HEALTH AND WELLBEING BOARD

Thursday, 13 February 2014 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
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. DECLARATION OF INTERESTS

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

3. JOINT HEALTH AND WELLBEING STRATEGY 2014-2019 (6:35-6:50PM)

(Pages 1 - 60)

To receive and approve Enfield's Joint Health and Wellbeing Strategy 2014 - 2019 set out in the report, from Keezia Obi, Head of Public Health Strategy.

4. ENFIELD CLINICAL COMMISSIONING GROUP (CCG) BUDGET AND STRATEGIC PLAN 2015-20 (6:50-7:00PM) (Pages 61 - 68)

To receive, consider and note the report from Liz Wise, Enfield Clinical Commissioning Group Chief Officer, on the development of the CCG 5 year budget, strategic and operating plan.

5. BETTER CARE FUND (FORMERLY INTEGRATED TRANSFORMATION FUND) (7:00-7:10PM) (Pages 69 - 122)

To receive an update on the development of the Better Care Fund and to grant authority to the chair of the Board to sign off the first submission of the Better Care Fund Plan.

6. HOUSING AND HOMELESSNESS STRATEGY (7:10-7:20PM) (Pages 123 - 180)

To receive a report from Sally McTernan, Assistant Director Community Housing, on the Housing and Homelessness Strategy.

7. CHILD AND FAMILY POVERTY STRATEGY UPDATE (7:20-7:35PM) (Pages 181 - 204)

To receive and note an update report from Andrew Fraser, Director of Children's Services, on The Drive Towards Prosperity: Enfield's Child and Family Poverty Strategy.

8. PHARMACEUTICAL NEEDS ASSESSMENT 2014/15 (7:35-7:45PM) (Pages 205 - 208)

To receive and approve the report and recommendations on the Pharmaceutical Needs Assessment 2014/15.

9. CHILDREN AND ADULT SAFEGUARDING ANNUAL REPORTS (7:45-7:55PM) (Pages 209 - 302)

To receive for information the following safeguarding reports:

a. Children Safeguarding Annual Report
b. Adult Safeguarding Annual Report

10. SUB BOARD UPDATES (7:55-8:20PM) (Pages 303 - 340)

To receive the following updates from the Sub Boards:

a. Health Improvement Partnership Board
b. Joint Commissioning Board
c. Improving Primary Care Board

11. MINUTES OF THE MEETING HELD ON 12 DECEMBER 2013 (8:20-8:25PM) (Pages 341 - 354)

To receive and agree the minutes of the meeting held on 12 December 2013.

12. WORK PROGRAMME 2013/14 (8:25-8:30PM) (Pages 355 - 356)

To receive and note any changes to the Board work programme for 2013/14.

13. DATES OF FUTURE MEETINGS

To note that the next full meeting of the Board will take place on Thursday 20 March 2014 at 8.30pm following the Board Development Session.

The meeting that was to have taken place on 24 April 2014 has been cancelled.

14. 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 a part 2 agenda)

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Agenda Item 3

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE:
Health and Wellbeing Board

13 February 2014

REPORT OF: Shahed Ahmad, Director of Public Health.

Contact officer and telephone number:
Keezia Obi, Head of Public Health Strategy
Keezia.Obi@enfield.gov.uk
Telephone: 020 8379 5010

Agenda - Part: 1	**Item:** 3
Subject: The Joint Health and Wellbeing Strategy 2014 -19 **Wards:** All **Key Decision No:**	
Cabinet Member consulted: Cllr Donald McGowan, Cabinet Member for Adult Services, Care and Health	

1. EXECUTIVE SUMMARY

During 2013 the Health and Wellbeing Board has overseen the delivery of the borough's first on-line Joint Strategic Needs Assessment (JSNA) and used this information to develop a Joint Health and Wellbeing Strategy (JHWS) 2014-19.

At a Board development session held on the 23 January, the final draft of the JHWS was considered and enclosed with this report is the final strategy for Board approval.

The strategy has been considered and agreed at Council Cabinet and Clinical Commissioning Group Governing Body.

As noted in the strategy document, a detailed action plan will be developed and the Board will review the progress of the action plan on a regular basis, updating the plan as required in response to changes in the evidence base (JSNA) and to reflect progress.

The full Joint Health and Wellbeing Strategy will be reviewed in 2018/19.

2. RECOMMENDATIONS – the Health and Wellbeing Board is asked to:

a) Note the success of the consultation process and that the majority of comments from both the questionnaires and public events have influenced the body of the report or the actions and measures of success.

b) Approve the Joint Health and Wellbeing Strategy 2014-19.

3. BACKGROUND

3.1 The Health and Wellbeing Board is responsible for developing and then publishing a Joint Health and Wellbeing Strategy (JHWS). The JHWS is the document that describes the key health and wellbeing priorities for the borough and central to this, is addressing the inequalities that exist in the borough and making a difference where it is needed most.

3.2 Many factors effect health and wellbeing; issues such as unemployment, poor housing and feeling unsafe can all impact upon mental and physical health. The Health and Wellbeing Board (HWB) has described in this strategy how they will work to mitigate such factors, as well as encouraging people to take a more active role in their own and others health, by promoting healthy weight management through diet and physical activity, controlling excess alcohol intake and supporting people to stop smoking.

3.3 The strategy sets out how the Enfield Health and Wellbeing Board (HWB) will work with partners and the population of Enfield to improve health and wellbeing across the borough over the next five years. The strategy was produced by a working group representing the partners on the HWB.

3.4 As set out in statutory guidance, the JSNA has been used as the evidence base upon which the strategy has been developed.

3.5 The HWB has already engaged the local community through the consultation on the priorities in this strategy. However, this is just the start of an on-going process. The HWB will continue to engage people through a mixture of formal consultations and activities, including with community and voluntary groups, faith groups, schools and children's groups and patient/service user groups throughout the implementation of this strategy.

3.6 This strategy will ensure greater integration between health and social care. The HWB are committed to the aim of supporting individuals to plan and control their care and bring together services to achieve the outcomes important to them. The Board will develop integration plans, which will involve the HWB in dialogue with both the population of Enfield and with local stakeholders.

3.7 The priorities and actions adopted in this strategy draw on the strengths of the HWB, and are designed to provide additional impetus for improving health and wellbeing in Enfield into the future.

4.0 Vision, principles and priorities

4.1 The HWB vision is:

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

4.2 The vision is underpinned by five supporting principles:

Prevention and early intervention – what people eat and drink, the amount of physical exercise they do, whether they smoke and other lifestyle choices has an impact on the likelihood of people developing long term conditions such as cancer, cardio-vascular disease or diabetes. The HWB recognise that in many cases, poor health can be avoided through better life choices and recognising risks to health. Early diagnosis, positive interventions and good quality service delivery will lead to the people of Enfield enjoying better health and wellbeing into the future.

Good health and wellbeing starts before birth. The HWB recognises the importance of ensuring that women, parents and families are able to give children the best start in life by encouraging and enabling early access to ante natal care and promoting healthy lifestyle choices before, during and after pregnancy.

Integration – service users should receive a seamless service, regardless of the source of the support; the HWB will encourage integration across all relevant health and social services, Schools' and Children's Services, and the voluntary and community sector where appropriate. The HWB recognise that as the main consumers of health and social care, integration of services is a key issue for older people.

Equality and Diversity – Enfield HWB initiatives will address equality and diversity, by ensuring services are accessible and high quality, tailored appropriately to the different groups in Enfield, particularly in the light of the east-west divide across the borough in health and wellbeing outcomes.

Addressing health inequalities – making a difference where it is needed most. The HWB will ensure that its initiatives will target health inequalities in Enfield, with the aim of minimising variation in health and life expectancy between East and the West of the borough, while also improving the health and wellbeing of all Enfield residents.

Ensuring good quality services – all services will be designed around the patient or user, will be safe, and will be caring and compassionate; the HWB will develop a response to the Mid Staffordshire Hospital and Winterbourne Review which will focus on this supporting principle.

4.3 The vision will be delivered through five key 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**

- ✓ **Reducing health inequalities -Narrowing the gap in life expectancy**

- ✓ **Promoting healthy lifestyles and making healthy choices**

4.4. The intended outcome of this strategy is a long-term generational change in health and wellbeing in Enfield.

5.0 CONSULTATION ON THE JOINT HEALTH AND WELLBEING STRATEGY

5.1 Consultation on the draft priorities took place from the beginning of October for a twelve week period. This consultation utilised a range of techniques in order to obtain views from the public, staff, carers and other key stakeholders.

5.2 Just over 2,000 responses to the consultation were received – this included 562 detailed questionnaire responses and 1,441 token box votes. A number of organisations also chose to provide a collective response on behalf of their members.

5.3 Questionnaire responses indicated that 99% of consultees supported a few, some, or all of the draft priorities, with over three quarters of respondents, (76%) supporting all five draft priorities. When asked to select which priority or priorities respondents thought were the most important, the top three most popular selections were:

- ✓ Enabling people to be safe, independent and well (71% of respondents)

- ✓ Ensuring the best start in life (61% of respondents)

- ✓ Promoting healthy lifestyles – was also supported by the majority of respondents (52% of respondents)

The two remaining priorities were selected by fewer respondents; however they were still supported as priorities for the strategy:

- ✓ Creating stronger, healthier communities (44% of respondents)

- ✓ Narrowing the gap in healthy life expectancy (33% of respondents)

5.4 Respondents to the detailed questionnaire were also asked to add any comments about what they thought to be the key areas for the health and wellbeing of local people. 210 respondents chose to provide a comment. These comments were then thematically grouped, findings of which are summarised in the word cloud below:

which a topic was mentioned by respondents – as such, we can see that the most commonly raised themes were Healthy Places, Health Promotion, Primary Care, Access to Services and Mental Health. The full list of themes can be viewed in the strategy consultation report.

5.6 Responses collected via the token boxes ranked responses in a slightly different order to the detailed questionnaire, though the popularity of priorities did vary depending on the token box location.

5.7 Overall, token box responses ranked the priorities in the following order:

- ✓ 'Creating stronger, healthier communities' with 39%
- ✓ 'Enabling people to be safe, independent and well and delivering high quality health and care services' with 21%
- ✓ 'Narrowing the gap in healthy life expectancy' with 17%
- ✓ 'Ensuring the best start in life' with 12%
- ✓ 'Promoting healthy lifestyles and making healthy choices' with 11%

5.8 A range of comments were also received from public events. These covered topics such as improving ease of access to information and advice, improving early diagnosis of long term conditions and offering holistic support, and offering a broad range of support to encourage people to adopt healthier lifestyles whilst promoting personal responsibility for health and wellbeing. Frequently commented upon themes included Primary care, Healthy activities and exercise, Community involvement, Health promotion and Access to services.

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5.9 During the consultation process, a number of comments were received regarding the meaning of the priority – 'Narrowing the gap in healthy life

expectancy'. This was discussed by the HWB, and the decision was made to rename the priority 'Reducing health inequalities - Narrowing the gap in life expectancy', to reflect comments from local people and organisations.

5.10 All comments received were reviewed and considered in the preparation of the strategy. The majority of comments from both the questionnaires and public events have influenced the body of the report or the actions and measures of success.

5.11 The HWB are committed to continuing the dialogue that has begun between the board, local people and organisations regarding health and wellbeing. As such, consultation on the JHWS will be an on-going process throughout the life of the strategy.

6. ALTERNATIVE OPTIONS CONSIDERED

None - it is a statutory requirement to produce a Joint Health and Wellbeing Strategy.

7. REASONS FOR RECOMMENDATIONS

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

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

8.1 **Financial Implications –** As detailed in other parts of the report, the purpose of the 5 year joint Health and Wellbeing Strategy is to improve the health and wellbeing of local people. The Health and Wellbeing Board (HWB) is a partnership of the Council, Enfield Clinical Commissioning Group (CCG), Healthwatch and the Voluntary and Community sector and they will oversee the implementation of the strategy.

The delivery of the strategy will be funded from existing Council and CCG resources and pooled funds. This includes the Better Care Fund (BCF) which is a pooled budget between the Enfield CCG and the Council. The BCF draft plan will be submitted to NHS England in February subject to agreement and sign off by the Health and Wellbeing Board

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

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

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

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

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

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

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

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

9. KEY RISKS

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

9.2 Partnership – key to the effective delivery of this strategy is collaborative working among the key partners represented on the Health and Wellbeing Board (HWB), particularly given the current financial climate and budgetary constraints. This will be mitigated by the agreement of this strategy by all partners, in particular the Council and Clinical Commissioning Group, and crucially the actions and measures of success contained within.

9.3 The delivery of the actions and measures of success – the risks associated with this are being mitigated by the production of a more detailed action plan (performance management framework) which the HWB will monitor at regular intervals and allows for corrective action to be taken as necessary.

9.4 Engaging local people – central to the success of the JHWS is the involvement of local people in implementing this strategy. This risk will be mitigated through the use of social marketing techniques, existing mechanisms available to partners on the HWB, alongside their

commitment to build on the success of the consultation of the HWB as outlined in the strategy.

10. IMPACT ON COUNCIL PRIORITIES

10.1 **Fairness for All**
Central to the delivery of the JHWS is addressing the inequalities that exist in the borough and making a difference where it is needed most.

10.2 **Growth and Sustainability**
Central to the delivery of the JHWS is addressing the wider determinants of health such as the environment in which we live, education and employment.

10.3 **Strong Communities**
One of the priorities of the JHWS is “creating stronger, healthier, communities”.

11. EQUALITIES IMPACT IMPLICATIONS

An Equalities Impact Assessment (EQIA) has been undertaken and summarised in the strategy document. EQIA’s will also need to be undertaken as services change as a result of commissioning arrangements.

12. PERFORMANCE MANAGEMENT IMPLICATIONS

The delivery of the JHWS will contribute to the achievements of the council and CCG’s priorities and key targets.

13. HEALTH AND SAFETY IMPLICATIONS N/A

14. HR IMPLICATIONS N/A

15. PUBLIC HEALTH IMPLICATIONS – this is a Public Health report.

Background Papers

None.

Enfield Joint Health and Wellbeing Strategy 2014-2019

Your Health and Wellbeing • Executive Summary

FINAL – January 2014

www.enfield.gov.uk/jhws

In partnership with local people and

NHS Enfield Clinical Commissioning Group

healthwatch Enfield

ENFIELD Council

Foreword and Executive Summary

Foreword

Work in progress – to be added.

By the Chair of HWB.

Executive Summary

Many factors effect health and wellbeing; issues such as unemployment, poor housing and feeling unsafe can all impact upon mental and physical health. The Enfield Health and Wellbeing Board (HWB) will work to mitigate such factors, as well as encouraging people to take a more active role in their own and others health, by promoting healthy weight management through diet and physical activity, controlling excess alcohol intake and supporting people to stop smoking.

This strategy is as much about wellbeing as it is about health. The HWB is committed to promoting and supporting wellbeing in our local community, enabling local people to live happy, fulfilling lives.

The purpose of this strategy is to set out how the HWB will work with the population of Enfield to improve health and wellbeing across the borough over the next five years.

The HWB has already engaged the local community through the consultation on the priorities in this strategy. However, this is just the start of an ongoing process. The HWB will engage through a mixture of formal consultations and other activities, including with community and voluntary groups, faith groups, schools and children's groups and patient/service user groups throughout the implementation of this strategy.

This strategy will ensure greater integration between health and social care. The HWB are committed to the aim of supporting individuals to plan and control their care and bring together services to achieve the outcomes important to them. The Board will develop integration plans, which will involve the HWB in dialogue with both the population of Enfield and with local stakeholders.

A detailed description of Enfield and the health and wellbeing of its people can be found within the Enfield Joint Strategic Needs Assessment (JSNA), on the Enfield Health and Wellbeing website[1].

1 www.enfield.gov.uk/jsna

The largest cause of death in Enfield is Cardiovascular disease (CVD) followed by cancer. Much of the burden of early mortality, and its associated morbidity could be avoided by changes in lifestyle. For example:

- Meeting the Chief Medical Officer's guidelines on physical activity reduces the risk of heart disease, stroke and cancer by 30% – in Enfield, 95% of the population is not physically active enough to maximise benefits to their health
- Not smoking reduces the risk of respiratory disease by up to 95% – in Enfield, 18.5% of adults smoke; it is estimated that 4% of 11-15 year olds smoke more than 1 cigarette a week
- In Enfield, 23.2% of the adult population is obese, and 24.2% of pupils in Year 6 are obese

Further strengthening clinical management of existing disease also plays a key role in reducing associated morbidity and mortality.

There is a stark discrepancy between the life expectancy of the residents of the East and the West of Enfield. Those in the East are expected to live significantly shorter lives than those in the West.

The Health and Wellbeing Board vision is:

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

The vision will be delivered through five key priorities, outlined below. For each of these, a number of key strategic actions have been identified, which have been selected as essential areas of work required under each of the health and wellbeing priorities.

The measures of success tables outline a number of key strategic outcomes the HWB wish to see realised through action in the short, medium and long term. This is not exhaustive, as further measures of success are included in the JHWS detailed action plan and performance framework, to be monitored by the HWB. The action plan is a living document, and will be developed and updated throughout the lifetime of the strategy to ensure that actions and measure of success continue to reflect local needs and challenge partners to deliver improved outcomes for local people.

Ensuring the best start in life: we want all children to realise their full potential, helping them to prepare from an early age to be self-sufficient and have a network of support that will enable them to live independent and healthy lives.	
Short term actions	• Understand and plan for the implications of the Children's and Families Bill on the changes for the SEN system up to age 25, including replacing Statements of Need with a local offer and Birth to 25 Education, Health and Care Plan. • Develop a multi-agency plan for reducing Infant Mortality, with the HWB having oversight of the plan and supporting its implementation. The plan will have a particular focus on child poverty, early access to ante natal services and integrating services. • Manage the transition of the responsibility for health visitors to public health, ensuring improved service delivery.
Medium term actions	• Develop a coherent overarching plan for transition to education for all children aged 2 and above which unifies the Healthy Child Programme and the Early Years Foundation Stage. • Redesign treatment pathways to ensure the delivery of high quality, integrated paediatric care, to provide more community-based care options and to improve the experience and outcomes of children who are ill. • Reduce paediatric admissions for asthma and other ambulatory care sensitive conditions by improving early identification and disease management in primary and community services. • Through more effective use of the School Nursing Service, and closer working with health colleagues, support schools in reducing pupil absence due to illness and medical appointments and thereby improve overall attendance rates.
Long term actions	• Improve educational attainment by ensuring all agencies involved with children in Enfield work together to provide the best educational experience possible for all children.

Ensuring the best start in life – Measures of success

- Child poverty to reduce to 25% by 2020, decreasing from the 2008 baseline of 36%
- Percentage of children receiving the full course of MMR by their 5th birthday to increase from 76.8% to 95% by 2019
- The gap between the most and least deprived wards measured in terms of child poverty to reduce from 42% (based on the 2009 baseline) to 30% by 2020
- 95% of new birth visits to be carried out between 10-14 days after birth
- 95% of pregnant women under the age of 18 who book for maternity care to receive a targeted antenatal intervention from Family Nurse Partnership/ Health Visitor Service
- The percentage of absences from school due to illness to improve on the 2012/13 rate of 2.7%

Enabling people to be safe, independent and well and delivering high quality health and care services: we want people of every age to live as full a life as possible, with good health and wellbeing being encouraged from the outset. This means that people are encouraged to have lifestyles which help to prevent the onset of some diseases. When they do occur, health issues both physical and mental, should be recognised as soon as possible, as early intervention is likely to lead to better long term outcomes. It also means that where people do have to live with long term conditions, they should be supported in such a way that the condition has as small an impact on their daily life as is feasible. We want to ensure that people with any form of disability or impairment are supported in a way that promotes inclusion, independence, choice and control.	
Short term actions	• Develop a register of carers which is co-ordinated across primary care, social care, acute care and mental health. • Increase the early diagnosis of HIV infection.
Medium term actions	• Ensure that there is an increased focus on the early identification of long term conditions, in particular diabetes, chronic obstructive pulmonary disease (COPD), dementia, hypertension and CVD. • Develop a network model of primary care to ensure better access to consistent, good quality services with the potential to maintain continuity of care by: – Developing a stable system/model for a more integrated delivery of health care focused around networks and general practices, which in part will support early identification and good disease management. – Implementing a 7 day delivery model for integrated care for older people, which will support reductions in the rate of acute admissions. • Ensure that more people are able to access psychological therapies (Improving Access to Psychological Therapies – IAPT) locally by increasing uptake of the service through integrated approaches. • Coordinating services around the needs of the young person and family to ensure a positive experience of transition to adult services. • Deliver on the Joint Adult Mental Health Strategy. • Establish an effective model of psychiatric liaison in North Middlesex University Hospital based on the RAID (Rapid Assessment Interface and Discharge) model. • Ensure co-ordinated care provision for people with co-occurring alcohol or substance misuse and mental health problems. • Increase the dementia diagnosis rate in line with the CCG's operating plan, and improve dementia care.
Long term actions	• Develop a mental health and wellbeing service which focuses on recovery and independence for people with mental health and aims to limit the number of people who require secondary mental health care. • Develop integrated models of care for older people. • Develop a whole-life mental health strategy.

Enabling people to be safe, independent and well and delivering high quality health and care services – Measures of success

- Late HIV diagnosis to reduce from 58% to 44% by 2019
- Access to psychological therapies (IAPT) to improve locally by increasing uptake from the current rate of 5% to 15% by the end of 2014/15
- Rate of admissions for people aged over 65 to residential and nursing care to reduce from 513.5 per 100,000 in 2012/13 to 512 per 100,000 by 2013/14
- Delayed transfers of care to reduce from 5.74 per 100,000 in 2012/13 to 5.00 per 100,000 by 2013/14
- Adult (18+) unplanned admissions to acute health care to reduce by 10% on the 2012/13 baseline of 20,371 admissions
- Rate of admissions of older people to acute health care to reduce by 20% on the 2012/13 baseline of 9,215 admissions

Creating stronger, healthier communities: a large part of the lifetime health and wellbeing experience of people relates not to the health and social care that they receive, but the environment in which they live. People who are able to contribute to society through meaningful employment, live in warm, clean, safe accommodation, and live in a community with strong networks, are less likely to suffer from both mental and physical health issues.	
Short term actions	• Develop understanding amongst local people of the role that community cohesion plays in improving health and wellbeing, including reducing loneliness. • Delivering an annual programme of community engagement with those who come from different backgrounds, and ensuring that Enfield residents can continue to contribute to the development and implementation of the JHWS. • Support the outcome of the Home Office review regarding the links between ending gang and youth violence. In particular agree tasks to be overseen and delivered by the partnership represented on the Health and Wellbeing Board. • Following the publication of the JHWS, HWB to review its structures to ensure effective engagement of local people in work to improve their health and wellbeing.
Medium term actions	• To support and work in partnership with faith groups, the voluntary and community sector, schools and children's centres and other local organisations to deliver specific projects aimed at improving community wellbeing. • Partners on the HWB show leadership by modelling healthy behaviours within their organisations (e.g. healthy eating choices, travel for work policies, work life balance). • Promote dementia friendly communities, which aim to improve awareness, inclusion and quality of life for people living with dementia and support for their carers. • Staff from North Middlesex Hospital to visit 50% of Primary and Secondary schools to raise aspirations of Enfield's young people to seek career opportunities and employment at the hospital and in other health related careers.
Long term actions	• Strengthen community networks to enable individuals and families to take responsibility for their own health and wellbeing. • Improve the awareness of people of all ages and communities to make healthy lifestyle choices through positive communication and community interaction • Building on the agreement with North Middlesex University Hospital, work in partnership with all large public sector providers and partners to promote and expand opportunities for employment, apprenticeships and volunteering for local residents, including children, young people and young parents in Enfield.

Creating stronger, healthier communities – Measures of success
• HWB structures to be reviewed by 2015 to ensure on going engagement of local people in improving their health and wellbeing • Faith forums and community leaders to be enabled to take a lead role in improving local health and wellbeing • Communications and Engagement strategy to be developed and implemented to support the on-going implementation of the HWB strategy • The percentage of people who feel safe outside in their local area after dark to increase by 2019

Reducing Health Inequalities – Narrowing the gap in life expectancy: we want to reduce the gap in life expectancy that exists within the borough, of 8 years for men, and 13 years for women.	
Short term actions	• Support implementation of Integrated Care Pathways to improve efficiency and patient experience. • Work with partners in Upper Edmonton to map existing community resources that support health and wellbeing, and identify where gaps exist when compared with evidence-based practice. • Encourage early diagnosis and management (including lifestyle change) of conditions such as CVD, diabetes, cancer and COPD, and work to reduce the risk of death amongst people living with long term conditions.
Medium term actions	• Work with the community to target and deliver specific interventions in Upper Edmonton which address health inequalities. • Reduce smoking rates amongst groups known to be particularly affected by high smoking prevalence. . • Further strengthen clinical management of CVD, diabetes and respiratory disease.
Long term actions	• Replicate the successful targeted interventions from the Upper Edmonton inequalities work to other deprived areas of the borough. • Work to address the wider determinants of health such as high levels of deprivation, low educational attainment, low levels of employment and poor housing.

Reducing health inequalities – Narrowing the gap in life expectancy – Measures of success
• 75% of Enfield GP practices to achieve 90% in the percentage of patients with coronary heart disease whose blood pressure is controlled by 2019 • The difference in female life expectancy between the best and worst wards to be reduced from 13 years to 10 years by 2019

Promoting healthy lifestyles and making healthy choices: the lifestyle choices that people make about diet, exercise, alcohol consumption, smoking and drug use can affect their health and wellbeing.

We want to ensure that local people understand the impact of these choices, and are supported to choose healthier options throughout their lives, making use of the council's regulatory powers to influence local businesses and make local areas healthy places to live.

Short term actions	• Produce a comprehensive obesity strategy, covering both children and adults. • Produce a comprehensive substance misuse strategy, covering both adults and young people. • Health and Education professionals to work jointly to support and promote the Healthy Schools London programme in the borough.
Medium term actions	• Agree on an action plan with schools and young persons' organisations to prevent and reduce smoking uptake. • Identify and develop more opportunities to deliver Identification and Brief Advice (IBA) interventions for harmful drinking, particularly through digital customer pathways. • Reduce the rate of alcohol-related acute representations to ensure that treatment is provided in appropriate, cost-effective settings. • Develop healthy workplaces throughout Enfield. • Promote healthy eating throughout Enfield.
Long term actions	• Ensure that transport and building developments prioritise active transport (particularly walking and cycling).

Promoting healthy lifestyles and making healthy choices – Measures of success

- The percentage of year 6 pupils classified as obese to reduce from 24% to 22% by 2019
- Smoking prevalence to reduce from 18.5% in 2012 to 12% by 2030
- Acute alcohol-related presentations to reduce by 10% on the 2014/15 baseline by 2015/16, and be maintained thereafter
- 90% of all drug users in treatment to receive HIV and Hepatitis B interventions, and 90% of injecting drug users receive Hepatitis C interventions
- The proportion of drug users successfully completing treatment in 2014/15 to increase to 4% above the 2013/14 target rate
- 30% of local authority schools to achieve the Healthy Schools London Bronze Award, and 10% of local authority schools to achieve Silver Award by December 2014

Next steps

There are some clear health and wellbeing challenges in Enfield and this strategy for Enfield recognises that the needs of local people vary across the Borough and the importance of working closely with communities and local organisations to meet those needs.

This Health and Wellbeing Strategy 2014-2019 sets out the priorities the HWB will focus on with the aim to making a real difference to the lives of Enfield people. There will be a more detailed action plan which will identify leads and outputs to deliver the program of work as set out in the strategy. The HWB will review the progress of the action plan on a regular basis and will update the plan as required in response to changes in the evidence base (JSNA) and to reflect progress.

The HWB is committed to increasing community engagement in the delivery of the strategy. Successful implementation of the strategy relies on community and stakeholder organisations all of whom have an important part to play in the delivery.

The strategy will be implemented at a time when there are significant public sector financial cuts, so innovative use of existing resources will become even more important.

The full Health and Wellbeing Strategy will be reviewed in 2018/19.

In partnership with local people and

NHS Enfield Clinical Commissioning Group

healthwatch Enfield

Contact Enfield Council
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ENFIELD Council

Enfield Joint Health and Wellbeing Strategy 2014-2019

Your Health and Wellbeing

FINAL – January 2014

www.enfield.gov.uk/jhws

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Contents

Appendices

1. Foreword and Executive Summary

1.1 Foreword

Work in progress – to be added.

By the Chair of HWB.

2. Introduction

2.1 Purpose of the strategy

Many factors effect health and wellbeing; issues such as unemployment, poor housing and feeling unsafe can all impact upon mental and physical health. The Health and Wellbeing Board (HWB) will work to mitigate such factors, as well as encouraging people to take a more active role in their own and others health, by promoting healthy weight management through diet and physical activity, controlling excess alcohol intake and supporting people to stop smoking.

This strategy is as much about wellbeing as it is about health. The HWB is committed to promoting and supporting wellbeing in our local community, enabling local people to live happy, fulfilling lives. The HWB wants to foster wellbeing throughout the life course; supporting parents to raise confident, happy children, improving opportunities for employment, training and education for young people, and enabling people to be independent and to benefit from meaningful social interaction. We want to build flourishing communities, in which everyone has someone to talk to, neighbours look out for each other, people have pride and satisfaction with where they live and feel able to influence decisions about their area.

Good mental health is as important to wellbeing as good physical health. Enfield supports the concept of “parity of esteem” between services for mental and physical illnesses, and this strategy incorporates actions which will impact directly or indirectly on residents’ mental health. This JHWS recognises that good mental health should be supported throughout people’s whole lives, from birth onwards.

The purpose of this strategy is to set out how the HWB will work with the population of Enfield to improve health and wellbeing across the borough over the next five years. The Joint Health and Wellbeing Strategy (JHWS) describes the key health and wellbeing priorities for Enfield. Central to this is addressing the challenges that exist in the borough and making a difference where it is needed most.

The HWB is a partnership which brings together the Council, Enfield Clinical Commissioning Group (CCG), Healthwatch and the voluntary and community sector. Its roles include producing needs information in a Joint Strategic Needs Assessment (JSNA), and responding to that information through the production of a JHWS.

The priorities and actions adopted in this strategy draw on the strengths of the HWB, and are designed to provide additional impetus for improving health and wellbeing in Enfield into the future.

The HWB sees its strategy as transformative, seeking to achieve a structural generational change in the health and wellbeing of the population of Enfield.

This JHWS document focuses on outcomes and high-level actions, and is supported by a range of working documents including a detailed action plan and a performance framework. The action plan is a living document, and will be developed and updated throughout the lifetime of the strategy to ensure that actions and measure of success continue to reflect local needs and challenge partners to deliver improved outcomes for local people.

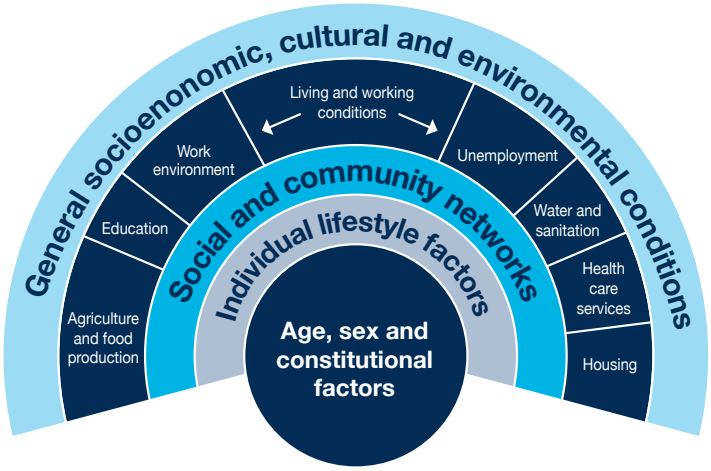
2.2 What is health and wellbeing?

The World Health Organisation defined health in 1946 as:

> "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

The model shown in the figure below summarises the many influences on health and wellbeing.

Figure 1: The wider determinants of health (1992) Dahlgren and Whitehead



As this diagram shows, social and community networks can have a significant influence upon an individual's health and wellbeing, as well as that of families and the wider community. Feelings of loneliness can have significant detrimental effects on people's mental and physical health and wellbeing. The HWB is committed to working with local people to strengthen communities and social networks to minimise the impact of loneliness and social isolation.

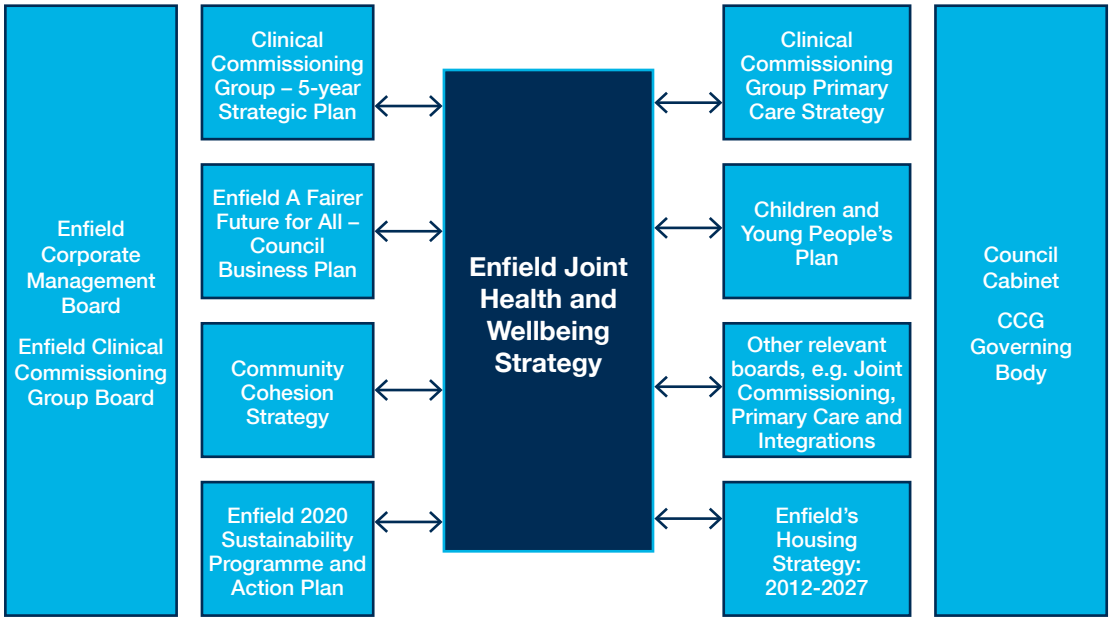
The HWB also needs to consider the very long term of 20 to 30 years, as changes to the wider determinants of health can take a generation to show their improvement in the population. This strategy provides the foundation on which the HWB can take positive steps towards making long term improvements in health and wellbeing.

This JHWS touches on many aspects of life in Enfield, and will require the cooperation of a wide range of stakeholders to ensure that it is effectively implemented. It also considers the inequalities which exist in the borough, and aims to make a difference where it is needed most.

2.3 How the JHWS relates to other local strategic documents

A key role of JHWS is to provide a strategic steer to encourage integrated working between health and social care commissioners, as well as between other health-related services such as housing, transport, the economy and environment. As such, the JHWS must influence, and be complemented by other local strategic commissioning documents. The diagram below highlights some of the key strategic documents and partnerships that the JHWS relates to:

Figure 2: Relationship of the JHWS with other strategies and work programmes



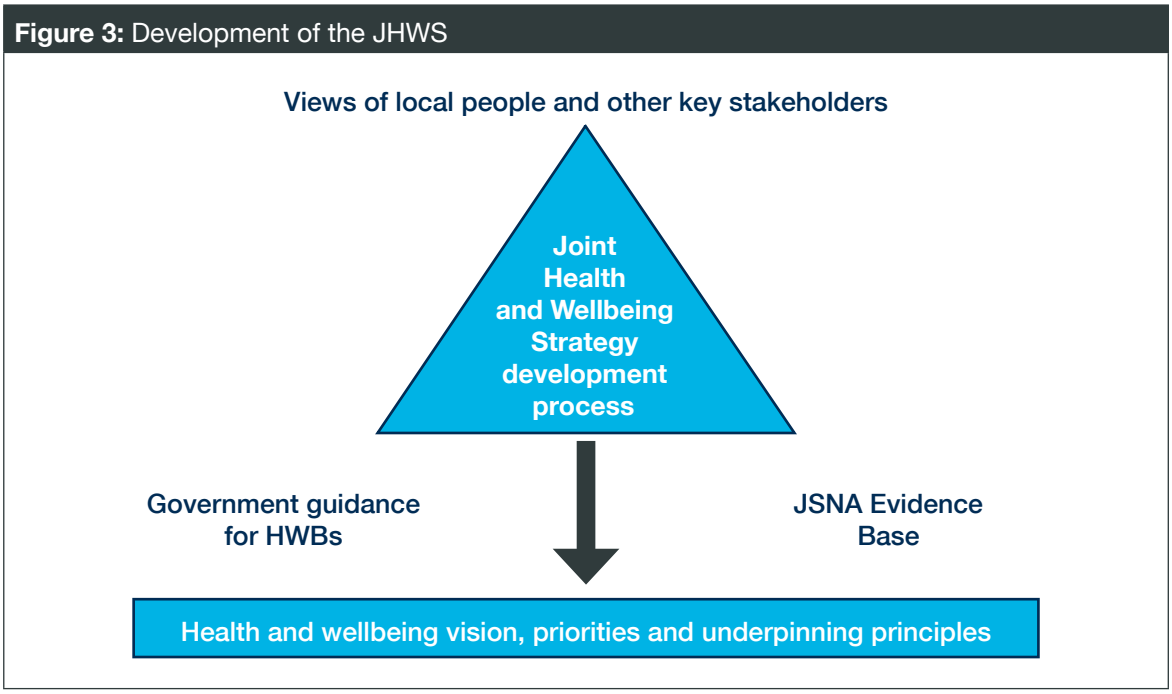
Enfield CCG is required to respond to the JHWS when developing its commissioning plans.

It should be noted that the strategies and work programmes shown in the figure are not exhaustive. A number of other relevant strategies are included in Appendix 4, and many others are available on the Council and CCG websites.

2.4 How this strategy was developed

This strategy has been developed through a rigorous process based on evidence, the views of the HWB partners, and the views of the local population, as shown in the figure below.

Figure 3: Development of the JHWS



The process has involved:

- The development of an evidence base through the updating of the JSNA
- The creation of a long-list of options for priorities at a workshop of the HWB
- An assessment of that long-list against a set of prioritisation criteria
- The development of draft priorities
- Consultation on the draft priorities
- Finalisation of the priorities in this document

2.4.1 The Joint Strategic Needs Assessment (JSNA)

The JSNA is a key resource of health and wellbeing information, which was produced as an online resource in 2013. The information within the JSNA forms the evidence base relating to the health and wellbeing needs of local communities, that underpins the JHWS. The JSNA is also a key resource of health and wellbeing information for commissioners, local people and organisations.

The JSNA is set out as follows:

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

The JSNA can be accessed at www.enfield.gov.uk/jsna

2.4.2 *Prioritisation of options*

When considering options for priorities to include in this strategy, the HWB considered the following questions:

- What is the scale of the problem?
- Will addressing the issue result in a reduction in health inequalities?
- Is there a financially sustainable solution available?
- Does resolving this issue contribute to the prevention and self-help agenda?
- What does the evidence-base tell us about the likelihood of success?
- What are the long-term implications of addressing this issue?
- Will it lead to a positive change in lives?
- What is the importance and quality of the service at the moment?

2.4.3 *The draft priorities*

The process described in this section produced a list of five draft key priorities, which are:

- 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 making healthy choices

These are described in more detail in Section 4.

2.4.4 *Consultation process*

The HWB has a duty to involve the local community in the preparation of the JHWS, for example Healthwatch, the voluntary and community sector, Youth Parliament and other user groups.

Consultation on the draft priorities ran for twelve weeks, between October and December 2013. This consultation utilised a range of techniques in order to obtain views from the public, staff, carers and other key stakeholders.

The consultation was publicised widely across the borough, having been promoted online, via email, at public events and meetings and in a number of local publications including Our Enfield.

The five draft priorities were consulted on using a questionnaire, available online and as paper copies. Copies of the questionnaire were also available in an Easy Read format, and in five alternative languages (Bengali, Greek, Turkish, Polish and Somali).

People were also able to respond by voting at one of the token boxes provided for the consultation, whereby individuals were given a token to vote for which priority they thought was most important. A number of public events also took place during the consultation period, some catering to the general public, and others directed towards specific groups and organisations – further details of the consultation methods are available in the JHWS consultation report.

By the end of the consultation, a total of 2,003 responses had been received; 562 questionnaire responses and 1,441 token votes. Comments were also gathered through consultation events, which included views of the community and local organisations.

Questionnaire responses indicated that 99% of respondents supported a few, some, or all of the draft priorities, with over three quarters of respondents, (77%) supporting all five draft priorities.

When asked to select which priority or priorities respondents thought were the most important, the top three most popular selections were:

- Enabling people to be safe, independent and well and delivering high quality care health and care services (71% of respondents)
- Ensuring the best start in life (61% of respondents)
- Promoting healthy lifestyles and making healthy choices (52% of respondents)

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

- Creating stronger, healthier communities (44% of respondents)
- Narrowing the gap in healthy life expectancy (33% of respondents)

Respondents to the questionnaire were also asked to add any comments about what they thought to be the key areas for the health and wellbeing of local people. 210 respondents chose to provide a comment. These comments were grouped by theme, the outcome of which is summarised in the word cloud below:

The size of the font in the word cloud indicates the relative frequency with which a topic was mentioned by respondents – as such, we can see that the most commonly raised themes were Healthy Places, Primary Care, Access to Services, Health Promotion and Mental Health. A range of comments were also classified as 'Other', as these comments did not fall into any of the themes. The full list of themes can be viewed in the consultation report.

The token box votes identified a slightly different order of preference for the priorities. The most commonly voted for priority was 'Creating stronger, healthier communities', with 39% of token votes, followed by 'Enabling people to be safe, independent and well and delivering high quality health and care services' with 21%. These were followed by 'Narrowing the gap in healthy life expectancy' with 17%, 'Ensuring the best start in life' with 12% and 'Promoting healthy lifestyles and making healthy choices' with 11%.

A range of comments were also received from public events. These covered topics such as improving ease of access to information and advice, improving early diagnosis of long term conditions, the prevention agenda, and offering a broad range of support to encourage people to adopt healthier lifestyles whilst promoting personal responsibility for health and wellbeing. Frequently commented themes included Primary care, Healthy activities and exercise, Community involvement, Health promotion and Access to services.

During the consultation process, a number of comments were received regarding the meaning of the priority – 'Narrowing the gap in healthy life expectancy'. This was discussed by the HWB, and the decision was made to rename the priority 'Reducing health inequalities – Narrowing the gap in life expectancy', to reflect comments from local people and organisations.

All comments received were reviewed and considered in the preparation of this strategy. The majority of comments from both the questionnaires and public events have influenced the body of the report or the actions and measures of success.

The HWB is committed to continuing the dialogue that has begun with local people and organisations regarding health and wellbeing. As such, consultation on the JHWS will be an on-going process throughout the life of the strategy.

2.5 Vision, principles and priorities

The Health and Wellbeing Board vision is:

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

The vision is underpinned by five supporting principles:

- **Prevention and early intervention** – The lifestyle choices that people make about diet, exercise, alcohol consumption, smoking and drug use can affect their health and wellbeing.

  The HWB recognise that in many cases poor health can be avoided through better life choices and recognising risks to health. Early diagnosis, positive interventions and good quality service delivery will lead to the people of Enfield enjoying better health and wellbeing into the future.

  Good health and wellbeing starts before birth. The HWB recognises the importance of ensuring that women, parents and families are able to give children the best start in life by encouraging and enabling early access to ante natal care and promoting healthy lifestyle choices before, during and after pregnancy.

- **Integration** – service users should receive a seamless service, regardless of the source of the support; the HWB will encourage integration across all relevant health and social services, Schools' and Children's Services, and the voluntary and community sector where appropriate. Service integration will require the use of single points of contact, to simplify interactions between local people and services, and improve coordination across health, social care and other departments or organisations. The HWB recognise that as the main consumers of health and social care, integration of services is a key issue for older people.

  The introduction of the Better Care Fund will ensure greater integration between health and social care. A pooled budget, which is subject to plans agreed by the Health and Wellbeing Board, will support individuals to plan and control their care and bring together services to achieve the outcomes important to them.

  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 wellbeing, and the extension of universal services away from high cost specialist services. This approach promotes quality of life and seeks peoples' engagement in their own community. To achieve these shifts we need to change the way services are commissioned, managed and delivered. It also requires the redesign of roles, changing the workforce and shifting investment to deliver agreed outcomes for people that are focused on preventative action.

- **Equality and diversity** – Enfield HWB initiatives will address equality and diversity, by ensuring services are accessible and high quality, tailored appropriately to the different groups in Enfield, particularly in the light of the east-west divide across the borough in health and wellbeing outcomes.

- **Addressing health inequalities** where it is needed most – the HWB will ensure that its initiatives will target health inequalities in Enfield, with the aim of minimising variation in health and life expectancy between east and the west of the borough, while also improving the health and wellbeing of all Enfield residents.

- **Ensuring good quality services** – all services will be designed around the patient or user, will be safe, and will be caring and compassionate; the HWB will develop a response to the Mid Staffordshire Hospital and Winterbourne View review which will focus on this supporting principle.

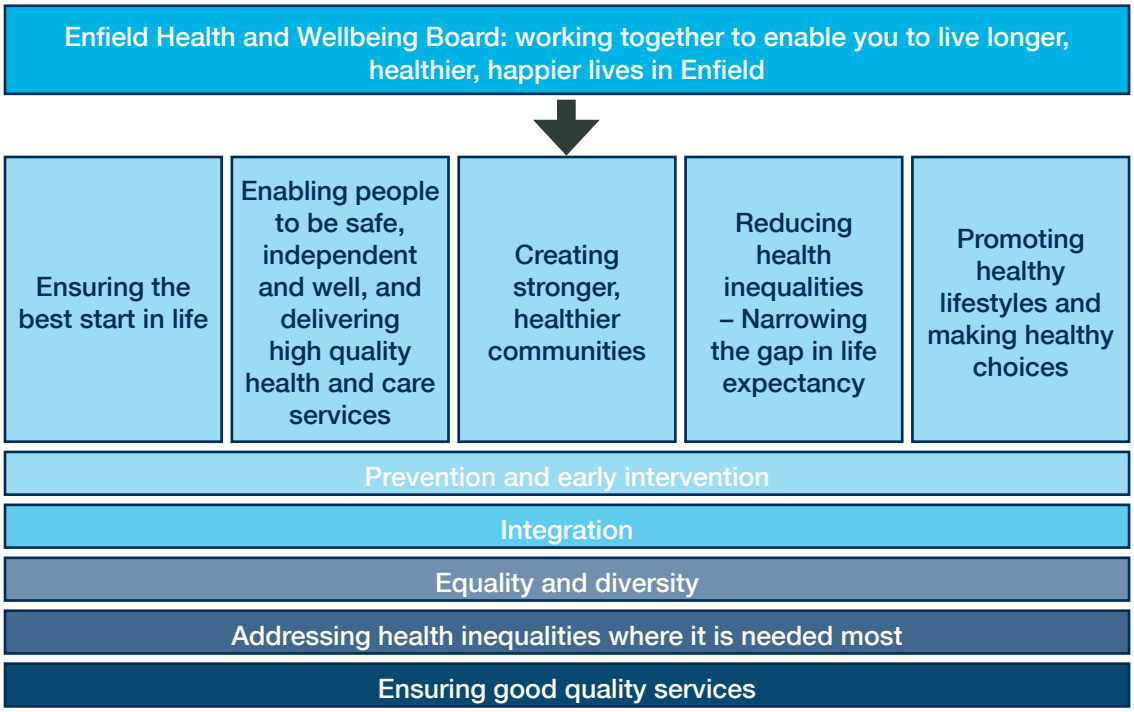
The HWB vision will be delivered through five key priorities:

- 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
- Reducing health inequalities – Narrowing the gap in life expectancy
- Promoting healthy lifestyles and making healthy choices

The implementation of the strategy priorities aims to deliver a long-term generational change in health and wellbeing in Enfield.

The figure below gives a summary of the vision, priorities and supporting principles of this strategy.

Figure 4: Enfield Joint Health and Wellbeing Strategy



The HWB's vision will be delivered in line with Enfield Council's three strategic aims, which underpin all of the Council's work and the decisions it makes, in support of the Council's vision of making Enfield a better place to live and work. These strategic aims and underlying priorities are:

- Fairness for all
  - Serve the whole borough fairly and tackle inequality
  - Provide high quality, affordable and accessible services for all
  - Enable young people to achieve their potential
- Growth and sustainability
  - A clean, green and sustainable environment
  - Bring growth, jobs and opportunity to the borough
- Strong communities
  - Encourage active citizenship
  - Listen to the needs of local people and be open and accountable
  - Provide strong leadership to champion the needs of Enfield
  - Working partnership with others to ensure Enfield is a safe and healthy place to live

3. Context and Case for Change

3.1 The national context

The Government has introduced new policy and legislation that will have a fundamental impact on the way in which public health, health services and social care are to be delivered. This change included giving local authorities, through Health and Wellbeing Boards (HWBs), a new role in encouraging joined-up commissioning across the NHS, social care, education, public health and other local partners.

Nationally the NHS is developing new models of primary care that; provide more proactive, holistic and responsive services for local communities, particularly for frail older people and those with complex health needs; play a stronger role in preventing ill-health; involve patients and carers more fully in managing their health; and ensure consistently high quality of care.

The Marmot Review in 2010, 'Fair Society, Healthy Lives' proposed evidence-based strategies for reducing health inequalities including addressing the social determinants of health in England, from 2010. It concluded that a good start in life, a decent home, good nutrition, a quality education, sufficient income, healthy habits, a safe neighbourhood, a sense of community and citizenship are the fundamentals for improving quality of life and reducing health inequalities. We understand that, to address health inequalities we need to improve opportunities for all our residents, with a focus on those who are experiencing poverty and deprivation.

Therefore this strategy also responds to the Marmot Review, the recommendations of which were:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

3.2 The local context

Service delivery in Enfield has undergone major changes, with a revision in the role of Chase Farm Hospital. This has seen the closure of emergency services and maternity and the expansion of elective care, including the development of an urgent care centre, an older people's assessment unit and a paediatric assessment unit on the site. Patient flows will change, with a larger role for North Middlesex Hospital, and the CCG is working to ensure primary and community care provision can prevent unnecessary emergency admissions. These changes are occurring within the context of significant financial pressures on health and social care, which will continue into the foreseeable future.

The Better Care Fund, which comes into operation in 2015/16, will see resources across England redirected with the aim of supporting the integration of health and social care. The Health and Wellbeing Board will be developing its vision and joint plan for how health and social care will work together in the borough to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospitals or care homes. This will require health and social care in Enfield to do things differently, work in partnership and encourage people to take responsibility for their own health.

Throughout the consultation, local people have made it clear that they are willing and keen to work in partnership with the HWB by taking a lead role in improving their own health and wellbeing.

3.3 About Enfield

A detailed description of Enfield and the health and wellbeing of its people can be found on the Enfield JSNA website[1]. The JSNA is continually updated and maintained as a live online resource. This section identifies some of the key facts about the health and wellbeing of the population of Enfield.

Population estimates for mid-2012 suggest that there were **a total of 317,287 individuals living in the borough.** Over the next decade, this figure is expected to steadily increase, reaching around 330,000 people by 2022, and **340,000 by 2032.**

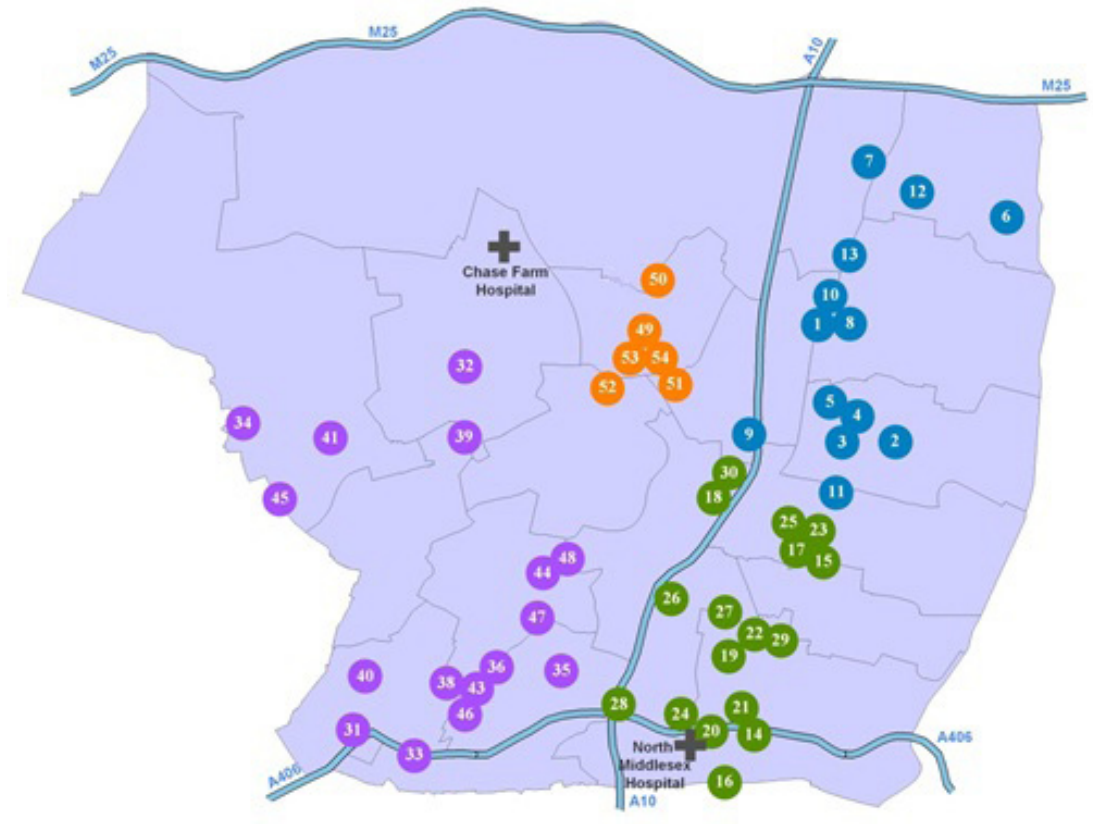
Enfield has a **large population of residents aged under 15**, representing just over one fifth (21.23%) of the population, while **12.6% of residents are aged 65 or over.** The proportion of residents aged 65 and over is expected to rise to 16.6% by 2032.

Enfield is a home to a hugely diverse population, with just under **two fifths of the population identifying themselves as belonging to a Black and Minority Ethnic (BME) group.** This strategy has been designed to respond to the many different groups that live and work in Enfield.

As of August 2013, there were **53 GP practices in the borough**, and two main hospitals; North Middlesex University Hospital and Chase Farm Hospital.

1 www.enfield.gov.uk/jsna

Figure 5: Distribution of GP practices and Hospitals in Enfield

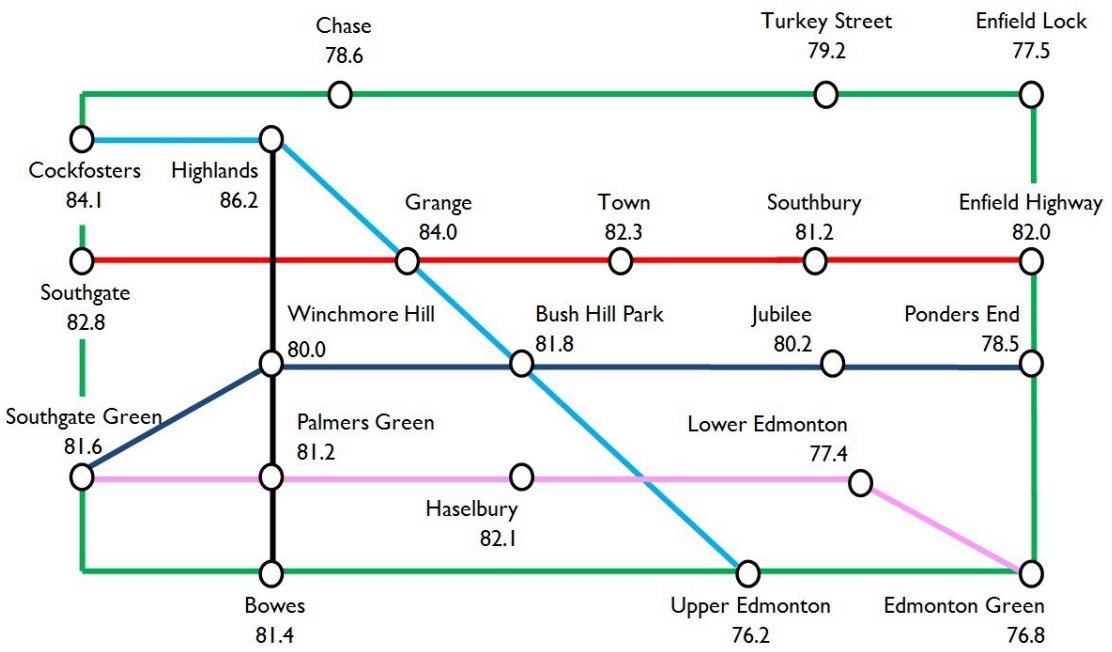


3.4 Case for change

Based on the evidence contained in Enfield's JSNA, and changes in funding for health and social care across England, Enfield must change to ensure improvements to health and wellbeing over the long term. This section highlights key issues in Enfield.

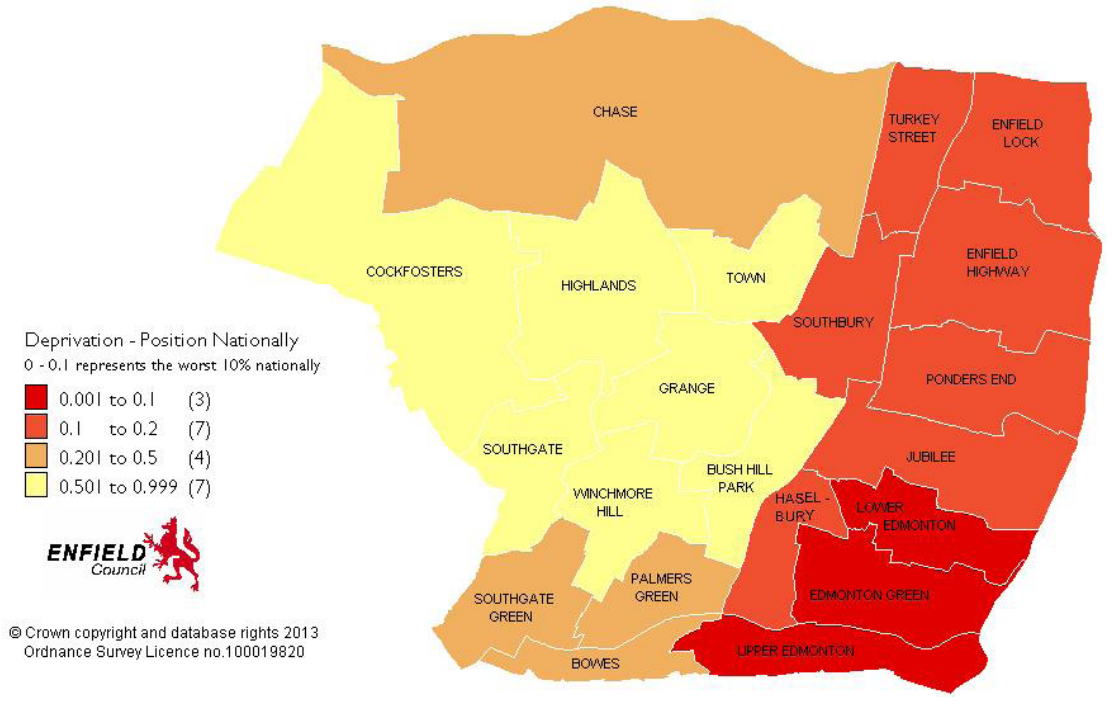
There is a stark discrepancy between the life expectancy of the residents of the east and the west of Enfield. **Those in the east are expected to live significantly shorter lives than those in the west.** For example, a man born in Edmonton Green is currently expected to have a lifespan nearly eight years shorter than a man born in Grange ward. Even starker is the difference in female life expectancy, with a woman born in Upper Edmonton expected to have a lifespan over 13 years shorter than a woman born in Highlands ward.

Figure 6: Enfield combined life expectancy, 2006-2010, by ward



Enfield is ranked as the 64th most deprived out of 326 local authorities in England. Deprivation is correlated with worse health, high morbidity and high mortality.

Figure 7: Deprivation by ward



Working age benefit data and the estimated under-18 population size can be used to produce a proxy indicator for the proportion of children in poverty.

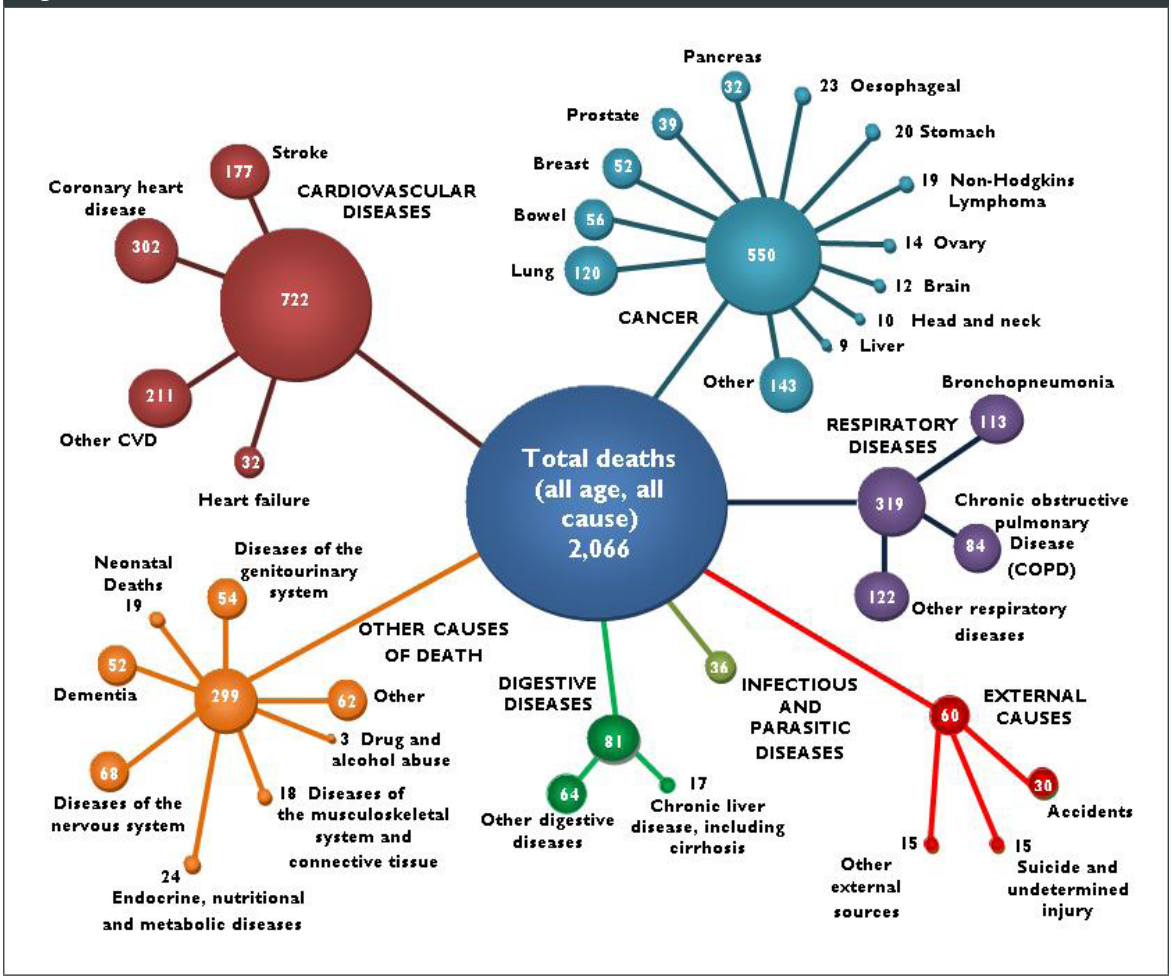
Table 1: Childhood poverty rates, 2010

Area	Childhood poverty rate
Enfield	33%
London	28%
England	21%

Enfield's rate equates to 26,870 children.

The figure below shows the causes of death in Enfield.

Figure 8: Causes of death in Enfield, 2007-2009



The **largest cause of death in Enfield is Cardiovascular Disease (CVD) followed by cancer.** Effective control of blood pressure and high quality clinical care can prevent many deaths.

Much of the burden of early mortality, and its associated morbidity could be avoided by changes in lifestyle. For example:

- Meeting the Chief Medical Officer's guidelines on physical activity reduces the risk of heart disease, stroke and cancer by 30%
- Not smoking reduces the risk of respiratory disease by up to 95% and eating the recommended levels of fruit and vegetables may reduce the risk of cancer
- Alcohol is associated with 7 cancers including breast and bowel

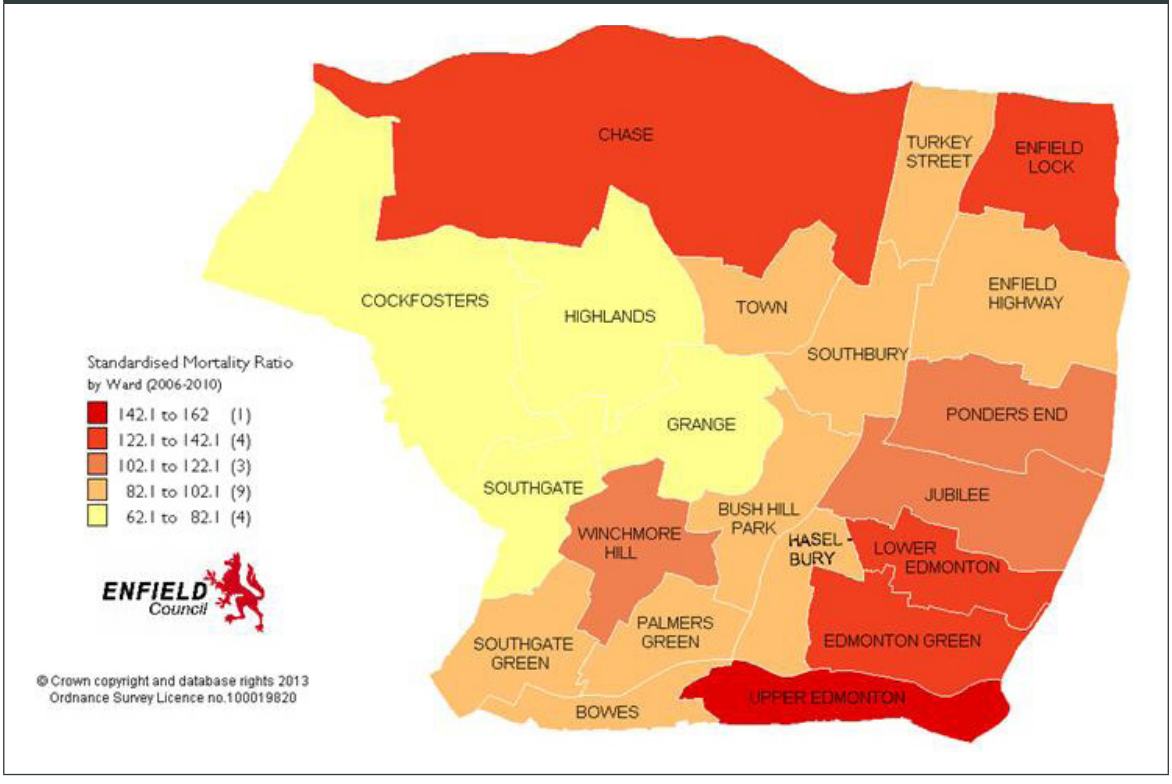
In Enfield:

- **18.5% of adults smoke;** it is estimated that 4% of 11-15 year olds smoke more than 1 cigarette a week
- **95% of the population is not physically active enough** to maximise benefits to their health
- 23.2% of the adult population is obese, and **24.2% of pupils in Year 6 are obese**

Long term conditions represent a significant cause of morbidity across the borough, and can be greatly influenced by a range of lifestyle factors. In 2012, **18,769 people aged 16 and over were thought to be living with diabetes**, around 18% of which were thought to be undiagnosed. Projections suggest that diabetes prevalence could rise from around 8.3% in 2012 to 9.5% by 2020 – an increase of approximately 3,500 cases. Similar projections for a range of other long term conditions, such as stroke and chronic obstructive pulmonary disease suggest that the prevalence of such conditions will be likely rise in future years.

Health is not evenly distributed across the borough. Figure 9 gives an indication of where people experience the best and worst health in the borough, based on rates of all-cause mortality.

Figure 9: All Age, All Cause Mortality in Enfield – Standardised Mortality Ratio by Ward: 2006-2010



The darker the colour on the map, the higher the relative rates of all-cause mortality. In Enfield the contrast is stark; those in Upper Edmonton have a mortality rate over 1.5 times that of the national average.

Immunisation coverage in Enfield is below the level required to achieve 'herd immunity', which is 95% in the UK. In 2012, **76.8% of children had received two doses of MMR before their 5th birthday.** This is lower than both the London and England rates.

In 2011, **HIV prevalence in Enfield was 4.0 per 1,000 population** aged 15-59 compared to 2.0 in England and 5.4 in London. **58% of people with HIV were diagnosed late in Enfield** in 2010 compared to 44% overall in London and 52% in England. 38% of men who have sex with men were diagnosed late (compared to 31% in London) and 65% of heterosexuals were diagnosed late (compared to 61% in London).

Mental health needs vary according to gender, ethnicity and age, and are influenced by family, social and environmental determinants. People with long term mental health problems are at increased risk of long term social exclusion, including worklessness and insecure housing.

Mental ill health is associated with an increased risk of premature death, with people suffering from severe mental illnesses dying on average 20 years earlier than the general population. **Enfield had the third highest excess mortality rate in London amongst people with severe mental illness** compared to the general population in Enfield in 2010/11.

In 2011/12 Enfield's **inpatient admission rate for mental health disorders amongst children and young people aged 0-17 years was the highest in London**, with 135 admissions being recorded.

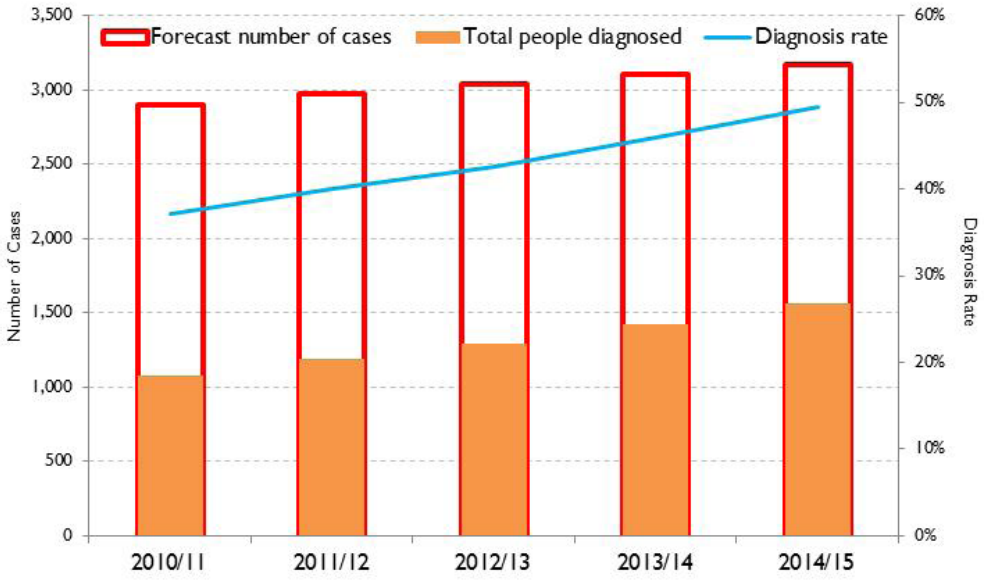
Table 2: Inpatient admission rate for mental health disorders 0-17 years

Area	Inpatient admission rate for mental health disorders, 0-17 years (rate per 100,000)
Enfield	171.90
London	87.8
England	91.3

The **estimated number of people living with dementia in Enfield is 2,828**[2], which is approximately 7% of Enfield's older persons population. The number of people with dementia is expected to increase by approximately 20% over the next 8 years to 3,500 people. This represents an increase of approximately 75 people per year. However, there is an issue with undiagnosed dementia, as illustrated by the figure below.

2 POPPI 2010

Figure 10: People living with dementia



Turning to some of the wider determinants of health and wellbeing, since 2004-05 there has been a **20% reduction in recorded crime in Enfield**, compared to a 23% reduction across the London region and a 29% reduction nationally. However, serious youth violence in Enfield escalated notably between 2007/08 and 2010/11, during which time **knife and gun injuries sustained by 10-19 year olds increased by 37%.**

Hotspots for gun and knife crime injuries sustained are largely concentrated in the south-eastern part of Enfield, with the three Edmonton wards combined accounting for 30% of gun and knife injuries in the Borough. Edmonton Green and Upper Edmonton both rank in the 30 highest London wards for gun, knife and weapons injuries in terms of London Ambulance Service Call-outs.

