI symptoms and visits GP, where urine dipstick is clear and PSA is ordered - Nigel is diagnosed with Prostate Cancer, and he is very shocked and upset	• Is in an at-risk group for prostate cancer and could have had prostate cancer for many years with no symptoms • Is unaware of the additional risks presented by ethnicity and therefore did not request any tests • Was not proactively identified in an at risk group or asked any questions that may have supported identifying the cancer earlier	• Having mechanisms to proactively support people, beyond reactive care in vulnerable groups is very important. • Earlier identification, diagnosis planning and multidisciplinary support in a neighbourhood setting. • Information and education for at risk groups based on ethnicity via community based health coaches.

North Central London Integrated Care System

NCL Population Health & Integrated Care Strategy - Delivery Planning

Borough Partnership approach

November 2023

Start Well, Live Well, Age Well

North Central London Integrated Care System

Vision

We want our population to live better, healthier and longer, fulfilling their full potential over the course of their entire life, reducing inequalities & the gap in healthy life expectancy

Start well

Every child has the best start in life and no child is left behind

- Improved maternal health and reduced inequalities in perinatal outcomes
- Reduced inequalities in infant mortality
  Increased immunisation and newborn screening coverage
- All children are supported to have good speech, language and communication skills

All children and young people are supported to have good mental and physical health

- Early identification and proactive support for mental health conditions
- Reduced prevalence of children and young people who are overweight or obese
- Improved outcomes for children with long term conditions
- Children have improved oral health

Young people and their families are supported in their transition to adult services

- All young people and their families have a good experience of their transition to adult services

Live well

Early identification and improved care for people with mental health conditions

- Improved physical health in people with serious mental health conditions
- Reduced racial and social inequalities in mental health outcomes
- Reduced deaths by suicide

Reduced early deaths from cancer, cardiovascular disease and respiratory disease

- Reduced prevalence of key risk factors: smoking, alcohol, obesity and physical activity
- Improved air quality
- Early identification and improved treatment of cancer, diabetes, high blood pressure, cardiovascular disease and respiratory disease

Reduction in the impacts of the wider social, economic and environmental conditions and places in which people live, on people's health and wellbeing

- Reduced unemployment and increase in people working in fulfilling employment
- People live in stable and healthy accommodation and are safer within the communities in which they live

Age well

People live as healthy, independent and fulfilling lives as possible as they age

- People get timely, appropriate and integrated care when they need it and where they need it
- Prevent development of frailty with active aging
- Earlier intervention and improved care for people with dementia

People remain connected and thriving in their local communities as they age

- People have meaningful and fulfilling lives as they age
- People are informed well and can easily access support for managing financial hardship (including fuel poverty), as they age

The 20% most deprived communities in NCL.

Our child and young people (CYP) NCL communities who experience greater health inequalities and poorest outcomes.

Our five key health risk areas where we can create the biggest impact in NCL.

Deprived communities

Key communities – Adults

Key communities – Children & Young People

Wider determinants

NCL population health risks

Our adult NCL communities who experience greater health inequalities and poorest outcomes.

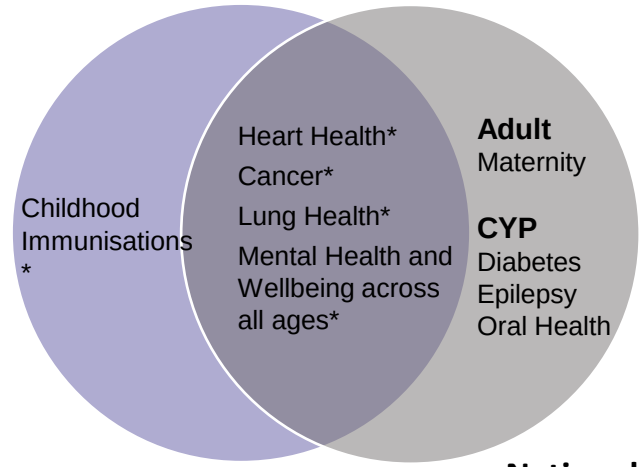
Focusing on the root causes of poor health.

PLUS priorities

- Inclusion Health Groups
- Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities
- Adults with severe mental illness and adults with learning disabilities
- Family carers
- Older adults with care and support needs
- Supporting residents at risk of hospital admission
- Supporting residents to recover following hospital admissions

PLUS priorities

- Children with Special Educational Needs and Disabilities (SEND)
- Children Looked After (CLA) and care leavers.
- Select Black, Asian and Minority Ethnic (BAME) groups experiencing inequalities
- Continuing Care for Children and Young People
- Safeguarding arrangements for designated doctors and nurses for Children and Young People



***NCL 5 population health risks**

National CORE20PLUS5 framework (not part of NCL strategy)

Opportunities for a system wide approach

North Central London Integrated Care System

Criteria for selecting opportunities:

- ✓ Where the contribution of multiple partners is important in order to achieve change
- ✓ That address a major population health challenge where there is the potential to significantly improve outcomes
- ✓ That enable the ICP to track progress, as it develops its own sense of role and purpose
- ✓ Where there is more value to doing something across NCL – this could mean:
    - Standardising pathways across boroughs/ looking at system capacity – e.g. SEND
    - Focussing on x outcome in each borough
    - Working differently in each borough, but sharing learnings – e.g. this could be helpful for CVD

Areas where current joint work could be further developed:

- SEND – access to therapies – driven by recruitment issues, but recognising existing system-wide working
- Mental Health – to share and learn, rather than standardise
- Inclusion Health (building on the findings from the Inclusion Health Needs Assessment)
- Existing ICP priorities (longer lives, heart health, family help in early years, SEND)

Further areas for consideration:

- Using the Directors of Childrens Services priorities as a starting point
- Childhood imms – sharing learning
- Focus on where our demand is as a system – LTCs are driving it, planning ahead for after embedding of LTC LCS
- Ask our providers what they would like to work on together

Opportunities for a system wide approach

North Central London Integrated Care System

The conversation also noted current "hot topics" across the 5 Borough Partnerships, which often impact day to day operational matters:

- Phlebotomy and diagnostics – non urgent blood test waits vary hugely by borough. Enablers for the LTC LCS.
- Signposting – e.g. for mental health services
- Physio and podiatry
- Sexual Health – achieving consistent provision
- Procurement & contracting being standardised and clear
- Increasing the number of health checks in community hubs

Key consideration:

- Whatever we choose to focus on, it is vital that we ask BPs who should be in the room to progress work – it is often the project champions/staff who can unblock issues

London Borough of Enfield

Report Title	Annual Adults' Statutory Complaints Report
Report to	Health & Adult Social Care Scrutiny Panel
Date of Meeting	28th November 2023
Cabinet Member	Cllr Alev Cazimoglu
Executive Director / Director	Tony Theodoulou – Executive Director, People Doug Wilson – Director of Health & Adult Social Care
Report Author	Will Wraxall – Complaints, MEQs and Corporate Functions Manager
Ward(s) affected	All wards
Classification	Part 1

Purpose of Report

1. This report presents the annual report on Adult Social Care Statutory Complaints for 2022-23, as the Council is required to publish it each year. The report provides insight into complaints received and upheld, identified themes in complaints, performance in responding promptly to complaints, and the actions proposed to improve experience for service users.

Main Considerations for the Panel

2. During 2022/23, Enfield Council received a total of 30 Adult Social Care statutory complaints. This is a decrease in volume of 18 complaints, although this is largely due to no longer processing complaints regarding financial assessments through the statutory process, following receipt of advice on the statutory remit.

3. Statutory complaint processes cover the care aspects of Adult Social Care, for which the complaints process which the Council must operate is laid out within legislation. It does not cover other aspects of adult social care work outside the process of assessing and providing care.

4. 30% of complaints were fully upheld, and 39% were partially upheld. The most common upheld elements of complaints were delays in assessment or provision, or individual case errors; the most commonly upheld service area was Older People and Physical Disabilities, although this was proportionate to the number of complaints received for that service, which serves the largest number of customers to whom statutory complaints processes would apply. The addition of upheld statistics is a new aspect of the report facilitated by new complaint management software.

5. Legislation requires that the Council respond to complaints within six months; all complaints responses achieved this. The Council has a voluntary local Key Performance Indicator (KPI) of 20 working days to respond to statutory complaints, of which 77% were achieved within the year. This is below the Council's target of 95% and was a decrease on the previous year; although for those complaints which were overdue, the extent to which the response was late, was lower than the previous year (a range of 1-16 working days late, as opposed to 1-26 in the previous year).

6. 4 complaints were investigated by the Local Government & Social Care Ombudsman of which 3 were upheld. Appendices B and C provide examples of upheld and not upheld Ombudsman decisions.

7. Key learning themes were identified as:

    a. Delays to assessments and provision
    b. Individual case errors or remedial actions
    c. Clarity of upheld points in complaint responses

    Actions are proposed in the report to address these areas and improve the quality of service and complaint responses, with the aim to further reduce incoming complaints in future.

Background and Options

8. The Council is required to publish its annual report on statutory complaints. The report provides the Council with the opportunity to reflect on complaints that have been received, and consider how the Council can further improve the experience adult social care service users get and ensure a better quality of service is delivered. The actions proposed in the report are designed to address particular areas which the Council has identified as trends in complaints.

Relevance to Council Plans and Strategies

9. The Complaints report aids in improving the service delivered to residents through the social care provision operated by the Council. It assists in

assuring that the Council's services do not merely meet statutory requirements, but are delivered in a person-centred manner, with effective, quality care and resolutions for service users.

Report Author: Will Wraxall
Complaints, MEQs and Corporate Functions
will.wraxall@enfield.gov.uk
0208 132 1426

Appendices

Appendix A – Annual Adults Statutory Complaints Report 2022-23
Appendix B – Upheld Ombudsman Complaint example
Appendix C – Not upheld Ombudsman complaint example

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Enfield Council

Adult Social Care
Statutory Complaints Annual Report

2022 - 2023

Contents

Executive Summary

Introduction

Between 1st April 2022 and 31st March 2023, Enfield Council supported nearly 4,800 clients to access long term care. We also undertook over 2,200 assessments and 3,000 reviews, supported nearly 3,200 carers and responded to over 3,500 safeguarding concerns. These statistics represent increased demand over the previous year.

Findings

During this period, the organisation received 30 complaints regarding Adult Social Care. The volume received decreased by 37.5% from 48 the previous year.

The significant decrease relates to Finance services due to changes in the Council's classification process following qualified advice on the remit of the statutory process received during 22/23. This results in financial assessment complaints now managed as corporate complaints.

The majority of complaints related to service quality and delays in assessment or provision.

14 complaints were referred by complainants to the Local Government Social Care Ombudsman (a decrease compared to the previous year's figure of 17). Of these, 4 were investigated further by the Ombudsman with 4 decisions made (3 were upheld and 1 was not upheld).

Improvement Actions

Learning from complaints received identified two key themes; delays regarding assessment and provision, and individual case errors. Additionally, a theme from the complaint responses has also been identified specifically around response quality. The Council has identified improvement actions to address these areas, including the improvement of templates and officer training.

1. Introduction

The purpose of this report is to provide an overview of complaints made about Enfield Council's Adult Social Care services during 2022-23, in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

The report provides information about all statutory complaints made between 1st April 2022 and 31st March 2023.

2. Overview of the Adult Social Care Statutory Complaints Process

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

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

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

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

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

3. Adult Social Care Service Users

In order to provide some context in relation to the complaints submitted, Enfield Council's Adult Social Care Service received over 7,280 contacts and enquiries from residents in 2022-23, alongside supporting nearly 4,800 clients to access long term care during the year. We also undertook over 2,200 assessments and 3,000 reviews, supported nearly 3,200 carers and responded to over 3,500 safeguarding concerns.

During this period:

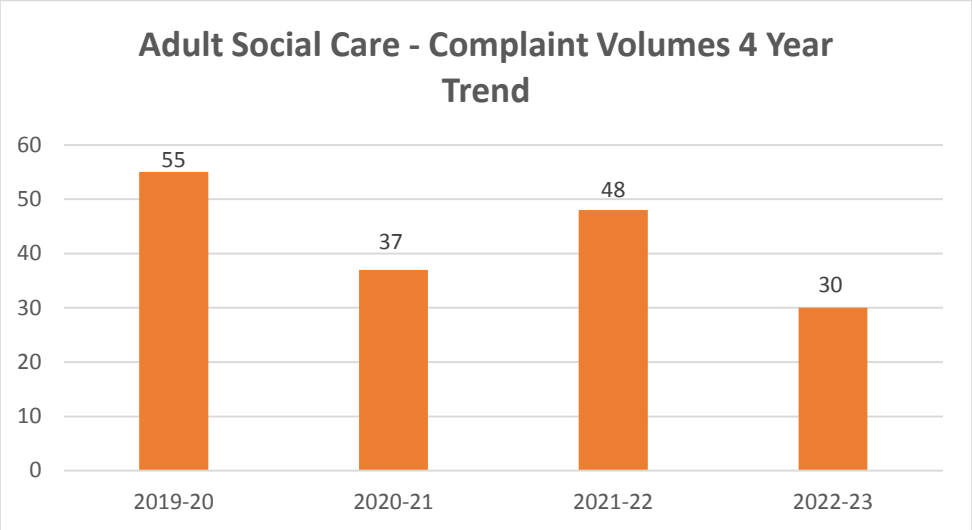
- 979 service users were assessed under the Care Act as being eligible for long term support.
- Over 10,100 pieces of equipment were provided to social care service users and over 3,680 home adaptations were undertaken.

These statistics represent increased demand over the previous year.

4. Complaints

4.1 Overview

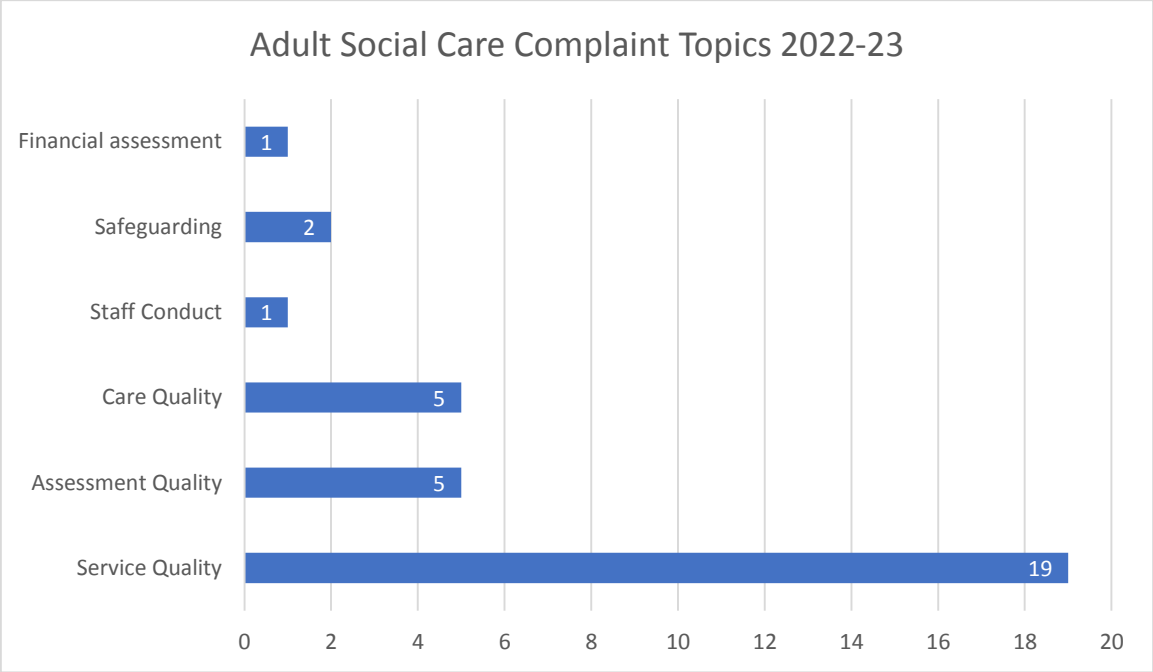
During 2022/23, Enfield Council received 30 Adult Social Care statutory complaints. This is the lowest figure across four years and represents 2% of the total number of complaints received by the Council across all corporate and statutory services during the year.



2022/23 complaints volume represents just 0.4% of the total number of contacts the service had with its customers during that year. The low complaint rate and decrease in complaints received is within the context of increased service pressures from resident demand and the ongoing staffing recruitment difficulties in adult social care.

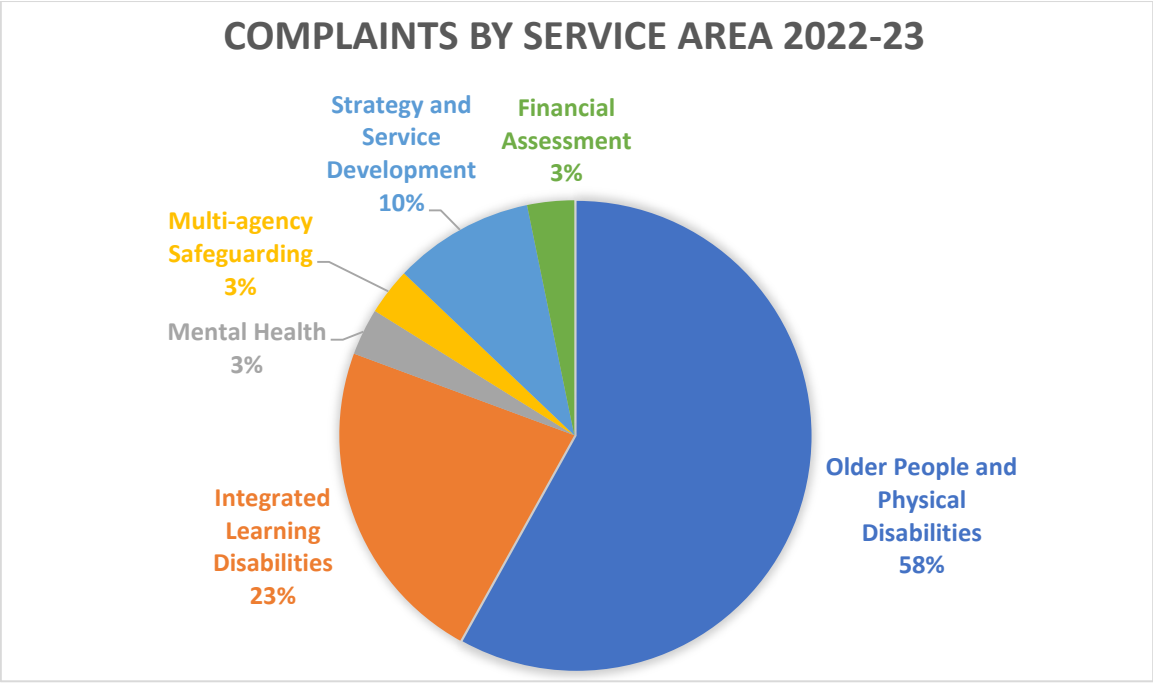
To give further context, there were 16 complaints about ASC finance activity last year as financial assessment complaints are only counted if there area other aspects of care involved in the complaint.

4.2 Nature of Complaints



The total number of topics does not match the number of complaints received, as complaints may cover more than one area. In terms of the types of complaints received during 22/23, the largest volumes related to dissatisfaction with service quality received.

4.3 Complaints by Service Area



Comparison to 21/22:

Service	2021-22	2022-23
Older People & Physical Disabilities	24	17
Integrated Learning Disabilities	3	7
Strategy and Service Development	4	3
Mental Health	0	1
Multi-Agency Safeguarding Hub (MASH)*	0	1
Finance	n/a	1

*The (Adults) MASH is located within Older People and Physical Disabilities service; however, it represents a different type of service to standard social care and occupational therapy services and is therefore represented individually within this report.

