

# Public Document Pack



## HEALTH AND WELLBEING BOARD

Tuesday, 14 July 2015 at 6.30 pm  
Conference Room, Civic Centre, Silver  
Street, Enfield, EN1 3XA

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## MEMBERSHIP

Leader of the Council – Councillor Doug Taylor (Chair)  
Cabinet Member for Health and Social Care – Councillor Alev Cazimoglu  
Cabinet Member for Public Health and Sport – Councillor Nneka Keazor  
Cabinet Member for Education, Children’s Services and Protection – Councillor Ayfer Orhan  
Chair of the Local Clinical Commissioning Group – Dr Mo Abedi  
Healthwatch Representative – Deborah Fowler  
Clinical Commissioning Group (CCG) Chief Officer - Liz Wise  
NHS England Representative – Dr Henrietta Hughes  
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)

## Non-Voting Members

Royal Free London NHS Trust – Kim Fleming  
North Middlesex University Hospital NHS Trust – Julie Lowe  
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright

## 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. **CHANGE TO THE HEALTH AND WELLBEING BOARD CABINET MEMBERSHIP (6:35-6:40PM)**

To note the changes to the membership of the Health and Wellbeing Board Terms of Reference relating to the cabinet members on the board:

- The Cabinet Member for Health and Adult Social Care is now the Cabinet Member for Health and Social Care.
- The Cabinet Member for Culture, Sport, Youth and Public Health is now the Cabinet Member for Public Health and Sport.

**4. SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014/15 (6:40-6:50PM)** (Pages 1 - 50)

To receive the Safeguarding Adults Board Annual Report for 2014/15.

**5. HEALTHWATCH REPORT - COMPLAINTS HANDLING (6:50 - 7:05PM)** (Pages 51 - 100)

To receive and note report from Deborah Fowler, Chair of Enfield Healthwatch, concerning the adoption of a recognised approach to complaints-handling.

**6. NHS ENGLAND: ANTE NATAL IMMUNISATION AND SCREENING IN ENFIELD (7:05-7:35PM)** (Pages 101 - 124)

To receive a presentation for discussion, from NHS England, on ante-natal, and new born and immunisation and screening programmes in Enfield.

**7. CLINICAL COMMISSIONING GROUP OPERATING PLAN 2015/16 (7:35 - 7:50PM)** (Pages 125 - 132)

To receive a report from Graham MacDougal, Director of Strategy and Partnerships Enfield Clinical Commissioning Group on the Enfield Clinical Commissioning Group Operating Plan 2015/16.

**8. SUB BOARD UPDATES (7:50 - 8:20PM)** (Pages 133 - 192)

To receive updates from the sub boards as follows:

- Health Improvement Partnership Board
- Joint Commissioning Board
- Primary Care Improvement Board
- Integration Board

**9. MINUTES OF THE MEETING HELD ON 14 APRIL 2015 (8:20- 8:25PM)** (Pages 193 - 202)

To receive and agree the minutes of the meeting held on 14 April 2015.

**10. FUTURE ITEMS (8:25-8:30PM)**

To note the items listed for consideration at the 15 October 2015 meeting of the Health and Wellbeing Board:

1. Enfield CCG Commissioning Intentions

2. North Central London New Governance Arrangements
3. Mental Health Sustainability

## **11. DATES OF FUTURE MEETINGS**

To note the dates agreed for future meetings of the Health and Wellbeing Board:

- Thursday 15 October 2015, 6,30pm
- Thursday 10 December 2015, 6.00pm
- Thursday 11 February 2016, 6.00pm
- Thursday 21 April 2016, 6.00pm

To note the dates agreed for board development sessions

- Tuesday 8 September 2015
- Wednesday 4 November 2015
- Wednesday 6 January 2016
- Wednesday 2 March 2016

All development sessions will start at 2pm unless otherwise indicated.

## **12. 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).

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**MUNICIPAL YEAR 2015/2016**

**MEETING TITLE AND DATE**  
**Health and Wellbeing Board**  
**14 July 2015**

Director of Health, Housing and Adult  
 Social Care

Contact officer and telephone number:  
 Georgina Diba, 020 8379 4432  
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<b>Agenda - Part: 1</b>	<b>Item: 4</b>
<b>Subject: Safeguarding Adults Annual Report 2014-15</b>	
<b>Wards:</b>	
<b>Cabinet Member consulted:</b>	
<b>Approved by:</b>	

## **1. EXECUTIVE SUMMARY**

The Safeguarding Adults Board are presenting their Annual Report for 2014-2015, which highlights the accomplishments of a partnership working in co-production with local people, service users and carers to prevent and respond robustly to the abuse of adults at risk. The Safeguarding Adults Board is a partnership of statutory and non-statutory organisations 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 Care Act 2014 has placed Safeguarding Adults Boards on a statutory footing. This will present an opportunity to work in a strengthened partnership and a starting point with clear aims and priorities. The Safeguarding Adults Board have consulted on the next three year strategy and through feedback from service users, carers and local people, the Safeguarding Adults Strategy 2015-2018 is now complete.

The Annual Reports presents the key accomplishments of the Safeguarding Adults Board, both in their strategic and assurance role for safeguarding in Enfield, but also the actions across the partnership which prevent abuse and ensure a robust response when harm does occur. The annual report aims to set out a summary of Board activities and its effectiveness in assessing and challenging safeguarding practice which keeps adults at risk safe.

## **2. RECOMMENDATIONS**

To note the progress being made in protecting vulnerable adults in the Borough as set out in the annual report of the Safeguarding Adults Board.

### 3. BACKGROUND

The Safeguarding Adults Board meets quarterly and has the key roles of:

- assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
- assuring itself that safeguarding practice is person-centred and outcome-focused
- working collaboratively to prevent abuse and neglect where possible
- ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

Our annual report sets out how we have met these aims and the significant accomplishments over 2014-2015. Enfield achieved Gold Standard in **Making Safeguarding Personal**, which means we have worked hard to ensure adults who have experienced abuse are in control of decisions and services which affect them. Further, we are one of the first London Boroughs to have set up an adult **Multi Agency Safeguarding Hub**(MASH). The MASH is a range of professionals who receive alerts or concerns and through sharing information appropriately and including this wishes of the person being harmed, can make judgements on the most appropriate route to process the referral.

Over the last year we saw **996 reports of abuse** made to the Local Authority. Of these 34% related to multiple abuse and 28% related to neglect. Further the majority occurred in people's own homes followed by being alleged to have occurred in residential or nursing homes. At the time of this report 73% of these progressed to an enquiry, while 5% required further information gathering. Our full data can be found in Appendix B of the annual report.

The Safeguarding Adults Board has a strong assurance role and in holding partners to account. Over the last year this has been achieved through actions including ensuring leadership in safeguarding adults; providing partnership oversight and scrutiny of data; receiving assurances that adults at risk and carers are partners in the development of partnership services; and through external audits of practice presented to the Board.

A key part of our quality assurance is through hearing from those who have been harmed and whether their outcomes were achieved. We found overall positive feedback, particularly around ensuring people felt listened to and being invited to meetings about them. There is always more that we can do, and we have set out recommendations and actions from this learning and other external audits which hold us to account.

The work of **our Quality Checkers** continues to grow and was acknowledged through an LGC Award joint with Children's for excellence in engagement in March 2015. Quality Checkers also contribute to the Dignity in Care Panel, which checks that adult social care are meeting the key Dignity in Care Standards.

Looking forward we have set ourselves some clear tasks to accomplish, which have been set out by requirements in the Care Act 2014, identified via themes and trends in our data, and through consultation feedback from service users, carers and local people:

- Develop strategies for management of self neglect, hoarding and honour based violence and domestic abuse which enables adults to have choice and control

- Continue to have receive assurances from all partners that co-production and participation with those who use services and their carers informs the development and delivery of safeguarding activity
- We will look at partnership data as a means to identify themes and trends and direct our activities to prevent abuse or address issues of significance
- Strengthen the partnership between Board and Voluntary Sector

Every partner on the Board has a strong commitment to safeguarding adults and activities take place within each organisation to contribute towards enabling people to keep themselves safe and respond when harm does occur. Our statement from partners, which includes their planned actions over the coming year, can be found in Section 8 of the annual report.

#### **4. ALTERNATIVE OPTIONS CONSIDERED**

The Care Act places a duty on Safeguarding Adults Boards to publish an annual report. Further guidance goes on to state that the SAB must publish a report on:

- what it has done during that year to achieve its objective,
- what it has done during that year to implement its strategy,
- what each member has done during that year to implement the strategy,
- the findings of the reviews arranged by it under section 44 (safeguarding adults reviews) which have concluded in that year (whether or not they began in that year),
- the reviews arranged by it under that section which are ongoing at the end of that year (whether or not they began in that year),
- what it has done during that year to implement the findings of reviews arranged by it under that section, and
- where it decides during that year not to implement a finding of a review arranged by it under that section, the reasons for its decision.

The statutory requirement for an annual report negates any alternative options.

#### **5. REASONS FOR RECOMMENDATIONS**

The report is being presented to the Health & Wellbeing Board to bring to attention the progress which has been made to support and enable adults at risk to be safe from harm, abuse and neglect.

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

##### **6.1 Financial Implications**

During 2014-2015 the Safeguarding Adults Board was not statutory, therefore there was no partner contribution or budget; primary support to the Board was provided via the LBE Strategic Safeguarding Adults Service.

With Boards becoming statutory from April 1, 2015, the Care Act states that members of the SAB are expected to consider what assistance they can provide in supporting the Board in its work. This might be through payment to the local authority or to a joint fund established by the local authority to provide, for example, secretariat functions for the Board. Partners have considered a pooled budget to ensure it is able to meet its statutory functions going forward for the coming financial year.

## **6.2 Legal Implications**

Section 42 of the Care Act 2014 imposes a duty on each local authority to establish a Safeguarding Adults Board (SAB) for its area. Schedule 2 of the Care Act 2014 sets out various requirements for SABs, including at paragraph 4 the duty to publish an annual report. Paragraph 4 prescribes the subjects which must be covered in an annual report and the people and bodies to whom the SAB must send copies.

The parts of the Care Act 2014 concerning SABs have been in force since 1 April 2015.

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

## **7. KEY RISKS**

Mitigation of risks in relation to vulnerable adults is demonstrated in the Board's annual report. The Board is required to work effectively within partner resources while ensuring it can meet the changing needs and trends emerging in relation to the harm and abuse of adults in its area. The Board is continually looking at options to enhance efficiency and joint working that minimises duplication while provide quality and safe service sot adults at risk. Needing to deliver I times of austerity, the Board will work in partnership with its statutory partners, namely the Police and Clinical Commissioning Group, alongside existing partnership Boards, to maximise its impact.

Restructures across organisations have to be carefully managed, particularly taking into account the changes required to be delivered by the Care Act. The Board has quality assurance mechanisms to consider the contribution from partners to keep people safe and are able to manage risks within this.

Delivering on the strategy action plan is a key priority for the Board and risk has been mitigated through identifying a project manager in the Strategic Safeguarding Adults Service. The Board's action plan will be reviewed at each quarterly meeting, which will highlight progress against each action.

Co-production and challenge on safeguarding adults is crucial and a clear requirement in the Care Act. This risk has been mitigated by the Service User, Carer and Patient sub group of the Safeguarding Adults Board.

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

### **8.1 Ensuring the best start in life**

There is representation on the Safeguarding Adults Board from safeguarding children, with a joint sub-group to enable issues which cross over to be addressed. This group ensures that wellbeing and safety from abuse is considered across all ages, such as joint working between adults and children's services when parents or carers have mental ill health and/or drug and alcohol problems.

### **8.2 Enabling people to be safe, independent and well and delivering high quality health and care services**

Our work over the last year has been based on an approach that concentrates on improving the life for the adults concerned; being safe is only one of the things people

want for themselves and there is a wider emphasis on wellbeing. Our work includes prevention of abuse and working with services and organisations to assure that they provide safe care that has quality at its centre.

### **8.3 Creating stronger, healthier communities**

Safeguarding practice includes working with people to resolve their circumstances, recover from abuse or neglect and realise the outcomes they want. In addition, we are setting ourselves the target of working with those who have harmed in an effort to prevent further abuse and contribute to safer communities.

### **8.4 Reducing health inequalities – narrowing the gap in life expectancy**

The Board does not directly reduce health inequalities. It is intended that the actions directly taken to support adults at risk of harm and abuse through the safeguarding adults' process will have an emphasis on an individual's well-being, which can include improved health outcomes.

### **8.5 Promoting healthy lifestyles**

Going forward the Board has set out actions towards reducing social isolation within high risk groups which may be at risk of abuse.

## **9. EQUALITIES IMPACT IMPLICATIONS**

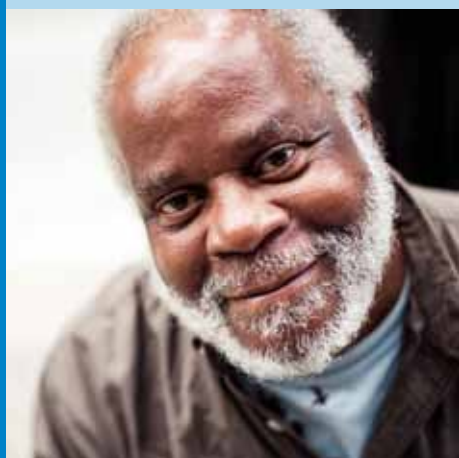
The data from reports of abuse made to the Local Authority is considered at each Board meeting and includes information on those who are alleged to have been harmed and against the person alleged to have caused harm. The data is considered to ensure we are targeting work appropriately to support those most at risk or under represented.

### **Background Papers**

None identified.

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# ENFIELD SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014/15





WORKING IN PARTNERSHIP WITH LOCAL PEOPLE AND



## STATEMENT FROM CHAIR

Thank you for your interest in safeguarding adults in Enfield. As independent chair of the Adult Safeguarding Board I am pleased to be introducing this Annual Report. This has again been a challenging year for the partnership with all partner organisations experiencing significant challenges in this period of austerity. Nonetheless we have done everything we can to ensure we keep adults at risk as safe as possible.

One of our main areas of focus this year has been to make sure that we hear the voice of people who have been identified as “at risk”. We wanted to make sure that they were included in the investigation and their views were listened to. Most importantly we wanted to make sure felt safer at the end of the safeguarding investigation. We have heard positive messages from the great majority of people we surveyed. Nationally Enfield has been identified as an area where we have made significant progress in involving victims in the safeguarding process but we recognise there is more that we can do and will continue to develop this area in the next year.

The Council Quality Checker programme has ensured that the quality of care services is checked by independent people, many of whom are users of social care services or their carers. From this programme we have developed a Dignity in Care Panel which has looked in depth at the quality of service provide by the Council. One of our panel members reminded us all “it is the small changes that can really make a difference” and we have ensured this prompts continuous improvement in the services visited.

We have continued to raise public awareness about what adult safeguarding is and how people can report concerns they may have about an adult at risk. All partners have contributed to this work and ensured that information about adult safeguarding is included in their public events.

The number of referrals for investigation as adult safeguarding enquiries continues to increase year on year. Financial abuse is a significant issue in Enfield and we will work with financial institutions and the police to minimise this. We have heard nationally in recent years of cases where adults have suffered harm in care homes and hospitals. Enfield is in a unique position with a large number of both residential and nursing care homes and because of this we are working closely with Healthwatch and our safeguarding information panel to identify places where poor care may be happening.

The partnership has continued to strengthen this year and the Clinical Commissioning Group has increased their efforts to ensure good quality services are available in Enfield, particularly by providing advice on good medical and nursing practice. I am very grateful for the support of all partner organisations for our work. I would particularly like to thank Ray James Director of Health, Housing and Adult Social Care at Enfield Council for his huge support and enthusiasm and the Councillors in Enfield, particularly Councillor McGowan for their interest and encouragement. Lastly I would like to thank the people of Enfield for their vigilance.



## EXECUTIVE SUMMARY

The Safeguarding Adults Board are presenting their Annual Report for 2014-2015, which highlights the accomplishments of a partnership working in co-production with local people, service users and carers to prevent and respond robustly to the abuse of adults at risk.

The Care Act 2014 has placed Safeguarding Adults Boards on a statutory footing. This will present an opportunity to work in a strengthened partnership and a starting point with clear aims and priorities. The Safeguarding Adults Board have consulted on the next three year strategy and through feedback from service users, carers and local people, the Safeguarding Adults Strategy 2015-2018 is now complete.

Over 2014-2015 there have been a number of significant accomplishments. Enfield achieved Gold Standard in **Making Safeguarding Personal**, which means we have worked hard to ensure adults who have experienced abuse are in control of decisions and services which affect them. Further, we are one of the first London Boroughs to have set up an adult **Multi Agency Safeguarding Hub (MASH)**. The MASH is a range of professionals who receive alerts or concerns and through sharing information appropriately and including this wishes of the person being harmed, can make judgements on the most appropriate route to process the referral.

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A key part of our quality assurance is through hearing from those who have been harmed and whether their outcomes were achieved. We found overall positive feedback, particularly around ensuring people felt listened to and being invited to meetings about them. There is always more that we can do, and we have set out recommendations and actions from this learning and other external audits which hold us to account.

The work of our **Quality Checkers** continues to grow and was acknowledge through an LGC Award joint with Children's for excellence in engagement in March 2015. Quality Checkers also contribute to the Dignity in Care Panel, which checks that adult social care are meeting the key Dignity in Care Standards.

Looking forward we have set ourselves some clear tasks to accomplish, which have been set out by requirements in the Care Act 2014, identified via themes and trends in our data, and through consultation feedback from service users, carers and local people:

- Develop strategies for management of self neglect, hoarding and honour based violence and domestic abuse which enables adults to have choice and control
- Continue to have receive assurances from all partners that co-production and participation with those who use services and their carers informs the development and delivery of safeguarding activity
- We will look at partnership data as a means to identify themes and trends and direct our activities to prevent abuse or address issues of significance
- Strengthen the partnership between Board and Voluntary Sector

Every partner on the Board has a strong commitment to safeguarding adults and activities take place within each organisation to contribute towards enabling people to keep themselves safe and respond when harm does occur. Our statement from partners, which includes their planned actions over the coming year, can be found in Section 8 of this report.

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## SECTION 1 INTRODUCTION AND AIMS

This is the annual report for the Enfield Safeguarding Adults Board, setting out how we work together to prevent and respond to the abuse of adults at risk. The Board is a multi-agency partnership which includes input from those who use services and local residents. The role of the Board is to assure themselves the way which local arrangements and partners act to help and protect adults from abuse is robust.

This annual report reflects the final year of implementing the Safeguarding Adults Strategy 2012-2015. Our aim has been to work with local people and our 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.

We have worked hard to make safeguarding adults everybody's business, which means all of the communities which make up the borough of Enfield. We aimed to ensure that people could understand and recognise abuse when it happens, knowing how to stop it and prevent it happening in the first place. We wanted people to know how to report abuse and receive a quality service when they seek support where they are listened to, taken seriously and believed. In addition, we wanted people to receive services that are safe and do not cause harm.

*We wanted people to know how to report abuse and receive a quality service*

The Board will set out in this report how it has met these aims over the last year and most importantly how it will work going forward. The **Care Act 2014** and Care and Support Statutory Guidance has had a tremendous impact on safeguarding adults and preparation for when it comes into effect on April 1, 2015.

The Act is placing Safeguarding Adults Boards on a **statutory footing**, with the three core duties of publishing a strategic plan, producing an annual report and conducting Safeguarding Adults Reviews.

Our strategic plan for 2015-2018, built through consultation with a range of stakeholders, those who use services and with Healthwatch, sets out our ambitions for the coming years to make Enfield a safe place to live and work. Safeguarding services are aimed at supporting people as human beings to lead whole lives; being safe may be only a part of this.

## SECTION 2

### KEY DEVELOPMENTS, OBJECTIVES AND PROGRESS

The Safeguarding Adults Board has a strong role in assuring and holding to account across the partnership how we work together to provide a safe and quality service around safeguarding adults. As a Board we have done this by:

- Ensuring leaders and senior officers show a commitment to safeguarding adults
- Provide a partnership oversight and scrutiny of data which directs focus on areas of risk
- Regularly review and work to progress the sub-groups of the Board which deliver and facilitate interventions
- Receive assurances that adults at risk, carers and local people are integral partners in the development of partnership services
- Been assured by external audits of practice which are delivered to the Board
- Have worked to widen the scope of safeguarding and our strategic view, which for example included presentation and discussion around safeguarding adults

The work of the Safeguarding Adults Board is shaped by our strategy and its action plan, which is developed through our conversations with service users, local people and many partners. Our action plan required us to ensure a range of information, advice and guidance on keeping safe is promoted by partners and easy to use. The Board believes strongly in raising awareness of abuse, so that not only adults at risk can report concerns about their safety, but their families, carers, those who work with them and the wider public. Across our partnership a range of awareness raising activities were undertaken, including the Enfield Town Show, presentations with the Fire Brigade and information to Probation Services. Awareness raising is also important within partner organisations for staff and Barnet Enfield and

Haringey Mental Health Trust have been delivering training in issues around domestic violence, adult and children's safeguarding and the Mental Capacity Act and Care Act 2014. Council Housing partners have run articles in our tenant and leaseholder magazine promoting safeguarding issues. We believe we can do more around this area so have set ourselves plans for the coming year to target community awareness campaigns, including links with children's services around Female Genital Mutilation, a joint Keep Safe Week in September 2015 and looking at the use of radio to target specific communities.

Safeguarding is about the person rather than the process; enquiries should seek to enable people to resolve their circumstances, recover from abuse or neglect and realise the outcomes they want. One of the biggest shifts during the year was in embedding Making Safeguarding Personal, which seeks to transform how adults who have experienced abuse are in control of decisions and services which affect them. Safeguarding adults is not linear but steps, considerations and decisions which are led by individuals and/or their representatives. The overarching intention of MSP is to facilitate person-centred, outcome-focused responses to adult safeguarding situations. MSP records 3 levels of engagement from Bronze, Silver and Gold. Enfield aimed for Gold which required an independent evaluation of work by a university.

In January 2015 we had Bournemouth University complete an independent evaluation of Making Safeguarding Personal and they found that:

- London Borough of Enfield clearly demonstrated six principles of safeguarding set out by the Department of Health are being met through MSP practice
- London Borough of Enfield demonstrated a clear commitment to empowering service users through personalised information and advice, with service users involved in the safeguarding process
- Creative methods used to engage and support service user voice

*The work of the Safeguarding Adults Board is shaped by our strategy and its action plan*

- Key strength is the commitment to work collaboratively with external agencies
- Evidence of learning culture
- Development of Information Technology systems and to capture outcomes

Areas for future consideration and development include:

- Exploring how information is presented to make the best impact
- Building on successful projects such as the Quality Checkers and committing to on-going recruitment and training of this resource
- Delivering an on-going commitment to share good practice within a learning culture promoted throughout the organisation and with partners
- Exploring new resources such as apps which can be used by practitioners to support their professional decision making and judgement in relation to risk and choice for service users

Enfield is operating at the Gold for Making Safeguarding Personal in March 2015. All partners on the Board are expected for the coming year to have an action plan around how Making Safeguarding Personal will be implemented. Many organisations already do, such as the Barnet Enfield Haringey Mental Health Trust, with monthly surgeries within the Trust attended by Clinicians.

A culture change in practice around how we involve adults who are harmed is challenging but not impossible. Enfield has created a shift to more personalised safeguarding which has been evidenced through face to face interviews with people who have been harmed or their advocates. These interviews identified that being part of these partnership meetings and feeling informed helps to make adults central to the safeguarding enquiry.