As well as crime, the population of Enfield is concerned about anti-social behaviour. There were **17,622 reports of anti-social behaviour to police in 2012** with a further 5,761 reports to the local authority regarding environmental anti-social behaviour (fly-tipping, abandoned vehicles, graffiti). However, in Enfield, **since 2008, there has been a 27% reduction in the volume of anti-social behaviour reports.**

In 2010, **12% of Enfield households were suffering from fuel poverty**, giving Enfield the fifth highest rate of fuel poverty in London, and the 4th highest number of households (13,124) in fuel poverty. The wards of Haselbury, Upper Edmonton and Ponders End had the highest levels of fuel poverty in Enfield.

National estimates suggest that about **30% of the population aged 65 and over feel mildly to intensely lonely**, with 12% of older people reporting feeling trapped in their own home. Loneliness and social isolation have been shown to have significant negative impacts on people's mental and physical health and wellbeing, and can affect people of any age. Groups who are particularly vulnerable to the effects of social isolation include those with sensory impairments or limited mobility, people from ethnic minority groups and people who care for a friend or family member.

The recent Welfare Reform Act has introduced a wide range of changes to the provision of welfare in England. This will impact on Enfield in a number of ways:

- As one of the first councils to implement the Government's benefit cap, Enfield has seen the highest number of capped households in London. It predominately affects single parents households (77%) and larger family sizes and places their housing at risk if they cannot qualify for an exemption or find the money to pay their rent.

- From April 2013, local authorities were required to introduce their own local schemes to support families who need financial assistance with Council Tax payments. In Enfield, over 27,000 households are affected by these changes which have seen working age claimants receive reduced levels of support.

- Other changes include reductions in housing benefit for single people under 35, reductions for social housing tenants who are considered to have too many bedrooms, both of which can affect disabled adults, the introduction of personal independence payments, the abolition of aspects of the crisis loan scheme and phased roll-out of universal credit.

It is not possible to accurately identify what risks may be encountered but early indications show an increasingly unstable private rental market where families on low incomes are being excluded from housing choices resulting in higher levels of homelessness. Other risks include financial hardship (increasing numbers of food bank and emergency payment requests), increased mobility, increased over-crowding linking to family health and relationships, and increased mental health concerns.

In 2011/12 Enfield had the third lowest achievement rate, for 5+ A*-C GCSEs including English and Maths, in London. 55.5% of pupils achieved this level (approximately 2060 pupils from an End of Key Stage 4 Pupil Population of 3712), compared to a London average of 62.3%. Enfield's rate was also below the England average of 59.4%. Only the Boroughs of Waltham Forest and Islington performed worse than Enfield.

Information for 2012/13 indicates that **63% of pupils in Enfield achieved 5 A*-C GCSEs including Maths and English.**

Figures for April 2012 to March 2013 show that the **rate of employment in Enfield is 67.0%.** This is the eleventh lowest rate in London – well below the London average of 69.5% and the England average of 71.1%.

At the same time, the **economic activity rate in Enfield was 74.7%.** This is the tenth lowest rate in London – just below the London average of 76.4% and the England average of 77.3%.

3.5 Key improvements

We are proud of improvements in health and wellbeing in Enfield in recent years. Some of our key improvements have been:

- Premature deaths in Enfield (that is, under the age of 75 years) are below the national average for cancers overall and for those cancers that are considered to be preventable.
- Under 75 mortality from CVD has declined in Enfield. In 2011, Enfield's rate of under 75 mortality from CVD was 49.3 per 100,000, well below the England rate of 58.8 per 100,000.
- Enfield was the first local authority area nationally where 100% of schools implemented the School Fruit and Vegetable Scheme as part of the '5 a day' programme. 96% of Enfield's primary and secondary schools meet the Healthy Schools scheme which includes a standard on Healthy Food.
- Child immunisation rates have been improving in recent years, reflecting on going work to improve data management, public awareness and provision and access to immunisation.
- Enfield's rate of smoking amongst pregnant women at the time of delivery has fallen steadily over the course of the last five years.
- Since 2006 Enfield's under-18 conception rate has steadily declined, and is now lower than that of both the London and England averages. Enfield's teenage pregnancy rate in 2011 was 25.8 per 1,000 females aged 15-17 years. This was lower than the London rate of 28.7 and the England rate of 30.7, and represented a 24.3% reduction from the Enfield rate in 2010 of 34.1 and a 44.4% reduction from the baseline rate in 1998 of 46.4 per 1,000 females aged 15-17 years.

4. The HWB's Priorities and Action Plan

The sections below describe each priority in more detail and set out key actions for the short, medium and long term. Short term is defined as within 2014/15 and medium term is defined as within 2-3 years.

In order for the Board to be able to provide the leadership needed, it will be putting a review of its Board structure in place. This action sits alongside the priority-related actions set out in this strategy.

The Board will also be developing integration plans through implementation of the Better Care Fund.

A detailed action plan will be developed and monitored by the HWB. Section 5 sets out the outcomes dashboard which the HWB will use to monitor the long term changes in health and wellbeing in Enfield which result from the implementation of the actions in this section.

4.1 Ensuring the best start in life

We want all children to realise their full potential, helping them to prepare from an early age to be self-sufficient and have a network of support that will enable them to live independent and healthy lives.

We want targeted programmes of support to have lasting impact, especially towards the most vulnerable, in order to prepare for the responsibilities of adulthood and build up resilience for the future. We will support all stages of childhood, pre-birth, infancy, pre-school and through school, with the aim of realising the potential in all children. Educational attainment is recognised as being a key to achievement of long term health and wellbeing.

All Health and Wellbeing Boards have been asked to sign up to the Disabled Children's Charter, which has been developed to support HWBs to meet the needs of all children and young people with disabilities, special educational needs (SEN) or health conditions. The Enfield HWB committed to the Charter at its December 2013 meeting, and this will ensure that the Board:

- Publicly articulates a vision for improving the quality of life and outcomes for disabled children, young people and their families
- Demonstrates an understanding of the true needs of disabled children, young people and their families in Enfield 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

"Good health and wellbeing must start with messages we give our children. Educating them at an early age as well as their parents and families, is crucial to the long term prevention of ill health and long term conditions." *Comment from the consultation responses*

The table below sets out the short, medium and long term actions for this priority.

Table 3: Ensuring the best start in life	
Short term actions	• Understand and plan for the implications of the Children's and Families Bill on the changes for the SEN system up to age 25, including replacing Statements of Need with a local offer and Birth to 25 Education, Health and Care Plan. • Develop a multi-agency plan for reducing Infant Mortality, with the HWB having oversight of the plan and supporting its implementation. The plan will have a particular focus on child poverty, early access to ante natal services and integrating services. • Manage the transition of the responsibility for health visitors to public health, ensuring improved service delivery.
Medium term actions	• Develop a coherent overarching plan for transition to education for all children aged 2 and above which unifies the Healthy Child Programme and the Early Years Foundation Stage. • Redesign treatment pathways to ensure the delivery of high quality, integrated paediatric care, to provide more community-based care options and to improve the experience and outcomes of children who are ill. • Reduce paediatric admissions for asthma and other ambulatory care sensitive conditions by improving early identification and disease management in primary and community services. • Through more effective use of the School Nursing Service, and closer working with health colleagues, support schools in reducing pupil absence due to illness and medical appointments and thereby improve overall attendance rates.
Long term actions	• Improve educational attainment by ensuring all agencies involved with children in Enfield work together to provide the best educational experience possible for all children.

4.2 Enabling people to be safe, independent and well and delivering high quality health and care services

We want people of every age to live as full a life as possible, with good health and wellbeing being encouraged from the outset. This means that people are encouraged to have lifestyles which help to prevent the onset of some diseases. When they do occur, health issues both physical and mental, should be recognised as soon as possible, as early intervention is likely to lead to better long term outcomes. It also means that people who do live with long term conditions should be supported in a way that helps to minimise the impact on their daily lives. People with any form of disability or impairment should be supported in a way that promotes inclusion, independence, choice and control.

Additionally, safeguarding children and adults from harm and abuse is fundamentally important for the health and wellbeing of individuals and the wider local community.

The greater people's independence, the less reliant they are on others. Independence, safety and wellbeing are interlinked: those who experience poorer health, or who feel less safe, are usually more dependent on others and less able to contribute to community life. Increasing levels of dependency create a demand for increasing intensity of service provision. We are working together to join up

services to support children and young people, older people and people with long term conditions. We want to avoid duplication, improve people's experience of our services and ensure services are safe, effective and of high quality.

"Importance of Dementia Awareness and choices for older people."

Comment from the consultation responses

The table below sets out the short, medium and long term actions for this priority.

Table 4: Enabling people to be safe, independent and well and delivering high quality health and care services	
Short term actions	• Develop a register of carers which is co-ordinated across primary care, social care, acute care and mental health. • Increase the early diagnosis of HIV infection.
Medium term actions	• Ensure that there is an increased focus on the early identification of long term conditions, in particular diabetes, chronic obstructive pulmonary disease (COPD), dementia, hypertension and CVD. • Develop a network model of primary care to ensure better access to consistent, good quality services with the potential to maintain continuity of care by: – Developing a stable system/model for a more integrated delivery of health care focused around networks and general practices, which in part will support early identification and good disease management. – Implementing a 7 day delivery model for integrated care for older people, which will support reductions in the rate of acute admissions. • Ensure that more people are able to access psychological therapies (Improving Access to Psychological Therapies – IAPT) locally by increasing uptake of the service through integrated approaches. • Coordinating services around the needs of the young person and family to ensure a positive experience of transition to adult services. • Deliver on the Joint Adult Mental Health Strategy. • Establish an effective model of psychiatric liaison in North Middlesex University Hospital based on the RAID (Rapid Assessment Interface and Discharge) model. • Ensure co-ordinated care provision for people with co-occurring alcohol or substance misuse and mental health problems. • Increase the dementia diagnosis rate in line with the CCG's operating plan, and improve dementia care.
Long term actions	• Develop a mental health and wellbeing service which focuses on recovery and independence for people with mental health and aims to limit the number of people who require secondary mental health care. • Develop integrated models of care for older people. • Develop a whole-life mental health strategy.

4.3 Creating stronger, healthier communities

A large part of the lifetime health and wellbeing experience of people relates not to the health and social care that they receive, but the environment in which they live, and community that they are part of. People who are able to contribute to society through meaningful employment, live in warm, clean, safe accommodation, and are supported by strong social networks of family, friends and neighbours, are less likely to suffer from both mental and physical health issues.

We want to build strong communities that are integrated and cohesive, and provide residents with more resilience to cope with adverse life events.

We want to reduce loneliness and social isolation, and enable local people to take an active role in building and nurturing strong social networks and vibrant communities.

"It would be helpful to involve the local community through local community groups who should be enabled (say through funding and assisting to create local structures) to fully participate and mobilise their communities at grassroots level." *Comment from the consultation responses*

We want to encourage individuals, families and communities to make healthier choices and take a proactive role in improving their health and wellbeing.

We will utilise evidence-based health promotion and social marketing techniques to work collaboratively with our communities to improve their health.

The table below sets out the short, medium and long term actions for this priority.

Table 5: Creating stronger, healthier communities	
Short term actions	• Develop understanding amongst local people of the role that community cohesion plays in improving health and wellbeing, including reducing loneliness. • Delivering an annual programme of community engagement with those who come from different backgrounds, and ensure that Enfield residents can continue to contribute to the development and implementation of the JHWS. • Support the outcome of the Home Office review regarding the links between ending gang and youth violence. In particular agree tasks to be overseen and delivered by the partnership represented on the Health and Wellbeing Board. • Following the publication of the JHWS, HWB to review its structures to ensure effective engagement of local people in work to improve their health and wellbeing.
Medium term actions	• To support and work in partnership with faith groups, the voluntary and community sector, schools and children's centres and other local organisations to deliver specific projects aimed at improving community wellbeing. • Partners on the HWB show leadership by modelling healthy behaviours within their organisations (e.g. healthy eating choices, travel for work policies, work life balance). • Promote dementia friendly communities, which aim to improve awareness, inclusion and quality of life for people living with dementia and support for their carers. • Staff from North Middlesex Hospital to visit 50% of Primary and Secondary schools to raise aspirations of Enfield's young people to seek career opportunities and employment at the hospital and in other health related careers.
Long term actions	• Strengthen community networks to enable individuals and families to take responsibility for their own health and wellbeing. • Improve the awareness of people of all ages and communities to make healthy lifestyle choices through positive communication and community interaction. • Building on the agreement with North Middlesex University Hospital, work in partnership with all large public sector providers and partners to promote and expand opportunities for employment, apprenticeships and volunteering for local residents, including children, young people and young parents in Enfield.

4.4 Reducing health inequalities – Narrowing the gap in life expectancy

We want to reduce the gap in life expectancy that exists within the borough, of 8 years for men, and 13 years for women.

We will work with local people to prevent them becoming ill in the first place by addressing key lifestyle factors more common in the deprived areas of the borough; and addressing the wider determinants of health such as high levels of deprivation, low educational attainment, low levels of employment and poor housing.

We will encourage early diagnosis and management (including lifestyle change) of major killer diseases such as CVD and cancer; a focus on people over 50 will have the greatest impact on reducing the life expectancy gap. Initially we will work intensively with Upper Edmonton, as set out in the Central Leeside Area Action Plan[3], and once models which work have been developed, these will be rolled out to other deprived areas.

"The difference in life expectancy across the Borough is shocking."

Comment from the consultation responses

The table below sets out the short, medium and long term actions for this priority.

Table 6: Reducing health inequalities – Narrowing the gap in life expectancy	
Short term actions	• Support implementation of Integrated Care Pathways to improve efficiency and patient experience. • Work with partners in Upper Edmonton to map existing community resources that support health and wellbeing, and identify where gaps exist when compared with evidence-based practice. • Encourage early diagnosis and management (including lifestyle change) of conditions such as CVD, diabetes, cancer and COPD, and work to reduce the risk of death amongst people living with long term conditions.
Medium term actions	• Work with the community to target and deliver specific interventions in Upper Edmonton, which address health inequalities. • Reduce smoking rates amongst groups known to be particularly affected by high smoking prevalence. • Further strengthen clinical management of CVD, diabetes and respiratory disease.
Long term actions	• Replicate the successful targeted interventions set out in the Upper Edmonton Action Plan and associated business case to other deprived areas of the borough. • Work to address the wider determinants of health such as high levels of deprivation, low educational attainment, low levels of employment and poor housing.

3 http://www.enfield.gov.uk/info/1000000456/local_plan_planning_policy/501/central_leeside__area_action_plan

4.5 Promoting healthy lifestyles and making healthy choices

The lifestyle choices that people make about diet, exercise, alcohol consumption, smoking and drug use can affect their health and wellbeing.

We want to ensure that local people understand the impact of these choices, and are supported to choose healthier options throughout their lives, making use of the council's regulatory powers to influence local businesses and make local areas healthy places to live.

We want to ensure that people are encouraged and are able to access the borough's open spaces, leisure facilities, sports clubs and other opportunities for activity, including active transport such as cycling and walking.

"I think in Enfield we have many open spaces where people can walk, walking is an excellent exercise, no costs involved, it should be encouraged more." *Comment from the consultation responses*

The table below sets out the short, medium and long term actions for this priority.

Table 7: Promoting healthy lifestyles and making healthy choices	
Short term actions	• Produce a comprehensive obesity strategy, covering both children and adults. • Produce a comprehensive substance misuse strategy, covering both adults and young people. • Health and Education professionals to work jointly to support and promote the Healthy Schools London programme in the borough.
Medium term actions	• Agree on an action plan with schools and young persons' organisations to prevent and reduce smoking uptake. • Identify and develop more opportunities to deliver Identification and Brief Advice (IBA) interventions for harmful drinking, particularly through digital customer pathways. • Reduce the rate of alcohol-related acute representations to ensure that treatment is provided in appropriate, cost-effective settings. • Develop healthy workplaces throughout Enfield. • Promote healthy eating throughout Enfield.
Long term actions	• Ensure that transport and building developments prioritise active transport (particularly walking and cycling).

5. Success Criteria – what does good look like?

5.1 Measure of success

The measures of success table below outline a number of key strategic outcomes the HWB wish to see realised through action in the short, medium and long term. This is not exhaustive, as further measures of success are included in the JHWS detailed action plan, to be monitored by the HWB.

Table 8: Measures of success

Ensuring the best start in life	
Child poverty to reduce to 25% by 2020, decreasing from the 2008 baseline of 36%	Percentage of children receiving the full course of MMR by their 5th birthday to increase from 76.8% to 95% by 2019
The gap between the most and least deprived wards measured in terms of child poverty to reduce from 42% (based on the 2009 baseline) to 30% by 2020	95% of pregnant women under the age of 18 who book for maternity care to receive a targeted antenatal intervention from Family Nurse Partnership/ Health Visitor Service – target to be agreed
95% of new birth visits to be carried out between 10-14 days after birth – target to be agreed	The percentage of absences from school due to illness to improve on the 2012/13 rate of 2.7%
Enabling people to be safe, independent and well and delivering high quality health and care services	
Late HIV diagnosis to reduce from 58% to 44% by 2019	Adult (18+) unplanned admissions to acute health care to reduce by 10% on the 2012/13 baseline of 20,371 admissions
Access to psychological therapies (IAPT) to improve locally by increasing uptake from the current rate of 5% to 15% by the end of 2014/15	Delayed transfers of care to reduce from 5.74 per 100,000 in 2012/13 to 5.00 per 100,000 by 2014/15, with this rate maintained in 2015/16
Rate of admissions for people aged over 65 to residential and nursing care to reduce from 513.5 per 100,000 in 2012/13 to 490 per 100,000 by 2015/16	Rate of admissions of older people to acute health care to reduce by 20% on the 2012/13 baseline of 9,215 admissions
Creating stronger, healthier communities	
HWB structures to be reviewed by 2015 to ensure on going engagement of local people in improving their health and wellbeing	Faith forums and community leaders to be enabled to take a lead role in improving local health and wellbeing
Communications and Engagement strategy to be developed and implemented to support the on-going implementation of the HWB strategy	The percentage of people who feel safe outside in their local area after dark to increase by 2019
Reducing health inequalities – Narrowing the gap in life expectancy	
75% of Enfield GP practices to achieve 90% in the percentage of patients with coronary heart disease whose blood pressure is controlled by 2019	The difference in female life expectancy between the best and worst wards to reduce from 13 years to 10 years by 2019

Promoting healthy lifestyles and making healthy choices	
The percentage of year 6 pupils classified as obese to reduce from 24% to 22% by 2019	Smoking prevalence to reduce from 18.5% in 2012 to 12% by 2030
Acute alcohol-related presentations to reduce by 10% on the 2014/15 baseline by 2015/16, and be maintained thereafter	90% of all drug users in treatment to receive HIV and Hepatitis B interventions, and 90% of injecting drug users receive Hepatitis C interventions
The proportion of drug users successfully completing treatment in 2014/15 to increase to 4% above the 2013/14 target rate	30% of local authority schools to achieve the Healthy Schools London Bronze Award, and 10% of local authority schools to achieve Silver Award by December 2014

5.2 Next steps

There are some clear health and wellbeing challenges in Enfield and this strategy for Enfield recognises that the needs of local people vary across the Borough and the importance of working closely with communities and local organisations to meet those needs.

This Health and Wellbeing Strategy 2014-2019 sets out the priorities that the HWB will focus on with the aim to making a real difference to the lives of Enfield people. There will be a more detailed action plan which will identify leads and outputs to deliver the program of work as set out in the strategy. The HWB will review the progress of the action plan on a regular basis and will update the plan as required in response to changes in the evidence base (JSNA) and to reflect progress.

The HWB is committed to increasing community engagement in the delivery of the strategy. Successful implementation of the strategy relies on community and stakeholder organisations all of whom have an important part to play in the delivery.

The strategy will be implemented at a time when there are significant public sector financial cuts, so innovative use of existing resources will become even more important.

The full Health and Wellbeing Strategy will be reviewed in 2018/19.

6. Communications and Partnership

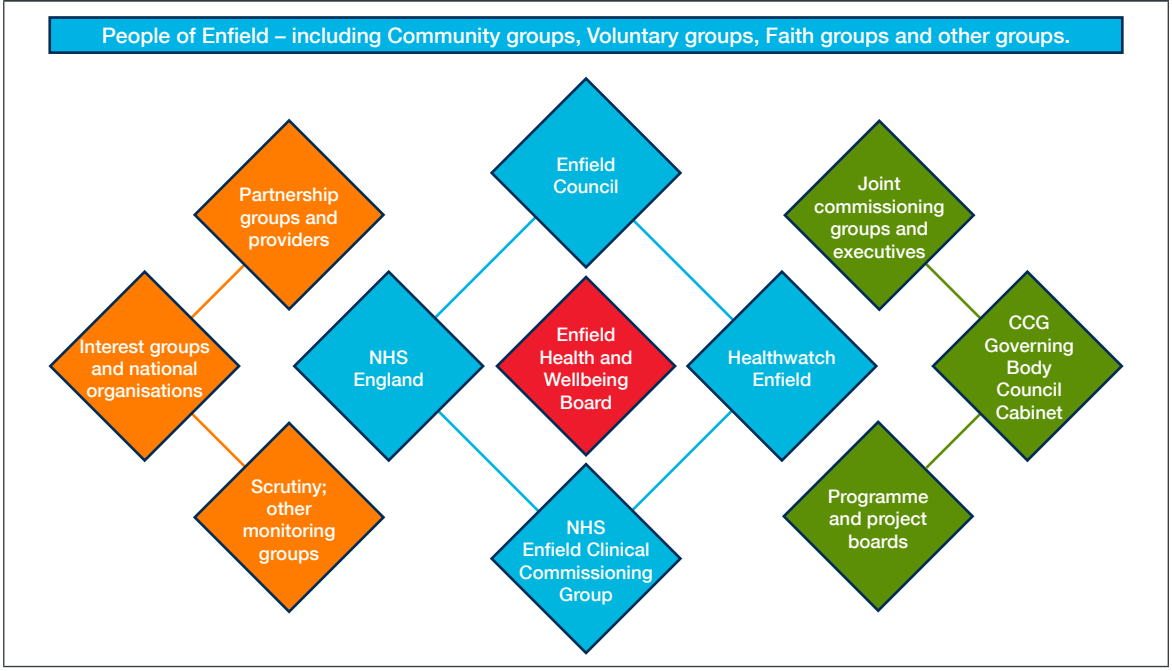
Our programme of change will require considerable partnership working between the HWB and other stakeholders within Enfield including the voluntary and community sector, private sector, police, local groups and Enfield residents. The HWB will develop a communications and engagement plan covering all stakeholders in this strategy. We will continue to provide evidence on the health and wellbeing needs of the local community and what we are doing to address these.

Partnership working will be crucial given the challenges brought about by the current economic climate and the fast changing environment in which the public sector is currently working.

In order to build on the success of the formal consultation that took place in the development of this strategy, we will review the HWB's current structures and ways of working. The aim of which is to develop mechanisms by which local people can take a lead role in the implementation of this strategy, thereby improving their own health and wellbeing. Additionally, our priority 'Creating stronger, healthier communities' sets out a number of actions to support this aim.

The figure below provides an overview of the HWB's approach to communications and partnership in delivering this strategy.

Figure 12: The HWB's communications and partnership approach



The HWB has already engaged the local community through the formal consultation on the priorities in this strategy. However, this is just the start of an on-going process. The HWB will engage with the community through formal consultations and other activities, including working with community and voluntary groups, faith groups, schools and children's groups and patient/service user groups, with the aims of:

- Working with community leaders to build strong relationships enabling all sectors of the local community to contribute to the implementation of the strategy
- Recognising the community as a valuable asset who can develop local solutions
- Understanding what is important to the people of Enfield when they think of their health and wellbeing
- Establishing what resources already exist in the community which could support the delivery of this strategy
- Exploring what works when encouraging people to make healthy choices
- Developing ideas for helping people take responsibility for their own health and wellbeing
- Shaping actions for delivering health and wellbeing, and developing future iterations of this strategy
- Holding the HWB accountable to the people of Enfield to deliver its key measures of success
- Creating and maintaining an open dialogue, to enable local people have their say on the on-going development of the strategy.
- Using the evidence base from the JSNA and social marketing techniques, we will work collaboratively with our communities to improve their health and wellbeing

At all times, the HWB will work in line with the government's ambition for shared decision-making – "nothing about me without me"[4].

4 http://www.official-documents.gov.uk/document/cm78/7881/7881.pdf

Appendix 1
Glossary of terms

Better Care Fund	A fund which will pool existing budgets in 2015/16 to enable greater integrated working and transformation of local services to older and disabled people
BME	Black and minority ethnic groups within the population
CCG	Clinical Commissioning Group – groups of GPs responsible for designing the local healthcare system, through the commissioning (purchasing) of a range of health and care services; CCGs work with patients and healthcare professionals and in partnership with local communities and local authorities. CCGS replaced Primary Care Trusts (PCTs) in April 2013.
Child Poverty	Children living in families where the reported income is less than 60 per cent of the national median (mid-point) income
COPD	Chronic Obstructive Pulmonary Disease – the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease
CVD	Cardiovascular disease – a group of diseases of the heart and blood vessels
Health Inequality	Differences in health experiences and health outcomes between different population groups
Health Promotion	Health promotion is the process of enabling people to increase control over, and to improve, their health
Healthwatch	The consumer champion in health and care, ensuring the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services
HIV	Human immunodeficiency virus – the virus attacks the immune system, and weakens your ability to fight infections and disease; there is no cure for HIV, but there are treatments to enable most people with the virus to live a long and healthy life
HWB	Health and Wellbeing Board – a partnership board whose purpose is to improve the health and wellbeing of the residents of Enfield and reduce current health inequalities
IBA	Identification and brief advice – a brief alcohol intervention which usually consists of using a validated screening tool to identify people at risk of harmful drinking, and the delivery of short, structured 'brief advice' aimed at encouraging the drinker to reduce their consumption to lower risk levels. It should be initiated by front line health and care workers whenever they have a good opportunity

Immunisation	The process by which an individual's immune system is strengthened against a particular type of virus or bacteria through vaccination
Infant Mortality	Deaths occurring before the age of one year of babies who were born alive
JSNA	Joint Strategic Needs Assessment – the collection and collation of information and intelligence about the health and wellbeing needs of the local community
Life Expectancy	The theoretical age of death an average person born today could expect to live to if he/she had the same rate of death at each age as the current population
LTC	Long term condition – conditions or chronic diseases for which there is currently no cure, and which are managed with drugs and other treatment, e.g. diabetes
Marmot Review	An independent review by Professor Sir Michael Marmot which was commissioned by the Government to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010
MMR	The triple Measles, Mumps and Rubella vaccine, given as a single injection
Morbidity	A diseased state, disability, or poor health due to any cause. Also used to describe the rate of illness and ill health in a population
Mortality	Relating to death; a mortality rate indicates the number of deaths within a population over a given period of time (e.g. per year)
Obese	Describes an individual who is clinically overweight, with a body weight more than 20% greater than recommended for their height; individuals who are obese have a body mass index of over 30
SEN	Special Educational Needs – children have a statement of special educational needs if they have a learning difficulty which calls for special educational provision to be made for them
SMR	Standardised Mortality Ratio – a ratio of the number of actual deaths associated with a particular disease or condition in a local area, and the expected number of deaths from the same disease or incident, based on age and gender specific rates within a reference population
Social Marketing	Social marketing is an approach used to develop activities aimed at changing or maintaining people's behaviour for the benefit of individuals and society as a whole, utilising techniques developed in commercial advertising.
Ward	An electoral ward is a division of an administrative area used to elect councillors to serve on the councils of the administrative areas
Wider Determinants	Also known as the social determinants of health, they have been described as 'the causes of the causes' – the social, economic and environmental conditions that influence the health of individuals and populations

Appendix 2
Consultation about this strategy

A public consultation on the draft priorities ran for twelve weeks between October and December 2013.

The five draft priorities were consulted on using a questionnaire, available online and as paper copies. Printed copied were also available in an Easy Read format, and in five alternative languages (Bengali, Greek, Turkish, Polish and Somali).

People were also able to respond by voting at one of the token boxes provided for the consultation, whereby individuals were given a token to vote for which priority they thought was most important. A number of public events also took place during the consultation period, some catering to the general public, and others directed towards specific groups and organisations.

By the end of the consultation, a total of 2,003 responses had been received; 562 questionnaire responses and 1,441 token votes. A number of organisations also chose to provide questionnaire responses. Comments were also gathered through consultation events, which included views of the community and local organisations.

Questionnaires

Responses from questionnaires indicate that:

- Over three quarters of respondents, (77%) supported all five draft priorities.
- Over 99% were generally in favour of either a few, most or all of the draft priorities.
- Less than 1% of respondents supported none of the priorities.

When asked to select the priority or priorities that they felt were most important, respondents completing the questionnaire selected:

- ‘Enabling people to be safe, independent and well and delivering high quality health and care services’, with 71%
- ‘Ensuring the best start in life’ with 61%
- ‘Promoting healthy lifestyles and making healthy choices’ with 52%
- ‘Creating stronger, healthier communities’ was chosen by 44%
- ‘Narrowing the gap in healthy life expectancy’ with 33%

(It should be noted that as respondents were able to select more than one important priority, summed percentages equal more than 100%)

Respondents to the detailed questionnaire were also asked to add any comments about what they thought to be the key areas for the health and wellbeing of local people. 210 questionnaire respondents chose to provide a comment. Some of the longer or more detailed comments were broken down to accurately capture the range of topics covered. The resulting 267 comments were then grouped by theme, the outcome of which is summarised in the word cloud below:

The size of the font in the word cloud indicates the relative frequency with which a topic was mentioned by respondents – as such, we can see that the most commonly raised themes were Healthy Places, Primary Care, Access to Services, Health Promotion and Mental Health.

Token Boxes

People were invited to place a token in one of five boxes, each box being labelled with one of the JHWS draft priorities. By placing a token in a particular box, individuals indicated their preference in terms of which of the five draft priorities they felt was most important.

These token boxes were placed in three locations throughout the Borough; Enfield Civic Centre, Enfield Town Library and Edmonton Green Leisure Centre. Each location hosted the token box for one week, during which time anyone could take a token and vote for the draft priority that was most important to them.

Responses collected via the token boxes ranked priorities in a slightly different order to the questionnaire, though the popularity of priorities did vary depending on the location of the token box.

Overall, token box responses ranked the priorities in the following order:

- 'Creating stronger, healthier communities' – 39%
- 'Enabling people to be safe, independent and well and delivering high quality health and care services' – 21%
- 'Narrowing the gap in healthy life expectancy' – 17%
- 'Ensuring the best start in life' – 12%
- 'Promoting healthy lifestyles and making healthy choices' – 11%

Public Events

A number of public events took place during the consultation period, some catering to the general public, and others directed towards some specific groups and organisations – full details of these events are available in the JHWS consultation report.

Generally, those attending public events were in favour of the five priorities, with a number of people commenting on the interlinking or overlapping nature of the priorities. A wide range of comments were made at the public events, with key themes including Primary care, Healthy activities and exercise, Community involvement, Health promotion and Access to services.

Appendix 3
Equalities Impact Assessment (EQIA) Summary

A key part of the Council's strategic aim of 'Fairness for All' is the principle of 'Serving the whole borough fairly and tackling inequality'. The Health and Wellbeing Board are committed to promoting equality and diversity, and working to reduce the disparities in health and wellbeing that exist across the borough. In some cases, positive action will be required to target improvements in health and wellbeing among particular groups in our community. This will require on-going, active engagement with local groups and communities to understand the diverse needs of the people of Enfield, and to put local people at the heart of shaping the way we deliver the Joint Health and Wellbeing Strategy (JHWS).

The impact of the implementation of the strategy on equalities in the borough will be monitored on an on-going basis, and further equalities impact assessments will be conducted as changes to local services are planned and implemented.

The full Equalities Impact Assessment report for the JHWS is available on the Council's webpage at http://www.enfield.gov.uk/healthandwellbeing/info/4/health_and_wellbeing_strategy

Below is the EQIA action plan for the JHWS, which identifies the key steps for the implementation, monitoring and review of the strategy:

Issue	Action required	Lead officer	Timescale	Costs
Publication of full consultation report	Publish on the Council's website. Provide in accessible formats as required.	Public Health	Post final JHWS sign off	To be determined
Implement JHWS	Produce and agree a detailed action plan and performance framework. New EIAs to be completed as advised and/or services are changed in response to commissioning decisions.	Health and Wellbeing Board	5 Year Strategy implementation/ Action plan	To be determined
Monitor JHWS action plan and risk register	Health and Wellbeing Board to have oversight of progress against JHWS detailed action plan and status of risk register.	Health and Wellbeing Board Public Health	On-going	No additional funding anticipated
Continue on-going consultation with community on Health and Wellbeing and impact of strategy	Develop communication and engagement strategy to lay out how the Health and Wellbeing Board will engage with local people.	Public Health	On-going	To be determined
Review of JHWS	Review strategy to assess outcomes and effectiveness.	Health and Wellbeing Board Public Health	Action plan to be reviewed as strategic needs change. Full strategy review due 2018/19.	No additional funding anticipated

Appendix 4
Other relevant strategies

- Barnet, Enfield and Haringey Clinical Strategy

- Enfield 2020 Sustainability Programme
  http://www.enfield.gov.uk/downloads/download/2227/enfield_2020_sustainability_programme
- Enfield A Fairer Future for All Council Business Plan 2012/2015
  http://www.enfield.gov.uk/download/downloads/id/851/enfield_business_plan-2012-2015
- Enfield CCG 5 year Strategic Plan – to be available at http://www.enfieldccg.nhs.uk/
- Enfield's Children and Young People's Plan 2011-2015
  http://www.enfield.gov.uk/ChildrensTrust/cypp
- Enfield Community Cohesion Strategy: 2010-2014
  http://www.enfield.gov.uk/esp/downloads/file/24/community_cohesion_strategy
- Enfield Core Strategy:
  http://www.enfield.gov.uk/info/200057/planning_policy/1047/core_strategy_2010
- Enfield Council Infrastructure Delivery Plan
  http://www.enfield.gov.uk/downloads/file/2075/infrastructure_delivery_plan
- Enfield Housing Strategy: 2012 – 2027
  http://www.enfield.gov.uk/downloads/file/6421/enfields_housing_strategy_2012-2027
- Improving Health and Wellbeing in Enfield, the Annual Report of the Director of Public Health 2012
  http://www.enfield.gov.uk/downloads/file/6581/public_health_report_2012
- Pharmaceutical Needs Assessment
  http://www.enfield.gov.uk/healthandwellbeing/downloads/download/1/pharmaceutical_needs_assessment
- Transforming the primary care landscape in North Central London – Primary Care Strategy
  http://www.enfieldccg.nhs.uk/Downloads/Policies/Primary%20care%20strategy.pdf

In partnership with local people and

NHS Enfield Clinical Commissioning Group

healthwatch Enfield

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ENFIELD Council

Agenda Item 4

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE **Health and Wellbeing Board** **13 February 2014**	**Agenda - Part: 1** | **Item: 4** **Subject: CCG Strategic Plan and Operating Plan Submission Requirements** **Wards: ALL**
Graham MacDougall, Director of Strategy and Performance Contact office e mail: graham.mcdougal@enfieldccg.nhs.uk	**Cabinet Member consulted: N/A**

1. EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board (HWB) on the submission requirements for the Strategic Plan for 14/15 – 18/19 and the Operating Plan for 14/15 – 15/16. It includes a summary of supporting national guidance, details of the proposed approach, and an explanation of the internal assurance process.

National Guidance to support the planning process, Everyone Counts, Planning for Patients 2014/15 to 2018/19, was published in December 2013. The Guidance identifies five key domains and seven outcome ambitions, which will drive the expected transformational change and deliver '*high quality care for all, now and for future generations'*.

CCG's are expected to produce a two year Operating Plan and five year Strategic Plan, with the Strategic Plans aggregated at Unit of Planning level, and a further requirement to submit a joint plan on a page. The Unit of Planning for Enfield consists of the five NCL CCG's. There is a further expectation of alignment with plans produced by providers and other commissioning organisations and with Health and Wellbeing Board and Better Care Fund Plans. Consultation with Health and Wellbeing Boards, providers and patients and public is expected. The Strategic Plan for the CCG has been previously discussed at the Health and Wellbeing Board on the 18th November 2013 and 23rd January 2014.

The deadline for the draft submission of the two year operating plan with covering letter is 14th February 2014 with final submission due on 4th April 2014. The deadline for the draft submission of the strategic plan is 4th April with the final submission due on 20th June 2014. NHSE will lead the assurance process through extensive challenge and a variety of templates have been issued for both operating plans and strategic plans.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the contents of the enclosed paper and the timetable for submission of plans

The board are asked to recommend this plan and to review the further budget and plans at its next development and formal Board

3. BACKGROUND

Objective(s) / Plans supported by this paper:
To deliver the CCG key Strategic Objectives with regard to strategic planning, our transformation programmes and our financial recovery

Audit Trail:
Health and Wellbeing Board – 18th November 2013, 23rd January 2014
NELSCU/CCG Strategic Planning Group – Fortnightly meetings
Enfield CCG Strategic Planning Group – Monthly Meetings

Patient & Public Involvement (PPI):
Enfield CCG has a communications strategy which includes patient and public engagement events specifically about our key priorities and transformation programmes. The most recent public engagement workshop looked at our key transformation programmes with specific public input into the development of long term conditions.

Equality Impact Analysis:
Equality Impact Assessment and Quality Impact Assessment are undertaken routinely as part of the CCG Transformation Programme. Those are undertaken for each initiative under each programme and reported to the Transformation Programme Group as part of business as usual.

Risks:
There will need to be significant reshaping of the current Enfield CCG plan to ensure that all the elements contained in the NHS planning guidance are included in the strategic plan, but submission is by template and therefore all necessary elements will be covered.

The timescales for delivery present a significant challenge to ensure appropriate joint working with Health and Wellbeing Boards and other stakeholders.

Finance and activity submissions will need to align across commissioners and providers, but this should be enabled by the challenge process.

Resource Implications:
Detailed financial plans are submitted as part of the operating plan and strategic plan.

Next Steps:
To proceed with plan development, co-ordinated by the Strategic Planning Groups at CCG and Unit of Planning level, with weekly progress reports provided to the Directors Meeting

Operating Plan and Strategic Plan Submission Requirements 14/15-18/19

This paper updates the Health and Wellbeing Board on the submission requirements for the Strategic Plan for 14/15 – 18/19 and the Operating Plan for 14/15 – 15/16. It includes a summary of supporting national guidance, details of the proposed approach, and an explanation of the internal assurance process.

During December, NHSE indicated that they wanted to see strategic plans from clusters of CCGs, which they termed as a Unit of Planning. According to the guidance the intention is to enable wider and more strategic health economy planning across CCGs, NHS England Area Teams, providers, and Local Authorities. The Unit of Planning for Enfield CCG is the North Central London CCG's of Barnet, Camden, Enfield, Haringey, and Islington. The strategic planning leads of the five CCG's meet fortnightly with NELCSU to co-ordinate the planning process and the development of the strategic plans, and the group reports regularly to the 5 CCG Chief Officer Group that meets weekly.

Each CCG has to submit a two year Operating Plan and a five year Strategic Plan, with the Strategic Plans accords the 5 NCL CCGs aggregated at Unit of Planning level and submitted together with the requirement to submit a 5 CCG Plan on a Page to NHS England.

There is an expectation of alignment to plans produced by providers and other commissioning organisations and with Health and Wellbeing Boards and the Better Care Fund submissions. As well as ongoing consultation with Health and Wellbeing Boards, engagement with providers and patients and public is expected. Enfield CCG held a market event for all its providers in December to discuss its strategic plan and our transformation programmes and to further signal any key changes for next year. In addition, Enfield CCG held its most recent patient and public engagement specifically on its strategic plan and its transformation programmes with particular input into the programme for long term conditions.

Prior to the publication of the planning guidance the five CCG's who form the Unit of Planning were required to submit a draft plan on a page on 18th December 2013. This initial submission is attached as Appendix A.

The deadline for the draft submission of the two year operating templates with covering letter is 14th February 2014 with final submission due on 4th April 2014. The deadline for the draft submission of the strategic plan is 4th April 2014 with the final submission due on 20th June 2014. NHS England will undertake and assurance process throughout this period which will include extensive challenge to CCGs on their plans.

Planning Guidance – Ambition

National Guidance to support the planning process, Everyone Counts, Planning for Patients 2014/15 to 2018/19, was published in December 2013. The Guidance describes the five domains and seven ambitions and service models which will drive the expected transformational change and deliver '*high quality care for all, now and for future generations'*.

Five domains

- We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society
- We want to make sure that those people with long-term conditions, including those with mental illnesses get the **best possible quality of life**
- We want to ensure patients are able to **recover quickly and successfully** from episodes of ill health or following an injury
- We want to ensure patients have a **great experience** of all their care
- We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm

Seven ambitions

- Securing additional life years of life for the people of England with treatable mental and physical health conditions.
- Improving the health related quality of life of the 15 million + people with one or more long term condition, including mental health condition.
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people with mental and physical conditions having a positive experience of hospital care
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

Plus what are described in the guidance as three more key measures:

- Improving health
- Reducing health inequalities
- Parity of esteem

The expectation is that Units of Planning will agree a set of outcome ambitions to deliver these national ambitions, which will be fundamental to the Operating Plan and Strategic Plan submissions. The outcome ambitions for the 5 CCG's to be agreed at the Horizon Setting Meeting on the 17th January 2014. In addition, The NHS has signalled the following models for transformation:

The six service models for achieving the expected transformational change are:

- A new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care

- Specialised services concentrated in centres of excellence.

Enfield CCG developed a 3 year Strategic plan for 2013/14 to 2016/17 and has been working on a five year plan in anticipation of the publication of the planning guidance. The 5 year plan that was being developed maintained our direction of travel on: commitment to the development of prevention and primary care services; further development of integrated care for older people and people with long term conditions, redesign of elective care where appropriate; the further development of maternity and children services; and the redesign of mental health services, learning disability services and continuing health care.

Whilst the structure and format of the plans to be submitted has changed, there is good fit between the vision, strategic goals, and six transformation programmes and the new ambitions and service models, although further work is being undertaken to assess current performance and plans against expected trajectory of change. This work is being progressed as a priority during the next few weeks.

There is an expectation that plans will be ambitious in their ability to deliver change and to achieve the national priorities. Primary care development continues to be a priority (supported by the announcement of the £50m Prime Minister's Challenge Fund) with the network model of care being given greater significance to deliver improved access and transformational service change to a greater population. Integrated care is given prominence and the expectation is that it will be delivered with ambition supported by the development of the accountable GP role that has been signalled for next year's GP contract.

Also signalled is greater flexibility in the use of contracts: the use of lead provider contracts; the use of longer term contracts; and the use of local financial models in order to deliver sustainable improved patient outcomes.

'*Parity of Esteem'* which requires commissioners to make sure they are just as *'focussed on improving mental as physical health and that patients with mental health problems do not suffer inequalities, either because of their mental health problems or because they then don't get the best case of their physical problems',* is an important underpinning principle.

Operating Plan 14/15 and 15/16

The Operating Plan submission consists of a two UNIFY planning templates, with a supporting letter, similar to last year's submission. The expectation is that whilst the five CCG's will need to work together to agree outcome ambitions, this will essentially be a piece of work for CCG's supported by CSU local staff. The Operating Plan consists of the following worksheets:

- Self certification (NHS Constitution, Impact of Provider CIP, MRSA)
- Ambitions for improving outcomes (5 year trajectories for improvement – baseline positions provided and support with trajectories promised)
- Quality Premium Measures (National and Local)
- Other measures (C. Dificile, Dementia, IAPT)
- A &E Activity.

- ProvComm Collection (Provider Commissioner activity sheets, with expectation that they will align)

The submission is essentially similar to the 2013/14 submission but even with supporting tools and a data atlas which includes national benchmarking of key metrics, developing trajectories that support the delivery of revised ambitions is expected to be challenging. Likewise aligning activity data and ensuring system wide fit across different commissioners and the providers. However the proposed challenge process following submission of draft templates should allow for reconciliation and amendments to ensure fit.. Timescales for consultation are challenging, so all available opportunities for engagement with stakeholders will need to be taken and an evidence log maintained.

Strategic Plan 14/15 to 18/19

There are three components:

- **Plan on a Page** at 5 CCG Unit of Planning level submitted on 18 December 2013 to NHS England.
- **Key Lines of Enquiry Template** to be completed at CCG level and aggregated up to strategic planning unit level, and used to refine the Plan on a Page. Individual CCG plans will need to be submitted together with an aggregated plan and the plan on a page.
- **Five year financial plan** which will need to support the planning templates and align across organisations

It has been agreed across the five CCG's to develop individual plans first and then aggregate plans up and carry out any reconciliation between the 5 CCG's, other commissioners, and local providers. As noted above, whilst the structure of the strategic plan differs from the plan developed in Enfield for 13/14 and started for 14/15 onwards, the content of existing plans is still relevant and therefore the CCG is in a good position to complete the plans. The expectation from NHS England is that the Key Lines of Enquiry format is followed strictly and succinctly. A supporting evidence base will need to be developed. Evidence of consultation with the Health and Wellbeing Board and patients and public will be key.

Assurance

The guidance states that the following principles of assurance will be adhered to:

1. *Assurance of the overall strategic plan will be at Unit of Planning level, including engagement with patients and public in the local community;*
2. *Operational plans will be assured at CCG and at Health and Wellbeing Board level, and at Area Team level for NHS England's directly commissioned services;*
3. *Area Teams to lead the assurance of CCG plans;*
4. *Regional Teams manage the assurance of Direct Commissioning plans;*
5. *Area Teams to assure the overall consolidated commissioning position and strength of local partnerships;*
6. *Area Teams and CCGs to ensure mutual assurance of Direct Commissioning plans, with escalation by exception; and*
7. *Boards and governing bodies should satisfy themselves that the outcomes or recommendations of the plan assurance process have been appropriately addressed prior to plan sign off.*

A detailed Project Plan has been developed, fortnightly meetings of the CCG Strategic Planning Group have been scheduled to support the development the plan, and it is proposed that weekly progress reports are provided to the Directors meeting.

The Governing Body is note the contents of this report and is asked to delegate authority to the CCG Executive to approve the first draft Operating Plan submission at its meeting on the 12th February 2014.

4. ALTERNATIVE OPTIONS CONSIDERED

There are no alternative options as this is a statutory condition to the CCG.

1

North Central London health economy is a system comprised of partners from Barnet CCG, Camden CCG, Enfield CCG, Haringey CCG, and Islington CCG who have come together to agree, refine and implement the following vision: To drive improvement in the delivery of high quality, evidence-based and compassionate services, defined and measured by outcomes not process, to the population of north-central London.

2

System Objective One
Reducing the number of years of life lost by the people of England from treatable conditions (e.g. including cancer, stroke, heart disease, respiratory disease, liver disease);

System Objective Two
Improving the health related quality of life of the 15 million+ people with one or more long-term conditions;

System Objective Three
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital;

System Objective Four
Increasing the proportion of older people living independently at home following discharge from hospital;

System Objective Five
Reducing the proportion of people reporting a very poor experience of inpatient care;

System Objective Six
Reducing the proportion of people reporting a very poor experience of primary care;

System Objective Seven
Making significant progress towards eliminating avoidable deaths in our hospitals.

4

Delivered through Integrated Care Programme

Each of the 5 CCGs has an Integrated Care Programme which seeks to deliver:

- Integrated care for children and young people.
- Integrated care for frail older people, to be extended over time to adults.
- Improvement in management of care in the community.
- Maximise the time spent at home during and after treatment.
- Promoting collaboration and communication between patients, staff and carers.
- Better alignment of physical and mental health services to improve outcomes for vulnerable groups experiencing high levels of mortality or ill-health.

Models and priorities vary by CCG and the specific detail for each is captured in the local 5 year strategy.

Delivered through Primary Care Programme

All 5 CCGs are committed to working closely with NHS England to improve quality and access to primary care. North Central London CCGs have in place Primary Care Strategies, with dedicated resource for implementation. Key goals include:

- Primary care strategy implementation.
- Develop primary care networks.
- Demand management within primary care.
- Improve patient experience.
- Improve capacity within primary care.
- Increasing Primary and Secondary Prevention.

Priorities vary by CCG and the specific detail for each is captured in the local 5 year strategy.

Delivered through Long Term Conditions Programme

CCGs plan to work with all providers to improve outcomes for patients with Long Term Conditions, this will include:

- Improving recorded prevalence.
- Primary and Secondary Prevention.
- Pathways redesign.

Models and priorities vary by CCG and the specific detail for each is captured in the local 5 year strategy.

Delivered through Commissioning for Value Based Outcomes

CCGs in north-central London are working collaboratively to move to a Value Based Commissioning Approach. This is beginning with work on frail elderly, mental health and diabetes and will be expanded to cover more areas in the future.

7

Delivered through Integration Transformation Fund (ITF)

All 5 CCGs are progressing plans for the Integration Transformation Fund in collaboration with colleagues from the respective London Boroughs for agreement by CCG Governing Bodies and Health and Wellbeing Boards.

5

Overseen through the following governance arrangements

- The strategic vision is set by the North London Clinical Commissioning Committee, comprised of CCG Chairs, COs and NHS England.
- Coordination of the plans is via the Chief Officers.
- Development of plans is via a cross CCG Planning and Contracting Organisational Group.
- All plans approved by each CCG Governing Body and Health and Wellbeing Board.

3

Measured using the following success criteria

- Success criteria to be developed in line with the work on Value Based Commissioning.
- All organisations within the health economy perform within financial plan in 18/19.
- Delivery of the system objectives (detail to be agreed once baselines are issued by NHS England on Friday 13th Dec).
- No provider under enhanced regulatory scrutiny due to performance concerns.
- Implementation of Value Based Commissioning.

6

High level risks to be mitigated

- Lack of political willingness for provider reconfiguration associated with the element of the plans focused on delivery of services in the community. Mitigation through robust evidence base for the case for change, co-creation with stakeholders and comprehensive stakeholder engagement.
- Lack of Provider willingness to engage in delivery of the strategic plan particularly where there is significant reconfiguration of provider services. Mitigation through robust evidence base for the clinical case for change and co-creation with providers.
- Lack of availability of resources (financial and managerial) to deliver the 5 year strategic plan. Mitigation through robust medium and long term financial and workforce planning for the 5 year strategic plan.
- Fragmented and disjointed care due to organizational boundaries of providers. Mitigated through collaboration with providers and partners across health, Local Authorities etc.
- Financial pressures. Mitigated through robust QIPP plans and implementation value based commissioning.
- Increasing demand on services from an increasing/more vulnerable in some areas/aging populations. Mitigation through engagement with populations, value based commissioning, increasing use of technology etc.

Agenda Item 5

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE **Health and Wellbeing Board** **13 February 2013**	**Agenda - Part: 1** | **Item: 5** **Subject: Development of the local Better Care Fund Plan** **Wards:** all
Director of Health, Housing and Adult Social Care Contact officer and telephone number: Peppa Aubyn E mail: peppa.aubyn@enfield.gov.uk	**Cabinet Member consulted:** Cllr Don McGowan

1. EXECUTIVE SUMMARY

The Better Care Fund is the creation of a pooled budget made up of existing resources, for the integration of local health and care from 15/16. There is a requirement for the Council and CCG to develop a joint plan to further enhance the integration of Health and Social Care locally. Health and Wellbeing Boards have been asked to agree plans, monitor progress and implementation. 25% of the fund will be performance related and linked to outcomes achieved.

The local allocation for the Better Care Fund is **£20.585m** which includes £18.518 m revenue and £2.068 m capital committed expenditure, which is drawn from existing local authority and CCG budgets. Please note; that the majority of the fund is top sliced from CCG core funding, which is currently committed to the delivery of acute services. *Key Note: £5.146 m (25%) of the funding will be linked to outcomes achieved.*

The Better Care Fund (BCF) is a major opportunity to develop our work across the Health and Wellbeing Strategy's priorities and deliver our vision. Accordingly, our BCF plan is based on a broad programme of activity which spans the key issues affecting our residents' health and outcomes. Underpinning all of these are a set of agreed principles which are shared jointly across commissioners, beginning with our focus on prevention and early intervention and recognising the shift in resources we need to make.

The conditions associated with the Better Care Fund and its performance framework, have been set down as: -

- Plans to be agreed jointly
- Protecting social care services
- 7 day services to support discharge
- Data sharing
- Joint assessment and accountable lead professional
- Agreement on the consequential impact of changes in the acute sector

Other key themes associated with the conditions are; to Set out arrangements for redeployment of funding held back in event of outcomes not being delivered.

The performance framework for the fund and measures for the 'Payment for Performance' element of the BCF, are based upon the following outcomes:-

- admissions to residential and care homes;
- effectiveness of reablement;

- delayed transfers of care;
- avoidable emergency admissions; and
- patient / service user experience.

Much of the emphasis of the Better Care Fund conditions is focussed on developing integration models that are specifically aimed at hospital avoidance and reducing admissions to residential care for frail older people and those with dementia. These two groups are predominantly the largest consumers of health and social care services, and would therefore benefit more in terms of further integration between health and care. The Integration Working Group has considered the information in the JSNA and has recommended that a large proportion of the BCF is invested in targeted interventions that seek to reduce hospital admissions for older people and populations that are at greater risk of hospitals admission.

The vision, aims and objectives for the local joint BCF plan are aligned with the draft Health & Wellbeing Strategy, the CCG's 5-year plan and the Council's vision. Part 1 of the local draft BCF plan can be found at **ANNEX 1.**

The details of the BCF plan, that is due to be submitted in draft on the 14th of February 2014, are still being developed. The BCF is made up of existing funding that is already committed to the delivery of front line services. Considering this, there is a need to finely balance our ambition between; how investment is re-distributed in a way that does not destabilise the existing system but seeks to strive to deliver more innovative services at the right point to promote prevention, reablement and recovery – a population that is more confident to self-manage with minimal intervention.

Our vision locally for integration of health and social care is: *"The system responding as a whole with the right intervention at the right time"* and the means for delivering this vision is for our integrated health and care system will deliver flexible, multi-agency, and multi-disciplinary working, always led by the needs of local people and founded on a firm evidence base of what works and what does not. Our determination to be person-centred in everything we do means that services will be tailored to respond to individuals, providing the care people need and where and when they need it.

The Integration Working Group who are leading on development of the local BCF plan have recommended that we take a life course approach to implementing the integration agenda locally. By targeting key areas and stages of the life course pathway (i.e. childhood, adults of working age, promotion of health and wellbeing and older age) and by providing the "right intervention at the right time" in a personalised and proactive way, we will enable the population of Enfield to lead healthy lives that they are more in control of. The Integration working group have developed the following innovative programmes of transformational change that are focussed on prevention, early identification, community intervention, hospital avoidance, reablement/ recovery and independence; throughout the life course(Childhood to End of Life Care) :-

- **Older people** – focussed on those experiencing frailty and/or disability
- **Working age adults** – focussed on those with long term conditions
- **Health and wellbeing –** focussed on those experiencing mental health issues
- **Children –** focussed on those with health needs

This paper focuses on what the local allocation is and provides an update in terms of development of the local plan and timeline.

2. RECOMMENDATIONS

The Health and Wellbeing Board are asked:

i. Note the work of the Sub-Group and Steering Group and the 4 priority populations; and
ii. Endorse the draft Better Care Fund submission [attached at annex 1] to NHS England;
iii. Note the contents of the part 2 report; and
iv. to receive a further report on the final submission at your March meeting prior to submission.

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 Better Care Fund and outlines the process for delivery of the local BCF plan within timelines set nationally. In terms of scene setting, this paper also highlights the challenges of the BCF and on balance, the opportunities that it creates.

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 Our approach to securing value for money and achieving efficiencies while putting the needs of our population first has been challenging in the current economic climate and it will remain so. Enfield council despite having already saved £60 m over the last 3 years will need to save a further £60 m over the next 3 years. The CCG has indicated a projected £12 m savings each year which means that the CCG will need to save in the region of £36 m over the next 3 years. The further integration of Health and Care is viewed by many as the means to ensure the future viability of the health and care system. The system will need to respond as a whole to meet individual's needs 'at the right time with the right intervention'. This will secure better outcomes for our population; while delivering services in the most streamlined and efficient way possible. To facilitate this transformation, we will need to challenge the way we do things now, understand and acknowledge what we are doing well together and where we can improve, and seek to invest in our joint infrastructure to support the process of greater integration between health and care.

3.4 *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.

3.5 Our vision locally for integration of health and social care is:

"The system responding as a whole with the right intervention at the right time"

Enfield has already embarked upon its journey towards the integration of health and care services, which is a key component of our Health and Wellbeing Board's vision of enabling local people to **'live longer, healthier, happier lives in Enfield'**.

Our Health and Wellbeing Strategy, sets out the following 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 communities

We welcome the Better Care Fund as a major opportunity to develop our work across the Health and Wellbeing Strategy's priorities and deliver our vision. Accordingly our BCF plan is based on a broad programme of activity which spans the key issues affecting our residents' health and outcomes. Underpinning all of these are a set of agreed principles which are shared jointly across commissioners, beginning with our focus on prevention and early intervention and recognising the shift in resources we need to make.

Our agreed delivery model across all areas is:

To invest in targeted community interventions and integrated 'first contacts' that offer preventative, personalised approaches to individuals that are at risk of crisis and / or hospitalisation. The 'first contact' will seek to offer holistic (health, care and support) assessments with the distinct purpose of working with the individual to understand individual life history, triggers and underlying issues that maybe contributing to the accumulation of difficulties managing daily living and increasing risk of vulnerabilities that lead to hospitalisation. The first contact will then work with the individual to apply the principles of recovery and re-ablement models to promote self-management, health and wellbeing. The groups we will be targeting experience "negative" symptoms that impair their motivation, organisational skills and ability to manage everyday activities (self-care, shopping, budgeting, cooking, etc) and place them at risk of serious self-neglect and if left unaddressed can led to hospitalisation or extended periods of treatment in costly specialist placements i.e. residential admissions.

Please refer to ANNEX 1 for further information on the local performance framework.

4. ABOUT THE BETTER CARE FUND (FORMERLY THE INTEGRATION TRANSFORMATION FUND):

4.1 The June 2013 Spending Round was challenging for health authorities and local government, 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 Better Care Fund (BCF). 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 of adult social care services and ensure that health services are more community focussed. The BCF does not come without its challenges. The BCF is made up of existing funding spread across health and care and is committed to the delivery of frontline services. Local Authorities and Clinical Commissioning Groups nationally are concerned that this is not new money so therefore presents a challenge to further enhancing the integration agenda locally. However, the Better Care Fund provides an opportunity to review the current health and care system and improve the lives of some of the most vulnerable people in our society, giving them control and placing them at the centre of their own care and support. In doing so we can provide them with better services and better quality of life. The fund will support the aim of providing people with the right care, in the right place at the right time, including through a significant expansion of care in community settings. This will build upon the work the CCG and local authority are already doing through jointly agreed priorities through the section 75 agreement, joint commissioning strategies and through the delivery of agreed objectives utilising the NHS Social Care Grant.

4.2 The local allocation for the BCF is **£20.585m** which includes £18.518 m revenue and £2.068 m capital committed expenditure. Costs and benefits modelling for expenditure of the BCF are currently being developed by the integration Working Group and finance teams from across the CCG and local authority. When this exercise is complete, it will produce an options appraisal that details how investment in integration in specific areas of the health and care system i.e. community intervention, prevention, reablement and recovery initiatives, will produce benefits in the medium and longer term that will benefit the whole health and care system by reducing acute and residential admissions and enabling vulnerable people to lead more healthy and independent lives in their own home and in the community.

4.3 The local allocation is made up of the following existing funding:

Total BCF			**£20.586m**
	Total Capital		**£2.068m**
	Disabled Facilities Grant - programme commitments	£1.345m	
	Social Care Grant - Mental Health: Health & Wellbeing Centre	£0.723m	
	Total Revenue		**£18.518m**
	Assumed Commitments: Care Purchasing already in Council MTFP (formerly NHS Social Care Fund), £4.5m in 2014/15 plus demand growth for 2015/16	£5.952m	
	Potential for consideration: LBE Enfield CCG	£12.566m	

Key Note: £5.146 m (25%) of the funding will be linked to outcomes achieved.

4.4. As the BCF includes NHS funding for carers' breaks and reablement, local plans will therefore need to demonstrate a continued focus on both these areas.

4.5 The Better Care funding will be pooled into a budget as from April 2015. The Better Care Fund guidance requires the Local Authority to manage the pooled fund. The BCF is subject to plans being agreed by local Health and Wellbeing Boards and signed off by CCGs and Council Leaders, and the Chair of the HWBB.

4.6 Draft Better Care Fund plans will need to be submitted to the NHS England by 14th of February 2014. The final plan that sets out Enfield's vision, objectives and planned changes for the next 3-5 years will need to be submitted on the 2nd of April 2014. In terms of conditions and expectations attached to the Better Care Fund, plans will need as a minimum to:

NATIONAL CONDITION	DEFINITION
Plans to be agreed jointly	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups.
Protecting social care services	Local areas must include an

	explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Dept. of Health guidance.
7 day services to support discharge	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement.
Data sharing	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information.
Joint assessment and accountable lead professional	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.
Agreement on the consequential impact of changes in the acute sector	Local areas should identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. in line with the Mandate requirements on achieving parity of esteem for mental health, plans should not have a negative impact on the level and quality of mental health services.

And consider the following:-

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

- In line with the Health and Social Care Act, that local plans have regard for the JSNA for their local population, and existing commissioning plans for both health and care, in how the funding is being used.

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

4.7 The national performance metric (measures) for the fund are as follows:

• admissions to residential and care homes;

• effectiveness of reablement;

• delayed transfers of care;

• avoidable emergency admissions; and

• patient / service user experience.

4.8 The Better Care Fund Performance Framework has been developed as part of the national BCF requirement, following national guidance. Baseline and trajectories have been produced for the following recommended outcomes:

1. Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
3. Delayed transfers of care from hospital per 100,000 population
4. Avoidable emergency admissions (composite of four indicators) - historic data is not yet available at local authority level, and so CCG based data have been used as a proxy measure. NHS England will provide this data in January 2014.
5. Patient/service user experience (to be assigned locally)

Baseline level of performance is based on 2012-13 data. Trajectories have been calculated for 2014-15 and 2015-16 which reflect the growth in population, given current levels of intervention. For comparison, trajectories have also been presented to reflect the level of performance over time if current levels of intervention were not in place.

4.9 Enfield experienced an increase in population in excess of both London and national averages between 2001 and 2011 (census figures) with numbers increasing by 36, 300 over the 10 years. It is now the fourth largest London borough by population with the latest GLA estimates adding 10,500 additional people to the population between 2011 and 2014 (population now estimated at over 323,000). Within this population figure it is clear that there are more people with disabilities or long term conditions and they are living longer. The increase in longevity has not been accompanied by an increase in the number of healthy

years lived, however. This population growth together with an increase in the prevalence of ill health and disability will result in more people requiring access to health and social care services. Target trajectories were developed based on what we know about our capacity to provide services (based on historical finance/activity trend data and future trend information), the move towards a more preventative model of care and support and the increasing number of people who will need those services. There are two trajectories with the first looking at how we would perform with the current level of resource and model of care. The second trajectory line takes into account a funded increase in capacity and full roll out of new preventative models of service as defined by the priorities within the Better Care Fund Action Plan in order to manage the demographic pressures.

4.10 Further technical guidance will be released on the national metrics including the detailed definition, the source data underpinning the metric, the reporting schedule and the advice on the significance of ambition for improvement. It is vital that Enfield make early progress against the National conditions and the performance measures set out in the local plan. This is important, since some of the 'Payment by Performance' is linked to performance in 2014/15.

4.11 In addition to the five national metrics, Enfield will need to select one additional indicator that will contribute to the 'Payment by Performance' element of the BCF.

The Integration Working Group is recommending that the local performance outcome is "Estimated diagnosis rate for people with dementia". The Integration working group have selected this indicator as this is a condition that will affect a large proportion of the Enfield population and requires targeted interventions to enable people to lead independent and fulfilling lives in the community.

Please refer to ANNEX 2 for further information on the draft performance framework which continues to be subject to validation and conformation.

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 BCF plan under the auspices of the Health & Wellbeing Board (HWBB) governance structures with additional powers to allow internal reporting. Executive management from the CCG and Enfield Council have been working together to develop a shared vision, aims and objectives for further integration of health and care that will benefit the local community. The proposed vision is based on and aligned to the priorities set in the draft health and wellbeing strategy.

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

- The groups have been established by the Health and Wellbeing Board through the approval of their Terms of Reference at its meeting on the 12th December.
- The purpose and regularity of the BCF Sub-Group is to meet monthly to formally make recommendations to the Health and Wellbeing Board
- The BCF Working Group are to meet on a weekly basis to overview all of the development to the BCF.
- Additional meetings are currently being co-ordinated for the co-chairs of the BCF Sub and Working Group to meet with the main providers affected by the BCF

- The Co-Chair of both groups are CCG Chief officer, Liz Wise and LBE Director of HHASC Ray James

5.3 The BCF 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 BCF 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. However, the Integration Working Group has been working together in partnership to challenge the way the current health and care system works locally and create a vision for integration for the future; that is balanced and takes into consideration existing arrangements but strives to implement integration that will benefit some of the most vulnerable people in the Enfield Community.

5.4 Commissoners from across the partnership (CCG and Enfield Council) agreed the following points to take the BCF Project forward locally:-

- Develop a shared understanding of the requirements and limitations of the BCF
- Be clear across organisations about the process required to access it
- Develop a shared vision and strategy for integrated care, which the BCF 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 BCF 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 BCF
- 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 BCF as a milestone for the medium term programme for integration

5.5 Enfield has already embarked upon its journey towards the integration of health and care services, which is a key component of our Health and Wellbeing Board's vision of enabling local people to **'live longer, healthier, happier lives in Enfield'**.

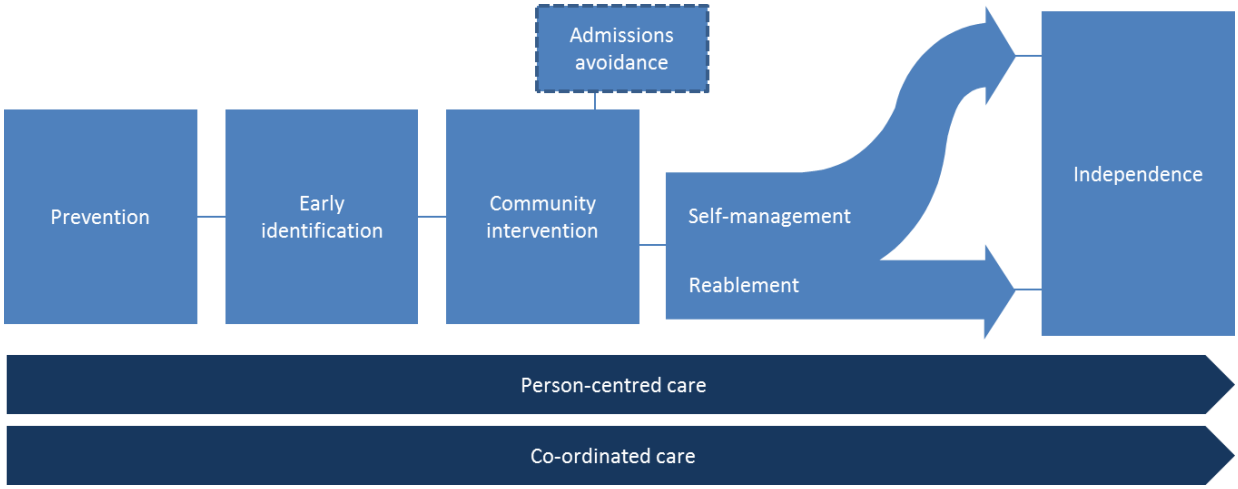
Our Health and Wellbeing Strategy, which is currently out for consultation, sets out five distinct draft priorities. Each one supports our mission of improving the health and wellbeing outcomes of all people in Enfield, regardless of where they live. These priorities are:

- 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 communities

5.6 We welcome the Better Care Fund as a major opportunity to develop our work across the Health and Wellbeing Strategy's priorities. Accordingly our BCF plan is based on a broad programme of activity which spans the key issues affecting our residents' health and outcomes. Underpinning all of these are a set of agreed principles which are shared jointly across commissioners, beginning with our focus on prevention and early intervention and recognising the shift in resources we need to make through reabling people after a health episode.

5,7 Our agreed delivery model across all areas is shown in the following diagram:



Co-ordinated and person-centred care underpins interventions at every stage.

Our integrated health and care system will deliver flexible, multi-agency, and multi-disciplinary working, always led by the needs of local people and founded on a firm evidence base of what works and what does not. Our determination to be person-centred in everything we do means that services will be tailored to respond to individuals, providing the care people need and where and when they need it. In Enfield's integrated system, people come before historic boundaries between organisations and their budgets.

5.8 Much of the plan is focussed on developing integration models that are specifically aimed at hospital avoidance for frail older people and those with dementia. These two groups are predominantly the largest consumers of health and social care services, and would therefore benefit more in terms of further integration between health and care. The Integration Working Group who are leading on development of the local BCF plan have recommended the following client groups and models of service are targeted with a view to developing innovative programmes of transformational change to the way health and care community services are delivered:-

Enfield BCF proposed population groups, initiatives and total resource

1. Proposed population group/ new programme heading	5. Example initiatives being considered for BCF support –	6. Planned BCF investment in £m
Older people – focussed on those experiencing frailty and/or disability	• Older People Assessment Unit [N.Mid/BCF] • Falls programme • End of life care • Tissue viability • Assistive technologies/Tele Health • Nursing beds capacity/Step down beds • Intermediate care/reablement support • Dementia support/memory clinic • Seven day working • Locality model support • Safeguarding and Quality – Nursing/SW/Quality checker volunteering • Carers support • Preventative services • Warm homes programme • Primary care implementation • Data sharing • Support to providers	**9.146**
Working age adults – focussed on those with long term conditions	• Outpatient avoidance • Wheelchair service • Personal health budgets • Alcohol interventions	**1.615**

Mental health	• IAPT extension • MH primary care model • RAID	**1.136**
Children with health needs	• Health and wellbeing networks • Early intervention in mental health support services • Post-transition/vulnerable young adult service	**0.525**

Detailed schemes and benefits proposed under each programme are provided in the part two report.

5.9 Interventions specifically targeted to support carers to continue in their caring role will be a key theme for the plan. Consideration is being given to carers breaks and enhanced services.

5.10 This report has set out the direction of travel in terms of how the local BCF plan is being developed. The final version of the recommended draft plan will be presented to the HWBB Board on the 13th of February 2014 for approval. This will then be submitted to the NHS England by 14th of February 2014. The BCF plan will continue to be developed by the Integration Working Group with a view to submitting the final plan on the 4th of April 2014.

5.11 As part of our development of integrated care over the past two years, we have held regular provider forums across commissions and client groups. Open days, including the CCG's Provider Day, bring together providers to discuss emerging trends in our population, as well as strategic and financial issues and commissioning intentions. The same is true in adult social care, where large events bring together providers from across the borough, alongside more specific client group activity. This is followed up with regular communication, including newsletters. Both the CCG and the Council have established a culture of open communication with our providers, including through one-to-one leadership sessions and our ongoing contract management and commissioner-provider relationships. For further detail on provider engagement please refer to the plan in ANNEX 1

6. ALTERNATIVE OPTIONS CONSIDERED

Do nothing – this is not a viable option and should not be considered. If we do not move forward and develop a plan with our health partners then we are unable to access the BCF.

7. REASONS FOR RECOMMENDATIONS

The development of the plan is a mechanism to access the Better Care Fund in order to develop closer integrated working between Health and Care. The HWBB is requested to note the activity reported in this paper and endorse the direction of travel in terms of developing the local BCF plan. The final version of the recommended draft plan will be presented to the HWBB Board on the 13th of February 2014 for approval. This will then be submitted to the Department of Health by 14th of February 2014. The BCF plan will continue to be developed by the Integration Working Group with a view to submitting the final plan on the 4th of April 2014.

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

8.1 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 – the Better Care Fund(BCF).

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 BCF 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.

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 BCF for Enfield will be subject to both jointly agreed local plans and in some cases locally set outcome measures, i.e. 'Payments for Performance'.

8.2 Legal Implications

8.2.1 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.

8.2.2 The legal mechanisms (such as section 75 agreements, etc.) for achieving the service delivery within the plan will be considered and approved by Legal Services, and will be in accordance with the Councils

Constitution (including procurement of any external services in accordance with Contract Procedure Rules).

9. KEY RISKS

9.1 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.

9.2 £1bn of the funding will be linked to outcomes achieved. This represents a significant proportion of the BCF. It is unclear at present what the impact could be if localities under perform..

9.3 Please refer to **ANNEX 1** – point 2 of the BCF local plan for details of the 12 risks associated with the BCF plan. Risks have been broken down into 3 categories; these are: Overall risks, Change risks and Organisational risks.

10. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

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

10.2 Narrowing the Gap – reducing health inequalities
The BCF 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.

10.3 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 focused on keeping people healthy and well in the community. In particular, it asks that health and care services are co-ordinated around the individual.

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

10.5 Strengthening partnerships and capacity
Development of the BCF 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.

11. EQUALITIES IMPACT IMPLICATIONS

An Equalities Impact Assessment will be undertaken at the same time that the Integration Transformation Fund (BCF) plan is being developed Background Papers

12. PERFORMANCE MANAGEMENT IMPLICATIONS

12.1 As defined by the conditions of the BCF, we are developing a performance framework that is focussed on understanding our baseline in terms of key activity and developing an outcomes framework to focus activity that promotes choice, control, empowerment, reablement and independence.

