**HEALTH AND WELLBEING BOARD**

Thursday, 12 December 2013 at 6.30 pm
Room 1, 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
Enfield 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**

**2. DECLARATIONS OF INTEREST**

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

**3. CHILDREN'S DISABILITIES CHARTER (6:35-6:45PM)** (Pages 1 - 10)

To receive a report from Andrew Fraser, Director of Schools and Children's Services, on the development of a Children's Disabilities Charter.

The Board is asked to sign up to the charter.

**4. JOINT HEALTH AND WELLBEING STRATEGY (6:45-7:00PM)** (Pages 11 - 18)

To receive and note the update from Keezia Obi, Head of Public Health Strategy, on the development of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.

**5. CHILDHOOD OBESITY AND PUBLIC HEALTH (7:00-7:10PM)** (Pages 19 - 22)

To receive a report from Glenn Stewart, Assistant Director of Public Health, on childhood obesity and public health.

**6. SECTION 75 AGREEMENT (ADULTS) 2013-14 MID YEAR REVIEW (7:10-7:20PM)** (Pages 23 - 36)

To receive and note a report on a half year review of the Section 75 Agreement (Adults) 2013-2014.

**7. INTEGRATED TRANSITION FUND (7:20-7:40PM)** (Pages 37 - 50)

To receive a report on the development of plans for the Integrated Transformation Fund.

The Board is asked to agree terms of reference for the Integrated Transformation Fund Working Groups.

**8. BETTER OUTCOMES FOR CHILDREN AND YOUNG PEOPLE'S PLEDGE (7:40-7:50PM)** (Pages 51 - 60)

To receive a report from Andrew Fraser, Director of Schools and Children's Services on the pledge "Better Health Outcomes for Children and Young People's".

The Board is asked to sign up to the pledge.

**9. SUB BOARD UPDATES (7:50-8:20PM)** (Pages 61 - 106)

To receive and note updates from the following sub boards:

1. **Health Improvement Partnership Board**

2. **Joint Commissioning Partnership Board**

3. **Improving Primary Care Board (To Follow)**

**10. MINUTES OF THE MEETING HELD ON 19 SEPTEMBER 2013 (8:20-8:25PM)** (Pages 107 - 120)

To receive and agree the minutes of the meeting held on 19 September 2013.

**11. WORK PROGRAMME 2013/14 (8:25-8:30PM)** (Pages 121 - 122)

To agree any changes to the Board Work Programme 2013/14.

## 12. DATES OF FUTURE MEETINGS

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

- Thursday 13 February 2014
- Thursday 24 April 2014

To note the dates agreed for Board development sessions:

- Tuesday 21 January 2014 (originally scheduled for 23 January)
- Thursday 20 March 2014

## 13. 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**
**12 December 2013**

| **Agenda - Part: 1** | **Item: 3** |
|---|---|
| **Subject:**<br><br>**Disabled Children's Charter For Health and Wellbeing Boards**<br><br>**Wards: All** | |
| **Cabinet Member consulted:** | |

**Report of:** Andrew Fraser, Director of Schools and Children's Services
Contact officer: Janet Leach
Tel: 020 8379 1316
E mail: janet.leach@enfield.gov.uk

## 1. EXECUTIVE SUMMARY

By signing the Disabled Children's Charter for Health and Wellbeing Boards we will be agreeing to provide evidence over the next 12 months of how our HWB meets each commitment.

Attached to this report is a report on the current situation with regard to each commitment. In brief the Board is stating that it is committed to improving the quality of life and outcomes experienced by disabled children, young people and their families. The Board will be agreeing to work in partnership with families to improve universal and specialist provision.

The Health and Wellbeing Board is committed to improving the quality of life and outcomes experienced by disabled children, young people and their families, including children and young people with special educational needs and health conditions. We will work together in partnership with disabled children and young people, and their families to improve universal and specialised services, and ensure they receive the support they need, when they need it. Disabled children and young people will be supported to fulfil their potential and achieve their aspirations and the needs of the family will be met so they can lead ordinary lives.

By (within 1 year of signing the Charter) our Health and Wellbeing Board will provide evidence that:

1. We have detailed and accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs.

2. We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board.

3. We engage directly with parent carers of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

4. We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account

5. We promote early intervention and support for smooth transition between children and adult services for disabled children and young people

6. We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners

7. We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners.

## 2. RECOMMENDATIONS

The Board formally signs up to the Charter.

## 3. BACKGROUND

3.1 The Charter was developed by EDCM - Every Disabled Child Matters in partnership with The Children's Trust, Tadworth. The Charter has been developed to support Health and Wellbeing Boards to meet the needs of all children and young people with disabilities, SEN or health conditions. The Charter includes commitments to collect accurate data, engage directly with CWD and their families, set clear strategic outcomes for partners to meet; and more. Signatories will need to provide evidence within one year of how their Board has/is meeting its commitments.

3.2 Through our current integrated working arrangements we identify a named person from health, social care and education to lead on the work themes in order to meet each commitment. This will necessitate agreeing a set of shared strategic outcomes for partners ensuring that mechanisms are in place to measure and monitor progress.

**3.3 Benefits to Health and Wellbeing Board of signing the Charter and meeting its commitments:**

- Publicly articulate a vision for improving the quality of life and outcomes for disabled children, young people and their families

- Demonstrate an understanding of the true needs of disabled children, young people and their families in our local area and how to meet them

- Gives greater confidence in targeting integrated commissioning on the needs of disabled children, young people and their families.

- Supports a local focus on cost-effective and child-centred interventions to deliver long term impacts

- Builds on local partnerships to deliver improvements to the quality of life and outcomes for disabled children, young people and their families.

- Develops a shared local focus on measuring and improving the outcomes experienced by disabled children, young people and their families.

- Demonstrates how our area will deliver the shared ambitions of the health system set out by the Government in 'Better Health Outcomes for Children and young people.

## 4. ALTERNATIVE OPTIONS CONSIDERED

Not signing the Charter

## 5. REASONS FOR RECOMMENDATIONS

Improving the life chances of disabled children and their families

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

### 6.1 Financial Implications

Financial Spend is in line with existing allocation and planned spending

### 6.2 Legal Implications

Section 195 (1) of the Health and Social Care Act 2012 imposes a duty on a Health and Wellbeing Board 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'.

The Health and Social Care Act 2012 inserted a new section 2B in the National Health Service Act 2006, which requires a local authority to 'take such steps as it considers appropriate for improving the health of people in its area'. This may include 'providing information and advice' (S2B(3)(a)). The recommendations within this report are within these powers.

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| **1.** We have **detailed and accurate information** on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs | **Status** | **Next Steps** |
|---|---|---|
| The full range of sources of information collected on disabled children, young people and their families which will be used to inform the Joint Strategic Needs Assessment (JSNA) process | Disabled children's information has informed the JSNA – parents and young people's views have been fully incorporated. This needs on – going monitoring | To utilize the Youth Parliament which has disabled children representation to ensure a wider range of views are sought - including those of children with complex disabilities - and inform the JSNA process |
| The quality assurance process used to ensure that information and data on disabled children, young people and their families used to inform commissioning is sufficiently detailed and accurate | Quality assurance process in place | |
| The way in which the JSNA will be used to assess the needs of local disabled children, young people and their families | The Joint Service needs to further develop its understanding of the local population so that it is sufficiently differentiated to understand the needs of all groups of children particularly those who face inequalities and then use the data to inform planning and commissioning | Work with Public Health to agree on extended data set – March 2014. |
| The way in which information on any hard to reach groups is sourced, and action taken to address any gaps of information with regard to local disabled children, young people and their families | See above also some consultation has taken place specifically with Somali and Turkish families. (P2P) Involvement with the PEP and training parents of CWD as Champions | As above – progress training of Parent Champions and ensure representation at all the Parent Engagement Panels (PEPS) |
| The way in which disabled children, young people and their families are strategically involved in identifying need, and evidence and feedback on their experiences is used to inform the JSNA process | Engagement of disabled young people in Enfield is well-developed. We have the Young Person Consultation Group and representation on the Youth Parliament – elections last month – need to broaden the engagement of children with more complex disabilities. | On-going |

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| Public information on how the HWB will support partners to commission appropriately to meet the needs of local disabled children, young people and their families | This work needs to be developed | The role of the HWB to be agreed, clarifying a governance structure so the work of the Joint Service fits under the Board |
| **2.** We **engage directly with disabled children and young people** and their participation is embedded in the work of our Health and Wellbeing Board | **Status** | **Next Steps** |
| Evidence of the way in which the HWB or its sub-groups have worked with disabled children and young people in the JSNA process, next steps for JSNA engagement | Statutory driver H&SC Act 2012. We have robust existing structures that can be developed. | As above |
| Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the preparation and delivery of the Joint Health and Wellbeing Strategy (JHWS), and next steps for JHWS engagement | This work needs to be progressed from the engagement work that is already on-going with disabled children and young people. Statutory driver U.N. Convention on the Rights of the Child Article 12 the child has the right to explain their views | Ensure the voice of the disabled child is “heard” at the HWB |
| Evidence of partnership working with any local groups of disabled children and young people | Young Person’s Consultation Group/ Youth Parliament and other forums. Breakaway Magazine | On-going |
| **3.** We **engage directly with parent carers** of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board | **Status** | **Next Steps** |
| Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the JSNA process, and next steps for JSNA engagement | Parent Forums Our Voice and ENAS and P2P have contributed to the JSNA process. Parents are represented on a full range of Steering/management groups including the Joint Service Steering Group, the SEND Steering Group and the Transition Implementation | On-going |

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| | Group | |
| Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the preparation and delivery of the JHWS, and next steps for JHWS engagement | This needs to be developed building on engagement and co-production work to date. Statutory driver H&SC Act 2012 – Involving people living and working in the area in the JSNA | Once HWB governance arrangements are agreed, this will be on-going |
| Evidence of partnership working with any local parent groups, including the local Parent Carer Forum(s) | Local parent groups **are** integral to developing services in Enfield. We are moving steadily to a system of co-production. They have in the past been commissioned to consult on a wide range of issues including short breaks and quality standards. Parents are currently part of our delivery programme to pre-school children who have a diagnosis of autism – Making a Positive Start for Autism. (MAPS) | On-going |
| **4.** We set **clear strategic outcomes** for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account | **Status** | **Next Steps** |
| Public information on the status of outcomes for local disabled children and young people based on indicators such as the NHS Outcomes Framework, the Public Health Outcomes Framework, etc. | This has been started through the JSNA process. Further work on outcomes is underway. | The on-going work on outcomes to be incorporated into the next iteration of the JSNA. This will continue. |
| Public information on the strategic direction the HWB is set to support key partners to improve outcomes for disabled children and young people. This may be encompassed by the JHWS, but would need to be sufficiently delineated to | The JSNA is being used to inform the commissioning cycle. | Ensure work is embedded in the Health and Wellbeing strategy. |

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| demonstrate specific objectives and action for disabled children | | |
| **5.** We **promote early intervention** and support for smooth transitions between children and adult services for disabled children and young people | **Status** | **Next Steps** |
| The way in which the activities of the HWB help local partners to understand the value of early intervention | Processes are in place and there is a clear local early intervention strategy – Early Help (CAF). We are developing a holistic Local Offer as per the Children and Families Bill – due to get royal assent early next year. | On-going |
| The way in which the activities of the HWB ensure integration between children and adult services, and prioritise ensuring a positive experience of transition for disabled young people | We have a clear and robust Moving On Strategy with transparent multi-agency policies and processes to support transition to Adult's Services. The Transition Implementation Group is a multi-agency strategic forum which progresses this work. Parents are represented on the TIG and have been integral to developing our strategy and to delivering and supporting training to professionals. | We need to address the needs of those young people not eligible for Adult Social Care support. For example young people with moderate physical disabilities or those with autism who may not meet threshold criteria |
| **6.** We work with key partners to **strengthen integration** between health, social care and education services, and with services provided by wider partners | **Status** | **Next Steps** |
| Details of the way in which the HWB is informed by those with expertise in education, and children's health and social care | Key drivers – Children and Families Bill and Health and Social Care Act – duty to encourage integrated working between commissioners of health and social care services. | Governance structure to be agreed so the Joint Service has an accountable reporting mechanism |
| Details of the way the HWB engages with wider partners such as housing, transport, safeguarding and the youth justice system | We have an established Disability Forum that brings together a range of wider partners which could act as a conduit to the HWB | As above |

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| Details of steps taken to encourage integrated working between health, social care, education and wider partners in order to improve the services accessed by disabled children, young people and their families | We have established integrated working arrangements via the Joint Service and the SEND Steering Group to work on the coming agenda - Children and Families Bill – integration of SEN, Health and Social Care. CWD access services across multiple agencies and therefore can be disproportionately affected by poor integration between health and social care services and a lack of co-ordinated commissioning | The expectation is that we continue to work with schools, Safeguarding Boards and Learning Disability Partnership Boards towards more seamless integration between the services that CWD and their families' access. We need to consider the impact of good health on educational outcomes. Consideration of how Section 75 flexibilities could further embed joint working. |
| **7.** We provide **cohesive governance** and leadership across the disabled children and young people's agenda by linking effectively with key partners | **Status** | **Next Steps** |
| Information on links to other local integration forums which set strategic direction for disabled children's services, e.g. the local children's trust arrangements, the local safeguarding board, the learning disability partnership board, the school forum, etc. | To be developed | |
| Evidence of how the JSNA and JHWS is aligned with other arrangements, such as: reviewing and commissioning of SEN services via the High Needs Block; safeguarding arrangements; child poverty strategies, etc. | Key elements are in place and as above | Achieve clarity regarding how the various governance arrangements are/will be linked |

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Agenda Item 4

**MUNICIPAL YEAR 2013/2014**

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| **MEETING TITLE AND DATE**<br>**Health and Wellbeing Board**<br>**12 December 2013**<br><br>**REPORT OF:** Director of Public Health, Dr Shahed Ahmad | **Agenda - Part: 1** \| **Item: 4**<br>**Subject: The Joint Health and Wellbeing Strategy (JHWS)**<br><br>**Wards: All** |
| Contact officer and telephone number:<br>E mail: Keezia.Obi@enfield.gov.uk<br>Telephone: 020 8379 5010 | **Cabinet Member consulted:** Cllr Don McGowan, Cabinet Member for Adult Services, Care and Health |

## 1. EXECUTIVE SUMMARY

Further to the report presented to the September Health and Wellbeing Board, and the development session held recently, this report is an update for the board on the JSNA, and the progress made to produce a new Joint Health and Wellbeing Strategy covering the period 2014 – 2019.

## 2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

1. Note that the JSNA is now available on line at www.enfield.gov.uk/jsna
2. Note the progress made to produce the JHWS.
3. Note the consultation arrangements and the views of local people on the draft priorities.
4. Continue promoting the consultation and encourage responses to the consultation questionnaire. This can be accessed via www.enfield.gov.uk/jhwsconsultation or if paper copies, easy read version or a PowerPoint presentation is required, by email to public.health.strategy@enfield.gov.uk

## 3. JSNA ON-LINE RESOURCE UPDATE

3.1 Following approval at the September Health and Wellbeing Board (HWB), the content of the JSNA has since been updated and this work continues. Additionally, the process of how the JSNA is maintained on an on-going basis is under consideration including what, how and when this will be undertaken. In the first instance, the JSNA steering group are considering these requirements and a policy and procedure will be produced. In order to facilitate an on-going quality assurance process and a JSNA that continues to develop in partnership, the intention is that the JSNA Steering Group will continue.

3.2 The Community Working Group, which is a sub-group of the JSNA steering group, has produced a public leaflet about the JSNA. This is attached as Appendix 2.

## 4.0 JOINT HEALTH AND WELLBEING STRATEGY

4.1 A HWB development session took place on 6th November to focus on the development of the strategy. The purpose of the session was to:

- Receive initial responses to the consultation
- Review the outline JHWS document and provide comments
- Consider key action plan proposals to the strategy including any actions, targets and outcomes
- Consider what success will look like and how the Board will measure progress – short, medium and beyond long term into 2025 and 2030
- Consider how the Board receives public views on health and wellbeing during the life of the strategy

4.2 Following this session, the JHWS working group (comprising of officers representing the council and the Clinical Commissioning Group) have met to work on the first draft of the strategy document. As to be expected, the strategy is being produced with due regard to statutory guidance and is set out in the following sections.

- ✓ Foreword and Executive Summary
- ✓ Introduction
- ✓ The Context and Case for Change
- ✓ Health and Wellbeing Board Priorities and Action Plan
- ✓ Communications and Partnership
- ✓ Success criteria – what does good look like?
- ✓ Appendices

4.3 Appendix 1 attached to this report describes the detail contained in the above sections.

4.4 Following full consideration of the results of the consultation and the draft strategy by the HWB and compliance with the necessary governance processes within the Council and CCG, the JHWS will be presented to Cabinet on 22nd January and to full Council on 26th February 2014.

## 5.0 CONSULTATION ARRANGEMENTS AND UPDATE

5.1 The consultation began at the beginning of October and closes on 22 December. A wide variety of events have taken place or are planned, including two public meetings, one in Edmonton and another in Enfield Town. Additionally, a range of tools to promote the consultation have been produced.

5.2 In the responses to the consultation as at 26th November, no one has objected to any of the priorities or suggested any additional priorities areas. Respondents were asked whether they supported the priorities. In order of support, when asked to state which priorities respondees thought were the most important, the top two most popular selections are:

- Enabling people to be safe, independent and well
- Ensuring the best start in life

Promoting healthy lifestyles – was also supported by the majority of respondees.

The two remaining priorities were selected by fewer respondees, however as noted they were still supported as priorities for the health and wellbeing strategy.

- Creating stronger, healthier communities
- Narrowing the gap in healthy life expectancy.

**6.0 ALTERNATIVE OPTIONS CONSIDERED**

It is a statutory requirement to produce a Joint Health and Wellbeing Strategy.

**7.0 REASONS FOR RECOMMENDATIONS**

As noted above, 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.

**8.0 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.

## 9.0 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.

## 10.0 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

## 11.0 EQUALITIES IMPACT IMPLICATIONS

11.1 Advice has been received and Equalities Impact Assessments will need to be undertaken as services change as a result of commissioning arrangements.

**Background Papers** – none.

**END.**

**APPENDIX 1 - JHWS report HWB 12 Dec 2013**

## Outline of the Joint Health and Wellbeing Strategy (JHWS) 2014-19 - the following describes the key sections of the document

**Foreword and Executive Summary**

The foreword will be a joint statement about Enfield's vision for the strategy and how the Health and Wellbeing Board will work together in partnership to improve (HWB).

The Executive Summary is a synopsis of the whole document which will also be produced as a separate document. There will be an Easy Read version.

**Introduction**

In this section we describe the purpose and scope of the strategy and the role it will play in Enfield's approach to Health and Wellbeing over the next 5 years. It describes the development of the strategy itself and public involvement, where we are now and where we want to get to - successes and key areas of improvement up to and beyond 2019.

Explains the wider determinants of health, our vision and priorities. Some context and background will also be found here, including the rationale and legal duty of the Board to produce a strategy. Also the relationship of the JHWS with other key strategies and boards.

**The Context and Case for Change**

This section describes the local and national context including the changing financial landscape e.g. the significant budgetary pressures, the demand for improved and different service provision and demographic change

Defining a strategy and delivering change is based on an identified need, this section contains the evidence base we have relied on to identify the key priorities that need addressing in Enfield that will feed to improved health outcomes and reduced health inequalities - the evidence base as set out in the JSNA.

**Health and Wellbeing Board Priorities and Action Plan**

This section describes the priorities in detail including the supporting principles that underpin the vision – prevention and early intervention, integration, equality and diversity, addressing health inequalities and ensuring good quality services. Draft priorities:

- Ensuring the best start in life
- Enabling people to be safe, independent and well and delivering high quality health and care services
- Creating stronger, healthier communities
- Narrowing the gap in healthy life expectancy
- Promoting healthy lifestyles and healthy choices

In order for a strategy to be successful it has to be delivered. This section includes the headline action plan that will underpin the strategy. Where possible, it will also provide details about what interventions we will commission continue to commission and where necessary decommission. There will also be a more detailed action produced for the HWB to monitor progress.

**Communications and Partnership**

Here we give a brief description about how the HWB will work with our partners in order to deliver our strategic objectives.

The Health and Social Care Act of 2012 places great emphasis on engaging our general public, patients and service users - to ensure they are able to contribute to the decision making process. This section provides the detail behind the approach we have taken to date and what we will adopt and develop over the coming years.

Here we describe the priorities and key outcomes in detail and what other key strategies, plans and initiatives e.g. Council, CCG, Healthwatch, commissioning and any other programmes that feed into and inform the strategy.

**Success criteria – what does good look like?**

This final section of the main document lays out our expectations of what success looks like, how we will know if we have delivered on our expectations - measuring outcomes and benchmarking; and have we realised the benefits we expected to realise?

**Appendices**

The appendices will contain all the supplementary information that supports the various other sections in the main body of the document – e.g. Demographic information, maps, tables, projections, clinical indicators, equalities impact assessment and consultation material etc.

## Health and Wellbeing Information – Joint Strategic Needs Assessment (JSNA)

This leaflet has some key facts from Enfield's JSNA. The JSNA is a collection of information about the health and wellbeing needs of the local population, including where health inequalities exist. The information collected in the JSNA helps to inform the way in which decisions about health, wellbeing and social care services are planned and arranged. This information is also used by the Health and Wellbeing Board to develop the borough's health and wellbeing strategy.

## What is included in the JSNA?

The JSNA provides information about Enfield including the extent of particular issues affecting the health of Children, Young People and their Families, Adults and Older People. In many cases it provides detailed analysis of a particular issue as well as what it may look like in future years.

## An online resource

This information has been produced as an online resource so information can be removed and replaced easily, ensuring we provide the most up to date information.

Free internet access is available at all libraries in Enfield, Enfield Civic Centre, John Wilkes House and the Edmonton Centre.


## Other formats

For help with translation of this leaflet, please call 020 8379 6499, or email public.health.strategy@enfield.gov.uk

Healthy Enfield

# Health and Wellbeing in Enfield



**This leaflet is about information to do with the health and wellbeing of local people. You can also find out more at our website.**

**www.enfield.gov.uk/jsna**

ENFIELD Council

# About Enfield... Did you know?

Population of Enfield in 2012 was estimated to be 312,287

Highest proportion of residents providing 50+ hours of unpaid care a week (2011 Census)

- Largest ward by area – 1,694 hectares
- Population 13,762 (2011 Census)


Second highest number of childminders for children aged 0-5 years in Enfield, 2013

Highest life expectancy for females born between 2006-2010 – 90.1 Years

More than one and a half thousand people in Enfield stopped smoking in 2012

The 2012 School Census found 166 languages or dialects being spoken by pupils who attend schools in Enfield

Lowest number of households in fuel poverty, 2009

- Smallest ward by area – 148 hectares
- Population 14,051 (2011 Census)

Highest number of toddlers (aged 0-4) in Enfield – 1,808 (2011 Census)



NHS Enfield Clinical Commissioning Group

healthwatch

ENFIELD Council

**MUNICIPAL YEAR 2013/2014**

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| **MEETING TITLE AND DATE**<br>**Health and Wellbeing Board**<br>**12 December 2013** | **Agenda - Part: 1** \| **Item: 5**<br>**Subject: Boroughwide Obesity Strategy for Adults and Children**<br>**Wards: All** |
| Director of Public Health<br>Contact officer and telephone number:<br>E mail: **glenn.stewart@enfield.gov.uk**<br>**0208 379 5328** | **Cabinet Member consulted:** |

## 1. EXECUTIVE SUMMARY

Enfield has high prevalences of both Reception Year and Year 6 obesity. Adult obesity is at least as high childhood obesity. Enfield has a childhood obesity strategy but as adults are often the gate-keepers for children's health behaviour obesity prevalence in the borough is not going to be reduced until both adult and children's health behaviour is changed.

## 2. RECOMMENDATIONS

To charge Public Health with producing a borough-wide obesity strategy to target both adults and children.