Building blocks of successful safeguarding include advocacy, personalised supporting, decision making by the adult at risk and access to services which prevent isolation and meet individual needs. Enfield Adult Social Care Commissioners completed a marketplace review of advocacy services, which means that we are clear which individual and organisations can provide advocacy and where their skills are. The Care Act 2014 has set very clear requirements for advocacy going forward and this will form part of our action plan for the coming year. We

found from our adult social care that data that 567 out of 731 adults at risk had a nominated advocate in place to support them through the safeguarding process.

Enfield is working hard to set up a Multi-Agency Safeguarding Hub (MASH) from April 2015. A MASH has a range of professionals who receive concerns and alerts related to adults at risk and seek a range of information to understand the circumstances surrounding this alert, including the wishes of the person being harmed. The information gathered will be used by MASH staff to make judgements about the most appropriate route to process the referral; this may include passing to social work team to meet with the adult at risk, redirected to another agency or to the Police if a crime has been committed. MASH will comprise of partners from a number of agencies, some are co-located and full time and others will attend on a part time or virtual basis. The three key agencies are Police, Health and Adult Social Care.

## SECTION 3

### OTHER ACHIEVEMENTS, CHALLENGES AND OPPORTUNITIES

As we come to the close of the our three year strategy we have time to reflect on a number of achievements across the partnership that has improved the safeguarding care and support to adults at risk. We have an action plan which we review regularly and help us to monitor progress.

The partnership has helped to prevent and respond to abuse by also:

- Holding a Pressure Ulcer Forum at BEH MHT
- Developed tools to help ensure family and friend engagement when concerns occur within provider services. We use feedback to quality assure if the provider is indeed improving.
- Looking for trends or patterns emerging of safeguarding and quality care issues through our Safeguarding Information Panel – we want to support providers from failing by preventing poor quality care escalating
- Continuing to support the Enfield Adult Abuse Line, so that there is a single point of contact for any person to use to report concerns, which is open 24 hours a day, 7 days per week.
- A seminar by the London Fire Brigade which focused on vulnerable adults and was open to a range of partners, including housing officers.
- Council Housing partner having refreshed safeguarding adults policy and appointing four safeguarding champions to support staff

Carers are people who provide unpaid care to family or friends due to a range of issues, for example such as a learning disability or mental health. The Board recognises the contribution that carers make to supporting others in what can often be a challenging role. Carers may be at risk of harm from the person they care for or they may be at risk of harming.

Actions which took place to support carers include:

- Ensured carers had information on how to keep themselves safe from abuse and who to contact if they were at risk of harming the person they cared for. This was done through our Carers Leaflet on safeguarding which was designed with service users, carers and local people.
- Our Carers Centre has posters on the Adult Abuse Line (tel: 020 8379 4432).

In spite of all the work undertaken by partners of the Board and many others, safeguarding those most vulnerable to abuse continues to be a challenge. We know from data that the number of alerts made continues to rise; there were 996 alerts in 2014-2015 compared with 957 in 2013-2014. While this is positive in that more adults at risk are getting access to support and care to help stop the abuse from happening, it also highlights the prevalence of abuse and that many more people need support.

We found from our data that the most prevalent type of abuse reported was multiple abuse in 34% of cases (this is where there are two types of abuse being experienced by the adult, such as verbal and physical). This was followed by neglect in 28% of cases. When we look at national data from the last financial year we found this is similar in neglect being reported the most. Neglect can occur anywhere, but many in the home or within care homes. Isolation can contribute towards neglect going unnoticed and for this reason the Board is looking at how we can gain assurance from partnership that there is support for people living in isolation.

In the news we often hear nationally of cases where adults have been harmed in care homes. Enfield is in a unique position with the large number of both residential and nursing care homes and because of this we remain vigilant. Our data showed that 26% of cases were of abuse that was alleged to have happened in residential or nursing homes. In light of this we will review how we manage concerns relating to safeguarding and provider failure within those organisations which provide care. Through organisational learning over the last year we discovered that how we respond to concerns without our Hospital Trusts and in partnership with Clinical Commissioning Groups has to be clarified and partnership work strengthened. We also need to work at preventing care homes from coming repeatedly under our provider concerns process.

We also found that most abuse happens in people's own homes, which can often make it hidden. For this reason it is important that we continue to raise awareness across all people who live and work in Enfield to identify and recognise what abuse is and how to report. Our data also showed that a family member was the person alleged to have caused harm in 136 cases. We will for this reason look at how we can work with those who are at risk of harming to understand the cause and whether we can prevent repeat incidences of abuse.

Our data also showed that:

- There were 996 reports of abuse this year compared to 957 the previous year
- 40% were alleged to have occurred in the person's own home
- Multiple abuse and neglect were the most reported, but there were also high numbers of financial abuse (118 cases) and physical abuse (134 cases)
- We did not have any reports of discriminatory abuse, so now we need to work on raising awareness of hate crime against vulnerable groups and ensuring these are reported
- Hospital staff raised the most alerts (23%) followed by independent and private providers (in 19% cases). This was similar to previous years.

We found that 73% of alerts raised proceeded under safeguarding adults, while 5% 'requires further information gathering' at the time of this report. Of these 731 cases which progressed, 567 had a nominated advocate involved (77.5% of cases).

We can report further on those cases which have come to a conclusion. We have a conclusion on 226 cases:

- 45% of these were substantiated or partially substantiated, 19.5% were inconclusive and 29% were not substantiated. In the remaining cases no further action was taken.
- Less than half the cases were closed within 7 weeks, so we have identified timeliness as an area that we have to focus attention upon.
- Outcomes for adult at risk were no further action in 33% of cases, followed by increased monitoring in 16% of cases and move to increase or different care in 10% of cases.

- For the person alleged to have caused harm there was 24% cases of increased monitoring and 26% cases of no further action recorded.

We are changing how we report data in future so that when we speak about 'outcomes' this represents what adults at risk have identified they would like to happen. When we talk about whether we were able to substantiate or not if abuse occurs, this will relate to judgements in the future. We believe it is important that we are more accurately identifying the outcomes for people so will be looking more closely at how we record our data.

The Safeguarding Adults Board also looks at the Deprivation of Liberty Safeguards (DoLS). The DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. Where someone needs to be detained in a care home or hospital to keep them safe a DoLS can be authorised which outlines the safeguards for that particular individual. There are six assessments which have to take place before a standard authorisation can be given. The Association of Directors of Adult Services (ADASS) and the Department of Health have now created new application forms to simplify the application process to Local Authorities. If a standard authorisation is granted, one of the most important safeguards is that the person has someone appointed with legal powers to represent them, to ensure that their placement or treatment stay remains in their best interests. This is called the relevant person's representative and will usually be a family member or friend. If a person is unbefriended or has no family, they will have a paid representative appointed for them and they can access the services of an Independent Mental Capacity Advocate (IMCA) if they need this level of representation. Other safeguards include rights to challenge DoLS Authorisations in the Court of Protection. There is also a streamlined process for having such safeguards put in place for people in Supported Accommodation or other settings than a care home or hospital. These judicial DoLS Safeguards have to be authorised by the Court of Protection who have now streamlined the application process for these cases.

*There were 996 reports of abuse this year compared to 957 the previous year*

In the last year there have been 585 requests for a Deprivation of Liberty Safeguard and 66 the year prior, which is a 786% increase.

These DoLS requests can be broken down further:

- 439 were authorised
- 88 were not authorised (declined)
- 10 were found to not be appropriate to be referred for a DoLS
- 48 of the cases are still in progress

The Care Act and its implementation will be the biggest challenge over the coming year. But, with this challenge comes many opportunities. Placing Safeguarding Adults Boards on a statutory footing will help to form stronger and clearer partnerships committed to safeguarding adults; the Board already has strong links with safeguarding children, our community safety partners and working with colleagues in Trading Standards. The requirement to have Safeguarding Adults Reviews when there is a death or serious abuse occurs will aid in preventing similar occurrences where we can share learning and improve our practice.

## SECTION 4

# QUALITY ASSURANCE AND ORGANISATIONAL LEARNING

Ascertaining service user views and experiences of the Safeguarding process is vital so that we can hear what we do well and where we can make improvements. This year we contacted 20 service users and carers who had recently been through the Safeguarding Adults process in order to find out what the outcomes for them were and where we could make improvements to ensure their wishes are met. We did this through face-to-face interviews and found that:

- Most of those interviewed felt that they would now recognise abuse or neglect if it happened again and they would know who to contact.
- The majority of those interviewed felt listened to and able to state what outcomes they wanted.
- Service users/representatives that had the opportunity to attend the relevant meetings felt very positively about the whole Safeguarding experience and felt that their wishes were central to the process and they were listened to.
- The majority (18 out of 20) of service users/representatives were very positive in terms of their ability to direct the process and give their views. Again, involvement in meetings is a key element in terms of adults at risk feeling involved and valued.
- Those who felt that protective measures were appropriate and had been followed through also felt that they were safer following the process.

Overall, it is clear that those who felt safer and involved in the Safeguarding Adults process were those who were invited to meetings (even if they were unable to attend) and received clear and concise communication. Planned work and recommendations include:

- Increase number of adults at risk or representatives invited to meetings

- Adding prompts into templates for staff to aid communication
- More resources for adults at risk to explain the safeguarding adults process
- Ensure adults at risk or their representative can give feedback more regularly.

In Adult Social Care cases are also audited, both within teams and by the Strategic Safeguarding Adults Service. These audits have highlighted that there is an improvement in practice that keeps that adult at risk central to the process and involved in decision making. There is demonstrated improvements in areas such as partnership working, which acknowledges that combining skills and expertise to achieve outcomes for individuals is the best way forward.

External audits are also very important to provide challenge to our work. In April 2014 we had an external audit report of cases, which was followed up by a focused audit of mental health case in July 2014. This audit identified a number of areas for improvement, such as a lack of evidence of partnership work, need to keep adults at risk more central and more work on the prevention agenda of safeguarding. The Mental Health Trust responded swiftly to these concerns by:

- Arranging a 'safeguarding surgery' with experts from different areas. The surgery has ensured better partnership working, bringing new legislation to staff awareness, promoting quality care in terms of safeguarding people, supporting staff in their practice and promoting a patient centred approach.
- Safeguarding champions, who can also address issues with performance
- Internal audit on monthly basis by managers
- Bespoke training on mental capacity and the deprivation of liberty safeguards. Subsequently awareness on the Independent Mental Capacity Advocates and Advocacy services has improved.

Enfield have a Dignity in Care Panel which checks that adult social care are meeting the key Dignity in Care standards, share examples of good practice and identify improvement where necessary. The Dignity in Care Panel are continuing to complete their pilot to review all services provided by the Independence and Wellbeing Services Teams focusing on dignity and respect.

The findings of the reviews are shared at a management level, along with recommendations for improvement and a timely revisit measures progress and the meeting of outcomes. A successful 'Launch' event of the panel took place on the 27th of February 2015, where Cllr Don McGowan and Ray James presented at the event along with the volunteer panel members. This event celebrated the significant achievements of the panel and the work plan for the future. An application for the Dignity in Care Panel has been made to present at the National Children and Adults conference in Bournemouth this year.

### WHAT ARE THE DIGNITY IN CARE STANDARDS?

1. Have a zero tolerance of all forms of abuse
2. Support people with the same respect you would want for yourself or a member of your family
3. Treat each person as an individual by offering a personalised service
4. Enable people to maintain the maximum possible level of independence, choice and control
5. Listen and support people to express their needs and wants
6. Respect people's right to privacy
7. Ensure people feel able to complain without fear of retribution
8. Engage with family members and carers as care partners
9. Assist people to maintain confidence and a positive self-esteem
10. Act to alleviate people's loneliness and isolation

The Quality Checker Program in Enfield won at the LGC Awards for excellence in engagement in March 2015. The Quality Checker Project has continued to visit social care providers to collect meaningful feedback from social care customers. The feedback collected is shared and heard at a strategic level to drive service improvement and highlight areas of concern for appropriate consideration and interventions if necessary. The Quality Checker Project attended and contributed at a focus group facilitated by the Bournemouth University auditing Enfield's response to the Making Safeguarding Personal agenda. The Quality Checker Project are planning a recruitment drive for more volunteers to ensure that the Quality Checkers are representative of the community that they serve.

*The Quality Checker Program in Enfield won at the LGC Awards for excellence in engagement*

## SECTION 5

# DIFFERENCE THAT SAFEGUARDING ADULTS MADE TO ADULTS WHO HAVE BEEN HARMED

We use this section to report on cases where adults at risk have identified a positive outcome by means of the safeguarding process. We can't always report details because it is important for people to retain their privacy, but the Integrated Learning Disabilities Service has demonstrated how adults at risk can and should have access to the justice system. They have:

- Supported people who have experienced sexual assault and rape through the criminal justice system and secured convictions.
- When abuse has occurred within families, supported people to maintain contact with other members of the family, when these relationships have been important to them. This has include working with the court of protection to obtain orders allowing supervised contact, and supporting people to hire staff who share a first language (when not English) to make sure the person remains safe.
- Obtained a number of 'Forced Marriage Orders', that both protect people from abuse and enable them to be fully engaged in cultural and family activities, including travel overseas.

In the Older People's Service we also have examples of practice which enables individuals experiencing harm to maintain control over decisions and services which affect them. Mrs Q was an older woman who lived in her marital home and had support from a number of adult children. She had experienced a history of psychological and emotional abuse on the part of her younger son and the previous year a non-molestation order was served on him following incidents of domestic abuse which had since lapsed thus allowing him to return to the family home. The Care Agency had to pull out of providing a service as it was deemed 'unsafe' for the care worker due to the son's behavior and alcohol intoxication. The social worker met with Mrs Q and had to ensure this was

done in an environment where Mrs Q was not under undue influence and able to speak freely. Through this the Care Management Team along with support from the Community Safety Unit were able to support Mrs Q to meet her identified outcomes. Consequently her daughter agreed to cover some of her mother's care and support needs supported by care workers from the crisis intervention team. Additionally a number of measures were taken to secure the property should the son attempt to return and a community alarm installed enabling Mrs Q to alert the Community Safety Unit in the event of any concerns.

Mrs Q supported by her family was referred to an organization supporting women suffering domestic abuse in pursuit of legal advice and support. This was also important because despite the risks Mrs Q wanted to maintain some contact with her son. The care agency was able to begin providing a service to Mrs Q and she was supported to attend a local day support service enabling her to meet people in her local community.

## SECTION 6

# SAFEGUARDING ADULT REVIEW

A Safeguarding Adults Review (SAR) is defined in the Care Act 2014 and is what was previously known as a Serious Case Review. The Safeguarding Adults Board has to carry out a SAR when an individual in their area dies or experiences serious injury as a result of abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

SARs are agreed by the Safeguarding Adults Board and an independent person is set up in Enfield to lead the enquiry. There is a separate protocol which sets out on behalf of the Board what a SAR is, how the process runs and the outcome.

Two Safeguarding Adults Reviews were set up on behalf of the Board in 2014-2015. These reviews have not been concluded but are expected to do so in the coming year. Any learning will be shared and each SAR will have an action plan which is reported to the Safeguarding Adults Board.

## SECTION 7 SAFEGUARDING ADULTS BOARD SUB-GROUPS

During 2014-2015 there were four established groups which supported the work of the Safeguarding Adults Board, with a new additional group dedicated to work between Safeguarding Adults and Safeguarding Children commencing.

### LEARNING AND DEVELOPMENT GROUP

Co-chaired by the Enfield Councils Learning and Development Team and a representative from the Barnet Enfield and Haringey Mental Health Trust, this group focused on how to improve the practice, understanding and the skills of those who work with adults at risk. This included for example setting up courses on Safeguarding and the Care Act, training for front line staff and managers, and completing investigations jointly with the Police.

In 2014-2015 we held the following courses and the number of staff which attended where:

Course Name	Session Date	Places Taken
Care Act – The New Safeguarding Structure	12/01/2015	29
	22/01/2015	21
	22/01/2015	25
Chairing Strategy Meetings	02/10/2014	15
Investigators – Working with the Police	08/09/2014	15
	27/01/2015	16
Safeguarding Alerters for New Starters	23/06/2014	15
	03/09/2014	21
	11/02/2015	22
Safeguarding Alerters Refresher	01/09/2014	17
	01/09/2014	16
	14/01/2015	17
	14/01/2015	19
Safeguarding Structure to SAB	23/02/2015	11

*In the coming year we are expanding upon the training we provide*

An e-learning package is also provided to the partnership which saw 46 staff members access this suite of courses.

In addition to the above, the Strategic Safeguarding Adults Service in London Borough of Enfield provides some specific and focused training when requested. This included for example to partners in the London Fire Brigade, Parent Champions, supporting training with Mental Health for Barnet Enfield Haringey Mental Health Trust, Learning Disabilities Partnership Board on safeguarding.

All of the courses we run have been reviewed to ensure they are compliant with the Care Act, Making Safeguarding Personal and with relevant information on the Multi Agency Safeguarding Hub.

In the coming year we are expanding upon the training we provide by providing additional courses on:

- Safeguarding and Domestic Abuse
- Female Genital Mutilation
- Completing Section 42 enquiries
- Mediation in social care
- Safeguarding from referral to closure
- Expert to enabler
- Positive record keeping

### POLICY PROCEDURE AND PRACTICE GROUP

With the imminent implementation of the Care Act 2014 from April 1, 2015, the Policy Procedure and Practice group have a remit around developing the information which supports those who safeguard adults to effectively carrying out their work. This will include, for example, making sure that staff have guidance on how to involve adults at risk to make decision about their safety and the outcomes they would like so. This will also include developing procedures around self-neglect, which is now recognised formally under safeguarding.

### SERVICE USERS, CARERS AND PATIENTS

The Service User, Carer and Patient group represents those in the community in Enfield who are passionate and committed about keeping people safe. The group

provide a challenge and steer to actions that partners take and also take forward projects that are of interest to them.

Over the last year the group:

- Gave feedback on the Making Safeguarding Personal toolkit to the Local Government Association
- Received training on the Care Act and safeguarding, while raising questions about areas such as advocacy
- Has been discussing issues around equalities and communication, with a particular focus on health services and barriers to access
- Received presentations from Healthwatch and Local Authority on equalities
- Feedback on the Safeguarding Adults Board strategy and action plan.

The group also reviewed their terms of reference and developed an action plan for the coming year. This will include for example reviewing and developing the publicity and communication for safeguarding adults. The group also feel there was a gap in how the care industry responds and supports the Lesbian, Gay, Bisexual and Transgendered community so are looking to address this area.

## QUALITY, SAFETY AND PERFORMANCE

The Quality, Performance and Safety sub group of the Safeguarding Adults Board has been set up to monitor the performance of partners in terms of how they keep adults at risk of abuse safe. In addition, this will include going forward the quality of services which both prevent and respond to abuse within their organisations.

The Group will agree the ToR yearly in order to focus on areas requiring oversight or additional challenge from partnership to embed service improvements. New terms of reference and an action plan has been drafted which will include focusing on:

- Scoping audits across partnership and providing quality assessments and gap analysis
- To assure the Board that partners are appropriately flagging domestic violence where there is an adult at risk, with appropriate outcomes recorded.

- To ensure that Serious Incidents within Hospitals which are appropriate for safeguarding adults are being referred in line with current pan London Policy.
- Establish how it will hold partners to account and gain assurance of the effectiveness of its arrangements.
- Establish ways of analysing and interrogating data on safeguarding notifications that increase the SAB's understanding of prevalence of abuse and neglect locally that builds a picture over time.

## SAFEGUARDING ADULTS AND SAFEGUARDING CHILDREN

Both the Enfield Safeguarding Adults Board and Enfield Safeguarding Children's Board recognises the importance of working together. A group has been set up to help support the completion of actions which will benefit the safety of children, young people and adults at risk.

This group has agreed to focus on the following areas:

- 'What about the Children?' A report by Ofsted on joint working between adults and children's services when parents or carers have mental ill health and/or drug and alcohol problems.
- Awareness raising events across services
- Community Help Point Scheme
- Child sexual exploitation and supporting adults who have experienced sexual exploitation as a child

*Both the Enfield Safeguarding Adults Board and Enfield Safeguarding Children's Board recognises the importance of working together*

## SECTION 8 PARTNER STATEMENTS

- Barnet Enfield and Haringey Mental Health Trust
- Enfield Borough Police
- NHS Enfield Clinical Commissioning Group
- London Community Rehabilitation Company
- London Fire Brigade – Enfield Borough
- North Middlesex Hospital NHS Trust
- One-to-One (Enfield)
- Royal Free London NHS Foundation Trust
- Safer and Stronger Communities Board

## BARNET ENFIELD AND HARINGEY MENTAL HEALTH TRUST

### INTERNAL ARRANGEMENTS FOR GOVERNANCE REGARDING SAFEGUARDING ADULTS

Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) and Enfield Community Services (ECS) understands and acknowledges that safeguarding adults is everybody's business and that everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect adults where abuse is suspected. The safeguarding of all our patients remains a priority for the Trust as we see it as a fundamental component of all care provided. Maintaining the consistency and quality of all aspects of safeguarding practice across the Trust is essential. Over the past year, the safeguarding arrangements across all Trust services has continued to be strengthened, with a particular focus on ensuring our staff receives an appropriate level of safeguarding training.

The Executive Director of Nursing, Quality and Governance is the Executive Lead for Safeguarding Adults in the Trust. The Trust has a Safeguarding Team consisting of the Head of Safeguarding People, the Safeguarding Adults Lead and Safeguarding Children's Lead.

The Trust's Safeguarding Annual Report and work plan continues to be developed on a yearly basis, for consideration and approval at the Governance and Risk Management Committee (GRMC) and is ratified by the Trust Board. The executive lead represents the Trust at the three Safeguarding Adults Boards. The management of safeguarding cases in Haringey is co-ordinated by Haringey Council. In Barnet, the management of safeguarding cases is co-ordinated by the Community Mental Health Team Managers and Team Managers within the integrated teams. This is similar to Enfield for the year 2014/15.

As part of our integrated governance structure, the Board receives an Annual Report and work plan on the Trust's Safeguarding Adults activities. At each

public Board meeting the Trust Board receives an update on the number of alerts, investigations and related activities.

The Trust ensures the Safeguarding Adult Committee meets on a quarterly basis. The Committee 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 authorities and CCGs. This meeting affords for the discussion and follow up on actions from both internal and external issues regarding safeguarding adults. The function of the Trust Safeguarding Adults Committee is to direct and ensure an overview of the safeguarding adult work programme and practice in the Trust. The Committee ensures that national and local practices are adhered to within the organisation and the sharing of learning.

There is a bi monthly practice development group co-ordinated by the Enfield Safeguarding Adults Team of which the Trust is a member. This forum allows for sharing of best practice and learning across all agencies.

The Trust has in place a Safeguarding Surgery. The surgery was developed in 2014 and has been well received and utilised by staff. The forum promote patient-centred approach; Making Safeguarding Personnel (MSP), collaborative working with our partners and bringing new legislation to staff awareness.

The Trust has a safeguarding audit that is completed on a monthly basis by managers. Strengths, areas for improvement and actions plans are agreed and delivered. The Trust's safeguarding committee has oversight of the process and improvements.

