Public Document Pack

HEALTH AND WELLBEING BOARD

Tuesday, 23 April 2013 at 6.30 pm
Room 1, Civic Centre, Silver Street, Enfield, EN1 3XA

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Members of the public and representatives of the press are entitled to attend meetings of the Health and Wellbeing Shadow Board and to remain and hear discussions on matters within Part 1 of the agenda which is the public part of the meeting.

MEMBERSHIP

Cabinet Member for Adult Services and Care – Councillor Donald McGowan (Chair)
Cabinet Member for Community Wellbeing and Public Health – Councillor Christine Hamilton
Cabinet Member for Children and Young People – Councillor Ayfer Orhan
Cabinet Member for Environment – Councillor Chris Bond
Chair of the Local Clinical Commissioning Group – Dr Alpesh Patel
Healthwatch Representative – Deborah Fowler
Clinical Commissioning Group (CCG) Chief Officer - Liz Wise
National NHS Commissioning Board Representative – Paul Bennett
Joint Director of Public Health – Dr Shahed Ahmad
Director of Health, Housing and Adult Social Care – Ray James
Director of Schools and Children's Services – Andrew Fraser
Director of Environment – Ian Davis
Voluntary Sector Representative: To be appointed

AGENDA – PART 1

1. WELCOME AND APOLOGIES

2. DECLARATION OF INTERESTS (6.30-6.40PM)

Members are asked to declare any disclosable pecuniary, other pecuniary or non pecuniary interests relating to items on the agenda.

All members of the Health and Wellbeing Board are reminded that they are required to comply with the Council's Code of Conduct.

3. BOARD TERMS OF REFERENCE (6.40-6.50PM) (Pages 1 - 18)

To receive a report on the establishment of the Enfield Health and Wellbeing

Board and to endorse the terms of reference as agreed at Council on 27 March 2013.

4. FINAL TRANSITION OF ENFIELD NHS TO ENFIELD CLINICAL COMMISSIONING GROUP (CCG) (6.50-7.10PM) (Pages 19 - 22)

To receive a report from Richard Quinton (Director of Finance - Enfield Clinical Commissioning Group) on the transition between Enfield NHS and Enfield CCG.

5. HEALTHWATCH (7.10-7.30PM) (Pages 23 - 26)

To receive an report from Bindi Nagra (Chief Commissioning Officer) and Deborah Fowler (HealthWatch Chair) updating the Board on the new Enfield HealthWatch organisation.

6. FAMILY NURSE PARTNERSHIP BID NEXT STEPS (7.30-7.50PM) (Pages 27 - 32)

To receive a report from Andrew Fraser (Director of Schools and Children's Services) setting out the next steps for taking forward the Family Nurse Partnership Bid.

The Board is asked to formally endorse this bidding process.

7. SUB BOARD UPDATES (7.50-8.00PM) (Pages 33 - 120)

To receive updates from the following:

1. Health Improvement Partnership

2. Joint Commissioning Partnership Board

3. Improving Primary Care Board (To Follow)

4. Children's Services Update

4.1 Change and Challenge Programme
4.2 Fulfilling Lives Big Lottery Bid

8. MINUTES OF PREVIOUS MEETING (8.00-8.05PM) (Pages 121 - 138)

To receive and agree the minutes of the meeting held on 14 February 2013.

9. DATES OF FUTURE MEETINGS

To note the dates provisionally set aside for future meetings of the Board:

- Thursday 20 June 2013
- Thursday 19 September 2013
- Thursday 12 December 2013
- Thursday 13 February 2014

- Thursday 24 April 2014

These may change following agreement on the whole Council Calendar at Council on 8 May 2013.

10. EXCLUSION OF PRESS AND PUBLIC

If necessary, to consider passing a resolution under Section 100A(4) of the Local Government Act 1972 excluding the press and public from the meeting for any items of business moved to part 2 of the agenda on the grounds that they involve the likely disclosure of exempt information as defined in those paragraphs of Part 1 of Schedule 12A to the Act (as amended by the Local Government (Access to Information) (Variation) Order 2006).

(There is no part 2 agenda)

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Agenda Item 3

MUNICIPAL YEAR 2012/2013 REPORT NO. 200

Agenda – Part: 1	**Item: 3**
Subject: Establishment of a Health and Wellbeing Board for Enfield **Wards:** All	
Cabinet Member consulted: Councillor Donald McGowan	

MEETING TITLE AND DATE:
Health and Wellbeing Board – 23 April 2013

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

Contact: James Kinsella (020 8379 4041) Felicity Cox (020 8379 3957)

E mail: james.kinsella@enfield.gov.uk, felicity.cox@enfield.gov.uk

1. EXECUTIVE SUMMARY

This report sets out the requirements for the establishment of a Health and Wellbeing Board and the specific proposals for Enfield. The establishment of the Board, along with the terms of reference, were approved by Council on the basis set out in the report at a meeting held on 27 March 2013.

The report includes information on the functions of the board, requirements for membership, voting, application of the council code of conduct, transparency and openness and working with other structures of the council

2. RECOMMENDATIONS

2.1 To note and endorse the terms of reference as set out in Appendix A to the report as agreed by Council.

2.2 To note that the Council's code of conduct will apply to all Board members. (Para 3.6)

2.3 To approve a change to the terms of reference, agreed at Council, that "membership of all non statutory board members be reviewed annually in line with the Council representatives".

2.4 The Health and Wellbeing Board is being asked to agree to the continuation of the following three sub committees which previously operated under the shadow board arrangements.

3. BACKGROUND

3.1 Under the Health and Social Care Act 2012 all unitary councils have had to establish a Health and Wellbeing Board by 1 April

2013. Health and Wellbeing Boards are being set up as partnership bodies involving local councils, GP's, other health professionals and the local Healthwatch, representing the views of patients, communities and the people who use the services. The stated purpose of the Government is to bring greater democratic accountability and legitimacy to the NHS, promoting better integration across health and social care in the interests of patients and the public.

At Enfield a Shadow Board was set up and has been in operation since December 2011. The Shadow Board has enabled Enfield to pilot its arrangements for delivery of the functions required under the Health and Social Care Act and to develop procedures for its effective operation. These have been subject to review and the terms of reference (set out in appendix A), agreed by Council on 27 March 2013 have been based upon those developed by the Shadow Board. They have also been developed to take account of the regulations published in February 2013 and to reflect national guidance produced by the Local Government Association and the Association of Democratic Services Officers.

3.2 Functions of a Health and Wellbeing Board

The Health and Social Care Act 2012 Sections 195 and 196 states that the functions of the board must include

- Preparation of the Joint Strategic Needs Assessment (JSNA), Pharmaceutical Needs Assessment (PNA) and Joint Health and Wellbeing Strategies (JHWSS)

- To encourage integrated working between health and social care commissioning including providing advice assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.

- A power to encourage close working between commissioners of health-related services and the board itself

- A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.

- Any other functions that may be delegated by the Council under section 196(2) of the Health and Social Care Act 2012. This will allow the Council to arrange for the Health and Wellbeing Board to exercise any functions exercisable by the authority.

3.3 Establishment of the Board

The Health and Wellbeing Board has been set up as a committee of the Council under section 102 of the local Government Act 1972. The regulations however modify and disapply certain provisions of the Local Government Act 1972 and the committee should be thought of as a section 102 committee but with some key differences.

3.4 Membership

3.4.1 The core membership of the Board must include

- At least one councillor – nominated by the Leader in councils operating executive arrangements
- The Director of Adult Social Services
- The Director of Children's Services
- The Director of Public Health
- A representative of the local HealthWatch organisation
- A representative of each relevant clinical commissioning group
- Any other members considered appropriate by the Council

3.4.2 Council agreed that the full board membership would be based upon the current Shadow Board membership with a slight amendment to the number of third sector representatives

- Cabinet Member for Adult Services, Care and Health
- Cabinet Member for Community Wellbeing and Public Health
- Cabinet Member for Children and Young People
- Cabinet Member of Environment

- Chair of the local Clinical Commissioning Group
- Clinical Commissioning Group Chief Officer

- Healthwatch Representative
- NHS Commissioning Board Representative
- Joint Director of Public Health
- Director of Adult Social Care
- Director of Children's Services
- Director of Environment
- Elected Representative of the Third Sector

Following on from the Council meeting, and further discussion with the Board Executive, a further addition has been put forward to enable the membership of all non statutory board members to be reviewed annually in line with the appointment of the council representatives.

3.4.3 Councillors

Under the regulations (Regulation 7) modifies sections 15-16 and Schedule 1 of the Local Government Housing Act 1989 to disapply political proportionality requirements for section 102 committees in respect of health and wellbeing boards – this means that it has been up to individual councils to decide the approach to councillor membership of health and wellbeing boards. The Cabinet Members for Adult Services, Care and Health, Community Wellbeing and Public Health, Children and Young People and Environment have been appointed to the Board.

The appointment of the Cabinet Member for Environment and the Director of Environment recognise the importance of community safety in health and wellbeing.

Councillor representatives will be nominated by the Executive Leader of the Council for approval by Council.

3.4.4 Council Officers

The Local Government Act 1972 does not allow officers to be members of local authority committees. Regulation 5(1) removes this restriction in relation to health and wellbeing boards by disapplying section 104 (1) of the 1972 Act to enable local authority officers to become members of health and wellbeing boards. The Directors of Adult, Health, Housing and Social Care, Schools and Children's Services and Environment have been appointed.

3.4.5 Clinical Commissioning Group (CCG)

It was agreed that both the Chair and the Chief Officer of the Enfield Clinical Commissioning Group will have places on the Board.

3.4.6 NHS National Commissioning Board

The NHS Commissioning Board has to appoint a representative for the purpose of participating in the preparation of JSNAs and the PNA and to join the health and Wellbeing Board when it is considering a matter relating to the exercise or proposed exercise of the NHS Commissioning Board commissioning functions in relation to the area and it is requested to do so by the Board. Enfield has set aside a position to enable a representative to sit on the full board. Paul Bennett is currently the nominated representative of the NHS National Commissioning Board.

3.4.7. HealthWatch

A new HealthWatch organisation came into being on a statutory footing on 1 April 2013. It will represent the views of patients, communities and people who use health and social care services. Healthwatch has appointed a Deborah Fowler to represent them on the Board. Deborah Fowler previously sat on the board, in her role as non executive Director of NHS Enfield.

3.4.8 Third Sector Representative

Membership of the Enfield Board will also include a representative from the third sector who will be able to represent the particular skills and perspectives of voluntary and community groups. The selection of this representative will be undertaken via an election process being run by the Electoral Reform Society.

The election process is due to take place shortly to enable the new representative to take up their post at the first meeting of the Board on 23 April 2013. An update on progress will provided at the Board meeting.

The elected representative will be supported by a deputy who will be the candidate with the second most votes. The deputy will only attend meetings when the first elected representative is unable to. They will then have voting and speaking rights.

3.4.9 Additional Members

The Health and Wellbeing Board can in agreement with full Council appoint additional members and, should the full council wish to add further members after the board is established on the principles of inclusiveness and shared ownership (under section 194 of the Health and Social Care Act 2012) it would need to consult the health and wellbeing board before doing so.

3.4.10 Substitutes

The approach to substitution is for local determination. At Enfield, other than for Overview and Scrutiny Committee, we do not operate with substitutes. Council did not agree to set up substitute arrangements for the Board.

3.5 Voting

Regulation 6 modifies the Local Government and Housing Act 1989 (section13(1)) to enable all members of health and wellbeing boards or their sub committees to vote unless the council decides otherwise. This means that the Council is free to decide, in consultation with the health and wellbeing board which members of the health and wellbeing board should be voting members.

The intention of the legislation is that all members of health and wellbeing boards should be seen as equals and as shared decision makers, acknowledging that health and wellbeing boards are about bringing political professional and clinical leaders and local communities together on an equal basis. It is hoped that this will be achieved by consensus, where possible.

However there will be some occasions where votes will have to be taken.

Council has agreed that all members including officers should have a vote in the interests of parity.

3.6 Codes of Conduct and Conflicts of Interest

The regulations under section 194 of the Health and Social Care Act 2012 do not modify or dis-apply any legislation relating to codes of conduct and conflicts of interest. This means that legislation in relation to these issues will apply to health and wellbeing boards.

All voting members of the health and wellbeing board will therefore be governed by the local authority code of conduct. On taking office they will have to sign up to the council's code of conduct and will have to register and declare disclosable pecuniary, other pecuniary and non pecuniary interests. Public notions of predetermination and bias will also apply.

Training on the Council's code of conduct was provided to Board members at their informal session held on 25 March 2013.

3.7 Transparency and Openness

Health and Wellbeing Boards will be subject to the same requirements on openness and transparency as other Section 102 committees.

This will require copies of the agendas and reports of meetings to be open for inspection by the public with the Freedom of Information Act 2000 also applying.

Provisions relating to public access to meetings and to information relating to the decisions of council executives and their committees to apply, that is the need to provide 5 working days notice of meetings.

The Data Protection Act 1998 providing for the regulation of the processing of information relating to individuals will also apply.

Council have agreed the protocol proposed by the Shadow Board for public wishing to speak at meetings. This is designed to reflect the desire to be as inclusive as possible whilst also ensuring that decisions can be taken as effectively as possible.

Informal sessions will also be held outside the formal board meetings to enable board learning and development and exploratory in depth sessions on particular topics. This will also enable the board to have early discussions on complex and sensitive issues before formal consultation and discussion.

3.8 Sub Committees

Regulation 3 of the regulations modifies section 101(2) of the Local Government Act 1972 to clarify that health and wellbeing boards can appoint

sub committees to discharge their functions in accordance with section 102 of the1972 Act.

All provisions that apply to health and wellbeing boards will also apply to all sub committees of the Board. The Board may decide to delegate some of their decision making powers to sub committees.

The Health and Wellbeing Board is being asked to agree to the continutation of the following three sub committees which previously operated under the shadow board arrangements.

- The Health Improvement Partnership Board – Chaired by the Joint Director of Public Health.

- The Joint Commissioning Partnership Board - Chaired by the Joint Chief Commissioning Officer

- Improving Primary Care Board – Chaired by the Chief Officer of the Clinical Commissioning Group

3.9 Accountability and relationships between the health and wellbeing board and other council structures and partnerships

3.9.1 Health and Wellbeing Boards are not committees of the executive or cabinet. Therefore their decisions will not need to go on the Council's key decision list, giving the statutory 28 days notice of executive decisions.

3.9.2 However if any additional functions are delegated to the Board, the council will need to adhere to the requirements of all applicable legal frameworks.

3.9.3 Health and Wellbeing and Overview and Scrutiny

Overview and Scrutiny will be able to scrutinise the work of the Health and Wellbeing Board in a similar way to the other work of the Council. However although the discharge of functions by health and wellbeing boards falls within the remit of scrutiny, the core functions will not be subject to call in, as they are not executive functions.

3.10 Executive

The Board will continue to have an executive group which will meet on a monthly basis to oversee on-going work in between board meetings. Its membership will consist of: the Joint Director of Public Health, CCG Chief Officer, Director of Children's Services and Director of Health, Housing and Adult Social Services.

4. ALTERNATIVE OPTIONS CONSIDERED

4.1 There are no alternative options as it is a statutory requirement that the Council sets up a Health and Wellbeing Board.

4.2 The terms of reference have been considered and agreed by Council and follow guidance from the Local Government Association and Association of Democratic Services Officers.

5. REASONS FOR RECOMMENDATIONS

5.1 To enable the Board to endorse the Council's establishment of the statutory health and wellbeing board in Enfield, meeting the requirements of the Health and Social Care Act 2012 and the board terms of reference.

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

6.1 Financial Implications

Any costs associated with the creation of the Health & Wellbeing board will be met from existing resources within HHASC.

6.2 Legal Implications

Section 194 (1) Health and Social Care Act 2012 requires a local authority to establish a Health and Wellbeing Board. This requirement comes into force on 1 April 2013. Section 194 (2) sets out the membership.

The functions of a Health and Wellbeing Boards are set out in sections 195 and 196 Health and Social Care Act 2012 and are as set out in paragraph 3.6 above.

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 relate to Health and Wellbeing Boards. They regulate the details of the establishment and arrangements for such Boards.

Section 194(2) sets out the required membership of the Board which includes three officers (the directors of children's services, adult social services and public health). Regulation 5 (1) disapplies the restriction in section 104 (1) Local Government Act 1972 on officers being members of local authority committees. The Director of Environment is not specifically mentioned but as the regulations and statute give local authorities the right to determine the membership of the Board there is no reason why officers other than the three statutory directors should not be appointed if the local authority wishes.

Regulation 6 modifies section 13 Local Government and Housing Act 1989 so that the assumption is that all members of a Board (including

members not set out in statute) will be voting members unless the establishing local authority directs otherwise.

Regulation 7 removes the requirement for allocations and political balance on the Board. The regulations therefore allow for local flexibility.

7. KEY RISKS

7.1 The Council is required under the Health and Social Care Act 2012 to have the Board formally established by 1 April 2013.

7.2 That the Board will need to ensure that it operates under the regulations and statutory requirements.

8. IMPACT ON COUNCIL PRIORITIES

8.1 Fairness for All

The Health and Wellbeing Board will work to ensure that everyone in the borough can access good high quality healthcare according to their needs.

8.2 Growth and Sustainability

Good healthcare is essential for growth and sustainability.

8.3 Strong Communities

An effective health and wellbeing board will ensure the provision of good health and social care services and improve local wellbeing. It will contribute towards the establishment of a strong community where everyone can work together to improve health and care services within the borough.

9. EQUALITIES IMPACT IMPLICATIONS

It has not been necessary to carry out an Equalities Impact Assessment in relation to setting up the Board.

10. PERFORMANCE MANAGEMENT IMPLICATIONS

The Board will monitor the performance of the health services and other bodies concerned with improving health and wellbeing.

11. PUBLIC HEALTH IMPLICATIONS

The Enfield Health and Wellbeing Board has been set up to improve the health and wellbeing of all Enfield residents.

Background Papers

None

Appendix A

Enfield Health and Wellbeing Board
Terms of Reference

Purpose

The purpose of the Board is to improve the health and wellbeing of the residents of Enfield and reduce current health inequalities. The Board will work with partner agencies in delivering improvements to the provision of health, adult and children's social care and housing services.

Vision

Our vision is for a healthier Enfield, where everyone is able to benefit from improvements in health and wellbeing. We want to reduce health inequalities in Enfield and for its people to have a healthier, happier and longer life. We want Enfield to be a healthy and happy place to live, work, raise a family and retire in.

Terms of Reference

1. Aims

The primary aims of the Board are to promote integration and partnership working between the local authority, Clinical Commissioning Group (CCG) and other local services and improve the local democratic accountability of health.

2. Name

The name of the Board will be 'Enfield Health and Wellbeing Board' (EH&WB)

3. Membership

- Cabinet Member for Adult Services, Care and Health
- Cabinet Member for Community Wellbeing and Public Health
- Cabinet Member for Children and Young People
- Cabinet Member for Environment
- Chair of the local Clinical Commissioning Group
- HealthWatch Representative
- NHS Commissioning Board Representative
- CCG Chief Officer
- Joint Director of Public Health
- Director of Health, Housing & Adult Social Care
- Director of Schools & Children's Service
- Director - Environment
- Elected Representative of the Third Sector

Additional members may be appointed to the Board by the agreement of all current members and Council.

NB the Board Manager or their representative will be in attendance at all Board and Executive Meetings.

4. Responsibilities

The Enfield Health and Wellbeing Board will ensure:

- London Borough of Enfield with its partners are equipped to meet its duties
- A Health and Wellbeing Board work plan is implemented, reviewed and updated
- An integrated approach to commissioning
- Alignment of commissioning plans between the Joint Strategic Needs Assessment (JSNA), Pharmaceutical Needs Assessment (PNA) and Joint Health and Wellbeing Strategy (JHWS) and the Clinical Commissioning Group (CCG) Commissioning Plans, including:
    1. Duty to provide opinion on whether the commissioning plan has taken proper account of the JHWS to the NHS Commissioning Board
    2. Power to provide NHS Commissioning Board with opinion on whether a published commissioning plan has taken proper account of the JHWS (a copy must also be supplied to the relevant CCG)
- The power to encourage integrated working across wider determinants of health:
    1. between itself and commissioners of health related services
    2. between commissioners of health and social care services and of health-related services

- The Council has an adequately resourced public health service
- HealthWatch service exists within Enfield and is represented at the Board
- The JSNA, PNA and Joint Health and Wellbeing Strategy are created
- Cabinet, CCG Governing Body and NHS Commissioning Board are kept informed of progress and work of the board
- A work programme for the sub committees is determined and this is kept on track
- To receive the annual public health report/public health issues
- Oversight over the Children's Trust Governance arrangements
- Oversight of the HealthWatch Plans / Annual Report
- The work of the EH&WB be communicated to all Enfield residents through its website and publications
- Equality and diversity issues are addressed
- Performance and quality management
- Promotion of integration and partnership across areas
- Determination of the allocation of any public health budgets

Appendix A

- Support for joined-up commissioning and pooled budget arrangements, where all parties agree this makes sense including Children and Adults Section 75 Arrangements

5. Proposals for Sub-Boards and Work Programmes:

The Enfield Health and Wellbeing Board will be able to appoint sub committees to discharge their functions in accordance with section 102 of the 1972 Local Government Act.

All Sub-Boards will have their Terms of Reference and membership approved by the Health and Wellbeing Board and will need to operate in accordance with the requirements of the full board.

The Board will have an executive group which will meet on a monthly basis to oversee on-going work in between board meetings. Its membership will consist of: the Joint Director of Public Health, CCG Chief Officer, Director of Children's Services and Director of Health, Housing and Adult Social Services.

6. Chairing

The Chair will be either the Leader of the Council or their appointed representative.

7. Voting

Each member of the Board shall have one vote and decisions will be made by a simple majority. The Chair will have the casting vote.

8. Quorum

The quorum for the Enfield Health and Wellbeing Board shall be at least four members or one quarter of the membership, to include a representative from the clinical commissioning group, and a councillor.

9. Frequency of Meetings

Each year there will be at least five formal meetings of the EH&WB as well as any other additional extraordinary board meetings and/or development sessions as called by the board.

10. Conduct of Business of the Health and Wellbeing Board

(a) EH&WB meetings will generally be open to the public and other councillors except where they are discussing confidential and exempt information. This will need to be in accordance with the requirements of the Local Government Act 1972 as amended.

(b) Members of the EH&WB will be entitled to receive a minimum of five clear working days notice of such meetings, unless the meeting is convened at shorter notice due to urgency.

(c) Any member of the Council may attend open meetings of the EH&WB and speak at the discretion of the Chair. A protocol for members of the public to speak at meetings has been drafted and is attached as Appendix 3 to the Terms of Reference.

(d) **Agendas and notice of meetings:** There will be formal agendas and reports which will be circulated at least five working days in advance of meetings.

(e) **Exempt and confidential items:** There will be provision for exempt or confidential agenda items and reports where the principles of the relevant access to information provisions of the Local Government Act 1972 (as amended) apply.

(f) **Reports:** Reports for the EH&WB will usually be prepared by the relevant officer or EH&WB member.

(g) Reports will be presented by the appropriate EH&WB Board member, and must include advice from relevant officers, including finance and legal implications and reasons for the recommendations.

(h) **Minutes of decisions made at EH&WB meetings:** Minutes will be made public within 10 working days of each meeting.

(i) **Officer advice:** Officer advice will be stated fully and clearly within reports to the EH&WB Board.

