HEALTH AND WELLBEING BOARD

Thursday, 19 September 2013 at 6.30 pm
Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

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MEMBERSHIP

Cabinet Member for Adult Services and Care – Councillor Donald McGowan (Chairman)
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 Bond
Chair of the Local Clinical Commissioning Group – Dr Alpesh Patel
Healthwatch Representative – Deborah Fowler
Clinical Commissioning Group (CCG) Chief Officer - Liz Wise
NHS England 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 Representatives: Vivien Giladi, Litsa Worrall (Deputy)

AGENDA – PART 1

1. WELCOME AND APOLOGIES (6.30-6.35PM)

2. DECLARATION OF INTERESTS (6.35-6.40PM)

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

3. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) (6.40-6.55PM) (Pages 1 - 4)

To receive a report updating the board on the production of the Joint Strategic Needs Assessment (JSNA).

The Board is asked:

1. To approve the JSNA on-line resource

2. To note the timescale for the availability of the JSNA on the Enfield Health and Wellbeing Website

4. JOINT HEALTH AND WELLBEING STRATEGY - DRAFT PRIORITIES (6.55-7.10PM) (Pages 5 - 14)

To receive a report about the development the 2013-2018 Joint Health and Wellbeing Strategy.

The Board is asked:

1. To note the draft Joint Health and Wellbeing Strategy priorities
2. To approve a 12 week public consultation period on the priorities.

5. ROYAL FREE ACQUISITION OF BARNET AND CHASE FARM HOSPITALS TRUST (7.10-7.30PM) (Pages 15 - 18)

To receive a report from Liz Wise, CCG Chief Operating Officer, updating the Board on the Royal Free Hospital proposals in regard to Barnet and Chase Farm Hospitals.

6. INTEGRATION SUB BOARD (7.30-7.50PM) (Pages 19 - 36)

To receive a report summarising existing integration arrangements, describing the conditions of the Integration Transformation Fund (ITF) and providing an overview of opportunities for integration in the future.

To agree to the creation of an Integration Sub Board, the board terms of reference and membership.

7. SUB BOARD UPDATES (7.50-8.20PM) (Pages 37 - 88)

To receive updates from the following:

1. Health Improvement Partnership Board

2. Joint Commissioning Partnership Board

3. Improving Primary Care Board

8. WORK PROGRAMME 2013-14 (8.20-8.25PM) (Pages 89 - 90)

To note the items programmed for consideration at Board meetings in 2013/14.

9. MINUTES OF THE MEETING HELD ON THURSDAY 20 JUNE 2013 (8.25-8.30PM) (Pages 91 - 106)

To receive and agree the minutes of the meeting held on Thursday 20 June 2013,

10. DATES OF FUTURE MEETINGS

To note the dates agreed for future meetings of the Board:

- Thursday 12 December 2013
- Thursday 13 February 2014
- Thursday 24 April 2014

To note the dates agreed for Board development sessions.

- Thursday 17 October 2013
- Tuesday 19 November 2013 (originally scheduled for 14 November)
- Tuesday 21 January 2014 (originally scheduled for 23 January)
- Thursday 20 March 2014

11. 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 2013/2014

MEETING TITLE AND DATE **Health and Wellbeing Board** **19 September 2013**	**Agenda - Part: 1** | **Item: 3** **Subject: Joint Strategic Needs Assessment** **Wards: All**
Director of Public Health, Dr Shahed Ahmad Contact officer and telephone number: E mail: Keezia.Obi@enfield.gov.uk Telephone: 020 8379 5010	**Cabinet Member consulted: Cllr Donald McGowan, Cabinet Member for Adult services, Care and Health**

1. EXECUTIVE SUMMARY

This report is an update of the progress on the production of the Joint Strategic Needs Assessment (JSNA) and to seek approval for the on-line resource.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- approve the JSNA on-line resource
- note the timescale for the availability of the JSNA on the Enfield Health and Wellbeing website

3. BACKGROUND AND UPDATE – JSNA

3.1 The final draft of the JSNA documentation was presented to the Health and Wellbeing Board (HWB) development meeting on 18 July 2013. Since then and following comments received, further work has been undertaken to refine the information. In addition, and in order to mitigate the risks associated with data inputting and potential for error, a quality assurance process has been applied. This work has included:

- additional information on need and analysis of key topic areas
- further internal quality checks by the council's Public Health Strategy Team
- quality assurance checks undertaken by the Clinical Commissioning Group (CCG). This has resulted in the transfer of data to analysis to be quality checked by an external partner of the council
- revisiting a number of key areas and updating information based on new information received

- proof reading all JSNA documentation
- commissioning a projections tool which will enable the HWB to plan for the future based on population projections
- Commencing work on producing locality profiles

3.2 The JSNA is set out as follows:

- Introduction
- Enfield People
- Enfield Place
- Enfield Resources
- Health and Wellbeing of Children, Young People and their Families
- Health and Wellbeing of Adults
- Health and Wellbeing of Older People
- Related Strategies and other information
- Projections and Locality Profiles
- Glossary

3.3 The JSNA is the evidence base for the development of the Joint Health and Wellbeing Strategy and has been used by Board members to inform the draft priorities for the strategy.

4. THE JSNA ONLINE WEBSITE RESOURCE

4.1 The JSNA is a valuable on line resource and as such is not to be viewed as a single finished piece of work or document. This allows for additions and updates to be made as these become available and for out of date information to be removed and replaced easily. It will be maintained on an on-going basis to ensure it remains relevant and a useful tool for commissioners, policy makers and other key stakeholders.

4.2 The JSNA will be available on the Enfield Health and Wellbeing website, which is due to be launched in early October. Until then, the JSNA is password protected but is available to anybody that requests it. This allows for the HWB to approve the on line resource, for on-going work to take place (this is an on-line resource so new information will be uploaded on an on-going basis) and in order to comply with information requirements. Please contact public.health.strategy@enfield.gov.uk or telephone 020 8379 6499 if you would like to receive the JSNA prior to its availability on the website.

5. PARTNERSHIP AND COMMUNITY ENGAGEMENT

5.1 The JSNA has been produced by a Steering Group comprising of members from across key stakeholder groups in the borough, including commissioners and local people. The steering group (and sub-groups) and the processes set up to support it, has enabled a JSNA to be produced and owned by a wide partnership. This is an essential factor for the on-going development of the new Health and Wellbeing Strategy.

5.2 The community working group established as a sub-group of the JSNA Steering Group is in the process of developing information for the public about the JSNA and is a valuable resource, informed by local people and voluntary and community groups in Enfield.

5.3 The community working group for the JSNA is to be asked to take on the role of advisory group for the consultation on the JHWS.

6. ALTERNATIVE OPTIONS CONSIDERED

It is a statutory requirement to produce a JSNA.

7. REASONS FOR RECOMMENDATIONS – It is a statutory duty on local authorities to produce a Joint Strategic Needs Assessment and to make it available to the public.

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

a. Financial Implications

Once approved all costs associated with the publication of the Joint Strategic Needs Assessment on the Enfield Health and Wellbeing website will be met from Enfield's Public Health grant allocation for 2013/14. Any costs for maintaining the website and documents after 2013/14 will be met from Public Health grant allocations in subsequent years.

b. Legal Implications

Section 116 of the Local Government and Public involvement in Health Act 2007 (the 2007 Act) (as amended by the Health and Social Care Act 2012) has been in force since 27 March 2012.

Section 116(1) of the 2007 Act states: *An assessment of relevant needs must be prepared in relation to the area of each responsible local authority.*

Section 196 (1) Health and Social Care Act 2012, which has been in force since 1 April 2013, states that the functions of a local authority and its partner clinical commissioning groups under section 116 of the Local Government and Public Involvement in Health Act 2007 are to be exercised by the Health and Wellbeing Board established by the local authority.

Section 116(7) of the 2007 Act requires each Joint Strategic Needs Assessment to be published.

The proposals set out in this report appear to comply with the above requirements.

9. KEY RISKS

It is vital that the planning and commissioning of services is informed by robust intelligence about needs and that there is transparency about the way in which decisions are reached. The JSNA will help to manage and mitigate the risks associated with both of these.

10. IMPACT ON THE PRIORITIES OF THE CURRENT HEALTH AND WELLBEING STRATEGY

a. Healthy Start – Improving Child Health
b. Narrowing the Gap – reducing health inequalities
c. Healthy Lifestyles/healthy choices
d. Healthy Places
e. Strengthening partnerships and capacity

11. EQUALITIES IMPACT IMPLICATIONS

11.1 The JSNA is based on a set of local and national indicators identifying need. In consultation with the council's Corporate Equalities Officer, Equalities Impact Assessments will be undertaken at the point of consultation for the Joint Health and Wellbeing Strategy, and as services change as a result of commissioning arrangements.

Background Papers

None

END.

Agenda Item 4

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE **Health and Wellbeing Board** **19 September 2013**	**Agenda - Part: 1** | **Item: 4** **Subject: Joint Health and Wellbeing Strategy** **Wards: All**
Director of Public Health, Dr Shahed Ahmad Contact officer and telephone number: E mail: Keezia.Obi@enfield.gov.uk Telephone: 020 8379 5010	**Cabinet Member consulted: Cllr Donald McGowan, Cabinet Member for Adult Services, Care and Health**

1. EXECUTIVE SUMMARY

This report summarises the responsibility of the Health and Wellbeing Board for preparing a Joint Health and Wellbeing Strategy and the progress made to produce a new strategy covering the period 2013 – 2018.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- note the contents of this report, specifically the draft priorities for the Joint Health and Wellbeing Strategy
- approve the consultation period for seeking local views on the draft priorities, in particular from local residents and other key stakeholders. It is proposed that the consultation process commences on 1st October for a 12 week period.

3. BACKGROUND

3.1 Health and Wellbeing Boards (HWBs) were given legislative effect by the Health and Social Care Act 2012. Included in their statutory duties is the production of a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS).

3.2 "JHWSs are strategies for meeting the needs identified in JSNAs and are produced by health and wellbeing boards, are unique to each local area, and there is no mandated standard format. In preparing JHWSs, health and wellbeing boards must have regard to the Secretary of State's mandate to the NHS CB (Commissioning Body) which sets out the Government's priorities for the NHS. They should explain what priorities the health and wellbeing board has set in order to tackle the needs identified in their JSNAs. ……This is not about taking action on everything at once, but about setting a small number of key strategic priorities for action, that will make a real impact on people's lives. JHWSs should translate JSNA findings into clear outcomes the board wants to achieve, which will

inform local commissioning – leading to locally led initiatives that meet those outcomes and address the needs."[1]

3.3 "Promoting integration between services - JHWSs can help health and social care services to be joined up with each other and with health-related services, such as housing, transport, the economy or the environment. Health and wellbeing boards must encourage integrated working between health and social care commissioners, and provide appropriate support to encourage partnership arrangements for health and social care services, such as pooled budgets, lead commissioning, or integrated provision. In JHWSs, health and wellbeing boards must consider how far needs can be met more effectively by working together in this way."[2]

3.4 The production of the JHWS and its draft priorities is intended to aid the strategic decision making process for commissioning services in the borough. The new strategy will set the foundation for the HWB to take a fresh and ambitious approach to how it conducts its strategic business. Supported by key needs and assets information, it will set out the agreed outcomes and priority areas for action. The draft priorities of the JHWS have been produced so that it informs the council's and CCG's autumn commissioning cycles.

3.5 Following a period of public consultation, the key deliverable will be the agreed published Joint Health and Wellbeing Strategy, informed by the JSNA and supported by a monitoring framework to enable the HWB and local people to track improvement, learn from experience and continually improve outcomes.

4. JHWS DRAFT PRIORITIES

4.1 Since the last formal meeting of the HWB and supported by an external facilitator, three development sessions have been held at which members revisited the Board's vision, agreed the approach to establishing draft priorities and the draft priorities for consultation.

4.2 The vision agreed by the Board is:

"Working together to enable you to live longer, healthier, happier lives in Enfield"

4.3 This approach to establishing draft priorities involved a method of evaluating the information contained in the draft JSNA (see appendix 1) which enabled a long list of key topic areas to be produced (see appendix 2). These key topic areas were analysed and discussed including applying local expert knowledge and understanding of specific issues. This process resulted in the following key priority areas which are currently being refined in preparation for consultation:

- **Ensuring the best start in life:**
  - by addressing the factors that impact on child poverty
  - ensuring children are well prepared for school (school readiness)
  - improving educational attainment
  - increasing immunisation rates
  - reducing the incidence of infant mortality

[1] Department of Health (2013) Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

[2] *Ibid*

- **Enabling people to be safe, independent and well by delivering high quality health and care services:**
  - by increasing early identification and enabling people to manage their long term conditions for example, diabetes, chronic obstructive pulmonary disease, cardiovascular disease and cancer
  - improving outcomes for children and adults with mental health needs
  - ensuring services for older people are holistic and able to respond to complex needs
  - ensuring easy access to HIV testing and enabling people with HIV to access appropriate treatment and services
  - ensuring carers are able to manage their health and wellbeing and be able to continue with their caring role without risk
  -
- **Creating stronger, healthier communities:**
  - by improving employment opportunities for local people
  - the impact of housing on the health of families and individuals
  - by creating an environment where people feel safe
  - tackling domestic violence and reducing its incidence

- **Narrowing the gap in healthy life expectancy**
  - by improving the effectiveness of public services and access to and quality of primary care
  - addressing health deprivation and improving the life expectancy of local people living in the east of the borough (for example, women living in Upper Edmonton dying at an average age of 76, compared to 90 years in Highlands)

- **Promoting healthy lifestyles and healthy choices:**
  - helping to prevent people developing long term conditions
  - promoting physical activity and healthy eating (nutrition)
  - reducing alcohol related harm
  - reducing the uptake of smoking and helping people top stop smoking
  - by preventing the uptake of drug use and minimising the wider impact of drug misuse
  - enabling earlier detection of cancer

5. THE JHWS DOCUMENT AND CONSULTATION ON THE DRAFT PRIORITIES

5.1 The production of the full JHWS is underway. A small working group comprising officers of the council and the CCG has been established to oversee this work and a draft will be presented at future development sessions of the HWB and the next formal Board in December. The final strategy will be presented at Cabinet on 22nd January and to Council on 26th February 2014.

5.2 The HWB has a duty to involve the local community in the preparation of the JSNA and the JHWS and other key stakeholders for example, Healthwatch, the voluntary sector, Youth Parliament, Patient Forums and other user groups. This process began with the production of the JSNA and should be an on-going process by consulting on the JHWS. Additionally, engaging with the private and business sector at an early stage will be of benefit given their role and the opportunities this will bring in promoting and building healthy communities.

5.3 It is proposed that the Health and Wellbeing Board agree a 12 week consultation process which is in line with the council's Compact agreement (an agreed set of principles and procedures for guiding the way that the statutory and the voluntary and community sector work together). It is proposed that the consultation process commences as soon as possible, but no later than the 1st of October.

5.4 The consultation on the draft priorities will involve a range of activities and approaches in order to obtain wider views and contributions. It is extremely important that the priorities for the 2013 -18 JHWS are informed by this process. Additionally, this consultation will help to raise to raise awareness of health and wellbeing in the borough.

6. ALTERNATIVE OPTIONS CONSIDERED

As noted in 3.1 it is a statutory requirement to produce a Joint Health and Wellbeing Strategy.

7. REASONS FOR RECOMMENDATIONS

It is a statutory duty on local authorities to produce a Joint Health and Wellbeing Strategy. Health and Wellbeing Boards are required to involve the local community in the preparation of this document.

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

a. Financial Implications

All costs associated with the production of the Joint Health and Wellbeing Strategy will be met from Enfield's Public Health grant allocation for 2013/14.

b. Legal Implications

Section 116A of the Local Government and Public involvement in Health Act 2007 (the 2007 Act) (as amended by the Health and Social Care Act 2012) has been in force since 1 April 2012.

Where a Joint Strategic Needs Assessment (JSNA) is prepared by a responsible local authority, Section 116A(2) of the 2007 Act requires the responsible local authority and each of its partner clinical commissioning groups to prepare a joint health and wellbeing strategy (JHWS) for meeting the needs identified in the JSNA by the exercise of the functions of the authority, the NHS Commissioning Board or the clinical commissioning groups.

Section 116A(3) requires the local authority and its partner clinical commissioning groups to consider, in preparing the JHWS, the extent to which the needs identified in the JSNA could be met by making arrangements under section 75 of the National Health Service Act 2006.

Section 116A(5)(b) requires people who live or work in the area to be consulted as part of the preparation of the JHWS.

Section 116A(6) requires the responsible local authority to publish each JHWS prepared by it.

Section 196(1) Health and Social Care Act 2012, which has been in force since 1 April 2013, states that the functions of a local authority and its partner clinical commissioning groups under section 116A of the Local Government and Public Involvement in Health Act 2007 are to be exercised by the Health and Wellbeing Board established by the local authority.

There is therefore a statutory duty on local authorities including London boroughs to prepare and publish Joint Health and Wellbeing Strategies. Local Authorities should follow the statutory guidance in preparing these documents unless there is a well-documented good reason not to do so.

The proposals set out in this report appear to comply with the above requirements.

9. KEY RISKS

9.1 The JHWS supports the on-going need for partnership and integration between local authority, health and voluntary and independent sector to find better ways of preventing ill health and meeting the health and wellbeing needs of local people. The JHWS will help to manage and mitigate the risks associated with this.

10. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

10.1 Healthy Start – Improving Child Health
10.2 Narrowing the Gap – reducing health inequalities
10.3 Healthy Lifestyles/healthy choices
10.4 Healthy Places
10.5 Strengthening partnerships and capacity

11. EQUALITIES IMPACT IMPLICATIONS

11.1 An Equalities Impact Assessments will be undertaken and as services change as a result of commissioning arrangements.

Background Papers

None

END.

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No.	Name	Notes
1	Scale of the problem	Measure through a combination of the number of people affected by the problem and the size of the impact on each person. What do the trends show? Should also take account of indirect impacts.
2	Reduction in health inequalities	Would tackling the issue significantly reduce the scale of health inequalities in Enfield? Would tackling the issue particularly help vulnerable groups?
3	Financial sustainability	Would tackling the issue be financially sustainable over the long-term? Will the benefits from the tackling the issue out-weigh the costs of the change? Would tackling the issue save resources? Is this likely to be an "invest to save" issue? If so, are the resources available in the short-term?
4	Contribution to the prevention and self-help agenda	Would tackling the issue mean fewer people suffering poor outcomes in the future? Would tackling the issue increase the population's ability to self-help?
5	What does the evidence base tell us?	Are there likely to be solutions available? How confident are we that we can make a difference? Does the evidence base suggest that something should be done (e.g. is Enfield particularly poor in comparison to its peers in this area)?
6	Long-term implications	Would tackling the issue target the cause of a problem, not the symptoms?
7	Positive change in lives	What is the extent of positive change in people's lives if we tackle the problem? Will people get involved in the change? Will it lead to people changing their behaviours? Will it give people more choice and control in their lives?
8	Importance and quality of the service	How important is the service involved (number of people using it, cost of delivering it, etc)? Are there any known quality issues with the service which should be resolved in the short term?

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Long list of key topic areas
Childhood obesity
Child poverty
Education attainment
Infant mortality
Readiness for school
Access to maternity services
Immunisation
Employment & Job creation
Housing
Poverty
Primary care
Dementia
Older People Complex Needs
Health of deprived populations (Edmonton Wards)
Adult Obesity
Physical activity/Exercise
Nutrition
Alcohol
Smoking
Chronic Obstructive Pulmonary Disease
Diabetes
Long term conditions
Cardio-vascular disease
Adult drug abuse
Cancer (lung, breast, colon)
Mental health prevention & treatment
Integrated care
Feeling safe
HIV
Carers

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Agenda Item 5

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE **Health and Wellbeing Board** **19 September 2013**	**Agenda - Part: 1** **Item: 5** **Subject:** **Proposed Acquisition of Barnet and Chase Farm Hospitals NHS Trust** **Wards: All**
Report of: Liz Wise (Enfield Clinical Commissioning Group Chief Officer) Contact officer and telephone number: E mail:	**Cabinet Member consulted:**

1. EXECUTIVE SUMMARY

As part of the Government's healthcare reforms, all NHS trusts are required to become foundation trusts.

In July 2012, following an independent financial review, the Barnet and Chase Farm Hospitals NHS Trust board concluded that it could not become a foundation trust alone and it invited competitive proposals from potential partners. The Royal Free was chosen as its preferred partner.

Under the proposal, Barnet and Chase Farm hospitals would become part of the Royal Free London NHS Foundation Trust.

Early feedback suggests that a larger trust could provide:

- co-ordinated and consistent care
- a centre of excellence
- a solution for the future financial challenges faced by the NHS.

2. RECOMMENDATIONS

The Health and Wellbeing Board should note this report

3. BACKGROUND

The NHS is faced with the major challenges of using resources more efficiently and meeting the needs of an ageing population. In order to meet these challenges, we need to focus on preventing ill-health and providing more care closer to home so people do not have to visit hospital so often.

A single organisation would be better placed to adapt to this change and take advantage of the opportunities to provide better quality, modern day hospital care. Clinicians from both trusts are working with local commissioners to identify

ways that services could be reshaped to better meet patients' needs and deliver a more financially sustainable model of care.

Alongside this, the Barnet Enfield and Haringey (BEH) Clinical Strategy will see obstetrics and emergency care concentrated at Barnet Hospital and North Middlesex Hospital; with Chase Farm Hospital developed as a specialist centre for elective care, outpatient, urgent care and diagnostics centre providing services in an improved estate.

Other than these planned changes, there are no major changes to the configuration of hospital services proposed as part of the acquisition. If any changes are identified in the future then we would undertake engagement and consultation in line with statutory requirements.

The NHS Trust Development Authority (TDA) is responsible for the foundation trust assurance process, which involves four sequential Gateways. Each Gateway requires NHS TDA approval and endorsement from the CCGs and the NHS Commissioning Board.

Business plans and financial models are currently being developed as part of the Gateway 3 documentation. The Royal Free board expects to submit its Gateway 3 documentation in autumn 2013.