### NOTABLE ACHIEVEMENTS IN ADULT SAFEGUARDING 2014/15

- The Safeguarding team has been working closely with the local authority and the various teams in driving the MSP agenda.
- Strong multi-agency partnership working, including internal and external partners.
- Review the DoLS and MCA policies and frameworks in light of Cheshire West ruling

- There are monthly safeguarding surgeries in the trust, attended by clinicians from across the organisation. Presentation includes the Care Act- (MSP), domestic violence/abuse, Child Protection and opportunity to discuss complex issues concern to staff.
- The pressure ulcer forum now meets monthly and is attended by clinicians from across services, the protocol has been agreed and a plan for roll out is being implemented.
- Datix Incident Reporting to link with safeguarding team enabling automatically generated alerts when incidents with a safeguarding element are reported.
- A restraint in care protocol has been developed for our older adults services.
- The Trust took part in the Oaks learning event. Areas for improvement/development have been fully implemented.
- Compliance inspections against the criteria in Outcome 7 (safeguarding) of the CQC's regulatory framework on all inpatient units and Community Teams. The Trust is fully compliant
- The Safeguarding Team have been delivering bespoke training to teams which has led to an increase in awareness that safeguarding is everyone business to ensure that the Trust deliver a safe, friendly and caring environment where people are treated with respect, courtesy and dignity
- We have developed safeguarding champions in different areas to support staff. Issues where processes are not understood or where there are performance issues these are brought to the attention of the champions and staff are supported to address issues/concerns.
- MCA/DoLS lead for the Trust has led on the delivery bespoke training to teams. Subsequently awareness in IMCA and Advocacy services has improved.
- Adult Safeguarding training level 1 is part of the mandatory training programme for all staff of which compliance is monitored through the Electronic Staff Record. Attendance record achieved above 85% throughout the year.
- There has been an increase in referrals for MARAC by the Trust as compared to last year. This is due to domestic violence training through the Safeguarding surgery.

- Safeguarding training have included the following; Female Genital Mutilation, Prevent and whistleblowing. This ensures staff are trained and understand the issues and know how to report concerns.

### **WORK PLAN AND PRIORITIES FOR 2015/16 IN ADDITION TO REGULAR AND CONTINUING ADULT SAFEGUARDING WORK TO SUPPORT BEST PRACTICE AMONGST PRACTITIONERS IN BEHMT**

- Have a continued programme of level 1 Safeguarding Adults training with 85% compliance achieved.
- Review of the Trust Self-Assessment using the Safeguarding Adults Assurance Framework for Healthcare Services.
- BEHMT recognises the importance of people's voices being heard and listened to within the safeguarding adult's procedures, staff to be compliant with the Care Act in relation to Making Safeguarding Personal (MSP) and the use of Advocacy services.
- Ensure learning from safeguarding cases is embedded into practice, via supervision and Trust training programmes.
- Remain responsive and reactive to changes as they occur in policy directives or good practice guidance.
- Continue to raise awareness of the PREVENT agenda and support staff to raise concerns
- Raise awareness and promote the system of reporting Mental Capacity Assessments (MCA) and Deprivation of Liberty (DoLS) applications amongst staff.
- As part of a quality measure, team managers to audit one case file per month on Meridian. Action plans, recommendations and lesson learnt for followed up to improve practice.
- The Trust will be strengthening the links between safeguarding and complaints and/or incident investigations.

## ENFIELD BOROUGH POLICE

Enfield Borough Police is committed to making Enfield a safer place to live, work and visit. This will be achieved by working together, and safeguarding some of the people who are most at risk of abuse, harm and neglect. The Enfield Borough Police is now a statutory partner on the Safeguarding Adults Board, as set out by the Care Act 2014. This presents a real opportunity to work with partners, communities and local people to prevent abuse and ensure a robust and transparent response when abuse of a vulnerable adult occurs.

### ACHIEVEMENTS OVER 2014-2015

There have been some key developments across this year, each of which have been founded upon excellent working relationships and partnerships. The innovative activity around setting up an adult Multi Agency Safeguarding Hub, to ensure greater cooperation and sharing of information, has been an exemplar of practice. The Enfield Borough Police has recruited a new Public Protection Lead, T/DCI Ben Warriss, who is committed to continue to drive forward improvements.

- Continued use of the Merlin System to properly record and identify vulnerable adults encountered by Police and share concerns with our strategic partners
- Officers have had ongoing training and the use of Vulnerable Adult Toolkit provide to officers which assured that officers are able to identify adults at risk
- Senior Police attend and actively participate in Safeguarding Adults Board and are an acting co-chair for the Quality, Safety and Performance sub-group of the Board
- Actively participated in the identification, then implementation of actions as a consequence of the Care Act 2014
- The Police is proud to have collaborated with the Local Authority and partners to be one of the first London boroughs to set up and deliver the adults Multi Agency Safeguarding Hub (MASH)

### ACTIVITIES PLANNED 2015-2016

The work of 2014-2015 has put our partnership in an excellent position to drive forward the safeguarding agenda over the next 12 months.

- We will strive to provide an outstanding service to adults at risk who have experienced abuse and come to the attention of the Police, to ensure a level of satisfaction with the support that is provided; this sits within the MPS Total Victim Care Strategy
- We will strive to engage with all the communities in the Enfield Borough with the ambition to improve confidence in the services provided
- We will continue to develop and contribute to the adults Multi Agency Safeguarding Hub, with the aim of capturing as many safeguarding adult concerns and referring to appropriate service.
- Ensure processes are in place that identify Vulnerable adults victims of crime at an early stage and that these cases are appropriately resourced by specialist officers to improve victim care and case outcomes.

### PROPOSED ACTIVITY RELATING TO TRAINING

- Police will participate at DI and DCI level in Local Authority commissioned training. This will include undertaking Section 42 enquiries.
- We will refresh training, particularly for new officers to the Borough on vulnerable adult crime and circumstances where a Merlin report can be completed.

### PROPOSED ACTIVITIES IN RELATION TO PROCESSES

- Daily review at management level of all crimes involving vulnerable adults
- All adults who come to notice (ACN Merlin) to be reviewed daily by police officers who form part of the adult Multi Agency Safeguarding Hub. Any of which that amount to a crime are to be fed back to the unit Detective Inspector.

### PROPOSED ACTIVITIES IN RELATION TO QUALITY ASSURANCE

- Detective Chief Inspector to co-chair the Quality Safety and Performance sub-group of the Safeguarding Adults Board

- Monthly oversight by unit Detective Inspector of all open and ongoing vulnerable adult crime investigations.

## **ORGANISATIONAL LEARNING AND ENGAGEMENT**

With Safeguarding Adults Boards on a statutory footing there is now a requirement to complete Safeguarding Adult Reviews where there has been a death or serious injury and (insert wording). The Enfield Borough Police will contribute and ensure that any learning in the coming year from SARs are fully embedded in the organisation.

### **STATEMENT WRITTEN BY:**

**T/DCI Ben Warriss**

Enfield Police, Public Protection

*Enfield Safeguarding Adults Board representative*

## NHS ENFIELD CLINICAL COMMISSIONING GROUP

Enfield CCG unequivocally has clear safeguarding expectations of organisations that provide both NHS services and private health care, ensuring that safeguarding is embedded into their core business. Specific safeguarding standards are included in the NHS contracts. With the current statutory requirements set out in the Care Act (2014); Enfield CCG will ensure NHS health care delivery complies with the criteria laid down in the Clinical Quality Review Group (CQRG). This group provides the accountability for providing proactive assurance, challenge and robust governance processes, for adults at risk in the population of Enfield. The CQRG meetings ensure that health services are working together with partners to protect people from abuse. With private providers of health care they are invited to the CCG strategic safeguarding committee to discuss and give assurance of how they discharge their safeguarding responsibilities. In Enfield nursing homes the safeguarding nursing team provides quality assurance and challenge in relations to the quality of nursing care offered.

Quality is at the heart of the work with the CCG, this can be seen in the Corporate Objective agreed for 2013/14: Delivery of Quality and Safety of the services.

Commissioning for quality is everyone's business and will be delivered through integrated, collaborative working which is fundamental to the principles of the CCG and central to the CCG's Quality Strategy which underpins the work of safeguarding adults at risk.

Through a partnership approach, the CCG will:

- Continue to work with people in aiming to improve their health and well-being by focusing on preventative services, reducing health inequalities, and enabling the population to take responsibility for their own health.
- Work with people to ensure the provision of safe, high quality, efficient and effective health services within available resources.

- Facilitate integration between health and social care services.
- Ensure good quality, safe healthcare in all settings.
- Have an Enfield Quality strategy that is clinically led; draw on research evidence and uses innovative, radical solutions to deliver the best possible care to patients and their carers.
- Focus on education and development support for clinicians to improve care and ensure that high quality services are delivered.
- Take action when we are not receiving high quality, efficient and effective health services.

The Quality Strategy is delivered using a patient-centred approach and implemented through working in a collaborative manner with patients, healthcare professionals and other non-clinical staff, as well as effective working relationships with the Commissioning Support Unit, London Borough of Enfield and other appropriate organisations.

A focus on the patient not only creates a positive experience of care for patients and their families but also supports clinical effectiveness and patient safety. The Quality Strategy will build upon the integrated approach to service planning and delivery already established locally.

Provider organisations and clinical staff will therefore be encouraged to focus on the needs of patients, as well as satisfying the requirements of regulators or other external bodies. This has shown to be a recurring theme in documents on quality in the NHS: 'Effective involvement of patients and carers is essential to ensuring that everyone is fully engaged in the drive for quality, and that this focuses on what really matters' (Department of Health 1998, para 3.10). Enfield CCG has devised and piloted a Patient Engagement Questionnaire in Enfield Nursing homes. This is to assist in gaining a holistic view of what the quality of life is for clients who live in Enfield nursing homes. The results are currently being populated.

### STAFF TRAINING

- The Safeguarding team has provided Safeguarding Adult Training to all the CCG staff to help them identify how they might recognise abuse
- All staff with Enfield CCG has had PREVENT training.

## KEY ACHIEVEMENT 2014-2015

- In September 2014, NHS England circulated a guide to all Clinical Commissioning Groups and gave advice on what assurances the CCG should be looking for from their providers regarding the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Based on the guidance, an audit and information collection tool was developed by Enfield CCG. The audit has been project managed as part of the MCA programme work being undertaken by Enfield and funded by NHS England.
- A number of nurse practitioners have been identified as requiring the Best Interest Assessors training (MCA and DoLS). Enfield CCG has ring-fenced funding for 6 practitioners.
- The Assistant Director for Safeguarding has undertaken and passed the Best Interest Assessors Course and is now assessing the Mental Capacity of patients in Enfield.
- Enfield CCG hosted a MCA and DoLS Conference in October 2014. The conference aimed to deliver a learning and awareness opportunity to providers across the borough of Enfield. Initially targeted at nursing homes and domiciliary care providers, the event was broadened to include health professionals from Primary Care mental health and the acute sector providing an opportunity for networking across the care pathway.
- Following the conference, workshops were developed by the CCG and the MCA and DoLS lead for the local authority to facilitate care home managers to attend to continue increasing awareness and training on this issue.

The CCG has secured some further funding to promote training of MCA and DoLS amongst GPs and other primary care staff. Training will take place in 2015-16.

- NHS Enfield designed and piloted a Patient Engagement Questionnaire in Enfield nursing homes. Analysis of findings will be included in the CCG Annual Report and reported at the Safeguarding Adults Board.
- The borough-wide Pressure Ulcer Protocol was facilitated and completed by Enfield CCG safeguarding staff.

- As part of the roll out programme for the Pressure Ulcer Protocol, the CCG have arranged workshops to be held locally to facilitate increased awareness and training on this issue for care homes and residential home staff. The workshops are open and available to staff at all levels in the care home. The workshops have been positively evaluated.
- Enfield CCG nursing staff has produced a number of investigator reports on nursing homes and the Coroners' office.

## PRIORITIES AND WORKPLAN 2014/15

- To continue face-to-face Safeguarding and PREVENT training for the continuation of promoting Safeguarding awareness in health professionals.
- Continue to ensure that the CCG provide assurance and monitoring of provider agencies in their delivery of the safeguarding adults' agenda.
- Ensure that CCG Staff in relation to Safeguarding adult receives adequate supervision.
- The CCG will work jointly with the local authority in embedding the Making Safeguarding Personal agenda, ensuring staff are trained in this concept.
- Support all identified staff in completing the Best Interest Assessors course in their understanding of Mental Capacity and DoLS.
- To work with the local authority in monitoring and reporting of pressure ulcers using the borough-wide Pressure Ulcer Protocol.
- Roll out Safeguarding training across the nursing homes.
- To continue to focus on delivering CQRG work plan in conjunction with the providers.
- CCG will continue with quarterly GP forums in updating on Safeguarding adults at risk issues.
- To ensure that GP's are trained in PREVENT.
- Safeguarding Conference to be held in July 2015 for the health economy and partner agencies.

## STATEMENT WRITTEN BY:

**Carole Bruce-Gordon**

Assistant Director for Safeguarding  
Enfield Safeguarding Adults Board representative

## LONDON COMMUNITY REHABILITATION COMPANY

### COMMITMENT TO SAFEGUARDING ADULTS AT RISK

The London Community Rehabilitation Company is committed to eliminating discrimination and encouraging diversity amongst the services we provide. Our aim is that we provide equality and fairness for all and not to discriminate on the grounds of gender, marital status (including civil partnership) race, disability, sexual orientation, age, gender reassignment, pregnancy or maternity and religion or belief. We oppose all forms of unlawful and unfair discrimination.

Safeguarding adults needs to be considered alongside responsibilities for safeguarding children.

Probation staff who work directly with service users who become aware, or have concerns that a service user; a) has care or support needs, b) is experiencing, has experienced or is likely to experience abuse and c) is unable to protect themselves, have a duty to act in a timely manner. Similarly, if they become aware of a service user presenting a risk of harm to an adult 'at risk'. This applies to staff in any probation setting.

The London CRC has introduced single points of contact in each area that are required;

- To be aware of what safeguarding adults arrangements are, including to whom they apply.
- To undertake training in Safeguarding Adults – probation, local authority.
- To promote Safeguarding Adults practice within the Cluster. For example, team meetings, daily briefings, discussions with colleagues.
- To undertake Suicide Prevention Training and cascade learning to colleagues within their Cluster.
- To promote Suicide Prevention best practice within their Cluster. For example, team meetings, daily briefings, discussions with colleagues.

- To be aware of how to contact/make referrals to the local authority Adult Safeguarding team within their Cluster and to share these details with their Cluster.
- To identify and promote local services for 'adults at risk'. For example, local adult learning disability services.

The London CRC intranet lays out the commitment of the London CRC to ensuring that all vulnerable adults get the service(s) that they require. The page has links to internal and external resources with practitioners guides and links to the Care Act.

## 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.

Our aim to reduce the risk of harm from fire to those most vulnerable within the community.

### 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 2014 TO 2015

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 the benefits of a fire suppression system in domestic and sheltered housing. To increase the total amount of Home Fire Safety Visits (HFSV's), compared to previous years, where we can provide safety information and fit where necessary, smoke alarms to provide early warning of fire within the home
  - Outcome: Partners were encouraged to consider the benefits of fire suppression systems to reduce the damage caused by fire, reduce the number of injuries and death to vulnerable people. 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
  - All Borough fire officers were updated by the Enfield borough council safeguarding team in regards to considerations and legal requirements when carrying out their daily roles in emergency incidents at the annual information day workshops
  - Senior fire officers attending borough area forums to ensure that all communities are aware of the important fire safety work carried out by fire officers and delivering 'Home Fire Safety Visits' to the most vulnerable members of our community
  - Attended a number of Community based events to promote home fire safety and raise awareness of the provision of arson proof letter boxes
  - Two thousand three hundred and eighty six home fire safety visits were completed within the borough and at least 80% of these were carried out in homes that statistically, were most likely to have a fire.
  - A Housing providers Forum was held in partnership with Enfield Council, where 68 housing providers attended, where we educated/informed them of the services we provide. Most importantly we stressed the importance of the responsible person concept for care homes and housing stock. Highlighting the importance of providing adequate care and fire protection for residents.

- 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 1 fatal fire, an internal review recommended considerations for serious case review where appropriate and recommendations made to housing providers to risk assess residents with medical conditions in regards to fire and escape routes.
  - 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 as 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 landlords 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 2015/16**

- Carry out home fire safety visits to all sheltered housing facilities within the borough
- Continually seeking improvements to reduce the number of incidents in sheltered accommodation by working closely with service providers
- Continue to raise awareness of the availability and provision of domestic fire suppression systems for very high risk adults
- 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 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

## NORTH MIDDLESEX HOSPITAL NHS TRUST

### COMMITMENT TO SAFEGUARDING ADULTS AT RISK

The Trust's Board takes the issue of safeguarding extremely seriously and receives annual reports on both safeguarding children and safeguarding adults. The Director of Nursing and Midwifery is the Trust's board lead for safeguarding adults.

This report outlines the work that has been undertaken by the Trust over the past year in respect of its commitments and responsibilities in maintaining the safety and protection of adults at risk. It contains a review of the Trust's progress against national and local commitments and identifies key objectives for further developments in Safeguarding Adults for 2015 to 2016.

### KEY ACHIEVEMENT FOR 2014-2015

The Trust is committed to learning so that we can make improvements. Some examples include:

- the Mental Capacity Act and Deprivation of Liberty Safeguards Policy has been updated to reflect the guidance provided following the Cheshire West Case Law issued in April 2014
- updated the Deprivation of Liberty Safeguard application forms issued by ADASS in January 2015
- the Trust has developed a Domestic Violence Policy which is available on the hospital intranet
- on 25th June 2014, Ward Managers and Matrons were invited to attend a Mental Capacity Act and DoLS training update
- a significant amount of work has been done to ensure that staff are trained to the correct level for level 1 and level 2 Safeguarding Adult training
- a DoLS briefing sheet/flowchart has been agreed and this has been circulated to all Consultant Medical Staff, Matrons and Ward Managers

The number of DoLS applications progressed by the Trust has gradually increased over the previous year as ward staff are now more aware of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguard requirements.

We continue to train staff through face-to-face training and e-learning packages. Safeguarding Adult Level 1 training is mandatory in the Trust for all new staff at induction. At the end of March 2015, 80% of all staff had completed their Safeguarding Adult level 1 training.

Safeguarding Adult Level 2 training is provided as face to face training for relevant groups of staff and covers the Mental Capacity Act and Deprivation of Liberty Safeguards. The training figures are presented to the Trust Risk and Quality Committee on a quarterly basis. At the end of March 2015, 66% of relevant staff had completed their level 2 Safeguarding Adult training.

There is also an ongoing training programme to raise staff awareness on the Government PREVENT programme, which teaches staff how to recognise vulnerable individuals who may be at risk of being drawn into terrorist activity.

### PRIORITIES AND WORK PLANNED FOR THE COMING YEAR

The Trust needs to update its Safeguarding Adults Strategy in line with the recommendations from the Department of Health Care Act 2014 statutory guidance for implementation<sup>1</sup> and in response to national directives arising from the Supreme Court judgement on the Cheshire West case.

#### Key priorities for the Trust in 2015/16 are to:

- ensure that Trust Safeguarding Adults Policies and procedures are up to date and comply with current legislation and implications of the Care Act 2014
- progress further work on the 'Making Safeguarding Personal' programme, to ensure that the adult, their families and carers are working together with agencies to find the right solutions to keep people safe and support them in making informed choices
- further work to develop a training plan for Mental Capacity, Best Interest Decisions and Deprivation of Liberty Safeguards
- ensure that reasonable adjustments are made as necessary for those with Learning Disabilities

<sup>1</sup> <https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation>

- improve Domestic Violence support available to patients
- further work in PreventWrap training for all staff to be progressed in 2015/16
- strengthen links for Safeguarding Adults and Child Protection work
- continue to implement recommendations from lessons learned from Safeguarding Adult investigations.
- develop our work with patients who may need to have restrictions and restraints on their behaviours in their best interests
- ensure that Deprivation of Liberty Safeguard applications are progressed as required
- ensure that Mental Capacity Assessments are audited by CBU Matrons.
- ensure that a Best Interest Assessment is completed and documented on patient's medical file, in the event that treatment is withheld
- give consideration to completing an End of Life plan, in the event that treatment is withheld
- give consideration to making applications for Deprivation of Liberties Safeguard for patients who lack capacity and are provided with one to one supervision

#### STATEMENT WRITTEN BY:

**Eve McGrath**

Safeguarding Adults Lead

### ORGANISATIONAL LEARNING AND SERVICE USER PARTICIPATION

The Making Safeguarding Personal programme requires us to ensure that the adult, their families and carers are working together with agencies to find the right solutions to keep people safe and support them in making informed choices. Family or representatives are now routinely invited to Safeguarding Adult Strategy meetings and Case Conferences to ensure their early involvement in decisions made and Protection Plans. Examples of recommendations made in respect of the substantiated SOVA's have been for staff to:

- ensure adequate handover of information about the patient's condition on discharge, including a discharge letter with a body map and description of any injuries and pressure ulcer management required
- utilise discharge checklists for discharge procedures in order to ensure that patients are discharged with relevant and up to date information
- ensure that capacity assessments (Mental Capacity Act 2005) and rationale for Best Interest Decisions are fully completed and discussed with family members
- discuss medical decisions/recommendations regarding treatment and care with family i.e. withholding treatment

## ONE-TO-ONE (ENFIELD)

One-to-One (Enfield) is very committed to protecting our members' physical and psychological well-being and safeguarding them from all forms of abuse. At One-to-One we recognise that safeguarding is a responsibility for everyone, and therefore seek to ensure that safeguarding is a priority throughout the organisation.

One of our key achievements for the year 2014-2015 is our work on Hate Crime. On 14th May 2015 One to One held a conference with over 100 people attending. This involved raising awareness on Hate Crime for our members, staff, volunteers, services working with people who have LD and carers. Hate crime is when someone does something bad to someone or takes advantage because the person has a learning disability. We want all safeguarding alerts to be considered as a potential Hate Crime.

To ensure our members are safeguarded against any abuse we work with the integrated learning disabilities team. At One-to-One we have a positive relationship between members, staff, volunteers and other partner organisations that encourages people to be open about concerns and helps people to learn from each other. There are continuous training and development opportunities for staff and volunteers.

We are currently working on our website to include information about One-to-One including safeguarding adults and protecting people from risks. Our website will have links to other service providers.

## ROYAL FREE LONDON NHS FOUNDATION TRUST

Since the acquisition of Barnet and Chase Farm hospitals we have continued to build on the strong foundations of safeguarding that were already in place. Our commitment to safeguarding has been demonstrated through the development of a forward looking safeguarding strategy which aims to achieve excellence in practice. Our strategy sets out how we plan to drive forward our safeguarding activities and our reputation over the next 3 years.

Our safeguarding strategy acknowledges the requirement of the Royal Free London NHS Foundation Trust to ensure there is board level focus on the needs of patient safety and that safeguarding is an integral part of the governance framework. To this end we have a newly formed Integrated Safeguarding Committee which reports into the Trust board. In addition we have strengthened our safeguarding team by appointing a head of safeguarding and a lead nurse for safeguarding adults based at Barnet and Chase farm Hospitals. We have also appointed a full –time learning disability nurse.

We recognise that safeguarding is a shared responsibility with a need for effective joint working between partner agencies and professionals. In order to do this we are committed to working closely with others to ensure that all the services we provide have regard to our duty to protect individual human rights, treat individuals with dignity and respect and safeguard against abuse, neglect, discrimination, embarrassment or poor treatment.

As a health care provider we are required to demonstrate that we have strong safeguarding leadership and a commitment to safeguarding at all levels of the organisation. This includes safe recruitment practices, effective safeguarding training for all staff, effective supervision arrangements and the identification of named safeguarding leads. We have ensured that we have a robust safeguarding policy and that staff know how to raise a concern; and that a culture exists where safeguarding really is everybody's business. This means that safeguarding is viewed as

an individual responsibility for all our staff as well as an organisation priority.