Appendix A

Appendix 1 to the Terms of Reference

Protocol

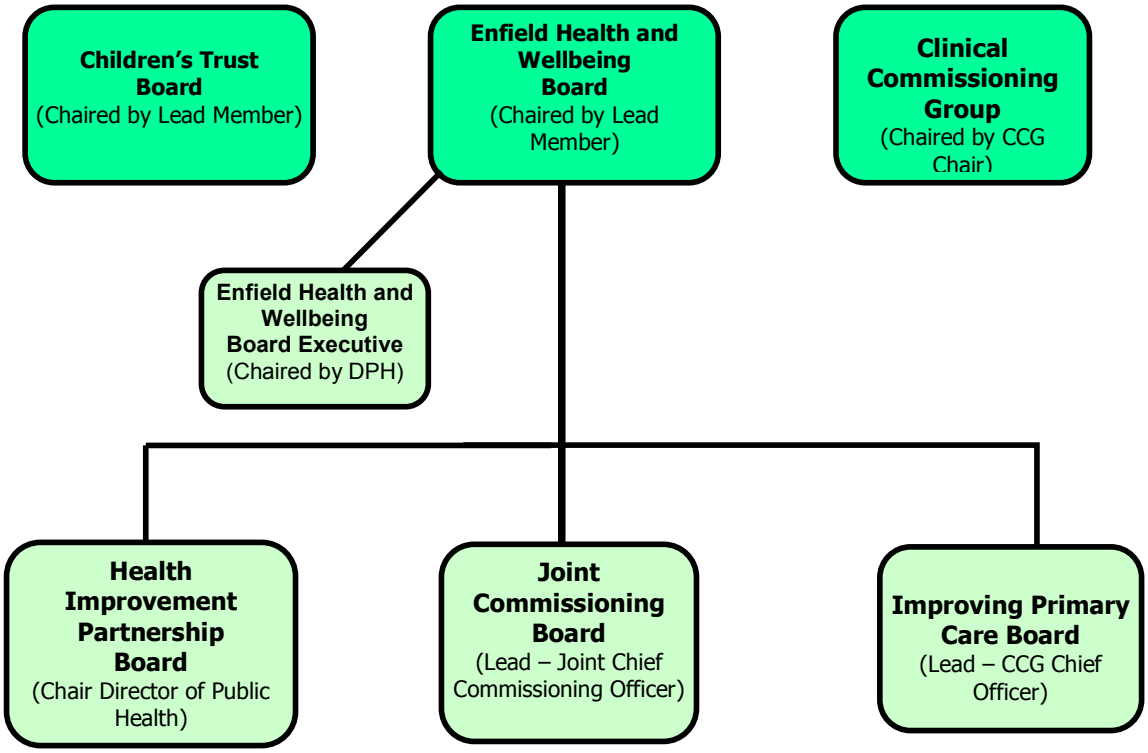
Responsibilities of Members of the Enfield Health and Wellbeing Board (EH&WB)

- Represent and speak on behalf of their sector or organisation
- Power to appoint additional members to the board as deemed appropriate
- Be accountable to their organisation or sector for their participation in the EH&WB and ensure that they are kept informed of the EH&WB business and information from their organisation/sector is reported to the EH&WB
- Support the agreed majority view when speaking on behalf of the EH&WB to other parties
- Attend the EH&WB meetings
- Sign up to the Council's Code of Conduct and declare any disclosable pecuniary, other pecuniary and non pecuniary interests that arise
- Read agenda papers prior to meetings so that they are ready to contribute and discuss EH&WB business
- Uphold and support EH&WB decisions
- Work collectively with other board members in pursuit of EH&WB business
- Ensure that the EH&WB adheres to its agreed terms of reference and responsibilities
- Listen with respect to the views of fellow board members
- Will be willing to take on special tasks or attend additional meetings, functions or developed activities of the EH&WB

Appendix A

Appendix 2 to the Terms of Reference

Structure Chart 2013/14 Enfield Health and Wellbeing Board including proposed sub boards



Appendix A

Appendix 3 to the Terms of Reference: Procedure for speaking at Health and Wellbeing Board Meetings

The Health and Wellbeing Board is a formal meeting. Members of the public cannot take part in the discussion unless they request permission in advance of the meeting, and then only with the agreement of the Chair.

The mechanism for raising an issue is through the deputation process.

If you want to speak at a meeting of the Health and Wellbeing Board you will need to request permission for a deputation.

A deputation must relate to an item on the agenda for the meeting. It can consist of no more than 5 people. Only one member of the deputation will be able to speak, for up to 5 minutes, to address the Board. Members of the Board will then be able to ask questions on the issues raised.

How to request a deputation to the Health and Wellbeing Board

All requests for a deputation to the Health and Wellbeing Board must be submitted in writing to:

The Health and Wellbeing Board Secretary
Governance Team
Finance, Resources and Customer Services Department
PO Box 50
1st floor, Civic Centre
Silver Street, Enfield
Middlesex EN1 3XA

Or by e mail to penelope.williams@enfield.gov.uk

We need to have your request by noon at least two working days before the Health and Wellbeing Board meeting that you wish to speak at.

You should include the following information:

- The purpose of the deputation – what is the matter to be discussed?
- The name, address and telephone number of the person leading the deputation.

How to find out the dates of the Health and Wellbeing Board meetings

Appendix A

The dates of all Health and Wellbeing Board meetings are available on the democracy pages of the Council's website www.enfield.gov.uk/democracy or by contacting the Governance Team on Tel: 020 8379 4098 or democracy@enfield.gov.uk.

Who decides whether the deputation will be allowed?

All requests for deputations to Health and Wellbeing Board meetings are considered by the Chair of the Board. The Chair will either:

- Agree the request;
- If the matter is not appropriate to the Health and Wellbeing Board the request may be referred onto the Chair of a more relevant body such as a scrutiny panel, other council committee or health body.
- Refuse the request.

The Board Secretary will advise you of the decision of the Chair regarding your request. If the request is refused you will be told why.

No more than two deputations will be allowed for any one agenda item at each Health and Wellbeing Board meeting.

A deputation should relate to the Health and Wellbeing Boards area of responsibility and relate to items on the agenda.

If you have any questions regarding the above please contact the Governance Team on 020 8379 4098.

Health and Wellbeing Board

23 April 2013

Agenda – Part: 1	**Item: 4**
Subject: **Update on Authorisation, Transition and Handover Process**	
Date: 23 April 2013	

REPORT OF: NHS Enfield Clinical Commissioning Group

Contact officer and telephone number:

Liz Wise, Chief Officer; 020 8238 3790

E mail: liz.wise@nclondon.nhs.uk

1. EXECUTIVE SUMMARY

This report provides a summary of the overall position of the Authorisation, Transition and Handover processes of NHS Enfield Clinical Commissioning Group by providing:

- An overview for Health and Wellbeing Board
- An update on the CCG Introduction event on 6 April 2013

2. RECOMMENDATIONS

2.1 The Health and Wellbeing Board is asked to note the contents of this report, in particular that:

- To receive and note the briefing about the Authorisation, Transition and Handover Processes.

- To receive and note the update to the CCG introduction event on 6 April 2013

3. AUTHORISATION UPDATE- FROM 1 APRIL 2013

3.1 NHS Enfield Clinical Commissioning Group (ECCG) was authorised by NHS England as a legally established organisation with 7 conditions (out of 119 criteria), including one legal direction, on 6 March 2013. On 1 April 2013, NHS Enfield CCG took on the commissioning responsibility for most of the health services for the Enfield population of 312,500 (2011 Census). It is a membership organisation that comprises all of the GP practices in the borough.

3.2 NHS Enfield CCG commissions services from hospitals, mental health and community services providers including Barnet and Chase Farm Hospitals NHS Trust, North Middlesex University Hospital NHS Trust and Barnet, Enfield and Haringey Mental Health NHS Trust.

3.3 NHS Enfield CCG will be supported by the North and East London Commissioning Support Unit (NEL CSU), which will provide a number of services including business intelligence information, technology and informatics; communications, support for Commissioning/QIPP planning and service redesign; procurement and market management and quality and provider management.

3.4 The CCG is producing a plan by 12 April that outlines the developments it will carry out to resolve the remaining conditions. A summary of the plan will be available following the Governing Body meeting on 24 April 2013.

3.5 NHS England will review the plan and advise the CCG of the outcome by 22 April 2013. Following which, ECCG will work with NHS England to resolve as many of the conditions by its first quarterly review in June 2013.

3.6 The CCG is expecting that there will be Monthly and Quarterly Assurance Reviews and Annual Assurance Reviews until all of the conditions are discharged.

4. ORGANISATIONAL DEVELOPMENT

4.1 NHS Enfield CCG is reviewing and updating the CCG's Organisation Development Plan and developing a new programme to support locality based working in the CCG. This will help to identify the strengths and development areas of the CCG.

5. TRANSITION AND HANDOVER PROCESS

5.1 The North Central London Cluster undertook a number of activities to ensure the smooth handover of PCT functions to CCGs within North Central London. These activities included senior level meetings; development of functional handover certificates and a final list of ongoing issues that would be need to be resolved post 31 March 2013,

where relevant, these have been incorporated in the CCGs risk register and mitigating actions are being taken by the lead CCG managers.

6. FIRST NHS ENFIELD CLINICAL COMMISSIONG GROUP PUBLIC EVENT

On 4 April 2013 NHS Enfield CCG held its first public event as a newly authorised NHS organisation.

Over 80 people attended the launch event at The Dugdale Centre in Enfield Town. During the first half of the evening there were presentations from Dr Alpesh Patel, Chair and Liz Wise, Chief Officer who explained the development and role of the CCG, Dr Shahed Ahmad, Joint Director of Public Health who gave an overview of Enfield's health needs and Richard Quinton, Director of Finance and Commissioning who presented the commissioning strategy and QIPP plans. Ray James, Director of Health, Housing and Adult Social Care at Enfield Council gave an update on Healthwatch Enfield and introduced the new chair Deborah Fowler. After the presentations, the public were invited to ask questions which were answered by the panel.

Following refreshments there were a series of workshops looking at some of the key areas that the CCG will be focusing on over the next year. Round table discussions were held on unscheduled care, the BEH Clinical Strategy, integrated care and primary care.
A full report on the event will soon be made available and in the meantime, the presentations are available at www.enfieldccg.nhs.uk.

7. REASONS FOR RECOMMENDATIONS

To brief Health and Wellbeing Board members on CCG development.

8. KEY RISKS

The CCG reports key risks in the risk register and assurance framework to the Governing Body. Authorisation risks have reduced and relate to implementing the action plan to discharge the 7 conditions. Transition risks have increased pending resolution of issues relating to CCGs' and NHS England's' respective commissioning responsibilities.

Background Papers

None

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Health and Wellbeing Board

23 April 2013

Agenda – Part:1	Item: 5
Subject: Healthwatch Enfield update	
Date: 12th April 2013	

REPORT OF:
Michael Sprosson

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1. EXECUTIVE SUMMARY

1.1 This report has been prepared to provide an update to the Health and Wellbeing Board on Healthwatch Enfield. It provides background and progress to date on development and implementation together with next steps to be carried out.

2. RECOMMENDATIONS

2.1 That the Health and Wellbeing Board note the contents of this report and progress to date.

3. BACKGROUND

3.1 Healthwatch Enfield will be at the heart of the local community, embracing Enfield's diversity, and playing a key part in enabling people to become active residents. As the independent local consumer champion for health and social care in the borough, it will effectively engage and involve individuals, organisations, professionals and the wider public to facilitate genuine improvements in health and social care services in Enfield.

3.2 Healthwatch Enfield will help to ensure people are aware of the health and social care services available to them and how they can get the best out of these services. It will also have a seat on the Enfield Health and Wellbeing Board, ensuring that the views and experiences of patients, carers and others are taken into account when preparing local needs assessments and commissioning strategies, including the Joint Strategic Needs Assessment (JSNA).

3.3 In its direction to local authorities, following the amendments to the Health and Social Care Act 2012, the Government is keen that Councils use flexible approaches in developing local Healthwatch organisations in the way that they think it will best serve their local communities. The Council has taken, and continues to take, account of the views of local people in making decisions about the way Healthwatch Enfield is set up and delivered.

3.4 The Council ran two well attended workshops with residents and key stakeholders present. Approximately 150 people (interested individuals, voluntary and community organisations , patient, user and carer groups, local LINKs representatives) contributed to the visioning of Healthwatch Enfield with a particular focus on the organisational model The Council also sought the views of the wider community through a postal and online questionnaire and through the Residents Panel survey. The Council is proceeding according to the overwhelming majority of respondent's feedback to this programme of engagement. It was agreed to:

- establish a Healthwatch Enfield Reference Group
- recruit a local Healthwatch Enfield Chair and Board members;
- support the development and implementation of a new independent Healthwatch Enfield organisation.

3.5 The Council had received more than 20 nominations for the membership of the Reference Group. The purpose of the Reference Group, comprised of a broad representation from local voluntary and community groups, is to support the development and implementation of Healthwatch Enfield and to carry the messages of Healthwatch Enfield into the local community and to aid consultation. The Reference Group held its first meeting on 4th March 2013 and there was overall acceptance to the approach being taken to developing and implementing Healthwatch Enfield.. It is envisaged that the Reference Group will play a key continuing role going forward,ensuring that the voice of Enfield people is heard.

3.6 From the extensive consultation and engagement carried out, local stakeholders asked for a new independent Local Healthwatch to be set up. The Council has facilitated the set up of a legally constituted body corporate that satisfies the requirements of the NHS bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012. This is a Community Interest Company limited by guarantee and is named as 'Enfield Consumers of Care and Health Organisation' (ECCHO). ECCHO will undertake the role of Healthwatch Enfield, which will be accountable to Enfield Council for the funding it receives and to Enfield residents for its functions.

3.7 To fulfil an immediate statutory responsibility from the 1st April 2013, an interim signposting function that will respond to enquiries from members of the public and provide information or guide to a direction where they can get the relevant information regarding health services, has been set up in within the Council's Access service. A telephone number (020 8379 8119) has been issued to Healthwatch England and NHS Enfield and has been publicised. In addition arrangements are being made to host the local Healthwatch Enfield website which will be up and running imminently.

3.8 The independent Chair, Deborah Fowler, was appointed on 22.3.2013. The Chair's role will include leading and developing Healthwatch Enfield as an independent organisation, setting the strategic plan and direction and introducing strong governance to enable Healthwatch Enfield to represent the views of Enfield's residents. The Reference Group inputted into the recruitment of the Chair by hearing presentations from short listed candidates and providing a view and comments to the interview panel. The interview panel was comprised of elected members, senior health and social care managers and the NHS North Central London Patient Experience and Complaints Manager.

4. CURRENT POSITION

4.1 The recruitment of Board Members for the new organisation is currently in progress. A total of 28 expressions of interest have been received from members of the local community with a variety of skills and experience. The role of Board Members is to act in the capacity of Director and Trustee contributing to the strategic direction of Healthwatch Enfield and ECCHO, and ensuring effective service delivery, and strong governance and management. Specialist skill sets sought from applicants include :

- Community Involvement and Engagement
- Championing the Consumer
- Finance
- Improvement and Quality
- Strategy, long-term planning
- Human Resources
- Governance, Compliance and Legal
- Marketing, communications, media and social media
- Health and Social Care Services

4.2 The Reference Group will not be participating in the recruitment process for Board Members to avoid any conflicts of interest given a number of applications received from local voluntary and community

sector organisations. Interviews for short listed applicants are scheduled for the 7th and 8th May 2013.

4.3 The recruitment for a Chief Executive Officer is currently in progress. The purpose of this key role is to : secure improvements to local health and social care services by collecting and using locally expressed views in a powerfully persuasive way ; meet all statutory, regulatory and contractual requirements and to devise and execute a strategy for the effective and efficient delivery of the roles of Healthwatch Enfield and ECCHO. An advertisement has been placed in the Guardian and has already attracted significant interest. The closing date for applications is 29th April 2013. The Reference Group have been asked to replicate the role it played in the Chair recruitment process and presentations to the group from shortlisted candidates has been scheduled for 9th May 2013 with final panel interviews scheduled for 13th May 2013.

4.4 Key next steps and milestones in the implementation of HEalthwatch Enfield include :

- staff and volunteer recruitment
- establish a base of operations
- to agree a signed service level agreement between the Council and ECCHO for the delivery of Healthwatch functions

4.5 Further updates on implementation can be provided to the Health and Wellbeing Board on request.

5. FINANCIAL AND LEGAL IMPLICATIONS

5.1 There are no implications to the recommendation made within this report.

END OF REPORT

Health and Wellbeing Board

Agenda – Part: 1	Item: 6
Subject: **The Family Nurse Partnership Programme (FNP)**	
Date: 23 April 2013	

REPORT OF:
Andrew Fraser
Director of Schools and Children's Services

Contact officer and telephone number:
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1. EXECUTIVE SUMMARY

The Family Nurse Partnership (FNP) is an evidenced based, preventative programme offered to vulnerable young mothers having their first baby. It is a nurse led intensive home-visiting programme from early pregnancy to the age of two. It has three aims:

- improve pregnancy outcomes;
- improve child health and development;
- improve parents' economic self-sufficiency.

It is a "licensed" programme with structured inputs and well-tested theories and methodologies. It has a strong and rigorous US evidence base, developed over the last 30 years and has been shown to benefit the most needy young families in the short, medium and long term across a wide range of outcomes, helping improve social mobility and break the cycle of inter-generational disadvantage and poverty.

The criteria for women to be offered the FNP are:

- All first time mothers aged 19 and under at conception;
- Living in the agreed catchment area;
- Eligible if previous pregnancy ended in miscarriage, termination, still birth, multiple births included.
- Enrolment should be as early as possible in pregnancy and no later than the 28th week of pregnancy. 60% should be enrolled by the 16th week of pregnancy.

Women are excluded if they plan to have their child adopted or they have had a previous live birth.

The Government made a commitment in October 2010 to double the number of places on FNP, to 13,000 places by 2015. There are now around 9,000 places in 74 teams in 80 local areas. There is a new commitment to increase the numbers to 16,000.

FNP will be fully funded for the first two years during which time commissioners will be expected to develop a strategic vision for FNP in Enfield as part of wider maternity and children's services and ensuring that the programme is included in future commissioning plans for the wider Health Visiting service from April 2015.

It is imperative that for FNP to succeed that it has senior sponsorship from the NHS and Local Authority, ie, LA Director of Children's Services, Director of Public Health, Chief Operating Officer in the provider organisation

2. RECOMMENDATIONS

The Health & Wellbeing Board are asked to:

Note:

- the aims of the Family Nurse Partnership (FNP); and
- progress to-date implementing the FNP in Enfield.

Agree:

- To support the development of FNP across Enfield.

3. BACKGROUND

3.1 FNP Team have caseloads of up to 25 families per practitioner, and therefore the work is much more intense, and relies heavily on the ability of the practitioner to build a trusting and lasting therapeutic relationship with the mother.

3.2 The Team undergo comprehensive training and are expected to maintain the "fidelity" of the programme by ensuring that they deliver the programme to the families they are working with as specified by the license. The license ensures that the programme is not diluted or compromised when implemented, ensuring that children and families are likely to benefit as shown in the research. Expected outcomes include:

- Improvements in antenatal health
- Reduced numbers of low birth weight babies
- Increase in breastfeeding rates
- Increased uptake of childhood immunisations
- Reductions in children's injuries, neglect and other abuse
- Improved parenting practices and behaviour
- Fewer subsequent pregnancies and greater intervals between births
- Improved early language development, school readiness and academic achievement
- Increased maternal employment and reduce welfare use
- Increases in fathers' involvement.

3.4 From the outset the parents know that FNP finishes when their child is two years old. During this time the Family Nurse works with the parents to help them become confident and independent making the most of local services, such as Children Centres.

3.5 FNP sits at the intensive end of the prevention pathway for more vulnerable children and families. It needs to be embedded within the local Healthy Child Programme and safeguarding arrangements as part of health visitor, children's centres, GP and maternity services.

3.6 FNP must have a Local Advisory Board who understand and are committed to the programme. The Board provides strong strategic leadership and clear accountability as well as ensuring that the conditions of the licence are met. They must also ensure that a project plan is in place and delivered on time, along with making sure that FNP is delivered to the highest quality standards, including information collection.

Progress in Enfield

3.7 A small project group has been established to initially set up and drive FNP. An immediate priority is to establish an FNP Advisory Board. Initial discussions have identified that the Board will have the following membership which is in accordance with what the programme recommends:

Name	Role on Advisory Board	Organisation
Claire Wright	FNP Lead Commissioner and Chair of Advisory Board	NHS North Central London
Kathy Soderquist	FNP Lead Provider	BEH Mental Health Trust
Eve Stickler	LA Lead	Enfield Council
Michele Guimarin	FNP Commissioner and Joint Implementation Manager	NHS North Central Lonond
Sarah McLean	Joint Implementation Manager	Enfield Council
Cath Fenton	Healthy Child Programme Lead	Public Health, Enfield Council
TBA	Children's Services (Safeguarding)	Enfield Council
TBA	Maternity Services	Acute Trusts
TBA	Service Users	-
TBA	Voluntary Sector	-
Jackie Luther	Children's Centre Lead	Enfield Council
TBA	Change & Challenge	Enfield Council
TBA	Designated Safeguarding Nurse	BEH Mental Health Trust

3.8 Members of the small project group have met with Pip O'Byrne to discuss progress, issues and ensure that we are committed to the FNP. Contact will be made with neighbouring Boroughs

such as Barnet who have been running FNP for a year so that we can learn from their experience.

3.8 Office and storage space has been identified for the Team on the St Michael's Hospital site.

3.9 Team members will need to be a qualified Health Visitor, School Nurse, Midwife or Mental Health Nurse. The Team will be supported by a part time administrator

3.10 An advertisement for the Supervisor post is currently being drafted. The appointee will need to attend 3 days residential training from 3 – 5 July 2013, and then a further 5 days residential training in October. Therefore, the rest of the team will need to be appointed by the end of September 2013 so that they are all able to attend the 5 day residential training.

3.11 In 2010, there were 192 births to women under 20 years of age and it June 2012, according to the Department of Health there were estimated to be 207 teenage mothers under the age of 20. Based on this figure, it has been agreed that in the first instance FNP in Enfield will be delivered by a team of 5 including a supervisor, who will have a smaller caseload of about 4. This will ensure that appropriate clinical supervision is available for the Team. Therefore, the total caseload of the team will be 104. They will need to achieve enrolment of 60% by 16 weeks of their pregnancy, and 80% by 28 weeks of their pregnancy.

3.12 During the first year it will be decided if the Team needs to be expanded to six.

4. ALTERNATIVE OPTIONS CONSIDERED

No alternative options have been considered.

5. REASONS FOR RECOMMENDATIONS

The FNP brings an opportunity for Enfield to participate in the delivery of a programme with 30 years of high quality US research which brings significant benefits for vulnerable young families in the short, medium and long term across a wide range of outcomes.

6. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

6.1 Financial Implications

The programme is fully funded by the Department of Health for first two years. During this time commissioners will be expected to develop a strategic vision for FNP in Enfield as part of wider

maternity and children's services and ensuring that the programme is included in future commissioning plans for the wider Health Visiting service from April 2015.

6.2 Legal Implications

6.2.1 Section 2B of the National Health Service Act 2006 came into force on 1 April 2013. Section 2B(1) imposes a duty on each local authority to take such steps as it considers appropriate for improving the health of the people in its area. Subsection 3 sets out the steps which may be taken under subsection 1. These include (a) providing information and advice; (b) providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way) and (c) providing assistance… to help individuals to minimise any risks to health arising from their accommodation or environment.

6.2.2 Section 195 (1) of the Health and Social Care Act 2012 also came into force on 1 April 2013. It imposes a duty on a health and wellbeing board, for the purpose of advancing the health and wellbeing of the people in its area, to 'encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner'.

6.2.3 This proposal would appear to meet the requirements of both these statutory duties.

7. KEY RISKS

7.1 The provider organisation are unable to recruit the right calibre of staff to FNP Team or there are delays due to notice periods.
7.2 General slippage in the overall implementation could delay the start of the FNP.
7.3 Strategic Leaders across the agencies are not committed to delivering FNP in Enfield.

8. IMPACT ON COUNCIL PRIORITIES

8.1 Fairness for All

FNP supports vulnerable young women and their families to access services and have improved health and education outcomes for themselves and their families.

8.2 Growth and Sustainability

FNP is proven to improve the take up further education and employment of this vulnerable group, and therefore, will impact not only on their own self-esteem but that of their family, and reduce the burden on the welfare state.

8.3 Strong Communities

Supporting some of our most vulnerable young families will encourage them to take-up services to help them become less reliant on others and have aspiration for the future. FNP has proven outcomes in term of crime prevention.

5. EQUALITIES IMPACT IMPLICATIONS

Further discussion is required with regard to the equalities impact implications.

6. PERFORMANCE MANAGEMENT IMPLICATIONS

The programme has very clear performance management outcomes that must be adhered to, and the staff, who will be employed by the provider organisation (Barnet, Enfield & Haringey Mental Health Trust) will follow the performance management scheme of that organisation.

7. HEALTH AND SAFETY IMPLICATIONS

The staff delivering the programme will be employed by the provider organisation, and will be protected by the organisation's policies in relation to health and safety, such as their Lone Worker Policy.

8. PUBLIC HEALTH IMPLICATIONS

By targeting vulnerable young women and their babies FNP has the potential to impact on the health and well-being of these families. For example, infant mortality, low birth weight, take up of immunisation. In addition, FNP aims improve parenting and attachment between mother and baby which will impact on the future outcomes of the child in terms of language and emotional development, school readiness and academic achievement.

Background Papers

None

Agenda Item 7

MUNICIPAL YEAR 2012/2013 REPORT NO.