If the acquisition goes ahead a new foundation trust is expected to be created in spring 2014.

4. ALTERNATIVE OPTIONS CONSIDERED

In July 2012, Barnet and Chase Farm Hospitals NHS Trust board concluded that it could not become a foundation trust alone and it invited competitive proposals from potential partners. The Royal Free was chosen as its preferred partner.

5. REASONS FOR RECOMMENDATIONS

5.1 All NHS trusts are required to become foundation trusts.

5.2 Clinicians and managers from both trusts have been looking together at how services could be provided more efficiently and effectively as one organisation. They have not yet reached their conclusions, but the potential for a variety of benefits is emerging.

Early feedback suggests that a larger trust could provide co-ordinated and consistent care, develop as a centre of excellence and address the future financial challenges faced by the NHS.

5.3 Co-ordinated and consistent care

A larger pool of clinicians would be able to deliver better quality care and make sure patients are always treated in the right place at the right time by the right people. The new trust could also deliver a better experience

for patients as there would be less administrative 'red tape' between services.

5.4 Creating a centre of excellence

A much larger patient population would have greater ability to attract research funding. Wider training and career opportunities and the chance to work for a leading provider of healthcare, research and education would also help attract and retain the best staff.

5.5 Addressing financial challenges

Significant efficiencies could be made quickly such as improving or reducing the duplication of 'back office' functions. This would put money where it is needed – in delivering high quality frontline services. A larger trust would be more resilient to the changing NHS landscape of moving services closer to people's homes.

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

6.1 Financial Implications

Both trusts believe that additional funding would be needed in the short term to ensure that any new single organisation starts on a strong financial footing.

The 2013/14 budget for Barnet and Chase Farm Hospitals NHS Trust shows a planned deficit of £16.4m. The trust will also receive significantly less income in future years as the CCG implements plans to provide more care outside hospitals and work with local authorities to integrate health and care services.

The Royal Free will seek transitional funding from NHS England to help with the costs of the acquisition and to cover the shortfall in running costs until such a time as the new organisation can deliver a financially balanced position.

There are no financial implications for the Council.

6.2 Legal Implications

There are no legal implications for the Council.

7. KEY RISKS

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Healthy Start – Improving Child Health
8.2 Narrowing the Gap – reducing health inequalities
8.3 Healthy Lifestyles/healthy choices
8.4 Healthy Places
8.5 Strengthening partnerships and capacity

9. EQUALITIES IMPACT IMPLICATIONS

Not undertaken.

The Cooperation and Competition Panel (CCP) has concluded that the merger was unlikely to give rise to significant costs to patients or taxpayers as a result of a loss of choice or competition.

Monitor will also undertake an external review to ensure the acquisition is in the best interests of patients and taxpayers.

Background Papers

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE **Health and Wellbeing Board** **19 September 2013**	**Part 1** | **Item: 6** **Subject:** Integrated Transformation Fund and plan **Wards:** All
Report of: Ray James (Director of Health, Housing and Adult Social Care) **Contact officer** Kate Charles 020 8379 2433 E mail: **kate.charles@enfield.gov.uk**	**Cabinet Member consulted:** Councillor Donald McGowan

1. EXECUTIVE SUMMARY

NHS Enfield Clinical Commissioning Group (CCG) and the Council are seeking to further develop joint integrated working arrangements. This paper summarises existing integration arrangements, describes the conditions of the Integration Transformation Fund (ITF) and provides an overview of opportunities for integration in the future.

The £3.8bn Integration Transformation Fund (ITF) will be a pooled fund, held by local authorities. It is estimated that the ITF will locally be £20.317m, which is drawn from existing local authority and CCG budgets. Conditions of the funding will be that it is pooled into a budget which will formally sit with local authorities but will be subject to plans being agreed by local Health and Wellbeing Boards (H&WBs) and signed off by CCGs and Council Leaders. Plans would also be subject to assurance at national level. As part of the wider 2014/15 planning round, it is envisaged that plans would be developed this year, signed-off and assured over the winter and would be implemented from 2014/15.

Health and social care integration and local accountability are not new concepts. They have been considered as options for improving local service delivery, improved patient / user satisfaction and produce better value for money . Today, rising demand for health and social care, combined with increasing scarcity of resources, is leading to renewed interest in 'integrated care' as a potential solution to a challenging economic climate and growing demographic pressures.

This paper focuses on partnership working and establishing a framework for a unified vision and plan for the future to ensure that integration is fully embedded in everything we do.

2. RECOMMENDATIONS

The Health & Wellbeing Board are requested to take note of the context of this report and particularly, the conditions of the ITF and requirements for a jointly agreed integration plan and agree the following actions:-

2.1. To set up an Integration Sub-group reporting directly to the HWBB (See attached draft Terms of Reference as Appendix 1).

2.2. To task the sub group with developing a jointly agreed ITF plan that is compliant with the conditions of the fund and seeks to deliver the integration agenda in the true spirit of partnership with a view to improving the customer experience, delivering better services and good value.

2.3 To provide local leadership of and positively market the integration agenda to ensure that the partnership workforce have information, guidance and support to feel empowered to deliver this ambitious agenda locally.

3. BACKGROUND

NHS Enfield Clinical Commissioning Group (CCG) and the Council are seeking to further develop joint integrated working arrangements. This paper summarises existing integration arrangements, describes the conditions of the Integration Transformation Fund (ITF) and provides an overview of opportunities for integration in the future.

Integrated care is not about structures, organisations or pathways, nor about the way services are commissioned or funded. It is about individuals and communities having a better experience of care and support, experiencing less inequality and achieving better outcomes.

The ambition of much Health and Social Care integrated working and commissioning is to shift the balance of resources from high cost secondary treatment and long term care to a focus on promotion of living healthy lives and well-being, and the extension of universal services away from high cost specialist services. This approach promotes quality of life and seeks peoples engagement in their own community. To achieve these shifts we need to change the way services are commissioned, managed and delivered. It also requires redesigning roles, changing the workforce and shifting investment to deliver agreed outcomes for people that are focussed on preventative action. This builds on existing arrangements between health & care.

A sound incremental approach needs to be taken to further develop integration between the Council and NHS Enfield, based on local circumstances, to developing and agreeing opportunities for integrated working and use of joint financial arrangements. Current governance structures, services and projects being delivered through integrated working initiatives are:-

- The Joint Commissioning Board (membership includes Adults and Childrens services) – *this Board essentially monitors progress of strategy implementation and projects but does not have decision making power in terms of agreeing new projects.*
- Joint Commissioning Team (Adults)

- Joint Mental Capacity Act and Deprivation of Liberty Safeguard Resource (Adults)
- Joint Safeguarding Nursing Assessor
- Independent Mental Capacity Advocacy Service (Adults)
- Integrated Community Equipment Service (ICES) (Adults)
- Drug and Alcohol Action Team (DAAT) (Adults)
- Joint Stroke Prevention and End of Life Pathway (Adults).
- Winter capacity planning
- Integrated Learning Disabilities Service (Adults)
- Mental Health Services (Adults)
- Joint Commissioning Strategies and implementation plans (Stroke, Dementia, End of Life Care, Intermediate Care/ Enablement and Autism (Adults)
- Single Point of Entry (SPOE) (Childrens)
- MASH (Multi Agency Safeguarding Hub) (Childrens)
- Change and Challenge (the local Troubled Families initiative)
- Behaviour Support Service(Childrens)
- Children's Centres provide services, over a minimum of 5 days a week, to meet the needs of families with pre school children (Childrens)
- SAFE (Service for Adolescents and Families in Enfield) (Childrens)
- Joint Service for Children with Disabilities (Childrens)
- Enfield Community Services is the 'health' part of the Joint Service and includes Carers, Nursery Nurses, Physiotherapists and Paediatric Occupational Therapists. (Childrens)

Children and Young People

The Council and NHS Enfield CCG, and now Enfield CCG, have a history of effective partnership working for children and young people. Joint priorities are set out in the third Enfield Children and Young People's Plan (2011 -2015). We aim to sharpen the focus on effective strategies to tackle child poverty, improve outcomes for vulnerable groups and ensure that all children and young people are safe, have a healthy start to life and achieve their full potential.

This approach has enabled the Council and NHS Enfield to make sound progress on developing joint arrangements in a challenging environment. Despite the achievements of the above mentioned functions and services, more could be done to ensure that Health & Social Care work together to better identify, assess, treat and support people earlier in the patient / customer pathway. With the introduction of the Integration Transformation Fund there is now an incentive to analyse existing structures, services and pathways to develop an agreed formalised plan at executive level with clear timescales on how to move forward the Integration Agenda in Enfield.

The Statutory Framework

The Section 75 partnership arrangements in the National Health Service Act 2006 (formerly Section 31 of the Health Act 1999 – Health Act Flexibilities) have been developed to give local authorities and NHS bodies the ability to respond effectively to improve services, either by joining up existing services or

developing new, coordinated services. Section 75 agreements can be agreed for one or more of the following:

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

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

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

Children and Young People

A Section 75 Partnership Agreement people was agreed in November 2012to enable the Council to take on lead responsibility for the joint commissioning of services for children and young. It enables the partnership to:

- achieve a better balance between prevention and early identification and intervention, and more specialist services;
- commission innovative and effective services; and
- develop the social infrastructure and market for integrated children's services.

Ultimately the anticipated benefits of the Agreement will include the ability to make better use of resources and deliver improved services for the local community. The Agreement is in line with national guidance which supports the further development of joint working and the integration of children's services.

- The Children's Act (2004) requires Local Authorities to take the lead in making arrangements to promote co-operation between agencies to improve the well-being of children in the authority's area, and establishes that relevant partners, including Primary Care Trusts, have a duty to co-operate with these arrangements.
- The Health White Paper "Equality and Excellence: Liberating the NHS" outlines the changes to be made to the NHS over the coming years, which include a new role for Local Authorities with regard to Public Health, and the abolition of Primary Care Trusts and the creation of Clinical Commissioning Groups and Health and Wellbeing Boards. The changes in responsibility for different elements children's health services make collaboration through Health and Wellbeing structures particularly important.

It is anticipated that the Section 75 Partnership Agreement for commissioned children's services offers the following opportunities:

- Improved commissioning that can consider the whole needs of children, young people and families
- Development of shared local priorities for service provision and the alignment of funding to deliver these
- An evidence based approach to commissioning which incorporates joint assessment of needs
- Development of a shared vision for services to deliver more cohesive and comprehensive outcomes for children young people and families
- Development of joint performance indicators, monitoring processes and key strategic information such as baselines and tracking systems
- Easier identification of gaps in provision
- Reduced bureaucracy
- Better use of resources to deliver improved value for money
- Production of joined up strategies, service specifications and care pathways for all children, young people and families service areas.
- Easier identification of gaps in provision
- Reduced bureaucracy
- Better use of resources to deliver improved value for money
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4. ABOUT THE INTEGRATION TRANSFORMATION FUND:

The June 2013 Spending Round was extremely challenging for local government, handing councils reduced budgets at a time of significant demand pressures on services. In this context the announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was a real positive. The funding is described as: "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities". This funding is called the health and social care Integration Transformation Fund (ITF). In '*Integrated care and support: our shared commitment*' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me". The ITF is a means to this end and by working together we can move toward fuller integration of health and social care for the benefit of the individual.

The £3.8bn Integration Transformation Fund will be a pooled fund, held by local authorities and funded from the following existing / budgets:-

Grant / Budget	**National allocation**	**Estimated local allocation**	**Sub totals**
NHS Social Care Grant *(existing)*	£0.9bn	£4.725m	£4.725m
Additional NHS Social Care Grant	£0.2bn	£1.050m	£1.050m
DH and other Government Dept. transfers (inc. DFG & capital grants)	£0.4bn	£2.100m	£2.100m

(existing)			
CCG pooled funding of: - Reablement funding - Carers' break funding - Core CCG funding *(existing)*	- £0.3bn - £0.1bn - £1.9bn	£1.575m £0.525m £9.975m	£12.075m
NHS contribution to Troubled Families Programme	£70m	£0.367m	£0.367m
			TOTAL: £20.317m

Key Note: £1bn of the funding will be linked to outcomes achieved. This means that the local 'Payment for Performance' amount is: £0.525m

All of the above will be pooled into a budget which will formally sit with local authorities but will be subject to plans being agreed by local Health and Wellbeing Boards (H&WBs) and signed off by CCGs and Council Leaders.

Plans would also be subject to assurance at national level. As part of the wider 2014/15 planning round, it is envisaged that plans would be developed this year, signed-off and assured over the winter and would be implemented from 2014/15.

4.1 National Conditions for the joint plan

A paper produced for the "London Health Chief Officers Group dated 30th of July 2013" stated the following in terms of conditions and expectations attached to the ITF plans will need as a minimum to :

- Protect social care in terms of services;
- Support the concept of 'accountable clinicians' for out of hospital care for the most vulnerable;
- Enable 7 day working;
- Take a joint approach to assessment and care planning;
- Facilitate information sharing, including use of the NHS number across health & social care;
- Take account of the implications for the acute sector of service reconfiguration;

- Set out arrangements for redeployment of funding held back in event of outcomes not being delivered.

DCLG are currently identifying how the Disabled Facilities Grant element of the capital funding will be handled, taking account of local statutory duties.

4.2 Impact on local CCG allocation

The average CCG contribution to the pooled ITF locally has been estimated at 3.00% or 10.0m. This is in addition to the money received through the Carers and Reablement funding.

It is likely that funding will not come directly to the Local Authority from NHS England through S256 requirements. More likely will be given directly to CCGs but this will require a change in legislation.

The executive decisions to be taken about the prioritisation, deployment of resources and the oversight of their effectiveness, set down in the joint plan will be with the executive functions of both the Council and NHS Enfield. However, the Health & Wellbeing Board will have a duty to monitor and ensure that the joint plan is delivered within timescale.

Plans would also be subject to assurance at national level. As part of the wider 2014/15 planning round, it is envisaged that plans would be developed this year, signed-off and assured over the winter and would be implemented from 2014/15.

The focus of this report is to make recommendations with regards to how we approach the development of the ITF plan and to outline the vision for integration going forward.

5. STRATEGIC DRIVERS FOR CHANGE – "A TIME FOR FAST PACED ACTION"

Health and social care integration and local accountability are not new concepts. They have been considered as options for improving local service delivery since as far back as 1974 when community health services and social care were split between the NHS and local government. Today, rising demand for health and social care, combined with increasing scarcity of resources, is leading to renewed interest in 'integrated care' as a potential solution.

The NHS Confederation and the Association of Directors of Adult Social Services (ADASS) have developed a joint programme of work looking at the issues around the commissioning and provision of integrated health and social care services. The shared vision is for integrated care to become the norm. One of the collaboration's first actions has been a call for 'health and social care integration pioneers' to demonstrate ambitious and innovative approaches – with the support of the 13 national partners – that will deliver integrated care efficiently, then to actively promote what they've learned for wider adoption across the country.

The collaboration recognises there is no ‘blueprint’ for how localities develop plans for integration. “While elements of different models will be transferable, every locality is unique and needs to develop its own model of integration to suit the needs of local people.”

Within five years, pioneers will be expected to have tackled local cultural and organisational barriers that prevent delivery of coordinated care and support and demonstrated a range of approaches and models involving whole system transformation across different settings.

The time seems right for true transformation, including a shift in thinking so that care is not defined by who gives it. “People everywhere are realising that integration is not just desirable but a necessity. I’m not talking about a little bit of integration … but full integration of health and care.”

One of the catalysts for this level of integration is a population that is living longer but with more complex needs, particularly the rising numbers of people with dementia, whose care needs to cross every sort of setting.

In recent months there have been some crucial developments that support major change. In March the King’s Fund, which has been instrumental in shaping national government policy on integration, published a paper *Making integrated care happen at scale and pace*, setting out steps to “convert policy intentions into meaningful and widespread change on the ground” based on lessons learned from experience.

April saw the new NHS structure become fully operational, offering opportunities for fresh thinking in response to local needs.

National commissioning body NHS England and foundation trust regulator Monitor have statutory duties to promote and enable integrated care. Health and wellbeing boards, comprising representatives from the local community, including the NHS, public health and local authorities including social care, housing, education and the police, have statutory duties to promote and encourage the delivery and advancement of integration within their local areas at scale and pace. Through joint strategic needs assessments and joint health and wellbeing strategies, these boards have the potential to facilitate initiatives on integrating care and support to suit local circumstances.

Integration is specifically covered in the 2013-14 assurance framework for clinical commissioning groups (CCGs), which states that they should recognise the importance of their relationships with other local commissioners, including local authorities.

The national collaboration (The NHS Confederation and ADASS) is working to clarify freedoms and flexibilities in the system, and some areas are already venturing into new approaches. In Solihull the plan is to create an integrated system with the acute hospital as the hub; having just one CCG and one local authority in the area should make this more achievable. The aim is to use the same housing and care provider that already offers rehabilitation to support

people into independent living on discharge to avoid hospital admissions in the first place, with complete care packages offering a realistic alternative to inpatient beds. Solihull is moving away from rigid payment systems and local commissioners have agreed a level of financial risk to enable more investment in care pre-admission and post-discharge.

This level of shared purpose is crucial to the success of transformation, and it is no surprise that 80% of 69 directors of adult social services and senior CCG leaders who took part in a recent ADASS and the NHS Confederation 'straw poll' saw strong leadership and commitment 'from the top' as the most important factors in taking forward integration locally.

The biggest obstacles to progress were considered to be data and IT systems, payment mechanisms and financial pressures. But to go from being a bit better at integrating what we have always done to undertake real transformation also requires personal resilience, energy and perseverance especially to continue relationships in the long term and take ownership of decisions and joint arrangements made by your predecessors. To truly achieve sustainable and realistic integration, that shared purpose must extend to not just everyone within an organisation but all those who use care services.

The NHS Confederation and ADASS, to support the pioneer sites and any providers and commissioners keen to learn from what others have done or share their own experiences, the national collaboration has established the Integrated Care and Support Exchange (ICASE), resource bringing together practical expertise from national partners. This will be an invaluable resource for developing an evidence base/ reference point for implementing the integration agenda.

The Health and Social Care information Centre already exists to manage data from across care, but now there is an impetus to break down silos to link data and make sense of it, not in relation to individual organisations but as a series of personal stories.

The report of the Children and Young People's Health Outcome Forum on **the Children and Young People's Health Outcomes Strategy** also highlights the importance of effective integration. Following on from Sir Ian Kennedy's 2010 report 2010 '***Getting it right for children and young people***' which concluded that "the health system has a poor track record in relation to children and has not seen it as a central concern" the report concludes that:

"Too many health outcomes for children and young people are poor, and for many this is involved with failures in care. Despite important improvements – for example, reductions in the number of young people smoking and of teenage pregnancies – and in some areas of specialist healthcare, more children and young people under 14 years of age are dying in this country than in other countries in northern and western Europe. There is enormous and unexplained variation in many aspects of children's healthcare, and the UK is worse than other countries in Europe for many outcomes that could be improved through

better healthcare and preventative interventions. This alone makes a compelling case for change."

The report welcomes the government's commitment to strengthening integration and goes on to conclude:

"Integration of care around the needs of children, young people and their families is absolutely fundamental to improving their health outcomes. It also reduces duplication and waste and saves significant sums of public money that can be spent on service improvement. It is particularly important for children and young people with disabilities or at risk of developing disabilities, with long term conditions, with complex needs or with mental health disorders. For example, the most effective commissioning for disabled children integrates specialist healthcare, community services like NHS therapists and local authority educational support services, special schools and children's social care services."

A significant development which will affect the delivery of integrated services for children and young people, and onwards into adulthood, will be the enactment of The Children and Families Bill 2013, which is expected to commence in 2014. This includes a requirement for local authorities and local clinical commissioning groups to '**work in partnership and make arrangements for commissioning special educational provision, healthcare provision and social care provision for children and young people with special educational needs for whom the local authority is responsible'**, and to 'consider and agree the special education, health, and social care provision required locally and to determine what provision is to be secured and by whom, in order to meet that need'.

The ITF plan will need careful planning and consideration as it will essentially form the cornerstone of how we build upon existing arrangements, embrace change and it will set out our commitment in terms of the vision for the future for Health and Social Care services in Enfield. Types of integration models can be seen in Fig. 1 (below)

6. AN OVERVIEW OF THE TYPICAL TYPES OF INTEGRATION MODELS

"Integration is a process. It's something you do in order to achieve something, not an objective in itself."

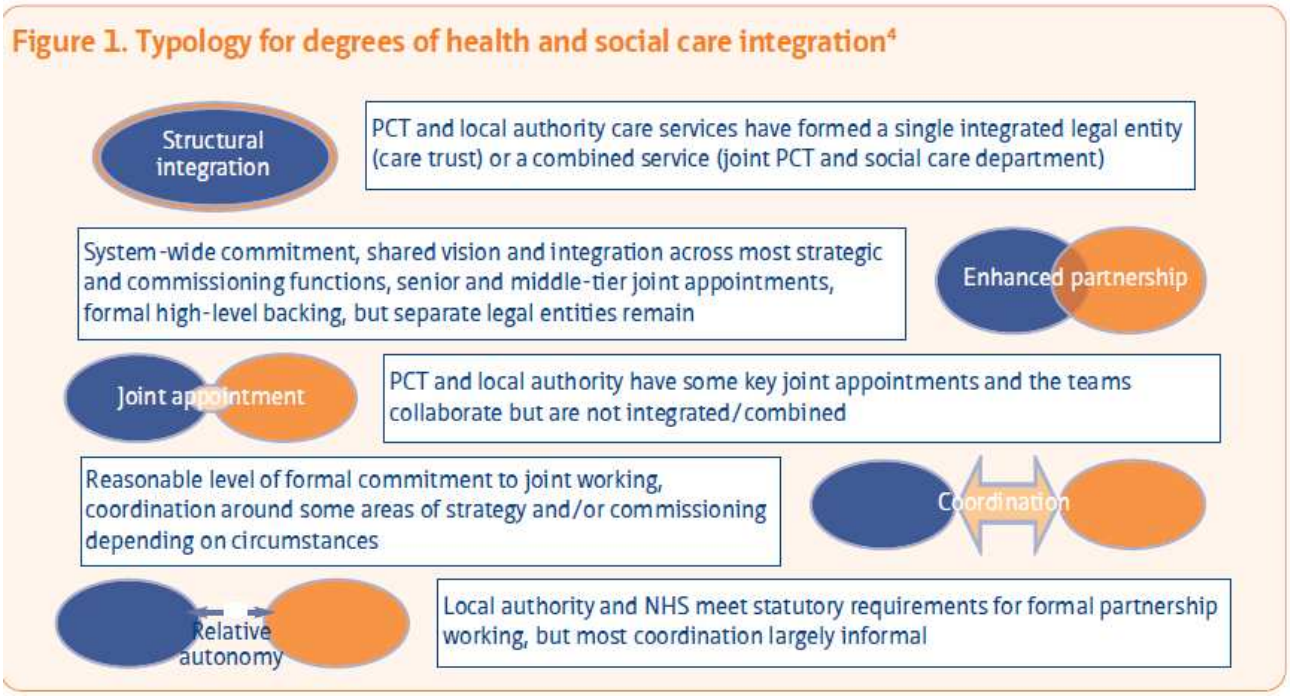
Health and social care integration covers a range of models, not a single solution. Local factors such as good relationships, commitment and joint strategy, and vision can enhance integration.