The table shows that there has been a notable decrease in complaint volumes for Older People & Physical Disabilities, followed by a slight decrease for Strategy & Development service. The Integrated Learning Disability Service have increased with marginal increases for Mental Health and MASH (multi-agency support hub).

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

The Older People and Physical Disabilities Service, as the largest service, receives the highest number of complaints. In 2022/23 complaints concerned:

- Service Quality: 10
- Assessment Quality: 2
- Care Quality: 3
- Staff Conduct:1
- Safeguarding Issues: 1

The Integrated Learning Disability Service's complaints related to

- Service quality: 3
- Assessment quality: 3
- Care quality: 1

Actions to address these themes are detailed within section 5.

4.4 Complaint Response Timescales

All complaints were responded to on time, within the statutory 6 months target as stated within regulations. With regard to the Council's voluntary local 20 working day target, 23 of the 30 (77%) received complaints were responded to within 20-days. This is a decrease on the previous year, in which 87.5% of complaints were responded to on time. However, complaints that were late in 22-23 ranged between 2 working days and 16 working days overdue, an improvement on 21-22, in which the longest complaint was 26 working days late.

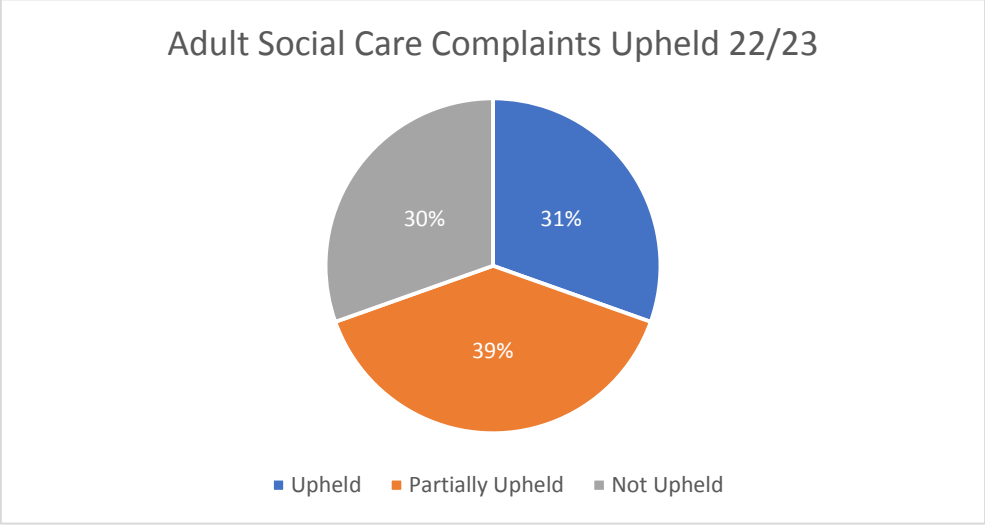
4.5 Upheld Rates

The introduction of a new case management system has allowed data capture of upheld rates, an improvement on previous years' reports. This covers complaints received since 22 June 2022, when the new case management system was introduced.

The Council has three categories:

- Upheld: all complaint points were upheld by the Council.
- Partially Upheld: some points of the complaint were upheld, but others were not.
- Not upheld: no aspect of the complaint was upheld.

The proportions of these were as follows:



This gives a fully upheld rate of 30% and a rate of complaints with at least one aspect upheld of 69%.

The upheld and partially upheld complaints occurred across services as follows:

Service	Upheld	Partially Upheld
Older People & Physical Disabilities	2	6
Integrated Learning Disabilities	3	3
Strategy & Service Development	2	0

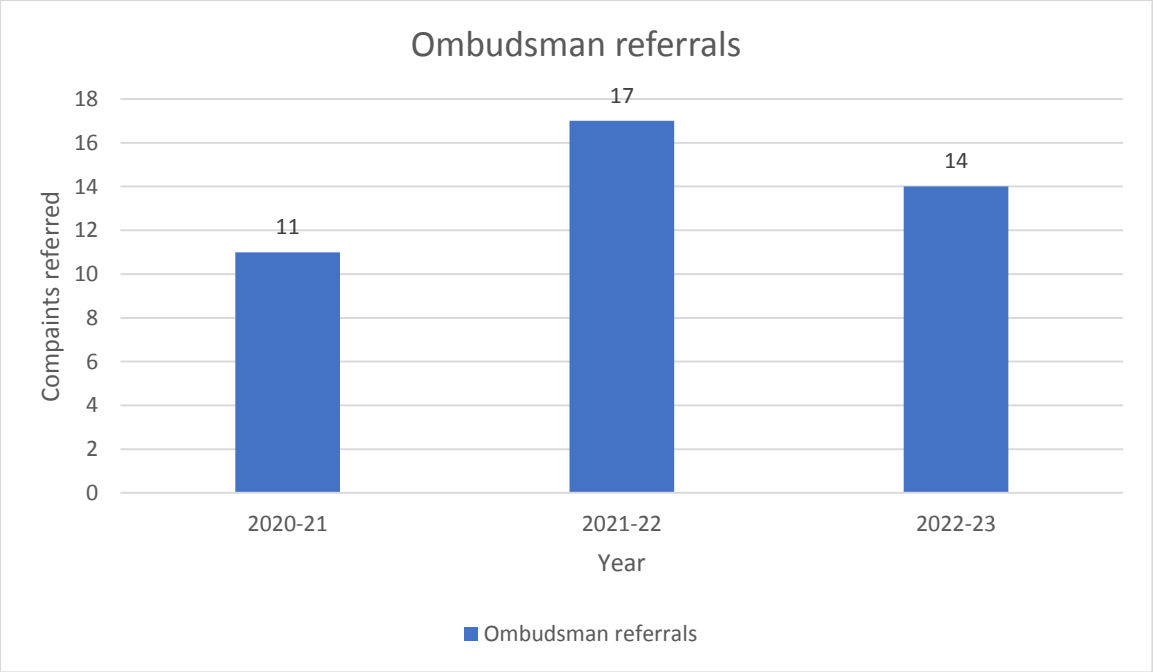
The key upheld aspects and trends observed within these complaints related to:

- Delays in assessment or service provision
- Individual errors made on cases
- Clarity of upheld complaint points

Actions to address these themes are detailed within section 5.

4.6 Ombudsman Complaints

In 2022/23, 14 complaints were referred to the Local Government & Social Care Ombudsman (LGSCO). This is a reduction from the previous year.



Upon review, the Ombudsman elected to investigate 4 of these complaints. The LGSCO can choose not to investigate for a variety of reasons. Our remaining complaints were dismissed primarily because they had not completed the Council's

internal complaint handling process, or there was insufficient evidence of fault identified by the Ombudsman.

Of the 4 investigated, LGSCO made 4 decisions.

- 1 confirmed Enfield Council was not at fault.
- 3 identified that Enfield Council was at fault due to delays in service provision or assessment.

The remedies required by the LGSCO have been apologies and compensation for inconvenience and delay. In its decisions, the LGSCO did not request that Enfield reconsider its procedures, indicating that after investigation, they were satisfied with these.

5. Learning & Improvement Themes

Learning from complaints provides valuable opportunities to gain wider understanding and ensure improvements are realised. This section outlines the improvement actions identified during 2022/23.

Learning themes arising from 2022/23 complaints (from complaints received and responses sent) fall into three main categories:

- Delays to assessments and provision
- Individual case errors or remedial actions
- Clarity of upheld points in complaint responses

Examples of improvement actions being implemented to address these are summarised below:

<u>Delays to assessment or service provision</u>

This related to delays in either the assessment for care, or for the provision of the agreed care (in the latter case sometimes due to external factors such as availability of care locally)

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

<u>Individual errors made on cases</u>

This concerned case errors resulting in inaccurate actions by the Council or delay/lack of service provision.

- There was no trend observable, these appeared to be one off errors. They were rectified as part of the complaint process.

<u>Clarifying upheld complaints</u>

Some complaint responses did not state as clearly as possible which aspects of the complaint were upheld. This reduces the quality of response for complainants, as they may be unclear what the Council's response to different aspects is and can cause confusion if complaints are escalated to the Ombudsman over whether the complaint points were upheld or not by the Council.

- The Complaints team will review templates and guidance to prompt services to clearly state which elements are upheld and will provide training sessions.

6. Compliments

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

During 2022-23, 66 compliments were logged centrally regarding Adult Social Care, an increase of 8 compared to 2021/22, and more than double the number of complaints received regarding statutory services. The majority of compliments related to members of staff.

Below are some examples of compliments received:

"More than anything, I feel like it's a safe place because you have my back and made me feel so welcome. I guess most of us feel we are imposing on others in the public outside world due to our conditions & needs but this switches that around. And that's so important! This will have such an impact in my quality of life I'm sure! My family are so happy because it means I have a safe space to be happy in and get better with different people. Can't wait to meet the other members like myself."

"Please can I take this opportunity to thank you, and your manager, for all your hard work and support with [X]. I cannot express how much of a difference you have made to [X] life, and for us as a family."

"Her return home and care package was dealt with by [X] and I cannot explain how truly grateful we all are with his help during this process. He made a very difficult time run very smoothly and explained everything to us so clearly and with such empathy and understanding of our needs.

"*I would like to pass on my thanks to the two officers who came to do the delivery and installation – they were on time, very respectful of my dad's property, were very polite and informative, showed me how to use the kit perfectly – I don't know their names but they were a pleasure to be with."*

"[X]'s communication was outstanding. Her emails were thoughtful and concise. She addressed each of my concerns and provided me with a clear idea of her next steps which was very helpful. [X] was always very quick to respond to my calls and emails. She understood the pressure the situation was causing and treated the circumstances with the urgency it deserved which I really appreciate."

"A quick note to reiterate my sincere thanks for all the support we have received from [X]. Following an adult assessment at Barnet Hospital, we were visited by [X] at home to discuss my husband's needs. Quite simply [X]'s professionalism, understanding and care shone out. He managed to secure equipment for us to improve and future proof my husband's care."

With the closure of the adult care home at St Elizabeth's, our daughter has now moved to Poppies Gardens, Ware. I cannot express how much my wife and I are pleased with this outcome we really believe she will benefit in all areas from this placement. We really are more than grateful to Enfield Council and your team for all your efforts in ensuring the move. Once again a sincere thanks to you, and every member of your team I just cannot put into words our thanks all the best to you all for the future.

"Thank you very much. I wish you all the best. You are very good with your work, and I appreciate your dedication and professionalism. Do keep it up. You are a good Advocate. Please pass on this message to your manager as a compliment."

7. Conclusion

During 1st April 2022 to 31st March 2023, over 4,800 people were supported by Adult Social Care to access long term care. Given the complex nature of this work, the number of complaints received remain low. There has been a decrease in volumes compared to the previous year both received by the Council and referred to the Ombudsman by complainants, while there has also been an increase in compliments received.

Whilst there were specific improvement actions taken at an individual level, learning from complaints demonstrates the need to ensure best practice is maintained, particularly in relation to assessment and provision delays, as well as improving the clarity of responses in stating what complaint points are upheld.

25 August 2022

Complaint reference:
21 014 334

Complaint against:
London Borough of Enfield

The Ombudsman's final decision

Summary: There was a delay in completing an occupational therapy assessment for Ms Y which caused avoidable inconvenience and frustration. The Council will apologise, make payments of £500 to Ms Y and £150 to Mr X for his avoidable time and trouble. It will also review procedures as described in this statement.

The complaint

1. Mr X complained for his relative Ms Y that London Borough of Enfield (the Council) took too long to complete an occupational therapy (OT) assessment for equipment and adaptations and did not say how long the wait for an assessment would be.
2. Mr X said this caused them avoidable distress, confusion and inconvenience.

The Ombudsman's role and powers

3. We investigate complaints of injustice caused by 'maladministration' and 'service failure'. I have used the word fault to refer to these. Service failure can happen when an organisation fails to provide a service as it should have done because of circumstances outside its control. We do not need to show any blame, intent, flawed policy or process, or bad faith by an organisation to say service failure (fault) has occurred. ***(Local Government Act 1974, sections 26(1), as amended)***
4. If we are satisfied with an organisation's actions or proposed actions, we can complete our investigation and issue a decision statement. ***(Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

5. I considered the complaint to us, the Council's response to the complaint and documents in this statement. A colleague discussed the complaint with Mr X. I interviewed a service manager responsible for the Council's OT service.
6. Mr X had an opportunity to comment on my draft decision. I considered any comments received before making a final decision.

What I found

Relevant policies, law and guidance

7. *Delivering Housing Adaptations for Disabled People (2013)* is good practice guidance which we consider when we investigate complaints about delay in dealing with requests for adaptations. It defines urgent and non-urgent adaptations (urgent ones are those needed before a person can be discharged from hospital or needed because they cannot access essential facilities). The target timescales for 95 % of non-urgent adaptations are:

- Stage 1: 20 working days from date of first contact to date of OT recommendation
- Stage 2: 50 working days from OT recommendation to approval of scheme (grant approval or issue of works order)
- Stage 3: 80 working days from approval of scheme to completion of works

(Total time from date of request to completion – 150 working days)

8. The guidance recommends councils record dates and monitor their performance.

9. I asked the Council for its policy and procedures for prioritising cases for OT assessments and for waiting times. The Council provided me with a document called '*Single Point of Access and Locality Team Roles and Responsibilities.'* This does not give any information about how to prioritise urgent versus non-urgent cases for assessment for adaptations or give any timeframes. The Council told me the target time for the Housing Adaptations Team, which is responsible for major adaptations like walk-in shower rooms, was four to six months from the date of receiving the referral from the OT.

What happened

10. Ms Y is disabled. She lives at home with her family and does not have any funded care arranged by the Council.

11. There is a record of a phone call between Mr X and an officer about Ms Y's difficulties accessing the entrance door at the start of September 2021. The social care team placed Ms Y's case on a waiting list for an OT assessment.

12. Mr X chased the Council up at the end of September and in November he made a formal complaint. The Council's response said there was a waiting list but did not say how long it was. It also explained it had accidentally created two files for Ms Y and this caused some confusion. It has now closed one of the files.

13. Mr X complained to us in January 2022.

14. An OT assessed Ms Y in February. The outcome was Ms Y needed a level access shower, a grab rail in the existing shower and a ramp to the main entrance door.

15. The Council told me the following actions had been completed:

- It installed a grab rail in February
- It made a referral to the NHS physiotherapy service in March
- It ordered a flexi ramp to assist Ms Y to get in and out of the house
- Its OT completed an assessment for a level access shower and funding was being considered under the Disabled Facilities Grant scheme.

16. The Council told me Ms Y's case was not an urgent one, but because of the lost time due to errors in recording, it would treat the case as a priority.

17. A service manager told me there was a national shortage of OTs and the Council was operating at 40% capacity for the last three years. She said there was a permanent advert, but there had not been any applications. The service manager also went on to explain the Council was reviewing procedures to get a better overview of priority versus non-priority cases and work had been started on a letter to send to all cases at first point of contact. This letter would set out approximate waiting times.

18. The service manager also explained:

- Ms Y's case was complex because of the configuration and layout of her bedroom and ensuite and the front access was also complicated because of pipes.
- There needed to be two visits by an OT and the company which made the ramp making the assessment process a complex one
- The service manager confirmed the ramp had been installed to the front entrance door since I started investigating the complaint and funding had been agreed for a walk-in shower which would involve increasing the ensuite space.

Findings

19. The Council was at fault in record keeping because it held two cases for the same person. This caused avoidable confusion and delay.

20. The Council was also at fault for not meeting the target timescales specified in good practice guidance (see paragraph seven). I have taken into account Ms Y's case was a complex one. I note also the timescales in guidance are targets and the guidance is not statutory. But we do take them into account as a reference point when considering complaints about delay. I consider the delay caused avoidable inconvenience and frustration.

21. There was also poor communication by the Council in its complaint response which was fault causing Mr X avoidable frustration because he did not get an answer when he asked how long the wait for OT assessments was. I consider the Council should communicate rough timescales for OT assessments and the failure to do so in this case was fault. I note the good practice guidance is not mandatory and so the Council is not required to use the timescales within it, but the Council should be able to tell members of the public approximately how long they will have to wait for an OT assessment.

22. I note the reason for the delay in this case was also in part due to a shortage of OTs which is not within the Council's control. The Council is taking all the steps it can to address this through recruitment.

Agreed action

23. Within one month of my final decision, the Council will apologise to Mr X and Ms Y, pay Ms Y £500 to reflect the avoidable inconvenience and frustration due to the delay in the OT assessment and pay Mr X £150 to reflect his avoidable time and trouble complaining.

24. Provisionally, within three months of my final decision, the Council will:

- Complete the work it has started on reviewing its policy and procedures so they explain priorities and what an urgent and non-urgent adaptation is and set out

some target timescales, having regard to the good practice guidance. (I am not saying the Council has to follow the timescales in good practice guidance, it just needs to consider them and set its own achievable target timescales based on currently available staffing resources.)

- Ensure people who have requested an OT assessment receive a letter confirming they are on the waiting list and an approximate time frame for completion of the assessment

25. We will require evidence of compliance.

Final decision

26. There was a delay in completing an occupational therapy assessment for Ms Y which caused avoidable inconvenience and a delay in installing her walk-in shower. The Council will apologise, make payments of £500 to Ms Y for avoidable inconvenience and £150 to Mr X for his time and trouble. The Council will revise its procedures as set out in this statement.

27. I have completed the investigation.

Investigator's so decision on behalf of the Ombudsman

Local Government & Social Care OMBUDSMAN

7 November 2022

Complaint reference:
22 009 693

Complaint against:
London Borough of Enfield

The Ombudsman's final decision

Summary: We will not investigate this complaint about a member of staff from a care provider being rude during a telephone call. There is insufficient evidence of fault to justify investigation.

The complaint

1. Mrs X complained a member of staff from a Care Provider was rude during a telephone call and did not properly explain how invoices were processed. Due to this, Mrs X says she had to stop her mother's service temporarily. Mrs X provided care during this time, causing her inconvenience. Mrs X wants an apology.

The Ombudsman's role and powers

2. The Ombudsman investigates complaints about 'maladministration' and 'service failure', which we call 'fault'. We must also consider whether any fault has had an adverse impact on the person making the complaint, which we call 'injustice'. We provide a free service, but must use public money carefully. We do not start or may decide not to continue with an investigation if we decide there is not enough evidence of fault to justify investigating. ***(Local Government Act 1974, section 24A(6))***

How I considered this complaint

3. I considered information provided by the complainant.
4. I considered the Ombudsman's Assessment Code.

My assessment

5. Mrs X complains about a telephone call with a Care Provider, during which she says a member of staff was rude and unhelpful. She is otherwise happy with the service the Care Provider has given her mother. It is not in the public interest to investigate this isolated incident. We could not come to sound conclusions about any fault by the Care Provider, because tone of voice is subjective and both parties' version of events could reasonably be argued.

Final decision

6. We will not investigate Mrs X's complaint because there is insufficient evidence of fault to justify an investigation.

Investigator's decision on behalf of the Ombudsman

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London Borough of Enfield

Report title	**Health Visiting, Breastfeeding and Women's Health (Screening)**
Report to	Health and Adult Social Care Scrutiny Panel
Date	Tuesday 28th November 2023
Cabinet member	Councillor Cazimoglu
Executive Director and Director	Tony Theodoulou (Executive Director – People) Dudu Sher-Arami (Director of Public Health)
Report authors	Andrew Lawrence (Head of Commissioning – CYP & Public Health) andrew.lawrence@enfield.gov.uk Gabriella Sarpong (Public Health Strategist) gabriella.sarpong@enfield.gov.uk Dr Chad Byworth (Public Health Registrar) chad.byworth@enfield.gov.uk Fanta Bojang (Programme Lead – NCL Cancer Alliance) fanta.bojang@nhs.net Ekta Patel (Senior Project Manager (Cancer prevention, awareness & screening) – NCL Cancer Alliance) ekta.patel9@nhs.net
Ward(s) affected	All
Classification	Part 1 – Public
Reason for exemption	Not applicable

1. Purpose of report

1. To provide an overview of service developments and performance within the Enfield Health Visiting Service.
2. To provide an update on activity to improve breastfeeding rates among Enfield residents.
3. To highlight uptake of women's health (breast and cervical) screening programmes and activity to increase uptake.