## 3. BACKGROUND

### Enfield Childhood Obesity

Enfield has high rates of childhood obesity in both Reception Year and Year 6 e.g. third highest prevalence in London for Reception Year and 10$^{th}$ highest for Year 6.

### Reception:

Enfield's rate of obesity amongst reception pupils is high compared to both London and national averages. 13.7% of reception pupils in Enfield are obese, compared to 11.2% across London and 9.6% in England. Enfield's rate is the third highest in London, behind only that of Hackney (including the city of London) and Barking and Dagenham.

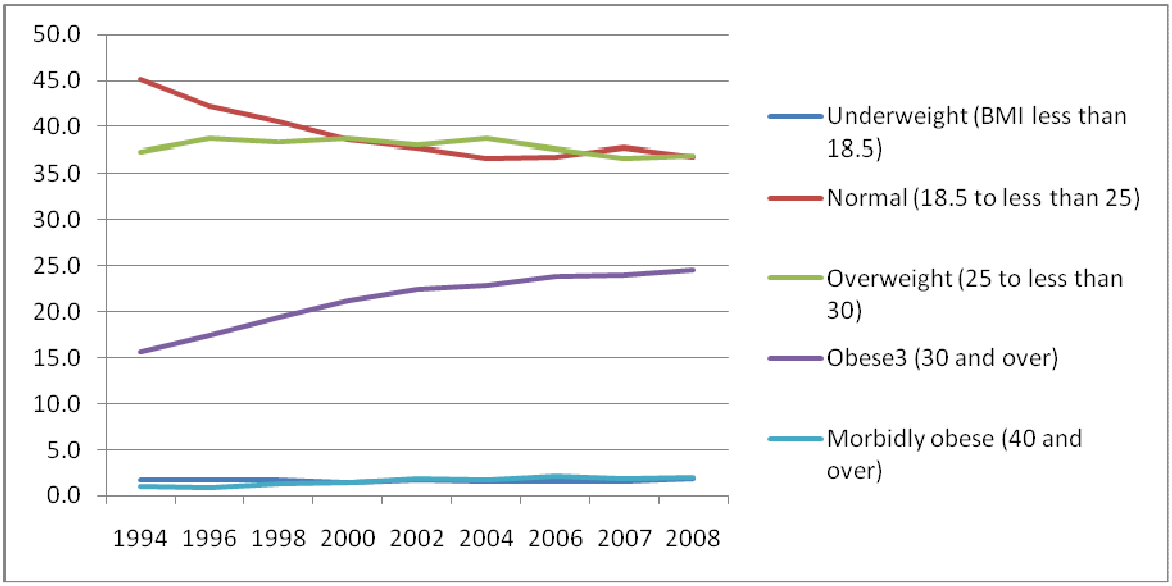
**Year 6:**

Enfield's rate of obesity amongst Year 6 pupils is almost double that of reception year with 24.2% of Year 6 pupils identified as being obese. This compares to the London's average of 22.1% and England average of 19%. Enfield's rate is the tenth highest in London.

**Adult Obesity:**

Prevalence of obesity has increased in the past 25 years over every age-group, social class, ethnicity and gender. In 1986 8% of men and 12% of women were obese. By 1993 this had increased to 13% and 16% respectively and by 2007 had risen again to 24% in both genders. Not only have the overweight become more so but BMI across the whole population has increased. In 2008 61.4% of all adults were either obese or overweight meaning that a 'normal BMI' was no longer the 'norm'.

**Percentages of English population underweight, normal, overweight, obese or morbidly obese.** (Source: Social Trends 40: 2010 edition, p.103 (adapted), Office for National Statistics (ONS), 2010).




**Why is this a problem?**

Obesity is related to some 45 diseases including heart disease, diabetes, cancer, high blood pressure and osteoarthritis and is estimated to cost the NHS some £1.5 billion a year. These costs are set to rise as levels of obesity rise. The estimated cost of obesity and overweight in 2007 was £75.7m, £78.6m in 2010 and is expected to rise to £84.1m in 2015.

**Is childhood obesity related to adult obesity?**

Obesity prevalence in Year 6 is double that of prevalence in Reception Year and already that of adults. There is no evidence to suggest that the causes of childhood obesity are different from the causes of obesity in adults. As adults are often the gate-keepers for children's behaviour and as obesity can develop at any age it would seem prudent to work at a borough level across all ages to

reduce population obesity prevalence as a means of reducing childhood obesity prevalence.

## 4. ALTERNATIVE OPTIONS CONSIDERED

Do nothing – this is disregarded as it will incur increasing expense to the health and social care economy as long-term conditions occur as a result of obesity.

Only concentrate on children. This is unlikely to reduce the disease and financial burden of obesity and is unlikely to be effective as adults are often the gatekeepers for children's behaviour.

## 5. REASONS FOR RECOMMENDATIONS

1) The disease burden of obesity is significant (over £40m)
2) The consequences for obese individuals are significant
3) As adults are very often the gate-keepers of children's behaviour a significant reduction of childhood obesity is unlikely without also targeting adult behaviour
4) There would be little gain if people were of normal weight at aged 11 only to become obese by adulthood.

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

### 6.1 Financial Implications

No financial implications beyond PH resource time.

### 6.2 Legal Implications

None

## 7. KEY RISKS

None

## 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

An effective borough-wide strategy to reduce obesity would impact on all the above.

## 9. EQUALITIES IMPACT IMPLICATIONS

None until a borough-wide strategy has been written. However, obesity prevalence also varies by ethnicity implying that a strategy would impact positively on equalities.

## Background Papers

None.

Agenda Item 6

**MUNICIPAL YEAR 2013/2014**

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| **MEETING TITLE AND DATE**<br><br>**Health and Wellbeing Board**<br>**12 December 2013**<br><br>**Report of:** Ray James, Director of Health, Housing and Adult Social Care<br><br>**Contact offic**er:<br>Hayley Coates Tel: 020 8379 3087<br>E mail: Hayley.coates@enfield.gov.uk | **Agenda - Part: 1** \| **Item: 6**<br>**Subject:** Section 75 Agreement (Adults) 2013-2014 Half Year Review<br><br>**Wards:** All<br><br>**Cabinet Member consulted:**<br>Cllr McGowan |

## 1. EXECUTIVE SUMMARY

In April 2013 the revised Section 75 Agreement for commissioned services for adults became operational. This report provides an update on the partnership arrangements between April – September 2013. Generally, the partnership arrangements are working well.

However, the payment is outstanding from the CCG for Q1 and Q2, and due to delays with the set-up of the new payment process for the public health services contracts, payment has not yet been made from the Council to the CCG.

Whilst a notice of termination of the Agreement was issued by the CCG, this has since been withdrawn (following clarity of the termination clauses) so the Agreement will continue for at least the first six months of 2014-2015 unless any changes are mutually agreed. The future of the partnership Agreement will be discussed as part of the Integrated Transformation Fund planning.

## 2. RECOMMENDATIONS

2.1 To note the content of the Section 75 Agreement half year review.

2.2 To note that payment is outstanding from the CCG for Q1 and Q2, and from the Council to the CCG. This is being progressed.

2.3 To note that a signed version of the Agreement is outstanding from the CCG but legal advice states that the relationship of the parties is governed by the conduct of both parties and is therefore governed by implied contract.

## 3. BACKGROUND

In April 2013 the revised Section 75 Agreement for commissioned services for adults became operational. Enfield Clinical Commissioning Group (CCG) has not

yet signed the Agreement under seal though approval has been given; however, legal advice confirms that there is an implied contract by conduct in place in accordance with the terms of the new Agreement. The table below shows the Schedules within the Agreement and the contribution of each Party.

In line with the Agreement this report provides a high level half year review of each Schedule from April – September 2013, to provide an update on performance and the effectiveness of the partnership arrangements. Generally the partnership arrangements are working well. A key concern of the Council is

| Service | Pooled/Integrated/ Lead | NHS Enfield CCG Contribution | Council Contribution |
|---|---|---|---|
| Mental Capacity Act and Deprivation of Liberty Safeguards | Pooled & Lead | £70,908 | £199,100 |
| Joint Commissioning Team | Integrated | £115,650.82 | £587,664.92 |
| Voluntary and Community Sector | Lead | £409,907 | £0 |
| Integrated Community Equipment Service | Pooled & Lead | £395,000 | £972,642 |
| Public Health | Integrated | £0 | £101,000 |
| Integrated Learning Disabilities Service | Pooled & Integrated | £1,459,430 | £3,970,850 |
| **TOTAL** | | **£2,450,895.82** | **£5,832,256.92** |

the absence of a signed Agreement from Enfield CCG, so this continues to be pursued. Additionally, payment has not yet been received for Q1 and Q2 from Enfield CCG to the Council pending confirmation of a payment code. Payment is also due from the Council to the CCG for the Public Health schedule, pending receipt of an invoice. The CCG issued a termination notice on 30th September but this was later withdrawn with a commitment to work with the Council to agree future partnership arrangements in light of the accepted benefits of closer working between health and social care and also the Integration Transformation Fund.

## 2. Mental Capacity Act and Deprivation of Liberty Safeguards

### 2.1 Overview of Schedule

The Local Authority Social Services Act 1970 outlines the requirement for the local authority to provide services to people of all ages with mental health

problems in Enfield. The National Health Services Act 2006 states that NHS Enfield CCG is required to provide mental health services to people of all ages in Enfield and beyond. Whilst the responsibilities of the functions relating to the Supervisory Body of the Deprivation of Liberty Safeguards (DoLS) transferred to the Council, CCGs retain the statutory responsibilities for the practice under the Mental Capacity Act (MCA) 2005. NHS Enfield CCG needs to ensure that the organisation and all the services it commissions are compliant with the MCA. The MCA and DoLS schedule identifies a partnership arrangement which permits information sharing between the Parties and the delivery of specialist experience of delivering training and auditing services. This includes a Joint Safeguarding Nurse Assessor post to provide pivotal support for adult safeguarding and to ensure that the requirements for professional supervision are met.

### 2.2 Governance

The governance structure outlined in the Agreement is being followed. The service is continuing to be managed by the Head of Safeguarding Adults, Quality Assurance and Complaints at the Council, who reports to the Assistant Director Strategy and Resources. Decisions about running the service are being made by officers at the Council responsible for delivering the service.

The Joint Safeguarding Nurse Assessor post has been employed by NHS Enfield CCG and line management arrangements are joint; clinical supervision is provided by the Head of Safeguarding within NHS Enfield CCG and day to day management is provided by the Head of Safeguarding Adults within the Council. All major projects are being developed and scoped jointly with appropriate arrangements in place for joint monitoring and review.

### 2.3 Financial

The contributions in the Agreement total £270,008. To date £80,267 has been spent, however, payment is outstanding from the CCG.

### 2.4 Key Achievements

- The DoLS Office has processed 32 DoLS applications, of which 26 have been authorised and six have been declined since April 2013. One application was receive from North Middlesex Hospital and 10 from Chase Farm Hospital.
- A system of recording is being maintained, with all DoLS applications and outcomes stored and available on requests.
- Three days of training has been delivered to Chase Farm Hospital and one day to North Middlesex Hospital.
- The partnership is allowing the CCG to access specialist advice from the Council.
- The number of DoLS applications has increased, which suggests that the awareness raising activity has been successful.
- DoLS applications are being processed within the legal timeframes.

### 2.5 Key Challenges

One of the main challenges for this time frame has been a further increase in the number of DoLS applications. In 2012-2013 there were a total of 33 DoLS applications, three of which were from Chase Farm Hospital. To date in 2013-2014 there have been over 33 DoLS referrals in a six month period, therefore it is a challenge to respond to the applications within the legal timeframes within existing resources. This increase in applications has had to take priority and has delayed some of the planned work for 2013-2014 with regards to the MCA training and the development of the DoLS action plan.

### 2.6 Key Priorities before 31st March 2014

- Develop a joint action plan with Enfield CCG for commissioned and provider services to raise awareness of the Mental Capacity Act and Deprivation of Liberty Safeguarding and use of the best interest decision making with all Health and Social Care providers. This will include additional training events and actions to ensure close working relationships with partner agencies including the CQC and Court of Protection.

- Deliver a further four days of training for CCG and hospital staff to promote awareness of the MCA and DoLS.

## 3. Joint Commissioning Team

### 3.1 Overview of Schedule

The Schedule establishes a Joint Commissioning Team across health and social care which seeks to work in partnership to manage an increase in demand against diminishing resources.

### 3.2 Governance

The Assistant Director Strategy and Resources is responsible for the joint commissioning function. Joint commissioning activity continues to be reported to the Joint Commissioning Board, a sub group of the Health and Wellbeing Board.

### 3.3 Finance

The contributions in the Agreement total £703,316. To date, £258,208 has been spent by the Council. Payment is outstanding from the CCG for the jointly funded posts.

### 3.4 Key Achievements

- There has been a significant reduction in the use of the Seacole Unit overnight bed days. This has delivered efficiencies; from £1.3 m spend in 2011/12 to a projected £213 k on beds days in the first 5 months of the financial year. This has prevented an overspend and contained usage within the existing contracting terms.

- Changes to the way services are commissioned for people with learning disabilities have been implemented in accordance with the Winterbourne View Concordat. The partnership was acknowledged by the Joint Improvement Partnership for its innovative approach to reducing admissions to assessment and treatment and the strength of partnership working.
- An integrated process for support planning and brokerage for personal health budgets has been agreed.
- Joint work is ongoing to establish the pilot for direct payments in residential care.
- Negotiations have commenced regarding the incorporation of Continuing Health Care equipment purchasing into the ICES schedule.
- Enfield Healthwatch was commissioned and established.
- Good progress continues to be made in relation to the implementation of the joint commissioning strategies. For example, the Palliative Care Support Service has enabled patients to choose where they die.
- Enfield's Dementia Action Alliance has formed and to date has 20 care and non-care private and voluntary sector organisations signed up.

### 3.5 Key Challenges

- Changes of personnel in the CCG following the NHS transition has meant identification of responsibility has been difficult.
- The Physical Disabilities Partnership board has not had CCG representation, which has limited the degree of joint working led by service user engagement.

### 3.6 Key Priorities before 31st March 2014

- Prepare for the implementation of the Social Care Bill.
- Agree allocation of the Integrated Transformation Fund.
- Further develop plans for the integration of the wheelchair service into ICES.
- Further develop plans for the implementation of personal health budgets.
- Issue a variation to the schedule once the revised structure has been agreed, following the resignation of post holders within the team.

## 4. Voluntary and Community Sector

### 4.1 Overview of Schedule

Under this Schedule the Council obtained the responsibility for commissioning 10 services from Voluntary and Community Sector (VCS) organisations on behalf of Enfield CCG.

### 4.2 Governance

There have been no changes made to the governance structure since the production of the Agreement.

### 4.3 Financial

The 10 contracts equate to a value of £409,907. To date, £164,986 has been spent and the remaining £244,921 will be paid when invoices are received from the organisations in Q3 and Q4.

### 4.4 Key Achievements

- Signed Service Level Agreements are in place with defined service aims, objectives, outcomes, terms, conditions and performance management arrangements.
- There is now consistent payment, monitoring and performance management requirements across health and social care, which has resulted in process and transactional efficiencies for both commissioners and providers.
- Positive feedback has been received from the VCS as a result of the approach to co-produced service level agreements and a consistent single point of monitoring and payment.
- Payments are being made quarterly in advance, subject to the production of monitoring data which is avoiding a lengthy time lag between service delivery and payment and enabling VCS organisations to remain viable.
- Service is being targeted appropriately to the health and social care needs of the local population demographics.
- Prior to the Section 75 Agreement the Service Level Agreements (SLAs) included generic descriptions, focusing on outputs only and had expired. The transfer of commissioning responsibility via the Section 75 Agreement has provided the opportunity to review the commissioning approach and resulted in new SLAs which contain individual service user outcomes, together with outputs, targets and key performance indicators. All the SLAs were co-produced with the voluntary and community sector organisation.
- Where appropriate, SLAs to cover both LBE and PCT funding have been combined, which has resulted in consistent monitoring and performance management requirements, process and transaction efficiencies and consistent user experience.
- Analysis of monitoring to date has revealed an overall compliance with specified requirements and delivery against targets.

### 4.5 Key Challenges

- Uncertainty of longer term funding arrangements restrict the degree of service development and innovations.

- The availability of resources within LBE to continue to be able to robustly validate monitoring returns for the 10 contracts, without any additional management funding through the Agreement.

### 4.6 Key Priorities before 31st March 2014

To ensure service aims, objectives, outcomes and targets are achieved through regular monitoring of service provision.

## 5. Integrated Community Equipment Service

### 5.1 Overview of Schedule

In line with the NHS and Community Care Act 1990, National Assistance Act 1948 and the Chronically Sick and Disabled Persons Act 1970, the Council and CCG provide an Integrated Community Equipment Service.

### 5.2 Governance

There have been no changes to the format of governance arrangements since the production of the agreement. The ICES steering group meets monthly to monitor spend, trends and to address challenges. The delivery and performance KPI's are monitored monthly within Provider Services, with data escalated via departmental financial scrutiny and performance monitoring processes as required.

### 5.3 Financial

The total contribution of both parties is £1,367,642. To date £658,526 has been spent. The service is reporting a zero variance at year end.

### 5.4 Key Achievements

- A mixed procurement model for equipment is being explored.
- Agreement has been reached regarding need and funding for SADLS support role to continue.
- A pilot for electric vans in progress.
- The service is operating well with a stand-alone store.
- The service is receiving positive feedback both from customers and other agencies/departments.
- 93.92% of items have been supplied within seven days.

### 5.5 Key Challenges

The ICES Manager has had a period of sick leave, so contingency plans have had to be put in place to ensure that the service could continue to operate.

### 5.6 Key Priorities before 31st March 2014

- Explore the financial viability of incorporating wheelchair services, incontinence services and equipment for Continuing Health Care customers into the Agreement.

## 6. Public Health

### 6.1 Overview of Schedule

On 1st April 2013 the Public Health function transferred to local authorities. As part of this the Council will commission and monitor three LES contracts with local GP Practices. However, it is problematic for the GPs to receive payment directly from the Council therefore the schedule formalises the transfer of funding for three specific contracts to NHS Enfield CCG so payment can be made via the Commissioning Support Unit through NHS Enfield CCG's core offer.

### 6.2 Governance

The responsibility for Healthchecks and Sexual Health contraception has been transferred to local authorities. Payments to GPs are being made through the National Commissioning Support Unit. The contracts are being monitored by the Council.

### 6.3 Financial

An indicative breakdown of payments is below:

| Public Health Service (previously known as Local Enhanced Service) | Projected budget (based on 2012/13 actual) |
|---|---|
| Healthchecks | £109,000 |
| IUCD contraception | £74,000 |
| Nexplanon | £39,400 |

To date, no payments have been made to Enfield CCG as a completed Vendor Form is outstanding from the CCG.

### 6.4 Key Achievements

- The payment process has been set up following liaison with four organisations.
- All practices signed up to the Public Health Services can input into a system that they are familiar with and receive payment via the preferred mechanism.

### 6.5 Key Challenges

- Getting agreement from all four organisations to complete the payment process via Open Exeter.
- Providing adequate assurance to Enfield GPs that they would be paid for their services over five months into the financial year during the set up.
- Obtaining monitoring information from the GPs.

### 6.6 Key Priorities before 31st March 2014

- Ensure that GPs are paid for the services carried out to date and that payment is made promptly in the future.
- All Public Health Services to be reviewed before 31st march 2014.
- Produce a specification for Healthchecks.

## 7. Integrated Learning Disabilities Service

### 7.1 Overview of Schedule

This Schedule formalises the arrangements for an adult specialist learning Disability service which covers both health and social care services.

### 7.2 Governance

The Integrated Learning Disabilities Service reports to the Health and Wellbeing Board through the Learning Disabilities Partnership Board and Joint Commissioning Board. At an operational level, the service is managed within the management structure of the Adult Division of Health, Housing and Adult Social Care. The service has monthly financial and performance reporting.

The service has a management and clinical governance structure including clinicians and managers. An external GP provides additional clinical advice to the governance meeting. Clinical governance feeds in to the ECS/BEH clinical governance structures. The ILDS reports to the CCG's LD Steering group and has a governance reporting line to the CCG Clinical Quality Committee.

### 7.3 Financial

The contributions total £5,430,280 in 2013-2014. To date, £2,092,812 has been spent with £3,337,488 remaining. It is anticipated that the LD pool will come in on budget in this financial year.

### 7.4 Key Achievements

There have been a number of significant achievements in the year 2013/14 to date. These include:

- Significant reduction in the Assessment & Treatment bed days used in 2013/14.
- All Winterbourne reviews have been completed with plans in place to place in alternative more local provision where necessary.
- High numbers of people being supported locally in the community with exceptionally low numbers of people in OATS.
- No permanent residential placements made in this financial year to date.
- Shared electronic health & social care record implemented in community nursing and occupational therapy. To be rolled out to all services by March 2014.

- Achieved approximately £900k care purchasing savings to half year position with an additional 600k projected to year end.
- Agreement with North Mid & Royal Free Trusts to continue the LD Acute Liaison Nurse role.

In addition the service is on target to achieve all performance indicator targets by the year end with the exception of D40. A plan is in place to address performance with D40 and to ensure achievement by March 2014. See below.

| Description | Target 13/14 | At 30.09.13 |
|---|---|---|
| NI130 Self Directed Support | 100% | 100% |
| NI130 Direct Payments | 180 | 153 |
| NI132 Timeliness of assessment (28 days) | 87% | 100% |
| D40 reviews | 82% | 31.4% |
| NI145 people with LD in settled accommodation | 79% | 78.6% |
| NI 146 People with LD in Paid Employment | 147 | 150 |
| NI135 Carers Assessments | 48% | 34% |
| C73 New admissions to Residential care | 6 max | 0 |

## 7.5 Key Challenges

- Achieving significant savings whilst continuing to provide effective services.
- Lack of LD acute liaison nurse function at Barnet & Chase farm Hospital Trust.
- Although a reduction in the numbers of safeguarding referrals on last year, overall an 80% increase over past 4 years with no additional resources. Increased complexity of alerts and increase need for police investigations.
- Continued inappropriate (and poor) transfers of care from other London boroughs/PCTs resulting in additional pressure/risks for the ILDS.
- Increased number of people becoming Ordinarily Resident in Enfield resulting in significant financial pressure.
- Increased number of people deemed to be no longer eligible for Continuing Health Care placing, shifting the financial pressure to the local authority.

## 7.6 Key Priorities before 31st March 2014

Continuing priorities for 2013/14 include:

- Continue to roll out the electronic health & social care record.
- Increase the numbers of people on direct payments.
- Introduce outcome focussed review process.
- Identify and achieve further savings and achieve balanced budget.
- Maintain reduce use of in-patient Assessment & Treatment beds and length of stays.
- Plan for the return (as appropriate) for those currently in OATS.
- Reduce the time from safeguarding alert to closure where possible and ensure effective oversight of longer term complex safeguarding investigations.
- Maintain excellent performance in PIs.

## 4. ALTERNATIVE OPTIONS CONSIDERED

**4.1** A number of options were considered about the most appropriate partnership arrangements prior to the production of the Section 75 Agreement, which was found to be the most suitable mechanism to formalise partnership arrangements. The half year review is a requirement of the Agreement, therefore must be undertaken to ensure compliance with the agreed terms between the Parties.

## 5. REASONS FOR RECOMMENDATIONS

- The Section 75 Agreement sets out the key partnership arrangements between the Council and NHS Enfield Clinical Commissioning Group. The half year review outlines the key achievements and challenges for each schedule and the Health and Wellbeing Board is asked to note this review, to monitor progress and the effectiveness of the partnership.

- This report highlights that whilst the services have been provided, payment is outstanding and needs to be progressed in accordance with the terms of the Agreement.

- The Agreement has not yet been formally signed and sealed by both organisations, so this is a priority for both Parties and the Health and Wellbeing Board is asked to note this.

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

### 6.1 Financial Implications

The total pooled funding within the section 75 Agreement between CCG and LBE is £8.282m for 2013/14. Detail of the financial position for each service at the mid-point in the year has been included within the main body of the report.