Below are a range of models being developed and applied nationally which are delivering locally integrated structural solutions. NB: this is only one part of the overall picture. Structural approaches when applied alone appear to detract from

or mean that less consideration is given to more practical based solutions such as pooled budgets, integrated teams and joint appointments.

Integration is a term open to wide variations in interpretation, from structural solutions to open book accounting across local public services. A working definition developed as part of the DH's recent survey may be useful in terms of establishing understanding of the range of models being considered (figure 1 below).

Figure 1. Typology for degrees of health and social care integration[4]



Other models referred to nationally include Horizontal and Vertical integration. A distinction can be made between horizontal and vertical integration. *Horizontal integration* occurs when two or more organisations or services delivering care at a similar level come together. Examples include mergers of acute hospitals as well as the formation of organisations such as care trusts that bring together health and social care. *Vertical integration* occurs when two or more organisations or services delivering care at different levels come together. Examples include mergers of acute hospitals and community health services, and tertiary care providers working with secondary care providers.

Both horizontal and vertical integration may be real or virtual: real integration entails mergers between organisations, whereas virtual integration takes the form of alliances, partnerships and networks created by a number of organisations. Virtual integration may occur along a continuum, ranging from formalised networks based on explicit governance arrangements at one extreme to loose alliances or federations at the other. Virtual integration is often underpinned by contracts or service agreements between organisations, as in the supply chains found in many manufacturing industries. It can therefore be seen as a form of contractual integration rather than organisational integration.

As part of the development of the ITF plan, close attention and monitoring of the ever-evolving national picture of applied and theoretical learning for integration will need to be undertaken to understand what is working well in terms of integration solutions. The ICASE system (referenced pg 6) will be invaluable resource in this context. Models will need to be evaluated and carefully considered to understand which ones may produce the best outcomes and results within our unique landscape.

The King's Fund suggests some key elements for integrated care to happen at scale and pace, include the following.

1. Find common cause with partners and be prepared to share sovereignty.
2. Develop a shared narrative to explain why integrated care matters.
3. Develop a persuasive vision to describe what integrated care will achieve.
4. Create time and space to develop understanding and new ways of working.
5. Identify services and user groups where the potential benefits from integrated care are greatest.
6. Build integrated care from the bottom up as well as the top down.
7. Pool resources to enable commissioners and integrated teams to use resources flexibly.
8. Use the workforce effectively and be open to innovations in skill mix and staff substitution.
9. Be realistic about the costs of integrated care.
10. Act on all these as part of a coherent strategy.

7. WHAT DO WE MEAN BY INTEGRATION – A PROPOSED SHARED DEFINITION

To enable a shared understanding of integrated care and support, nationally there is a drive to adopt a shared definition and narrative. The preferred and often referred to national definition is the one that *National Voices* have developed which places focus on the service user voice as the driving force and unifying factor behind integration. This definition is often aligned to 'Making it Real' from Think Local Act Personal (TLAP).

The proposed shared narrative for the locality is therefore: ***"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"***

NHS Enfield and the Council are often making reference to the above narrative in papers related to integrated working so therefore it would appear that it has already been informally adopted by staff on the ground who are delivering integration. It is therefore recommended that the localities definition / narrative is based upon the above-mentioned National Voices observation.

8. OPPORTUNITIES

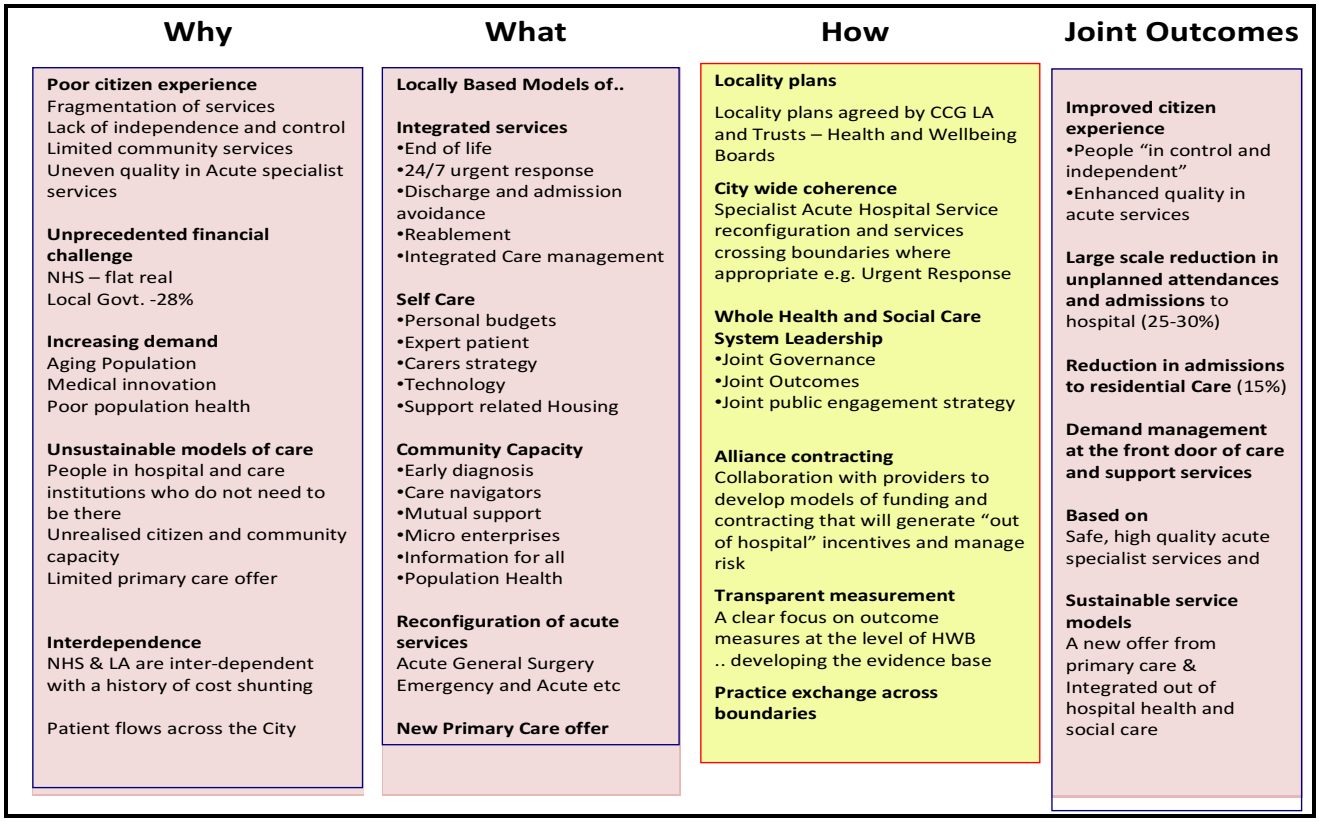
There is a clear and unifying emphasis on improving the quality of patient / customer experience as a core outcome of integration. This is underpinned by a presumption of service reconfiguration across acute, primary, secondary, tertiary and community services in terms of the customer pathway. There is a commitment to pursuing the evidence base for which models most benefit and produce results that are aligned to the preventative agenda.

There is definite scope for creative thinking and innovation as neither the national models nor the community budget sites (set up by the ADASS and the NHS Confederation) are prescribing models yet. It is often described that local commissioners across the spectrum (Health and care) will lead the local development of preferred integration models.

The following services and user groups have been identified by Enfield NHS and the Council as potential areas that integrated care maybe described as of greatest benefit:-

- Development of joint working across Enfield council services; Childrens and education and Health and Adult Social Care.
- Reconfiguration of patient / customer pathways to reduce hospital re/ admission and keep people well in their own homes with support options that are individualised and responsive to their own needs.
- Integration of wheel chair services with integration community equipment services
- Consolidation of commissioning, procurement, contracting and performance management support
- Further enhancement and development of the Transition pathways across the client groups
- Development of Older People Assessment Units at Chase Farm and North Middlesex Hospital
- Development of Assistive Technology
- Development of an integrated Falls pathway
- Opportunities for co-location of staff, meeting areas and delivery resources
- The delivery of Choice and Control through health and care personal budgets which includes market stimulation and management (NHS operating framework requires the set up personal budgets for CHC use by November 2013)
- The further exploration of pooled budget arrangements for Continuing Health Care, Section 117 and ad-hoc secondary services (i.e. Occupational Therapy assessment)
- Exploration of risk share arrangements for assessment and treatment pathways (non client group specific)
- Exploration of shared resources in terms of back office functions (i.e. Human Resources, IT and Communications, Facilities Management, Legal advice etc)

All of the above mentioned areas can and will be considered when developing the ITF plan. The below figure indicates the process of implementation from identification of priority areas to the development of joint outcomes.



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

5.1 Financial Implications

As part of the 2013 spending round, it was announced that £3.8bn would be placed in a pooled budget to create an Integration Transformation Fund (ITF). The Table within Section 4 above provides an estimate of Enfield's allocation.

This rough estimate is based on our current percentage allocation of the 2013/14 NHS social care grant. Information on Enfield's 2014/15 actual allocation has not been received yet

It should also be noted that as detailed in Table 4, the fund consists of both existing funds being reallocated and new funds

The actual allocation of the ITF locally will be subject to both jointly agreed local plans and in some cases locally set outcome measures, i.e. performance payments

6.2 Legal Implications

Section 195(1) of the Health and Social Care Act 2012 imposes a duty on Health and Wellbeing Boards *to encourage persons who arrange for the*

provision of any health or social care services in that area to work in an integrated manner, for the purpose of *advancing the health and wellbeing of the people in its area.*

Section 195(2) of the Health and Social Care Act 2012 states that *A Health and Wellbeing Board must, in particular, provide such advice, assistance or other support as it thinks appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.*

Section 195 of the Health and Social Care Act 2012 has been in force since 1 April 2013.

Section 75 of the National Health Service Act 2006 has been in force since 1 March 2007.

Section 75(1) of the National Health Service Act 2006 enables the Secretary of State to make provision for enabling prescribed NHS bodies and prescribed local authorities to enter into prescribed arrangements in relation to prescribed functions of the NHS bodies and prescribed health-related functions of the local authorities, if the arrangements are likely to lead to an improvement of the way in which those functions are exercised.

Section 75(2) sets out the type of arrangements which may be prescribed.

The proposals set out in this report appear to meet the requirements of section 75 National Health Service Act 2006 and the duty to promote integrated working set out in section 195(1) of the Health and Social Care Act 2012.

APPENDIX 1 –

Enfield Health and Wellbeing Board – Sub-Board: Integration Development Board

Terms of Reference

Purpose

- The Government have established at £3.8billion of funding to be distributed across all local authorities for social care funding, to explicitly develop an integrated care system.
- This fund is being called the Integrated Transformation Fund.
- This Sub-Board of the Health and Wellbeing Board is to meet to formulate the planning and preparation for allocating its share of the fund into developing an integrated system in Enfield until April 2014.
- Allocated funding is to come from joint NHS Funding for carer's breaks and reablement funding, with LBE funding for Disabled Facilities Grant, Adult Social Care Capital Grant and NHS Transfer due to the Health White Paper in addition to further allocation funding from the NHS
- Funding is to establish 7-day working arrangements, better data sharing joint approach to assessment and car planning, implications for the acute sector of service redesign and creating an accountable lead professionals for joint care packages

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 integrated health and social care system.

2. Name

The name of the Board will be Integration Development Sub-Board

3. Membership

- CCG Chief Officer
- Director of Health, Housing and Adult Social Care
- Director of Schools and Children's Services
- Enfield CCG Director of Finance
- LBE Assistant Director of Finance - Finance, Resource and Customer Service
- LBE Assistant Director of Strategy and Resources- HHASC
- CCG Head of Commissioning, Integrated and Acute Care

Additional members may be appointed to the Board by the agreement of all current members and approved by the Health and Wellbeing Board.

NB the support officer or their representative will be in attendance at all Sub-Board Meetings.

4. Responsibilities

The Integration Development Sub-Board will ensure:

Development of a time table for funding and work to be completed
Produce a plan by the end of 2013 for allocation of funding for 2014/15
Ensure the plan is formally agreed by April 2014 for financial years 2014/15 and 2015/16
Sign-off arrangements are in place with the Enfield Health and Wellbeing Board
Integration plans are to include a minimum of:

- Protect social care in terms of services
- Support the concept of an accountable clinician for out of hospital care for the most vulnerable
- Enable 7 days working
- Take a joint approach to assessment and care planning
- Facilitate information sharing, including the use of NHS number across health and social care
- Take account of the implication for the acute sector of service reconfiguration
- Set out arrangements for redeployment of funding held back in the event of outcomes not being delivered

5. Proposals for Sub-Boards and Work Programmes:

The Integration Sub-Board of the Health and Wellbeing 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 Sub-Board will develop its fixed term work plan and bring it to the Health and Wellbeing Board for formal approval

6. Chairing and Voting

The Chair will be a joint appointment between CCG Chief officer and LBE Director for Health, Housing and Adult Social Care

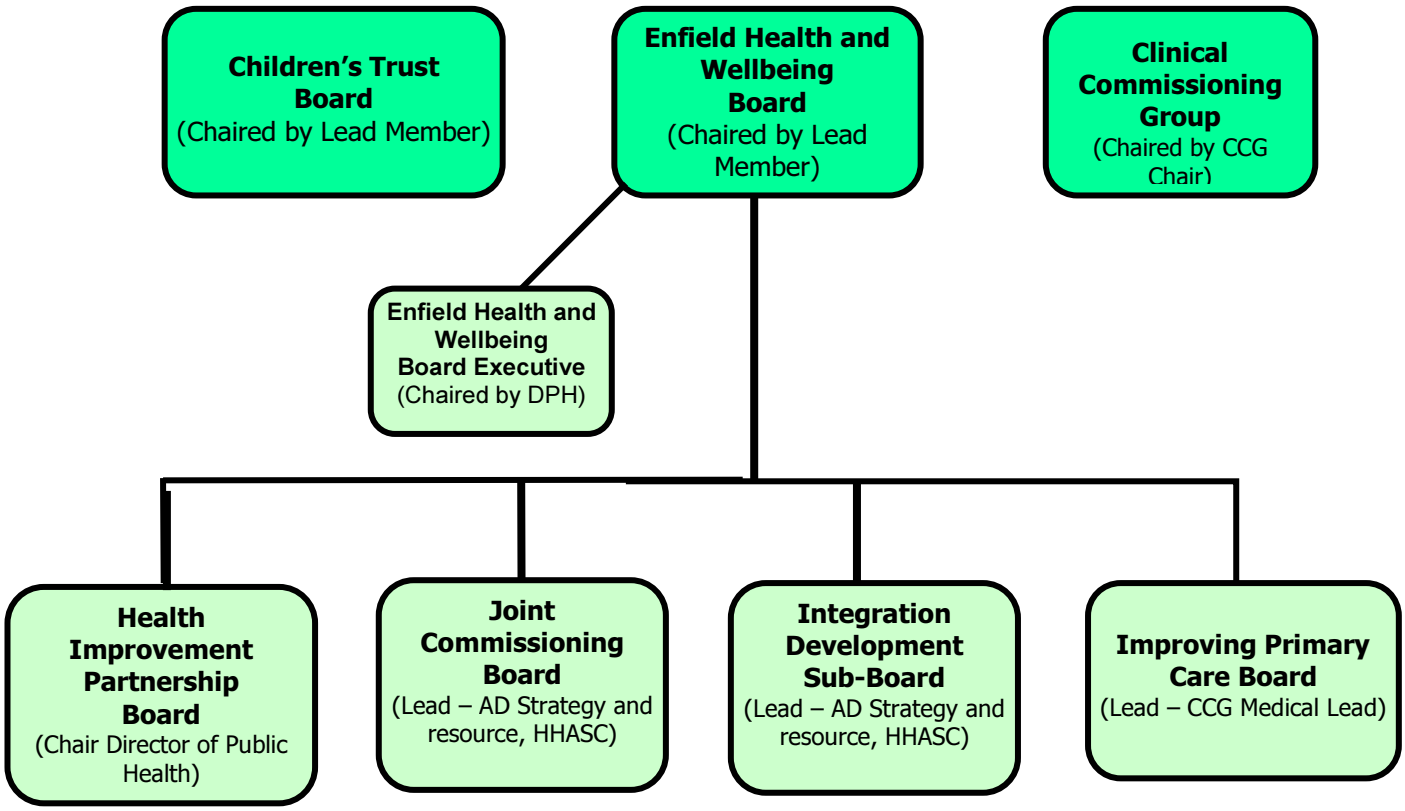
Each member of the Sub-Board shall have one vote and decisions will be made by a simple majority. The Chair will have the casting vote.

7. Frequency of Meetings

The Integration Sub-Board is a fixed term development board as to function on behalf of the Enfield Health and Wellbeing until the approval of an integration plan for 2014/16 is established by April 2014

Appendix 1 to the Terms of Reference

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



Agenda Item 7

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE:
Health and Wellbeing Board
19 September 2013

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

REPORT OF:
Dr Shahed Ahmad
(Director of Public Health)

Contact officer and telephone number: Glenn Stewart 0208 379 5328

E mail: glenn.stewart@enfield.gov.uk

1. EXECUTIVE SUMMARY

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

- Tobacco control / smoking cessation
- Childhood Obesity
- JSNA and Health update
- Joint Strategic Needs Assessment
- Updates on Maternity Services
- Childhood Poverty
- Child Health / Adult Health update
- Adult Health update
- CCG update
- MoreLife

2. RECOMMENDATIONS

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

- Enfield has the 16th highest smoking prevalence in London. The smoking quitters target has been achieved.
- The JSNA is nearing completion
- A review of maternity services is to take place in the Autumn.
- Public Health England has published data on premature mortality for all boroughs

3. Tobacco Control / Smoking Cessation

3.1 The smoking four-week quitters target was achieved; 1584 quitters against a target of 1568.

3.2 Work in schools is continuing; posters have been distributed and 'Smoke Storm' has been launched in 8 schools (interactive multimedia education).

3.3 Enfield is one of the 1st boroughs to implement no smoking in parks and play areas.

3.4 Three local shisha premises have been closed and control measures enforced in a further three (regulations regarding product testing and no underage usage).

3.5 In August training will begin in the North Middlesex Hospital for the automatic referral system of all smokers to stop smoking services.

3.6 The Integrated Household Survey measured smoking prevalence between April 2011 – March 2012 as 18.5% (95% confidence interval 15.8% to 21.2%). The complexity of the methodology for this survey though means that this is only an indicative figure.

4. CHILDHOOD OBESITY

4.1 The new Healthy Weight Co-ordinator has started. One of their first tasks is to organise a workshop with stakeholders to update the work programme to reflect new NICE guidance.

4.2 National Childhood Measurement Programme (NCMP) letters have been sent out.

5. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) AND HEALTH AND WELL-BEING STRATEGY (HWBS) UPDATE

5.1 A final draft of the JSNA was presented to a development session of the HWB Board on 18th July.

5.2 Pending final comments the structure of the JSNA will be:

- Introduction
- Enfield People
- Enfield Place
- Enfield Resources
- Health and Well-being of Children, Young People and their families
- Health and well-being of Adults

- Health and well-being of Older People

5.3 The JSNA will be an online resource and should be accessible to all by September.

6. MATERNITY SERVICES

6.1 CCG Chief Officer gave an overview of commissioning and the issues surrounding Maternity care. A review is to take place in the Autumn. The key issues for the review are:

- Assurance that staff are trained and regularly updated to ensure competence in cardiotocography (CTG) interpretation
- Assurance that staff identified with a learning/practice gap in their clinical skills are supported, supervised and where indicated performance managed appropriately.
- Review of systems for providing advice to women out of hours
- Focus on joint working between Hospitals and the Public Health leads to review pathways and staff training for stop smoking, healthy eating and community-based interventions for overweight and obese pregnant women.
- Review of information to women and partners particularly in relation to postnatal problems e.g. urgent medical or mental health assistance.
- Enhancing postnatal community care pathways, particularly on how communication passes from hospital to community.
- More robust Serious Incident reporting processes.

7. CHILDHOOD POVERTY

7.1 An update was given on the Child/Family prosperity strategy with a request that the board consider the review and further development of Aim 5: the Drive towards prosperity strategic action plan. Discussions with other champions for the aims of the strategy have taken place and review of actions pending.

7.2 The key targets of the strategy are to reduce child poverty and to narrow the gap. However it was noted that it is important to monitor how the gap is narrowed and that a reduction does not occur because people are becoming more impoverished rather than an improvement in situation.

7.3 It was reported that there is to be an expansion of provision for early years (2 year olds / looked after children/children with disabilities) and that Enfield has the second highest target London (13 000 children). There is a need to ensure there is a quality benchmark used.

The HIP felt there were too many actions in the current Child Poverty Strategy. The AD for Children felt the most important action was to create jobs and increase employment.