2. Relevance to the Council Plan

This work contributes to achieving two of the five priorities:

- Strong, healthy and safe communities.
- Thriving children and young people.

3. Main considerations for the panel

1. To note the current arrangements for health visiting, the impact of COVID-19 and actions leading to recovery of service performance, and the financial context for future service provision.
2. To note the up-and-coming development regarding provision to support breastfeeding through the Children and Family Hubs.
3. To note that Enfield is, broadly, the best performing of the North Central London (NCL) boroughs with regards to cervical and breast screening uptake and the forthcoming programme of work by the NCL Cancer Alliance that aims to (1) reduce inequalities in uptake and (2) improve overall performance which currently lags the England average.

4. Health Visiting

4.1. Overview of the service

The Health Visiting Service is provided by North Middlesex University Hospital Trust (NMUH) as part of the 0-19 Healthy Child Service, which includes School Nursing (for mainstream schools) and is part of a Section 75 agreement.

Delivering against a nationally agreed service specification, with local need and demographics being taken into account, the service must provide as a minimum:

- Antenatal contact
- New birth visit by 14 days
- 6-8 week check
- 8-12 month check
- 2-2.5 year check.

4.2. Overview of the service

The service transferred to the current provider in October 2020 and experienced challenges to provision due to the national COVID-19 infection prevention and control restrictions, which limited face-to-face contact, restricted clinical session size and moved all services to an appointment only model. Since the lifting of restrictions – which for NHS-provided services was as late as April 2022, with national guidance requiring a return to more traditional delivery models by September 2022 – the service has developed, resulting in performance improvements.

Work to develop the service has included:

- Increasing the number of community sites for the delivery of Healthy Child Clinics and one-to-one appointments.
- Ensuring families are invited to a check within the permitted timeframe (for example, if a child receives their 6-8 week check at 8 weeks and 1 day they are not counted in the national metrics).
- Delivery of catch-up clinics including a clinic on Saturday mornings.
- Use of bank staff to temporarily fill vacancies.
- Implementation of RiO, a dedicated patient database that is owned by NMUH allowing the Trust to improve data quality and accuracy.
- Engagement with national programmes to increase the number of public health nurses by offering training and student placements.

- A skill mix model, which uses a range of nursing and non-nursing roles to improve value for money and helps to alleviate current challenges in recruiting to nursing posts.

4.3. Performance

As a result of the various changes that commissioners have put in place, working collaboratively with the service provider, the following key improvements have been seen:

- New birth visits continue to remain at 97%, which is higher than the NCL average of 89.2%.
- 6-8 week checks, which had dipped to 55% at the end of March 2022, have steadily improved, averaging 69.5% for Q1 2023/24. This is now close to the national average of 69.6%.
- Improved data collection shows that the 69.5% of 6-8 week checks recorded in national metrics related to checks carried out by 8 weeks. If this window is increased to 10 weeks, the average for the same period improves to 81.9%. Work is therefore ongoing to increase the number of people seen within the 6-8 week timeframe.
- 8-12 month checks, which had dipped to 16% at the end of March 2022, have improved to 58% by July 2023. Again, if the window is extended to 15 months, this figure rises to 89%.
- 2-2.5 year checks have improved from a low point of 36% at the end of March 2022 to 74% as of July 2023.
- Attendance at Healthy Child Clinics (drop-in clinics for parents offering child weight checks and an opportunity to speak to a member of the Health Visiting Service) has improved from 2,857 at the end of March 2022 to 5,900 at the end of March 2023. Projections based on data captured in Q1 2023/24 suggests that attendance by March 2024 can be expected to reach between 8,000 to 9,000.

4.4. Financial considerations

Enfield's Health Visiting cost per capita (£51.45) is ranked 11th out of the 16 local authorities for which these costs could be calculated. When compared to NCL, Enfield has the second lowest cost per capita for the 0-19 Service as a whole. This is against the backdrop of Enfield being the second most deprived of the NCL boroughs using the Income Deprivation Affecting Children Index (IDACI) 2019.

This, combined with annual Public Health Grant increases well below the level of inflation, continues to provide a significant challenge and will be a key factor affecting service delivery going forward.

5. Breastfeeding

5.1. Benefits of breastfeeding

The World Health Organization and the National Institute for Health and Care Excellence (NICE) recommend exclusive breastfeeding for the first six months of life, yet in England only 1% of babies continue to be exclusively breastfed until that age. Comparing internationally, England has one of the lowest breastfeeding rates in Europe.

UNICEF states that work to support breastfeeding is based on extensive and resounding evidence that breastfeeding saves lives, improves health and cuts costs. Benefits to breastfeeding include:

- Infant Health – protects infants from a range of illnesses including infections, diabetes, asthma, heart disease, obesity, otitis media (an infection of the middle ear), necrotising enterocolitis (a serious and potentially fatal illness that involves inflammation of the bowel – it can require surgery) as well as hospital readmission.
- Maternal Health – a strengthened maternal-infant relationship and improved mental health of both, alongside reductions in the risk of breast cancer, ovarian cancer, osteoporosis (a reduction in bone strength in older age that increases the risk of fractures), obesity and cardiovascular disease.

There are also significant cost savings associated with breastfeeding, both to the individual as well as to the health system. UNICEF[1] state that even moderate increases in breastfeeding would translate into cost savings for the NHS of up to £50 million and tens of thousands fewer hospital admissions and GP consultations.

Despite the benefits, inequalities still exist. The NCL Breastfeeding Gap Analysis states, *"Young, low-income mothers and those living in deprived areas are the least likely to breastfeed, so improving breastfeeding rates in these groups in particular should form part of the overall NCL plan for reducing inequalities."*

5.2. Breastfeeding statistics and activities

In 2021-22 (most recent published data), 49.2% of babies in England, 54.3% in London, 53.9% in NCL and 48.9% in Enfield were fully or partially breastfed at 6-8 weeks. This is very low compared to rates in other European countries but has been increasing nationally since 2015.

A gap analysis was undertaken across NCL which generated 48 recommendations and the following feedback from families as to the barriers to breastfeeding:

- Lack of expert help with initiating and maintaining breastfeeding.
- Lack of consistent advice and correct information provided
- Avoidable re-admissions to hospital are often due to feeding issues
- There is a need for more accessible community-based breastfeeding support

There is significant activity to increase breastfeeding rates in Enfield alongside hospital provision to support infant feeding[2] including breastfeeding.

Enfield is one of 75 local authorities in receipt of grant funding (Department of Education) as part of the Family Hubs and Start for Life Programme, to establish Family Hubs within the borough and develop and embed Enfield's core 'Start for Life' service offer.

The Infant Feeding strand of the programme includes developing Enfield's Infant Feeding support system and service offer for parents and carers across the borough, so that it reflects the needs of the local community, and mothers and families receive seamless and consistent support throughout their infant feeding journey.

[1] UNICEF UK (2012) 'Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK'

[2] Infant feeding support is the support provided to parents that encompasses breastfeeding, expressed breastmilk, formula feeding and starting solids.

An *Infant Feeding Strategic and Training* Lead post has been created to develop a local infant feeding strategy and plan, ensuring:

- There is a joined-up approach across services and organisations with clear referral pathways.
- That services are tailored to Enfield's local communities and targeted support is available for those who need it.
- The infant feeding workforce is well-trained and supervised and has the capacity and capability to provide high-quality care.

Additionally, an *Infant Feeding Multidisciplinary Task and Finish Group* has been established, to deliver the breastfeeding support activities outlined in Table 1.

Table 1 – Breastfeeding support activities

Activity	Status
Deliver breastfeeding support from Enfield's Youth and Family Hubs	In place
Establish a breastfeeding peer support service	In progress
Establish a breastfeeding equipment loan service	In progress
Create welcoming, safe, and secure breastfeeding spaces within our Family Hubs network and across the borough, for mothers to breastfeed and meet other breastfeeding parents, with access to relevant health professionals	In progress
Develop and maintain Enfield's breastfeeding digital and physical leaflet offer	In place
Achieve UNICEF BFI accredited status at our Youth and Family Hubs and Children Centres	In progress
Improve and standardise data recording	In place but being refined

The *Infant Feeding Multidisciplinary Task and Finish Group* will also support Maternity Services to maintain UNICEF Baby Friendly accreditation as well as establish a Breastfeeding Friendly Programme in the Borough.

6. Women's health[3] (screening)

6.1. What is screening?

Screening is a healthcare process that attempts to identify apparently healthy people (that is individuals with no symptoms of a disease) who are at high risk of the disease. Screening is disease specific and uses investigations (or tests) to identify early markers of a disease process so that treatment can be started before symptoms present – the aim is to treat disease before it becomes more serious or more difficult to treat. Screening can be targeted based on individual factors (such as the presence of a precursor disease, for example diabetes) or population factors (such as age or sex). Any screening programme must balance the potential benefits against the potential harms, for more information on this please see Appendix 1.

[3] For ease of reading, and because it mirrors how automatic invitations for the programmes are generated, this report will use the terminology women/female. However, it is important to recognise that women's health screening programmes are also used by non-binary and transgender people and the specific challenges faced by these groups in accessing the programmes are discussed within the report at section 6.5.

6.2. Specific women's health screening programmes

There are three national screening programmes that are specific to females:

- Cervical screening (previously known as a "smear test"),
- Breast screening,
- Screening tests in pregnancy.

This report will detail cervical and breast screening.

Cervical screening

Cervical screening aims to identify individuals at high risk of cervical cancer. It is automatically offered to all females aged 25 to 64, screening occurs every 3 years for individuals aged 25 to 49, and thereafter every 5 years until age 64.

Cervical screening involves taking a small sample of cervical cells using a soft brush. These are then tested for a virus known as Human Papillomavirus (HPV) – more than 95% of all cases of cervical cancer are caused by HPV infection. If the sample is HPV negative the individual is assessed as low risk. If the sample is HPV positive then the individual is assessed as high risk and is offered further tests to assess for cancer.

Cervical screening is highly effective and using HPV testing it is possible to identify abnormal cells before they have become cancerous – this enables monitoring or early treatment. It is estimated that cervical screening currently prevents 70% of deaths from cervical cancer and this figure could be 83% if all eligible people attended screening.[4]

Breast screening

Breast screening aims to identify individuals with early signs of breast cancer. It is automatically offered to all females from the age of 50 up until their 71st birthday, screening occurs every 3 years.

Breast screening involves mammography, this is a series of X-rays of the breasts (two for each breast). The X-rays are then assessed by a specialist who looks for features suggestive of breast cancer – this process is in part subjective and there is variability in image interpretation. Individuals who are assessed as having features suggestive of breast cancer are offered further investigation.

The evidence of effectiveness for breast screening is less clear cut and for some the programme is contentious. However, a large UK meta-analysis by an independent panel has concluded the benefits outweigh harms[5] – see Appendix 1 for more information.

6.3. Delivery of women's health screening programmes

Invitations to NHS screening programmes are centrally managed.

Cervical screening

The administration of cervical screening invitations and results is managed by NHS Digital. Cervical screening is typically delivered by the individual's registered GP

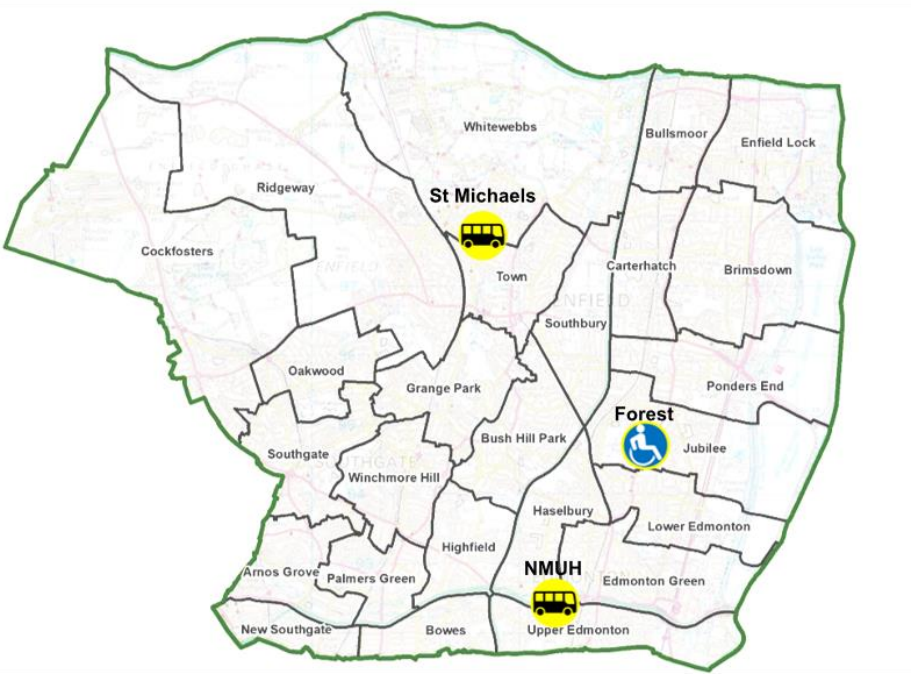
[4] Landy R and others (2016) 'Impact of cervical screening on cervical cancer mortality: estimation using stage-specific results from a nested case–control study'
[5] Independent UK Panel on Breast Cancer Screening (2012) 'The benefits and harms of breast cancer screening: an independent review'

practice. At some sites in England it is also possible to access cervical screening via sexual health clinics, however, this is not routinely offered by the provider in Enfield.

Breast screening

The administration of breast screening invites and results is carried out by the administration hub. The service is delivered by Royal Free London NHS Foundation Trust on behalf of all London breast screening services. Breast screening within Enfield is delivered by the North London Breast Screening Service which is also managed by the Royal London NHS Foundation Trust. The service provides screening at the following locations in Enfield: Forest Primary Care Centre (wheelchair accessible), North Middlesex Hospital (mobile van), St Michaels Primary Care Centre (mobile van) – these are depicted in Figure 1.

Figure 1 – The location of mammography sites in Enfield[6]



6.4. Local performance[7]

On the following pages, Figures 2, 3 and 4 depict the coverage (in percent) for cervical screening (aged 25 to 49), cervical screening (aged 50 to 64) and breast screening (aged 50 to 70) respectively. Coverage is the proportion of eligible women who underwent a screening examination within the screening interval – either the last 3.5 years, 5.5 years or 3 years respectively. The year indicates the end of the relevant financial year, for example 2022 is the financial year 2021-22.

Cervical screening

Cervical screening performance is lower amongst people aged 25-49 years compared to those aged 50-64 as shown in Figures 2 and 3. This trend is seen nationally as well as in Enfield. Additionally, there has been a gradual decline in coverage for over a decade. The coverage target of 80% is not met in Enfield however when compared to the NCL average, participation is higher in the borough. The

[6] Base-map courtesy of The Local Government Boundary Commission for England
[7] Performance data via Office for Health Improvement and Disparities 'Fingertips' tool

reasons for low coverage are multi-factorial; research studies and feedback from services cite the following as some of the common reasons for lack of participation:

- Fear and embarrassment of the test
- Lack of access to convenient appointments
- Lack of understanding of the importance of screening
- Misunderstanding of HPV
- Screening not prioritised due to busy lifestyles
- Prior uncomfortable or painful experience of the test

Figure 2 – Cervical screening coverage (aged 25 to 49)

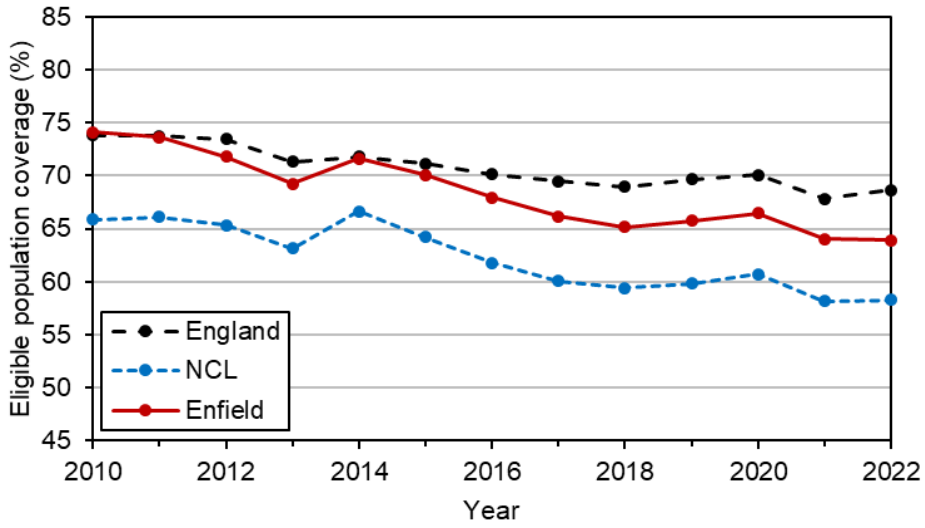
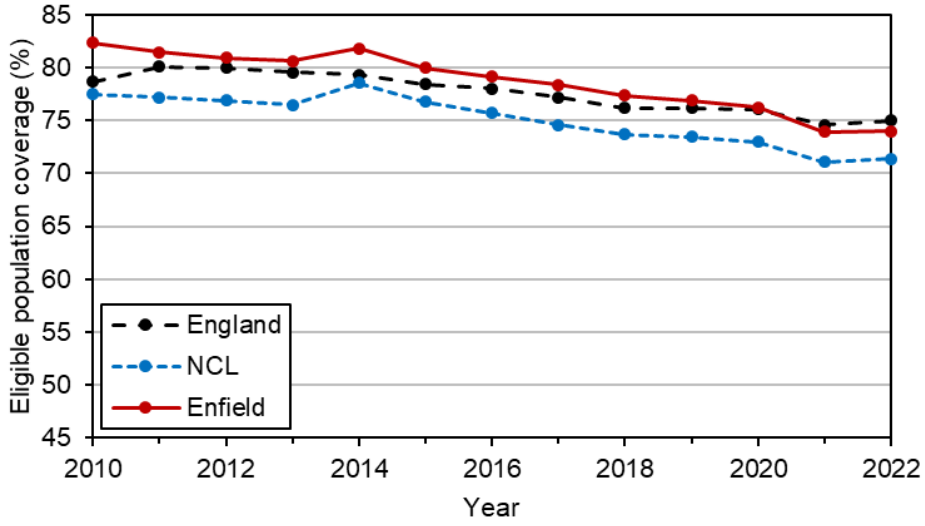


Figure 3 – Cervical screening coverage (aged 50 to 64)



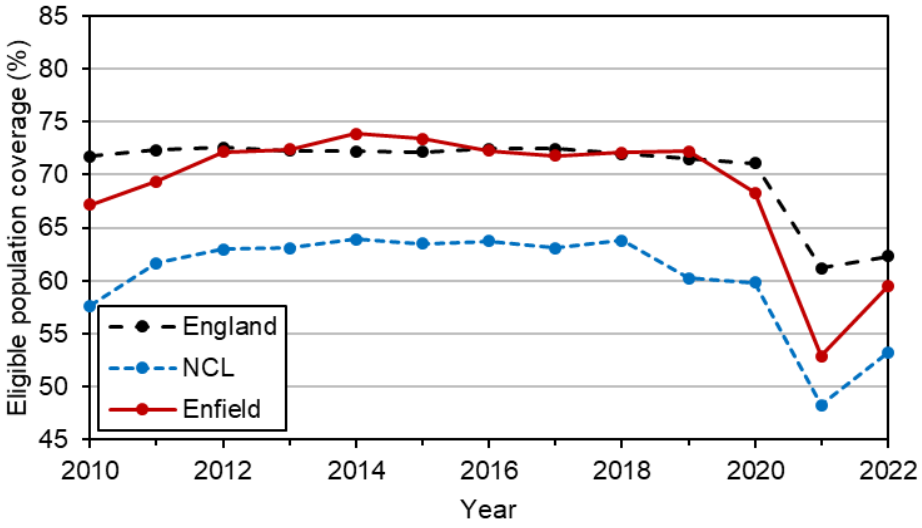
Breast screening

Breast screening performance is measured by two statistical measures, “uptake” and “coverage”. To enable comparison against cervical screening this report uses coverage as defined above.