ANNEX 1 – the local joint BCF plan - *draft*

The London Borough of Enfield and Enfield Clinical Commissioning Group Better Care Plan

Our approach to Better Care Planning

The London Borough of Enfield and Enfield CCG's Better Care Plan (BCP) is based on accelerating our progress to deliver the priorities and outcomes agreed by our Health and Wellbeing Board. This document has been prepared by the Borough and CCG. It should be considered a work in progress and forms the basis of our first initial February submission. We will be continuing to work together including as part of the national NHS strategic planning process, in line with national timescales.

We know we have challenges in what is a large and mixed London borough feeding several acute and provider trusts spanning CCG and borough boundaries. We are the fourth largest London borough and as our Joint Strategic Needs Assessment (JSNA) makes clear the numbers of residents is set to increase to 340,000 by 2032. We are home to a larger than average population of young people, but our older population is also set to increase dramatically to over 16.6% of our population by 2032. For these reasons, and because of our particular demographic pressures, our plan is targeted at improving outcomes across four population groups. These are the population groups around which our NHS and local authority planning is based, and we have used these groups in order to provide clarity across our commissioning intentions.

The population groups are:

1. Older people – focussed on those experiencing frailty and/or disability
2. Working age adults – focussed on those with long term conditions
3. Adults experiencing mental health issues
4. Children with health needs

We have agreed a common pathway approach across all of our population groups – which spans the full range of our ambition from prevention and early intervention right through to integrated pathways and support for people at home. Our pathway is backed up by the locality structure we have already developed with our Health and Wellbeing Board, providers and partners in response to the priorities they have helped us to shape. In doing so, we will address multiple issues, including accelerating our existing programme for integrating care for older people, investing in safeguarding and quality, supporting carers,

maximising the contribution of the third sector and building our infrastructure to support more integrated ways of working.

In this plan, we set out the shared vision and strategic agreement we have in place, our overall agreed model for delivering integrated care, the four programmes we will deliver based on our population groups and and the impact and benefits we expect to see. We describe our agreed vision for health and social care in Enfield and the locality based delivery model we will use to make our vision a reality.

Underpinning all of this work is our shared evidence base in the Joint Strategic Needs Assessment (JSNA), Joint Health and Wellbeing Strategy (JHWS), our commissioning frameworks and corporate plans. We have already committed to integrate our commissioning and pathways based around shared resources and plans.

Our plan is being underpinned by a shared draft action plan for delivering on the programmes of work we have identified and our benefit modelling so that we can ensure that the schemes of work deliver what is required. Our benefit modelling is based on a combination of managing increasing demographic demand, meeting productivity and efficiency savings, managing the number of people requiring services through early intervention and prevention, improving the impact of services by redesigning and respecifying them and driving through process savings in our current services and contracts. Our strong governance and accountability arrangements and the performance framework we have agreed will guide our appreciation of the progress we are making across the programmes and allow us to make adjustments as these are required.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Enfield**
Clinical Commissioning Groups	**Enfield Clinical Commissioning Group**
Boundary Differences	**None**
Date agreed at Health and Well-Being Board:	**13 February 2014**
Date submitted:	**14 February 2014**
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£18.518m**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£18.518m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Enfield Clinical Commissioning Group
By	Alpesh Patel
Position	Chair
Date	13 February 2014

Signed on behalf of the Council	London Borough of Enfield
By	Councillor Doug Taylor
Position	Leader of the Council
Date	13 February 2014

Signed on behalf of the Health and	Enfield Health and Wellbeing Board

Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Donald McGowan
Date	13 February 2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Engagement of our service providers is key to how the CCG and Council are driving and sustaining the integration of health and social care, based on our jointly-agreed JSNA and the priorities and plans agreed by the Health and Wellbeing Board. We have well-established mechanisms for doing this, which have been extended in response to the specific opportunities presented by the Better Care Fund.

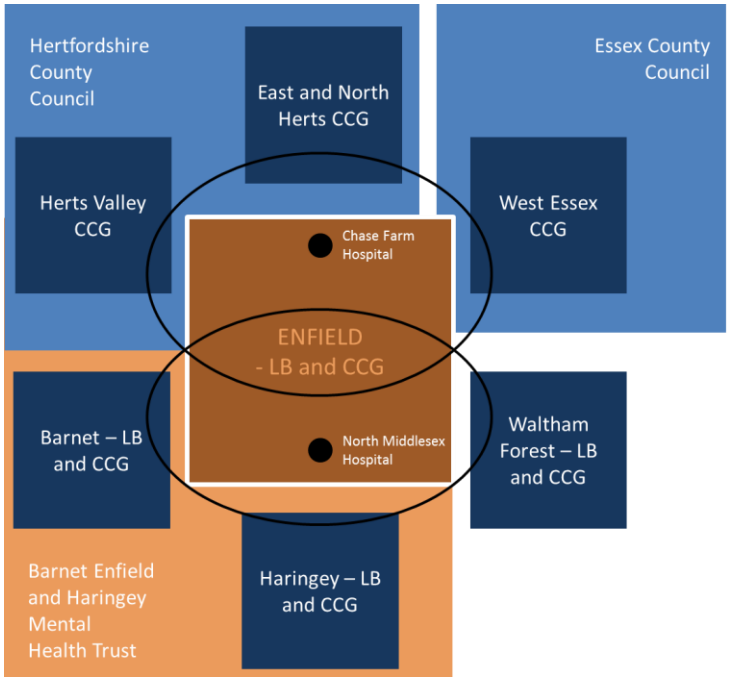
As part of our development of integrated care over the past two years, we have held regular provider forums across commissions and client groups. Open days, including the CCG's Provider Day, bring together providers to discuss emerging trends in our population, as well as strategic and financial issues and commissioning intentions. The same is true in adult social care, where large events bring together providers from across the borough, alongside more specific client group activity. This is followed up with regular communication, including newsletters. Both the CCG and the Council have established a culture of open communication with our providers, including through one-to-one leadership sessions and our ongoing contract management and commissioner-provider relationships.

We work hard to establish our engagement on the basis of partnership working and increasingly our engagement is joint enterprise between the CCG and Council. This has been true on our Better Care Fund plans in particular, about which we have held two group meetings with Enfield's acute, mental health, and community providers, including Barnet and Chase Farm Hospitals NHS Trust, North Middlesex University Hospital NHS Trust, Royal Free London NHS Foundation Trust, and Barnet Enfield and Haringey Mental Health NHS Trust. The first meeting, in November 2013, set out our strategic thinking in light of the BCF and the second meeting, in February 2014, described our emerging planning. We have made changes to our plan based on the providers' feedback and were pleased to note that our approach to engagement was highlighted by the King's Fund in a recent paper on this subject.

In addition to this provider engagement, because we understand that there will be cross-CCG implications arising from the BCF we are working actively with our neighbouring CCGs, including most specifically the CCGs that act as lead commissioners for our two main acute providers.

The geography of service provision around Enfield

The complex and interlocking geography of commissioners and providers is shown schematically in the diagram below.



In addition, to the network of commissioners and providers in health, we also have a diverse and rapidly changing market in adult social care. We have primary relationships with a small number of preferred domiciliary care providers and through our commissioning and brokerage relationships we also have preferred relationships and established quality standards with a number of residential care providers. Residential care provision in the Borough is not strong, but the commissioning mechanisms we have in place mean that we are able to communicate effectively and engage with our primary partners in the delivery of social care services.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The broader engagement that informs our Better Care Fund plan is grounded in the extensive work we conducted whilst developing our Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS). This year's JSNA focussed on core themes relevant to this programme of work and the JHWS has been refreshed alongside the development of this plan.

The engagement on which the JSNA and JHWS are based includes:

- Partnership boards with service users and carer representatives from across all areas of our services;
- Ongoing activity through our customer network, which has a diverse community membership of over one hundred people actively influencing what we do;
- Specific and targeted consultation activities centred on the production of the JSNA and the JHWS, including questionnaires and public events; and
- Ongoing staff engagement events, which are key to developing the business plan priorities that emerge from our broader public engagement.

This long-standing public engagement means that our plan to integrate health and social care in Enfield is based on what we know about local needs, what local people have already told us is important to them, and what they think about our refreshed priorities in the JHWS.

In addition to this, through our work on Value Based Commissioning we have engaged with specific client groups to understand what is most important to them. This directly informs our commissioning planning and the dialogue we have with service users and patients, as well as providers. The client groups covered in this BCF plan have all been engage and include older people, adults with long-term conditions, adults with mental health issues, children with health needs, and carers.

Engagement with patients and the public has been complemented by a variety of other forums, including:

- Patient Participation Group representation on the CCG's governing body;
- The CCG's Patient and Public Engagement Committee
- User and carer representation at provider management meetings in adult social care;
- Healthwatch Enfield, along with community and voluntary organisations;
- Our Health and Wellbeing Board (HWB), at which we have used innovative means of seeking out and understanding people's priorities for us as commissioners, including recently a voting approach to understand the public's most important priorities in the JHWS.

We will continue our engagement across patients, service users, and the public as we further develop our integrated care system, always ensuring that our work is informed by the views of our local population. Updates on progress will be provided at HWB meetings, through the Council's decision-making process (including the Overview and Scrutiny Committee structure), at the CCG's public

governing body meetings, and through information posted on our websites and through social media.

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Enfield JSNA	Setting out our changing demographic pressures and arranged according to a series of themes, in order to make it accessible. www.enfield.gov.uk/healthandwellbeing/info/3/joint_strategic_needs_assessment_jsna
Enfield JHWS (for link to consultation survey)	Setting out our agreed priorities for the area. www.enfield.gov.uk/healthandwellbeing/info/4/health_and_wellbeing_strategy
Enfield CCG – Plan on a Page	Providing the basis for our strategic planning and work with neighbouring CCGs. www.enfieldccg.nhs.uk/Downloads/Policies/ECCG%20Plan%20FINAL%204%20280313.pdf
North Central London Primary Care Strategy	Setting out the acute commissioning landscape and changes agreed across Boroughs. www.enfieldccg.nhs.uk/Downloads/Policies/Primary%20care%20strategy.pdf
Enfield's Joint Commissioning Strategy for End of Life Care 2012-16	Our priorities and plans for this important group. www.enfield.gov.uk/downloads/file/8457/enfields_joint_commissioning_strategy_for_end_of_life_care_2012-16
Enfield's Joint Stroke Strategy, 2011-2016	Explaining our priorities in this condition-specific area. www.enfield.gov.uk/downloads/download/2627/enfield_joint_stroke_strategy_2011-16
Enfield's Joint Dementia Strategy, 2011-2016	Setting out our initial plans for dementia sufferers in the Borough. http://www.enfield.gov.uk/downloads/download/1317/joint_dementia_strategy_2011__2016
Enfield's Joint Carers Strategy, 2013-2016	Explaining our joint plans for carers, working across health and social care. www.enfield.gov.uk/downloads/download/2429/enfield_joint_carers_strategy_2013-2016
Enfield's Joint Intermediate Care and Reablement Strategy, 2011-2014	This important strategy sets out our approach to increasing the numbers of people supported through our intermediate care work as well as continually improving outcomes as a result of our interventions. www.enfield.gov.uk/downloads/download/1319/joint_intermediate_care_and_re-ablement_strategy_2011-2014
Adult Social Care - Voluntary and Community	This document has been shaped by our partners in the voluntary and community sector and explains our plans

Sector Strategic Commissioning Framework 2013-2016	for supporting them to meet need in the community. www.enfield.gov.uk/downloads/file/8459/voluntary_and_community_sector_strategic_commissioning_framework_2013-2016

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

OUR VISION FOR HEALTH AND CARE IN ENFIELD

Enfield has already embarked upon its journey towards the integration of health and care services, which is a key component of our Health and Wellbeing Board's vision of enabling local people to 'live longer, healthier, happier lives in Enfield'.

Our Health and Wellbeing Strategy, which has been refreshed alongside the development of this plan, sets out five distinct draft priorities. Each one supports our mission of improving the health and wellbeing outcomes of all people in Enfield, regardless of where they live. These priorities are:

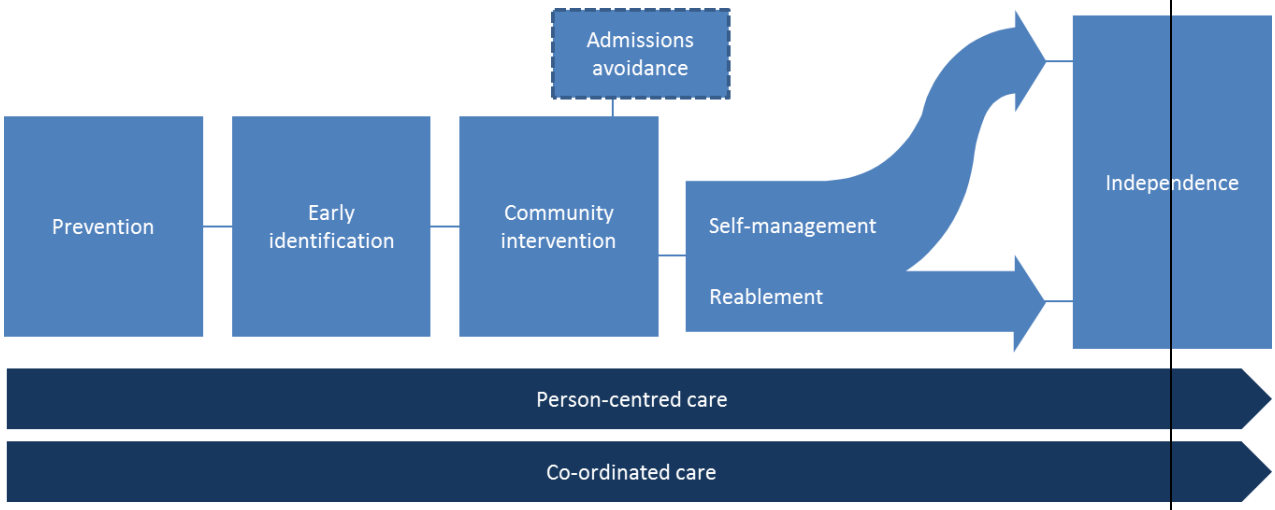
- Ensuring the best start in life – so that all children are able to realise their full potential, helped to be self-sufficient and part of a network of support that will enable them to live independent and healthy lives.
- Enabling people to be safe, independent, and well, and delivering high-quality health and care services – so that people of every age are able to live as full a life as possible, with health issues, both physical and mental, recognised as soon as possible.
- Creating stronger, healthier communities – with people living in stronger communities and able to contribute through meaningful employment, living in warm, clean, safe accommodation, supported by a strong network of family and friends and creating the resilience for residents to cope with adverse life events.
- Narrowing the gap in healthy life expectancy – by reducing the gap in life expectancy within the Borough by continuing to review and apply the evidence base on health inequalities, whilst working with communities to develop initiatives that will improve the health and wellbeing of local people through a series of short, medium, and long-term goals.
- Promoting healthy lifestyles and healthy communities – by helping residents to understand how their choices affect their health and wellbeing and supporting them to choose healthier options throughout their lives.

We welcome the Better Care Fund as a major opportunity to develop our work across the priorities contained within our Joint Health and Wellbeing Strategy. Accordingly, our BCF plan is based on a broad programme of activity which spans the key issues affecting our residents' health and outcomes. Underpinning all of these are a set of agreed principles shared jointly across commissioners, beginning with our focus on prevention and early intervention and recognising the

shift in resources we need to make through reabling people after a health episode.

Our agreed delivery model for integrated health and social care across all areas

Our agreed model is shown in the following diagram:



Co-ordinated and person-centred care underpins interventions at every point through the stages of care, starting with an emphasis on prevention and early identification. Providing both health and social care interventions in the community is a key part of our admissions avoidance strategy, which is designed to yield benefits related to both wellbeing and financial sustainability. Following up health and social care interventions with an emphasis on reablement and self-management is a key part of our objective of maximising the independence of all people within Enfield who have received health and social care interventions. In common with other areas, we are increasing focussing on enabling people – especially people with long term health conditions – to manage their conditions.

Our integrated health and care system will deliver flexible, multi-agency and multi-disciplinary working, always led by the needs of local people and founded on a firm evidence base of what works and what doesn't. Our determination to be person-centred in everything we do means that services will be tailored to respond to individuals, providing the care people need and where and when they need it. In Enfield's integrated system, people come before historic boundaries between organisations and their budgets.

In this plan, we set out how this overarching model will be increasingly applied to four specific population groups. These reflect the needs we have evidenced and discussed with our partners, as well as the significant opportunity the BCF provides to accelerate the delivery of our model.

The four population groups are:

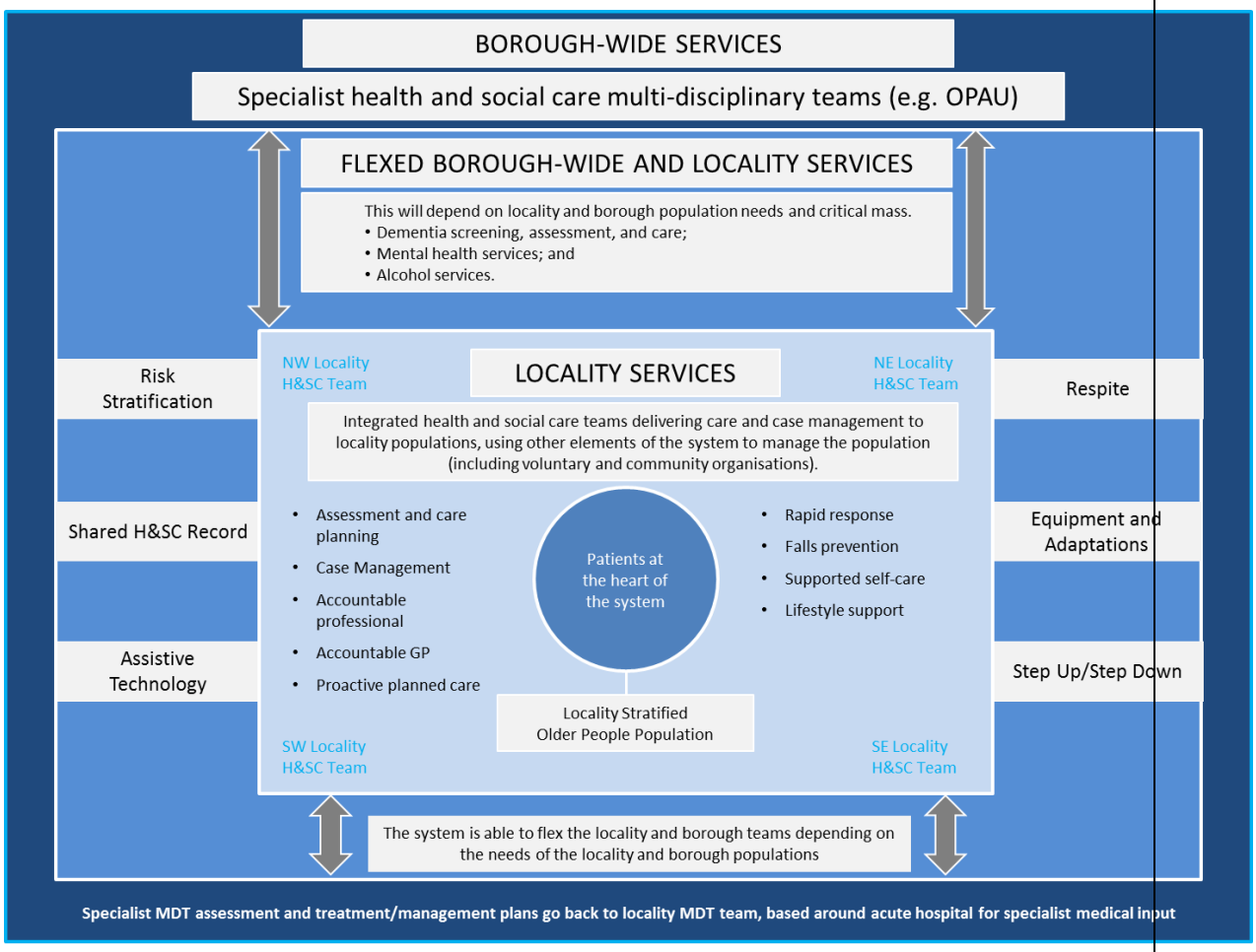
1. Older people – focussed on those experiencing frailty and/or disability
2. Working age adults – focussed on those with long term conditions

3. Adults experiencing mental health issues
4. Children with health needs

In all of these population groups and across our work, our services will be delivered through our locality based model.

Our agreed locality model across our population groups

The locality model is depicted in the following diagram:



Enfield CCG and LBE have been working with all our providers over the past year to develop our model of integrated care for older/ people. This model is currently being implemented but remains dynamic in terms of being able to adapt to necessary changes and pressures. All our models will be based on providers working together holistically and where relevant supporting MDT's either at a locality level or at a borough-wide level.

The above diagram aims to show the model of care for older people but can be applied across populations. The model shows that patients and service users are placed at the heart of the integrated health and social care system. They will interact with this system on three levels, working outwards from the middle of the diagram:

- Through services provided only through the localities, such as assessment

and care planning, case management and working with their accountable professional.

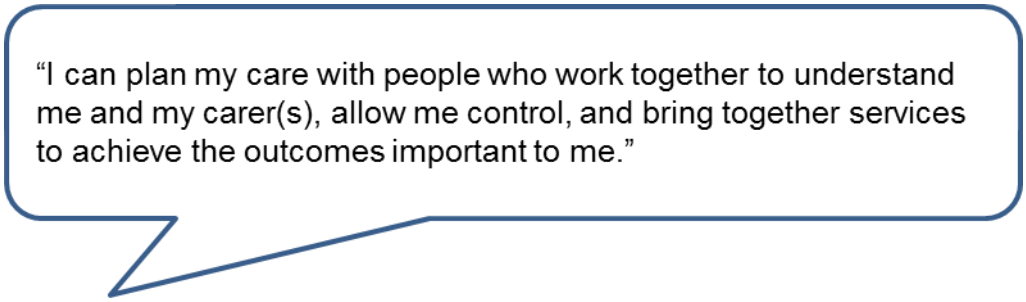
- Through services provided either through the localities or borough-wide – the system will be able to flex its locality and borough teams depending on the needs of the locality and the borough population.
- With services provided borough-wide, such as the Older Person's Assessment Units and specialist MDTs, recognising the interventions that specialists may need to make.

The system is support by our risk stratification model, assistive technology and a shared health and social care record.

Our ambition is that this model will be developed for all client groups, across both health and social care. This will drive the achievement of an integrated care system that is:

- person-centred, focussed on 'the outcomes I want to achieve'.
- more connected.
- more targeted.
- delivered through our localities.
- flexible and evidence-based.
- based on multi-disciplinary working.
- supportive to carers.
- promotes social inclusion and independence.
- focussed on prevention, early intervention, patient self-management and minimising unnecessary hospital admission.

Our focus on delivering person-centred services in particular means that every person in Enfield should be able to say,



As National Voices makes clear, this is founded on care planning, joint decision making, access to information, communication, the prioritisation of personal goals and outcomes, and effective transitions. These are all integral to our vision of integrated care and will enable us to provide care that is preventive, proactive, planned and personalised.

We will also encourage local people to take a more active role in their own and others' health, thereby extending the strengthened partnership between the CCG and Council to our local communities and involving local residents as active patients and service users. This is a core theme and priority in the way we deliver our model.

Together, the CCG and Council have identified four programmes based on our population groups that, with funding from our BCF, will drive forward our integration agenda through our locality model. These are listed below. They

have been discussed and agreed at the Health and Wellbeing Board and reflect discussions we have had with our providers: both will continue to be involved in ongoing discussions about prioritisation and timeframes as we work up our final submission. This will take place in addition to the governance arrangements detailed below. The tables in the following two sections detail the aims and objectives of each programme and describe our planned changes in each area.

A summary of our vision in the four population groups highlighted in our BCF plan

No.	Our population based programme in..	Enabling us to..
1.	**Older people – focussed on those experiencing frailty and/or disability**	Accelerate the work of our established Integrated Care for Older People program with rapid assessment through our Older People's Assessment Units (OPAUs), and more integrated support at every stage of care pathway
2.	**Working age adults – focussed on those with long term conditions**	Provide enhanced, integrated intervention acute and primary care settings to avoid t need for work in outpatients
3.	**Adults experiencing mental health issues**	Expand our rapid intervention model for o people experiencing dementia and expan our mental health care model
4.	**Children with health needs**	Enhance our health and wellbeing networ and provide better early intervention in psychosis and better post-transition supp vulnerable young adults.

The specific changes driven by these programmes will be achieved in part by working with our providers in a new way, facilitating and incentivising them to work collaboratively as a single system. We have already started this work, in part through the ongoing work within the programmes themselves and in part through the initiative of our providers for this better care fund. We will work together to incentivise them to deliver the outcomes desired by people in our Borough. This represents a major shift away from the historic focus on single-agency activity, input and process-led measures.

Our implementation of this new system will also successfully manage demand for unscheduled care, which is a major expense within our local economy. It will do this as a result of the identification of need, with necessary interventions, before a person enters a crisis. This, in turn, provides a whole-system efficiency across

health and social care and further assists both the CCG and the Council as we continue to shift the balance of resources from high-cost secondary treatment and long-term care to a focus on the promotion of living healthy lives and a picture of continually improving wellbeing.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

A number of core aims and objectives underpin our vision for integrated care in Enfield and drive the four programmes covered by our BCF plan. The aims and objectives underpinning our vision are:

- Eradicating fragmentation and silo working across health and social care.
- Ensuring that every part of the system is working effectively.
- Maximising health and wellbeing outcomes from the available resources.
- Minimising health and wellbeing inequalities across our borough.
- Improving the ability of the local population to make lifestyle choices that reduce future demand for health and social services.
- Improving the capacity of the local population to self-care, especially for minor ailments and long-term conditions.
- Avoiding unnecessary admissions to hospitals and care homes.
- Ensuring that nobody stays in a hospital or care home longer than they need to.
- Maximising the knowledge and skills of all staff, which underpins the achievement of all other objectives.

The aims and objectives of the four programmes covered by Enfield's BCF

This table sets out in more detail the aims and objectives of the four programmes that drive our integrated care programme.

Programme		Aims and Objectives
1.	**Older people –**	The aims of Enfield's integrated care system for older peop

	focussed on those experiencing frailty and/or disability	are to: 1. Assess, plan and provide appropriate, early prevention-focussed interventions to enable Enfield's older people to avoid a health and/or social care crisis, or to be quickly stabilised following a crisis. 2. Make the patient narrative on what's important to them a critical part of care planning and to actively engage patients (and their carers) in decisions about what care they may receive. 3. Ensure that all elements of the system act together to provide care delivered in the most appropriate setting for the patient and their needs and circumstances, and, where possible, closer to patients' homes and/or in a community setting. 4. Manage activity and cost across health and social care such that no unnecessary activity and costs are incurred within the system and thereby support its long-term sustainability.
	Older people – focussed on those experiencing frailty and/or disability (continued)	We anticipate that the key health gains for older people will be two-fold: 1. **A reduction in unnecessary admissions to hospital as a result of more preventative and planned care.** There was an 8% increase in acute sector costs in Enfield over the last three financial years, over 80% of which were attributable to those aged over 75. An audit of these additional admissions suggested that many could have been proactively managed in the community. A direct gain of the integrated care system is therefore associated with demand management in reducing unnecessary admission to hospital as a result of more preventative and planned care. Similarly, there should be a reduction in the number of people presenting to the Council at a crisis point and therefore needing intensive social care, including admission to care homes. Instead, cases will be identified at a more preventative stage and/or earlier – and be less expensive to treat. 2. **Improved self-management.** This is an indirect gain arising from patients and their families being equal partners in the planning and management of care, which will help them better self-manage their conditions and circumstances. For example, there is evidence nationally that assistive technology initiatives produce a health gain in terms of reduced health interventions, such as admissions to hospital. Four key parts of this approach – which span all of our population groups but are particularly important in this one – are: 1. **Our approach to safeguarding and quality in everything we and our providers do.** A core objective

	Older people – focussed on those experiencing frailty and/or disability (continued)	underpinning all of our health and social care services is that they deliver quality outcomes and safeguard the health, safety and wellbeing of the most vulnerable members of our community. We aim to deliver this by boosting various elements of our safeguarding capacity as well as through our Quality Checker Volunteering Programme, which provides key community intelligence and engagement. 2. **Improving our approach to the way we support carers.** Across all of our patient and service user groups, a major issue is the health and wellbeing of carers – the 30,000 carers who save our local economy the equivalent of £572.7m per annum by delivering unpaid care. There is a particular need for improved support for carers and, most importantly, respite breaks. By providing increased support to carers, we aim to see improved health and wellbeing outcomes for patients and recipients of care, improved health and wellbeing outcomes for carers (who suffer a disproportionally high level of ill health) and reductions in unwanted admissions, readmissions, delayed discharges in hospital settings, unwanted residential care admissions and lengthier periods of stay in settings. 3. **Working more closely with our Voluntary and Community sector partners.** Our Joint Strategic Framework, which was developed in collaboration with stakeholders from this sector, makes clear our aim to work in partnership with voluntary and community sector organisations. The objective of this is to complement statutory provision and enhance the range of quality services and supports that are available to meet community care needs. We see the BCF as an opportunity to accelerate our work in this area and, in particular, our aim to develop voluntary and community services that support existing work to delay and, where possible, to prevent hospital admissions and requirements for social care services. Incorporating these organisations more deeply into our ongoing work in this area will increase the capacity, capability and flexibility with which we can achieve this. 4. **Investing in our infrastructure to support integrated care.** We recognise that this is a key challenge and that changes will not be introduced without us doing more on the business systems and commissioning processes which are required to make this our new way of working. We aim to deliver effectively integrated services supported by infrastructure that is fit for purpose. We define this as meaning that the infrastructure supports our staff to deliver the outcomes our patients and service users desire. This means that our ability to deliver the patient outcomes that are at the heart of how we work with our population groups

		must not be compromised by systems and process issues. It is for this reason that we have made infrastructure a key element of our planning, with dedicated funding.
2.	**Working age adults – focussed on those with long term conditions** **Working age adults – focussed on those with long term conditions – continued**	The key objective of work with adults with long-term conditions is to enable them to develop their capacity to self-manage their conditions. Although this is our overriding aim across our population groups, this is especially important in this one. The aim of our programme here is both to normalise a greater semblance of wellbeing for patients and reduce the frequency with which they require outpatient and/or specialist interventions. This is in line with our broader objective to limit attendance in secondary care only to cases where this is clinically necessary. Where adults have multiple long-term conditions, our integrated care programme aims to provide them with flexible and multi-disciplinary teams that focus their care around the needs of the individual, co-ordinated through an active case management approach. There are two key targets for this approach through the BCF. They are: 1. **Our work with people experiencing issues with alcohol.** Our alcohol strategy aims to turnaround the health and wellbeing outcomes of the 3,648 people in our Borough who are dependent on alcohol through a range of brief interventions. Using the BCF as an enabler for this, we will target our work on high-risk individuals through brief interventions in primary and acute care. We will reduce the number of alcohol-related admissions to primary and secondary care, which currently has an associated cost of £6.57m in our local health and social care economy. 2. **The support we currently provide to adults through our s.75 agreement.** We fund a range of interventions for adults of working age through our agreement, and we plan to use the BCF to review and refine the support we provide through this fund. This will bring together the work we do as individual organisations as well as our commissioning work in condition specific groups including strokes, heart conditions and other public health related factors such as chronic pulmonary disorders (CPD). We recognise the significance getting this right will have on our residents' outcomes as well as the effectiveness and sustainability of the services we commission.
3.	**Adults experiencing mental health issues**	We are currently consulting our shared vision and joint commissioning strategy for adults requiring mental health treatment and support: in addition to the need we are experiencing in this area, the BCF provides another enabler for us to do this. Our shared vision is a focus on the quality of and access to integrated services, recovery and outcomes, delivered through effective partnerships. Through this programme we aim to:

	Adults experiencing mental health issues – continued	• Support patients and service users to find meaningful occupation or employment, maintain their income and develop meaningful relationships. • Increase the community presence of our services for adults with mental health problems. • Reduce the stigma and discrimination associated with mental health conditions, by, for example, increasingly working with our voluntary and community sector partners. • To tackle current challenges in local mental health services by putting patients and service users at the heart of the services they receive – this objective will be achieved by prioritising the outcomes that patients and service users have told us they value. • Support carers in providing effective care and maintaining their own health and wellbeing. Our work on value based commissioning with CCGs across North Central London has shown that the outcomes prioritised by patients and service users include: • Coping with adversity. • The ability to take care. • Psycho-education. • Timely and responsive services. • Continuity of care. • Autonomy. • Physical health. Our mental health programme will deliver these and relevant patient outcomes through effective incentivisation of our providers delivering services.
4.	**Children with health needs**	The core objective of our broader programme of work for children with health needs is to deliver high-quality and integrated paediatric care with more community-based care options, designed to improve the experience and outcomes of children who are ill. Our aims cover five main headings: 1. **Heath improvement**: There are a number of multi-agency plans in place aimed at reducing infant mortality, obesity, and teenage pregnancy and increasing immunisation uptake and early access to maternity services. These reflect our commissioning priorities for 2013/18. 2. **Early identification and intervention and building resilience**: Our aim is to ensure that services are better co-ordinated by using a 'team around the child' approach. Core services will be evidence-based and available to all. Through the Building Resilience strategy, priority is given to prevention and early intervention, with greater targeting and concentration of resources towards those children and

	Children with health needs – continued	families who are most vulnerable and most at risk. 3. **Primary Care:** We aim for an integrated provider or an integrated network of providers to support providing primary care practitioners with the opportunity to maintain the skills and competencies required in the assessment of acutely or critically ill children. 4. **Community-based specialist child health services**: We aim that specialist community health services provide as much care as possible in the child or young person's home, children's centres, schools and special schools, with specialist assessment and treatment centres available when required. 5. **Hospital provision**: We are reviewing the role of the district hospital on an ongoing basis with the objective that hospital-based services will increasingly be for specialist and tertiary services only. Another key objective for children and young people is that fewer people aged under 19 will be admitted to hospital for conditions such as asthma, diabetes, epilepsy and lower respiratory tract infections, as a result of better care in primary and community services.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

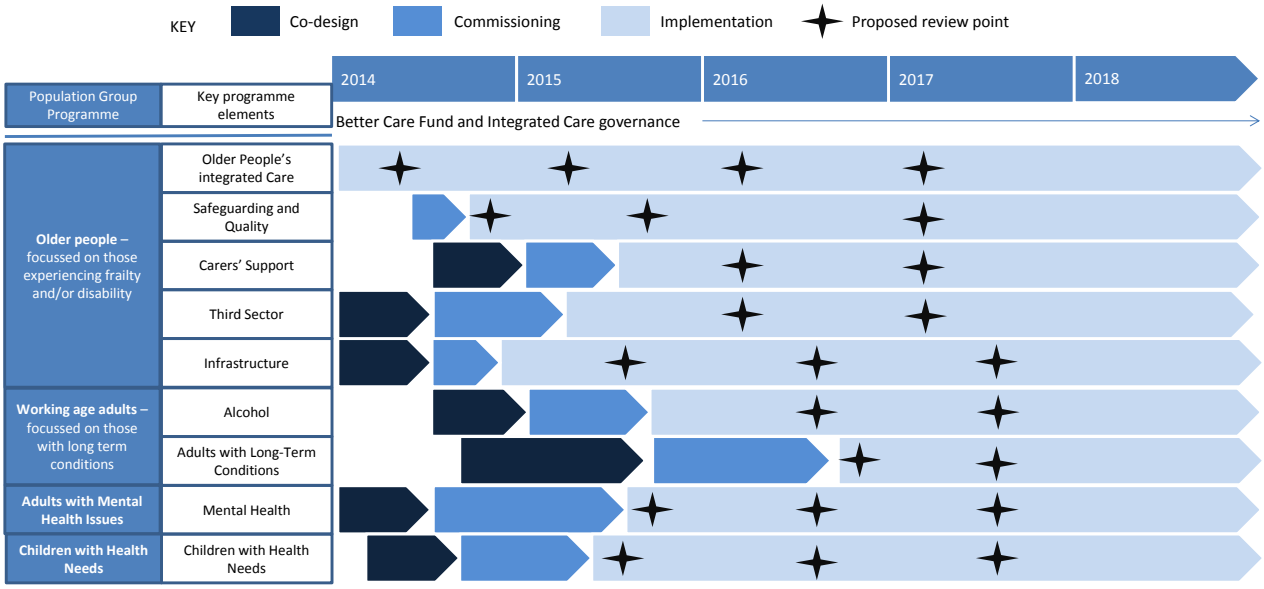
We will deploy our established partnership governance structures and processes, which cover all aspects of the commissioning cycle from the JSNA to individual commissioning plans and delivery networks, to ensure delivery of our integrated care programme in accordance with the key success factors set for each of our programmes. These in turn will form the key driving force for our wider commissioning activity, working as partners with our providers. Our performance management framework will allow us proactively to measure the impact of our programmes as well as the integrated care programme as a whole, supporting the achievement of both the outcomes desired by the people of Enfield and the financial benefits that we need to see and anticipate being realised.

By bringing together the CCG and Council, along with other partners and stakeholders where necessary, these structures will also be the means by which we ensure the alignment of all the activity covered by our Better Care Fund programmes. This includes ensuring that they remain rooted in our evolving JSNA and JHWS, the CCG's commissioning plans and the Council's plans corporately and for social care.

How we will deliver our BCF programmes

The diagram below shows at a high level how we will implement the four programmes we have identified in this BCF plan. We have not attempted to show the work we have undertaken so far in all of these areas but rather how we will phase our work and activity

following the completion of this BCF plan. It should be noted that the programmes are at different levels of development and implementation with the programme for older people by far the most developed with implementation proceeding.



Some of the important factors to note include the following:

- We have set deliberately ambitious timeframes for delivery but tried to focus our early work on where our benefits modelling and the available evidence and research tells us we should have most impact on quality and budgets most quickly. Our work on the older people's integrated care programme is already in train and beginning to deliver results. As the diagram below shows, following agreement to this plan we will instigate a review of this programme to identify what is working and what isn't, and where we can take action to accelerate improved outcomes more quickly.
- We have built in regular review points, and our reviews will be tied into our governance of the BCF. As the diagram shows, we have identified review points which allow us to take stock of progress so far, take place at the beginning of major commissioning activity and happen at least annually thereafter. We have also factored into our thinking national events, including the development of the CQC's inspection framework for adult social care and developments in their role which will come forward in the Health and Social Care Bill and associated regulations. We understand that this will have an impact on our work in safeguarding and quality, for example, as national and local responsibilities are defined in more detail in adult social care in particular.
- We are conscious of the timescales for the delivery of this work and the performance improvements we need to see in 2015/16 in particular, but we are also mindful that some of this work – particularly changing our whole approach to elderly care – is going to take us the full 5 years specified by this plan to fully embed. We see the delivery of our vision and aims as a continuous and iterative process, with adjustments being made on a regular basis. This means that the timeframes for delivery are ambitious and we have not specified end points for our work in the diagram below.
- We will ensure that other related activity aligns through our governance

arrangements, which are set out later in this plan, but we will also ensure alignment through regular and meaningful communication, especially with our providers, which has been assisted by the development of this Plan. We have been very fortunate to have had great support for our planning from our acute provider partners in particular and they have committed to working alongside us to implement our vision and to meet the challenges we all face as health and social care system leaders.

Description of planned changes

We believe that success will be more likely if we are clear up front about what we are looking to do and when. Although this is a draft plan and sets out our thinking at this stage (before more detailed discussions take place between now and April), this planning process has enabled us to be quite clear about what we expect to see in each of the four areas we have highlighted.

This table below outlines specific changes planned under each of the programme headings.

Programme		Description of Planned Changes
1.	**Older people – focussed on those experiencing frailty and/or disability**	The Better Care Fund will enable the integrated care model to become embedded in our health and care system. **The key changes will include:** • Overall we are trying to design a new care system for older people bringing together as much of the evidenced based initiatives as possible to create a system that works far better for older people and where providers accept collective responsibility for the outcomes for our older people. What is presented below are the elements of that new system which are in varying stages of implementation. • Access to well-trained and fully-informed GPs in primary care as the key gateway to early diagnosis and interventions, including in ensuring the cases of patients are managed, as far as possible, outside of an acute setting and delivering care closer to home. • Risk stratification supporting the identification of those people at particular risk of unnecessary hospitalisation and crisis. GPs and other lead professionals will be supported in assessing, planning and managing these cases through development of multi-agency and multi-disciplinary locality-based teams comprising of district and specialist community nursing, social care professionals, as well as input from clinical staff in secondary care, e.g. consultant geriatrician as part of planned or urgent care for individuals at risk. These are currently being developed • Access to specialist, consultant-led but multi-disciplinary and multi-agency Assessment Units, which provide planned assessment, diagnoses, treatment and health and social care interventions as part of a pathway available to the lead

	Older people – focussed on those experiencing frailty and/or disability – continued	professional in primary care to support those at risk. A similar "dementia hub" will be developed with the same function for this condition, and this relates directly to the priority we are setting on dementia support and the local measure we have identified for the BCF. Both Older People Assessment Units are now operational. • Improved access to intermediate care and reablement services and continuing health care to avoid hospital admission or to facilitate hospital discharge as part of these pathways, with an emphasis on developing increased capacity of different forms of intermediate care tailored to differing needs learning from best practice elsewhere, e.g. better support in hospitals for those with dementia to reduce lengths of stay, extended community-based "active convalescence beds" to support frail elderly people with a view to returning home, alongside shorter-stay "step-down"; models and turnaround services to prevent subsequent hospitalisation and admission to care homes. We have expanded enablement as part of the new system. • Re-design of hospital discharge planning to ensure it is better coordinated and supported across care professionals learning from best practice elsewhere and this planning, and the solutions to support it, consistently incorporate post-discharge planning, reducing the risk of hospital re-admission or admission to care homes so they can continue to live at home. • These solutions will be augmented through the deployment of assistive technology, including telecare and telehealth known to be under-utilised in Enfield, to ensure that people are as safe, healthy and live with the condition as independently and effectively as possible and an appropriate planned or urgent response is available to support people to live at home (avoiding inappropriate hospital admission). We are currently piloting this to inform the new system. • Building on progress in developing person-centred solutions across health and social care, e.g. personal budgets, solutions will be delivered and tailored to best support individuals and their families to live as well, healthily and independently as possible in the way they want. This will include, for example, further development of personal health budgets and a greater range of specialist personal assistant options so people can exercise as much choice and control as possible; as well as jointly delivered routine and urgent care support tailored to individuals, including to those with dementia, to support individuals at home for as long as possible. • Building on progress so far in the End of Life Strategy, the need to ensure older people with terminal conditions consistently have access to specialist and joint palliative

	Older people – focussed on those experiencing frailty and/or disability – continued	care solutions, which will lead to more people having advanced care planning and dying in a place of their choosing (often at home). • Building on plans in Enfield's Joint Carers' Strategy, the need to ensure carers and their needs are recognised and supported not just in continuing and managing their caring role (including managing their own health needs), but in having a life of their own. • The above solutions will be under-pinned through well-governed and appropriately accessible shared information about the patient through e-shared records which will track them through their access across the health and social care system as part of their pathway. • These solutions include a key role for the voluntary sector in providing information, advice and support alongside health and social care professionals to enable people and families to achieve the outcomes important to them. This includes in locality-based working within community and primary care settings (particularly preventative targeting of those most at risk during the winter months), facilitating hospital discharge ("hospital to home") and developing person-based solutions tailored to them to improve their health, mental or physical well-being and independence. Through the Better Care Fund we will work towards the delivery of these changes including in the following specific areas: • The continued operation of the Older People's Assessment Units at the North Middlesex and Barnet and Chase Farm. • The provision of additional step-down beds to reduce blockages in acute hospital beds and counter the recent increase in delayed discharges. • The provision of much-needed capacity in nursing beds for social care and continuing care, particularly around dementia care. • The further development of seven-day working practices to improve response to what would traditionally be considered out-of-hours cases, enabling a more timely and proactive interventions to reduce use of crisis situations and reduce unplanned hospital admissions. • A comprehensive falls programme. • An enhanced tissue viability service. • Dementia Friendly Communities and memory clinics, supporting people who suffer from dementia and their families to improve quality of life and inclusion in the community. • Specialist dementia nursing capacity.

		Key system changes will include: 1. **Changes in our approach to safeguarding and quality –** including the supporting of quality assurance through the Enfield Quality Checker Volunteer Programme, which currently has over fifty members, an additional safeguarding nurse assessor, who will provide additional capacity and vital assurance on safeguarding issues, further support for the costs of adults safeguarding and additional safeguarding capacity through additional social workers. 2. **An increased number of carers supported by us** – reaching out to more carers by listing more on the carers' register and providing additional capacity for carers' respite breaks, in addition to the current base contract. 3. **More funding for voluntary and community sector services that prevent ill health and hospital admissions –** including working towards reducing winter deaths through the Enfield Warm Households Programme. 4. **A more robust infrastructure and better investment in integrated care** – including funding for programme management to implement the Primary Care Strategy (with a focus on changes to GP's premises), funding for data and analytics support and fund management and funding to prepare the acute sector for a shift in resources to community based services .
2.	**Working age adults – focussed on those with long term conditions**	The two key focusses of our activity in this area are on the prevention of escalating issues in alcohol misuse and support to help people manage their long term conditions. Key changes will include: 1. **In alcohol services** – a reduction in alcohol-related admissions to secondary care through brief interventions in both the primary and acute sectors, with an associated reduction in the financial cost of treatment. Programmes of interventions will be delivered by substance misuse liaison nurses – the nurses will also co-ordinate activity between primary and secondary care. 2. **In long term condition management** – we aim to develop a new system for people with long term conditions focused on MDts within localities which deliver as much a care and case management as possible without the requirement for hospital care. The system will work across prevention model through to end of life care and maximise self-management. This will build on the redesign already underway, more

		outpatient admissions will be avoided through the deployment of personal health and social care budgets, contributing towards better outcomes for people, such as living independently at home with maximum choice and control; and, more efficient use of existing resources by avoiding duplication and ensuring people receive the right care, in the right place, and at the right time; and improved access to, and experience of, health and social care services. In addition to this, we will improve people's access to the vital aids, adaptations and equipment required to live independently and well. One specific change we will make is the movement of wheelchair services to ICES (Integrated Community Equipment Service). This move will also generate economies of scale across the health and social care economy.
3.	**Adults experiencing mental health issues**	The Better Care Fund will be used to support three specific elements of our new system approach to mental health: 1. **Supporting our RAID (Rapid Assessment Intervention Discharge) model**, the benefits of which include reduced admission rates to inpatient beds, lengths of hospital stay, and readmission rates to hospital for adults and older people; 2. **The continuation and extension of IAPT**, including targeting older people – this will provide more people with psychological therapies to support them in the community and thereby avoid hospital admissions. 3. **Developing our local primary care mental health model**, providing robust community support options for people with mental ill health and services that are more accessible, thereby reducing inpatient admissions. More broadly, our new system approach to mental health involves a number of elements: • More involvement of the service user and carer (where appropriate) in the delivery of care, including the development of personalised care plans for each service user and bringing relevant individuals agencies together to deliver an effective, seamless package of care. • Better integration of care and services within and across agencies through the development of integrated care pathways and integrated whole systems of care for adults of all ages, whether they have an organic or non-organic illness or a common mental health problem or serious mental illness. • The development of a community- and primary care-based mental health services model aimed at enabling individuals who do not need access to specialist mental health treatment to be supported effectively. This will

		build on the GP locality networking model, which aims to deliver a multi-agency approach to support in the community thorough an approach that brings voluntary and community sectors and specialist services into an effective network of treatment and support 24/7. • The establishment of an effective model of psychiatric liaison in the North Middlesex University Hospital, operating 24/7 and based on the RAID model. This will be linked to an integrated community-based system of care and ensure a timely and appropriate response to adults of all ages presenting with both an organic or non-organic illness, thereby avoiding preventable admissions and re-admissions. • Ensuring that the needs of adults with either and/or autism, drug and alcohol problems and forensic needs are met in a co-ordinated way. This will include ensuring that practitioners with the appropriate skills come together to work with the service user and his/her carer where appropriate, to understand and plan to meet those needs. • A cultural shift in the delivery of treatment and support that puts the service user, and carers where appropriate, in the driving seat when it comes to determining outcomes. This will be achieved through a focus on easily accessible, personalised and recovery-orientated care that is focussed on delivering positive experience and outcomes for individuals; and A number of tools, including multi-agency and stakeholder work to develop integrated care pathways, will be used to deliver better co-ordinated care that is more accessible and available earlier in the course of the illness.
4.	**Children with Health Needs**	The BCF will deliver the following changes in the way we work: • **Child Health and Wellbeing Networks** will deliver improved and more integrated paediatric care with more community-based care options, as well as improved early identification and disease management. A key benefit here is a reduction in paediatric admissions for asthma and other ambulatory care sensitive conditions. • **Enhanced early intervention in psychosis service**, which will improve the experience for children and young adults experiencing psychosis thanks to more community-based care options and fewer inpatient admissions. • A post-transition/vulnerable young adult service, which will ensure a smooth transition from children's to adults' services with better continuity of care and improved experience of support services.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

We are currently working through the implications for our acute sector partners and plan to do this with them as far as we can: we shared our initial understanding of the plans in early February as part of preparing this plan and have agreed to do more of this in future. The savings required to deliver the Better Care Fund will come significantly from our two acute main providers, which are North Middlesex Hospital and Barnet and Chase Farm Hospital. Enfield CCG's investment in the two organisations is £66.7m and £79.3m respectively. It is unlikely that any savings can be delivered via our community or mental health contracts, although we are looking at how we achieve greater productivity through those contracts. Both BCF and NMUH will be affected by other commissioners and we are currently working across the five CCGs of North Central London to understand the total impact on our acute providers.

Enfield CCG met with all its providers (BCF, NMUH and BEHMHT) to discuss the high-level impact of the Better Care Fund. A further meeting took place in February 2014 prior to submission of the plan. Further discussion will take place via CE-to-CE as well as through any acute-focused Transformation Boards and via the development of the North Central London Strategic Plan. Detailed activity and financial modelling will be undertaken to determine the impact for Trusts across NCL including specialty level impact. There will need to be a staged approach to the reduction of acute activity and funding with the acute providers in order to mitigate the risk of any potential destabilisation.

The realisation of savings will be delivered by the redesign of systems relating to the agreed transformation programmes and some of this activity reduction has already begun this year via the integrated care for older people programme and emergency admissions. Where savings are realised then service delivery and quality will be maintained or improved through those new systems being operational. Where savings are not realised then there will be high levels of unfunded activity at both our acute providers which may cause destabilisation to both providers and the CCG. In addition, this is likely to impact negatively on our key performance indicators including NHS Constitution, RTT, A&E Emergency Admissions and Ambulatory care.

d) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The Enfield Health and Wellbeing Board has established a group called the Integration Transformation Fund Sub Working Group ('BCF Working Group'). This group is responsible for overseeing and governing the progress and outcomes associated with our Better Care Fund plan. It comprises senior offices from both Enfield CCG and the London Borough of Enfield; additional members may be appointed to the Board by the agreement of all current members prior to approval by the Health and Wellbeing Board.

Sign-off arrangements are in place with the Enfield Health and Wellbeing Board. The working group will make recommendations to the Health and Wellbeing Board and individual internal governing bodies.

Individual leads across the partnership have the responsibility to ensure that their relevant governing bodies are sighted on all work of the working group and are acting on their behalf.

The Health and Wellbeing Board has agreed that this sub-group will exist on a temporary basis until April 2014, when the terms of reference for the Health and Wellbeing Board as a whole will be reviewed. Decisions about the governance arrangements for the implementation and monitoring of the plan will be made as part of this review process. Currently we anticipate that the sub-group will continue and assume responsibility for performance managing the implementation of the plan. Our emphasis in devising these arrangements will be to mainstream BCF governance to the greatest extent possible, in order to achieve the maximum alignment of the programmes involved into existing change programmes.

NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Enfield will continue its current practice of providing social care support to adults and older people assessed as having either critical or substantial needs. This is considered to be broadly in line with the national eligibility criteria being proposed in the Care Bill. The preferred model for this is, and will continue to be, a personal budget.

In addition to the ongoing support described above, there is targeted provision of equipment, reablement, community alarms and other telecare, aimed to improve outcomes for local citizens and either reduce or avoid the need for ongoing care or complement ongoing support.

Please explain how local social care services will be protected within your plans.

Our plans protect local social care services in three main ways:

- Funding for personal budgets/care packages, recognising unavoidable demand and demographic growth;
- Funding increased capacity to meet growing demand for reablement,

telecare, and associated interventions to reduce ongoing demand and cost; and

- Funding increases in capacity/infrastructure to ensure more integrated case management and, crucially, to protect the supply of locally available services.

Given the reductions to local government funding, the Council's previously agreed Medium Term Financial Strategy (4-year budget plan) assumes that £4.5m of NHS to Social Care Grant is used to fund ongoing care packages/personal budgets in 2014/15. The Better Care fund will need to fund the 14/15 level, plus unavoidable demographic/ demand growth in 2015/16.

The table below sets out the level of demographic/demand growth in recent years by care group:

Care Group	Projected annual increases over three years	Spend in 2015/16 a current trend
Older People	5.7%	£900k
Physical Disability and Sensory Impairment	11.6%	£850k
Learning Disability	14.6%	£2,900k
Mental Health	23.0%	£950k

This data will be subject to ongoing review and continue to be openly shared to inform ongoing decisions about the use of the Better Care Fund.

In addition to the direct spend on care set out above, local infrastructure to deliver more integrated case management capacity and safeguarding oversight will also be required.

Enfield has CQC-recognised leading practice in identifying and responding to concerns about the quality of care in local providers. We have seen a significant rise (38%) in safeguarding investigations during 2013/14, with a particular focus on nursing homes. This impacts system capacity both through the potential for increased hospital admissions and a reduction in nursing home capacity to support discharges where restrictions on new care home admissions follow confirmation of safeguarding concerns.

It is therefore proposed that the BCF is used to supplement existing investment in this area to protect the locally available supply of safe and appropriate care in the independent sector and to respond in a timely way to emerging alerts of abuse and/or poor quality care.

Our current planning assumption, based on demand trends, is that reablement capacity will need to be increased 29% over the period during the period 2013-14/2015-16.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The development of the integrated care model includes a commitment to

extended hours in all services within the pathway, with the aim being to facilitate coordinated work through resourcing seven-day working provision for all relevant agencies within this model. It is planned to analyse and model the needs and resources for 7-day working jointly across agencies as part of on-going development of the integrated care, because of the need to ensure proposals represent good value for money through assuring productivity levels during extended working for all agencies.

The more preventative and pro-active approach should allow a more planned approach to assessing individuals and delivering their care across health and social care partners which will mitigate demand for short-term unplanned responses outside of weekdays, e.g. limiting the need for weekend A&E attendance. In turn, this will enable resources to support extended working to be invested in preventative, rather than reactive, solutions to support individuals in the community.

However, the CCG, Council, hospital Trusts and their partners recognised the need for urgent action in Enfield in Winter 2013/14 as it is a Borough with two challenged health economies with high levels of A&E attendances at both Trusts. Partners locally therefore agreed to invest in solutions to support A&E and wider hospital performance that would also be critical elements of new or extended ways of working within the integrated care model with the aim of understanding how a longer-term approach could be embedded across agencies. For example, the social care hospital discharge and enablement teams implemented extended 7-day working to facilitate hospital discharge and help avoid hospital admission during the winter; whilst a RAID model was developed to support individuals with dementia across the hospital discharge process. The effectiveness and efficiency of these solutions will be evaluated post-winter to inform development of integrated care and its costed business case.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Enfield CCG as a commissioner of healthcare services has no legal right to use patient identifiable data, including the NHS number, without relying on a secure legal basis, i.e. patient consent or section 251 approval. However, all clinical services commissioned by the CCG use the standard NHS contract conditions in the NHS Standard Contract for 2013/14 at Section E paragraph 13.4, which requires providers to use the NHS number in accordance with the NPSA guidelines and for it to be part of the Health Record of the Service User and be shared in any medical correspondence in accordance with the law.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please see the previous box.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

In line with NHSE guidance, Enfield CCG is committed to migrating towards the use of open APIs and standards. The CCG and Council will work closely together to ensure that there is a joint approach towards achieving the effective and efficient use of data sharing across the two organisations.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

The Council's Information Governance controls cover operational practice, including joint working with the NHS. Robust IG clauses are included in all contracts with third party providers of social care services and the Enfield Strategic Partnership (ESP) has agreed an Inter-Agency Information Sharing Protocol. The Council's ESP includes local NHS partners. The Council complies with all recommendations in the Caldicott 2 Review, has an N3 connection, and has approved status for v10 of the IG Toolkit for Social Care Delivery (including Public Health). The contract documents used by Enfield CCG to commission clinical services conform to the NHS standard contract requirements for Information Governance and Information Governance Toolkit Requirement 132. Enfield CCG, as a commissioner and to the extent that it operates as a data controller, is committed to maintaining strict IG controls, including mandatory IG training for all staff, and has a comprehensive IG Policy, Framework, IG Strategy and other related policies. Information Governance arrangements and the IG Framework conform to the IG Toolkit requirements in Version 11 of the IG Toolkit, including clinical information assurance as set out in requirement 420 and the requirements for data sharing and limiting use of personal confidential data in accordance with Caldicott 2.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

As part of the development of integrated care, the multi-disciplinary, multi-agency team approach within a primary care setting will jointly determine care needs and coordinate planned solutions with individuals and their carers, with the necessary professional support and resources flexed around personalised needs and preferences. This approach will be under-pinned by IT-enabled information-sharing about individuals to achieve the key principles about care planning identified by National Voices.

Where it makes sense, fully integrated assessment processes will continue as part of a wider approach to integrated care, including assessments associated with hospital discharge planning, Continuing Health Care/Personal Health Budgets or intermediate care/reablement pathway. Intelligence sharing within the MDT approach in integrated care will also enable health and social care to streamline and coordinate their own statutorily-required assessment, review, and care planning arrangements (e.g. social care assessment within the framework of the Community Care Act).

The CCG and Council are committed to the allocation of accountable lead professionals, who will be appointed from different parts of the local health and care system according to patients' and services users' specific circumstances. Allocation will be informed by our developing risk stratification process (see below) and the need for the accountable lead professional to provide the necessary service at the right time and in the right place. Establishing this will involve looking closely at staff skill and qualification levels, so that we can be sure can be sure that staff are allocated in the most efficient way possible, with nursing and other staff from primary care used where their skills are most well suited to need.

The CCG and its partners have implemented a risk stratification tool based on the Combined PARR+ model as part of the integrated care model. This tool allows GPs and the MDTs that support them to view all primary and secondary health and adult social care episodes about patients on their lists, with a focus on those at highest risk. This indicates there are around 7,900 Enfield residents of all ages at "high" or "very high" risk of admission to hospital. The full integrated care model, including risk stratification, has only recently been introduced, and the CCG and its partners are currently establishing a baseline for the number of people that would benefit from a joint approach to care planning, as well as who is the most suitable lead professional. The CCG and Council are currently working with their risk stratification tool supplier to develop another care data-driven algorithm. Its purpose is to better identify those patients with frailties who are at risk of needing repeat hospitalisation or intensive social care, but who may not yet have a "high-risk" combined PARR+ tool to improve the effectiveness of preventative intervention.

It is also estimated there are 2,750 older people with dementia, with 1,250 with advanced dementia, in Enfield. At 48%, diagnosis rates are in line with the national average, but clearly need to improve, and partners believe risk stratification tools can facilitate this.

As the government has determined, there will be a specific focus during 2014-15 on patients aged 75 and over and those with complex needs. The new GP contract secures specific arrangements for all patients aged 75 and over to have an accountable GP and, for those who need it, a comprehensive and co-

ordinated package of care.

Our expectation is that similar arrangements will apply to increasing numbers of people with long-term conditions in future years. Enfield CCG will support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. The CCG will also provide additional funding to commission additional services that practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. In some instances, practices may propose that this new funding be used to commission new general practice services that go beyond what is required in the GP contract and the new enhanced service.

The CCG will also work with practices to make sure that their plans are complementary to other initiatives through the Better Care Fund, as described in this document.

2) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
Information sharing arrangements to provide accurate/timely information is not robust resulting in low referral rates to MDTs and OPAUs	High amber	3	4	12	• Information Sharing protocols in place • NHS No used as common identifier across all parties • Risk Stratification project in train	• Access to Case finding tool to be provided to OPAUs • Performance Framework to be agreed and implemented to monitor outcomes • Contract with existing provider of RS tool for 2/3 year period with ongoing development work of further case-finding tools
Failure to manage increasing demand for services through prevention/community services	Red	3	5	15	• Council & CCG planning & savings work predicated on change of focus away from reactive to proactive interventions • OPAUs & MDTs established to do preventative work • Business plans & Strategies across joint areas agreed or in process with a greater focus on early intervention and support in the community	• Development of the BCF plan across partnerships with shared priorities
Need to deliver savings drives disinvestment &	Amber	3	4	12	• Early and broad engagement with providers and	• Alignment of savings and investment plans through agreement

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
creates viability & sustainability issues for providers					organisations engaged in health and social care • Monitor of impact of Savings Plans on providers • Impact of plans on quality of service delivery monitored	of BCF plan and priorities within the H&WB strategy to be delivered
Failure to agree strategic redirection of resources to meet the objectives within the BCF plan with resultant impact on commissioning decisions, investment decisions across health & social care	High Amber	3	5	15	• Health & Wellbeing Board strategic partnership • Development of robust business cases to support investment and disinvestment decisions • Agreement of strategic priorities within the BCF plan	• Further development of integrated service delivery projects with robust evidence base to measure success
Community/ primary service capacity and quality insufficient resulting in increased demand for crisis services (residential/hospital services)	High Amber	3	5	15	As above	As above
Change risks						
Transition hiatus between existing and new model of services leads to risks related to quality and safety	High amber	3	5	15	• The development of the BCF and strategic plan have been used as a key means to forward plan in detail • Accountability to H&WB board as well as internal governance boards	• A robust performance and quality outcomes framework needs to be developed to monitor outputs and quality of outcomes
Moving effectively from a focus on "services" to a focus on the "whole system"	High amber	3	5	15	• Work on jointly developed commissioning priorities and value based commissioning supports this • Accountability to H&WB board as well as internal governance boards	• A performance framework which captures a more holistic view of people's journey through the care and support systems • A programme of culture shift to support education and change in practice across all partners
The scale and pace of the change required with risk of increase in	High amber	3	5	15	• Review of quality and Safeguarding arrangements in place to respond to and learn from any	• Development of a Multi Agency Safeguarding Hub (MASH) to deliver a more joined up

Risk	Risk rating	Likelihood	Impact	Risk rating	Mitigating Actions	Further Actions
number of SUIs and safeguarding referrals across the partnership					issues that arise • Accountability to H&WB board as well as internal governance boards • Review of existing resource capacity to deal with SUIs and Safeguarding referrals	approach to safeguarding and SUIs
Organisational risks						
Staff within partnership organisations do not receive sufficient support to manage the change with resultant impact on morale and service delivery	High amber	3	5	15	• Workforce strategies across partners need to take into account change requirements	• High level strategic intentions need to translate into practical system, practice and process change support for staff delivering the change • Service & team plans reflect high level priorities
London local elections in May 2014 - risk of programme delay in the event of political leadership changes	Amber	3	3	9	• Cross-party member briefings have taken place about this plan and the wider Health and Wellbeing Strategy	
Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs	High amber	3	4	12	• Appropriate governance structures in place • Provision of regular, timely and accurate information to support monitoring of services	

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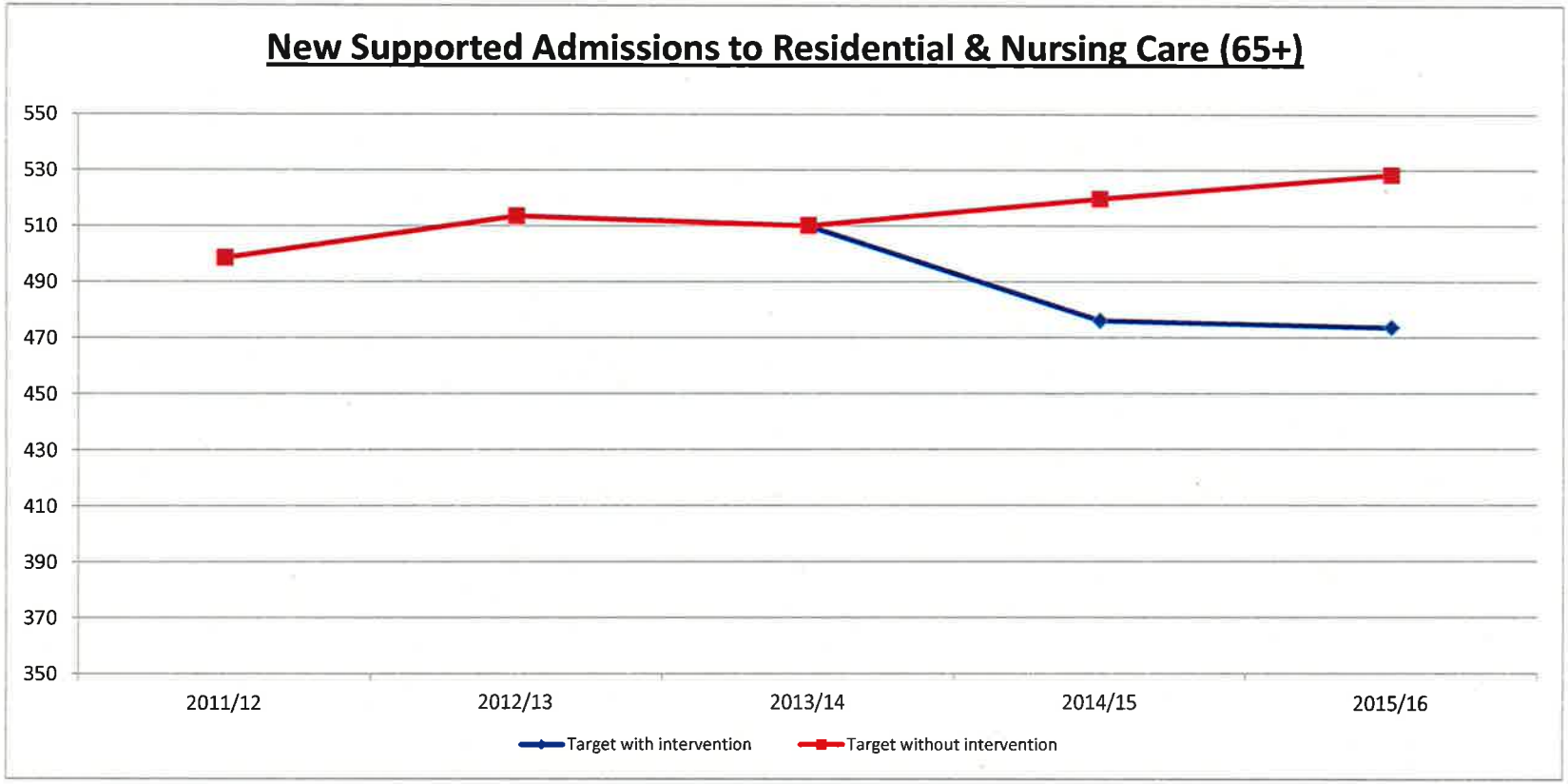
Current Performance & Targets

Indicator	2011/12	2012/13	London 2012/13	London Rank 2012/13	National 2012/13	Target 2013/14	2013/14 Q1	2013/14 Q2	2013/14 Q3	2013/14 Q4	Target 2014/15	Target 2015/16
Admissions to residential and nursing care (aged 65 years and over) per 100,000 population	498.5	513.5	493.6	19/32	676.8	512	124.3	261.8			476.12	473.63

	2011/12	2012/13	2013/14	2014/15	2015/16
Target with intervention	498.5	513.5	510	476.12	473.63
Target without intervention	498.5	513.5	510	520	528



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Agenda Item 6

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE **Health and Wellbeing Board** **13 February 2014**	**Agenda - Part: 1** | **Item: 4** **Subject:** **Enfield's Homelessness Strategy 2013-2018** **Wards:** All
Director of Health Housing and Adult Social Care **Contact officer and telephone number:** Sally McTernan AD Community Housing Services Tel: 020 8379 4465 Email sally.mcternan@enfield.gov.uk	**Cabinet Member consulted:** Councillor Ahmet Oykener, Lead Member for Housing and Area Improvement

1. EXECUTIVE SUMMARY

Enfield Council approved a new five year Homelessness Strategy at Cabinet in December 2013.

As a Strategic Housing Authority, it is a legal requirement for the Council to carry out a Homelessness Review and formulate a strategy based on the results of the review which includes plans for:

- Preventing homelessness
- Ensuring sufficient accommodation is available for people who are, or who may become homeless
- Ensuring there are satisfactory support services for people who are, or may become homeless, or who need support to prevent them from becoming homeless again

Enfield's Homelessness Strategy plays an essential part in delivering aspects of Enfield's 15 Year Housing Strategy which was agreed by Cabinet in July 2012.

It also underpins a key priority and area of work for Enfield on tackling and preventing homelessness in the borough which requires considerable and continuing resources and strong collaboration with a wide range of partner organisations

A copy of the Report presented to Cabinet in December 2013 and a copy of Enfield's agreed Homelessness Strategy and Action Plan are attached to this report.

2. RECOMMENDATIONS

That the Health & Wellbeing Board note Enfield's five year Homelessness Strategy and Action Plan for 2013-2018.

3. BACKGROUND

3.1 Reasons for Having a Homelessness Strategy

The Homelessness Act 2002 requires housing authorities to carry out a Homelessness Review and formulate a strategy based on the results of the review that includes plans for:

- Preventing homelessness
- Ensuring sufficient accommodation is available for people who are, or who may become homeless
- Ensuring there are satisfactory support services for people who are, or may become homeless, or who need support to prevent them from becoming homeless again

Enfield's new 5 year Homelessness Strategy plays an essential part in delivering aspects of Enfield's 15 year Housing Strategy agreed by Cabinet in 2012. It also underpins a key priority and area of work for Enfield on tackling and preventing homelessness in the borough which requires considerable and continuing resources. Enfield's Homelessness strategy sets out the Council and it's partner's plans to prevent and address homelessness in the borough

3.2 How Enfield developed its Homelessness Strategy

Enfield's Homelessness Strategy has been developed using findings from a comprehensive Review of homelessness undertaken between January-June 2013. This involved:

- Setting up a Homelessness Strategy Steering Group made up of statutory, private sector and voluntary organisations to oversee the Review and development of the strategy.
- Setting up a Homelessness Operational Steering Group to involve front-line staff in shaping and developing the Homelessness Strategy.
- Consultation and involvement with a wide range of stakeholders, including private and voluntary sector partners, Council Members, local residents, service users and staff
- A review and evaluation of outcomes from the previous homelessness strategy and action plan 2008-2013
- A review of statistical data and trends about homelessness.
- Analysis of recent Census data to understand the demographics and potential growth in population in Enfield for the future.
- Comparing Enfield's performance against best practise and other Local Authorities performance.
- Writing the Strategy and producing a detailed 5 year action plan.

3.3 Key issues identified from Enfield's Homelessness Review

3.3.1 Partnership Working

Effectively preventing and reducing homelessness in Enfield relies upon the council working with a wide range of partners. Our partner's commitment to our ambitions and a willingness to play their part are essential to the success of addressing homelessness in the borough. Pooling knowledge, resources and expertise has never been more important in the current economic climate with resources being stretched.

3.3.2 Changes in Government Policy

Enfield's Homelessness Strategy has been developed at a time of significant change to national policy relating to welfare and social housing reform. Two key changes in government policy are now driving the context in which homeless services are provided:

Welfare reform Act 2012 - key changes are:

- Caps on welfare benefit so that working age households can no longer receive more than a total in benefits per week of £500 for a family and £350 for a single person or couple without children
- Council Tax Local Support Scheme, requiring all working age claimants to pay something towards council tax
- Bedroom Tax, any working age claimant in social rented housing will no longer receive housing benefit for a spare room.

The Localism Act 2011 - Key changes are:

- Discharge of the main homelessness duty with an offer of a suitable home in the private rented sector.
- Greater flexibility for Council's to decide who can apply to their housing register to obtain social rented housing.
- Reduced funding for Registered Providers to build affordable new homes.
- Flexibility for Housing Providers to use shorter fixed term tenancies and the Affordable Rent Model.[1]

3.3.3 The Economic downturn

The impact of the economic downturn on Enfield has been:

- Increased deprivation in the area, Enfield has risen six places in the last 5 years to 64th[2] most deprived local authority in England
- Increased levels of un-employment, figures for 2012 showed Enfield has the fifth lowest employment rate in London and above average increases in all the main working age benefits since 2008

[1] Ability to charge rent up to 80% of the local market rents
[2] Index of multiple deprivation figures

- Reduced income levels both earned and from welfare benefits
- Increased inability to access affordable housing options

3.3.4 Changes in the local housing market

An understanding of the housing markets in Enfield and the changes happening within them is important for addressing homelessness. Enfield's homelessness review found the following facts about Enfield's local housing market:

- Social rented homes in Enfield are in very short supply. The Council let 693 Council and housing association homes in 2012/13[3]. Enfield's Lettings Forecast predicted 568 will become available for letting in 2013/14
- Under the Government's Affordable Homes Programme 2011-15, there are no new 'handovers' of housing association homes to be let on social rent terms planned in Enfield beyond 2013/14[4].
- Owner occupation in Enfield has seen a significant decline. The high cost of home ownership has made it increasingly difficult for local people to buy somewhere to live with prices rising faster than earnings. Many of those who would have bought now rent
- There has been dramatic growth in Enfield's private rented sector over the last decade. Rents are escalating and demand is outgrowing supply. Reasons for increasing demand and supply include:
  - Low levels of social rented homes becoming available for letting so households who expected a home in the social rented sector are looking to the private rented sector instead.
  - Competing claims across the sector, e.g. other Authorities with larger budgets outbidding for the supply
  - Landlords withdrawing from letting homes to benefit dependent households due to Government changes to reduce the LHA and reform to welfare benefits

3.3.5 Changing reasons for homelessness acceptances

Under the Homelessness Law, the main reason for homeless acceptances has changed in Enfield during the last five years, from family or friend ejection, to the loss of private rented accommodation.