It should be noted that there remains a cash flow risk to the authority whilst the CCG have not formally signed the contract and released payment towards their contribution for Q1 and Q2 of the agreement.

## 6.2 Legal Implications

6.2.1 The Council has the power to enter into the partnership Agreement with the CCG pursuant to section 75 of the National Health Service Act 2006 ("NHSA 2006") as amended by the Health and Social Care Act 2012 ("HSCA"). The HSCA 2012 abolished the Primary Care Trust and amends the Act to include CCG's in the definition of NHS bodies able to enter into Section 75 Agreements. The unsigned Section 75 Agreement referred to in this report has been drafted in accordance with the requirements of the NHSA 2006 and the half yearly review is in accordance with the terms of the Agreement.

6.2.2 The Council should obtain a written confirmation from the CCG that it would make the outstanding payments in accordance with the terms of the Agreement as the Services have been delivered in accordance with the terms of the Agreement based on the understanding of both parties.

6.2.3 As the parties have carried out their obligations from April 2013 in accordance with the terms of the unsigned Agreement with the CCG, the Courts are likely to take the view that the terms of the unsigned agreement govern the relationship of the parties based on the conduct of the parties. To ensure certainty of contractual terms, the Council should ensure that both parties execute the contract and ensure that payment is received.

6.2.4 Any amendments to be made to the Agreement must be in accordance with the NHSA 2006 and must be in a form approved by the Assistant Director of Legal Services.

## 7. KEY RISKS

- The Agreement is terminated and partnership working is adversely affected. This is mitigated by a six month notice period forming part of the Agreement, to ensure sufficient notice to terminate contracts resulting from the Agreement. Notice has not been provided and both parties have indicated a commitment to continue the Agreement in 14-15.

- Payment is not received for the services provided placing financial burden on the Council for monies owed from NHS Enfield Clinical Commissioning Group and those owed from the Council to NHS Enfield Clinical Commissioning Group.

- The absence of a signed Agreement destabilises the partnership working. This has been mitigated by continuing the arrangements in line with the schedules pending formal approval.

## 8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

### 8.1 Healthy Start – Improving Child Health

This priority is not applicable to the Adult Section 75 Agreement.

### 8.2 Narrowing the Gap – reducing health inequalities

The Section 75 Agreement includes a Public Health schedule and three sexual health contracts, which are contributing to reducing health inequalities.

### 8.3 Healthy Lifestyles/healthy choices

This priority is not applicable to the Adult Section 75 Agreement.

### 8.4 Healthy Places

This priority is not applicable to the Adult Section 75 Agreement.

### 8.5 Strengthening partnerships and capacity

The Section 75 Agreement sets out the parameters of the key partnership working between Enfield Council and NHS Enfield Clinical Commissioning Group. This provides a framework for the parties to work together, strengthening arrangements and utilising local resources to best effect.

## 9. EQUALITIES IMPACT IMPLICATIONS

An Equalities Impact Assessment was undertaken at the production of the Agreement.

**Background Papers**

None.

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Agenda Item 7

**MUNICIPAL YEAR 2013/2014**

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| **MEETING TITLE AND DATE**<br>**Health and Wellbeing Board**<br>**12 December 2013** | **Agenda - Part: 1** **Item:**<br>**Subject:** Development of local Integration Transformation Fund (ITF) Plan<br><br>**Wards:** All |
| Director of Health, Housing and Adult Social Care<br><br>Contact officer and telephone number: Bindi Nagra – Assistant Director of Strategy & Resources, HHASC.<br><br>E mail: Bindi.nagra@enfield.gov.uk | **Cabinet Member consulted:**<br>Councillor McGowan |

## 1. EXECUTIVE SUMMARY

The Spending Round 2013 announced a pooled budget of £3.8 billion, which is made up of existing budgets, for integration of local health and care systems from **2015/16 –** the Integration Transformation Fund (ITF). The budget will require councils (under the auspices of local Health and Wellbeing Boards) and their health partners (Clinical Commissioning Groups) to work together to develop and agree local plans before they can access this funding. Failure to achieve agreed outcomes will result in a proportion of the allocated funding being withdrawn by the Department of Health. It is therefore critical that the integration agenda is fully embraced by local authorities and their health partners.

The final conditions associated with the fund and its performance framework, are yet to be released. However, the following is an indicator of the data sets being considered for the ITF performance framework:-

- Delayed transfers of care
- Emergency admissions
- Admissions avoidance
- Effectiveness of reablement
- Admissions to nursing and residential care
- Patient and service user experience

*The CCG budgets associated with the ITF are committed mostly to the delivery of acute services*. We are deeply concerned that this is not new money so therefore limits our ability to innovate and enhance the integration agenda locally.

*Key Note: £1bn of the funding will be linked to outcomes achieved.*

This paper focuses on what the ITF is and what it is not, the project plan to deliver the local ITF plan and an overview of the Terms of Reference for the Integration sub group and working group.

**2. RECOMMENDATIONS**

- note the progress to date on the development of the ITF plan
- note the key issues raised
- endorse the direction of travel set out in initial scoping of the ITF plan and add comments
- note and agree the terms of reference for the Integration Transformation Fund Sub Board and Working Group

## 3. BACKGROUND

3.1 This paper sets out to provide an overview of what is meant by integration when we are referring to health and care. It describes the conditions of the Integration Transformation Fund (ITF) and outlines the process for delivery of the local ITF plan within timelines set nationally. In terms of scene setting, this paper highlights the challenges of developing the local ITF plan and on balance, the opportunities that it creates. Also, it includes the recommended Terms of Reference for the HWBB Integration sub group and working group.

3.2 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 people's 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.

3.3 *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.*

## 4. ABOUT THE INTEGRATION TRANSFORMATION FUND:

4.1 The June 2013 Spending Round was extremely challenging for local government and NHS Clinical Commissioning Groups handing reduced budgets at a time of significant demand pressures on services. The announcement of £3.8 billion worth of funding to ensure closer integration between health and social care was viewed by many as 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 message was clear that integration was viewed by many as a means to ensure the future viability services. However, access to the ITF does not come without its challenges. It was then identified that the £3.8 billion was in actual fact made up of existing funding spread across health and care. The funding was already committed to the delivery of services. Local Authorities and Clinical Commissioning Groups nationally are deeply concerned that this is not new money so therefore limits ability to innovate and enhance the integration agenda locally.

4.2 The conditions are due to be officially released at some point in December 2013. Guidance has not been specific in terms of what resource allocation methodology will be applied to produce local allocations.

4.3 In addition to the ITF, there is the additional NHS contribution for integration which includes Troubled Families Funding.

4.4 Discussions with the CCG will need to take place to understand the potential for considering the needs of children and young people in transition for funding. It has been indicated through guidance that performance measures are focussed on adults at present and we require the full set of conditions before we are able to deduce whether or not this prohibits expenditure of the fund on Children's and young people services. 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** |
|---|---|
| NHS Social Care Grant *(existing local government funding agreed by NHS based on conditions set)* | £0.9bn |
| Additional NHS Social Care Grant | £0.2bn |
| DH and other Government Dept. transfers (inc. DFG & capital grants) *(existing Local government funding)* | £0.4bn |
| CCG pooled funding of:<br>- Reablement funding<br>- Carers' break funding<br>- Core CCG funding<br>*(existing NHS funding)* | <br>- £0.3bn<br>- £0.1bn<br>- £1.9bn |

*Key Note: £1bn of the funding will be linked to outcomes achieved.*

4.5 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.

4.6 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.

4.7 A paper produced for the "London Health Chief Officers Group dated 30th of July 2013" and confirmed in a letter dated 17th of October 2013 sent to CCG leads, 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.

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

4.9 Key guidance received so far:-

- "The funding must be used to support adult social care services in each local area, which also has a health benefit"

- "*The fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015/16, which remain very challenging….Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals" "It will be essential for CCGs and Local Authorities to engage from the outset with all providers, both NHS and social care".*

4.10 Interpretation of the above-mentioned key guidance locally is that:-

- The ITF is focused on adults

- There is an expectation that funding will be reconfigured away from specialist services to reinvest in community interventions for adults especially older people – there is a focus on reablement in particular

- that engagement with providers especially those in acute services will need to take place immediately to ensure that funds are released in time for 2015/16 deadline – for activity to start.

4.11 Impact on local CCG allocation

i) The average CCG contribution to the pooled ITF locally could be as much as £13m.

ii) 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.

4.12 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. The Health & Wellbeing Board will have a duty to monitor and ensure that the joint plan is delivered within timescale.

4.13 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 the remainder of this paper is to outline our approach to the development of the ITF plan and the governance structure to take it forward.*

## 5. DEVELOPMENT AND DELIVERY OF THE LOCAL PLAN

5.1 NHS Enfield Clinical Commissioning Group (CCG) and Enfield Council has put in place processes and structures to develop the ITF plan under the auspices of the existing Health & Wellbeing Board (HWBB) governance structures. Executive management from the CCG and Enfield Council have begun the process of developing a shared vision through formal and informal communication channels. The project plan and timeline can be referred to in *Appendix 1*.

5.2 The ITF is viewed by the CCG and Enfield Council as a means to drive forward fast paced change to deliver the integration agenda and facilitate closer working between health and care. It is not without its challenges. The Partnership have openly acknowledged - in recent workshops - that the budgets that contribute towards the ITF pooled fund are already committed which means that there is a natural inclination to protect existing services and limits the ability to commit to new initiatives or ‘doing things’ radically differently. This view is changing through open, transparent partnership communication and a commitment to work

collaboratively to deliver integrated services that will benefit the Enfield community.

5.3 Executive Management Teams on both sides of the partnership (CCG and Enfield Council) to date have agreed the following points to take the ITF Project forward locally:-

- Develop a shared understanding of the requirements and limitations of the ITF
- Be clear across organisations about the process required to access it
- Develop a shared vision and strategy for integrated care, which the ITF would support
- Engage the full range of stakeholders involved early on – including providers, members, clinicians, users and others
- Align and marry up change programmes and initiatives across the CCG and local authority (as well as with providers) so that resources could be deployed efficiently
- Recognition that the money for the ITF has already been allocated to existing services
- The role of the commissioners is to jointly define the problem / issue to be resolved
- In terms of a solution form should follow function, the focus is about outcomes in an organisationally agnostic way
- Providers need to be in the room as we define the use of the ITF
- The sustainability of providers needs to be considered and this includes looking at the impact of plans made by other commissioners on each provider
- Representatives from the local population (that reflects the different populations) must be a voice in the room
- Think of the ITF as a milestone for the medium term programme for integration
- To commission a Professional Advisor to take forward the project locally

## 6.0 GOVERNANCE STRUCTURE FOR DEVELOPMENT OF THE LOCAL ITF PLAN

6.1 The Sub-Group and Working Group of the ITF are working to develop the ITF Plan for the approval of the Health and Wellbeing Board. .

- The groups are currently being established by the Health and Wellbeing Board through the approval of their Terms of Reference. Please note Appendices 2
- The purpose and regularity of the ITF Sub-Group is to meet monthly to formally make recommendations to the Health and Wellbeing Board
- The ITF Working Group are to meet on a weekly basis to overview all of the development to the ITF**.**
- Additional meetings are currently being co-ordinated for the co-chairs of the ITF Sub and Working Group to meet with the main providers affected by the ITF
- Please note; that the membership of both the Sub and Working Group of the ITF. The Co-Chair of both groups are CCG Chief Executive Liz Wise and LBS Director of HHASC Ray James

6.2 ***Please refer to the project plan and timeline referred to as Appendix 1.***

## 5. REASONS FOR RECOMMENDATIONS

Members of the Health & Wellbeing Board are requested to:-

5.1 note the progress to date on the development of the ITF plan

5.2 note the key issues raised

5.3 endorse the direction of travel set out in initial scoping of the ITF plan and add comments

5.4 note and agree the Terms of Reference for the HWB Integration Sub and Working group

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

### 6.1 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 new fund will be 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 CCG and LBE. To access the ITF local plans will need to be developed by March 2014, which will need to set out how the pooled funding will be used and the ways in which the national and locally agreed targets attached to the performance-related element of the funding will be met.

Plans for the use of the pooled monies will need to be developed jointly by NHS Enfield CCG and the local authority and signed off by each of these parties and Enfield's Health and Wellbeing Board.

The Table within Section 4 above provides an estimate of Enfield's allocation.
This estimated allocations are based on LBE 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 resources being reallocated and additional NHS Social care grant funds.

The actual allocation of the ITF for Enfield will be subject to both jointly agreed local plans and in some cases locally set outcome measures, i.e. 'Payments for Performance'.

Any set up costs, including the commissioning of professional advice will be met from existing resources within HHASC with recharges to CCG for their contribution during the development of the plan. Once the local ITF has been implemented, any shared costs will be met from within the pooled funds.

**6.2 Legal Implications**

Section 195(1) of the Health and Social Care Act 2012 imposes a duty on a Health and Wellbeing Board 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'. There is also a power under section 195(4) for a Health and Wellbeing Board to 'encourage persons who arrange for the provision of any health or social care services in its area and persons who arrange for the provision of any health-related services in its area to work closely together.' The proposals set out in this report would appear to be covered by these provisions.

## 7. KEY RISKS

7.1 As indicated above this is not new money and any plans for integration / re-design needs to carefully consider the impact on local services, especially acute.

7.2 £1bn of the funding will be linked to outcomes achieved.. This represents a significant proportion of the ITF.

7.3 The present payment mechanism between CCG, NHS England and Enfield Council is considered poor. We need to ensure that the LGA and NHS England can offer assurances that this situation is improved and funding is received in a timely manner.

7.4 The ITF conditions have not as yet been finalised therefore please note that the information in this report is predominantly based on guidance and interpretation at a local level.

## 8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Healthy Start – Improving Child Health
The main thrust of the ITF is to integrate health and care further which will have a positive impact on the whole health and care economy in Enfield.

8.2 Narrowing the Gap – reducing health inequalities
The ITF is a means to ensure closer working between health and care so that adults living in the Enfield community are offered a range of services to keep them well and healthy in their own home or in a community setting, including those with long term conditions.

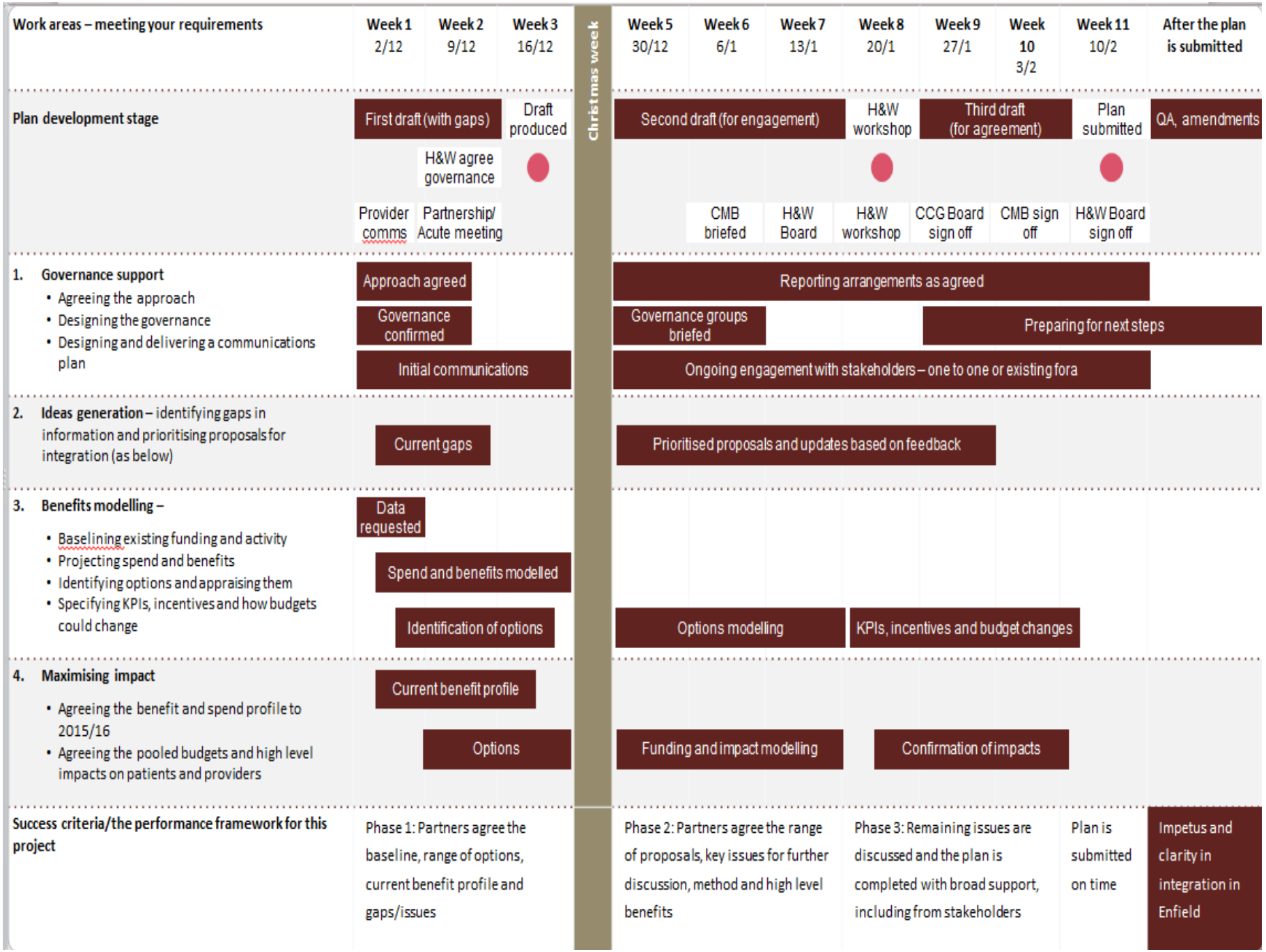
8.3 Healthy Lifestyles/healthy choices
Further integration of health and care services will produce better outcomes for people living in the Enfield community. It will ensure that people are at the heart of decision making with health and care outcomes that are foccussed on keeping people healthy and well in the community. In particular, it asks that health and care services are co-ordinated around the individual.

8.4 Healthy Places
By working in partnership, the ITF will ensure that we make Enfield a healthier place and address health inequalities faced by our adults living in the community.

8.5 Strengthening partnerships and capacity
Development of the ITF is an opportunity for closer working between health and care. It calls for clear leadership, accountability and assurance so that the partnership works for the benefit of all adults. We are asked to commission and work in an integrated way. This will of course strengthen partnerships and capacity to deliver services that meet the need of our adults living in the community.

## 9. EQUALITIES IMPACT IMPLICATIONS

An Equalities Impact Assessment will be developed at the same time as the Integrated Transformation Fund local plan.


Work areas – meeting your requirements
Week 1 2/12
Week 2 9/12
Week 3 16/12
Christmas week
Week 5 30/12
Week 6 6/1
Week 7 13/1
Week 8 20/1
Week 9 27/1
Week 10 3/2
Week 11 10/2
After the plan is submitted
Plan development stage
First draft (with gaps)
Draft produced
Second draft (for engagement)
H&W workshop
Third draft (for agreement)
Plan submitted
QA, amendments
H&W agree governance
Provider comms
Partnership/ Acute meeting
CMB briefed
H&W Board
H&W workshop
CCG Board sign off
CMB sign off
H&W Board sign off
1. Governance support
• Agreeing the approach
• Designing the governance
• Designing and delivering a communications plan
Approach agreed
Governance confirmed
Initial communications
Reporting arrangements as agreed
Governance groups briefed
Preparing for next steps
Ongoing engagement with stakeholders – one to one or existing fora
2. Ideas generation – identifying gaps in information and prioritising proposals for integration (as below)
Current gaps
Prioritised proposals and updates based on feedback
3. Benefits modelling –
• Baselining existing funding and activity
• Projecting spend and benefits
• Identifying options and appraising them
• Specifying KPIs, incentives and how budgets could change
Data requested
Spend and benefits modelled
Identification of options
Options modelling
KPIs, incentives and budget changes
4. Maximising impact
• Agreeing the benefit and spend profile to 2015/16
• Agreeing the pooled budgets and high level impacts on patients and providers
Current benefit profile
Options
Funding and impact modelling
Confirmation of impacts
Success criteria/the performance framework for this project
Phase 1: Partners agree the baseline, range of options, current benefit profile and gaps/issues
Phase 2: Partners agree the range of proposals, key issues for further discussion, method and high level benefits
Phase 3: Remaining issues are discussed and the plan is completed with broad support, including from stakeholders
Plan is submitted on time
Impetus and clarity in integration in Enfield

**Appendix 2**

# Integration Transformation Fund Sub Board and Working Group

# Terms of Reference

## Purpose

- The Sub Board of the Health and Wellbeing Board and its working group has been set up to formulate the planning and make preparation for, allocating Enfield's share of the Government's Integration Transformation Fund.
- The Government have established an Integration Transformation Fund made up of worth £3.8billion of funding to be distributed across all local authorities for health and social care, with the aim of developing a more integrated care system.
- This fund is being called the Integrated Transformation Fund.
- The Working Group 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.
- It is time limited to 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
- The funding will be provided to enable Enfield to establish 7-day working arrangements, better data sharing, a joint approach to assessment and care planning, and will have implications for the acute sector of service redesign, creating accountable lead professionals for joint care packages.

### 1. Aims

The primary aims of the Sub Board and Working Group are: to promote integration and partnership working between the local authority, Clinical Commissioning Group (CCG) and other local services; and to improve the local democratic accountability of an integrated health and social care system.

### 2. Names

The name of each body will be:

a. The Integration Transformation Fund Sub Board
b. The Integration Transformation Fund Working Group Board.

### 3. Membership

### 3.1 Integration Transformation Fund Sub Board

- CCG Chief Officer Enfield CCG
- Director of Health, Housing and Adult Social Care LBE

- Director of Schools and Children's Services LBE
- Representative of HealthWatch Enfield

*Additional personnel may be invited to attend the board by agreement of the current members

### 3.2 Integration Transformation Fund Working Group

The Sub Board will also have a working group, which will include all the members of the Sub Board as well as the following:

- Director of Finance Enfield CCG
- Assistant Director of Finance - Finance, Resource and Customer Service LBE
- LBE Assistant Director of Strategy and Resources - LBE
- CCG Director of Strategy and Partnerships Enfield CCG
- Assistant Director of Adult Social Care LBE
- Director for Public Health LBE
- AD for Commissioning, Community Engagement, Schools and Children's Services LBE

Additional personnel may be invited to attend the working group by agreement of the current members

**NB** the support officer or their representative will be in attendance at all Working Group Meetings.

## 4. Responsibilities

The working group shall meet frequently to present the on-going work of the ITF, they shall produce the recommendations for the ITF Sub Board to agree for the approval and ratification of the Health and Wellbeing Board for the sign-off of the ITF submission

The Sub Board, supported by the Working Group will be responsible for:

- Development of a time table for funding and work to be completed. Producing a plan by the end of 2013 for allocation of funding for 2014/15.

- Ensuring that the plan is formally agreed by April 2014 for financial years 2014/15 and 2015/16Ensuring sign-off arrangements are in place with the Enfield Health and Wellbeing Board;

- Making recommendations to the Health and Wellbeing Board and individual internal governing bodies.

Individual leads across the partnership will have the responsibility to ensure that their relevant governing bodies are sighted on all work undertaken by the Sub Board or the Working Group and are acting upon their behalf.

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 the Sub Board and ITF Working Group and Work Programmes:

The ITF Sub Board and Working Group of the Health and Wellbeing Board 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 and Working Group will develop its fixed term work plan and bring it to the Health and Wellbeing Board for formal approval.

The Health and Wellbeing Board or its Executive will receive recommendations, briefings and time Frames for developing the ITF Submission.

## 6. Chairing and Voting

The Chair will be a joint appointment for both groups, between Enfield CCG Chief Officer and LBE Director for Health, Housing and Adult Social Care.

All recommendations to the Health and Wellbeing Board by the Sub Board and Working Group will aim to be agreed through a consensus, which must include one member from the London Borough of Enfield and one from Enfield Clinical Commissioning Group. Where a consensus cannot be found, this will be reported to the Health and Wellbeing Board.