8.0 CHILD HEALTH UPDATE

8.1 An interim Consultant is leading work on the Child Deaths Overview Panel. Child poverty and smoking are recognised as the greatest contributors to infant mortality. .

9.0 ADULT HEALTH UPDATE

9.1 Public Health England has published data. Enfield compares well to other Local Authorities in the prevention of premature deaths (defined as deaths before the age of 75).

9.2 Enfield ranked 32nd /150 local authorities and 1 / 15 similar Local Authorities. for avoiding premature deaths. Enfield also ranks 1st amongst its statistical neighbours:

Enfield Premature Mortality (aged U75) and Rankings (2009-11) compared to ALL Local Authorities

	Enfield compared to ALL Local Authorities, ranking / premature deaths per 100,000	ALL Local Authority Best / premature deaths per 100,000	ALL Local Authority Worst / premature deaths per 100,000
Overall deaths per 100,000	32nd / 237	Wokingham / 200	Manchester / 455
Cancer	17th / 95	Harrow / 83	Manchester / 152
Heart Disease and Stroke	50th / 59	Wokingham / 40	Manchester / 116
Lung disease	42nd / 19	Bromley / 14	Blackpool / 62
Liver disease	51st / 13	Wiltshire / 9	Blackpool / 39

Enfield Premature Mortality and Rankings (2009-11) compared to SIMILAR Local Authorities

9.3 Within the above it was noted although the above is welcomed important to recognise the success in increasing the average life expectancy of the borough, the life expectancy gap cannot be ignored.

	Enfield compared to SIMILAR Local Authorities ranking / premature deaths per 100,000	SIMILAR Local Authority Best / premature deaths per 100,000	SIMILAR Local Authority Worst / premature deaths per 100,000
Overall deaths per 100,000	1st / 237		Wigan / 324
Cancer	1st / 95		Darlington / 121
Heart Disease and Stroke	2nd / 59	Brighton and Hove / 58	Peterborough / 79
Lung disease	2nd / 19	Camden / 18	Wigan / 32
Liver disease	1st / 13		Wirral / 25

10.0 CLINICAL COMMISSIONING GROUP (CCG) UPDATE

10.1 The CCG has become reasonably well established over the past 3 months and has the following priorities:

- Improve primary care
- Deliver service transformation with providers working with an integrated approach
- Achieve financial balance

10.2 The CCG authorisation process took place between November 2012 and March 2013 and it was authorised with certain conditions:

- Must have the capacity to meet all initial challenges
- Ability to develop and deliver a strong and stable financial plan

10.3 The CCG is working with NHS England to lift conditions by September 2013.

10.4 There was a public board meeting on 31st July to which all were invited.

10.5 The CCG is working on a 3 year primary care improvement plan and an Older peoples assessment unit is to provide a service to avoid admittance into hospitals

11.0 MoreLife

11.1 MoreLife (UK) Ltd provides residential summer weight-loss camps for 8 – 17 year olds.

11.2 Enfield CCG has recruited 30 children and young people to attend Morelife beween 18th and 31st August. There is a waiting list in case of drop-out.

11.0 REASONS FOR RECOMMENDATIONS

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

Background Papers: None

Health and Wellbeing Board

Thursday 19 September 2013

Agenda – Part: 1	Item: 7.2
Subject: Joint Commissioning Board Report	
Wards: All	

REPORT OF:

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1. EXECUTIVE SUMMARY

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

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

1.3 This report includes note that:

- The **Section 75 Agreement** for Adults has been re-drafted to reflect new statutory responsibilities and governance changes resulting from the NHS transition.
- The spending plan for the **NHS Social Care Grant** has been approved and is due for consideration at the Finance, Resources and QIPP Committee on 4th September.
- Members have ratified the creation of a Community Interest company, limited by guarantee named as 'Enfield Consumers of Care and Health Organisation (ECCHO), which will be independent of the Council, to deliver the **Healthwatch** functions in Enfield. This company has not been transferred to the Healthwatch Board to operate as an independent service
- The priority outcome from the **Voluntary & Community Sector Strategic Commissioning Framework** (VCSSCF) is the development, commissioning and implementation of an integrated information, advice and advocacy service for adults in Enfield with health and social care needs.
- In recognition of Enfield changing status from being a pilot site to a trailblazer site for **Direct Payments in Residential Care**, DH awarded the borough with additional funding for two years and extended the scope to consider nursing homes.
- Following the **transition of responsibility for public health services** to the local authority in April 2013, Enfield, Barnet, Haringey, Camden and Islington have formed the NCL Local Authority Sexual Health Commissioning Group to work strategically across the five boroughs to commission cost effective, high quality sexual health services.

1. EXECUTIVE SUMMARY (CONTINUED)

- Enfield Council's success in both applications for capital funding and its partnership with Newlon Housing Trust to improve specialist accommodation for people with disabilities in the borough

- The **Safeguarding Adults Board** has received performance data that highlights a 159% increase in the number of safeguarding adult alerts. The September Board will consider audit options.

- The 3 year **Integrated Care Plan** will work on reshaping services used by older people to achieve a significant reduction in non-elective activity, A&E attendances and outpatient appointments

- **Winter Pressures Funding** planning is in progress. The Council is expectant that DH will fund the Warm Homes, Healthy People 2013/14 project and will invite the voluntary and community sector partners to be involved.

- Voluntary and Community partners are preparing events in September and October to promote **Dementia awareness**. Enfield is the first borough in London where partners have formed the Enfield Dementia Action Alliance with the aim of using the national approach to promote the needs of those living with dementia

- Enfield, Barnet and Haringey will jointly tender a consolidated Independent **Mental Health** Advocacy (IMHA), Independent Mental Capacity Advocary (IMCA) and Deprivation of Liberty Safeguards (DoLS) for the new contract to commence April 2014.

- LBE and NHS Enfield CCG have jointly developed an action plan in response to the **Winterbourne View concordat** that emphasises the commitment to review all people with learning disabilities and / or autism within in-patient facilities.

- The building renovation at the **Enfield Carers Centre** is now completed and offers more confidential working space and improved accommodation for staff members.

- The **Family Nurse Partnership** (FNP) team is fully appointed. A launch event will be held 9th October at the Dugdale Centre

- **Drug and Alcohol Action Team (DAAT)** has achieved a rate above London, national and the PbR Pilot averages for Successful Treatment completions.

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 As reported in June 2013, the Section 75 Agreement which relates to commissioned services for Adults requires amendment. This is to reflect new statutory responsibilities and governance changes resulting from the NHS transition.

3.2. The Agreement has been re-drafted and formal approval has been obtained from the Director of Health, Housing and Adult Social Care and the Lead Member for Adult Services and Care at the Council. The Agreement is still subject to formal approval at NHS Enfield Clinical Commissioning Group and is due for consideration at the Finance, Resources and QIPP Committee on 4th September and at the NHS Enfield Clinical Commissioning Group later in September 2013. Subject to receiving formal approval from NHS Enfield Clinical Commissioning Group the Agreement will be signed under seal by both parties.

3.3 Discussions have commenced about the content of the Agreement in 2014-15, so notice can be issued by either party as necessary before the 30th September 2013 in line with the Agreement terms.

3.4 The half year review is scheduled to take place in early October 2013, to assess how effectively the partnership arrangements have functioned between April 2013- September 2013 and an update will be provided to the Health and Well-being Board following this.

4. NHS SOCIAL CARE GRANT

4.1 As reported in June 2013, the spending plan has been re-profiled to factor in the grant allocation for 2013-14 and also the assumed allocation in 2014-15, and has provisionally allocated funding up until 2017. The indicative spending plan has now been approved by the Director of Health, Housing and Adult Social Care and the Lead Member for Adult Services and Care at the Council.

4.2 However, the Department of Health issued new guidance in June 2013. This reiterates the earlier conditions of use and states that funding must be used to support adult social care services which also have a health benefit. The guidance also states that the spending plan should take account of the Joint Strategic Needs Assessment and existing commissioning plans for both health and social care but also that funding can be used to support existing services or transformation programme, where services may otherwise be reduced. This also requires local Clinical Commissioning Groups to approve the plans before funding can be transferred from NHS England to the local authority.

4.3 The Council is now progressing approval of the indicative spending plan from NHS Enfield Clinical Commissioning Group following this

new guidance issued in June. The spending plan has been approved by the Joint Commissioning Board and is due to be considered at the Finance, Resources and QIPP Committee on 4th September. Subject to approval the Memorandum of Agreement will then be signed and submitted to NHS England to process the funding transfer to Enfield Council for 2014-15.

5 HEALTHWATCH ENFIELD

5.1 At the full Council meeting of 17th July 2013, Members ratified the creation of a Community Interest Company limited by guarantee, named as Enfield Consumers of Care and Health Organisation (ECCHO) that will deliver the Healthwatch functions in Enfield. The Chair and Board Members are in the process of registering themselves as Directors of the company.

5.2 The Council recognises and values the operational independence of ECCHO and does not have the power to determine its work programme.

5.3 The Council will not be an owner or member of ECCHO but will develop a Service Level Agreement between itself and ECCHO which will set out agreed key outcomes, outputs and will contain proportionate 'light touch' processes to assure and validate service delivery.

5.4 ECCHO will be grant funded by the Council and funding will be disbursed on a regular basis throughout the term on the basis that ECCHO demonstrates its ability to carry out its functions effectively through regular reporting and effective liaison.

5.5 ECCHO Board members are in the process of sourcing suitable accommodation and are planning an official launch to be held during the Autumn

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

6.1 The first phase review of organisations in receipt of core funding and support with running costs has recently concluded. As a result of the review a number of queries have arisen requiring clarification. To maintain stability for the organisations, service users and other stakeholders, current funding arrangements will continue until the Autumn 2014. This will allow sufficient time to garner the necessary information and ensure that proper governance is effected regarding any recommendations and decisions to be taken. Officers are maintaining the commitment to give organisations a 6-month notice period following any decisions taken.

6.2 The development, commissioning and implementation of an integrated information, advice and advocacy service for adults in Enfield with health and social care needs is a priority outcome from the VCSSCF. Commissioning managers have been co-producing service aims, objectives and outcomes together with measures for assuring and ensuring quality with a wide range of stakeholders which include service users, carers and partnership boards across all client groups. The work also includes consideration on how the service will be delivered to ensure optimum coverage and reach to meet advocacy needs across the borough. The preference determined from stakeholders is for local voluntary and community sector organisations to combine their specialisms and experience into a formal partnership or consortium to bid for funding to provide a holistic and accessible service. A draft service specification has been produced.

6.3 Commissioning managers will be embarking on the review (Phase 2) of local VCS organisations that are currently grant funded to provide information, advice and advocacy to measure what outcomes and value for money have been delivered. This is scheduled to commence in the Autumn 2013 with the intention to carry out a competitive grants process for the new service. The envisaged timescale for completion of the review, competitive grants process and service commencement is January 2015. This will allow sufficient time for appropriate decommissioning and a reasonable timescale for orgs to put a bid together, implement the service and be ready to commence new service provision. A partnership of local VCS organisations is emerging, that has received the draft service specification and has been briefed on a regular basis with emerging service requirements.

7. PERSONALISATION

7.1 Direct Payments in Residential Care

7.1.1 The scope of this national project has changed - Originally the pilot that we bid for was predicated on the exam question “Can Direct Payments work in residential care?” however this has now changed to “How **will** direct payments work in residential care?” .The reason for this is that the project now is much more closely linked to Dilnot and the social care bill which means that in April 2016 the regulations restricting direct payments for residential care will come off for all authorities (they will come off for Enfield in about October time).

7.1.2 This means that Enfield has ceased to be a pilot site and is now a trailblazer site. In recognition, an extra £20K has been awarded by the DH this year and another £20K next which brings the total funding for the project to £54K. In addition the scope has been extended to consider the social care costs in nursing homes.

7.1.3 First quarter progress in the project has been strong, with project initiation documents produced, a project board configured and a project

plan under construction. The project board consists of key stakeholders including operational managers and staff, commissioners, procurement leads, en engagement and policy officers, in-house and external residential care providers and a brokerage provider. We will be adding VCS, Health and service user and carer reps shortly

7.1.4 There are four work streams sitting under the project board: Service user and Carer engagement, Contracting and market management, Operational Process and Cultural Change and Support Planning. Activity is taking place in all areas however the Support Planning workstream is furthest advanced in that MySupportBroker have been commissioned to provide support planning for an initial 22 service users in residential care. This activity has already started.

7.1.5 A report on the project was given to Older People and Vulnerable Adults scrutiny panel on the 9th July 2013 and was well received with requests for regular updates as the project progresses.

8. SPECIALIST ACCOMMODATION

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 successful bid applications has now been made. The local authority, has been successful in all applications submitted and has subsequently been awarded £315,000 for the development of wheelchair accessible homes for people with disabilities, including accessible shared ownership options for people with care and support needs. In addition to this, the local authority has worked in partnership with Newlon Housing Trust to secure £840,000 for the remodelling and improvement of supported housing services for adults with disabilities in the borough, including older people with learning disabilities and dementia. Work now commences to progress these exciting new developments in partnership with key stakeholders.

9. Homelessness Private Rented Sector Investment Project

In March 2013 Enfield had approximately 2,000 households living in temporary accommodation and was ranked 7th highest nationally, with most of those households living in the private rented sector. As the number of households in temporary accommodation continues to rise, there is a pressing need for more affordable housing stock to provide greater value for money but to also provide security for tenants.

Enfield Council has recently been selected a pathfinder authority to work with Social Finance, a not for profit organisation, and the Department of Communities and Local Government, to assess the feasibility of developing an institutional investment scheme, which could secure external investment to purchase properties and lease

these to the Council. This would secure affordable accommodation to be used to house homeless persons.

Work is currently being undertaken to review the viability of this and the most appropriate structure of the model, with a view to developing a market ready proposition by December 2013. This project has the potential to secure a portfolio of properties that can be used by the Council to discharge homelessness duties at a more affordable rate, whilst providing greater security than nightly paid temporary accommodation currently provides thus contributing to improved health and wellbeing.

10. SAFEGUARDING

10.1 Safeguarding Adults Board (SAB)

The Safeguarding Adults Board has received performance data which identifies that the number of safeguarding adults alert received by adult social care has continued to rise; there were 253 alerts in the first quarter of 2013-2014, compared to 159 in quarter one of 2012-2013, equivalent to a 159% increase. Multiple abuse and neglect are the most prevalent types of abuse reported. The Board monitors the performance and data at every quarterly meeting in order to identify trends and patterns which can be targeted through the work of all partners.

The Safeguarding Adults Strategy Action Plan 2012-2015 is in its second year, and sets out the priorities and work areas for all partners on the Board. This is project managed by Enfield Councils Central Safeguarding Adults Service, who now meet with partners to gather evidence, feedback and support achievement of targets. Many actions have been accomplished, are on track or plans are in place to ensure achievement within timescales.

The Safeguarding Adults Strategy action plan identifies a number of actions under leadership, partnership and commissioning, including ensuring the Safeguarding Adults Board has an effective governance and work programme, and to audit the performance of the Board against good practice guidance and relevant legislation. The September Board will consider audit options, which will then be facilitated by the Central Safeguarding Adults Service by the end of the financial year.

10.2 External Audit Case Practice

The previous emphasis on process in safeguarding has been shifting radically to that of outcomes; has the interventions taken place not only contributed to someone being safe, but meeting their desired wishes. The Central Safeguarding Adults Service will be completing 20 interviews in 2013-2014 with service users as they go through the safeguarding adults' process. A questionnaire has been developed and

agreed by the HHASC Equalities Steering Group which will provide both quantitative and qualitative information on outcomes for adults at risk.

10.3 Safeguarding Information Panel (SIP)

The Safeguarding Information Panel brings together Enfield's Safeguarding Adults Team, Procurement & Contracting, Environmental Health, the Care Quality Commission, CCG Safeguarding Lead and Community Nurses team. The SIP has been running successfully for over a year as a forum for sharing intelligence on the quality of care and addressing high risk safeguarding issues within care and nursing homes in Enfield. This may result in an inspection from the Care Quality Commission being brought forward, fact-finding visits from various professionals, monitoring visits from the Procurement and Contracts Team or Environmental Health or the beginning of the Provider Concerns process (whereby an service improvement plan is put in place to drive up quality of care).

The intelligence brought to the SIP includes information from Enfield Council about the number of safeguarding adults alerts, information from health about the number of pressure ulcers, and (recently made available) information from CQC about the number of deaths within care homes. CQC also inform the Panel about Registered Managers who are leaving care or nursing homes as this is a recognised area of high risk. As of August 2013 data around Mental Health resources can now be considered and with the established process for residential provision, the SIP is moving into analysing information around Supported Tenancies and Domiciliary Care provisions.

10.4 Quality Improvement Board (QIB)

The most recent Quality Improvement Board was held on Wednesday 21st August 2013. The QIB has approved the Terms of reference for the Dignity in care panel. Once established, this will be a panel of Quality Checkers, with an independent chair, reviewing services in the Adult Social Care department to determine whether we are meeting the national Dignity in Care quality standards. The Chair of Safeguarding Adults Board has agreed to chair the panel. The QIB also considered the various work streams currently in operation to ensure good quality of care in care homes, in light of the project to establish a support network for carers of people who live in care homes. This is being developed in partnership with Enfield's Carers' Centre.

10.5 Quality Checker Volunteering Programme

Quality Checkers are volunteer service users and carers who visit our in-house and commissioned services and tell us what they think about them. The pilot for our care home visits has been completed and the findings presented to the provider forum. No care homes have opted out of the visits, so all 100+ care homes will be visited from the 1st week of September. We are working with our In-house Domiciliary care team on a pilot programme to develop our home care visits. This pilot

will help us identify and manage the key risks for this pivotal area of work. We are hoping to have visits to our contracted home care provider within the next 3 months. The programme is now running with only one support staff, which an objective of the original brief.

11. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

11.1 Implementing Joint Commissioning Strategies

Enfield CCG is working in partnership with local secondary, primary, community and intermediate service providers across health and social care, to further develop a managed, whole system, approach to **integrated care** over the next three years resulting in reshaping how services are used by older people and aims to achieve a significant reduction of non-elective activity, A&E attendances and outpatient appointments. See Appendix 1 for an updated and detailed summary.

11.2 Admission Avoidance & Early Supported Discharge

11.2.1 Network Multi- Disciplinary Team & Risk Stratification

The Risk Profiling and Care Management Scheme DES was agreed by the LMC and circulated to practices early August, to date 43 of the 53 GP Practices have signed up to the DES. All practice will be rolled out by October / early November within a phased programme with the North West practices having gone live; South West practices going live next week and the East practices scheduled to be rolled out by October early November.

The Chase Farm and North Middlesex MDT teams operate on difference days and will include mental health from September. Practices are being offered 10 minute slots per patient for discussion on the conference call and have been grouped into West and East practices to access the service on alternate months with flexibility built into the system.

The implementation of the Risk Stratification Tool has been delayed whilst IG issues are addressed, which arose as a result of the change from PCTs to CCGs. We are working collaboratively with the providers and council to secure a solution to the situation and pseudononymised patient information at source is currently being tested across all providers and Health Intelligence.

It is anticipated that the risk stratification tool will become available to GP practices shortly and will support the identification of patients for case. management and MDT teleconference. However in order for GP practices to comply with the Data Protection Act, this Autumn they must take ‘reasonable steps’ to inform patients that identifiable data will be extracted from their records and used by the NHS and private companies. Practices will be responsible for informing patients of how their data will be used, and are required to give the patient the opportunity to opt out. It is suggested that practices inform patients through posters, leaflets, notices on websites, discussion with the

practice participation group and ensure all staff know about the changes so they can inform patients and enter the correct read codes if patients object.

11.2.2 Older People's Assessment Unit (OPAU)

Both NMUH and CF have regular mobilisation meetings with the CCG and their own internal meetings up and running. Despite a slow start, the last meeting at CF was encouraging and they are now on track to start 16 September.

Agreement on the referral is being reached on type and the number of patients who can be referred from day one and how it will work internally at the OPAU. Agreement will also be needed on the types of patients GPs should be putting through and how to time the referrals.

.
The CCG has been hosting operational workshops to work through how the multiple providers will work to and operationalize the service. These will continue over the opening of the CF OPAU and the start of the NMUH OPAU to enable an opportunity to refine service delivery. In addition quarterly workshops for more senior stakeholders have been set up to March 2014.

11.2.3 Falls Prevention and Fracture Liaison Clinic

Fracture Liaison Nurse continues to work within Chase Farm to case find patients that would benefit from management.
She now has full access to the trusts PAS system which enables easier identification of the most appropriate patients to target. This has led to a reduction in the number of DEXA scans requested but the referrals are more appropriate.

Weekly clinics have been established on the St Michaels site for the Fracture Liaison Service.

The Bone Health Nurse is liaising with the CHAT team and is now targeting homes that the team are not working with; currently working with four homes.
She is also working with Community Matrons; access to GP practices is proving difficult as they are failing to engage with the service.

Using information from medicines management to target practices with high steroid prescribing and low Bisphosphorates

The Bone Health Nurse has established a working relationship with the Community Alarm Service whereby they inform her of any residents that fall for follow up.

11.2.4 Care Homes Project

The teams are now working in 16 homes care homes.

Evaluation of the project was undertaken in May this looked at all aspects of the project and included a questionnaire that was sent to both the care home staff and the care home owners. Overall the feedback from this was very positive about the contribution the team makes to the well-being of the residents in the care homes. See attached Appendix 3

Review of 12-13 data compared to 10/11 baseline demonstrates an 18% reduction in A&E attendances from the participating care homes and a 10% reduction in Emergency admissions. LAS call out is also beginning to show a downward trend.

The Tissue Viability Service continues to work in 19 homes; in quarter 1 31 new residents have been referred to the service by 7 of the participating homes; the service works to identify residents needing support with the non- referring homes. Formal training sessions are provided for the homes in addition to education in practice training which continues on each visit. A link nurse scheme is being developed in 8 homes.

Falls audit was undertaken post training in one of the homes with the highest number of falls which demonstrated a 50% reduction. See Appendix 2 Work continues with this home and further falls training is being provided to homes with high levels of fallers.