A summary of Enfield's Homelessness Review is available in the Member's library and on the Council's website.

3.4 Challenges for Enfield in Addressing Homelessness

3.4.1 Sustaining the involvement of Partners

It is essential that partners ensure homelessness and their role in helping to manage it in Enfield becomes and remains a priority for them. The challenge for the Council will be to obtain and sustain the involvement of partners in preventing

[3] Breakdown of lettings: Council General Needs: 392; Council sheltered: 93; Housing association: 208
[4] Enabling Programme Outcomes 2008/13 – Enabling Team 21/6/13

and tackling homelessness in Enfield, whilst recognising the pressures they face and the differences in our respective roles and responsibilities.

3.4.1 An increased demand for housing options and advice services

After declining for many years, the number of homeless acceptances and homeless decisions in Enfield has risen; this has led to a significant increase in demand for Enfield's housing options and advice services for homeless households or those threatened with homelessness covering:

- Sustaining tenancies in the private rented sector
- Assisting households with care and support needs
- Preventing increased street homelessness

3.4.2 The lack of affordable, good quality private rented homes in Enfield to meet the increased demand from those in housing need.

It has become far more difficult for Enfield to source good quality, affordable local homes for:

- Preventing homelessness
- Discharging Enfield's legal duty to provide housing for homeless households
- Maintaining Enfield's emergency housing portfolio for homeless households

3.4.4 The impact of a shortage of Council and Housing Association Homes for letting

The serious shortage of council and housing association homes to meet housing need has resulted in the Council having to prioritise who is allocated the homes available. The current housing priorities for the Council are:

- rehousing tenants living in homes that are included in the Council's Estate Renewal programme and
- Housing homeless households living in expensive emergency accommodation prior to 9/11/12 who are owed a housing duty by the Council.

The remaining homes are prioritised for those with high care and support needs, which means:

- Those without high care and support needs will find themselves renting from a private landlord and will need to consider alternative affordable housing options.
- It will take longer to house homeless households placed in Enfield's emergency housing before 9/11//12 who are owed a full housing duty by the Council

3.4.5 Engaging effectively with residents about the changes and how Enfield can assist.

Enfield's Homelessness Strategy has been developed at a time of unprecedented welfare and housing policy change, the changes and their impact need to be communicated effectively to local people and the organisations that work with and support them. We need to continue to assess the impact of the changes on service users and plan services accordingly

3.4.6 Continuing to provide an effective and value for money housing options and advice service.

Making best use of Council money and partnership working is key to successfully achieving value for money housing options and advice service in Enfield. In a climate of increased demand for services, increased costs of homelessness and cuts to public spending it is ever more challenging to continue to provide effective and value for money services, making it essential to share knowledge, expertise and pool resources with partners to meet that challenge

3.5 Enfield's Vision for preventing and tackling homelessness

Extensive external consultation took place on the following vision for preventing and tackling homelessness which is set out below:

Eliminate homelessness in the borough and enable people to make their own informed choices for housing that they can afford

3.6 Enfield's Ambitions for its Homelessness Strategy

Enfield's Homelessness Review identified that the five key ambitions from Enfield's Homelessness Strategy 2008 – 2013 are still relevant. The wording of these ambitions were refined and consulted on at the same time as the vision above.

Ambition 1	Preventing homelessness in Enfield and enabling households to find homes they can afford
Ambition 2:	Securing adequate accommodation to meet the needs of homeless households and those at risk of homelessness.
Ambition 3:	Enabling those with assessed support needs to live independently in their own homes and safeguard those who cannot
Ambition 4:	Providing an excellent standard of customer service
Ambition 5:	Ensure best use of public money and other resources

3.7 Consultation

Two rounds of consultation were undertaken to inform the development of Enfield's Homelessness Strategy. A summary of survey questions

and responses is available in the member's library and on the Council's Website.

3.8 Action Plan

Enfield's Homelessness Strategy contains a comprehensive Action Plan, setting out Enfield's key priorities for achieving the ambitions identified from the review. It is envisaged that as Enfield's Action Plan is implemented and work with our partners continues, it will be subject to change and update.

4. ALTERNAFTIVE OPTIONS CONSIDERED

No alternative options were considered as it is a statutory requirement for every local authority to publish a Homelessness Strategy every 5 years

5. REASONS FOR RECOMMENDATIONS

It is imperative that at this time of unparalleled national policy change and Government financial austerity measures, the strategic direction is clearly set out by Enfield Council and its Partners for preventing and tackling homelessness in the borough, and that it is endorsed by Cabinet to demonstrate Enfield's corporate commitment to addressing homelessness in Enfield.

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

6.1 Financial Implications

Enfield's homelessness strategy includes a comprehensive action plan, setting out Enfield's key priorities for achieving the ambitions identified above. Finance was presented with an action plan which shows that all actions will be funded within existing Community Housing resources plus an additional £3.329m available to the service in 2014/15 through the Council's MTFP.

Where additional resources are required, the service will approach other groups, RSL partners, and the HRA for further funding to enable the action plan to be achieved.

6.2 Legal Implications

By the Homelessness Act 2002 section 1, housing authorities were required to carry out a homelessness review and devise and publish a strategy based on the review. By sections 1(3) and (4), the first such strategy had to be drawn up within a year of the section coming into force and thereafter at least every five years.

A homelessness strategy is defined at section 3(1) as one formulated in order to:

a) Prevent homelessness in an authority's area;

b) Secure that accommodation is and will be available in that area for people who are or may become homeless; and
c) Provide support for such people or those who have been homeless and need support to prevent it recurring.

There is no legal requirement that specific objectives or plans should be included in the strategy as such matters are left to the discretion of the Authority. However authorities must when formulating or modifying a homelessness strategy have regard to its current allocation scheme, its current tenancy strategy, the current London housing strategy and equalities issues.

6.3 Property Implications

None

7. KEY RISKS

Any risks identified when implementing the Strategy and Action Plan will be managed through existing departmental risk management arrangements.

8. IMPACT ON COUNCIL PRIORITIES

8.1 Fairness for All

Enfield's Homelessness Strategy is based on intelligence obtained from the Homelessness Review, including demographic and homeless trends in Enfield. The Homelessness Strategy and its associated action plan were developed from this intelligence and aim to ensure the fair provision of homelessness services targeted to the individual needs of homeless households and those threatened with homelessness.

8.2 Growth and Sustainability

Enfield's Homelessness Strategy supports national and local priorities for addressing worklessness, and encourages partnership working to assist homeless households in the borough with training and employment opportunities

The Strategy also provides business opportunities and support for local private sector housing providers.

Enfield's Homeless Strategy also seeks to improve on existing partnership arrangements with the voluntary and community sector, to ensure that there is an adequate range of homelessness prevention, advice and support services available for the whole community

8.3 Strong Communities

Enfield's Homelessness Strategy is committed to providing services that have regard to a household's contribution to the community through

employment or voluntary work particularly when making decisions around suitability of accommodation or the location of any accommodation provided

9. EQUALITIES IMPACT IMPLICATIONS

A full predictive equality impact assessment has been carried out on the proposed Homelessness Strategy, and is available for inspection. Consultation has been undertaken with a wide range of stakeholders including partners in the private and voluntary sector, Members, residents, service users, homeless households in temporary accommodation and staff. As a result, the Action Plan within the Strategy sets out a range of measures for tackling homelessness in Enfield through providing positive interventions and promoting the inclusion of all disadvantaged groups. No adverse impact is envisaged**.**

10. PERFORMANCE MANAGEMENT IMPLICATIONS

A performance management framework is in place to monitor outcomes from the work of Enfield's Homelessness Services.

Enfield's Homelessness Strategy Action Plan will be kept under review with outcomes reported to Enfield's Housing Strategic Partnership annually.

11. HEALTH AND SAFETY IMPLICATIONS

None

12. HR IMPLICATIONS

None

13. PUBLIC HEALTH IMPLICATIONS

Enfield's homelessness strategy supports the national and corporate commitment to reducing inequality in health outcomes for homeless households. Housing is one of the greatest determinants of life-expectancy and potentially health inequality. Life expectancy for the homeless is less than 50 yrs of age[5], which is more than a third lower than the borough average. This strategy aims to prevent and reduce homelessness and to support those who either become or are in danger of becoming homeless. The success of the strategy will be monitored but it is expected that it will contribute to maintaining or improving public health

Background Papers
None

[5] Information provided by Glenn Stewart, Public Health

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MUNICIPAL YEAR 2013/2014 REPORT NO.

MEETING TITLE AND DATE:
Cabinet
11 December 2013

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

Contact officer and telephone Number:
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Agenda – Part:	**Item:**
Subject: Enfield's Homelessness Strategy 2013-2018 **Wards: All** **Key Decision No: KD 3822**	
Cabinet Member consulted: **Cllr Oykener**	

1. EXECUTIVE SUMMARY

1.1 It is a legal requirement under the Homelessness Act 2002 for local authorities to carry out a Homelessness Review and formulate a Homelessness Strategy based on the results of the review every five years.

1.2 Enfield's new 5 year Homelessness Strategy underpins a key priority and area of work for Enfield on tackling and preventing homelessness in the borough which requires considerable and continuing resources.

1.3. Enfield's Homelessness Strategy sets out the intentions of the Council and its partners to prevent and address homelessness in the borough.

1.4 Information is provided in this report on:

- Why a new Homelessness Strategy is needed
- How a new one has been developed
- The key issues arising from Enfield's Homelessness Review
- The key issues and challenges for Enfield in addressing homelessness
- The Vision, Ambitions and Action Plan for Enfield's new Homelessness Strategy

2. RECOMMENDATIONS

- The report requests Cabinet approval for the Council's Homelessness Strategy 2013-2018 and Action Plan

3. BACKGROUND

3.1 Reasons for Having a Homelessness Strategy

The Homelessness Act 2002 requires housing authorities to carry out a Homelessness Review and formulate a strategy based on the results of the review that includes plans for:

- Preventing homelessness
- Ensuring sufficient accommodation is available for people who are, or who may become homeless
- Ensuring there are satisfactory support services for people who are, or may become homeless, or who need support to prevent them from becoming homeless again

Enfield's new 5 year Homelessness Strategy plays an essential part in delivering aspects of Enfield's 15 year Housing Strategy agreed by Cabinet in 2012. It also underpins a key priority and area of work for Enfield on tackling and preventing homelessness in the borough which requires considerable and continuing resources. Enfield's Homelessness strategy sets out the Council and it's partner's plans to prevent and address homelessness in the borough

3.2 How Enfield developed its Homelessness Strategy

Enfield's Homelessness Strategy has been developed using findings from a comprehensive Review of homelessness undertaken between January-June 2013. This involved:

- Setting up a Homelessness Strategy Steering Group made up of statutory, private sector and voluntary organisations to oversee the Review and development of the strategy.
- Setting up a Homelessness Operational Steering Group to involve front-line staff in shaping and developing the Homelessness Strategy.
- Consultation and involvement with a wide range of stakeholders, including private and voluntary sector partners, Council Members, local residents, service users and staff
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- Analysis of recent Census data to understand the demographics and potential growth in population in Enfield for the future.

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- There has been dramatic growth in Enfield's private rented sector over the last decade. Rents are escalating and demand is outgrowing supply. Reasons for increasing demand and supply include:
  - Low levels of social rented homes becoming available for letting so households who expected a home in the social rented sector are looking to the private rented sector instead.
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[2] Index of multiple deprivation figures
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Under the Homelessness Law, the main reason for homeless acceptances has changed in Enfield during the last five years, from family or friend ejection, to the loss of private rented accommodation.

A summary of Enfield's Homelessness Review is available in the Member's library and on the Council's website.

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3.4.1 Sustaining the involvement of Partners

It is essential that partners ensure homelessness and their role in helping to manage it in Enfield becomes and remains a priority for them. The challenge for the Council will be to obtain and sustain the involvement of partners in preventing and tackling homelessness in Enfield, whilst recognising the pressures they face and the differences in our respective roles and responsibilities.

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After declining for many years, the number of homeless acceptances and homeless decisions in Enfield has risen; this has led to a significant increase in demand for Enfield's housing options and advice services for homeless households or those threatened with homelessness covering:

- Sustaining tenancies in the private rented sector
- Assisting households with care and support needs
- Preventing increased street homelessness

3.4.2 The lack of affordable, good quality private rented homes in Enfield to meet the increased demand from those in housing need.

It has become far more difficult for Enfield to source good quality, affordable local homes for:

- Preventing homelessness
- Discharging Enfield's legal duty to provide housing for homeless households
- Maintaining Enfield's emergency housing portfolio for homeless households

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The serious shortage of council and housing association homes to meet housing need has resulted in the Council having to prioritise who is allocated the homes available. The current housing priorities for the Council are:

- rehousing tenants living in homes that are included in the Council's Estate Renewal programme and
- Housing homeless households living in expensive emergency accommodation prior to 9/11/12 who are owed a housing duty by the Council.

The remaining homes are prioritised for those with high care and support needs, which means:

- Those without high care and support needs will find themselves renting from a private landlord and will need to consider alternative affordable housing options.
- It will take longer to house homeless households placed in Enfield's emergency housing before 9/11//12 who are owed a full housing duty by the Council

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Enfield's Homelessness Strategy has been developed at a time of unprecedented welfare and housing policy change, the changes and their impact need to be communicated effectively to local people and the organisations that work with and support them. We need to continue to assess the impact of the changes on service users and plan services accordingly

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Making best use of Council money and partnership working is key to successfully achieving value for money housing options and advice service in Enfield. In a climate of increased demand for services, increased costs of homelessness and cuts to public spending it is ever more challenging to continue to provide effective and value for money services, making it essential to share knowledge, expertise and pool resources with partners to meet that challenge

3.5 Enfield's Vision for preventing and tackling homelessness

Extensive external consultation took place on the following vision for preventing and tackling homelessness which is set out below:

Eliminate homelessness in the borough and enable people to make their own informed choices for housing that they can afford

3.6 Enfield's Ambitions for its Homelessness Strategy

Enfield's Homelessness Review identified that the five key ambitions from Enfield's Homelessness Strategy 2008 – 2013 are still relevant. The wording of these ambitions were refined and consulted on at the same time as the vision above.

Ambition 1	Preventing homelessness in Enfield and enabling households to find homes they can afford
Ambition 2:	Securing adequate accommodation to meet the needs of homeless households and those at risk of homelessness.
Ambition 3:	Enabling those with assessed support needs to live independently in their own homes and safeguard those who cannot
Ambition 4:	Providing an excellent standard of customer service
Ambition 5:	Ensure best use of public money and other resources

3.7 Consultation

Two rounds of consultation were undertaken to inform the development of Enfield's Homelessness Strategy. A summary of survey questions and responses is available in the member's library and on the Council's Website.

3.8 Action Plan

Enfield's Homelessness Strategy contains a comprehensive Action Plan, setting out Enfield's key priorities for achieving the ambitions identified from the review. It is envisaged that as Enfield's Action Plan is implemented and work with our partners continues, it will be subject to change and update.

4. ALTERNAFTIVE OPTIONS CONSIDERED

No alternative options were considered as it is a statutory requirement for every local authority to publish a Homelessness Strategy every 5 years

5. REASONS FOR RECOMMENDATIONS

It is imperative that at this time of unparalleled national policy change and Government financial austerity measures, the strategic direction is clearly set out by Enfield Council and its Partners for preventing and tackling homelessness in the borough, and that it is endorsed by Cabinet to demonstrate Enfield's corporate commitment to addressing homelessness in Enfield.

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

6.1 Financial Implications

Enfield's homelessness strategy includes a comprehensive action plan, setting out Enfield's key priorities for achieving the ambitions identified above. Finance was presented with an action plan which shows that all actions will be funded within existing Community Housing resources plus an additional £3.329m available to the service in 2014/15 through the Council's MTFP.

Where additional resources are required, the service will approach other groups, RSL partners, and the HRA for further funding to enable the action plan to be achieved.

6.2 Legal Implications

By the Homelessness Act 2002 section 1, housing authorities were required to carry out a homelessness review and devise and publish a strategy based on the review. By sections 1(3) and (4), the first such strategy had to be drawn up within a year of the section coming into force and thereafter at least every five years.

A homelessness strategy is defined at section 3(1) as one formulated in order to:

a) Prevent homelessness in an authority's area;
b) Secure that accommodation is and will be available in that area for people who are or may become homeless; and
c) Provide support for such people or those who have been homeless and need support to prevent it recurring.

There is no legal requirement that specific objectives or plans should be included in the strategy as such matters are left to the discretion of the Authority. However authorities must when formulating or modifying a homelessness strategy have regard to its current allocation scheme, its current tenancy strategy, the current London housing strategy and equalities issues.

6.3 Property Implications

None

7. KEY RISKS

Any risks identified when implementing the Strategy and Action Plan will be managed through existing departmental risk management arrangements.

8. IMPACT ON COUNCIL PRIORITIES

8.1 Fairness for All

Enfield's Homelessness Strategy is based on intelligence obtained from the Homelessness Review, including demographic and homeless trends in Enfield. The Homelessness Strategy and its associated action plan were developed from this intelligence and aim to ensure the fair provision of homelessness services targeted to the individual needs of homeless households and those threatened with homelessness.

8.2 Growth and Sustainability

Enfield's Homelessness Strategy supports national and local priorities for addressing worklessness, and encourages partnership working to assist homeless households in the borough with training and employment opportunities

The Strategy also provides business opportunities and support for local private sector housing providers.

Enfield's Homeless Strategy also seeks to improve on existing partnership arrangements with the voluntary and community sector, to ensure that there is an adequate range of homelessness prevention, advice and support services available for the whole community

8.3 Strong Communities

Enfield's Homelessness Strategy is committed to providing services that have regard to a household's contribution to the community through employment or voluntary work particularly when making decisions around suitability of accommodation or the location of any accommodation provided

9. EQUALITIES IMPACT IMPLICATIONS

A full predictive equality impact assessment has been carried out on the proposed Homelessness Strategy, and is available for inspection. Consultation has been undertaken with a wide range of stakeholders including partners in the private and voluntary sector, Members, residents, service users, homeless households in temporary accommodation and staff. As a result, the Action Plan within the Strategy sets out a range of measures for tackling homelessness in Enfield through providing positive interventions and promoting the inclusion of all disadvantaged groups. No adverse impact is envisaged**.**

10. PERFORMANCE MANAGEMENT IMPLICATIONS

A performance management framework is in place to monitor outcomes from the work of Enfield's Homelessness Services.

Enfield's Homelessness Strategy Action Plan will be kept under review with outcomes reported to Enfield's Housing Strategic Partnership annually.

11. HEALTH AND SAFETY IMPLICATIONS

None

12. HR IMPLICATIONS

None

13. PUBLIC HEALTH IMPLICATIONS

Enfield's homelessness strategy supports the national and corporate commitment to reducing inequality in health outcomes for homeless households. Housing is one of the greatest determinants of life-expectancy and potentially health inequality. Life expectancy for the homeless is less than 50 yrs of age[5], which is more than a third lower than the borough average. This strategy aims to prevent and reduce homelessness and to support those who either become or are in danger of becoming homeless. The success of the strategy will be monitored but it is expected that it will contribute to maintaining or improving public health

Background Papers
None

[5] Information provided by Glenn Stewart, Public Health

Enfield's Homelessness Strategy 2013 – 2018

CONTENTS

EXECUTIVE SUMMARY

Introduction

Welcome to Enfield's Homelessness Strategy 2013 – 2018, which sets out the Council's plans, in collaboration with our partners, for effectively tackling homelessness in the borough, over the next 5 years.

Key to addressing homelessness in Enfield is maximising the supply of homes for local people and making best use of Enfield's existing housing stock. These are important corporate priorities. Our plans are set out in more detail in Enfield's Housing Strategy and will evolve in response to changing circumstances. Our plans include:

- utilising Enfield Councils Investment Partner Status to compete for more funding to build council homes
- actively maximising the development of council owned land, including small sites and garages as well as using other innovative approaches to increase the supply of homes
- joint working with our partner Housing Associations to develop new housing supply

This summary covers:

- Why Enfield has a Homelessness Strategy
- How Enfield's Homelessness Strategy was developed
- Key issues identified in Enfield's Review of homelessness
- Key challenges in addressing homelessness
- Enfield's Homelessness Strategy: Vision and Ambitions
- The structure and content of Enfield's Homelessness Strategy

Why Enfield has a Homelessness Strategy

It is a legal duty to have a Homelessness Strategy housing authorities are required to carry out a Homelessness Review and formulate a strategy based on the results of the review that includes plans for:

- Preventing homelessness
- Ensuring sufficient accommodation is available for people who are, or who may become homeless
- Ensuring there are satisfactory support services for people who are, or may become homeless, or who need support to prevent them from becoming homeless again

Enfield's new 5 year Homelessness Strategy plays an essential part in delivering aspects of Enfield's 15 year Housing Strategy agreed by Cabinet in 2012. It also underpins a key priority and area of work for Enfield on tackling and preventing homelessness in the borough which requires considerable and continuing resources.

How Enfield developed its Homelessness Strategy

Enfield's Homelessness Strategy 2013-2018 has been developed using findings from a comprehensive Review of homelessness undertaken between January-June 2013.

This involved:

- Setting up a multi-agency Homelessness Strategy Steering Group and a Homelessness Operational Steering Group of front-line staff to oversee the Review and development of the strategy.
- Consultation and involvement with a wide range of stakeholders –
- A review and evaluation of outcomes from Enfield's previous Homelessness Strategy and Action Plan 2008-2013
- A review of statistical data and trends about homelessness in Enfield
- Analysis of Census data
- Comparing Enfield's performance against best practise and other Local Authorities performance.
- Writing the Strategy and producing a detailed 5 year Action Olan.

A summary of Enfield's Review of Homelessness and outcomes from the consultation are can be found on the Council's website.

Key Issues identified within Enfield's Homelessness Review

Enfield's Homelessness Review undertaken between January – June 2013 identified a number of issues that have an impact on homelessness or the way homelessness is addressed they include:

- **Partnership Working**

Effectively preventing and reducing homelessness in Enfield relies upon the council working with a wide range of partners, pooling knowledge, resources and expertise has never been more important in the current economic climate with resources being stretched.

- **Changes in Government Policy**

Two key changes in government policy are now driving the context in which homeless services are provided:

Welfare reform: key changes are:

- Caps on welfare benefits so that working age households can no longer receive more than a total in benefits per week of £500 for a family and £350 for a single person or couple without children
- Council Tax Local Support Scheme requiring all working age claimants to pay something towards Council Tax
- The spare room subsidy or "Bedroom Tax" which means any working age claimant in social rented housing no longer receive housing benefit for a spare room.

The Localism Act 2011: key changes are:

- Discharge of the main homelessness duty with an offer of a suitable home in the private rented sector.
- Greater flexibility for the Council to decide who can apply for their housing register to obtain social rented housing.
- Reduced funding for Registered Providers to build affordable new homes.
- Flexibility for Housing Providers to use shorter fixed term tenancies and the Affordable Rent Model.[1]

- **The Economic downturn**

Has led to increased deprivation in the area, increased levels of un-employment, reduced income levels and an increased inability to access affordable housing options

- **Changes in the Local Housing Market**

An understanding of the housing markets in Enfield and the changes happening within them is important for addressing homelessness. The review identified:

  - Social rented homes in Enfield are in very short supply.
  - Under the Government's Affordable Homes Programme 2011-15, the supply of new homes people can afford has diminished
  - The high cost of home ownership has made it increasingly difficult for people to buy somewhere to live with prices rising faster than earnings
  - Over the last decade there has been dramatic growth in Enfield's private rented sector, rents are increasing and demand is outgrowing supply.

Private Rented Sector demand and rents are increasing because other London local authorities are using larger budgets to outbid each other for the supply. There is a reduction in private rented lettings for benefit dependent households arising from government changes to welfare benefits and high cost of home ownership producing a new market of professional people who now rent because they cannot afford to buy.

[1] Ability to charge rent up to 80% of the local market rents

- **Changing Reasons for Homelessness Acceptances[2] by Enfield Council**

The main reason for homelessness has changed in Enfield over the past five years. Loss of private rented accommodation has become the main reason replacing family/ friend ejection.

Key Challenges for Enfield in Addressing Homelessness

- Dealing with the increased demand for Enfield's homelessness services
- A lack of affordable, quality private rented homes in Enfield for responding to the increased demand for affordable housing inside and outside of the borough
- Improving standards of management within Enfield's private rented sector.
- Managing the impact of a shortage of Social rented homes, re-prioritising who is allocated the social rented homes available:
    - Tenants living on Council's Estates in the Renewal programme
    - homeless households living in expensive emergency accommodation prior to 9/11/12, owed a full housing duty by the council
    - those with high care and support needs,
- Maintaining a balanced portfolio of emergency accommodation to meet the needs of Enfield's homeless households
- Finding ways to maintain effective homeless services in a climate of budget cuts and limited resources
- Communicating the many changes impacting on homelessness and the way we have to provide homeless services in the future with Enfield's stakeholders
- Sustaining the involvement of Partners in addressing homelessness

Enfield's Homelessness Strategy: Vision and Ambitions

- **Enfield's Vision**

Outcomes from the homelessness review and consultation have resulted in a new vision for preventing and tackling homelessness which is set out below:

[2] Acceptances – households who Enfield owes a full housing duty to under the homelessness legislation

Eliminate homelessness in the borough and enable people to make their own informed choices for housing they can afford.

- **Enfield's Ambitions**

Enfield's Homelessness Review identified that the five key ambitions from Enfield's Homelessness Strategy 2008 – 2013 are still relevant and in this strategy they have been refined.

Our ambitions are:

Ambition 1:	Preventing homelessness in Enfield and enabling households to find homes they can afford
Ambition 2:	Securing adequate accommodation to meet the needs of homeless households and those at risk of homelessness
Ambition 3:	Provide the relevant support to enable households with assessed support needs to live independently in their own home
Ambition 4:	Providing an excellent standard of customer service
Ambition 5:	Make best use of council money and other resources

There are three sections within Enfield's Homelessness Strategy:

Part 1: Context for Developing Enfield's Homelessness Strategy

Enfield's review of homelessness in the borough and revised Homelessness Strategy has been informed by strategic and policy objectives at national, regional and local level, details of which are set out in this Homelessness Strategy.

Part 2: Addressing Homelessness in Enfield

Part 2 of the strategy sets out key findings from Enfield's Homelessness Review, the challenges the borough faces in tackling homelessness and the vision and ambitions identified to address homelessness in Enfield over the next 5 years

Part 3: Enfield's Homelessness Strategy Action Plan

Enfield's Homelessness Strategy Action Plan has been developed to cover key priorities for the coming years. Where possible the resource associated with each Action has been identified and made available. As the Action Plan is implemented and work with our partners continues, the Action Plan will be revised and updated.

For more information about Enfield's Homelessness Strategy contact:
Housing Strategy, IT and Business Support Team
Community Housing Services
Department of Health, Housing and Adult Social Care
London borough of Enfield
Tel: 020 8379 1000

ENFIELD'S HOMELESSNESS STRATEGY 2013-2018

Introduction

This is Enfield's Homelessness Strategy 2013 – 2018 which sets out the Council's plans for effectively tackling homelessness in the borough over the next 5 years.

It supports Enfield's Housing Strategy which sets out the borough's long term plans for housing in Enfield, including housing supply.

Enfield's Homelessness Strategy has been developed at a time of unprecedented change, including social housing reforms and welfare reforms. It builds on the achievements of Enfield's previous Homelessness Strategy whilst responding and adapting to the changing environment in which homelessness and support services are delivered.

A key aim of this Homelessness Strategy is preventing homelessness and providing assistance to individuals and households to enable them to make informed choices about sustainable, affordable housing options.

Defining Homelessness

Homelessness is defined as "the state of having nowhere to live"[3]. It includes people who are sleeping rough, homeless people for whom the local authority has a duty to find a pathway into appropriate housing, the "hidden homeless" who are living with friends and relatives or those at risk of homelessness because they are living in insecure, overcrowded conditions or accommodation which is in disrepair.

Enfield's definition of homelessness also includes the following:

- Households for whom it has provided emergency housing before 9 November 2012, because the Council agreed a full duty to house them under the homelessness law. These households are waiting for a Council or housing association home.

- Households to whom the Council owes a full homelessness duty after 9 November 2012 are also provided with emergency housing under the homelessness law. The Council will assist most of these households with finding a suitable home in the private rented sector.

Background

A legal duty to have a Homelessness Strategy

The Homelessness Act 2002 requires housing authorities to carry out a Homelessness Review and formulate a strategy based on the results of the review that includes plans for:

[3] Reference Collins on-line dictionary.

- Preventing homelessness
- Ensuring sufficient accommodation is available for people who are, or who may become homeless
- Ensuring there are satisfactory support services for people who are, or may become homeless, or who need support to prevent them from becoming homeless again

How Enfield developed the new Homelessness Strategy

The Homelessness Act 2002 places a duty on local housing authorities to carry out a homelessness review and, in consultation with local partners and stakeholders formulate and publish a Homelessness Strategy based on the findings of that review, at least every five years. Enfield's Homelessness Review included an assessment of the level and trends in homelessness and of existing provision and services for those facing homelessness in the borough.

Enfield's Homelessness Strategy has been developed using findings from a comprehensive Review of homelessness undertaken between January-June 2013. This involved:

- Setting up a Homelessness Strategy Steering Group made up of statutory, private sector and voluntary organisations to oversee the Review and development of the strategy.
- Setting up a Homelessness Operational Steering Group to involve front-line staff in shaping and developing the Homelessness Strategy.
- Consultation and involvement with a wide range of stakeholders, including private and voluntary sector partners, Council Members, local residents, service users and staff. A summary of responses to the consultation is set out in Appendix 1.
- A review and evaluation of outcomes from the previous homelessness strategy and action plan 2008-2013
- A review of statistical data and trends about homelessness.
- Analysis of recent Census data to understand the demographics and potential growth in population in Enfield for the future.
- Comparing Enfield's performance against best practise and other Local Authorities performance.
- Writing the Strategy and producing a detailed 5 year action plan.

A summary version of the review can be found in Part 4 of Enfield's Homelessness Strategy

What does Enfield's Homelessness Strategy cover?

- Part 1 sets out:
    - How national, regional and local government policies and laws, are affecting the way Enfield addresses homelessness and provides appropriate services.

- Part 2 sets out
    - Key Issues arising from Enfield's Homelessness Review
    - The key challenges ahead
    - Enfield's Strategic vision and Ambitions for addressing homelessness
    - What Enfield and its partners plan to do to address the challenges and meet the Council's ambitions for addressing homelessness over the next five years
- Part 3 contains Enfield's detailed Homelessness Strategy Action Plan

What Enfield's Homelessness Strategy does not cover and why

Enfield's wider plans for addressing long term housing supply are outside the scope of this strategy. This is because the borough's plans for maximising housing supply, shaping supply and making best use of existing stock are set out in Enfield's Housing Strategy 2012-2027.

This Strategy will set out the borough's Strategic position on accessing suitable, affordable accommodation in sufficient quantities to meet the needs of homeless households and those at risk of homelessness

Part 1: Context for Developing Enfield's Homelessness Strategy

Enfield's review of homelessness in the borough and revised Homelessness Strategy have been informed by strategic and policy objectives at national and regional level. This chapter will touch on these influences and their relationship with Enfield Council's strategic objectives and key strategies. A summary of Enfield's Review of Homelessness is available as a separate document.

National Strategies and Policies relating to Homelessness

The key national level strategies and policies that are influencing Enfield's Homeless Strategy include:

- Government's National Housing Strategy for England: Laying the Foundations, November 2011
- Simplifying the welfare system and making work pay, August 13
- Improving the rented housing sector, June 2013
- A fairer future for social housing, November 2010
- Tackling Overcrowding in England: an Action Plan
- Providing housing support for older and vulnerable people, April 2011,
- Adult Safeguarding: Statement of government policy, May 2011
- Promoting Health and Well-being: Implementing the national health promotion strategy

Regional Strategies and Policies relating to Homelessness

From the 1st April 2012 the Mayor became directly responsible for strategic housing, regeneration and economic development in London. The Mayors strategies and policies that influence Enfield's Homelessness Strategy are:

- The Revised London Housing Strategy
- The Mayor's Covenant

Local Strategies and Policies relating to Homelessness

Addressing homelessness is an important local strategic priority for Enfield. It supports Enfield Council's corporate vision 'to make Enfield a better place to live and work, delivering fairness for all, growth and sustainability and strong communities.' Enfield's plans for addressing homelessness support the council's aims and objectives.

Enfield's Homeless Strategy sits underneath and is supported by a range of local strategies, policies and plans. Many of these are set out in Enfield's fifteen year Housing Strategy.

The diagram below shows the relationship between Enfield's Housing Strategy, Homelessness Strategy and other borough wide strategic plans

Enfield's Homelessness Strategy in relation to other Corporate Strategies and Plans

Homeless Prevention Plans:

- Enfield's Allocations Scheme
- Enfield's Older Persons' Accommodation (in development)
- Enfield's Joint Strategic Needs Assessment (in development)
- Enfield's Health and Wellbeing Strategy (in development)
- Safeguarding Adults strategy 2012-15
- Housing Assistance Policy (in development)
- Joint Commissioning Strategy for People with Autism (in development)
- Mental Health Strategy (in development)
- Rough sleepers Action plan
- Housing Assistance policy
- Accredited Landlords Scheme
- Overcrowding Action Plan
- Empty Homes Policy

Homeless Related Plans:

- Shaping Enfield's Future: Enfield's Place Shaping Strategy 2013
- Safer and Stronger Communities Board (SSCB) Partnership Plan 2013-14
- The Drive Towards Prosperity: Enfield's Child and Family Poverty Strategy 2012
- Enfield's Children & young Peoples Strategy 2011-15
- Enfield's Tenancy Strategy 2013
- Enfield's Skills and Employment Strategy (in development)
- Enfield's Leaner Programme
- Enfield's Estate Renewal Plans
- Enfield Tackling Gangs & Serious Youth Violence Strategy (in development)
- Unauthorised Encampment Policy in development)

Part 2: Addressing Homelessness in Enfield

Part 2 of this strategy sets out key findings from Enfield's Homelessness Review as well as the challenges the borough faces in tackling homelessness and the measures identified to address homelessness in Enfield over the next 5 years

Key issues identified from Enfield's Homelessness Review

Enfield's Homelessness Review undertaken between January – June 2013 identified a number of issues that have an impact on homelessness or the way homelessness is addressed. A summary of the key issues is set out below, more detailed information to support this section is in the appendix attached

Partnership Working

Effectively preventing and reducing homelessness in Enfield relies upon the council working with a wide range of partners. Our partner's commitment to our ambitions and a willingness to play their part are essential to the success of addressing homelessness in the borough. Pooling knowledge, resources and expertise has never been more important in the current economic climate with resources being stretched.

Changes in Government Policy

Enfield's Homelessness Strategy has been developed at a time of significant change to national policy, relating to welfare and social housing reform. Two key changes in government policy are now driving the context in which homeless services are provided:

Welfare reform: key changes are:

- Caps on welfare benefits so that working age households can no longer receive more than a total in benefits per week of £500 for a family and £350 for a single person or couple without children
- Council Tax Local Support Scheme requiring all working age claimants to pay something towards Council Tax
- The spare room subsidy or "Bedroom Tax" which means any working age claimant in social rented housing no longer receive housing benefit for a spare room.

The Localism Act 2011: key changes are:

- Discharge of the main homelessness duty with an offer of a suitable home in the private rented sector.
- Greater flexibility for the Council to decide who can apply for their housing register to obtain social rented housing.
- Reduced funding for Registered Providers to build affordable new homes.

- Flexibility for Housing Providers to use shorter fixed term tenancies and the Affordable Rent Model.[4]

The Economic downturn

The impact of the economic downturn on Enfield has been:

- Increased deprivation in the area, Enfield has risen six places in the last 5 years to 64th[5] most deprived local authority in England
- Increased levels of un-employment, figures for 2012 showed Enfield has the fifth lowest employment rate in London and above average increases in all the main working age benefits since 2008
- Reduced income levels both earned and from welfare benefits
- Increased inability to access affordable housing options

Changes in the Local Housing Market

An understanding of the housing markets in Enfield and the changes happening within them is important for addressing homelessness. Enfield's homelessness review found the following facts about Enfield's local housing market:

- Social rented homes in Enfield are in very short supply. The Council let 693 Council and housing association homes in 2012/13[6]. Enfield's Lettings Forecast predicted 568 will become available for letting in 2013/14.

- Under the Government's Affordable Homes Programme 2011-15, there are no new 'handovers' of housing association homes to be let on social rent terms planned in Enfield beyond 2013/14[7].

- Owner occupation in Enfield has seen a significant decline from 77994 to 70549 between 2001 and 2011. The high cost of home ownership has made it increasingly difficult for people to buy somewhere to live with prices rising faster than earnings. Many of those who would have bought now rent.

- Over the last decade there has been dramatic growth in Enfield's private rented sector from 13,105 to 27,500 properties rented out. Rents are increasing and demand is outgrowing supply. The drivers for increasing rents and demand include:

    - The high cost of home ownership producing a new market of professional people who now rent because they can't afford to buy somewhere to live.
    - Low levels of social rented homes becoming available for letting so households who expected a home in the social rented sector are looking to the private rented sector instead.

[4] Ability to charge rent up to 80% of the local market rents
[5] Index of multiple deprivation figures
[6] Breakdown of lettings: Council General Needs: 392; Council sheltered: 93; Housing association: 208
[7] Enabling Programme Outcomes 2008/13 – Enabling Team 21/6/13

- Competing claims from other London local authorities who are procuring private rented homes in the borough for their own households in housing need. Many are using larger budgets to outbid each other for the supply
- A reduction in private rented lettings for benefit dependent households arising from government changes to welfare benefits including reductions in Local Housing Allowance rates. There is evidence that private landlords are choosing to let to different rental markets

Emerging from a growing private rented sector are concerns about a rise in anti- social behaviour and a need to introduce a range of more effective measures to improve standards of management.

Maximising housing supply for local people, including affordable homes and making best use of Enfield's existing housing stock are important corporate priorities. Our plans are set out in more detail in Enfield's Housing Strategy and will evolve in response to changing circumstances. Plans include:

- utilising Enfield Councils Investment Partner Status to compete for more funding to build council homes
- actively maximising the development of council owned land, including small sites and garages as well as using other innovative approaches to increase the supply of homes
- joint working with our partner Housing Associations to develop new housing supply

Changing Reasons for Homelessness Acceptances[8] by Enfield Council

The main reason for homelessness has changed in Enfield over the past five years. Loss of private rented accommodation has become the main reason for homelessness in Enfield moving from 21.9% of all homelessness acceptances in 2010/11 to 43% in 2012/13. Previously the main reason for homelessness was households being evicted from the home of family or friends. This has resulted in a 13% reduction in the proportion of homeless acceptances.

Key Challenges for Enfield in Addressing Homelessness

The issues from the homeless review outlined in section 1 present a number of key challenges for Enfield in preventing and tackling homelessness in the borough, this section sets out to explain what those challenges are.

Sustaining the involvement of Partners addressing homelessness

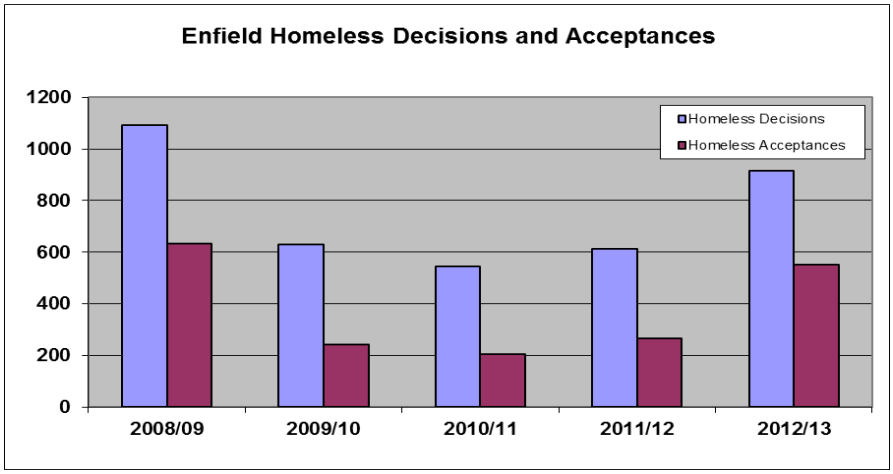
It is essential that all of our partners ensure homelessness and their role in helping to manage it in Enfield becomes and remains a priority for them. The challenge for the

[8] Acceptances – households who Enfield owes a full housing duty to under the homelessness legislation

Council will be to obtain and sustain the involvement of partners in preventing and tackling homelessness in Enfield, whilst recognising the pressures they face, including financial ones, and the differences in our respective roles and responsibilities

Increased demand for housing options and advice services

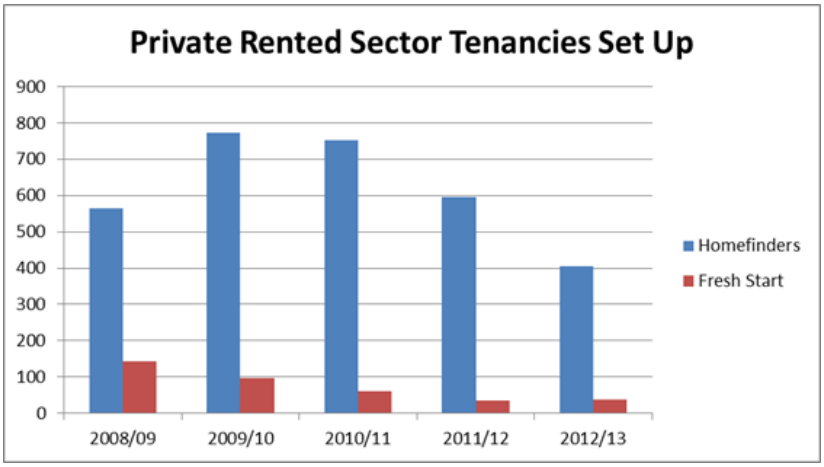
After declining for many years, the number of homeless acceptances and homeless decisions has begun to increase again in common with both London and national trends. However during 2012/13 the rise in homeless acceptances has been far more pronounced in Enfield, as illustrated in the chart below.



A rise in homelessness will result in a significant increase in demand for Enfield's housing options and advice services for homeless households or those threatened with homelessness covering:

- Sustaining tenancies in the private rented sector
- Enabling households to find accommodation that they can afford either within or outside of the borough
- Assisting households with care and support needs
- Preventing street homelessness

A lack of affordable, quality private rented homes in Enfield to respond to increased demand



As illustrated in the chart above the earlier success of Enfield's rent deposit schemes has declined since 2011/12. Part of the explanation for this decline can be found in the changes in Enfield's private rental markets highlighted above, resulting in a reduction in the supply of suitable, affordable homes for low income households and those on benefits.

It has become far more difficult for Enfield to source affordable local homes for:

- Preventing homelessness
- Discharging the homelessness duty in Enfield to households who are homeless
- Enfield's emergency housing portfolio

A large private rented sector presents challenges in terms of maintaining quality standards of management and letting and addressing anti-social behaviour. The Council is looking at ways of working with private landlords and other organisations to find a coordinated and comprehensive set of measures to tackle rogue landlords and unreasonable behaviour.

The impact of a shortage of Council and Housing Association Homes for Letting

The serious shortage of council and housing association homes to go around in Enfield has resulted in the Council having to prioritise who is allocated the homes available. The current housing priorities for the Council are:

- rehousing tenants living in homes that are included in the Council's Estate Renewal programme and
- housing homeless households living in expensive emergency accommodation prior to 9/11/12 who are owed a housing duty by the Council.

The remaining homes are prioritised for those with high care and support needs, which means:

- Those without high care and support needs will find themselves renting from a private landlord and will need to consider alternative affordable housing options.
- It will take longer to house pre-9/11/12 homeless households placed in Enfield's emergency housing

Continuing to provide an effective housing options and advice service whilst making best use of the Council's Money

Partnership working is key to successfully achieving value for money housing options and advice service in Enfield. In a climate of increased demand for services, increased costs of homelessness and cuts to public spending it is ever more challenging to continue to provide effective and value for money services, making it essential to share knowledge, expertise and pool resources with our partners in order to meet that challenge

Communicating Enfield's approach to addressing homelessness

Enfield's Homelessness Strategy has been developed at a time of unprecedented welfare and housing policy change. The changes, their impact and the steps being taken to address homelessness in Enfield need to be communicated effectively to local people and the organisations that work with and support them.

We need to continue to assess the impact of the changes on service users and plan services accordingly

Enfield's Homelessness Strategy: Vision and Ambitions

Outcomes from the homelessness review and consultation have resulted in a new vision for preventing and tackling homelessness which is set out below:

Eliminate homelessness in the borough and enable people to make their own informed choices for housing they can afford.

Enfield's Ambitions for its Homelessness Strategy

Enfield's Homelessness Review identified that the five key ambitions from Enfield's Homelessness Strategy 2008 – 2013 are still relevant and in this strategy they have been refined.

Our ambitions are:

Ambition 1:	Preventing homelessness in Enfield, and enabling households to find homes they can afford
Ambition 2:	Securing adequate accommodation to meet the needs of homeless households and those at risk of homelessness
Ambition 3:	Provide the relevant support to enable households with assessed support needs to live independently in their own home.
Ambition 4:	Providing an excellent standard of customer service
Ambition 5:	Make best use of council money and other resources

There is strong political commitment and support from senior officers for addressing homelessness in the borough.

Enfield has adopted good practice identified by the Department of Communities and Local Government and other local authorities in tackling homelessness in the borough and preventing repeat homelessness, but there is more work to be done to meet the challenges identifies.

The next section sets out what Enfield intends to do over the next 5 years to achieve its ambitions.

Ambition 1: Preventing homelessness in Enfield, and enabling households to find homes they can afford

2013-2018 We will:

- Use local intelligence and information to continue to forecast and manage the demand for Housing Options and Advice services
- Respond to main cause of homelessness in the borough - loss of a private rented tenancy.
- Improve the range of advice and support provided[9] to all households approaching the housing options and advice service to enable them to access housing that they can afford in and outside of the borough
- Work in partnership to address the correlation between homelessness and worklessness
- Work with housing association partners providing homes for single people at risk of homelessness to ensure that supply continues to meet identified housing need.
- Ensure low levels of rough sleeping
- Strengthen partnership working across the private, voluntary and community sector.

Ambition 2: Securing adequate accommodation to meet the needs of homeless households and those at risk of homelessness

2013-2018 We will:

- Ensure an optimum accommodation portfolio inside and outside of the borough, to meet the needs of homeless households and those threatened with homelessness
- Reduce the use of nightly paid accommodation for Enfield's homeless households.
- Increase the number of private rented sector homes available to let

[9] Advice to include affordable housing options, budget management and sign posting to work, education and training oppertunities

- Ensure all properties used by the service comply with minimum safety and quality standards

- Evaluate options available to the Council to tackle the link between the private rented sector (used to meet housing need of homeless households) and elevated levels of anti-social behaviour

Ambition 3: Provide the relevant support to enable households with assessed support needs to live independently in their own home

2013-2018 We will:

- Enable as many households as possible with care and support needs to remain living independently in their own home
- Keep under review the demand for appropriate Housing Related Support services for homeless households with assessed care and support needs.
- Ensure social housing resources are prioritised to house vulnerable homeless households who are not able to help themselves
- Safeguard vulnerable people from abuse and harassment by joint working with partners to support them with their housing need

Ambition 4: Providing a good standard of customer service

2013-2018 We will:

- Deliver our plans for an accessible, innovative housing options and advice service, with those at risk of homelessness being fast tracked for services

- Introduce and publish new service standards

- Set new customer satisfaction targets

- Improve customer engagement and involvement to further develop our homeless services

Ambition 5: Make best use of council money and other resources

2013-2018 We will:

- Keep under review the impact, costs and benefits of all homelessness related services
- Implement Enfield Council's online housing options and advice service
- Explore all opportunities for partnership working and pooling resources
- Reduce the unit cost of emergency housing

Part 3: Enfield's Homelessness Strategy Action Plan

Enfield's Homelessness Strategy Action Plan has been developed to cover key priorities for the coming years. Where possible the resource associated with each Action has been identified and made available. As the Action Plan is implemented and work with our partners continues, the Action Plan will be reviewed and updated.

Performance management of Enfield's Homelessness Strategy and Action Plan

This strategy will evolve over time to reflect alterations in policy and legislation and the changing needs, expectations and priorities of our customers and partners.

A performance management framework is in place within Community Housing Services to monitor service outcomes, including homelessness. Responsibility for reviewing and updating Enfield's Homelessness Strategy and supporting Action Plan will lie with Enfield's Housing Strategy, IT and Business Support Team. Outcomes will be monitored through the Community Housing Services' Housing Strategy Board with outcomes reported annually to Enfield's Housing Strategic Partnership.

Ambition 1: Preventing Homelessness and enabling households to find homes they can afford.

Key Outcomes:

1. In the next 5 years reduce the number of households living in emergency housing where Enfield Council accepted a full housing duty before 9/11/12 by 1000 (from a baseline of 1719 as at November 2013) (1.2). (PI:NI156i)
2. A yearly increase in the number households in the private rented sector helped to remain in their own homes from a baseline figure 2012/13 of 207 total (PI:CHS002)
3. Help 30 more people every year with a home in the private rented sector (Baseline 2012/13 406 (PI:CHS001)
4. Levels of rough sleeping in the borough are below 5 on any one night with no second night out
5. Improve the range of advice and support provided to all households approaching Enfield's Housing Options and Advice Service (to include affordable housing options, budget management and signposted to work, training and education opportunities)
6. Target of 25 homeless households engaged in employment, education or training per year

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
1.1	Keep under review the main causes of homelessness and the need for homelessness prevention services -	✓	✓	✓	✓	✓	Head of Housing Options and Advice	Existing resources

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
	P1E returns							
1.2	Deliver an agreed annual target for Enfield Council's homeless acceptances (households owed a full housing duty under the homelessness law)	✓	✓	✓	✓	✓	Head of Housing Options and Advice	Existing resources
1.3	Make available 30-40% of all social rented homes that become available per year to offer to discharge Enfield's housing duty to households the Council accepted before 9 November 2012	✓	✓	✓	✓	✓	Head of Housing Options and Advice Enfield Homes Registered Providers	Existing Resources RSL partners – nominations / developments HRA
1.4 **1.4a** **1.4b**	Respond to the biggest cause of homelessness, loss of a private rented tenancy, by:- • Delivering a tenancy sustainment service which helps Enfield's private tenants to stay where they are – annual targets to be set • Delivering Enfield's Homefinder Private Rented Sector rent deposit scheme to Enfield's private tenants who have no alternative but to move to another private rented sector home – annual targets to be set -	✓ ✓	✓ ✓	✓ ✓	✓ ✓	✓ ✓	Head of Housing Options and Advice Head of PSH & Accommodation services Ptnr: Landlords /Agents Turkish Community groups	Existing Resources Homelessness Grant DHP Existing Resources

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
	annual targets to be set							
1.4c	• Develop and deliver an engagement and involvement campaign targeted at Turkish community groups who are disproportionately represented in households losing private rented sector tenancies.		✓					Existing Resources
1.5	Target DHP at preventing homelessness including tenancy sustainment and housing options – monitor DHP allocation	✓	✓	✓	✓	✓	Revenues and Benefits	Govern-ment DHP allocation
1.6	Respond to the lack of housing options for single people and couples without children under 35 by investigating funding and development opportunities for affordable housing options for			✓			Head of Housing Options and Advice Head of PSH & Accommodation services Enfield's Single Homeless Forum	
1.6a	• People under 35 with substance and alcohol misuse		✓				DAAT Key Partners: Planning Landlords / Agents Housing associations Enfield Faith Network Charitable agencies	DAAT funding
1.6b	• People under 35 who are unemployed or on a low income			✓				Existing Resources Hope Worldwide Charitable funding
1.7	Strengthen partnership working within Enfield Single Homeless Forum (ESHF)to ensure single homeless people and couples		✓				Head of Housing Options and Advice	Existing Resources

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
	without children have a voice and resources are pooled for developing sustainable housing options and services by:						Key Partners: London Street Rescue Revs and Bens Housing Related Support Faith Groups Providers for single homeless DWP & Job Centre+	
1.7a	• Marketing campaign to expand the membership of ESHF		✓					
1.7b	• Monitoring the borough's action plan on rough sleeping	✓	✓	✓	✓	✓		
1.8	Carry out an audit of the voluntary and community sector and compile a register of all organisations that provide housing options and advice services with detail of what they provide to make best use of their services for preventing homelessness		✓				Head of Housing Options and Advice Partners: Voluntary & Community Sector	Existing Resources
1.9	Respond to the link between homelessness and worklessness by targeting households **at risk of homelessness** presenting to the Council for housing options and advice services:						Head of Sustainable Communities Team	Existing Resources
1.9a	• Refer unemployed households for work opportunities to partner employment providers e.g Job Centre + Reed employment - report on take up and outcomes	✓	✓	✓	✓	✓		

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
1.10	Responding to the link between homelessness and worklessness, by targeting households in Enfield's emergency housing for work , education and training opportunities:		✓				Head of PSH & Accommodation services Head of Housing Options and Advice Ptnrs: Head of Sustainable Communities Team Registered Providers Voluntary & Community Sector DWP Job Centre + Children & Families	
1.10a	• Housing Association partners to target in-house work and training programmes at occupiers of Enfield's Housing Association Lease Schemes - report on referrals and outcomes annually		✓					
1.10b	• Sustainable Communities Team to ensure effective targeting and marketing of work fairs and training events - report on events and take up annually		✓					
1.10c	• Develop an involvement and engagement plan with local community groups to encourage their members to break the benefit cycle and help identify employment and training opportunities within their communities – plan in place and outcomes		✓	✓				Voluntary & community group resources

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
	monitored							
1.11	Produce a marketing campaign to raise awareness about the criteria for eligibility for Disabled Facilities Grants		✓					

Ambition 2: Securing adequate accommodation to meet the needs of homeless households and those at risk of homelessness

Key Outcomes

1. Ensure a supply of the right mix of good quality, reasonably priced accommodation types, that increases the supply of longer term leased accommodation and reduces the use of short term nightly paid accommodation (Optimum portfolio 13/14 850PLA, 750PSL, 215NPA & 50B+B)
2. Bring back into use **60** empty homes from the private rented sector per year for emergency housing
3. All properties used by the service comply with minimum safety and quality standards under HHSRS[10] minimum statutory standards.

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
All Accommodation								
2.1	Implement Enfield's emergency housing and private rented sector Procurement Plan. Monitor targets set and report fortnightly to CHS Operations Board	✓	✓	✓	✓	✓	Head of PSH & Accommodation Services Ptnrs: Local landlords & agents Out borough LL & agents Other London Boroughs	Existing CHS Resources & New Homes Bonus
Emergency Accommodation								
2.2	Improve the process for planned referrals of homeless households from Housing Options and Advice Services to Accommodation services for emergency housing to reduce the use of Nightly Paid Accommodation	✓	✓	✓	✓	✓	Head of Housing Options and Advice Ptnr: Accommodation Services Landlords /Agents	Existing Resources
2.3	Implement the Project to use empty decanted council homes as emergency housing until they are	✓	✓	✓			Head of PSH & Accommodation Services Ptnrs: Enabling Team	Existing Resources

[10] Health & Housing Safety Rating Standard

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
	ready for demolition						Registered Providers	
2.4	Carry out annual inspections of emergency housing to ensure compliance with the Housing Health and Safety Rating System (HSRS) standards	✓	✓	✓	✓	✓	Head of PSH & Accommodation Services Ptnrs: Landlords & agents Enviro- crime	Existing Resources
Private sector								
2.5	Make use of the Governments New Homes Bonus to increase the number of empty homes brought back into use in the borough and use as emergency housing through the Council's Grants and Nominations Scheme (Gans - short term housing scheme	✓	✓	✓	✓	✓	Head of PSH & Accommodation Services Ptnrs: empty home owners Council tax team paradigm Housing	New Homes Bonus
2.6	Implement the DCLG Homelessness Private Rented Sector Investment Project for increasing the supply of private rented homes for Enfield's homeless households	✓					AD Strategy and Resources HHASC Estate Agents DCLG	Existing Resources Project Budget
2.7	Ensure Private rented sector homes used to discharge the council's main housing duty into the PRS sector meet the Housing Health and Safety Rating System (HSRS) standards	✓	✓	✓	✓	✓	Head of PSH & Accommodation Services Envirocrime <u>Partners</u>: Landlords & agents	Existing Resources
2.8	Consider options available to the Council to improve standards of tenancy management arising from a growth in the private rented sector.	✓	✓				Head of PSH & Accommodation Services Envirocrime Partners: Landlords & agents	

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources

Ambition 3: Provide the relevant support to enable households with assessed support needs to live independently in their own home

Key Outcomes

1. 95% of clients receiving Housing Related Support funded services are satisfied with the service provided to enable them to live independently[11]
2. Ensure annual quotas are set and delivered for social housing resources to be prioritised to house vulnerable homeless households who are not able to help themselves
3. Safeguard vulnerable people from abuse and harassment by working with partners to support survivors with their housing needs
4. All staff who deal with clients with support needs have received mandatory safeguarding training

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
3.1	Implement Enfield's Domestic Violence Protocol by Jan 2014 to prevent the homelessness of social rented tenants who are victims of domestic violence. Make best use of the NLSR DV reciprocal agreement	✓					Head of Strategy, IT & Business Support Ptnrs: Community Safety Team Enfield Homes Registered Providers Children & Families Voluntary Sector NLSR partners	Existing Resources

[11] Target supplied by Procurement and Contracting Team

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
3.2	Ensure Enfield's Allocations Scheme provides pathways for households at risk of homelessness with assessed support needs - monitor and keep under review demand, outcomes from Housing Panels for allocations arising from those with learning difficulties, mental health, physical disabilities, leaving care to monitor allocation quotas	✓	✓	✓	✓	✓	Head of Housing Options and Advice Enfield Homes Registered Providers Adult Social Care	Existing resources Council properties Registered provider properties
3.3	Keep under review the demand for appropriate Housing Related Support (accommodation based and floating support services) in Enfield for homeless households with assessed care and support needs and commission or decommission services as required	✓	✓	✓	✓	✓	Head of Housing Related Support Pauline Kettless Ptnr: Adult Social care CHS Enfield Homes Registered Providers Private Sector Care Providers	Housing Related Support Funding North London sub-regional funding sources
3.4	Deliver Enfield's Disabled Facilities Grants and Care & Repair funding to enable those with care and support needs to remain living independently in their own homes	✓	✓	✓	✓	✓	Head of PSH & Accommodation Services Ptnr: Adult Social Care GP's / Health partners Private Landlords Private Building Contractors	Govern-ment DFG's

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
3.5	Ensure Providers of Housing Related Support meet their contractual obligations 'to move on households who have had their housing and support needs met and no longer need Enfield's supported housing schemes		✓				Head of Procurement and Contracting Ptnrs: CHS Private Care Contractors Landlords / Agents Voluntary Sector	Existing Resources
3.6	Review the use of the Governments NOTIFY system in Enfield for tracking the movement of homeless households placed in or moving between or leaving emergency housing in London boroughs.	✓	✓				Head of Housing Strategy IT and Business Support Children and Families Education	Existing Resources

Ambition 4: Provide an Excellent Standard of Customer Service

Key Outcomes

1. Deliver Customer satisfaction targets in line with customer service standards
2. Customer service standard targets are set and delivered
3. 95% of recipients receiving DFGs have improved their ability to manage in their own home and live independently

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
4.1	Develop Services Standards for delivering Housing Options and Advice Services and review annually	✓					Head of Housing Option & Advice	Existing Resources
4.2	Develop a Service level Agreement (SLA) between CHS and the main OSC for delivering Housing Options and Advice services and monitored annually	✓					All CHS Heads of Service	Existing Resources
4.3	Ensure the housing web pages on the Council's website have a rolling programme of review and updating and customer are involved in reviewing the content and navigation for quality and access		✓	✓	✓	✓	All CHS Heads of Service	Existing Resources
4.4	Develop customer engagement and involvement model for shaping Housing Options and Advice services		✓				All CHS Heads of Service	Existing Resources
4.5	Improve access to HOAS for preventing homelessness by Implementing an on line Housing Options Checker and Housing Application Form	✓					All CHS Heads of Service	Existing Resources
4.6	Produce a manual of clear written work processes, work instructions and procedures for Housing Options and		✓				Head of Housing Option & Advice	Existing Resources

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
	Advice services post implementation of the new Service model for community Housing Services							
4.7	Provide Customer Services training for all Operational staff providing Housing Options and Advice Services on a rolling programme - No.s staff trained annually	✓	✓	✓	✓	✓		
4.8	EQIAs	✓	✓	✓	✓	✓		

Ambition 5: Make best use of Council money and other resources

Key Outcomes

1. 100% take up of Enfield's online, housing options and advice service.
2. Reduce the gross unit cost of the provision of nightly paid and B&B accommodation provided to homeless households by 5%.(fFrom a baseline cost as at year end 12/13)
3. Monthly targets are met to ensure the steady reduction in housing options and advice caseload numbers from a baseline figure of 181 at 12/13

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
5.1	Implement a new Customer Service model for Community Housing Services in support of the Council's Customer First Programme and keep under review via CHS Operations Board	✓	✓				Sally McTernan	Existing Resources Pro-gramme budget
5.2	Explore all opportunities for partnership working and pooling resources to deliver Homelessness Services	✓	✓	✓	✓	✓	All CHS Heads of Service	Existing Resources
5.3	Lobby and bid for financial resources from all sources to prevent and address homelessness in Enfield (DCLG, NLSR, private, voluntary and private sector)	✓	✓	✓	✓	✓	Head of Housing Strategy IT Business Support	Existing Resources
5.4	Keep under review the impacts, costs and benefits of homelessness prevention services	✓	✓	✓	✓	✓	Head of Housing Options and Advice	Existing Resources
5.5	Keep under review the cost Enfield's emergency accommodation portfolio and act to mitigate any negative the impact on budgets via Council Budget Monitoring mechanisms.	✓	✓	✓	✓	✓	Head of PSH & Accommodation Services	Existing Resources

Ref	Actions	2013 - 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018	Lead organisation / officer Key Partner(s)	Resources
5.6	Keep under review the impact of DFGs financial regime changes in 2015		✓				Head of PSH & Accommodation Services	Existing Resources

Agenda Item 7

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE
Health and Wellbeing Board
13 February 2014

Andrew Fraser - Director of Schools and Children's Services

Contact officer and telephone number:
Eve Stickler – AD Commissioning & Community Engagement
E mail: eve.stickler@enfield.gov.uk

Agenda - Part: 1	**Item: 7**
Subject: The Drive Towards Prosperity: Enfield's Child and Family Poverty Strategy – Update **Wards: All**	
Cabinet Member consulted: **Cllr Ayfer Orhan**	

1. EXECUTIVE SUMMARY

1.1 This report offers an update on the Drive Towards Prosperity (TDTP), Enfield's Child and Family Prosperity Strategy, and the development of the strategic action plan with its 5 key aims defining the areas of work:

- Aim 1 – Supporting families to access employment, education, training and skills to maximise income and develop financial resilience
- Aim 2 – Improving education and learning experiences for all Enfield's children and families
- Aim 3 – Increase employment of residents of Upper Edmonton at the North Middlesex Hospital
- Aim 4 – Encourage the development of sustainable housing
- Aim 5 – Reducing and preventing crime

1.2 The report gives a brief update on the national child poverty picture offering greater context for the challenges faced at local level.

1.3 The report explains the progress made in developing the action plan with partners, employing existing local strategic infrastructure and defining Child and Family Prosperity Champions for each aim to drive the work forward.

1.4 Finally, the report summarises encouraging progress so far against local pledges.

2. RECOMMENDATIONS

2.1 The Board are asked to note the contents of the report, the recently revised action plan and progress updates.

3. BACKGROUND

3.1 Enfield published The Drive Towards Prosperity; the Child and Family Prosperity Strategy (TDTP) in July 2012, Setting out a vision for the borough:

"Our vision is that every Enfield child will have the same opportunities and life chances no matter in what part of the borough they are born or live.

Through the development of active, vibrant communities our children will be well supported to play, learn and grow up into resilient, happy, healthy adults, well equipped to enter the world of work and to succeed."

Key characteristics in Enfield at the time of the statutory child poverty needs assessment (2010) and reported in the strategy gave a startling picture of poverty, and indicating that more than one in three of Enfield's children were living in families in poverty, with most of those families living in tightly defined geographical areas. The strategy describes the ways in which Enfield Council and its strategic and operational partners will work to reduce the unacceptable cost of child poverty through a range of measures based on the Council's core areas of: Fairness for all, Growth and Sustainability and Strong Communities. The strategy is attached at appendix 1.

3.2 TDTP set out 2 key pledges within the document:

- By 2020 we will have reduced child poverty to 25% from the 2008 figure of 36%.
- By 2020 we will have narrowed the gap between the most and least deprived wards, measured in terms of child poverty, from 42% to 30%

4. THE NATIONAL CHILD POVERTY PICTURE

4.1 Under the Child Poverty Act 2010 a child is defined as being in relative poverty if they live in a household where income is less than 60 per cent of the national median income. The Government undertook consultation on revised ways of measuring child poverty which closed in February 2013. No feedback has yet been issued following this consultation and therefore the measurement method still exists.

4.2 In September 2013 HMRC issued guidance that the Revised Local Child Poverty Measure was to be renamed the Children in Low-Income Families Local Measure. The change was intended to help distinguish these statistics from the official national child poverty measures and help users to interpret them appropriately. The Children in Low-Income Families Local Measure is based on administrative tax credits and benefit data sources and includes children who are living in families in receipt of out-of-work benefits, or in receipt of tax credits with reported income less than 60 per cent of median income. This local measure attempts to create a proxy for the official relative child poverty measure in order to enable local (sub-national) analysis. However, for several methodological reasons it is not equivalent.

4.3 The most recent HMRC figures for the Children in Low-Income Families Local Measure (2011), the nearest equivalent figure to the original Child Poverty Measure, show that compared to the 2010 figure of 35%, in 2011 33% of Enfield children are living in poverty.

4.4 The “End Child Poverty” statistics, recently published but using a different statistical basis, show that at 29%, whilst this is a percentage improvement, Enfield still ranks as the 8th highest London Borough for Child Poverty and numerically the 3rd worst with 23,652 children in poverty. In percentage terms Edmonton is ranked the 19th worst parliamentary constituency (having not been in the top 20 in 2011).

4.5 Alan Milburn’s “State of the Nation” report 2013 from Social Mobility and Child Poverty Commission suggests that on a national level the legally binding goal of ending child poverty by 2020 is likely to be missed by a considerable margin. The Commission is monitoring progress of government and others in tackling child poverty. His paper reports that:

- since 2010 workless households have fallen by 10% but recently there has been a 275,000 rise in numbers of children in absolute poverty
- More people are in work than ever before, but numbers of young people unemployed for 2 years or more is at a 20 year high
- Real median earnings are now lower than they have been for a decade
- Poverty is more an issue for working families than workless ones

5 ENFIELD’S PROGRESS UPDATE

5.1 Since the strategy was launched and the original action plan was constructed and consulted on, the following milestones and activities have taken place:

- The Council identified Neil Rousell, Director of Regeneration, Leisure and Culture as its overall Child and Family Poverty Champion.
- The Child Poverty Needs Assessment, TDTP Strategy and Action Plan were formally adopted by the Council and ESP. The Action Plan can be found in full at appendix 2.
- The original Child Poverty Steering Group has been expanded to offer a more holistic perspective including representatives from agencies across the council and its partners and re-established in January 2013
- Quarterly meetings have been held during the year
- Thematic Action Group (TAG) Child Poverty Champions have been agreed for all Aims within the Strategy
    - Aim 1 – Supporting families to access employment, education, training and skills to maximise income and develop financial resilience. Lead TAG: Employment and Enterprise. Champion: Anna Loughlin
    - Aim 2 – Improving education and learning experiences for all Enfield’s children and families. Lead TAG: Children’s Trust. Champion: Eve Stickler
    - Aim 3 – Increase employment of residents of Upper Edmonton at the North Middlesex Hospital. Lead TAG: Health Improvement Partnership. Champion: Shahed Ahmed
    - Aim 4 – Encourage the development of sustainable housing. Lead TAG: Community and Economic Development. Champion: Sally McTernan
    - Aim 5 – Reducing and preventing crime. Lead TAG: Safer and Stronger Communities Board. Champion: Andrea Clemons

- All TAGs reviewed and revised their Aim and agreed their actions July – October 2013
- Revised Strategic Action Plan agreed October 2013

- Monitoring framework was established and baseline and progress data is being collected November 2013 onwards.

5.2 Progress Summary – Individual Aims

5.2.1 **Aim 1. Support families to access employment, education, training and skills to maximise income and develop financial resilience.**

- Joint Enfield / JCP Partnership agreement signed
- JCP Employer Advisor seconded to Business and Economic Development Service to capture local vacancies
- Establishment of sector fora through NLCC to support businesses to recruit locally (construction already established; Social Care, Green, Logistics on stream)
- Better, more accurate data-sharing established to enable more targeted support to families
- Recruitment of 15 benefit cap claimants into the Council's workforce

5.2.2 **Aim 2. Improve education and learning experiences for all Enfield's children and families**

- Terrific Twos Programme launched providing free places in early years learning for eligible 2 year olds – more than 1000 children engaged at the time of writing
- Key Stage 1 (provisional) – improvement in Reading, Writing & Maths
- Key Stage 2 (provisional) – above National rates for progression
- 5+ GCSE A*-C, incl. English and Maths (provisional) above National Average
- Skills and Learning for Work Service launched incorporating Adult & Community learning, Apprenticeships, Traineeships, Work Related Learning, Work Experience & Careers Advice, ESOL
- Parent Engagement Panel work has been reviewed and refocused with a new manager. Consolidation of area meetings to enable greater sustainability and new parents being engaged from across 13 wards

5.2.3 **Aim 3. Increase employment of residents of Upper Edmonton at the North Middlesex Hospital**

- Job seekers are to be targeted for employment and volunteering opportunities at North Middlesex hospital. Initial meetings have been held with NM to identify suitable opportunities, potential barriers and how these can be addressed
- Upper Edmonton postcodes obtained and shared with JCP to be matched to job seekers. This will allow effective targeting and monitoring
- Initial discussions taken place on the longer term aim of raising aspiration through work experience and volunteering. Initial contacts identified
- Family Nurse Partnership programme launched and initial clients recruited

5.2.4 **Aim 4. Encourage the development of sustainable housing.**

- Implemented Enfield's new 5 year Housing Allocations Scheme supporting families with high care and support needs
- Consulted on Enfield's new draft 5 year Homelessness Strategy
- Supported families affected by welfare reform to maintain their existing home or move somewhere cheaper
- Finalised joint Domestic Violence Protocol between the Council and Housing Associations to prevent homelessness through DV
- Liaised with those affected by Enfield's Estate Regeneration Scheme
- Continued implementation of the Decent Homes Programme

5.2.5 **Aim 5 – Reducing and preventing crime.**

- Youth Robbery at lowest recorded level - Enfield has won the international Goldstein Award in recognition of our work
- Victims of serious youth violence reduced by 34% in last 12 months
- Enfield awarded national "Stop Loan Sharks" award
- Funding secured for additional youth services in A&E and YOS
- Home Office peer review of our gangs work has led to national identification of some of our key processes
- Gangs and ASB work has reduced crime in some of our most troubled families
- DV co-ordinator supporting SPOE highlighting the strong links between areas such as DV and Child Protection cases

5.3 Progress on Enfield's 2012 pledges

Our TDTP strategy pledges remain and progress has been made but it is against the context set out in section 4 above.

5.3.1 Pledge 1. "By 2020 we will reduce child poverty to 25%"
The baseline was 36% in 2012 and has improved to 33% in 2013
(2012 figure of 36% is from HMRC 2010 data – Child Poverty measure
2013 figure of 33% is HMRC 2011 Children in Low-Income Families measure)

5.3.2 Pledge 2. "By 2020 we will narrow the gap between the most and least deprived wards, measured in terms of child poverty, from 42% to 30%"
The baseline of 42% was taken from the last available (2009) HMRC figures when carrying out the child poverty assessment. This has improved in 2013 to 35% (2012 fig.)

5.4 Next steps

- Establish clear performance management processes including establishing full baseline figures, realistic targets and
- Develop a simple, clear reporting structure, using Covalent or an equivalent system, where data is populated and verified by all TAG champions to inform the Board and Enfield Strategic Partnership. This will include opportunities to record good or exceptional performance along with explanations where progress has not been good and to identify good practice.
- Review and update The Drive towards Prosperity Strategy – Enfield's child and Family Poverty Strategy. The original strategy was mainly developed in 2011 and adopted in 2012 and is therefore significantly out of date. The review is dependent on capacity and any Government announcement following consultation on future ways of measuring poverty
- Identify a new borough Child Poverty Champion in light of the imminent retirement of Neil Rousell

6. ALTERNATIVE OPTIONS CONSIDERED

N/A

7. REASONS FOR RECOMMENDATIONS

7.1 The Health and Wellbeing Board are asked to note the contents of the report, the recently revised action plan and progress updates.