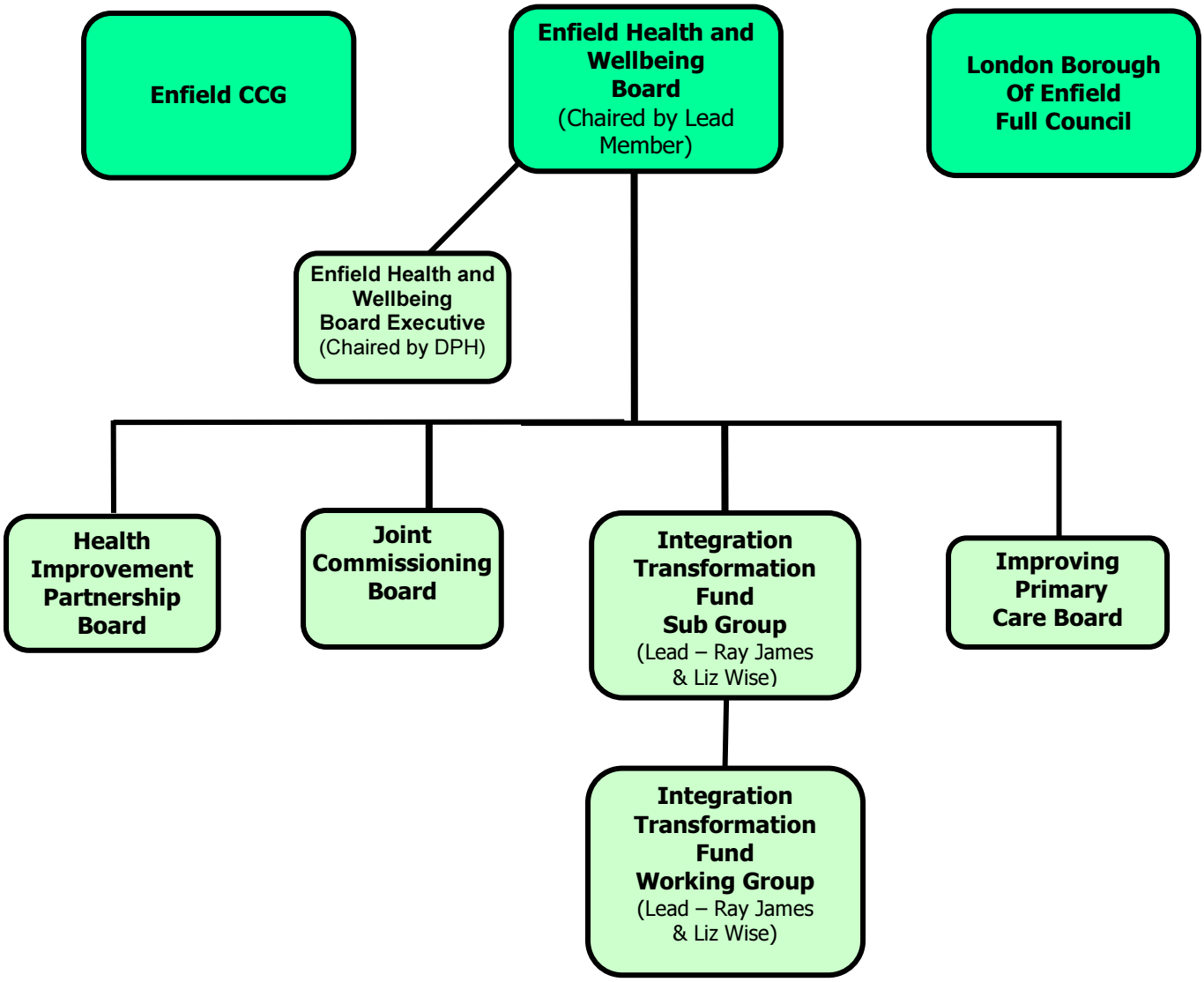
## 7. Frequency of Meetings

The ITF Sub Board is a fixed term group to oversee the ITF Working Group and is to function, on behalf of and to make recommendations to the Enfield Health and Wellbeing Board and will meet monthly until the approval of an integration plan for 2014/16 is established by April 2014.

The ITF Working Group has been established to ensure the activity and development of the ITF plan is progressed and is likely to meet on a weekly basis.

**Appendix 1 to the Terms of Reference**

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



Agenda Item 8

**MUNICIPAL YEAR 2013/2014**

| | |
|---|---|
| **MEETING TITLE AND DATE**<br>**Health and Wellbeing Board**<br>**12 December 2013** | **Agenda - Part: 1** **Item: 8**<br>**Subject:**<br>**Better Health Outcomes for Children and Young People Pledge**<br><br>**Wards: ALL** |
| Andrew Fraser<br>Director of Schools & Children's Services<br><br>Contact officer and telephone number:<br>Sarah McLean<br>Policy Officer<br>020 8379 5592<br>E mail: sarah.mclean@enfield.gov.uk | **Cabinet Member consulted:**<br><br>Cllr Ayfer Orhan |

## 1. EXECUTIVE SUMMARY

Local Authorities are now responsible for delivering and commissioning a range of public health services for five – 19 year olds, with responsibility for children under 5 following from 2015. This puts local authorities and health and wellbeing boards in a prime position to tackle the poor health outcomes experienced by some children and young people.

The Joint Strategic Needs Assessment and engagement with children and young people themselves will inform the Health and Wellbeing Strategy. This will in turn, ensure that services can be commissioned that give children the best start in life.

The Department of Health is asking organisations who have the power to make a difference to sign up alongside the government and do everything they can to improve the care that children and young people receive and reduce avoidable deaths. A number of organisations have already signed up to the Pledge.

The Department of Health, Local Government Association, Royal College of Paediatrics and Child Health, Public Health England and the Children & Young People's Health Outcomes Forum wrote to Lead Members for Children's Services and Chairs of Health and Wellbeing Boards asking them to share resources available to assist councils with this increased responsibility and to sign up to the "Better health outcomes for children and young people – Our Pledge". It also signposted to a number of other resources that would help the vision to become a reality and asked Local Authorities to share examples of good practice.

Signing up to the Pledge will demonstrate a commitment to giving children the best start in life. It will also start local conversations about how the Health and Wellbeing Board, the Local Authority, Health and wider partners can work together to improve health outcomes for children and young people, and tackle the unacceptable variation in quality of care for children and young people across the country and reduce health inequalities.

## 2. RECOMMENDATIONS

The Health and Wellbeing Board are asked to signed up to the "Better health outcomes for children and young people's Pledge". The Pledge outlines how we will work in partnership, both locally and nationally, with children, young people and their families to make this happen:

The shared ambitions of the Pledge are:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be co-ordinated around the individual, with an optimal experience of transition to adult services for those young people who require on-going health and care in adult life.
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

In addition the Health & Wellbeing Board are asked to consider a mechanism to carry out a predictive equalities impact assessment across the partnership to determine that by signing up to the Pledge that they will address the health inequalities faced by some children and young people in Enfield.

## 3. BACKGROUND

The need for improvement in children's health outcomes is not new, and there have been initiatives that have led to improvements in specific areas, but have not resulted in the system wide changes required to improve outcomes. What is new is the opportunity to ensure the focus on outcomes in the new health and care system includes children and young people clearly and explicitly, from conception through to adulthood.

At a national level the new Children and Young People's Outcomes Board, led by the Chief Medical Officer (CMO), brings together key system leaders in child health to provide a sustained focus and scrutiny on improving outcomes across the whole child health system.

A new Children & Young People's Health Outcomes Forum will provide both on-going expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

**Why sign the Pledge?**

Latest evidence tells us that:

- The all-cause mortality rate for children aged 0 – 14 years has moved from the average to amongst the worst in Europe
- 26% of children's deaths showed "identifiable failure in the child's direct care"
- More than 8 out of 10 adults who have ever smoked regularly started before 19
- More than 30% of 2 – 15 year olds are overweight or obese
- Half of life time mental illness starts by the age of 14
- Nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint
- About 75% of hospital admissions of children with asthma could have been prevented in primary care.

By signing the Pledge, the Enfield Health and Wellbeing Partners will demonstrate a joint commitment and effort to improve outcomes by:

- Reducing child deaths through evidence based public health measures and by providing the right care at the right time.
- Preventing ill health for children and young people and improve their opportunities for better long-term health by supporting families to look after their children, when then need it, and helping children and young people and their families to prioritise healthy behaviour.
- Improving the mental health of our children and young people by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it.
- Supporting and protecting the most vulnerable by focusing on the social determinants of health and providing better support to the groups that have the worst health outcomes.
- Providing better care for children and young people with long term conditions and disability and increase life expectancy of those with life limiting conditions.

## 4. ALTERNATIVE OPTIONS CONSIDERED

None.

## 5. REASONS FOR RECOMMENDATIONS

The Department of Health, Local Government Association, Royal College of Paediatrics and Child Health, Public Health England and the Children & Young People's Health Outcomes Forum wrote to Lead Members for Children's Services and Chairs of Health & Wellbeing Boards inviting them to sign the pledge.

Signing the pledge demonstrates our commitment locally to improving health outcomes for children and young people through joint

commissioning, sharing of resources and putting them at the heart of decision making.

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

### 6.1 Financial Implications

There are no direct financial implications as a consequence of the recommendations in this report. Any activity arising will be met from within existing budgets.

### 6.2 Legal Implications

A local authority has a general power of competence under s1(1) Localism Act 2011. This permits a local authority to do anything which individuals generally may do.

Section 2B (1) National Health Service Act 2006 states that 'Each local authority must take such steps as it considers appropriate for improving the health of the people in its area.'

A commitment to improve the health outcomes for children and young people would appear to be covered by these provisions. These provisions would also appear to cover the signing of a pledge to pursue such outcomes.

## 7. KEY RISKS

Lack of commitment from one or more of the partners could potentially jeopardise the Local Authority's ability to commission services in an integrated way.

The Pledge encourages an early intervention approach. If this is not achieved, it is likely that more costly interventions will be required later on.

If partners continue to commission in isolation this could potentially result in duplication of services. By working in partnership this will result in better use of already scarce resources.

## 8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

**8.1** Healthy Start – Improving Child Health
The main thrust of the Pledge is to improve health outcomes for children and young people.

**8.2** Narrowing the Gap – reducing health inequalities
The Pledge asks that partners treat all interventions with equal importance, including those with long term conditions.

**8.3** Healthy Lifestyles/healthy choices
The Pledge asks that children and young people are at the heart of decision making with the health outcomes that matter to them most taking priority. In particular it asks that care and services are co-ordinated around the individual to ensure an optimal experience of transition to adult services.

**8.4** Healthy Places
By working in partnership with the CCG and other colleagues the Pledge will ensure that we make Enfield a healthier place and address health inequalities faced by our children and young people.

**8.5** Strengthening partnerships and capacity
The Pledge asks for clear leadership, accountability and assurance so that the partnership works for the benefit of all children and young people. We are asked to commission and work in an integrated way. This will of course strengthen partnerships and capacity to deliver services that meet the need of our children and young people.

## 9. EQUALITIES IMPACT IMPLICATIONS

It is recommended that the Health & Wellbeing Board carry out an predictive equalities impact assessment on the Children's Outcome Pledge to ensure that there are no health inequalities for children and young people living in Enfield.

The Board would need to identify a mechanism for all partners to contribute to the assessment.

## Background Papers

Better health outcomes for children and young people – Our Pledge
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/207391/better_health_outcomes_children_young_people_pledge.pdf

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# Better health outcomes for children and young people

## Our pledge

> "The foundations for virtually every aspect of human development – physical, intellectual, and emotional – are laid in early childhood."
>
> **(Marmot)**

Children and young people growing up in England today are healthier than they ever have been before. Health care and social changes have had dramatic impacts. Previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

But international comparisons and worrying long-term trends demonstrate there is room for improvement, with poor health outcomes for too many children and young people compared with other countries. A smaller group of more vulnerable children – such as looked after children – suffer much worse outcomes. The variation in outcomes and quality of healthcare for children and young people is unacceptable. The clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence-based early interventions can have significant positive impacts does not always inform how services are commissioned.

The need for improvement is not new; numerous reports have highlighted the issues. Individual initiatives have led to improvements in specific areas, but have not resulted in the system wide changes required to improve outcomes. What is new is the opportunity to ensure the focus on outcomes in the new health and care system includes children and young people clearly and explicitly, from conception through to adulthood.

## We are committed to improving the health outcomes of our children and young people so that they become amongst the best in the world.

System-wide change is required to achieve this and each part of the system, at each level, has a vital contribution to make. To this end we pledge to work in partnership, both locally and nationally, with children, young people and their families.

## Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

**We all have a part to play in promoting the importance of the health of our children and young people.**

## Through our joint commitment and efforts we are determined to:

- **reduce child deaths** through evidence based public health measures and by providing the right care at the right time;
- **prevent ill health for children and young people and improve their opportunities for better long-term health** by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- **improve the mental health of our children and young people** by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- **support and protect the most vulnerable** by focusing on the social determinants of health and providing better support to the groups that have the worst health **outcomes**;
- **provide better care for children and young people with long term conditions and disability** and increase life expectancy of those with life limiting conditions.

## Because

- **the all-cause mortality rate for children aged 0 – 14 years has moved from the average to amongst the worst in Europe**[1]
- **26% of children's deaths showed 'identifiable failure in the child's direct care'**[2]
- **more than 8 out of 10 adults who have ever smoked regularly started before 19**[3]
- **more than 30% of 2 to 15 year olds are overweight or obese**[4]
- **half of life time mental illness starts by the age of 14**[5]
- **nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint**[6]
- **about 75% of hospital admissions of children with asthma could have been prevented in primary care**[7]

## Building momentum

At national level a new **Children and Young People's Health Outcomes Board**, led by the Chief Medical Officer, will bring together key system leaders in child health to provide a sustained focus and scrutiny on improving outcomes across the whole child health system.

A new **Children and Young People's Health Outcomes Forum** will provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

The Children and Young People's Health Outcomes Forum report and system response can be found at **http://www.dh.gov.uk/health/2012/07/cyp-report/**

**For the very first time, everyone across the health and care system is determined to play their part in improving health outcomes for children and young people.**

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1 Wolfe I, Cass H,Thompson MJ et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms. BMJ 2011; 342:d1277
2 CEMACH report 2008
3 Healthy Lives, Healthy People – our strategy for public health in England. Department of Health (2010)
4 Health Survey for England 2010
5 Kessler R, Angermeyer M, Anthony J et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007 Oct; 6(3):168-76
6 DfE Outcomes for children looked after as at 31 March 2012
7 Asthma UK. Wish you were here – England (2008).

Agenda Item 9

**MUNICIPAL YEAR 2013-14**

**Health and Wellbeing Board**
**12 December 2013**

| **Agenda – Part: 1** | **Item: 9a** |
|---|---|
| **Subject:** Health Improvement Partnership and Public Health Report | |
| **WARDS: All** | |

**REPORT OF:**

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**EXECUTIVE SUMMARY**

This report provides an update on the work of the **Health Improvement Partnership** and the **Public Health Department** in Enfield from April 2013 to November 2013 (Month 8 of financial year).

Updates for all key public health areas are included, as are relevant updates on health improvement activities from of the Health Improvement Partnership and its sub-groups. Additionally the report provides an update on some commissioning intentions and public health proposals for Q4.

A more detailed report under separate cover is provided for the Upper Edmonton Health Inequalities Project.

**RECOMMENDATIONS**

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

## 1. HEALTH IMPROVEMENT PARTNERSHIP - UPDATE ON FUNCTIONS

2.1 Joint Strategic Needs Assessment (JSNA)

The JSNA (Joint Strategic Needs Assessment) had been created as an on line resource, which would be continually updated as the data changes. The JSNA online went live in October 2013.

2.2 Health and Well-being Strategy (HWBS)

The draft Joint Health and Wellbeing Strategy priorities are being consulted on. The consultation closes on Sunday, 22 December 2013 and a consultation report will be available on the Enfield website in January 2014.

On Friday 6th December two public meetings are scheduled - one at Green Towers Edmonton (AM) and the other at the Dugdale centre (PM).

2.3 HEALTH IMPROVEMENT STRATEGIES

The HIP has received reports or updates on the following this financial year: tobacco strategy action plan, childhood obesity, maternity services, childhood poverty, patient equality monitoring, regeneration and domestic violence.

REVIEWS OF PERFORMANCE ON HEALTH IMPROVEMENT INDICATORS

2.4 The last meeting of the HIP took place on 16th October 2013. The HIP received updates on the Upper Edmonton Project – Life Expectancy and Employment Opportunities at North Middlesex Hospital; housing and homelessness; JSNA and HWB Strategy; Annual Public Health Report and immunisation. A presentation was received from the Life Opportunities Commission. Updates were also received from Child Health and Adult Health sub-groups and from the Health and Wellbeing Board and CCG.

## 3. PUBLIC HEALTH SERVICES – MANDATORY AND NON-MANDATORY

3.1 MANDATORY SERVICES

### 3.1.1 Sexual Health

Officers across commissioning, youth services (on teenage pregnancy) and public health contribute to the local authority agenda for sexual health.

Sexual health represents the single largest cost for public health. There remain some areas of uncertainty and risk affecting the costs of some contracts. For instance, Genito-urinary Medicine (GUM) represents the highest area of spend and is an open access service with unlimited demand. Due to the nature of the service and expectation of confidentiality there are currently fewer mechanisms for commissioners to challenge provider data. Agreeing a common approach to commissioning with neighbouring boroughs and commissioning NHS commissioning support have been employed to in part mitigate the risk.

The focus of public health commissioning has been on disaggregating contracts and to determine the likely costs of provision in 2013/14.

The focus of the public health team has been on sexual health promotion and disease prevention. Public health has developed and is delivering a HIV

testing campaign on the lead up to World Aids Day (1st December 2013); commissioned targeted work on HIV testing with identified communities; was involved in has signing up Enfield to the Pan-London HIV prevention work. These activities are directed at improving the uptake of HIV testing and securing a reduction in late HIV diagnosis.

Additionally, the specifications for a comprehensive sexual health needs assessment for Enfield have been developed. The sexual health needs assessment is on-going. The will inform the planning and commissioning of services for Enfield residents.

The public health work plan for sexual health includes the development of a specification for agreement with general practitioners in line with national guidance for sexual health and HIV to work towards decreasing the number of people in Enfield infected by a Sexually Transmitted Infection (STI) and HIV, by actively offering HIV testing to all new adult (15-59) registrations and STI screening to those who are identified as at risk or who present with symptoms. The specification will also reward practices for screening 15-24 year old patients for Chlamydia as identified in the National Chlamydia Screening Programme.

### 3.1.2 Health protection (and immunisations)

As with many boroughs in London, Enfield is not recording immunisation levels necessary to eliminate the risks of disease outbreaks. There appears to be a discrepancy between low coverage indicating a vulnerable population and threats such as the recent Welsh measles outbreak which did not result in a measles in London / Enfield despite reported cases.

Actions taken to improve immunisation uptake and coverage include the provision of information and resources to different community settings; a marketing campaign, utilising London buses and bus stop advertising space; articles within community newsletters; speaking to parents and carers and distributing written information during the Town Show; the production of a Public Health Newsletter specifically directed on raising awareness of the importance of MMR vaccination.

Additionally, nursery staff are asked to raise the importance of immunisation during home visits for children entering the school system. A letter was sent from the DPH to all head teachers in the borough to encourage immunisation uptake – outlining the risk of disease amongst not just unimmunised pupils but the staff that teach them; and a well attended vaccination and advice session was given at Eldon School in July.

A joint paper, written with PHE, was presented at the June Health and Wellbeing Board.

There remains on-going work around data capture and monitoring; and awareness raising in schools focussed on MMR vaccination and the routine childhood vaccination programme.

With respect to tuberculosis, the steering group co-ordinated by a public health officer to agree the community TB prevention plan has been set up with representation from partners across the care community.

### 3.1.3 Working with the CCG – the core offer

Public health has contributed or been engaged in the older people integrated care workshop, the community services redesign project, the child health integrated care steering group and workshop as well as in supporting the CCG Commissioning Strategic Plan – that is workshop and authoring chapters of the document.

Additionally, public health is involved in a modelling exercise project linking in health and social care data; the analysis and performance framework associated with the Integrated Transformation Fund; supporting the CCG operating plan and the development of practice profiles.

### 3.1.4 National Child Measurement Programme (NCMP)

The NCMP provides robust public health surveillance data on child weight status: to understand obesity prevalence and trends at local and national levels, to inform obesity planning and commissioning and underpin the Public Health Outcomes Framework indicator on excess weight in 4-5 and 10-11 year olds. The NCMP has a significant role in raising awareness of childhood obesity, by providing much needed evidence of the scale of the problem and informing action to address this.

For this academic year, 2012/13, the NCMP letters have been sent out; measurements taken and data uploaded. The public health team provided support to the school nursing team through this process. There are plans for the public health team to provide further training to the school nursing team on data capture, recording and entry; as well as completing any necessary NCMP obesity analysis.

Additionally, the NCMP can provide parents with feedback on their child's weight status: to help them understand their child's health status, support and encourage behaviour change and provide a mechanism for direct engagement with families with overweight and obese children (delivery of this element of the programme is not mandated).

With the healthy weight action plan for Enfield are proposals for a programme to support at least 100 children (and their families) who receive letters that show either overweight or obese category. Additionally, there are proposals to establish a care pathway by 2015 and explore the need for and if so establish a GP exercise referral scheme by 2015.

### 3.1.5 NHS Health Check Assessments

With the move of healthchecks to the LA from the PCT / NHS the former contract (LES) has needed to be re-written and has been updated. Following

national guidance the agreement now includes signposting of dementia services (for those aged 65+) and Audit C (alcohol screening).

The provider of community healthchecks continues to increase delivery and concentrates its activities in the South East of the borough, including expansion to faith-based locations such as the mosque opposite the Angel Centre.

At the end of Q2 4001 NHS health checks had been delivered and 7838 delivered. As such delivery is approximately 45 per cent over trajectory.

Additionally, the process and mechanisms for GP payments for health checks following the transfer to local authorities have been clarified and are functional.

3.2 NON-MANDATORY SERVICES

**3.2.1 Tobacco Control / Smoking Cessation Services**

Smoking has been identified as a major cause of health inequalities in Enfield. Smoking remains the greatest cause of preventable death, disability and morbidity in the borough. The greatest health gain comes not from quitters but from stopping people from starting to smoke / use tobacco.

The Enfield and Haringey Tobacco Control Alliance therefore organised a conference on reducing prevalence / stopping people starting to use tobacco on 23rd September. Speakers included Duncan Selbie, Chief Executive of Public Health England, Jo Locker, Tobacco Control lead for London and Dr. Subhash Pokhrel, University of Brunel and author of the NICE Return on Investment tobacco control tool. Public Health is an important stakeholder in the Tobacco Control Alliance.

Smoking prevention message continues to be distributed through schools via posters. An online programme “Smoke Storm” has been launched at 8 schools in Enfield. In June 2013 the Stop smoking service, public health and trading standards collaborated to deliver the dangers of smoking message.

Smoking prevalence in Enfield is approximately 18.5% of adults aged 18+.

**3.2.2 Obesity And Community Nutrition Initiatives**

The Child Healthy Weight Coordinator has been recruited. There is an active Childhood Healthy Weight Board / Healthy Weight Steering Group. The next meeting of the group is scheduled for 4th December 2013. The draft Healthy Weight Action Plan is currently out to stakeholders for comments.

**3.2.3 Increasing Levels Of Physical Activity In The Local Population**

In collaboration with the Senior Travel Awareness Officer, Cycle Enfield Programme – that is, cycle training, family bike rides, fun days will be

promoted. Within the Healthy Weight Plan, at least 3 new walking/cycling initiatives are to be implemented.

### 3.2.4 Dental Public Health Services

The recent PHE survey of dental health published in September reported that more than a quarter (27%) of five-year-olds in England has tooth decay down from 30% in a 2008 survey. Deprived areas had the highest numbers affected by decay. Children with decay had, on average, between three and four affected teeth.