Breast screening coverage in Enfield is below the national target of 80% however, performance is higher than the NCL average as shown in Figure 4. A large decline in

coverage was seen due to the impact of the pandemic however, this is gradually improving as the breast screening service has fully recovered. Processes are being implemented by the screening provider to continue to improve coverage, address health inequalities and build better resilience in the service.

Figure 4 – Breast screening coverage (aged 50 to 70)



Performance by ward

Table 2 and Figures 5, 6 and 7 below depict the coverage by ward for the financial year 2021-22. These figures have been calculated by the Enfield Public Health team using the following methodology:

1. Data detailing screening programme coverage by GP practice is available,
2. Individual GP practices were assigned to a ward using the practice address,
3. A ward screening programme coverage rate was calculated from the rates of all the GP practices within the ward boundary (excluding Medicus Health Partners).

Some wards do not contain a GP practice and so a figure was not calculated. Practice boundaries are not coterminous with ward boundaries and many practices (which are depicted as grey dots in Figures 5, 6 and 7) sit close to ward boundaries and will thus serve patients within multiple wards. As such, these figures should be considered as approximate figures for the ward and neighbouring wards. They are provided to highlight geographic disparities in the uptake of the screening programmes using the best available data but should not be considered as reflective of the exact population coverage within any one ward.

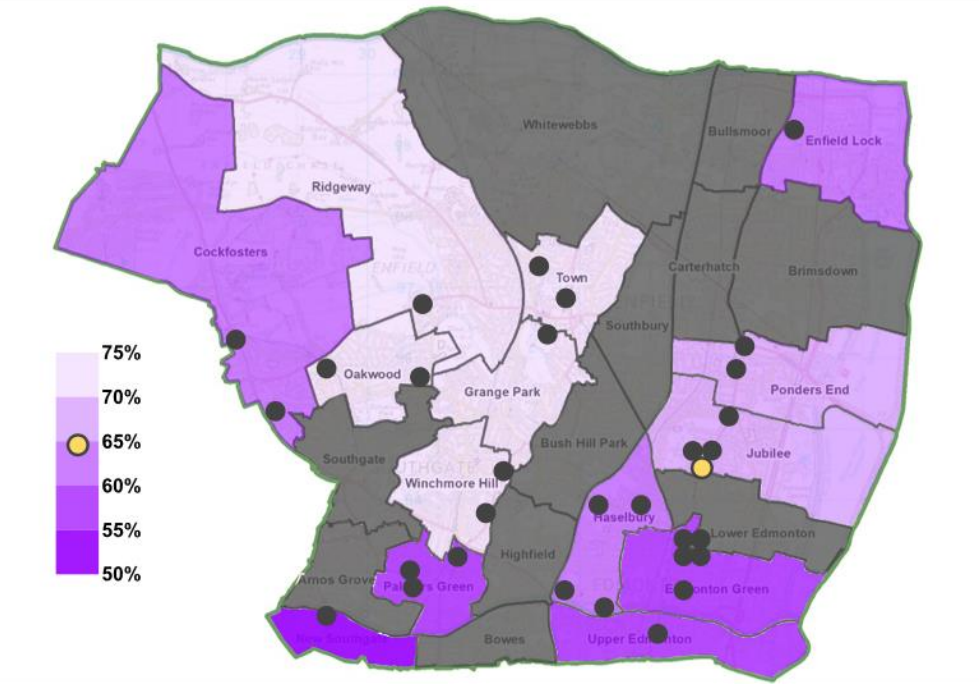
Medicus Health Partners is a conglomerate of 12 “sub-practices” across the eastern half of the borough. However, coverage rates are only available for the whole conglomerate. As such, Medicus Health has been included separately and is depicted as a yellow dot (at the primary site in Jubilee) in Figures 5, 6 and 7.

Table 2 - Coverage of women's health screening programmes by ward (2021-22), figures highlighted (*) are the lowest and highest rates within the programme

Ward	Coverage of eligible population (%)		
	Cervical Screening (aged 25 to 49)	Cervical Screening (aged 50 to 64)	Breast Screening (aged 50 to 70)
Cockfosters	64	71	56
Edmonton Green	58	71	56
Enfield Lock	62	70	**39***
Grange Park	71	77	60
Haselbury	65	76	56
Jubilee	69	**82***	58
New Southgate	**53***	**58***	47
Oakwood	72	77	49
Palmers Green	59	69	55
Ponders End	70	77	44
Ridgeway	71	78	**68***
Town	**74***	78	66
Upper Edmonton	59	71	54
Winchmore Hill	**74***	78	**68***
Medicus Health	67	75	56

In the following figures[8] the coverage rate is indicated using shades of purple, the darker the shade the worse the coverage – note the scale varies slightly between figures. Wards that have not had a rate calculated are greyed out. Individual GP practices are indicated with grey dots except for Medicus Health Partners which is indicated using a yellow dot (on the scale to indicate the Medicus Health Partners rate and on the map to indicate the primary address in Jubilee).

Figure 5 – Cervical screening coverage (aged 25 to 49) by ward (2021-22)



[8] Base-map courtesy of The Local Government Boundary Commission for England

Figure 6 – Cervical screening coverage (aged 50 to 64) by ward (2021-22)

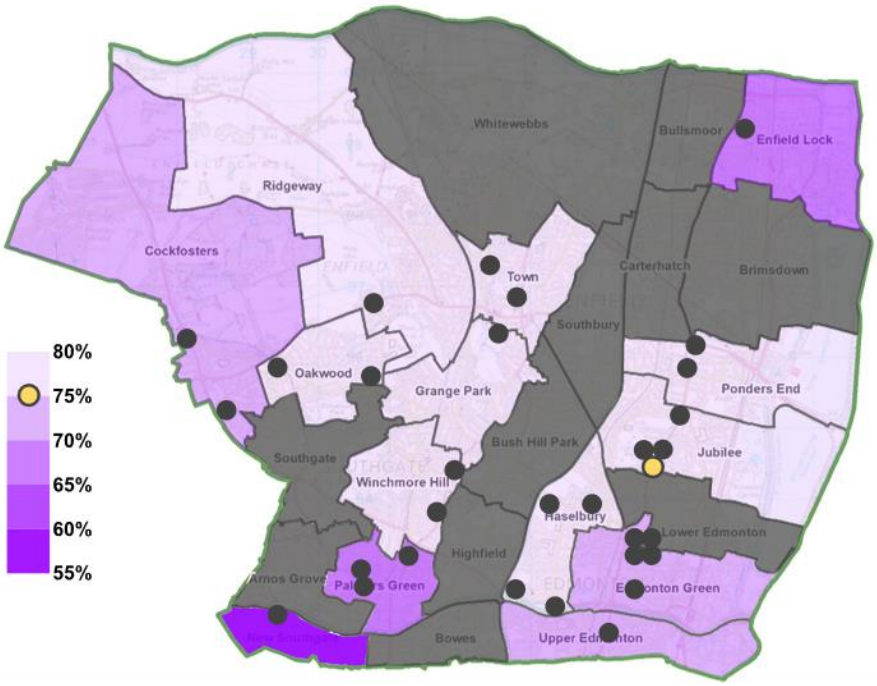
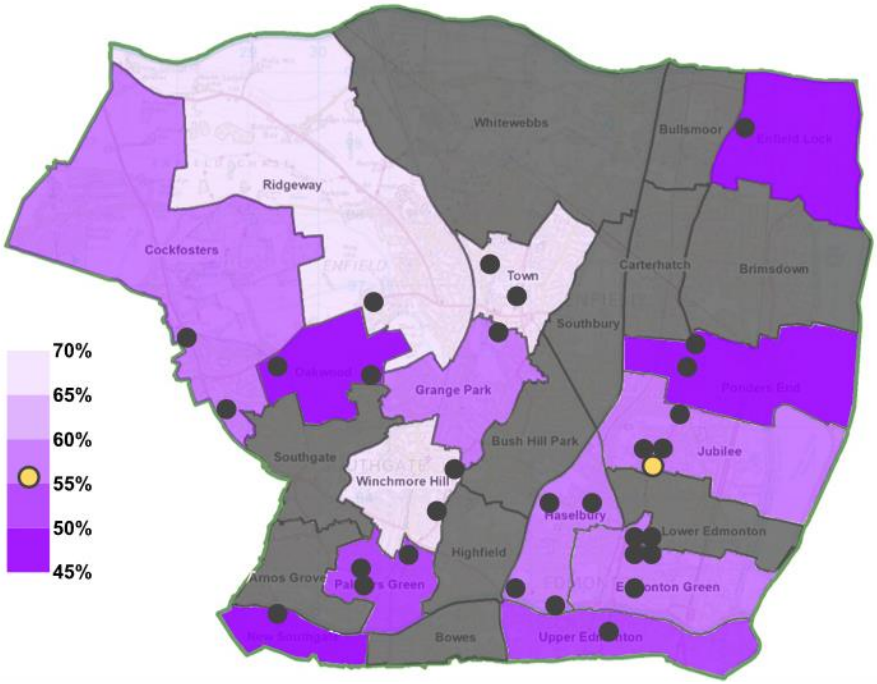


Figure 7 – Breast screening coverage (aged 50 to 70) by ward (2021-22)



6.5. Inequalities in women's health screening programmes

Inequalities in uptake

National evidence tells us there are many inequalities in the uptake of women's health screening programmes:

- People with learning disabilities – uptake is lower for both cervical and breast screening amongst people with learning disabilities. In 2014-15 coverage for cervical screening amongst people with learning disabilities was 30.2% compared

to 73.5% for all females aged 25 to 64 years; for breast screening coverage was 54.5% for people with learning disabilities aged 65 to 69 versus 73.7% amongst people in the wider population.[9]

- People living with severe mental illness – uptake is lower for cervical screening amongst women aged 45 to 64 (20% more likely not to participate) as well as for breast screening (18% more likely not to participate).[10]
- Socioeconomic deprivation – women from more deprived groups are less likely to attend cervical or breast screening when compared to women from less deprived groups but are more likely to die from both cervical and breast cancer.[11]
- Ethnicity – Women from ethnic minority groups are less likely than white women to attend cervical screening (white women are 2.2 times more likely to attend than women from non-white ethnic groups). For some groups the disparity is even worse, Bangladeshi women are 12.86 times less likely to attend than white women.[10]
- Social marginalisation – socially marginalised groups (for example, people who are homeless, from Gypsy/Roma/Traveller backgrounds, or work as sex workers), frequently experience multiple barriers in accessing care.[12]

Evidence based measures to increase uptake

Evidence suggests the following interventions are effective at increasing uptake:[13]

- Reminder messages that include a timed appointment,
- GP letters for non-responders,
- For cervical screening – HPV home self-test kits (these are currently under trial at sites in England including within Barnet, Camden and Islington between January and December 2021).

Specific considerations for non-binary and transgender people

There are a number of considerations for non-binary and transgender people with regards women's health screening programmes:

- Invitations to the screening programmes are generated using the sex recorded within the GP practice's electronic patient record system. Where this sex differs from the patient's sex at birth (for example, a patient was born female but has since registered as male), there is no mechanism for indicating this. As such, trans-men who have changed the sex recorded at their GP practice to male will not receive automatic invites to women's health screening programmes and will need to request an invite should they wish to undergo screening.
- Trans-men should consider cervical screening unless they have undergone total hysterectomy. Trans-men should consider breast screening unless they have undergone double mastectomy with no residual breast tissue. If they have residual breast tissue, depending on the volume of tissue this may or may not be amenable to mammography and there is currently no alternative screening programme if mammography is not possible.

[9] NHS Digital (2016) 'Health and Care of People with Learning Disabilities'
[10] Public Health England (2021) 'Severe mental illness (SMI): inequalities in cancer screening uptake report'
[11] Public Health England (2020) 'PHE Screening inequalities strategy'
[12] Public Health England (2021) 'Inclusion Health: applying All Our Health'
[13] Office for Health Improvement and Disparities (2022) 'Population screening: review of interventions to improve participation among underserved groups'

- Trans-women who take hormone therapy will have an increased risk of breast cancer compared to cis-men and should consider breast screening. If they have registered as female with their GP practice then they will receive an automatic invite; if they have registered as male, they will need to request an invite. Trans-women do not require cervical screening.

6.6. Strategy to improve cancer screening participation

This year, a strategy was developed for NCL by the NCL Cancer Alliance which focuses on delivering work to improve cancer prevention, increase the public's knowledge of key cancer signs and symptoms to encourage earlier presentation to primary care, and drive higher participation in the screening programmes. A summary of the strategy is provided in Appendix 2.

Delivery of the strategy will help contribute to the NHS Long Term Plan ambition of diagnosing 75% of cancers at an earlier stage, when the chances of successful treatment are higher. For cervical cancer, the strategy will take forward work in three areas – supporting the adoption and roll out of HPV self-sampling in the screening programme, increasing uptake of HPV vaccinations amongst school-aged children, and supporting changes to the programme where frequency of screening will be adjusted for some people.

Work on breast cancer will focus on engaging non-responders to encourage screening attendance, develop champions in local areas to target and encourage communities with low screening participation to engage, and work to improve screening records in primary care to enable better identification and targeting of non-responders. Additionally, national and regional screening campaigns will be amplified locally to further reach the diverse Enfield population. This will be done primarily through working with VCS organisations and community pharmacies as well as other local partners.

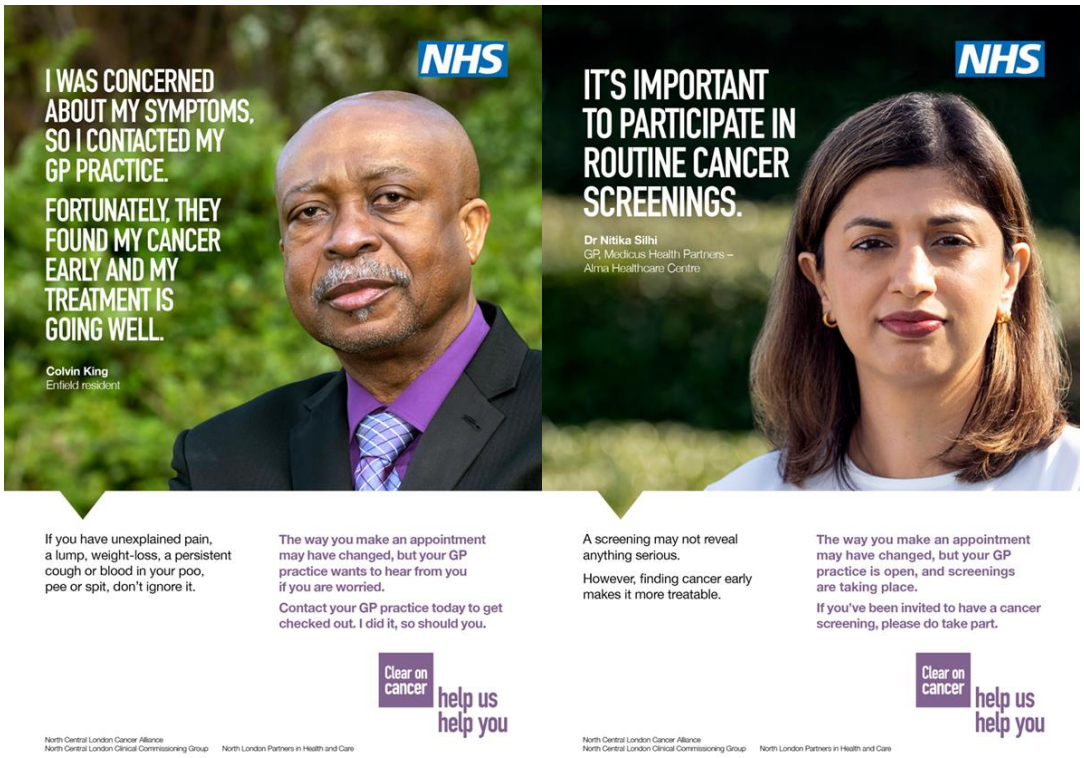
In addition to interventions that will be launched to deliver the strategy, below are examples of some current activities that are being delivered regionally by NHSE London screening team or locally by Enfield Council, NCL Cancer Alliance and primary care:

- Cervical screening text message reminders – a text message reminder is sent to all individuals two weeks after their invitation letter is issued if they are yet to book and attend an appointment for their screen.
- Follow-up of non-responders – GP practices are incentivised through their primary care contracts to identify their patients that have missed their cervical screen, and book them in to attend.
- Sample taker training – NCL Cancer Alliance is working with the NCL Training Hub and primary care, to identify and train staff to carry out cervical screening. This will help increase capacity to carry out more screens in GP practices.
- Cervical screening in sexual health clinics – NHSE London is continuing to work with sexual health providers to increase the number of cervical screens they are able to offer.
- Follow-up of breast screening non-responders – the North London Breast Screening Service has been provided additional funding to pro-actively follow-up people that did not attend their appointment and re-book them.
- Supporting people with a learning disability – North London Breast Screening Service is working with the Enfield community learning disability team and GP

practices, to identify and provide additional support to individuals to attend their screening appointment.

- Supporting people experiencing homelessness – screening providers, Enfield GP practices and the Enfield GP Federation are working to implement reasonable adjustments to better support those experiencing homelessness to attend their screen.
- Awareness raising activities – Enfield Council Public Health and Communications teams continue to adapt screening campaign materials, and work with local organisations to disseminate messages across multiple platforms and networks.

Figure 8 – Example NHS NCL Cancer Alliance posters featuring Enfield residents[14]



[14] NCL "small c" campaign: www.smallc.org.uk/get-involved/ncl-cancer-awareness-campaign/

London Borough of Enfield

Report title	**Health Visiting, Breastfeeding and Women's Health (Screening)** **Appendix 1 – Balancing the benefits and harms of screening**

Because investigations are never 100% effective there are three risks associated with screening programmes. First, there is the risk of a "false negative" – this is where the test indicates low risk but the individual subsequently develops the disease. This can cause harm because the individual may be falsely reassured by the screening test and ignore subsequent symptoms of disease.

The second risk is the risk of a "false positive" – this is where the screening test indicates high risk but the individual does not have a disease. Although the individual does not have the disease they are still at risk of harm. Alongside the psychological harm associated with worrying about a potentially serious illness there is also the risk of physical harm from follow-up investigations that attempt to confirm the screening result.

Finally, a similar risk exists for individuals who would have only developed a mild or nonprogressive case of the disease which would never have caused them symptoms or harm but who are identified by screening. This is known as overdiagnosis and is depicted in Figure 1A. Screening tests cannot predict the likelihood that an early case of a disease is likely to progress or not and most people opt for further investigations and treatment. For individuals with mild disease this can lead to unnecessary treatment (overtreatment), which again comes with the risk of psychological and physical harms.

Because of these risks it is important that screening programmes are only implemented when there is good evidence that the benefits of screening outweigh the potential harms. This requires, amongst other things, a disease process that has an early asymptomatic stage, an investigation that minimises both "false negatives" and "false positives", an investigation that is tolerable to the population, and an effective treatment for the disease.

In the UK, all NHS screening programmes are evaluated and approved by the UK National Screening Committee which applies a modified version of a set of medical criteria known as the Wilson and Jungner criteria. These criteria (of which some examples are given above) list the important factors that must be considered to ensure a screening programme is effective. Figure 2A depicts the assessment of this balancing for breast screening using the best available evidence.