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

8.1 Financial Implications

There are no specific financial implications in the context of this report.

8.2 Legal Implications

The Health and Social Care Act 2012 inserted a new Section 2A into the National Health Service Act 2006.

Subsection 1 of Section 2A National Health Service Act 2006 imposes a duty on each local authority to 'take such steps as it considers appropriate for improving the health of the people in its area'.

Subsection 3 sets out the steps which may be taken under subsection 1. These include 'providing information or advice' (subsection 3a); 'providing services or facilities designed to promote healthy living' (3b); 'providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment' (3e); providing or participating in the provision of training for persons working or seeking to work in the field of health improvement' (3f); and 'making available the services of any person or any facilities' (3g).

The proposals set out in this report appear to be covered by the provisions set out above.

9. KEY RISKS

A full Risk Assessment was carried out as part of the development of the strategy. This will be revisited as part of the strategy review as there have been significant changes since the original strategy was written including the impact of welfare reform, population increase, reductions in council resources, on-going service restructures and new government initiative such Free Entitlement for Two Yea Olds and Universal Free School Meals for Key Stage 1 children. It is anticipated that the review will take place during 2014.

10 IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

10.1 Within the 5 Aim areas of the TDTP Strategy and Action Plan, there are a number of objectives that broadly address the priorities identified by the HWB and its proposals for the revisions of the Health and Wellbeing strategy. Aim 3 is the specifically Health focused aim, defined by health partners and led by the Director of Public Health. However, other Aims within the plan also address the HWB priorities as follows (the list is illustrative and not exhaustive):

- **Healthy Start** – **Improving Child Health** – Addressed in TDTP Aim 2 through the holistic approach to nursery provision for 2 year olds and increased access to multi-agency services for under 5's and their families through the children's centre programme.
- **Narrowing the Gap** – **reducing health inequalities** Pledge 2 of the strategy is to narrow the gap between the most and the least deprived wards. Aim 1 (1.1.1) recognises the need to map local services, identifying gaps and building capacity and (1.1.4) recognises the need to focus resources and efforts on Enfield's most deprived wards where child and family prosperity is most concentrated. The latter links to the actions under Public Health's Aim 3

which are focussed on Upper Edmonton ward which has the poorest health outcomes.

- **Healthy Lifestyles/healthy choices –** Addressed in TDTP Aim 1 (1.3.3) – Continue to develop initiatives that reduce youth violence and gang membership by opening up pathways to work
- **Healthy Places –** An objective in TDTP Aim 4 (4.4) to address severe overcrowding
- **Strengthening partnerships and capacity –** Addressed in TDTP Aim 1 (1.3.4) Better integrate JC+ and Improve Access to Psychological Therapies (IAPT) services, to open up the world of work, promote active citizenship and social inclusion to family members suffering with mental health conditions

11 EQUALITIES IMPACT IMPLICATIONS

11.1 A full equalities impact assessment was completed with the development of the strategy, and the work of the action plan has equalities at its heart in working to deliver

"Our vision is that every Enfield child will have the same opportunities and life chances no matter in what part of the borough they are born or live.

Through the development of active, vibrant communities our children will be well supported to play, learn and grow up into resilient, happy, healthy adults, well equipped to enter the world of work and to succeed".

Background Papers

The Drive Towards Prosperity: Enfield's Child and Family Poverty Strategy
http://www.enfield.gov.uk/ChildrensTrust/downloads/file/77/child_and_family_poverty_strategy_2012

Appendix 1
The Drive Towards Prosperity: Enfield's Child and Family Poverty Strategic Action Plan

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The Drive towards Prosperity:
Enfield's Child and Family Poverty Strategy

Strategic Action Plan

November 2013
Monitoring Report – January 2014

Enfield Child Prosperity Action Plan 2013

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
Aim 1: Supporting families to access employment, education, training and skills to maximise family income & develop financial resilience							
Lead ESP TAG: Employment and Enterprise					**TAG Champion: Anna Loughlin**		
- JCP Partnership Agreement, signed July 2013 - Reduce the JSA register to fewer than 10,000 by the end of March 2013, with a further reduction of 8% to 9,500 by December 2013 - Reduce the 18-24 Claimant Count by 18% to fewer than 2,000 by December 2013 - Reduce the register size for those claiming JSA for over 1 year by 10 % to 2700 by December 2013							
1.	**Addressing embedded deprivation and embracing social justice**						
1.1.1	1.1 Jobcentreplus to second two officers to the Change and Challenge programme in Enfield Council to support troubled families back to work	JCP/ Anne Stoker	Change and Challenge JCP Programmes	Prosperous/ Safer comms Learning, opps & employment School exclusions & poor attendance Parenting		Secondment to take place by mid October 2013	Complete. People in post
1.1.2	Identify the 200 longest term unemployed(JSA claimants only) in the borough and design appropriate individualised programmes to help them back to work with particular focus on families within this cohort (about 50% on WP)	AL with JCP	JCP Programmes	Prosperous/ Healthier Communities Learning, opps & employment	No. of families identified within this cohort Specific interventions designed for each family.	Identify by November 2013	Complete. Actions being identified now
1.1.3	Map local services for vulnerable people, identifying gaps and building capacity ahead of Universal Credit	JCP/Kate Robertson	JCP Programmes	Prosperous/ Healthier Comms Learning, opps & employment	Mapping carried out	by December 2013	Initial exercise complete and on-going

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
1.1.4	Focus resources and efforts on Enfield's most deprived wards where child and family prosperity is most concentrated	AC/ JCP /Simon Lord Link to Area Partnerships		Prosperous/ Healthier Comms Learning, opps and employment	LMI analysis to be received at of Area Partnerships for discussion.	Quarterly meetings	On-going – SL working with JCP to identify claimants by deprived wards so can work strategically with them
2.	**The Employer Offer**						
1. 2.1	Actively promote self-employment and provide support to contractors	JCP with EE and NLCC		Prosperous Communities Learning, opps & employment		On-going	Yes, Jobsnet advisor working with JCP to talk about self-employment
1.2.2	Train and employ 15 Benefit Cap customers in the Local Authority	KR		Prosperous/ Healthier Communities Learning, opps & employment		Staff in place by October 2013?	In place
3.	**Addressing barriers**						
1.3.1	Better track the success of English for Speakers of Other Languages (ESOL) provision within Enfield to ensure language is not a barrier to employment and inform the continuous improvement of provision through smarter working with providers.	AL/JCP + S&CS - LSW		Prosperous/ Healthier/ Safer/Cohesive Communities Learning, opps & employment		On-going over the next 1 – 2 years	On-going
1.3.2	Analyse childcare needs and requirements within Enfield to ensure sufficient, affordable childcare for working families and families seeking, particularly for families with 3+ children	AL/SCS		Prosperous/ Healthier Communities Learning, opps & employment Parenting		On-going over the next 1 – 2 years	On-going

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
1.3.3	Continue to develop initiatives that reduce youth violence and gang membership by opening up pathways to work	AL/JCP		Safer/ Cohesive/ Prosperous Communities Engagement with young people Policing		On-going over the next 1 – 2 years	On-going
1.3.4	Better integrate Jobcentreplus and Improve Access to Psychological Therapies (IAPT) services to open up the world of work, promote active citizenship and social inclusion to family member suffering with mental health conditions	Team Manager, Edmonton Jobcentre		Healthier/ Cohesive/ Prosperous communities Learning, opps & employment		On-going over the next 1 – 2 years	On-going – meeting scheduled to discuss proactively with head of IAPT
1.3.5	Provide careers/labour market advice in schools and design a programme to support school leavers that are deemed 'at risk'	JCP + LSW		Prosperous /Safer Communities School exclusion & poor attendance Learning, opps and employment		On-going over the next 1 – 2 years	Working with SCS; large careers event being planned; follow-up school heads conference

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
Aim 2: Improving education and learning experiences for all Enfield's children and families.							
Lead ESP TAG: Enfield Children's Trust				**TAG Champion: Eve Stickler**			
Our Actions support the Council and ESP Aims and are in line with the Council Commission recommendations operating within our principles of an inclusive early intervention and equal opportunities approach.							
2.1	<u>Early Years</u> Support opportunities for the most disadvantaged 2 year olds to participate in good quality early learning through the delivery of the Terrific Twos programme.	Head of CACEY / Head of Early Years Team	Early Years Sufficiency Duty Two Years Olds Free Entitlement Strategy	Learning, opportunities and employment	• 1,300 places available through the 2 year old offer	March 2014	**2013** 1,670 eligible two year olds received funding under the offer
					• 80% of places offered taken up	March 2014	**December 2013** 870 children were placed representing 66.1% of target
					• 2,000 places for eligible 2 year olds available ongoing	March 2015	With effect from September 2014
					• Increased take up of free early years education by 3 and 4 year olds - retention	March 2015	**Spring 2013** Take up of the free entitlement by 3 and 4 year olds increased by 6.1% over the same period in 2012.
					• Improved EYFS outcomes (NI072)	May 2016	**2013** APS 33.4 (national 32.8) Good Level of Development 49% (national 52%). *new calculation in 2013, comparison with previous years is not possible.

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
2.2	<u>Primary</u> Ensure that all pupils have access to good quality primary education attend a school which is at least good. Narrow the achievement gaps for disadvantaged pupils	Head of School Imp	School Intervention and Support Strategy	Learning, opportunities and employment	• Key Stage 2 results (NI073)	Annual	**2013** <u>achieving the expected level of 4+</u> 76% (national 75%) <u>2 levels of progress</u> Reading – 89% (88%) Writing – 93% (91%) Maths – 90% (88%)
					• No schools below floor target	Annual	**2013** 1 LA and 1 academy below floor
					• Narrow the gap between pupils eligible for FSM and their peers at KS2	Annual	**2012** 13%
					• Percentage of pupils attending a primary school judged as Good or Outstanding	Annual	**2013** 73%
2.3	<u>Secondary</u> Ensure that all pupils have access to good quality secondary education attend a school which is at least good. Narrow the achievement gaps for disadvantaged pupils	Head of School Imp	School Intervention and Support Strategy	Learning, opportunities and employment	• Key Stage 4 results (NI075 & NI75.1)	Annual	**2013** (Provisional) 5+A*-C, including English and maths 64% (national around 60%)
					• No schools below floor target	Annual	**2013** no schools are below floor
					• Narrow the gap between pupils eligible for FSM and their peers at KS4	Annual	**2013** Not yet available

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
					• Percentage of pupils attending a secondary school which is Good or Outstanding	Annual	**2013** 86%
2.4	<u>Post 16</u> Ensure pupils have access to a range of Post 16 provision that encompasses academic, vocational, training and employment routes.	Head of School Imp. Head of Learning and Skills for Work	School Intervention and Support Strategy	Learning, opportunities and employment	Reduction in • NEETS (NI117)	Annual	**June – August 2013** 3 month average 4.9% (London 5.7%)
					• Unknowns (YSS15)	Annual	**June – August 2013** 3 month average 6.5% (London 9.9%)
					• A broader range of provision including increase in apprenticeships	Annual	Recent curriculum at KS5 to include increased vocational level 2 and 3 in Health and Social Care (including traineeships and apprenticeships) and construction. Proposed curriculum plans in logistics and warehousing for 2014/15.
					• Improved A level results	Annual	**2013** (Provisional) <u>APS per entry</u> 210.8 (national 209.5) <u>APS per pupil</u> 695.8 (national 691.1)
					• Achievement of a level 3 qualification by 19 (NI080)	Annual	**2012** 64% (London 61%), (National 55%)

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
					• Percentage of teenage mothers in employment and education	To be confirmed	**July 2013** 31.9% of Enfield's teenage parents are EET (London 36.1%)
					• Increase range and take up of Work Experience	To be confirmed	
2.5	<u>Parenting</u> Preserve family life where feasible Reduce dependency and increase income Increase engagement and resilience	Head of CACEY Part. and Involvement Officer	Children's Centres Core Purpose PEP Action Plan and Steering Group	Parenting	Increased • parents completing evidence based parenting programmes • parents supported into work • families supported with entitlement benefits • involvement in Parent Engagement Panels • Parent Champions • Decreased no. of 0-4s living in households dependent on workless benefits	To be confirmed	Initial data collection process and baselines are currently being established.

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
Aim 3: Health To increase employment of residents of Upper Edmonton at the North Middx Hospital							
Lead ESP TAG: Health Improvement Partnership					**TAG Champion: Shahed Ahmad**		
3.1	Increase employment opportunities for residents of Upper Edmonton ward						
3.1.1	Obtain and send Upper Edmonton postcodes to JCP	Glenn Stewart	Upper Edmonton employment, NMUH business case	Prosperous Communities / Cohesive Communities Learning opportunities and employment	Postcodes obtained Number of claimants identified by JCP	End of March	Complete
3.1.2	JCO to match postcodes with people looking for employment				No. of UE residents put forward for NMUH jobs No. of UE residents recruited by NMUH	End of March	Complete – round one – on going.
3.1.3	Promote variety of jobs at NM Hospital in schools				Location and number of schools engaged. Numbers of sessions run.	End of March	On going
3.1.4	Promote variety of jobs at NM Hospital at community centres and other services				Location and number of community centres and other services engaged. Numbers people engaged.	End of March	On going
3.2	Increase opportunities for volunteering by residents of Upper Edmonton ward						
3.2.1	Explore potential volunteering work with Housing Associations	Glenn Stewart	Upper Edmonton and employment, NMUH business case	Prosperous Communities / Cohesive Communities Learning opportunities and employment	Contact to be made	End of March	
3.2.2	Facilitate volunteering opportunities with NMUH				No. of UE residents volunteering at the hospital % of volunteers in paid employment after 6 months/1 year of completing placement	To be confirmed	On going
3.2.3	Facilitate work placement				No. of UE young		On going

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
	opportunities with NMUH				people (16-19) undertaking work placements at NMUH		
3.3	Increase aspirations for residents of Upper Edmonton Ward						
3.3.1	Increase aspirations of children in primary schools	Glenn Stewart	Upper Edmonton and employment, NMUH business case	Prosperous Communities / Cohesive Communities Learning opportunities and employment	Changes in aspiration Baseline child aspiration measure (to be determined)	To be confirmed	Baseline measures of aspiration being developed through evidence-based practice.
3.3.2	Increase aspirations of children in secondary schools				Changes in aspiration Baseline pupil aspiration measure (tbd)	To be confirmed	Baseline measures of aspiration being developed through evidence-based practice.
3.9	Work with Family Nurse Partnership to increase aspiration of young parents		FNP Programme		Number of young mothers engaged in the programme. Baseline measure of aspiration (tbd)	End of March	

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
Aim 4: Encouraging the development of sustainable housing							
Lead ESP TAG: Community and Economic Development					**TAG Champion: Sally McTernan**		
4.1	Develop a Domestic Violence Protocol for Council and Housing Association Providers to prevent homelessness	Head Of Housing Strategy, IT & Business Support	Enfield's Housing Strategy	Safer Communities	Number of household affected by DV housed into alternative social and affordable rented homes rather than the private rented sector.	Implement Autumn 2013	Protocol almost finalised. Updates required from DV Co-ordinator. Implementation still on target for August 2013
4.2	Implement an additional and selective licensing scheme for private sector homes to improve housing conditions	AD Community Housing	Enfield's Housing Strategy	Cohesive Communities	Number of licensed HMOs and numbers of occupants	Scheme currently being formulated. Likely imp April 2014	Currently out to consultation on scheme. If agreed by Cabinet, implementation due October 2013.
4.3	Increase the supply of family size homes (3B+) by implementing and monitoring Policy 5 of Enfield's Core Strategy	Head of Strategic planning and Design	Enfield's Housing Strategy	Cohesive Communities	Social housing Target 65% Market Housing Target 60%	April 12-March 14	Feedback being requested – continue to be a challenge
4.4	Address Severe overcrowding within Enfield Council's Housing stock	Head of Business Dev. Enfield Homes	Enfield's Housing Strategy	Healthier Communities	Number of assisted mutual exchanges for overcrowded families through by moving under occupying tenants	New Scheme being introduced April 13 – March 14	Feedback being requested Continuing to be a challenge. Underoccupying has not resulted in
4.5	Implement Enfield Council's Decent Homes Programme to improve the quality of housing	Director of Tec & Property Services Enfield Homes	Enfield's Housing Strategy	Healthier Communities	1,330 homes made decent using Government's Decent Homes funding	April 13 – March 14	Feedback being requested On track - green

Action	Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
Aim 5: Reducing and preventing crime						
Lead ESP TAG: Safer & Stronger Communities Board				**TAG Champion: Andrea Clemons**		
5.1	Improve information sharing in order to manage offending and risk	SSCB	SSCB Plan, IOM process, Gangs Strategy, A&E depts	Safer and Stronger, Healthier	TBC	Quarterly	Information Sharing arrangements still being developed with North Middlesex Emergency Dept and a Youth Worker being appointed to liaise with young people attending with injuries
5.2	Work with partners to identify risks of increased crime and disorder linked with economic factors and shape services to meet emerging need	SSCB	Research & Problem-Solving Tasking	Safer and Stronger	Performance framework SSCB, MPS Plan, MOPAC7	Six months	Monitoring of MOPAC 7 crimes is showing high levels of acquisitive crime. Operation Spyder is launched to tackle vehicle crime and ongoing work to reduce victims of burglary is being led by the partnership. Offender and geographical profiles developed through the Strategic Assessment which will influence commissioning and new joint tasking arrangements and problem solving.

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
5.3	Support young people to make healthy choices and be resilient to negative influences from gangs	SSCB, ETYEB. Health and Wellbeing	Gangs Strategy	Safer and Stronger Healthier	TBC but including measures on offences such as robbery	Quarterly	Links with H&WB assessed by the Home Office and favourable report produced. A planning event is being arranged to ensure that both strategic boards are prioritising this work. The Gangs Strategic Group is about to launch to direct activity and the results of a research project into gangs and Girls is due in March 2014. Safe and Secure to support re-housing of gang members, the Call in process at court all overseen by the gangs action group

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
5.4	Support young people to make healthy choices and be resilient to bullying and violence, including VAWG	SSCB, ETYEB. Health and Wellbeing	SSCB Partnership Plan- VAWG strategy	Safer and Stronger, Healthier Environment	Performance framework SSCB, SPOE, ETYEB, PHOF	Quarterly	Research project will inform some activity. H&WB have commissioned 25 GPs through the IRIS project to identify early girls who may be affected by VAWG including those where gangs are a factor. Schools policing teams and the YEP are helping and mentoring young people at risk of involvement with crime or from violence. SSCB have a regular input into Junior Citizens to promote personal safety and Community Help Points providing safe refuge in local communities. The Safe Choices programme gives school pupils the tools with which to build personal strategies.

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
5.5	Ensure that offenders receive drugs and alcohol treatment to improve their health and support to manage their offending, in order to tackle crime	SSCB, Health and Wellbeing Board	DAAT Plan, IOM Process, SSCB	Safer and Stronger Healthier	Performance framework SSCB-SAADIAN (being developed) PHOF, DAAT PbR	Quarterly	GAG and IOM are linked and supported by the YOS. Within this integrated process drug and alcohol support and treatment is provided and commissioned through the SSB process. Mental Health is identified as a main element of work through the draft H&WB strategy which links with dual diagnosis and treatment of young people and adults.

Action		Lead Officer	Delivery Mechanism	ESP Theme(s) & CC recommendations	Performance Measures	Timescales	Progress January 2014
5.6	Support young people to make healthy choices and be resilient to pressure to abuse alcohol and the negative consequences of drinking and tobacco use	SSCB, Health and Wellbeing Board ETYEB	SSCB, Environment & DAAT/ Health & wellbeing Tobacco Control Alliance	Safer and Stronger, Healthier Environment	PHOF. TP, SSCB, ETYEB, Underage sales, counterfeit goods	Quarterly	Work to reduce under age sales and the availability of super strength drinks is underway along with the DPPO which will be extended to cover the whole borough. The approach of the TCA which incorporates both health and enforcement for tobacco is to be extended to reflect alcohol work (TBC). Positive activities are promoted to increase health and reduce the levels of childhood obesity. Healthy eating and the Food Strategy is supported through Regulatory Services and young people are encouraged to make best use parks and open space and parks

Agenda Item 8

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE **Health and Wellbeing Board** **13 February 2014**	**Agenda - Part: 1** | **Item: 8** **Subject:** **Pharmaceutical Needs Assessment** **Wards: All**

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1. EXECUTIVE SUMMARY

The purpose of this report is to assist the HWB to understand its role, responsibilities and the implications of the Pharmaceutical Needs Assessment.

2. RECOMMENDATIONS

1. To note that from 1 April 2013 the Board assumed responsibility for the Pharmaceutical Needs Assessments (PNA) published by NHS Enfield and that it has to publish its first PNA by April 2015.

2. To note that the inherited PNA was assessed externally as fit for purpose

3. To adopt the inherited PNA for 2014/15

4. HWB to set up a PNA steering group by April 2014 to produce a project plan for the HWB detailing timescales, governance structure, membership.

5. BACKGROUND

1.1 The Health and Social Care Act (2012) changed the responsibilities for commissioning of pharmaceutical services to meet the new provider landscape.

From April 2013:

- The Department of Health will continue to have the power to make regulations.
- The NHS Commissioning Board – now NHS England – has the

responsibility to commission pharmaceutical services taking into account the local need for services.

- Local HWB have the responsibility to undertake PNAs.

1.2 PNAs will be key documents for NHS England as they will inform its decisions on applications to open new pharmacies and dispensing appliance contractor premises. PNAs will also inform the commissioning of enhanced services from pharmacies by NHSE. Enhanced services are services such as anti-coagulation monitoring, on demand availability of specialist drugs, and out of hours services.

1.3 PNAs map local pharmacies and services currently including dispensing, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users. A PNA also describes the demographics of its local population, and their needs. It should look at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs. The PNA should contain relevant maps relating to the area and its pharmacies.

1.4 The preparation and consultation on the PNA should take account of the Joint Strategic Needs Assessment (JSNA) and other relevant strategies. However, the PNA cannot be subsumed as part of these other documents (but can be annexed to them).

1.5 Upon receiving a pharmacy application the Local Area Team of NHS England notifies interested parties of the application and since April 2013 HWBs are included as an interested party. The Local Area Team invites interested parties to make written representation on the applications within 45 days, should they wish. It then considers all representations and arranges an oral hearing to determine the application if it identifies a matter on which it wishes to hear further evidence.

1.6 The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 came into force on the 1st April 2013. These Regulations are made under s.128A of the National Health Service Act 2006 (see Appendix 1). Health and Wellbeing Boards (HWBs) will be required to produce the first Pharmaceutical Needs Assessment by the 1st April 2015 with revised assessments within three years thereafter. If there are significant changes to the availability of pharmaceutical services since the publication of its PNA within this time, the HWBs are required to publish a revised assessment as soon as is reasonably practical unless it is satisfied that making a revised assessment would be a disproportionate response to those changes. The HWBs can, if necessary, publish supplementary statements to the Pharmaceutical Needs Assessment as necessary.

1 . 7 The current Pharmaceutical Needs Assessment was undertaken and published by NHS Enfield in March 2011.

http://www.enfield.gov.uk/healthandwellbeing/downloads/download/1/pharmaceutical_needs_assessment

1.8 North Central London PCT Cluster commissioned independent consultants to review the quality of Enfield's PNA to ensure that it complied with the legal guidance. The review concluded that the local PNA is comprehensive and it addresses a number of the regulatory requirements fully and partially meets all other requirements in the regulations. It is suggested that future PNAs could be improved by ensuring that the report of the consultation conducted is a narrative account of what happened. Future PNAs will therefore place specific emphasis on the ensuring that is states clearly how protected characteristics of populations are provided for.

6. ALTERNATIVE OPTIONS CONSIDERED

None

5. REASONS FOR RECOMMENDATIONS

From 1st April 2013, every Health and Wellbeing Board (HWB) in England will have a statutory responsibility to publish and keep up to date a statement of the needs for pharmaceutical services of the population in its area, referred to as a pharmaceutical needs assessment (PNA). This paper explains the relevance of this to Enfield's Health and Wellbeing Board (HWB), and proposes the steps it can take to produce relevant, helpful and legally robust PNAs. The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, which came into force on 1 April 2013, requires each HWB to:

- Publish a revised assessment where it identifies changes to the need for pharmaceutical services which are of significant extent. The only exception to this is where the HWB is satisfied that making a revised assessment would be a disproportionate response
- Publish its first PNA by 1st April 2015.

HWBs will therefore need to put systems in place that allow them to:

- Identify changes to the need for pharmaceutical services within their area
- Assess whether the changes are significant and
- Decide whether producing a new PNA is a disproportionate response.

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

6.1 Financial Implications

In 2012 the London Public Health Transtion Group estimated that a PNA took on average 9 months to produce and cost £60,000. It is proposed that various options are considered when deciding how the next PNA will be produced. These options are likely to include commissioning an external consultancy company or the local CCG.

6.2 Legal Implications

The statutory duties on the Council with respect to the PNA are contained in the following regulations:

- Section 128A of National Health Service Act 2006, as amended by Health Act 2009 and Health and Social Care Act 2012
- Part 2 of National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013

The HWB must assess the needs for pharmaceutical services in its area and publish a statement of its first assessment and of any revised assessment.

The assessment must take account of likely future needs and certain specified persons must be consulted about specified matters when making an assessment. Regulations prescribe the matters to which the HWB must have regard when making an assessment.

Other legal implications are set out within the body of this report.

7. KEY RISKS

The use of PNAs for the purpose of determining applications for new premises is relatively new. Decisions made by the NHSE may be appealed and there may be judicial reviews of decisions made by the NHSE. It is important that PNAs comply with the requirements of the regulations, due process is followed in their development and that they are kept up-to-date.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

None

9. **EQUALITIES IMPACT IMPLICATIONS**

None

Background Papers - *None*

Agenda Item 9

MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE: **Health and Wellbeing Board** **13 February 2014**	**Agenda - Part: 1** | **Item: 9** **Subject: Safeguarding Children Board and Safeguarding Adults Board Annual Reports 2012-2013** **Wards:** All
Director of: Director of Schools and Children Service & Director of Director of Health, Housing and Adult Social Care **Contact officer:** Georgina Diba & Daniel Crampton **Telephone number:** 020 8379 4432 **E-mail:** Georgina.diba@enfield.gov.uk Daniel.Crampton@Enfield.gov.uk	**Cabinet Members consulted:** Councillors Ayfer Orhan & Don McGowan

1. EXECUTIVE SUMMARY

The Safeguarding Children Board exists as a statutory body and has a range of duties including implementing national policy developments and scrutinising and challenging local child protection and early help practice. Section 14 of the Children Act 2004 sets out the objectives for the LSCB as:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area and;
- To ensure the effectiveness of what is done by each such person or body for these purposes

The Safeguarding Adults Board is a partnership of statutory and non-statutory organisations, including local people and those who use services and their carers, committed to preventing and responding to the abuse of adults at risk. The primary aim of the SAB is to work with local people and partners, so that adults at risk are:

- safe and able to protect themselves from abuse and neglect;
- treated fairly and with dignity and respect;
- protected when they need to be; and
- able to easily get the support, protection and services that they need.

The intention of the draft Care and Support Bill is for Safeguarding Adults Boards to be put on a statutory footing.

This report brings to attention the annual reports from both respective Boards for 2012-2013. The annual reports aim to set out a summary of Board activities and its effectiveness in assessing and challenging safeguarding practice which keep children, young people and adults at risk safe.

2. RECOMMENDATIONS

To note the progress being made in protecting vulnerable adults and children in the Borough as set out in the annual reports from the Safeguarding Children Board and Safeguarding Adults Board..

3. BACKGROUND

The Safeguarding Children Board annual report has demonstrated that the Board is carrying out its statutory duties effectively. The Board has a two year business plan running from 2012-2014; a review of the business plan in March 2013 showed that progress was being made against actions.. New and emerging themes were incorporated to reflect the priorities of the Borough as well as nationally, including those arising from Serious Case Reviews and Independent Management Reviews.

The Safeguarding Children Board has a number of sub groups, supported by all agencies.. All sub groups are on track to achieve their objectives. The sub groups are as follows:

- Child Death Overview Panel – reviews the deaths of children and young people. Cases are reviewed and assessed as to whether there were any modifiable factors present i.e. could anything have been done or be done in the future to prevent such deaths.

- Child Sexual Exploitation and Trafficking Group - this group ensures a focus on child sexual exploitation and has built into its programme for the coming year the issue of missing children. Work undertaken includes a joint conference with Barnet and a risk assessment to enable better co-operation across different agencies when dealing with missing children and young people.

- Training and Development – ensures all staff across agencies have access to development opportunities which contribute to up to date safeguarding practice. This includes any new messages or learning arising from serious case reviews, independent management reviews and case audits. The group ensures that such learning is embedded in training programmes across all agencies.

- Quality Assurance – production and monitoring of a comprehensive data set that highlights activity, trends and key performance data within Enfield.

- Prevention - focuses on awareness raising of safeguarding in the community and the participation of children and young people. Activities in the last year include tackling knife crime in the Borough through in-school training, support of the voluntary sector and other youth fora.

- Serious Case Review Panel - reviews serious cases and ensures lessons are learnt and embedded from serious case and independent management reviews through the creation and monitoring of multi-agency action plans.

Additional key successes over the last year include recruitment of two lay members adding the voice of the community to the Board; high profile and successful events in collaboration with other Boroughs and adult services; creation of a responsive and reflective learning and development programme; improving the involvement of children and young people; and the on-going support from agencies that enables safeguarding concerns to be addressed and actions to be agreed and implemented.

The Safeguarding Children Board also recognises that in a changing environment it needs to adapt to the many challenges ahead. Some of the work areas outlined in the annual report as being undertaken include:

- Involvement of children and young people in the work of the Board – taking into consideration their views, including those who are under child protection. A

number of initiatives including consultation, a shadow board and surveys such as Viewpoint enabling children and young people to express their views are being worked on and developed for completion in 2013-14.

- Planned review of the new Working Together 2013 and the potential impact of this on the role and workings of the Board.
- Inspection frameworks and findings – there is a need to ensure that the work of the Board incorporates any findings in its own work plan and addresses these accordingly.
- Consideration of more cross borough working and sharing of practice in some key areas e.g. training, audits, joint initiatives – this is not only cost effective, but is a way of increasing sharing of ideas and best practice.

The Safeguarding Adults Board reviewed its strategy in 2012 and asked local people what actions we should take to meet the priorities of the Board in the coming three years. The answers from the consultation and other activities in the community have helped to inform the action plan in the Safeguarding Adults Strategy 2012- 2015. This will directly impact on and inform what we do to prevent and respond to the abuse of adults at risk. The strategy action plan for 2013-2015 is project managed by the Council's Safeguarding Adults Service and reported upon progress at each quarterly meeting.

The Board is supported by four sub groups, which are chaired by Board partner agencies. The four groups are:

- Service User, Carer and Patient Group
- Learning and Development
- Policy, Procedure and Practice
- Quality, Safety and Performance

The Safeguarding Adults Board have had a number of key achievements including challenging care and nursing homes to the dignity standards; continued raising of awareness of abuse to adults at risk through partnership events; practice based forums to share learning; initiatives by Board partners to include those who use services in the quality assurance and service development; aiming to improve access to the justice system by joint meetings between Local Authority and Police, as well as new initiatives by the Police to ensure adults at risk are flagged.

Keeping safe adults at risk is receiving increased focus in the media, following high profile cases such as 'Winterbourne View Hospital' and the public enquiry into events at Mid Staffordshire Hospital. In the coming year, we will consult on a policy for Health, Housing and Adult Social Care on the use of overt and covert surveillance to deter and detect abuse, seeking feedback from residents and key stakeholder on its implementation.

The Board is particularly keen to learn from the experiences of people who use services. To ensure we keep people central to the safeguarding adults process, where their views and experience drive practice, the Enfield Safeguarding Adults Service are developing methods for feedback which can be translated into service improvement.

Nationally, we are also seeing major changes in the political and economic context in which services and activities are planned and provided. We have the impact of the national and internal budget deficits, coupled with the impact of poverty and health inequalities faced by some groups. All of this will affect the capacity of individuals and whole communities to care well for themselves and the more vulnerable residents. The Boards will face these challenges to ensure that children, young people and the most

vulnerable are kept safe from harm and that the routine analysis of abuse takes into consideration trends associated with these political and economic changes.

The above national changes may also impact on carers and families, so we need to improve our understanding of the stress faced by families, in order to be able to take a holistic approach to care and risk planning. By improving our understanding and working across adult and children's services, where necessary, we can help alleviate the strain placed on families and the potential for harm.

Work between the Safeguarding Children Board and the Safeguarding Adults Board is an important part of how we keep everyone safe. In addition to joint events, the two Boards will need to consider how we can join up projects and initiatives which keep all communities safe and taking into account the need for smarter working and better use of resources. The extension of the existing Community Help Point Scheme for young people to also be open to adults at risk, in March 2013, was an example of this and further projects will be considered in 2013/14.

4. ALTERNATIVE OPTIONS CONSIDERED

Not applicable.

5. REASONS FOR RECOMMENDATIONS

Not applicable.

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

6.1 Financial Implications

Under Working Together 2013 the statutory partners on the Safeguarding Children Board contribute to a Board budget. The need to make best use of the resources and contributions from partners is paramount, while also recognising the need to maintain or increase contributions as the demands on the work of the SCB increase. The annual report provides details of the income of the Board, including agency contribution, other incomes and expenditure. This does not include the additional contribution from LBE for staffing of the Business Unit.

The Safeguarding Adults Board, currently non-statutory, does not have access to partner contributions or a budget at present. Primary support to the Board is provided via LBE through the Councils Safeguarding Adults Service.

6.2 Legal Implications

Section 13(1) of the Children Act 2004 places a duty on local authorities to establish a Local Safeguarding Children Board for their area. Section 14(1) of the Children Act 2004 sets out the objective of a Local Safeguarding Children Board as being to co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area of the authority by which it is established; and to ensure the effectiveness of what is done by each such person or body for those purposes.

Section 14A of the Children Act 2004 requires Local Safeguarding Children's Boards to prepare and publish a report about safeguarding and promoting the welfare of children in

its local area at least once in every 12 month period, and to submit a copy of that report to the local Children's Trust Board.

The preparation and publication of the report of the Local Safeguarding Children Board is done in accordance with these requirements.

There is no statutory provision for a Safeguarding Adults Board but paragraph 3.4 of the guidance 'No Secrets' (Department of Health, 2000) suggests that it may be helpful to establish a multi-agency management committee which 'should determine policy, co-ordinate activity between agencies, facilitate joint training, and monitor and review progress'.

The general power of competence set out in s1(1) of the Localism Act 2011 gives a local authority power to do anything that individuals generally may do. Section 4 (c) of the Localism Act 2011 gives a local authority power to do an act 'for …the benefit of the authority, its area or persons resident or present in its area'.

The general power of competence set out in s1(1) above gives the local authority the power to establish a Safeguarding Adults Board and to publish a report although there is no specific statutory authority to do so.

6.3 Property Implications

No property implications noted.

7. KEY RISKS

The raison d'être of both the Safeguarding Children Board and the Safeguarding Adults Board is to manage risks in relation to vulnerable children and adults respectively. Mitigation of these risks is demonstrated in both reports.

Restructure across a number of agencies, such as police, health and council services, will need to be considered and carefully managed to minimise the impact on children, young people and vulnerable adults. Both Boards have quality assurance mechanisms to consider the contribution from partners to keep people safe and are able to manage risks within this.

The Boards are required to work effectively within resources, while continually striving to achieve innovative services. Partners of the Safeguarding Children Board held a development day to discuss and agree the future operation of the Board, which would enhance efficiency and effectiveness of joint working, including membership and commitment. Needing to deliver in times of austerity, for both Boards, will be mitigated through an emphasis on joint work between children and adult services.

During 2012/13 we saw the number of referrals for safeguarding adults increase to 797, which of these 660 proceeded to the safeguarding adults process. The coming year will also see the Police use Merlins, which are a reporting system for adults coming to the notice of police personnel. This may result in a higher number of referrals to adult social care, which need to be screened and assessed to ensure the safety of individuals and to determine whether they require progression under safeguarding adults procedures. In response to these two factors, the Council's Safeguarding Adults Service are working with Adult Social Care Teams, to review the resources needed to effectively and safely manage safeguarding alerts.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

Fairness for All

Both Boards are committed to tackling inequalities and ensuring those disadvantaged and at risk of abuse are provided support and opportunities to protect themselves from harm and improve their well-being.

Strong Communities

Both Boards have strong leadership for independent chairs. In addition, partners on all Board are of appropriate seniority to promote the vision that 'safeguarding is everyone's business.' The work of the Boards must be responsive to the needs of local people and those who use services; this is achieved through a range of activities and quality assurance mechanisms.

Above all, the Boards work in partnership to improve safety of people in Enfield, linking to issues such as hate crime and domestic violence.

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

9. EQUALITIES IMPACT IMPLICATIONS

The annual reports are not equality impact assessed; work undertaken by the Board which may require assessments are done on an individual basis, such as policy or strategies produced.

10. PERFORMANCE MANAGEMENT IMPLICATIONS

Council Services supporting children are inspected though rigorous regulatory inspection frameworks and conducted by Ofsted and HMI Probation (young offenders). In 2015 the regulatory framework will be extended to inspect the roles played by other statutory partners including Health services and the Police.

Background Papers

None

Enfield Safeguarding Children Board

Annual Report 2012-2013

www.enfield.gov.uk

ENFIELD Council

Contents

Foreword by Independent Chair of the ESCB

2012/13 has been a very demanding and difficult time for all those agencies and individuals whose main focus is the protection and safety of children.

Almost on a weekly basis there have been news headlines and stories about child abuse on a very worrying scale, with several high profile names of current and former celebrities potentially being involved. Many of these cases go back over the last 40 years and it is almost as though the Jimmy Saville scandal brought with it some 'permission' for older cases to get the attention they should have received before.

Additionally we have also heard of some truly shocking current examples of child sexual exploitation, organised, extensive, and again on a scale unknown before. The Children's Commissioners Office continues its exploration into this worrying behaviour and is due to report in the Autumn 2013.

How then does the Enfield Safeguarding Children Board (ESCB) respond to these national examples when it does appear that the existing systems of safeguarding have failed to protect children. How do we keep delivering a balanced, disciplined yet focused multi-agency approach locally without slipping into any false complacency?

This interim Annual Report highlights what has been looked at during this year, what has worked well and what our focus needs to be in the year ahead. As the Chair it is important for me to understand as much as possible about what practice looks like at the frontline and where the stretch is likely to be most felt and importantly what are the barriers that can get in the way of truly effective partnership work. So far I have made 18 visits across a broad range of the partnerships around the table and have several more still to complete. My visits ranged from spending a day with a paramedic, to bring involved in a year 6 school assembly, sitting in on a 'strategy meeting' of a 12 year old boy, attending A&E, as well as sitting in at the multi-disciplianry meetings on domestic violence incidents and public protection cases at Edmonton Police Station.

All the agencies and individual workers (health, social care, education, police, probation,voluntary sector and others) I have seen and spent time with are dedicated, focused, active, and committed to the safeguarding of children. Yet we all know that we do need to 'continuously improve' and learn from each other to reduce harm and protect children.

As I write this introduction this Annual Report needs to be seen very much as 'work in progress', there are always new developments both nationally (e.g. new Working Together document March 2013) and locally (e.g. integrating local public health into the safeguarding boards formal structures) which will influence what we do and how. We need to be alert at all times to learn from local individual case examples and those already mentioned nationally to improve what we do and how we can get better.

I thank all the partnership agencies around the table, I warmly welcome the involvement of our two 'lay members' from the Enfield Community, and I look forward to developing many more real conversations with the young people of Enfield on whose behalf the Board needs to keep 'working together'.

Geraldine Gavin
Independent Chair of the ESCB
June 2013

Comments by the Author

I came into post in August 2012 as the new Business Manager and this represented an opportunity to review processes and the work of the Board with 'fresh eyes'.

This was and remains particularly important in view of the ongoing pressures to be more efficient and effective. Since coming into post, business and administrative processes have been streamlined to ensure that the sub groups of the Board and their chairs received effective support. We have also introduced new ways of training such as lite bites – shorter more focussed training sessions which have ensured that more staff are receiving the training and support they need while keeping time away from their 'day job' to a minimum. This work to deliver 'more for less 'and make best use of contributions from partner agencies continues.

My work focuses on supporting the Board and the Chair and our partner agencies and ensuring that the work of the ESCB is promoted as much as possible including to the communities we serve. I help the Board to continually review how we work and what we could do better, learning lessons from other Boards and also of course taking action to ensure that any lessons to be learned from serious cases are implemented through our partner agencies.

I remain passionate about the wide range of work the Board carries out with its partner agencies to protect and safeguard our children and young people. I am also committed to supporting the Board engage more effectively with the community it serves and hearing the voice of our young people in our planning. Since coming into post, I have been impressed at the commitment of all Board partner agencies to do the best they can to protect our children and young people.

I write this report as a reflection of the progress made not only from my point of view but also taking into consideration the views of others. The report includes some personal reflections and comments from some of those involved in this work including our lay members who provide a 'community voice' on the Board. It is also based on evidence and examples reviewed for the 2012-13 Business Plan and the ongoing progress the Board is making to transform the way it works to meet future challenges in safeguarding our children and young people.

Alison Cutler
Business Manager ESCB

Executive Summary

This report represents an update on the work of the Enfield Safeguarding Children Board for 2012-13 as required under the terms of Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children. (HM Government 2013). The report aims to provide a summary of Board activities and its effectiveness in assessing and challenging safeguarding practice across partner agencies.

The Board has a number of sub groups all of which are well supported by partner agencies and all of which have shown considerable progress against objectives set as part of the two year Business Plan. They are all functioning well and their work areas and terms of reference continue to be reviewed to ensure they remain fit for purpose. These sub groups are the key mechanism in the Board for challenging practice and any gaps or weaknesses in service provision. The review of the Business plan and the activities of the sub groups shows overall that the Board is continuing to make a difference to safeguarding practice across the Borough.

Key highlights 2012-13:

- Recruitment of 2 Lay Members
- Recruitment of Business Manager and Information Officer following a period of interim arrangements
- Delivery of high profile and successful events in collaboration with other Boroughs and adult services.
- Delivery of a responsive and reflective learning and development programme that is cost effective and also meets the needs of practitioners and agencies
- Children's conference and development of processes to better involve children and young people
- Business plan on target and flexible to reflect emerging issues
- Ongoing support from agencies – with overall good commitment to attending meetings and supporting the work of the Board. This enables discussions and challenges to any concerns to be addressed.
- Continued focus on improvement and challenge by looking at business processes in the Board and challenging agencies and practice where needed
- Development of a website to promote the work of the Board, ensure information about safeguarding and support is available to the community and share best practice amongst practitioners
- Continued links and sharing practice with other Boards, with ESCB representatives attending London Board groups and thus contributing to pan London safeguarding practice.

Areas for development in 2013-14 – what we could do better:

- Involvement of children and young people in the work of the Board and development of a Shadow Board
- Planned review of the new Working Together 2013 and the potential impact of this on the role of the Board
- Inspection frameworks and findings – there is a need to ensure that these form also part of the improvement plans and actions in the Board
- Restructure across a number of agencies e.g. probation, police, health and education with academies and free schools and any potential impact on safeguarding practice
- Focus on sexual exploitation following the children's commissioners' report and the joint Enfield/Barnet Sexual Exploitation conference
- Need for smarter working and better use of resources
- Consideration of more cross borough working and sharing of practice in some key areas e.g. training, audits, joint initiatives
- Making best use of actions plans, data and case examples to continue to robustly challenge areas of concern

This report shows that overall the Board is carrying out its statutory duties effectively. However there are areas for development as cited above and this will form the basis of ongoing work in 2013-14.

Introduction

Scope of this report

The Local Safeguarding Children Board (LSCB) is required under the terms of Working Together 2013 to produce an annual report.

In Enfield, the Enfield Safeguarding Children Board (ESCB) has a two year business plan in place running from 2012-2014. This is scrutinised annually in order to ensure progress against targets and also that any changes required are incorporated into the plan.

In consequence, the Annual Report presented here is an interim report which considers the following:

- The role of the Board
- Key activities and achievements
- Key challenges
- Next steps for 2013-14
- Conclusions about the effectiveness of the Board

This interim report represents 'work in progress' for the Board in ensuring that it functions effectively in carrying out its statutory duties, is responsive to the changing environment and also that it ensures that all partner agencies are working to keep children and young people safe from harm.

Role of the Board – what do we do?

The Board exists as a statutory body and has a range of roles including developing policies and procedures and scrutinising and challenging local safeguarding practice.

Section 14 of the Children Act 2004 sets out the Objectives for the LSCB as:

- To co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area and;
- To ensure the effectiveness of what is done by each such person or body for these purposes.

While the LSCB do not have the power to direct partner agencies, they have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding. (Working Together to Safeguard Children, 2013)

The role therefore of the Board is thus to have an independent co-ordinating and challenge role around safeguarding practice across its partner agencies. Within Enfield this is carried out via each of the sub groups, details of which are outlined later in this report.

For 2012-13, membership of the Board and representation from all agencies on each of the sub committees was good (see Appendices 1 and 2 agency statistics and membership), however, it is recognised that improvements can be made in the way the Board functions to ensure that it better discharges its statutory functions.

The Board is thus considering the way meetings are run, how information is shared and presented and how it can more effectively challenge practice. Work has begun on this already and will be moved forward further in 2013-14.

Key activities of the Board in 2012-13

Business plan on target

A review of the Business plan in March 2013 showed that in most key areas progress was being made against the actions (see Appendix 3) and where any were delayed or showing as 'red' work has been undertaken to rectify these. It was felt also that new and emerging themes needed to be incorporated into the plan moving forward to reflect the priorities in the Borough as well as nationally from arising from Serious Case Reviews and Independent Management Reviews. These will form the basis of individual work plans for each of the sub groups in 2013-2014.

These themes include:

- Domestic Violence
- Sexual Exploitation and trafficking
- Missing children
- Private fostering
- Promoting the work of the Board
- More cross borough work

Sexual abuse also remains high on the agenda and work will continue in this area in 2013/14 through monitoring practice, disseminating learning from for example the Saville report and running awareness campaigns and training.

Briefings on lessons from Serious Case Reviews were carried out in 2012/13 and further events are planned for 2013 including a conference covering these key themes.

Following the success of the children's conference in October 2012, engagement with young people and involvement in the Board is an area for further development in 2013. Working with the participation sub group of the Children's Trust and its partners, the Board will have a mechanism in place to support a shadow board and involve young people in shaping the future work of the Board. The Board recognises that work to involve young people is not as advanced as it could be and thus actions are being progressed to rectify this. Such actions include having a consultation mechanism in place, repeating a children's conference in 2013 and inviting young people to a development day with the Board to ensure their views are taken into consideration when setting the business plan.

LSCB Business Unit

The Business Unit of the Board is taking on increasing responsibilities following the publication of Working Together 2013 and is thus currently under review. The appointment of a full time Business Manager with a team of administrative co-ordinators (2 full time equivalents) to oversee the work of the Board has helped to streamline processes and look at new ways of working. The appointment of an Information Officer in 2013 has been crucial in further developing the Board's communication and profile with the third sector, the local community and young people in particular. The further development of the website as well as the community handbook are two areas of work currently being progressed.

Karen Duncan, the Information officer for the ESCB comments as follows on her work:

> "My role is to promote ESCB on a multi agency basis within partner agencies and the wider community and to ensure that the board reflects their needs. An example of joint agency working is the production of the Community Handbook and redesign of the ESCB website to raise awareness and promote the welfare of children. The Community Handbook also offers ideas and helpful tips from professionals and what to look out for.

Third sector engagement is an important element in shaping policy and developing stronger communities. I've worked with Enfield Children and Young People Service, Enfield Voluntary Action, other community groups and services to ensure that Enfield communities receive the information they need about safeguarding services available to them. Those who work in these organisations are dedicated and work tirelessly in the work that they do. I am also working with Enfield 'SPOE' to increase involvement with the Third Sector. We must ensure however that we also reach out with otherwise disengaged and hard to reach groups within our community.

One of my highlights was 'Keep Safe Week' where ESCB, Enfield Safeguarding Adult Board, our partners and the Third Sector came together to deliver a programme of events held across the borough to support our diverse communities and raise awareness of safeguarding children and young people. During 'Keep Safe Week,' whilst I was manning a stall in Enfield Town, a vulnerable adult approached and said that he had walked all across the Enfield Town to find the stall. It was a freezing cold day and he smiled widely when I provided the information he required and shuffled off with the leaflets stuffed into a ruffled plastic bag. 'This is what it is all about' I thought. The Diversity day event was well received and attended by our Mayor Kate Anolue.

I am inspired by the young people at 'KRATOS' (Children in Care Council') their commitment and enthusiasm to provide a platform to ensure that voices of young people are heard. I am engaging with them on ideas for the ESCB website and Community Handbook and I look forward to continue working with young people involved in the participation agenda.

My role as Information Officer also extends to policy development and training and development. I am working with colleagues and stakeholders in shaping local protocols and guidance arising from the 'sexual exploitation' agenda and working alongside colleagues to roll out the ESCB training programme.

I am fortunate to be in a position to assist with shaping the future together with our partners, because 'Safeguarding is everybody's business'."

Lay members

The Board now has two volunteer lay members whose role has been essential in offering the 'community voice' to the Board and challenging what the Board does. They provide the link between the strategic work of the Board with the local community and have proved invaluable in assisting with audits, recruitment and community awareness-raising events such as Safeguarding Week.

One of our lay members has this to say about her work:

" Children's safeguarding is a subject that is close to my heart and it was for this reason that I decided to become a lay member on the ESCB, to learn more about the work of the board and to be able to give a voice for the 'ordinary' person on the street.

I have been genuinely impressed by the scope of the ESCB's role in bringing together all the agencies involved in children's safeguarding as one, more powerful force for change. The wealth of services available to vulnerable families and children to safeguard, educate, empower and enhance their lives has been an education to me. It's been heartwarming to witness the commitment of all the agencies involved and to know there are people who care so passionately about the welfare of our children.

And it is this message, I would like to see conveyed more effectively to the general public. In doing so, to lessen the stigma of asking for help and the 'fear' of being 'involved' with social services, so the frightened child will feel more able to seek help. Through greater public awareness I feel the services available to help vulnerable families and children will, therefore, be made more accessible and uptake levels improved.

I plan to support the board and contribute by taking advantage of the training courses available to enhance my knowledge and understanding of child protection issues and the legal framework.

To engage in the exchange of ideas and information at meetings and keep abreast of the latest child protection issues. To question if I don't understand or agree with any points of discussion and offer an independent viewpoint. To draw on personal experience to convey the concerns and expectations of the general public and highlight any issues and problems the board may not be aware of."

Our other lay member also comments:

> This is the second Annual Report that I have written for and the last year has been really interesting. I have been joined by another lay member and together we will hope to represent the community on the board as best we can.
>
> I have taken the opportunity to take part in many training sessions and events that have been available to me and find that my knowledge on the many issues that affect the safety of the children and young people in our community is increasing all the time.
>
> There have been several high profile cases in the press recently involving young people within our borough, some them through gang activity and others for other serious offences, but an area that is of increasing concern for all of us in the trafficking and exploitation of young people. The ESCB is working hard with its partners on dealing with this problem and we, as lay members hope to be involved in some of the initiatives around this.
>
> I have been fortunate enough to have attended talks from CEOP (Child Exploitation and Online Protection Centre) and an organisation called AFRUCA (Africans Unite Against Child Abuse) which highlighted many issues including the practise of Witchcraft and female genital mutilation, this was a very enlightening and really brings home the task of making lives better for young people and children in our communities.
>
> Again I would like to thank the team for making us feel involved and offering us the help and guidance we need in order to represent the community at board level.

Collaboration and multi-agency working – events

2012-13 saw a number of successful awareness raising events being carried out by the Board. The aim of each of these was to promote safeguarding to the community and young people and these were carried out in collaboration with partner agencies including the voluntary sector, police, adult and children's services and health.

A successful area of collaboration included Keep Safe Week – a joint initiative between the ESCB and the Enfield Adult Safeguarding Board. This was an important event to raise safeguarding awareness amongst the community as well as professionals. Part of this week also included a children's conference which enabled young people to engage with the safeguarding agenda and presented an opportunity for the Board to take their views into consideration. This event was run in October 2012 and again in March 2013.

In March 2013, a Diversity Day also formed part of Safeguarding week – this was run in conjunction again with partner agencies and was run across the Borough to promote the breadth of services available to support children, young people and their families. In this way, the ESCB was helping local organisations as well as partner agencies to directly deal with the communities they serve to raise awareness around safeguarding issues.

All of these activities are crucial in supporting joint working by bringing together services who work with adults and children to better support families, but also to raise safeguarding awareness to the wider community.

Additional areas of work

The Board also monitors other areas of work. This includes monitoring of cases to the LADO (Local Authority Designated Officer), Licensing and Private Fostering.

Report from the Local Authority Designated Officer (LADO) 2012-13

The role of the LADO is set out in the Working Together to Safeguard Children (2013).

The LADO should be alerted to all cases in which it is alleged that a person who works with children has:

- behaved in a way that has harmed, or may have harmed, a child
- possibly committed a criminal offence against children, or related to a child
- behaved towards a child or children in a way that indicates s/he is unsuitable to work with children

The LADO role applies to paid, unpaid, volunteer, casual, agency and self-employed workers. They capture concerns, allegations or offences emanating from outside of work. The LADO is involved from the initial phase of the allegation through to the conclusion of the case.

In Enfield, the role of the LADO is undertaken by the Deputy Head of Safeguarding, who has overall responsibility for overseeing investigations, alerting senior council officers to allegations of a serious nature, and making referrals to the Disclosure and Barring Service (formerly ISA).

In addition, advice is offered to agencies when it is not clear whether a referral to the LADO is necessary. Schools, in particular, have fed back, that this has been very helpful. Very effective working relationships with Humans resources and more specifically Schools Personnel have been developed.

Training has been provided over the years around managing allegations, both via the LSCB and single agency.

The LADO will be delivering training to Enfield foster carers on 1st July. A similar session will be delivered to Heads and Governors on 2nd July.

In 2012-13 the LADO dealt with 56 allegations. This ranged from very low allegations when a strategy meeting was not necessary, to serious allegations of sexual assault of children, leading to a member of staff being charged with sexual assault.

Maria Anastasi
Deputy Head of Service and LADO
Safeguarding Children and Quality Assurance Service

Licensing

Licensing figures for 2012-13 are as follows:

In the period 01 April 2012 to 31 March 2013 the Enfield Safeguarding Board received notice of 80 licence applications which is 12 less than last year.

The premises included:

- 15 Restaurants
- 11 Supermarkets
- 6 Public Houses
- 4 Petrol Stations
- 3 Off Licences
- 3 Banqueting venues

The rest were various venues such as a Wine Bar, cafes, mini-markets and takeaways.

There were 2 applications where children under 18 were not admitted therefore no conditions necessary.

Not all applications included the sale of alcohol but related to the public showing of films /videos which are restricted to the recommendations of the British Board of Film Classification. Some of the applications were with regard to changes in opening hours. There were 3 applications for Gambling Licences.

Private Fostering

In terms of Private Fostering, activity of the Board continues to raise awareness of this in the community via leaflets and roadshows, as well as training for statutory and voluntary sector organisations.

As at March 2013, the number of children in private fostering arrangements was 7.

Budget

In these times of greater demands on budgets, the Board is focussed on doing more with less. The need to make best use of the resources and contributions from partners is paramount, while also recognising the need to maintain or increase contributions as the demands on the work of the LSCB increase.

The LSCB budget is managed with continual tight control, with an emphasis on value for money and transparency. Contributions are made from all areas as below:

Income 2012-2013:	
Agency Contribution	**Amount**
Metropolitan Police	£5,000
NHS Enfield	£5,0000
North Middlesex Hospital	£3,000
Chase Farm Hospital	£3,000
London Probation Service	£5,000
CAFCASS	£550
BEH Mental Health Trust	£3,000
Enfield Children's Services	£23,400
Total	**£47,950**

Other income:	
	Amount
Munro monies	£12,586
Income from training charges	£1,250
Carried forward from 2011-12	£54,000
Total Income for 2012-2013	**£115,786**

Expenditure:	
	Amount
Training	£13,612.78
Catering/room hire	£2,006.70
Chair	£26,979.68
Conferences/events	£859.50
IMR	£8,021.16
Promotional items	£2,424.71
Misc	£97.81
Written off	£5,000.00
Total	**£59,002.34**

Please note this income and expenditure does not include the additional contributions from LBE for staffing of the Business Unit.

Budget for 2013-14

The projected spend for 2013-14 will be broadly similar with a £40k carry over from 2012-13 ring-fenced for any Serious Case reviews. Other areas of spend will include the children's conference, additional promotional work and initiatives such as e learning.

The Executive agreed that budget contributions for 2013 -14 should remain as 2012- 2013 in view of the carry over of £40k for 2013-14.

However, this budget should also be considered in view of the increased demands on the Board and reinforcement of its role in Working Together 2013. This has required additional hours being worked by the Chair and other members of the ESCB Business unit to fulfil these increased demands, as well as an ongoing streamlining of processes. The budget will thus be reviewed again in September 2013 to assess spend against income and consider further the resource requirements of the ESCB Business Unit in supporting the work of the Board.

Learning from practice

Audits and their findings remain an important influence on the work of the Board as they provide evidence of any areas of improvement needed.

The Board carried out a Section 11 Audit in 2011. This audit is designed to allow agencies to consider their working practices against Section 11 of the Children Act 2004 i.e. to ensure that their functions have regard to safeguarding and promoting the welfare of children.

While the outcome of this audit was that overall no concerns were apparent, a further Section 11 is being undertaken in 2013 with an emphasis this time on making the audit more practice related and practice based – this will ensure that examples can be given of where practice is working and where it is not. To this end, a joint event with Barnet was held in December 2012 to determine how both Boards could streamline the process and make it more 'real'– recommendations included using examples, sharing information across boroughs and reviewing the structure of the Board. These are all being implemented in 2013 and the findings of the Audit will be subject to further challenge and scrutiny – each agency being asked to present findings to a panel made up of the Board Chair, Head of Safeguarding and Quality Assurance and a Lay Member.

Other initiatives that are being actively implemented to improve auditing of practice include the robust monitoring of action plans from recent Independent Management reviews and ensuring that all learning and action has been taken. An example of this has been improving the communication flow between the Coroner and the LSCB to ensure all relevant information is made available at inquest – the Chair, Business Manager and Head of Safeguarding met with the Coroner to look at ways of achieving this in the future.

The Independent Chair of the ESCB is also visiting all agencies and observing front line practice to ensure that the Board is able to see 'behind' the audit information and view what is occurring 'on the frontline'. The aim of this being to ensure greater connection between the Board and front line practice – thereby highlighting areas of excellent practice as well as any gaps that need to be addressed. Her findings will again form part of the work of the Board in 2013-14.

The Board is also supporting particular initiatives to improve front line practice – for example supporting training of GP's and encouraging their participation in Child Protection conferences. Such initiatives help support and improve the quality of safeguarding practice for our children and young people.

Key achievements and activities from the sub groups 2012-13

All sub groups of the Board are supported by the different agencies, with each having multi agency membership and attendance (see Appendices 1 and 2). Each have reviewed their progress against the Business plan, as well as their terms of reference. This has ensured that they are on track to achieve their objectives and where any gaps have been identified, that actions are in place to correct these.

Child Death Overview Panel

The Child Death Overview Panel (CDOP) has met regularly to review the deaths of Enfield infants and children. Cases were reviewed and assessed as to whether there were any modifiable factors i.e. could anything have been done or be done in the future to prevent such deaths. As a result of this, annual professional update sessions are held jointly with Haringey CDOP at North Middlesex hospital to remind practitioners of for example the evidence around sudden unexplained deaths in infancy (SUDI) and safer sleeping. Such cases will continue to be monitored and any arising themes will form the basis of future awareness raising sessions. Learning is also co-ordinated with information from other CDOP's nationally so that any lessons can be identified and included in training programmes and the work of the Board.

Child Sexual Exploitation and Trafficking Group (CSET)

2012-13 showed an even greater focus on child sexual exploitation which included a joint conference with Barnet – this joint venture increased awareness across the boroughs of sexual exploitation and trafficking amongst professionals from different agencies. This conference was extremely successful and the outcomes and feedback from this has led to further training being implemented such as a lite bite training session about online sexual exploitation. It also forms part of the basis of the work of the Board and this sub group in this area on 2013-14.

Some of the comments received about the event from delegates included;

'Best event I have attended in 30 years', 'Fantastic event', 'Fascinating and useful information' ' More of these events please'

The CSET group is completing a self-assessment of the current position within the two boroughs and will shortly be issuing a set of draft protocols for missing children and updating agencies' understanding of the key issues regarding CSET across agencies. More joint events are planned, as well as specific areas of training as identified and requested by delegates to support them in their work. Further progress includes the establishment of CSET as a full sub committee of the Board, focussing on the area of child sexual exploitation and trafficking. This group will also consider the issue of missing children and this has been built into its work programme for 2013-14. A further area of work for this group has been the completion of a risk assessment form to enable better co-ordination across the different agencies when dealing with missing children and young people so that improved support can be put in place. Key to the success of this has been a close partnership with St Christopher's Fellowship and multi agency Single Point of Entry Service within the Council which deals with initial safeguarding concerns before cases are referred to the appropriate agencies for action.

Training and Development

The group produced an annual training plan with attendance from agencies as below and continues to review areas where there may be gaps in training and development so that these can be addressed. It should be noted that while Police have not to date attended training, they attend conferences – this is very much in line with other boroughs. This is a gap however that will be addressed in 2013 by further discussion and agreement with the police as to how to best engage officers in multi agency training in future including linking with any training leads in the police service.

The development of 2 hour 'lite bite' sessions on a variety of themes based primarily on lessons from Serious Case Reviews and Independent Management Reviews has proved popular and this will continue to be developed in 2013-14. Such areas include: online sexual exploitation, domestic violence and drug and alcohol abuse. Other methods of training such as e-learning and learning fora are also being considered.

Attendance on core multi agency training programmes 2012-2013

Agency	Number
Local Authority	124
Education	152
Police	0
Health	64
Mental Health	29
Independent/Voluntary	102
Out of Borough	0
Probation	0
Total	**471**

Schools continue to receive training for all their designated persons directly to ensure that their practice is up to date.

Work is also currently being undertaken to ensure that all agencies have access to safeguarding training – this applies especially to agencies where safeguarding is not their only focus, such as housing services. An analysis of possible gaps in training provision and actions for addressing this via for example e-learning is being considered.

A train the trainer programme was implemented to ensure that all of our internal trainers are supported in good practice training methods and this will be further developed in 2013-14 by the development of a trainer forum where best practice can be shared. The use of a primarily internal training resource ensures that the training provided is effective, based in local issues and is cost effective.

The training sub group also ensures that any new messages for learning arising from serious cases, independent management reviews and audits is embedded in local agency training programmes – examples of this include Private Fostering, new processes such as the Single Point of Entry and sexual exploitation and trafficking. This ensures that all staff have access to the latest information and can thus keep their practice up to date. This work will continue in 2013-14.

Quality Assurance

The Quality Assurance sub-group of the Board refreshed its terms of reference in February 2012. Since that time, the group has successfully produced a comprehensive data base of child centred organisations activity and key performance data within Enfield. The sub group analyses the data and provides quality assurance and challenge to agencies. At the present time the information is largely quantitative and the groups aim is to condense this information into a qualitative briefing that can be presented to the Board and their members.

Prevention

The group continues to focus on awareness raising about safeguarding in the community and the participation of children and young people. A successful children's conference was run in 2012 and this is planned again for 2013, working closely with the Participation group of the Children's Trust and the youth service. This conference was planned by young people and presented by them in 2012 and will follow a similar format in 2013. The prevention group will also work with the Children's Trust to facilitate the development of a young persons shadow Board in 2013 to ensure that young people play an active role in developing the work plans of the main Board.

A key difference made as a result of the conference was a survey of young people; over 20% thought it was acceptable to carry a knife. This shocking statistic was raised at the main Board by our lay member who was present at the conference. This issue has been addressed via in-school training and the support of the voluntary sector and other youth fora in awareness raising about knife crime. In this way, the Board and its partners has played an important role in trying to reduce knife crime in the Borough.

The Community Handbook is also a key piece of work to be completed in 2013 which will also be featured on the safeguarding Board website. Ongoing engagement with the community and the voluntary sector remains a key focus and events such as the Diversity Day and Safeguarding Week have played an important role in disseminating safeguarding information to the community.

Serious Case Review Panel

This group continues to review any cases and address and follow through actions from previous Serious Case and Independent Management Reviews. This ensures that any lessons learned are implemented. Learning events are also being planned and have been delivered around lessons arising from Serious Case Reviews (SCRs) and Independent Management Reviews. These include Domestic Violence, Sexual Abuse and Safer Sleeping. Lessons from national cases are also included in training across all agencies and this is implemented via the work of the training sub group. Examples of work arising from actions plans include: a review of communication and information sharing between and within agencies especially around parents with additional needs, improved advocacy for children who have difficulties with communication, and a review of processes such as transferring cases across teams. All of these improvements have been implemented as a direct result of lessons arising from such cases.

Enfield has been involved in SCRs with Brent and Haringey and contributes to Domestic Homicide Reviews in Hertfordshire and Hackney. Any learning or action plans arising from these will be implemented once complete.

A programme of peer reviews is already in place to consider lessons from practice. Panel members are also attending training on systems models from SCIE (Social Care Institute of Excellence) in June 2013 to consider how to implement more effective ways of learning lessons from cases in the future.

Summary of successes 2012-13

The Board can show some key successes in the year 2012-13:

- Recruitment of 2 lay members adding the voice of the community to the Board
- Recruitment of Business Manager and Information Officer following a period of interim arrangements – this has led to the introduction of more streamlined and effective processes and increased profile raising of the work of the Board within the Community
- Delivery of high profile and successful events in collaboration with other Boroughs and Adult services
- Delivery of a responsive and reflective learning and development programme that is cost effective and also meets the needs of practitioners and agencies
- Children's conference and development of processes to better involve children and young people
- Business plan on target and flexible to reflect emerging issues with examples of where practice has been improved
- Ongoing support from agencies – with overall good commitment to attending meetings and supporting the work of the Board. This enables challenges to any concerns to be addressed and actions to be agreed and implemented
- Examples from all sub groups of actions that are making a difference to safeguarding practice in Enfield
- Continued focus on improvement and challenge by looking at business processes in the Board and challenging agencies and practice where needed
- Development of a website to promote the work of the Board, share good practice with professionals and ensure information on safeguarding and support is available to the community
- Continued links and sharing practice with other Boards, with representatives from the ESCB also sitting on the London Board groups and thus contributing to pan-London safeguarding practice.

Challenges and next steps

The Board also recognises that in a changing environment it needs to adapt to the many challenges ahead and that improvements can be made. Work is thus already being undertaken to address the following:

- Involvement of children and young people in the work of the Board – taking into consideration their views, including those who are under child protection. A number of initiatives including consultation, a shadow board and surveys such as Viewpoint enabling children and young people to express their views are being worked on and developed for completion in 2013-14.
- Planned review of the new Working Together 2013 and the potential impact of this on the role of the Board.
- Inspection frameworks and findings – there is a need to ensure that the work of the Board incorporates any findings in its own work plan and addresses these accordingly.
- Restructure across a number of agencies e.g. probation, police, health and education with academies and free schools – consideration to be given on the impact of this on safeguarding practice especially also in light of tightening budgets. One challenge remains that attendance at ESCB sub group meetings is sometimes sporadic due to increased work pressures on attendees especially where restructures are in progress.
- Focus on sexual exploitation following the children's commissioners' report and the joint Enfield /Barnet Sexual Exploitation conference.
- Awareness and measurement of the impact of welfare reforms on safeguarding – including demand for housing and more school places with the potential migration of more families into the Borough.
- Need for smarter working and better use of resources – doing more with less.
- Consideration of more cross borough working and sharing of practice in some key areas e.g. training, audits, joint initiatives – this is not only cost effective, but is a way of increasing sharing of ideas and best practice.
- Consideration of how the work of the Board links to other Boards such as Adult Safeguarding Board, the Health and Well-Being Board and how and where joint working can become more effective.
- Ongoing awareness raising amongst the community including a re- design of the ESCB website to make it more user friendly and informative.

Conclusions

In summary, it can be said that there has been real progress made to continue to improve safeguarding practice across the Borough primarily via the work of the Board sub groups in 2012 -13 – with many examples of where the Board and its partner agencies has made a difference in safeguarding practice. There are also however some gaps and areas of improvement that have been identified which are currently being addressed and will continue to be worked on in 2013 -14.

The Board continues to develop an ethos of ongoing challenge and improvement not only of its partner agencies but also of itself. With this in mind, the ESCB looks to challenge the way we do business – complacency in this important area of work of safeguarding children and young people is clearly not an option. We will continue to seek out what we can do better to support the community we serve and ensure that the message that 'safeguarding is everyone's business' continues to be promoted.