Enfield was London's poorest performer, similar to Haringey. The average number of obviously decayed, missing (due to decay) and filled teeth per child was 2.05 (for instance, compared with the Richmond figure of 0.4, best in London).

Decay stems largely from a poor diet, but also poor dental care - not brushing teeth properly and not visiting the dentist often enough. Although healthy adult teeth will come through in children whose milk teeth have been affected by decay, if such bad habits become ingrained, there will also be problems with those teeth.

Following the survey, public health staff have met the Operational Clinical Lead for Dentistry Whittington Health (Haringey & Enfield Arm) to follow up on sampling used for the survey and further understand what oral health promotion activities are available locally. There is on-going work examine options for further enhancing oral health promotion for Enfield. Additional work proposed include literature review of current research and innovative evidence based interventions to improve oral health and identifying cost effective solutions for Enfield; benchmarking Enfield dental health services against similar borough; oral health needs assessment; and a comprehensive oral health strategy for Enfield.

### 3.2.5 Local Initiatives On Workplace Health

Public Health, working with colleagues across many departments, is coordinating the Council's bid to become accredited under the Greater London Authority's Healthy Workplace Charter, which provides a framework for addressing health and wellbeing over a number of areas, including healthy eating and physical activity, tobacco and alcohol, mental health and attendance management. This charter, introduced in 2012, provides practical guidance for organisations to improve the health and wellbeing of their staff over these areas and more, as well as engaging employees and ensuring high-level support. The Charter will provide official recognition for Enfield Council's work towards supporting staff in living healthy and balanced lives.

Public health is working with colleagues and officers across the council is also looking at how the Council can continue to improve health and wellbeing at work, including encouraging healthy eating, physical activity, and how to avoid stress, alcohol and smoking. This includes leading on a number of

healthy workplace initiatives such as the provision of free fruit in the canteen and at the Health Fair on 27th November. This will be followed by weekly fruit delivery to the Civic Centre, Charles Babbage House, Triangle House, Thomas Hardy, Moulson Road Depot and John Wilkes House until 18th December. This initiative is geared towards making it easier for Enfield staff to get the 5-a-day and eat healthily this winter.

More initiatives are planned for January – to support sustaining New Year resolutions - and beyond

### 3.2.6 Public Mental Health Services

A mental health needs assessment is scheduled for January 2014 and will inform future approaches to public mental health services.

### 3.2.7 Behavioural and Lifestyle Campaigns To Prevent Cancer and Long-Term Conditions

A range of health promotion campaigns are being delivered including those to raise awareness about stroke symptoms and alcohol.

Public health is developing a series of structured diabetes education sessions. Additionally, diabetes social marketing campaign has been commissioned to run alongside the diabetes education sessions.

### 3.2.8 Public health aspects of promotion of community safety, violence prevention and response

Predictive modelling around domestic violence is to be scheduled within the public health intelligence work plan. Public health officers contributed to domestic homicide review.

## 3.3 SERVICE AREA PUBLIC HEALTH ACTIVITY – PUBLIC HEALTH INTELLIGENCE / INFORMATION

In addition to many of the information and intelligence work that has informed prior mentioned activities, the public health intelligence function has been engaged in

- The development of locality profiles;
- Ongoing cardiovascular disease needs assessment;
- Ongoing cancer needs assessment;
- Chronic obstructive pulmonary disease needs assessment;
- Ongoing comprehensive looked after children health needs assessment;
- Setting out an understanding of the relationship between private rented accommodation and anti-social behavior. This was completed collaboratively with staff across other departments in LBE.

Additionally, the following needs assessments are planned or on-going for diabetes, looked after children, early access to maternities, sexual health; and Turkish and Kurdish communities.

Public Health Intelligence products such as Enfield factsheets are being developed for inequlities, alcohol, CVD, cancer, mental health, oral health and sexual health.

3.4 SERVICE AREA PUBLIC HEALTH ACTIVITY – CHILDREN, YOUNG PEOPLE & FAMILIES

**3.4.1 Maternities**

Over the last two years, the proportion of expectant mothers in Enfield who have seen a midwife or maternity health care professional by 12 weeks and 6 days of pregnancy has increased steadily. It is important to keep the momentum going. As such, a health campaign around this issue is running from 18th November to 1st December 2013.

The campaign has involved the redesign of the campaign materials to better reflect the ethnic diversity of Enfield. There has been a targeted element of the campaign around the Upper Edmonton area, with adverts placed at local bus stops; and working closely with identified communities. Campaign resources are also to be distributed through Children's Centres, libraries and community pharmacies.

Additionally, specifications have been developed for a health needs assessment, incorporating a health equity audit on access to maternity services.

In future, it is hoped that there will be greater 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.

There is an on-going pilot of health trainers working with the maternities services to support women with BMI >30. There are proposals for additional health trainer intervention with mothers with BMI over 25 but less than 40 for obesity and emotional wellbeing. The trialling of blood sampling for smoking in pregnancy over a two-week period is also proposed to enhance understanding of the prevalence of smoking in pregnancy beyond self-reporting. There is on-going work on the feasibility of public health / public health midwife working closely with Somali women and also investigating this project as a route to employment.

**3.4.2 Breastfeeding**

The proportion of women in Enfield who have initiated breast-feeding within 48 hours of delivery has risen steadily over the last four years. Over 90% of women in Enfield now initiate breastfeeding within 48 hours of birth. This figure is above both the London and England averages. Figures for

breastfeeding at 6-8 weeks after birth have also risen over recent years, and are above both the London and England averages.[1]

Twelve breastfeeding peer supporters were recruited and trained in 2011/12. In 2012/13, a further 23 were trained up and graduated in May. Twenty of these peer supporters are active. There are currently 21 active peer supporters volunteering in Enfield's Children's Centres. We are looking to improve retention rates.

Additionally, there are proposals to reintroduce the Enfield Breastfeeding Welcome Scheme; commission breast-feeding training for health care professionals and parent champions; develop a pregnancy pal and birth buddy initiative.

### 3.4.3 Infant mortality rate and Enfield Children and Young People Scrutiny Panel

From 2003-05 to 2006-08 Enfield's infant mortality rate was statistically significantly higher than both the London and the England rate, that is, there is very likely to be a true causal difference and is most unlikely to be due to chance or to normal variation. However, from 2007-09 to 2009-11, the Enfield infant mortality rate has not been statistically significantly different from the London or national rates. Although the numbers of deaths are relatively small this does not mean that the issue is resolved: an average of 28 babies are still dying before their first birthdays each year in Enfield.[2]

Infant mortality is a sensitive measure of the overall health of a population and reflects a likely association between the causes of infant mortality and other factors that influence the health status of whole populations. Interventions that are effective in reducing infant mortality will also improve the general health of the population: they are doubly beneficial.

In a recent report to the Enfield Children and Young People Scrutiny Panel, it was recommended that only if we can enable everybody to see reducing infant mortality – and more generally, improving the well-being of the borough's population – as part of their business and not somebody else's, that we will be likely to make any significant impact on the local population's health. This will require a much wider range of people, especially those in front-line services of all types, to understand the key issues, raise them with their clients/patients, and signpost them to relevant services.

### 3.4.4 Safeguarding

In a report of the Enfield Child Death Overview Panel (CDOP) to the Enfield Safeguarding Children Board earlier this year, it was noted that over half (18)

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1 http://www.enfield.gov.uk/healthandwellbeing/info/16/the_health_and_wellbeing_of_children_young_people_and_their_families/91/maternal_care [LAST ACCESSED 03.10.13]

2 http://www.enfield.gov.uk/healthandwellbeing/info/16/the_health_and_wellbeing_of_children_young_people_and_their_families/92/infant_mortality [Last accessed 03.10.13]

of the 30 deaths that occurred in the year 2012/13 were attributable to chromosomal, genetic, congenital anomalies or to perinatal/neonatal events – in each of the latter cases to prematurity related to spontaneous early onset of labour – and thus were, in the current state of knowledge, unavoidable.

No cases reviewed required referral for special case review and in only one was there considered to be a modifiable factor (relating to clinical practice, dealt with through developing new clinical guidelines).

Enfield CDOP is reviewing its ways of working with a view to enabling more detailed review of deaths where there might be lessons to be learned that might be more generally applied (to improve health and well-being for a large number of people) rather than those which might relate specifically to each death in question.

### 3.4.5 Vulnerable children: Looked after children

As of 31st March 2013, Enfield Council was responsible for 300 LAC. Looked-after children often have poorer health and social outcomes than other children. This is particularly true when considering the issues of educational attainment, mental health and homelessness.

A preliminary report following our analysis of data on looked after children has been recently issued, in support of the pending Ofsted inspection. The report is being used to facilitate dialogue between commissioners and providers and to support their development of a suitable action plan. The comprehensive health needs assessment for looked after children is ongoing and should provide recommendations for the systematic use and analysis of the data for planning and commissioning.

### 3.4.6 School nursing

From April 2013, local authorities became statutorily responsible for delivering and commissioning public health services for children and young people aged 5-19. This will include providing prevention and early intervention services, delivering the Healthy Child Programme and addressing key public health issues such as sexual health, emotional health and wellbeing issues, obesity, drug, alcohol and tobacco misuse.

The school nursing service offers a structured approach to delivering the Healthy Child Programme (5-19), providing public health advice and ensuing the emphasis is on providing early help to children and young people from school nurses.

We have developed specifications for a needs assessment for school nursing. The aim of the health needs assessment is to gather data to help determine the actions required to further improve the provision of school nursing services in Enfield. This is being done by identifying what the level of needs are amongst 5 – 19 year olds; determining strengths and weakness of

current provision; determining if there any gaps current provision and identified need; and how any such identified gaps can be addressed.

### 3.4.7 Family Nurse Partnership (FNP)

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.

Public health is represented on the steering group for the FNP and engaged with the launch of the FNP in October 2013.

### 3.4.8 CYP-PH Work Plan

In addition to the activities and plans set out above, the JSNA is being systematically examined to define the public health CYP work plan / programme which will also be closely aligned with the Enfield Health and Well-being Strategy.

## 3.5 SERVICE AREA PUBLIC HEALTH ACTIVITY – ADULTS / HEALTH INEQUALITIES

On 16 July a conference was held to develop a plan to improve female life expectancy in Upper Edmonton. Over 100 people including four council cabinet members, councillors, three NHS chief executives and members of the voluntary sector attended the conference. The keynote presentation was by Chris Bentley, former Head of the National Support Team for Health Inequalities.

Following the conference, an action plan was put together and is now being implemented. The delivery is in part being led the Upper Edmonton Life Expectancy Steering Group which met for the first time on 10th October 2013; and has met again in November.

Membership of the steering group is drawn from partners: CCG, NMUH, LBE and voluntary sector.

An UE LE action plan addresses 12 themes identified. Many of the themes are cross cutting with work that is already being delivered by the LBE public health team. The action plan has been costed and set in a work programme.

A more detailed update on the Upper Edmonton project is provided to the HWPB under separate cover.

## 5.6 SERVICE AREA PUBLIC HEALTH ACTIVITY – HEALTHY LIFESTYLES AND PLACES

From April 2013, public implications became a consideration for all cabinet reports.

Public health contributed to the mini-Holland bid. Highlights from the Enfield bid included introducing a Dutch style roundabout, with protected cycle lanes, in Edmonton Green, segregated routes along main roads and a "Cycle Superhub" in Enfield town centre.

Enfield is one of 8 boroughs shortlisted for the Mayor's £100 million "mini-Holland" funding from the initial 20 outer London boroughs. The three or four winners are to be announced early next year, with the £100 million to be shared between them, though not necessarily equally.

There are proposals in development for Enfield to become a World Health Organisation (WHO) designated city / town.

3.7 SERVICE AREA PUBLIC HEALTH ACTIVITY - IFR

Twenty-five individual funding requests have been processed.

## 4 PUBLIC HEALTH TEAM AND WORKFORCE

The recruitment and retaining of permanent staff to the public health department has been a challenge following its transition to local authority.

There have been vacancies at the consultant levels for a substantial part of the financial years, which have impacted on the progress on a number of work streams within the department. However with the engagement of interims across most staff grades, some of the capacity issues have been resolved.

A permanent consultant in public health has been recruited and is expected to start in the New Year.

The department is also embarked on some team / organizational development initiatives to further boost team performance.

To further enhance the community development work of public health and in part to respond to the healthy weight agenda, there are proposals for the expansion of the health trainer team.

**[END OF REPORT]**

**MUNICIPAL YEAR 2013/14**

# Health and Wellbeing Board

12 December 2013

| | |
|---|---|
| **Agenda – Part: 1** | **Item: 9b** |
| **Subject:** Joint Commissioning Board Report | |
| **Wards: All** | |

**REPORT OF:** Bindi Nagra

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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:

- Both the Multi-Disciplinary Team (MDT) teleconference and the risk stratification tools were presented at the October Practice Managers' Forum, with the risk stratification tool going live with practices on 5th November. 32 practices have received the training with a further 5 waiting [3.1]
- Public Health (PH) is carrying out an Oral Health Needs Assessment to ascertain the viability and appropriateness to link the (soon to expire) Schools and Childrens Services (SCS) contract with the existing PH contract with Whittington NHS Trust [4.2]
- The Clinical Commissioning Group's (CCG) five-year Strategic Plan has been presented, outlining its vision, strategic goals and underpinning values [5]
- A validated Winter Pressure checklist and detailed Action Plan has been developed, outlining the arrangements in place between health and social care agencies to manage the demands of the winter season [6.1.1]
- The formation of the borough's Hospital Discharge Steering Group to better understand and address the reasons for delays and to improve the overall hospital process [6.1.2]
- With the final draft of the Joint Adult Mental Health Strategy, the public consultation period is diarised to commence on the 10th February 2014, which will include meetings with those with a direct interest in mental health services to the wider community [6.2.1]
- The Learning Disability Partnership Board's contribution to the draft Autism Strategy [6.3.1]
- The Learning Disabilities Self-Assessment Framework (SAF) is reflective of the national drive to promote closer working between health and care [6.3.3]

## 1. EXECUTIVE SUMMARY (CONTINUED)

- The Carer Centre's partnerships in setting up an Asian Carers Support Group and supporting a Somali Parents Coffee Morning [6.4.3]
- The commencement of Enfield's Family Nurse Partnership [6.5]
- The continued upward trend of the Drug Alcohol Action Team's (DAAT) performance against the Public Health Outcomes Framework Indicator [6.6]
- Formal approval has been received from the Clinical Commissioning Group (CCG) for the approval of the indicative spending plan of the NHS Social Care Grant with the4 signed documents being sent to NHS England [7]
- The operational launch of the Keeping House Scheme is planned for the beginning of 2014 [10]
- The Safeguarding Adults Board to meet to discuss the increase in safeguarding adult alerts and the significant number of reports of abuse [11]

1.4 The Integrated Transformation Fund report is a separate item on the agenda and therefore, not included in this Report

1.5 The half year review on Section 75 is a separate item on the agenda and therefore, not included in this Report

## 2. RECOMMENDATIONS

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

## 3. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

### 3.1 Multi- Disciplinary Team (MDT) teleconference & Risk Stratification

Engagement meetings have been held with the GPs and Practice Managers to discuss MDT procedures, the need for patient consent, Data Sharing Agreement (DSA), risk stratification, training, and any concerns or issues that the practice may have. At the October Practice Managers Forum, both the MDT process and the risk stratification tool were presented.

Practices have been advised to gain patient consent before discussing patients on the MDT Teleconference, to record electronically and to display the patient information poster and patient leaflets as a minimum. The paperwork sent to the Local Medical Committee (LMC) in September has now been agreed but in the meantime, practices have been advised to use the patient consent poster and leaflet produced by NHS England to inform patients. Referrals to the MDT are increasing with 31 referrals in October and 32 referrals to date in November.

The risk stratification tool went live with practices on 5th November, and all parties signed off the Information Governance (IG) process. 32 practices have received the training with a further 5 waiting training. The acute providers pseudonymise their own service users' data and this goes to the risk stratification provider along with the social care data. Combining the data sets allows GPs to risk stratify patients.

### 3.2 Older People's Assessment Unit (OPAU)

Older Peoples Assessments Units (OPAU) have been developed on both acute sites. The OPAU service at Chase Farm started on 16th September for phase one and phase one at North Middlesex University Hospital (NMUH) commenced 23rd October. Although some in reach to Accident and Emergency (A&E) is still undertaken by the teams.

Chase Farm is getting a steady flow of referrals and has seen 80 patients to date. Chase Farm needs to increase its activity to meet investment targets and is working hard to communicate the new service to more GP practices e.g. at Plractive Learning & Teaching (PLT) meetings.

The NMUH OPAU started slowly; the service is now getting one patient per day and they will need to increase this soon to hit activity targets there have been 10 patients to date. NMUH has joined the marketing stall to PLT and is extending provision to GPs in south west practices. Both NMUH and Barnet and Chase Farm (BCF) teams are attending the CCG is holding a workshop on 19th November to discuss OPAU pathways, experiences to date and readiness for phase two implementation to support the A&E closure at Chase Farm.

### 3.3 Falls

The Fracture Liaison Nurse is continuing to screen fracture clinic and admitted Trauma patients from B&CF Acute Trust, for those at risk of further fragility fracture. The Service is exploring what systems are needed to be put in place to ensure that the changes to patient flows, resulting from the Barnet, Enfield and Haringey (BE&H) clinical strategy, do not affect the ability to case-find the at risk patients .i.e. strengthening links with Barnet and North Middlesex Hospitals.

The Community Bone Health Clinician is continuing to work closely with the Nursing Homes, targeting high risk patients and educating staff. She has put a process in place to receive the London Ambulance Service list of patients who have fallen but the call out did not result in the patient requiring A&E services. Similarly she is receiving information from the Community Alarm service regarding patients who have requested assistance as a result of a fall. She is now contacting both these groups of patients and triaging those at risk of further falls offering/providing assessment, advice and onward referral to other community services. She is being increasingly used as a resource by other community staff to review patients with issues relating to Osteoporosis management and medication.

Both clinicians attended a practice meeting with interested GPs and are using the positive feedback they received to inform their working practice in relation to other Primary Care Clinicians. They were due to attend the GP PLT session in Sept but this was unfortunately cancelled by the PLT team but the Service is proactively trying to get this rearranged for early in the New Year.

### 3.4 Care Homes Project

The Care Homes Assessment Team (CHAT) service is now working in 17 homes with an outreach geriatrician service provided by NMUH for the South. The commissioning team are examining options for increasing primary care support to the homes. In addition, they are examining how to configure the team now that the OPAU is in place. A recent survey of the homes indicates that many are happy with the service offered by the team. We have requested data from Health and Social Care Information Centre (HSCIC) to assess admissions from care homes. Community Matron in South continues to provide unplanned support to the homes by way of accepting telephone calls and where necessary visiting the homes – in September there were 12 calls resulting in 4 visits avoiding 5 unnecessary admissions.

The Bone Health nurse now holds clinics at care homes and accepts referrals from the CHAT team and works with them around falls prevention.

The Tissue Viability service is now working with 20 homes and continues to work to educate care home staff around wound management. A link nurse scheme is being developed and 8 of the 9 care homes contacted have signed up to participate in the scheme so far.

The Consultant Geriatrician from NMUH is planning to review the service and carry out a quantitative service evaluation undertaking a comparison between care homes that are supported by CHAT and those that aren't. There are also plans to review Advance Care Planning (ACP) and Do Not Attempt Resuscitation (DNAR)s; audit looking at whether plan was in place when patient died and whether it was in preferred place and to undertake a carer relative satisfaction survey.

Year to date, the team have seen 1756 patients in acute clinics and a further 168 in rolling review.

More patients are dying in their preferred place – till the end of September it is 92% where preferred place is known. Only 5 people did not die in their preferred place.

This financial year, the team have put in place a total of 65 ACP and 67 DNRs to September; the home avoiding unplanned admissions; if validated and costed at an average 2012/13 HRG cost would equate to £111,648 in savings.

### 3.5 Primary Care Locality Case Management

Primary care case management was defined in the business case for Integrated care. The primary care team (or the integrated local team as it will become known as) will be developed on a locality basis with the core being GP, Community Matron, Social Worker and a Community Nurse. The objective is to deliver proactive assessment and care of the elderly. The analysis suggests that the initial cohort of patients will be those > 75.

An initial meeting between Enfield Community Services (ECS), social services and the clinical lead took place to shape the development of an outline approach which was presented to the West Locality group on 14th November 2013. The locality has agreed to design and implement the integrated local team with the support of ECS and LBE. A number of GPs have volunteered to support this and to define the outcomes to be measured and develop an implementation plan. The aim is to complete this outline approach by 6th December 2013 with a view to

starting implementation prior to Christmas. It is recognised that this is an ambitious target. Review meetings will be built into the implementation plan so that the impact on patient care and GP practices can be monitored and the services improved based on feedback. This supports the government drive to have a named GP for those > 75.

### 3.6 Assistive Technology

The Assistive Technology Steering Group has been set-up, the first meeting has been held with a presentation by LBE on Assistive Technology in Enfield. Requirements have been discussed and a scoping document has been drafted for a pilot project that will focus on 50 older people with complex needs across two localities with different demographics and using two suppliers (partners). This will test how the tools could work in primary and integrated care.

Prospective companies have been contacted and invited to present at the AT Steering Group Meeting on 26th November 2013.

## 4. PUBLIC HEALTH TRANSITION

As the majority of the contracts transferred from the NHS to Enfield Council were extended for a year to end 31 March 2014 to enable the Council to assess the service delivery and Key Performance Indicators (KPIs) of all contractors, all Service Specifications will be reviewed and renegotiated to ensure that the specifications address the needs of the borough (in accordance with the Joint Strategic Needs Assessment (JSNA) and service needs assessments) for 2014/15

| | |
|---|---|
| Number of contracts and agreements: | 138 |
| | |
| Contracts / agreements expiring 31/03/2014 | 137 |
| Service Level Agreements with Enfield GPs and Pharmacists | 127 |
| Contracts that LBE is an Associate | 8 |
| Contracts / Service Level Agreements with independent contractors | 3 |

### 4.1 Sexual Health

4.1.1 The projected growth of numbers attending Genitourinary Medicine (GUM) services. (GUM) clinics nationwide is 10 – 15% increase on last year's figures. The national arrangement for all GUM services to be open access continues to place the council at risk financially. The agreed way forward is to enter into contractual agreements with other significant providers for 2014/15.

4.1.2 The agreements with London Commissioning Support Units (CSU) to monitor and manage GUM services has, so far, not been successful, which has resulted in some London local authorities terminating their

agreement with the CSUs from 31 March 2014 and grouping as a formal collaborative for the negotiation and placement of 2014-15 contracts for the provision of some sexual health services. The London Boroughs being: Barnet, Brent, Camden, Ealing, Islington, Hammersmith & Fulham, Haringey, Harrow, Hounslow, Kensington & Chelsea and Westminster (the North West London Sexual Health Group(NWL)).
Enfield Council has been invited to be a part of this collaboration and is still in negotiations regarding the arrangements and resources available in the new formation and with the N&EL CSU.

In light of the new formation of the NWL SH Group, Haringey, Barnet, Camden and Islington have withdrawn from the N&EL Local Authority Sexual Health Commissioning Group. Enfield will continue to meet with Waltham Forest and City & Hackney

**4.2 Oral Health Promotion and Prevention**

Following the notification that SCS will not be renegotiating the oral health promotion contract for 0 – 5 years with NHS Whittington; Public Health is carrying out an Oral Health Needs Assessment to ascertain the proposal to add the children's service to the existing Oral Health contract.

**4.3 Barnet, Enfield & Haringey Mental Health Trust (BEH MHT) Contract**

Enfield CCG has served notice to Barnet, Enfield & Haringey Mental Health Trust for the contract to expire 30 September 2014. The CCG has informed LBE of its intention to put the services out to tender as a block contract. The Council is part of the discussions and arrangements.

Note: Services relating to Enfield Council, with an indicative value of £3.7m:

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

**5. CCG Commissioning Intentions**

All CCGs are required to develop a Five-Year Strategic Plan of which the first two years – 2014/15 and 2015/16 – must be in operating plan level detail (see Appendix 1).