Figure 1A – Screening and the relationship with cancers of varying aggressiveness[1]

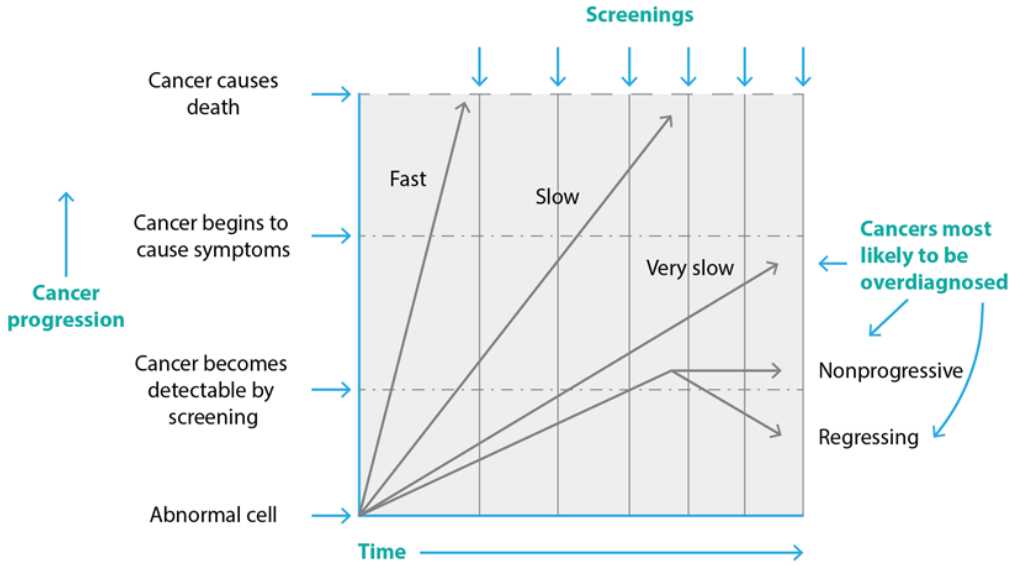
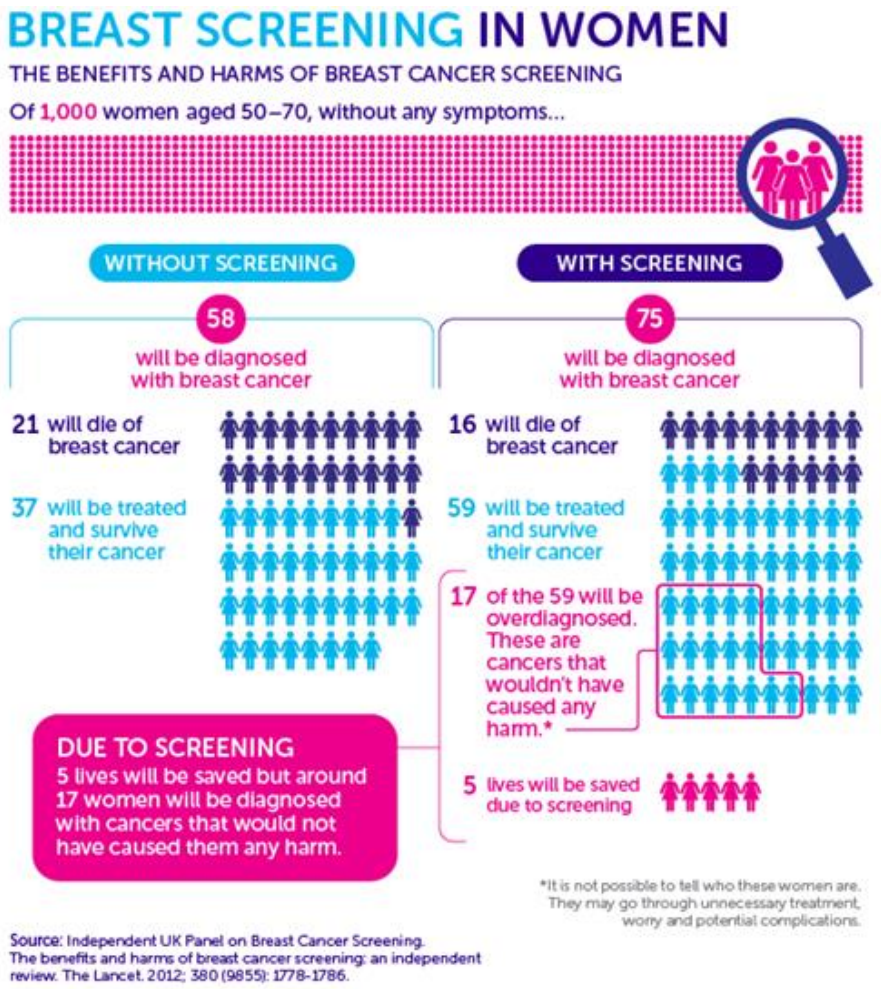


Figure 2A – The benefits and harms of breast cancer screening[2]



[1] Carter SM, Barratt A (2017) '[What is overdiagnosis and why should we take it seriously in cancer screening?]' Public Health Research & Practice

[2] Cancer Research UK (2018) '[Overdiagnosis: when finding cancer can do more harm than good]'

North Central London Integrated Care System

NHS

North Central London Cancer Prevention, Awareness and Screening

Strategy summary 2023-28

Introduction

The cancer prevention, awareness and screening strategy was first drafted in 2019/20 by North Central London Cancer Alliance and its partners to set the direction and priorities for North Central London (NCL) on these topics.

We are now well into delivery of the strategy and it is being refreshed to align with the evolving health and care landscape, to reflect the current status of services and impact of the pandemic and to draw on learning from work already delivered. This summary document outlines the key areas of focus. The action plan is detailed in the full version of the strategy.

This updated strategy and action plan provides health, social care and community organisations across NCL, who are working to improve the earlier diagnosis of cancer, with information to inform the design and delivery of initiatives.

The overall aim of the strategy continues to be supporting delivery of the NHS Long Term Plan cancer ambitions by 2028 as well as that of the NCL cancer system - **diagnosing 75% of cancers at stage 1 and 2** and for each year, **55,000 more people to survive for five years** or more following a cancer diagnosis.

The 2019 NHS Long Term Plan sets out two ambitions for cancer by 2028

75%
people with cancer will be diagnosed at **stage 1 and 2**

55,000
more people to survive **5+ years**

Our objectives are informed by the modelling carried out by NHS England and Cancer Research UK, which estimates the impact on early diagnosis rates of relevant interventions. Additionally, latest data and progress on delivery of the strategy, further informs our aims and objectives for the next five years.

Whilst the strategy focuses on prevention, awareness and screening, we recognise a need for alignment with interventions that identify people with an increased risk of cancer, as they are closely linked to the screening programmes or target a similar demographic. These include liver cancer case finding and surveillance and Lynch Syndrome testing and surveillance.

...we recognise a need for alignment with interventions that identify people with an increased risk of cancer

Context

Population profile

North Central London has a diverse population.

About 60% of residents in NCL come from White ethnic backgrounds, about 20% Asian and 20% Black. Barnet and Camden have larger Asian communities, whereas Haringey and Enfield have larger Black communities.

Ethnicity

60% White

20% Asian

20% Black

There is a high level of population health need and inequalities across NCL. People living in the most deprived areas are more likely to be diagnosed with cancer, and at a later stage of disease for some types of cancers.

1.8 million
residents live in NCL

5 boroughs

Barnet
Camden
Enfield
Haringey
Islington

200,000
people living with a disability

25% of people do not have English as their main language

Cancer incidence

North Central London in 2020/21

297 new cancer cases per **100,00**

England in 2020/21

456 new cancer cases per **100,000**

Cancer diagnosis

North Central London in 2021/22

2,784 new cancer cases referred through the urgent suspected cancer pathway

983 emergency presentations

Cancer mortality

Cancer causes about than **1 in 4** of all deaths in the UK. **NCL (22.6%)** has a lower mortality rate when compared to **England (24.3%)** in 2021.

Cancer screening

Bowel screening

In 2022, the coverage in NCL was below the England average 70.3%, ranging from **57% in Camden** to **63.5% in Enfield**.

Breast screening

In 2022, the highest breast screening coverage rates were in **61.9% in Barnet** and the lowest were **46.9% in Islington**. Levels of coverage across all NCL boroughs were significantly lower than the England average of 64.9%.

Cervical screening

Screening coverage is lower amongst 25-49 year olds compared to 50-64 year olds. In 2022, **Enfield 63.9%** and **Haringey 59.4%** had the highest coverage in the 25-49 age group, which was above the London average 53.9%.

74% in Enfield and **71.2% Haringey** also had the highest coverage in the 50-64 age group.

Targeted Lung Health Checks

The NCL lung health checks programme is still at an early stage. **Uptake is around 30%,** which is below the national average and target of **50%**.

Context

Prevention

- In NCL, **smoking prevalence is 11.4%**, which is similar to the London average and below the England average.
- About **1 in 2 adults have excess weight** in NCL.
- There is an **increased rate of alcohol consumption** in NCL since the COVID-19 pandemic.

Awareness of cancer

Between 2018 and 2020, the **Cancer Awareness Measure Survey** was carried out to gain local insights on the public's awareness, to inform improvement initiatives.

4,755 respondents completed the survey and their awareness of key themes is shown opposite.

Respondents were aware of the following signs and symptoms of cancer

(Order: most recognised to least recognised)

- A lump / mole
- Change in weight/unexplained
- Weight loss
- Persistent cough
- Change in bowel habits
- Difficulty in swallowing
- Pain
- Bleeding
- Tiredness/fatigue
- Unhealed sore

Respondents recalled the following as causes of cancer

(Order: most recognised to least recognised)

- Smoking
- Eating processed foods/ not enough fruit and vegetables
- Age
- Being overweight
- Alcohol
- Infection with genital warts

Respondents provided their preferred method of engagement/how to access information

(Order: most preferred to least preferred):

- Social Media
- Posters at GP or pharmacy
- Face to face
- Public transport
- Council newsletter/website
- Through the door
- Community centres
- Magazines
- Radio
- YouTube

Our aims over the next five years

NEXT 5 YEARS

Prevention

- Develop a **new universal smoking cessation** offer for inpatients.
- Work to **minimise the impact of alcohol** on the most vulnerable in our communities.
- Develop and embed a standardised **Making Every Contact Count (MECC)** approach across the system.
- Develop a **new in-house support offer for expectant mothers**, and their partners.
- Enhance the **weight management service provision** to support more people.

Population awareness

- Develop and deliver activities that **drive timely presentation to the health system** when people have worrying symptoms.
- **Improve awareness of cancer signs** and symptoms across NCL.
- **Reduce inequalities in awareness** of cancer signs and symptoms between different population groups.
- **Embed cancer awareness** raising as part of our work and future strategies that get developed.

Screening

- **Increase participation in the bowel, breast and cervical screening programmes** towards the national targets and closer to the national average.
- **Reduce inequalities in uptake of screening** across NCL particularly amongst groups that have lower participation rates..
- **Adapt screening improvement activities** in line with national and regional work to meet local needs.
- **Fully roll out the Targeted Lung Health Checks** programme and increase participation to achieve the national target.
- Support the creation of greater alignment between **identification of people with an increased risk of cancer** and surveillance services, and relevant screening programmes.

Our objectives

The objectives focus mostly on population awareness and screening.

Objectives relating to prevention cut across multiple areas and are captured in other ICS plans. Working to address health inequalities is an important thread that runs through the objectives identified.

1. **Engage PCNs with low screening uptake** to improve patient participation
2. **Augment national and regional campaigns** and utilise community engagement and social media platforms
3. **Incorporate cancer awareness education** in the prevention programme
4. **Improve screening participation** for people experiencing homelessness
5. **Improve screening awareness** for people with severe mental illness and for mental health teams
6. **Include cancer screening as part of annual health checks** for people with a learning disability
7. **Support bowel screening age extension** to ensure good uptake in younger age cohort
8. **Support integration of Lynch Syndrome pathway** into the bowel screening programme
9. **Support introduction of risk stratification** within the bowel screening programme
10. **Support lowering of the bowel screening test threshold** to identify more early-stage cancers
11. **Support implementation of a reminder system** to improve uptake of breast screening
12. **Develop a network of champions** to target population cohorts with lower breast screening uptake
13. **Create a paper light breast screening pathway** through regional collaboration
14. **Support adoption and roll-out of HPV self-sampling** within the cervical screening programme
15. **Increase uptake of the HPV vaccine** amongst school-aged children
16. **Support implementation of extension of screening recall** frequency for cervical screening
17. **Expand delivery of the Targeted Lung Health Checks** programme to invite everyone that is eligible to participate.
18. **Support over 50% of the invited population** to attend a lung health check
19. **Increase uptake of lung health checks** amongst people living in deprived areas and other populations not taking up their invites

addressing health inequalities runs through all our objectives identified

To view the full version of the

NCL Cancer Prevention, Awareness and Screening strategy and action plan

visit

www.nclcanceralliance.nhs.uk

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London Borough of Enfield

HASC Scrutiny Report

28th of November 2023

Subject: Update report on 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 development of the Self-Assessment document and supporting evidence for Adult Social Care. 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.

Background

0. 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 sets out legislative proposals for a health and care Bill. The White Paper brings 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 proposes introducing 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.

1. CQC's new responsibilities under the Health and Care Act 2022 are twofold. Firstly, there will be a role in reviewing Integrated care Systems 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.

2. 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

3. Emerging CQC scope for reviews of Adult Social Care has started to be shared. It is apparent that the initial focus on Local Authorities Adult Social Care functions will be across the following four key themes.

   - **Working with People**
     - Assessing Needs
     - Supporting People to live healthier lives
     - Equity in Experience and Outcomes

   - **Providing support**
     - Care Provision, Integration and continuity
     - Partnerships and communities

   - **Ensuring Safety**
     - Safe systems, pathways and transitions
     - Safeguarding

   - **Leadership and Workforces**
     - Learning, improvement and innovation
     - Workforce equality, diversity and inclusion

4. CQC will use a variety of methods to evidence a Council's Adult Social Care functions as follows:

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

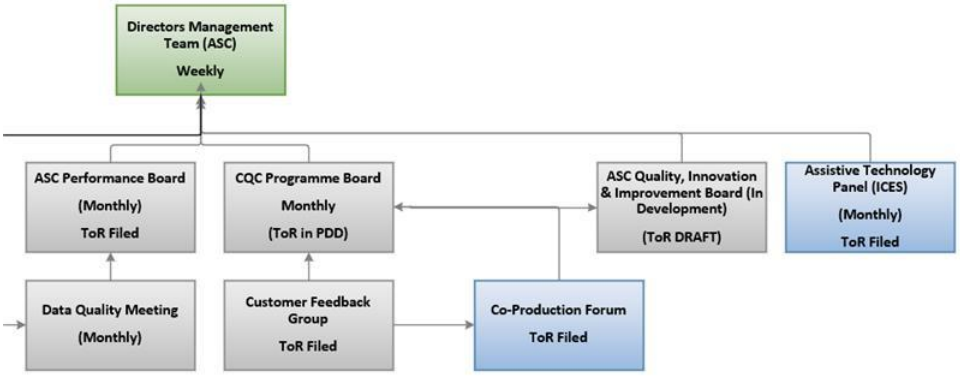
5. Adult Social Care (excluding regulated service provision) has not been subject to regulation of this kind for over ten years. The timetable for reviews to begin is April 2023. Enfield, as in other Councils, have had a period of austerity and resultant cuts in funding have forced Councils to prioritise front line service delivery, often to the detriment of other vital types of services seen as nice to have. Engagement with our local population, strategy and communications are included in these to name but a few.

6. The Programme Board continues to meet, but now at more regular intervals (every 4 weeks). The Programme Board is chaired by the ASC Director and, since the 2nd October, our Service Directors, Jon Newton and Vicky Main are leading on inspection preparation.

7. The 2 workstreams now in place are ‘CQC Inspection Readiness’ and ‘CQC Inspection Stakeholder Engagement’. These workstreams meet every 2 – 3 weeks in order 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.

8. The CQC Inspection Readiness workstream is focussing on developing the self-assessment document and supporting evidence. The CQC Stakeholder Engagement workstream monitors an engagement plan for various stakeholders.

9. New Board and groups that we have set –up:



Customer feedback working group - has been looking at ways that teams are currently collecting feedback. A text messaging solution, notify.gov, is being implemented to not only collect feedback, but also to keep in touch with those on waiting lists.
Co-production forum - has been established to develop our Co-production framework and co-ordinate training across the department.
Quality Improvement, Innovation Board – this Board has been established to make sure that improvements identified through our self-assessment process are being addressed. These improvements include areas such as the development of a universal policy around managing backlogs / waiting lists. This group will also be overseeing the work to identify the 50 cases that will be forwarded to the CQC. The QIIB is also overseeing the implementation of a digital solution designed to improve presentation and (access for health colleagues) of social care policies and procedures. It is called Tri.X and goes live in January 2024 and will ensure that our processes, procedures and guidance for staff is easily accessible and available to all.

10. We are engaging extensively with our staff. We held an event for staff, partners and service users in July 23 to further raise awareness of the pending inspection and to gather input for our self-assessment document. We have held multiple workshops with staff to get their additional input; the ASC seminar in September was particularly well received. There have been regular newsletters, and our intranet page provides up-to-date information around CQC inspection. Managers have been asked to carry out a ‘CQC inspection quiz’ in team meetings to inform discussions.
We have a communications plan in place that includes our internal and external partners, including VCS organisations.

11. **Areas of Strength** (Some examples where we are proud of services)

- Responsive and pro-active front door services
- Meeting increasing demand with static staffing levels requiring innovative and creative ways of working
- Unique OT led hospital ‘discharge to assess’ service in LBE
- LBE has the lowest OPEL Discharge trend within North Central London
- Safeguarding

12. Overall numbers contacting Adult Social Care are increasing and have been since March 2020, following a dip, no doubt due to the Covid pandemic. As can be seen from the figures below.

Period	Monthly Average
2020-21	361
2021-22	520
2022-23	607
2023-24 (Apr-Sep)	692

13. We are proud of the processes we have in place that support people to be safely discharged from hospital and have successfully integrated with our health colleagues to ensure that a person is discharged as soon as it is appropriate to do so, on the right pathway and assessed outside of an acute setting. Our Discharge to Assess team working in collaboration with the Enablement Team is successful, receiving positive feedback and compliments on the service it delivers both from people receiving their support and partners from across health and social care. This supports the system whilst ensuring people are receiving the right support in the right place and in their own homes where possible.

14. We have worked hard over the past few years to ensure Safeguarding is everyone’s responsibility. We have a comprehensive training offer in place, accessed by staff, managers, providers, etc. Staff are well supported by processes and procedures, with a strategic Safeguarding Team leading and directing our approach. Our independent audit of safeguarding work by RedQuadrant, highlighted good practice, particularly around Making Safeguarding Personal (the way we involve clients in the safeguarding process and work with them to keep them safe and achieve their outcomes).

15. Example of compliments:

‘It was such a pleasure to meet you and I know you said you gave me nothing, but honestly you gave me a lot of hope and put into place things that I really feel will slowly get me back to living a more "normal" life.

Everything you have done and the care you have shown are so appreciated. You came into my home like a ray of sunshine and left us both with positivity and it's been a while since either of us have felt that to be honest.

Please know that I meant it when I said if you're around and want to pop in for a cup of tea, you are more than welcome.'
(Service User feedback for D2A OT)

'L is doing very well and thinks he can manage to have a shower and dress himself without the help... I can't thank you enough for the efficient and kind way you have dealt with his needs. It has made everything so much easier.'
(Service User's carer feedback for D2A OT)

16. **Integrated Learning Disabilities Team (ILDS) -** Our vision is to be the best integrated learning disabilities service (ILDS) in the country, where people are healthy, independent, experience positive wellbeing and lead fulfilling lives.