MEETING TITLE AND DATE:
Heatlh and Wellbeing Board
23 April 2013

REPORT OF:
Director of Public Health

Agenda – Part: 1	**Item: 7.1**
Subject: Health Improvement Partnership Board Update **Wards: All**	
Cabinet Member consulted:	

Contact officer and telephone number: Glenn Stewart 0208 379 5328

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1. EXECUTIVE SUMMARY

1.1 This report provides an update on the work of Public Health, including:

- Tobacco control / smoking cessation
- Immunisation
- Big Lottery Funding – Fulfilling Lives
- Joint Strategic Needs Assessment / Health and Well-being Strategy
- Sexual Health
- Transport and Health
- Child health update
- Adult Health update
- Public Health Transition to the Local Authority

2. RECOMMENDATIONS

2.1 The Board is asked to note the contents of this report, in particular that:

- Smoking is the greatest cause of death in the borough.
- Good progress has been achieved on immunization rates
- Enfield is in the process of submitting a bid to the Big Lottery Fulfilling Lives fund.
- Enfield is submitting a bid to the GLA as part of the Mayor's Vision for Cycling. The potential impact of increased cycling is noted.
- Work continues on childhood obesity though prevalence remains high
- Life-expectancy has improved but the female life-expectancy gap between wards is amongst the worst in London and the country.
- Public Health will transfer to the Local Authority from 1st April 2013 with a number of responsibilities transferring from the NHS to the Local Authority.

3. Tobacco Control / Smoking Cessation

3.1 Smoking is the greatest preventable cause of death in the borough responsible for approximately 20% of deaths in the borough.

3.2 The smoking trajectory target of 950 four-week quitters by the end of Q3 was achieved by 10th March. Q4 data is not due until 17th June (due to data reporting requirements reporting is always approximately 2.5 months after the quarter ends).

3.3 A number of events were held for National No-Smoking Day (11th March 2013). These included a stall in the Enfield Town Market place and the instigation of smoke-free play areas in parks. This has been forwarded to the Institute of Health Equity (headed by Sir Michael Marmot) for possible inclusion on their website as good practice.

4. IMMUNISATION

4.1 Sustained work in chasing and cleaning data has resulted in good results for Enfield with improvements seen for all immunisations.

4.2 However, analysis of levels of immunisation reporting within the quarter indicates the importance of retaining a focus on data quality and completeness to ensure that coverage figures remain high.

4.3 There has been a range of promotional activities undertaken since the last HIP; this includes:

- The development of a new poster
- Advertising in the local newspaper
- Advertising on and in buses
- Work with schools has resulted in many local schools agreeing to display banners on their perimeter fences to promote immunisation to their families
- Working with schools and children's services has resulted in a leaflet to go to parents when their child obtains a place at a local primary school.
- Following encouraging feedback from parents and professionals of a magnet displaying the immunisation schedule, further magnets are being ordered for distribution.

4.4 It is however a concern that large numbers of children, e.g. 130 in the age one cohort, have an unknown GP but cannot be removed from the system therefore distorting figures.

4.5 The following table illustrates progress on childhood immunisations to date highlighting plan to date and current period:

Target	Immunisation	Plan YTD	Current Period
90%	Immunisation, 1 yr old Dta/IPV/Hib	79.5%	86%
	Immunisation, 2 yrs PCV	73.5%	83.3%
	Immunisation, 2 yrs HIB/MenC	70.7%	80.1%
	Immunisation, 2 yrs MMR	73.9%	83.8%
	Immunisation, 5 yrs DTaP/IPV	67.2%	81.2%
	Immunisation, 5 yrs MMR	65.1%	78.2%

5. Fulfilling Lives: A Better Start – Big Lottery Funding Bid

5.1 Fulfilling Lives: A Better Start aims to deliver a step change in the use of preventative approaches for babies and children from pregnancy to three years of age.

5.2 The total funding available for the programme is £165million and which is expected to be awarded tot between 3 and 5 areas over 8 to 10 years.

5.3 The deadline for expressions of interest was 22nd February 2013 and that between 30 and 50 areas will be long-listed. Applicants successful at this stage will be invited to submit a stage 1 application form. Areas successful at this stage will be notified on on April 9th.

5.4 Enfield has submitted an expression of interest headed by Eve Stickler, Assistant Director of Commission / Community Engagement.

6. JSNA and HWB Strategy Update

6.1 Work to produce the refresh of the JSNA is underway and key staff including Information Analysts are now in place. The steering group/project board is meeting regularly and the commitment and engagement from across the partnership is positive.

6.2 Project planning work has highlighted the tight deadlines that need to be met to deliver the strategic needs information and other agreed outputs by end of April 2013, as follows:

- 'on line access' to the data
- information for local residents including leaflets

- factsheets in key areasa high level summary document - this will summarise the available intelligence and identify the key issues for the borough in order to inform the Health and Wellbeing Board and shape the community engagement on priorities that will follow

6.3 The risk of slippage is being monitored and mitigated by:

- prioritising those deliverables essential to inform the development of the Health and Wellbeing Strategy and draft priorities including the accompanying consultation exercise
- securing additional external capacity as identified as needed as the work proceeds

6.4 Factsheets will be prepared and made available by the end of April and further factsheets produced as work progresses.

6.5 The JSNA will be primarily an on-line source of information providing information and intelligence based on the indicators identified within the public health outcome framework, the adult social care outcome framework, locally agreed key children and young people's indicators and indicators identified from the NHS outcome framework.

6.6 The JSNA will be a source of intelligence that will grow as time and resources permit.

6.7 The above inputs will directly inform the development of the Health and Wellbeing Strategy by identifying key issues based on the data refresh. The JSNA will not itself set priorities as this will be the role of the Health and Wellbeing Board for inclusion in their strategy and accompanying action plans.

6.8 Project planning process for the Joint Health and Wellbeing Strategy has commenced. The positive partnership work being undertaken for the JSNA is proving invaluable in establishing some of the key contacts essential for this work.

7. Transport and Health

7.1 The London Mayor has launched a new strategy to increase cycling in London; 'The Mayor's Vision for Cycling'. This seeks to make a transformative change to cycling prevalence in London by making cycling a normal part of everyday life. The vision is explicit that this is not aimed at people who wear lycra or who already cycle.

7.2 Over the next 10 years £913 million will be spent to achieve this. Most of the additional expenditure will be focussed on inner London but outer London will also see a significant increase – from £3 million to over £100 million.

7.3 There is an intention to work with 3 outer-London Boroughs where there will be very high spending on relatively small areas creating 'mini-Hollands' in the boroughs.

7.4 Journeys under 2 miles in Enfield have been estimated to cost Enfield residents approximately £14 million per year and £85 million per year for journeys under 5 miles.

7.5 Health benefits from cycling include access to employment, services, reduced congestion, increased social cohesion, reduced air pollution, reduced road traffic injuries and increased physical activity. The benefit cost ratios of improving infrastructure to increase cycling prevalence in more robust studies are approximately 5:1.

7.6 Enfield will be making a bid to attract this funding with a submission date in September 2013.

8.0 Child Health Update

8.1 Breastfeeding

Work to promote, encourage and support breastfeeding has continued. This has included:

- Trained breastfeeding helpers are working within Children's centres. A further 24 women will be trained 2013
- Local advertising has taken place to raise awareness of the importance of breastfeeding and to "normalise" the practice
- "Breastfeeding welcome" is being promoted throughout premises in the borough so that women can easily see (through the display of a sticker) where they will be welcome to breastfeed; to date over 60 businesses have signed up to the scheme.
- A new specialist health visitor has recently been appointed who will lead on breastfeeding within the service;
- 30 members of community health staff recently received specialist breast feeding trained by Middlesex University.

8.2 **Childhood obesity**

During 2011/12 the highest participation rate ever in NCMP was recorded for Enfield. Whilst the prevalence of obesity remains significantly higher than England and London averages; prevalence in both reception and year 6 aged Enfield children fell from the preceding year.

Work to reduce prevalence has continued:

- Change4Life programmes (to support healthy eating and increased physical activity) for 1-4 year olds was rolled out in Children's Centres in the summer of 2011. Initial results are encouraging.

- Joint initiatives with the Sports Development team and the Health Trainers service are being explored to provide support to school aged children; the first pilot project started February 2013.
- The British Heart Foundation attended our local Child Health Steering Group to promote the support that they can offer Enfield. They also attended the "Say it like it is" event to promote the resources available to local schools. A range of resources were supplied to all Enfield primary schools during February to encourage physical activity and healthy eating
- Following ideas suggested by children at the "Say it like it is" event, a healthy eating cookbook is being developed including recipes from children to reflect the diversity of the borough. Taster physical activity sessions are also being offered at primary schools, including sessions such as Latin dance and Zumba.
- Work with young people will create a new advertising campaign, using their messages, ideas and media to increase effectiveness and relevance
- A childhood obesity board has been established to oversee the work taking place in the borough

8.4 Teenage pregnancy / sexual health

The number of conceptions in Under 18 year olds is falling in Enfield and this has been a consistent trend; this is the 4th year of continuous decline and the second largest decline in London since 2006.

However there are other areas of sexual health which require more work – this is relevant for all age groups rather than just young people.

- There is still work to be done in reducing the proportion of HIV cases diagnosed late and in increasing the number of people screened for Chlamydia.
- Sexual Health in Practice (SHIP) training has been offered to practice staff in Enfield and there has been an encouraging uptake by practice nurses and GPs. The aim of the training is to normalise the provision of testing for sexually transmitted infections within primary care.

9. Adult Health

9.1 No new data has been released since January 2012, a further release is expected in 'the summer' of 2013 but a more exact date has not been released.

9.2 In males January 2012 data indicates that between 2007-9 and 2008-10 male life-expectancy at birth in Enfield rose by 4 months from 79.1 to 79.5 years. This compares to a rise of 3 months in London and 4 months in England.

9.3 Enfield male life-expectancy is the 129th best in England and Wales. Highest life expectancy is Kensington and Chelsea (85.1) and worst, Newham, 76.2 years (ranked 303).

9.4 In females January 2012 data indicates that life-expectancy rose from 82.9 in 2007-9 to 83.0 years in 2008-10. This compares to a rise in London of 0.2 years from 81.3 to 83.3 and an England rise from 82.31 to 82.57 (0.26 years).

9.5 Enfield female life-expectancy is the 154th best in England and Wales. Highest life expectancy is Kensington and Chelsea (89.8) and worst, Bolton, 80.6 (ranked 303).

9.6 Despite the above ward level data indicates that female life-expectancy in Upper Edmonton is now in the worst 5% of wards in London.

9.7 The life-expectancy gap between Upper Edmonton and Highlands is 13 years e.g. 90 years compared to 77.

9.8 A workshop on this has been held between LBE and partners with further workshops and an action plan being developed.

10. Transition

10.1 From April 1st Public Health transferred into the Local Authority. As part of this transfer the Local Authority will have responsibility for:

- Health Checks
- Sexual Health services
- Drug and Alcohol Misuse services
- School Nursing Services
- Dental Public Health
- Obesity & Weight management services
- Tobacco control and Smoking Cessation
- TB Find & Treat (Infection Control)

10.2 The Local Authority will also have responsibility for the 66 indicators contained in the Public Health Outcomes Framework (PHOF). The PHOF contains four domains:

- Domain 1: Improving the wider determinants of health
- Domain 2: Health Improvement
- Domain 3: Health protection
- Domain 4: Healthcare public health and preventing premature mortality

10.3 The transition workstream is almost complete. However, some finance arrangements have not been finalised and LBE is seeking clarity on a number of contracts. These include block contracts such as sexual health and componants of the smoking contract e.g. the transfer of funding for Nicotine Replacement Therapy (NRT).

11. REASONS FOR RECOMMENDATIONS

The above recommendations reflect current work within the Directorate of Public Health

12. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

12.1 Financial Implications

No financial implications

12.2 Legal Implications

No legal implications

Background Papers

None

Health and Wellbeing Board
23 April 2013

Agenda – Part: 1	Item: 7.2
Subject: Joint Commissioning Board Report	
Date: Tuesday 23rd April 2013	

REPORT OF:

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1. EXECUTIVE SUMMARY

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

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

1.3 Haringey and Enfield CCGs have invited the Council's Director of Health, Housing and Adult Social Care to join their commissioning and contracting discussions with the North Middlesex University Hospital Trust, as part of plans to widen the agenda to explore how the Trust can make a contribution to both more integrated health and social care systems and to the wider determinants of health in the local area.

1.4 The report notes that:

- Section 75 Agreement schedules are being updated to reflect new governance structures and reporting lines resulting from NHS transitional changes and the transfer of some responsibilities to the Council.

- A NHS Social Care Grant draft spending plan has been produced in accordance with conditions set by the National Commissioning Board.
- An Efficiencies Workshop, led by the Adult Social Care Efficiencies Group, took place on Thursday 28th March 2013, with the purpose of identifying and prioritising efficiency measures to meet the 2014/2015 departmental savings gap. Emerging good practice will be shared with the Local Government Association to inform the national Adult Social Care Efficiencies Programme.
- The Healthwatch Enfield Reference Group held its first meeting on 4th March 2013. An independent Chair was appointed on 22nd March 2013. Work now progresses to recruit trustees to the new organisation. This will be followed by the recruitment of a full time Chief Executive in April 2013.

- Following approval of the Voluntary and Community Sector Strategic Framework (VCSSCF) by Cabinet on 23rd January 2013, work is now underway to review grant funded organisations, to ensure that services being delivered are achieving value for money, and are strategically relevant.

1. EXECUTIVE SUMMARY (CONTINUED)

- The Council has been successful in its application to the Department of Health to become a development site for the implementation of direct payments in residential. A two-year pilot programme now commences.

- A Department of Health consultation seeking views on the roll out of direct payments in healthcare commenced 1st March 2013 and will close 26th April 2013. A joint consultation response shall be prepared.

- The Quality Checker programme has now recruited and provided training to 50 Quality Checkers who will visit services and give their view on the quality of care. The Quality Checkers have now undertaken 57 site visits and identified 191 things that have impressed, and 101 areas of improvement.

- Work continues as part of the Integrated Care for Older People Programme:

  - a Network Multidisciplinary Team has now been established in the North West locality;
  - good progress continues in relation to the implementation of Joint Commissioning Strategies;
  - North Middlesex University Hospital & Barnet & Chase Farm Hospitals now have their admission avoidance services in place and outcomes are being evidenced;
  - the Fracture Liaison Service is in place and working well; 197 patients have been identified for follow up from the fracture clinic, 116 screening calls have been made, where advice has been given.

- On 1st April 2013, 145 contracts were transferred from NHS Enfield to the local authority and two contracts were wavered, as part of the transition of Public Health services.

- In February 2013, a bid was submitted for £660,000 against the European PROGRESS social fund to develop Dementia Friendly Communities in Enfield. The European Union will make a decision on the bid in June/July 2013.

- A procurement exercise to commission work opportunities, support and associated employment activity for people with mental health issues has now been completed and a contract has been awarded to The Richmond Fellowship.

- The Enfield Clinical Commissioning Group has developed an action plan in response to the Winterbourne View Concordat. The key messages from the concordat are that each locality should commit to jointly reviewing all people with learning disabilities and / or autism within in-patient facilities to ensure that people are appropriately placed in good quality, safe provision.

- Funding has been approved through NHS Enfield CCG for two new posts at Enfield Carers Centre.

- Enfield CCG and the Enfield Council have confirmed their commitment to the development of the Family Nurse Partnership, which is an intensive early intervention programme for vulnerable young first time mothers.

2. RECOMMENDATIONS

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

3. SECTION 75 AGREEMENT – COMMISSIONED SERVICES FOR ADULTS

3.1 Section 75 Agreement schedules are in the process of being updated to reflect new governance structures and reporting lines resulting from NHS transitional changes and the transfer of some responsibilities to the Council. Schedules relating to Public Health, the Drug and Alcohol Action Team and Deprivation of Liberty Safeguards will be removed as the statutory responsibility now lies with the Council or funding is now transferred directly to the local authority negating the need for a Section 75 Agreement. The changes to the Agreement are being progressed and will be subject to final approval by the Director of Health, Housing and Adult Social Care and the Chair of Enfield Clinical Commissioning Group in April 2013. A final year review of 2012-13 is being undertaken and will be presented to the Joint Commissioning Board in April 2013, so learning can be applied in 2013-14.

4. NHS SOCIAL CARE GRANT

4.1 A NHS Social Care Grant draft spending plan has been produced in accordance with the conditions set by the National Commissioning Board. The plan accounts for 2013/2014 income, in addition to agreed carry forwards from previous allocations in 2011/2012 and 2012/2013, plus an assumed income for 2014/2015. The draft spending plan includes a contribution to ensure existing services that would otherwise reduce continue and contribute to demographic pressures. In addition it is proposed that the funding is use to support a number of the existing projects funded by the grant and some invest to save initiatives in 2013-14. The draft spending plan is subject to approval by the Director of Health, Housing and Adult Social Care and Cabinet Member for Adult Services and Care in April 2013

5 ADULT SOCIAL CARE EFFICIENCY PROGRAMME

5.1 Following completion of the Local Government Association Efficiencies Programme (Phase One) an Adult Social Care Efficiencies Group has been set up, with the purpose of taking forward selected efficiency recommendations internally and identifying additional opportunities to realise efficiencies across the department.

5.2 An Efficiencies Workshop, led by the Adult Social Care Efficiencies Group, took place on Thursday 28th March 2013, attended by Commissioning, Procurement and Operational Managers across Adult Social Care, with the purpose of identifying and prioritising efficiency measures to meet the 2014/2015 departmental savings gap. The workshop provided a real opportunity to share knowledge, expertise and ideas around how we may best work together to deliver both short term (2014-2015) and long term

(2015-2017) efficiencies whilst improving outcomes for people who use services. The Efficiencies Group will now work to prioritise the 'top three' areas of action to progress, for agreement by the Health, Housing & Adult Social Care Departmental Management Team.

5.3 Engagement with the Local Government Association continues, and the Council will share good practice that emerges internally to inform the national Adult Social Care Efficiencies Programme.

6. HEALTHWATCH ENFIELD

6.1 The Healthwatch Enfield Reference Group held its first meeting on 4th March 2013. There was overall acceptance to the approach being taken to develop and implement Healthwatch Enfield. The Reference Group has informed the recruitment of the Chair by hearing presentations from short listed candidates and providing a view and comments to the interview panel. It is envisaged that the Reference Group will play a key continuing role going forward, ensuring that the voice of Enfield people is heard.

6.2 An independent Chair of was appointed on 22nd March 2013. The Chair's role will include leading and developing Healthwatch Enfield as an independent organisation, setting the strategic plan and direction and introducing strong governance to enable Healthwatch Enfield to represent the views of Enfield's residents. The interview panel comprised of elected members, senior health and social care managers and the NHS North Central London Patient Experience and Complaints Manager. Officers have met with the Chair and early discussions have taken place on how the Council may best support the Chair in the further development and implementation of Healthwatch Enfield.

6.3 Work now progresses to recruit trustees to the new organisation. This will be followed by the recruitment of a full time Chief Executive by the Chair and trustees. The Chief Executive, along with recruited volunteers and paid staff, will be responsible for the operational function of Healthwatch Enfield ensuring that the statutory functions of Healthwatch are delivered. Officers are now working closely with the Chair to prepare the recruitment process to this key position. Appointments for board members and the Chief Executive position have been targeted for completion by the end of April 2013.

6.4 From the extensive consultation and engagement carried out, local stakeholders asked for a new independent Local Healthwatch to be set up. The Council has facilitated the set up of a legally constituted body corporate that will be responsible for the delivery of statutory Healthwatch functions. This is a Community Interest Company limited by guarantee and is named as 'Enfield Consumers of Care and Health Organisation' (ECCHO).

6.5 To fulfil an immediate statutory responsibility from the 1st April 2013, an interim signposting function that will respond to enquiries from members of the public and provide information or guide to a direction where they can get the relevant information regarding health services, has been set up in within the Council's Access service. A telephone number has been issued to

Healthwatch England and NHS Enfield and will be publicised. In addition arrangements have been made to host the local Healthwatch Enfield website which will be up and running on 3rd April 2013

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

7.1 Following approval of the VCSSCF by Cabinet on 23rd January 2013, work is now underway to review grant funded organisations, to ensure that services being delivered are achieving value for money, and are strategically relevant. This will be a phased process conducted over the next three years as follows:

- Phase One: March – September 2013 : A review of all organisations in receipt of core funding
- Phase Two: September 2013 – January 2015 : A review of organisations currently funded for the provision of information, advice and guidance and advocacy services
- Phase Three: September 2014 – June 2015 : A review of organisations currently funded to provide high value preventative/day care/carers services
- Phase Four: 2015 – 2016 : A review of organisations currently funded to provide low value preventative/day care/carers services

7.2 Work is also in progress to commission a new integrated information, advice and advocacy service to be provided by local VCS organisations. Commissioners are engaging with a wide range of stakeholders including service users, carers and VCS organisations to co-produce service outcomes, aims and objectives.

8. PERSONALISATION

8.1 Direct Payments in Residential Care

8.1.1 The Council has been successful in its application to the Department of Health to become a development site for the implementation of direct payments in residential. A two-year programme of piloting sponsored by the Department of Health, will now be launched in a number of sites across England. The aim is to explore whether and how direct payments for people in residential care can give them and their families control over the resources available to pay for all or some of their care, and the possible wider impacts, with a view to informing Ministers' consideration of potential wider roll-out.

8.2 Consultation on Direct Payments for Healthcare

8.2.1 Following the pilot of personal health budgets in over 60 sites across England from 2009 to 2012, the Government wants personal health budgets to become an option for patients across the country. As a first step, the DoH have said that from April 2014, all patients receiving NHS Continuing Healthcare will have the right to ask for a personal health budget. Clinical Commissioning Groups (CCGs) and in some cases, the Board, will also be

able to offer them to other people who they think may benefit, where the benefits outweigh any potential additional costs.

8.2.2 The DoH want to give all parts of the country the power to offer direct payments for healthcare by removing the pilot site restriction. They intend to make changes to the rules for how direct payment for healthcare work.

8.2.3 A consultation seeking views on the proposed changes commenced 1st March 2013 and will close 26th April 2013. A joint consultation response shall be prepared.

9. SPECIALIST ACCOMMODATION

9.1 Mayor's Care & Support Specialist Housing Fund

In January 2013 the Council submitted two bids to the Mayor's Care & Support Specialist Housing Fund for capital funding to improve specialist accommodation for people with disabilities in the borough. A decision on whether these bids have been successful is now expected in May 2013. The Health & Wellbeing Board will be updated accordingly.

9.2 Improving Housing Design

Following a presentation to the regional Housing Learning & Improvement Network(LIN) on designing homes for people with learning disabilities and challenging behaviours, Enfield's local design guide (produced by housing, occupational therapy and adult social care commissioning colleagues in partnership with service users and their carers) will be uploaded onto the Housing LIN website for national reference. Work to improve local design guidance as a tool for informing good quality housing development for other service user groups, including people with dementia continues.

10. SAFEGUARDING

10.1 Safeguarding Adults Board

10.1.1 The Safeguarding Adults Board was held on the 11th March 2013 and continues to monitor progress on the Safeguarding Adults Strategy action plan. Partners contributed information on how their organisations involve those who use services in the quality assurance and development of their safeguarding activity. In addition, the Police presented a report on safeguarding activities within the organisation, identifying areas for further review in an effort to ensure adults at risk have equal access to the justice system. A number of recommendations were made from this report, which if implemented, will strengthen the multi-agency work to safeguard adults from abuse and the response when abuse does occur.

10.2 Community Help Point Scheme(CHPS)

10.2.1 The Community Help Point Scheme, recognised nationally as the first of its kind, was set up originally for children and young people to support their safety as they navigate throughout the Borough. Businesses and organisations nominate themselves to act as help points and undergo DBS checks and training. From the 18th March, this scheme was extended to cover adults at risk. Any person feeling lost, frightened or afraid can look for the CHPS symbol to access support.

10.3 Organisational Learning with Providers

10.3.1 Concerns with the quality of care and safety of residents within provider services are managed within the Safeguarding Adults Provider Concerns Process. A multi-agency partnership, led by the Central Safeguarding Adults Service in Housing, Health and Adult Social Care, focuses on improvement planning with the provider, with protection planning and immediate steps to ensure wellbeing and safety of all residents. Recently, the Central Safeguarding Adults Service held an organisational learning event with a Provider following an improvement plan and number of actions to drive forward quality of care. This learning event highlighted areas for change across both the process and how we work in partnership, with application to other residential and nursing home providers in Enfield; it also sought to reduce repeat safeguarding and quality concerns within providers.

10.4 Overt and Covert Surveillance

10.4.1 The use of both overt and covert surveillance to deter and detect the abuse of adults at risk is being considered and set out in policy. The use of overt surveillance will be encouraged and supported for individuals in their own homes and for those living in residential, nursing and supported housing services. Overt surveillance will help to deter behaviours and actions that put an adult at risk of abuse in any form, including the risk of being treated with a lack of dignity and respect. The use of covert surveillance will be used in cases where there is substantial concern that adults are at risk of abuse. Covert surveillance requires legal authorisation and will be used when necessary and proportionate to identify perpetrators of abuse and to obtain evidence to support a criminal prosecution. Policy is expected in September 2013.