In order to support our strategy a dynamic work plan has been developed based on 10 key aims:

1. To provide positive assurance that safe and effective processes and systems are in place to effectively safeguard all patients who access services across the Trust
2. To ensure effective systems for prevention, reporting, responding and learning
3. To work in partnership with other agencies to ensure an effective and joined up approach to safeguarding
4. To ensure safeguarding is given a high priority across the organisation
5. To ensure we are a learning and improving organisation
6. To ensure we have a safe and effective workforce in relation to safeguarding
7. To ensure we are continually responsive to changes in the safeguarding landscape, both at a national and local level
8. To ensure we continually drive the safeguarding agenda forward
9. To ensure we improve practice in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards
10. To ensure we are responsive to vulnerable groups such as patients with learning disabilities and patients who disclose domestic abuse

### STATEMENT WRITTEN BY:

**Deborah Sanders**

Director of Nursing

## SAFER AND STRONGER COMMUNITIES BOARD

The Enfield Safer and Stronger Communities Board (SSCB) is the statutory Community Safety Partnership locally. The Crime and Disorder Act 1998 as amended by the Police and Justice Act 2006 places a duty on responsible authorities to work together to understand the issues related to crime and community safety in their area and to have an agreed partnership plan to bring about improvements.

The Enfield SSCB have been recognised for strong achievement and good practice both nationally and internationally, contributing to current agendas such as tackling serious and organised crime, counter terrorism and tackling gangs and CSE (child sexual exploitation).

### CURRENT POSITION

The Safer and Stronger Communities Board comprises the local authority, the police, the fire brigade, probation services and the clinical commissioning group (CCG). Senior officers from these agencies promote the activity of the Safer and Stronger Communities Board within their own agencies. The lead member for Community Safety is also a member of the SSCB.

There have been significant changes to probation services as a result of the transforming rehabilitation agenda and the probation service has now been split into two different agencies providing the statutory offender management services. These are the National Probation Service (NPS) and the Community Rehabilitation Company (CRC). In London the services of the CRC are being provided by MTCnovo. Both of these agencies are responsible authorities under Section 5 of the Crime and Disorder Act 1998 and are represented on the SSCB.

The SSCB work in partnership with community groups, neighbouring boroughs, central government and the Mayor's Office for Policing and Crime and has representatives from the local Youth Offending Unit, other criminal justice agencies, housing providers and voluntary organisations. It has embedded links

with other key groups such as Safeguarding Boards, the Health and Wellbeing Board, Drug Alcohol Action Team (DAAT) and the Enfield Targeted Youth Engagement Board (ETYEB). Regular representation and updates between these boards help us tackle areas of joint concern such as domestic abuse.

The partnership receives support from the Council's Regeneration and Environment Department and the Head of the Community Safety Unit is a member of the Safeguarding Adults Board.

It is within the Safeguarding Adults Board that the wider agenda of community safety is brought to the attention of partners and links made with those adults who may be more at risk to harm, abuse and exploitation. In this year we saw a presentation on Human Trafficking and how partner organisations on the Safeguarding Adults Board can contribute towards tackling this area. Further, we are going to work with the Metropolitan Police Service to develop a Serious and Organised Crime plan which will include this issue.

In addition, we found that Hate Crime against vulnerable adults continues to be underreported and that this is an important issue for the Safeguarding Adults Board. In the coming year we hope to improve on this area through awareness raising and links with the voluntary sector who support many adults at risk to report.

We know from data that domestic violence against adults at risk continues to be highly reported. In particular, there are specific issues faced by older women who have experienced domestic violence and a more tailored approach to support individuals will be developed along with our colleagues in the Council's strategic safeguarding adults service.

### KEY ACHIEVEMENTS OF 2014-15 INCLUDE:

- Continued investment in CCTV provision across the borough
- Serious acquisitive crime has shown significant improvement in 2014-15, and has fallen by 22.5% (as at 12th March 2015)
- Continued to support our Safehouse scheme to support the target hardening of vulnerable residents' homes
- Delivered high profile seasonal crime prevention messages around personal safety to appropriate audiences

- We have improved our links and data sharing with health agencies, notably North Middlesex Hospital
- Delivered further Court “Call-ins” sessions to highlight the risks of gang membership and offer support to exit the gang lifestyle
- Better oversight of anti-social behaviour cases through the action group (ASBAG) and regular case management meetings
- Further work around Domestic violence including a further 12 months support for Project IRIS working with GPs to identify domestic violence and intervene safely

## **PRIORITIES IN THIS YEAR'S PARTNERSHIP PLAN ARE:**

### **Our Mayor's Office for Policing and Crime (MOPAC) 7 priorities are:**

- Burglary
- Criminal Damage
- Robbery
- Theft from a motor vehicle
- Theft of a motor vehicle
- Theft from a person
- Violence with injury

### **Our SSCB priorities are:**

- Tackling serious youth violence
- Tackling domestic abuse and violence against women and girls
- Tackling Anti-Social Behaviour
- Reducing property crimes such as burglary and car crime
- Delivery of the Prevent agenda locally
- Development of a Serious and Organised Crime plan in conjunction with the MPS and local partners

We are also aware of key cross cutting themes that impact on all of the above such as substance misuse, the management of offenders in the community and hate crime. These themes will also be key areas of work for us during 2015-16.

## **STATEMENT WRITTEN BY:**

**Andrea Clemons**

Head of Community Safety

*Enfield Safeguarding Adults Board representative*



## APPENDIX A PERFORMANCE DATA

This summary report is intended to draw attention to the patterns or trends identified in the safeguarding adults data report for Q4 2014-2015.

The data sets considered for the Safeguarding Adults Board include the following:

- Total number of alerts
- Number of alerts via team
- Types of alleged abuse
- Place of alleged abuse
- Route of safeguarding referral
- Relationship of the person alleged to have caused harm
- Outcome of alerts in terms of progression under safeguarding adults
- Involvement of a nominated advocate
- Outcome of cases
- Outcome for adult at risk
- Outcome for person alleged to have caused harm

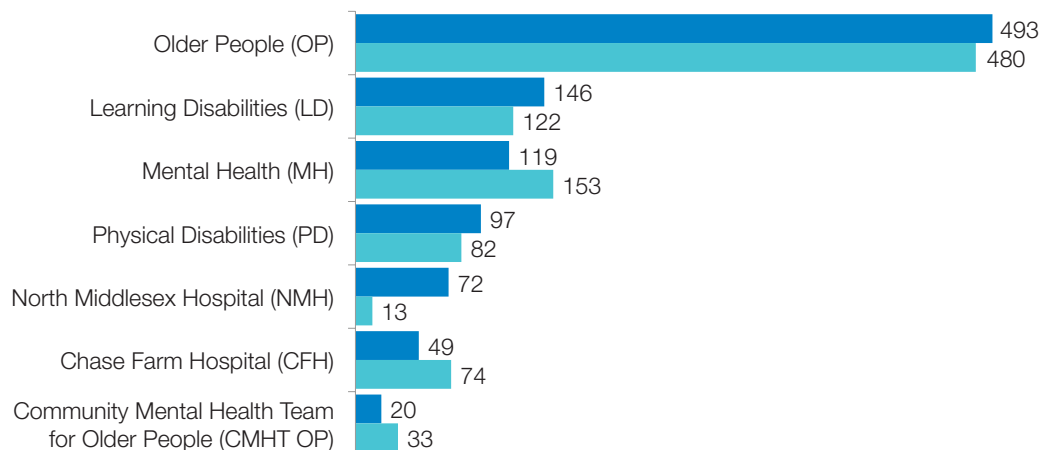
Some of the key patterns or areas of notice identified this quarter are as follows:

1. During 2014/15 there were **996 alerts** raised to adult social care, compared to 957 in 2013/14 (4% increase). This is a change from the previous trend where the number of alerts reported in 2012/13 had increased by 16% from 2011/12. This trend continued into 2013/14 with a 20% increase in the count of alerts from 2012/13.
2. The **largest referrals increase** across all teams is **North Middlesex Hospital 454%**, (13 alerts in 2013/14 to 72 alerts in 2014/15). The Mental Health team reported a 21% decrease in the number of referrals reported for 18-64s (146 to 116).
3. Most alerts relate to **Multiple Abuse** (34%) with Neglect at (28%). Neglect is higher when compared to 2013/14 which has seen a 22% increase (227 to 278).
4. **40%** referrals are in relation to alleged abuse in the **Adult at Risk's own home** and 26% are in a residential/nursing home. Referrals where the location of abuse is 'Mental health inpatient setting' is lower when compared to 2013/14 (61 to 44).
5. Of the 76 alerts where the location is alleged abuse as 'acute hospital' the count of alerts against each named hospital is confirmed as North Middlesex 45, Chase Farm 19, Barnet 9, Royal Free 2, University College London Hospitals 1.
6. The **largest referral** source continues to be **Hospital Staff at 23%**, followed by Private/Independent Provider at 19%.
7. **Family members** and **paid staff** continue to be the **highest** proportion of those alleged to have **caused harm**. Other vulnerable Adults make up 8% of those alleged to have caused harm, this is compared to 14% in 2013/14 (69 to 35).
8. The outcome of the initial alert is 73% 'proceed with Safeguarding' and 5% 'require further information gathering' (at the time of reporting).
9. There is an increase in the number of adults at risk whom have a nominated advocate involved 31% (433 to 567) since 2013/14. The type of advocacy is set by the request or requirement of the adult at risk and can include family members, friends, or paid advocates for example.
10. 45% of closed cases were substantiated or partially substantiated (compared to 48% in 2013/14). The outcome in 29% of referrals concludes 'The allegation has not been substantiated' this is an increase from 2013/14 with 24%.
11. 38% of alerts raised during 2014/15 were closed within 7 weeks, this is a decrease when compared to 2013/14 with 48%.
12. The proposed outcome for the adult at risk is recorded as 'no further action' in 53 (33%) of closed alerts, this is an increase when compared to 2013/14 (28%).
13. The main outcome for the Adult alleged to have caused harm is 26% 'no further action' followed by 24% 'action by continued monitoring' this is a change when compared to 2013/14 which reported 26% and 35% respectively.

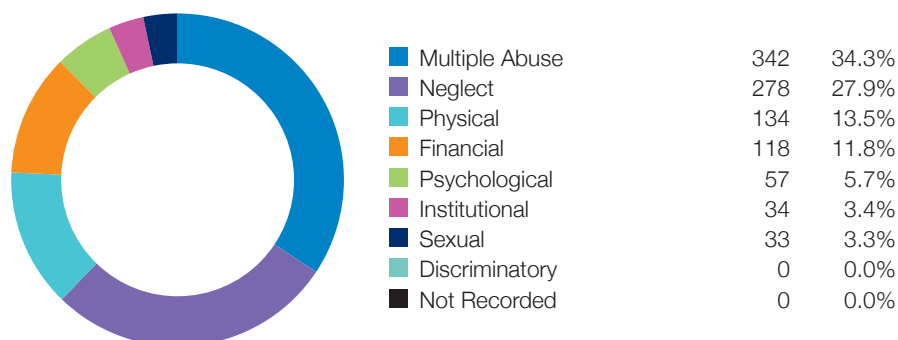
## REFERRALS (ALERTS)

### INITIAL ALERTS BY TEAM

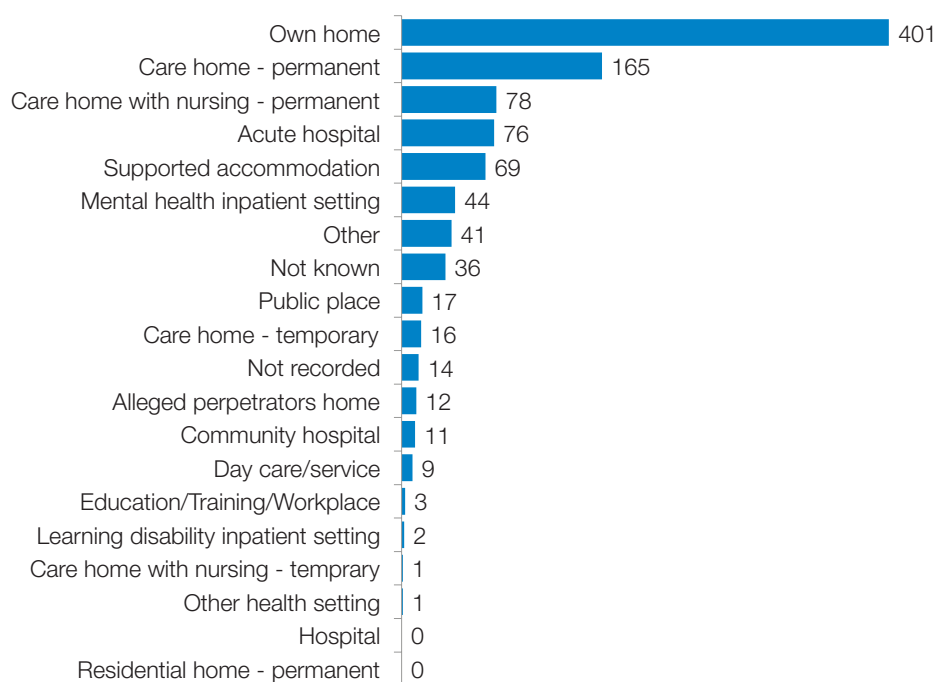
■ 2014/15  
■ 2013/14



### TYPES OF ALLEGED ABUSE



### PLACE OF ALLEGED ABUSE



## ROUTES OF REFERRAL

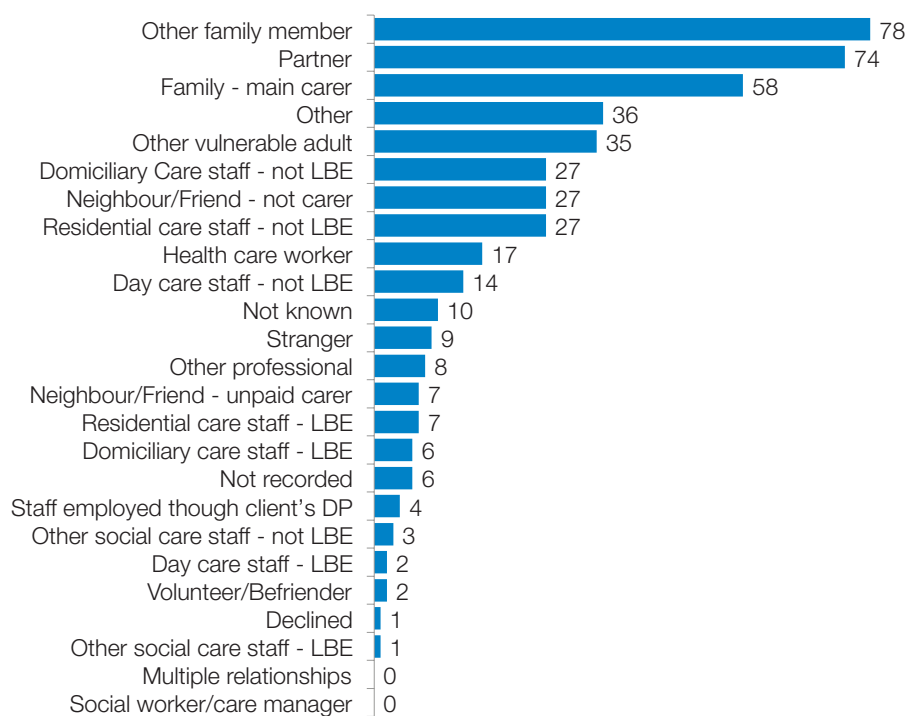
Referer	2012/13	2013/14	% change
Hospital staff	225	208	8.2%
Private/Independent Provider	188	151	24.5%
Community Health Professional	136	95	43.2%
LBE - HASC	129	139	-7.2%
Relative	57	68	-16.2%
LBE not HASC	39	33	18.2%
Domiciliary staff	33	27	22.2%
Voluntary/Religious	31	11	181.8%
Ambulance Service	27	30	-10.0%
CQC	23	21	9.5%
Self referral	15	13	15.4%
Police	14	15	-6.7%
General Practitioner	14	11	27.3%
Other	12	27	-55.6%
Day care staff	12	16	-25.0%
Anonymous	12	15	-20.0%

Referer	2012/13	2013/14	% change
Neighbour/Friend	9	9	0.0%
Carer	7	7	0.0%
Housing/RSL	5	17	-70.6%
Not recorded	5	5	0.0%
Partner	3	0	0.0%
Mental Health staff - joint teams	0	32	-100.0%
Council staff	0	7	-100.0%
Education provider	0	0	0.0%
Financial Institution - Bank	0	0	0.0%
Guardian/Office of Public Guardian	0	0	0.0%
Other service users	0	0	0.0%
PCT	0	0	0.0%
Public	0	0	0.0%
Social Services staff - not LBE	0	0	0.0%
<b>Total</b>	<b>996</b>	<b>957</b>	<b>4.1%</b>

## INFORMATION ABOUT THE PERSON ALLEGED TO HAVE CAUSED HARMS

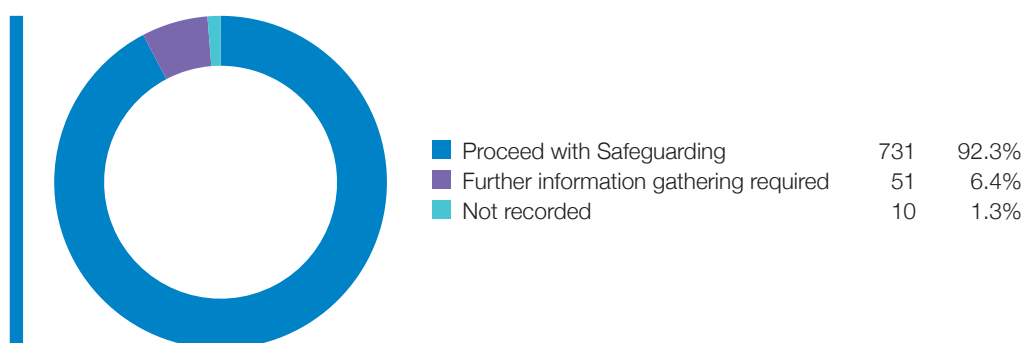
Relationship to Adult at Risk of those alleged to have caused harm. Only for those alerts where the type of alleged perpetrator is an individual.

### PERSON ALLEGED TO HAVE CAUSED HARMS RELATIONSHIP TO ADULT AT RISK



## OUTCOMES OF ALERTS

### OUTCOME OF INITIAL ALERT

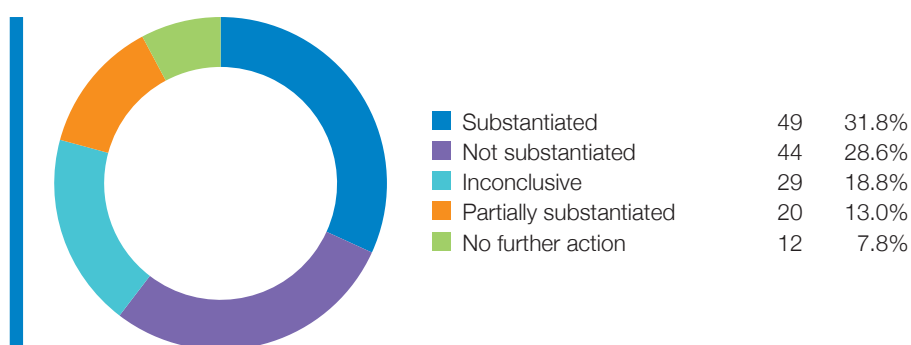


### NOMINATED ADVOCATE INVOLVED?

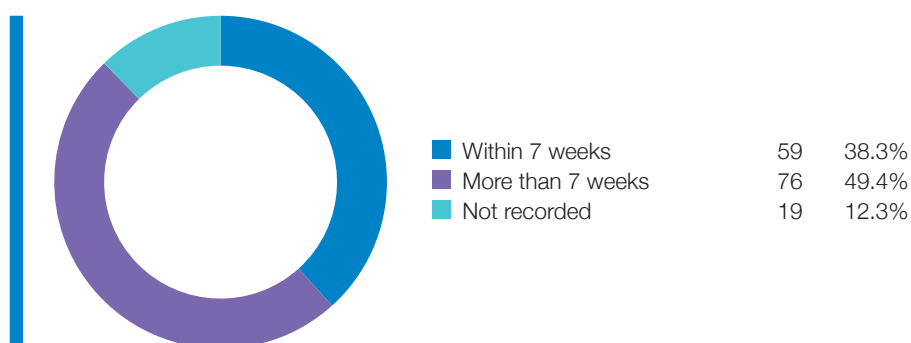
	2014/15	2013/14	% change
Yes	567	433	30.9%
No	48	264	-81.8%
Not applicable	110	31	254.8%
Not recorded	6	5	20.0%
<b>Total</b>	<b>731</b>	<b>733</b>	<b>-0.3%</b>

## OUTCOMES OF CLOSED CASES

### OUTCOME OF THE SAFEGUARDING ADULT INQUIRY/ INVESTIGATION



### DAYS FROM ALERT TO INQUIRY CLOSED



## OUTCOME PROPOSED FOR ADULT AT RISK

Data Measured	2012/13	2013/14	% change
No further action	48	63	31.3%
Community Care Assessment and Services	6	11	-45.5%
Increased Monitoring	37	57	-35.1%
Restriction/Management of access to AP	3	4	-25.0%
Moved to increase/Different Care	8	23	-65.2%
Review of Self Directed Support	3	1	200.0%
Management of Access to Finances	3	4	-25.0%
Application to change appointee-ship	0	2	-100.0%
Continuing care placement required to meet patients cultural needs	0	2	-100.0%
Removed from Property or Service	9	10	-10.0%
No Further Action	53	63	-15.9%
Other Outcome	9	25	-64.0%
Not Recorded	16	18	-11.1%
Application to Court of Protection	2	3	-33.3%
Referral to Counselling/Training	3	1	200.0%
Referral to MARAC	2	2	0.0%
<b>Total AAR Outcomes</b>	<b>154</b>	<b>226</b>	<b>-31.9%</b>

## OUTCOME PROPOSED FOR PERSONS ALLEGED TO HAVE CAUSED HARM

Data Measured	2012/13	2013/14	% change
Action by CQC	0	3	-100.0%
Action by Contract Compliance	6	9	-33.3%
Action by Continued Monitoring	38	78	-51.3%
Community Care Assessment	0	1	-100.0%
Counselling/Training/Treatment	12	6	100.0%
Criminal Prosecution/Formal Caution	1	2	-50.0%
Disciplinary Action	6	15	-60.0%
Exoneration	7	4	75.0%
Management of Access	7	8	-12.5%
Police Action	1	2	-50.0%
Removal from Property or Service	5	8	-37.5%
No Further Action	42	59	-28.8%
Other (specified)	0	0	0.0%
Not Recorded	17	20	-15.0%
Not Known	12	9	33.3%
Referral to Registration Body	0	2	-100.0%
<b>Total AP Outcomes</b>	<b>154</b>	<b>226</b>	<b>-31.9%</b>

# APPENDIX B

## OUR SUMMARY ACTION PLAN

### KEY PRIORITY 1: EMPOWERMENT

#### PEOPLE BEING SUPPORTED AND ENCOURAGED TO MAKE THEIR OWN DECISIONS AND INFORMED CONSENT

- The Partnership will develop strategies for management of self neglect, hoarding and honour based violence and domestic abuse which enables adults to have choice and control.
- The Board will assure itself that adults at risk are involved strategically in safeguarding and through to involvement in individual cases.
- We will ensure children and young people are aware of adults at risk and who they can speak to if they have concerns.
- Board partners to provide assurances that they can achieve requirements of 'Making Safeguarding Personal'.