17. The ILDS service serves approximately 900 clients in Enfield. To ensure service users and their families receive the best possible service available we decided to integrate over ten years ago. This means that a range of health specialists have been seconded into the team from the local Trust.

18. **Compliment:**

'Thank you very much for translating this email into Turkish. You informed me a lot about this matter. You did your job meticulously and very well. I am very glad to have met you. Thank you very much for everything.'

(Compliment from a carer of a service user regarding the Speech and Language Therapy service they received.)

19. **Areas of Improvement and what we are doing to improve** (a couple of highlighted examples)

Consistency in interpretation of strengths-based approach: Our data suggests that the strengths-based approach is delivering better outcomes, however our discussions with staff have highlighted that interpretation of strengths-based practice is different for different officers (from QA event on 11th July 2023). Work is underway (see improvement actions) to improve consistency of understanding and further improve outcomes through a new strengths-based framework, and training for staff (which includes officers show casing their good practice examples of strength-based practice).

Waiting lists: As with most other local authorities, we have waiting lists for those people who may require an assessment. Most are waiting for an assessment of care or provision of equipment. Local processes ensure that we assess people most at risk. Currently, individual teams have their own processes with managers prioritising cases rather than a consistent approach with a written process that all services in ASC follow. We are aware of this and are working with managers to develop and have this in place by Winter 2023.

20. The timeline below shows activity and progress, including the dates, of key events in the development of our self-assessment (CQC engagement event of 11th July 23 and ASC Staff Seminar 21st September 23):

RAG	Progress:	Timeline	Leads
	Completed Actions:		
	Programme Team assembled and development work split among 7 x workstreams, sponsors are Sharon & Doug	Summer 2021	Doug, Sharon & Programme Team
	Workstreams condensed from 7 into 3: - Culture & Change led by Trevor and Debbie - Comms & Partnership Working, led by Matt & Anna - Data, Performance, Reporting & Quality, led by Bharat & Sabine	December 2021	Paul
	Development work carried out by the 3 x workstreams; outcomes included: - Power BI reporting development in Eclipse - MyLife and intranet pages brought up to date - ASC policies updated including on-going monitoring - Strengths-Based approach outcomes report, including significant cost-avoidance - Development of various frameworks, including co-production - Comms strategy development - ASC newsletter development - EDI policy to be adopted Council-wide	Jan 22 – Jan 23	Leads, SME's from ASC / LBE / Partners, Paul

	Quality Assurance Programme Away-Day to focus on work completed and next steps	October 22	Programme Team
	ADASS evidence checklist work; identifying evidence available for CQC inspection	June 22 – Jan 23	Paul, Leads, SME's
	Workstream reconfiguration from 3 x development workstream to 2 x inspection preparation workstreams: - CQC Preparation – Readiness Workstream led by Bharat and Anna - CQC Preparation – Stakeholder Engagement & Improvement Workstream led by Trevor & Matt	Feb 23	Paul
	CQC Preparation – Readiness Workstream remit: - Lead on ASC self-assessment development - Lead on evidence gathering for self-assessment - Lead on self-assessment narrative drafting	Mar 23 - **Ongoing**	Leads, Paul
	CQC Preparation – Stakeholder Engagement & Improvement Workstream remit: - Develop engagement strategy with all stakeholders - Develop & circulate CQC Prep information to staff and partners inc. newsletters, briefings, factsheets - Lead on briefing staff and partners at meetings etc.	Mar 23 - **Ongoing**	Leads, Paul
	Self-Assessment checklists (ADASS Stage 1)) for all domains draft 1	End of May 2023	Anna, Bharat, Mandy, Paul
	Identify and arrange required focus groups to review self-assessment	End May 2023	Anna, Bharat, Matt, Trevor, Paul
	Hold 4 x staff focus groups to feed-back on self-assessment	June 23	Leads
	Hold Self-Evaluation Consultation Event with staff and partners	11th July 23	All
	Write-up feedback from Consultation Event and first draft of action-plan for improvements	End July 23	Mandy, Caroline, Paul
	Pull in all feedback from self-assessment checklists (Stage 1),	04th August 23	Bharat, Paul, Mandy

	including away-day and arrange into all themes and sub-themes in preparation for organisational statements with ADASS guidance		
	Complete draft 1 of 'T3 Ensuring Safety' quality statement and circulate	04th August 23	Bharat, Paul
	Send theme 1, 2 & 4 templates to leads to draft quality statements	04th August 23	Bharat, Paul
	Hold workshops with Directors & Heads of Service to gather information on services and evidence for draft statements	September – October 23	Paul, Bharat, Doug, Vicky, Jon
	Build on draft quality statements for Themes 1, 2, 3 & 4 (ADASS Stage 2)	September – October 23	Bharat, Paul, Anna, Matt, Trevor
	Presentation on CQC inspection preparation at ASC staff seminar	21st September 23	Bharat, Anna
	Service Directors became leads of inspection preparation, focus has been on self-assessment	02nd October 23	Jon, Vicky
	Weekly meetings in place with ASC Director, Service Directors and inspection leads	02nd October 23 – onwards	Jon, Vicky, Bharat, Paul, Sharon
	Further engagement with staff groups re. self-assessment to Team Manager level - T1 - Bharat, Paul visited Forensic MH team / Mirella on 5th September - T1 - Vicky, Paul, Bharat with MH colleagues on 11th October - T1 - Vicky, Paul, Bharat with ILDS colleagues on 12th October - T1 - Paul with Sabine, Luciana, Anna on 26th October - T3 - Vicky, Jon, Paul, Bharat with colleagues working on Transition on 28th November - More sessions will be booked with colleagues by Theme	02nd October - onwards	Jon, Vicky, Bharat, Paul and leads
	Review & finalise draft quality statements for Theme 1 with Service Directors	03rd November 23	Bharat, Paul, Service Directors

	Present draft of Theme 1 to ASC Director	07th November 23	Service Directors, Bharat, Paul
	Bring Theme 2, 3 & 4 quality statements up to the quality of Theme 1, following guidance of ASC Director	November – December 23	Service Directors, Bharat, Paul, Heads of Service
	ADASS process Stage 3 Narrative – decide which services we wish to highlight and which areas of improvement we want to focus on in the narrative document	November – December 23	ASC Director, Service Directors
	ADASS process Stage 3 - Narrative to be drafted, using organisational statements	December 23	Service Directors, Bharat, Paul
	Narrative to be matched with specific evidence	December 23	Leads, Rod, Adam, SME's, Paul
	Narrative to go through sign-off process	December 23 – January 24	Senior Management

Report Author
Doug Wilson, Director of Adult Social Care
Sharon Burgess, Head of Strategic Safeguarding and Community Services

Date of report 15/11/2023

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London Borough of Enfield

Report Title	Draft Joint Local Health and Wellbeing Strategy
Report to	Health and Adult Social Care Scrutiny Panel
Date of Meeting	28 November 2023
Cabinet Member	Cllr Alev Cazimoglu, Cabinet Member for Health and Social Care
Executive Director / Director	Dudu Sher-Arami, Director of Public Health
Report Author	Victoria Adnan, Policy and Performance Manager, Corporate Strategy Service
Ward(s) affected	All
Classification	Part 1 Public
Reason for exemption	N/A

Purpose of Report

1. To seek feedback from the Health and Adult Social Care Scrutiny Panel on the draft Joint Local Health and Wellbeing Strategy 2024-30.

Main Considerations for the Panel

2. The draft Joint Local Health and Wellbeing Strategy sets out: our vision, **to empower every Enfield resident to live healthier for longer**; and our long-term ambition, for every resident to ***Start Well, Live Well*** and ***Age Well***. The strategy brings together a series of important priorities based on each stage of our lives:

3. **Start Well: Thriving children and young people**

   - **Priority 1:** Support children to thrive in the early years and to be ready for their school or education setting
   - **Priority 2**: Improve nutrition, oral health and physical activity among children and young people

- **Priority 3**: Support children and young people to maintain good emotional wellbeing and mental health
- **Priority 4**: Deliver early interventions and empower young people and families to seek out preventative healthcare

4. **Live Well: Strong, healthy and safe communities**

   - **Priority 1:** Empower residents to grow their *'Health Literacy'* to make healthy choices
   - **Priority 2:** Support residents to manage their long-term conditions
   - **Priority 3:** Build a healthy environment that protects and promotes good health and an active lifestyle
   - **Priority 4**: Create connected communities that support good mental health, emotional wellbeing and resilience

5. **Age Well: Healthier, more independent and longer lives**

   - **Priority 1:** Assist every Enfield resident to have the social network they need to support their wellbeing
   - **Priority 2**: Help every Enfield resident prevent the risks of age-related ill-health
   - **Priority 3:** Enable every Enfield resident to live a resilient and independent life into older age
   - **Priority 4:** Ensure every Enfield resident receives world class care at the end of life that makes the last stages of life as valued as every other

6. The draft strategy has been presented to the Health and Wellbeing Board for their feedback on Monday 2nd October 2023 and People DMT on 25th October 2023. The draft has been refined and further developed based on their comments ahead of wider engagement and the consultation phase.

7. The final strategy is subject to approval by the Health and Wellbeing Board ahead of Enfield's Cabinet in April 2024 and Full Council in summer 2024.

Background

8. The Health and Wellbeing Board is developing their new Joint Local Health and Wellbeing Strategy for Enfield. This strategy will replace the current Joint Health and Wellbeing Strategy 2020 – 23, which expires at the end of this year.

9. The existing strategy sets out the multi-agency approach to improving the health and wellbeing of the local community and for reducing health inequalities. It includes four priority areas:

   - **Priority 1:** Having a healthy diet
   - **Priority 2:** Being active

- **Priority 3:** Being smoke free
- **Priority 4:** Being socially connected

10. Since the publication of Enfield's current Joint Health and Wellbeing Strategy 2020-23, there have been significant changes to how public health and healthcare organisations work together.

11. In 2021, the Government abolished Public Health England and established two new agencies, the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID). Locally and regionally, there have been new organisations established to co-ordinate and plan sustainable health and social care provision to improve population health outcomes, together these form elements of the new Integrated Care Systems.

12. Following the introduction of the Health and Care Bill (2022) the local authorities, NHS institutions and voluntary sector organisations of the five boroughs in North Central London (NCL) partnered to form an Integrated Care System (ICS). The NCL ICS is responsible for planning health and care services across North Central London and aims to: tackle inequalities; enhance productivity and value for money; and help the NHS support broader social and economic development.

13. The ICS is led in partnership by two committees. The Integrated Care Partnership (known as the NCL Health and Care Partnership) comprises the five NCL local authorities and the executive team of the NCL Integrated Care Board (ICB); the ICP is responsible for setting the strategic direction and aspiration for health and care across North Central London. The Integrated Care Partnership (ICP) develops local plans through Borough Partnerships – for Enfield this is an alliance of local organisations that include Enfield Council, North Middlesex University Hospital, local mental health services, social care services, community care, voluntary sector and primary care networks (these are groups of primary care practices). The committee works together to collaborate and co-ordinate care in the borough by responding to local borough needs.

14. The ICB (which replaced the NCL Clinical Commissioning Group) is the local NHS organisation responsible for commissioning and spending on healthcare in the borough and is responsible for developing NHS services that align with the priorities set by the ICP.

15. In April 2023, the North Central London Population Health and Integrated Care Strategy was published, and sets the ICS' strategic vision for health and care integration, and actions to improve population health and to tackle inequalities across North Central London.

Enfield's approach for developing a new Joint Local Health and Wellbeing Strategy

16. Enfield's approach for developing the new strategy, was agreed by the Health and Wellbeing Board on 18 July 2023. The agreed approach encompasses four key elements:

- The strategy should be evidence informed, considering local evidence of need, best practice and existing research.
- Feature a clear and relatable structure – the board agreed on a life course model based on a population health approach.
- Set overarching long-term ambitions (over six years) to focus sustained improvements over time.
- Include medium-term priorities, which guide biennial action plans designed to be responsive to evolving local, regional, and national developments.

17. Benchmarking has also been carried out to ensure a clear read across the new NCL Population Health and Integrated Care Strategy.

Consultation

18. The statutory guidance on Joint Local Health and Wellbeing Strategies states that Health and Wellbeing Boards must involve the local Healthwatch organisation and the local community in the strategy development process. The guidance further recommends that consideration should be given to identifying inclusive opportunities to involve people from across the community and should aim to allow active participation throughout the process.

19. A plan for consultation has been presented and agreed with People DMT and the Cabinet Member for Health and Social Care. The consultation will run for 10 weeks, launching week commencing 20 November 2023.

Discussion at existing board/group meetings ahead of consultation

20. Ahead of the formal consultation, the Joint Local Health and Wellbeing Strategy Development Working Group has engaged with a range of boards and groups on the draft priorities. The working group has also sought to gain insight into the barriers to being healthy in Enfield. The following groups have taken part in early engagement to help inform the development of the draft ahead of the wider consultation:

    - Enfield Borough Partnership Board
    - Public Health Team Meeting
    - Corporate Strategy Service Team Meeting
    - Members of the Voluntary and Community Sector through the VCS Awards
    - Voluntary and Community Stakeholder Reference Group
    - Early Years Partnership Board
    - Big Health Day
    - Over 50s Forum (25 October 2023)
    - Enfield Black Community Health Forum (25 October 2023)
    - Enfield Racial Equality Council (26 October 2023)

Who will be consulted next?

21. Representatives of partner organisations including the voluntary and statutory sectors.

22. Residents including adults and young people. The consultation will seek to gain a range of views from across the borough, including hearing from groups currently experiencing health inequalities.

Questionnaire

23. The questionnaire will look to capture the views of residents and people who study or work in Enfield, including health, education and social care practitioners, local business owners, and representatives of organisations from the statutory and voluntary sectors.

24. The questionnaire will be hosted on the 'Have your say' section of the Council website and has been generated using the Council's licensed consultation software SNAP.

25. A standard and easy read version is available, and we will seek to further promote the consultation through Council and partner networks.

26. In addition to the questionnaire, we are seeking the views of practitioners, adult residents and young people on *"the barriers to being healthy in Enfield".* To capture responses the Council is building a series of word clouds. The word clouds will help to illustrate different health experiences locally.

Relevance to Council Plan

27. The Joint Local Health and Wellbeing Strategy has been developed using a population health approach, which aims to improve the health and wellbeing of our entire population, while reducing health inequalities. As an approach it recognises that there are lots of factors (or determinants) that effect our health and wellbeing. This includes the wider determinants of health such as income, education and housing.

28. This strategy therefore embeds all the priorities of the Council Plan and further directly contributes to the delivery of **strong, healthy and safe communities**, and **thriving children and young people**.

Report Author: Victoria Adnan
Policy and Performance Manager
Victoria.adnan@enfield.gov.uk
02081321440

Appendices

Appendix 1: Draft Joint Local Health and Wellbeing Strategy 2024-30

DRAFT

Enfield's Joint Local Health and Wellbeing Strategy 2024-2030

www.enfield.gov.uk

Healthy Enfield

North Central London Integrated Care System

ENFIELD Council

Contents

Foreword

Our vision is to empower every Enfield resident to live healthier for longer.

Good health takes resources, but good health is also a vital resource both for individuals and communities. As our partnership publish this strategy, Enfield, the rest of London and the UK, are facing challenges from the impacts of inflation, rising interest rates and the cost-of-living crisis. As residents, businesses, local authorities, the NHS, and voluntary and community sector organisations – this affects us all.

We are also facing unprecedented demands on health and social care services at a time of rising childhood and adult obesity rates, stagnating life expectancy and widening health inequalities. In Enfield, far too many of our residents do not have fair and equal opportunities, and health inequalities are contributing to shorter lives with more years spent in ill health. In our borough, over 30% of children live in poverty; and residents living in our most deprived wards are likely to live seven years fewer than their wealthier neighbours, and over 15 years fewer in good health. Each year thousands of residents remain unregistered with a GP, which can further drive and contribute to health inequalities.

Enfield's Joint Local Health and Wellbeing Strategy sets out our ambition for every resident to ***Start Well, Live Well and Age Well***. It outlines our commitments to supporting every child to have the best start in life and to thrive as they grow up; helping our communities to live active, healthy, and socially connected lives; and supporting residents to maintain independence well into older age. An important element of this journey is supporting the health and care workforce to empower our residents to identify and navigate information, advice, and support services. This enables our residents to take an active role in their own health and wellbeing, participate in their care, and to navigate local health and social care systems.[1]

This strategy builds on the important work already happening locally to tackle inequalities and to join up services and support in our community and across health and social care. In implementing our strategy, we are committed to both improving the health and wellbeing of Enfield residents, but also to ensuring the services and support we provide are cost-effective, accessible, and sustainable.

Working with communities to prevent ill health takes time, but evidence shows that public health interventions can save money in the long-term, by reducing demand on the wider health and social care system.[2] [3]

We pledge to work together across our local partnership and with our community to tackle inequality and to deliver the best possible services, so that every Enfield resident can live healthier for longer.

Cllr Alev Cazimoglu
Cabinet Member for Health and Social Care

1 https://www.healthliteracyplace.org.uk/why-health-literacy/
2 The cost-effectiveness of public health interventions
3 Promoting health, preventing disease: is there an economic case?

Introduction

Our vision is to empower every Enfield resident to live healthier for longer.

Enfield's Joint Local Health and Wellbeing Strategy (HWBS) sets our shared vision, ambition, and priorities for the next six years.

Enfield is home to an estimated 330,000 people and our long-term ambition is for every resident to ***Start Well, Live Well and Age Well***. Our strategy groups together a series of important priorities based on each of these different stages of our lives.

START WELL

Thriving children and young people

Support every child to have the best start in life and thrive from conception to the age of 19 or 25 for young people with special education needs and disabilities (SEND)

LIVE WELL

Strong, healthy and safe communities

Support our communities to live active, healthy lives and work with our partners to provide high quality and accessible health services

AGE WELL

Healthier, more independent and longer lives

Support people to maintain good health and independence well into older age, ensuring every stage of life is valued and spent in the best possible health

The role of our Health and Wellbeing Board

Enfield's Health and Wellbeing Board (HWB) plays a key role in improving the health and wellbeing of our local population. The HWB is a forum in which the Council Leader, Councillors and key leaders from the local health and care system, including the voluntary and community sector, provide strategic direction to improve health and wellbeing in the borough.

The HWB is responsible for assessing the needs of the population and publishing this strategy, which identifies and agrees the health and wellbeing needs of Enfield's population. This directly informs the joint commissioning arrangements for different services and support provided locally.

As a board, our actions are guided by five, equally important, principles:

- **Tackle inequalities and promote equitable outcomes.**
- **Prioritise prevention and early intervention to help residents stay healthy and treat health problems before they become serious.**
- **Empower our residents to maximise their health knowledge and maintain independence.**
- **Ensure clear communication and effective team-working with partner organisations and residents.**
- **Develop and provide sustainable and cost-effective services that are person-centred and fit for the future.**

In applying our principles we consider health in its fullest definition – this means working to improve physical health, mental health, and social wellbeing.

Over the next six years, the HWB will oversee the development and delivery of biennial action plans (every two years), based on the priorities set out in this strategy. Each action plan will include:

- What we need to do to deliver on our priorities and what success looks like.
- The organisations and lead individuals responsible for managing and delivering the work.
- When the actions need to be completed and any milestones along the way.
- What progress has been made and other considerations such as funding or potential risks that might impact the completion of the action.

The action plan will be a dynamic document, which is regularly reviewed and updated, to make sure it responds to local, regional and national developments.

A "Population Health" approach

The foundations of our strategy are built on a population health approach.