10.5 Quality Checker Programme

10.5.1 The Quality Checker programme has now recruited and provided training to 50 Quality Checkers who will visit services and give their view on the quality of care. The Quality Checkers have now undertaken 57 site visits, including visits to all of the Council's in-house provider sites and 11 private care home sites. So far, the Quality Checker visits have identified 191 things that have impressed, and 101 areas of improvement. The project was put forward to represent Enfield Council in the 2013 MJ Awards in the Innovation in Social Care category. Although the bid was not short listed, the decision by senior

managers to support a submission to the MJ Awards recognises the outstanding efforts of our volunteers to help us make sure that out services are effectively meeting our service users' and carers' needs.

11. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

11.1 Primary Care Development

11.1.1 A Network Multi Disciplinary Team was established in February 2013 in the North West locality. GPs have an opportunity to phone in weekly to get advice regarding the management of complex patients in the community; these are patients that have been identified as being at high risk of A&E.

11.1.2 The North West Network are fully engaged with this process and so far 67 patients have been reviewed. A presentation was made to the South West Network PLT and was received positively. The MDT will go live there at the end of April 2013.

11.2 Implementing Joint Commissioning Strategies

11.2.1 Good progress continues in relation to the implementation of Joint Commissioning Strategies, in particular the Joint Intermediate Care & Reablement Strategy. A publicly available progress summary that includes strategy outcomes and next steps will be made available in the summer of 2013.

11.2.2 A summary of progress made against objectives set out in the Dementia Strategy, End of Life Strategy, Intermediate Care & Reablement Strategy and Stroke Strategy can be located in *Appendix A*.

11.3 Admission Avoidance & Early Supported Discharge

11.3.1 Risk Stratification

Risk Stratification is being mobilised in the North West Locality. The tool has been reviewed with Adult Social Care with a view to the inclusion of data to support case finding.

11.3.2 Older People's Assessment Unit

The Older People's Assessment Unit Project Group has met to review objectives and agree outcomes. A smaller clinical group has met to refine proposals for the hubs. There will be a further larger clinical meeting at the end of April 2013 to walk through scenarios and test outline proposals.

11.3.3 Admission Avoidance

Both North Middlesex University Hospital & Barnet & Chase Farm Hospitals now have their admission avoidance services in place with case finders working in A&E to identify patients who need not be admitted. So far NMUH

have managed to avoid 64 admissions since the 6th December and Chase Farm have avoided 16 since the18th February. Both trusts are working to ensure patients are identified and managed prior to the four hour wait target in order to avoid a short stay. Social care is established in both services and Chase Farm are working to employ a CPN as part of the service.

Feedback from the Enablement and Intermediate Care team suggests that they still have capacity and are not receiving as many referrals as they would have expected. A review of the service on both sites is to be undertaken in April 2013 and a report will be taken to the Integrated Care Group.

11.3.4 Falls Prevention & Fracture Liaison Service

The Fracture Liaison Service is in place and working well; 197 patients have been identified for follow up from the fracture clinic and 116 screening calls have been made with advice provided.

An appointment has now been made to the bone health post and it is hoped that this service will commence by the end of April 2013.

The full integrated service model has been agreed and assumptions on changes in activity with potential cost spend and savings are being calculated, with a view to presenting the model to the next Financial Recovery and QIPP Committee in April 2013. Integration with the voluntary sector has begun and is a fundamental part of service delivery and a key aspect in contacting hard to reach groups. Research is being undertaken with the providers of the risk stratification tool to establish algorithms for stratifying those most at risk of a fall and/or fracture.

11.3.5 Care Homes Project

The care homes project was started as a pilot in early 2012 and subsequently rolled out to 10 care homes from October 2012. The Care Homes Team (CHAT) consist of a North and South facing team of a consultant geriatrician employed by the respective trusts, a community matron and a clinical psychologist. Each team attends each nursing home one day a week reviewing patients in the morning and completing clinics in the afternoon. Care plans are developed and medication is reviewed for each resident, and where appropriate, Advanced Care Plans (ACP) and DNARs are put in place. The team also provide training for the care homes staff on managing challenging behaviour and advanced care planning. The aim is to roll the project out to the 17 homes that had the highest emergency admissions in 2010/11. Although the service has many qualitative benefits, it has yet to substantially reduce emergency admissions. A review of the project has now been undertaken resulting in several actions to understand why the emergency services are called when the team are not present on site and to design and implement an out of hours service with the aim of reducing admissions: A full report is located in *Appendix B.*.

12. PUBLIC HEALTH TRANSITION

12.1 On 1st April 2013, 145 contracts were transferred from NHS Enfield to the local authority and two contracts were wavered. A DAR authorising the transition of contracts was signed on Thursday 28th March 2013 and published 2nd April 2013.

12.2 The local authority now holds responsibility for the following Public Health Services:

- Health Checks
- Sexual Health Services
- School Nursing Services
- Dental Public Health
- Tobacco Control and Smoking Cessation
- Drug and Alcohol Misuse

12.3 The local authority was unable to obtain historical data from NHS NCL for several contracts and, therefore, 2013/14 will demand close performance and financial monitoring. In order to ensure that all services are being strictly monitored, the local authority has entered into a one year agreement with NHS CSU to manage the five open access sexual health genitourinary medicine (GUM) contracts. This agreement incorporates mechanisms to control costs in addition to providing the local authority with the necessary and timely intelligence to understand and review the services.

13. ENFIELD'S JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

13.1 A full update on the development of the JSNA can be located in *Appendix C.*

14. JOINT COMMISSIONING BOARD

14.1 The last Joint Commissioning Board took place Thursday 21st February 2013. Amended Terms of Reference were agreed and the Board received an update on the Mental Health Strategy, Integrated Care (specifically the Care Homes Project), Winter Pressures Funding and Children's services, including a statement of commissioning priorities for the service.

15. SERVICE AREA COMMISSIONING ACTIVITY

The scale of joint commissioning activity is significant. This report seeks to update the Health & Wellbeing Board on key areas of commissioning activity relating to key service user groups worth particular note.

15.1 Older People

15.1.1 Improving Environments of Care: Dementia Funding Bid

In January 2013 an expression of interest was submitted to the Department of Health seeking funding to improve the environment of care for people with

dementia. This expression of interest was for £350,000 against the £25,000,000 capital investment to create dementia-friendly environments in care homes.

The fund was three times over-subscribed and the council was unsuccessful in its bid; the department of health has yet to feed back the reasons for turning down the bid. However, a bid submitted by North Middlesex University Hospital NHS Trust for £32,000 for capital to improve toilet facilities in their outpatient department was successful.

15.1.2 Winter Pressures Funding

Spending plans for the £882,000 Department of Health monies for 2012/13 have now been finalised. The funding is aimed at increasing social care and intermediate care capacity at peak times, and improving prevention for this, and next, winter. NHS London also provided additional funding to acute Trusts to maintain or improve A&E performance, ambulance handover times, or provision of community-based beds in the winter. Both North Middlesex University Hospital and Barnet & Chase Farm acute Trusts were successful in their respective capacity-building bids (total: £2,200,000).

15.1.3 My Home Life (MHL)

A My Home Life celebratory event was held on 12th February 2013 to recognise what care homes do well and to highlight what could be improved. A My Home Life Programme consultant facilitated the event and the Executive Director of the Programme made a presentation highlighting what all can do to improve quality of life in older people's care homes. The message from the day was that all parties would need to work together to further improve quality of services and to ensure the safety of residents. Joint work is now underway to sustain the legacy of the Programme. This includes the continuation of focus groups to encourage more care home managers to get involved.

15.1.4 Enfield's Dementia Friendly Communities Bid (EDFC)

In February 2013, a bid was submitted for £660,000 against the European PROGRESS social fund. The purpose of the fund is to promote social inclusion and improve outcomes for older people, at a time of recognised European budgetary constraint.

The Enfield Dementia Friendly Communities bid (EDFC) takes a life-course approach to supporting households concerned about memory loss/dementia through working together to improve information, advice, guidance, training & support. The bid, which was developed collaboratively with public, private and voluntary sector partners, seeks to build on national programmes outlined in response to the Prime Minister's Dementia Challenge, by improving awareness about, and help for those living with, dementia in communities. The bid will look to promote the National Dementia Programme locally BY enlisting the support of residents who can choose to find out more about the

condition or even volunteer to help. A key theme is to develop dementia friendly communities through a partnership approach. The EU will make a decision on the bid in June/July 2013.

Regardless of whether the bid is successful, the Council and CCG will continue to work with voluntary sector partners to improve dementia awareness and the coordination of information, advice & support in line with Voluntary & Community Sector Strategic Framework. This will be completed in advance of Dementia Awareness Week, which is set to take place in May 2013. Promotional activities are already planned in Edmonton, Southgate & Enfield Town based on the national initiatives.

15.2 Mental Health

15.2.1 Out of Area Treatments (OATS)

Negotiations regarding the delegation/devolution of Out of Area Treatments (OATS) budgets across the three boroughs continue. A further update will be provided to the Health & Wellbeing Board when available.

15.2.2 Return to Employment

A procurement exercise to commission work opportunities, support and associated employment activity for people with mental health issues has now been completed. The Richmond Fellowship were awarded the contract at the end of March 2013. The organisation are now supporting existing service users through the transition process. The Richmond Fellowship will be working in partnership with the stakeholders to improve awareness of and access to employment opportunities for people with mental health issues.

15.2.3 Independent Mental Health Advocacy (IMHA)

The way IMHA services are commissioned is changing. As from April 2013, commissioning responsibility will be transferred from the former PCT's to local authorities. Locally, the existing contracts expire at the end of March 2013. A decision has been taken at a tri-borough level to extend existing arrangements for the next 6 months with a view to planning a procurement exercise that considers inclusion of IMCA and Dols advocacy. Progress will be reported to the Health and Wellbeing Board.

15.3 Learning Disabilities

15.3.1 Learning Disabilities Self Assessment Framework (SAF)

A SAF implementation plan has now been drafted. Endorsement of the implementation plan will now be sought from the Learning Disabilities Partnership Board Health Sub Group and the Joint Commissioning Board. The plan focuses on:

- improving access to health services;

- addressing inequalities when accessing health services;
- ensuring that quality and governance structures are in place to promote healthy lifestyles that focus on wellbeing and keeping people safe.

The plan will be implemented by the Learning Disabilities Partnership Board Health Sub group, following endorsement.

15.3.2 Winterbourne View Concordat

The Enfield Clinical Commissioning Group has developed an action plan in response to the Winterbourne View Concordat. The key messages from the concordat are that each locality should commit to jointly reviewing all people with learning disabilities and / or autism within in-patient facilities to ensure that people are appropriately placed in good quality, safe provision. Where people are inappropriately placed, there is an emphasis on considering repatriation to a community setting. Parent and carers will play a key role in the assessment and review process as part of the action plan. Commissioners are reviewing the assessment and treatment pathway for people with learning disabilities with a view to reducing admissions to this type of service and ensuring that where admissions are unavoidable then stays are not disproportionately long. The benefits of community intervention models are being explored in addition to how existing independent advocacy services can be best used.

15.3.3 Seacole Assessment & Treatment Service

Negotiations are underway to secure block provision for the Seacole Assessment and Treatment Service which is located locally within the Chase Farm Hospital Site. There has been a reduction in use of Assessment and Treatment beds from an average of 9 to 2 admissions over the last quarter. This has been attributed to the joint work being undertaken by the project group associated with the review of the Assessment & Treatment pathway.

15.4 Carers

15.4.1 Enfield Carers Centre

Work has been ongoing between Enfield Carers Centre and Enfield Mental Health Carers to merge the organisations by 1st April 2013. A Service Development Plan has been agreed between the two existing Boards of Trustees. At the AGM in February trustees from Enfield Mental Health Carers were ratified onto the Board of Trustees for Enfield Carers Centre.

The Centre is currently recruiting to a number of new posts – an Advocacy Worker, a Young Carers Worker, a Primary Care Development Officer and a Carers Nurse. These have been funded through the merged funds, reserves and NHS Enfield CCG.

15.4.2 Carers Direct Payment Scheme

The pilot year for the Carers Direct Payment Scheme ends in April 2013. It has been confirmed that the Scheme will continue with the same eligibility criteria. An overview of the past year will be prepared for May 2013.

15.4.3 Carers Week

Carers Week falls on the week beginning Monday 10th June 2013. The Council and Enfield Carers Centre have produced a joint plan of events throughout the week including an evening question and answer session, outings, information events and a Carers party.

On Thursday 13th June 2013, the Enfield Carers Centre will host a re-launch following the merger with Enfield Mental Health Carers. This will include an invitation to the Mayor, MPs and councillors and practitioners to visit the Centre and find out about the services on offer.

15.4.4 Primary Care Strategy

Funding has been approved through NHS Enfield CCG for two new posts at Enfield Carers Centre. The first is a two year fixed post contract for a Primary Care Development Officer to work with GPs and other primary care settings to identify, recognise and refer carers. The second post is also a two year fixed post for a Carers Nurse whose time will be split between the Carers Centre and a GP surgery. The Nurse's role will be to work with carers to support them to maintain and improve their health and wellbeing, to undertake carer specific health checks and flu vaccinations. Recruitment is currently underway.

15.4.5 The Employee Carers Support Scheme

The Support Scheme is underway with 21 employees with caring responsibility wishing to join. A meeting was held in March where the Terms of Reference was discussed and finalised and the format of support discussed. The 'Carers Action Group' as it will now be known, will meet quarterly with the next meeting being held during Carers Week in June.

15.4.6 Safeguarding

A new booklet entitled – 'Keeping Safe – a guide for carers' has been produced and will be ready for distribution in April 2013. The booklet provides information and support about managing stress and the caring role, employing care staff and what to do if they are being abused or at risk of becoming an abuser. The booklet was reviewed by the Safeguarding User and Carer reference group.

15.4.7 Corporate Research

A qualitative study into carer's health and wellbeing is currently being planned through the Corporate Research Team. A number of focus groups will be held with carers over April and May to look at how they manage their own health and wellbeing so they can continue caring, focusing particularly on what services and support helps them and where support is lacking. The results will be used to plan preventatively to ensure carers supported to remain healthy thus reducing the likelihood of carer breakdown.

15.5 Children

15.5.1 The Health Visiting Service

Changes in the NHS London definition of who to include in the Health Visiting count mean that the BEH MHT are now reporting a funded workforce of 57.74 WTE. The actual trajectory target for 2012/13 is 48.7 WTE HV and there are currently 44.54 Health Visitors in post. Interviews for three further HV posts have been held within the last two weeks. Responsibility for commissioning Health Visiting Services passed to the National Commissioning Board on 1st April 2013. The National Commissioning Board is keen to work with local stakeholders in preparation for the transfer of commissioning responsibility for Health Visiting to Public Health at the Council from April 2015.

Enfield CCG and the Enfield Council have confirmed their commitment to the development of the Family Nurse Partnership, which is an intensive early intervention programme for vulnerable young first time mothers. The service will be provided by BEH MHT. A national advert for the team supervisor was published in early April and interviews are to be held at the end of April. The full team is expected to be in post by September 2013. Project leads for the NHS and the Council have been identified, and a Project Board has been set up. Health and Wellbeing Board oversight is one of the conditions of acceptance on the programme and the Board will be updated regularly on progress with implementation.

15.5.2 Occupational Therapy Service

Progress on implementation of the Action Plan developed following the Serious Incident Report, continues to be reviewed through monthly Clinical Quality Review Group meetings. The joint service review is close to completion and enhanced activity and KPI reports have been agreed as part of the 2013/14 contract.

15.5.3 Paediatric Integrated Care

BCF and NMH have agreed to participate in the Primary Care paediatric pilot It is anticipated that BCF and NMH will start running clinics week commencing 1st April 2013.

15.5.4 Maternity Services

The new children's health commissioner is now leading on maternity services. Initial focus has been on the Early Access to Maternity Services target, supporting the implementation of the new maternity tariffs and reviewing maternal deaths and safety. The new maternity tariffs will result in significant savings and improvement to local services.

UCL Partners (partnership of Medical Schools and Universities) have agreed to assist Enfield in improving infant mortality rates and maternal health.

15.5.5 CAMHS

An application for CAMHS IAPT, a training and transformation support scheme, with a small amount of funding for backfill of existing staff is to be submitted by 30th April 2013. The scheme is evidence based, focussed on improved outcomes, and will support PbR implementation. The work is being led by CAMHS, in conjunction with Enfield Parents and Children as the voluntary sector partner. There are ongoing discussions with other services about possible participation. The Youth Participation Team has also been contacted to support the work.

15.6 Drug and Alcohol Team (DAAT)

15.6.1 The Treatment Completion

The DAAT is continuing on an upward trend for the Successful Treatment Completion performance with the National Treatment Agency ratified February 2012 to January 2013 data now confirming a partnership rate of 16.3%. The number of patients retained in Effective Treatment remains slightly above the trajectory trend line for drug misusers. The number of alcohol users in treatment is forecasting that Compass is likely to reach its end of year target of 293. The Partnership between the Young People's Substance misuse Service and the Youth Offending Service (YOS) has achieved marked progress with over 50% of all referrals now being received from the YOS for specialist treatment interventions. The DAAT has reconvened the DAAT Commissioning Group which commenced reviewing the opportunities for Payment by Results in April and the DAAT Board is focusing on developing the Partnership's vision and priorities which will lead to the production of a local substance misuse strategy in the summer/autumn of 2013.

15.6.2 Break the Cycle

Break the Cycle has continued to engage with more drug and alcohol misusers with the most recent performance evidencing that just over 230 people have used the drop-in service alone during February 2013. Break the Cycle now deliver the following services: the café (at the Claverings Treatment Centre), outreach, drop-in, complementary therapies, group work, counselling, and support with education training and employment. The

service users are keen to secure funding for a shopping street based café as that element of provision is proving to be extremely popular with substance misusers through providing a safe venue for them to meet. The DAAT will assist Break the Cycle with this ambition.

16. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

16.1 Learning Difficulties Partnership Board (LDPB)

16.1.1 The last Learning Disabilities Partnership Board, held Monday 11th March 2013, focussed on devising the Board's work plan for the next two years. The Board suggested priorities and identified key work areas. Work will now be undertaken with work stream leads to finalise the plan, which will be circulated at the next Partnership Board in May 2013.

16.1.2 The Board discussed options for setting up a Learning Disability Parliament or Experts Panel. Advantages and disadvantages of each model were considered and priorities were set, including the need to provide a transparent and democratic method of electing members, and engage with the wider learning disabilities community in a meaningful way.

16.1.3 The Board heard a presentation on the 'Making the most of Life…' End of Life Care resource books. The Board gave feedback and a draft of the resource books will be circulated for further comment prior to sign off.

16.2 Carers Partnership Board

16.2.1 The last Carers Partnership Board held on 29th January 2013. The Carers Partnership Board Away Day took place on Monday 25th March 2013. At these meetings the Board took time to consider their forward plan and undertake carers week planning. Consideration was also given to the Carers Strategy, including the membership and Terms of Reference for the Implementation Group. Sub groups were discussed (including structure and governance) and the delivery plan was reviewed by the Board. Further applications from Carers wishing to join the Board were received by the group. It was noted further health representation was required and a request to the Chair of the CCG has now been made.

16.3 Mental Health Partnership Board

16.3.1 The last Mental Health Partnership Board, held Tuesday 19th February 2013, received a commissioning update on key priorities which include the current cycle of contracting for the acute mental health contract led by NCL and conducted on a Tri-Borough basis; the development of an Enfield and Tri-borough wide mental health strategy and; the development of QIPP plans to identify and deliver efficiencies for the years 2013-14 and 2014-15. IAPT funding was discussed and it was noted that £32,000 was still available within the budget. The provider members of Partnership Board were invited to make bids up to a maximum of £6,000 per organisation.

16.4 Older People Partnership Board

16.4.1 Members of the Health & Wellbeing Board are fully up to date on the Older People Partnership Board – no Board meetings have taken place since the last report.

16.5 Physical Disabilities Partnership Board

16.5.1 Members of the Health & Wellbeing Board are fully up to date on the Physical Disabilities Partnership Board – no Board meetings have taken place since the last report.

Joint End of Life Care Strategy -
Implementation Update April 2013

The Palliative Care Support Service
The team have now cared for 81 patients to the end of February. During January and February 16 patients being supported by the service died of which 15 died at home and 1 died in hospital but all were in their preferred place.

Contributes to objectives 3, 4, 5, 6 and 8

DNAR Policy Implementation: Further work is needed linking the policy with advanced care planning and GSF. A workshop is being held on 4th April lead by Dr. L Schofield Consultant in Specialist Palliative Care; the workshop will provide a comprehensive introduction to advanced care planning and an overview of GSF.

Contributes to objectives 2, 3, 4 and 6

Multi Disciplinary team working with 10 care homes ensures advance care plan in place where appropriate-

The team have completed 110 advanced care plans and 116 Do Not Attempt Resuscitation forms. This has led to 96% of patients dying in their preferred place.

Contributes to objectives 2, 3, 4, 6, 7, 8 and 9

There is a pan London EoLC register '**Coordinate My Care**' that LAS have access to that the GP / palliative care leads in put patient information in to which eventually will replace our palliative care handover forms and the system we currently use. The soft launch of 111 took place on 20th February 2013 and the public launch was on 12th March 2013. Full uptake of co-ordinate my care may be delayed however, as our main hospice provider does not currently have an N3 connection; this will be vital to manage co-ordination of care.

Contributes to objectives 2, 3, 4 and 9

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Joint Intermediate Care and Enablement Strategy
Implementation Update January 2013

Community Rehabilitation Stroke and Non Stroke
The Rehab team continues to work closely with the Intermediate Care and Enablement Team. The teams continue to manage people in the community enabling them to rehabilitate in their own environment and remain at home.

In the **2nd quarter** the team supported 116 new patients for general rehabilitation and 179 people to avoid admission; in **quarter 3** they supported 140 for general rehabilitation and 203 to avoid admission.

The stroke element of the team supported 66 new referrals for rehabilitation and 10 ESD direct from HASU in **quarter 2**; in **quarter 3** they have supported 35 rehabilitation patients and 19 ESD direct from HASU more than double the target. This would account for the decline in the number rehabilitation patients as the number of patients on the case load remained constant at an average of 80.

92% of patients said they had improved after input from the team in quarter 3.

Contributes to objectives 1, 2, 3, and 5

Admission avoidance
Both North Middlesex University Hospital & Barnet & Chase Farm Hospitals now have their admission avoidance services in place with case finders working in A&E to identify patients who need not be admitted. So far NMUH have managed to avoid 64 admissions since 6th December and Chase Farm 16 since18th February. Both trusts are working to ensure patients are identified and managed prior to the four hour wait target in order to avoid a short stay. Social care is established in both services and Chase Farm are working to employ a CPN as part of the service.

Feedback from Enablement and Intermediate Care team suggests that they still have capacity and are not receiving as many referrals as they would have expected. A review of the service on both sites is to be undertaken in April and a report will be taken to the Integrated Care Group.

Contributes to objectives 1, 2, 3, and 5

The Multi Disciplinary Care Homes Team Admissions in October, November and December have shown minor reductions from the 2011 figures. Comparing just the month of December, emergency admissions are lower than in 2011 (29 v. 34).

A&E attendances were higher in December than the previous year (49 v 45) with an accompanying £164 increased cost.

Outpatients attendances are 56 lower (350 –v 406), and the cost £9.5K lower.
However, Patient deaths following emergency admission rose to 8 in December.
In addition, CHAT report that they have

- Seen >1401 patients as part of the rolling review and acute clinics;
- Have completed 110 ACPs and 116 DNRs between May 2012 and February 2013; and
- Stopped 267 medications and taken 34 patients off anti-psychotics

Tissue viability

- The project is now in 19 care homes with additional support being provided for residential homes by the District Nursing Service.
- The team is now fully staffed – a Band 7 Specialist nurse was recruited in November. A secondment for a Band 5 nurse from the DN service started in January 2013. The TVS team as a whole is responding to the needs of the Care Home Sector in relation to tissue viability education and training and clinical practice.
- Patients suffer from a variety of wound care problems however the main problems are related to pressure ulceration, not all of which have developed in the homes; a a significant number are being admitted from hospital with these wounds.
- To date:
    - Education and training has been delivered to 92 care home staff from 13 care homes;
    - Tissue viability care has been delivered to 98 residents
    - Referrals from Care homes are increasing

Contributes to objectives 1, 3, 4 and 5

Joint Strategy for Dementia
Implementation Update April 2013

The working group continues to review **Memory Services** provision across Barnet, Enfield and Haringey with a view to developing a single service that is in line with the Department of Healths commissioning toolkit.

A business case has been developed and has been presented to Barnet and Haringey CCGs where there has been an acknowledgement that there is a need to invest in the Memory Service; there is further work required to identify the number of appropriate referrals, demonstrate the benefit of early diagnosis and understand the impact of returning long term management of people with a diagnosis of dementia to primary care.

Contributes to objectives 2, 4 and 6

The **Multi Disciplinary Care Home Team** continues to work with care homes around the management of patients with dementia.

Training programmes have been delivered to staff in a number of care homes by the Clinical Psychologist on Dementia, Managing Challenging Behaviour and Depression. Evaluation of the training demonstrated that more than 90% of attendees stating that they had improved understanding and confidence in managing residents.