#### EMPOWERMENT OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- Guidance available that supports staff to deal with specific safeguarding issues with adult at risk central to interventions and support.
- Evidence of service user, carer and patient engagement at strategic board level, in partner organisation safeguarding development, and through to the safeguarding adults process.
- Data show that children and young people have information, understanding and feel able to report concerns.
- All partners are working to the ethos of Making Safeguarding Personal and have action plans that demonstrate deliverance.

### KEY PRIORITY 2: PROTECTION

#### SUPPORT AND REPRESENTATION FOR THOSE IN GREATEST NEED

- Safeguarding Adults Board will meets its statutory requirement as set out by the Care Act 2014.
- The Board will clarify the surveillance and community alarm options for adults at risk and their representatives and have assurances this in within legal parameters.
- Partners on the Board will facilitate intervention on the issue of dehydration and hold providers to account for implementation.

#### PROTECTION OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- There is a Safeguarding Care Act Implementation Group which reports and is accountable to the Board.
- Surveillance or community alarm options are set out and we are able to report back on uptake.
- Through quality checks we can evidence that dehydration interventions are being appropriately implemented by care providers.

### KEY PRIORITY 3: PREVENTION

#### IT IS BETTER TO TAKE ACTION BEFORE HARM OCCURS

- Our local health economies will be monitored and have indicators that ensure people are kept safe from abuse.
- Board will have partnership data through an integrated performance report from the Police, Local Authority and CCG.
- The Board will develop and deliver on creating pathways of support for those isolated and at increased risk of abuse and exploitation.

#### PREVENTION OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- Partnership demonstrates through Board and Quality Assurance Groups that we are acting on data to prevent harm.

- Board meetings have partnership data report which informs trend and theme analysis to support performance risk prediction.
- Partnership approach to identifying isolated individuals who we can evidence are able to access support from across services.

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## KEY PRIORITY 4: PROPORTIONALITY

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### THE LEAST INTRUSIVE RESPONSE APPROPRIATE TO THE RISK PRESENTED

- The Board will support strategic discussions around the Multi-Agency Safeguarding Hub (MASH) for adults at risk, to ensure information sharing and cooperation in line with the Care Act.
- We will seek service user feedback from those who have been harmed to improve practice.
- Board will facilitate pathway programme in place for people at risk of harming others.

### PROPORTIONALITY OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- Our recording can inform practice and provide aggregated outcomes for the SAB.
- Feedback from adults at risk confirm that they feel safe and have a positive experience of care and support.
- People at risk of harming others access support to prevent harm or prevent repeat abuse.

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## KEY PRIORITY 5: PARTNERSHIP

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### LOCAL SOLUTIONS THROUGH SERVICES WORKING WITH THEIR COMMUNITIES COMMUNITIES HAVE A PART TO PLAY IN PREVENTING, DETECTING AND REPORTING NEGLECT AND ABUSE

- Develop a quality assurance framework for the Board to embed learning culture across the partnership.
- Partners will provide assurance to the Board that their service provision is in line with the Dignity Standards.

- We will strengthen the partnership between Board and the voluntary sector.

### PARTNERSHIP OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- The Board has set out how it will quality assure itself and partners, with a timetable in place and activities underway.
- We can look at the strategic plans of partners on the SAB and find evidence of safeguarding adults.
- Voluntary sector report feeling more engaged with safeguarding through the SAB and evidence of more joined up activities as reported in the annual report.

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## KEY PRIORITY 6: ACCOUNTABILITY

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### ACCOUNTABILITY AND TRANSPARENCY IN DELIVERING SAFEGUARDING

- Board will set out its arrangements for peer review and self-audits.
- Board will assure itself that decision to proceed under safeguarding and decisions to prosecute are transparent.
- Carry out Safeguarding Adults Reviews (SAR) where there is a statutory obligation and ensure learning is widely disseminated.

### ACCOUNTABILITY OUTCOMES WE EXPECT TO SEE AND REPORT ON:

- Board has evidence of how it has been audited against statutory requirements and action plans in place to address gaps.
- We can evidence number cases which went to prosecution and access to justice system.
- SAR included in annual report and wider learning across the partnership with action plans in place.

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<b>Report to:</b>	<b>Enfield Health and Wellbeing Board, July 2015</b>
<b>Subject:</b>	<b>Complaints Handling: What Good Looks Like</b>
<b>From:</b>	<b>Healthwatch Enfield</b>
<b>Lead:</b>	<b>Deborah Fowler, Chair</b> deborah.fowler@healthwatchenfield.co.uk <b>Lorna Reith, Chief Executive</b> lorna.reith@healthwatchenfield.co.uk 020 8373 6283

## 1. Summary

- 1.1 Well-run organisations in any sector welcome feedback and complaints as an opportunity to identify and act on areas requiring improvement. The Francis Report into the failings at Mid-Staffordshire NHS Foundation Trust highlighted how essential this is to the health and social care sector, given the impact of their work on people's health and wellbeing.
- 1.2 In November 2014, the Local Government Ombudsman (LGO), Healthwatch England, and the Parliamentary and Health Service Ombudsman (PHSO) jointly published '*My Expectations for Raising Concerns and Complaints*', a User-Led Vision for the complaints system. The joint Report set out universal expectations of good complaints handling, drawn up in co-production with consumers of health and social care services.
- 1.3 In December 2014, the Care Quality Commission (CQC) adopted this new framework for complaints handling in '*Complaints Matter*', and set out its new focus on complaints as a mandatory Key Line of Enquiry for CQC inspections. The CQC said that it "now knows what good looks like" and criticised many health and social care providers for being defensive when faced with complaints and feedback. The CQC now takes into account how well complaints and concerns are handled by an organisation in judging and rating that organisation's responsiveness to its patients, service users, and carers.
- 1.4 The Health and Wellbeing Board and its members are being asked collectively and individually to endorse the framework established by the User-Led Vision for Raising Concerns and Complaints and adopted by the CQC, and to incorporate them into service contracts.

## 2. Recommendations

The Health and Wellbeing Board:

- 2.1 notes the user-led complaints framework published jointly by the LGO, Healthwatch England and PHSO and adopted by the CQC for use in its inspection regime;
- 2.2 asks commissioners from the CCG, NHS England and local authority to adopt the new complaints framework, as appropriate, in their provider contract specifications relating at least to health and social care, to achieve a consistent approach across Enfield;
- 2.3 asks that, in monitoring *existing* contracts, the CCG, NHS England and local authority commissioners are informed by the new complaints framework and encourage their providers to improve their existing complaints systems;
- 2.4 notes that NHS England has assured the LGO, Healthwatch England and PHSO that it will use the new user-led complaints framework as a performance management tool to be built into the NHS Outcomes Framework;
- 2.5 resolves that, as part of its role in promoting and reviewing integrated care arrangements, the HWB will consider and review how well the user experience of complaints-handling matches the expectations set out by the CQC; and,
- 2.6 notes that when reviewing complaints-handling in provider organisations, Healthwatch Enfield will adopt the user-led complaints framework.

### 3. Background

3.1 The importance of complaints processes in improving safety and the quality of services for service users has been highlighted in a number of high profile reports since 2013:

- (1) The Francis Inquiry Report into the failings of Mid-Staffordshire NHS Foundation Trust (February 2013)
- (2) The Clwyd Hart Review of NHS Hospital Complaints System - Putting Patients Back in the Picture (October 2013)
- (3) The Healthwatch England Report “Suffering in Silence” (October 2014)
- (4) Joint Report of the LGO, Healthwatch England and PHSO “My Expectations for Raising Concerns and Complaints” (November 2014)
- (5) CQC Report, “Complaints Matter” (December 2014).

3.2 In practice, since the Francis Inquiry Report in 2013 raised public consciousness of the need for transparent systems and the importance of complaints, progress on the ground has been slower than might have been expected. The Healthwatch England Report “Suffering in Silence” (October 2014) highlighted that:

- 26% of people with concerns about their health care did not complain because they were worried about negative repercussions;
- 61% did not complain because they thought they would not be taken seriously;
- 49% of those who did complain never received an apology.

The Report also highlighted the fact that there were 70 different organisations involved in handling complaints just in relation to NHS services and this was extremely confusing for a potential complainant.

3.3 Most recently, in June 2015, the National Audit Office (NAO) released a report called, *‘Public Service Markets: Putting Things Right When They Go Wrong’*. This looks at how the public sector handles and learns from feedback and complaints and, as with the earlier reports, concludes that it frequently does neither very well.

3.4 A significant conclusion in a number of these Reports, and highlighted in the joint Report of the LGO, Healthwatch England and PHSO, “My Expectations for Raising Concerns and Complaints”, is that the way that an organisation deals with complaints reflects its own values of openness and transparency. “Learning” organisations tend to embrace feedback and complaints so that they can learn from them and improve.

### 4. Approach to Complaints-Handling by the CQC

4.1 The recommendations in the Reports cited above are complementary. The CQC Report (attached as Appendix 1) confirms that it has formally adopted the LGO, HWE and PHSO framework for complaints-handling. Complaints processes will be a significant Key Line of Enquiry in the CQC inspection regime for both health and social care services. CQC inspection reports will now include a description of the provider’s handling of complaints.

- 4.2 Where the CQC find breaches of complaints-handling standards, they will start to use their range of enforcement powers: warning notices, suspending or cancelling registration and ultimately prosecution. The CQC will actively work with partners to encourage improvement.
- 4.3 The CQC's study of the state of complaints-handling 'Complaints Matter' (Appendix 1) concludes that although there are limited data about how well providers handle complaints and concerns in the sector, there does appear to be variation in the accessibility of the complaints process, and in the provision of advocacy and support for people who want to complain. As part of its inspection process, the CQC plans to develop more thorough methods of reviewing complaints-handling, so that it can better capture how well health and social care providers encourage, listen to and respond to complaints.
- 4.4 The CQC standard for assessing complaints reflects the "user-led" vision for complaints-handling developed by the LGO, Healthwatch England and the PHSO, as set out below.

## A USER-LED VISION FOR RAISING CONCERNS AND COMPLAINTS



From 'My Expectations for Raising Concerns and Complaints', November 2014, reproduced in 'Complaints Matter', CQC, December 2014

4.5 The CQC see complaints-handling as a good proxy for the open, transparent and learning culture that they would expect to see in well-led organisations. Embedding complaints and concerns in the CQC's regulatory model has two aims:

- to improve how they use the intelligence from concerns and complaints to better understand the quality of care being provided;
- to consider how well providers handle complaints and concerns so as to encourage improvement.

4.6 In pursuing the new complaints Line of Enquiry, the CQC will consider complaints-handling from a *user* point of view, asking:

- whether people who use a service know how to make a complaint or raise concerns, are encouraged to do so, and confident to speak up;
- whether the complaints system is easy to use, people are treated compassionately and given the help and support they need to make a complaint; and,
- whether the outcome of the complaint is explained to the individual, there is openness and transparency about complaints, and concerns are dealt with.

4.7 The CQC Line of Enquiry will also include a requirement on providers to demonstrate a *positive* culture around complaints and feedback, including the expectation that they will show what changes have been made as a result of their complaints and feedback.

## 5. Duty of Candour and Whistleblowing

5.1 The CQC is explicit that it wants complaints and feedback from health and social care staff to be properly dealt with as well. This is supported by the new "Duty of Candour" and also by Whistleblowing Policies, as complaints by staff can be particularly valuable in highlighting concerns about service failures. The introduction of a statutory Duty of Candour is a major step towards implementing a key recommendation from the Mid-Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry). The Duty of Candour will place a requirement on providers of health and adult social care to be open with patients when things go wrong. Providers should establish the duty throughout their organisations, ensuring that honesty and transparency are the norm in every organisation registered by the CQC.

5.2 Following a February 2015 review of Whistleblowing policies and procedures in NHS Trusts by Sir Robert Francis, the Government announced that NHS Hospital Trusts would be expected to appoint "Speaking up Guardians" to support staff who raise concerns about safety, quality of services, bullying and other significant

issues within their organisations. It was clear from the evidence collected as part of the “Freedom to Speak Up Review”, which heard evidence from 600 individuals and received 19,000 replies to an on-line survey, that in many cases staff felt that the Whistleblowing policy in their trust was not adequately protecting them.

## 6. The Local Picture

- 6.1 The Healthwatch Enfield experience relating to complaints processes in local provider organisations suggests that the priority given to this area of work is not yet what the new CQC standard will require, both in respect of complaints-handling and of using that intelligence to improve services. Some of the signposting enquiries received by Healthwatch Enfield are, in essence, complaints. But we find that people have rarely used the formal complaints process, whether because they are unaware of how to access it, or because they are concerned about personal ramifications, or because they lack the belief that it will make any difference.
- 6.2 In the recent audit undertaken by Healthwatch Enfield of the information made available to patients by Enfield GP practices, a positive finding was that all Enfield GP practice websites now include information on “how to make a complaint”. Over time, we also plan to visit all practices to see if they display visible posters or notices about the complaints process. We have not conducted similar information audits of other NHS-funded providers such as dentists or opticians, nor do we have systematic evidence relating to social care providers. However there is some evidence from recent CQC inspections of local care homes that there is a need for greater attention to complaints-handling.
- 6.3 We do have knowledge and experience of complaints processes in the three local NHS Trusts from our and our neighbouring Healthwatch’s involvement in patient experience committees and quality/contract review meetings. We also receive a number of signposting enquiries from service users relating to failures in the complaints processes at the trusts. The dedicated resources necessary for managing the complaints process, from dealing with the initial enquiry to improving the system and embedding the learning, have not always been in place. In practice, response targets have often not been met, which causes further frustration for the complainant.
- 6.4 We hope that the early adoption by providers in Enfield of the new standards for complaints-handling will raise the general level of complaints services locally and help providers to welcome complaints as representing opportunities for improvement.

## 7. The HWB Role re Complaints-Handling

- 7.1 Increasingly, there are factors that add further complexity for potential complainants in what is already a difficult landscape. In particular, there is the

move towards greater service integration between health and social care, as well as commissioning of services across a larger geographical area. Although integration is generally welcome, this blurring and extension of boundaries, together with the outsourcing of services, can make for user confusion as to who is providing a service and who is responsible for its quality. Participants at Healthwatch Enfield's Conference 'How Complaints and Feedback can improve Services' in April 2014 expressed their concerns about the complexity of knowing who to complain to amid a myriad of complaints processes.

- 7.2 The HWB has a unique role in the local health and social care economy of promoting and overseeing greater service integration. It is essential that feedback and complaints from patients and service users are captured and fully acted on, even as services continue to develop, merge, and change. As part of its strategic overview of ongoing service change initiatives, the HWB will no doubt wish to be kept informed as to how well feedback and complaints are being handled by sector participants providing increasingly integrated services.

## **8. Next Steps Locally**

- 8.1 The decision by the CQC to include complaints as a Key Line of Enquiry and to adopt the user-led vision framework from the LGO, HWE and PHSO Report should encourage providers to implement more effective complaint-handling systems. To encourage prompt adoption of the principles, Healthwatch Enfield would like to see commissioners reflect the standards in their new contract documentation and at contract review meetings with providers. This is reflected in the recommendations to the HWB.
- 8.2 From a Healthwatch perspective, an effective complaints system and a good system for collecting broader feedback, are fundamental to improving patient and service user experience and the quality of care. We agree with the CQC that complaints-handling is a proxy for an open, transparent and learning culture that one would expect to see in well-led organisations. The introduction of the new CQC standard is an opportunity to promote good practice across all health and social care providers in Enfield and we therefore ask the HWB and its member organisations to adopt the new standards so that people in Enfield can benefit from enhanced complaints-handling that meets CQC standards and that contributes to local providers being 'learning' organisations.
- 8.3 Healthwatch Enfield intends to review information it receives about complaints-handling by local providers against the new standards.

## **Appendix 1**

CQC 'Complaints Matter' Report, December 2014



# COMPLAINTS

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# MATTER



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# FOREWORD

## Complaints matter – to individuals, to health and social care services and to CQC.

They matter for people using services, who deserve an explanation when things go wrong and want to know that steps have been taken to make it less likely to happen to anyone else.

They matter for health and social care organisations, because every concern or complaint is an opportunity to improve. Complaints may signal a problem – the information can help save lives, and well-handled concerns will help improve the quality of care for other people.

Complaints matter to CQC, because they tell us about the quality of care. They tell us about how responsive a provider is, how safe, effective, caring and well-led they are. We can use our powers as a regulator to shine a light on good and bad handling of complaints and encourage organisations to improve.

CQC has placed feedback from people who use services at the heart of our work, because every concern is an opportunity for services to improve the quality of care. We also want to hear about positive experiences so we can highlight good and outstanding care.

Complaints and feedback from people who use services is a central part of our ‘Intelligent Monitoring’ of health and social care providers. We are also making it central to our inspections, and will include a lead inspector for complaints and

staff concerns in large inspection teams. How well health and social care providers handle complaints will feed into our regulatory judgements about how responsive they are to people’s needs.

CQC’s new approach to inspection, with this strong focus on complaints, has just begun and there is a distance to go before we are able to offer a clear and comprehensive picture of complaints handling across all the sectors we inspect.

We take complaints seriously – and we expect providers to do so too. All our new inspection reports will describe complaints handling. Poor practice will be found and acted on. Good practice will be shared.

This report provides a snapshot in which some things are already fairly clear. There is wide variation in the way complaints are handled and much

more could be done to encourage an open culture where complaints are welcomed and learned from. While most providers have complaints processes in place, people’s experiences of the systems are not consistently good.

And we know, from the thousands of people who contact CQC each year, that many don’t even get as far as making a complaint. Sometimes they don’t want to make a fuss. Some are put off by the confusing system or worried about the impact that complaining might have on their care.

We will hold health and social care services to a high standard of listening and acting on people's concerns. We are committed to apply the same standards to ourselves and we know we need to do more to explain to people what we will do with their information if they tell us about their experience of care.

We will continue to work on making it easier to give us good quality feedback, and work with our partners to improve people's experience beyond CQC.

It's time for all of us – regulators, providers, professionals and commissioners – to make the shift to a listening and learning culture that encourages and embraces complaints and concerns as opportunities to improve the quality of care.



**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**



# SUMMARY

**Complaints matter in health and social care and for too long they have not been taken seriously enough. Too often complaints are met with a defensive culture instead of a willingness to listen and learn.**

This report does two things: it describes how complaints and concerns fit into CQC's new regulatory model, and it presents early findings on the state of complaints handling in hospitals, mental health services, community health services, GP practices, out-of-hours services and adult social care services.

Several reports have influenced our work on complaints, including the public inquiry led by Sir Robert Francis QC, and the complaints review by the Rt Hon Ann Clwyd MP and Professor Patricia Hart, which led to this report from CQC.

## Complaints and concerns matter to CQC

CQC is not directly responsible for resolving individual complaints for people<sup>1</sup>; this is the role of providers and the ombudsmen. However, we do want to hear from people who experience or know about poor care because we use this information when we are inspecting services.

About 50 concerns about services are raised with CQC every day through our National Customer Service Centre. This number is increasing as public awareness of CQC grows.

We use feedback from people who share their experience with us in many ways. It feeds into our Intelligent Monitoring of the quality of services and it helps us decide when to inspect a service. We may decide to bring forward a comprehensive inspection or carry out a focused inspection based on concerns shared with us.

## Complaints and concerns in our new approach to regulation

Embedding complaints and concerns in CQC's regulatory model has two aims:

- z To improve how we use the intelligence from concerns and complaints to better understand the quality of care.
- z To consider how well providers handle complaints and concerns to encourage improvement.

Complaints handling is an excellent proxy for an open, transparent and learning culture that we would expect to see in well-led organisations.

1. The only exception is complaints relating to use of the Mental Health Act 1983

The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England have set out universal expectations of good complaints handling. We now have a clear vision of ‘what good looks like’ for people who use services – and providers need to meet these expectations.

In October 2014 we introduced a mandatory key line of enquiry for inspections of hospitals, mental health services, community healthcare services, GP practices, out-of-hours services and adult social care services. This looks at how well complaints and concerns are handled. This assessment forms part of our judgement and rating of an organisation’s responsiveness. For consistency in all inspections, this will apply to dentists, independent hospitals and ambulance services from April 2015.

New and robust methods help inspection teams to understand how well providers listen to people’s concerns and learn from them to improve quality.

Before a CQC inspection, we gather information relating to complaints and concerns, including details from partners such as the health and social care ombudsmen, local authorities, Healthwatch England and complaints advocacy services.

We request a range of information from providers before we inspect, such as a summary of complaints from the last 12 months and how these were resolved.

We ask what people who use services think about the way complaints and concerns are handled, using surveys, comment cards, and conversations during inspections, often led by CQC’s Experts by Experience.

During site visits, our inspectors review a sample of complaints files to understand if these have been handled in a way that matches the good practice we expect to see.

On large inspections (in hospitals, mental health services and community healthcare services), we are introducing a lead inspector for complaints and staff concerns to draw evidence together.

Our inspection reports now include a description of the provider’s handling of complaints. And the new fundamental standards include requirements around complaints handling as well as the new duty of candour. Where we find breaches of these standards, we will use our range of enforcement powers: warning notices, suspending or cancelling

registration and ultimately prosecution. We will work with partners to encourage improvement.

## Concerns raised by staff (whistleblowing)

A service that is well-led and wants to improve will encourage staff to raise concerns without fear of reprisal.

We want the staff of care providers to tell CQC if they know about poor care. While we have no legal power to protect individual members of staff from actions their employers might take, CQC expects all organisations to have effective arrangements to encourage staff to raise concerns and ensure these are taken seriously. Concerns may sometimes be

termed ‘whistleblowing’, although staff have told us they do not like the word.

We expect complaints and concerns to be used to improve the quality of care, and that employees who raise concern are valued, respected and protected. Reprisals such as victimisation or bullying are unacceptable.

In every inspection and as part of assessing an organisation’s leadership, CQC will look at processes in place to handle staff concerns. This report gives an update on CQC’s work in this area – we plan to publish a fuller account when Sir Robert Francis QC publishes the outcomes of the Freedom to Speak Up review, to which CQC has contributed.

## Health and social care services

We have analysed a range of data sources, including existing national data collections, concerns and feedback that we receive directly, our own published inspection reports and information collected directly from providers.

This report presents a partial picture of the state of complaints. It is not comprehensive and in general, caution should be applied in the interpretation of complaints data.

A care provider that actively encourages, seeks feedback and publicises its complaints process is likely to receive more complaints than another with a more defensive approach. However, in general you would expect an organisation providing poorer quality services to also receive higher volumes of complaints.

## NHS acute, mental health and community health services

There is far too much poor practice in NHS providers' responsiveness and treatment of people who make complaints. This is backed up by findings in patient surveys.

The total number of written complaints received by all NHS hospital and community health services has increased every year since 2011/12, although this overall increase masks decreases in numbers of complaints in some areas. When considered against estimates of increased activity, the rate of complaints per 1,000 patients has changed little over the last three years.

We found variable practice in complaints handling throughout the different stages of complaints management. However, there was more evidence of good practice than poor. Most poor practice reported by inspectors related to providers' responsiveness and treatment of people who complain. Most positive practice was found where providers learned lessons from complaints and demonstrated actions taken due to complaints.

People do not consistently receive information about how to complain and they find complaining stressful. We are concerned about the timeliness of investigations of complaints, and people feeling that their concerns are not taken seriously or adequately addressed.

## Adult social care and primary care services

There is less evidence available for us to analyse and judge how well complaints and concerns are handled.

Many providers report that they receive very few complaints (five or less over a 12-month period). There is much positive practice at all stages in the process of making a complaint. However, in response to a survey about complaints handling, many inspectors felt they did not have enough evidence, often because the locations inspected reported receiving very few complaints.