Appendix 1

Enfield Safeguarding Children Board Partner Agencies

ENFIELD Council

METROPOLITAN POLICE

TOTAL POLICING

PROBATION SERVICE

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

NHS
Enfield
Clinical Commissioning Group

Barnet and Chase Farm Hospitals NHS
NHS Trust

North Middlesex University Hospital NHS
NHS Trust

Cafcass
Children and Family Court Advisory and Support Service

Barnet College | Southgate College

LFB
LONDON FIRE BRIGADE

Children & Young Persons' Services

2 Lay members

Appendix 2

Attendance by Agency at Board and Sub-Group Meetings 2012-13

Enfield Safeguarding Children Board Meetings

	Date of meeting				
Agency	22/05/12	02/10/12	30/11/12	29/01/13	26/03/13
Community Health	5	2	2	3	6
Barnet & Chase Farm Hospitals	1	1		1	1
North Middlesex University Hospital	2	1	1	1	1
Public Health		1		1	
Children & Adolescents Mental Health Service					
Mental Health	1	1	1	1	1
Police – Child Abuse Investigation Team	1	1	2	1	2
Police – other	2	2	1	1	
Youth Offending Service	1	1		1	
Community Safety Unit	2	2	2	1	1
Probation	1	1	1		
Education	2	1	1	3	1
Further Education	1		1	1	1
Children & Family Court Advisory and Support Service	1		1		
London Fire Service	1		1	1	1
London Ambulance Service					
Social Care	2	2	1	2	1
Safeguarding Children & Quality Assurance Service	2	2	2	1	2
Third Sector	1	1	1	1	1
Other London Borough of Enfield	1	5	7	5	5
Enfield Safeguarding Children Board	2	3	1	3	2
Other	1	1	1	1	1
Total no. attendees	**30**	**28**	**27**	**29**	**27**

Enfield Safeguarding Children Board Executive Group

	Date of meeting					
Agency	01/05/12	06/07/12	14/09/12	06/11/12	07/01/13	05/03/13
Community Health	1	1	1	3	1	1
North Middlesex University Hospital		1				
Public Health				1		
Police – Child Abuse Investigation Team		1	1	2	1	1
Police – other	1	2	1	1	1	
Community Safety Unit				1	1	1
Social Care		1	1	1	1	1
Safeguarding Children & Quality Assurance Service	1	1	1	1	1	1
Third Sector	1		1			
Other London Borough of Enfield	1			1		
Enfield Safeguarding Children Board	2	1	1	1	2	2
Total no. attendees	**7**	**8**	**7**	**12**	**8**	**7**

Serious Case Review Panel

Agency	Date of meeting 02/04/12	02/05/12	11/06/12	17/09/12	06/11/12	21/01/13
Community Health	2	2	2	1	3	3
Barnet & Chase Farm Hospitals	2		2	1	2	1
North Middlesex University Hospital	1	2	1	1	1	1
Public Health					1	
Children & Adolescents Mental Health Service	1		1		1	
Mental Health	1	1	1	2		2
Police – Child Abuse Investigation Team	1	1			1	
Police – other	2	1	1			
Community Safety Unit				1		1
Probation						
Education				1	1	
London Ambulance Service		2	1			
Social Care	2	1	3	2	2	1
Safeguarding Children & Quality Assurance Service	1	2	2	2	2	2
Other London Borough of Enfield				1	1	3
Enfield Safeguarding Children Board	1	2	1	2	1	2
Total no. attendees	**14**	**14**	**15**	**14**	**16**	**16**

Quality Assurance Sub-Group

Agency	Date of meeting 23/04/12	15/06/12	24/09/12	27/11/12	12/02/13
Community Health	3	2	1		
Barnet & Chase Farm Hospitals	1	1			1
North Middlesex University Hospital		1		1	1
Children & Adolescents Mental Health Service	1	1	1	1	
Mental Health			1	1	
Police – Child Abuse Investigation Team	1	1	1	1	1
Youth Offending Service					2
Probation			1		
Education					1
Social Care		2	1	1	2
Safeguarding Children & Quality Assurance Service	1	1	1	1	1
Other London Borough of Enfield	1	1	1	2	2
Enfield Safeguarding Children Board	2	1	1	1	1
Total no. attendees	**10**	**11**	**9**	**9**	**12**

Child Death Overview Panel

Agency	Date of meeting 26/06/12	25/09/12	04/12/12	12/03/13
Community Health	1	1	2	2
Barnet & Chase Farm Hospitals	1	2	2	2
North Middlesex University Hospital	2	2	1	2
Public Health		1	1	1
Police – Child Abuse Investigation Team	1	2		1
Police – other	1	1	1	
London Ambulance Service		1	1	1
Social Care	1	1		
Safeguarding Children & Quality Assurance Service	2	1	1	2
Enfield Safeguarding Children Board			1	1
Total no. attendees	**9**	**12**	**10**	**12**

Prevention Sub-Group

Agency	Date of meeting 17/05/12	19/07/12	05/11/12	05/02/13
Community Health	1	1		
Community Safety Unit	1			1
Education				
Safeguarding Children & Quality Assurance Service			1	
Third Sector	1	1	1	2
Other London Borough of Enfield	4	5	4	3
Enfield Safeguarding Children Board	1	1		2
Other		1		
Total no. attendees	**8**	**9**	**6**	**8**

Training & Workforce Development Sub-Group

Agency	Date of meeting 17/04/12	10/09/12	23/10/12	13/12/12	13/02/13
Community Health	2	1	1	2	
Barnet & Chase Farm Hospitals			1		1
North Middlesex University Hospital	2	1	1		1
Community Safety Unit			1		1
Education		1	1	1	
Social Care	1		1	3	3
Safeguarding Children & Quality Assurance Service	2	2	1		1
Third Sector	1	1			1
Enfield Safeguarding Children Board			1	1	1
Total no. attendees	**8**	**6**	**8**	**7**	**9**

Child Sexual Exploitation & Trafficking Group						
	Date of meeting					
Agency	18/04/12	30/05/12	11/07/12	21/11/12	24/01/13	27/03/13
Community Health	2	1			1	1
Barnet & Chase Farm Hospitals		1	1		2	1
North Middlesex University Hospital	1					
Police – Child Abuse Investigation Team	2	1	1	1		1
Police – other	1	1			2	
Youth Offending Service	1	1		1	2	
Community Safety Unit			1	1	1	
Probation			1			
Education	1	1			1	1
Social Care				1	2	2
Safeguarding Children & Quality Assurance Service	1	1	1	2	1	2
Third Sector	1	1		1	1	1
Other London Borough of Enfield	1	1	2	2	1	3
Enfield Safeguarding Children Board						1
Other		1		1		1
Total no. attendees	**11**	**10**	**7**	**10**	**14**	**14**

Appendix 3

ESCB Business Plan 2012-2014

Objectives	Actions	Timescale	Lead Agency / Group	Outcomes	RAG Status	Update January 2013
Core Business Child Protection						
Co-ordinate local work	Develop and publicise annual multi agency training plan	March 2013	Training Sub-group	Availability of a skilled workforce	Green	In place
	Disseminate learning from CDOP and SCRs via briefings and workshops	Six monthly	Training Sub-group	All partner agencies are aware of lessons learnt and implications for evidence based practice	Green	In place
	Continue implementation of Pan London Strategy for Faith and Minority Ethnic Groups	Ongoing	Training Sub-group	Children of whatever faith, ethnicity or culture are safeguarded and their welfare promoted.	Green	Part of training plan
	Continue to promote the Private Fostering strategy	Ongoing	Prevention sub-group	Children away from their parents care are properly safeguarded	Amber	Plan in place
Develop Policy and procedures	Develop and implement a consultation/participation strategy for Children and Young People and monitor the strategy	September 2012	Prevention sub-group/ QA Subgroup	Participation levels routinely recorded in individual agency systems Children/young people actively involved in planning services and their own care.	Amber	In progress via Children's Trust and will be further considered at Board in March.
	Revise local procedures in line with new Working Together	January 2013	Prevention sub-group	All agencies can demonstrate compliance with statutory requirements re: availability and access to up to date procedures.	Green	In place via ECYPS
Raise Awareness	Organise an annual half-day workshop to raise awareness of safeguarding protocols and training	November 2012/2013	Training Sub- group	Satisfy ESCB that safeguarding issues are being appropriately communicated to the community and partner agencies.	Amber	To clarify what is required and plan in accordingly.
	Organise awareness raising sessions for professionals, faith, community leaders and parents with focus on FGM, Forced Marriage, Spirit possession and Honour violence.	Six monthly	Prevention sub-group & Training Sub-group	Communities have increased awareness of safeguarding	Green	In place. Further work/events planned.
	Finalise and implement Communication Strategy	June 2012	Prevention Sub-group	Satisfy ESCB that safeguarding issues are being appropriately communicated to the community and partner agencies.	Green	Completed
	Establish and update ESCB Website to provide information for professionals, children and young people and the wider community.	November 2012	Prevention Sub-group	Informed professionals and young people	Amber	In progress – website updated
Monitor and evaluate	Assure the quality of frontline practice and agency working	Quarterly	QA Sub-group	Children are safer at home, at school and in the community.	Green	
	Review numbers of agencies and schools undertaking safer recruitment training	Annually	QA Sub-group	Safer recruitment practice fully embedded across all agencies.	Amber	To agree if this should sit with Training group
	Audit of agencies training for employees	Annually	QA Sub-group	Agencies compliant with training requirements and regular reports to ESCB	Amber	To agree if this should sit with Training group

Objectives	Actions	Timescale	Lead Agency / Group	Outcomes	RAG Status	Update January 2013
Monitor and evaluate cont'd	Staff survey re: effectiveness of training	Bimonthly	QA Sub-group	Staff feel confident and equipped at appropriate skill level for their role. Children and families are engaged in individual and strategic planning.	Amber	To agree if this should sit with Training group
	Collation of audit findings re: consultation and participation of children, young people and parents with reports to ESCB on outcomes.	April 2013	QA Sub-group	Children/ young people actively involved in planning services and their own care.	Amber	Work in progress
	To implement a local model of Performance Management and Quality Assurance based on good practice Guidance, Improving Local Safeguarding Outcomes' LGG and London SCB.	April 2012 + ongoing	QA Sub-group	Peer review process within and across agencies in place	Green	In place
	Review/agree accessible dataset and gather/ collate all relevant ESCB partner information appertaining to Safeguarding Children within the Borough	September 2012 + quarterly	QA Sub-group	Viable and Embedded QA framework which has been agreed by all partners and enables clear quantitative and qualitative outcome measures	Green	In place
	Interrogation of key performance data to identify areas for improvement.	Ongoing, bi-annual report	QA Sub-group	Children at risk are being properly safeguarded with effective and timely interventions.	Green	
	Monitor quality of CP Plans	September 2012	QA Sub-group	CP plans demonstrate clear focus on outcomes for children and young people	Green	
	Review and implement methodology for audit of partner agencies compliance under section 11 of the Children Act 2004	January 2013	QA Sub-group	ESCB can evidence compliance with Working Together s3.7 – 3.10 and effective challenge to drive improvements.	Amber	To complete June 2013
	To link with work of London SCB in refining shared data sets to enable informed benchmarking across London boroughs	October 2012	QA Sub-group	Agreed dataset which is monitored by London and individual Boards	Green	
	To conduct a Risk Assessment and create a Risk Register for ESCB for regular review by the Board	November 2012 / Biannual	QA Sub-group	ESCB is aware of key areas of risk and takes appropriate action to address these creating a robustly managed LSC Board.	Amber	To consider if this should be role of Executive
Early help and Safeguarding						
Co-ordinate local action	Promoting a model of early help for children and families which reduces demand and cost (Munro review)	June 2012	Prevention Sub-group	Reducing numbers of children at higher tiers of intervention , including children in care and subject to CP	Green	Supporting SPOE
	Co-ordination of response to Children and Young People's fear of gangs and knife crime.	October 2012	Prevention Sub group	Children and young people feel safe in their neighbourhoods.	Green	Activities in place – working with schools and Police
	To support implementation of Multi Agency triage service in response to referrals (MASH) and Single Point of Entry(SPOE) and ensure the co-ordination and communication re: local services	June 2012	Prevention Sub group	Clearer, streamlined access to safeguarding services and better identification and targeting of interventions to those most in need at an early stage.	Green	SPOE in place and supported

Objectives	Actions	Timescale	Lead Agency / Group	Outcomes	RAG Status	Update January 2013
Develop policies and procedures	Review of social care thresholds document and embedding of CAF as multi agency referral form across all agencies	June 2013	Quality Assurance-sub group	Thresholds are understood, embedded and effective at reducing numbers of inappropriate and repeat referrals.	Green	In place. Review in June 2013.
	Review tools/protocols to promote improved information sharing, risk assessment and partnership working	August 2012	Board Chair	Improved identification of risk to children and young people and timely response Increased flow of information across services etc	Amber	Work to continue via Building Resilience Programme
Raise awareness	Threshold document to be publicised to all agencies through launch and supported by relevant documentation.	September 2012	Prevention subgroup	Thresholds are understood, embedded and effective reducing numbers of inappropriate and repeat referrals.	Green	In place via ECYPS
	Ensure that communities are aware of locally available services	May 2012	Prevention Sub-group	Local services respond to identified need and are well used.	Green	Regular forums and events run by ECYPS.
Monitor and evaluate	ESCB to receive reports on quality of child protection and early help practice from multi agency case file audits	From June 2013	QA Sub-group	Multi agency audit framework embedded and operational.	Amber	Process in place. Review from June 2013.
Sexual Exploitation and Trafficking						
Co-ordinate local action	Embed local protocol for Sexual Exploitation and build capacity of multi-agency staff to engage in prevention work	September 2012	CSE & T working party	Improved identification of sexual exploitation and delivery of support to young people at risk	Green	
	To establish links with local, national and international services and agencies to facilitate the protection of children who may be at risk from trafficking and exploitation	November 2012 and throughout the Olympic/ Para-Olympic period	CSE & T working party	Improved identification of sexual exploitation and positive delivery of support to young people at risk	Green	To continue to develop
	To support young people in identifying trafficked children and in identifying themselves as trafficked children	November 2012	CSE & T working party and Prevent sub-group	As above.	Amber	
	To participate in and support safeguarding issues in respect of the Olympics.	September 2012	CSE & T working group	Minimise harm to Children at risk due to associated issues	Green	Completed
	To combine expertise to act as a point of authority and reference in matters associated with child trafficking and exploitation	Ongoing from August 2012	CSE & T working group	An effect local set of Policies and procedures to assist practitioners in identifying and making provision for Children who may have been Sexually Exploited or trafficked	Green	Work to develop and continue
Develop policies and procedures	Review e-safety strategy and work carried out in schools including awareness-raising sessions for parents	January 2013	CSE & T working group	Children and Young People feel safer and have access to advice and information and are aware of how to stay safe online.	Green	To continue to develop
	To develop mechanisms to collate intelligence by the Children and Young People's Services and the Police	October 2013	CSE & T working group	Improved identification of children and young people at risk,	Green	Work on this via the SPOE
	To raise awareness and encourage the reporting of concerns about trafficked children and perpetrators of this crime.	April 2013	CSE & T working group and Prevention Sub-group	Increased awareness of how to respond to a concern	Green	ECYPS training/ ESCB training – further work needed. Conference was a success.

Objectives	Actions	Timescale	Lead Agency / Group	Outcomes	RAG Status	Update January 2013
	To support / provide training to professionals, families and community groups to understand the profile of trafficked children and their needs.	April 2013	CSE & T working group, Training sub-group, Prevention Sub-group	Increased awareness of how to respond to a concern	Amber	Training in place. Further work in community.
	To promote interagency and community participation in tackling child trafficking	Ongoing	CSE & T working group	Increased awareness of how to respond to a concern	Amber	Review outcomes of conference. Look at cross-borough working.
Monitor and evaluate	Collate and monitor data on all children missing from education, care and home with regularly reports to ESCB.	March 2013	QA Sub-group	Missing Children local protocols and procedures in place. 'Safe and well' interviews for children missing from care	Amber	Work continuing
Domestic Violence						
Co-ordinate local action	Ensure inclusion of impact of DV on children in training programme.	March 2013	Training Sub-group	Children and young people are protected from the effects of DV.	Green	In place.
	Ensure DV is accorded a high profile in cross agency working	Ongoing	QA Sub-group	Reduction in numbers of CP plans where DV is an issue	Amber	Sit with Prevention group / monitor via QA
	Ensure DV is highlighted in information sharing protocols	September 2012	Board Chair	Availability of high quality risk assessment tools to support front line practice.	Green	In place
Develop policies and procedures	Review use of DV risk assessment matrices and standardise practice.	October 2012	Prevention Sub-group/ QA Sub-group	Availability of high quality risk assessment tools to support front line practice.	Amber	DV protocol being updated
	Review requirements re DV Homicide Review and ensure appropriate procedures are in place	September 2012	Prevention Sub-group/ SCR Sub-group	Availability of high quality risk assessment tools to support front line practice.	Amber	Under review
Raise awareness	Ensure that local agencies and community are aware of DV strategy and locally available resources	May 2012	Prevention Sub-group	Communication strategy to include variety of mechanisms both public and confidential for access to information re DV resources.	Green	ECYPS & ESCB training supports this
Monitor and evaluate	ESCB to receive regular reports re: incidence and level of DV in families where there are children within the authority	November 2012	QA Sub-group	Children and young people are protected from the effects of DV	Amber	To commence Nov 2013
	Monitor compliance with DV policy and procedure.	April 2013	QA Sub-group	ESCB satisfied with multi agency compliance	Green	
	Centralisation of cross agency data at DV Strategic Group to be reported in summary to ESCB.	April 2013	QA Sub-group	ESCB fully informed re level and extent of DV impact	Green	
Co-ordination with Adults services						
Co-ordinate local action	To ensure that the ESCB is properly connected with wider initiatives including Safe and Stronger communities, Health and Well Living Boards, Sports services including the Olympics.	Ongoing	Board Chair	Adults services recognise and respond to safeguarding needs of children and young people	Green	Links in place
	Co-ordinate and agree relationship and accountability between the ESCB and the emerging Clinical Commissioning Groups (CCGs)	December 2012	Board Chair	Safeguarding issues are understood and addressed within the new health commissioning arrangements.	Amber	Meetings in place to discuss

Objectives	Actions	Timescale	Lead Agency / Group	Outcomes	RAG Status	Update January 2013
Co-ordinate local action cont'd	To ensure that CCGs are meeting responsibilities for Safeguarding across the Health economy.	April 2013	Board Chair	Safeguarding issues are understood and addressed within the new health commissioning arrangements.	Amber	Meetings in place to discuss
	To continue to promote effective and strong relationships with the Adults Safeguarding Board	Ongoing	Board Chair	Joint safeguarding events and protocols are in place	Green	Work continuing. Planned meeting with Adults Board. Safeguarding Week was successful.
	To ensure that local Housing strategies include focus on safeguarding.	July 2012	Board Chair	Arrangements for fast track and support for vulnerable children (particularly homeless and in temporary accommodation) are in place and working effectively.	Amber	Under review
	To consider the needs of new and emerging communities particularly those in temporary accommodation in all strategic documents.	September 2012	Prevention Sub-group	Children and young people from all backgrounds are kept safe within the community.	Green	Outreach programmes in place
	To strengthen joint working with Adult Services and the Young Carers protocol with particular emphasis on mental health.	Ongoing	Prevention Sub-group	Children of parents with mental health problems are safeguarded	Amber	To be looked at in view of SPOE
Review of Child Deaths						
Review of Child Deaths	Review information to determine whether child deaths are preventable	September 2012, and at each CDOP thereafter	CDOP		Green	
	Collation and dissemination of data	March 2013 and six-monthly	CDOP	Six-monthly reports to be shared with Board	Amber	Now being progressed with new chair
	Annual returns to the Department for Education	April 2013	CDOP	Compliance with statutory responsibility	Green	
Ensure effective partnership	Review action Plan and Terms of Reference	March 2013	CDOP	Ensure all agencies clear about roles and responsibilities in respect to CDOP	Amber	Development Day planned
	Representation at Pan London meetings – Chairs; SPOC/Co-ordinators	September 2012 and ongoing	CDOP	Formulate good partnership working across London, and sharing of good practices.	Amber	CDOP co-ordinator attending

Key:

Red — Not achievable or no satisfactory update

Amber — Monitor closely/behind schedule

Green — Achieved/on track

Glossary

CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CSET	Child Sexual Exploitation and Trafficking
CT	Children Trust
ESCB	Enfield Safeguarding Children Board
LSCB	Local Safeguarding Children Board
QA	Quality Assurance
SCR	Serious case review
SIT	Safeguarding Investigation Team
WT	Working Together

The board will continue its involvement in the wider safeguarding agenda and will monitor through six monthly and annual reports the following areas, responding with targeted activity when necessary:

Title	Lead Agency
Safer recruitment	Local Authority Designated Officer
Elective Home Education	Admissions service
Allegations Management	Local Authority Designated Officer
Anti Bullying	Anti bullying forum
Child Protection conferences	Safeguarding Children & Quality Assurance Service
Domestic violence – MARAC	Domestic Violence co-ordinator
MAPPA	Probation Services
Private fostering	Children Services
Road Safety	Road Safety Unit
Children missing from care and home	Young runaways service
Licensing and gambling	Education lead for safeguarding
Homeless young people	Parenting Support Service

Enfield Safeguarding Children Board Away Day - 17th July 2012 Priorities

What must we achieve to safeguard children and young people and why?	What would get in the way and how to overcome this	What would it look like?	ESCB Outcome
Every front line worker in each agency and voluntary sector can identify vulnerable children and young people and know what to do and is competent to do it. (Top priority – 23 green stickers)	• Lack of resources – think joined up – integration • Communication – use branding, regular communications, newsletters. • Diversity of organisations – more multi agency training. • Lack of understanding – thorough training needs assessment and use of language which practitioner can understand – e.g. Voluntary sector so that they appreciate importance of safeguarding.	**Politicians and Leaders** • Robust QA multi agency system which stands up to scrutiny. • Public perception/confidence in services. **Practitioners and Managers** • Clear directions and shared purpose. • Confidence – feeling supported and enabled. **Children, Families, Community** • Children feel safe, heard and well supported. • Children, parents and families feel that they matter.	All agencies in Enfield LSCB have a well trained and confident safeguarding workforce. **Measurements** • Numbers trained • Training availability • Competency assessments • Feedback from Children and Young People • Feedback from families • Feedback /evaluation from staff
Quality assurance and two way feedback. (14 green stickers)	• Critical comments • Working in silos • Inability to respond • Limited resources/pressures • Inconsistent thresholds • Use common language • Knowing when and how to share • Creation of a safe environment/ permission		Identifying, sharing and responding to emerging themes.
Informed and educated front line practitioners who know what to do and how to do it. (13 green stickers)	• Lack of clarity re: thresholds – thresholds document, common language, SPOE.	**Politicians and Leaders** • Leading from the front • Being actively involved • Clear positive message • Prioritisation for funding **Practitioners and Managers** • Steer and support • Confidence in practice • Blame free consultation • Less criticism, more learning **Children, Families, Community** • To be clear that their concerns will be acted upon • Outcomes improve and they feel safer	Provision of appropriate and timely intervention and referral.
Reduce harm to children impacted upon by domestic violence. (8 greens)	• Too low status in current agenda • Arrangements reactive – short term fix. • Police and others not co-ordinated.	**Politicians and Leadership** • Place the issue much higher on the agenda • Less denial – own the problem as real **Practitioners and Managers** • Activity/Ownership • Embedded in practice • Greater awareness • Proactive • Battle harder – active research of case by evaluation and review **Children, families and the community** • Somewhere safe to go to and be listened to.	Prioritise early action with an appropriate early response. "The right response at the right time" **Measurements** • Themed audits • Preventable deaths of children • Reduction in significant harm physical/mental • Reduction of repeat victimisations (e.g. with IDVA involvement repeat victimisation stops in 70% of cases. • Prevention of domestic homicides

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Enfield Safeguarding Adults Board
Schools and Children's Services

July 2013

ENFIELD Council

Enfield Safeguarding Adults Board

Annual Report 2012/13

www.enfield.gov.uk/safeguardingadults

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Working in partnership with local people and

NHS

Enfield Clinical Commissioning Group

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

Barnet and Chase Farm Hospitals NHS
NHS Trust

North Middlesex University Hospital NHS
NHS Trust

London Ambulance Service NHS
NHS Trust

METROPOLITAN POLICE
Working together for a safer London

LFB
LONDON FIRE BRIGADE

CareQuality Commission

enfieldhomes
www.enfieldhomes.org

over 50s forum

age UK

People with Learning Difficulties
One to One
Making Life Better

Message from the Chair

Marian Harrington
Independent Chair of the Enfield Safeguarding Adults Board

This report marks the end of my first year as Independent Chair of the Enfield Safeguarding Adults Board. I would like to thank Ray James for the strong position the Board was in when I took over and his support over the last year in my new role. During the year we have reviewed the way the Board operates and the membership of the Board. We established new sub groups for the Board to ensure we complete all the actions we promised in the Safeguarding Adults strategy. We have continued to emphasise the importance of all vulnerable people being treated with dignity, respect and compassion.

During the year we have consulted on and published our new three year safeguarding adults strategy. We were pleased in the interest shown by local people and made sure the comments and suggestions they made were included in our plans for future work.

This has been a very challenging year for adult safeguarding. The details of the terrible events at Winterbourne View and Mid Staffordshire Hospital which have emerged over the year have served as a clear reminder that we can never be complacent about the quality of services. This has shown so clearly how important it is to listen to the voice of people who use services and their carers.

We have worked hard over the year to continue to raise awareness around adult safeguarding. We have placed articles in local publications and have had two, specific, awareness-raising events during the year. We have seen an increase in the number of adult safeguarding referrals received by the social work teams.

This year has seen the shadow formation of Enfield Clinical Commissioning Group to commission local health services. I have been pleased to see how seriously they have taken their responsibilities around adult safeguarding. I have been pleased to be invited to speak to lead GPs and the Governing Body over the last year. I wish them well for their first year of operation and look forward to continuing to work closely with them to keep adults in Enfield safe.

There are over 160 care homes in Enfield and the Council and CCG have been keen to support them to provide the highest quality service. The My Home Life programme provides support for homes managers and helps to emphasise the positive aspects of residential and nursing care for older people. The Councils Safeguarding Adults Service and the Care Quality Commission are vigilant in following up all issues about the quality of services which are reported to them and challenging poor practice.

The Quality Checker Programme has been very successful, in its first year, with local volunteers visiting a whole range of local services and feeding back on the quality of the services they find. They have been able to establish rapport with people who use the services and provide the Council with a unique insight into their views.

I would like to thank elected Councillors in Enfield for their continued support and interest in safeguarding adults. I would also like to thank all the members of the Board and partner organisations for their enthusiastic work on all areas of safeguarding adults and to the residents of Enfield for their vigilance.

Message from Service Users, Carers and Patients on Board Sub-Group

The Service Users, Carers and Patients contribute towards actions and oversight of safeguarding adults in Enfield, and were asked about how they feel we keep people safe. This is their response.

"We hear all the time about the abuse of people and to know there are those out there who will overlook, act and stop abuse is a good thing. The group will take some time but the ideas and intentions are good."

"I think the work being done keeps people safe; more people know we are there to help them, even if they are not ready yet to take that help, its nice to know people are around. I hope we can help someone to keep safe through the work the group is doing, which is good and interesting."

"We are pleased that the Safeguarding Adults Board recognises and values the Service User, Carer and Patient Group. During the last year we have been restructured and with new members."

"We have been able to pass back information to the community, such as through the Talking Newspaper, which will help people to know what abuse is."

Glossary of Terms

Abuse includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.

Adult at risk are people over 18 years of age who are or may be in need of community care services by reason of mental health, age or illness, and who are or may be unable to take care of themselves, or protect themselves against significant harm or exploitation. The term replaces 'vulnerable adults'.

Personalisation – the Personalisation agenda aims to ensure that everyone receiving social care support has more choice and control over how services are delivered to them.

ADASS	The Association of Directors of Adult Social Services
B&CFHT	Barnet & Chase Farm Hospitals NHS Trust
BEHMHT	Barnet, Enfield and Haringey Mental Health NHS Trust
CMHT	Community Mental Health Team
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DoLS	Deprivation of Liberty Safeguards
DH	Department of Health
DVSG	Domestic Violence Strategic Group
EDA	Enfield Disability Action
ESCB	Enfield Safeguarding Children's Board
GP	General Practitioner
HHASC	Health, Housing and Adult Social Care
HASC	Health and Adult Social Care
HM	Her Majesty's (Government)
IDVA	Independent Domestic Violence Advocates
ILDS	Integrated Learning Disabilities Service
DBS	Disclosure and Barring Service
LBE	London Borough of Enfield
LD	Learning Disabilities
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act
MH	Mental Health
NHS	National Health Service
NMUHT	North Middlesex University Hospital NHS Trust
OP	Older Persons
OP CMHT	Older Persons Community Mental Health Team
OT	Occupational Therapy
PCT	Primary Care Trust
PD	Physical Disabilities
RSL	Registered Social Landlord
SAB	Safeguarding Adults Board
SCIE	Social Care Institute for Excellence
SSCB	Safer and Stronger Communities Board
VAWG	Violence against women and girls

Contents

1. Introduction and Strategy

This report sets out how Enfield has worked to safeguard adults from abuse in 2012/13 and how we intend to continue and expand upon this work in the coming year.

Keeping adults safe has always been a high priority in Enfield, which was one of the first partnerships in the country to produce a safeguarding adults strategy, in 2009. Our primary aims, since this time, have remained largely unchanged, as we want to work with local people and partners, so that adults at risk are:

- **safe** and able to protect themselves from abuse and neglect;
- treated fairly and with **dignity and respect**;
- **protected** when they need to be; and
- able to easily get the **support**, protection and services that they need.

The Safeguarding Adults Board is a partnership of statutory and non-statutory organisations, including local people and those who use services and their carers, committed to preventing and responding to the abuse of adults at risk. The Board meets every quarter and has an action plan to ensure we remain focussed on key activities to keep people safe.

Since our first strategy in 2009, we achieved many of the outcomes we set ourselves. In early 2012, we reviewed our strategy and asked local people what actions we should take to meet the priorities of the Board in the coming three years. The answers from the consultation and other activities in the community have helped to inform the action plan in the Safeguarding Adults Strategy 2012-2015. This will directly impact on and inform what we do to prevent and respond to the abuse of adults at risk.

The two main areas that respondents wanted more focus on were **raising community awareness** and **ensuring action is taken immediately** once a concern is reported.

Some of the points raised by respondents were:

- The way information is provided needs to be diverse, particularly for those who are born deaf or use British sign language.
- Immediate responses need to be ensured and service users visited in their own home.

> "Safeguarding Board should offer abused person as a first choice to be seen at their own home as they feel comfortable there."

- Advocacy services need to be provided; e.g. one respondent spoke about the needs of people that are isolated in care homes.
- Provision of help for people who are at risk but not identified or known to social services needs to be considered.

> "As a local GP, there is always a fear that vulnerable people might be left out of care, either due to not asking for help/not having (or difficulty having) access to health care and social needs. A dedicated service serving whole or part of Enfield, either to serve or co-ordinate access to service, will help."

- There was the request for more free safeguarding adults training.
- There was the call to improve the quality of care homes.
- The use of information technology was considered to be an exciting development.

We are responding to all these points through the Safeguarding Adults Strategy 2012-2015, which has been published and an action plan developed.

The ten priorities of the strategy are:

1. To continue to raise community awareness of safeguarding adults – we want the people of Enfield to be able to recognise, prevent and report abuse.
2. To work with organisations and agencies to ensure they treat people with dignity and respect – we want to make sure systems are in place to prevent the abuse of adults at risk who use support services, including dignity in care and quality improvement programmes.
3. To continue to improve our practice in responding to reports of abuse and quality assure those responses – we want to make it easier for people to report abuse and make sure they receive a good quality service, when they do so, by reviewing our safeguarding interventions and protection arrangements.
4. To listen to, and ensure people who are at risk of abuse, or have been abused, are fully involved in local safeguarding arrangements and improvements to services – we want people to feel they are listened to and, most importantly, to feel safe.
5. To support people to protect themselves from abuse – we want adults at risk to have access to advice and information to help them protect themselves from abuse and to enable them to make choices and manage risk, relevant to their own situation.
6. To support people who choose to arrange their own care to do this in a way that protects them from abuse – we want to ensure people have the opportunity to take responsibility for their own protection and are supported to manage risk.
7. To make sure adults at risk get access to the justice system – we want the police, the Crown Prosecution Service (CPS) and the courts to make sure adults at risk get equal access to the justice system.
8. To work with people to avoid situations where they may be at risk of abusing others – we want to work with people to manage risk to themselves and others.

9. To collect and analyse statistics about reports of abuse and take action to improve local safeguarding arrangements – we want to use the information we collect to improve local safeguarding arrangements by looking at trends, areas of concerns and what we can do to address them.
10. To promote and implement the use of Information Technology for safeguarding adults – for example, using appropriate surveillance technology to detect or identify abuse of adults at risk.

2. Key Developments, Objective and Progress

The key objective of the Safeguarding Adults Board has continued to be the raising of awareness of abuse and how we work to prevent it. We believe safeguarding adults is everyone's business – it is an issue that can affect any one of us and together we can stop it.

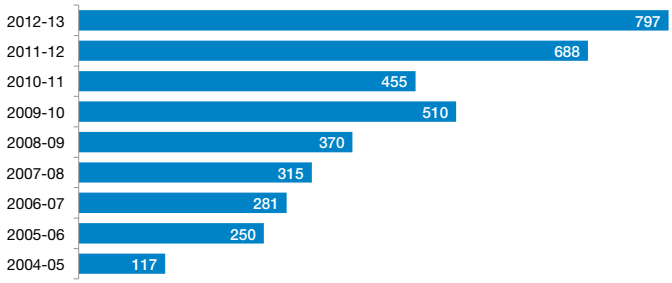
We have continued to see the number of safeguarding adults referrals received by adult social care increase; this year we saw 797 referrals made- an increase of 14%. In spite of this increase in reporting, the abuse of adults at risk continues to be under-reported and under-represented in some of the communities in Enfield. The Board has continued with efforts to raise awareness and the profile of safeguarding adults, so that more people understand what abuse is and how to seek support.

Two, successful, week-long, event programmes were held, one during October 2012 and one during March 2013. In conjunction with the Enfield Safeguarding Children's Board, these events aimed to bring together information on how to keep oneself safe and prevent abuse. Partners, such as the London Fire Brigade, Safer Neighbourhood Team, Trading Standards and the North Middlesex Hospital NHS Trust, took part.

We also saw the re-launch of the Community Help Point Scheme in March 2013. Originally set up in 2007 to provide places of support to enable young people to safely navigate the borough, this scheme has now been extended to cover adults at risk. Businesses and organisations nominate themselves to act as help points for people who are lost, frightened or afraid and in need of assistance. At the re-launch event, volunteers from One to One Enfield did a short play on hate crime and how it impacts on people with learning disabilities, while Face Front Inclusive Theatre acted out scenarios of people who may need to access, for assistance, the Community Help Point Scheme.

The Board continued to raise awareness through the many mechanisms available, including articles in Our Enfield, Enfield Homes magazine and the Essential Guide for 2012-2014. With the support of a member of our Service User, Carer and Patient Group, we also had information on safeguarding adults in the Talking Newspaper.

The following graph displays the number of referrals received since the local multi-agency policy was launched in 2003 and until March 2013. The date indicates that the result of heightened awareness, following community events and other actions having been undertaken by Board partners, has been effective.



Key themes from the safeguarding adults referrals, include (for further information, please see Appendix B):

- April 2012 to March 2013 there were 797 referrals (alerts) received. This is an increase of 14% from the previous year.
- There has been a 31% increase in alerts related to people over 65 years of age.
- Most alerts relate to multiple abuse (29%) or neglect (26%).
- 40% of the referrals are in relation to alleged abuse in the Adult at Risk's own home and 30% are in a residential/nursing home.
- Hospital staff made the most referrals, at 18%.
- 36% of alerts relate to adults aged 18-64 while 64% to adults aged over 65 years.
- There is an increase in referrals from Black and Ethnic Minority communities.
- For the person alleged to have caused harm, 243 (31%) are family/friends/neighbours of the adult at risk and 245 (31%) are formal social carers.
- Of the 797 safeguarding adults referrals (alerts) received, 660 proceeded to the safeguarding adults process.
- 33% of cases had a nominated advocate involved, which may be both paid or a family or friend.
- 88% of the strategies agreed were within the target of five working days from the alert.
- In 87% of cases, the alerter was informed of the strategy on the same day it was agreed, if considered appropriate. This is an improvement from 38% in 2011/12.

Relating to the cases which are now closed:

- Of the 170 cases that have an outcome following investigation, 35% of them were substantiated or partially substantiated (34% in 2011/12).
- 63% of eligible cases had a review.
- Some of the outcomes for adults at risk included: supporting individuals to move away from the property or service causing them harm in seven cases, and in 48 cases we increased monitoring to contribute towards protection planning and safety.
- In 19% of closed cases, the outcome for the person alleged to have caused harm was 'continued monitoring', whilst in 11 cases there was disciplinary action recorded.

In addition to raising awareness, a range of actions took place across the partnership to prevent abuse and keep people safe. The Police Community Safety Unit meet regularly with the Council's Safeguarding Adults Service to review that all referrals being made are progressing appropriately; access to the justice system is important for adults at risk. The Police have also internally audited and reported on how safeguarding adults is flagged, recorded and addressed within their organisation. From this data a range of proactive recommendations has been made, to ensure equality of service for adults at risk.

The Enfield Clinical Commissioning Group (CCG) officially begun its role from April 1, 2013. The CCG is led by local GPs and will commission the majority of health services, giving the opportunity for health-related services to be arranged and delivered which are responsive to local need. Over 2012/13, much work was done to ensure responsibilities were transferred to the CCG, which includes how it will safeguard adults at risk. The CCG have set out their policy on safeguarding adults, in terms of what it will expect from the services it commissions and a number of groups have been set up, including one which focuses on quality and safety. Members of the CCG Board have also had training in relation to their safeguarding adults responsibilities.

Training and development opportunities are important for staff who work with adults at risk. Enfield Council has continued to open up its e-learning and classroom-based training session to partners, focusing on areas such as investigators training. In addition, the Enfield Safeguarding Adults Service delivered safeguarding adults training to all General Practitioners, in early 2013.

At the centre of everything we do is the experience of and contribution from adults at risk; this includes learning from the experiences of such adults. To improve safeguarding, all of our Board partners include the participation of people who use their services. Examples of where this takes place, include:

- Barnet and Chase Farm Hospital Trust have a patient and carers advisory group with an action plan; they also arrange audits of wards by service users with questionnaires.
- In the Barnet Enfield and Haringey Mental Health Trust they have a dignity audit, completed by service users who go out to the ward and ask questions about people's experiences. There are carers on management group meetings and a service user representative on a clinical governance group.
- Patient story and learning experience is brought to the North Middlesex Hospital NHS Trust senior management group. There are also service users and carers on the Patient and Quality Group.

We know that unpaid carers, such as family or friends, are often under pressure with the level of care they provide. This can lead to carers putting at risk of abuse the person they care for and there are also cases of the cared for being the abuser. In response, the carers' commissioner for adult social care has worked to set up targeted events for carers, in conjunction with the Carers Centre. A leaflet is also being developed to help carers keep themselves, and the person they care for, safe and well. Information, such as this, will help to prevent abuse from happening, in the first place.

3. Other achievements, challenges and opportunities

In addition to the above, a number of achievements have been demonstrated by the Board and across the partner agencies. We have:

- Ensured adult social care has practice-based forums, to focus on sharing good learning examples and how we continue to keep adults at risk in the centre of the process.
- Developed an electronic newsletter for professionals in Health, Housing and Adult Social Care, promoting information on safeguarding adults, including changes that occur at national and local levels.
- Demonstrated analysis of reports of abuse and learned from trends, in such areas as advocacy and protection planning.
- Delivered information sessions to carers, on safeguarding adults, alongside colleagues in the Brokerage service, which focused on personalisation.

The Central Safeguarding Adults Service is working with the Council's Drug and Alcohol Action Team (DAAT) to ensure that adults at risk, living with substance misuse, are safeguarded from potential or actual abuse, as well as against posing a risk to others. The DAAT has contributed to the development of an action plan and is attending practice forums. The Central Safeguarding Adults Service is currently promoting awareness of safeguarding procedures, amongst DAAT staff and their managers, and developing safeguarding practices to promote identification of drug and alcohol users at risk, preventative actions and risk minimisation.

We saw an increase in requests for Deprivation of Liberty Safeguards (DoLS) authorisations in 2012/13. The DoLS are for people who lack mental capacity and may require care or treatment in a hospital or care home, where their freedom may need to be restricted to the point of depriving them of their liberty. This can only be done lawfully if appropriate authorisation for a Deprivation of Liberty Safeguard has been sought. There were **36 DoLS requests made**, of which 33 related to people in residential or nursing homes and 3 related to people in hospital. Of these, 28 were authorised and 8 were declined. There were also 3 DoLS reviews conducted, all of which resulted in the authorisation being ceased.

Personalisation is about ensuring that everyone who receives social care support has more choice and control over how services are delivered to them. We have helped to develop the local personalisation arrangements, across adult social care, by working to balance increasing choice for people, while keeping them safe. An example of this is our contribution to how the Social Care Market Place has developed, including planning for how services will be vetted, in the future. The market place will enable you to view services and providers and purchase services, with a personal budget or by using your own money. We believe clear and transparent information about the types of services and support available will enable safer and more informed choices.

The voluntary sector in Enfield has continued to show a high level of commitment and drive to keep people safe from harm. Over the last year, we have had three voluntary sector organisations supporting the work of the Board and sharing information across partners; these are: Age UK Enfield, One-to-One Enfield and Enfield Disability Action. These partners have provided support to raise awareness of abuse, to target information for service users who use their services and also to raise reports on abuse, when they have concern.

Safeguarding adults is very much about how people are treated with **dignity and respect**. We believe in promoting the Dignity Standards, which are:

1. To have a zero tolerance of all forms of abuse
2. To support people with the same respect you would want for yourself or a member of your family
3. To treat each person as an individual, by offering a personalised service
4. To enable people to maintain the maximum possible level of independence, choice and control
5. To listen and support people to express their needs and wants
6. To respect people's right to privacy
7. To ensure people feel able to complain, without fear of retribution
8. To engage with family members and carers, as care partners
9. To assist people to maintain confidence and a positive self-esteem
10. To act to alleviate people's loneliness and isolation

We have written to all residential and nursing homes, to challenge them to meet these standards and display the Dignity Challenge Poster. Our local hospitals have also shown a commitment to the dignity standards. A range of actions and activities, to ensure that their patients are treated well, have taken place, such as the Butterfly Scheme in Barnet and Chase Farm Hospital, in which care to patients with dementia has been supported.

The Safeguarding Adults Board works within a challenging area, and despite the evidence of good work being undertaken and positive outcomes for adults at risk, there is always much more to do.

Keeping safe adults at risk is receiving increased focus in the media, following high profile cases such as 'Winterbourne View Hospital' and the public enquiry into events at Mid Staffordshire Hospital. Events at Winterbourne View Hospital, a facility for people with learning disabilities, were uncovered by BBC Panorama and evidenced the most appalling abuse and violence against adults at risk. The use of covert surveillance by the BBC has demonstrated the effectiveness of surveillance in uncovering inappropriate and, indeed, violent behaviour towards vulnerable individuals. In the coming year, we will consult on a policy for Health, Housing and Adult Social Care on the use of overt and covert surveillance to deter and detect abuse, seeking feedback from residents and key stakeholder on its implementation.

Changes in health will have a big impact on how we keep people safe. Clinical Commissioning Groups will have responsibility for identifying the needs of the local population and commissioning health services to meet these needs. This is a real opportunity for the Board to work with Enfield CCG, to ensure that these services are safe and do not cause harm. The Enfield CCG has already joined up with the Local Authority to fund a safeguarding adults nurse assessor, which provides invaluable clinical input into high risk cases and developing network of health investigators for safeguarding adults; this post will continue during the coming year.

The Care and Support Bill has set out its intention for **Safeguarding Adults Boards to become statutory**. We are well placed in Enfield to deal with this challenge and see this as a great opportunity to strengthen the existing partnership.

Nationally, we are also seeing major changes in the political and economic context in which services and activities are planned and provided. We have the impact of the national and internal budget deficits, coupled with the impact of poverty and health inequalities faced by some groups. All of this will affect the capacity of individuals and whole communities to care well for themselves and the more vulnerable residents. The Board will face these challenges to ensure those most vulnerable are kept safe from harm and that the routine analysis of abuse takes into consideration trends associated with these political and economic changes.

The above national changes may also impact on carers and families, so we need to improve out understanding of the stress faced by families, in order to be able to take a holistic approach to care and risk planning. By improving our understanding and working across adult and children's services, where necessary, we can help alleviate the strain placed on families and the potential for harm.

Our work with the Safeguarding Children's Board is an important part of how we keep everyone safe. In addition to joint events, the two Boards will need to consider how we can join up projects and initiatives which keep all communities safe. The extension of the Community Help Point Scheme, in March 2013, was an example of this and further projects will be considered in 2013/14.

During 2012/13 we saw the number of referrals for safeguarding adults increase to 797, which of these 660 proceeded to the safeguarding adults process. The coming year will also see the Police use Merlins, which are a reporting system for adults coming to the notice of police personnel. This may result in a higher number of referrals to adult social care, which need to be screened and assessed to ensure the safety of individuals and to determine whether they require progression under safeguarding adults procedures. In response to these two factors, the Council's Safeguarding Adults Service are working with Adult Social Care Teams, to review the resources needed to effectively and safely manage safeguarding alerts.

The safeguarding adults process is aimed at ensuring that the outcomes identified by the adult at risk are achieved; its about asking their views on whether risk has reduced without compromising the other things that are important to them. To ensure we keep people central to the safeguarding adults process, where their views and experience drive practice, the Enfield Safeguarding Adults Service are developing methods for feedback which can be translated into service improvement.

We know from our data that reports of abuse involving older adults continues to increase in Enfield. There were 38,880 people aged over 65 years in Enfield in 2011, with 5,345 aged 85+ years (ONS Census). Of these individuals, around 7,200 have two or more problems with daily living, such as washing and getting around and about their home, due to an underlying health problem. As a result of their circumstances, such individuals are some of the most vulnerable older people living in Enfield, and are therefore at risk of harm, abuse and/or neglect. Our awareness events will shift to target this area and work towards a more preventative model in care homes with our health partners and commissioners in the Clinical Commissioning Group. We will also continue to work with **Trading Standards** to raise awareness of rogue traders and scams, particularly against older people.

One group of older people, especially at risk because of their condition, are those with **dementia**. It was estimated 2,700 people in Enfield suffer from the condition, with 1,225 of these having advanced dementia. Households living with dementia can be doubly at risk because, even at any early stage, such individuals can begin to lose contact with friends and family, leading to social isolation. The Board will continue to ensure that issues of **mental capacity**, prevention of abuse and providing information to help people make informed decisions continues in the coming year.

Learning from events at Winterbourne View Hospital and Care Quality Commission reports into the application of the Deprivation of Liberty Safeguards has highlighted the need to continue to raise awareness of this area. The Enfield DoLS Office has responded proactively by setting up targeted training with the care homes and hospitals most in need of support, including a programme of 'train the trainer' courses. In this coming year we will focus on setting out a **Deprivation of Liberty Safeguards and Mental Capacity Action Plan**. Only 4 DoLS cases of 2012/13 related to people in hospitals. NHS trusts have been prompted to commission more training for their staff to ensure there are no unauthorised deprivations of liberty occurring and we will continue to support NHS Trusts to improve in this area.

The personalisation agenda in Enfield remains a priority for the coming year, so that adults at risk and their carers are empowered to take a lead role in how they are cared for and supported. This will include helping them to manage risk and protect themselves from harm. We also saw from our data that advocates, both paid and informal, were recorded in 33% of cases. **Advocacy** is particularly important for adults at risk to support their voice to be heard and identify those outcomes which will improve their quality of life; the Service User, Carer and Patient sub group of the Board is very passionate about challenging and improving this area in the coming year.

4. Quality assurance and organisational learning

The Safeguarding Adults Board has a range of activities which aims to ensure the high quality of our responses to reports of abuse and that learning from these activities is embedded in our future practice. The Quality Checker Programme, in Adult Social Care, is an example of how service users and carers directly impact on how care is provided.

The Council's Health, Housing and Adult Social Care department commissioned an external safeguarding adults case audit, where an independent consultant reviewed a number of safeguarding adults cases, selected at random. The aim of this review is to look at case practice, against a standard of excellence, and identify where there have been improvements, in previous years, and where further work needs to be done.

The audit found that the following had changed for the better:

- There is better recording and follow-through action, in relation to individuals or organisations that have caused harm.
- More staff and managers are following the principles of keeping adults at risk as central to the safeguarding adults process and to participation and are maintaining a record of this.
- There has been some improvement in protection planning, but more needs to be done for the medium-to-long term.

The areas of good practice noted, in some cases, were:

- The clarity, relevance and timeliness of **recording**.
- The **Timeliness** of safeguarding actions taken.
- The quality of **risk assessment**.
- The quality of the **investigations** which were held.
- The quality and wide use of **protection planning**, in some form.
- The **person-centred** approaches to adults at risk.
- An increasingly sophisticated use of the **Mental Capacity Act**.
- The effective **chairing of safeguarding meetings**.
- The recording of episode **closures and outcomes**.
- Where **a child** is linked to a Safeguarding Adults case, there is excellent, pro-active liaison with Children's Services.

Areas identified for focus, in the coming year, include:

- Due rigor, care and probity should be ensured when working with all organisations alleged to have caused harm.
- More adults at risk or their representatives should be invited to and actively supported to attend safeguarding meetings (or parts of these).
- Ensuring that recording-related improvements, such as managers' decisions, sending of minutes and sign-off of safeguarding templates, occur in a timely manner.

In addition to the external audit, the Central Safeguarding Adults Service complete quarterly case file audits with managers or staff who worked on a case. This helps to ensure that any learning can be done from the ground up and continuous improvement is put into practice. The Central Safeguarding Adults Service want to ensure that practice **reflects the achievement of outcomes that the adult at risk identifies**; to achieve this, the audit form will be amended and an emphasis placed in practice recording which accurately portrays how the safeguarding process has improved safety and well-being of the adult at risk.

Managers working in Barnet, Enfield and Haringey Mental Health Trust also have an audit process, which helps to assure case practice for adults at risk that have mental health needs. This is done on a monthly basis and promotes best practice.

Quality assurance activities must have those who use services as key participants. Enfield's Quality Checker Programme exemplifies the commitment to include those who are services users and carers to directly influence how care is provided. Quality Checkers are service user and carers who have provided feedback and insights that have helped improve our day centres, residential units, extra-care sheltered housing units, private care homes and equipment retailers. We are currently working on pilot projects for home care and, following the recent Winterbourne View Report, hospital wards for learning disability service users.

> "Learning from the personal experiences of people who receive care services, I believe is the best way to improve care services and drive up quality."
>
> *Bindi Nagra, Joint Chief Commissioning Officer*

By the end of March 2013:

- We have recruited and trained 50 Quality Checkers
- We have sent 22 Quality Checkers out on visits. 11 of these Quality Checkers are now 'buddies', which means they will visit services in pairs. This means that we usually have carers, service users and different client groups represented on each visit, resulting in excellent and balanced feedback.
- We have completed 57 Quality Checker 'mystery shopper' visits.
- In addition, there has also been one 'mystery shopper' call to Brokerage.

So there are now 58 pieces of Quality Checker feedback/ improvement plans being processed, currently.

Some examples of the difference the Quality Checkers have made to services include:

Day centre to social club

After two Quality Checker visits to different older persons' day centres, a common theme emerged: Our Quality Checkers felt that the day centres should feel like social clubs and that this was not found in these centres. Managers were made aware of this, with the suggestion that re-organising the chairs so that they were in smaller circles, rather than in one big circle or against walls, would help make conversations between service users easier. This is something that all Enfield Council-run, older persons' day centres are now doing.

100%

One of our day centres for adults with learning disabilities achieved a perfect score – all of the Quality Checkers' feedback fell into the "Things that impressed" category. This was very satisfying for the day centre staff. The feedback also highlighted a difference in cultures between the older persons' and learning disabilities services. To help address this issue the Quality Assurance Team is organising Improvement Hub meetings for the day centre managers.

How do I get in?

On a visit to one of our larger equipment retailers, the Quality Checkers felt the signage identifying the store and how to get into the building was an area that needed to be improved. Their concern was that once on the industrial estate where the retailer is based, service users or carers would not be able to find their way in to the retailer and might feel unsafe on the estate. This has been fed back to the store manager, who is organising new signs.

No price tags, no receipt, no chance!

On a visit to a smaller equipment retailer, the Quality Checkers found that the price of equipment for self-funders was not clearly displayed. They also found that the retailer did not provide a receipt after a transaction had been made. These practices have led to the retailer being issued with a warning. If such practices are still evident on future visits, the retailer will be removed from our retailers list.

5. Difference that safeguarding adults has made to those who have been harmed

The Care Management Service received a safeguarding alert from a home care agency stating that **Mr. and Mrs. A** seemed to have money missing from their account. The Care Management Service spoke to Mr. and Mrs. A and then contacted the police, following which an investigation was opened.

It transpired that the money had been taken from a cash machine, by a member of the home care agency's staff, and the member of staff was suspended immediately. Because of the prompt communication with the police, CCTV evidence was discovered and the member of staff was charged and eventually found guilty of fraud. Mr. and Mrs. A received compensation from the court and the member of staff has received a Community Order and is registered with the Disclosure and Barring Scheme, so they will not be able to work with other vulnerable people, in future.

Mr. and Mrs. A also had their care needs reassessed, as part of the process, and they are now supported to manage their finances, through the London Borough of Enfield. This should protect them from further financial abuse, in the future. They have reported that they have found the professionals that they worked with to be caring and are happy with the result.

Ms. B is a younger woman, with a diagnosed Mental Health condition, who works with the Community Rehabilitation Team. During her work with the team, it emerged that her accommodation was in desperate need of improvement and that the manager of her supported tenancy was alleged to have been verbally abusive to her.

The team worked with Ms. B to establish that her wishes and that she had capacity to make her own decisions about her accommodation. They investigated and insisted that improvements be made. As a consequence, Ms. B's accommodation is now properly ventilated and the bathroom is fixed. The manager apologised to her and they have a more positive working relationship. Most importantly, Ms. B says she now knows who to call if she has a problem and that she will be listened to and treated with respect.

Mrs. C is an older woman who suffers from dementia and is cared for by her husband, Mr. C. The London Ambulance Service visited the home and were concerned that Mr. C might be being emotionally abusive to his wife.

A social worker visited Mrs. C at her day service and spoke to other professionals who knew the couple. She was able to determine that Mr. C was a loving husband who was struggling to care for Mrs. C and was very isolated. She conducted a Carer's Assessment. He didn't want extra practical help as he wanted to do this himself but the social worker arranged for Mr. C to make contact with both the Carer's Centre and Age UK so that he could make connections with others in the same situation. He said that he was grateful to be talked to as an individual and to have everything that he did to help his wife recognised.

Miss D is a woman with learning disabilities who lives in a care home in Enfield. She told a friend that she had been assaulted by another resident. The Integrated Learning Disabilities team visited her the day that they received the report, in order to see that she was safe. The person alleged to have caused harm was found alternative accommodation and Miss D was supported to report to the Police.

Miss D's capacity was assessed in accordance with Mental Capacity Act (2005) and she had an advocate working with her throughout the process. The Integrated Learning Disabilities team also worked closely with the residential home and the CQC in order to make sure that all residents were safe and that the risks had been properly assessed.

Miss D has been given support from the Occupational Therapy team around how she might keep herself safe, in future.

6. Quality of Care in Provider Services

People who use care services have an expectation that they will be safe, that the service which is delivered has quality embedded in all aspects and that these care services will be delivered with dignity and respect. Enfield is committed to ensuring that those, who receive a service, are kept safe and have a number of processes in place to achieve this.

The events at Winterbourne View Hospital awakened many people to a reality that care is not always synonymous with quality and that abuse can and does happen within provider services. They showed that how services are provided encompasses a complex web of multiple partners and that multi-agency working has to be key, if we are to uncover failings in the system.

Abuse was revealed at Winterbourne View Hospital by the BBC in Panorama Undercover Care: the Abuse Exposed, in May 2011. Winterbourne View was a private hospital for adults with learning disabilities and autism and, following the exposure of widespread, institutional abuse, was closed on 24th June 2011. Many of the conditions which allowed the abuse to occur were present from 2008, which included the use of restraint by untrained staff, the lack of a registered manager in post, poor oversight of patients and a lack of patient advocacy. The environment created was one in which "patients lived in circumstances which raised the continuous possibility of harm and degradation" (Flynn, 2012, SCR).

Partners on the Safeguarding Adults Board reported in December 2012 and March 2013 how their organisations have learned from the events at Winterbourne View, in order to prevent and put in place systems which will assure that people are kept safe. This includes, for example, changing how we commission services and review placements at hospitals, our advocacy service and ensuring we monitor trends and numbers in alerts, complaints and other factors which can highlight a failing care provider.

This year we also saw the Francis Report in response to the care provided by Mid Staffordshire NHS Foundation Trust. The Inquiry Chairman, Robert Francis QC, concluded that patients were routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and which lost sight of its fundamental responsibility to provide safe care. Robert Francis QC has made 18 recommendations for both the Trust and Government. His final report is based on evidence from over 900 patients and families who contacted the Inquiry with their views.

How Enfield has responded to concerns about the quality of care delivered by local providers, including hospitals, has developed in line with a number of factors. The emphasis on prevention, as set out by the Safeguarding Adults Board's first strategy, in 2009, shifted the focus to stopping abuse in the first place. There is recognition that taking reasonable steps to improve the quality of care, before significant failings or a detrimental impact on residents well-being takes place, as opposed to responding when harm has occurred, will always be the preferred option. Furthermore, the fostering of relationships between the local authority, as lead for safeguarding adults, and organisations, such as the Care Quality Commission, Clinical Commissioning Group and the police, has created a strong partnership, committed to responding robustly to concerns raised within provider organisations.

The Safeguarding Information Panel (SIP) was created, stemming from a partnership of the Councils Central Safeguarding Adults Service and the Care Quality Commission. The panel brings together information from the Council, such as safeguarding, health and safety and information held by commissioning staff, with that of partner organisations. The panel is instrumental in helping partners share information and in identifying common areas of concern. Some of the outcomes from these meetings, include:

- To ensure that care homes, where the provider concerns process is needed, are identified
- To link homes with specific audits. These will be undertaken by pharmacists, to improve medication management
- To co-ordinate joined-up interventions, such as work by the Local Authority and the Clinical Commissioning Group
- To set out a work plan for a policy on pressure care.

The Panel has also successfully identified a complex theme, involving risk assessment in care plans meeting Health and Safety guidelines. This was then implemented at the Quality Improvement Board, which manages projects with service users and carers.

The Central Safeguarding Adults Service in Enfield Council manages the provider concerns process. This process is put in place in response to concerns or information which highlights that a care provider is failing to meet the reasonable expectations in terms of quality, safety and dignity in care. We will work with our partners to support provider of care services to implement improvement plans, which will increase the standard of care for all residents. Service users and their families and friends play a big part in providing feedback on their experiences of the provider and letting us know when they are happy with the quality of the care and the dignity upheld by it.

> As someone with a loved one in a nursing home, I have to thank the Central Safeguarding Adults Service for their quick action in sorting out problems within the home and, by doing so, ensuring a safe environment for elderly and often extremely vulnerable people; some without a voice of their own. It is vitally important for close relatives to have someone to contact at Enfield Council, when they have serious concerns about a home, and to be able to do so with confidence.
>
> *Relative*

In 2012/13 we had 22 providers under our concerns process.

Nursing Home C had undergone a previous improvement plan to look at issues regarding quality of care. Concerns still existed and some residents, their families and visiting professionals raised further issues with staffing levels, quality of care and safety of residents. A range of partners worked together, such as the Central Safeguarding Adults Service, Care Quality Commission and NHS Enfield/Shadow CCG.

An improvement plan was put in place, along with a range of protective measures, to assure us that all current residents were safe to remain in the home.

Because this home had been through the provider concerns process before, everyone wanted to learn from this process and see how concerns of this nature can be prevented in the future. A learning event was held with a range of professionals and many staff from the nursing home, itself. This event identified some areas where improvements can be made, in future, including:

- Improving and setting out our communication strategy for sharing information
- Introducing a risk evaluation process to establish levels of risk and proportionate action
- Establishing greater liaison with families and friends, at an early stage; including their involvement in devising relevant policies and procedures
- Giving greater choice and control to residents
- Introducing into the process timescales for service improvement

The improvement plan was implemented and results were achieved. Subsequently, residents and their families were very happy with the running of the home and felt that the culture of the home had changed completely. Those friends and families that felt disengaged said they really felt that they were being listened to, when they commented on the home. The home is now regarded as a place of excellence.

7. Safeguarding Adults Board Sub-Groups

During 2012/13, we reviewed the sub-groups which support the work of the Safeguarding Adults Board. The Board agreed for there to be four groups, which would be chaired by members of the Board.

The four groups agreed were:

- **Service User, Carers and Patients Group** (co-chaired by Age UK and Over 50's Forum)
- **Quality, Performance and Safety Group** (co-chaired by the police and Clinical Commissioning Group)
- **Learning and Development Group** (co-chaired by Barnet, Enfield and Haringey Mental Health Trust and London Borough of Enfield)
- **Policy, Procedures and Practice Group** (co-chaired by North Middlesex Hospital NHS Trust and London Borough of Enfield)

Service User, Carers and Patient Group

This group, that was previously called the Safeguarding Adults Reference Group and consisted of service users, carers and local residents, was revised. The changes included that the Group would consist primarily of those who use services and their carers (including patients).This acknowledges the health element and input of health-related services in keeping people safe.

The Group currently consists of three service users, one carer and three patients. There is an active drive to recruit new members onto the Group, which can include up to twelve individuals. Support for those needing assistance to attend will be given. The Group is aware of the need to be inclusive and representative of the population of Enfield.

The Group has been meeting, monthly, since January 2013 and, since this time, a number of actions have been taken to contribute to the safety of adults at risk. The Carers Commissioner presented a leaflet that is being developed on supporting carers to remain healthy and well. This will include advice on how to report abuse if they are being harmed or feel at risk of harming the person for which they care. The Group has provided feedback on all areas, including suggesting information which needs to be included to keep carers safe and to enable them to access appropriate support.

Group members have also received information on advocacy. This is currently being reviewed by the Commissioning Service for Health, Housing and Adult Social Care. Members brought external challenges to how commissioning of advocacy will develop and its accessibility to those who need it. The Group will also be reviewing the service specification, in order to provide feedback and comments.

In March, the Group reviewed the safeguarding adults literature and publicity used by the partnership. Feedback was provided, which was shared with partners.

The Group would like to develop a DVD on the different types of abuse, in an effort to increase the understanding of service users, carers and local people. It is felt that a DVD could also include translating and signing for the deaf community, which is a focus of the Safeguarding Adults Strategy Action Plan for 2013/14.

The Group will continue to challenge and review developments in safeguarding, such as how service users are supported to participate in safeguarding adults. This is currently being done through review of case audits.

Policy, Procedure and Practice Group

The Policy, Procedure and Practice Group will focus on ensuring guidance to staff in line with national and local changes, including multi-agency working to ensure best outcomes for adults at risk. Practice will be reviewed to ensure lessons learnt can be embedded and inform how we safeguard adults at risk.

To date, the group has set out and agreed the terms of reference and membership requirement; as the policies and procedures are multi-agency in nature and require sign-up from partners, it is important for a range of professionals and local people to take part.

The Group reviewed a Safeguarding and Serious Incidents Policy which had been submitted for consideration. Members approved the policy, which aims to provide clarity on how the two processes should run, while reducing the risk of duplication.

The Group is currently writing a multi-agency Hoarders protocol, to ensure joined-up working.

The Group will continue to review policies put forward for consideration and lead on any new policies, in line with national or local guidance. In addition, the Group has led for practice developments and, therefore, will consider how multi-agency sharing of lessons learnt can improve how we safeguard adults at risk.

Learning and Development Group

Learning for adults is a diverse activity and spans a range of activities, including formal training sessions, e-learning, group activities and one-to-one reflective practice, to name a few.

The Learning and Development Group is tasked with supporting those in Enfield who both work and support adults at risk to gain a minimum basic competency set, with commissioning training courses and embedding organisational learning, that arises from the many activities we do.

The following training is mandatory, where relevant, for staff whose organisations are represented on the Safeguarding Adults Board:

- Basic Awareness
- Investigators
- Managers Introduction
- Managing from referral to closure
- Chairing Strategy Meetings
- Refresher course

The multi-agency training programme is currently managed and administered by the Learning and Development Team of the Council's Health, Housing and Adult Social Care department.

The organisations represented on and numbers of people attending multi-agency training courses are as follows:

Course	HHASC	BEH MHT	Police	Private & Voluntary	Totals
Alerters	93	7	0	36	**136**
Investigators	16	6	6	0	**28**
Financial Abuse: Stage 1	10	3	0	0	**13**
Financial Abuse: Stage 2	4	3	0	0	**7**
Legal Context	4	2	0	1	**7**
Managers of staff who raise alerts	10	0	0	9	**19**
Chairing Strategy Meetings	9	2	0	0	**11**
Referral to Closure	6	1	0	0	**7**
Total	**152**	**24**	**6**	**46**	**226**

The courses being run, in 2013/14, include:

- Basic Awareness (e-learning)
- Alerters
- Investigators
- Financial Abuse: stage 1 and stage 2
- The Legal Context
- Managers Introduction
- Managing from referral to closure
- Working with domestic violence and safeguarding adults: Practitioners Course
- Safeguarding Adults and Domestic Violence for Managers

The Learning and Development Group is planning to review the safeguarding adults learning strategy over the coming year, which will include how safeguarding learning is planned, commissioned, delivered and evaluated. The Group will also ensure that all organisations have learning opportunities for their staff, so that everyone will have the knowledge and skills to understand, identify, respond to and report abuse.

Quality, Performance and Safety Group

The Board's Quality, Performance and Safety Group has been set up to ensure oversight of the quality and care of providers and internal processes of partners; this will include audits of case practice and the Board's quality assurance activities.

The tasks that the Group intends to undertake over the coming year, include:

- To scope audits completed across the partnership and provide a quality assessment and gap analysis. This will include referring organisational learning points back to the Safeguarding Adults Board.
- To inform the Board of the effectiveness of partner commissioning functions, to be able to integrate safeguarding adults into its cycle.
- To review and advise partner organisations on how contractual arrangements safeguard adults at risk. To review two partners on an annual basis.
- To advise the Board on the effectiveness of local data collection; including its consistency, timeliness and reliability and its ability to meet national requirements.
- To secure reasonable assurance on safe employment practice; including effectiveness of policies and procedures for recruitment, supervision of people working with adults at risk and compliance with Disclosure and Barring Service (DBS).

8. Partner Statements 2012/13

- Barnet and Chase Farm Hospitals NHS Trust
- Barnet and Chase Farm Hospitals NHS Trust and Enfield Community Services
- Enfield Clinical Commissioning Group
- Enfield Homes
- Enfield Safer and Stronger Communities Board
- London Ambulance Service
- London Fire Brigade – Enfield Borough
- Enfield Borough Police
- North Middlesex Hospital NHS Trust

Barnet and Chase Farm Hospitals NHS Trust

Internal arrangements for governance regarding Safeguarding adults:

- The Director of Nursing is the director responsible for Safeguarding.
- One of the Deputy Director of Nursing acts as the corporate lead for Vulnerable Adults.
- A Medical Matron on each site acts as an operational lead, providing advice and support to staff on adult protection policies and procedures.
- The Trust has a vulnerable adult's board which meets quarterly and has a safeguarding strategy group, to ensure that learning from both children's and adults' safeguarding are taken forward within the organisation.
- An Annual Report which includes the Annual Reports from both the London Borough of Barnet and London Borough of Enfield is taken to the Trust Board.
- A quarterly report, which includes the number of safeguarding alerts/investigations and the numbers of staff who have attended safeguarding training, is taken to the Quality and Safety Committee.

Internal arrangements for training regarding Safeguarding adults:

- There is a session on induction for all staff.
- Additional training has been provided by an external trainer.
- The Trust has e-learning packages for all statutory and mandatory training including Safeguarding, Mental Capacity Act, Deprivation of Liberty Safeguards and Dementia.
- 85% of staff have safeguarding training as of March 2013.
- The Trust solicitor provides training on the Mental Capacity Act.
- Training has been provided on caring for patients with dementia in an acute setting as part of the Trust's Dementia Strategy.

Work undertaken/planned and achievements/ progress in 2012/13:

- As part of safeguarding awareness week and Nurses day the Trust had information stalls on both sites.
- The "We Care" campaign introduced the Quality of Interaction Observational Tool (QUIS) to improve the quality of interaction and communication between staff and patients.
- QUIS audits are undertaken monthly and staff are using this tool to reflect on how they care and to agree actions as a team to continue to improve care and communication. The results of the QUIS audits are reported on as part of performance review.
- The Trust has a Patients and Relatives Group and members of this group undertake QUIS audits.
- The Trust is making environmental changes within the ward areas, to improve the facilities for patients with dementia; this includes the use of symbols and colours to identify key areas within the wards.
- The Trust continues its ongoing commitment to reducing the inequalities experienced by people with learning disabilities, when accessing healthcare environments.
- Training in Learning Disability awareness is provided in a number of formal and informal sessions.
- The Acute Liaison Nurse has provided training to specific wards and departments and has supported the Day Surgery Unit to identify reasonable adjustments they can make to their pathways.
- The Acute Liaison Nurse for patients with a learning disability undertakes sessions on recognizing the needs of people with a learning disability as part of the student nurse induction.
- The Trust has revamped its safeguarding pages on the intranet and has a combined safeguarding page for children and adults, with signposts to relevant sections.
- The Trust implemented the dementia pathway as part of its dementia strategy. As part of this, a range of information and advice sheets are available to patients, staff and their relatives.
- The Trust has implemented the 'green cup' scheme for patients, with dementia, to prevent dehydration.
- Distraction boxes have been implemented for patients with dementia.
- The Trust has implemented a 'carers' badge' scheme.

Work planned for 2012/13:

- As part of Nurses Day, the Trust intends to continue holding safeguarding awareness stalls.
- The Trust is planning further environmental changes, as part of its dementia strategy, and extending the use of colour and symbols to identify specific areas.
- The Trust has trained key staff as dementia trainers and will continue its dementia training programme.
- The Learning Disability Liaison Nurse will continue to work with the communications department to develop patient information leaflets in an accessible form.
- The ALN is also looking at ways our cancer services and pre-admission clinics can be improved to take into consideration the unique needs of some of our patients with learning disabilities.
- The Trusts will revise its Patient Experience Strategy in line with the Chief Nursing Officers '6 C's' and will incorporate the recommendations from the government's response to the Francis Enquiry.

Statement written by:

Teresa McHugh
Deputy Director of Nursing
Enfield Safeguarding Adults Board representative

Barnet and Chase Farm Hospitals NHS Trust and Enfield Community Services

Internal arrangements for governance regarding Safeguarding Adults

As part of the governance structure in Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) and Enfield Community Services (ECS) the Safeguarding Adult Committee meets on a quarterly basis. The Safeguarding Adults Committee meeting is chaired by the Executive Director of Nursing, Quality and Governance. Other members of the committee are assistant directors from each service line or their representatives and safeguarding leads from the local authority. This meeting affords for the discussion and follow up on actions from both internal and external issues regarding safeguarding adults. A Safeguarding Annual Report and work plan continues to be developed on a yearly basis, for presentation at the Governance and Risk Management Committee (GRMC) and the Trust Board. The executive lead and assistant directors represent the Trust at the three Safeguarding Adults Boards.

The Executive Director of Nursing, Quality and Governance is the Board Lead for Safeguarding Adults in the Trust. The Trust has a specific post of Assistant Director for Safeguarding Adults who reports to the Executive Director of Nursing, Quality and Governance.

The management of safeguarding cases is co-ordinated by the Community Mental Health Team Managers and Team Managers in integrated teams. This arrangement has been reached with Barnet and Enfield local authorities. The process for Enfield Community Services is different as all safeguarding alerts are sent to and managed by the London Borough of Enfield.

The Trust participates in the bi-monthly practice development group, co-ordinated by the Enfield Safeguarding Adults Team.

Work undertaken/planned and achievements/ progress in 2012/13

During 2012/13, the practice in safeguarding adults has continued to ensure the best outcomes for the service user, if they have been subject to a type of abuse. To ensure compliance with “Protecting Adults at Risk: London multi-agency policy and procedures to safeguard adults from abuse” (Pan-London Procedures) case file audits on Meridian have been carried out as part of a quality assurance measure.

The Trust has achieved the following in terms of learning and development:

- Development of safeguarding adults’ e-Learning refresher level 1 training.
- Level I training has continued to be delivered in the Trust, on mandatory training days.
- Bespoke Safeguarding Adults training was undertaken and delivered to managers and staff in the Forensic service.

In total, **2,203 staff attended level 1 safeguarding adults training during 2012/13.** This training is offered as part of the mandatory training day.

Additional achievements across the Trust include:

- The Self-Assessment Assurance Framework was reviewed and signed off by the Enfield Safeguarding Adults Board, in November 2012.
- A Domestic Violence and abuse protocol has been developed jointly with Safeguarding Children, in the Trust.
- Compliance inspections against the criteria in Outcome 7 (safeguarding) of the CQC’s regulatory framework on all inpatient units and Community Teams.
- A Domestic Violence factsheet and flowchart have been developed for each borough in the Trust.
- Safeguarding Adults updated information on the new Trust website.
- A Safeguarding Adults Flowchart/Poster has been developed for Enfield Community Services.

Work planned for 2013/14

The Trust will incorporate the following elements into its safeguarding adults work programme for 2012/13:

- Continue to raise awareness among staff, in the practice of Safeguarding Adults.
- Continue to ensure that the Trust deliver a safe, friendly and caring environment where people are treated with respect, courtesy and dignity.
- Learning from Safeguarding cases to be embedded in the Trust and across the partnership.
- Quality of care on secure wards to be maintained.
- Ensure appropriate referrals are sent to the Disclosure and Barring Service.
- Safeguard adults by ensuring that any case of abuse is reported and managed though the London Multi-agency policy and procedure.
- Have a continued programme of level 1 Safeguarding Adults training with 85% compliance achieved.
- With the increased activity in the number of referrals being reported, services to ensure that adequate resources are available to support and respond to alerts in a timely way.
- Staff to access domestic violence and abuse training through the local authority or in the Trust, in order to improve awareness and gain further understanding of the referral process and support available to victims.
- Raise awareness in the use of the Domestic Violence and Abuse protocol.
- As part of a quality measure, team managers to audit one case file per month on Meridian.
- Maintenance of the Trust-wide Safeguarding Adults Database.
- Review of the Trust Self-Assessment using the Safeguarding Adults Assurance Framework for Healthcare Services.
- A planned programme of compliance inspections against the criteria in Outcome 7 of the CQC regulatory Framework to be carried out as part of the Trust peer review process.
- As part of the implementation the Bournemouth Competency Tool, to work with the local authorities training sub-group to ensure competences are linked to safeguarding adult training and to afford consistency in the Trust.

Statement written by:

Mary Sexton
Executive Director of Nursing, Quality and Governance
Enfield Safeguarding Adults Board representative

Enfield Clinical Commissioning Group

Introduction

Keeping "adults at risk" safe whilst they are receiving health care in Enfield remains at the heart of all NHS Enfield Clinical Commissioning Group (CCG) planning and decision-making. The CCG has continued to work in partnership with all agencies to achieve this and to ensure all providers understand their role in the health and wellbeing of "adults at risk".

The Commissioning Strategy for Safeguarding Adults 2012/13 sets out the CCG's plan to improve its systems and processes to deliver high standards of safeguarding adults practice, via our commissioning responsibilities, during a time of significant organisational change.

At the time of transition, the CCG assured the Department of Health, NHS England (London) and Enfield Safeguarding Adults Board (SAB) that its statutory obligations in relation to safeguarding adults are being followed and strengthened, through on-going developments.

Key Achievements

There have been several notable achievements in the safeguarding function in NHS Enfield Clinical Commissioning Group, between 2012/13, including:

An authorisation process that demonstrated the CCG had appropriate systems in place, in respect of safeguarding adults, when discharging their responsibilities:

- The CCG staff were trained in recognising and reporting safeguarding issues. Additionally all GPs across Enfield were trained in the recognition and reporting of adults at risk.
- There is a clear line of accountability for safeguarding adults, clearly reflected in the CCG's governance arrangements.
- Appropriate arrangements to co-operate with local authorities in the operation of the Enfield Safeguarding Adults Board.
- A safeguarding adults lead, a Mental Capacity Act lead and a PREVENT lead are in place, supported by the relevant policies and procedures.
- A comprehensive Safeguarding adults commissioning policy, in relation to safeguarding concerns and developments identifying adult individuals at risk, is in place, ratified by the local Safeguarding Adult Board (SAB).
- Links with Enfield SAB support a consistent partnership approach to interagency working to promote a multi-agency process of managing Safeguarding Alerts is in place.
- Annual Self-Declaration of Assurance which is the Safeguarding Adults Assurance Framework (SAAF) against specified safeguarding adults standards was completed and passed by NHS London, in 2012.
- We have recruited to the Nurse Assessor's post which is jointly funded between the Local Authority and the CCG.
- The CCG continue to contribute to the Domestic Violence Strategy, which includes the commissioning of a project to aid General Practice staff in the Identification and Referral to Improve Safety (IRIS). The CCG co-ordinated a Master class on Domestic Violence for both GPs and local community staff, including Health Visitors. The organisation has contributed to a number of Domestic Homicide Reviews. The CCG will continue to work with partners across the health economy to ensure that suitable processes are implemented so that effective and meaningful Domestic Homicide Reviews are produced.
- The CCG work to ensure that the safeguarding recommendations from the Winterbourne review are fully implemented in health commissioning and health services in Enfield.