Contributes to objectives 2, 8, 9 and 10

Dementia Awareness : a new group has been established to take this work forward including representatives from the voluntary sector. Following an initial meeting an approach has been made to a marketing company to promote dementia awareness. They are available 13th - 19th May, and we have provisionally agreed to use them to host 2 week long roadshows one in Palace Gardens, the other at Edmonton. They will aim to promote dementia awareness, and specifically to get people to sign up to either the dementia friends programme and/or to get their contact details for someone to get in touch with them after the roadshow The roadshow will be manned, and managed, by the company, but they are to work with colleagues from the voluntary sector.

Contributes to objectives 1 and 6

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Stroke Update March 2013

Community Stroke Rehabilitation and Early Supported Discharge
The Rehab team continues to work closely with the Enablement Team to manage people in the community enabling them to rehabilitate in their own environment and remain at home. The team also undertakes the six week reviews post discharge home for all stroke patients.

The team supported 66 new referrals for rehabilitation and 10 ESD direct from HASU in **quarter 2**; in **quarter 3** they have supported 66 rehabilitation patients and 12 ESD direct from HASU. 54 six weeks review was completed in **quarter 3**. **Quarter 4** data is yet to be finalised.

92% of patients said they had improved after input from the team in quarter 3

Stroke Navigator:
The Stroke Navigator supports stroke survivors, their families and carers to navigate health and social care systems in Enfield. The navigator continues to work closely with the community rehab team and other voluntary sector services such as Attend, Stroke Action and Ruth Winston Centre to encourage those affected by stroke to re-engage with their community and access life after stroke.

The navigator supports stroke patients, their families and carers in their discharge home process and as such undertakes a discharge home experience questionnaire within ten days of the patient being discharged home. **In the 3rd and 4th quarter** 77 stroke patients completed the discharge home questionnaire, 70/77 rated their overall journey as good, very good or excellent. Feedback/issues arising from the discharge home experience questionnaire were feedback to the relevant trusts. Representatives from both North Middlesex Hospital and Barnet and Chase Farm hospital attend the monthly stroke pathway monitoring meeting where these findings are discussed. The feedback process has led to an improvement in patients' experiences.

The navigator provides six weeks review (Non CSRT) to stroke patients. This cohort of patients are either those that leave the HASU and are so high functioning need no community involvement or patients who are at the other end of the spectrum and not referred to CSRT as no perceived rehab gains possible. **In the 3rd and 4th quarter**– 10 stroke patients received the six weeks review.

Life Role Facilitator:
The Life Role Facilitator facilitates stroke survivors to re-integrate back into the community through taking up volunteering opportunities. She also undertakes the six month reviews for all stroke survivors. In **quarter 3** 36 patients received the six months review, 7 patients returned back to work and 5 took up volunteering roles; in **quarter 4** 28 received the six months reviewed, 9 returned back to work and 3 took up volunteering roles.

Social Support
The service provides community based social support network for stroke survivors, including awareness and secondary prevention. In **quarter 3** 25 referrals were made to the team, awaiting data for **quarter 4**

The carer forum which was set up by the social support team is doing very and they are working very closely with the Enfield Carers Centre, the forum is held quarterly

Befriending Scheme at North Middlesex Hospital
The befriending scheme at North Middlesex Hospital is now up and and has taken off really well. There are 4 befrienders who are all stroke survivors, each of them are assigned to a patient or group of patients on the stroke unit and they assist with activities that support communication, understanding of living with stroke and patient experience.

MEETING:	Joint Commissioning Board
DATE:	21 February 2013
TITLE:	Integrated Care – Care Homes
LEAD DIRECTOR/ MANAGER:	Graham MacDougall
AUTHOR:	Miriam Lemar
CONTACT DETAILS:	Miriam.lemar@gmail.com

SUMMARY:

Background

The care homes project was started as a pilot in early 2012 and subsequently rolled out to 10 care homes from October 2012.

North (Chase Farm)		South (North Middx)	
Home	Start date	Home	Start date
Elizabeth Lodge	Jan 2012	The Hollies	Oct 2012
Springview	Jan 2012	Sunbridge Care Centre	Oct 2012
Parkside	Jan 2012	Murrayfield	Oct 2012
Nairn House	Jan – On hold	Southgate Beaumount	Oct 2012
Autumn Gardens	July 2012		
Hugh Myddleton	July 2012		

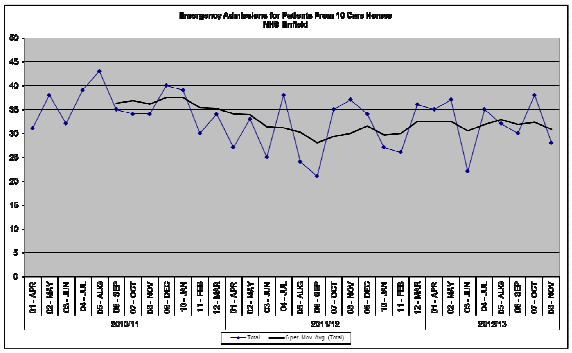
The Care Homes Team (CHAT) consist of a North and South facing team of a consultant geriatrician employed by the respective trusts, a community matron and a clinical psychologist.. Each team attends each nursing home one day a week reviewing patients in the morning and completing clinics in the afternoon. Care plans are developed and medication is reviewed for each resident, and where appropriate, Advanced Care Plans (ACP) and DNARs are put in place. The team also provide training for the care homes staff:

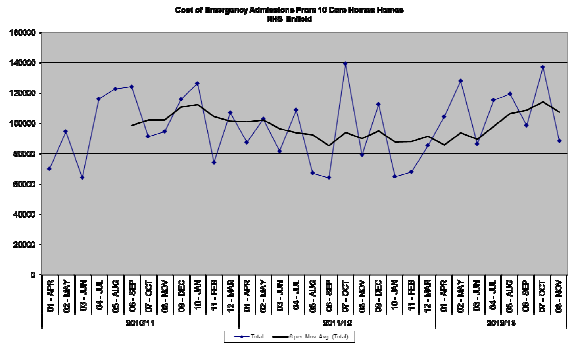
- Managing challenging behaviour; and
- Advanced care planning.

The aim is to roll the project out to the 17 homes that had the highest emergency admissions in 2010/11. Although the service has many qualitative benefits, it has yet to substantially reduce emergency admissions. Below are KPIs reported by the CHAT team:

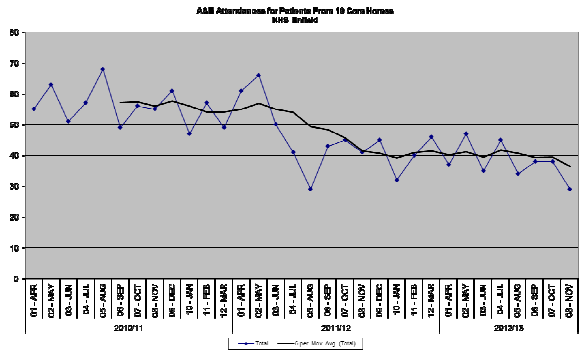
- Of people who died in home from May to December 96% of people died in their preferred place of care
- >950 patients reviewed (Rolling Review & Acute Clinic) May to December
- 54 ACP's and 108 DNR's completed April to December
- 169 medications stopped and 21 patients taken off antipsychotics to date
- The teams view is that
    - 296 GP calls were avoided May to December
    - 299 admissions were admissions May to December .

An analysis of SUS data till the end of November shows that, since the start of the project, there have been 13 more admissions than in the equivalent period in 2011, the cost of which is £136K higher. The graphs below highlight the gradual decreasing trend of admissions and the increasing trend in costs.





Admissions in both October and November have shown a minor reduction from the 2011 figures. Comparing just the month of November, emergency admissions are lower than in 2011 (28 v. 37), but the cost is £9k higher. .



A&E attendances are 26 lower (242 v. 268)(see table opposite), but the cost is only £1.1k lower. However, in November, attendances were 12 lower and in October - 2 lower.

Outpatients attendances are 59 lower (303 v. 362), and the cost £8.3K lower. However, Patient deaths following emergency admission rose to 6 in November, the highest figure since February.

Further analysis is being completed to understand the reasons for increased unit costs.

Proposed Actions

A review of the project was undertaken resulting in several actions to understand why the emergency services are called when the team are not present on site and to design and implement an out of hours service with the aim of reducing admissions:

- The team started audits at each of the homes to understand the numbers of LAS callouts, assess the reasons for the calls and track if these resulted in an admission – this will be completed by 24/2/13;
- Discussions have started with LAS to assess the possibility of having a 'paramedic' led service that could assess the patient's condition with a view to directing them to CHAT the following day, ICT or the acute as appropriate;
- The aim is to pilot the service in 4 homes (Autumn Gardens, Springview, Murrayfield and Sunbridge) from the end of February and to assess the impact on admissions. On the assumption this is successful; it will be implemented in the remaining 6 homes from the end of March. Another review should be completed at the end of May to assess progress.

- The meeting with LA on 11/2 agreed, in principle, to work together to define a strategic approach to care homes which will ultimately deliver an outcome based contract for 2014/15 ideally, thereafter care homes will be asked to contribute suggestions building on the infrastructure LBE have implemented as part of the 'my home life' project. This is about care homes taking more responsibility for improving quality of care and delivery of staff training.
- For the homes involved to date, a workshop is being planned to get their feedback on the project and to understand what else they can do to support a reduction in emergency admissions. GPs will also be asked to attend and provide their feedback. This will take place by the end of March.
- At the next review meeting(CHAT and commissioner), scheduled for 28/2, we will be presenting the plans for integrated care and assessing how CHAT can adapt given the future landscape and the need to deliver a reduction in emergency admissions whilst sustaining a cost effective service
- It has become clear that there are many GPs aligned to care homes (e.g. one home has 24 GPs linked to it) – further analysis is required to assess if this is the best approach for the care homes residents.

Tissue viability

- The objective of this service is to provide specialist input to care homes to provide input and training on how to manage pressure ulcers at an earlier stage to prevent grade 3 and 4 pressure sores.
- The project is now in 19 care homes with additional support being provided for residential homes by the District Nursing Service.
- The team is now fully staffed – a Band 7 Specialist nurse was recruited in November. A secondment for a Band 5 nurse from the DN service started in January 2013. The TVS team as a whole is responding to the needs of the Care Home Sector in relation to tissue viability education and training and clinical practice.
- Patients suffer from a variety of wound care problems however the main problems are related to pressure ulceration, not all of which have developed in the homes; a a significant number are being admitted from hospital with these wounds.
-
- To date:
    - Education and training has been delivered to 92 care home staff from 13 care homes;
    - Tissue viability care has been delivered to 98 residents
    - Referrals from Care homes are increasing

SUPPORTING PAPERS:

Appendix A project plan.

RECOMMENDED ACTION:

The Board is asked to:

- NOTE the contents of this report.
- Approve the plan of action
- Agree the end of June date for further review

Objective(s) / Plans supported by this paper: This supports the Integrated Care programme delivery

Audit Trail:
The paper is being presented to FR&Q and will form the basis of a paper for the Joint Commissioning Board.

Patient & Public Involvement (PPI):
Patient carer feedback to be included in the plan

Equality Impact Assessment:
Will address as roll out continues

Risks: Risks are included on the attached plan – Appendix x and include

Resource Implications:

Risk	Mitigation
NMUH do not agree to funding the project with the 30 day readmissions funding	Commissioner to negotiate with NMUH
GP practices not fully signed up to the model	Include GPs in the workshop to review current model
Care homes unwilling to change their practices	Work with the LA to develop a joint approach to care home commissioning ensuring that there is focus on continuous improvement for the benefit of services users/patients
Responsibilities for partaking organisations is unclear	Clear definition of expectations from GPs, Care homes, ECS and LA to be developed
Emergency admissions continue to rise	Work with care homes to understand the causes of admissions, work with the care homes to implement a process to reduce admissions.
Inconsistent data reporting across the system	Information analysts to review and provide robust approach
Access to patient data required in and out of hours	Protocols for information sharing to be agreed by all parties
The number of coroner inquests could increase as more patients/residents die in their place of choice	Meet with Coroner to discuss and agree approach

- Support from LAS will be required to deliver the revised service
- Project management capacity is required to address the task outlined above.
- Further information analysis support will be required.

Next Steps:
- As above

Report to: Health and Wellbeing Board	
Report Title: The Joint Strategic Needs Assessment (JSNA).	**Date**: 23rd April 2013

Summary: This report is an update on progress on the production of the JSNA.

Recommendations: For information.

Author: Keezia Obi, Head of Public Health Strategy
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1.0 Update on the development of the JSNA

1.1 Following the recruitment of a dedicated team, the work to produce the refresh of the JSNA is now well underway. The steering group/project board is meeting regularly and the commitment and engagement from across the partnership is positive. Where individuals are unable to attend the steering group, discussions and meetings are being held outside of this to ensure as full engagement as possible.

1.2 The project planning work has highlighted the tight deadlines that need to be met to deliver the strategic needs information and other agreed outputs by end of April 2013, as follows:

- 'on line access' to the data (based on 200+ indicators)
- information for local residents including leaflets
- factsheets in key areas
- a high level summary document - this will summarise the available intelligence and identify the key issues for the borough in order to inform the Health and Wellbeing Board (HWB) and shape the community engagement on priorities that will follow

1.3 This clear risk of slippage is being closely monitored and mitigated by:

- prioritising those deliverables essential to inform the development of the Health and Wellbeing Strategy and draft priorities including the accompanying consultation exercise
- securing additional external capacity as identified as needed as the work proceeds
- close monitoring of the risks associated with the delivery of the project and appropriate responses to these

1.4 As noted a number of factsheets will be prepared and made available by the end of April and further factsheets produced as work progresses. At present, the criteria for the factsheets has been based on the advice of the Director of Public Health and other areas considered important and identified by partners represented on the steering group. It should be noted that this first tranche of factsheets is not a priority list. Post April, the steering group has agreed to revisit the criteria.

1.5 The JSNA will be primarily an on-line source of information. It will provide information and intelligence based on the indicators identified within the public health outcome framework, the adult social care outcome framework, locally agreed key children and young people's indicators and indicators identified from the NHS outcome framework.

1.6 Project/steering group progress includes:

- identifying key indicators and steering group agreement on indicator list
- where required, incorporating any indicators that were in the previous JSNA
- Data collation: sources of demographic data, resources (assets and spend LBE and NHS and voluntary sector) data and place data are being identified
- Responses from data leads detailing what data is available, the level of disaggregation of the data and any benchmarking information available
- Processing of data and charts
- Drafting of factsheets as noted in 1.3
- Scoping out online access to the JSNA and webpage content
- headings of high level summary and analysis document drafted

1.7 The JSNA will be a source of intelligence that will grow as time and resources permit.

1.8 The above outputs will directly inform the development of the Health and Wellbeing Strategy by identifying key issues based on the data refresh. The JSNA will not itself set priorities as this will be the role of the HWB for inclusion in their strategy and accompanying action plans.

1.9 Once the outcome of the JSNA is presented to the HWB and agreement is reached on the key areas, this will enable members to agree draft priorities for community consultation.

1.10 The project planning process for the Joint Health and Wellbeing Strategy has commenced. The positive partnership work being undertaken for the JSNA is proving invaluable in establishing some of the key contacts essential for this work.

2.0 Community Engagement

2.1 The statutory guidance for JSNA's and Joint Health and Wellbeing Strategies makes clear that local HWB's must involve people from different parts of the community including people with particular communication needs. This is important to ensure that differing health and social care needs are understood, reflected, and can be addressed by commissioners. Due regard must be given to local Compact agreements and recognised within the JSNA and JHWS process.

2.2 A community working group has been established as a sub-group of the project board.

End of report.

Stage one application form

The expression of interest (EOI) your partnership submitted to Fulfilling Lives: A Better Start has been successful. As lead organisation for the partnership, you've been invited to submit a stage one application on its behalf. If your stage one application is successful you will then be invited to submit a stage two application.

About this form

To use this form you need Adobe Reader version 10.0 or above installed on your computer. If you have an earlier version or use other software the form won't work properly. Follow this link to get the latest version of Adobe Reader, which is free to install and use.

Before you start

Make sure you've saved the form to your own computer before you start to fill it in.

Filling in the form

You must answer all of the questions. We strongly recommend you read through the summary in full before starting to fill in the form.

Sending us your application

Email a copy of your application and any supporting documents to abetterstart@biglotteryfund.org.uk or post it to:

Fulfilling Lives: A Better Start
Big Lottery Fund
2 St James Gate
Newcastle upon Tyne
NE1 4BE

Keep a copy of this application form for your records as you may need to refer back to it if you are invited to stage two.

Deadline for applications

Your application and supporting documents must reach us by 12 noon on 7 June 2013. We won't accept any applications after this.

Fulfilling Lives: A Better Start - summary

A Better Start will invest in delivering a step change in the use of preventative approaches in pregnancy and the first three years of life, to improve the life chances of disadvantaged babies and young children.

Three to five areas across England, each with a total population of between 30,000 and 70,000, will receive between £30 and £50 million each. Through this investment each area must:

- give disadvantaged and vulnerable children a better start in life
- reduce the costs of dealing with later health and social problems
- harness the skills, commitment and resources of voluntary, health and local authority practitioners and sector leaders working together and
- provide effective, sustainable and scalable preventive approaches in pregnancy and very early life.

In each of the three to five final areas, we will invest in a portfolio of individual projects which together must lead to a systemic change which embeds the principle of first years prevention in the services and mindset of all members of the partnership

Throughout this form where we use the term 'project' we mean all of the activities or services your portfolio of individual projects will deliver through this investment.

To find out more about Fulfilling Lives: A Better Start visit www.biglotteryfund.org.uk/betterstart

What are we looking for?

Each area must improve the life chances of children by investing in their earliest years, and achieve positive outcomes in three main areas of child development:

- communication and language development
- social and emotional development, and
- nutrition.

Each area must also achieve a 'systems change' in the way that its local health, public services and voluntary sector work together in the long term, efficiently and effectively, to improve outcomes for children. This means prioritising the prevention of harm and the promotion of healthy development in pregnancy and the first years of a child's life, across all services. You must be able to demonstrate how you will do this during the life of the investment and beyond.

You must describe the four main outcomes that you will bring about at question 3.1. You must show how what you want to do will achieve outcomes in all three of the areas listed above, including systems change. Our Getting funding and planning successful projects guide explains the key elements of our approach to funding and outcomes and has examples that will help you complete your application.

You must take a scientific or evidence based approach to meeting your outcomes. This means designing activities and services which use specific interventions which have already been proven to be successful. You should be able to describe how the interventions will fit with and improve current first years provision in your area. You may also include new activities that are not yet proven, but are based on sound scientific evidence, and will be evaluated throughout.

For a breakdown of the short, medium and long term outcomes A Better Start aspires to achieve in each area of child development, see the framework on the next page. The long term outcomes may not be achievable during the timescales of this investment,

but have been included here to help you understand what we want A Better Start to achieve in the long run. This framework is not a prescriptive list you must adhere to, but it should be used to help inform your planning. Your partnership may identify other outcomes that are relevant for your area and fit with what A Better Start aims to achieve.

Short-term outcomes	Medium-term outcomes	Long-term outcomes
Communication and language development		
Children have increased verbal and non-verbal communication skills and an increased vocabulary. Children are empowered by the ability to express themselves.	Children start to talk earlier and by three are able to express themselves and interact easily with adults and children through their use of language. Children have age-appropriate vocabulary and can use language to express their physical needs and have positive social interaction. Children are able to resolve conflict and understand the consequences of actions, through verbal communication. Children use physical contact less in response to frustration. Children make good progress through pre-school and are more school-ready.	Children have better literacy and language skills, better social skills and better school achievement. Children have better job prospects. Improved educational attainment for women positively impacts on their children. Children develop improved social and emotional adjustment and cognitive skills, which improves long- term success in career and in relationships.

Table continued...

Short-term outcomes	Medium-term outcomes	Long-term outcomes
Social and emotional development		
Fewer pre-natal families experience domestic violence. More infant and primary carer or parent relationships have good quality attunement. More 15-month olds have secure attachment. Fewer children are hospitalised for non-accidental injuries and accidental injuries. Fewer children experience abuse or neglect.	More toddlers have good social and emotional development, with lower levels of high aggression in pre-schoolers. Children have greater empathy. Children have higher levels of key soft skills: conscientiousness, perseverance, self-esteem, motivation, ability to pay attention, self-regulation, self-esteem, ability to defer gratification, sociability. More children arrive at school 'school-ready'. Pre-schoolers are more able to socialise. Parent-child relationships are improved. Children have an improved ability to handle stress.	Children have improved school behaviour and engage positively with their peers and teachers. Children have lower levels of aggression, crime, antisocial behaviour and violence in adulthood. Children have higher emotional intelligence and empathy and improved mental health. Children have improved educational performance and better career outcomes, which leads to a higher proportion of tax-contributing citizens and fewer tax-burden citizens. Children have better long-term levels of heart, liver and lung disease; diabetes; alcoholism; tobacco and drug consumption; depression, suicide and mental illness.
Nutrition		
Fewer pregnant women are overweight or obese. Breast-feeding is increased at birth, at 6 weeks and at 6 months of age. More parents introduce solid foods to their child after 6 months. Parents have improved confidence and understanding of nutritional issues.	Birth outcomes for children are improved and there is a reduced risk of complications in pregnancy. Fewer children are overweight or obese at school entry age. Fewer children have diabetes. Fewer children are bullied as a result of being overweight. Children have a more positive attitude towards physical exercise. Children have improved self-esteem. Fewer children have dental decay.	Children have improved health and well-being into adulthood. Breast feeding has a positive impact on the health of the mother and child, and adults who were breastfed as children have lower blood pressure, lower levels of cholesterol and lower frequency of diabetes. The NHS costs of dealing with life-long obesity health risks are reduced. Children have improved dental and general health into adulthood.

Who can apply?

The lead voluntary and community sector (VCS) organisation identified in the EOI should complete the stage one application form on behalf of the area's partnership.

If your partnership is considering a different lead VCS organisation to the one identified in the EOI, you must contact us as soon as possible and before submitting the stage one application form, at abetterstart@biglotteryfund.org.uk If we agree to the change, the new lead VCS must complete the stage one application form and will be responsible for any funding awarded.

The partnership must involve relevant local VCS and public sector organisations, including the local authority children's services, local health agencies and other relevant bodies.

How much can you ask for?

You can ask for development funding of up to £400,000 (which would be in addition to any final award), to help you develop a stage two application if you are successful at stage one.

We expect to make three to five final awards, of between £30 and £50 million each, which can last up to 10 years. Individual projects within the portfolio can be delivered by both the lead organisation and members of the partnership, across a number of sites in each area.

How much is available?

Fulfilling Lives: A Better Start has up to £150 million funding available for stage two awards.

What can you apply for?

You can apply for 100 per cent of your costs, however you are more likely to be sustainable and successful in the longer term and achieve 'systems change' if you receive contributions from partners. This is something we will review at assessment. Partners would also need to pay for any statutory activities that BIG can't fund, but that are needed to make your work a success, for example training for statutory staff working with pregnant women and babies (see what we won't pay for below).

We'll pay for:

- some or all of your costs for up to ten years
- revenue and capital costs, including land or building purchase or refurbishment work
- a contribution towards the lead applicant's overheads.

But we won't pay for:

- your day-to-day running costs, current or regular activities, general appeals, endowments or activities to raise funds for your organisation
- anything you start, spend money on or agree to spend money on before we confirm our funding
- activities that are statutory obligations or will replace statutory funding, including activities on the curriculum in schools
- services that local agencies are expected or mandated to provide
- training in statutory organisations
- feasibility studies
- items that only benefit one person
- loans or interest repayments
- activities to promote religion or belief
- political activities
- travel outside the UK.

What happens when?

The key dates are:

- 7 June 2013 - Deadline for stage one applications.
- Early August 2013 - We tell you our decision on your stage one application.
  - 10 to 15 areas will be invited to apply to stage two.
  - If you are invited to apply to stage two, we'll give you a stage two application form to complete and make any development funding offers.

- August 2013 - Attend a briefing event for partnerships and key stakeholders, if invited to apply to stage two. Locations of the events will be confirmed nearer the time.
- January 2014 - Deadline for stage two applications.
- 3 to 6 March 2014 – All stage two applicants will be required to give a presentation to the decision making panel on their application during this period.
- By the end of March 2014 - We tell you our decision on your stage two application and announce the final three to five areas to be funded.

All stage one and two applications will be reviewed by a decision making panel made up of Big Lottery Fund England Committee members and experts in the field of health, education and social development.

What makes a good application?

When we assess your stage one application we'll consider the following areas:

- Need: Is the project needed?
- Outcomes: Will the project bring about the changes we are looking for?

We'll also consider the following, which will be assessed in more detail at stage two:

- Approach: Is the way the project will be delivered realistic?
- Capability: Does the organisation applying for funding have the skills, experience and resources to deliver the project?

What else do I need to know?