**5.1** Enfield CCG has presented its Five Year Strategic Plan – "clinically led, evidence based, with innovative solutions to deliver quality care to patients":

5.1.1 The vision being a commitment to commissioning services that improve the health and wellbeing of the residents of Enfield through the securing of a sustainable, whole system care.

5.1.2 The vision is supported by the following strategic goals:

- Enable the people of Enfield to live fuller longer lives by tackling the significant inequalities that exist between communities
- Proactively provide children with the best start in life
- Ensure the right care in the right place first time
- Deliver the greatest value from every NHS pound spent
- Commissioning care in a way, which delivers integration between health, primary, community and secondary care and social care services

5.1.3 The underpinning values being:

- Actively engaging with the Enfield patients and public in decisions about their own and their communities' health and wellbeing
- Working collaboratively with other CCGs, partners and stakeholders to deliver seamless, integrated care

## 6. SERVICE AREA COMMISSIONING ACTIVITY

### 6.1 Older People

6.1.1 **Additional Winter Pressures Funding**

Winter planning is underway, with reporting to NHS England in place:

- A validated Winter Pressure Checklist and detailed action plan were developed by NHS Enfield CCG and its partners, outlining the arrangements health and social care agencies have in place to manage winter demand.

- Health and social care partners received targeted funding from NHS England to relieve pressure on A&E and hospital admissions, with the health economies associated with Barnet & Chase Farm Hospitals and North Middlesex University Hospital NHS Trusts identified as two of the 10 London challenged health economies. The purpose of this funding is to assure A&E and hospital performance in Winter 2013/14. NHS England allocated £5.1m & £3.8m to the Barnet & Chase Farm and NMUH NHS Trusts health economies, respectively, and hence to individual health & social care partners' schemes to prevent hospitalisation, promote timely & safe discharge and prevent readmission in a 24/7 care economy. Progress in implementing these Plans, which also reflect future planning arrangements for integrated care, are monitored with NHS England on a weekly basis.

- Most of the actions in the plan have either been implemented or are in the process of being implemented. This includes the development

of hospital-based schemes to better support the hospital experience and discharge for people with dementia Rapid Assessment and Interface and Discharge (RAID), and health- and social care-based solutions to prevent hospital admission and facilitate discharge (e.g. Post-Acute Community Enablement (PACE)), including within an integrated care setting, and to fund extended hours of support.

- The one area that proved the most difficult to implement was to increase capacity of step-down beds in care homes in advance of winter. However, significant progress has recently been made, with around 20 additional nursing beds secured, most of which are in Enfield, but with additional beds in Ilford. The Council and CCG continue to work on solutions for increasing capacity, including appointing a coordinator to monitor patients' progress in the step-down beds.

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. As discussed in the previous report, this had many positive outcomes.

- The Department of Health announced there would no similar national Programme funded this year. However, because of last year's outcomes, the Council intends to provide £120k funding for a local Enfield Warm Homes Programme from December, targeted at the most vulnerable families and households in the winter.

6.1.2 **Delayed hospital discharges**

There was on average a 22% increase in the number of delayed transfers of care from hospital between the same periods April – September in 2012 and 2013, and an even more significant increase in the number of health-related delays (with a reduction in social care delays over the same period), a trend that continued into October & November. Furthermore, the corresponding overall number of bed day delays (for various reasons) increased by 42% over the same period to 2,827 over the same six month periods, or just over an average of 100 per week in April - September 2013.

Nearly two-thirds of the delays were due to people waiting for assessments, as well as those for Continuing Health Care, or those requiring intermediate care, including step-down solutions in nursing care.

In response to the above and the acknowledgement for all agencies in the process to share collective responsibility for appropriate, timely and safe discharge of patients from hospital, the Council, CCG, BEH MH

Trust and the hospital Trusts have formed a Hospital Discharge Steering Group to better understand and address the reasons for delays and to improve the overall hospital discharge process and its consistency for patients.

The Group has:

- Developed a set of aspirations that all agencies have committed to working towards in re-design & implementation of these pathways. This includes, for example, the aspiration people not needing an acute hospital bed should be discharged in 24 hours in safe & dignified way ensuring appropriate support in place;

- Developed and initiated a pilot to set revised discharge processes within the wider context of integrated care;

- Developed a set of interim commissioning solutions to address the need for a greater number of step-down/intermediate care beds, which has been identified as a key issue in increasing the number of delays.
  Winter funding monies has helped fund an additional 35 step-down beds to be opened & staffed in nursing homes, mostly outside the Borough.

- Discussions amongst partners are continuing regarding the longer-term solutions that need to be in place for 2014.

6.1.4 **Successor to My Home Life (MHL)**
The legacy of the successful My Home Life Project will be sustained through the Improved Lives Group, a joint collaboration between the Council, NHS and Care Homes using the MHL framework, and is linked to the Provider's Forum.

6.1.5 **Enfield Dementia-Friendly Communities**
*Enfield Everybody Active Older People's Enablement Project:* The Centre for Social Action Innovation Fund is a £14m fund run by NESTA to provide financial and non-financial support to help grow the impact and reach of innovations that mobilise people to help each other. One of the priorities is encouraging older people to improve their health, well-being and independence as they age. Enfield Council, supported by NHS and voluntary sector partners, developed an innovative proposal to extend the multi-agency Everybody Active Programme into the primary/integrated care environment to improve the physical & mental health, well-being & independence of harder-to-engage people – those in ill-health or with a long-term condition, isolated or carers – through working in collaboration with the voluntary sector in designing, coordinating & delivering different elements of the Programme. Central to the development will be a multi-agency "VCS hub" operating within primary/integrated care to navigate individuals' access to voluntary sector-led solutions, including existing opportunities in the Everybody

Active and other Programmes, and in VCS organisations & newly-developed solutions. The initial bid was for £360k over 2 – 3 years.

6.1.6 **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, and the project development is being led by Enfield Voluntary Action supported by a wide range of public-, voluntary- and private-sector partners, including the Council and CCG. This partnership submitted an £18k Development Fund in Nov-13 to help develop a costed Vision & Strategy document to be submitted to BLF for Apr-14, from which the 15-20 areas will be selected. Engagement events with older people and voluntary sector are being developed for early 2014.

**6.2 Mental Health**

6.2.1 **Joint Mental Health Strategy Consultation**

**[**www.enfield.gov.uk/amhsconsultation]

The consultation draft of the Joint Adult Mental Health Strategy is now finalised. A full 12 week public consultation on the strategy will be held, finishing on 10 February 2014. The strategy is available on the Council, CCG and BEH websites, as well as the websites of key mental health voluntary sector organisations. The intention is to significantly extend stakeholder engagement and involvement which is already extensive – more than 120 people have been involved so far in 1:1 conversations or small group discussions. There have been several meetings and conversations with some key people, including the clinical lead, BEH trust managers and the joint commissioning manager based at the CCG. The consultation will include a series of meetings with individuals and groups and extends beyond those with a direct interest in mental health services to the wider community.

There are 2 strategic goals:

- To improve the mental health and wellbeing of the population of Enfield
- To improve recovery for adults with mental health problems

and 8 strategic objectives to enable achievement

- **To improve the mental health and wellbeing of the population in Enfield**
- To address the wider determinants of mental health and wellbeing

- To reduce inequalities in mental health and wellbeing
- To consider establishing a mental health and wellbeing centre for the borough
- To improve the mental health and wellbeing of all carers and recognise and improve support for carers of adults with mental health problems

➢ **To improve recovery for adults with mental health problems in Enfield**

- To enable adults with mental health problems to lead independent, meaningful lives as active members of the communities in which they live and work
- To ensure delivery of personalised services focussed on supporting recovery and positive outcomes for adults with mental health problems
- To improve the accessibility and effectiveness of secondary care services
- To develop a strong partnership between mental health services commissioners and providers and ensure that service users and carers are fully involved in service improvement and planning

The focus is on improving recovery and outcomes. Work to develop meaningful outcomes that measure recovery and progress towards recovery will be developed by practitioners, commissioners, service users and carers working together. The work to develop outcomes will build on the work on value based commissioning currently being facilitated by Cap Gemini and Beacon UK on behalf of NCL.

The strategy will be signed off by the Cabinet and the CCG Governing Body in April 2014 with implementation starting immediately if the strategy is approved.

## 6.3 Learning Disabilities

### 6.3.1 Draft Autism Strategy

The draft Autism Strategy was the 'Big Issue' of the September Learning Disability Partnership board. Comments from stakeholders and advocates included references to developing a fully accessible version of the document and that there needed to be greater focus on what success looks like in terms of outcomes achieved. These comments have been taken on board and will be reflected in the final version of the strategy.

It is now out of public consultation and these comments have been taken on board and will be reflected in the final version of the strategy. Once finalised, the strategy will be available on the council's website.

The board agreed to nominate an Autism champion to sit on the Autism steering group, and devised a draft work plan to support implementation of the strategy for people with Autism and Learning Disabilities.

### 6.3.2 Autism Self-Assessment Framework

The Department of Health Autism Self Evaluation Framework 2013 has been developed to support local areas to understand how well they are doing in terms of implementing the national autism strategy (Rewarding and Fulfilling lives dated 2009) and improving local services for people with autism and their parent / carers. The Autism self-evaluation framework focussed on the following key themes:

1) Partnership Working,
2) Co-ordination and delivery of the local strategy,
3) promotion, training and awareness,
4) transition arrangements,
5) developing a clear and consistent diagnosis pathway and
6) self-advocate testimonials.

Enfield Self Evaluation Framework was scored as amber or green with no activity reported as red / areas requiring immediate attention. The document was submitted by the 30th of September 2013 to the IHaL website.

The autism framework prioritises improving the co-ordination of autism services across Enfield. This will give a focus to existing resources and services and a point of expertise for practitioners across the health and social care economy. The key outcomes are:

- A focus and single point of reference for autism across Enfield
- Improved co-ordination of services
- A high level care pathway for autism
- A set of condition specific pathways e.g. a pathway for adults with a learning disability who also have autism
- Improved access to information and advice
- Improved signposting to the services and support available
- Improved identification of adults with autism
- A network of autism champions based in all relevant health and social care teams and other relevant services in Enfield
- Improved awareness of autism across health and social care teams and other relevant services in Enfield
- Improved effectiveness of existing services
- Better use of resources invested in autism services

The Council and the CCG recognise the need to continue to focus on delivering the local joint autism strategy and to work in partnership with statutory and non-statutory agencies, and stakeholders to improve local services for people with autism and their support network. We view this as a key priority for the present and into 2014/15

6.3.3 **Learning Disabilities Self-Assessment Framework (SAF)**

The Self-Assessment Framework (SAF) and subsequent improvement plans will ensure a targeted approach to improving health inequalities and adult social care services for people with learning disabilities. A

simple public health model (Lalonde's health field 1994) highlights that people with learning disabilities are disadvantaged in all four domains and experiencing poorer health than the non-disabled population, because of:

1. Greater risk of exposure to social determinants of poorer health such as poverty, poor housing, unemployment and social disconnectedness.

2. Increased risk of health problems associated with specific genetic, biological and environmental causes of learning disabilities.

3. Communication difficulties and reduced health literacy.

4. Personal health risks and behaviours such as poor diet and lack of exercise.

5. Deficiencies relating to access to healthcare provision.

*People with learning disabilities are 58 times more likely to die before the age of 50 than the general population [Hollins et al 1999]*

There are numerous reports on the Improving Health and Lives (IHAL) website about the health and well-being of people with learning disabilities. IHAL: http://www.improvinghealthandlives.org.uk/publications

The Learning Disabilities SAF is a retrospective self-assessment that takes place on an annual basis. It usually includes topical themes such as Integration, admission avoidance and how well localities are responding to the Winterbourne View Concordat.

The Learning Disabilities Self-Assessment for 2012-13 is different from previous years. Instead of focusing purely on Health, it is reflective of the national drive to promote closer 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 are 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 continues on 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 30th of November 2013 but this may

be extended. The HWBB will be provided with an overview of the final version of Enfield's SAF at the next meeting.

6.3.4 **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 low-high 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 focus on 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. Regular updates will be provided to the HWBB.

**6.4 Carers**

6.4.1 **Enfield Carers Centre**

Enfield Carers Centre is currently in the process of recruiting a full time Benefits Advisor for a one year contract. This is due to the high demand from carers following the benefits changes.

The Hospital Liaison Worker started in late November and is currently working to establish relationships with North Middlesex and Chase Farm Hospitals. North Middlesex Hospital has provisionally agreed to provide an office base within the hospital for the Worker.

Recruitment for the Carers Nurse post has been delayed due to issues associated with the employer needing to be registered with Care Quality Commission (CQC) due to the clinical nature of the role. The Centre has contacted the CCG and individual doctor's surgeries but has been unable to find a host. The Centre has referred this back to the CCG Project Manager to progress.

The Advocacy Worker has been taking up cases and has also been promoting the services within the VCS and with practitioners. Last month they undertook casework for 22 carers.

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. They are also working with a number of other schools to deliver assemblies.

The Centre is now setting up an Asian Carers Support Group in partnership with Naree Shakti. The Carers Support Officer is also attending a Somali Parents Coffee Morning at Durants School which supports parents with children at Durants, Waverley and Russet House.

The Centre has also been running some interesting training sessions for carers. The first being an 11 week course for Mental Health carers entitled 'Supportive Family Training' which helps carers to learn and understand the mental health assessment process, how to work with practitioners and problem solving techniques. Feedback from carers has already been incredibly positive with a friendship network planned for when the course finishes, allowing the carers to continue to come together as a group to continue to support each other. 12 carers have attended this course.

The Centre has also run a Solution Focused Therapy six week course to provide carers with group therapy and coping strategies to improve their wellbeing. 16 carers are currently attending this training.

A Healthy Living Day will be held on Friday 22nd November, providing carers with health trainer advice, health screening, cancer awareness, advice on healthy eating, therapy sessions and mediation and relaxation sessions.

The Carers Centre AGM will take place on Monday 25th December. The focus will be Expert Health Partners with speakers including the GP Liaison Manager, CCG Practice Manager lead, BEHMHT, the Carers Commissioner for LBE and the Director for Policy from the Carers Trust.

6.4.2 **Carers Direct Payment Scheme**

We now have 108 carers receiving a Direct Payment through Enfield Carers Centre with others awaiting approval. It is anticipated that this number will decrease slightly as the annual review period is taking place to ensure all carers still meet the criteria.

6.4.3 **Carers Rights Day**

Enfield Carers Rights Day's event will take place at the Centre on Friday 29th November from 10am. The day will provide carers with information around benefits, telecare, the Joint Service for Disabled Children, VCs organisations and carer engagement and involvement. Benefits and legal advice will also be available. Consultation will also take place of the BEHMHT Carer Experience Strategy and the Mental Health Strategy. An evening event will held on Wednesday 27th

November at 6pm for carers that can't attend during the day. The focus of this session will be the Benefits Changes and carer support.

6.4.4. **Primary Care Strategy**
The GP Liaison Project Manager (funded from ECCG's primary care strategy programme) began in June and has visited all but 12 GP practices in the Borough, with meetings currently being arranged for the remaining surgeries. They have been successful in raising awareness of carers issues with practice staff, providing literature and posters.

A forum was held in September to consult with carers about their experience with their GP in relation to their caring role. The feedback was collated and has been feedback to all GPs surgeries via the regular Carers Email Bulletin that goes to all surgeries.

6.4.5. **The Employee Carers' Support Scheme**
The September meeting looked at the approach other Local Authorities take in supporting its employees. It was agreed that the Group would like to see the Council adopt a Carers Policy as well as developing a Carers Personal Plan that can be used to stimulate discussion between a carer and their line manager in a one-to-one setting. These documents are currently being developed.

6.4.6. **Relatives Support Network**
To build on the planning of the network for carers and relatives of those in residential care, a funding bid has been submitted to NESTA for funding for a Project Manager post and additional resources to Enfield Carers Centre to support the development of the Network

6.4.7. **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. Agenda items for the December meeting includes reviewing 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 the New Year.

The Parent & Young Carers Group is due to have their first meeting in January.

The Carers Strategy Implementation Group is due to meet again on the 9th December. Following the resignation of one carer representative a new carer representative has been recruited and will join the Group at the December meeting.

The Carers Communication Working Group has now agreed the expenditure associated with a new Carers Awareness campaign with poster and leaflet design ready for January 2014.

## 6.5. Children's Services

### 6.5.1 Family Nurse Partnership (FNP)

Enfield Family Nurse Partnership commenced on 1st November 2013, following a successful launch on 9th October 2013. The team received six referrals in the first ten days. Additional young people were not eligible for the FNP due to being too advanced in their pregnancy and were referred onto the Young Teenage Parents Service. Given the level of teenage pregnancies there is an expected 10 referrals per month. The team is meeting potential referrers and encouraging further referrals. Publicity about the FNP scheme has been circulated to GP practices and via the GP newsletter.

### 6.5.2 School Nursing

The Public Health Team at the Council are currently undertaking a health needs assessment that will support decisions to be made about future direction and focus of the service

### 6.5.3 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. The CCG's Finance Recovery and Quality Innovation Productivity and Prevention (QIPP) Board agreed funding for an additional 2 wte (whole time equivalent) Occupational Therapists on the 4th September 2013.

### 6.5.4 Community Services Redesign

Community services are a critical part of any integrated care system, across both adult and children's services. They have traditionally been commissioned under block contracts, via service line commissioning, with varying levels of specification and outcomes. This model of commissioning community services, as well as the model of provision of community services, will not meet the future challenges of care delivery nor will it provide sufficient leverage to change the system for our population. The CCG has signalled it's intent in future to move to outcome based commissioning of community health services by population, and Price Waterhouse Cooper are currently working with CCG on Phase 2 of the Community Services Redesign Project.

### 6.5.5 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.

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 was held on the 31st October 2013** and there was very good multi-agency attendance. Matrix is using the outcomes of the workshop to carry out the economic and financial modelling with a final report due before the end of the year.

## 6.6 Drug and Alcohol Action Team (DAAT)

### 6.6.1 Successful Completions (Drugs)

The DAAT's performance against the Public Health Outcomes Framework Indicator 2.15, *Successful Treatment Completions*, has continued on an upward trend with the latest ratified Public Health England (PHE) data confirming that Enfield has achieved 28.8% for the 12 month rolling period Oct 2012 – Sep 2013. Enfield is now placed 5th in London against this Indicator. The London average is 17.9%; and the National average is 14.6%.

### 6.6.2 Numbers in Effective Treatment (Drugs)

As reported at the last Health and Well-Being Board the Number of Drug Users in Effective Treatment is still very slightly below the trajectory target of 1068 (*N = 32*). Performance improvement against this measure will be achieved before year end as there remains good opportunity give the time lag delays in this performance indicator.

### 6.6.3 Numbers in Treatment and Successful Completions (Alcohol)

The number of alcohol users in treatment has increased by 13% since the start of the year based upon the new 12 month rolling data release by PHE. It is pleasing to note that along with quantity performance improvements we have also witnessed quality gains with 38.1%

successfully completing during the latest period. This is higher than the London Average of 33.6% and above the National Average of 35.8%.

6.6.4 **Young People's Substance Misuse Performance – Q2 2013-14**
There has been a significant increase in the number of young people engaged with the service in 2012/13 and 2013/14. The rolling 12 month figure for young people in treatment in September 2013 is 187 which represent a 30.7% increase in numbers compared to the same period last year and it has more than doubled since 2011.

6.6.5 **Tender Programme**
The tender programme for the three Council substance misuse contracts remains on target with the ITT stage due to finish on the 29th November 2013. The contracts include the Adult Substance Misuse Recovery Service contract, the Young People's Substance Misuse Service contract, and the Crime Reduction Substance Misuse Recovery Service contract. It is expected that Cabinet approval will be sought during the January 2014 meeting for the award of the new contracts.

6.6.6 **Adult and Young People's Substance Misuse Strategy**
The DAAT Board held an Adult and Young People's Substance Misuse Strategy development meeting on the 11th November 2013 to produce the key strategic priorities the community wants to address substance misuse within the Borough. The meeting was well attended and the DAAT Officers will now be producing a draft strategy to include the content from the 4 workshops before circulating for wider consultation. The draft Strategy will need to be approved by DAAT Board before escalating to the SSCB and the Health and Well-Being Board for consideration. It will then obtain Cabinet approval before being implemented.

## 7. NHS SOCIAL CARE GRANT

7.1 As previously reported, the Council has sought formal approval of the indicative spending plan from NHS Enfield Clinical Commissioning Group and the completion of documentation required by NHS England to authorise the release of the funding. Formal approval has now been received from NHS Enfield Clinical Commissioning Group and signed documents have been sent to NHS England, so payment is now being processed.

7.2 As per the spending plan, a total of £3,822,890 has been allocated in 2013-14 of the total allocation for this period; the remainder of which has been allocated for projects in the early part of 2014-15 to provide stability to on-going projects over a 12 month period for those that did not begin at the start of the financial year. Of this £3.8m, £2m has been allocated to maintain eligibility criteria and existing services and £1.8m was allocated to specific projects.

7.3 Quarterly updates are being produced to monitor progress of the individual projects. It is currently reported by the project leads that the forecast spend by 31st March 2014 will be £3.6m. The progress during Quarter 3 is being monitored closely and alternative plans are being reviewed given the forecasted underspend of £178K.

7.4 Some highlights of the outcomes delivered to date include:

**Care Home Pharmacist** – the provision of a 12 month pharmacist has provided support to the Council's safeguarding team on medicines issues and to GPs who prescribe for care homes. A baseline self-assessment audit has been sent to all homes and a workshop programme is being developed to provide further training to care home staff.

**Tissue Viability Service** – Tissue viability care has been delivered to 33 new residents with 49 follow up visits. Education and training has been delivered to 82 care home staff to increase their skills and knowledge in providing wound care to patients.
**Quality Checker Programme** – an effective model to visit care homes has been delivered and 12 visits have taken place to date, with generally very good feedback.

**Falls Prevention** – The Fracture Liaison Nurse is continuing to screen fracture clinic and admitted trauma patients from B&CF Acute Trust for those at risk of further fragility fracture. To date 371 patients have been identified from the clinic, advice has been given via 185 telephone by the Fracture Liaison Nurse.

## 8 HEALTHWATCH ENFIELD

8.1 Following full Council approval to create Enfield Consumers of Care and Health Organisation (ECCHO), the Community Interest Company that will be responsible for delivering the Healthwatch functions in Enfield, the Chair and Board Members have now registered themselves as Directors. ECCHO has established its base of operations at Community House in Edmonton and held its official launch at the Green Towers Community Centre in Edmonton on 15.10.2013. The event was well attended with representatives present from statutory and voluntary sectors together with a number of service users, carers and patients.

8.2 Whilst the Council cannot set ECCHO's work programme, Commissioners and the ECCHO senior management team are currently finalising the terms of the Service Level Agreement between the Council and ECCHO which sets out agreed key outcomes, outputs and contains proportionate 'light touch' processes to assure and validate service delivery of the statutory Healthwatch functions.

ECCHO will be grant funded by the Council and the first payment has been disbursed. Further payments will be released quarterly, on the basis that ECCHO demonstrates its ability to carry out its functions effectively through regular reporting and effective liaison.

## 9. VOLUNTARY & COMMUNITY SECTOR STRATEGIC COMMISSIONING FRAMEWORK (VCSSCF)

9.1 Following the completion of the Phase 1 review of grant funded organisations, Commissioning proposals and recommendations are being finalised for approval that :

- ensure that the strategic aims of the Council can be contributed to in the most appropriate way;
- are aligned and consistent with corporate commissioning arrangements;
- address the provision of support to ensure that equalities issues are being addressed in Enfield (covering Age and Disability) ;
- secure locally focussed service provision for adults with health and social care needs delivered by partners with the relevant experience of working in and for Enfield's diverse communities ; and
- provide stability for local voluntary and community sector partners.

9.2 Phase 2 will focus on the commissioning of an integrated information, advice and advocacy service that will be secured through a competitive grants process. Service aims, objectives and outcomes have been co-produced with service users, carers, voluntary and community sector (VCS) organisations and health and social care professionals. The preference from service users and carers is for local VCS organisation to combine their specialisms and expertise into a local partnership and provide a one-stop shop solution. The commissioning process will commence during next year.