The CCG has been committed to sharing, receiving and using information from other agencies and organisations, where this is relevant to the performance management of a provider in relation to safeguarding adults. This may include exchanging information with:

- Safeguarding Adults Department in the Local Authority
- Safeguarding Adults Board
- Police
- NHS providers and contractors
- Care Quality Commission
- Care Homes
- Provider concerns meetings

Governance Arrangements and Next Steps for 2013/14

The CCG will comply with its governance arrangements and move forward in the following way:

- There is now a GP and a Head of Safeguarding in place for safeguarding adults who as part of their portfolio will ensure strategic ownership of safeguarding adults at Board level. These officers' will champion the organisation's vision and responses and provide high level support for staff in leadership positions related to safeguarding adult issues.
- A safeguarding committee is in place and is chaired by the Director of Service Quality and Integrated Governance from April 2013; meetings will be quarterly to oversee compliance for safeguarding all adults who access provider services. The CCG is committed to developing robust arrangements to ensure that safeguarding becomes fully integrated into provider services systems, which will create greater openness and transparency about clinical incidents and learning from safeguarding concerns with partner agencies.
- Dedicated links to PREVENT will be established and joint working arrangements will be developed in order to achieve effective multi-agency working across the health economy in conjunction with local authority and the police.
- Seek assurance from providers that staffs are knowledgeable about the Mental Capacity Act and are applying the principles of the Act in everyday practice.
- The CCG will design a Quality Assurance Tool that will be sent out to all Nursing Homes twice a year.
- The CCG will be working towards safeguarding adults as integral part of their commissioning cycle in:
  - planning services with patients to address the needs of patients at greatest risk of neglect and abuse
  - securing contracts with services that set clear standards for safeguarding adults
  - monitoring services through a comprehensive assurance framework that support improvements and address concerns.

Statement written by:

Carole Bruce-Gordon
Head of Safeguarding for Enfield CCG
Enfield Safeguarding Adults Board representative

Enfield Homes

Commitments to Safeguarding Adults at Risk

Enfield Homes is committed to work in partnership with all organisations to prevent adults at risk from being abused in the first place and reduce the suffering caused by abuse in Enfield.

Enfield Homes is an ambitious organisation that believes quality, affordable housing is crucial to help shape vibrant, cohesive and social inclusive local communities, making the borough a safer place to live. Having gone live as an Arms Length Management Organisation on 1st April 2008, it has an easily understood mission – to deliver quality homes, excellent services and successful communities.

The primary focus for Enfield Homes is the delivery of high quality services to its customers and maintenance/ repair of their property to be a good standard. However, the organisation's objectives also embrace community development and improvement, working in partnership with the Council, community groups and other agencies and developing staff to achieve their own and the organisations aspirations.

One part of delivering a successful community is through our aim to help prevent abuse, making sure our tenants, leaseholders and staff know what to look out for and who to contact for advice and support.

Ensuring safeguarding adults remains a strategic priority is driven by representation on the Safeguarding Adults Board by a member of Enfield Homes and will continue to be driven for 2013/14.

Key achievements

Enfield Council's Safeguarding Adults Team attended the Enfield Homes Tenants Conference in 2012 and spoke about how Enfield safeguards its residents.

The Sheltered Housing Service achieved in August 2011 the Centre for Housing and Support's Code of Practice for Housing Related Support. This included submitting evidence substantiating that our staff are aware of the policies and procedures and their practice safeguards our residents, they understand their professional boundaries and that we are committed to participating in a multi-agency approach to safeguarding. It was also evidenced that our residents understand what abuse is and know how to report concerns. Working within the Code of Practice ensures that there is continuous improvement within the service.

We have promoted awareness within Enfield Homes and all staff who regular come into contact with adults at risk, to ensure they can access advice and support and know how to report their concerns.

An article about 'Preventing Abuse' was included in our March 2012 and edition of our quarterly newsletter 'Housing News' to enable our tenants and leaseholders to recognise, prevent and report abuse. The Adult Abuse Line telephone number is again in the March 2013 edition.

Priorities for 2013/14

The article about 'Preventing Abuse' is due to be included in our June 2013 edition of Housing News and will continue to be a regular feature every six months.

All staff within Enfield Homes are now required to undertake the London Borough of Enfield Safeguarding Adults Awareness e-learning module this is due to be rolled out within the next couple of months, with a completion target of the end of October 2013 for all staff.

Work with the local authority to ensure the implementation of the Pan London Safeguarding Policy and Procedures raise staff awareness and make sure the procedures and guidance are easily accessible on our internal directory on 'Staffnet' for staff.

For Enfield Homes to include Safeguarding Adults in its Business Plan and Delivery Plan for 2013/14 as part as our commitment to prevent adults at risk being abused.

Enfield Homes works to an internal Hoarder's Protocol, which seeks to engage multi-agency partners in supporting those who are at risk. This model has been recognised by other partners in Enfield and during 2013/14, we will work with a sub-group of the Safeguarding Adults Board to develop a multi-agency protocol.

Statement written by:

Jan Goodkind
Principle Housing Manager
Enfield Safeguarding Adults Board representative

Enfield Safer and Stronger Communities Board

The Enfield Safer and Stronger Communities Board (SSCB) is the statutory Community Safety Partnership locally and has responsibility to maintain an understanding of crime and anti-social behaviour, develop and consult on a strategy to bring about improvements and drive forward the delivery of a Partnership Plan.

The Partnership has an excellent reputation for innovative and effective joint working, delivery and value for money. There is a strong emphasis on performance management and a programme of continuous improvement.

Current position

The Safer and Stronger Communities Board comprises of the local authority, the police, the fire and rescue service, the probation trust and health agencies. Senior officers from these agencies promote the activity of the Safer and Stronger Communities Board within their own agencies.

They work in partnership with the Mayors Office for Policing and Crime and with representatives from the local Youth Offending Team, other criminal justice agencies such as the Crown Prosecution Office and the Courts, Housing Providers, Elected Members and voluntary organisations.

The partnership receives support from the Council's Community Safety Team which sits within the Environment Department. The Assistant Director for Community Safety and Environment is a member of the Safeguarding Adults Board and is responsible for ensuring support is provided to the Board.

There are considerable changes underway in the landscape of community safety, including the introduction of the Local Policing Model and the selling of parts of the police estate. Probation Trusts are unlikely to manage offenders in the same way, following the introduction of Ministry of Justice reforms and the other parts of the Criminal Justice System, such as the Courts and the Crown Prosecution Services are also undergoing major change.

These changes to how offenders and victims are dealt with in general will have obvious implications for dealing with complex cases, aggravated offences and vulnerable victims. We also know that in the current climate, more offenders than ever are citing financial pressure as a reason for offending.

Key achievements of 2012 to 2013 and how we will deliver improvements in the following year

In the last 12 months the SSCB focussed on the following priorities:

- Working with young people as victims and offenders
- Tackling violence against women and girls
- Reducing serious acquisitive crime
- Tackling anti-social behaviour (including improving offender management)
- Improving community engagement
- Ensuring local community safety during the Olympic Games 2012.

We have made progress in the area of tackling violence against women and girls and are reviewing cases through the Multi-agency Risk Assessment Conference (MARAC) and the Domestic Violence Steering group, in order to shape services and support cases through the criminal justice system. Examples of this include the provision of cameras and video cameras for the police who attend incidents. In this way we have already seen an improvement in the number of early guilty pleas, which in turn reduces further stress on the victim.

We have successfully applied for funding for Independent Domestic Violence Advocates from Mayors Office for Policing and Crime (MOPAC) to continue the support for victims, which we know reduces the attrition rates.

Although the number of domestic violence cases has increased, the number of repeat offences is starting to reduce; this would indicate that there is greater confidence in the services and that we are working with those cases of highest risk.

There is acceptance however that we can still improve the confidence of those who fall outside the definition of "intimate partner" perpetrated violence and are victims of familial violence. This may be more prevalent in some communities and the same is true of those with Learning Disabilities or who are otherwise vulnerable. The new performance framework has the ability to highlight gaps and focus attention of partners.

We are currently conducting a Domestic Violence Homicide Review following a fatal attack on a young woman in the borough. The lessons learned from this will inform services about how better to engage with communities to reduce the risks to others.

The Hate Crime Case Management Panel continues to discuss specific cases and determine whether all appropriate action has been taken. Our Integrated Offender management process now coordinates activity to tackle perpetrators of domestic violence and some other violent crimes, excluding Multi-agency Public Protection Arrangement (MAPPA) cases. Previously this has only focussed on property crimes.

We have continued to fund target hardening for homes in cases where the victim is vulnerable. This service is provided free of charge to those who qualify.

The SSCB is working with the Health and Wellbeing Board to ensure that investment is made in preventative work. This includes the introduction of the IRIS project where GPs are trained to safely discuss domestic violence with patients who appear at risk.

Statement written by:

Andrea Clemons
Head of Enfield Council Community Safety Unit
Enfield Safeguarding Adults Board representative

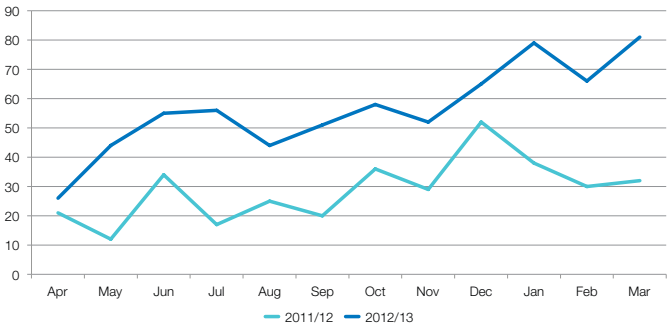
London Ambulance Service

The London Ambulance Service NHS Trust has been working hard over the past year to ensure that we can keep the people we have come into contact with safe.

- In November 2012 we appointed a Head of & Named Professional for Safeguarding Adults in line with the Children's Named Professional.
- We reviewed our Adults at Risk policy and this is currently undertaking an Equality Impact Assessment and will be published on our safeguarding web pages.
- We now have named local leads for all safeguarding boards, although it is recognised that it is not always possible for us to attend all meetings.
- We have reviewed our training and deliver both child and adult at risk training together for all clinical staff.
- We provided safeguarding training for the LAS Trust Board and are due to present to them again at the end of 2013.
- We reviewed our contracts with private providers and ensured safeguarding training is undertaken and to the required standard.
- We have undertaken Prevent training for our officers.
- We reviewed the recommendations from Winterbourne View and have written to Safeguarding Chairs to outline our response and actions.
- We have produced safeguarding easy read materials for the public.
- We have updated our web pages and included an easy read section.
- We have produced a safeguarding pocket book for staff which is being issued in June.
- We are holding a safeguarding conference on 5th June for 100 LAS staff plus 6 national leads.
- We are undertaking a review of our referral system and processes.
- We are meeting the Chairs group this month to discuss how best we can engage with adult safeguarding.

Our referrals continue to rise month on month pan London we now make 2,300 referrals a month for children and adults. For Enfield figure please see below.

As a Pan-London it is not possible for us to write 32 reports for the safeguarding boards. We complete a Trust report annually which is published on our website and covers safeguarding. Likewise we have provided a response to the Winterbourne View Report and recommendations which is being given to the chairs group.



Statement written by:

John Carmichael
Enfield Borough, London Ambulance Service
Enfield Safeguarding Adults Board representative

London Fire Brigade – Enfield Borough

The London Fire Brigade has a strong commitment to safeguarding adults at risk and continues to work to develop service delivery by focusing preventative work streams to better identify at risk individuals as well as responding appropriately following referral through links with inter professional groups. We recognise that robust safeguarding arrangements are essential to managing risk. We believe that all residents have the right to be treated fairly and with dignity and respect.

The London Fire Brigade has a good reputation for working closely with and supporting multi-agency teams to deliver adult safeguarding services in accordance with the pan London 'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse ' framework.

Current position

As part of the London Fire Brigade's adult safeguarding responsibilities, it is required to provide a representative as board members on the local multi-agency safeguarding adult board. The Borough Commander Enfield Borough is currently on Enfield Safeguarding Adults Boards and is an integral decision maker in the development and progression of the local safeguarding agendas. The London Fire Brigade has maintained an active participation in the Safeguarding Adults Board, undertaking work streams as required throughout the year.

The Borough Senior Officer for Community and Fire Safety has also been nominated to attend Enfield Safeguarding Adults Board subgroup for the multi-agency Safeguarding Adults Policies, Procedures and Practice Group.

Key Achievements 2012/13

Last year London Fire Brigade Enfield Borough planned the following activities and achieved the following outcomes:

- Raise awareness of partners, organisation and agencies of risks to adults from fire in particular dangers of hoarding and provision of arson proof letter boxes.
  - Outcome: Partners were invited to 2 seminars hosted by London Fire Brigade in relation to the identification of repeat callers to London Fire Brigade, recommending future practise and the availability and provision of domestic fire suppression systems.
  - Work commenced on the development of a Multi-agency Hoarding Protocol through the Policies, Practices and Protocols sub group of the Adults Safeguarding Adults Board.
  - Attended a number of Community based events to promote home fire safety and raise awareness of the provision of arson proof letter boxes.
- Work with partners to ensure a robust information sharing process is established that sits within data protection act.
  - Incorporated data sharing provision within Multi-agency Hoarding Protocol which is currently being drafted.
  - Maintained current information sharing provision within current Safeguarding Adults procedures.
- To develop protocol between LFB and adult social services reporting referral outcomes in relation to safeguarding.
  - Local systems within London Fire Brigade Enfield have been developed to ensure follow up calls are made with Adult Social Services following referral.
  - Following a fatal fire, an internal review recommended considerations for serious case review where appropriate.
  - Through joint working with Enfield Adult Social Services and Enfield Borough Council Safeguarding Adults Service identified and offered a free home fire safety risk assessment to adults vulnerable to fire incidents in the home.
- Raising awareness of fire crews as to what other services are available for adults at risk.
  - A training programme is incorporated into each Fire Stations training plan in relation to Safeguarding policy and procedure for both Children and Adults.
- Monitor outcome reports.
  - Standing agenda item on all Borough management meetings to monitor and evaluate/quality assure previous 28 days safeguarding issues and referrals.

- Working with at risk groups such a the deaf community to improve services, involving the provision of free smoke detectors for the deaf and provision of information about home fire safety and calling the emergency services.
  - London Fire Brigade have made excellent links with the local drop in services and received a number of referrals from the deaf community for home fire safety visits. This has been delivered by fire fighters with British Sign Language level 2 proficiency.
- Officers to refer to appropriate agency through Safeguarding protocol where evidence suggest this is necessary.
  - London Fire Brigade Watch officers have made a number of referrals throughout the year in accordance with Brigade Policy. Of these only a small number have been referred through the urgent referral agreement. The remainder have been referred to appropriate services and agencies.
- Work with partners to address vulnerable adults at risk from exploitation by unscrupulous land lords to receive support through implementation of statutory enforcement.
  - London Fire Brigade Regulatory Fire Safety Team have worked with Enfield Council to raise awareness of these issues and offer assistance and advise when necessary.
- Officers to identify evidence of abuse, preserve scene and early passing of information to the Police as possible crime scene.
  - London Fire Brigade Officers have received awareness training and referred cases to Police where appropriate.
- Support partners by providing advice in relation to fire safety in the home when requested.
  - Senior Officers attended a seminar hosted by Enfield Borough Council Safeguarding Adults Services, for Residential Social Landlords, to raise awareness of home fire safety and regulatory fire safety matters.
- A centrally held safeguarding referral database to identify safeguarding adults trends pan London, by developing LFB policy and outcomes shared with partners is ongoing.

Staff Training in Safeguarding Adults

Safeguarding adults training is mandatory for all staff. The training is provided internally by the Watch based managers. This is programmed for refresher training at least twice per year per member of staff.

As Safeguarding encompasses a wide range of legal responsibilities the training sessions include coverage of:

- Policy Statement
- Definition of Adults at risk
- Disclosure and Barring Service (previously Independent Safeguarding Authority)
- Recognising harm to adults
- Reporting procedures
- Information sharing and data protection.

Priorities for 2013/14

- Raising staff awareness of domestic violence.
- Focusing our prevention and protection activities on ensuring that older people living in care home and in sheltered housing are as safe as possible.
- Developing further local recording and quality assurance programmes.
- Continue to raise awareness of partners, organisation and agencies of risks to adults from fire, in particular dangers of hoarding and provision of arson proof letter boxes and fire retardant bedding.
- Continue to raise awareness of the availability and provision of domestic sprinklers for very high risk adults.
- Continue to develop protocol between LFB and adult social services reporting referral outcomes in relation to safeguarding adults or otherwise.
- Support partners by providing advice in relation to fire safety in the home when requested.
- Regular analysis of centrally held safeguarding referral database and other incident related databases, to identify safeguarding adults trends pan London to develop LFB policy and outcomes shared with partners.

Statement written by:

Les Bowman
Enfield Borough Commander, London Fire Brigade
Enfield Safeguarding Adults Board representative

Enfield Borough Police

Enfield Borough Police are committed to safeguarding adults at risk, previously known as vulnerable adults, and are setting out work to improve performance in this area. Full details of all proposed activity for Enfield Police are recorded in the Safeguarding Adults Board Action Plan for 2012-2015. All police actions in relation to the plan were updated and reviewed in April 2013.

Achievements over 2012/13

In February 2013 DCI Mark Rochester conducted a review of the way in which Safeguarding Adult investigations were handled by the Borough. This review looked at the processes used to identify and prioritize risk, together with the outcomes of investigations into safeguarding adult matters. This review has been presented to the Safeguarding Adults Board and the recommendations from the review will form the basis for future activity.

In addition to the above, the Police took forward a number of actions to keep adults at risk safe, including:

- Continued meetings with the Councils Safeguarding Adults Service on a frequent basis, in order to ensure all alerts which may be a crime are reviewed and progressed
- Joint investigators training with the Council
- Review of domestic violence processes and support
- Co-chairing of the Quality, Performance and Safety Group of the Safeguarding Adults Board.

Activities planned for 2013/14

The review process identified a number of areas where safeguarding adult matters could be more effectively addressed. On a national level guidance around safeguarding adults investigations is limited and the lack of clear solvability factors make achieving judicial outcomes challenging. The following proposed changes were identified as being necessary to improve the Borough's handling of vulnerable adult investigations and to ensure that wherever possible risks are identified and addressed.

Proposed activity relating to Training:

- Detective Sergeant (DS) with safeguarding adults responsibility to provide training to frontline officers regarding actions at the scene of a possible offence and appropriate referral.
- Detective Chief Inspector (DCI) for Public Protection to provide training to Acting Inspectors in role of Duty Officer to emphasize risk-management and the need for intrusive supervision around the initial response to Safeguarding incidents.
- Frontline officers to be briefed regarding the use of appropriate flags for adults at risk, as these appear to be underused at present; clarification will be sought from the Territorial Police on flagging process and policy.

Proposed activity relating to Processes:

- Relevant departments within Enfield Police to conduct daily review of all crimes recorded in the previous 24 hours, to ensure that all crimes are flagged appropriately.
- Safeguarding Adults Supervisor role to be created within the Community Safety Unit. This supervisor will deal exclusively with safeguarding adults and matters referred to the Multi-Agency Risk Assessment Conference (deals with high risk domestic violence). This Detective Sergeant will be responsible for the supervision and standards of investigation for all safeguarding adults offences.
- Dedicated Detective Constable (DC) to work under Safeguarding Adults Supervisor – this DC will investigate the most complex adult abuse cases and provide guidance to other officers dealing with safeguarding adult investigations.
- Further analysis to be completed of Adult at Risk crimes to ensure that these more complex investigations are being appropriately dealt with and judicial outcomes being obtained where possible.

Proposed activity relating to Quality Assurance:

- Detective Inspector for Community Safety Unit to randomly dip-sample 'Alert' referrals where no crime created each month, to ensure crimes are being recorded where necessary.
- Comparative review to be completed to ensure that safeguarding adults investigations are achieving a similar sanctioned detection rate to non-safeguarding adults investigations. An initial analysis of performance suggests that whilst SD rates are not high, they are comparable with the SD rates for non-safeguarding adults investigations.
- Dip-sample to be completed of cases where Suspect identified but not arrested. The Domestic Violence Arrest for Named Suspects is currently 82% for Enfield Borough. There is a concern that suspects for safeguarding adults cases may be inappropriately discontinued, particularly given the positive action policy that exists around safeguarding adults cases.
- All safeguarding adults and adult abuse crimes to be brought to the daily 1,000 Pacesetter meeting in order to review the risk management measures put in place and the investigation plan set.

Statement written by:

DCI Mark Rochester
Enfield Police, Public Protection
Enfield Safeguarding Adults Board representative

North Middlesex Hospital NHS Trust

The North Middlesex University Hospital NHS Trust has a strong commitment to safeguarding adults at risk and continues to work enthusiastically to enhance this focus through stronger links with inter professional groups, community patient groups and the voluntary sector. We recognise that robust safeguarding arrangements are vital to managing risk. We believe that all patients have the right to be treated with dignity and respect.

The Trust has a good reputation for working closely with all teams to ensure that all patient care and safety is patient centred and work with our inter professional agencies within the pan London 'Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse' framework.

Current position

As part of the Trust's adult safeguarding responsibilities, it is required to provide trust representatives as board members on the local multi-agency safeguarding adult boards. The Trust is currently represented on both the Enfield and Haringey Safeguarding Adults Boards and is an integral decision maker in the development and progression of the local safeguarding agendas. The Trust has maintained an active participation in the Safeguarding Adults Boards undertaking work streams as required throughout the year.

The Deputy Director of Nursing has also been nominated as Chair of the Enfield Safeguarding Adults Board subgroup for the multi-agency Safeguarding Adults Policies, Procedures and Practice Group.

Key Achievements 2012/13

Each year the Trust is reviewed against the Department of Health SAAF (Safeguarding Adults Self Assessment and Assurance Framework For Health Care Services). The Trust was assessed on Friday 16th November 2012 and was found to be compliant with all areas assessed, including those relating to services for those with learning disabilities.

Areas of best practice highlighted included:

- Positive discrimination to place learning disability patients on specific wards where learning disability champions are based.
- Side room allocation to allow open visiting to family and carers where possible and in consultation with wishes of patients to stay with no restriction of visiting hours.
- Pre-surgical assessment referral to Learning Disability Acute Liaison Nurse who works between community and the acute hospital.
- Learning disability acute liaison nurse available to support patients and ward staff.
- Carers policy to support and improve the patient experience.
- Carer's passport to allow a parking badge and access to extended visiting.

Our dedicated Safeguarding Adult intranet pages have been updated to reflect latest legislation and to support staff with adult safeguarding and the use of the Mental Capacity Act.

We continue to have an Acute Liaison Nurse Specialist who works with patients from the community and into the hospital. This involves patient and carer visits to the hospital and departments, and also local teaching in the clinical areas. This overarching link between the community and hospital has proved to be very informative for both patients and hospital staff. This has resulted in easier hospital admission for patients. Pathways have also been agreed to alert staff when patients are admitted and to ensure that their needs are taken into account.

The Trust has a forum for 'Embracing Carers' to discuss and identify areas where improvements can be made. Carers have also been invited to the Trust Patient Story sessions and to the Patient Safety and Quality Committee to provide with feedback from their experiences in hospital. Following a carers story in October 2012, we continue to investigate the possibility of building a specific toilet (Changing Places[1]) and changing area for adults with learning disabilities who are also physically disabled. A proposal has been submitted to the Trust Executive team for approval to progress installation of a Changes Places Toilet facility in our outpatient department.

The Trust is also currently participating in a two way peer review of Trust policies, procedures and resources available to support those with Autism and Learning Disabilities with Moorfields Eye Hospital. This will enable us to identify gaps and best practice and to provide evidence to support compliance with CQUIN Indicator 1C.

[1] Changing Places. www.changing-places.org

Staff Training in Safeguarding Adults

Safeguarding training for adults is mandatory in the Trust for all staff. The training is provided internally by the Learning, Education and Development Team. There are 3 levels of training provided currently:

- Level 1: Basic awareness training for all staff at induction
- Level 2: Intermediate training for staff with regular contact with patients
- Level 3: Advanced training for senior clinicians and on-call managers.

As Safeguarding encompasses a wide range of legal responsibilities and types of patient the training sessions include coverage of:

- Mental Capacity Act
- Deprivation of Liberty
- Caring for patients with a Learning disability
- Caring for patients with Dementia
- Addressing issues around dignity.

The Trust has continued to develop training for all staff in conjunction with our partner Enfield Social Services who provide our level 3 training. This training will continue to be delivered by the Trust and also by our host The London Borough of Enfield.

We have identified that there is further development work in relation to a training plan for safeguarding adults, and areas will be targeted to have updates in safeguarding adults at all levels. We continue to train staff through face-to-face and e-learning packages. The level 2 training includes Deprivation of Liberty and the Mental Capacity Act. The training figures are presented to the Patient Safety and Quality Board on a quarterly basis.

Priorities for 2013/14

The Trust has a Safeguarding Adults at Risk Strategy with an associated action plan which is updated annually with a progress update and new priorities added when necessary. This years priorities have been updated accordingly to reflect the priorities outlined below:

- To ensure that the Trust Safeguarding Adults at Risk Strategy continues to remain within the current and future pan London procedures and that all subsequent and inter related Trust policies embrace this format.
- To maintain and develop training for all staff across the Trust covering all required areas to ensure compliance with our targets, and to ensure that our services are fit for purpose, whilst ensuring that retraining occurs in a purposeful cycle.
- To ensure that Prevent training is provided as part of the Trust mainstream training programme.
- To continue to work collaboratively with our multi-agency and inter professional groups to ensure that our patients are protected and that alerts are raised as necessary.
- To continue to improve our responses to reports of abuse, in order that investigations can be clearly undertaken timely with our partners.
- To make it easier for people to report abuse and make sure they receive a good-quality service when they do. To assist adults at risk to recognise and prevent abuse and to put them in touch with a range of support services, including places where they can be safe from harm.
- To clarify Domestic Abuse referral pathways and to ensure that all staff are aware of how to escalate concerns internally and to relevant authorities.

Statement written by:

Eve McGrath
Senior Project Manager for Corporate Nursing and Interim Safeguarding Adults Lead
Enfield Safeguarding Adults Board representative

Appendix 1
Safeguarding Adults Strategy: Action Plan 2012-2015

Introduction

This is the Safeguarding Adults Strategy action plan, incorporating actions for year one (2012-2013) only. The plan is based on the 10 key priorities agreed by the Safeguarding Adults Board and is informed by partners own action plans and by the results of the public consultation that took place between April – June 2012. The Safeguarding Adults Board (SAB) will monitor the delivery of these actions. Partners will report on progress to the SAB at the quarterly meetings.

The other key work areas for the Safeguarding Adults Board are concerned with its leadership and partnership role and with ensuring that safeguarding is embedded with all commissioning activities across health and adult social care. These actions are described below.

Leadership, Partnership and Commissioning

The Safeguarding Adults Board will:

- review the Safeguarding Adults Board structure and Terms of Reference including membership
- ensure the Safeguarding Adults Strategy is regularly reviewed and updated to reflect changes in national and local position
- continue to support the development of the Reference Group and ensure there is effective feedback from all Sub Groups
- ensure that leaders across partnership demonstrate a personal commitment to Safeguarding Adults
- undertake a review of the training and development strategy
- ensure adults at risk are supported to attend meetings and events, both individually and as representative/s
- produce a new information sharing protocol for the safeguarding partner agencies
- ensure the Safeguarding Adults Board has effective governance and work programme
- ensure Safeguarding is embedded within all new services specifications
- develop a Commissioning Strategy for Safeguarding Adults with London Borough of Enfield (LBE) Safeguarding Adults and Commissioning Service and the Clinical Commissioning Group (CCG)
- ensure sufficient resources are available to deliver the safeguarding adults work programme
- audit the performance of the SAB against good practice guidance and relevant legislation
- work closely with commissioners to make sure that the requirement to demonstrate a commitment to safeguarding adults and to delivering against safeguarding standards is clearly laid out within contract specification, tender appraisals and contract monitoring
- work closely with the Clinical Commissioning Group to ensure compliance with safeguarding requirements
- work closely with the Safeguarding Children's Board to ensure systems are in place to ensure safe transition to adult services (minimising risk to them and from them to others) including the transition to adult mental health services and to the adult welfare criminal justice system
- develop and sustain effective professional relationships across Children's and Adults' Services in order to ensure assessment and services which minimises risk to both children and adults at risk in households with need.

"What difference did we make?"
"Is anyone better off?"

No.	Work Area/Project Outcome	Lead	Progress	Status
1.	**Community awareness**			
1.1	Information and advice: • Continue to provide an up to date portfolio of leaflets, bulletins, web- based advice/ information for use across the partnership and the Council, suitable for diverse audiences. • Provide suitable articles about preventing and tackling abuse and keeping safe. • Ensure information about how to report abuse is easily accessible and is in suitable formats including British Sign Language and easy read format. BSL changes targeted 2013/14.	All Board Partners	• Website updated and information on partner websites. Articles included in partner publications, such as Enfield Homes, Our Enfield and the Enfield Talking Newspaper. • British Sign Language changes targeted 2013/ 2014	●
1.2	Learning and development: • Continue to provide a range of learning and development opportunities including e-learning and workshop events that are available for staff across the partnership, including joint training where feasible • All partner agencies to publish data showing which staff are required to receive safeguarding adults training and evidence this is happening	SAB – Learning Strategy sub-group	Learning and Development Group has been restructured and a range of multi-agency training has been provided. Partners show data of the training undertaken in each of their organisations.	●
1.3	Learning and development: • Offer training to all Council Members and Non-Executive Directors of NHS Trusts • Offer training to Older People and Vulnerable Adults Scrutiny Panel	Safeguarding Service Head LBE	Complete.	●
1.4	All partners have in place organisational learning arrangements.	SAB – all Board Partners	This is in place and learning is shared at the Board.	●
1.5	All partners ensure that domestic violence training is available and quality assured.	SAB – all Board Partners	Not all partners have domestic violence training and this will be monitored over 2013/14.	●
1.6	To arrange regular public awareness raising events, including annual safeguarding awareness week • To ensure all community events feature safeguarding adults – crime prevention, preventing neglect and abuse.	SAB – all Board Partners	Two 'Keep Safe Weeks' where held with many partners in attendance.	●
1.7	To raise awareness of the interface between Hate Crime and Safeguarding Adults.	LBE Community Safety Unit & SAB partners	LBE Community Safety Unit has done a range of actions to promote hate crime against adults at risk. We now need to evidence that all partners are raising awareness.	●
1.8	To use all existing staff, engagement and partnership events – Boards, team meetings, away days etc to raise the profile of safeguarding adults.	SAB – all Board Partners	Evidence of safeguarding adults strategic outcomes in partner plans.	●
1.9	To use different ways to raise awareness – e.g. through opticians, dentists, pharmacists, banks, radio advertising, sandwich boards and enabling senior management to speak to local people around Enfield.	SAB – all Board Partners	We use many ways to raise awareness, but will try different methods over the coming year.	●

Key: ● Achieved/on track ● Monitor closely/behind schedule ● Not achievable or no satisfactory update received

No.	Work Area/Project Outcome	Lead	Progress	Status
2.	**Work with organisations and agencies – dignity and respect**			
2.1	Service users experience to be sought regularly and routinely – focus on how adults at risk are treated with dignity and respect.	SAB – All Board Partners	All Board partners fed back at the March 2013 meeting how they include service user experience. This included, for example, service user attendance at meetings and through audit process.	●
2.2	Feedback routinely obtained after incidents of abuse and learning is captured.	SAB – All Board Partners ensure internal monitoring arrangements	There has been improvements seen through the audit process of learning but we will continue to focus on this area.	●
3.	**Work with organisations and agencies – dignity and respect**			
3.1	Ensure that clear standards and procedures are in place for safeguarding adults responses with achievable time targets for actions for each partner.	SAB – All Board Partners	All partners responses and involvement are in line with pan London safeguarding adults policy and procedures.	●
3.2	50% safeguarding investigations to be completed within 7 weeks.	LBE – HHASC	Achieved.	●
3.3	Police to conduct audit of safeguarding adult cases referred to them, focusing on decision to investigate and prosecutions.	Police	Police are reviewing their structure and policy for safeguarding adults. The audit of cases will be completed in 2013/14.	●
3.4	Ensure that there are well understood alert processes between partners within the initial response to an allegation of abuse and that feedback is provided to referrers.	SAB – All Board Partners	Improvement in alerts sent in timescales, meaning adults get immediate protection plan and are safe. Providing feedback to referrers is important we will continue to monitor.	●
3.5	Ensure that all care assessments and reviews demonstrate that adult at risk and those who support them have up to date and accessible information about safeguarding services.	NHS and LBE	Quality assurance activities demonstrate that adults at risk and carers know how to report abuse.	●
3.6	Agree a policy and joint whistle blowing procedure across the partnership.	SAB – Safeguarding Service Head, LBE	Achieved.	●
4.	**Service user engagement**			
4.1	Develop a range of ways in which service users can easily make their voices heard, including people with mental health problems, learning difficulties and dementia.	SAB – All Board Partners	Service user/patients are part of service development and have mechanisms to become active partners in how safeguarding work keeps people safe-evidence submitted by partners in annual report statements.	●
4.2	All partners ensure that adults at risk are involved in quality assuring services.	SAB – All Board Partners	As above.	●
4.3	Ensure that the review of the Safeguarding Adults Board increases active involvement from adults at risk.	SAB	As above.	●

Key: ● Achieved/on track ● Monitor closely/behind schedule ● Not achievable or no satisfactory update received

No.	Work Area/Project Outcome	Lead	Progress	Status
5.	**Self protection strategies**			
5.1	All appropriate public events hosted by partnership members to include information about and for adults at risk e.g. crime prevention, keeping safe, financial training – which directly relate to self protection.	SAB – All Board Partners	Achieved. All events promote prevention of abuse and self-protection.	
5.2	Provide regular action and advice on preventing abuse – e.g. self protection strategies.	SAB – All Board Partners	Risk assessments demonstrate action taken to reduce risk of abuse occurring.	
6.	**To support people who choose to arrange their own care to do this in a way that protects them from abuse**			
6.1	Make easily available public information about the risks of adult abuse, especially targeted at: • Adults at risk who arrange own care • Carers of self-funders • At critical times like hospital discharge, using a multi-discipline approach.	SAB – All Board Partners HHASC Carers Commissioner and NHS	All partner agencies able to evidence information is given as routine to adults at risk. Work with Carers is developing through carers network in 2013/14.	
6.2	Ensure all service providers are able to demonstrate how service quality is assured.	HHASC – Head of Commissioning	Providers able to demonstrate quality assurance are directed to resources which prevent providers concerns process from being initiated.	
6.3	Maintain multi-disciplinary approach ensuring relevant partners are aware of adults at risk at the point of hospital discharge, incl. assessing mental capacity.	SAB – Hospital Trusts	We are working to prevent hospital discharge which may put adults at risk. This is being monitored through commissioners.	
6.4	Ensure all personalisation developments including risk management and the 'market place' embed safeguarding adults.	HHASC – Commissioning Department, LBE	Market place has information on how to keep safe and a plan for how services on the marketplace will be vetted.	
7.	**Access to justice system**			
7.1	Conduct review of barriers to adult at risk cases being prosecuted – *see 3.3 – 'Police to conduct audit of safeguarding adult cases referred to them'*.	CPS and Police	Recommendations delivered which aim at improving processes that increase access to the justice system for adults at risk.	
7.2	To improve understanding of barriers to prosecutions involving adults at risk, for the Board to receive learning from cases of hate crime and domestic violence which did not result in a prosecution.	LBE Community Safety Unit	Complete for Domestic Violence cases and information relating to hate crime will be presented to the September 2013 SAB.	
7.3	Ensure that all partners are clear about the Crown Prosecution Service (CPS) requirements/considerations for: neglect, fraud, common assault and sexual offences.	Police		
7.4	Share learning when CPS decides not to pursue – explore feasibility of action through civil action.	Police	Actions to be identified from the learning which will be added to the strategy action plan.	
7.5	Agree a protocol with Coroner's Office re death in care homes and investigations.	SAB– Safeguarding Service Head		

Key: Achieved/on track Monitor closely/behind schedule Not achievable or no satisfactory update received

No.	Work Area/Project Outcome	Lead	Progress	Status
8.	**Work with perpetrators**			
8.1	Ensure carers and carers organisations recognise and report abuse.	HHASC Carers Commissioner, LBE and Carer Centre	Achieved and on going.	●
8.2	Support the early identification of carers under stress and help them understand when they need more help and where to access the support.	SAB – All Board Partners	A leaflet for carers is being developed and will be sent out in 2013/14. We also have specific events for carers as part of Keep Safe Week.	●
8.3	To implement safer recruitment principles to ensure all staff and volunteers working with adults at risk are safely recruited and appropriately supervised.	SAB – All Board Partners	Our staff and volunteers are best placed to support our client bases – prevent unsuitable people from working with adults at risk and evidence we have embedded safer recruitment principles through feedback to SAB.	●
8.4	Staff – each agency has processes in place to manage allegations against staff and volunteers in line with Pan London policy.	SAB – All Board Partners	Partners are asked to show evidence of their process in 2013/14.	●
9.	**Data and statistics**			
9.1	Safeguarding Adults Board to receive statistical reports from partners on alerts, and actions including learning from Serious Incidents Panel and risk management arrangements.	SAB – all partners	Partners to maintain own internal reporting arrangements and share data with SAB, which will help best practice to be embedded across partnership.	●
9.2	Agree revised management and performance reporting requirements to SAB focussing on in depth analysis.	HHASC Strategy & Performance, LBE	Achieved.	●
10.	**Information technology**			
10.1	Agree use of Regulatory Investigatory Powers Act for safeguarding adults – e.g. review options for surveillance – cameras in capturing evidence for police etc.	SAB – All partners with HHASC SA	Draft policy on surveillance which will be going to the December 2013 SAB.	●
10.2	Explore and use Telecare alarm options for adults who have been or are at risk of abuse.	SAB – HHASC	Adults at risk have increased protective strategies in their home.	●

Key: ● Achieved/on track ● Monitor closely/behind schedule ● Not achievable or no satisfactory update received

Appendix 2
Safeguarding Adults Referral Report 2012/13

This report is an analysis of Safeguarding Adults referrals received from 1st April 2012 to 31st March 2013. The total number of referrals (alerts) received during this period was 797 compared to 688 for 2011/12, an increase of 14%.

Referrals (Alerts)

The graph below shows the number of referrals (alerts) received by team. The Hospital Teams are now only investigating cases where the alleged abuse took place on the hospital site.

Figure 1: Number of Referrals (Alerts) by Teams

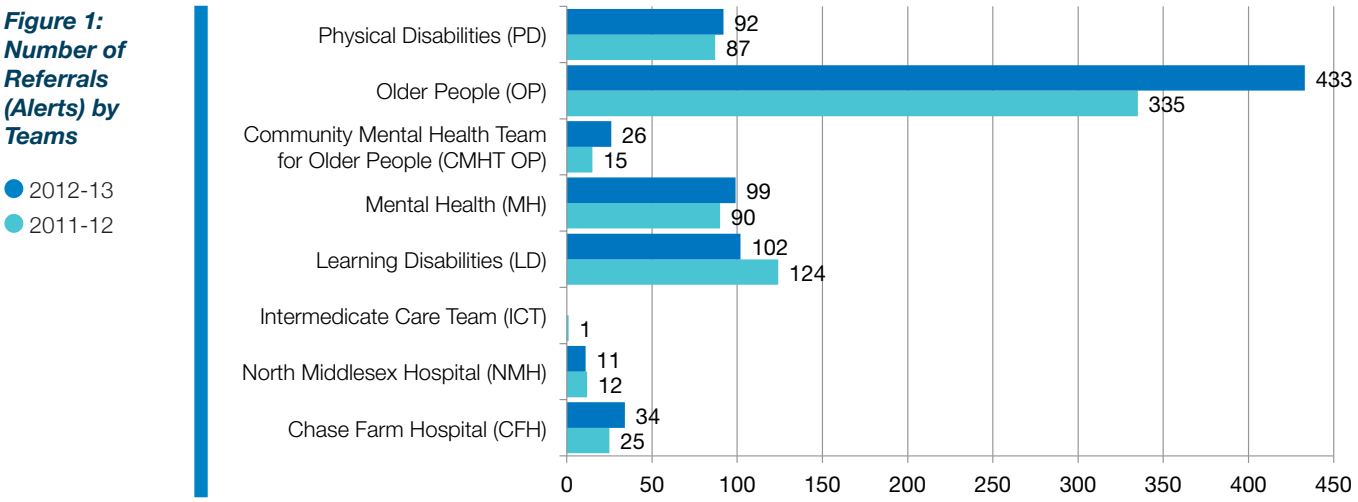


Figure 2: Type of Alleged Abuse at point of Referral (Alert)

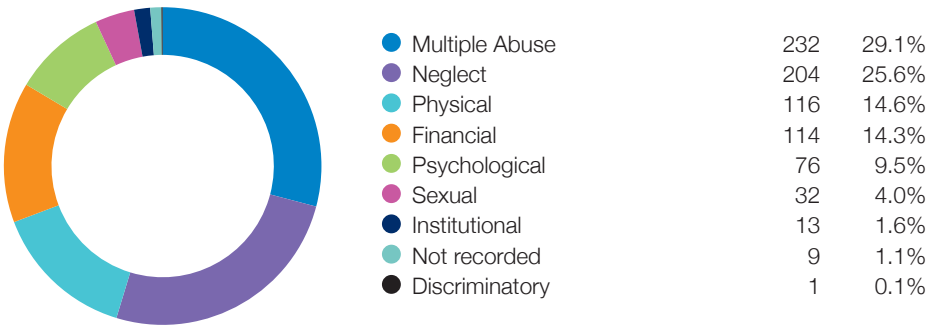
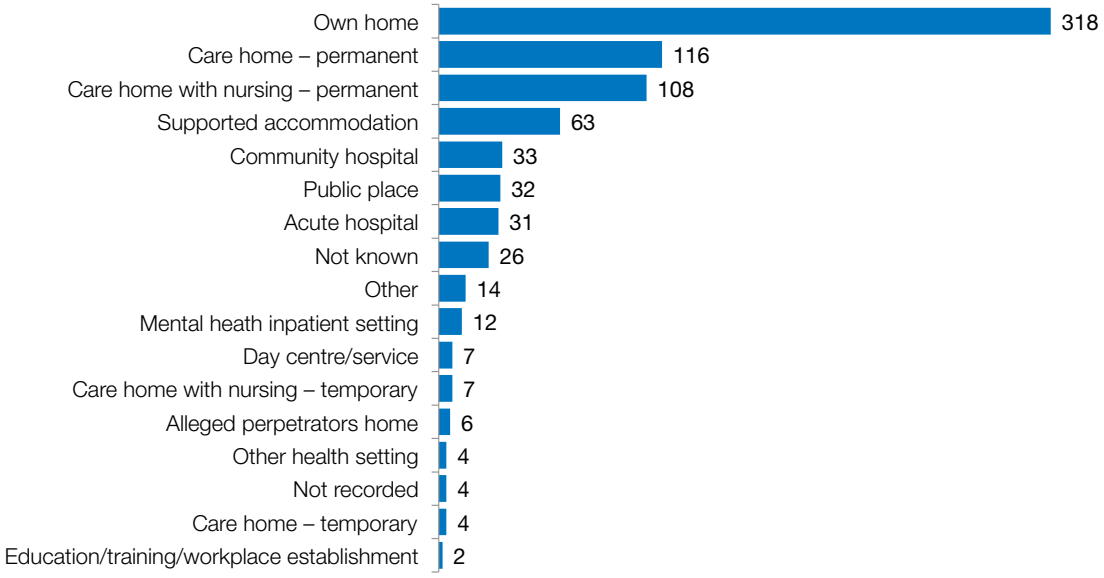


Table 1: Type of alleged abuse at point of referral (alert) by team

	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
Financial	1	0	15	18	5	64	12	**115**
Institutional	0	0	0	7	0	6	0	**13**
Neglect	23	6	8	1	3	151	11	**206**
Physical	4	1	23	29	3	43	12	**115**
Sexual	0	0	12	9	2	7	1	**31**
Psychological	0	0	13	23	13	16	11	**76**
Multiple abuse	5	4	30	12	0	141	42	**234**
Not recorded	1	0	1	0	0	5	2	**9**
Total	**34**	**11**	**102**	**99**	**26**	**431**	**92**	**797**

Figure 3: Place of Alleged Abuse at point of referral (alert)



40% of the referrals are in relation to alleged abuse in the Adult at Risk's own home and 30% are in a residential/ nursing home.

Table 2: Referral routes

Referer	2012-13	%	2011-12
Hospital Staff	142	17.8%	*104*
LBE – HASC	112	14.1%	*93*
Residential Care Home	92	11.5%	*0*
External Provider	78	9.8%	*124*
Ambulance Service	50	6.3%	*18*
Relative	47	5.9%	*40*
Community Health Professional	43	5.4%	*53*
Housing/RSL	29	3.6%	*32*
Domiciliary staff	27	3.4%	*9*
LBE not HASC	26	3.3%	*94*
Third sector organisation	21	2.6%	*14*
Mental health staff – joint teams	15	1.9%	*22*
Police	15	1.9%	*24*
Homecare external	14	1.8%	*0*
Day care staff	10	1.3%	*8*
Self Referral	10	1.3%	*10*
Other	7	0.9%	*14*
Primary Health/ Community Health Teams	7	0.9%	*0*
CQC	5	0.6%	*1*

Referer	2012-13	%	2011-12
Ward staff	5	0.6%	*0*
General Practitioner	4	0.5%	*7*
Hospital Psychiatry	4	0.5%	*0*
Neighbour/Friend	4	0.5%	*14*
Anonymous	3	0.4%	*0*
Carer	3	0.4%	*4*
Community Mental Health Trust	3	0.4%	*0*
Other Service Users	3	0.4%	*0*
Out of Hours Team	3	0.4%	*0*
Primary/Community Mental Health Teams	3	0.4%	*0*
Financial Institution	2	0.3%	*2*
Guardian/Office of Public Guardian	2	0.3%	*0*
Member of Public	2	0.3%	*1*
Secondary Health Staff	2	0.3%	*0*
Not recorded	2	0.3%	*0*
Education/training/ workplace establishment	1	0.1%	*0*
Fire Brigade	1	0.1%	*0*
Total	**797**	**100.0%**	**688**

Those referred

Information about the Adults at Risk referred

The following information is the demographic information for each of the 797 referrals (alerts) received. The gender of 'various' is used when the alert relates to a complete residential home.

Figure 4: Gender of Adults as Risk

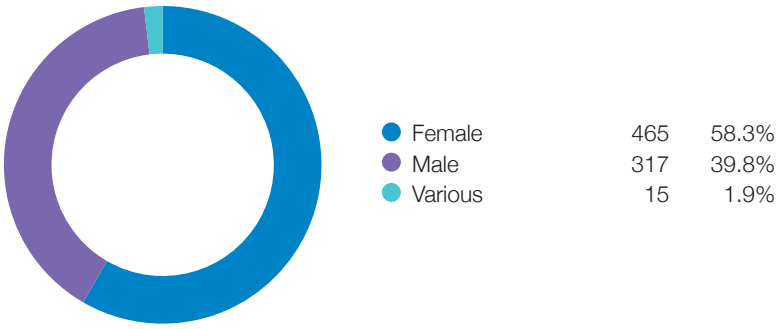


Table 3: Gender of Adults at Risk

	Female	Male	Various	Total
Multiple abuse	147	77	8	**232**
Neglect	124	77	3	**204**
Physical	72	44	0	**116**
Financial	53	61	0	**114**
Psychological	41	35	0	**76**
Sexual	22	10	0	**32**
Institutional	1	8	4	**13**
Not recorded	5	4	0	**9**
Discriminatory	0	1	0	**1**
Total	**465**	**317**	**15**	**797**

For both females and males, the highest alleged abuse types are Multiple (31% for females, 24% for males) and Neglect (27% for females, 24% for males).

Figure 5: Age Band of Adults at Risk

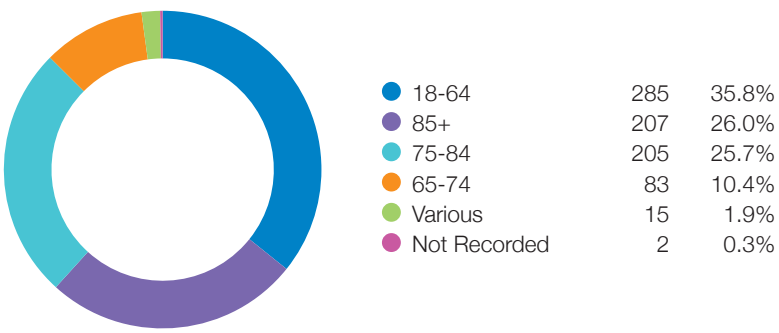
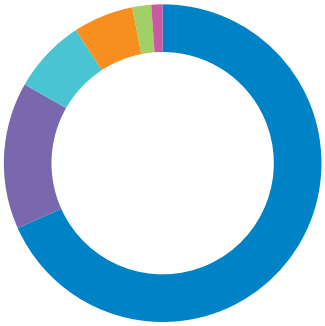


Figure 6: Ethnicity of Adults at Risk (excludes 'Whole Homes' Alerts)



White	534	68.3%
Black	117	15.0%
Not known	59	7.5%
Asian	48	6.1%
Other	15	1.9%
Mixed	9	1.2%

67% of the referrals received are for White British, White Irish, and White Other ethnicities (71% in 2011/12).

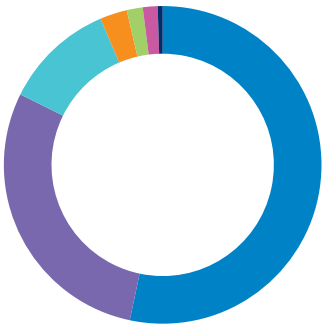
Information about the Person alleged to have caused harms

Figure 7: Gender of Person alleged to have caused harm

Male	278	34.9%
Not known	245	30.7%
Female	159	19.9%
Not recorded	86	10.8%
Various	29	3.6%

35% of Person alleged to have caused harm are male and 20% are female. Of all referrals (alerts) received, in 31% of the cases, the gender of the Person alleged to have caused harm is unknown.

Figure 8: Age of Person alleged to have caused harm



Not known	425	53.3%
18 to 64	231	29.0%
Not recorded	90	11.3%
Various	22	2.8%
77 to 85	13	1.6%
65 to 76	12	1.5%
Over 85	4	0.5%

29% of Person alleged to have caused harm are aged 18-64. There are a high percentage of Person alleged to have caused harm with unknown age (53%). It is often difficult to obtain this information, as the Person alleged to have caused harm is not always known or they are unwilling to give personal details.

48 (21%) of the Person alleged to have caused harm aged 18-64 are care staff. 114 (49%) of Person alleged to have caused harm aged 18-64 were a family member or friend.

Figure 9: Ethnicity of Alleged Perpetrator

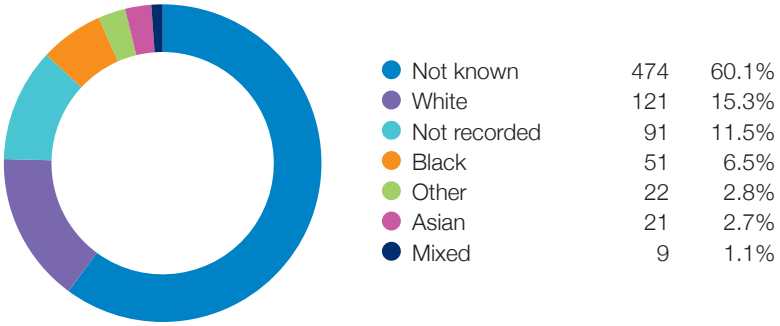


Figure 10: Person alleged to have caused harms Relationship to Adult at Risk

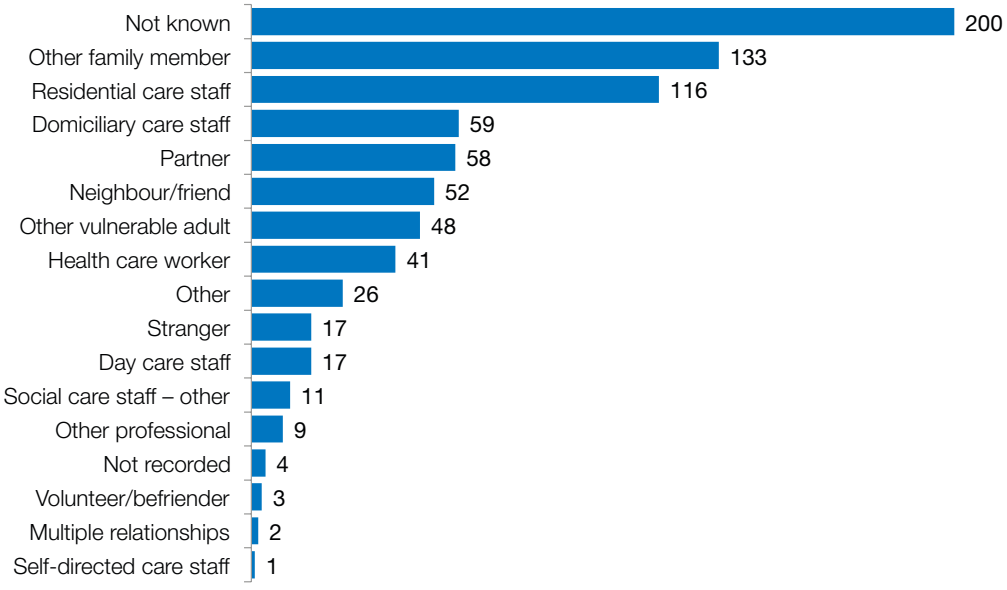


Figure 11: Outcome from Initial Inquiries

Of the 797 safeguarding adults referrals (alerts) received, 660 (82%) proceeded to the safeguarding adults process.

Safeguarding adults process

The following sections of this report look at the 660 referrals that have had a strategy agreed. An action plan has been developed to look at the timescales and also to consider ways to improve the performance against timescales and outcomes.

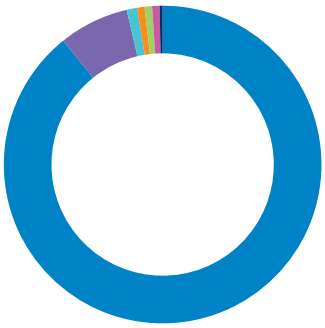
Figure 12: Police informed of Referrals

No	412	62.4%
Yes	183	27.7%
Not applicable	65	9.8%

Table 4: Interim Protection Plans

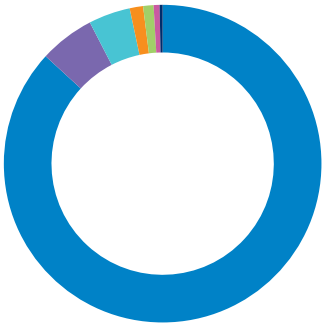
Type	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
Protection Plan Offered	8	4	65	36	20	333	64	**530**
Total	**10**	**9**	**89**	**54**	**22**	**398**	**78**	**660**
% age of alerts offered a protection plan	80%	44%	73%	67%	91%	84%	82%	**80%**

Figure 13: Police informed of Referrals



Within 5 working days	589	89.2%
6 to 10 working days	47	7.1%
15 to 21 working days	7	1.1%
11 to 14 working days	5	0.8%
22 to 28 working days	5	0.8%
Not Recorded	5	0.8%
More than 28 working days	2	0.3%

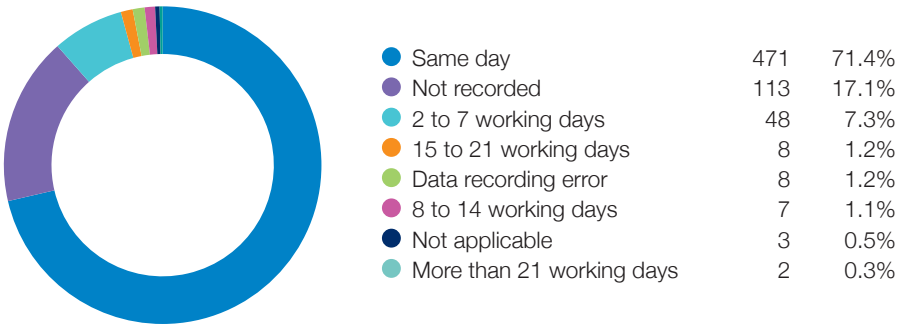
Figure 14: Days from Strategy agreed to Alerter informed



Same day	573	86.8%
Not recorded	37	5.6%
2 to 7 working days	28	4.2%
Data recording errors	9	1.4%
8 to 14 working days	7	1.1%
More than 21 working days	4	0.6%
15 to 21 working days	2	0.3%

88% of the strategies agreed were within the target of five working days from the alert. This is a reduction from the full year 2011/12 position of 93%.

Figure 15: Days from Strategy agreed Adult at Risk informed

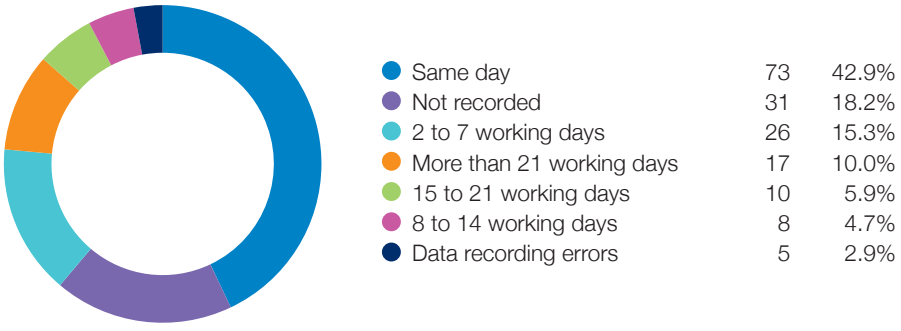


In 87% of cases, the alerter was informed of the strategy on the same day it was agreed, if considered appropriate. This is an improvement from 38% in 2011/12.

Outcome of the Safeguarding Adult Inquiry/Investigation

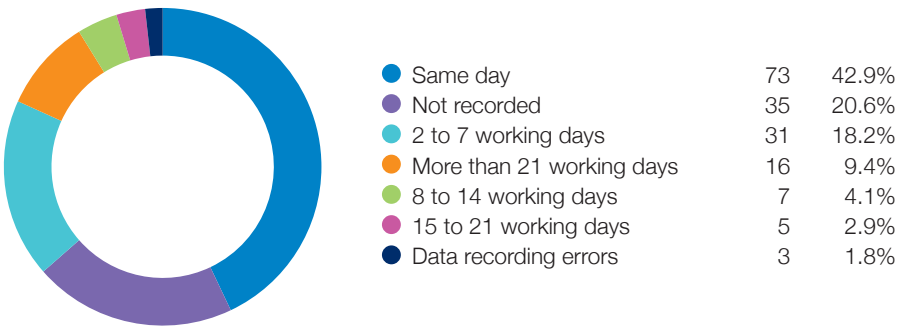
Of the 660 Alerts that have had a strategy agreed, 248 required an investigation of which 170 are now closed. The following information relates to those 170 closed cases.

Figure 16: Days from Inquiry closed to Adult at Risk Informed



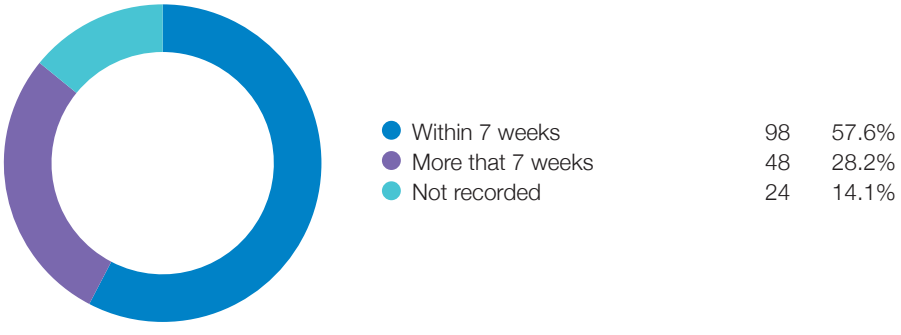
In 43% of cases, the Adult at Risk was informed of the outcome of the Inquiry on the same day it was decided, if considered appropriate.

Figure 17: Days from Inquiry closed to Alerter Informed



In 43% of cases, the Alerter was informed of the outcome of the Inquiry on the same day it was decided, if considered appropriate.

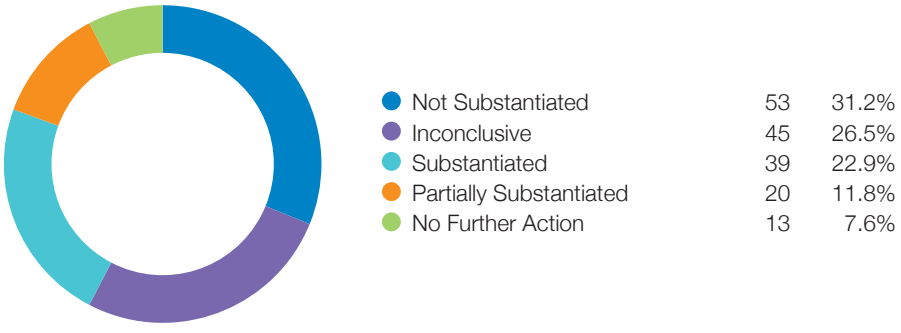
Figure 18: Time from referral received to inquiry closed



The policy requires the timescale from the receipt of referral to either a reconvened strategy or inquiry closure to be 35 working days or less. In some cases, depending on the complexities of the case, it can be longer.

Outcomes

Figure 19: Outcome of the Safeguarding Adult Inquiry/ Investigation



Of the 170 cases that have an outcome following investigation, 35% of them were substantiated or partially substantiated (34% in 2011/12).

Table 5: Breakdown of the outcomes by team

Type	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
Substantiated	0	0	7	13	2	15	2	**39**
Partially Substantiated	0	0	4	9	1	6	0	**20**
Inconclusive	0	0	13	5	8	17	2	**45**
Not Substantiated	3	1	5	19	8	17	0	**53**
No Further Action	0	1	1	0	0	10	1	**13**
Total	**3**	**2**	**30**	**46**	**19**	**65**	**5**	**170**

Table 6: Outcome of the allegation and the type of abuse

Type of Abuse	Substantiated	Partially Substantiated	Not Substantiated	Inconclusive	No Further Action	Total
Multiple Abuse	7	8	10	9	6	**40**
Financial	11	2	9	6	2	**30**
Neglect	8	4	10	6	1	**29**
Emotional	6	3	7	11	2	**29**
Physical	6	2	10	8	0	**26**
Sexual	0	1	3	4	2	**10**
Institutional	1	0	3	0	0	**4**
Not recorded	0	0	1	1	0	**2**
Total	**39**	**20**	**53**	**45**	**13**	**170**

Review process

The following tables show the review type and outcomes of the completed safeguarding investigations. 63% of eligible cases had a review (this compares to 64% in 2011/12).

Table 7: Review type

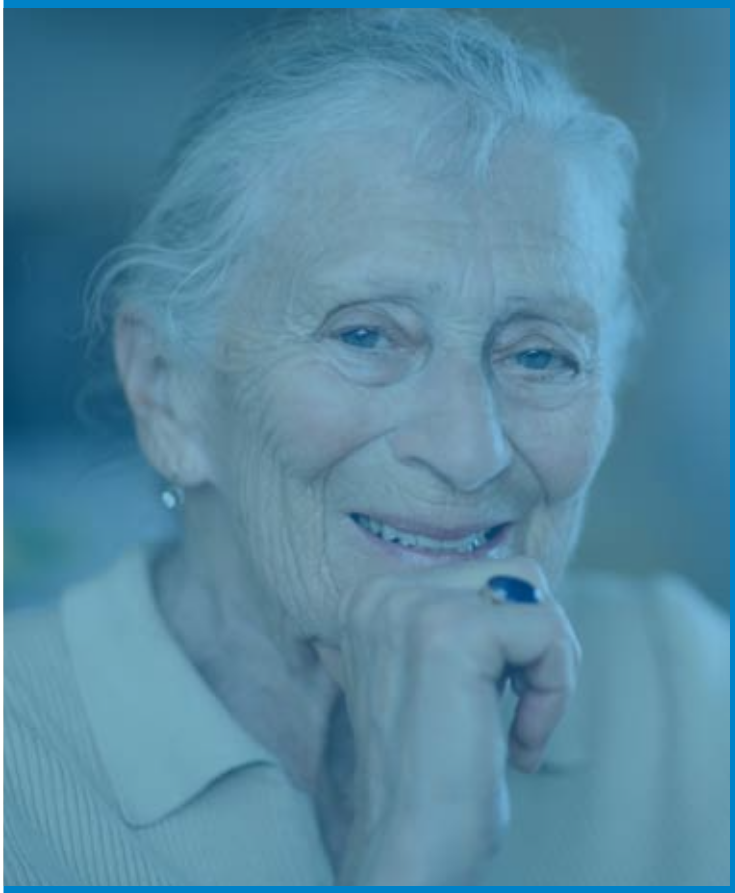
	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
Safeguarding Review	0	0	26	0	1	13	0	**40**
Care Plan Review	0	0	0	33	11	7	1	**52**
Not required	3	1	3	12	7	26	1	**53**
Not recorded	0	1	1	1	0	18	3	**24**
Total	**3**	**2**	**30**	**46**	**19**	**65**	**5**	**170**
% age of eligible cases with a review	0%	0%	90%	73%	63%	43%	50%	**63%**

Table 8: Outcome for the Adult at Risk

	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
Increased monitoring	0	0	10	12	10	15	1	**48**
No further action	1	1	2	20	1	23	0	**48**
Other	1	0	13	9	0	8	0	**31**
Community care assessment and services	1	0	1	1	4	3	0	**10**
Not recorded	0	1	1	0	0	5	1	**8**
Moved to increase/different care	0	0	0	0	0	5	2	**7**
Vulnerable Adult removed from property or service	0	0	2	0	0	5	0	**7**
Management of access to finances	0	0	1	1	0	0	0	**2**
Restriction/Management of access to Person alleged to have caused harm	0	0	0	2	0	0	0	**2**
Action Under MHT Act	0	0	0	0	1	0	0	**1**
Information not available	0	0	0	0	1	0	0	**1**
Referral to complaint procedure	0	0	0	0	1	0	0	**1**
Referral to counselling/ training	0	0	0	1	0	0	0	**1**
Referral to MARAC	0	0	0	0	0	0	1	**1**
Removed from property/ service	0	0	0	0	1	0	0	**1**
Review of Self-Directed Support	0	0	0	0	0	1	0	**1**
Total	**3**	**2**	**30**	**46**	**19**	**65**	**5**	**170**

Table 9: Outcome for the Person alleged to have caused harm

	CFH	NMH	LD	MH	OPCMHT	OP	PD	Total
No further action	1	1	9	22	12	28	2	**75**
Continued monitoring	1	0	7	8	1	15	0	**32**
Not recorded	0	1	2	0	1	7	1	**12**
Disciplinary action	0	0	3	0	1	6	1	**11**
Action by Contract Compliance	0	0	0	8	0	1	0	**9**
Counselling/training/ treatment	0	0	5	3	0	1	0	**9**
Exoneration	1	0	0	0	2	2	0	**5**
Not known	0	0	3	0	0	1	1	**5**
Management of access to the Vulnerable Adult	0	0	0	3	0	0	0	**3**
Removal from property or Service	0	0	1	1	1	0	0	**3**
Police action	0	0	0	1	1	0	0	**2**
Referral to PoVA List/ISA	0	0	0	0	0	2	0	**2**
Action by Care Quality Commission	0	0	0	0	0	1	0	**1**
Criminal prosecution/formal caution	0	0	0	0	0	1	0	**1**
Total	**3**	**2**	**30**	**46**	**19**	**65**	**5**	**170**



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Safeguarding Adults
Health, Housing and Adult Social Care

June 2013

ENFIELD Council

HHASC442

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MUNICIPAL YEAR 2013/2014

MEETING TITLE AND DATE
Health and Wellbeing Board
13 February 2014

Agenda – Part: 1	**Item: 10a**
Subject: Update to Health and Wellbeing Board **Wards: All**	
Cabinet Member consulted:	

REPORT OF:
Director of Public Health Dr Shahed Ahmad

Contact officer and telephone number:

Glenn Stewart 0208 379 5328

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

1. EXECUTIVE SUMMARY

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

- Health and Wellbeing Strategy
- Tobacco control / smoking cessation
- Upper Edmonton
- Physical activity and transport

2. RECOMMENDATIONS

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

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

3. Health and Well-being Strategy

3.1 The Health and Well-being strategy has now been finalised. Consultation ran for 12 weeks between October and December 2013.

3.2 2,003 responses were received; 562 questionnaire responses and 1,441 token votes.

3.3 Over three quarters of respondents, (77%) supported all five draft priorities. 99% were generally in favour of either a few, most or all of the draft priorities. Less than 1% of respondents supported none of the priorities.

3.4 When asked to select the priority or priorities questionnaire responses were:

- Enabling people to be safe, independent and well and delivering high quality health and care services (71%)
- Ensuring the best start in life (61%)
- Promoting healthy lifestyles and making healthy choices (52%)
- Creating stronger, healthier communities (44%)
- Narrowing the gap in healthy life expectancy (33%)

3.5 Token box responses ranked the priorities in the following order:

- Creating stronger, healthier communities' (39%)
- Enabling people to be safe, independent and well and delivering high quality health and care services (21%)
- Narrowing the gap in healthy life expectancy (17%)
- Ensuring the best start in life (12%)
- Promoting healthy lifestyles and making healthy choices (11%)

3.6 An action plan to implement the above priorities is now being developed.

4. Tobacco Control / Smoking Cessation

4.1 At the end of Q2 Enfield had achieved 724 four-week smoking quitters against an end of year target of 1572.

4.2 This trajectory matches 2012/13 and previous years when the target has been consistently achieved.

4.2 Q3 data is not due until March 14th.

5. Upper Edmonton

5.1 A report has been written. There are 167 activities in the project. There is a brief write-up and notable achievements of the team and its partners have been recounted. In brief:

- Needs assessment and health and equalities (with the Public Health Intelligence team)
- Face, Arm, Speech and Time (FAST) (at risk individuals) and HIV campaigns
- Smoking cessation
- Diabetes pathway – working with GPs, with a focus on the south-east of the borough
- CVD and stroke prevention and root cause analysis, with a focus on the south-east of the borough
- Diabetes structured education programme (particularly concerning Somali and Turkish groups)
- Diabetes social marketing campaign
- North Middlesex University Hospital to encourage employment
- Stakeholder event (end of January) – to be multilingual and focussed on female participation and discussions on preventative health topics.
- Small grants scheme with Shaun Rogan's team. This will be a one-off as it's not sustainable in all areas. Community-related, small activities, cancer, child health

6. Physical activity and transport

6.1 The HIP received a paper indicating that if Enfield had the same levels of active transport as Croydon this would equate to some 9,000 more people being physically active everyday.

7. Heath Needs Assessment

7.1 There are a number of on-going needs assessments including cancer, cardiovascular disease, diabetes, musculoskeletal (MSK), Looked after Children and Chronic Obstructive Pulmonary Disease (COPD).

7.2 The majority of these should be completed by the new financial year.

8.0 Mental Health Strategy

8.1 The HIP received a report on the Mental Health Strategy for public consultation. There will be a strong focus on service quality, recovery and outcomes delivered through effective partnerships.

8.2 It is envisaged that there will be improved access to:

- Support to maintain mental health and wellbeing for all
- Early diagnosis and intervention
- Information about services and support
- Evidence based assessment, treatment and support
- Housing with flexible support
- Support by GPs and in community settings
- Good quality support for people during acute phases of illness

- Support to find meaningful occupation or employment and to maintain income
- Support to develop meaningful relationships and participation in community activities
- Support to address both mental health and physical needs
- Support for carers

9.0 Childhood obesity

9.1 The latest National Childhood Measurement Programme data was released in December 2013 for academic year 2012/13.

9.2 In 2012-13 in Enfield 13.6% of reception age pupils were overweight and a further 12.6% obese. More than one in four Reception Year children in Enfield was overweight or obese (26.2%), well above the London (23.0%) and England (22.2%) averages and the 5th worst in London

9.3 15.0% of Year 6 pupils were overweight and a further 24.1% obese. 39.1% of Year 6 children in Enfield were overweight or obese, well above the London (37.4%) and England (33.3%) averages. This was the 13th highest rate in London.

9.4 Latest Health Survey for England (HSE) data indicates that by the age of 55 some 70% of adults (aged 16+) are either overweight or obese.