Primary care delivery in the care homes is variable with some homes supported by a single practice while others have residents registered with multiple practices. The CHAT team have found that where this is the case the team are often requested to provide primary care support. To improve Primary Care delivery to the Care homes a Local Enhanced Service (LES) specification has been developed with a view to reduce the number of GPs providing care to the homes. The LES will clearly define the expectations for primary care delivery and will enable the CHAT team to work with the more complex cases that require specialist input. In time this will allow the team to expand the service to provide cover to all older peoples care homes in the borough.

The teams have completed 143 ACP's in 2012/13 and in quarter 1 a further 13 which have resulted in 96% of people dying in preferred place of care; medication reviews more than 1200 have been carried out leading to 386 people having their medication reduced in 2012/13 and so far in quarter1 a further 102 medications stopped.

12. PUBLIC HEALTH TRANSITION

The transition of services from the NHS to local authorities has presented many challenges to the council.

12.1 Sexual Health

Due to the national arrangement for GUM, the Council has three arrangements with providers

(i) contractual with providers in NCL,
(ii) non contractual with providers outside NCL where a significant amount of activity and expenditure take place e.g. Chelsea & Westminster, and
(iii) non contractual 'spot' payment arrangement for the smaller invoices received from around the country e.g. recently received an invoice from Devon for one treatment.

LBE has entered into an agreement with North & East London Commissioning Support Unit (NEL CSU) to manage and monitor all GUM data and the non-contractual 'spot' payments to reduce the administrative burden on the council.

Two* local authorities have joined the newly formed Local Authority Sexual Health Commissioning Group - Enfield, Barnet, Haringey, Camden, Islington, Waltham Forest*, City & Hackney*. This group will meet regularly to:

1. work collectively to negotiate the best deal for GUM services for 2013/14 following the NHS transition with each member taking the lead on a provider contract.

2. work together to plan and prepare interactions with NEL CSU ensuring we all receive value for money on the 2013/14 contract.

3. work collectively re the planning of commissioning sexual health services responsive to local assessed need for 2014/15

12.2 BEH MHT Contract

The negotiations are complete and the block contract is now circulating amongst the stakeholders for signature. The services relating to Enfield Council, with an indicative value of £3.7m (therefore requiring the contract to be stamped with the Council's seal), are:

- School Nursing Services
- Family Planning
- Teenage Pregnancy
- GUM services
- Reproductive and Sexual Health [RASH] service (Shout for Young People)

13. JOINT COMMISSIONING BOARD

The last Joint Commissioning Board took place Tuesday 27th August 2013. The Board received an update on: Proposals to develop telehealth and to further develop the Councils telecare offer; NHS Social Care Grant: Current and projected spend; Blood Transfusion Partnership (proposal was supported by Board); update on integrated care; options paper to increase uptake of GSF accreditation in Care Homes (the Board rejected proposals to fund accreditation unless a more robust business case could be made however it was agreed that training should continue); Winter Capacity Commissioning Plans; Development of Mental Health Needs Assessment and Strategy; and proposal to invest one-off funds to manage the Memory Service waiting list (proposal was supported and will go to CCG F&Q Committee for approval).

The next joint Commissioning Board is set for Thursday 26th of September 2013 and an update will be provided to the next Health & Wellbeing Board

14. SERVICE AREA COMMISSIONING ACTIVITY

14.1 Older People

14.1.1 Winter Pressures Funding

Winter planning is well underway. The NHS England asked local areas to:

- Provide a validated Winter Pressure Checklist outlining the arrangements health and social care agencies have in place to manage winter demand coordinated through NHS Enfield CCG, partner agencies have now completed this Checklist, and a more detailed plan being pulled together for the same purpose locally by the CCG;

- Consider how health and social care partners might use the additional funding available from NHS England to relieve pressure on A&E and hospital admissions, with the health economies associated with Barnet & Chase Farm Hospitals NHS Trust – i.e. the Boroughs of Barnet & Enfield – identified as one of 10 London challenged health economies targeted for additional funding across relevant health and social care partners to assure A&E and hospital performance in Winter 2013/14. NHS England have provisionally allocated £5.1m against which health & social care partners, coordinated by the acute Trust and CCG, can bid to prevent hospitalisation, promote timely & safe discharge and prevent readmission in a 24/7 care economy as a matter of urgency. Draft bids are being coordinated, with the final bids agreed, together with a letter of commitment co-signed by NHS and Council providers, submitted no later than 12th Sep-13. NHS England will announce the final allocation by the end of Sep-13. NHS England have stated this is the only winter pressures monies it will make available in 2013/14.

Last winter, the Council received £882k for Social Care Winter Pressures Grant from the Department of Health via a Section 256 agreement with NHS Enfield CCG. These monies were used to support the entire health and social care economy and focussed on additional capacity for hospital social workers and intermediate care solutions. As discussed in the last update, there was good evidence of the difference the funding made last year in terms of reducing delayed transfers of care, successful enablement and admissions to residential/nursing care. No announcement has yet been received about whether this non-recurring Grant will be available in 2013/14.

Last winter, the Department of Health funded the national Warm Homes, Healthy People Programme. It allocated £148k to Enfield following the submission of the Council-led bid, which contained 16 individual proposals from statutory and voluntary sector partners, to which the Council's Directorates of Health, Housing & Adult Social Care and Children's Services added a further £77k from internal funding to make £225k available for Enfield's local Programmes.
The 16 schemes helped over 8,500 individuals across Enfield's diverse population and in deprived wards through 16 individual schemes ranging from simple information and advice about how to keep warm and healthy in winter; through to delivering food parcels to vulnerable adults and families or tackling social isolation; and delivering alterations or repairs to individuals' properties.
The Department of Health has yet to make an announcement about whether this national Programme will continue into 2013/14, and therefore there is no knowledge of potential funding. However, the Council has asked voluntary and community sector partners to consider whether and how they would like to be involved if the national Programme continued this winter, as last year the timescales between DH announcement (mid-Sep-12) and submission of Enfield's overall bid (early Oct-12) were very short, placing pressures on partners.

14.1.2 Successor to My Home Life (MHL)

Following the completion of the My Home Life (Enfield) Project in February 2013, work is progressing to ensure that the legacies of the project are sustained. Care home managers are keen about the continuation of the joint (Council, NHS and Care Home) quality focus group created as part of the programme. The sector appreciates the work of My Home Life and commented positively about it during the last providers' forum meeting in July. The sector would like the group to exist as a platform of discussing specifically the care home quality issues besides the periodic providers' forum that encompasses all providers.

A joint planning group consisting of Enfield Council, NHS and interested Care Home managers have completed drafting terms of reference for the focus group. Once the terms of reference is signed-off by appropriate bodies and provided availability of Council/NHS resources to take this forward, it is intended to utilise the group as a platform to explore and address common

issues and to feed findings/ learning into the borough's overall quality improvement framework. The implementation and effectiveness of this desire will require the support of the Council and the NHS

14.1.3 Enfield Dementia-Friendly Communities

The Council, NHS and voluntary sector partners continue to improve dementia awareness and the coordination of information, advice & support in line with Voluntary & Community Sector Strategic Framework. Partners are preparing promotional events in September and October, particularly targeted at diverse communities.

Partners formed the Enfield Dementia Action Alliance, a national approach, though Enfield is the first Borough in London to do so, with the aim of promoting the needs of those living with dementia amongst organisations – those associated with providing care, but also wider private, public and voluntary sector organisations, e.g. emergency services, schools, retailers and banks. Terms of reference and aims and outcomes were agreed. Each organisation that agrees to sign up to the Alliance will identify and publicly publish three actions they will undertake to improve their organisation's interaction with those with dementia and their carers. The Alliance will have its own public web-site, managed by the Alzheimer's Society, to track individual organisations' progress in completing these actions. The Alliance's launch is on 6th September 2013.

As detailed in recent updates to the Board, a bid was submitted for £660,000 against the European PROGRESS social fund to support people with dementia in Feb-13. Unfortunately, this bid was unsuccessful and partners in the Enfield Dementia Action Alliance are exploring alternatives.

14.1.4 Social Isolation Bid

The Big Lottery Fund announced a new programme, Fulfilling Lives: Ageing Better, which aimed to reduce isolation, improve older people's ability to deal with change, and give them greater power to make choices. They have agreed to commit up to £70 million to 15-20 local areas in England, supporting holistic and creative approaches to tackling social isolation amongst the older population. The Borough was one of 32 local areas to be accepted onto the next phase of bidding following its successful Expression of Interest in Jul-13, with the BLF organising a Partnership Planning Day on the 9th September. The next phase of the process is a full project partnership approach through a lead VCS organisation by April 2014. Thereafter 15 – 20 areas will be selected for funding. The ambition of an Inclusion Programme with a strong focus on empowering older people to design, manage and sustain solutions tailored to them.

14.2 Mental Health

14.2.1 Independent Mental Health Advocacy (IMHA)

Enfield Council has approved the proposal to jointly tender (with Barnet and Haringey) a consolidated Independent Mental Health Advocacy (IMHA),

Independent Mental Capacity Advocacy (IMCA) and Deprivation of Liberty Safeguards (DoLS). A tender timetable has been drawn up with prequalification questionnaire to be issued in September 2013. Enfield will be leading on the joint procurement. It is envisaged that the new joint contract will be in place from April 2014. The Health and Wellbeing Board will be updated on progress at its subsequent meeting.

14.2.2 Joint Mental Health Commissioning Manager

Both the Council and the CCG successfully recruited on an interim basis to the Joint Mental Health Commissioning Manager posts in June 2013. The strategic lead sits with the Council and therefore the commissioner is based with the Council leading on the development of the Joint Adult Mental Health Strategy. The process of recruiting substantively to the role in the Council is underway with a view to recruiting by January 2014.

14.2.3 Joint Mental Health Strategy

The first draft of the Joint Adult Mental Health Strategy has been considered by the Joint Commissioning Board. A consultation document will be produced for consultation for 12 weeks from 19 September 2013 (ending 10 December 2013). The consultation will be either undertaken jointly or aligned to the consultation on the Enfield Health and Wellbeing Strategy. The final strategy document will be considered by the Joint Commissioning Board on 19 December 2013 and will be submitted to the Cabinet for either its February or March 2014 meeting.

The strategy reflects the priority given by The Council and Enfield CC to adult mental health services. It is a joint framework that identifies and addresses gaps in mental health and wellbeing of the population of Enfield and the support and services needed to meet the health and social care needs of people recovering from mental health problems effectively. It will identify the joint priorities and commissioning intentions of The Council and Enfield CCG for mental health services in Enfield. It integrates key Council drivers and priorities, including the priority already being given to improving access to settled accommodation and employment and to address inequalities / problems. In relation to health funded services, the strategy is guided by the principles and priorities set out in the draft Barnet, Enfield and Haringey Mental Health Commissioning Strategy developed by Enfield CCG such as developing support by GPs and in primary care and community settings for adults with mental health problems and increasing access to psychological therapies in both primary and secondary care or adults with depression and/or anxiety, older people and people with long term physical health conditions.

14.3 Learning Disabilities

14.3.1 Learning Disabilities Self-Assessment Framework (SAF)

The Learning Disabilities Self-Assessment for 2012-13 is different from previous years. Instead of focussing purely on Health, it is reflective of the national drive to improve better working between Health and Care, and is a joint self-assessment framework. This year the themes are; Staying healthy, Being Safe and Living Well and is aligned to the following key policy and frameworks: -

- Winterbourne View Final Report
- Adult Social Care Outcomes Framework 2013-14
- Public Health Outcomes Framework 2013-2016
- The Health Equalities Framework (HEF) An outcomes framework based on the determinants of health inequalities
- National Health Service Outcomes Framework 2013-14
- 6 Lives Report

Work is underway to start collecting information from the different service areas across Health and Adult Social Care who contribute to providing evidence for the Learning Disabilities Self-Assessment Framework. The deadline for submission is the beginning of November2013.

14.3.2 Winterbourne View Concordat

NHS Enfield Clinical Commissioning Group (CCG) and the council have developed a joint action plan in response to the Winterbourne View concordat. 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. Where people are considered as inappropriately placed there is emphasis on considering community based services that are close to home. Enfield completed reviews by the June 2013 deadline and are currently on track in terms of meeting the conditions of the concordat action plan. Patient choice and parent / carer involvement continues to be the focal point of implementation of the concordat action plan. Commissioners continue to review the assessment & treatment pathway for people with learning disabilities with a view to reducing admissions to this type of service and are monitoring discharge to ensure that stays are not disproportionately long. The benefits of community intervention models continue to be explored.

14.3.3 Autism Strategy development and Autism Self-Assessment Framework

The draft joint commissioning strategy for adults with autism, which is aligned to the national strategy Rewarding and fulfilling lives (2009), was launched for public consultation in May 2013. The consultation period ended on the 19th of August 2013. The feedback is currently being analysed and a summary of findings will be included in the final version of the strategy. We are hoping to launch the strategy in

December of this year. The joint strategy and implementation plan seeks to promote awareness of autism and improve access to advice, guidance and support for adults with autism and their parent carers living in Enfield.

The Autism Self-Assessment Framework is currently being completed by relevant stakeholders of services. Enfield's response will be submitted to the National Improving Health and Lives (IHal) website by the end of September 2013.

14.4 Carers

14.4.1 Enfield Carers Centre

The building renovation has now been completed and has created more confidential working space and improved accommodation for the new staff members. This is a real improvement to the Centre and also gives the Centre the possibility of further income through room hire.

Enfield Carers Centre now has the following posts in place: GP Liaison Project Manager, Advocacy Worker and a Young Carers Worker. These posts have made an immediate impact and the Centre is now recruiting for a Hospital Liaison Worker and the Carers Nurse, both of which will be managed by the GP Liaison Project Manager.

The Advocacy Worker has been taking up cases and has also been promoting the services within the VCS and with practitioners. Leaflets have been circulated to increase knowledge of the service.

The Young Carers Worker has now identified four schools to work intensively with to develop services and support for young carers – Suffolk Primary, George Spicer primary, Edmonton County Secondary and Oasis Hadley Secondary school.

The Worker and a former Young Carer have delivered one assembly at Suffolk Primary School which led to four children identifying themselves as a young carer.

In additional a summer activity of a Graffiti Workshop for young carers took place in August with 7 young carers attending.

The Centre has also launched a new respite breaks calendar, ranging from short break holidays to meals at local restaurants. A copy of the programme can be requested from the Centre.

14.4.2 Carers Direct Payment Scheme

We now have 88 carers receiving a Direct Payment through Enfield Carers Centre with another 12 awaiting approval. A review of the scheme so far will be completed by October.

14.4.3 Carers Week

Carers Week was successful although some activities were poorly attended, such as the Question and Answer session on the Monday evening and the Carers Information Forum on the Wednesday. However the Monday event identified two new carers who were not know to services previously and whilst only 20 carers attended the information forum, we had a further 40 members of staff from the Council, Health and the VCS attend, either as visitors or stall holders. The overwhelming feedback from the professionals is that it was very helpful to be able to learn about different services available.

The Carers Centre open day was well attended by both carers and professionals, with the Mayor giving a speech recognising the importance of carers.

14.4.4 Primary Care Strategy

The GP Liaison Project Manager (funded from ECCG's primary care strategy programme) began in June and has visited all the GP practices in the North West cluster. They have been successful in raising awareness of carers issues with practice staff, providing literature and posters and one practice, Woodberry Practice in Winchmore Hill, has now agreed to host the Carers Nurse and provide clinical supervision allowing recruitment to begin. Leaflets and posters for the service have been created and distributed.

14.4.5 The Employee Carers' Support Scheme

The official launch took place on Tuesday 11th June, during Carers Week, and James Rolfe attended as the Council's Equality Champion ands poke about how carers fit into the equalities agenda. Human Resources also attended and discussion was focused around the need for a Carers Policy, training for line managers and paid carers leave.

14.4.6 Relatives Support Network

Work has begun under the Quality Improvement Board to develop a Relatives Support Network – a network that will provide information and support for carers whose cared for is in residential care. This work will include the Quality Checkers including Relatives Group in their initial visit and visiting established groups to look at how they support the quality of care. The work will also work with homes to create Relatives Groups and to ensure these carers have access to information and advice. A support group will also be established at Enfield Carers Centre.

14.4.7 Carers Strategy Implementation

As reported in the section above the governance structure for the implementation of the Carers Strategy has been approved.

The first Carers Practitioners Working Group meeting has taken place with representatives from all the Social Work teams to look at practice and procedures that affect carers. The focus for further work of the group is to review and update the Carers Assessment form and the paperwork for a Carers Party to Event assessment, improved and increased communication on carers' issues and training for practitioners.

The BEH Mental Health Carers Project Group met in July to provide joint feedback to the Trust's Carers Experience Strategy. The group has offered expertise and support to develop the strategy further. Training for MH practitioners is currently being discussed and is looking to be delivered in late autumn.

The Parent and Young Carers Group is due to have their first meeting in October.

The Carers Strategy Implementation Group initial meeting had to be postponed due to poor attendance and has been rescheduled for the second week of September.

14.5 Children's Services

14.5.1 Family Nurse Partnership (FNP)

Good progress is being made on implementation of the Family Nurse Partnership – an evidenced based, preventative programme offered to vulnerable young mothers having their first baby with the aim to:

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

The team has now been fully appointed and are gradually coming into post during September 2013 prior to attending the national training course in October and formal start of the project on November 1st 2013. **A launch event is being held on Thursday 10th October, 3.30pm – 5.30pm at the Dugdale Centre in Enfield Town, and members are invited to attend.**

14.5.2 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 (CQRG) and Contract Review meetings. Good progress is being made and the business case is being considered by the CCG's Finance Recovery and QIPP Board on the 4th September 2013.

14.5.3 Paediatric Integrated Care

The need for a paediatric integrated care work-stream to support implementation of the Barnet, Enfield and Haringey Clinical Strategy has been identified. The proposed work programme has a number of elements:

- to support the development of the Urgent Care Centre and the Paediatric Assessment Unit on the Chase Farm Hospital Site;
- to improve collaboration across primary, community and secondary care;
- to increase the knowledge and confidence of GPs and other primary care professionals in working with children who are ill;
- to develop and implement protocols and/or care pathways for common childhood illnesses and long term conditions;
- to develop care closer to home, and reduce A&E and Outpatient attendances and unnecessary admissions to hospital.

Initial focus has been on the development of a specification for the PAU and the implementation of primary care paediatric pilots in two GP network localities. Through the primary care paediatric pilots, all non-urgent paediatric outpatient referrals will be triaged by the Enfield Referral Service against agreed care pathways/eligibility criteria. Inappropriate referrals will be sent back to GPs with a case management plan, and appropriate referrals sent either to a consultant paediatrician working in a primary care setting or to secondary care. As part of the pilot, agreed protocols and/or care pathways for common childhood conditions will be disseminated to each practice and reinforced through established education forums and practice meetings, and arrangements agreed with both Trusts to establish single points of contact to improve collaboration. Other opportunities for training and support will be explored including debriefing sessions following the primary care clinics. The next phase of the project will look at the potential to reduce A&E attendances and integrated care pathways for long term conditions, starting with asthma.

Capacity issues have caused some delays in implementation, but Barnet and Chase Farm Hospital commenced a pilot in the North East Locality on the 8th April 2013 and feedback is promising. The North Middlesex Hospital have still to start and this is being actively pursued.

The CCG has commissioned an organisation called Matrix to carry out some economic and financial modelling, to support the development of the integrated care model which will include options around ‘gain sharing’ across organisations. **A workshop is being planned for the afternoon of 31st October 2013 and Board members are invited to attend**. Clinicians and managers from BCF, NMUH, ECS and the CCG, and a representative from the Council are on the working group supporting the development of the new model.

14.5.4 Identification and Referral to Improve Safety (IRIS)

IRIS is a general practice based domestic violence training, support and referral programme for primary care staff that has been launched in Enfield. A national pilot in Bristol and Hackney GP practices demonstrated the effectiveness of the IRIS model. It is a targeted intervention for female patients 16 years and over who are experiencing domestic violence from a current or ex-partner or from an adult family member. IRIS provides care pathways for all patients living with abuse as well as information and signposting for male victims and for perpetrators.

The model is based on one full time advocate educator, who is a specialist domestic violence worker, based in a local domestic violence service and working with 25 practices. The team has been recruited and trained and is ready to start work

14.5.5 Section 75 – Services for Children

Following review, the Section 75 for Children's Services has now been updated by the Interim Head of Commissioning in partnership with Legal Services. The Agreement now sits with Health services for update and agreement, prior to sign off.