Development support

An external service provider(s) experienced in supporting voluntary and public sector partnerships and with knowledge of preventative approaches in pregnancy and the first years of life, will provide a package of tailored support to all areas that progress to stage two.

This support will assist areas to develop high quality, science or evidence-based strategies and plans to demonstrate new ways to design and deliver effective preventative services for expectant mothers, carers, babies and young children.

This support must be taken up by all areas that progress to stage two and will be provided during the time available to develop stage two applications. Briefing events will be held to outline details of the support that will be provided and the stage two application process.

The service provider(s) will also work with each area applying to stage two to help them develop alternative options should they not receive a final award from A Better Start.

The three to five areas that do receive a final award will also receive support from the service provider(s) for the first six months of funding, in any areas identified as needing further development and support.

We'll give you more details on the briefing events and the service provider(s) if you are invited to apply to stage two.

Development funding

The option to apply for up to £400,000 development funding will also be available to each area which progresses to stage two. This funding is to cover the costs of developing the area's strategy and plan for service re-design and also to purchase any further support required to:

- engage with the right people so that you can demonstrate how you will bring about systems change to put prevention in pregnancy and the first years of life at the heart of delivery
- secure senior level engagement and support from all the relevant agencies and leaders in the fields of health, local authorities and the voluntary and community sector
- increase understanding of preventative practice in pregnancy and early life

- engage with local people to involve them in developing your project.

Each partnership will be responsible for purchasing the additional support described above directly from an appropriate service provider, who must meet our minimum standards for knowledge, skills and experience. You can find the minimum standards on our website at www.biglotteryfund.org.uk/betterstart

Development funding should be requested at Q4.4 of the stage one application form if required. Tell us what the development funding will pay for and detail any services to be purchased (including the chosen service provider, the reason they were selected and the cost of the service).

Areas receiving development funding will be required to blog on their activities and progress during the development period to exchange ideas and good practice. More details on this will be provided to successful areas.

The development funding must be spent by March 2014.

Evaluation

We plan to evaluate Fulfilling Lives: A Better Start.

A learning and evaluation contractor will support continuous learning and improvement in the three to five areas receiving a final award and will support each area to deliver better outcomes for children by:

- identifying what works well, for whom and in what circumstances
- sharing learning and best practice across the three to five areas and
- evaluating outcomes for babies, children and families.

This learning and evaluation contractor will gather common data in each area throughout the funding period, and support each partnership to put in place appropriate evaluation plans. The final areas will therefore be required to share data and findings and cooperate with the evaluator, and attend learning events.

We also plan to carry out a cost/benefit analysis of the financial savings that might result from investing in effective preventative approaches in pregnancy and the first years of life, by reducing the costs of dealing with preventable health and social problems in later life.

Project plan and partnership agreement

If you are invited to apply to stage two, you will need to provide a project plan and draft partnership agreement with your stage two application. If you are successful at stage two, the draft partnership agreement must be approved by us and finalised prior to any funding being released. You can find guidance on what a project plan and partnership agreement should include at www.biglotteryfund.org.uk/betterstart

Please do not provide a partnership agreement or project plan with your stage one application.

Capital funding

There is no upper limit on the amount of capital funding you can request to pay for land or building purchase or refurbishment. You can also include costs to develop the capital part of the project at question 4.4.

However, if you do apply for capital funding you need to explain at question 4.3 why this is the best way to deliver the project and achieve the outcomes for A Better Start. Please also make sure that you will be able to meet our capital requirements at stage two. You can find guidance on these at www.biglotteryfund.org.uk/betterstart

How do I find out more?

For more information please visit www.biglotteryfund.org.uk, email us at abetterstart@biglotteryfund.org.uk, or join the discussion and follow the latest developments on twitter @BigLotteryFund using #abetterstart.

If you or your main contact have any particular communication needs, such as Braille, audiotape, large print, sign language or a community language, please call us on 0845 4 10 20 30 (textphone 0845 602 1659 available for those with a hearing impairment).

Part one: What will your project do?

1.1 What would you like to call your project?

Give your project a short title, something we can use in publicity.

You can write up to 40 characters (including spaces).

1.2 What does your project involve?

Summarise what you plan to do, using straightforward language.

You can write up to 2,000 characters (about 300 words).

1.3 What will you spend the money on?

Write a list or a description of what our money would pay for.

You can write up to 2,000 characters (about 300 words).

1.4 When are you planning to start and finish your project?

Make sure the dates you put fit with the key dates under What happens when? at the beginning of this form and your start date is after the date when we'll confirm our decision.

Start date (dd/mm/yyyy)

Finish date (dd/mm/yyyy)

Part two: Why is your project needed?

2.1 Why would you like to do this project?

Describe what you would like to change for the people, communities or organisations who will benefit from your project. This could be about:

- helping them make more of the strengths they already have
- tackling a problem they face or a situation affecting them
- addressing a need they have that isn't currently being met.

Make sure it's clear how your answer fits with what we want this programme to achieve. We describe this under What's it all about? at the beginning of the form.

You can write up to 2,000 characters (about 300 words).

2.2 How do you know there is a need for your project?

Describe the evidence you've gathered from:

- the success of any previous work you've done
- research you or others have completed
- any consultation you or others doing similar work have carried out with the people who would benefit.

You can write up to 2,000 characters (about 300 words).

2.3 How will your project fit with what others are doing?

Explain how your project will:

- fill gaps in provision or enhance existing services
- increase the impact of relevant local, regional or national plans or strategies.

Make sure it's clear how your project will be additional to anything statutory bodies have an obligation to provide, as we can't fund this work.

You can write up to 2,000 characters (about 300 words).

Part three: What difference will your project make?

3.1 How will people benefit from your project?

Describe up to four changes you expect your project to bring about, using straightforward language. We call these your project outcomes.

Having more outcomes won't necessarily make your application stronger. We're also interested in other things, such as the kind of changes you're trying to bring about.

You can write up to 150 characters in each box (about 30 words)

1.
2.
3.
4.

3.2 How will you improve overall provision for the people who'll benefit from your project?

Explain how your project will join up with and enhance the services or activities run by other organisations working in the same field.

You can write up to 2,000 characters (about 300 words).

Part four: How will you carry out your project?

4.1 How will you run your project?

Explain how you'll manage your project, make decisions and know if it's going well.

You can write up to 2,000 characters (about 300 words).

4.2 How much will your project cost and how much would you like from BIG?

- Include the cost of everything you'll need for your project, even if you're not asking us to fund it.
- Only include VAT if you can't recover it from HM Revenue and Customs.
- Capital costs include buying equipment, constructing a building, altering a building, buying land or landscaping.
- Revenue costs include things like training, travel, venue hire and volunteer expenses.

If you're asking us for all the costs make sure the total cost and amount from BIG is the same.

	Total cost (£)	Amount from BIG (£)	How many years is this for?
Capital			
Revenue			
Total			

Are the total project costs more than the amount you'd like from us?

☐ Yes ☐ No

If you have answered yes, where will you get the other funding from and have you secured it yet? You can write up to 2,000 characters (about 300 words).

4.3 Will your project include constructing a building, altering a building, buying land, buying a building or any kind of landscaping?

☐ Yes ☐ No (If no, go to question 4.4)

4.3.1 If your answer to 4.3 is yes, is a capital project the best way to meet the need?

Explain what other options you've considered, how you've considered them and why you think the capital project you've chosen is the best way to meet the need.
You can write up to 2,000 characters (about 300 words).

4.3.2 If your answer to 4.3 is yes, do you need planning consent, change of use approval, buildings regulations approval, listed building consent or party wall agreements?

☐ Yes - What permissions do you need and have they already been granted. If they haven't, when will you hear a decision? You can write up to 500 characters (about 80 words).

☐ No – How have you found out you don't need any planning or other permissions? You can write up to 500 characters (about 80 words).

4.3.3 If your answer to 4.3 is yes, do you own the land or building?

- [ ] Yes (Please note we may ask for proof that you own the land or building)
- [ ] No

4.3.4 If you have answered no to 4.3.3, tell us who owns the land or building. You can write up to 250 characters (about 40 words).

Do you plan to buy the land?

- [ ] Yes
- [ ] No

If yes, what stage have you reached? You can write up to 500 characters (about 80 words).

Do you hold a lease or written permission that can't be brought to an end by the landlord?

- [ ] Yes
- [ ] No

If yes, what stage have you reached and how long a lease do you have or plan to get? You can write up to 500 characters (about 80 words).

To find out more about our land and buildings requirements visit www.biglotteryfund.org.uk/betterstart

4.4 Development funding

How much will it cost to develop your project?

The development or feasibility costs you can ask us for are explained under What else do I need to know? at the beginning of the form.

- Include the costs of everything you will need to do to develop your project, even if you're not asking us to fund it.
- Be as detailed as you can, using clear headings followed by a short description.
- Only include VAT if you can't recover it from HM Revenue and Customs.
- Use a different row for each heading.

Item or activity	Total cost (£)	Amount from BIG (£)
Totals		

Are the total development costs more than the amount you'd like from us?

☐ Yes ☐ No

If you have answered yes, where will you get the other funding from and have you secured it yet? You can write up to 2,000 characters (about 300 words).

Part five: Do you have the skills, experience and resources to run your project?

5.1 What experience do you have in running similar projects?

Provide details of your organisation's relevant experience (and the experience of any other organisations you'll be working with), what you've learned from your previous work and how this will help you with the project you'd like us to fund.

You can write up to 2,000 characters (about 300 words).

5.2 Partner organisation details

List your main partners, their relevant experience and what they will deliver as part of your project.

Organisation name	Relevant experience	Role in the project

5.3 How will the partnership operate?

Describe the processes and structures you have developed or will put in place to ensure your partnership works together well and links up more widely with other organisations.

You can write up to 2,000 characters (about 300 words).

5.4 What is your organisation's current financial position?

Select one option and fill in the amounts from your accounts or projection.

- [ ] Information from the latest accounts approved by your organisation.
- [ ] 12 month projection because you've been running less than 15 months.

Account year ending (dd/mm/yyyy)	
Total income for the year	£
Total expenditure for the year	£
Surplus or deficit at the year end	£
Total savings or reserves at the year end	£

5.5 Where can we find your latest accounts?

☐ BIG already has our latest accounts.

☐ We're sending our accounts, or a projection if we've been running less than 15 months, with this form.

5.6 Have your accounts been independently audited?

☐ Yes ☐ No

If yes, give the name and address of your auditor

5.7 Working with children, young people or vulnerable adults

As a minimum we expect you to:

- have safeguarding policies appropriate to your organisation's work and what you are asking us to fund, which you review at least every year
- complete a rigorous recruitment and selection process for staff and volunteers who work with children, young people or vulnerable adults, including checking criminal records at least every three years and taking up references
- follow statutory or best practice guidance on appropriate ratios of staff or volunteers to children, young people or vulnerable adults
- provide child protection and health and safety training or guidance for staff and volunteers
- carry out a risk assessment and secure extra insurance, if appropriate.

Does your organisation meet these requirements?

☐ Yes ☐ No

Part six: Who will benefit from your project?

Your answers help us understand who benefits from our funding but we don't use them to decide which applications are successful.

6.1 Will your project mostly benefit people from a particular ethnic background?

Yes ☐ No ☐

If yes, which ethnic background? You can select up to three.

White

- ☐ English/Scottish/Welsh/Northern Irish/UK
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other white background

Mixed/Multiple ethnic groups

- ☐ Mixed ethnic background

Asian/Asian UK

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background

Black/African/Caribbean/Black UK

- ☐ African
- ☐ Caribbean
- ☐ Any other Black/African/Caribbean background

Other ethnic group

- ☐ Arab
- ☐ Any other

6.2 Will your project mostly benefit people of a particular gender?

Yes ☐ No ☐

If yes, which gender?

Male ☐ Female ☐

6.3 Will your project mostly benefit people from a particular age group?

Yes ☐ No ☐

If yes, which age group? You can select up to two.

- ☐ 0 - 24 years
- ☐ 25 - 64 years
- ☐ 65 + years

6.4 Will your project mostly benefit disabled people?

Yes ☐ No ☐

6.5 Will your project mostly benefit people of a particular religion or belief?

Yes ☐ No ☐

If yes, which religion or belief?

- ☐ No religion
- ☐ Christian
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Other

6.6 Will your project mostly benefit lesbians, gay men or bisexual people?

Yes ☐ No ☐

Part seven: Provide your details

7.1 What is the full legal name of your organisation, as shown on your governing document?

7.2 Does your organisation use a different name in your day to day work?

Yes ☐ No ☐

What other name do you use?

7.3 What is the main or registered address for your organisation?

Flat number

Building number

Building name

Street

Town or city

Postcode

Phone number one

Phone number two or text phone

7.4 What is the main email address for your organisation?

This should be the email address people use to contact your organisation?

7.5 Does your organisation have a website?

Yes ☐ No ☐

What is its address?

7.6 What sector does your organisation fit into?

- [ ] Public sector
- [ ] Private sector
- [ ] Voluntary and community sector
- [ ] Other – please describe your organisation in the space below

7.7 Give any reference or registration numbers you have.

Charity Commission for England and Wales

Charity Commission for Northern Ireland (or HMRC reference number)

Office of the Scottish Charity Regulator

Companies House

Financial Services Authority

Health Authority number

School reference number

Other reference or registration number

Please give details

If your organisation is unincorporated and not registered as a charity, you'll need to send us a copy of your governing document with your application form.

7.8 When was your organisation set up?

Give the date when your organisation adopted its current legal status (dd/mm/yyyy).

7.9 What is your VAT status?

- [ ] VAT registered
- [ ] Not VAT registered

If you are VAT registered, what is your registration number.

7.10 Is your organisation independent, or a branch or department of a larger organisation?

- [ ] Independent
- [ ] Branch or department

If you are a dependant branch, please provide the name and address of the larger organisation as they may have some legal responsibility if we award you a grant. You must also send us a letter of endorsement from your parent organisation.

Name

Address

7.11 How many people are on the committee that runs your organisation?

7.12 Are there any restrictions on who can join your organisation?

Yes [ ] No [ ]

What restrictions are they and why do you have them?

- If your organisation has a membership we expect this to be open to all and that anyone can join, unless you can provide a good reason why not.
- We will usually consider proposing and seconding to be unacceptable and we expect there to be the right of appeal for anyone refused membership.

You can write up to 400 characters with spaces (about 50 words)

Primary contact details

7.13 Who should we contact if we have questions about your application?

They must be someone who runs or works for your organisation. We need their date of birth and home address for our standard fraud prevention checks.

Title

Forenames

Surname

Date of birth

Job title or position

Home address

Flat number

Building number

Building name

Street

Town or city

Postcode

Telephone number one* (or textphone)

Telephone number two* (or textphone)

At least one of these must be a landline telephone number

Email address (if applicable)

Web address (if applicable)

Address for correspondence, including postcode. Write 'as above' if this is the same as the organisation's registered address in question 7.3.

Flat number

Building number

Building name

Street

Town or city

Postcode

If the address for correspondence is different from the organisation's registered address in question 7.3, please tell us why.

Communication needs

Tell us about any particular communication needs your main contact has. This might include textphone, sign language, large print, audiotape, Braille or a community language.

☐ We'd like to send you information about Big Lottery Fund and other Lottery good causes. Tick this box if you don't want to receive this information.

☐ We'd like you to help us improve our customer service by taking part in market research, surveys or product testing. This may involve passing your details to other organisations who do this work for us. Tick this box if you don't want to take part in these activities.

Legally Responsible Contact

7.14 Who in your organisation will be legally responsible for the funding?

- For companies they should be a company director or the company secretary.
- For local authorities and health bodies they should be your chief executive or a director.
- For town, parish or community councils they should be the clerk to the council (or office bearer).
- For all other types of organisations they should be your chair, vice chair or treasurer.

They must be over 18 years old and can't be the same as the person we should contact if we have questions about your application. We need their date of birth and home address for our standard fraud prevention checks.

Title | Forenames | Surname

Date of birth

Job title or position

Home address

Flat number

Building number

Building name

Street

Town or city

Postcode

Telephone number one* (or textphone)

Telephone number one* (or textphone)

*At least one of these must be a landline telephone number

Email address (if applicable)

Web address (if applicable)

Address for correspondence, including postcode. Write 'as above' if this is the same as the organisation's registered address in question 7.3.

Flat number

Building number

Building name

Street

Town or city

Postcode

If the address for correspondence is different from the organisation's registered address in question 7.3, please tell us why.

Tell us about any particular communication needs your main contact has. This might include textphone, sign language, large print, audiotape, Braille or a community language.

Declaration

Check the box to confirm that:

- the information you have given is accurate and true
- your application has been authorised by the governing body of your organisation
- your organisation has the legal power to deliver the project you have described in this form
- you understand that if you make misleading statements or withhold information at any point, your application will be invalid and you will be liable to repay any money you have received
- you will be able to meet our Standard Terms and Conditions of grant, which you can find on our website at www.biglotteryfund.org.uk/betterstart
- you agree we may use the information you have provided for the purposes described under Data Protection below.
- you accept that if information about this application is requested under the Freedom of Information Act we will release it in line with our Freedom of Information Policy.

☐ I agree

Name of legally responsible person

Data protection

We will use the information you give us during assessment and during the life of your grant (if awarded) to administer and analyse grants and for our own research purposes. We may give copies of all or some of this information to individuals and organisations we consult when assessing applications, administering the programme, monitoring grants and evaluating funding processes and impacts. These organisations may include accountants, external evaluators and other organisations or groups involved in delivering the project.

We may share information with organisations and individuals with a legitimate interest in Lottery applications and grants or specific funding programmes. We have a duty to protect public funds and for that reason we may also share information with other Lottery distributors, government departments, organisations providing matched funding or for the prevention and detection of crime.

Your information may be transferred to an IT service provider based outside the European Economic Area (EEA). If your information is transferred outside the EEA, we will ensure it is sufficiently protected.

We might use personal information provided by you in order to conduct appropriate identity checks. Personal information that you provide may be disclosed to a credit reference or fraud prevention agency, which may keep a record of that information.

If you provide false or inaccurate information in your application or at any point in the life of any funding we award you and fraud is identified, we will provide details to fraud prevention agencies, to prevent fraud and money laundering. You can obtain further details explaining how the information held by fraud prevention agencies may be used from our Head of Information Governance, by emailing dataprotection@biglotteryfund.org.uk or by telephoning our advice line on 0845 4 10 20 30, or by writing to: Head of Information Governance, Big Lottery Fund, 1 Plough Place, London, EC4A 1DE.

We might use the data you provide for research purposes. We recognise the need to maintain the confidentiality of vulnerable groups and their details will not be made public in any way, except as required by law.

Freedom of Information Act

The Freedom of Information Act 2000 gives members of the public the right to request any information that we hold. This includes information received from third parties, such as, although not limited to grant applicants, grant holders, contractors and people making a complaint.

If information is requested under the Freedom of Information Act we will release it, subject to exemptions; although we may choose to consult with you first. If you think that information you are providing may be exempt from release if requested, you should let us know when you apply.

A Better Start Further copies available from:

Email enquiries@biglotteryfund.org.uk
Phone 0845 4 10 20 30
Textphone 0845 6 02 16 59 (this is for those with a hearing impairment)
Our website www.biglotteryfund.org.uk

Accessibility

Also available upon request in other formats including large print.

Our equality principles

Promoting accessibility; valuing cultural diversity; promoting participation; promoting equality of opportunity; promoting inclusive communities; reducing disadvantage and exclusion. Please visit our website for more information.

We care about the environment

The Big Lottery Fund seeks to minimise its negative environmental impact and only uses proper sustainable resources

Our mission

We are committed to bringing real improvements to communities and the lives of people most in need.

Our values

We have identified three values that underpin our work: making best use of Lottery money, using knowledge and evidence and being supportive and helpful.

You can find out more about us, our values and the funding programmes we run by visiting our website www.biglotteryfund.org.uk

The Big Lottery Fund is committed to valuing diversity and promoting equality of opportunity, both as a grantmaker and employer. The Big Lottery Fund will aim to adopt an inclusive approach to ensure grant applicants and recipients, stakeholders, job applicants and employees are treated fairly.

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MUNICIPAL YEAR 2012/2013 REPORT NO.

MEETING TITLE AND DATE: **Health & Wellbeing Board April 2013**	**Agenda – Part:** **Item:**
REPORT OF: Andrew Fraser Director of Schools and Children's Services	**Subject: Change and Challenge Update** **Wards: All** **Key Decision No:**
	Cabinet Member consulted: Cllr Charalambous and Cllr Orhan

Contact officer and telephone number:

Eve Stickler

Assistant Director, Commissioning and Community Engagement

E mail: eve.stickler@enfield.gov.uk

1. EXECUTIVE SUMMARY

1.1 This paper provides information to the Health and Wellbeing Board on the strategic and operational development of the Change and Challenge programme in Enfield.

1.2 This report gives an update on the following:

- breadth and scope of the project and the continuum of need and allied activity
- family identification with partners and stakeholders,
- development of effective referral mechanisms (Enfield's model now being seen as an example of good practice shared with other London LAs) (Attached at Appendix 1)
- commissioning activity and outcomes
- current family activity information and "attachment fee" information for 2013/14
- management transition arrangements
- Job Centre Plus
- Year 2 targets

2. RECOMMENDATIONS

2.1 This report requests that the Health and Wellbeing Board note the information and continue to engage with and promote the programme as appropriate as it contributes to achieving positive outcomes for Enfield's families.

3. BACKGROUND

3.1 Enfield's target is to turn around the lives of 775 families of over the 3 years of the DGLG Troubled Families Programme. To date the programme has had the following key characteristics:

- 3 areas of focus (these being: crime and anti-social behaviour, education and worklessness)
- crime and antisocial behaviour being the priority area for Enfield in the initial phase of the programme
- proposed refocused activity for year 2 (for April delivery) considering our priorities for Employment (adults pathway to work, NEETs, families in poverty) alongside the Education and Crime filters (youth crime, anti-social behaviour, persistent absence, school exclusion, as well as the consideration of substance misuse, domestic violence, gang involvement and child health and wellbeing)
- data sourcing, collection, cleansing and filtering
- proposals for greater partnership engagement, participation and reward as part of the local discretion permitted by the DCLG
- Programme launch date: April 1st 2012.

3.2 This report offers information on progress both in regard to continued strategic links in order to achieve a collaborative transformation through the life span of the initiative, and in terms of operational activity.

4 MANAGEMENT TRANSITION ARRANGEMENTS

4.1 The Board are informed that with effect from the 2nd April 2013, management of the Change and Challenge Programme has passed to Anne Stoker, Head of Parenting Support Service and Parent Commissioner. The move of the programme to this portfolio of services forms part of the wider transformation of services aimed at building resilience for future delivery. The role of the Change and Challenge Co-ordinator will be integrated into a new management structure aligning it more closely with other preventative services areas including the Parent Support Service, and the Homeless Young People's Project and the Asylum and Homeless Families Service.

5 SYSTEMIC TRANSFORMATION AND THE CONTINUUM OF NEED

5.1 It is clear that the Change and Challenge Programme does not operate in isolation, and must play its part in the redesign and transformation of services to families across sectors. The development of appropriate strategic links in the design and delivery will address a whole continuum of need, reduce duplication, increase joint working and learning, and engagement of agencies to a greater preventative outcome.

5.2 The development of the Single Point of Entry (SPOE) is a practical illustration of the transformation that is taking place through a pragmatic partnership approach to the assessment of family need. Having gone live at the end of 2012 the SPOE is already reaping benefits in ensuring a holistic and multi-agency response is made to presenting need, and appropriate agency referral is made with a lead professional assigned swiftly. Referrals are being made from a range of agencies including schools, clinicians and voluntary sector partners.

5.3 Further work is taking place to ensure our CAFs are fit for purpose, streamlined, electronic and appropriate for all key partners and eCAF is due to go live in April 2013. A further ICT system to integrate the identification process is in development (see 6.5).

5.4 Restructuring is taking place within the Council's Schools and Children's Services Department and under the "Building Resilience" pillar of the Leaner Programme. Services have been reconfigured under 3 leadership teams: Children's Services, Education Services and Commissioning and Community Engagement. Work is currently in place that makes significant changes to management structures within these 3 teams and affecting many of the services within. Full consultation processes are already either underway or planned as appropriate and implementation across the whole department should be completed in the autumn.

6 FAMILY IDENTIFICATION WITH PARTNERS AND STAKEHOLDERS

6.1 In order to identify the list of target families a host of agencies have been consulted and their data collected, shared and matched. These include:

- Civica Housing database
- Database of families affected by the welfare benefit reforms in relation to the housing benefit cap
- Open cases to the Education Welfare Service
- Current roll at the Primary Behaviour Support Service
- Current roll at the Secondary Tuition Centre and families known to the Secondary Support Service
- Open cases to the Children in Need Service
- Young people known to the Youth Support Service who are NEET or on the Teenage Pregnancy database
- Open cases to the Youth Offending Service on both databases
- ASB cases known to Enfield Homes
- Persistent absence data (from the schools census)
- Exclusions data (from the schools census)
- Gangs and call in list
- CAF database
- Data from 4 RSLs
- Data from EPC/4Children Turnaround Project
- Compass Young People substance misuse data
- Police database (cross matching with YOS)

6.2 In filtering the data the team narrowed down the initial 6,000 identified potential individuals to a declared list of 334 families for year one of the programme, with a target to attach 280.