The large majority of people using adult social care services said they knew how to raise concerns, and they were very positive about the actions of care agencies in response to complaints made. People's feedback about adult social care and primary care services highlighted issues with the timeliness of investigations of complaints and responses. People felt that their concerns were not taken seriously or adequately addressed.

Based on negative feedback from websites, combined with our survey that showed inspectors often had insufficient evidence around complaints handling, we believe that our picture does not fully represent how well providers encourage, listen to and respond to complaints and concerns in adult social care and primary care.

We consider that much more could be done to encourage an open culture where concerns are welcomed, particularly as high numbers of providers in these sectors report that they receive very few or no complaints at all.

## Conclusion

Improving the data available in these sectors will be crucial to presenting a truer picture of the state of complaints.

CQC's new and more thorough methods of reviewing complaints handling will allow inspectors to get a more comprehensive picture of the state of complaints. We will continue to review inspection findings and refine our methods if necessary.

We understand that the next stage of reform to the Health and Social Care Information Centre data

collection will focus on improving response rates and quality of primary care returns, and will consider the extension of the collection to adult social care. We hope these changes are implemented as a priority.

This report paints a partial picture of the state of complaints in health and social care services, but some things are clear: there is wide variation in the way complaints are handled and much more

could be done to encourage an open culture where concerns are welcomed and learned from.

Most providers have complaints processes in place, but people's experience is not consistently good.

CQC will continue to work closely with partners so that everyone – regulators, providers, professionals and commissioners – makes the shift to a listening culture that encourages and embraces complaints and concerns as opportunities to improve the quality of care.



# 1. INTRODUCTION

## Complaints matter in health and social care. For too long they have not been taken seriously enough.

It is still common for people who have suffered poor care to have their negative experience compounded when they make a complaint. Too often, complaints are met with a defensive culture, instead of a willingness to listen and learn.

Feedback from people who use services – compliments, concerns or complaints – should be valued. Every concern must be seen as an opportunity to improve the quality of care.

At CQC, we take complaints and concerns seriously – and we expect the same of providers. Putting the views of people at the centre of everything we do is our top priority.

This report sets out the work we are doing to place concerns, complaints and feedback at the heart of quality regulation. We are on a journey and have some way to go. The report also draws together for the first time early findings from our new inspections, to give us an indication of the state of complaints handling in health and adult social care services.

Several reports have influenced our work in this area. In their review of the NHS complaints system in October 2013, the Rt Hon Ann Clwyd MP and Professor Tricia Hart called for complaints to be taken seriously.<sup>2</sup> They received 2,500 responses

to their review, some from people who had not complained because they felt the process was too confusing or they feared for their future care. CQC took part in this review and made the following pledges:

- z To develop the way we use complaints information, as well as other views and feedback from people who use services in our surveillance model, to ensure they are embedded consistently and given significant weighting.
- z To analyse the number and themes of complaints and feedback we receive directly.
- z To work closely with and share information with our regulatory partners about complaints.
- z To strengthen how we consider complaints as we develop our approach to assessing the quality and safety of hospitals and other services.

The Secretary of State for Health commissioned the Clwyd/Hart review in response to the second Francis Inquiry report, published in January 2013. Sir Robert Francis QC called for regulators to make better use of the information contained in complaints.

2. [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/255615/NHS\\_complaints\\_accessible.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255615/NHS_complaints_accessible.pdf)

## FRANCIS RECOMMENDATIONS FOR CQC RELATING TO COMPLAINTS

- z **Recommendation 38:** CQC should ensure as a matter of urgency that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out, probably via its local relationship managers. Any bureaucratic or legal obstacles to this should be removed.
- z **Recommendation 39:** CQC should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes.
- z **Recommendation 40:** It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.
- z **Recommendation 121:** CQC should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.

CQC has also taken part in inquiries led by the Health Select Committee and the Public

Administration Committee looking at aspects of complaints handling in health and social care.

Recent reports from the Local Government Ombudsman, the Parliamentary and Health Service Ombudsman and Healthwatch England clearly demonstrate that, although actions have been taken to improve the complaints system, there is a long way to go before people who use services, and those close to them, feel an improvement.

CQC's approach to complaints in our regulatory model has been developed over time and through consultation. We have worked with people who have made complaints, staff who have raised concerns, and providers that we regulate. The work has benefited from the support and advice of our National Safety Advisor, James Titcombe, and also

Dr Kim Holt, who worked with CQC on secondment for six months.

## FOCUS GROUP WITH PEOPLE WHO HAVE MADE COMPLAINTS

In September 2014, CQC held a joint workshop with the Patients Association and nine members of the public who had experience of serious healthcare failures and of navigating the complaints system. This was to listen to their experiences, and gather feedback on CQC work to improve its assessments of how well providers encourage, respond and learn from complaints.

Many of the people who attended the event had lost loved ones as a result of poor care. One person described the response to their complaint:

*"...an absolute nightmare. They deny everything... and take months to reply to anything. You ask them specific questions and you end up with very general policy statements."*

This experience was typical of other people who spoke to us. These are examples of organisations failing to undertake high-quality investigations following serious healthcare failings, and patients and families finding that the complaints process failed to adequately respond to their concerns.

We have tested our new approach during inspections, including in-depth pilots with the Patients Association on 11 acute hospital

inspections. National partners have been involved in the development of this work through the Department of Health Complaints Programme Board. This has included several opportunities to share our work with voluntary sector partners.

CQC has been working to improve how it incorporates concerns raised by care staff in its regulation. Mostly, we treat concerns in the same way, regardless of whether they are raised by people who use services, those close to them, or staff.

However, CQC is a prescribed body under the Public Interest Disclosure Act. This means that employees of health and social care organisations can make disclosures to us where they have concerns about their employing organisation. This report gives an update on CQC's work in this area – we plan a fuller account when Sir Robert Francis QC publishes the outcomes of the Freedom to Speak Up review, to which CQC has contributed.

In their review of NHS complaints, the Rt Hon Ann Clwyd MP and Professor Patricia Hart asked CQC to report on complaints handling in acute trusts that we inspected in the year following their report.

This report does two things: it describes how complaints and concerns fit into CQC's new regulatory model, and it presents early findings on the state of complaints handling in hospitals, mental health services, community health services, GP practices, out-of-hours services and adult social care services.

Where the report presents information on the state of complaints, we considered existing national data collections, such as the Health and Social Care Information Centre's (HSCIC) annual publication of written NHS complaints. We also reviewed concerns that came directly to our National Customer

Service Centre, feedback submitted through our online 'Share Your Experience' form, our published inspection reports, and information collected directly from providers to inform our new inspection model. For adult social care, and GP and out-of-hours services, we also asked our inspectors about how these providers handled complaints in the inspections they carried out, between August and October 2014.

This creates a partial picture; only now are we fully implementing our new approach to regulation. Some of our analysis is based on samples of available data and may not be representative of the sector as a whole.

This report presents an impression of the state of complaints. It is not comprehensive and, in general, caution should be applied in the interpretation of complaints data. We would expect an organisation providing poorer quality services to also receive higher volumes of complaints. But organisations that openly welcome feedback may have higher rates of complaints too.

In CQC's monitoring and inspection activity, we treat numbers and rates of complaints – high or low – as indicators to prompt potential further investigation.

We know that people want services to be open and to encourage people to speak up. We must not assume that rising numbers of complaints mean worsening care. If we do, we risk making it less likely for services to value concerns and to use them to help improve the quality of care.



## 2. COMPLAINTS AND CONCERNS MATTER TO CQC

**People who are unhappy with the care or treatment they have received from any NHS or social care service should contact the service directly to make a complaint. This gives providers the chance to try to put things right.**

If people are not happy with the outcome of the complaint or how it was dealt with, they can ask the Health Service Ombudsman or the Local Government Ombudsman (for adult social care, both publicly and privately arranged and funded) to investigate it. The ombudsmen are free, independent complaints services. If they decide that the service has got things wrong, they can make recommendations to put things right.

CQC is not directly responsible for resolving individual complaints for people<sup>3</sup>; this is the role of providers and the ombudsmen. However, we do want to hear from people who experience or know about poor care because we use this information when we are inspecting services.

Concerns raised by people using services, their families and friends, and staff working in services all provide vital information that helps us to understand the quality of care. We also want to hear about positive experiences so we can highlight and share examples of good and outstanding care.

Feedback from people who share their experience is used in many ways:

- z To feed into our ongoing Intelligent Monitoring of the quality of services.
- z To help us decide when to inspect a service – we may decide to bring forward a comprehensive inspection, or carry out a focused inspection based on concerns shared with us.
- z To help shape our lines of enquiry before an inspection, to ensure we direct our resources to areas of greatest concern.
- z To raise concerns with providers and seek a response. We may ask for verbal assurance that a matter has been dealt with, ask for evidence or request an investigation by the provider's manager and a report back to CQC.

Many people contact CQC feeling that they have nowhere else to go. They have tried to raise their concerns with providers, commissioners and ombudsmen. Some are frustrated that CQC can only look at issues that have a bearing on the current quality and safety of care provided. We were concerned that there appeared to be a gap for people who have a historic complaint. We welcome the Parliamentary and Health Service Ombudsman's statement that for serious health cases which are outside of the normal 12 month period specified in law, the Ombudsman will positively consider

3. The only exception is complaints relating to use of the Mental Health Act 1983.

whether an effective investigation is possible given the passage of time.

Just as there are people who feel they have exhausted every option, we know there are many people who never reach the stage of making

a written complaint. They are put off by a confusing system or worried about the impact that complaining might have on how they are treated. Healthwatch England recently estimated that 250,000 incidents went unreported last year. These are said to be people who felt unable to complain.<sup>4</sup>

We support Healthwatch England's call for there to be 'no wrong door' for complaints and concerns and are working to make it a reality. For example, we have an agreement with the Local Government

Ombudsman to make direct phone transfers so that no matter who receives the initial call, people are put through to the organisation best placed to address the issue they are raising. Similarly, complainants should not have to think hard about which ombudsman to turn to where they have a complaint about health or social care services. We welcome the recommendations by the Public Administration Select Committee for a unified ombudsman service.

CQC receives a huge number of contacts from people telling us about poor care and this number is increasing across health and social care sectors. In 2013/14, there was a total of 18,455 concerns about regulated services received by our National Customer Service Centre – about 50 a day.

We cannot be sure what has caused this increase but we know the public's awareness of CQC is increasing. In May 2014, 55% of people had heard of CQC compared to 22% in 2012. The concerns that people share with CQC are valued and we are working hard to encourage more people to share their experience with us by making it as easy as possible for people to give us feedback.

Improving the experience of individuals giving feedback to CQC and using the information effectively in our regulatory activities will create a

virtuous circle. A survey by YouGov for Healthwatch England suggested that 82% of people would be more likely to raise a concern about poor care if they knew the information would be used to inform CQC's inspection processes.<sup>5</sup>



CQC is working to better understand how we can gain the maximum value from the feedback people give us. This includes developing our qualitative analysis techniques, and ensuring that we collect feedback in the most efficient and effective way.

We want to make listening and responding with compassion and clarity a core competence of CQC staff. We are developing training so that all our employees are clear about their role in handling feedback and concerns about the providers we regulate. We are also reviewing our own corporate complaints procedure (for complaints about CQC, rather than concerns about the providers we regulate).<sup>6</sup>

**CQC has reviewed its own whistleblowing policy and in January 2014 appointed a non-executive director (Michael Mire) with responsibility in this area.** This in line with a recommendation in the Clwyd/Hart report.

4. [www.healthwatch.co.uk/sites/default/files/final\\_complaints\\_large\\_print.pdf](http://www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf)

5. [www.healthwatch.co.uk/sites/default/files/final\\_complaints\\_large\\_print.pdf](http://www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf)

6. [www.cqc.org.uk/content/complain-about-cqc](http://www.cqc.org.uk/content/complain-about-cqc)

## 'TELL US ABOUT YOUR CARE' / PARTNERSHIPS WITH THE COMMUNITY AND VOLUNTARY SECTOR

To increase our access to people's experiences of care (both good and bad) CQC has established partnerships with a number of national health and social care charities. We currently work with the Patients Association, the Relatives & Residents Association, Carers UK, Mind, Action against Medical Accidents and (from November 2014) The Silver Line. Through the partnerships, we can demonstrate the range of action that we take in response to this information.

We receive an average of 280 items of feedback each month across all the partners. Of these, 42 (15%) are positive comments and 238 (85%) are concerns about care.

Of the 238 concerns, on average 24 (10%) are serious enough to prompt us to make a safeguarding referral to the local council because someone may be at risk of, or experiencing, abuse. Fourteen concerns (6%) prompt us to carry out a responsive inspection or bring forward the date of a planned inspection.

On average, 57 concerns (24%) prompt us to raise the issues with the service provider and seek a response from them. This ranges from a discussion with the provider and verbal assurances, or a request for evidence (such as staff rotas), to a request for an investigation to be carried out by the registered manager and a report submitted to CQC. It also includes requesting a copy of the provider's response to the complaint, where an individual has indicated they are intending to make a complaint to the service.

For around 103 concerns (43%) the relevant inspector advises that no immediate action is required, but the information will be used to inform the next scheduled inspection. Sixteen concerns (7%) require no action because the areas raised had been covered at a recent CQC inspection. And 22 concerns (9%) do not provide enough information or do not prompt any action because the concern is about an experience that took place too long ago and/or there have been changes to the service in the meantime.

## Complaints in CQC's new approach to regulation

CQC has a clear purpose: to make sure health and social care services provide people with safe,

effective, compassionate and high-quality care, and to encourage services to improve. We put people who use services at the heart of our work.

To fully understand people's experiences of care, the focus of our inspections is on the quality and safety of services, based on the things that matter to people. We always ask five questions of services:

- z Are they safe?
- z Are they effective?
- z Are they caring?
- z Are they responsive to people's needs?
- z Are they well-led?

A service that is safe, responsive and well-led will treat every concern as an opportunity to improve. It will encourage its staff to raise concerns without fear of reprisal. It will respond to complaints openly and honestly.

Embedding complaints and concerns in CQC's regulatory model has two aims: to improve how we use the intelligence from concerns and complaints to better understand the quality of care; and to look at how well providers handle complaints and concerns to encourage improvement (**FIGURE 1**).

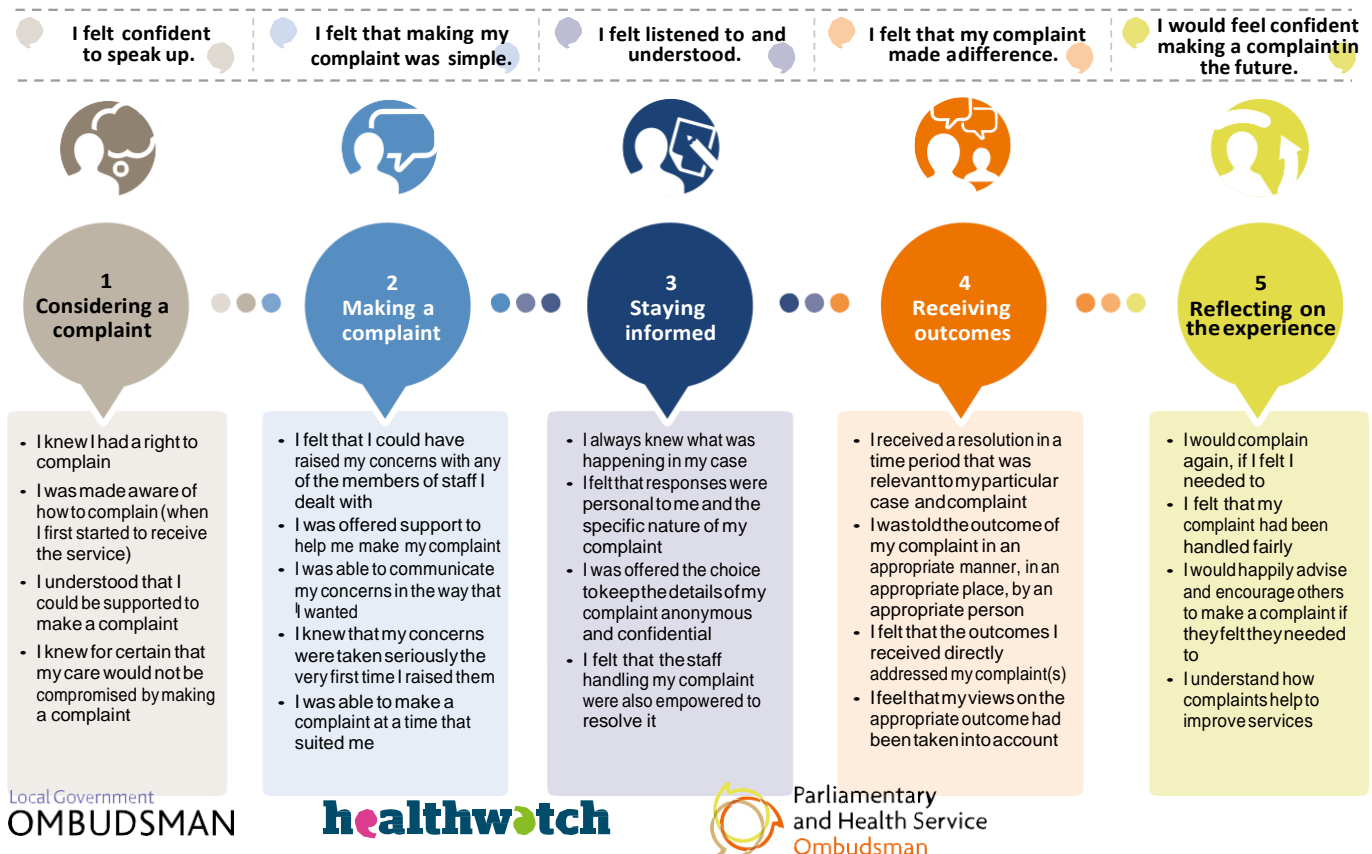
FIGURE 1: EMBEDDING COMPLAINTS AND CONCERNS IN CQC'S REGULATORY MODEL



The Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England, have set out universal expectations of good complaints handling

(FIGURE 2). We now have a clear vision of ‘what good looks like’ from the point of view of people who use services.

FIGURE 2: A USER-LED VISION FOR RAISING CONCERNS AND COMPLAINTS



We have built on these expectations, with input from a wide range of people with expert and personal knowledge of raising concerns in health and social care. Feedback from people who use services – and from care staff – is now at the heart of our new approach to regulation.

In October 2014 we introduced a mandatory key line of enquiry for inspections of hospitals, mental health services, community healthcare services, GP practices, out-of-hours practices and adult social care services that looks at how well complaints and concerns are handled. We will do the same in sectors where we are still developing our new approach, such as the ambulance sector. The key line of enquiry asks how people's concerns and complaints are listened to, acted on and used to improve the quality of care. Each key line of enquiry is accompanied by a number of prompts that inspection teams will consider as part of the assessment. We call these prompts.

- z Do people who use the service know how to make a complaint or raise concerns, are they encouraged to do so, and are they confident to speak up?
- z How easy is the system to use? Are people treated compassionately and given the help and support they need to make a complaint?
- z Is the outcome explained appropriately to the individual? Is there openness and transparency about how complaints and concerns are dealt with?

Inspection teams use evidence from ongoing local relationships, local and national data, pre-inspection information gathering and on-site inspection to answer the key lines of enquiry.

Following comprehensive inspections, we award ratings on a four-point scale:

- z Outstanding
- z Good
- z Requires improvement
- z Inadequate.

How well providers handle complaints feeds into our overall rating of how responsive they are. The characteristics of each rating include:

- z Outstanding – there is active review of complaints and how they are managed and responded to, and improvements are made as a result across the services.
- z Good – it is easy for people to complain or raise a concern and they are treated compassionately when they do so.
- z Requires improvement – people do not find it easy to complain or raise concerns, or are worried about raising concerns or complaining. When they do, a slow or unsatisfactory response is received.
- z Inadequate – there is a defensive attitude to complaints and a lack of transparency in how they are handled. People's concerns and complaints do not lead to improvements in the quality of care.

Full details of key lines of enquiries, prompts and ratings characteristics can be found in CQC's guidance for providers.<sup>7</sup>

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7. [www.cqc.org.uk/content/guidance-providers](http://www.cqc.org.uk/content/guidance-providers)

## EXTRACTS FROM INSPECTION REPORTS SHOWING EXAMPLES OF GOOD PRACTICE

### THE HANDBRIDGE MEDICAL CENTRE, CHESTER (GP PRACTICE)

The Patient Participation Group worked with the practice to improve services and feedback was welcomed. We found evidence that feedback from patients, public and staff was acted on and improvements made. They told us the practice was very eager to engage with its patients and listened to them.

### GREEN ACRES NURSING HOME, LEEDS (CARE HOME)

We saw the record of complaints kept in the home and reviewed how one complaint was dealt with. This showed that when a complaint was made it was taken seriously and investigated fully. We also looked at the record of significant events and saw there was learning from these. We could see that learning from any complaints, incidents and investigations was fed back to staff at meetings and during individual staff supervision, if appropriate. People were clear who they would talk to if they had a concern or complaint. They said they were happy to tell any of the staff.

### FRIMLEY PARK HOSPITAL, SURREY (ACUTE TRUST)

Feedback from a 'Friends and Family' test was visible on all wards visited. Along with complimentary feedback and high levels of recommendation, we saw examples of feedback on areas for improvement. This included a comment on noise levels at night and the action taken to resolve this, which included raising staff awareness, settling people earlier, and turning lights off. On a ward we saw that feedback included a request for televisions and improved arrangements for take-home tablets. Action in response to this included the installation of televisions and doctors were to write up take-home medication in a timely manner. The unit displayed the number of plaudits and complaints it received every month for relatives and patients to see. It reported four plaudits and no complaints for July 2014.

### MILTON KEYNES URGENT CARE SERVICES (CIC) (OUT-OF-HOURS SERVICE)

We sampled the complaints log from the service and found that where complaints were upheld, the service invited the complainant (after they had received the final outcome letter) to visit the service, meet with staff and managers, discuss the outcome and share ideas from their experience.

### BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST

Staff told us they knew how to support people who used the service, or their carer or relatives, if they wanted to make a complaint. People said that they felt listened to, and that they were able to provide feedback to the service. They knew how to make a complaint and were listened to by the trust when they did this.

All reported incidents were screened by the clinical lead and incidents, complaints and feedback were discussed in the minuted directorate business meetings (held monthly).

We found examples where learning from complaints had been used to change front line practices and training for some staff. For example, within the community services for older people, the trust had a care home liaison service to minimise inappropriate care home placements, particularly for those with rare or complex forms of dementia.

### SOLENT NHS TRUST (COMMUNITY HEALTH TRUST)

We found that services actively sought feedback from patients and they told us of improvements they had made. For example, access hours to some children and family clinics had been changed to reflect feedback from parents.

The majority of staff that we spoke with said that the trust listened to their feedback and responded to it. The trust was committed to increasing patient feedback from a range of sources and was piloting innovative methods of real-time feedback on computer tablets, to increase participation.

## Intelligent Monitoring

‘Intelligent Monitoring’ is how we describe the processes CQC uses to gather and analyse information about services. This information helps us to decide when, where and what to inspect.

By gathering and using the right information, we can make better use of our resources by targeting activity where it is most needed.

Feedback from people who use services is central to this model. In acute NHS trusts, Intelligent Monitoring uses various indicators:

- z CQC National Customer Service Centre qualified whistleblowing alerts<sup>8</sup>
- z CQC’s National Customer Service Centre safeguarding concerns
- z CQC ‘Share your experience’ negative comments
- z NHS Choices negative comments
- z Patient Opinion negative comments
- z Complaints received by CQC
- z Provider complaints (sent to CQC by the HSCIC).