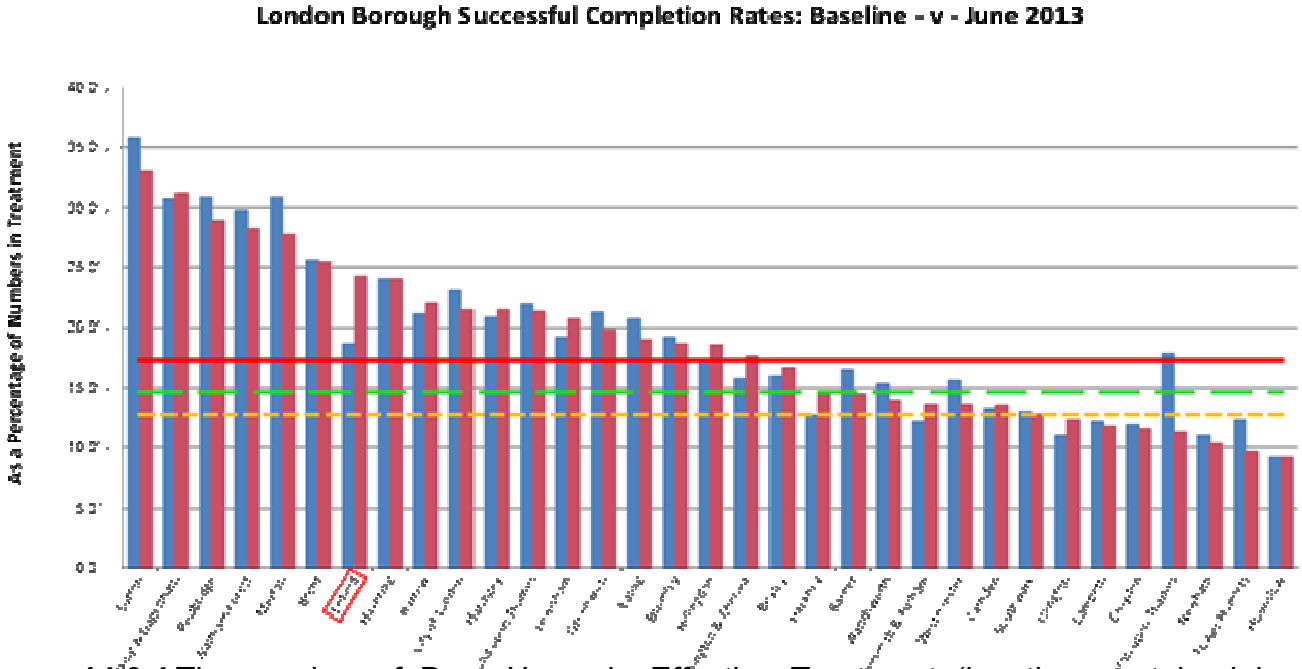
14.6 Drug and Alcohol Action Team (DAAT)

14.6.1 Performance for Successful Treatment Completions has continued on the upward trend with the latest Public Health England data release confirming that the DAAT has achieved a 24.2% rate for the period July 2012 to June 2013. This is 6.9% above the London average, 9.6% above the National average and 11.4% above the PbR Pilot average.

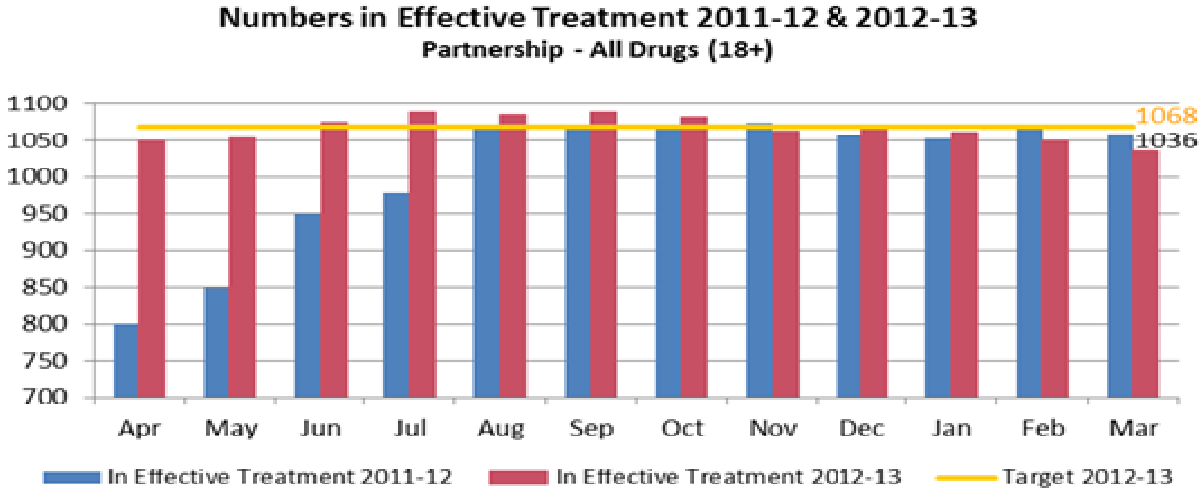
14.6.2 Enfield DAAT Successful Completions

	Apr 2012 to Mar 2013	May 2012 to Apr 2013	Jun 2012 to May 2013	Jul 2012 to Jun 2013
Partnership				
Number of Successful Completions	205	217	240	266
Numbers in treatment	1094	1095	1093	1098
% Successful Completions	**18.7%**	**19.8%**	**22.0%**	**24.2%**
% London Average	**17.6%**	**17.5%**	**17.5%**	**17.3%**
% National Average	**14.9%**	**14.8%**	**14.7%**	**14.6%**
% PbR Pilot Averages	**12.3%**	**12.4%**	**12.6%**	**12.8%**

14.6.3 The graph below shows that Enfield DAAT is now ranked 7th in London for successful treatment completions; a 4 place improvement over previous reports.



14.6.4 The number of Drug Users in Effective Treatment (i.e. those retained in treatment for 12 weeks or more or discharged drug free within 12 weeks) is still below the trajectory target of 1068 by 32 patients. This remains addressed and the operational changes implemented by the providers will start to show a positive change in performance against this measure within the forthcoming 5 month period.



14.6.5 The number of young people receiving substance misuse treatment has also continued on an upward trend with the latest Public Health England data confirming that 172 young people received structured drug or alcohol treatment during the 12 month rolling period July 2012 to June 2013; 32% higher than was achieved for the same 12 month rolling period in 2011/2012.

14.6.6 The DAAT has three contracts that need to be re-tendered during the year as they are unable to be extended without placing risk to the Council. These are the Adult Substance Misuse Recovery Service contract, the Young People's Substance Misuse Service contract, and the Crime Reduction Substance Misuse Recovery Service contract. The three Business Cases were presented to the Strategic Procurement Board in July and approved on the 7th August 2013. This was following a highly successful market engagement event at the Dugdale Centre on the 29th July where 53 people attended, representing 35 interested suppliers. The PQQ stage of the tender commenced on the 14th August and the new contracts will formally be implemented on the 1st July 2014. The DAAT is mindful of mitigating for risks in performance in the event that the incumbent suppliers change and it will ensure these risks are managed to best effect.

14.6.7 The DAAT Board is currently producing a new drug and alcohol strategy and a partnership away day is being convened for the 11th November 2013. This will ensure that the community are fully involved in highlighting the local priorities they want included, as well as identifying which elements of the National Drugs Strategy 2010 and National Alcohol Strategy 2012 need incorporating. It is proposed that this community based strategic development approach will be most effective with supporting the partnership achieve its vision of '*Making Enfield a Safer, Healthier and More Prosperous Community by Reducing Harmful Drinking and Illicit Drug Use'.*

14.7 Joint Commissioning team

The current Deputy Joint Chief Commissioning Officer is returning to New Zealand to take up a national role with the NZ Health Ministry. We are reviewing the current structure and how it might be better integrated with the Procurement and Contracting functions of the department

A further update on the management of the Joint Commissioning Programme will be provided at the next Health & Wellbeing Board

15. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

15.1 Learning Difficulties Partnership Board (LDPB)

Consideration is being given to the development of a local LD Parliament. One-2-one (local Community Advocacy Group) is currently working with the LD commissioning Manager to explore options.

There are two Acute Liaison Nurse Posts working with Enfield residents with learning disabilities using acute hospital services.

People with learning disabilities experience huge health inequalities and higher mortality rates. There are a number of reports (Mencap: Death by Indifference, 74 Lives and Counting, Sir Jonathan Michaels:

Healthcare for All) which highlight the greater risk to people with learning disabilities of early mortality through poor access to health care or from inadequate healthcare provision from primary and acute services. Acute Liaison Nurses play a key role in response to the recommendations set out in these reports. ALNs also play a key role in ensuring the safety of people with learning disabilities whilst in hospital, a key priority given the recent events at Winterbourne View.

One post if funded by Barnet CCG and covers Enfield and Barnet residents using the Barnet & Chase Farm Hospital Trust. The second post covers Enfield and Barnet residents using the North Middlesex and Royal Free Hospital Trust. This post was previously funded by Enfield Council and Enfield PCT from LDDF grant monies and latterly by Enfield Council from the NHS Social Care Grant funding. This funding was agreed for one year in order to identify further funding to continue this important work. This funding ceases at the end of August.

A number possible of options have been identified:

- For the current arrangement between LBE & Barnet CCG to continue and for LBE to identify alternative sources of funding.
- For the project to be funded by Barnet and Enfield CCGs.
- For Barnet &Chase Farm and the Royal Free and North Middlesex Hospital Trusts to pick up responsibility for the funding and management of the post within their setting.
- For the project to cease.

In addition to the cessation of the North Middlesex post in August, the post holder working at the Barnet and Chase Farm Hospital Trust has been offered a promotion at another hospital trust and has handed in her notice. This means that there is no acute liaison nurse function for Enfield residents in either of the local acute hospital trusts.

The Head of Integrated Learning Disability Service met with the previous Director of Nursing at the North Middlesex and the Director of Nursing at the Royal Free Hospital Trust to discuss them picking up responsibility for this post. The Royal Free have agreed and will be recruiting to a LD Nurse Liaison post which is positive although will have little impact on Enfield residents. North Mid had agreed to recruit to a part time post, which they later changed to a Safeguarding Nurse post with some responsibility for LD. This was far from ideal but at least maintained some of the nurse liaison function.

North Mid original plans appeared to have stalled with the change of Director of Nursing and CEO. The Head of the Integrated Learning Disabilities Service has been in contact with the new Director of Nursing to arrange a meeting to establish what their plans are but this has not been possible. Further attempts will be made to progress this.

In addition the CCG has recently set up a steering group for learning disabilities and this matter has now been discussed in this forum. Dr Ujal Sarkal, CCG lead for learning disabilities has asked that the QUIPP project manager and the LD Joint Commissioner consider the possibility of whether the CCG can take responsibility for this post.

The Head of Integrated Learning Disabilities Service has had discussions with Barnet CCG and has asked to be kept informed of their discussions with Barnet & Chase Hospital Trust as to progress on replacing the ALN based in BCF. They have indicated they hope to continue with this post and are in discussion with BCF about this. They have agreed to keep us informed.

15.2 Carers Partnership Board

Christie Michael, the Carer Co-Chair, attended her first meeting in her new role. Christie has many years' experience caring for her mother and balancing her education, employment and own medical conditions. Training has been offered to ensure she feels confident in her new role.

The Partnership Board has officially ratified the structure and membership on the Carers Strategy Implementation Group and its sub groups.

Further work and discussion has taken place within the Board for the training needs of the Carer representatives and how they wish to see the Board operate. The Board is keen to take a greater role in steering and monitoring carers' services and an away day is planned for early 2014 to focus on this role.

15.3 Mental Health Partnership Board

(Taken from Minutes of 18 June)

Kate Charles advised the Board of the plans to develop local Enfield Mental Health strategy and introduced the interim MH commissioning manager.

Solutions for Public Health has been commissioned by LBE to undertake a health needs assessment of mental health for the borough.

The Board noted the common themes that were highlighted at the Away-day:

- Healthy lifestyles
- Keeping safe
- Economic wellbeing
- Service-user involvement

The Board was asked to work on the templates to scope the actions currently covered in each of their organisations in order to inform the areas where the Partnership Board can collaborate through workstreams

Note: Key issues regarding health needs and views on current service provision project (ended July) will be reported in the next H&W report.

15.4 Older People Partnership Board

The last Older People Partnership Board took place on 7th August 2013. The Board received several papers and updates, including about some of the issues highlighted in this report: in particular, feedback about the success of the multi-agency dementia awareness-raising, development of the Enfield Dementia Action Alliance, Assistive Technology and integrated care. The Board received a paper about the Developing Vacant Property Options for People Living in Residential Care, which included a discussion about setting up a scheme whereby individuals in residential care can lease their properties if they wish to the Council for a time-limited period (up to 5 years) to generate revenue with which to pay for their care. The report was well received, but members asked for further details before committing to help shape the scheme

15.5 Physical Disabilities Partnership Board

Not available

Appendix 1

Implementing Joint Commissioning Strategies [ref 11.1]
The managed, whole system approach is building on what is currently working effectively in Enfield and to identify the areas which require a level of change and / or investment in order to optimise their contribution to a reduction in

unscheduled care and reduced length of inpatient hospital stay where clinically appropriate.

There are three key aspects that have developed in Enfield:

- **Admissions Avoidance**: the development of a consultant geriatrician led MDT which is based within the A&E department at Chase Farm Hospital (until it becomes a standalone UCC) and NMUH with the aim of managing appropriate patients to avoid admissions. This will be achieved through rapidly seeing and treating the patient within the four hour waiting target and linking effectively with community services and with GP led primary care. The service will be commissioned to rapidly respond and take on the ongoing care of appropriate patients with the continued support of a consultant geriatrician. This is the embryonic OPAU which is further developed in this specification.

- **Early Supported Discharge**: the development of a MDT who will work within BCF and NMUH to swiftly identify patients who with the right support or care package in place could be discharged back to their own home or stepped down to be managed in intermediate care beds.

- **Case Management**: the development of a MDT case management team who will take responsibility for patients who either avoid an acute admission (i.e. from the admissions avoidance service in A&E or the proposed OPAU subject to this specification) or are subject to early supported discharge as set out in items one and two above. The team will continue to oversee the care of this cohort of patients and ensure that additional support is provided as and when is required to avoid further admissions where possible. This will extend in a phased manner to act as the underpinning mechanism for all integrated care for Enfield. This will mean for example acting as the vehicle to work with primary care to result in the development of risk stratification and resulting cohort risk registers. It is envisaged that over time this team will be able to take direct GP referrals thus negating the need for patients to be sent to A&E at the acute providers. It remains subject to discussion with local authority colleagues but ideally this team would represent both health and social care, and be in a position to work effectively across and with both agencies to maximise the effectiveness of all available resources including intermediate care beds currently based at Magnolia Ward, as well as preventative respite, enhanced domiciliary care and enablement.

It is envisaged that over the course of the next one to two years that a Case Management MDT Service as articulated above will serve as the vehicle for building enduring and co-ordinating links through a case finding, case management and care coordination approach that reflects the elements identified in the model of integrated care and as such the model will deliver more care closer to home.

A joint proposal has been developed setting out the high level vision for the use of **Assistive Technology** in Enfield to form "*personalised technologically-enabled solutions to promote residents' safety, health and independence as*

part of a coordinated care- and housing-related response to need." This vision will be realised by working together to deliver 3 different AT solutions to meet the 3 customer groups.

Enfield Safe & Connected will meet the needs of the general population to provide reassurance about their safety and well-being by offering:

- A reactive, 24/7 response to an alarm/sensor being triggered, either by contacting a named individual or as part of a mobile response (as agreed with the customer). If the latter is required, staff will be appropriately trained in first-aid, e.g. in falls management or basic triage, and will work with the London Ambulance Service. The Service, as it does now, will also act as a contact point for safeguarding alerts and for activation of carers' solution as part of the Carers' Card scheme;
- A pro-active "keep-in-touch" offer in which the technology would be used to contact – particularly very elderly - customers who may feel isolated and need reassurance. The Service will work with the voluntary sector as the "first contact" in developing befriending or self-sustaining day opportunity schemes to tackle social isolation.

This Service will help identify when customers' needs are changing at an early stage as part of a preventative agenda.

The **Telecare Service** will provide Assistive Technology to those with care needs in collaboration with HHASC and other care organisations (including in integrated care, e.g. GP-led case conferences), as part of the "tool-kit" available to professionals. Its customers will use Assistive Technology to help them live independently. In doing so, they are less likely to need as intensive care packages as early, providing HHASC, NHS and other organisation savings - if the right devices are tailored to meet specific individuals' needs. Knowledgeable and well-trained staff will help customers decide on the right devices for them and will actively market Tele-care. The technology will act as an enabler for service developments, e.g. in Intermediate Care.

Tele-Health pilots will develop collaboratively with health professionals to target patients whose vital signs and symptoms Assistive Technology will manage remotely. Research suggests Tele-Health is most effective if used with well-briefed patients with specific long-term conditions, most notably those with diabetes or respiratory conditions.

LBE will work with the CCG to pilot the use of 50 such devices provided to appropriate patients to evaluate the impact of Assistive Technology. Tele-Health devices improve patients' self-management and help maintain individuals' health and well-being and can provide help before a crisis. Studies suggest they can reduce the resulting use of health resources, e.g. reducing professionals' call-outs or A&E attendances.

Stroke

Community Stroke Rehabilitation and Early Supported Discharge

The community stroke rehabilitation 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.

In quarter 1 (Apr-Jun) of 2013/14 the team supported 74 new referrals for standard rehabilitation, 29% of patients fully achieved their goals at six weeks while 74% of patients who were kept longer than 6 weeks fully achieved their goals at discharge. 13 referrals to the ESD direct from the HASU, 34% of patients fully achieved their goals at six weeks while 37% of patients who were kept longer than 6 weeks fully achieved their goals at discharge

Community Rehabilitation / Early Supported Discharge team regularly monitoring referrals from the HASUs to ensure patients are accessing the appropriate pathway. Any concerns are discussed between the two organisations.

Stroke Navigator

In quarter 1 (Apr-Jun) of 2013/14 the navigator received 17 new referrals 9 (53%) were from the acute stroke unit, HASU and the community rehabilitation team, 8 (47%) were from family/Self-referrals and the voluntary sectors.

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. Discharge home experience review: In quarter 1 (Apr-Jun) 2012/13 86 (100%) stroke patients were offered the 10 day discharge questionnaire and 45 (52%) completed the questionnaire and 41 (48%) letters were sent to patients who were unable to be contacted. 91% rated their overall discharge home 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 also 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 quarter 1 (Apr-Jun) 2012/13 the navigator provided six weeks review to 3 patients.

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 1 (Apr-Jun) 2013/14 the life role facilitator received 3 referrals, of the 3 referrals 1 client took up volunteering role.

The life role facilitator undertakes review at six months post stroke. In quarter 1 (Apr-Jun) 2013/14 45 (100%) of stroke patients were offered the six months review, 23 (51%) of those offered the review received it, 13 (29%) did not respond to offer and 4 (9%) refused the offer. Of the 23 stroke survivors who

received the six months review 2 (9%) returned back to work and 2 (9%) took up volunteering roles.

Social Support

The service provides community based social support network for stroke survivors, including awareness and secondary prevention. In quarter 1 of 2013/14 17 referrals were made to the team

Outcome achieved – Stroke survivors

- 12 stroke survivors took part in the Stroke Ambassador development course
- 5 stroke survivors went back to driving

The carer forum which was set up by the social support team is working very closely with the Southgate Beaumont residential home, the forum is held quarterly.

Outcome achieved - Carers

- Stroke Centre offers respite to carers e.g. time out from caring
- Carers able to return back to work – x2, volunteering – x6 and training – x

Psychological support for stroke survivors and family members

The IAPT team together with the stroke navigator organised a workshop for stroke survivors in June 2013. The main aim of the workshop was to provide information about IAPT services and reduce stigma around the labels of depression and anxiety to enable individuals to consider more openly how the IAPT service could benefit them. 12 stroke survivors attended the workshop; a Cognitive Behavioural Therapist, Psychological Wellbeing Practitioner and the Stroke Navigator were also present.

The outstanding actions on the implementation plan of the strategy relate to developments in primary care; this will be the focus of work for the remainder of 2013/14. A GP lead is being sort to support this work from a clinical perspective. The implementation will be taken to the GP Network leads and shared and their view sort as to how this work can be best taken forward.

Dementia

The Dementia Strategy did not have any funding attached to its implementation changes to services have to be funded by releasing efficiencies in the pathway and service redesign. Planned changes to the Continuing Healthcare Beds should release funding to enable recurrent investment in 14/15 in the reconfiguration of the **Memory Service.** However, with increasing awareness of Dementia the waiting times continue to grow. The CCG acknowledged this as an issue and has proposed a one off investment to manage the waits down to an acceptable level.
Week long **Dementia Roadshows** were held in May at two locations in the borough, Enfield Precinct and Edmonton Green Mall, to raise awareness of Dementia and promote early diagnosis. People were encouraged to leave

their contact details if they wanted further information 20 forms were completed and distributed to the appropriate organisation to respond.
A range of public, private and voluntary sector organisations in Enfield have come together to promote awareness about dementia and to make sure people's experience and quality of life improves, not just in the social and health care and support provided, but also in living in the wider community. To do so, these organisations have formed the **Enfield Dementia Action Alliance** (an independent consortium of organisations chaired by the National Alzheimer's Society), modelled on a national initiative.
The Dementia Steering Group is developing a **GP training programme** to promote and improve the diagnosis and management of people with Dementia in primary care. The programme will be based on a the training developed UCL Partners and will be delivered by a Consultant Geriatrician from NMUH and Consultant Psychiatrist from BEH –MHT in the autumn.
The Clinical Psychologist continues to work with care home; staff showing improved understanding of Dementia, Depression and Challenging Behaviour and increased confidence in managing residents. In 2012/13 training was undertaken with 211 care home staff; in Quarter 1 2013/14 training has been completed by 118. This is likely to lead to more residents having symptoms recognised requiring assessment for formal diagnosis and commencement of treatment by a Consultant Psychiatrist.
Both **Acute trusts** have established Dementia Steering Groups working to improve the care of dementia patients in a hospital setting. The Steering Groups on both sites have developed Dementia Strategies to ensure that work continues to be taken forward in a focussed way.

End of Life Care
Gold Standard Framework (GSF) we are currently working with 46 Care homes and 15 Domiciliary care agencies; Bi monthly meetings have been set up with a palliative care link worker to support those that have completed the training to make sure that it is embedded.
Audits and data are being collected from the 13 Nursing homes.
Data collected also shows that :-

- Recording of bereavement support and follow up remains unchanged
- Decrease in the recording of family involvement in discussions
- Decrease in the prescribing of anticipatory drugs
-

A Survey Monkey has been set up and will run for two weeks, from 7th – 21st August 2013, to audit the use of **end of life care registers** and the associated multi disciplinary meetings. The results from this will form a baseline and shape future work with primary care. This piece of work will be championed by the clinical lead for EoLC, Dr Manish Kumar.

The Palliative Care Support Service has supported 38 people at home in quarter 1; 30 for end of life care and 8 for crisis intervention with 100% of people dying in their preferred place. An evaluation of this service is underway and the outcome will be reported to the next Older Peoples Board.