6.3 As stated above, the development of the Single Point of Entry (SPOE) is one of the key features of the transformation that is taking place in Children's Services; engaging partners across all sectors who may have a concern about a child they are working with. The increased capacity created within the SPOE through this initiative will enable them to check all their referrals against the Change and Challenge criteria and cross match with the list of target families. On the allocation of a matched case to any agency as the lead professional additional consideration will be made to a complete family plan as part of the programme.

6.4 In addition, secondary schools have been consulted on the best way to gather and cross match data on the families high on their day to day concerns. Work has started

to contact each secondary school with a list for them to check and agree (on the basis of the data listed above at 6.1) and add to as appropriate.

6.5 Further development of the Multivue (Visionware) programme has taken place to enable multiple datasets to be searched and compared automatically in future to match individuals who appear across different services. This will provide a single view of a child, noting address and the services or agencies to whom the individuals are known.

6.6 Since December we have met with the software company and started the process of integrating information from Youth Offending Service, Youth Support Service, and Common Assessments. The next steps will be to integrate education data it is envisaged that a usable programme will be running by April 2013.

6.7 Arrangements are currently being put in place for active information sharing on those presenting directly to both the Youth Offending Service and Adolescent Support Teams, similar 'live' information sharing will be put in place between Behaviour Support and ASB services.

7 DEVELOPMENT OF EFFECTIVE REFERRAL MECHANISMS

7.1 The year one cohort of families was identified through cross matching of existing service information rather than through active referral into the programme, as we move into year two, we need to establish effective pathways into the programme including the SPOE, direct identification and open referrals from partners as described below.

7.2 Following discussion with the Enfield Strategic Partnership in December, it was felt that a mechanism was needed to ensure that all partners would have the opportunity to both identify families and take on the role of a lead agency, as part of the Change and Challenge programme.

7.3 Opening up the identification process to the whole partnership in a more proactive and transparent way would enable organisations to refer families of concern into the initiative and ensure that there was no sense of exclusivity in relation to the programme.

7.4 A guidance pack was designed and issued across the partnership on the 20th December. The guidance explained how partners could get involved with the programme through the identification of potential families that meet the Change and Challenge Programme criteria and express an interest in taking a lead professional role with families that they have referred.

7.5 The initial 'Open Identification and Referral' process was open from 20th December 2012 to 31st January 2013.

7.6 In February 2013, the Change and Challenge Advisory Group reviewed the document and decided that it remained a useful mechanism for identifying potential new families. It has now been uploaded to the Children's Trust Website. http://www.enfield.gov.uk/ChildrensTrust/info/27/change_and_challenge/48/change_and_challenge_family_identification_and_referral_guidance

7.7 On the 4th March the Government announced that further support would be put in place to support the employment strand of the Troubled Families agenda.

"*The employment goals of the Troubled Families Programme are ambitious, and rightly so. We know that employability and – ultimately – employment is critical to tackling the often intergenerational cycle of benefit dependency and low aspiration for families with particularly complex needs.*

Problems such as poor school attainment, crime, mental illness, substance misuse and domestic violence can make it incredibly hard for troubled families to secure and retain employment. The Troubled Families Programme aims to address these long-standing barriers to work and ***make employment an ambition for all****.*

Building upon the good work already underway in many local areas, this agreement sets out a series of commitments to which the Government hopes all upper-tier local authorities in England and Jobcentre Plus will sign up to.

This is a ***national approach*** *that aims to boost the employment and employability objectives of the Troubled Families Programme. This approach will be supplemented, at a local level, with a similarly joined-up approach to engagement between local authority and Jobcentre Plus partners with skills and welfare to work providers, as well as local employers.*
The Department for Work and Pensions is offering the top 94 upper-tier local authorities with the highest numbers of troubled families fully-funded and dedicated Jobcentre Plus secondees – ***Troubled Families Employment Advisers****.*

They will be in place for the remainder of the programme (until May 2015) and will support the delivery of these ambitious employment and employability goals. The 94 local authorities are working with over 80% of England's troubled families."

(DCLG Delivery Agreement: Putting Troubled Families on the Path to Work, 4th March 2013)

7.8 Enfield will be allocated one JCP Troubled Families Adviser.

8 COMMISSIONING ACTIVITY AND OUTCOMES

8.1 Commissioning Round 1

Expressions of Interest were invited from partners through the distribution of funding application packs on the 16th October. This was disseminated to all Children's Trust Board members, Safer and Stronger Communities Board Members, Employment and Enterprise Board Members, Schools Communications (all Head teachers and Governors), ETYEB, Steering Group Members, all SCS Managers and it has been further distributed to the wider partnership through networks.

8.2 In order to meet the time constraints and maximise benefits to families we are initially working on the basis of enhancing existing services with a proven track record and evidence base in meeting the needs of families with complex needs. At the same time we will be assessing future needs from the wealth of data available, in order to provide further targeted support to meet the outcome targets of the programme.

8.3 A commissioning fund of £350,000 was identified from the attachment fee for this element of the programme. Bids received from partners totalled approximately £1.2 million. 16 bids were received including two bids from third sector organisations, two bids from schools and one bid from a mental health provider.

8.4 The Change and Challenge Advisory Group met on the 18th December to review all of the bids received and make recommendations to ETYEB for final decision. Below is a summary table of approved bids. The recommendations were approved by Cllr. Bambos Charalambous and Andrew Fraser on behalf of the Enfield Targeted Youth Engagement Board on January 14th 2013. Two bids from Youth Offending Service and Edmonton County were subsequently considered and agreed pending further negotiation on the 28th February 2013.

Bid Summary	Bid Amount	Organisation
Gangs Plus, activity budget to compliment the Parent Support Adviser role agreed in December	15,000	Community Safety
Hub family support, offering intensive targeted support to challenging families.	20,000	Oasis Academy Hadley
Mentoring , counselling and parent support services	12,500	*Life Youth Resource Centre
Engagement of Parent Support Adviser to work with, train and support parent champions	47,537	Parenting Support Service
Youth Offending Social Workers and parenting support	140,000	Youth Offending Service
School based support	25,000	*Edmonton County School

Approx. Value £ 260,937

8.5 As a part of this commissioning process we have been able to join some projects up to enable them to form part of a continuum of support and challenge in a specific area.

8.6 Welfare Reform

The Change and Challenge initiative has been working closely with LBE's Revenues and Benefits Service to identify where those identified as meeting the programmes criteria will also be adversely impacted upon by the reforms to the welfare programme.

8.7 Of the 334 families (572 individuals) 99 Individuals are identified as living in households who will be impacted on by the upcoming changes. The majority of these families are known to the Children in Need in Service, they have been working with the 'Benefits Taskforce' to ensure families are aware and signposted to support as appropriate.

8.8 In year two of the programme there will be an increased focus on worklessness, supported by the additional identified resource from Job Centre Plus, this will enable us to work proactively with families where the impact of welfare reform will be felt most keenly.

8.9 We also recognise that there may be particular risks associated between these changes and families where there has been prior offending.

8.10 Additional Capacity

At the December meeting of the Enfield Strategic Partnership four posts were agreed to add delivery capacity to the programme (CAF Screening Advance Practitioner for the SPOE, DV worker for the SPOE, Employment Liaison Officer, and a Parent Support Advisor for gangs work). Appropriate recruitment processes are now underway for these posts. A Programme Support Officer has now been appointed to assist in the day to day business management of the programme. In addition, a small allocation has been made to the Police for initial vital data matching. We are aware that a further request for support will be forthcoming in order to sustain the data work for the life of the programme.

8.11 A graduate trainee has been allocated to the programme for a period of 6 months to assist in the development of a Commissioning Strategy for year 2 of the programme, to monitor and evaluate current commissioned programme and to consult partners on a refresh of the local priorities.

8.12 As discussed under 7.7 there will be additional resource within Job Centre Plus of a Troubled Families Advisor, this worker gives additional capacity within employment strand to focus on this agenda.

9 CURRENT FAMILY ACTIVITY AND ATTACHMENT INFORMATION 2013/4

9.1 As stated above we identified a list of 334 families for year one of the programme, with a target to attach 280. In our return to the Troubled Families Unit earlier this month we were able to declare that we have attached 239 families. These attachments were largely through the YOS and Gangs projects already in place.

9.2 At Appendix 2 is a comparison table of London Authorities year one progress to date. In summary - of the 33 London Boroughs, we had identified the 8th highest number of families so far (334) - those LAs identifying more were: Tower Hamlets (423), Lambeth (1080), Newham (783), Lewisham (378), Islington (377), Redbridge (364) and Harrow (340). In numerical terms the DCLG data shows Enfield as 15th in London in relation to the number of families attached.

10. MONITORING OUTCOMES AND IMPACT

10.1 The recent letter to Local Authorities from Louise Casey at the DCLG recognises that the vast majority of the work undertaken to date in Local Authorities with their partners has concerned the identification of families, data analysis, data cleansing and the setting up of systems to enable develop the programme. This is further borne out in the messages shared at the coordinators network meetings to which Enfield's Coordinator is a participant. However, the letter is also clear that the focus for the coming months should be working effectively with those families now identified and ensuring that their pathways into work, school and out of crime should be established and monitored effectively. It is on clear evidence of this that any reward payment can be claimed.

10.2 The development work in Enfield to date has been focused on "attachment" and identification of families, along with developing broad participation opportunities for partners in the delivery of projects and work-streams. Whilst it is too early to have outcome data on these attachments it is imperative that we now track their progress and the recent recruitment to key support posts within the Change and Challenge Team, the SPOE, along with financial support for additional capacity within YOS and the Police will enable appropriate performance monitoring to take place.

10.3 The DCLG Troubled Families Unit have revised their monitoring and claims schedule and will be facilitating quarterly returns from July 2013 and will require evidence of outcomes monitoring in order for claims to be paid. In accordance with the local governance arrangement Enfield's returns will be circulated to ETYEB and the ESP in order that all partners are aware of progress.

10.4 In addition to the formal PBR claim process discussed above, the DCLG have engaged a consortium Ecorys UK to evaluate effectiveness of the Troubled Families Programme. This is likely to be through a dip sampling process of 10% of local cohorts.nThe Ecorys UK consortium is made up of 5 organisations, with each leading on different parts of the evaluation:

- Ipsos MORI
- National Institute for Economic and Social Research
- Clarissa White Research
- Bryson Purdon Social Research
- Thomas Coram Research Unit, Institute of Education

The consortium won the 3-year evaluation contract worth an average of up to £435,000 per year after a full tender process. The Local Government Association will contribute £100,000 per year and the Department for Communities and Local Government up to £335,000 per year. The evaluation contract will run from 2013 to 2016 to allow for a full assessment of the troubled families payment-by-results programme, which is funded until 2014 to 2015. It will produce regular interim reports and its findings will be made public

11. THE GOVERNANCE MODEL

11.1 **Advisory Group**

The former Change and Challenge Steering group have revised their terms of reference to more accurately reflect their advisory role to the Enfield Targeted Youth Engagement Board. It will now be referred to as the Change and Challenge Advisory Group. Both the Voluntary Sector Forum and the ESP have been invited to nominate members to join the advisory group.

12. ALTERNATIVE OPTIONS CONSIDERED

N/A

Enfield's participation in the Troubled Families Initiative is not optional.

13. REASONS FOR RECOMMENDATIONS

This report requests that the Health and Wellbeing Board note the information and continue to engage with and promote the programme as appropriate as it contributes to achieving positive outcomes for Enfield's families.

14. COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

14.1 Financial Implications

In 2012/13, which was Year 1 of the Troubled Families programme, the Council received an attachment fee grant of £745,600 plus a coordinators grant of £100,000. This grant funding has been used or earmarked to fund additional posts to support the grant objectives and to commission targeted services. It is estimated that a balance of £752,000 will be carried forward into 2013/14.

We received notification on 12th February 2013 of the DCLG intentions for the attachment fees for 2013/14. Although all LAs submitted management information to the Troubled Families unit in January, the attachment fees will be calculated using the information in the final quarter of the current financial year to ensure any new family activity is captured.

"DCLG Proposals for issuing attachment fees

We will split areas into one of three groups depending on performance at 31 March 2013:

- *Group 1:* Areas working with 75% or more of Year 1 families as of 31/3/2013 to be paid all of requested Year 2 attachment fees in full, in one payment in the first quarter of 2013/14.
- *Group 2:* Areas working with between 33% and 75% of their Year 1 families as of 31/3/2012 to be paid half of requested Year 2 attachment fees in first quarter of 2013/14 with the remaining half to be paid in the second quarter of 2013/14 providing they have caught up (i.e. commenced working with remainder of Year 1 families) by then.
- *Group 3:* Areas working with less than 33% of their Year 1 families as of 31/3/2013 won't be paid Year 2 attachment fees until they have caught up, at which time we will agree with them a realistic ambition for the remainder of Year 2."

14.2 On the 12th March 2013 the DCLG wrote to Local Authority Chief Executives regarding attachment fee claims for year two of the programme. The letter confirmed that the DCLG are ready for councils to commence working with an additional 50% of their troubled families in 2013/14. The aim "*has been to give councils reassurance around continuing funding and thereby sustain the fantastic momentum that has been building, whilst also acknowledging that a few councils have a little way to go in spending their Year 1 allocation before they're ready to start claiming all of their Year 2 monies*".

14.3 Enfield submitted the formal bid for attachment fees by the 8th April deadline. Our return, as stated above at 9.2, shows that we met the required 75% threshold (210) and as a Group 1 we are allowed to claim the maximum attachment fee for 2013/14. In addition, we have responded that we will aim to identify all of our remaining target number of families in year 2 (495 families representing 64% of our total target figure). Under the terms of PBR we confirmed that we will be working with 413 and this is the basis for the upfront 60% attachment fee (giving £991,200). There will also be further allocations of the £100,000 Coordinators grant in 2013/14 and 2014/15.

This gives maximum opportunity to receive the 60% attachment fee, but time to offer a real focus on those remaining families for the 2 year remaining life span of the initiative. There will be further opportunities to claim the PBR element of the

Troubled Families grant for the families that we have been successful with. We have estimated that by July we will see evidence of turnaround for 14 families. This figure will increase later in the year once the targeted services are introduced and more focused working by existing services is implemented.

14.4 **Legal Implications**
In order to comply with the data protection principles under the Data Protection Act 1998, the sharing of data should be covered by a data sharing agreement to ensure that common standards are set and that all parties understand the requirements.

Section 2B of the National Health Service Act 2006 came into force on 1 April 2013. Section 2B(1) imposes a duty on each local authority to take such steps as it considers appropriate for improving the health of the people in its area. Subsection 3 sets out the steps which may be taken under subsection 1. These include (a) providing information and advice; (b) providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way) and (c) providing assistance to help individuals to minimise any risks to health arising from their accommodation or environment.

Section 195 (1) of the Health and Social Care Act 2012 also came into force on 1 April 2013. It imposes a duty on a health and wellbeing board, for the purpose of advancing the health and wellbeing of the people in its area, to 'encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner'.

This proposal would appear to meet the requirements of both these statutory duties.

14.5 **Property Implications**
N/A

15. KEY RISKS

15.1 The targets for Enfield are challenging and the current climate of welfare reform and family mobility compound the challenges. Enfield has made representation to the DGLG Troubled Families Unit in this regard and is working alongside other London LAs, through the coordinators network, who face similar challenges to monitor the situation and ensure the join up of work on this initiative to other services and schemes to tackle multiple disadvantage and challenge.

16. IMPACT ON COUNCIL PRIORITIES

16.1 The Change and Challenge Programme meets the Council priorities of Fairness for all, Growth and Sustainability, and Strong Communities by working intensively with families to ensure they reduce incidences of crime, truancy and worklessness, through positive, personalised and tailor made interventions and therefore create a more positive outlook for the whole family and the community at large.

17. EQUALITIES IMPACT IMPLICATIONS

17.1 A full strategy document is currently being prepared and will be accompanied by an Equalities Impact Assessment

18. PERFORMANCE MANAGEMENT IMPLICATIONS

18.1 See also section 10.3. Performance of the Change and Challenge programme is monitored by the DCLG through quarterly reporting. Locally this takes place through the Advisory Board and the regular reporting to ESP, SSG and ETYEB. Since the scheme carries both attachment funding and payment by results elements we recognise the performance monitoring and management to be of vital importance.

19. PUBLIC HEALTH IMPLICATIONS

19.1 Although Department of Health money forms part of the cross-government funding for the national troubled families programme, no Government national performance targets were set. Local areas were at liberty to establish local priorities, for year one of the programme Enfield included young people's substance misuse as an area of concern.

19.2 Inevitably the complex nature of Enfield's Change and Challenge families will mean that as lead professionals are identified a fuller picture will emerge of families experiencing issues such as adult mental health, poor nutrition, childhood obesity and infant mortality. It will at this point be essential to fully ensure effective protocols and partnership working across the health agenda are utilised to secure the best possible outcomes for families, identifying cost saving benefits to existing provision such as accident and emergency or employing leverage on the commissioning of additional services for families through the Clinical Commissioning Group to secure provision to meet needs.

19.3 The Health and Wellbeing Board will have a role on informing future local targets, the Enfield Strategic Partnership have already suggested a higher focus on families where childhood obesity is an issue.

19.4 The Common Assessment Framework form and process are currently being reviewed with health colleagues who work across borough boundaries to ensure referrals can be captured effectively in frontline practice situations.

Background Papers

Appendix 1 – Referral Guidance
Appendix 2 – Progress Table

London Boroughs TFP progress and families turned around as at December 2012

London Boroughs	Total number of Families	Number of families identified at December 2012	*Percentage of total required families identified*	Number of families worked with as at December 2012	*Percentage of identified families worked with*	Number of families turned round at January 2013	*Percentage of families turned round at January 2013*
Inner London							
Tower Hamlets	1120	423	*37.8%*	344	*81.3%*	0	*0.0%*
Southwark	1085	250	*23.0%*	250	*100.0%*	54	*21.6%*
Lambeth	1080	1080	*100.0%*	455	*42.1%*	0	*0.0%*
Hackney	1000	306	*30.6%*	117	*38.2%*	19	*6.2%*
Newham	985	783	*79.5%*	121	*15.5%*	0	*0.0%*
Lewisham	910	378	*41.5%*	168	*44.4%*	17	*4.5%*
Haringey	850	270	*31.8%*	199	*73.7%*	0	*0.0%*
Islington	815	377	*46.3%*	252	*66.8%*	11	*2.9%*
Westminster	790	255	*32.3%*	54	*21.2%*	0	*0.0%*
Camden	755	240	*31.8%*	240	*100.0%*	94	*39.2%*
Wandsworth	660	262	*39.7%*	262	*100.0%*	5	*1.9%*
Hammersmith and Fulham	540	314	*58.1%*	40	*12.7%*	0	*0.0%*
Kensington and Chelsea	400	106	*26.5%*	59	*55.7%*	0	*0.0%*
City of London	25	3	*12.0%*	3	*100.0%*	0	*0.0%*
Outer London							
Ealing	880	300	*34.1%*	265	*88.3%*	11	*3.7%*
Brent	810	303	*37.4%*	174	*57.4%*	0	*0.0%*
Greenwich	790	136	*17.2%*	65	*47.8%*	0	*0.0%*
Croydon	785	275	*35.0%*	207	*75.3%*	22	*8.0%*
Enfield	775	334	*43.1%*	154	*46.1%*	0	*0.0%*
Waltham Forest	760	290	*38.2%*	229	*79.0%*	9	*3.1%*
Barnet	705	256	*36.3%*	256	*100.0%*	34	*13.3%*
Barking and Dagenham	645	247	*38.3%*	237	*96.0%*	11	*4.5%*
Hounslow	585	208	*35.6%*	120	*57.7%*	0	*0.0%*
Hillingdon	555	80	*14.4%*	52	*65.0%*	0	*0.0%*
Redbridge	550	364	*66.2%*	122	*33.5%*	0	*0.0%*
Bromley	490	90	*18.4%*	90	*100.0%*	0	*0.0%*
Havering	415	109	*26.3%*	112	*102.8%*	9	*8.3%*
Bexley	400	172	*43.0%*	45	*26.2%*	0	*0.0%*
Harrow	395	340	*86.1%*	97	*28.5%*	0	*0.0%*
Merton	370	104	*28.1%*	45	*43.3%*	0	*0.0%*
Sutton	320	218	*68.1%*	24	*11.0%*	9	*4.1%*
Kingston upon Thames	225	90	*40.0%*	49	*54.4%*	0	*0.0%*
Richmond upon Thames	190	89	*46.8%*	21	*23.6%*	0	*0.0%*

An average of 40.7% of total number of families required have been identified across London boroughs as at December 2012. Inner London boroughs have identified an average of 42.2% and Outer London an average of 39.6%. Lambeth have found their total number required 1080 (100%) as at 31st December 2012 and have began to work with 455 (42.1%). An average of 60.2% of families have been worked with across London boroughs as at 31st December 2012. Inner London boroughs have worked with an average of 60.8% and Outer London an average of 59.8%. Southwark, Camden, Wandsworth, Barnet and Havering (102.8%??) have worked with all families identified as at 31st December 2012. 39.4% of all London boroughs have turned some families around (claimed PBR) as at 31st December 2012, 6 Inner London and 6 in Outer London.

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING SHADOW BOARD HELD ON THURSDAY, 14 FEBRUARY 2013

MEMBERSHIP

PRESENT Dr Shahed Ahmad (Joint Director Public Health), Chris Bond (Cabinet Member for Environment), Peter Coles (NHS Commissioning Board), Ian Davis (Director of Environment), Deborah Fowler (Non Executive Director, NHS Enfield), Andrew Fraser (Director of Schools & Children's Services), Christine Hamilton (Cabinet Member for Community Wellbeing and Public Health), Ray James (Director of Health, Housing and Adult Social Care), Donald McGowan (Cabinet Member for Adult Services and Care), Ayfer Orhan (Cabinet Member for Children & Young People), Dr Alpesh Patel (Chair of Local Clinical Commissioning Group), Richard Quinton (Director of Commissioning and Finance (CCG)), Jill Raines (Crossroads Care Enfield), Tony Seagroatt (Age Concern), Peter Smith (Healthwatch) and Litsa Worrall (Greek & Greek Cypriot Community of Enfield)

ABSENT Liz Wise (CCG Chief Officer)

OFFICERS: Mike Ahuja (Head of Corporate Scrutiny Services), Jill Bayley (Senior Lawyer - Safeguarding), Andrea Clemons (Acting Assistant Director Community Safety and Environment), Felicity Cox (Partnership Manager, Health and Well-being), Linda Leith (Scrutiny Support Officer), Bindi Nagra (Joint Chief Commissioning Officer), Glenn Stewart (Assistant Director Public Health) and Eve Stickler (Assistant Director - Commissioning and Community Engagement) Penelope Williams (Secretary)

Also Attending: Graham MacDougall (Head of Commissioning, Integrated and Acute Care), Dr Nicholas Losseff (Medical Director for Secondary Care), Dr Mo Abedi (Chair of the Primary Care Implementation Strategy Group), Siobhan Harrington (BEH Clinical Strategy Programme Director)

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the last formal meeting of the shadow board. Apologies for absence were received from Litsa Worrall and for lateness from Councillor Orhan, Andrew Fraser, Deborah Fowler and Peter Coles.

Mike Ahuja, Head of Corporate Scrutiny and Community Outreach, read out a statement regarding speaking at the meeting.

The Chair spoke of the challenges which will be faced by the statutory board from 1 April 2013 including: the large numbers living in poverty; high levels of childhood obesity; high death rates – women living in Upper Edmonton have the highest death rate in North Central London; while some GP practices are excellent, provision throughout Enfield was patchy; the continuing controversy surrounding Chase Farm Hospital; and the historic underfunding whereby Enfield receives 20% less than it needs: Ealing, a similar borough, receives £70m more per year than Enfield.

2
DECLARATION OF INTERESTS

There were no declarations of interests.

3
HEALTH AND WELLBEING BOARD - GOVERNANCE ARRANGEMENTS

The Shadow Board received a report on the proposed governance arrangements for the new statutory Board, which will be set up from April 2013.

1. Health and Wellbeing Board Governance Arrangements

Dr Shahed Ahmad, Director of Public Health, highlighted the following from the report:

- The three sub groups will be the engine, though which the Board will operate.
- The terms of reference will be subject to change, following the recent publication of Department for Health regulations.
- Pharmaceutical matters have not been included in the list of responsibilities, but these will be added.

2. Questions/Comments

2.1 Any further comments on the terms of reference should be sent to Felicity Cox.

2.2 Jill Bayley, Senior Lawyer, reported that, although the terms of reference had been drafted before the regulations had come out, there was nothing in them that was incompatible.