Population health is an approach aimed at improving the health and wellbeing of our entire population, while reducing health inequalities. As an approach it recognises that there are lots of factors (or determinants) that effect our health and wellbeing, many of which are outside of the reach of health and care services.[4]

There are **four interconnected pillars** to a population health approach:

Wider determinants of health | **Lifestyle and behaviours** | **Integrated health and care systems** | **Places and communities we live in**

Pillar 1: Wider determinants of health

In 2010, the Marmot Review highlighted the relationship between social and economic inequalities and inequalities in our health outcomes.

A large proportion of these differences arise due to the wider determinants of health – these are factors such as income, education and housing. They affect people differently, based on factors like our age, gender, ethnicity, sexuality, and disability, and people will often experience multiple social inequalities that further reinforce the differences in their health outcomes.[5]

The message today is still clear – the distribution of power and resources have a profound impact on how we start life, live and age. The wider determinants influence our access to and interaction with opportunities and resources, and ultimately, our health and wellbeing.[6]

Acting on these wider determinants will require us to work with partner organisations across the whole of society – this includes organisations like schools and education settings, housing organisations and landlords, police and fire services, and private sector companies like shops, restaurants and cafes, alongside our existing partners in the health, social care and voluntary sectors.

- **The percentage of pupils eligible for Free School Meals has increased in Enfield by 50% from 19.4% in 2019/20 to 29.1% in 2022/23 (an increase by 9.7 percentage points).**
- **Enfield has an acute shortage of social and affordable homes, with over 6,000 households on the Housing Register and over 3,000 households living in temporary accommodation.**
- **The median household income in Enfield is £41,100. This is the 10th lowest of the London boroughs.**
- **10,000 (4.5%) people in Enfield do not have any qualifications. This is lower than the London and national average.**

4 King's Fund (2022) What is a Population Health Approach?
5 The Health Foundation (2018) What makes us healthy
6 Health Equity in England: The Marmot Review 10 Years On

Pillar 2: Lifestyle and behaviours

Our lifestyle can have a significant impact on our overall health and wellbeing. Behaviours such as inactivity, smoking, consuming too much alcohol, eating an unhealthy diet, and not protecting our skin from excessive sun exposure, can have a negative impact; and behaviours such as regular exercise or activity, good sleep quality, and developing skills to manage stress, can have a positive impact.

The wider determinants of health can influence the opportunities we have to make healthy choices.[7] For example, income inequality increasingly prevents many people from accessing a healthy, balanced diet – food poverty is on the rise in Enfield and more of our residents are having to use food banks. Locally, two community-run food pantries have been set up in Edmonton Green and Enfield Town library.

- **62.7% of adults in Enfield are physically active, doing at least 150 minutes of moderate intensity activity each week compared with 66.8% in London and 67.3% in England (2021/22).**
- **13.5% of Enfield adults smoke (more than 35.400 residents), this is higher than the London and England average of 11.7% and 12.7%. 5.4% of Enfield mothers are still smokers at the time of delivering their baby. This is higher than the London average (4.6%) but lower than the England average (8.8%).**
- **59.7% of Enfield adults are overweight or obese compared with 55.9% the London average.**
- **8.4% of Enfield residents are living with diabetes, higher than London and England averages.**

Pillar 3: Integrated health and care systems

In recent years there have been significant changes to how public health and healthcare organisations work together. In 2021, the Government abolished Public Health England and established two new agencies, the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID). Locally and regionally, there have been new organisations established to co-ordinate and plan sustainable health and social care provision to improve population health outcomes, together these form elements of the new Integrated Care Systems.

Following the introduction of the Health and Care Bill (2022) the local authorities, NHS institutions and voluntary sector organisations of the five boroughs in North Central London (NCL) partnered to form an Integrated Care System (ICS). The NCL ICS is responsible for planning health and care services across North Central London and aims to: tackle inequalities; enhance productivity and value for money; and help the NHS support broader social and economic development.

The ICS is led in partnership by two committees. The Integrated Care Partnership (known as the NCL Health and Care Partnership) comprises the five NCL local authorities and the executive team of the NCL Integrated Care Board (ICB); the ICP is responsible for setting the strategic direction and aspiration for health and care across North Central London. The Integrated Care Partnership (ICP) develops local plans through Borough Partnerships – for Enfield this is an alliance of local organisations that include Enfield Council, North Middlesex University Hospital, local mental health services, social care services, community care, voluntary sector and primary care networks (these are groups of primary care practices). The committee works together to collaborate and co-ordinate care in the borough by responding to local borough needs.

7 The Health Foundation (2018) What makes us healthy

The ICB (which replaced the NCL Clinical Commissioning Group) is the local NHS organisation responsible for commissioning and spending on healthcare in the borough and is responsible for developing NHS services that align with the priorities set by the ICP.

An effective and integrated health and care system requires a joined-up and sustainable approach to working with our population, particularly as we manage the growing number of patients with multiple long-term conditions. In April 2023, the North Central London Population Health and Integrated Care Strategy was published, and sets the ICS' strategic vision for health and care integration, and actions to improve population health and to tackle inequalities across North Central London.

NCL Population Health and Integrated Care Strategy

We currently focus a high proportion of resources on urgent care and the existing healthcare system treats individual conditions but not always the underlying drivers of poor health. The NCL Population Health and Integrated Care Strategy aims to move the partnership away from being a collection of health and care organisations that are often reactive, demand-driven and focused on their part of the pathway (or services).

Instead, to become a population health system, the NCL ICS will focus on prevention and proactive care, and work together to act on the wider determinants of health. Our system needs to improve life chances, prevent illness, and promote physical and mental well-being. We want our residents to stay well and be in control of their health, feel heard, and be confident that the system is working and that their care is right for them. This will help our population to live more of their life in good health.

- **The number of emergency hospital admissions in Enfield was 1,748 per 100,000 in 2022/2023. This was higher than the London average.**
- **The rate of delayed transfers of care from hospitals to adult social care in Enfield was 5.5 per 100,000 in 2019/20. This is below the London average.**
- **Between April 2018 and March 2023, 14.8% of Enfield adults eligible for a health check were offered one (aged 40-74), this is the lowest rate in London for this time period.**

Pillar 4: Places and communities we live in

The places and spaces we use such as town centres, libraries and leisure centres can influence our health and how we feel. For example, well maintained and accessible public areas like parks and green spaces can help us to be more physically active and socially connected.[8] Locally, we are investing in the biodiversity of our borough through the introduction of new wetlands, wildlife programmes and green spaces. This is providing more people with access to nature and the associated health and wellbeing benefits this brings, while also helping to mitigate climate change and protecting residents and businesses from the impacts of changing and extreme weather that we are starting to experience.

We know that opportunities to socially connect play a vital role in influencing people's physical and mental health and wellbeing. Social connection, including community, friends and family help us to live longer, healthier, and happier lives. Evidence shows that loneliness and social isolation are associated with a 30% increased risk of heart disease and stroke.[9]

8 The Health Foundation (2018) What makes us healthy
9 The Health Foundation (2018) What makes us healthy

Across the borough, we are nurturing and celebrating our arts, heritage and creative sectors, enabling more people to experience culture and connect with one another in our town centres, museums, theatres and libraries. Our libraries provide a range of services for local people and opportunities to socially connect. This includes books and digital access, makerspaces (where people can engage in crafts and other activities), support groups for all ages and access to skills and training, health and wellbeing support. The library service has developed partnerships with over 100 organisations to provide a range of universal services.

The new Council Plan: Investing In Enfield, sets out our priorities for investing in the places and communities we live in. These are summarised below:

Priorities

- Clean and green places
- Strong, healthy and safe communities
- Thriving children and young people
- More and better homes
- An economy that works for everyone

Principles

- Fairer Enfield
- Accessible and responsive services
- Financial resilience
- Collaboration and early help
- Climate conscious

Future outcomes

- Residents live happy, healthy and safe lives
- Residents earn enough to support themselves and their families
- Children and young people do well at all levels of learning
- Residents age well
- Residents live in good quality homes they can afford
- Residents live in a carbon neutral borough

- **In 2022/23 12,636 young people engaged in our local youth offer (including our universal youth services and Inspiring Young Enfield).**
- **Enfield's crime rate was 111.2 offences per 1,000 residents, lower than the London average of 123.6, in the past 12 months (ending October 2023). This is a decrease of 1.4% from the previous 12 months (ending October 2022).**
- **Enfield has 1,030 hectares of parks and open spaces, attracting 13 million visitors each year.**
- **During the year 2022/23 there were over 1 million visitors to Enfield libraries.**

Addressing health inequalities

What are health inequalities?

Health inequalities are avoidable differences in health between individuals, communities, or populations.

Health inequalities contribute to shorter lives with more years spent in ill health. Evidence shows that individual factors like our genetics only contribute to a small portion of our overall health – the greatest contribution comes from the wider determinants which contribute to at least 50% of our health outcomes.[10]

What this means for most people is that our health outcomes are not predetermined. It is therefore vital we work to reduce health inequalities by acting on the wider determinants and that we take collective action across every part of our society. [11]

To inform our work, we take insights from both our *Joint Strategic Needs Assessment*, *Equality Impact Assessments*, research, and community and partner engagement. This helps us to inform all decisions and action across the pillars of population health. Our goal is to develop and provide universal services but with a focus on reducing barriers to good health for those most in need**.**

Action to reduce health inequalities is a core commitment of our strategy

As we provide and develop services alongside our partners, we will always ensure that the actions we take will contribute to reducing inequalities. Alongside work to make sure that our universal services offer helps to reduce health inequalities, we will also ensure that the right bespoke support is available for people from the most vulnerable groups in society. These groups will have varied and unique needs and we will need to provide focused support to achieve the aspirations set within our priority areas. Our biennial action plans will set out the specific groups of people, and the actions to help improve their health, in detail.

Core20PLUS5

As part of our commitment to tackling health inequalities, Enfield Council is currently working with our local healthcare partners on the **Core20PLUS5** initiatives. This is a national approach that aims to target action at those groups most vulnerable to health inequalities – the **Core20**, who are the most deprived 20% of the total population[12] and the **PLUS** groups.

The **PLUS** population groups are groups of people that face substantial barriers to accessing care and are underserved by existing services.

This includes people from 'inclusion health groups' who are especially vulnerable, including people experiencing homelessness, Gypsy, Roma and Traveller communities and victims of modern slavery.

The approach identifies **5** key clinical areas of health inequalities for adults and **5** key areas for children and young people:

Adults:

- Maternity care
- Physical health checks for people living with severe mental illness
- Seasonal vaccines for people living with COPD
- Early cancer diagnosis
- Hypertension and high cholesterol

Children and Young People:

- Asthma
- Diabetes
- Epilepsy
- Oral Health
- Mental Health

We also want our work to address local priorities and to achieve this North Middlesex University Hospital have expanded **Core20PLUS5** with our local **+2** – HIV and sickle cell anaemia. Two important conditions that are more common in Enfield when compared to the rest of the UK.

10 The King's Fund (2018). 'A vision for population health: Towards a healthier future' page 16
11 Barr B and others (2017). 'Investigating the impact of the English health inequalities strategy: time trend analysis' British Medical Journal: volume 358, issue 8116
12 Based on a measure called 'Index of Multiple Deprivation'

The effects of COVID-19

The COVID-19 pandemic had a profound impact on our lives and on our health. Lockdown helped to keep us all safe whilst the COVID-19 vaccines were developed, but we cannot ignore the harms it caused. People's lives were upended and many of us lost loved ones and friends, jobs, and vital connections with our support networks. Children and young people faced substantial challenges and disruption.

Alongside the direct challenges that caring for people with COVID-19 presented, our communities have also had to deal with disruption across the wider healthcare system. There were significant reductions in capacity for long-term condition care and there is now a sizeable backlog of people waiting longer for care. During the pandemic people were also less likely to seek help for non-COVID-19 illnesses, and this has led to health problems being diagnosed later, when they are typically both more severe and less treatable.

Exacerbating risk factors for poor health[13]

Over the course of the pandemic, we saw an increase by nearly 10 percentage points in the number of adults drinking with "increasing" or "higher" risk. The consequences of heavy drinking are far reaching, and alcohol causes many diseases including liver disease, hypertension and stroke, cancers, and mental ill health.[14] The greatest increase in drinking was observed in the most deprived groups[15] and evidence shows that more deprived groups are at greater risk of harm than less deprived groups even when the amount of alcohol consumed is similar. As a result, the differences in COVID-19-related alcohol use between communities will likely worsen inequalities in the development of alcohol related diseases.

Additionally, between 2020 and 2022 the uptake of screening services (which aim to catch disease early whilst it is more treatable) also reduced.

Nationally, the proportion of eligible women who undergo breast cancer screening within six months of invitation fell from nearly 70% to 55% and in 2022 only 65% of eligible women had a screening examination in the prior three years. In Enfield this figure is 60%.[16]

Our mental health was also impacted and in Enfield, referrals to NHS mental health services for anxiety increased three-fold between 2019 to 2022.[17]

Harnessing the lessons learnt

The pandemic challenged us all and has highlighted the profound health inequity in our society. It is vital that we commit to tackling these inequalities and we must also ensure that we continue to harness the power of the positive changes we made to the way we work.

We built strong partnerships with our local voluntary and community sector and strengthened our commitment to working with our partner organisations in the health system across North Central London. We also harnessed the power of technology to utilise new ways of working, with the transformation of services to digital and hybrid models. Across Enfield we are continuing to provide opportunities for people to socially connect through volunteering, mentoring, and befriending initiatives. This builds on the good practice of local organisations, and volunteer networks established during the pandemic and on the legacy of our *Enfield Stands Together* initiative. Our local partnerships will be vital to tackling the new and ongoing challenges we face.

We also saw the success of public health measures and crucially, vaccination.

13 Office for Health Improvement and Disparities. 'Wider Impacts of COVID-19 on Health (WICH) monitoring tool' accessed: 31st August 2023
14 Lopez AD and others (2014). 'Remembering the forgotten non-communicable diseases' BMC Medicine: volume 12, article 2008
15 Institute of Alcohol Studies (2022). 'The COVID hangover: Addressing long-term health impacts of changes in alcohol consumption during the pandemic' page 10
16 Office for Health Improvement and Disparities. 'Public Health Outcome Framework' accessed: 8th September 2023
17 NHS Digital. 'Mental Health Services Data Set (MHSDS)' accessed: 12th September 2022

START WELL

Thriving children and young people

The best start in life for children and young people
Families are empowered and informed about health and wellbeing
The right support, in the right place, at the right time

- **By the age of five, 4% of children in Enfield have had a tooth removed due to decay. This is the worst rate for dental extraction in 5-year-olds in London.**
- **Enfield has the third lowest uptake of the MMR vaccine (at least one dose) in England at 75% and only 65% of cjildren have received their second MMR dose by age 5.**
- **In 2022/23, 43% of year 6 children in Enfield were overweight or obese, this is higher than the London average of 39% and England average of 37%.**
- **In 2021/22, 170 young people in Enfield received treatment for cannabis use disorder compared with 95 in 2009/10.**
- **4,041 children and young people with special educational needs and disabilities (SEND) have an Education, Health and Care Plan (EHCP) maintained by Enfield Council as of 1 May 2022.**
- **In Enfield, 24% of children do not meet the expected level of communication and language skills at the end of reception, compared to the London average of 21%.**

We want every child and young person in Enfield to thrive. The first 1,001 days of their lives (from conception up until the age of 2), can have a significant impact on their development and their life chances; including how well they build relationships, achieve at school and their future job prospects, to their overall health and wellbeing. However, their development and their life chances can also be impacted by different factors, such as early relationships and the care they receive, living in poverty or becoming looked after.

Throughout the COVID-19 pandemic, children and young people faced substantial challenges and disruption, which deepened existing inequalities. The pandemic had a disproportionate impact on children from deprived backgrounds[18] and those with special educational needs and disabilities (SEND).[19] COVID-19 impacted every stage of our children and young people's education, including in the critical early years, when interaction with others is a key factor in the development of speech, language, and social skills. Education outcomes are one of the key drivers of health outcomes in later life with high quality education known to reduce health inequalities.[20]

Locally, with the support of grant funding, we are investing in new Community Hubs, Family Hubs and Children's Centres; improving take up of funded early years education places; and helping families access the right information, advice, and support for their children as early as possible. We are also further developing the range of inclusive play, leisure, social and informal learning opportunities available in the community. This will support children and young people to engage in positive activities which enable them to learn new skills and build healthy relationships and confidence. Importantly, it will enable them to have fun and boost their physical health, mental health and emotional wellbeing.

Young people have a crucial and leading role to play in supporting their own health and wellbeing and that of their peers. We believe in empowering young people to seek out preventive

18 Centre for Evidence and Implementation (2022). 'Implications of COVID for Early Childhood Education and Care in England' page 14
19 https://www.gov.uk/government/news/children-and-young-people-with-send-disproportionately-affected-by-pandemic
20 The King's Fund. 'Healthy schools and pupils' accessed: 11th September 2023

healthcare and to make informed choices about their health and wellbeing. Locally, young people have been working together with the Council to campaign, raise awareness and to empower their peers around health and wellbeing. This includes "How are you?" a film about emotional wellbeing by Enfield's Young Mayor and Youth Parliament, and the launch of the "Looking after your mental health and emotional wellbeing" online guide.

Finally, we are working with our partners in Enfield to create places and spaces where children and young people can be healthy and feel physically and emotionally safe. This includes reducing the number of vehicles on our roads and improving air quality, and we are working together with our partners such as the Police to tackle violence and exploitation affecting children and young people under the age of 25.

Project Spotlight: Youth and Family Hubs

In 2022, Enfield was selected as one of 75 local authorities to receive grant funding for 3 years to develop and implement Family Hubs.

We are transforming our delivery of early help and will be providing Start for Life services from two brand new Youth and Family Hubs at Ponders End and Craig Park, in addition to satellites across the borough. Enfield's Youth and Family Hubs bring together lots of different services for children and families, making it easier to get the help at the right time. This will include parenting support, infant feeding through development of a breastfeeding peer support programme, sessions and resources to help parents and carers provide a thriving home learning environment, and perinatal mental health support with a focus on promoting positive early relationships.

Our Youth and Family Hubs programme will provide support to parents and carers, contribute to a reduction in inequality in health and education outcomes, and help build the evidence base for what works when it comes to improving outcomes for babies, children, and families.

Our Priorities

Priority 1

Support children to thrive in the early years and to be ready for their school or education setting

Becoming a new parent can be an exciting and hopeful time for many people. It can also be a time of heightened anxiety and worry. We want to support all parents to feel empowered, to do the best for their babies, and to establish a strong and secure relationships with their infants through our integrated Start for Life offer.

During these crucial first years, early education opportunities including communication and language, personal, social, and emotional development, and physical development, provide the crucial foundations for learning, health and wellbeing and later independence into adulthood.

We are committed to improving the take-up of funded high-quality early education. We will also be working hard to support our early years workforce to develop the skills they need to implement and embed trauma-informed practice in their day-to-day work, and to identify and provide the right support to children with additional needs including speech, language and communication needs (SLCN) as early as possible.

Priority 2

Improve nutrition, oral health and physical activity among children and young people

According to the National Child Measurement Programme (NCMP) 2021/22 data, the prevalence of childhood obesity in Enfield remains above the national average, and there is a notable increase in obesity between Reception and Year 6.

Childhood obesity is a health inequality which puts children and young people at risk of worse health outcomes as they grow up, including tooth decay, poor mental health and type 2 diabetes.[21] Childhood obesity increases the risk of long-term conditions in adulthood.[22] Obesity is driven by multiple factors including the food our

21 North Central London Whole System Approach to Obesity Mapping
22 Public Health England (2021) Guidance, early years high impact area 4: Supporting healthy weight and nutrition

children and young people consume, physical activity levels, the environment we live in and social norms.[23]

Locally, we are committed to supporting children, young people and their families to access healthy food, maintain a healthy weight, and to be more physically active. This includes by delivering the HENRY (Health, Exercise, Nutrition for the Really Young) programme; the Holiday Activities and Food Programme (HAF); and increasing the range of inclusive play and leisure activities available in the borough. We are also promoting the benefits of active travel and making it easier to choose.