The **Multi Disciplinary Team** continue to work with 15 care homes to ensure that where appropriate advanced care plans and DNARs are put in place. This has led to 96% of residents dying in their preferred place.
The group wish to develop a **Bereavement Guide**; the current booklet is very post bereavement focussed and the group would like to see a more general guide covering both planning for and post bereavement. Examples of existing guides from partner organisations will be used to guide development. It is planned to have a new guide signed off ready to be launched at the awareness event planned for September /October 2013.

Gentle Dusk ran a project to provide training to volunteers from within existing community organisations with a particular focus on the over 55s age group and carers. The volunteers are given the knowledge, skills and tools to become Peer Educators in End of Life Care Planning so they can cascade information to members of their local communities. Unfortunately during the life of the project Enfield only managed to recruit 2 volunteers for training. The project has now finished but the Peer Educators remain in place and are linked in to a Network for support.
Planning for awareness raising event continues. EOLC will form part of a wider event covering 4/5 themes; this will take place in September /October.

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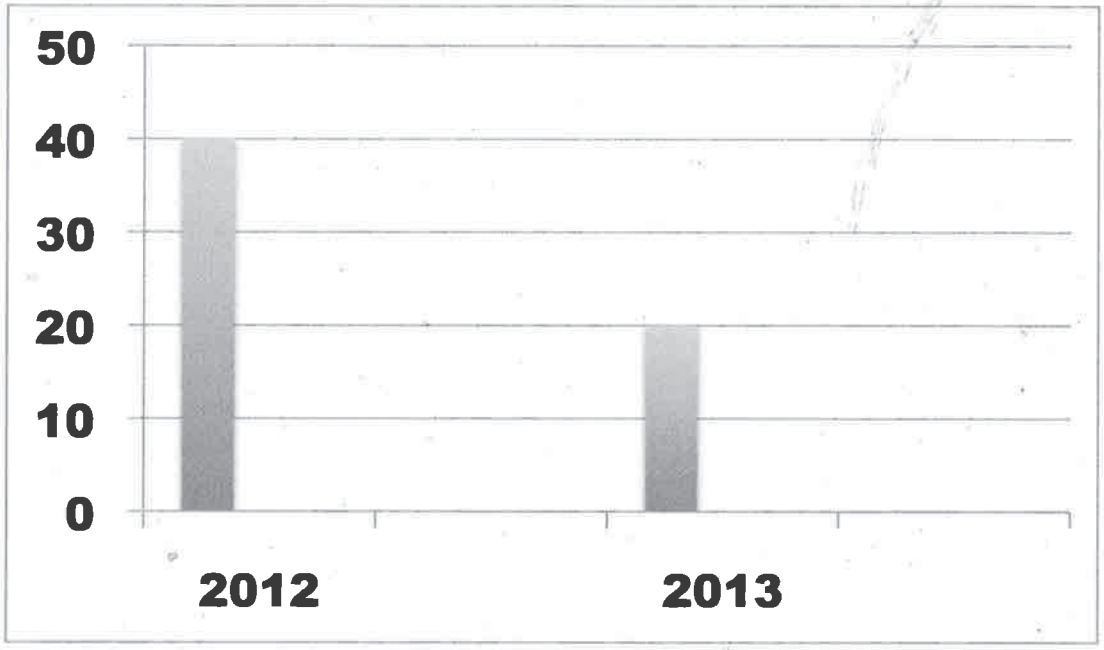
REDUCTION IN NUMBER OF FALLERS IN SPRINGVIEW RH (8 WEEK PERIOD)



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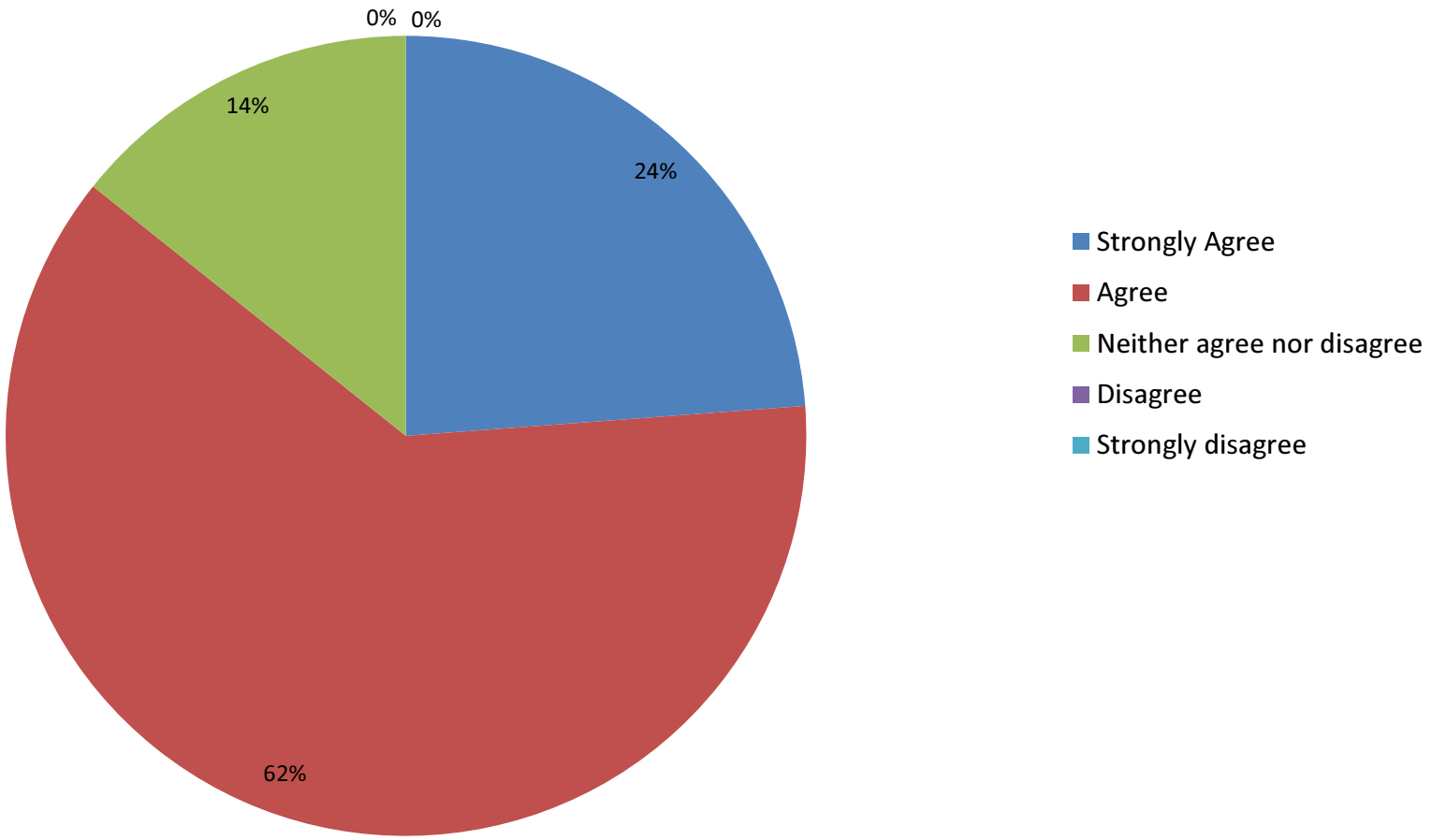
Q6 - When a resident is nearing end of life we use the end of life care plan to determine how the resident should be cared for



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Health and Wellbeing Board

19 September 2013

Agenda – Part: 1	Item: 7.3
Subject: Primary Care Strategy for Enfield	
Wards: All	

REPORT OF:

Contact officer and telephone number:

Gail.hawksworth@enfieldccg.nhs.uk

EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board on work to date to implement the primary care strategy across the borough of Enfield. There are some 15 approved schemes with the budget allocation of £3.4 million.

The project team will report jointly to the CCG and the Health and Wellbeing Board.

Key Deliverables:

1. 27,000 additional practice appointment slots delivered via telephone consultation, face-to-face at practice or home visit for participating practices covering 82% of the population
2. The Minor Ailment Scheme provides 500 patient contacts per month. The Minor Ailment Scheme (MAS) commenced on the 18th February 2013, between February and July 2013, a total of 3159 face to face consultations have been provided. Since July the scheme has introduced a number of patient satisfaction/experience questions into the consultation process. Patient satisfaction data recorded in July reports that out of the 585 patients consulted, 95% of patients were seen (face-to-face consultations) within a 10 minute waiting period, 97% of patients would use the service again and 97% of service users would recommend this service to a friend or family member.
3. From 18 – 30 August, up to 30 overweight and obese children from Enfield were funded to attend a residential summer camp. The children and their families are being offered post-camp support through to November 2013.

RECOMMENDATIONS

The Enfield Health and Wellbeing Board are asked to note the report.

NHS Enfield Primary Care Strategy
August 2013 Update

1. Introduction

This paper updates the Health and Wellbeing Board on work to date to implement the primary care strategy across the borough of Enfield.

2. Update on the Primary Care Strategy

There are a number of schemes and enabling workstreams that continue to be monitored through the Primary Care Strategy Implementation Board that is chaired by the Medical Director of Enfield Clinical Commissioning Group (CCG). These schemes include:-

2.1. Access

2.1.1. Enhanced Access Scheme

38 practices have signed up to the Access LES, which has created approximately 3,400 additional GP slots per month (in excess of 40,000 additional appointments for the year of the scheme). The slots are either telephone triage/consultation or face to face consultations. 22 practices have completed the exercise and received a practice visit from the Primary Care Foundation (PCF) and the CCG access lead to discuss the report. 5 practices have submitted their data and are awaiting the practice visit, 6 practices are currently collecting their data. 5 practices have not registered with the PCF and the CCG is in contact with these practices to support them to engage in the process. The scheme covers 82% of the population in Enfield.

A total of 110 GPs have attended Telephone Triage Training and 152 Reception staff have attended training on enhancing communication skills provided by an external company – Effective Professional Interactions (EPI). EPI is providing support to practices that have completed the PCF exercise. This support is in the form of a programme over 12 months and includes practice workshops, GP to GP telephone support and workshops for Practice Managers. 5 practices out of the 22 who have completed the PCF exercise have taken up this additional on-going support.

2.1.2 Minor Ailment Scheme

The scheme utilises pharmacy expertise and capacity to improve access for patients suffering from minor ailments. The scheme creates a direct access pathway for patients entitled to free prescriptions by removing the prerequisite, for the patient, to visit a GP to provide simple over the counter medicine and/or advice, free, via prescription; provision that already exists for paying consumers. Patients with minor ailments, who need advice or simple over the counter medication,

obtain a “MAS Passport” that enables the patient to be seen at local Pharmacy(s) freeing up the GP time for patients requiring complex interventions.

The Minor Ailment Scheme (MAS) commenced on the 18th February 2013, between February and July 2013, a total of 3159 face to face consultations have been provided. Since July the scheme has introduced a number of patient satisfaction/experience questions into the consultation process. Patient satisfaction data recorded in July reports that out of the 585 patients consulted, 95% of patients were seen (face-to-face consultations) within a 10 minute waiting period, 97% of patients would use the service again and 97% of service users would recommend this service to a friend or family member. The Scheme has increasingly been used by the 16s and under and this now accounts for nearly 50% of total activity. The MAS pilot evaluation is expected to be completed and published in October 2013.

2.1.3 Carers Health support

Enfield Clinical Commissioning Group Primary Care Strategy Programme monies has enabled the Enfield Carers Centre to recruit a GP Liaison Worker, Fiona Jones started in post on the 12th June 2013 on a fixed term contract ending 31st March 2015. Funding was also approved to recruit a Carers Nurse and following a short delay due to issues relating to finding the appropriate employing organisation; a resolution has been found and recruitment is currently in progress with the Carers Nurse expected to be in post by the middle of September.

The aims of this project are to:

- Ensure early identification of carers to enable the provision of the right support when carers need it
- Provide support for GPs and practice teams with carer issues
- Assist the prevention of carer breakdown which avoids hospital admission
- Help Keep carers healthy both physically and mentally
- Provide a link between primary care, the Enfield Carers Centre and other services in the local community
- Provide a clear referral pathway for GPs and practice staff to a GP Liaison Worker and Practice Nurse

There has been a lot of activity and promotion of the service, over 60% of practices have been contacted regarding the service and provided with leaflets, posters and referral forms. Awareness is growing in Enfield regarding the services available for carers and the Carers Centre is reporting an increase in activity due to the project.

Going forward Enfield CCG will be ensuring regular reporting is in place to measure the outcomes and benefits of this project both quantitative and qualitative.

2.1.4 ECCG/University College of London (UCL) Joint Initiative

Four Academic Clinical Associates or ACAs (newly qualified GPs) are to be employed for a two year fixed term contract (full time). The main objectives for this initiative are as follows:

- Approximately 17000 extra primary care appointments across Enfield over the two year period;
- Service improvements through research and re-design in the following areas:
  - Elderly Mental Health
  - Palliative Care
  - A&E attendance reduction
  - Diabetic management with considerations to both CVD and stroke;
- Raising the profile of Enfield as a borough for newly qualified GPs to settle within long term

These posts are now called 'Principal Clinical Teaching Fellows'. They have been advertised with a closing date of 13 September 2013 with interviews occurring late September/early October 2013.

'Host' Practice applications have now been shortlisted and site visits are due to take place late September/early October 2013.

2.2 Improving Patient Experience

The schemes below enable patients to obtain this higher level of care closer to home, increasing the likelihood of people being seen and treated and reducing the need to go to hospital for their care.

Such schemes include:

2.2.1 Blood Pressure Monitoring

By the end of August, a total of 45 stand-alone blood pressure (BP) and Body Mass Index (BMI) health kiosks known as PODs have been deployed across Enfield, covering 48 GP Practices (practices share PODs where they collocate). These 'state of the art' PODs, are being deployed in accessible areas of GP Practices and are cost free for patients. The remaining 3 PODs will be located in strategic locations where they can fill the gap in provision, bringing a total of 48 PODs to Enfield.

Patients will give their results to their GP practice for inclusion in patient records and they are called back if a change to medication or BP/BMI management is required. The project activity is being obtained throughout September and so far the first 8 practices to respond have

confirmed that the PODs have been used on 7,587 occurrences. The Primary Care Strategy is liaising with LBE graphics team to mobilise a campaign via the 'Our Enfield' magazine to increase awareness.

2.2.2 Childhood obesity

The plan with the service provider that will support the management of childhood obesity is to:

- Provide pathway development which will analyse the current strategies and JSNA and develop a set of recommended pathways based on best practice/evidence base to be considered for future development.
- Provide a weight management intervention which consists of a residential weight loss summer camp for up to 30 children.
- Training provision – Will consist of 60 places of 1 day introduction to managing childhood obesity training and 30 places on a 2 day toolkit training which will provide be more detailed about interventions. This will be offered to all GP practices and School Nurses across Enfield.

The project is well underway and so far 50 GP practices have agreed to start a child obesity register. From 18 – 30 August, up to 30 overweight and obese children were funded to attend a residential summer camp. The CCG is awaiting confirmation of the outcomes from their camp attendance. The children and their families are being offered post-camp support through to November 2013. The project is working cohesively with the ECS school nursing team to avoid duplication of effort.

2.2.3 Patient Experience Tracker

The NHS nationally recognises that patients care about their experience of care, as much as clinical effectiveness and safety. The Primary Care strategy has pump primed a 'turnkey' solution that will enable GP Practices to better capture their patients opinions and views on the services they provide. The project will enable practices to become more responsive to their patients' needs and allow GP Practices the ability to focus/tailor their investments into areas expressed by their patients. 34 GP Practices are signed up to the service and the project is currently procuring the tablet devices that will eventually be used within the identified practices. The Steering Group and a Survey Development group are in place and will continue to meet during September to ensure all prerequisites are in place for a November launch.

2.3 Health Outcomes

The following services help to support the improvement of the health outcomes of the local population:

2.3.1 HiLo Initiative

In conjunction with Queen Mary's University London (QMUL) this is a pilot project to improve the management of CHD and BP in general and in particular, those patients traditionally referred to secondary care for management following poor improvement outcomes when recommended primary care treatment guidelines are followed. Practices have been selected on a basis of geographical need and size of practice in order to reach the greatest number of the patients and were offered the opportunity to participate. Both practices have accepted and participation is about to commence.

2.3.2 Cancer Screening

Cancer Screening information leaflets have been sent to over- 50's in Enfield with a total of 80,000 leaflets distributed. Promotional materials were provided to all pharmacies in Enfield for distribution in June 2013. Health Trainers have now been recruited to promote cancer screening in the community. Two training sessions were delivered to the Health trainers and Pharmacy Assistants in 'Getting to know Cancer' campaign. Pharmacists are distributing 'Getting to know Cancer' leaflets when they dispense medication.

2.3.3 Domestic Violence

The project aims to work with up to 25 general practices across Enfield to implement a domestic violence identification, training, support and referral programme for primary care staff that will support female patients aged 16 and above who are experiencing domestic violence and abuse. A full time Advocate Educator, supported by an IRIS Clinical Lead will train practice teams and provide expert advocacy.

The Advocate Educator and IRIS Clinical Lead have both been appointed.

3.0 IT Developments

Enfield practices are being refreshed with new hardware (PCs, printers and iPads for doctors making home visits). The clinical systems that hold patient records are being upgraded to cloud-based technology with at least 50% of practices having their hardware updated with new scanners, printers, arrival screens and patient information boards.

iPLATO text messaging services continues to support GP Practices reduce their 'did not attend' rates. During May 2013 to July 2013 a further 956 clinical appointments or (159 clinical hours- based on 10 minute appointments) have been saved, enabling GP Practices to reallocate this access back into their provision.

4.0 Conclusion

The developments outlined above provide a summary of the progress to achieving long term sustainable improvements in the delivery of primary care services that will support the improvement in the health and wellbeing of the residents of Enfield.

5.0 Next Steps

6.1. Continue to develop the business case for the next 2 years 2013/14 and 2014/2015 for PC Strategy Investment.

6.2. Continue to the development of the Investment Programme of Initiatives for 2013/2014

6.3 Start the development of Networks.

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Health and Wellbeing Board
Work Programme 2013-14

Board	16th May 2013	20th June 2013	18th July 2013	19th Sept* 2013	17th October 2013	14th Nov 2013	12th Dec 2013	23rd January 2014	13th February 2014	20th March 2014
	(Development)	(Formal)	(Development)	(Formal)	(Development)	(Development)	(Formal)	(Development)	(Formal)	(Development)
Pre-Agenda Meeting	26/04/13	23/05/13	21/06/13	19/08/13	20/09/13	21/10/13	11/11/13	24/12/13	13/01/14	21/02/14
Paper Work Deadline	03/05/13	10/06/13	08/07/13	09/09/13	07/10/13	07/10/13	02/12/13	09/01/14	03/02/14	10/03/14
Health Improvement Partnership	Regeneration		Tobacco Action Plan Sue McDaid		Upper Edmonton Employment & Life Expectancy Glen Stewart		Physical Activity & Transport Glenn Stewart		Educational Achievements Andrew Frasier	
	Domestic Violence									
			Childhood Obesity Public Health & Glenn Stewart		Housing and Homelessness Sally McTernan		Food and Health Eating Sue McDaid		Health & Wellbeing Strategy Shahed Ahmad	
			Childhood Poverty Maternity Services Eve Stickler		Public Health Report Karen Keane				London Cancer First Review Prof Pitchard-Jones	
			Public Health Outcomes Framework Glenn Stewart		Health Protection Committee Report					
					Immunisation Karen Keane					
			JSNA Keezia Obi							
Joint Commissioning Board	School Nursing	Winter Pressures	Telecare	*August	Children's Section 75 Review	Mental Health Strategy Kate Charles				
	Integrated Care	ICES Integration	NHS Social Care Grant	Teir 3 Children's Mental Health Services						
		Mental Health Strategy Kate Charles			Adult's Section 75 Review					
	Children's S75									
			MH Strategy & Assessment							
		Winterborne Action Plan		Public Health Commissioning						
			Joint Strategy Review							
		Disabled Children Charter		Integrated Care						
				CCG Commissioning Intentions Richard Quinton						
	Serious Youth		Public Health		HWB Strategy	Upper Edmonton Life		Educational		

Health and Wellbeing Board Development Session	Crime Andrea Clemons		Outcomes Framework Glenn Stewart		Keezia Obi	Expectancy Glen Stewart		Achievements Andrew Frasier		
	JSNA Keezia Obi		Housing and Homelessness Sally McTernan		Mental Health Strategy Kate Charles	Council Budget Consultation Richard Tyler		HWB Strategy Keezia Obi		
	HWB Workplan Fliss Cox		JSNA Keezia Obi		Childhood Obesity Public Health & Glenn Stewart	Health & Wellbeing Strategy Shahed Ahmad				
Health and Wellbeing Board Formal Session		JSNA Keezia Obi		HWB Strategy Keezia Obi			HWB Strategy Keezia Obi		HWB Strategy Keezia Obi	
		HWB Workplann Fliss Cox		Integration Sub-Group Establishment Bindi Nagra			Mental Health Strategy Kate Charles		Housing and Homelessness Sally McTernan	
		Serious Youth Crime Andrea Clemons		JSNA Keezia Obi			Childhood Obesity Public Health & Glenn Stewart		Upper Edmonton Employment & Life Expectancy Glen Stewart	
		Immunisation Karen Keane		Acquisition of Chase Farm by RBF Liz Wise			Section 75 Review		Physical Activity & Transport Glenn Stewart	
				HWB Workplann Fliss Cox			Disabled Childrens Charter Andrew Fraser		Childhood Poverty & Maternity Services Eve Stickler	
							Scrutiny Report Findings of Mental Health and Older Peoples Services			

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 20 JUNE 2013

MEMBERSHIP

PRESENT Donald McGowan (Chair - Cabinet Member for Adult Services, Care and Health), Shahed Ahmad (Director of Public Health), Chris Bond (Cabinet Member for Environment), Ian Davis (Director of Environment), Deborah Fowler (Enfield HealthWatch), Ayfer Orhan (Cabinet Member for Children & Young People), Liz Wise (Clinical Commissioning Group (CCG) Chief Officer), Paul Bennett (NHS England) and Litsa Worrall (Voluntary Sector)

ABSENT 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), Dr Alpesh Patel (Chair of Local Clinical Commissioning Group) and Vivien Giladi (Voluntary Sector)

OFFICERS: 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), Tony Theodoulou (Assistant Director Schools and Children's Services) and Karen Keane (Public Health Manager) Penelope Williams (Secretary)

Also Attending: Graham MacDougall (Head of Head of Commissioning, Integrated and Acute Care, Enfield CCG) Maggie Lock (NHS England)

1 WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting.

Apologies for absence were received from Dr Alpesh Patel (Chair of the Enfield CCG), Andrew Fraser (Director of Schools and Children's Services), Vivien Giladi (Voluntary Sector Representative), Ray James (Director of Health, Housing and Adult Social Care).