AGREED

1. The re-freshed Enfield Health and Wellbeing Board Terms of Reference including the procedures for the Board meetings to take place in public.

2. The increase in the number of Council appointed representatives to allow the Cabinet Member for Environment to be added to its membership. This appointment will be subject to confirmation by the Council.

3. That the board review and acknowledge the plans to elect the representatives of the third sector to its membership.

4. To note the need for the establishment and terms of reference to be subject to further review once the regulations have been published and to delegate any amendments to the Chair in consultation with the Director of Public Health and the Board Executive in advance of the referral to Council.

5. The procedure, to enable the public to speak at board meetings, as set out in Appendix B to the report.

4
ACHIEVEMENTS OF HEALTH AND WELLBEING SHADOW BOARD

The Board received a report setting out the achievements of the Health and Wellbeing Shadow Board and the progress made on the Joint Health and Wellbeing Strategy 2012/14.

Key achievements included:

- The creation of the three sub groups; the Health Improvement Partnership Board, Primary Care Strategy Implementation Board and the Joint Commissioning Board.

- The best improvement in mortality rates in North Central London, increased immunisation rates, improved screening, decreased teenage pregnancy, improvement in infant mortality, roll out of health checks, achieving stop smoking targets, establishment of Tobacco Control Alliance, becoming a British Heart Foundation Heart Town, influencing the UCL Partners academic and health sciences network, producing the joint strategic needs assessment and the Cancer Shop in Edmonton Green.

- The next steps would be reducing childhood obesity, improving blood pressure and cholesterol control in primary care, improving female life expectancy in North Central London and developing a local approach to health improvement.

AGREED to note the achievements of the Board to date.

5
CLINCAL COMMISSIONING GROUP - AUTHORISATION DEVELOPMENTS

The Board received a report from the Enfield Clinical Commissioning Group updating the Board on authorisation developments.

Dr Alpesh Patel, Chair of the Clinical Commissioning Group, presented the report highlighting:

- Recruitment to the Governing Body was now complete, all the vacant posts filled.

- Following the NHS Commissioning Board visit on the 7 January 2013, the number of red rated authorisation criteria had now been reduced to 14.

- Using input from the moderation panel report, a further five can be addressed through work on documentation.

2. Questions/Comments

2.1 The outstanding issues are mainly related to funding and managing the deficit.

2.2 The commissioning intentions are in line with the Health and Wellbeing Strategy.

2.3 A risk sharing agreement with the other five North Central London commissioning Groups should help.

2.4 The outcomes from the authorisation site visit were more encouraging than hoped for.

2.5 One of the red rated authorisation criteria concerned agreement by the Health and Wellbeing Shadow Board that the CCG's Commissioning Board intentions were in alignment with the Joint Strategic Needs Assessment and Health and Wellbeing Strategy. As this had now been agreed, the red rated authorisation criteria could now be reduced to 13.

6
THE IMPACT OF CREATIVE ARTS AND THEATRE TO ENHANCE ASPIRATIONS AND RESILIENCE VIA BEHAVIOURAL CHANGE - LIFE OPPORTUNITIES COMMISSION REPORT

The Board received a report from the Life Opportunities Commission on the impact of the creative arts and theatre on enhancing the aspirations and resilience of young people.

1. Mike Ahuja, Head of Corporate Scrutiny and Community Outreach, presented the report to the Board. He highlighted:

- The view of young people that theatre was a powerful tool for behavioural change.

- That the Enfield Strategic Partnership had asked for the paper to be circulated to all partnership boards for comment.

- The Partnership had wanted the Board's views on what they felt should be included in the development of a strategic and borough-wide approach to the use of drama and the performing arts in changing the attitudes and behaviour of young people.

- A key focus would be the 2013/14 Year 6 Junior Citizenship programme.

2. Questions/Comments

2.1 The Youth Parliament was represented on the Life Opportunities Commission.

2.2 The Parent Engagement Panel and headteachers had also been involved.

2.3 Andrew Fraser, Director of Schools and Children's Services, felt that this was an opportunity to provide consistent clear messages in this area.

2.4 Ray James, Director of Health, Housing and Adult Social Care, was supportive of the concept and thought that working with voluntary organisations would be beneficial.

AGREED that progress would be discussed by the Health Improvement Partnership Board in 6-8 months time.

7
CLINICAL COMMISSIONING GROUP COMMISSIONING PLAN AND INTENTIONS

The Board received a report from Richard Quinton, Director of Commissioning and Finance, summarising the first draft of the Clinical Commissioning Group Operating Plan for 2013/14.

1. Graham MacDougall, Head of Commissioning, Integrated and Acute Care, presented the report to the Board. He highlighted the following:

    - All CCG's have to produce an operating plan laying out their commissioning intentions.

    - Intentions are based on national priorities set by the Government and local priorities aligned with both the local Health and

Wellbeing Strategy and Joint Strategic Needs Assessment (JSNA).

- The report includes an executive summary of the first draft of the operating plan.

- The national drivers are centred on five domains: preventing people from dying prematurely; enhancing the quality of life for people with long term conditions; helping people to recover from episodes of ill health or following injury; ensuring people have positive experience of care; treating and caring for people in a safe environment and protecting them from harm.

- The four main local themes from the Health and Wellbeing Strategy are a healthy start for children, reducing health inequalities, healthy lifestyles and choices and healthy places.

- Final submission of the plan will be made by 5 April 2013.

- The commissioning intentions will be delivered through four main programmes and two care groups; prevention, primary care, integrated care, clinical and cost effectiveness, children and young people; and mental health.

- The commissioning intentions will be aligned against each of the health and wellbeing strategy themes.

- A range of different services have been put in place to improve diagnosis and prevention, to help reduce inequalities.

- There was a good alignment between the work of the health bodies and the local authority to provide a healthy start for children.

- A range of services were being put in place to encourage healthy lifestyles including stop smoking and alcohol liaison services.

- Healthy choices included improving access to psychological therapies and stroke prevention measures.

- Improving integrated care had been an NHS priority for 18 months and further investment had been allocated to deliver planned care and reduce the likelihood of emergency unplanned care. Investing in care homes will also help reduce emergency admissions.

- Another initiative has been set up to reduce hospital admissions and to improve case management. In total, it was planned to invest £2.5m.

- Care Closer to Home, an initiative to redesign patient services in the community has been extended to include a redesign of hospital out patient services. Agreeing local tariffs will also help ensure that services can be more cost effective. The redesigned services will be monitored using outcome measures.

2. Questions/Comments

2.1 Improving quality and reducing costs are both priorities.

2.2 Further investment in improving primary care is planned. The risk sharing agreement with the hospitals should mean that more funds will be available. Ensuring that the primary care improvements are in place before the closure of the Chase Farm Hospital services was part of the strategy.

2.3 Andrew Fraser, Director of Schools and Children's Services, welcomed the health input into the council's work with troubled families, the use of the common assessment framework and supported the partnership working.

2.4 Similar work on integrated care for children to that being done for older people was being considered but there were differences in providing services for children who were mostly well. A separate model was also needed for children with long term health conditions. Working with children with disabilities was part of the wellbeing agenda.

2.5 Serious youth violence data on a ward by ward basis would be sent to Dr Alpesh Patel. **Action: Andrea Clemons**

2.6 A sub-committee had been set up to monitor the work on troublesome families. Andrew Fraser offered to provide information for the Board.

2.7 Councillor Hamilton felt that more needed to be done to ensure that there was a health input into the Safer Stronger Communities Board.

2.8 Ray James, Director of Adult Health and Social Care, welcomed the representative from the NHS Commissioning Board and commended the engagement activity planned. It was the intention that the public engagement activity should be as big and inclusive as possible.

2.9 The issue of the high early death rate of women in the Upper Edmonton Ward was a concern and it was felt that there should be a co-ordinated, focussed effort to make sure that women in the area have access to health checks.

2.10 Even once agreed the plan would continue to be developed throughout the year to adapt to changes which occured. Richard Quinton stressed that he was happy to continue to work jointly with the local authority in setting strategies and making sure that they were aligned.

2.11 Andrew Fraser felt that there should be some focus on Looked After Children.

2.12 The Primary Care Strategy Board would be making significant investments which were applauded by Dr Shahed Ahmad, Director of Public Health, including £100,000 for childhood obesity, £180,000 for cardiovascular services, and £200,000 for early cancer awareness.

2.13 The JSNA for 2013/14 was in the process of development with input from the CCG.

2.14 The Commissioning Plans are consistent with and do deliver against the Health and Wellbeing Stategy.

AGREED

1. That the Board is assured that the plan supports the delivery of the Joint Health and Wellbeing Strategy.

2. To note the advice provided for further development before the March Board of the Enfield Clinical Commissioning Group Governing Body.

3. To note that the plan to deliver Joint Health and Wellbeing Strategy objectives is a requirement of final approval by the National Health Service Commissioning Board.

4. To note the steps required before final submission to the National Health Service Commissioning Board on 5 April 2013.

8
SUB BOARD UPDATES

1. Health Improvement Partnership Board

The Board received an update from the Director of Public Health on the work of the Health Improvement Partnership.

Glenn Stewart, Assistant Director of Public Health, introduced the report highlighting the following:

- Smoking is the greatest cause of preventable death in the Borough. Enfield is on target to meet the end of year target for stopping smoking. In Enfield, the latest estimate is that 20% of adults (16 plus) smoke. A stop starting conference is planned in March. An agreement has been reached with North Middlesex Hospital to make referral for smokers to stop smoking services automatic.

- Immunisation rates are improving. Advertisements have been placed on buses and immunisation is being promoted via the Life Channel and on hospital screens.

- Much work has already been carried out on the transition of public health services to the borough. The transfer of all the NHS functions will be completed from 1 April 2013. Government has still to provide some guidance on the exact value and responsibilities of some contracts including sexual health and school nursing.

- The upper age limit for the emergency hormonal contraception scheme has been increased from 18 to 25. The peak age for terminations is 21-25. Enfield's rate at 34.5 is now below both the London and the national average.

- The prevalence of HIV between 2005 and 2010 has had a 52% increase probably due to screening rates being 99% at North Middlesex and 95% at Chase Farm Hospital.

- Health checks have been rolled out to the West of the Borough. An independent provider has been employed to carry out checks on those who do not respond to invitations from GPs.

- Indications are that there will be a big improvement in childhood obesity rates this year although it is still a problem. Projects including a changeable health programme and working with the Children's Trust on a Healthy Enfield Cook Book.

- A pop up cancer shop had been established in Edmonton, 7 days a week for a period of one month.

- Over 50 clients have been seen by health trainers to help them improve their life style behaviours and to become health champions.

- A Public Health Outcomes Framework had been produced although Department of Health guidance was still awaited.

- Good progress is being made on the JSNA, two data analysts have recently been employed and a project steering group established.

- University College London Partnerships, an academic health science network, attended a meeting of the Health Improvement Partnership Board to outline the work they do, using the latest academic research, on improving health outcomes.

2. Questions/Comments

2.1 UCL Partners is a partnership organisation involving hospitals and universities across London. One in ten babies in the country is born to

UCL Partner organisations. They are working not just in tertiary care but also on prevention. Enfield is situated in the centre of the area and should be able to benefit from their input.

2.2 Andrew Fraser welcomed the work being done on undiagnosed HIV infection which had been a problem in a serious case review a few years ago.

2.3 Tackling childhood obesity is a challenge which needs to be addressed as early as possible, starting with pre-school. Fantastic work is being carried out by the Healthy Weight Board in this area. Improvements are already being seen in Year 6 children. A number of ethnic groups have high rates of childhood obesity. Community development work needs to be taken forward.

AGREED to note the contents of the report especially:

- Smoking is the greatest cause of death in the borough and the Health Improvement Partnership is planning a conference on this in March.
- Good progress has been achieved on immunisation rates and cancer. A Cancer 'pop-up' shop has opened in Edmonton 7 days a week from 1 February to 3 March 2013.
- Good progress was made on healthchecks until Quarter 3. This is being addressed by the CCG and Public Health.
- Childhood obesity remains an area for concern but there have been significant improvements.
- Public Health will transfer to the Local Authority from 1 April 2013 with a number of responsibilities transferring from the NHS to the Local Authority. The Public Health Outcomes Framework is being developed but to date a number of indicators have not been defined.

3. Joint Commissioning Partnership Board

The Board received a report from Bindi Nagra, Joint Chief Commissioning Officer updating them on the work of joint commissioning across health and social care in Enfield.

He highlighted the following from his report:

- Confirmation had been received that the social care grant will continue in 2013/14. The programme ranges from health checks to medicines management and will continue.

- Work is underway to recruit a local Health watch chair and establish a steering group. Five applications for the position of Chair have been received.

- An expression of interest for £350,000 worth of capital funding to improve the environment of care for people with dementia has been submitted.

- The Department of Health had allocated £882,000 to provide support for social care in the winter.

- A bid for support for schemes from Warm Homes Healthy People funding has been made to provide help for vulnerable people.

- Commissioning Intentions for mental health both borough specific and tri borough have been produced and negotiations with the Mental Health Trust on contracts begun.

- Bids to the Mayors Care and Support Specialist Housing Fund for £900,000 to improve specialist accommodation for people with disabilities in the Borough.

- Cabinet recently approved the Voluntary and Community Sector Strategic Framework and the Joint Carers Strategy.

- Work is underway to ensure the smooth transition of NHS Public Health contracts to the local authority. Contracts include sexual health, health checks and other primary care services.

- The NHS Commissioning Intentions have been detailed. Joint commissioning activity will be central to delivering the key themes.

- A report on the Winterbourne View Hospital had been presented to the Partnership Board in December outlining recommendations arising and the Council's response.

4. Questions/Comments

4.1 The health visitor vacancy rate is at 20%. This year the Barnet, Enfield and Haringey Mental Health Trust has struggled to recruit to the posts despite being given additional monies to help them achieve the target. Pay grades had been lower than those of surrounding boroughs, but these had now been adjusted. The census has indicated that there were also more children with complex needs in the borough who would need more support.

4.2 Ray James reported that Enfield had historically had a very low allocation for health visitors and that there was some way to go before more could be recruited. Different methods were required to address the problem, including programmes to recruit and train local people.

4.3 Peter Coles, National Commissioning Board Representative, acknowledged that health visitors were due to become the responsibility of the Commissioning Board but the transition was still being processed. Once established he agreed to pass on the Health and Wellbeing Shadow Board's concerns with a view to developing

broader training and recruitment packages. After a year the responsibility was due be to passed on to the Council.

4.4 Andrew Fraser said that he would bring a report to the next meeting to update the Board on the health visitor situation as well as the Occupational Therapy Services.

4.5 Concern was expressed by Peter Smith, about the recruitment process for Chair of the Health Watch, which he felt had limited the number of applications received.

4.6 A report on the outcomes from the Child Healthy Weight project was requested for consideration at a future meeting of the Board.

4.7 The possibility of creating a Child Health and Wellbeing Strategy was proposed.

4.8 The commissioning intentions for mental health were set out on page 73 of the agenda pack.

4.9 Funding for Improving Access to Psychological Therapies had been increased but there had been no corresponding improvements in the service.

4.10 There were a range of provider organisations in both the NHS and the third sector which could be used if the Barnet, Enfield and Haringey Mental Health Trust could not provide satisfactory services. Moving away from a single provider was being encouraged. Negotiations with the trust were continuing and a final decision had not yet been taken.

4.11 A more in depth sub report on the Mental Health Trust would be provided at the next meeting.

4.12 The target for this year had been 5%, 3.8% is likely to be achieved. Next year the target will be 15%.

4.13 At the moment Commissioning as a whole were neither, over, or under spending, as savings have been achieved within the portfolio.

4.14 It was suggested that future reports should include more specific information including the numbers and sums of money involved in each area.

AGREED that the Board note the report.

5. Improving Primary Care Board

The Board received a report from Sean Barnet (Implementation Programme Manager NHS North Central London), and Siobhan Harrington (BEH Clinical

Strategy Programme Director) updating them on the Primary Care Strategy for Enfield and the Barnet, Enfield and Haringey Clinical Strategy.

Dr Mo Abedi (Chair of the Primary Care Implementation Strategy Group) highlighted the following on primary care:

- The report sets out the actions being taken to address the two strategies priorities.

- The enhanced access scheme had resulted in over 70,000 GP patient contacts. GPs and their receptionists have attended training sessions on new practices including technology to enable better use of a GPs time

- Care Closer to Home aims to improve the quality and safety of the patient experience. For example stable patients on long term warfarin therapy for clotting disorders will be able to have their blood tests carried out locally from April 2013. Training and equipment have been provided to enable patients with deep vein thrombosis to be treated in the community rather than in Accident and Emergency.

- Training and up skilling GPs and other health staff is in process.

- In Enfield there is a high prevalence of under diagnosis. This will be helped by the implementation of more health checks and improvements to blood pressure monitoring, projects to address childhood obesity and other issues.

- Education, training and development of the workforce are key priorities. Enfield has challenges recruiting GPs and has an aging workforce. To address this an arrangement has been reached with University College London to work with four newly qualified GPs who will be based in each of the four quarters of the Borough. This will be equivalent to approximately 17,000 extra appointments per year but will also encourage innovation and make Enfield a more attractive place for GPs to work.

- Investment has been made to bring primary care in Enfield up to the twenty first century. The PLATO text messaging services to remind people about appointments has already saved over 150 appointments These were then allocated to other patients.

- An audit of all GP practice premises had begun with a view to bringing them up to the Care Quality Commission Standards. Work on the first wave is almost complete and the second wave is underway. New premises are to be set up at Ordnance Road, Moorfields and Southgate Town Hall.

- Eighty percent of the extra £3 million allocated for primary care has been allocated and work is continuing to ensure that as much of the

remaining 20% as possible is spent, before the end of the financial year.

6. Questions/Comments

6.1 The CCG was working to maximise the use of the available resources, ensuring that the necessary infrastructure was in place. Enfield has made dramatic progress over the past year and has had significant backing from local GPs. Practices are working well together with secondary and social care providers.

6.2 In response to a question from Councillor Hamilton on when patients would be likely to see improvements in health care, it was stated that improvements are being made and should soon be seen to have an effect.

6.3 The network leads within each of the GP Forums were talking through the various schemes, and encouraging GPs to take them on.

6.4 A Patient Participation Group has been established in 29 practices and work is continuing to set them up for every practice. This will facilitate patient involvement and enable the CCG to take account of patient views.

6.5 Each practice has its own “on line” presence.

6.6 Ray James said that he was heartened by the work that had been done as there had been a historic underinvestment in, and neglect of, primary care in Enfield.

6.7 Members were keen to ensure that any money that was not spent this year could be carried forward for projects in Enfield in the next financial year.

6.8 The number of patient participation groups had increased from 11 to 29 in less than 12 months for which the CCG deserved credit.

6.9 Dr Shahed Ahmad welcomed the improvements in the quality of primary care which was one of the strongest determinants, he delighted in the number of patient participation groups which would help provide a user voice for the JSNA.

6.10 As Upper Edmonton had the worst female life expectancy in the country, it was suggested that the additional GPs should have an extra focus in the Upper Edmonton Area. All the initiatives proposed will help women in the area.

7. Dr Nicholas Losseff, Medical Director for Secondary Care (NHS North Central London), highlighted the following from the report on Barnet, Enfield and Haringey Clinical Strategy.

- A key milestone had been reached with the approval by the Barnet, Enfield and Haringey CCGs for the clinical strategy business case.

- Building work had started at both Barnet and North Middlesex Hospitals.

- There are five clinical work streams: emergency care, maternity and neonates, paediatrics, planned care and urgent care and three enabling: transport, workforce and communications and engagement.

- Governing the programme are a Clinical Cabinet, A Chase Farm Vision Group and a Reference Group.

- The aim of the groups is to stretch ambitions in quality and safety, ensure a step change in quality and that safety is maintained during transition.

- Reconfiguration of the services will result in big changes in process.

- Milestones include the establishment of an urgent care centre in Barnet.

- The delivery of the BEH Clinical Strategy is aligned with the vision and objectives of the Enfield Health and Wellbeing Strategy.

8. Questions/Comments

8.1 Peter Smith (Healthwatch Representative) said that the public were frustrated with the lack of progress and uncertainty around issues such as the changes at Chase Farm and the status of mental health services at St Ann's Hospital. Currently at accident and emergency there was often standing room only. He questioned whether an emergency walk in centre would work properly.

8.2 Siobhan Harrington responded that there were many changes happening at Chase Farm, but plans were in place for an urgent care centre, for planned care to take place and for an outpatient service providing anti and post natal support. Dr Alpesh Patel was part of the Chase Farm Vision Group who were considering the changes and consulting with patients through the patient participation groups. The Vision Group will be producing a final report is due to be produced at the end of March.

8.3 It was acknowledged that communication should be improved to make sure the public is aware of the changes as implementation progreses.

8.4 A central programme team involving representatives from the Barnet, Enfield and Haringey CCGs has been set up to work with the hospital trust.

8.5 Councillor Hamilton expressed concern that there was a widespread perception that the standard of care at Chase Farm was poor and that staff morale was low.

8.6 The aim of the clinical strategy was to ensure that residents and patients receive the best possible care. Some areas need improvement and that was what the clinical strategy was working to achieve. Services will be moved between the hospitals and it was acknowledged that it would not be possible to meet modern standards of care in all the hospitals without making changes. Of the three hospitals, Chase Farm was most vulnerable. The strategy enables changes to be planned to ensure the provision of high quality care and that the right workforce is in the right place.

8.7 Ray James observed that there were 3 questions arising out of the Board Assurance and Extreme Risk Report reported at meeting of the boards of the 5 primary care trusts to which answers were required.

- The Leader of the Barnet, Enfield and Haringey Clinical Strategy and of the five primary care trusts had stated that it was the intention that changes would be made by November 2013, was this when the changes would occur?

- Assurance was sought that all the reconfiguration panel pre conditions were met before changes were made. Was this to be so?

- The primary care trust boards had received assurance that the implementation of the primary care services would take place before a decision on the future of the hospitals was implemented. Was this so?.

The judgement of the chief executives of the 5 primary care trusts was clear and transparent. A written response was required.

8.8 Dr Shahed Ahmad asked if site specific hospital mortality data existed. North Middlesex Hospital was expanding its workforce and it was suggested that they should be encouraged to employ people from the Upper Edmonton area. A large children and families block was to be built at North Middlesex Hospital.

8.9 Andrew Fraser requested that the Clinical Cabinet should look ways to address the high infant mortality rate.

8.10 The twenty four hour blood pressure monitoring scheme was due to be rolled out this month. This had not yet been publicised, but it was felt that, at first, it would be best to roll out the scheme gradually, publicising it, once established.

AGREED that the Board note the report.

9. Children's Services Report

The Board received a report from Eve Stickler, Assistant Director Commissioning and Community Engagement, containing information on the Big Lottery – Fulfilling Lives: A better Start Scheme.

Eve Stickler introduced the report highlighting the following:

- This was an opportunity for Enfield to lever extra money into the area partnership.

- The project was at an early stage but it was intended that Enfield should put in an initial expression of interest.

- The bid would be led by the voluntary sector.

- The steering group of the Enfield Strategic Partnership had recommended that the Enfield Highway, Enfield Lock and Turkey Street are the wards selected for the bid. The paper goes to the full Enfield Strategic Partnership Board next week. In total these wards have a population of 44,889 which is younger than average: nine percent of the population is under 5. Birth rates in these areas are also high and expected to rise. Approximately 50% of these children live in poverty and they have high levels of obesity.

- The initial stage of preparing this expression of interest has involved mapping the area and working out a gap analysis.

- Success could provide additional leverage concerning the proposals for "grow your own" health visitors.

10. Questions/Comments

10.1 Those Voluntary and Community Sector organisations who have helped in the preparation of the bid at this stage and who have expressed their interest in being leading partners are, the Children's Food Trust and 4Children with the latter wishing to be named as the lead. In addition the NCT wish to be a key partner.

10.2 Initial consultation with local smaller voluntary sector providers of early years and childcare provision has taken place but will continue if successful through this first application round.

10.2 Consultation with voluntary sector providers would take place after the initial stages were complete.

10.3 The Board was asked to endorse the first stage of the process.

10.4 Councillor Hamilton asked about the possible risk associated with voluntary sector partners – this would be mitigated by dealing with large national organisations.

AGREED that the Board would endorse the recommendation of the Enfield Strategic Partnership Steering Group to the Enfield Strategic Partnership Board that the wards selected to put forward as part of the expression of interests for the Big Lottery Project are Enfield Highway, Enfield Lock and Turkey Street.

9
MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 6 December 2012 were agreed as a correct record.

10
DATES OF FUTURE MEETINGS

The Board noted the dates agreed for future meetings.

- Monday 25 March 2013 at 6pm (Informal Session)
- Thursday 23 April 2013 at 6.30pm (First full Board meeting in public)

11
EXCLUSION OF PRESS AND PUBLIC