10. REASONS FOR RECOMMENDATIONS

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

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

11.1 Financial Implications

No financial implications

11.2 Legal Implications

No legal implications

11.3 Property Implications

None

MUNICIPAL YEAR 2013/14

Health and Wellbeing Board
13 February 2014

Agenda – Part: 1	**Item: 10b**
Subject: Joint Commissioning Board Report	
Date: Thursday 13 February 2014	

REPORT OF:

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Housing, Health & Adults Social Care

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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:

- Older Peoples Assessments Units (OPAUs) were implemented on both Chase Farm and North Middlesex University Hospitals acute sites
- The re-launched assistive technology Council service – Safe & Connected Service – will be launched in March/April 2014
- The Oral Health Needs Assessment was written by Public Health (England), which highlighted the borough's priorities
- Health and social care partners received targeted funding from NHS England to relieve pressure on A&E and hospital admissions, with Barnet & Chase Farm Hospitals and North Middlesex University Hospital identified as two of the 10 London challenged health economies
- The Council instigated a local £120k Enfield Warm Households programme to replace the decommissioned national Warm Homes, Healthy People DoH programme
- The variance to the Learning Disabilities SAF, being a joint self-assessment framework, reflective of the national drive to promote closer working between health and care
- Development of the Enfield Carer GP project and the establishment of the Hospital Carer Liaison Worker
- The CCG's intention to move to outcome based commissioning of Community Health service by population

1. EXECUTIVE SUMMARY (CONTINUED)

- The CCG has commissioned the economic and financial modelling to support the development of the paediatric integrated care model
- Enfield is ranked within the top quartile position in London with regards to the DAAT's performance against the Public Health Outcomes Framework Indicator [2.15 Successful Treatment (Drug Free) Completions]
- Feedback from the Chief Executive of Enfield HealthWatch
- Launch of new and innovative mobile safety app – Tap-IT
- Creation of a multi-agency safeguarding hub for vulnerable adults
- The 2013/14 Section 75 Agreement has been formally signed by both parties
- Transformation of the Enfield Safeguarding Children Board (EXCB)

2. RECOMMENDATIONS

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

3. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

3.1 Multi- Disciplinary Team teleconference & Risk Stratification

The risk stratification tool has now gone live with GP practices, following sign off of the Information Governance processes. In particular, patients had an opportunity to refuse consent to use their data for risk stratification and multi-disciplinary review purposes prior to implementation of the project.

Unless the patient refused to consent, personal and activity-based service user data from the relevant GP surgery, acute providers and adult social care data are pseudonymised and then combined. A risk stratification algorithm is then applied to this combined data to determine individuals' risk of needing intensive care, e.g. admission to hospital. Some 42 (out of 52) practices have signed up to the risk stratification process: 40 received training on the risk stratification software with a further 2 awaiting training.

A sub-set of those patients flagged at "high" and "very high" risk should therefore be the subject of a multi-disciplinary team (MDT) Tele-Conference led by the GP, but with access to a geriatrician, community matrons, social care and other care professionals to discuss an individuals' case.

Referrals to the MDT remain steady with 43 cases being discussed in December and to date 21 cases discussed in January with a further 10 pending discussion.

3.2 Older People's Assessment Unit (OPAU)

The two Older Peoples Assessments Units (OPAUs) were implemented on both acute sites. Chase Farm continues to receive a gradually increasing level of referrals, though this needs to continue to rise as more GPs make active use of this element of the integrated care model. Further communication is being conducted with GP practises, e.g. at Practise Learning Time events and OPAU workshops.

A pathway is being developed with LAS which would enable them to take patients directly to OPAU; the pathway would enable LAS crews to access the OPAU triage service before conveying the patient to determine the best destination for them. Out of hours this triage would be undertaken by the Intermediate Care Team and where necessary a referral made for the patient to attend the OPAU the following day.

GP referral rates to the North Middlesex University Hospitals OPAU have started to increase from a low baseline, and need far greater acceleration with focussed GP engagement in the South of the Borough. To aid this, the NMUH OPAU staff, including the consultant lead, worked with practises to improve their awareness of the alternatives that exist for their patients, as opposed to A&E attendance. Further focussed awareness-raising is planned over the next 3 months.

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 BE&H clinical strategy and has already established links with the Trauma Service at NMUH and are in the process of setting up systems to receive appropriate information from the team to ensure these patients can be picked up by the service and have the same access to assessment and Dexa scanning if required.

The Community Bone Health Clinician has continued to case find patients through liaising with the Nursing Homes. This part of the service is picking up some of the more complex patients and referrals are being made to other community HCPs, the community Falls programme, and when required, to the medical led falls clinics. The LAS and community Alarms process is now embedded.

3.4 Care Homes Project

The 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 survey of the homes indicates that many are happy with the service offered by the team. We have requested data from HSCIC to assess admissions from care homes to analyse the impact that the team are having on admission avoidance and emergency admissions. The Community Matron in South continues to provide unplanned support; this service has now also commenced with the team in the north to the homes by way of accepting telephone calls and where necessary visiting the homes avoiding 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 continues to work with 20 homes educating 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. Tissue viability care has been delivered to 37 new residents and 61 follow up visits, education and training has been delivered to 41 care home staff in practice to support and increase their knowledge and skills in providing wound care for patients.

Relationships with care home managers and staff are developing and care delivery issues are being identified and addressed.

3.5 Primary Care Locality Case Management

Primary care case management was defined in the business case for integrated care. The integrated local integrated primary care team is being developed on a locality basis, with the core being GP, Community Matron, Social Worker and a Community Nurse. Its objective is to deliver proactive assessment, care and support for those who are frail, in ill-health and aged 75+ years. This supports the government drive to have a named GP for all patients in this age group.

The nature and structure of the integrated team around the GP is currently in development between Enfield Community Services (ECS), adult social care and the clinical CCG leads, with a view about to pilot the approach from March 2014 in the North West locality: some 10 GP practises have expressed an interest. 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.

3.6 Assistive Technology

"Assistive technology" is "any telecommunications device that assists a person in retaining or improving their independence, safety, security & dignity". It includes sensors/alarms for individuals or in households, whose manual or automated activation triggers an alarm to a remote central control room which can then provide a telephone and/or mobile response to check on the individual, and offer help if needed. Just over 3,000 people in Enfield benefit from the in-house Community Alarm & Tele-care Service which provides the equipment and its installation, the control centre and mobile response. Around 600 have more complex Tele-care equipment to support their social care needs.

The Council, CCG and its partners developed a vision for personalised technologically-enabled solutions as a key element of a coordinated housing-related, health & social care approach to promote residents' safety, health, well-being & independence. This vision will be realised by working together to deliver 3 different AT solutions to meet 3 customer groups, the first two of which are subject to Council charging:

- *"Community Alarm"* generally supporting older residents whose reason for using AT is for reassurance. As well as continuing to provide an alarm & response services, customers will benefit from a pro-active approach to "keeping in touch;
- *Tele-care* for People with Problems in Daily Living: Mostly older individuals with care needs, whose reason for using AT is to promote safety, quality of life and independence;
- *Tele-Health*: People with long-term conditions, e.g. respiratory conditions, whose vital signs or symptoms, e.g. lung capacity, blood pressure, blood sugar etc., can be monitored remotely. There is currently no Tele-Health available in Enfield.

The re-launched Council Service will be re-branded as the "Safe & Connected Service" and will serve the first two customer groups in March/April 2014.

Tele-Health ("Remote Monitoring Pilot"

The Remote Monitoring AT Steering Group consists of CCG clinicians, ECS professionals and commissioners. A project was developed to provide remote monitoring to 50 people with complex needs within the South East and North West localities as part of integrated care. To this end, 2 suitable providers (one for each locality) were selected to test how the technology and response would work. These providers will supply and install the equipment for patients, training for patients, families and professionals and provide the "first-line" response should the individuals' vital signs be outside their personalised

normal range. The process of escalation should an alert occur is part of a clinical protocol which will need to be developed with both providers. The CCG and Council are in negotiation with a number of GP practises about being involved in the pilot, with community matrons being the "on-the-ground" case managers.

The plan is to identify and implement remote monitoring for the week commencing 17th Feb-14 for a three month trial. Evaluation criteria are being finalised to determine the success of the pilot.

4. PUBLIC HEALTH TRANSITION

4.1 Sexual Health

4.1.1 A Sexual Health Needs Assessment is currently being carried out to identify the priority areas for improving sexual health provision, reducing inequalities and improving access

4.2 Oral Health Promotion and Prevention

4.2.1. Local Authorities have new statutory responsibilities (Statutory Instrument 2012 No. 3094 Section 4) specifically relating to oral health improvement.
The responsibilities include:

- Assessing the oral health needs of their population
- Developing oral health strategies
- Commissioning appropriate population-based oral health improvement programmes to meet those needs
- Commissioning oral health surveys as part of the national dental epidemiology programme or other local surveys
- Local Authorities are also responsible for delivering the Public Health Outcomes Framework Indicator 4.2 'Tooth decay in children aged 5'

4.2.2. Public Health (England) has carried out an Oral Health Needs Assessment for Enfield, which will feed into the 2014/15 Oral Health Promotions contract.
Example of areas highlighted:

4.2.2.1 <u>Children</u>

- In the latest survey of 5-year old children, there was significant deterioration of the oral health of children in Enfield in terms of prevalence and severity over the past 4 years (presenting significant challenges in delivering the PH Outcomes Framework Indicator 4.2).
- Action to prevent oral diseases needs to be started at the earliest possible opportunity working with ante-natal clinics, parents, health visitors, children's centres and the programmes are to be focussed on effective interventions

4.2.2.2 <u>Adults, older adults and older children</u>

- Local data for adult oral health in Enfield is not available but more adults in London have a functional dentition and fewer adults decayed teeth and a high percentage report good and very good oral health
- Fewer adults in London have healthy gums and more adults have dental abscesses
- Fewer adults in Enfield have oral cancer compared to London and England
- Older people are keeping their teeth longer, have complex dental needs often compounded by complex systemic disease or medication

4.2.2.3 Vulnerable Groups

- Children with special needs are more likely to have teeth extracted than filled and have poorer gum health
- Adults with learning difficulties have poor oral health with those living in the community having poorer oral health than those in residential care
- Excluded groups at risk of poor oral health included looked after children, people in long term institutional care, the homeless and asylum seekers

(see Appendix 1 for identified priorities in the Needs Assessment)

4.3 BEH MHT Contract

NHS ECCG has extended the notice to Barnet, Enfield & Haringey Mental Health Trust, in respect of Enfield Community Services, to 31 March 2015 to allow for the block contract to go out to tender. LBE intend to remain an associate of this block contract, in the first instance

Service specifications and KPIs for 2014/15 are currently being negotiated

5. CCG Commissioning Intentions

5.1 NHS Enfield CCG presented its 5-year Strategic Plan at the Health and Wellbeing (informal) Board meeting on Thursday 23rd January 2014, which covered the CCG's:

- programme and commissioning intentions
- five National Domains and seven National Ambitions
- Six service models for achieving the expected transformational change
- funding baselines and financial position

(see Appendix 2)

5.1.1 The deadline for the draft submission of the Strategic Plan is 4th April 2014, with the final submission due on 20th June 2014

5.1.2 The deadline for the draft submission of the 2-year Operating Plan templates is 14th February 2014, with the final submission due 4th April 2014

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.

- Schemes were implemented for the winter and their effectiveness is now monitored through routine Tele-conferences across Barnet, Haringey and Enfield and with NHS England. These schemes included development of hospital-based schemes to better support the hospital experience and discharge for older people, including those with dementia, through Rapid Assessment, Interface & Discharge (RAID) and health- and social care-based solutions to prevent hospital admission and facilitate discharge (e.g. Post-Acute Care Enablement (PACE) and social care enablement), including within an integrated care setting, and to fund extended hours of support, particularly within an integrated care setting.

- As noted in the last report, the one area that originally proved the most difficult to implement was to increase capacity of step-down beds in care homes. However, the CCG has successfully procured up to 37 short-term step-down beds in a number of nursing homes, of which all but 9 are in Enfield. These beds are used by patients well enough to be discharged from hospital, but not well enough to return home. These cases are being managed through a clinical gate-keeper/case manager to assure patients' recoveries are being actively managed in the home rather than having an indefinite stay.

- The main issue seems to be the slow take-up of several of the schemes, including PACE, RAID and step-down, though levels of activity in these schemes are gradually improving, as with activity at the Older People's Assessment Units; and the difficulties in recruiting appropriate nursing staff to a small number of schemes.

- In summary, the winter pressure schemes helped alleviate some of the pressures on A&E attendances, and therefore emergency hospital admissions, although North Middlesex University Hospitals remains below the national performance target of 95% of A&E patients seen in no more than 4 hours. However, the schemes have contributed to bed management in the whole system and have played a significant part in reducing delayed transfers of care (see next section).

6.1.2 **Enfield Warm Households Programme**

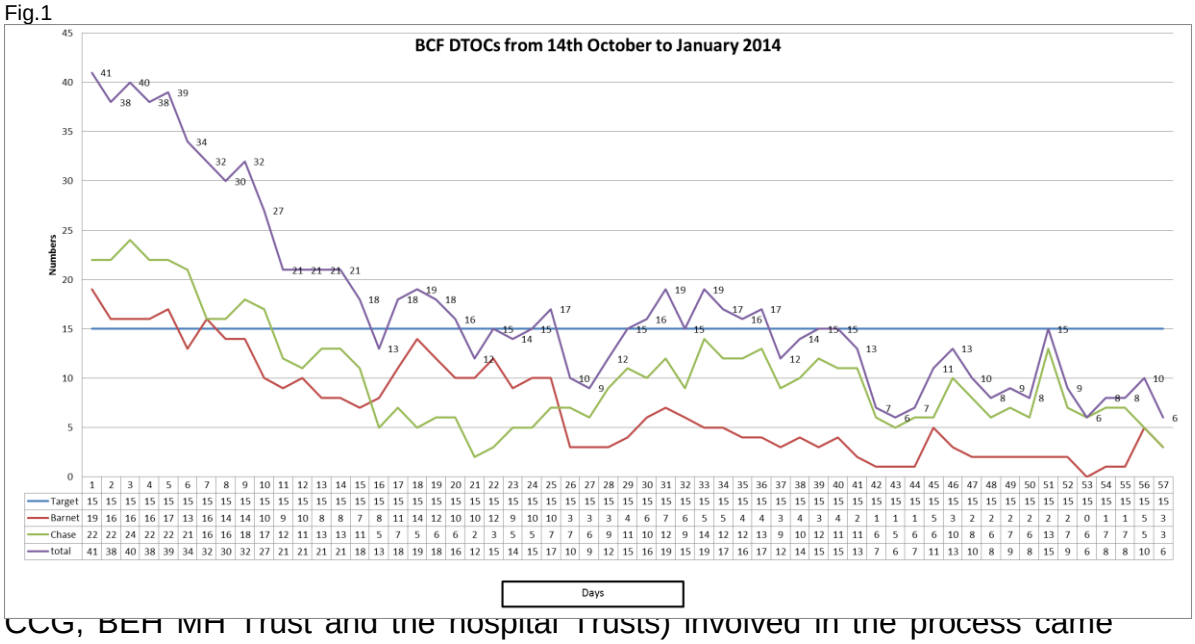
As noted in the last report, the Department of Health did not continue with its previous annual national Warm Homes, Healthy People Programme in 2013/14. In response, the Council decided to instigate a local £120k Enfield Warm Households Programme to grant-fund schemes targeted at the most vulnerable families and households at risk of adverse health outcomes or hardship over the winter. Following a competitive grants process, 8 applications were awarded funding, each for no more than £20k each, in early Jan-14. The Council asked successful voluntary sector partners to complete

an review form for Apr-14, describing how many people were helped, and what outcomes were achieved.

6.1.3 Delayed hospital discharges

Figure 1 shows the number of delayed discharges of Enfield patients over the last 3 months. There was a significant improvement in the number of delayed transfers of care from hospital following the increase noted for April – September 2013. This was partly due to better management of existing multi-agency hospital discharges, including quick wins identified through redesign of these processes, but also due to the winter pressures schemes discussed above.

Fig.1



CCG, BEH MH Trust and the hospital Trusts) involved in the process came together to share collective responsibility for appropriate, timely and safe discharge of patients from hospital. This Hospital Discharge Steering 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 a set of revised discharge processes within the wider context of integrated care around these aspirations, and begun to embed them in practise;
- Progressed interim commissioning solutions to address the need for a greater number of step-down/intermediate care beds, with the winter pressures money funding 37 additional nursing beds, and discussions on-going about longer-term arrangements.

6.1.4 Improving Lives: 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. An action plan has now been developed which is the process of sign-off

6.1.5 **Enfield Dementia-Friendly Communities**

The last report noted that a bid had been submitted to NESTA for funding of an innovative proposal to extend the multi-agency Everybody Active Programme to improve the physical & mental health, well-being & independence of harder-to-engage people working in collaboration with the voluntary sector. Central to the development was that of a multi-agency "VCS hub" operating within primary/integrated care to navigate individuals' access to voluntary sector-led solutions. Unfortunately, this bid was unsuccessful, but nonetheless was well-supported across all public- and voluntary-sector partners, and, as a result, other funding alternatives are being explored.

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 is one of 32 local areas to be accepted onto the next phase of bidding following its successful Expression of Interest. 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 was awarded an £18k Development Fund in Jan-14 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 Feb-14.

6.2 Mental Health

6.2.1 **Joint Mental Health Strategy Consultation**

Consultation on the Enfield Joint Adult Mental Health Strategy is proceeding as planned. Two public consultation events have been held during January. One was held in Enfield Town, the other in Edmonton Green. A good mix of people with representation from all stakeholder groups amongst the 58 people who attended. Engagement at the events was excellent, with useful feedback on the strategic goals and objectives being given. Discussions centred on the main strategic priorities:

i) Stable accommodation
ii) Employment and meaningful occupation and support to maximise income
iii) Support on discharge from acute care and in the community

The Joint Commissioning Manager (MH) also presented the strategy at 3 senior and middle management meetings within the Barnet, Enfield and Haringey Mental Health Trust during December. The aim was to ensure that managers within the trust are aware of the strategy, have the opportunity to comment on its findings and recommendations and promote it to their staff. In addition, the intention was to encourage participation in the public consultation events. 6 members of the Trust, including 2 consultant psychiatrists attended the public events.

During December and January, presentations on the strategy have also been made to:

i) The Older Adult Partnership Board
ii) The Carers' Partnership Board
iii) The Health Improvement Partnership
iv) The Enfield Carers' Centre – Carers' Rights Day and the MH Carers' Sub-Group
v) Enfield Mental Health User Network AGM
vi) The Health Improvement Partnership
vii) The Voluntary Sector Strategy Group

The information provided by participants will inform the final draft of the strategy. This will include a more detailed implementation plan for each strategic objective.

The revised strategy will be considered by the Enfield CCG Governing Body and the Health and Wellbeing Board in March 2014. The strategy will be agreed by Council at its meeting in May 2014

6.2.2 **Draft Autism Strategy**

The autism strategy has been revised to incorporate all feedback received during the consultation. The revision includes a re-balancing of the strategy so that it pays equal attention to the needs of adults with a learning disability who have autism as well as the needs of those with high functioning autism. Carers who are members of the Learning Disabilities Partnership Board who petitioned for this amendment are being consulted on the revised version. Any further comments will be incorporated as appropriate. The strategy will then be printed and distributed to all stakeholders.

During 2013, via the Joint Commissioning Board, the Council and the CCG agreed to fund a co-ordination function to facilitate the provision of robust information, advice and signposting for adults with autism, reasonable adjustments for autism in mainstream settings and key services and establish a network of autism champions. Council funding is to come from the Health and Social Care Grant. Progressing the establishment of this role has been delayed due to a delay in confirmation that the funding will be available. The Joint Commissioning Manager (Mental Health) is reviewing the issue with Partners.

6.3 Learning Disabilities

6.3.1 **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

Information was collected from the different service areas across Health and Adult Social Care who contribute to supporting people with learning disabilities to stay healthy and well in Enfield. The services provided information that supported the scoring of the self-Assessment framework (SAF). The SAF was submitted on 5th of December 2013 within timescale. All areas were self-assessed as either meeting or exceeding the requirement with no areas of concern reported. We are waiting for feedback from IHaL on the submission then the final version with action plan will be monitored by the Learning Disabilities Partnership Board.

6.3.2 **Winterbourne View Concordat**
NHS Enfield Clinical Commissioning Group (CCG) and the council have developed a joint action plan in response to the Winterbourne View concordat.

Key messages from the concordat are that each locality should commit to jointly reviewing all people with learning disabilities and / or autism in 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 closer 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 CCG has agreed to fund the new community intervention model for a 6-month period. The community intervention service will focus on reducing admissions to assessment & treatment services by supporting people to remain healthy and well in the community. Regular updates will be provided to the HWBB.

6.4 Carers

6.4.1 Enfield Carers Centre

The Centre now has 2254 carers on the Carers Register. This is somewhat of a decrease due to a large scale data clean having taken place – remove duplicates and those who are no longer caring. In addition, 696 carers hold a Carers Emergency Card. In the September-December quarter the Centre registered 208 new carers.

The Carers Centre respite programme has allowed 266 carers to receive a break between September-December and the newly set up befriending programme has resulted in a further 10 carers receiving a break.

Enfield Carers Centre is currently finalising paperwork for the recruitment of the Benefits Worker.

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 provided an office base within the hospital for the Worker. Chase Farm is also allowing the worker access and space to advertise support. In the September-December quarter of 2013 the Hospital Worker identified 40 carers.

Recruitment for the Carers Nurse post has continued to be delayed. 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. In the September – December 2013 quarter they provided support to 55 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. In the September-December 2013 quarter the Young Carers Project identified 37 young carers.

The Centre's training programme including Supportive Family Training, Solution Focused Therapy as well as day courses has seen 417 carers attend a training sessions over the September-December quarter. A further 23 carers have received one to one counselling during this period.

The Carers Centre AGM took place on Monday 25th December. The focus was 'Expert Health Partners' with speakers including the GP Liaison Manager, CCG Practice Manager lead and the Director for Policy from the Carers Trust. This event was very well attended, with carers enjoying it greatly but also by raising the profile of the Carers Centre locally and nationally with the Carers Trust.

6.4.2 **Carers Direct Payment Scheme**

We now have 102 carers receiving a Direct Payment through Enfield Carers Centre with others awaiting approval.

A new factsheet to promote the Carers Direct Payment Scheme is currently being designed.

6.4.3 **Carers Rights Day**

Enfield Carers Rights Day's event took place at the Centre on Friday 29th November. The day was well attended by carers and professionals. Information was provided by a wide range of services, as well as presentations on benefits reform and the Mental Health strategy. The Community Alarm team also gave demonstrations of the equipment which carers' feedback was "…really useful". One to one benefits and legal advice was also offered.

6.4.4. **Primary Care Strategy**

The GP project has now seen 63 new carers registered through either the GP or the self-referral method from the surgery information. Eight surgeries has now held information stands with four having a regular carers information stall. Another five surgeries have requested volunteers from the Carers Centre to come and run a regular stall at their surgery. 45 of the 52 surgeries have now been visited and all of these have been given an information pack and provided with referral forms with their own surgery code alongside the self – referral cards which also hold a unique surgery code. 35 practices are now actively engaging in the project.

6.4.5. **The Employee Carers' Support Scheme**

The Carers Policy has been written, updated to reflect comments made by the Carers Action Group and submitted to HR for consideration. All members expressed a need for paid carers leave which is included in the policy. A Carers Personal Plan has now been developed which can be used as a tool for managers and employees to discuss the employee's caring responsibility and the flexibility that can be applied to support them within their job role

6.4.6. **Relatives Support Network**

Following an unsuccessful bid to NESTA we are still to continue to deliver the Care Home Carers Network in partnership with the care homes and Enfield Carers Centre. The first network meeting is to be held in mid-February

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 Carers Practitioners Working Group has now reviewed the Carers Assessment form and the paperwork for a Carers Party to Event assessment and looked at how we can improve and increase communication on carers' issues and training for practitioners. We have agreed to run some drop in sessions for practitioners with Enfield Carers Centre

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 next meeting of the Project Group is to be held in the Spring, date tbc. Consultation around both the Carers Experience Strategy and the Adult Mental Health Strategy has highlighted that mental health carers tend to feel less supported and involved than carers for other conditions. This will be raised with the Trust and support offered to improve the carers journey.

The Children and Families Carers Working Group met in January and was a very productive meeting where some simple changes were agreed to help identify young carers – such as changes to the SPOE form. The next meeting will focus on the assessment of young carers and how Enfield can ensure the capacity with changes forthcoming with the Children and Families Act.

The Carers Communication Working Group has now agreed the expenditure associated with a new Carers Awareness campaign - poster and leaflet design ready for January 2014. This poster has now been designed with translations in the most popular five languages in Enfield to try and reach carers within the BME community.

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 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 (Drug Free) Completions*, has started to stabilise with the latest ratified Public Health England (PHE) data confirming that Enfield has achieved 28.4% for the 12 month rolling period Dec 2012 – Nov 2013. Greater consistency in the performance against this Indicator was reported at the previous Health and Wellbeing meeting and was to be expected given the high level of increase that had already been achieved during 2013. It is pleasing to note that Enfield is ranked within the top quartile position in London as it is currently placed in 6th position. The London average is 18.3% and the National average is 14.6% so Enfield's performance against this Indicator remains extremely good

6.6.2 Numbers in Effective Treatment (Drugs)

As reported at the last Health and Wellbeing meeting the Number of Drug Users in Effective Treatment has now started to rise and we are still forecasting achieving the target of 1068 by year end.

The current performance is now 1046 for the latest 12 month rolling period. This is 22 below the end of year target but a good improvement against the last reported position.

6.6.3 Numbers in Treatment and Successful Completions (Alcohol)

The number of alcohol users in treatment has increased by 13.5% since the start of the year based upon the new 12 month rolling data release by PHE.

Along with quantity performance improvements, we have also witnessed quality gains with 37.0% successfully completing during the latest period.

This is higher than the London Average of 34.1% and above the National Average of 36.4%.

6.6.4 Young People's Substance Misuse Performance – Q2 2013-14

Since the date of the last Health and Wellbeing Board meeting PHE has not released any further performance information in respect of young people. Our performance against this element remains very strong with 187 young people in treatment year to date; witnessing a 30.7% increase in performance against 12/13 levels.

6.6.5 Tender Programme

The tender programme for the three substance misuse contracts (Adult Substance Misuse Recovery Service Contract; The Young People's Substance Misuse Contract; and the Adult Crime Reduction Substance Misuse Recovery Service Contract) has been successful. Cabinet unanimously agreed to approve the award of the three contracts to two successful bidders on the 22nd January 2014.

The DAAT Officers will be able to formally announce the successful bidders following the end of the Council's Procurement procedures on the 3rd February 2014. Douglas Charlton, Assistant Chief Probation Officer London Probation Trust, has kindly agreed to chair a monthly tender implementation group to ensure the new recovery system is set up to best effect.

6.6.6 **Adult and Young People's Substance Misuse Strategy**
The Head of Drug and Alcohol Services has now received the written feedback from each of the four working groups that contributed towards the Adult and Young People's Drug and Alcohol Strategy 2014-2017 away day which was held at Forty Hall on the 11th November 2013. The production of the strategy will take precedence once the tender contracts have been awarded; ensuring the satisfactory completion of the tender process is given the priority required. It is anticipated that a draft Strategy will be ready for circulation to the Health and Wellbeing Board in Spring 2014 for consultation and ultimate approval.

7. NHS SOCIAL CARE GRANT

7.1 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 ongoing 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.

7.2 Quarterly monitoring is continuing to assess the outcomes delivered as a result of this funding. These include:

- **LD Hospital Liaison Officer** – this has ensured a presence in the acute sector to provide much needed and valued support to those with learning disabilities and their carers whilst accessing hospital.

- **Primary Care Development Manager (Premises)** – this has supported the development of relationships across NHS Property, NHS England, local GP practices, businesses and other stakeholders to facilitate the development of the primary care estate. A number of possible primary care development projects have been identified and are being explored.

- **Safeguarding Nurse Assessor** – this has led to the development of a network of health investigators that the authority can call upon for clinical advice and easier access to health expertise in safeguarding matters and investigations.

- **End of Life Care** –100% of patients ended their life in their chosen place

8 HEALTHWATCH ENFIELD

8.1 The Chief Executive – Lorna Reith – commenced September 2013 and Healthwatch was formally launched in October 2013

8.2 The statutory roles given to Healthwatch organisations can be broadly summarised as follows:

8.2.1 **Promoting greater involvement by local people in the planning and provision of health and social care services:**

- working closely in partnership with health and social care sector organisations to understand what steps they already take to involve local people and how these can be enhanced;

8.2.2 **Collecting feedback from local people about health and social care services, identifying themes, and using this feedback to secure improvements to services:**

- working closely with local voluntary and community groups so that we hear a broad range of representative views;

8.2.3 **Raising local people's expectations about what to expect from health and social care services and helping them to find out what is available:**

- supporting national campaigns to encourage people to expect more from their health and social care services;

8.2.4 **To assist us carry out our roles we have specific powers to:**

- Make visits to gather evidence about people's experiences –these are called Enter and View powers
- Publish reports and make recommendations to care providers and commissioners, which they must respond to
- Have a voting place on the Health and Wellbeing Board.

8.3 Work is organised into three main areas:

8.3.1 **Information/signposting**

This function was taken over from the Council at the beginning of December. "*We are gradually building a comprehensive database of information about both statutory and voluntary provision in the borough. Our website is being developed as a key information resource and we plan to produce newsletters to share information and seek views. Visit us at www.healthwatchenfield.co.uk and follow us on Twitter @healthwatchEnf"*

8.3.2 **Policy and Insight**

"We have now met with key stakeholders from across the local authority, NHS organisations and local voluntary sector as well as the CQC and Voiceability (who deal with individual health service complaints). We have attended NHS London and National/London Healthwatch meetings and events to obtain and share information. Board members have been attending key partnership meetings (Health and Wellbeing Board, CCG, various sub-committees and working groups) since their appointment in late Spring.

We are part of the national Healthwatch network and are active at the London level in collaborating with other Healthwatch organisations. We are developing close links with neighbouring Healthwatch organisations in Haringey and Barnet".

8.3.3 **Community Engagement**

- To date 13 engagement activities have taken place. Some of these have been specifically targeted and others were taking advantage of planned events. Through these we have met with older people, carers, people with learning disabilities, Deaf people, Asian residents, blind and partially sighted residents, people with mental health problems and Enfield Homes tenants.
- There have been some clear issues relating to access to services for people with sensory impairments which have been taken up.

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

No progress since last report – still drafting commissioning proposals for sign off and approval

10. SPECIALIST ACCOMMODATION
The Keeping House Scheme

The Keeping House Scheme has been set up for people living in or moving into long term care who own a vacant property in the borough of Enfield. The scheme enables people to lease their house to the local authority in return for a guaranteed rent for a fixed period of time. The rental income generated is used to fund the costs of care. This Scheme will reduce the amount of deferred debt which the Council takes on; enable people to keep rather than sell their homes and to fund the cost of their care and support without depleting their savings. Grants are available to bring properties back up to a decent standard and leasing options running from two to five years.

There are currently around 100 people who would be eligible to enter the scheme. An engagement event was held at Park Avenue to consult on the scheme and feedback has been very positive both from staff and from the public. The Scheme has just gone live and we currently have seven cases going through the process.

11. SAFEGUARDING
11.1 Safeguarding Adults Board (SAB)

The Safeguarding Adults Board in December 2013 considered performance data in relation to the reports of abuse being made to Adult Social Care. While there continues to be a significant increase in alerts noted of 29.8% from the previous year, there was evidence of improved practice and outcomes; this included a continued increase in the number of adults at risk whom have a nominated advocate involved. The type of advocacy is set by the request or requirement of the adult at risk and can include family members, friends, or paid advocate for example. Notably there has also been an increase over the years of the number of cases in which there is a substantiated or partially substantiated outcome. This was found to be at 47.5% of cases which were closed in Q2 of 2013-2014, which is above the full year national data set for 2012-2014 at 43% of cases found to be substantiated or partially substantiated. For the cases in Q2 which have been closed and an outcome known, 38 out of 80 were substantiated or partially substantiated (47.5%). The national data set for 2012-2013 identified that 43% of cases were either substantiated or partly substantiated.

NHS England has set out an audit tool for London Safeguarding Adults Board which related to individual partners on the Board. Enfield Safeguarding Adults Board partners will be completing this audit by March 2014. It is expected that

completion of this audit tool will allow for the benchmarking and identification of themes, improvement needs and best practices according to localities, sector, sub-regional and London wide level. The purpose of this tool is to provide all organisations in the Borough with a consistent framework to assess monitor and/or improve their Safeguarding Adults arrangements. In turn this will support the Board in ensuring effective safeguarding practice across the Borough. The completed self-evaluation by partners will then be opened up for discussion with the Board Chair and with partner agencies at a Board Challenge & Support Event.

In addition to the audit by individual partners in respect to their safeguarding adults' arrangements, to Safeguarding Adults Board is also auditing its own effectiveness at a Board level. The outcome of this audit is expected in April 2014.

There are four sub-groups which support the work of the Safeguarding Adults Board: Service User, Carer and Patient Group; Performance, Quality and Safety Group; Learning and Development Group; and the Policy, Procedure and Practice Group. All sub-groups report to the Board bi-annually on the work it has achieved, which is included in the Board's Annual Report.

11.2 Community Help Point Scheme on Tap-IT

Tap-IT is a new and innovative solution to keep you and your loved ones connected. It has been developed as a mobile safety app which is free to download and free to use on smartphones. It has been designed to help people stay connected by putting them one tap away from friends and family. Useful functions on the app include requesting someone collect you (and gives GPS coordinates), ask someone to interrupt you or simply just check in. All of these functions are a simple way of letting family and friends know that we need assistance or just to reassure them. Tap-IT also helps to locate the nearest police station and 'safe sites' that have been approved by your local council through the CHYS scheme. For further details see the website www.tap-it.com and download the app from iTunes Store and Google Play.

11.3 Dignity in Care

A provisional date for the Dignity in Care conference has been set: Thursday 27th March 2014 at Park Avenue Day Centre. We are in the process of contacting the Social Care Institute of Excellence and Professor Hilary Brown to speak at the event. The conference will be open to all Enfield Safeguarding Adult Board partners and volunteer Quality Checkers. The event will be for a 100 delegates.

11.4 Safeguarding Information Panel (SIP)

The Safeguarding Information Panel is made up of Enfield Council Safeguarding Adults, Procurement & Contracting, Commissioning, Environmental Health, Enfield Clinical Commissioning Group (CCG) Safeguarding, and Care Quality Commissioning inspector. The meetings now are regularly considering information about home care providers (complaints and safeguarding alerts) as well as information about care homes. The Panel is also overseeing a joint project with the CCG and NHS London around

Pressure care (this includes training and recognition, reporting and investigation).

11.5 Quality Checker Programme

The Quality Checkers are service user and carer volunteers who visit services and give us feedback. Between August 2012 and December 2013, 121 visits were completed. These have been to care homes, Enfield Council's In-house Provider Services and home care providers. Our home care visits are still at the pilot stage. So far 20 visits have been completed, and lessons from these are being implemented. Our focus until April 2014 will be home care visits to service users who are in receipt of Direct Payments.

11.6 Quality Improvement Board (QIB)

The December Quality Improvement Board has agreed that the MyHomeLife legacy group – "Improving Residents' Lives" will become a sub-group of the Board. The Improving Residents' Lives group brings together care home managers with officers from Enfield Council and Enfield CCG to improve the quality of care offered to care home residents.

The Board was also informed that Care Home Carers' Network, an improvement project which has been suggested by Quality Checkers and is being led by Rosie Lowman, Enfield's Carer Commissioner, is launching on 18th February 2014. This event will bring carers from different care homes together to discuss the homes their loved ones are in. The Network will be used as a way of increasing the number of residents and relatives groups across care homes in the borough.

The Dignity in Care panel met on the 21st January 2014. The panel is made up of Quality Checkers, and their role is to determine if services are meeting the Dignity in care challenge. The panel agreed a provisional methodology for the reviews. This will be tested with an Enfield In-house Day centre over the next two months.

11.7 Multi-Agency Safeguarding Hub (MASH)

As part of its ongoing work to transform services in Enfield Adult Social care is seeking to create a multi-agency safeguarding hub (MASH) for vulnerable adults. With a significant increase in the number of safeguarding referrals year on year –13/14 is already 38% up on the same period the previous year – and a need to respond quickly, often across multiple areas of responsibility, developing a MASH which will see the co-location of staff from adults services, police and health makes sense.

There is currently a SPOE (single point of entry) within children's services with a MASH for children operating within a single location. With the infrastructure already in place, it would make sense to "bolt on" the adults MASH, though with very different areas of responsibility and statutory frameworks, the two teams will continue to operate separately whilst sharing resources from the police, health and other areas. The SPOE/Children's MASH is located within the civic centre.

Currently all safeguarding referrals come through the Access service in Adult Social Care. This is not a multi-disciplinary team. Access acts as a triage service and all referrals that require further investigation are sent out to the responsible care management teams.

The MASH will deal with all new safeguarding concerns including merlins from the police, where someone is concerned about the safety or wellbeing of an adult, or think they might be at risk of harm.

11.7.1 **How will the MASH operate?**

Within the MASH, information from different agencies will be collated and used to decide what action to take. As a result, the agencies will be able to act quickly in a co-ordinated and consistent way, ensuring that vulnerable adults at risk are kept safe. Where there is a need for further investigation, these cases will be transferred to the appropriate service. Where it is decided that no further investigation is required appropriate information and advice will be given. Given the potential for a multitude of different agencies to be involved in the referrals which come through, it would be appropriate for some agencies to be virtual members of the MASH. This means that, although a physical presence may not be necessary, a named resource will be contactable and available to provide information and advice as necessary.

The MASH should have a dedicated phone number for all queries. There will also be an on-line form available for people to refer directly to the MASH. Developments are already underway to develop on-line forms that will feed directly into the client information system (CareFirst). These will all go to a dedicated MASH clipboard.

11.7.2 **Why develop and Adults MASH?**

The MASH is an excellent way for organisations to make improvements to the way they share information with each other.

In Enfield there has been a lot of work done to improve the way agencies and organisations work together, including through the development of information sharing arrangements and tools. It is a business priority both for the Council, Adult Social Care and for partner agencies to develop better joint working arrangements where we consider a person's circumstances more holistically and deliver interventions appropriately rather than focusing on a single issue or problem. Learning from many high profile investigations tells us that failure of agencies to link up and share information is one of the most significant and recurrent failings in the system where things go wrong. The MASH will be a part of that work.

12. SECTION 75 AGREEMENT

The Section 75 Agreement for 2013-2014 has now been formally signed by both parties and executed as a deed, so outstanding matters of payment should shortly be resolved. Discussions have now commenced about the variations to necessary for 2014-2015, as part of the planning for the implementation of the Better Care Fund. This includes a proposal to create a schedule for Personal Budgets for health,

whereby the Clinical Commissioning Group would utilise the Council's systems for delivery, to ensure a streamlined and efficient system.

13. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

13.1 Learning Difficulties Partnership Board (LDPB)

There has not been a partnership board meeting since our last report. Our next meeting is on the 17th of February, and the 'Big Issue' is Health and Mental Health.

13.1.1 Annual health Checks

The Health Sub Group reports that the comparison of GP and LA registers is very near complete. The Community Nursing Team will now begin working directly with individual GP practices to ensure everyone with a Learning Disability as an annual health check next year.

13.1.2 Acute Liaison Nurse posts

The North Middlesex Hospital has agreed to fund a post for one to two days per week. Although Paulette Blackwood has now retired she has agreed to cover the post for one day a week while recruitment takes place. Barnet and Chase Farm Hospital have agreed to fund a full time post, and the ILDS have supported them to recruit and agency nurse to cover for six months, while recruitment to the permanent post takes place.

13.1.3 Intervention Service

Funding has been agreed to expand the Community Nursing Team to include an out of hour's intervention service. This service will respond to crisis situations and is intended to reduce the numbers people being admitted to hospital or assessment and treatment units.

13.1.4 New Options Re-Provisioning

Work has now started on the new site. Staff, service users and family carers have visited and are fully involved in the re-provision process.

13.1.5 Transition Events: Further Education

Transition implementation group hosted a very successful information event focused on Further education. It was well attended with over 50 parents and carers attending. Feedback was very positive, and all local colleges were represented at the event.

13.1.6 London Wide Transition Seminars

Enfield is leading on and hosting a series of London wide 'Transition seminars' for transition leads in children's and adult's services. We have had two seminars attended by representatives from 15 local authorities.

13.1.7 Young Leader's

TIG is developing a young leader's course in partnership with one to one. The course will be the first accredited course of its kind in the country. We are planning to roll out the programme from September 2014.

13.1.8 **End of Life Care pathways**

Members of the working group have now become accredited NAPPI End of Life Care trainers. Six training courses are being offered to specialists from the integrated team, EPS staff and private and voluntary providers.

13.2 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.

The Board is still looking to recruit new members and adverts have gone out through the carers network and in the Cheviots centre newsletter.

Recently the Carers Partnership Board has provided joint feedback on the Council Tax Support Scheme Consultation which led to carers receiving increased support through the scheme. Recently the Board has been consulted on the Adult Mental Health Strategy and as a result, the Mental Health Commissioner has been invited to join the Board on a permanent basis to allow the Board to influence delivery.

The March meeting brings the annual away day where the Board will be reviewing the Terms of Reference, governance arrangements and membership. The Board will also be looking at the Council's budget, with a presentation from Corporate Finance and for allow the Board to look at what we see as priority areas for carers services over the next year.

13.3 Mental Health Partnership Board

A sub group of the Mental Health Partnership board is the steering group for agreeing the current consultation process for Enfield's Mental Health Strategy. There has been two well attended public consultation events held in the East and West of the borough. The events encouraged discussion and feedback on focused aspects of the strategy ie Vision for Community Mental Health Services; Accommodation; Employment. Mental Health and wellbeing for Enfield's BMG population is to be another focused aspect for consultation in the strategy. This will proactively include Enfield's faith forums and other community organisations. The consultation closes on 10th Feb.

Enfield's Mental Health Services statutory services are currently largely shaped and work within Barnet Enfield and Haringey three borough CCG's Mental Health Commissioning Strategy 2012-2015 which informs Barnet Enfield and Haringey Mental Health Trust's Clinical Strategy for 2013–18. The current Enfield focused strategy that is out for consultation is an additional joint strategy commissioned by Enfield Local Authority and Enfield CCG. The strategy is increasing the focus on early intervention and global community support that can be more easily accessed by those receiving Mental Health treatment from their GP.

The MH partnership board is continuing to develop its sub groups that enable opportunities for the partners to work together on common outcomes.

The February meeting of the 'keeping safe' sub group is bringing together representatives from relevant organisations to consider actions that can

address Enfield Borough having the highest number of deaths on its railways lines relative to other London Boroughs.

The Economic wellbeing group is developing a suite of information for MH service users and will consider actions to work with local employers to increase opportunities.

Representation from service users and carers has been increased on the board's membership.

13.4 Older People Partnership Board
No update, as meeting was cancelled. Next scheduled for February

13.5 Physical Disabilities Partnership Board
Update from 20th January 2014 meeting not available

13.6 Enfield Safeguarding Children Board (ESCB)
The Board has undergone a transformation by streamlining its membership and processes. This is to enable the Board to be able to be better able carry out its strategic duties and facilitate greater challenge and debate between partner agencies. The first meeting of the streamlined Board is on 27 January. At this meeting, the business plan will be reviewed and a new plan agreed moving forward.

As part of this on-going development, we continue to engage with our health colleagues who not only sit on the Board but also our sub committees. These include Serious Case Review Panel, Child Death Overview Panel, Quality Assurance, Training and Trafficking Sexual Exploitation and Missing Children. Other key projects moving forward include tackling Female Genital Mutilation and joint work on Violence against Women and Girls – our health colleagues and Public Health will continue to have an important role to play in all these areas in the future.

The launch of the new ESCB website in November 2013 – www.enfieldlscb.org has also created greater opportunity for promoting and sharing information from ourselves and our partner agencies. We wish to further build on this moving forward so we can continue to promote excellent and effective safeguarding activities to the community and professionals.

The Board remains committed to working with partners across all agencies as well as other Boroughs. We are hoping to increase participation levels and set up a Childrens "shadow" Safeguarding board to ensure Young Peoples voices are clearly heard across the partnership. We are also working to build on joint initiatives with the Adult Board following on from our successful collaboration around such activities as Keep Safe week which raises awareness of safeguarding issues across the Borough. Activities moving forward include a joint audit with the Adult Board, joint training and a joint conference. We are in the process of undertaking a section 11 audit of all agencies - this will also serve to inform aspects of the joint audit.

Appendix 1 (ref. Section 4.2.2.)

Priorities identified in the Enfield Oral Health Needs Assessment

Priority Area	Action needed	Responsibility
Improving oral health in young children	Commission a school-based fluoride varnish programme for children aged 3-5 years targeted at schools in the most deprived parts of the borough	Lead -Local Authority
	Review the coverage of the 'Brushing for Life' programme and target the programme at children aged less than 3 years	Lead -Local Authority Support - Oral health promotion
	Review the specification for the oral health promotion service and develop a service with identified outcomes and KPIs which includes training the trainers and an oral health promotion programme in schools and Children's Centres	Lead -Local Authority Support - NHS England
	Continue to support the NHS Dental Epidemiology programme and consider a larger sample to allow more in-depth analysis for local planning	Lead -Local Authority
	Develop a strategy for increasing uptake of dental services in children	Lead - Local Authority/ NHS England/Local dentists
Improving oral health of adults and older people	Develop strategies for addressing the needs of vulnerable and older people	Lead – Local authority/ NHS England
	Mouth cancer awareness programme and provide training on screening for mouth cancer for dentists	Lead – Local Authority Support – NHS England
	Develop a strategy for increasing uptake of dental services in older adults	Lead -Local Authority/ NHS England

Patient experience	Develop a public awareness campaign about availability, costs and how to access dental services Set a target for patient experience to converge with London figures	Lead - Local Authority/ NHS England
Dental services	Support the implementation of the new arrangements for urgent care dental out of hours services Support the reviews of primary care specialist and hospital dental services	Lead – NHS England Support – Local Authority Lead – NHS England

Appendix 2 (ref. Section 5)

Health and Wellbeing Board

13 February 2014

Agenda – Part: 1	Item: 10c
Subject: Primary Care Strategy for Enfield	
Date: 13 February 2014	

REPORT OF: Improving Primary Care Sub Board

Contact officer and telephone number:

Jenny.Mazarelo@enfieldccg.nhs.uk

EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board on work to date to implement the Primary Care Strategy across the borough of Enfield.

The Primary Care Strategy project team reports jointly to the CCG Primary Care Strategy Implementation Board and the Health and Wellbeing Board.

RECOMMENDATIONS

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

NHS Enfield Primary Care Strategy
February 2013 Update

1. Introduction

This paper updates the Health and Wellbeing Board on work to date to implement the Primary Care Strategy across the borough of Enfield.

2. Update on the Primary Care Strategy

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

2.1. Access

2.1.1. Enhanced Access Scheme

A full evaluation of the Access LES for the six months to June 2013 was completed in December 2013. In summary, this confirmed that the LES:

- Delivered an additional 16,432 GP appointments (632 per week)
- Provides excellent value for money at £16 per appointment compared to the average cost of a GP appointment of £43*
- Covered 82% of Enfield's population (39 practices)
- 60% of patients surveyed as part of the review reported that access had improved in the last year
- 100% of practices said they would recommend the process to other practices

Due to such positive results and as the local health economy moved into the final quarter of the financial year and winter pressures, it was agreed that the LES be extended for a further three months to 31st March 2014 in order to provide the additional primary care capacity required to sustain improving access. The extension has been offered to all GP Practices in Enfield.

2.1.2 Minor Ailment Scheme

This pilot scheme has utilised pharmacy expertise and capacity to improve access for patients suffering from one of a pre-approved list of twenty minor ailments from fifty-two different sites. A total of 1,385 Pharmacy consultations were delivered in November and December 2013, peaking at 776 consultations in December - the highest level since the Scheme's implementation in February. The Scheme has been extended to 31st March 2014, however the CCG's intention to mainstream the Scheme in 2014/15 has been superceded by an indication in NHS England's draft commissioning intentions that it intends to commission this service in 2014/15.

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

The main objectives for this initiative are:

- To improve access to primary care by providing additional capacity of approximately 17,000 extra primary care appointments across Enfield over the two year period;
- To deliver service improvements through research and re-design in a priority service development area.
- To raise the profile of Enfield as a borough for newly qualified GPs to settle in the long term

Four Principal Clinical Teaching Fellows (PCTF) commenced their induction with UCL, the CCG and their Host practices on 6th January 2014. Each PCTF will undertake five clinical sessions in their Host practices, two Academic sessions at UCL, two service development sessions at the CCG and have one CPD session per week. Each PCTF will work with a CCG Clinical and Management Lead on one of four development projects, namely Diabetes, Urgent Care, Older People's Mental Health and Palliative Care.

Four Host GP practices (Bounces Road, Carlton House, Gillan House and White Lodge) have a Principal Clinical Teaching Fellow placed with them for twelve months with a further four new Host practices to be identified for the second year of the initiative.

2.2 Improving Patient Experience

2.2.1 Patient Experience Tracker

The project will enable practices to better assess and respond with real-time results to patient opinion and views on the services provided via the use of tablet devices. Thirty-four GP Practices have expressed an interest in this service and mobilisation of this initiative is now underway.

2.3 Improving Health Outcomes

2.3.1 Childhood obesity

The evaluation from the weight loss camp completed by 24 participants and three month follow-up reflects that:

- 100% of campers achieved a reduction in BMI SDS;
- 50% of campers who attended follow-ups achieved further SDS reduction at three months;
- 100% of campers reduced sedentary behavior due to intensive daily activity schedule;
- 80% of campers scored at three months had further reduced their sedentary behavior;
- 57% of campers who started with low self-esteem, increased their self-esteem score; and

- 40% of campers with low self-esteem showed a continued trend of improved self-esteem.

The CCG will continue to work closely with London Borough of Enfield to support the delivery of its Obesity strategy for the local population.

2.3.2 HiLo Initiative

This pilot project is being delivered in conjunction with Queen Mary's University London (QMUL) and aims to improve the management of CHD and BP in general and in particular, those patients traditionally referred to secondary care for management, following poor improvement outcomes when recommended primary care treatment guidelines are followed. Two practices (SE and NE localities) identified 744 patients on their CHD register and initial findings are:

Blood Pressure Control

- 404 patients need further support
- Average age of 64 years
- Average baseline reading 152/84
- 173 of these 404 patients are diabetic
- 48 have existing ischaemic heart disease
- 20 have had previous stroke or TIA
- More women than men (212 vs 192)

Lipid (Cholesterol) Control

- 444 patients
- Average age of 64 years
- Baseline Total Cholesterol 5.5 mmol/l
- Baseline LDL 3.0 mmol/l
- Baseline HDL 1.32 mmol/l
- 235 of these 444 patients are diabetic
- 67 have existing ischaemic heart disease
- 21 have had a previous stroke or TIA
- More women than men (250 vs 194)

QMUL will work with both practices over the coming year to improve treatment of uncontrolled risk factors, reduce patient risk of preventable events, improve the confidence of practice staff to manage patients in future, leave lasting changes in healthcare team behaviours to benefit subsequent patients beyond HiLo and build a positive reaction for such interventions for future initiatives, or elsewhere in the CCG area.

2.3.3 Cancer Screening

LBE Health Trainers are continuing to establish and deliver community outreach to promote screening.

2.3.4 Domestic Violence

The aim of this project is to increase the identification and referral of domestic violence and abuse through training and support of practice staff in the IRIS model. Both the IRIS Clinical Lead and Advocate Educator, have been appointed to work with up to twenty-five GP practices. Fourteen practices have so far agreed to participate in the project which went live in November.

3.0 IT Developments

iPLATO text messaging services continues to support GP Practices reduce their ‘did not attend’ rates, enabling GP Practices to offer this released capacity to patients who require an appointment.

4.0 Conclusion

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

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 12 DECEMBER 2013

MEMBERSHIP

PRESENT Donald McGowan (Cabinet Member for Adult Services, Care and Health), Shahed Ahmad (Director of Public Health), Chris Bond (Cabinet Member for Environment), Andrew Fraser (Director of Schools & Children's Services), Ray James (Director of Health, Housing and Adult Social Care), Deborah Fowler (Enfield HealthWatch), Ayfer Orhan (Cabinet Member for Children & Young People), Dr Alpesh Patel (Chair of Local Clinical Commissioning Group), Liz Wise (Clinical Commissioning Group (CCG) Chief Officer) and Vivien Giladi (Voluntary Sector)

ABSENT Ian Davis (Director of Environment), Christine Hamilton (Cabinet Member for Community Wellbeing and Public Health) and Paul Bennett (NHS England)

OFFICERS: Bindi Nagra (Joint Chief Commissioning Officer), Felicity Cox (Partnership Manager, Health and Well-being), Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Keezia Obi (Head of Public Health Strategy), Hayley Coates (Special Projects Business Manager), Glenn Stewart (Assistant Director of Public Health) and Jenny Mazarelo Koulla Panaretou (Secretary) and Penelope Williams (Secretary)

1
WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies for absence were received from Councillor Hamilton and Paul Bennett and for lateness from Ray James. Councillor Orhan, Deborah Fowler, Andrew Fraser and Felicity Cox apologised for leaving early.

2
DECLARATIONS OF INTEREST

There were no declarations of interest.

3
CHILDREN'S DISABILITIES CHARTER

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

Janet Leach, Head of the Children's Disabilities Joint Service Board presented the report to members.

She highlighted the following from her report:

- The Charter was developed as part of the Every Disabled Child Matters and the Aiming High National Transformation Programme.

- The Health and Wellbeing Board is being asked to commit to seven key areas as part of the charter.

- Clause 170 of the Children and Families Bill, which is currently going through Parliament, will be asking local authorities to ensure clinical commissioning priorities for children with disabilities.

- Enfield has over 1,300 children with Special Educational Needs (SEN) statements: 815 of these have disabilities.

2. Discussion of the Report

The following points were made during the discussion on the report:

2.1 Members welcomed the report and the recent news that there were increasing numbers of disabled people taking part in sports activities, following up on the success of the Paralympics.

2.2 The Board had to careful to be aware that it could not micro manage services, but could promote integration, encouraging services to work together. Any new work would have to be carried out within existing resources.

2.3 In the future it may be necessary to create a Children and Families sub group of the Health and Wellbeing Board to oversee work in this area. The Children's Disabilities Board currently reports in to the Schools and Children's Services Senior Management Team. Arrangements were in transition.

2.4 With the growth in the numbers of children and young people will come a growth in the number of children with disabilities. This is also due to better health care, enabling disabled children to live longer lives.

2.5 Next year Children's Services will become responsible for children in care from 0-25. Their assessment plans will cover the move to adult services.

2.6 Enfield's Learning Disabilities Team has an excellent careers service and Enfield has a higher proportion of disabled people in work than any other London Borough. A higher proportion is also supported at home

by their families. Children who had had out borough placements have also been bought back into the borough over the past few years.

2.6 The disabilities service is in a period of transition, but is developing.

2.7 Information on children with disabilities will be included in the JSNA: integration of services for them will also form part of the Health and Wellbeing Strategy.

AGREED that Board would formally sign up to the Charter.

4
JOINT HEALTH AND WELLBEING STRATEGY

The Board received an update from Keezia Obi, Head of Public Health Strategy, on the development of the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS).

Keezia Obi highlighted the following from her report:

- The JSNA is now live. The Steering Group will continue so that they can oversee the further development of the JSNA.

- The working group, made up of officers from both the CCG and the Council, have been working on putting together the Joint Health and Wellbeing Strategy developing the format to be put to the Board.

- So far over 400 individual responses to the consultation have been received. Officers have also gathered views though attendance at meetings with voluntary groups and others. All except one of the responses were in favour of the priorities. Activities will continue.

- The most popular priorities so far were “Enabling People to be safe, independent and well”, “Ensuring the best start in life” and “Promoting healthy lifestyles”.

- Respondents were supportive of the emphasis on prevention.

- Most of the respondents were females living or working in the Borough. Eight per cent were carers. Nineteen per cent were under 24 and 12% under 16.

- More work was needed to encourage people from ethnic minority communities to take part in the consultation, but this was being addressed.

- Suggestions also included removing vending machines.

2. Discussion of the Report

The following points were made during the discussion on the report:

2.1 Members welcomed the work being carried out.

2.2 There is a statutory responsibility to produce the JSNA. Resources needed to extend and broaden it will be found from within the Public Health budget.

2.3 Concern was expressed about the number of fast food outlets near to schools.

2.4 It was felt that people consulted were aware that responsibility for good health lay with them.

2.5 Ante-natal care was very important linking across all priorities. There were particular issues encouraging people from some communities, who have no concept of anti natal care, to take up the care offered.

2.6 Information and feedback gathered as part of the consultation would be passed on to CCG officers.

2.7 Consultation using CCG events had also taken place. The CCG had a new lead on engagement who would be happy to work with the Council.

2.8 It was suggested that engagement could continue after the end of the formal consultation period.

AGREED 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.

5
CHILDHOOD OBESITY AND PUBLIC HEALTH

The Board received a report on the development of a borough wide obesity strategy for children and adults.

1. Report

Glenn Stewart, Assistant Director Public Health, highlighted the following from his report:

- The latest National Child Measurement Programme (NCMP) obesity figures were released on the previous day. The figures are slightly different but broadly similar to those in the report.

- Enfield suffers from high rates of obesity. It has the fifth highest reception rate, and the sixth highest Year 6 rate in London. The Year 6 rate is almost twice that of reception.

- Twenty three per cent of adults are obese and 40% are obese and overweight. Nationally two thirds of the population are now overweight or obese. This problem has increased and is set to increase further.

- The costs of obesity are large: they are expected to rise from £75m in 2007 to £84.1m in 2015. Obesity can also lead to many long term conditions that cost the health service millions of pounds.

- Adults are the gatekeepers for children's behaviour and the causes of their obesity are the same: therefore it makes sense to combine obesity strategies.

2. Discussion of the Report

The following points were made during the discussion:

2.1 Board members welcomed the approach.

2.2 Children can help persuade their parents of the need to lose weight.

2.2 Persuading people in the workforce to eat more healthily was important. The Council had a commitment to creating a healthy workplace and had recently introduced a free fruit initiative and was working towards healthy workplace accreditation. Improving mental health was also important.

2.3 Collaborative working would be helpful. The CCG was keen to work with the Council on the development of a strategy.

2.4 Fast food outlets around schools were a concern, including the recent proliferation of outlets in the market square, near three secondary schools. Councillor Bond, Cabinet Member for Environment reported that regulations would change in February to allow the Council to turn down applications for fast food outlets within 400 metres of a school. The vans in the market square would soon be moved on.

2.5 NHS England also needed to be involved to enable discussions about moving funding from third tier acute services to early intervention.

2.6 Sweet fizzy drinks were also a problem: up to 20 per cent of calorie intake in children could be due to them.

2.7 It was important to support and empower communities to take responsibility for their own weight problems.

2.8 The strategy will be developed independently and then fitted back into the main Health and Wellbeing Strategy to enable relative prioritisation. The action plan setting out all priorities will be key.

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

6
SECTION 75 AGREEMENT (ADULTS) 2013-14 MID YEAR REVIEW

The Board received a report from Ray James, Director of Health, Housing and Adult Social Care on the Section 75 Agreement (Adults) 2013-14 Half Year Review.

Bindi Nagra (Joint Chief Commissioning Officer) and Hayley Coates (Project Manager), presented the report to the Board. They highlighted the following:

- The schedules within the agreement include Mental Capacity Act and Deprivation of Liberty Safeguards, Joint Commissioning Team, Voluntary and Community Sector, Integrated Community Equipment Service, Public Health and Integrated Learning and Disabilities Service. They add up to £5.8m from the Council and £2.4m from the CCG.
- The agreement is working well.
- Some issues have still to be resolved including the formal signing of the agreement.
- The Mental Capacity Act has formalised information sharing to enable delivery of training, auditing and awareness raising.
- There has been an increase in the number of Deprivation of Liberty Standards applications from 3 to 33.
- Key priorities are the development of a joint action plan and delivering training to staff.
- The Joint Commissioning Team is working well.
- Twenty organisations have already signed up to the newly formed Enfield Dementia Alliance.
- Personnel changes at the CCG following the NHS transition have led to some difficulties.
- The Council has taken on responsibility for commissioning 10 services from the Voluntary and Community Sector for social care and health. Challenges arise due to uncertainty of funding.
- Processes for the Integrated Community Equipment Service are well established: 90% of items are being supplied within 3 days.
- In Public Health schedules are being put in place to ensure the necessary payments are made.
- £900,000 care purchasing savings have been made by the Integrated Learning Disabilities Service, so far, this year.

- A Learning Disabilities Acute Liaison Nurse at North Middlesex Hospital is being funded.

2. Discussion of the Report

The following points were raised:

2.1 Liz Wise, CCG Chief Officer, advised that she was unaware of several of the issues raised in the report including that the Section 75 agreement had not formally been signed, that the Physical Disabilities Board did not have a CCG representative or that there were any concerns regarding the changing of personnel in the Joint Commissioning Team.

AGREED

1. To note the content of the Section 75 Agreement half year review
2. To note that the payment is outstanding from the CCG for Quarters 1 and 2 and from the Council to the CCG, but that this is being progressed.
3. To note that a signed version of the Section 75 Agreement is outstanding from the CCG but that legal advice states that the relationship of the parties is governed by the conduct of both parties and is therefore governed by implied contract.
4. To note that the agreement would be signed within the next three weeks.

7
INTEGRATED TRANSITION FUND

The Board received a report from the Director of Health, Housing and Adult Social Care, on the development of the local Integration and Transformation Fund Plan.

The following points were highlighted from the report:

- The Fund has recently been renamed the Better Care Fund by the Government.

- A sub group of the Board with a working group has been set up to develop a plan for the use of the fund during the transition period from 2014/15.

- The Board was asked to agree the terms of reference for the sub board and working group.

- The fund will come into being fully in 2015/16.

- Formal national guidance on the operation of the fund was due to be published in the week following the meeting.

- A joint draft plan should be ready by February 2014, for final approval by the 4 April 2014.

- There has been a high level of engagement in the working group, progress is being made and key milestones agreed. A further report will be provided for the next meeting.

- No new money is being offered for this work. The funds will be taken from the CCG's existing resources.

- Agreement will be required from the CCG, the Council and the Health and Wellbeing Board.

- £1billion of the funding will be linked to performance outcomes.

2. Discussion of the Report

The following points were raised during the discussion:

2.1 The purpose of the fund was that from a public point of view care should appear to be provided seamlessly. It was therefore important to involve patients and service users.

2.2 An independent professional advisor is to be employed to move the work forward.

2.3 The plan for the fund will be outcome focussed. Ideas will be subject to public engagement and testing. It will dovetail with the work taking place on the Health and Wellbeing Board Strategy.

2.4 The Acute providers will be involved. They are already aware of the proposals and there is some concern about how the changes will be implemented particularly in the changeover period between the new system coming in and the old system being completed.

2.5 Some beds will be lost from the acute system to free up funds for integration. This will be a difficult period to manage and it will be necessary to find ways to avoid destabilising the whole service while changes are made. Good planning will be essential.

2.6 It will be essential for the Council and the CCG to work closely together and to be mindful of others circumstances, when managing the changes. The fund planning group will involve the five neighbouring boroughs, especially Haringey which also uses North Middlesex Hospital.

2.7 The Government's purpose in making these changes is to encourage authorities to work together more closely, more quickly.

2.8 It was suggested that the University College London Partners should also be engaged in the planning for the fund.

2.9 Maintaining the stability of the acute providers would be essential.

AGREED

1. To note the progress to date on the development of the Better Care (Integrated Transformation) Fund Plan.
2. To note the key issues raised.
3. To endorse the direction of travel set out in the initial scoping of the Better Care Fund Plan.
4. To note and agree the terms of reference for the Better Care Fund Sub Board and Working Group.

8
BETTER OUTCOMES FOR CHILDREN AND YOUNG PEOPLE'S PLEDGE

The Board received the report on Better Health Outcomes for Children and Young People Pledge from Andrew Fraser, Director of Schools and Children's Services.

1. The Report

Andrew Fraser introduced the report and highlighted the following:

- The department had received a letter from the Department of Health asking Health and Wellbeing Boards to sign up to the pledge.
- 28% of Enfield's population is 0-19 years old.
- 15% of 11-15 year olds have long term conditions.
- The pledge contains 5 shared ambitions which are set out in the report.
- The pledge is a joint commitment to improve outcomes for children and young people.

2. Discussion of the Report

The following points were made during the discussion:

2.1 The Board Members welcomed the report.

2.2 The aims will be reflected in the Joint Health and Wellbeing Strategy.

2.3 Enfield Healthwatch had already signed up to the pledge.

AGREED that the Health and Wellbeing Board would sign up to the pledge for better health outcomes for young people.

9
SUB BOARD UPDATES

1. Health Improvement Partnership Sub Group Update

The Board received an update report from Shahed Ahmed, Director of Public Health, on the work of the Health Improvement Partnership and the Public Health Department.

Glenn Stewart, Assistant Director of Public Health, highlighted the following from the report:

- Work with the CCG is continuing to increase HIV testing.
- Immunisation records are not up to date but withstanding recent threats such as the recent measles outbreak indicate that levels are higher than recorded. Work on improving record keeping continues.
- Health Check assessments are going well. At the end of Quarter 2 4001 checks had taken place: 45% over the trajectory.
- A conference on reducing the prevalence and stopping people starting smoking had taken place in October. Smoking prevalence in Enfield is 18.5% of adults compared with the England average of 20%.
- The healthy weight co-ordinator is doing good work and has set up 7 sub-groups across the borough.
- The Council has applied for funding from the Greater London Authority (GLA) as part of the mini Holland bid to help increase physical activity through cycling in the Borough.
- Enfield has high levels of tooth decay; the rate of decayed missing and filled teeth among 5 year olds is the highest in London. Work on improving this is taking place.
- Public Health is co-ordinating the Council's bid to become accredited under the GLA Healthy Workplace Charter.
- Work on the domestic violence and anti-social behaviour is continuing.
- Uptake of maternity services by 12 weeks and 6 days of pregnancy is increasing.
- Breastfeeding is above the London and England averages.
- Infant mortality is still high: an average of 28 babies die every year in Enfield. This is also concerning as infant mortality is an indicator of population health.
- A conference was held in July to develop a plan to improve female life expectancy in Edmonton.
- Work is continuing to improve employment opportunities at North Middlesex Hospital for Edmonton residents.
- All Cabinet reports now have a section to complete on public health implications.
- Vacancies in the public health team and difficulties in recruitment have caused some delays in the development of programmes, but all vacancies are now covered, some with agency staff.

2. Discussion of the Health Improvement Partnership Update Report

The following points were raised during the discussion:

2.1 Late diagnosis of HIV infection not only means that the disease is not dealt with at an early stage, but also increases the likelihood that individuals will infect more people. HIV testing needs to be more routine and regular. This is cost effective as treating the disease at a later stage is very expensive.

2.2 Voluntary sector representation on groups is welcome.

2.3 Interventions such as “brushing for life” are being planned to help prevent tooth decay.

2.4 Tooth decay and high infant mortality rates are symptoms of poverty.

2.5 Fluoridation of the water supply has been considered but in order for it to be implemented all the London Boroughs would have to agree to it. Some thought that the water in Enfield naturally had good levels of fluoride. Some dentists in the South are encouraging their patients to use fluoride toothpastes.

2.6 It was questioned whether infant mortality is still a reliable predictor of access to healthcare services in Enfield. Infant mortality can also be high in affluent areas due to mothers having babies later in life.

2.7 Averages can mask problems as rates can be high in some areas and low in others. In some areas smoking prevalence can be as high as 70%. It is helpful to consider outliers and to consider carrying out surveys in specific local areas. Obesity in eastern Enfield is higher than the in the west. Although the west is also higher than it should be.

2.8 More work was needed to tackle HIV infections particularly among some African and other communities living along the North Circular Road.

2.9 The Over 50’s Forum was keen to get involved in helping to improve public health.

2.10 In significant parts of Edmonton a significant group of people are putting sugar into babies’ bottles.

2.11 The Over 50’s Forum felt that the public health and CCG Budget was not high enough and were planning to present a petition to NHS England to this effect.

AGREED to note the content of the report.

3. Joint Commissioning Sub Group Update

The Board received a report updating the Board on the work of the joint commissioning across health and social care in Enfield.

3.1 Discussion of the Report

The following points were raised during the discussion:

3.1.1 Paragraph 4.3 should state that the Enfield CCG had served notice on the community health services element of the Mental Health Trust Contract, not on the whole contract. The CCG and the Council were working together to work out how the services should be reshaped.

3.1.2 The Older People's Assessment Unit is not being well used, but rates have improved since the report was written and it would take time for it to become established. More GPs are now referring patients. Updated use figures would be presented to the next meeting. There had been problems with the ambulance service which were being resolved. Most of the referrals would however be from GPs or the Urgent Care Centre. Reports from those who have used it were positive.

3.1.3 The review of the Winterbourne View investigation was due to be published that week which is likely to make recommendations for Health and Wellbeing Boards.

AGREED to note the report.

4. Improving Primary Care Update Report

Mo Abedi, Medical Director for Enfield CCG and Jenny Mazerelo, Programme Manager Primary Care, provided a verbal update to the Board.

The key points of the presentation were as follows:

- Improving access to GP's, a major priority, has resulted in an extra 2,750 GP appointments per month. 39 practices have signed up to the scheme covering 82% of the Enfield population. More work with the 20 worst practices is also taking place to improve their patient access.

- Public satisfaction with the Minor Ailments Scheme is high and they have indicated that they would like it to continue. It has therefore been agreed that it will continue indefinitely.

- The University College London Scheme for 4 new GPs which is projected to bring in 17,000 extra appointments per year is almost ready to begin recruitment. This scheme will raise the profile of Enfield and hopefully encourage more newly qualified GPs to the area.

- The newly installed health kiosks for measuring blood pressure, height and weight were recently advertised in Our Enfield Magazine.

- Initial results from the childhood obesity camp are encouraging.

- The Patient Experience Tracker will enable practices to better assess and respond to issues. Thirty four practices have expressed an interest in this service.

- The pilot HiLo Initiative is to operate in two of the larger practices in conjunction with Queen Mary University helping to manage Coronary Heart Disease and high blood pressure.

- Health trainers have been recruited to promote the benefits of cancer screening to the community.

- Enfield Carers Strategy has enabled the recruitment of a GP Liaison Worker and Carers nurse who are working on early identification of carers, health promotion and other carer issues.

- The IT in most GP practices has been upgraded. The new text messaging service has saved 3,976 appointments and 615 clinical hours. The possibility of extending the texting service to include health promotion messages was being considered.

- Future planning includes focussing on the development of the GP networks to encourage collaborative working between practices, setting up an innovation fund to enable practices to bid for funding. A great deal of work has taken place over the past 18 months.

5. Discussion of the Report

The following points were raised during the discussion of the report:

5.1 Concern was expressed that not all GPs had the necessary IT to enable them to offer on line appointments from 1 April 2014. The requirements were that they should be able to do this during the 2014/15 year, which was what the CCG were working to achieve.

5.2 Concern was expressed about the availability of overnight urgent care. Board Members were assured that a doctor and a nurse would be available through the night at Chase Farm Hospital.

5.3 Some patient forums had felt that the questions in the patient survey were leading. Questions had been developed in consultation with voluntary groups including the Over 50's Forum and Healthwatch and had been commented on by the Local Medical Council. The questions will be subject to evaluation at a later date. It was hoped that the questionnaire will provide good intelligence about the patient experience.

5.4 The University College London investment was welcome and should provide a catalyst to make Enfield a beacon of excellence. Good communication was key.

5.5 The outcomes of the patient survey will be reported back to the next meeting of the Board.

AGREED to note the report.

10
MINUTES OF THE MEETING HELD ON 19 SEPTEMBER 2013

The minutes of the meeting held on 19 September 2013 were agreed as a correct record with the following amendments:

- Minute 9 item 2.2.13 to add the words “it was advised that NHS Enfield had said that” in front of “this was due to”.

- Minute 7 2.5 pg 10 University of Central London should be replaced with University College London.

11
WORK PROGRAMME 2013/14

The Board received and noted the work programme 2013/14.

12
DATES OF FUTURE MEETINGS

1. The following dates for future meetings of the Board were noted:

- Thursday 13 February 2014
- Thursday 24 April 2014

2. The following dates for future development sessions were noted:

- Thursday 23 January 2014 (not 21 January 2014 as previously advised).
- 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 Andrea Clemons JSNA Keezia Obi HWB Workplan Fliss Cox		Public Health Outcomes Framework Glenn Stewart Housing and Homelessness Sally McTernan JSNA Keezia Obi		1. HWB Strategy Keezia Obi 3. Mental Health Strategy Kate Charles 2. Childhood Obesity Public Health & Glenn Stewart	1. Upper Edmonton Life Expectancy Glen Stewart 5. Council Budget Consultation Richard Tyler 2. Health & Wellbeing Strategy Keezia Obi 3. CCG Budget and Strategic Plan Liz Wise 6. Children's Outcomes Pledge Eve Stickler 4. Pharmaceutical Needs Assessment Paul Gouldstone Integrated Transition Fund Ray James		6. Educational Achievements Andrew Frasier 2. HWB Strategy Keezia Obi 1. CQC Update CQC Rebecca Bauer Ray James 4. Private Landlord Scheme Sally McTernan 5. Integrated Transition Fund Ray James 7. CCG Budget and Strategic Plan Liz Wise 3. Upper Edmonton Life Expectancy Glen Stewart 8. Childhood Poverty & Eve Stickler		2. Integrated Transition Fund Ray James 1. CCG Budget and Strategic Plan Liz Wise 1. CQC Update CQC Rebecca Bauer Ray James
		JSNA Keezia Obi HWB Workplann Fliss Cox		HWB Strategy Keezia Obi Integration Sub-Group Establishment			1. HWB Strategy Keezia Obi 2. Childhood Obesity Public Health &		4. HWB Strategy Keezia Obi 3. Housing and Homelessness Sally McTernan	

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