Our approach to Intelligent Monitoring will vary according to the quality and availability of information. For example, there tends to be more information available for NHS trusts than for other providers.

## Inspection

Our inspections are at the heart of our regulatory model and are focused on the things that matter to people. There are two types of inspection:

- z A focused inspection is used to follow up specific concerns from earlier inspections, or respond to new information that has come to our attention, including concerns raised with us by people using services or staff concerns.

- z A comprehensive inspection reviews the service in relation to the five key questions and leads to a rating on each on a four-point scale. This section relates to comprehensive inspections, unless otherwise stated.

### Before the site visit

In addition to our Intelligent Monitoring analysis, we gather a great deal of information relating to complaints and concerns before an inspection.

Our local inspection teams make contact with a wide range of partners to help plan inspections. These vary depending on the sector and more detail can be found on the ‘guidance for providers’ section of our website. Some of the partners we contact to find out more about concerns and complaints and how services handle these include:

- z Professional regulators (for example, General Medical Council, Nursing and Midwifery Council)
- z Parliamentary and Health Service Ombudsman
- z Local Government Ombudsman
- z Royal colleges
- z UNISON
- z Local authority<sup>9</sup>
- z Local Healthwatch
- z NHS Complaints Advocacy
- z Clinical commissioning group
- z Monitor regional team
- z NHS Trust Development Authority regional office
- z NHS England regional director
- z Local voluntary and community groups.

Since September 2013, CQC has written on a quarterly basis to all NHS complaints advocacy services to inform them of our announced inspections and ask for their contributions. Our inspection teams have said that the input they receive is valuable.

8. ‘Qualified’ means a disclosure that meets the criteria set out in the Public Interest Disclosure Act (that is, there is harm or risk of harm to people; possible or actual criminal activities; failure to comply with a legal obligation; miscarriages of justice; damage to the environment; or a deliberate attempt to cover up any of the above).

9. Adult social care contracts monitoring teams, regarding complaints specifically.

As well as reviewing the information from people who use services, our inspectors use additional methods to gather views ahead of an inspection, such as speaking with community, patient and carer groups.

We request a range of information from providers before we inspect. We ask providers to send us their complaints policies in advance of an inspection, along with a summary of complaints from the last 12 months and how these were resolved.

We are rolling out a 'self-report' for hospitals, mental health services and community healthcare services to tell us how they handle complaints before we inspect. This helps us to know what to focus on during the inspection.

Although our inspections include many opportunities for people who use services to share their views, we want to understand more about the experience of making a complaint. From now on, we will ask providers to share with us any survey they have carried out of people who have complained to them in the last 12 months.

In adult social care, we survey people who use home care services and Shared Lives schemes and those close to them before an inspection. We ask if they know how to complain or raise a concern, and how the organisation and staff handled any concerns they did raise.

## WHAT WE ASK IN THE TRUST SELF-REPORT ON COMPLAINT HANDLING

**Leadership:** Who is responsible for complaints at the trust? Please include the executive and non-executive lead, as well as the individual with day-to-day responsibility and the total number of staff dedicated to complaints.

**Governance:** Please describe the trust's governance arrangements for complaints: how often are they discussed at board level? What committees review the handling of complaints and compliments, and any themes within them?

**Awareness:** Describe how patients and relatives are made aware of how they can raise concerns or make formal complaints. Please describe what processes are in place to resolve complaints before they become formal.

**Investigation:** Describe how complaints are investigated: who leads on investigating complaints and how is this decided? How is the investigation documented? Who checks the responses and is responsible for sign-off?

**Timeliness:** What are your local standards for providing a response to complaints (timeliness) and how well are you achieving this? Are there any areas that struggle to achieve the standards?

**Learning:** How do you disseminate learning from complaints? Can you point to any changes made as a result of learning from complaints?

**Evaluation:** How do you ascertain whether complainants are satisfied with the complaints process and the outcome?

## Site visit

Our new approach to inspections provides many opportunities for inspection teams to gather evidence of how well providers handle complaints. For example:

- z Speaking individually and in groups with people who use services.
- z Using comment cards placed in reception areas and other busy areas to gather feedback.
- z Using posters to advertise the inspection to allow people an opportunity to speak to the inspection team.
- z Speaking with a range of staff during the inspection and with focus groups held with staff in hospitals.
- z Interviewing the member of staff with responsibility for complaints.
- z Observing interactions, for example at reception desks, and looking for information about how to complain and give feedback.

We often include ‘Experts by Experience’ on our inspections. Experts by Experience are people who use care services or care for someone who uses health and/or social care services. Their main role is to talk to people who use services and tell us what they say.

Many people find it easier to talk to an Expert by Experience rather than an inspector. Experts by Experience can also talk to carers and staff, and can observe the care being delivered.

During site visits, our inspectors review a sample of complaints files to understand whether these

have been handled in a way that matches the good practice we expect to see.

Inspectors will usually look at up to five complaint files, which should be selected by inspectors, not by the provider. They usually include at least one serious complaint and, if possible, one relating to a person who may find it more difficult to have their voice heard. Most will be closed, which helps the inspector to review the full process from beginning to end, but inspectors may select an ongoing case.

## PILOTWORK WITH THE PATIENTS ASSOCIATION

The Patients Association has carried out significant work on standards in relation to complaints in recent years. Its methodology for reviewing the effectiveness of complaints procedures and the experience of complainants provided a useful framework for CQC to learn from and build on its own approach.

CQC worked with the Patients Association in 11 acute hospital trust inspections that took place in late 2013 and early 2014. The inspections trialled methods of pre-inspection analysis and on-site activity to review the effectiveness of providers’ complaints processes, and to understand the experience of complainants and the ability of providers to learn and improve as a result of complaints.

### KEY FINDINGS:

- z A pre-inspection survey of people who had complained to the provider was useful in shaping lines of enquiry for the inspection.
- z Having a lead for complaints on the inspection team ensured the information was captured to show evidence for the complaints key line of enquiry.
- z Reviewing complaints files was a robust method for understanding the effectiveness of the complaints process.

This method is particularly useful for understanding the tone and content of response letters that are sent to people who have complained. CQC expects responses to be empathetic and to provide a full explanation and apology where appropriate. The NHS Litigation Authority is clear that “saying sorry is not an admission of legal liability; it is the right thing to do”.<sup>10</sup>

10. [www.nhs.uk/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf](http://www.nhs.uk/claims/Documents/Saying%20Sorry%20-%20Leaflet.pdf)

Reviewing complaints files is resource-intensive for inspection teams. Based on testing with the Patients Association, we believe that reviewing around five cases is achievable within current resource levels and provides useful insight into complaints handling.

Along with all the methods described here, CQC will keep this under review and make changes if needed.

On large inspections (in hospitals, mental health services and community healthcare services) we are introducing a lead inspector for complaints and staff concerns who will draw this evidence together. All members of the inspection team are responsible for listening and responding to people using services or staff raising concerns, but having a lead gives responsibility for pulling information together to a single individual.

Over the coming months we are rolling out guidance and training to support inspection teams in using these methods effectively to understand complaints handling. The aim is that every inspection will consistently and effectively use the full range of methods from January 2015.

## Requiring and encouraging improvement

Our ambition is to see an improvement in the quality of complaints and concerns handling in all services. We believe that this is an important part of ensuring that people receive safe, high quality care.

Our inspection reports will now always include a description of the provider's handling of complaints. For large inspections where the reports tend to be very long, we will ensure that complaints handling features in the summary of how responsive the provider is. We will recognise good practice and set out clearly where complaints handling falls short.

Although we are not an improvement agency we will act to encourage improvement. We will work closely with stakeholders and partners to

drive improvement. For example, local complaints advocacy groups have told us that they are able to inspect reports. In some sectors, we include key lever change by challenging providers who have had issues about complaints handling flagged in their

local partners in the 'quality summits' we hold after inspections to ensure that they are aware of the improvements we require.

### POOR PRACTICE AND CQC INTERVENTION

The Parliamentary and Health Service Ombudsman asks NHS providers to send a copy of their responses to complainants to CQC.

We recently received a copy of a letter that was distinctly lacking in empathy. Our inspector contacted the trust's chief executive about the tone of the letter, which we felt missed the opportunity to make a heartfelt apology and to emphasise the positive learning and changes that had been made. CQC will provide feedback like this when it is warranted.

CQC can take enforcement action against registered providers who breach regulations. One of the new fundamental standards, Regulation 16<sup>11</sup> (which will come into effect in April 2015, subject to parliamentary process) relates to complaints. It is intended to ensure that anyone can make a

complaint about any aspect of care and treatment planned and/or provided, and to ensure that providers investigate complaints and take appropriate and timely action to rectify any failures identified by the complaint or investigation.

If a provider applying to be registered with CQC cannot demonstrate that it will meet the

requirements of this regulation from its first day of operation, CQC may refuse its application for registration.

In our new comprehensive inspections, we primarily look for good care, rather than checking compliance with regulations. We have ensured that all the

areas covered by the regulations are also covered in our key lines of enquiry. Where care requires improvement or is inadequate, we will also consider whether a regulation has been breached.

[www.cqc.org.uk/content/publishing-new-](http://www.cqc.org.uk/content/publishing-new-)



In focused inspections, where we are following up specific concerns from earlier inspections or responding to new information that has come to our attention, we assess whether the provider has improved so that they are no longer in breach of

regulations, or whether the new concern amounts to a breach of regulations.

Where there is a breach of regulations, CQC has a range of enforcement powers, including

issuing warning notices, suspending or cancelling registration, and prosecution. Monitor or the NHS Trust Development Authority may also decide to take action as a result of CQC's findings, if they relate to NHS foundation trusts or NHS trusts.

The fundamental standards also introduce a new duty of candour. This came into force this autumn in NHS bodies and will apply to other sectors from April 2015. It aims to ensure that providers are open and honest with people who use services if things

go wrong with their care and treatment. To meet the requirements of the regulation, a provider has to:

- z Make sure it has an open and honest culture across and at all levels within its organisation.
- z Tell people in a timely manner when particular incidents have occurred.
- z Provide in writing, a truthful account of the incident and an explanation about the enquiries and investigations that it will carry out.
- z Offer an apology in writing.
- z Provide reasonable support after the incident.

This organisational duty of candour sits alongside the existing duty of candour for professionals. It means that every care professional must be open and honest with patients if something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress.

The new duty of candour will, for the first time, place a legal duty on all provider organisations to be open and honest with patients and families following serious cases of avoidable harm or death. Where processes for identifying and properly investigating serious incidents in health and social care are poorly implemented, people may turn

to the complaints system to seek answers and assurances that lessons have been learned. There should be no need for people who use services, or their families or friends affected by serious failures, to raise a written complaint.

We welcome the Parliamentary and Health Service Ombudsman's recent decision to review the quality of investigations in 250 cases involving serious healthcare failings. CQC wants to make sure that the quality of incident investigations – and the learning – is audited as part of its inspection process. This will feed into our overall rating of the organisation.

If a provider fails to do any of the things listed above and breaches the duty of candour, CQC can use its range of enforcement powers or move directly to prosecution without serving a warning notice.

## Concerns raised by staff (whistleblowing)

Every concern is an opportunity for services to improve and for CQC to understand more about the quality of care. A service that is well-led and wants to improve will encourage staff to raise concerns without fear of reprisal.

Whereas complaints tend to follow an experience of poor care, concerns raised by staff are often an attempt to prevent something going wrong. Staff draw on their knowledge and experience of service delivery, and the issues they raise provide vital information about potential risks of poor quality or harm. Concerns may sometimes be termed 'whistleblowing', although staff have told us they do not like the word.

CQC is a prescribed body under the Public Interest Disclosure Act 1998. This means that employees of health and social care organisations can make disclosures to us where they have concerns about

their employing organisation. CQC wants staff to tell us if they know about poor care. Many already do. Between 1 April 2014 and 31 October 2014, some 5,638 staff contacted CQC. These contacts are logged by a team at CQC's National Customer Service Centre

and they are tracked to ensure the relevant inspector responds to them in a timely manner.

CQC uses this information to inform its regulatory activities. We know we need to do more to explain what action we take when people bring us

information, and to provide clarity over what we can and cannot do.

For example, people often think CQC can protect them from any detrimental impact if they disclose information, but we have no legal power to protect individuals from actions their employers might take. However, CQC expects all organisations to have effective arrangements to encourage staff

to raise concerns, to ensure that these are taken seriously, that they are used to improve the quality of care, and that employees who raise concerns are valued, respected and protected from any

detriment. Victimisation or bullying is unacceptable. We will look at the process in place to handle staff concerns in every inspection as part of assessing the leadership of an organisation.

Information shared with CQC will be dealt with in confidence and we will not disclose people's identity without consent. Staff can also raise concerns anonymously. However, it can be difficult to investigate issues of quality and safety and preserve anonymity.

People with historic cases also contact CQC in the hope that we can help resolve their concerns or hold a provider to account for its actions. While each case provides learning for us about the problems that can occur, and how we need to mould our new methods of inspection to detect similar problems and take effective action, we do not have the remit to resolve an individual case. As with complaints, we believe there is a regulatory gap in this area and we welcome the Freedom to Speak Up review, including its focus on historic cases.

Through our new approach we will assess the leadership and culture of the organisation in more depth than previously attempted. Staff confidence about raising concerns is an indicator of openness in

an organisation and how it might want to learn and improve.

Some key lines of enquiry and prompts that we ask as part of assessing leadership in a service include:<sup>12</sup>

- z How does the leadership and culture reflect the vision and values, and encourage openness and transparency and promote good quality care?
- z Does the culture encourage candour, openness and honesty?
- z How are staff supported to question practice and how are people who raise concerns, including whistleblowers, protected?
- z Is the value of staff raising concerns recognised by both leaders and staff? Is appropriate action taken as a result of concerns raised?

The following are ratings characteristics at each level, describing leadership in an organisation:

- z **Outstanding:** Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to raise concerns.
- z **Good:** Staff have the confidence to question practice and report concerns about the care offered by colleagues, carers and other professionals.
- z **Requires improvement:** Staff do not always raise concerns or they are not always taken seriously or treated with respect when they do.
- z **Inadequate:** There is bullying, harassment, discrimination or violence. When staff raise concerns they are not treated with respect. The culture is defensive.

Our Intelligent Monitoring includes staff concerns (whistleblowing) raised with CQC. We make extensive use of indicators from the NHS staff survey and the General Medical Council trainee survey, including questions covering feedback, concerns, errors, near misses and incidents, bullying, harassment and abuse, staff sickness and staff turnover.

12. See our guidance for providers for more information [www.cqc.org.uk/content/guidance-providers](http://www.cqc.org.uk/content/guidance-providers)

## FOCUS GROUP WITH STAFF WHO HAVE RAISED CONCERNS

In developing our work on staff concerns and whistleblowing, we brought together a group of people with experience of raising concerns in health and social care services. CQC staff met with the group in February and July 2014. We listened to their experiences, discussed the issues and asked how CQC might act to encourage change.

We heard people describe how the organisational response to their concerns was to take the focus away from the actual issues raised and instead focus attention on the person raising concerns. We heard how staff with previously exemplary records were suddenly faced with allegations. Often they found themselves subject to bullying and harassment. We heard about how the stress from this treatment had resulted in sickness and the inability to carry on as normal.

These events helped CQC develop our approach to ensure that the way staff are encouraged to raise concerns – and how issues are investigated and responded to – is integrated as part of our inspection work. The feedback from this group also helped us to understand the links with other cultural issues within the organisation. For example, inspection teams now consider information about bullying from staff surveys. They also look at factors such as staff sickness rates and the priority placed at board level on openness and transparency relating to safety concerns.

Before an inspection of either a homecare agency, hospice or a Shared Lives scheme, CQC carries out a staff survey. We ask if they agree with these statements:

- z “My managers are accessible, approachable and deal effectively with any concerns I raise.”
- z “My managers ask what I think about the service and take my views into account.”

CQC inspections now include specialist professionals who play a key role in helping teams understand whether there are problems with the way staff concerns are handled. We encourage members of staff to raise any concerns with our inspectors.

For example, on hospital inspections we hold focus groups with junior doctors, run by a junior doctor who is on our inspection team, to encourage them to share any concerns. Other staff forums are conducted by a peer on the inspection team and are held with senior doctors, junior nurses and care assistants, senior nurses and administrative staff.

We offer to speak to people who have contacted us to raise concerns directly and confidentially, one-to-one or at a drop-in sessions. We also provide comment cards that people may complete and send to the inspection team, to provide their views about services. We always interview key staff, including HR directors and non-executive directors, and we are able to review a sample of closed investigations.



### 3. STATE OF COMPLAINTS IN HEALTH AND SOCIAL CARE SERVICES

**In their review of NHS complaints, the Rt Hon Ann Clwyd MP and Professor Patricia Hart asked CQC to report on complaints handling in the acute trusts that we inspected in the year following their report.**

We have a clearer picture of the state of complaints for NHS trusts than for primary care and adult social care providers.

In acute, mental health and community health services there is far too much poor practice in providers' responsiveness and treatment of people who make complaints. This is backed up by the negative findings from patient surveys.

There is less evidence available on which to judge how well complaints and concerns are handled

in adult social care and primary care. Much more could be done to encourage an open culture where concerns are welcomed, particularly as high numbers of providers in these sectors report that they receive very few or no complaints at all.

Across all sectors, we believe that the new methods we are introducing to look at complaints handling, along with reforms by others such as the Health and Social Care Information Centre, will enable us to present a more complete picture of the state of complaints in the future.

#### NHS acute, mental health and community health services

##### Complaints received

NHS acute, mental health and community health services share information about their written complaints with the Health and Social Care Information Centre (HSCIC).<sup>13</sup>

We analysed this data and found that the number of written complaints received by all NHS hospital, mental health and community health services increased every year since 2011/12. This overall increase masks decreases in some areas, including acute inpatient services in 2013/14 and maternity services (TABLE 1 AND FIGURES 3-5).

13. It is mandatory for all NHS hospitals and community health services to return information on complaints to the HSCIC data collections. The response rate from NHS trusts is usually 100%.

## DATA SOURCES ANALYSED IN THIS REPORT

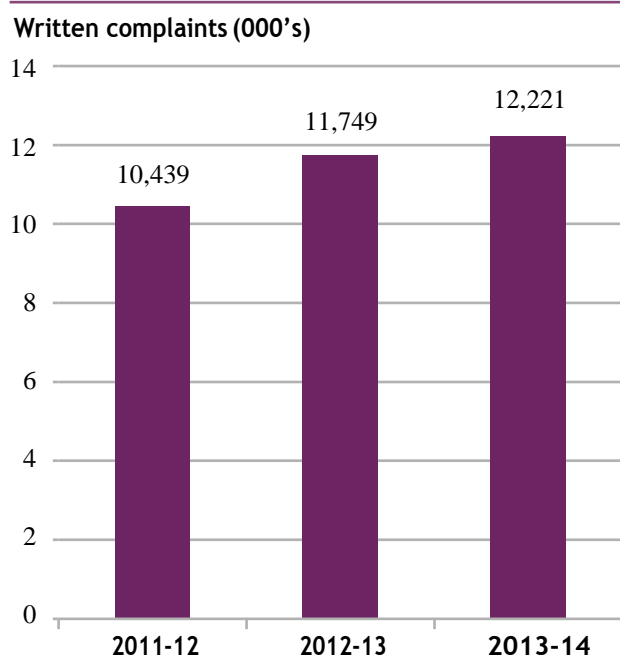
- z **Health and Social Care Information Centre – Data on written complaints in the NHS (2011/12 to 2013/14)**
- z **CQC National Customer Service Centre** – concerns received from 1 April 2012 about the quality of care in the providers we regulate.
- z **Published inspection reports** – we reviewed information relating to complaints handling in inspections carried out using our new approach. We looked at 165 adult social care inspection reports, 83 GP practice and out-of-hours service reports, 98 acute NHS hospital reports, seven NHS mental health service reports and eight community health service reports. We carried out qualitative analysis of the text to identify key themes and issues within sectors.
- z **Inspector survey** – we asked inspectors carrying out inspections in adult social care and GP practices between August and October 2014 to complete a survey about complaints handling.
- z **Provider information requests** – before carrying out an inspection, we ask providers for certain information that includes numbers, themes and timeliness of resolution of complaints. We reviewed information returned by 628 adult social care providers inspected during quarter 2 of 2014/15. We drew numbers and themes of complaints and timeliness of resolution from the adult social care information.
- z **User surveys** – in the acute sector, we carried out a survey with the Patients Association of people who had complained in four trusts, inspected in March 2014. Responses were received from 273 people. We also surveyed people using home care agencies and Shared Lives schemes that we were scheduled to inspect in quarter 2 of 2014/15. We received responses from 1,753 people using home care agencies and 38 people using Shared Lives schemes.