The Chair presented an update to the Board as follows:

Further guidance for the Joint Strategic Needs Assessment and the Pharmaceutical Needs Assessment has been released by the department of health outlining the new requirements for CCGs and Local Authorities. The guidance for JSNA is included in the board's paperwork. This includes a requirement for JSNAs to project needs into the future.

Longer Lives, a new website showing the variation in early death rates has been launched by Public Health England (PHE). The website compares this authority to 15 similar authorities across England, for example Enfield are marked against Camden and Luton amongst others in a category labled “more deprived”. Out of the 15 Enfield has the lowest premature death rate (2009-11).

The South East Public Health Observatory has now released figures for cardiovascular mortality. These show that from 2008-2011 Enfield had a 34% drop in cardiovascular disease death rate; twice the national average. This was the fourth best level of improvement in London. Much of this will be due to the increased focus on smoking cessation, tackling high blood pressure and cholesterol levels . Whilst this news is to be welcomed , CVD death rates are about 70% higher in parts of our most deprived area than parts of our more affluent areas. This means that our attempts to reduce unnecessary deaths in our poorest populations is even more important than ever and that the CCGs investments initiatives should have a real focus on our most deprived populations.

The Department of Health have updated the Dementia Action plan and strategy for 2013/14, the objective is to develop more prevention and services for this growing need.

The JSNA team has continued to developed Enfield's new look JSNA. Following on from our development session in May, further events are being coordinated for the board later in the year for the continued development of both the JSNA and the Health and Wellbeing Strategy, in addition to regular updates brought to the board. The draft chapters of the JSNA are:

- Enfield People
- Enfield Place
- Enfield Resources
- Health and Wellbeing of Children, Young People and their Families
- Health and Wellbeing of Adults
- Health and Wellbeing of Older People

The process for the recruitment of a childhood healthy weight coordinator is currently underway; this post is to lead on the development of healthy weight promotion and interventions across the borough.

The Public Health Team are working with NHS England and the Emergency Planning Team in the Authority to ensure that all emergency planning is up to date following Public Health’s transition into the Local Authority.

A development workshop on improving life-expectancy, and particularly female life-expectancy was held on 24th May. The outcome is a conference on this subject to be held on 16th July.

Enfield's Department of Public Health has led on the development of the pan London Public Health Consultants Development Programme which was opened by Duncan Selbie; Chief Executive of Public Health England on June 18.

Enfield has achieved its stop smoking target and we are expecting Duncan Selbie to make presentation at the conference.

Enfield achieved the health checks delivery target this year, delivering 5503 health checks to Enfield residents.

Following the appointment of an independent Chair on 22nd March 2013, a full time Chief Executive Officer of Healthwatch Enfield has now been appointed.

The Council has been awarded £14,000 from the Department of Health for the development of direct payments in residential care in Enfield as part of a pilot programme. Work will commence in July 2013.

As recommended by the Health and Wellbeing Board In May 2013, an expression of interest was submitted by the Council in partnership with voluntary and community sector agencies to the Big Lottery Fund 'Fulfilling Lives, Ageing Better'.

The CCG, following consultation with the Health and Wellbeing Board and other partners have published, in line with their National timelines, their prospectus - Local clinicians working with local people for a healthier future, the final version will be presented to the board later on the agenda.

A Joint Mental Health Commissioning Manager has been recruited and has started in post June 2013.

As discussed at the Health and Wellbeing Board earlier this year, work is being progressed on the implementation of the Family Nurse Partnership. A project plan has been developed and a team supervisor appointed. A Project Board has been established that will report into the Health and Wellbeing Board.

2
DECLARATION OF INTERESTS

There were no declarations of interest.

3
GANGS AND SERIOUS YOUTH VIOLENCE

The Board received a report from Andrea Clemmons (Assistant Director Community Safety and Environment) providing examples of some of the

current activity in Enfield to tackle gangs and promoting the benefit of further investment in and support for preventative work, together with a draft strategy for tackling gangs and serious youth violence.

Dr Shahed Ahmad invited comments on the report.

NOTED the Chair's statement that "whilst final priority setting and resourcing decisions will follow the priorities set within and agreement of the Joint Health and Wellbeing Strategy – the Health and Wellbeing Board commits to working with partners to address the recommendations set out below".

AGREED

1. To note that following the presentation of the Tackling Gangs and Serious Youth Violence Strategy to the informal development meeting of the Health and Wellbeing Board, the work to tackle serious youth violence is now an identified area of need within the Joint Strategic Needs Assessment (JSNA) and will form part of the Joint Health and Wellbeing Strategy. This will enable the Health and Wellbeing Board to support better early identification of problems and information sharing.

2. To note that as part of the JSNA review process the Health and Wellbeing Board will receive further analysis from the Youth Offending Service on the levels of support for young people with mental health needs.

3. To note that as tackling Serious Youth Violence is part of the JSNA it will be considered as part of the Commissioning processes for Health and Wellbeing partners, including the Clinical Commissioning Group, Police and Local Authority.

4. A communications plan to publicise nationally this exemplar of good practice which for the first time in England aligns the work of the Health and Wellbeing Board with that of the Safer and Stronger Communities Board to tackle gang and serious youth violence.

4
IMMUNISATION

The Board received a report informing the Board of NHS England's plans to improve immunisation rates in Enfield.

1. Presentation of the Report

Maggie Luck from NHS England presented the report to the Board supported by Karen Keane, Senior Public Health Manager highlighting the following:

- NHS England has plans to improve childhood immunisation rates within Enfield and across London to achieve the World Health Organisation's recommended 95% of the population coverage.

- NHS England is planning to deliver an MMR catch up campaign for 10-16 year olds and to instigate changes to the routine immunisation schedule.

- The responsibility for commissioning immunisation lies with the NHS England. In London this is generally done through GPs and schools in conjunction with local authorities.

- In Enfield immunisation levels are below the level required for herd immunity and more work needs to be done to bring Enfield up to the 95% rate of coverage.

- There are 5 areas of work including information management, GP performance, community services, training staff and raising public awareness.

- Changes to the UK immunisation schedule include removal of the second priming dose of men C conjugate vaccine to be replaced by a booster given in adolescence, the introduction of rotavirus vaccine for infants at 2 and 3 months and the introduction of a pilot child flu vaccination scheme.

- A temporary steering group has been set up to run an 6 months MMR catch up campaign, to immunise those who have missed being vaccinated and to help avoid a measles outbreak.

- Only three practices in London have opted out of the campaign.

- Enfield has consistently lower rates of vaccination than other parts of North East London, London and England as a whole.

- The new plans will provide more opportunities to develop local agency partnerships.

2. Questions/Comments

2.1 None of the surgeries who had opted out of the MMR Catch-Up Campaign were in Enfield.

2.2 A communications plan is being developed. The possibility of targeting resources at those communities where there are the most problems was raised. Communication through schools has been shown to capture the greatest numbers. Posters and newsletters will be distributed among learning centres, libraries, community groups and the usual public places.

2.3 Figures of children not vaccinated are not available per primary school as this information is held by GPs, but it was possible that information on the number of children invited for vaccination, booked in and not attended could be gathered. The scheme started on 2 June 2013.

2.4 NHS England was working with GPs to deliver the programme overall.

2.5 Links with school nurses were unclear. Further details would be provided.

2.6 Dr Mo Abedi said that he felt that there was a need for a more robust recall system for immunisations that had to be given over a period of time. Where this had been implemented, immunisation rates had improved.

2.7 It was felt that more robust data gathering was needed.

2.8 NHS England is in negotiation with local providers to provide the necessary training for staff who are to implement the proposed changes.

2.9 The CCG, local public health teams, NHS England and Public Health England are all working together, pooling their expertise and knowledge to improve the way immunisations are to be provided. Improvements will be based on good evidence based practice.

2.10 The figure of 85.7% of one year olds listed in the report which had been immunised would indicate that about 190 children had not been. As these children would still be under the care of a health visitor, health visitors could be asked to follow up to ensure that these children are immunised.

2.11 In quarter 1 (12/13) there had been an increase in the numbers vaccinated. 92.1% in Enfield closer to the 95% target. This was thought to be because at this time there had been a big push on the issue and a large increase in focus.

2.12 Ian Davis (Director of Environment) suggested that research was needed to find out why Enfield was so out of step with the rest of London to identify the root cause of the problem.

2.13 Data has not been not collected on an ethnic basis. Litsa Worrall suggested that more work should be done with the voluntary sector to enable them to be more proactive in encouraging different ethnic communities to make sure that their children were immunised.

2.14 Liz Wise (CCG Chief Officer) welcomed the introduction of the rotavirus vaccine as this had caused a lot of sickness in the past.

2.15 A national change was being made to the MenC vaccination programme so that one dose was given in early childhood and a booster at aged 12-13 which would provide more protection for young people of university age when they are more at risk from the disease.

2.16 Immunisation had been a risk area during public health transition as there had been some ambiguity about where responsibility for the area lay but this had now been resolved. Lead responsibility now lies with NHS England, but the CCG and the public health team have a key role to play.

2.17 In Enfield there has historically been a problem with recording the data on immunisation, much of which had been inaccurate. NHS England has recently agreed to pay for a new recording tool which will enable Enfield to capture immunisation rates more accurately. This will give GP's more confidence in the system and ensure that referrals are followed up more effectively.

2.18 There was an opportunity to make sure children were immunised with the introduction of the new free school nursery places for two year olds. The school admissions process could also be used to help ensure that children starting school were up to date with their immunisations.

2.19 An update report will be provided to the next meeting of the Board including the action plan and more information on data analysis and why Enfield is different from the rest of London.

AGREED to note the changes to the routine immunisation schedule and to endorse the plans to protect the community from the effects of vaccine preventable diseases.

5
ENFIELD CLINICAL COMMISSIONING GROUP PROSPECTUS 2013-2020

The Board received the Enfield Clinical Commissioning Group Prospectus 2013-14.

Liz Wise (CCG Chief Officer) presented the prospectus to the Board. She highlighted:

- The prospectus had already been discussed at the Board development session in May and comments received and incorporated.
- It was aligned with the Health and Wellbeing Strategy.
- This was the beginning of the a three year strategy including ambitious plans for transforming primary care services in Enfield, to meet the needs of the population, particularly those who in the past had had difficulty accessing services.

- The prospectus will be a live document, continually updated.

- A users event had been held in April 2013 and a larger public event was planned for the later in the summer.

- A communications package is set out on page 29 of the report.

AGREED to endorse the Enfield Clinical Commissioning Group Prospectus 2013-14.

6
WORK PLAN 2013/14

The Board received the draft work plan for 2013/14.

NOTED

1. The work plan had been discussed at the May Development Session.

2. Topics will be discussed informally at sub groups and development sessions before being bought to the full Board. Although in the early months of the plan this has not always been possible.

3. A suggestion was made that employment opportunities at North Middlesex Hospital be discussed at the October meeting.

4. Ian Davis suggested that childhood obesity and physical activity be considered at the same meeting. Councillor Orhan had wanted childhood obesity to be considered at the earliest opportunity.

5. Litsa Worrall felt that social care should have more prominence.

6. Liz Wise was keen to ensure that CCG commissioning intentions were aligned with the Health and Wellbeing Strategy.

7. Integrated Care will be discussed by the Joint Commissioning Board and any issues will be reported up the main board. The latest guidance sets out key roles, responsibilities and opportunities for integrated working which will involve housing and environment as well as health and social care. Bindi Nagra reported that he will be mapping areas of current integration and the opportunities that there were to involve health and social care in the wider community.

8. Councillor Bond felt that environment was key in determining people's health, thought that issues such as air quality were important and that the second development session should pick up on environmental issues. The GLA were doing some work in this

area and he felt that the Board could invite them to attend a meeting to talk about it.

9. Access for disabled people in parks and for all services was also an issue that ought to be addressed.

10. The work plan included only headline issues. Details would be completed later.

AGREED the work plan for 2013/14, taking account of the suggestions above.

7
JOINT STRATEGIC NEEDS ASSESSMENT UPDATE (JSNA)

The Board received an update report on the development of the Joint Strategic Needs Assessment.

NOTED

1. A good working draft has been produced together with factsheets. The draft is due to be sent round to Council directors for comment and will be finalised next month.

2. The outcomes will feed into the priorities of the Health and Wellbeing Strategy.

3. Two away days are planned to put together the priorities. A session in September for the wider community, followed by another in October for all Board members. Dates to be confirmed.

8
SUB BOARD UPDATES

The Board received the following updates from the Sub Boards as follows:

8.1 Health and Improvement Partnership Update

Glenn Stewart, Assistant Director of Public Health highlighted the following from his report on the work of public health in the Borough.

- The annual patient equalities monitoring report had been received from Barnet and Chase Farm NHS Hospital Trust. Most of their patients come from the northern part of the borough. People in the south are more likely to attend North Middlesex Hospital.

- Regeneration projects in Ponders End and Meridian Water are progressing.

- Domestic Violence in Enfield is a major concern. The definition has been widened to include those aged 16-17. Over a third of violence reported to the police in Enfield is domestic or intimate partner violence.

- Enfield was the first London borough to receive White Ribbon Status for its work with violence amongst young people, but more needed to be done.

- Training in 25 GP Surgeries has begun, implementing a single point of entry system and developing protocols for routine health visitor enquiries.

- The Childhood Obesity Co-ordinator should be stating work next week.

- Enfield participation in the National Child Development Programme is higher than it's ever been.

- Breastfeeding is being promoted throughout the borough and 30 staff recently received specialist training at Middlesex University.

- No new data has been issued on life expectancy which continues to be an issue in Upper Edmonton. A workshop will take place on 16 July 2013.

- Enfield met its target for delivered health checks this year, delivering 5,503 checks.

- The smoking target was exceeded: 1,584 quitters against a target of 1,568.

8.2 Questions/Comments

8.2.1 As regards transport, Lucy Saunders, had given a report to the Health Improvement Partnership Board on the bus review being carried out and there was a transport working group as part of the Barnet, Enfield and Haringey Clinical Strategy.

8.2.2 The figures for domestic violence are in line with national averages and are the most up to date available. It was acknowledged that there was a lot of under reporting in this area and not all the cases were being picked up. Statistics are reported quarterly to the Safer Stronger Communities Board. The recent welfare reforms may increase tensions in families and could lead to more cases. All cases where children are involved are reported through the single point of entry database.

8.2.3 It was likely that the obesity fall in reception and year 6 was either due to better reporting or increased activity.

8.2.4 Councillor McGowan thought that there might be a very low threshold for what was considered obese. It was made clear that BMI categories are agreed internationally and are not subject to local variation. People's perceptions of what a 'normal' BMI is and looks like have increased with the population increase in BMI.

8.2.5 Some concerns were expressed that the new blood pressure machines were situated too publicly; consideration would be given to how they were situated, including the possibility of putting them behind curtains to allow some privacy.

AGREED to note**:**

- That the Barnet and Chase Farm NHS Hospital Trust had presented a patient equality monitoring report to the HIP.
- The regeneration priority areas in the North East, South West and South East of the Borough.
- That domestic violence is a major concern in the borough, a factsheet for this is being developed and will feed into the Health and Well-being Strategy.
- That work is being done to promote vaccination, particularly in relation to the measles outbreak in Wales.
- That Participation in the National Childhood Measurement Programme was the highest yet recorded in 2011-12.
- A workshop on improving life-expectancy in Upper Edmonton has been run with a further workshop is being held on 16th July.
- Enfield achieved the health checks delivery target in 2012-13 but not the offer target.

8.3 Joint Commissioning Partnership Board

The Board received an update report from Bindi Nagra (Joint Chief Commissioning Officer) on the work of the Joint Commissioning Sub Board.

Bindi Nagra highlighted the following from his report:

- Partners including the Council, NHS and voluntary sector have agreed to form the Enfield Dementia Action Alliance with the aim of promoting the needs of those living with dementia.

- In Enfield there are 2,800 people with dementia: 1,225 of them advanced. One in three 3 over 65s will develop the disease and live with it for an average of 7-12 years. Partners are working together sharing resources and organising training to make Enfield more dementia friendly.

8.4 Questions/Comments

8.4.1 Litsa Worrall added that local businesses were also involved, one aspect of their involvement included alerting shop workers to the problems of dementia suffers. The Alliance will welcome the support of the Health and Wellbeing Board.

8.4.2 Risk stratification involves combining information from different databases to enable easier identification of families at risk or need of interventions which will help in the development of preventative strategies.

8.4.3 Questions were asked about why Enfield residents had to go to Chingford for bone density scanning. Bindi Nagra agreed to find out and report back to the Board.

8.4.4 The Section 75 agreement has been completed and is about to be signed.

8.4.5 HealthWatch is developing well.

8.4.6 There are still some issues about some of the contracts bought over to the Council as a result of public health transition; these are worth about £400,000. If any new cost pressures emerge Public Health England has indicated that they may adjust next year's financial settlement.

8.4.7 The NHS Social Care Grant had been notified to the council at a late stage and it had not been possible to spend all the money within the year. The grant covers this year and next but there are no guarantees for the future thereafter. The funds had been allocated on the basis that future funding could not be guaranteed. Investments had been made in areas such as stroke and intermediate care which should help save money by managing preventative care and reducing the incidence of disease for the future.

8.4.8 Paul Bennett, NHS England, affirmed that future funding was uncertain but he agreed that the council was acting prudently in the way that funds were being allocated.

AGREED that the Board note the report.

8.5 Improving Primary Care Board

The Board received a report updating them on the work to date carried out to implement the primary care strategy across Enfield.

The report was presented by Dr Mo Abedi, (CCG Medical Director). He highlighted the following:

- Eight clinical champions are working with GP Practices across the borough promoting collaborative working.

- 39 out of a total of 59 practices had signed up to an enhanced access scheme which has created an extra 8,000 doctor patient appointments and telephone consultations. The Primary Care Foundation is working with an extra 10 practices on managing capacity/demand processes. Further work will continue.

- Blood pressure and body mass index monitoring pods will be installed in 43 practices by the end of June. Another 5 pods will be installed in strategic locations across the borough. Two practices will have the facility for 24 hour blood pressure monitoring.

- Chronic Obstructive Airways Disease (COAD), a disease which affects smokers and can result in significant numbers attending hospital unexpectedly, is being tackled through a new initiative involving training and the provision of spirometry equipment.

- The Minor Aliments Scheme has resulted in about 1,200 diverted appointments and over 230 hours of GP's time saved.

- The ECCG/University College of London Joint Initiative involving the recruitment of four newly qualified GPs who will be employed in a four different practices. They will be able to improve systems and develop networks across the borough.

- Schemes to address conditions including deep vein thrombosis, anti coagulation, blood pressure monitoring and urology are also up and running.

- IT equipment is being updated across all GP practices to make it easier to transfer and share information between both practices and hospitals.

- Practice premises are also being bought up to Care Quality Commission standards.

Graham Macdougall (Head of Commissioning, Integrated and Acute Care, Enfield CCG) spoke about CCG plans for the coming year:

- Last year the CCG had focussed on activity and outputs, this year more emphasis would be put on preventions and impact on patients to demonstrate that the CCG is making a difference.

- More work will be done to develop GP support networks to enable GP's to work more closely together to improve services.

- Resources will be aligned to the different needs in the different quarters of the borough.

- Further service developments are planned together with the introduction of new health checks and the use of the extra GP

appointments. There will be further investment to provide intensive support to those practices that are struggling to meet demands or with poor outcomes.

- Work with the 40 patient groups, set up in most practices will continue.

2.6 Questions/Comments

2.6.1 Councillor Orhan felt that obesity initiatives should be targeted on those areas where the problem was highest. The pathway development review will be analysing current strategies and working out the most effective ways to manage childhood obesity.

2.6.2 Ian Davis felt that the more work needed to be done to evaluate the success of the minor ailments scheme, to identify which pharmacies and which practices were making use of it and how effective it was.

2.6.3 The UCL doctors would be placed one in each of the four quarters of the borough and they will spend a year in a practice.

2.6.4 Dr Shahed Ahmad congratulated the CCG on all the initiatives started so far including the work on Chronic Obstructive Airways Disease (COPD) and improving life expectancy.

2.6.5 The HiLo Initiative, a pilot project to improve the management of Coronary Heart Disease and blood pressure is being carried out in conjunction with Queen Mary University. It is likely that it will be focussed on larger practices in Edmonton and Ponders End.

2.6.6 Councillor Orhan felt that there was too much focus on adults and not enough being done for children.

2.6.7 Ian Davis suggested that a set of key performance indicators including patient satisfaction should be drawn up so that it would be possible to measure improvements from year to year. It was also suggested that a dashboard of key outcome measures be produced which could then be reported on regularly at board meetings to enable progress to be measured. These could be linked to the JSNA. This could be a subject for discussion at a Board development session.

2.6.8 The Chair felt that the good work being done should be promoted.

AGREED to note the report.

9
MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 23 April 2013 were agreed as a correct record.

10
DATES OF FUTURE MEETINGS

The Board noted the dates agreed for future meetings:

Full Board Meetings

- Thursday 19 September 2013
- Thursday 12 December 2013
- Thursday 13 February 2014
- Thursday 24 April 2014

Development Sessions

- Thursday 18 July 2013
- Thursday 17 October 2013
- Tuesday 19 November 2013 (originally scheduled for 14 November)
- Tuesday 21 January 2014 (originally scheduled for 23 January)
- Thursday 20 March 2014

11
EXCLUSION OF PRESS AND PUBLIC

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