9.3 Subsequent phases of the framework will focus on commissioning a range of preventative services to support local people to promote local people's health, wellbeing and support them to live independently in the community.

9.4 Current activity is also focussed on the design of a new invigorated Performance Management framework to ensure regular, consistent monitoring is carried out and service delivery is validated.

## 10. SPECIALIST ACCOMMODATION
## Mayor's Care & Support Specialist Housing Fund

10.1 **Specialist Accommodation for Adults with Learning Disabilities**
In July 2013, Newlon Housing Trust, supporting by Enfield Council and the Health & Wellbeing Board were awarded £840,000 for the demolition and redevelopment of outdated specialist accommodation located off Carterhatch Lane. The new service will deliver 14 x 1-bedroom units of accommodation with communal facilities for adults with Profound & Multiple Learning Disabilities (PMLD) and older people (50 years +) with learning disabilities and dementia.

Planning submissions for this redevelopment are now imminent and works has commenced in relation to the assessment and decant existing tenants. Decant is planned for the end of January 2014. The build programme is scheduled to commence March-June 2014 and completion is set for June 2015.

The planned development responds to feedback from people with learning disabilities and their carers during a review of the service undertaken in 2009. People with disabilities shall be actively involved in shaping this development, to ensure the delivery of a new service that effectively responds to need.

10.2 **The Keeping House Scheme**
The Keeping House Scheme has been set up to extend upon the current Empty Property Grant Scheme to reduce the number of vacant properties in the borough by appropriately targeting and supporting people living in long term residential care who own vacant property that they wish to lease to the local authority (via a housing association partner) for a fixed period in return for rental income.

Potential benefits of the scheme include:

- an increase in choice for people who self-fund their care, by providing an attractive offer that will enable people to maintain ownership of property and generate new income rather than depleting savings;
- in increase in local housing supply - bringing empty properties back into use to better meet escalating housing demand,
- a reduction in the negative impact of empty properties on neighbourhoods including inappropriate use and vandalism;
- a reduction in debt accrued by the Council through the minimisation of deferred payment scheme applicants;
- a reduction in the local authority's care funding budgets, as self-funders are supported to maintain financial independence;
- income generation by way of the New Homes Bonus Grant (currently set at around £1,400 per Band D property brought back into use)

Following completion of information and consultation events for referring agencies, homeowners and their carers in December 2013, operational launch of the Keeping House Scheme is planned for early in the New Year. A cross departmental project monitoring and review group shall meet on a quarterly basis to assess impact and outcomes of this new scheme. This is an innovative new approach to reducing empty properties with cross cutting benefits that has yet to be trialled elsewhere. Should anticipated benefits be realised, learning shall be shared with other authorities who have expressed an interest in finding out more about the scheme.

## 11. SAFEGUARDING

### 11.1 Safeguarding Adults Board (SAB)

The Safeguarding Adults Board meets on the 2nd of December 2013 and will review performance data which identifies that the number of safeguarding adults alert received by adult social care has continued to rise; in Q2 of 2012-2013 there were 373 reports of abuse, while during this year's Q2 there has been 485. This is an increase of 29.8%. There has been a significant increase in the number of reports of abuse which identify 'multiple abuse' as the type. This is positive in terms of identification of the abuse and ensuring that a safeguarding adults response consider the multiple and complex nature of harm. Neglect and Physical abuse are the most reported single types of abuse, whereas this used to be financial abuse in Enfield. The National data returns for 2012-2013 concurred with Physical abuse and neglect as the most common types of abuse reported in referrals, accounting for 28 per cent and 27 per cent respectively of all allegations.

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. Each Board meeting receives a project management update which highlights areas requiring attention of partners.

The Safeguarding Adults Board will be undertaking an audit of its effectiveness to keep people safe. This has been agreed to be completed as a cross audit with the Safeguarding Children Board; young people, service users and carers will also form part of the panel that challenges and reviews the submission of the Board in respect to its effectiveness and ability to prevent and respond to the abuse of adults at risk. The results of this audit are due in March 2014.

11.2 **Surveillance Policy**

The Strategic Safeguarding Adults Service has developed a draft Surveillance Policy for Health, Housing and Adults Social Care. This was agreed at the September 2013 meeting of the Safeguarding Adults Board and by the Service User, Carer and Patient sub-group of the Board. The Service is seeking Cabinet approval in January 2014. The Policy is intended to further protect vulnerable adults within the limits of the relevant legislation and in so far as it is judged to be legal, feasible and proportionate.

The policy framework will help to deter behaviours and actions that put an adult at risk of abuse in any form, including the risk of being treated with a lack of dignity and respect.

The use of surveillance will be used in cases where there is substantial concern that adults are at risk of abuse. Covert surveillance requires legal authorisation and will be used when necessary and proportionate to identify perpetrators of abuse and to obtain evidence to support a criminal prosecution

11.3 **Audit of Case Practice**

Quality assurance and continual learning to improve practice are integral parts of safeguarding. The Strategic Safeguarding Adults Service undertakes quarterly case fail audits in partnership with the adult social care teams. The audit tool used by the service has been amended to place an emphasis on how the safeguarding process has improved the safety and well-being of the adult at risk. This audit tool will also be used by our external auditor in January 2014.

11.4 **Dignity in Care**

The Safeguarding Adults, Quality and Complaints Service are arranging a Dignity Conference on 5th of March 2014. The aim of the day is to consider: How do we maintain and improve dignity in light of the changing local and national context. This day will be open to all partners on the Safeguarding Adults Board and those whom use services and their carers.

11.5 **Safeguarding Information Panel (SIP)**

The November 2013 Panel, marked two years of meetings. We now intelligence from a variety of sources, including safeguarding alerts, the London ambulance service, complaints from home care contracts. We also receive information on which homes are without managers, have CQC notices, and the number of deaths. We are working to improve pressure ulcer information, which has been inconsistently available in recent months. The focus of the Panel is to identify preventative measures that can be implemented by the partners.

11.6 **Quality Checker Programme**

The visits to care homes are currently underway. From the 31 care homes visits, the feedback has been generally positive. We are concentrating on visits to care homes where we have no information at the Safeguarding Information Panel (10.5). The pilot programme of visits to our In-house Domiciliary Care Service clients has highlight a number of issues for our risk assessments of such visits. So far, 14 visits to our In-house Domiciliary Care Service have been completed and feedback of this service has been very positive. Over the coming three months, the focus will be home care visits, with the project still on course to achieve 70 home care visits this financial year.

11.7 **Quality Improvement Board (QIB)**

The Quality Improvement Board is due to meet on the 18th December. The two key projects are the Dignity in Care panel and the Care Home Carer's Network. The Dignity in Care conference (10.4) will be the occasion for launch of our Dignity in Care panel. In-house provider services have volunteered to be the first service to go through the Dignity in Care panel review, with a focus on identifying any areas of good practice, improvement or training. Quality Checkers are on each visit are asking if care homes have relatives and residents group, and these will be the first groups the volunteers will visit. They will be advising residents and relatives groups of support available through the Carer's Centre and how to raise concerns or let us know about excellent practices that we can share with other care home providers. The Board will be reviewing its structure to ensure that all Quality Assurance and Improvement activities feed into it. The My Home Life legacy group (Improving Residents' Lives group), which is a group set-up with care home managers and the CCG and focusses on improving quality of practice across all partners, will, subject to Quality Checker approval, become a sub-group of the Board.

## 12. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

### 12.1 Learning Difficulties Partnership Board (LDPB)

12.1.1 **Draft Autism Strategy**

This was the 'Big Issue' of the September Learning Disability Partnership board. Comments from stakeholders and advocates included references to developing a fully accessible version of the document and that there needed to be greater focus on what success looks like in terms of outcomes achieved.

The board agreed to nominate an Autism champion to sit on the Autism steering group, and devised a draft work plan to support implementation of the strategy for people with Autism and Learning Disabilities.

12.1.2 **Reviews**

The board commented on the draft 'What to expect at your review' document. This will include 'Talking about money'. It will explain the care co-ordinators will look at creative ways to achieve peoples

outcomes more effectively. These will be conversations about negotiated savings, rather than ‘cuts’.

12.1.3 **Finance**

The board were updated on the current financial situation and a number of conversations were and on strategies to move forward.

12.1.4 **New Options Re-Provisioning**

Demolition on the site is now complete, and work on the new building is due to start.

12.1.5 **Employment**

The employment sub group of the partnership board has convened its first meeting. There was very good engagement from all providers and a real commitment to achieving the outcomes of the employment work plan.

12.1.6 **PCP Conference**

The first of what is hoped to be a series of PCP conference took place in November. This is an inclusive event for the people we support, families, providers and specialists. There were workshops on writing your own outcomes, staying health, End of Life Care, Relationships and Sexuality, and Challenging behaviour. 40 people attended and feedback had been very positive.

12.1.7 **‘My Health Folder’**

The health sub group has revised the Hospital Passports and Health Actions plans into a new ‘My Health Folder’. A draft was given out at the PCP conference for comment. Feedback was very positive, and a number of improvements were suggested. These will be applied and taken to the Health sub group in January for approval, before being made available on line.

12.1.8 **End of Life Care pathways**

The End of Life Care pathways, and ‘Making the most of life…’ resource books have now been signed off. These were presented at the PCP conference, to very positive feedback. They will be made available on line. The End of Life steering group is in the process of developing into an operation group to oversee the implementation of the new pathways.

12.1.9 **Section 75 – ILDS**

Discussions between the CCG and the LBE are currently underway to agree the LD service specification for 2014/5 and beyond. It is envisaged that the new specification will be outcome based rather than activity based. Partners have expressed a commitment to continuing with an integrated service for people with learning disabilitie**s.**

**12.2 Carers Partnership Board**

The Carers Partnership Board is now to be chaired by Rosie Lowman, the Commissioning Manager for Carers Services. Christie Michael continues in her role as the Carer Co-Chair.

It has been acknowledged that the Board needs to review its membership particularly in light of recruiting new carers representatives following the resignation of three carers this year. An advert has been circulated via the Carers Centre and VCS contacts as well as members of the Board.

Recently the Carers Partnership Board has provided joint feedback on the Council Tax Support Scheme Consultation, Customer Engagement Framework and the BEHMHT Carers Experience Strategy as well as overseeing the delivery of the Joint Carers Strategy 2013-16.

The role and function of the Board is to be reviewed in the January 2014 meeting to ensure the Board can continue to represent the voice of carers and those working with carers. This will include the formulation of a Board work plan.

**12.3 Mental Health Partnership Board**

Following a facilitated away day with all partners, the board has developed a work programme to highlight and focus on priority areas across the partnership. The priority areas are aligned with the development of the Enfield MH strategy. The board will continue to act as a reference point in the borough for MH related initiatives. The 4 work streams will focus on Economic wellbeing, keeping safe, healthy living and service user partnerships.

Through the board a bid has been made for time to change grant funding that is aimed at tackling stigma. The outcome will be known in January. The board has recently supported a proposal that Enfield Council nominated itself to the MH champions scheme, which seeks a champion be nominated in the elected leadership to promote awareness of MH related policy and practice.

A collaborative and successful World mental health day celebration was coordinated by board members in October. The event was this year held in the restaurant in the Chase Building and was focusing on health living with mental health and ageing. It enabled health to be celebrated as opposed to a focus on treating illness. Over the course of the day scores of users, carers and partner organisations joined together to promote and celebrated positive features of a Mental Health Community.

**12.4 Older People Partnership Board**

The last Older People Partnership Board took place in Nov-13. The Board received several updates about some of the issues highlighted in this report: in particular, feedback about development of the Enfield Dementia Action Alliance, integrated care and the voluntary sector bids in progress. The Board received a presentation about the Adults Mental Health Strategy and identified a need to better support older people's functional mental health needs.

**12.5 Physical Disabilities Partnership Board**

The last Physical Disabilities Partnership board took place on the 15th July 2013. The board received updates on welfare reform and the carer's strategy. EDA presented an update on the effects of welfare reform on disabled people and raised a number of concerns. The board asked to be kept updated and for council officers assurance that support is being provided to those made more vulnerable by the changes. The carer's strategy was well received by the board. Future agenda items include: transport, continuing health care and sensory impairment.

**Appendix 1 (ref. Section 5)**

**ENFIELD CCG 5 YEAR STRATEGIC PLAN**

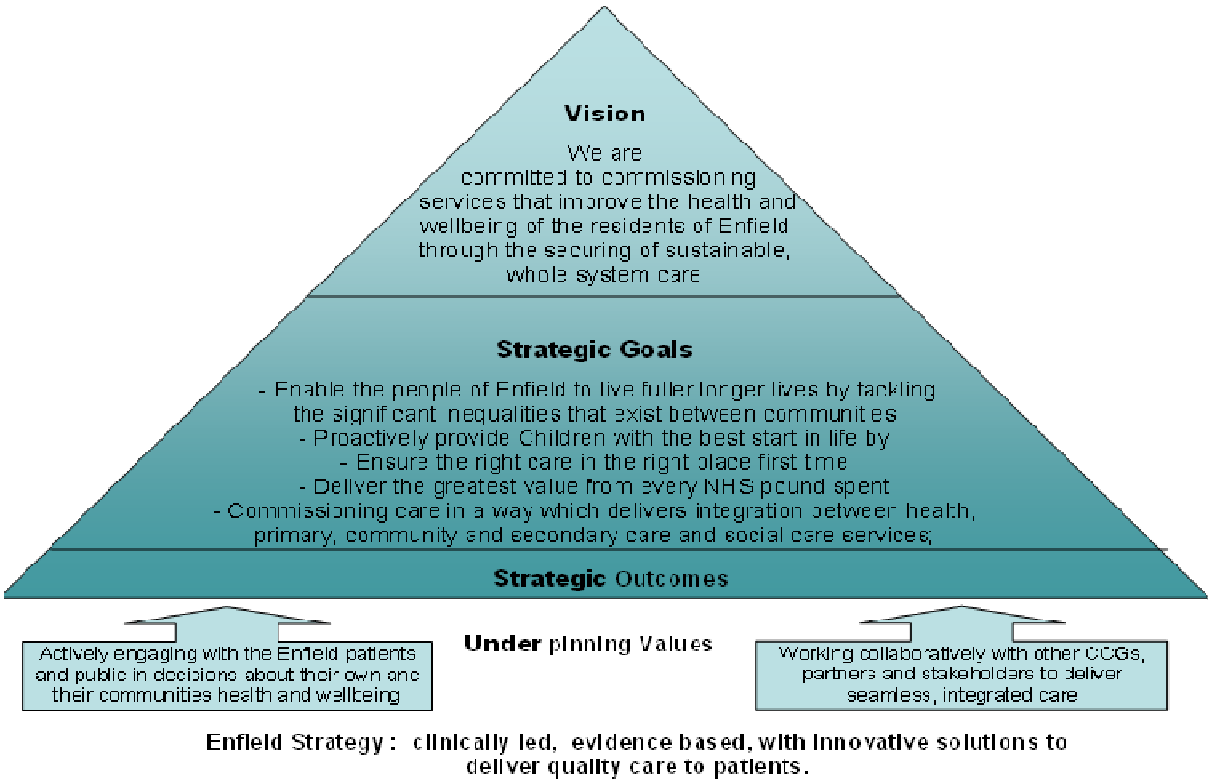
**Introduction**

This report updates the Health and Wellbeing Board on the development of Enfield CCG's Five Year Strategic Plan with particular focus on its commissioning intentions for 2014/15. The paper outlines Enfield CCGs five year financial plan, it key strategic transformation programmes, and how the commissioning intentions of those strategic programmes align to the Health and Wellbeing Strategy that is currently out for consultation.

**Background**

All Clinical Commissioning Groups are required to develop Five Year Strategic Plans of which the first two years, 2014/15 and 2015/16 must be in operating plan level detail. CCG allocations will be announced on 17 December 2013 and will include the allocations for both 2014/15 and 2015/16. While the funding formula has changed to place greater emphasis on older people, which favours Enfield CCG considerably, it has already been indicated that the pace of change towards moving to the new allocation formula will be slow. Therefore, the assumptions on which the 5 year strategic plan and financial plan is based are on current knowledge of growth for next year. In addition, the plan for 2015/16 must include the development of the Integrated Transformation Fund.

**Enfield CCG Vision**




The values that lie at the heart of the CCG's work continue to be:

- continually improving the health and wellbeing of the CCG's population and reducing health inequalities;
- listening to individuals and patients groups to ensure that service user needs are central to our work;
- improving quality and access to primary and community care services;
- improving integration and coordination of all health and social services;
- ensuring the optimum use of all available resources; and

In addition, Enfield CCG developed strategic goals to deliver the vision which remains as:

- **Enable the people of Enfield to lead longer, fuller lives by tackling the significant inequalities that exist between communities**
- **Provide children with the best start in life**
- **Ensure the right care in the right place, first time**
- **Deliver the greatest value for every NHS pound spent, and**
- **Commission care in a way that delivers integration between health, primary, community and secondary care and social care services.**

**Health and Wellbeing Strategy (draft)**
Enfield's Health and Wellbeing Strategy is currently undergoing a consultation process on the following key priority areas:

- **Ensuring the best start in life** – for example, by making sure our children are ready for school and increasing the number of children who are vaccinated against a range of avoidable infectious diseases
- **Enabling people to be safe, independent and well and delivering high quality health and care services** – for example, supporting you to manage your own health and wellbeing, and if you need them, ensuring the services you receive are high quality
- **Creating stronger, healthier communities** – for example, improving job opportunities for local people and how safe you feel
- **Narrowing the gap in healthy life expectancy** – for example, by reducing the difference in life expectancy and improving public services.
- **Promoting healthy lifestyles and making healthy choices** – by creating places and environments where it is easier to live a healthy life

Underpinning these priority areas are a number of populations which will be discussed as part of describing the CCG transformation programmes and the commissioning intentions below. In addition, the updated JSNA has been used to support the development of commissioning intentions in some of the following ways:

1. Older People with Complex Needs used as part of the CCG business case for integrated care for older people
2. Children with Disability used to identify requirement of autism pathway and the future commissioning of autism services
3. Diabetes used to inform the commissioning of integrated services for people with diabetes and future activity modelling

**5-Year Financial Position**
The following outlines the CCG financial position for the next 5 years and its progress towards achieving financial balance. It should be noted that the table below is based on current assumptions about the CCG allocation and is therefore a draft plan. Allocations for both 2014/15 and 2015/16 will be announced on 17 December 2013 and the financial plan will be finalised following those allocations. 2015/16 will be a particularly challenging year as the CCG aims to achieve the requirements of the Integrated Transformation Fund from funding that is currently committed.

DRAFT Financial Plan 2013/14 – 2018/19

| | Base Case | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|---|---|---|
| A | **Resource Limit** | £000 | £000 | £000 | £000 | £000 | £000 |
| | Baseline Allocation | £327,941 | £334,500 | £341,164 | £347,714 | £354,396 | £361,211 |
| | Other allocations - Non recurrent(surplus £2110 GPIT 1196) - Transfer to LBE | £3,197 | £1,196 | £1,196 | £1,196 | £1,196 | £1,196 |
| | Return of prior year surplus/ deficit | £0 | £0 | £0 | £0 | £0 | £0 |
| | Running Cost Allocation | £7,672 | £7,672 | £7,672 | £7,672 | £7,672 | £7,672 |
| | Health & Social Care | £0 | (£1,300) | (£13,633) | (£13,633) | (£13,633) | (£13,633) |
| | | **£338,810** | **£342,068** | **£336,399** | **£342,949** | **£349,631** | **£356,446** |
| B | **Commissioning Expenditure** | | | | | | |
| | **Sub - Total Commissioning** | **328,477** | **330,081** | **310,659** | **300,245** | **302,207** | **304,382** |
| C | **Other Costs** | | | | | | |
| | **Sub Total Corporate Costs (incl. contingency & Reserve)** | **10,333** | **20,642** | **19,930** | **19,300** | **19,500** | **19,704** |
| | | | | | | | |
| | **Total CCG Expenditure before QIPP** | **338,810** | **350,723** | **330,589** | **319,545** | **321,707** | **324,086** |
| | Investment | | | 1,500 | 6,844 | 11,111 | 11,111 |
| | Current QIPP Plan | | (12,000) | (8,000) | 0 | 0 | 0 |
| | Required and Additional QIPP | | (0) | 5,486 | 9,607 | 9,726 | 14,026 |
| | **Sub Total QIPP & Investment** | 0 | (12,000) | (1,014) | 16,451 | 20,836 | 25,136 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Total CCG Expenditure + QIPP** | **338,810** | **338,723** | **329,576** | **335,995** | **342,543** | **349,223** |
| | | | | | | |
| **Year End Target Surplus** | **0** | **3,345** | **6,823** | **6,954** | **7,088** | **7,224** |

**Transformation Programmes**

The table below outlines the 6 Transformation Programmes and some of their key associated commissioning intentions and their alignment to the Health and Wellbeing Strategy. It is clear that some of the strategic areas of the HWBS align more to health commissioning than others but there is a close alignment to populations that have been jointly identified as priorities – e,g, children and young people, people with mental health issues, frail older people and people with long term conditions .

The first row represents the HWBS priorities, followed by the CCG transformation programmes followed by some of the key commissioning intentions

| **Narrowing the Gap in healthy life expectancy Promoting healthy Lifestyles and Making Healthy Choices** | **Ensuring people are safe, independent and wll and delivering high quality health and care services Creating Stronger, Healthier Communities** | **Ensuring people are safe, independent and will and delivering high quality health and care service** | **Ensuring the Best Start in Life** | **Ensuring people are safe, independent and wll and delivering high quality health and care service Creating Stronger, Healthier Communities** | **Ensuring people are safe, independent and will and delivering high quality health and care service Ensuring the Best Start in Life** |
|---|---|---|---|---|---|
| **Prevention and Primary Care** | **Integrated Care for Older People** | **Planned Care and Long term conditions** | **Improving Care for Children and Young People** | **Mental Health, Learning Disabilities & Continuing Healthcare** | **Unscheduled Care** |
| Meeting immunization targets Access to maternity services Continue implementing Primary Care Strategy | Further development of the Integrated care Model: Continuing to develop OPAU Development of locality integrated | Commissioning integrated services for people with long terms conditions including the development of integrated local teams | Ongoing implementation of health visiting programme Continued work on developing and implementing integrated care | Commissioning of a Stepped Care Recovery Model for Mental Health taking account of employment, housing and income | Continue commissioning of urgent care centres at both NMUH and CFH (managing adults and children)_ Explore |

| | | | | | |
|---|---|---|---|---|---|
| Supporting population on public health targets including stop smoking, reducing obesity. Healthchecks | teams<br>Develop use of technology including telehealth, risk stratification, telemedicine<br>Commission redesigned community services | Commission redesigned MSK, trauma and orthopoedics, rheumatology and pain services as a single integrated service<br>Commission redesigned diagnostic services<br>Commission ambulatory care services across range of specialties | for children and development of child health networks<br>Development of new CAMHS Strategy<br>Further commissioning of Paediatric Assessment Unit at CFH<br>Working with Schools and families, jointly implement Children and families Bill<br>Providers meeting maternity standards for care | Commissioning of RAID as part of wider integrated care<br>Commissioning community options for people with MH who require long term care – EMI and enhanced EMI<br>Commission Personality Disorders across all 3 boroughs<br>Take account of MH Strategy once consultation completed | commissioning of 111, GP OOH and UCCs as single integrated service<br>Develop locality model for urgent primary care that supports UCCs (managing adults and children) |
| **Clinically effective and safe services** | | | | | |
| **Patient centred – a good patient experience** | | | | | |
| **Most effective use of NHS resources** | | | | | |

## Conclusion

The development of the Strategic Plan has taken account of the updated JSNA to underpin the development of the CCG commissioning intentions for 2014/15 and beyond. In addition, the CCG is an integral partner in the Health and Wellbeing Board and has therefore been involved in the development of the Health and Wellbeing Strategy, identifying its key priority areas and its key priority populations.

# MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 19 SEPTEMBER 2013

## MEMBERSHIP

**PRESENT** Donald McGowan (Cabinet Member for Adult Services, Care and Health), Shahed Ahmad (Director of Public Health), Ian Davis (Director of Environment), Ray James (Director of Health, Housing and Adult Social Care), Deborah Fowler (Enfield HealthWatch), Dr Alpesh Patel (Chair of Local Clinical Commissioning Group), Liz Wise (Clinical Commissioning Group (CCG) Chief Officer) and Vivien Giladi (Voluntary Sector)

**ABSENT** Chris Bond (Cabinet Member for Environment), Andrew Fraser (Director of Schools & Children's Services), Christine Hamilton (Cabinet Member for Community Wellbeing and Public Health), Ayfer Orhan (Cabinet Member for Children & Young People) and Paul Bennett (NHS England)

**OFFICERS:** Bindi Nagra (Joint Chief Commissioning Officer), Keezia Obi (Head of Public Health Strategy), Glenn Stewart (Deputy Director of Public Health), Andrea Martin (Policy, Engagement and Partnership's Manager (Health, Housing and Adult Social Care)), Pragati Somaia (JSNA Project Manager), Jill Bayley (Principal Lawyer - Safeguarding), Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Eve Stickler (Assistant Director - Commissioning and Community Engagement), Andrea Clemons (Acting Assistant Director Community Safety and Environment) and Kate Charles (Commissioning Manager- Health & Adult Social Care) Penelope Williams (Secretary)

**Also Attending:** Alison Frater (NHS Enfield)

## 1
## WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies for absence were received from Councillors Orhan, Hamilton and Bond, Paul Bennett (NHS England), Andrew Fraser (Director of Schools and Children's Services) and for lateness from Ian Davis (Director of Environment)

## 2
## DECLARATION OF INTERESTS

There were no declarations of interest.

## 3

## JOINT STRATEGIC NEEDS ASSESSMENT (JSNA)

The Board received a report from Keezia Obi, Head of Public Health Strategy, updating the board on the production of the Joint Strategic Needs Assessment (JSNA).

Keezia Obi presented the report to the Board:

- The JSNA (Joint Strategic Needs Assessment) had been created as an on line resource, which would be continually updated as the data changed. Approximately 400 pages had been uploaded but this will continue to rise.
- It was planned that it will go live on Tuesday 1 October 2013.

### 2. Questions/Comments

2.1 Members of the Board congratulated Keezia and her team for their excellent work.

2.2 Suggestions were made to improve accessibility, spelling out JSNA and providing signposts to more information. Links to and from the Council website would be included.

2.3 A communications strategy was planned.

**AGREED**

1. To approve the JSNA Strategy Online 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

The Board received a report about the development of the 2014-19 Joint Health and Wellbeing Strategy.

### 1. The Report

Keezia Obi, Head of Public Health Strategy, highlighted the following from the report:

- The JSNA had been used to inform the strategy.

- Over the Summer Board members had met, in three development sessions, to work on the priorities.

- Local knowledge and expertise had been drawn on.

- The Board had agreed a vision for the strategy "working together to enable you to live longer, healthier, happier lives in Enfield".

- Five priorities had been identified:

  - Ensuring the best start in life
  - Enabling people to be safe, independent and well by delivering high quality health and care services
  - Creating stronger, healthier communities
  - Narrowing the gap in healthy life expectancy
  - Promoting healthy lifestyles and healthy choices.

- Consultation on the priorities was due to begin in early October 2013.

## 2. Questions/Comments

2.1 The consultation will include the ability to rank priorities indicating what is most or least important, a double page spread in Our Enfield, questionnaires on the website, and a series of other meetings and activities that are in the process of being planned.

2.2 The established JSNA Communities Working Group will be asked to advise on the consultation on the strategy priorities.

2.3 Ray James suggested that the vision could be amended to make more explicit the desire to tackle inequality, adding "making a difference where it is needed most" or that it is made clear in the consultation documents.

2.4 In the consultation documents, it will make clear that responses will be valued and what the public says has considerable weight.

2.5 Eve Stickler asked that there should be engagement with young people and that it should be made clear to them that their feedback was heard and truly considered.

2.6 Care should be taken to ensure that the responses are representative.

2.7 A consultation report would be published.

2.8 Board members were asked to put forward suggestions for engagement.

2.9 Two formal consultation meetings were requested: one in Enfield Town and another in Edmonton Green. Other possibilities included the area forums, Youth Parliament, Over 50's Forum and CCG meetings. Liz Wise mentioned that the CCG were planning an event in early October which would be a good opportunity. It was also hoped that each patient participation group could contribute.

2.10 A copy of the consultation plan will be circulated to Board members.

**AGREED** that the Board:

1. Note the contents of the report, specifically the draft priorities for the Joint Health and Wellbeing Strategy.

2. 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 1 October 2013 for a 12 week period.

**5**
**ROYAL FREE ACQUISITION OF BARNET AND CHASE FARM HOSPITALS TRUST**

The Board received a report from Liz Wise (Chief Officer Clinical Commissioning Group) updating them on the Royal Free Hospital proposals for Barnet and Chase Farm Hospitals.

**1. Report**

Liz Wise highlighted the following from her report:

- Proposals were at an early stage.
- Last year, following new Government requirements that all NHS trusts become foundation trusts, Barnet and Chase Farm had concluded that financially and clinically they could not become a trust alone and had looked for other partners.
- The Royal Free had been chosen as the preferred partner, as it was felt that they would be able to provide the level of stability required.
- Acquisition would be a complex and formal process.
- No final decisions had yet been made.
- A formal business case is being prepared, which will be presented to the Royal Free Board and to the NHS England Commissioning Board in autumn 2013.
- The CCG were concerned to ensure that the proposals were in the best interests of Enfield residents.
- Regular update reports would be provided to the Board.

**2. Questions/Comments**

2.1 The Royal Free Hospital had recently been asked to support Basildon and Thurrock University Hospital Trust, via a buddying arrangement, providing expertise to a struggling organisation. Liz Wise reported that as far as she was aware, this was not a formal acquisition, but she would report back to the Board when she had more information.

2.2 This could be a concern in that there might be less focus on Barnet and Chase Farm Hospitals.

2.3 The Royal Free have indicated that they are fully behind the Barnet and Chase Farm reconfiguration plans and would only be interested in taking over the hospitals if these plans went ahead.

2.4 It was suggested that the Board invite a representative from the Royal Free Hospital to one of their development sessions to discuss the proposals.

**AGREED** that the Board note the report.

**6**
**INTEGRATION SUB BOARD**

The Board received a report briefing the Board on the proposals for the Integrated Transformation Fund from Ray James (Director of Health and Adult Social Care).

Bindi Nagra (Joint Chief Commissioning Officer) and Kate Charles (Deputy Joint Chief Commissioning Officer) presented the report to the Board, highlighting the following:

- The report describes the proposals for further developing joint integrated working arrangements between the CCG and the Council.

- A pooled fund including the £3.8m Integration Transformation Fund will be agreed. This will be partly made up of £20m from the Council and approximately £10m from the CCG.

- As a minimum, the fund conditions are anticipated to include at least the following:
  - Protection for social care in terms of services
  - Enabling 7 day working
  - Taking a joint approach to assessment and care planning
  - Facilitating information sharing including the use of the NHS number across health and social care
  - Taking account of the implications for the acute sector of service reconfiguration.
  - Set out arrangements for redeployment of funding held back in the event of outcomes not being delivered.

- The proposal includes setting up a sub group to work on the proposals. Timescales are tight.

- Work will be informed by discussions around the JSNA and the Health and Wellbeing Strategy.

**2. Questions/Comments**

2.1 It is speculated that funding will be allocated according to a formula which has not yet been decided.

2.2 Ray James said that this was potentially a fantastic opportunity and should facilitate more services for local people. This is especially welcome in terms of the national context and the 10% reduction in local authority funding.

2.3 The CCG would have to find the money from existing resources. There would be no new money. Liz Wise added that this could be a catalyst to enable things to be done in a different way. However the money for the services could only be found by taking funding from other services which are already being provided, and this could be difficult, especially as there were significant funding pressures on the NHS as a whole. NHS England have anticipated that the national health service will need an extra £30 billion just to stand still.

2.4 Deborah Fowler was concerned that the integration of services should considered from the point of view of the client receiving the services, focussing on individuals.

2.5 The new integration sub board will be time limited**.** It will be separate from the Joint Commissioning Board and will not replace it.

2.6 Councillor McGowan was concerned that there was a risk that if targets were not met, a percentage of the money would be lost. The risk would not be known until the conditions are published. Lobbying is currently taking place so that the targets can be agreed locally, although it is likely that there will, at the least, be some ministerial sign off of local plans.

2.7 The Health and Wellbeing Board would seek to influence any target setting to make sure targets were reasonable and deliverable.

2.8 The Health and Wellbeing Board will be the best body to help to help the integration proposals succeed.

2.9 A two year plan had to be produced within the next two months.

2.10 A suggestion was made that the contribution from the CCG would increase the QIPP. This did not follow as the money would most likely have to be taken from that currently allocated to acute services.

2.11 Requests were made that Ian Davis, a clinical representative, someone from HealthWatch and service users be included in the membership of the proposed sub group.

2.12 Liz Wise said that a decision on the creation of a sub group and its terms of reference would need to be taken back to the CCG Governing Body for approval.

2.13 It was proposed that a working group be set up to work up some detailed recommendations including the two year plan and to develop the proposals for a formal sub board.

**AGREED**

**1.** To set up a working group including the members of the sub board proposed in the terms of reference attached to the report as well as a representative from HealthWatch, the Director of Environment and a clinical representative from the CCG.

**2.** The working group will pull together the initial plans for the Integrated Transformation Fund, once the conditions and expectations are confirmed by Government.

**3.** The Working group will also work on a governance structure, including terms of reference, for future approval by both the Health and Wellbeing Board and the CCG Board.

**7**
**SUB BOARD UPDATES**

**1. Health Improvement Partnership Board**

The Board received a report from Shahed Ahmad (Director Public Health) updating the Board on the work of the Health Improvement Partnership Board.

Glenn Stewart highlighted the following from the report:

- There was good news on the Tobacco Control/Smoking Cessation. The smoking quitters target has been achieved, but the focus would be maintained. Enfield has the 16th highest smoking prevalence in London.

- A new Healthy Weight Co-ordinator had started work.

- A final draft of the JSNA was presented to the Board development session on 18 July 2013.

- The CCG Chief Officer gave the sub board an overview of commissioning and the issues surrounding maternity care. A review of maternity services is to take place in the Autumn 2013.

- An update on childhood poverty had been received.

- A consultant is leading work on the Child Death's Overview Panel.

- Enfield has come out well on the Public Health England data on prevention of premature deaths. We were 32nd out of 150 local authorities and 1 out of 15 in similar authorities.

- MoreLife(UK) had been providing summer weight loss camps for 8-17 year olds.

**AGREED** that the Board noted the contents of the report.

## 2. Questions/Comments

2.1 KPIs were being developed for the Board.

## 3. Joint Commissioning Sub Board Update

The Board received a report updating them on the work of the Joint Commissioning Sub Board.

Bindi Nagra (Joint Chief Commissioning Officer) highlighted the following from his report:

- A community interest company had been created, independently of the Council to deliver the HealthWatch functions.
- Enfield have just been informed that they will not be receiving the Warm Homes funding from the Government which would have been used to cover winter pressures this year. This is disappointing as last year the voluntary sector had provided an enormous amount of support with this funding. Other options for funding will be investigated.

## 4. Questions and Comments

4.1 The section 256 agreement had now been updated and signed. The Board had received information on the 13/14 allocations. Bindi Nagra would confirm when this had occurred and provide an audit trail.

4.2 Deborah Fowler invited all to the HealthWatch launch event.

4.3 Clarification of the issue about GPs failing to engage with the bone health nurse would be provided.

4.4 Liz Wise reported that she had written to the Chief Executive of the North Middlesex Hospital about the delays in implementing the paediatric integrated care work stream. She would keep the board briefed on developments.

4.5 Two learning difficulties nursing posts were in danger of being lost. Alternatives were being pursued. An update on the situation would be provided to the next meeting.

**AGREED** that the Board note the contents of the report.

## 5. Improving Primary Care Board

The Board received an update on the work to date to implement the primary care strategy across Enfield.

Dr Mo Abedi, Chair of the Primary Care Strategy Improvement Board highlighted the following from the report:

- The money available to deliver the primary care strategy was £11m over 3 years.
- Thirty eight practices had signed up to the Access Scheme which has created 3,400 additional GP slots per month, a projected 40,000 extra over a whole year, covering 82% of the population. An evaluation of the effectiveness of the scheme is being undertaken by the Primary Care Foundation.
- A total of 152 GP reception staff attended training on enhancing communication skills, given by Effective Professional Interactions who are also providing extra support to some of the practices evaluated.
- The Minor Ailments Scheme has resulted in an extra 3,159 face to face consultations with local pharmacists. Patient satisfaction data revealed that 95% of patients were seen within 10 minutes and 97% would use the service again. Evaluations would continue.
- Enfield Carers Centre had recruited a GP liaison worker and the funding has been made available for a Carers Nurse. Work was progressing, promoting carers support and developing a clear referral pathway for carers, for GPs and practice staff.
- The joint initiative with University College London to employ four academic clinical associates is well underway: posts have been advertised, interviews planned and host practices shortlisted. Once recruited, these extra doctors, will result in an extra 17,000 primary care appointments across Enfield, over 2 years. They bring in service improvements through research and redesign and raise the profile of Enfield as a borough for newly qualified GPs to settle in, in the long term.
- Several schemes to improve the patient experience including in blood pressure monitoring, management of childhood obesity and a patient experience tracker have also been introduced.
- A HiLo Initiative in conjunction with Queen Mary University has been set up in two practices to improve the management of Coronary Heart Disease and Blood Pressure.
- Over 80,000 cancer screening leaflets have been distributed to the over 50's and two trainers recruited to promote screening.
- A domestic violence project to work with up to 25 general practices has been set up.
- IT improvements have been bought in, providing at least half of practices with new hardware and to enable better communication between practices and with other health organisations.
- This year £3.4m has been allocated to Enfield's primary care strategy. The business case for a further two years of funding has been put forward.

- A series of GP networks have been set up and clinical leads identified to engage with practices in each of the different localities across Enfield.

## 2. Questions/Comments

**2.1** Vivien Giladi who thanked Dr Mo Abedi for his positive report, expressed some reservations on behalf of the Over 50's Forum about the minor aliments scheme, but would wait to comment until after an evaluation had taken place in October 2013.

2.2 She reported concerns that she had received from visitors, at the Enfield Town Show, about the primary care provision in North East Enfield and referred to the evidence, discussed at the Enfield Health Reference Group, about 5 wards, in North East Enfield, which had been identified as those that would be most adversely affected by the proposed changes at Chase Farm Hospital.

2.3 Some of these concerns may be addressed when the Joint Service Centre planned for North East Enfield became fully operational.

2.4 The GP Network Leads were continuing to work with and engage those practices that had not taken part in the Access Scheme and to develop links, with all practices to enable them to better support each other.

2.5 The four extra University of Central London doctors would be placed in areas of shortage, but needed to be in practices where they would receive good support and training.

2.6 Access, patient satisfaction and attendance at Accident and Emergency Centres were due to be discussed at the next Improving Primary Care Board Meeting.

2.7 Councillor Don MCGowan queried whether the Clincial Commissioning Group (CCG) was happy with the rate of progress in the development of the GP networks. In response the Board were informed that the first stage had been achieved, to obtain buy in from the practices, but work was continuing on the second stage, to develop them to enable them to work together more effectively.

2.8 Dr Alpesh Patel said that in the past Enfield had not had a culture where GPs worked together and it was difficult to align the different ways of working amongst a large group of GPs who were used to working independently. It was the CCG's job to make a case for the clinical and financial advantages to be gained from working together, but this would take time. Progress was being made.

2.9 Ray James referred to the context of the Barnet, Enfield and Haringey Clinical Strategy in relation to the improvements required in primary care. He felt that there were some areas of progress but that the report had focussed

on the areas where there had been progress and did not give a complete picture of what progress had and had not been made in all areas of the primary care strategy, as had originally been set out, two years ago.

**AGREED** to note the report.

**8**
**WORK PROGRAMME 2013-14**

The Board received the work programme for 2013-14.

NOTED

1. The CCG Strategy and Commissioning Intentions would be discussed at the November development session of the board.

2. Key performances indicators would be formulated linked to the Health and Wellbeing Strategy priorities and discussed at a later development session.

**9**
**MINUTES OF THE MEETING HELD ON THURSDAY 20 JUNE 2013**

**1. Minutes of the meeting held on 20 June 2013**

The Board agreed the minutes of the meeting held on 20 June 2013 as a correct record.

**2. Matters Arising**

**2.1 Immunisation (Item 4 – 2.19)**

Alison Frater (NHS England) provided a verbal update to the Board on immunisation following the discussion at the last formal meeting and the request that more information be provides for this meeeting.

- Responsibility for Immunisation had recently been transferred to NHS England. The transition had gone relatively smoothly and investment was continuing.
- All commissioning was carried out, working closely with the CCG.
- As part of the Health and Social Care Act, Public Health England had been given ownership of all the immunisation data: there had been delays in receiving data from them. NHS England was unable to share any data until it had been published by Public Health England. Publication had been delayed.
- However informally, Enfield's Quarter One data looked encouraging and there had been some improvement in MMR uptake in the 2-5 age group.

- Three main action plans were being put together to improve the services:
- The first to establish a better set of information – much of the current data was inaccurate – and to invest in local systems creating a better engagement strategy.
- The second to target local communities where immunisation rates were low.
- The third to look at different work force models – currently a large proportion of immunisation is carried out by GPs - this would include looking at the feasibility of establishing a taskforce made up of health visitors to work with schools and nurseries for example while relying on the core GP delivery model.
- More could be done if GPs could improve the sharing of information on immunisation. Peer reviews between practices could improve uptake.
- More work to support the uptake of the seasonal flu vaccines, widening access to community pharmacies perhaps, would be undertaken.
- Immunisation uptake amongst health professionals themselves was poor and needed to be increased: they were at greater risk of infection.
- They would also be seeking to support work with, and raise awareness amongst at risk groups.

**2.2 Questions/Comments**

2.2.1 Ray James noted the reassurance that long established local schemes would continue and that possible risks during transition seem to have been overcome.

2.2.2 Data from Q1 was due to be published on 17 September 2013 and is now scheduled for mid October. In the past this had been provided in June.

2.2.3 It was suggested that Public Health England should be encouraged to issue data more quickly. Local Public Health could co-ordinate work to generate a better understanding of immunisation uptake practice by practice by asking GPs to send through copies of the data that they sent to Public Health England.

2.2.4 In general there has been a poor uptake across London, due to the high proportion of the population who were mobile and unregistered. But the reporting and data recording system was not working well. During the recent MMR campaign the level of immunisations was significantly under reported. If the level had been as poor as records indicated, there would have been a measles outbreak. A recent evaluation had indicated an uptake rate of 95%.

2.2.5 With improvements in technology reporting should become more reliable.

2.2.6 During the recent MMR campaign, GPs were asked to interrogate their systems and write to families who were not recorded as being immunised, they found that many were.

2.2.7 Including the MMR within the school leaver booster was being considered.

2.2.8 Providing more immunisation through Children's Centres was also a possibility.

2.2.9 There have been issues within the Traveller and Somali communities and some other hard to reach groups which need some targeted interventions.

2.2.10 An average of 95% is not enough to provide herd immunity. The rate does need to be increased.

2.2.11 Dr Mo Abedi said that there was a problem with the validity of the data and that he would urge greater collaborative working.

2.2.12 Doctors would welcome more information on the new flu campaign.

2.2.13 The Over 50's Forum had welcomed the new Shingles Vaccine which was being offered to the over 70's, but were disappointed that it only seemed to be available to 70 and 79 year olds. This was due to a shortage of vaccine.

2.2.14 Doctors did have difficulty with the recording system. It would be more effective if the surveillance data was linked to the payment system.

2.2.15 Enfield had invested heavily in the immunisation and there was a concern that NHS England would not be able to provide as much resource. Enfield had been able to employ a full time borough level co-ordinator enabling them to make good progress.

2.2.16 Once the data from Public Health England was available, it would be possible to target support where it was needed, and improve uptake.

**10**
**DATES OF FUTURE MEETINGS**

NOTED the dates agreed for future meetings of the Board:

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

NOTED the dates agreed for Board Development Sessions:

- Thursday 17 October 2013

- Tuesday 19 November 2013
- Tuesday 21 January 2014
- Thursday 20 March 2014

# Health and Wellbeing Board
# Work Programme 2013-14

| Board | 16th May 2013 (Development) | 20th June 2013 (Formal) | 18th July 2013 (Development) | 19th Sept* 2013 (Formal) | 17th October 2013 (Development) | 19th Nov 2013 (Development) | 12th Dec 2013 (Formal) | 23rd January 2014 (Development) | 13th February 2014 (Formal) | 20th March 2014 (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 | 08/11/13 | 02/12/13 | 09/01/14 | 03/02/14 | 10/03/14 |
| **Health and Wellbeing Board Development Session** | Serious Youth Crime<br>Andrea Clemons<br><br>JSNA<br>Keezia Obi<br><br>HWB Workplan<br>Fliss Cox | | Public Health Outcomes Framework<br>Glenn Stewart<br><br>Housing and Homelessness<br>Sally McTernan<br><br>JSNA<br>Keezia Obi | | 1. HWB Strategy<br>Keezia Obi<br><br>3. Mental Health Strategy<br>Kate Charles<br><br>2. Childhood Obesity Public Health &<br>Glenn Stewart | 1. Upper Edmonton Life Expectancy<br>Glen Stewart<br><br>5. Council Budget Consultation<br>Richard Tyler<br><br>2. Health & Wellbeing Strategy<br>Keezia Obi<br><br>3. CCG Budget and Strategic Plan<br>Liz Wise<br><br>6. Children's Outcomes Pledge<br>Eve Stickler<br><br>4. Pharmaceutical Needs Assessment<br>Paul Gouldstone<br><br>Integrated Transition Fund<br>Ray James | | 6. Educational Achievements<br>Andrew Frasier<br><br>2. HWB Strategy<br>Keezia Obi<br><br>1. CQC Update<br>CQC Rebecca Bauer<br>Ray James<br><br>4. Private Landlord Scheme<br>Sally McTernan<br><br>5. Integrated Transition Fund<br>Ray James<br><br>7. CCG Budget and Strategic Plan<br>Liz Wise<br><br>3. Upper Edmonton Life Expectancy<br>Glen Stewart<br><br>8. Childhood Poverty &<br>Eve Stickler | | |
| | | JSNA<br>Keezia Obi<br><br>HWB Workplann<br>Fliss Cox | | HWB Strategy<br>Keezia Obi<br><br>Integration Sub-Group Establishment | | | 1. HWB Strategy<br>Keezia Obi<br><br>2. Childhood Obesity Public Health & | | 4. HWB Strategy<br>Keezia Obi<br><br>3. Housing and Homelessness<br>Sally McTernan | |

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| **Health and Wellbeing Board Formal Session** | | Serious Youth Crime<br>Andrea Clemons | | Bindi Nagra | | | Glenn Stewart | | | |
| | | | | JSNA<br>Keezia Obi | | | 3. Section 75 Review<br>Bindi Nagra | | 5. Childhood Poverty & Maternity Services<br>Eve Stickler | |
| | | Immunisation<br>Karen Keane | | Acquisition of Chase Farm by RBF<br>Liz Wise | | | 4. Integrated Transition Fund<br>Ray James | | 7. Children & Adult Safeguarding Annual Reports | |
| | | | | HWB Work plan<br>Fliss Cox | | | 5. Children's Outcomes Pledge<br>Eve Stickler | | 6. Pharmaceutical Needs Assessment<br>Paul Gouldstone | |
| | | | | | | | 6. Disabled Children's Charter<br>Andrew Fraser | | 1. CCG Budget and Strategic Plan<br>Liz Wise | |
| | | | | | | | | | 2. Integrated Transition Fund<br>Ray James | |