Improving oral health remains an important focus and we are continuing to promote oral health in schools and early years settings through our local dental health advocates, as well as providing the fluoride varnish service in early years settings to help prevent tooth decay.

Priority 3

Support children and young people to maintain good emotional wellbeing and mental health

We all need good emotional wellbeing and mental health so that we can live happy and healthy lives. Physical activity and eating well is important for us to stay healthy; looking after our mental health is as important. It helps us to be ready to do the things we want to do with our friends and family and to make healthy life choices. We want 'mental health' and 'mental health help' to be talked about using a common language that everyone understands, and we want young people to be informed to make decisions about the support they need.

Locally, we are developing a new approach to emotional health and wellbeing services for children and young people in Enfield, focusing on prevention and early intervention. The THRIVE Framework[24] is a way of organising mental health support for all children and young people aged 0-25 (and their families). It involves thinking about the needs of the child or young person rather than focusing on a diagnosis.

Priority 4

Deliver early interventions and empower young people and families to seek out preventative healthcare

Access and confidence in seeking out preventative healthcare and early interventions is crucial as we empower young people with the information, advice, and support they need. Locally we are focusing on 4 key areas:

- **Vaccinations:** we are committed to significantly increasing the take up of early years and childhood vaccinations including the MMR vaccine (which protects against measles, mumps and rubella) and the 6-in-1 vaccine.
- **Sexual and reproductive health:** we are continuing to work in partnership to deliver a comprehensive range of sexual and reproductive health services for adolescents, including access to education, advice, and support; and addressing barriers to prevention, testing and treatment.
- **Drugs and excessive alcohol:** we are continuing to deliver substance misuse support to young people and their families including the delivery of information, advice, guidance and access to treatment services.
- **Smoking and vaping:** we are working with our schools and in our community to implement the "don't smoke outside our school gates" initiative and smoke free zones to de-normalise smoking as a behaviour and to protect children and young people from second-hand smoke.

Our partnership's key strategies include:

- Empowering Young Enfield
- Looked after Children Strategy
- SEND Partnership Strategy
- Tackling Child Neglect Strategy
- Youth Justice Plan
- Enfield Inclusion Charter
- NCL Children and Young People's Mental Health and Emotional Wellbeing Transformation Plan
- NCL Start Well: Opportunities for improvement in maternity, neonatal, children and young people's services in North Central London

23 North Central London Whole System Approach to Obesity Mapping
24 THRIVE Framework for System Change

LIVE WELL

Strong, healthy and safe communities

People with the knowledge and confidence to live healthy lives
An environment and community that keeps us healthy
Health services that support and empower residents

- **Just 20.7% of Enfield residents stated they 'definitely' had enough support from local services to manage their long-term condition compared to 25.2% of North Central London residents.**
- **In Enfield, 6.4% of deaths are attributable to poor air quality, this compares to 6.5% in London and 5.5% in England.**
- **Nearly two-thirds of Enfield adults are now physically active but only 1.4% of people in Enfield cycle to work and only 5.7% travel on foot compared to the 32.5% who travel by car or van.**
- **In Enfield, 8.1% of our residents aged over 16 feel lonely *'often'* or *'always'* compared to 6.5% of London and England residents.**

In Enfield we are committed to working with our residents and partners to build and maintain strong, healthy and safe communities where people lead active lifestyles, have access to healthy food, are smoke-free, feel safe in and connected to their community, and live in good health for as long as possible.

Making *"the healthy choice, the easiest choice"* has been an aspiration in many parts of the UK for some time and was a core focus of Enfield's previous Joint Health and Wellbeing Strategy. Supporting and empowering our residents to make healthy choices and to lead an active life could not only lead to fewer hospitalisations and deaths each year, but also reduce the financial demand on services.

Physical activity is a significant factor in determining people's health, with inactivity increasing the risk of long-term conditions including heart disease, diabetes and other obesity-related illnesses. People in Enfield are less likely to be physically active and our rates of obesity are higher than London averages.

Access to healthy food is another important determinant of health. Income inequality is increasingly preventing many people from accessing a healthy, balanced diet – food poverty is on the rise in Enfield and more of our residents are having to use food banks. We are continuing to work with our partners to help residents experiencing financial hardship to access low cost, sustainable and healthy food in community-run pantries across the borough, and we have already set up two food pantries in Edmonton Green and Enfield Town library.

As with all life stages, to live well, we need to also address the wider determinants of physical and mental health including housing, education, welfare, work and poverty – and contribute to reducing health inequalities.

Our Priorities

Priority 1

Empower residents to grow their 'Health Literacy' to make healthy choices

It has been estimated that health literacy related problems may account for up to 5% of all NHS spending, and there is a close link between socio-economic deprivation and lower health literacy.

The NHS defines health literacy as *"…a person's ability to understand and use information to make decisions about their health."*[25] Important elements of health literacy include *"having enough knowledge, understanding, skills and confidence to use health information."* This enables us to take an active role in our own health and wellbeing, participate in our care, and to navigate our local health and social care systems.[26]

Locally, we are committed to supporting the health and care workforce to empower our residents to identify and navigate information, advice and support services. This includes promoting registration with a GP, enhancing local signposting schemes to support informed decision making and improved outcomes, and raising awareness of support in the community such as from our Community Hubs and Family Hubs, our libraries, and from voluntary and community sector groups and organisations across the borough.

We also want to explore opportunities to work in partnership with our communities to empower them to be providers and champions of information to help us to address the health literacy challenge, including through *Community Health Checks.*

Priority 2

Support residents to manage their long-term conditions

Improvements in healthy lifestyle have stalled nationally, particularly amongst more deprived communities, further exacerbating health and other inequalities.[27] A proportion of our residents have or will develop long-term conditions. These include conditions like cardiovascular disease, chronic respiratory disorders and diabetes.

Alongside our commitment to promoting good health literacy (that empowers individuals to make the daily decisions that support the good management of their long-term conditions, such as stopping smoking, being active and maintaining a healthy weight) we are also developing a programme of *Community Health Checks.* By working with our voluntary and community sector partners we can provide easy opportunities for routine monitoring for things like blood pressure. We will also ensure our targeted NHS Health Checks continue to provide support to those eligible, to help identify and reduce the risk of certain health problems such as heart disease, diabetes, kidney disease and stroke. This enables people to review their health with a professional, catch hidden problems early, and discuss health positive changes they can make to their lives.

By catching these common problems early, we will be more likely to prevent people from developing complications associated with the condition – this is known as *'secondary prevention'* and it is a key measure to enabling people to live longer, healthier lives.

Priority 3

Build a healthy environment that protects and promotes good health and an active lifestyle

Places and spaces, including public buildings, the homes we live in, and parks and green spaces, are major determinants of our health and wellbeing.

Locally, we are making our roads safer and more pleasant environments for walking or cycling, to encourage active travel and improve air quality. And we are also continuing to invest in improving everyone's access to sport, including new opportunities for activity in our parks and improving the activity offer inside our leisure centres.

We are working toward a vision of more and better homes for Enfield in the context of unprecedented financial challenges, with rising inflation, significant interest rate increases, a cost-of-living crisis and insufficient funding to support the increasing number of households in need of affordable housing. We know that too many Enfield residents do not have access to a home they can afford, and we need to work as a partnership to minimise the negative impact of this in the short and medium term, while continuing to work toward our longer-term vision of more and better homes for Enfield.

25 NHS Health Literacy Definition
26 https://www.healthliteracyplace.org.uk/why-health-literacy/
27 https://www.england.nhs.uk/ourwork/prevention/secondary-prevention/

In our role as a landlord, Enfield Council is investing in and improving our council homes in partnership with our tenants and leaseholders, so that homes are safe, secure and comfortable, both now and for the future. This means people can live with sufficient space and in thermal comfort, free from the negative impacts of damp or mould, extremes of temperature, and poor air quality. We also want people to live in mixed-income neighbourhoods where they feel a sense of belonging, can access healthy and nutritious food, green spaces, leisure facilities and community services.

As the local population grows and their health needs change, we also need to work together as a partnership to identify and secure the facilities needed for primary, secondary and tertiary care and the wider health and care system, so that there is sufficient healthcare provision in the places where it's needed.[28]

Priority 4

Create connected communities that support good mental health, emotional wellbeing and resilience

The communities we live in really matter for our emotional wellbeing and mental health. Sustainable employment, good quality homes, strong social networks and a sense of belonging play a big role in ensuring we live a happy life in good health. On the other hand, isolation, whether defined in social, physical or psychological terms is well known to have adverse health impacts, both physically and emotionally.[29]

Locally, we are supporting our communities to be well-connected and digitally included, tackling the harmful impacts of social isolation through activities like our Tea and Toast sessions that run in our libraries. Furthermore, we are committed to tackling the stigma that continues to pervade how our society talks about mental health and we will continue to support the most vulnerable in society – a key focus must be on preventing and supporting people in crisis and we are committed to leading local efforts on suicide prevention through the ongoing development of our local *'Suicide Prevention Plan.'*

Equally, we recognise that traditional service offers across health and non-health sectors do not meet the needs of people living with mental ill health. Because of this, we will continue to explore innovate new work areas with our partner organisations, such as the NHS Core20PLUS5 approach of offering an annual physical health check to people living with severe mental illness.

Our partnership's key strategies include:

- Enfield Early Help for All Strategy
- Climate Action Plan
- Blue and Green Strategy
- Enfield's Local Plan
- Community Safety Plan
- Safeguarding Adults Strategy
- Violence Against Women and Girls Strategy
- Housing and Growth Strategy
- Enfield Housing Allocation Scheme
- Economic Development Strategy
- Tenancy Strategy
- Preventing Homelessness and Rough Sleeping Strategy
- North Central London Green Plan 2022-2025
- NCL Joint Plan Summary 2023-24
- NCL Learning Disabilities and Autism Programme Plan
- NCL Working with our People and Communities Strategy 2022/23 to 2025/26
- North London Mental Health Partnership Strategy
- North Middlesex University Hospital Trust Strategic Vision
- Royal Free London NHS Foundation Trust Strategic Vision

28 https://www.gov.uk/guidance/health-and-wellbeing
29 https://heart.bmj.com/content/102/13/1009

AGE WELL

Healthier, more independent and longer lives

People living healthier and socially connected lives
Communities that nurture and promote independence
The right support at every stage of life

- There are currently 44,500 people aged 65 and over living in Enfield – this is set to increase to 50,200 by 2025.
- In 2021, 36% of people aged 65 and over living in Enfield lived alone.
- The most common cause of injury resulting in hospital admission for people aged 65 and over is falls.
- The average life expectancy at birth in Enfield is 84.1 years in females and 78.9 years in males.
- In 2021/22, 225 Enfield residents suffered a hip fracture.
- Only 68% of older people living in Enfield have their flu vaccine each winter.
- It is estimated that only 66.8% of people living with dementia in Enfield have been diagnosed and seen a specialist.
- Research suggests that 2 in 3 people want to die at home but in Enfield currently only 38% of people die at home.
- Enfield has one of the largest numbers of care providers in London, including 82 care homes.

The key to healthy ageing is to nurture positive health behaviours early in life. Eating well, keeping active, maintaining a healthy weight, and avoiding health harming behaviours like smoking and drinking too much alcohol all reduce the risk of developing long-term conditions and of having poorer health later in life.

But even if you don't start early, it's never too late to make a health improving change and for this reason it's important we target action early but continue to promote health positive behaviours throughout the life course. It is equally vital that we provide high quality care and work collaboratively with our partners across the health and care system, to create joined-up services that support those living with long-term conditions so that they can maximise their independence and live life to the fullest.

At every step we will ensure our work provides the right help for all but prioritises support to those with the greatest need so we can reduce inequalities and give every Enfield resident the opportunity to live a healthier, longer, and more independent life well into old age.

Project Spotlight: PainChek® and SMART Living Projects

In 2021, Enfield became the first local authority in the UK to introduce AI-powered **PainChek®** technology in care homes to better identify and support residents who may be experiencing pain but are unable to express this verbally.

Moreover, our **SMART Living Project** aims to reduce social isolation through introducing digital technology into care homes to connect service users with friends and family. This innovative project was selected as a 2023 MJ Awards Finalist in the 'Digital Transformation' category.

Projects like this help to ensure that people stay happier, healthier, and independent for longer through the introduction of next generation technology in our current social care offer. Looking ahead, we will continue to harness the power of the communities we live in to tackle social isolation and support independence.

Our Priorities

Priority 1

Assist every Enfield resident to have the social network they need to support their wellbeing

Social isolation and loneliness are an all-too-common feature of older age, but they are not inevitable. Loneliness can lead to poor physical and mental health, and it is estimated that loneliness is as bad for our health as smoking 15 cigarettes a day.[30]

Locally, we will be working in partnership to identify those at greatest risk of isolation, such as people living with severe frailty and unpaid carers, and helping them to prevent loneliness, by encouraging community engagement and signposting to support. This includes working with our voluntary and community sector organisations to provide opportunities for volunteering, hobbies and social interaction. We will also be exploring opportunities to tackling age-related stereotypes and stigma by promoting intergenerational programmes that bring together older people and younger generations.

Priority 2

Help every Enfield resident prevent the risks of age-related ill-health

There are many health problems that we are more likely to develop with age, from infections like shingles and pneumonia, through to long-term problems like osteoarthritis, loss of eyesight and hearing, and dementia. Each of these problems has an impact in different ways, but there are things we can do to prevent and mitigate the harm from all of them.

Looking ahead, we are continuing to work in partnership to support people to maintain their independence by encouraging early access to vision and hearing care; helping people to understand and access vaccinations to prevent infections; and supporting people to maintain a healthy weight to reduce the impact of osteoarthritis.

We are also working hard to ensure access to specialist dementia services, so that people get the timely diagnosis and treatments that help to keep them well for as long as possible. Additionally, we are supporting our communities to reduce the impact of dementia by encouraging people to live *'brain stimulating lives'* with local opportunities for high quality education, employment, and community activity.

Priority 3

Enable every Enfield resident to live a resilient and independent life into older age

Frailty reduces the ability of people to maintain their physical and mental independence and increases the risk of even minor illnesses. Preventing older people from developing frailty is a key action to help residents maintain their independence and live happy and healthy lives.

Our existing services are designed to maximise opportunities for maintaining independence with a focus on early intervention and support before people lose vital abilities. We aim to empower

30 Holt-Lunstad J and others (2010). 'Social Relationships and Mortality Risk: A Meta-analytic Review' PLOS Medicine: volume 7, issue 7

people to act on the risk factors for developing frailty by making positive health changes earlier in life and raise awareness of the simple exercises that older people can do from home to maintain strength and balance.

We recognise the crucial role of unpaid carers, in supporting loved ones to live their lives in the setting that's right for them – it is equally vital that we also provide the right support that keeps them well.

Priority 4

Ensure every Enfield resident receives world class care at the end of life that makes the last stages of life as valued as every other

At the end of life most people want a good death: comfortable, dignified and with seamless support for them and their loved ones. But many people are scared to talk about death and dying and worry about the impact on their friends and family. Good care takes good planning and alongside providing compassionate end of life care services we also need to tackle the stigma surrounding talking about death and dying. Only this can help us achieve good wellbeing at every stage of life.

In Enfield, we will seek to break down barriers and empower people to talk about dying and the end-of-life process, so that they can plan and prepare for this important stage of life. We will also be working in partnership to develop processes that help people to take control of their care; and supporting loved ones and communities by working with our NHS, voluntary and community sector partners to provide high-quality bereavement care.

Our partnership's key strategies include:

- Supporting Independence: A Local Prevention Strategy
- Market Position Statement Addendum 2021-2026: Older Person Specialist Accommodation
- Respite Care Policy
- Provider Concerns Policy
- Self Neglect and Hoarding Policy
- Mental Capacity and Deprivation of Liberty Safeguards (DoLS)
- HASC Strength based Supervision Policy

Our Governance Framework

Led by:	The Health and Wellbeing Board are responsible for providing strategic direction and leadership throughout the borough to deliver our vision and ambition, principles, and priorities. The Board are also responsible for developing and monitoring our action plan. The associated action plan will be kept up-to-date and will be regularly reviewed throughout the 6-year lifecycle of the strategy. On a biennial basis the strategy can be reviewed and refreshed as required, to respond to local, NCL or national updates. Any updates to the strategy are subject to agreement by the Health and Wellbeing Board and the Council's Executive Management Team.
Supported by:	The Health and Wellbeing Board is part of a wider network of boards and groups which are responsible for overseeing the successful implementation of the action plan. This includes partnerships such as the Enfield Borough Partnership, the Mental Health Partnership Board, and the SEND Partnership Board which bring together representatives from our community, statutory partners and the Voluntary and Community Sector.
Delivered by:	Individual actions are the responsibility of the named partner within the workforce. This could include the Local Authority, NHS, Voluntary and Community sector, schools and education settings, and commissioned services. These partners report on progress through their relevant internal governance structures which will feedback to the Health and Wellbeing Board.

Thank you for reading our Joint Local Health and Wellbeing Strategy 2024-2030.

If you would like to find out more about our plans and services, how we're doing and how to get involved, please visit our website www.enfield.gov.uk

EnfieldCouncil EnfieldCouncil

Date of meeting 2023/24	Topic	Report Author	Lead Members	Executive Director/Director	Scope
19 June 2023	**Work Programme Planning**				
20 Sept 2023	Draft Safeguarding Adults Strategy	Sharon Burgess	Cllr Cazimoglu	Tony Theodoulou	Members to receive the annual update and briefing.
	Annual Safeguarding Report	Sharon Burgess /Bharat Ayer	Cllr Cazimoglu	Tony Theodoulou	The Annual report is brought to this Panel for discussion.
	Vaccinations & Immunisations	Louisa Bourlet	Cllr Cazimoglu	Dudu-Sher-Arami	Update requested (with a focus on the uptake of childhood immunisations in the borough/ links with family hubs & community grants).
28 November 2023	Borough Partnership Plan	Stephen Wells	ICS Led	ICS Led	Members wished to receive a further update on this item.
	Adults & Children's Social Care Annual Statutory Complaints Report	Eleanor Brown	Cllr Cazimoglu	Fay Hammond	The Annual report is brought to this Panel for discussion. Members will receive data on trends.
	Health Visiting, Breastfeeding & Women's Health (Cancer Screening)	Andrew Lawrence	Cllr Cazimoglu	Dudu Sher-Arami	The panel have requested an in-depth review of the areas listed. (Originally scheduled for Feb. meeting / brought forward)
	CQC Inspections Update	Bharat Ayer	Cllr Cazimoglu	Dudu Sher-Arami	Members wished to receive a further update on this item.
	Joint Health & Wellbeing Strategy Review - Progress	Mark Tickner	Cllr Cazimoglu	Dudu Sher-Arami	For Noting by the Panel.

28 February 2024	Access to Primary Care, Dental Care & Oral Health Promotion	Deborah McBeal	Led by ICS	Deborah McBeal/ICS	The Panel have requested an in-depth review of services (with a key focus on Children's Dentistry Provision). Report to also include information on access to services via Technology- digital exclusion etc.
	Enfield Sexual Health Community Services	Fulya Yahioglu	Cllr Cazimoglu	Dudu Sher-Arami	Members wished to receive a further update on this item. (Originally scheduled for Nov. meeting / deferred)
	Public Health - Substance Misuse	Andrew Lawrence	Cllr Cazimoglu	Dudu Sher-Arami	Update requested (to include information on the use of Nitrous Oxide 'balloons').
Date TBC	Mental Health Transformation/Reforms	Deborah McBeal	ICS Led	ICS Led	The panel have requested an in-depth review and what this will mean for local services in the borough (to include young people in mental health crisis following Covid).