**TABLE 1: HEALTH AND SOCIAL CARE INFORMATION CENTRE – NHS WRITTEN COMPLAINTS  
2011/12 TO 2013/14**

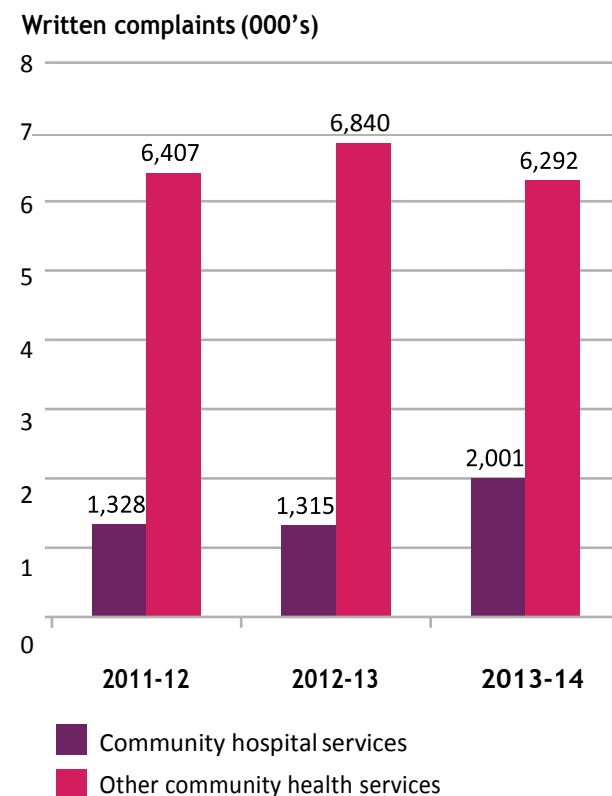
	2011/12	2012/13	2013/14	Change 2012/13 to 2013/14	Percentage change 2012/13 to 2013/14
Hospital acute services: A&E	9,362	9,680	9,919	239	2.5%
Hospital acute services: Inpatient	33,873	34,872	34,422	-450	-1.3%
Hospital acute services: Outpatient	29,559	30,019	31,083	1,064	3.5%
<b>Total acute services</b>	<b>72,794</b>	<b>74,571</b>	<b>75,424</b>	<b>853</b>	<b>1.14%</b>
Community hospital services	1,328	1,315	2,001	686	52.2%
Other community health services	6,407	6,840	6,292	-548	-8.0%
<b>Total community health services</b>	<b>7,735</b>	<b>8,155</b>	<b>8,293</b>	<b>138</b>	<b>1.69%</b>
<b>Mental health services</b>	<b>10,439</b>	<b>11,749</b>	<b>12,221</b>	<b>472</b>	<b>4.0%</b>

**FIGURE 3: ACUTE SERVICES 2011/12 TO 2013/14**

Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

**FIGURE 4: MENTAL HEALTH SERVICES 2011/12 TO 2013/14**

Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

**FIGURE 5: COMMUNITY HEALTH SERVICES 2011/12 TO 2013/14**

Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

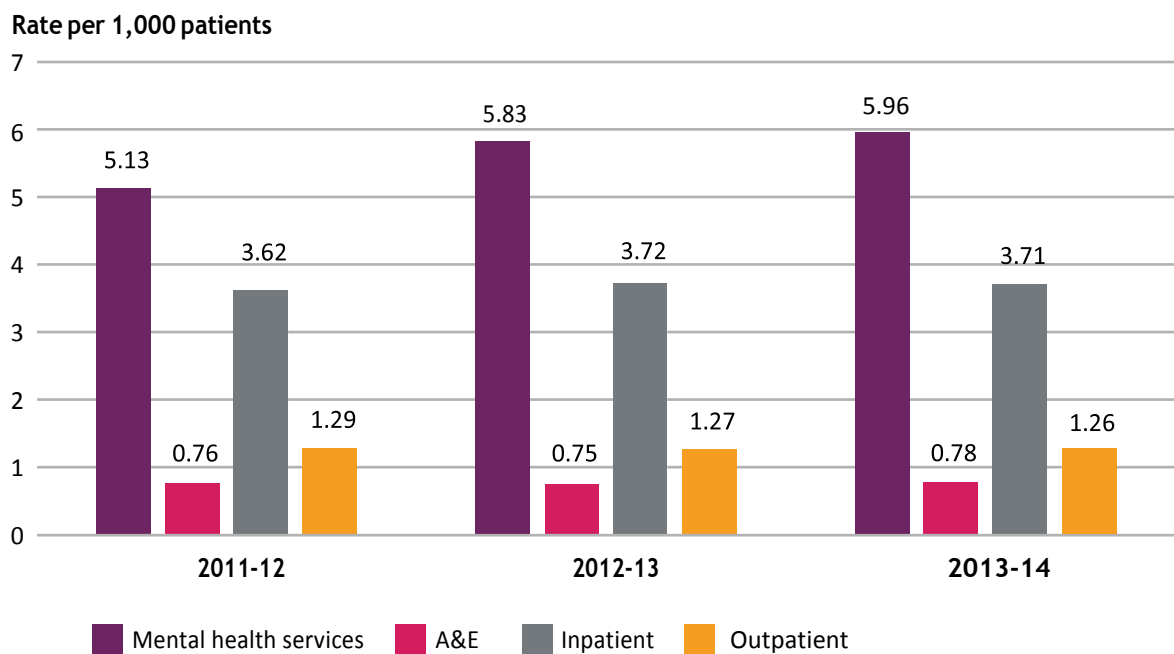
When considered against estimates of increased activity over the last three years, the rate of complaints per 1,000 patients has changed little in acute services, although it does appear to be increasing in mental health services (**TABLE 2 AND FIGURE 6**).<sup>14</sup>

14. The estimates of activity are drawn from the total counts of unique patients recorded across Hospital Episode Statistics (HES) and the Mental Health Minimum Dataset (MHMDs). The total count of unique patients does not take account of multiple attendances or length of inpatient stay, both of which may have a bearing on the likelihood of raising a complaint. Different rates may be produced if a different estimate of activity is used.

TABLE 2: RATE OF COMPLAINTS 2011/12 TO 2013/14

	2011/12	2012/13	2013/14
	Rate per 1,000 patients	Rate per 1,000 patients	Rate per 1,000 patients
Mental health services	5.13	5.83	5.96
Hospital acute services:			
A&E	0.76	0.75	0.78
Inpatient	3.62	3.72	3.71
Outpatient	1.29	1.27	1.26

FIGURE 6: RATE OF COMPLAINTS 2011/12 TO 2013/14



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2011/12 to 2013/14

There is variation in acute and mental health services between the organisations receiving the lowest numbers of complaints and those receiving the most complaints, even when activity levels are taken into account (**TABLE 3 AND FIGURES 7-8**).

This variation is not necessarily linked to differences in the quality of care. As we have already noted,

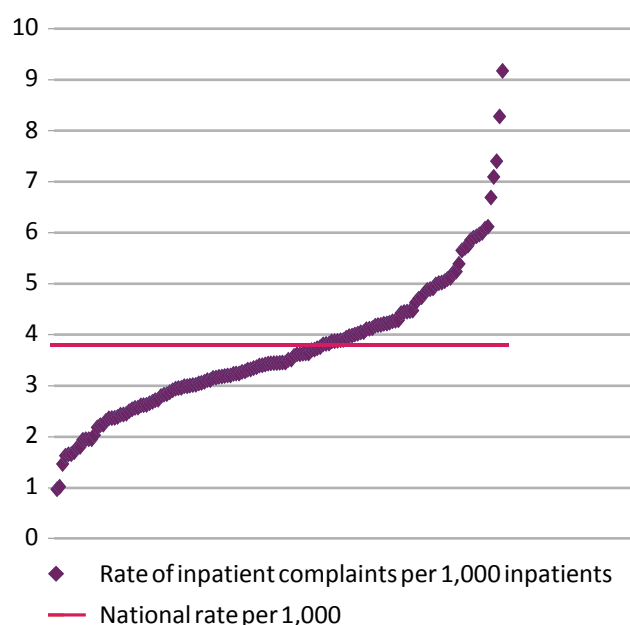
an organisation that actively encourages and seeks feedback and proactively promotes its complaints process is likely to receive higher volumes of complaints than an organisation with a more defensive approach. Higher numbers and rates of complaints should not automatically be seen as a negative, but should prompt further investigation.

**TABLE 3: RATE OF COMPLAINTS TO NHS TRUSTS 2013/14<sup>15</sup>**

	Acute A&E complaints	Acute inpatient complaints	Acute outpatient complaints	Mental health complaints
Maximum rate of complaints per 1,000 patients	3.05	9.17	3.76	14.63
Minimum rate of complaints per 1,000 patients	0.13	0.98	0.16	1.97
Average rate of complaints per 1,000 patients <sup>16</sup>	0.86	3.73	1.35	6.33

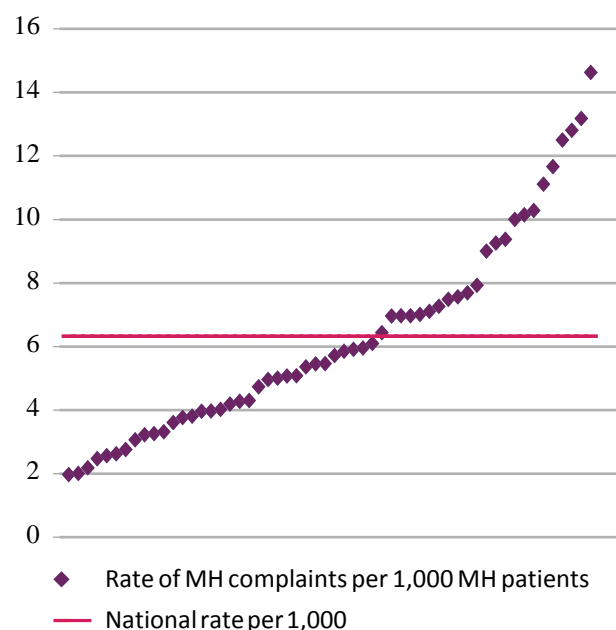
CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

**FIGURE 7: RATE OF INPATIENT COMPLAINTS**



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

**FIGURE 8: RATE OF MENTAL HEALTH COMPLAINTS**



CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

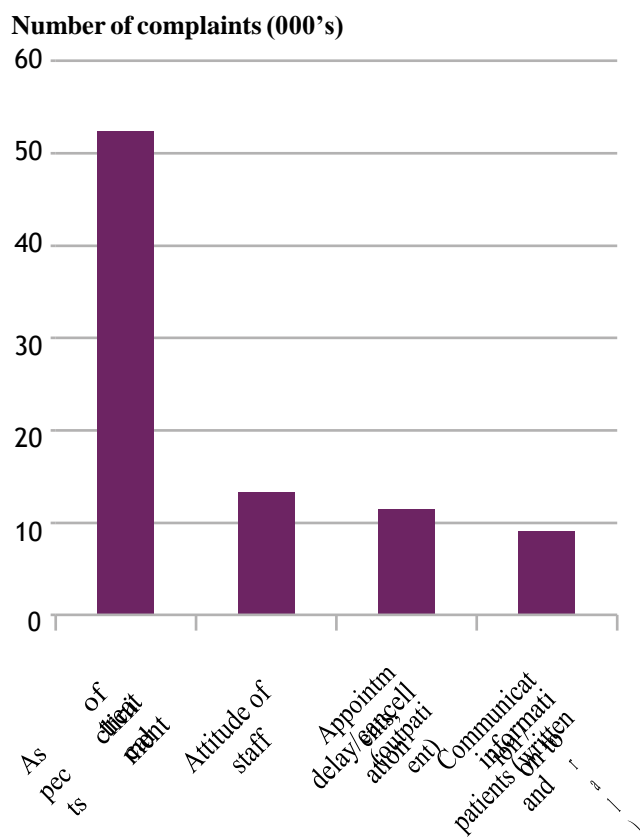
15. NHS acute trusts with known HES data quality issues have been excluded from these calculations.

16. The average figures presented in this table only relate to acute NHS trusts and mental health NHS trusts; the figures presented in the previous table relate to any organisation that received complaints regarding NHS A&E, inpatient, outpatient or mental health services.

Data from the HSCIC has informed this report and it has shown that over the last three years the main four themes of complaints across all NHS hospital and community health services are unchanged (**FIGURE 9**).

In November 2014 a Parliamentary and Health Service Ombudsman report showed that, in the first two quarters of 2014/15, 28% of its investigations into complaints about NHS acute trusts were about reported inadequate apologies or personal remedies. This has doubled from the 14% in 2013/14.

**FIGURE 9: MOST COMMON SUBJECTS OF WRITTEN COMPLAINTS IN NHS HOSPITAL AND COMMUNITY HEALTH SERVICES 2013/14**



Health and Social Care Information Centre data on NHS written complaints 2013/14

Four issues have remained in the Ombudsman's top five list of the most mentioned reasons for complaining about NHS trusts over the past 18 months:

- z Clinical care and treatment
- z Communication
  - z Diagnosis (including delay, failure to diagnose and misdiagnosis)
- z Attitude of staff.

As part of our new approach, we are encouraging people to share their experience of care with us, because this information helps us to understand the quality of providers. We have seen large increases in the numbers of concerns shared with our National Customer Service Centre (**FIGURE 10**). (See the start of chapter 2 for a description of the system.)

**FIGURE 10: CONCERNS RECEIVED BY CQC – NHS TRUSTS Q2 2012/13 TO Q2 2014/15**



Information from CQC National Customer Service Centre 2012/13 to 2014/15 – represents concerns received regarding a total of 1,307 NHS services

The marked increase in concerns raised with CQC from all sectors began around the end of 2012, when we were consulting on a new strategy and making significant changes to our organisational leadership, including beginning the recruitment of the new Chief Inspectors. We cannot be sure what has caused this increase but we know the public's awareness of CQC is increasing. In May 2014, 55% of people had heard of CQC compared to 22% in 2012.

## Complaints handling

We analysed a number of data sources to understand how well NHS providers are handling complaints and concerns.

Qualitative analysis of published inspection reports using our new approach showed variable practice in complaints handling (from knowledge and awareness of how to complain to providers learning lessons from complaints), although overall there was more evidence of good practice than poor.

Most poor practice reported by inspectors related to providers' responsiveness and treatment of people who complain (FIGURE 11).<sup>17</sup>

The majority of positive practice was found where providers were learning lessons from complaints and demonstrating the actions taken as a result of complaints.

We analysed a sample of qualitative data from a number of sources that collect feedback from

people who use health and care services, regarding care received across NHS services between 2011 and 2014 (including our own 'Share your experience' web form).<sup>18</sup> This type of feedback tends to be skewed negatively as people are more likely to report negative experiences than come forward to report acceptable or good experiences of care.

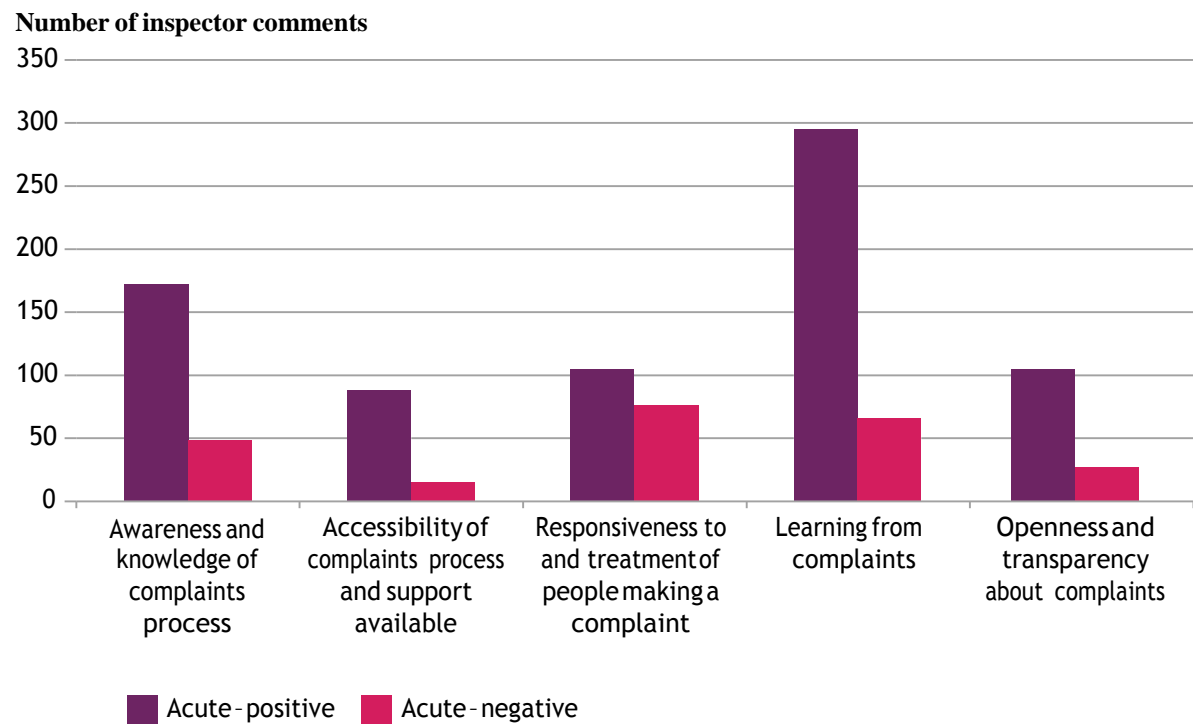
Key areas of concern across acute, mental health and community services include issues with the timeliness of investigations of complaints and people feeling that their concerns were not taken seriously or adequately addressed (FIGURE 12).

We carried out a survey with the Patients Association of 237 people who had complained in four NHS acute trusts, inspected in March 2014. It showed that people felt the experience of complaining had been difficult (FIGURE 13).

17. We reviewed inspection reports from our new approach for 98 acute NHS locations, from which 998 comments from CQC inspectors about complaints handling were analysed; seven inspection reports for mental health providers, from which 44 comments were analysed; and eight inspection reports for community health providers, from which 25 comments were analysed. The taxonomy that we have used to categorise inspectors' comments has been applied retrospectively to the inspection reports. At the time of undertaking these inspections, inspectors were not working to the detailed methodology around complaints handling that has since been rolled out, and may not therefore have reported on all aspects of complaints handling that they do now.

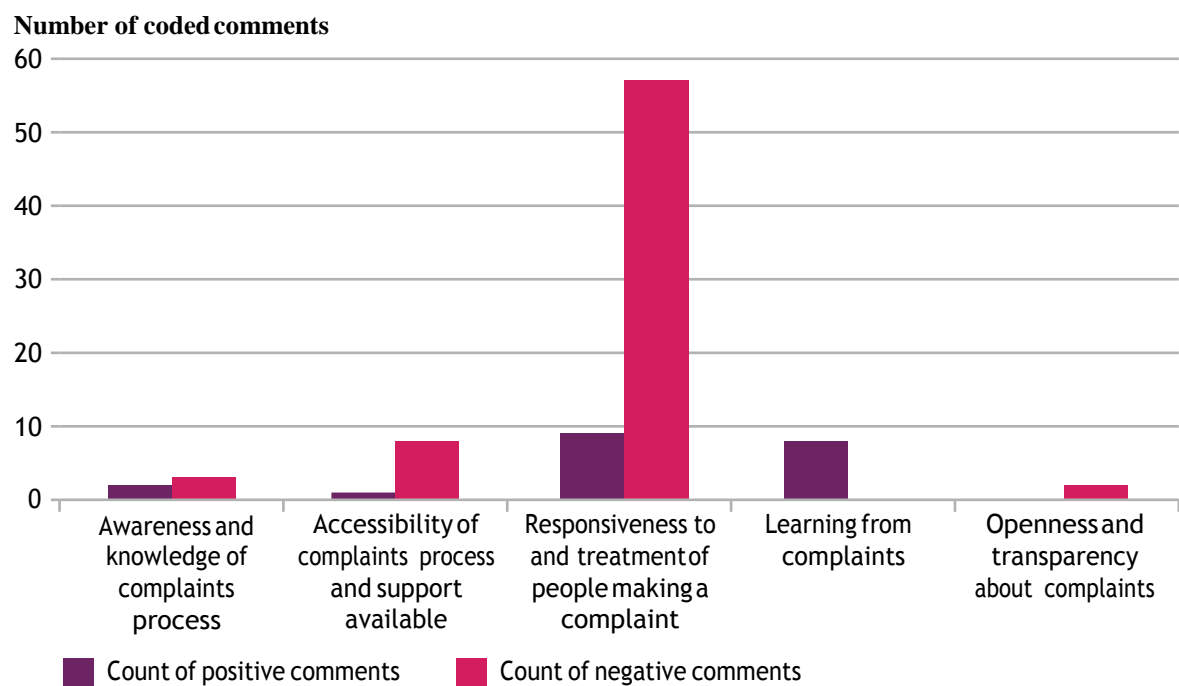
18. This data was categorised against the regulation relating to complaints handling in our outgoing ('old approach') framework. We reviewed 113 comments about NHS acute services, 48 about NHS mental health services and 11 about NHS community health. We only reviewed a sample of comments for acute services. The total number of available comments for mental health and community health services was low.

FIGURE 11: NHS INSPECTION REPORTS – COMPLAINTS HANDLING THEMES



CQC inspection reports

FIGURE 12: ACUTE 'USER VOICE' FEEDBACK REGARDING COMPLAINTS HANDLING



We found that people were concerned that complaints could impact on current or future care and were often unhappy with the speed of the complaints handling process. Both of these findings were echoed in online surveys conducted by Healthwatch England in 2014.<sup>19</sup>

Our analysis only shows some of the findings from the Patient's Association and Healthwatch surveys. These surveys highlighted other issues

around complaints handling. Full findings from the Healthwatch survey, conducted by YouGov: [www.healthwatch.co.uk/sites/default/files/final\\_complaints\\_large\\_print.pdf](http://www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf).

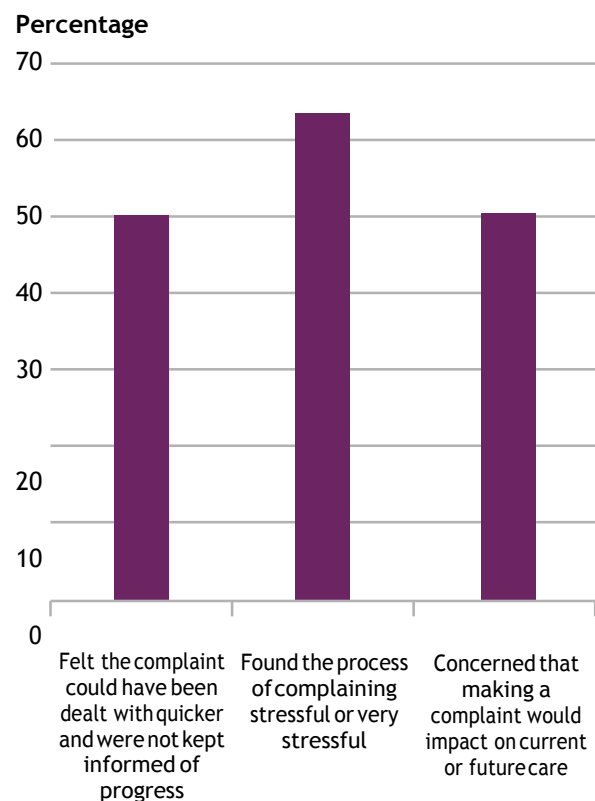
Nationally, responses to CQC's 2013 inpatient survey showed only one in four people recalled having seen or being given information explaining how to complain to the hospital about care received. Across most trusts there was limited variation in responses to

19. Healthwatch England conducted two online surveys in 2014 to understand people's experience of raising complaints about health and social care, one hosted on their own website and another hosted on their behalf by YouGov. Both surveys found that fear of negative repercussions on care was a common reason for not complaining (60% of 85 respondents in Healthwatch England survey and one in four people (26%) in YouGov survey). The surveys also found dissatisfaction over the speed of complaints handling (71% of 211 respondents to Healthwatch England's survey and 60% of 182 responses to the YouGov survey [www.healthwatch.co.uk/sites/default/files/final\\_complaints\\_large\\_print.pdf](http://www.healthwatch.co.uk/sites/default/files/final_complaints_large_print.pdf))

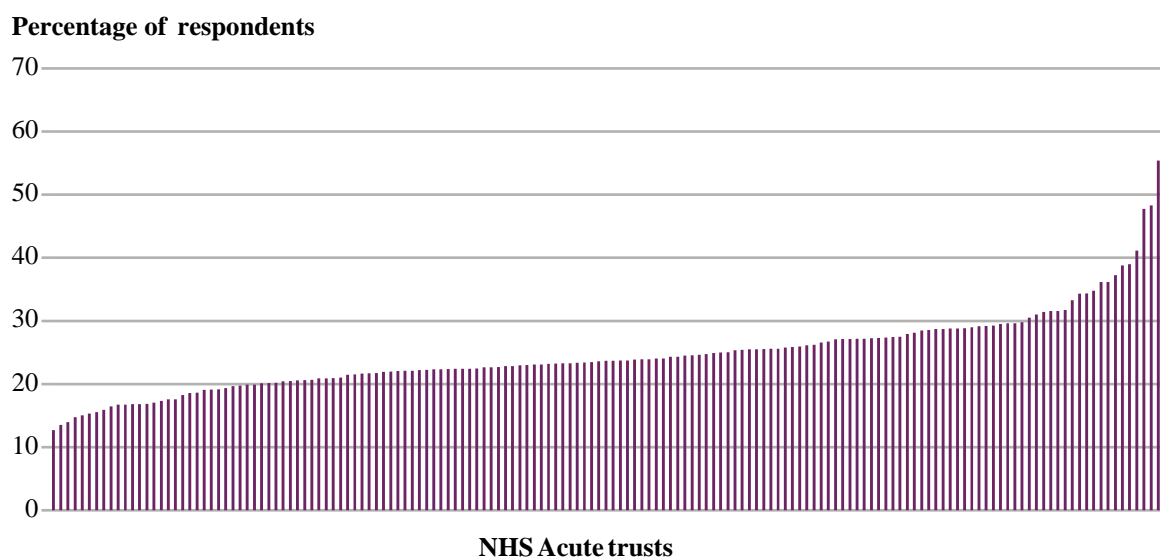
this question (FIGURE 14). However, there are a small number of trusts, mostly acute specialist trusts, that performed much better than others.

Responses to the NHS staff survey showed that staff responded positively when asked if their organisation acted on concerns raised by people using services (FIGURE 15).

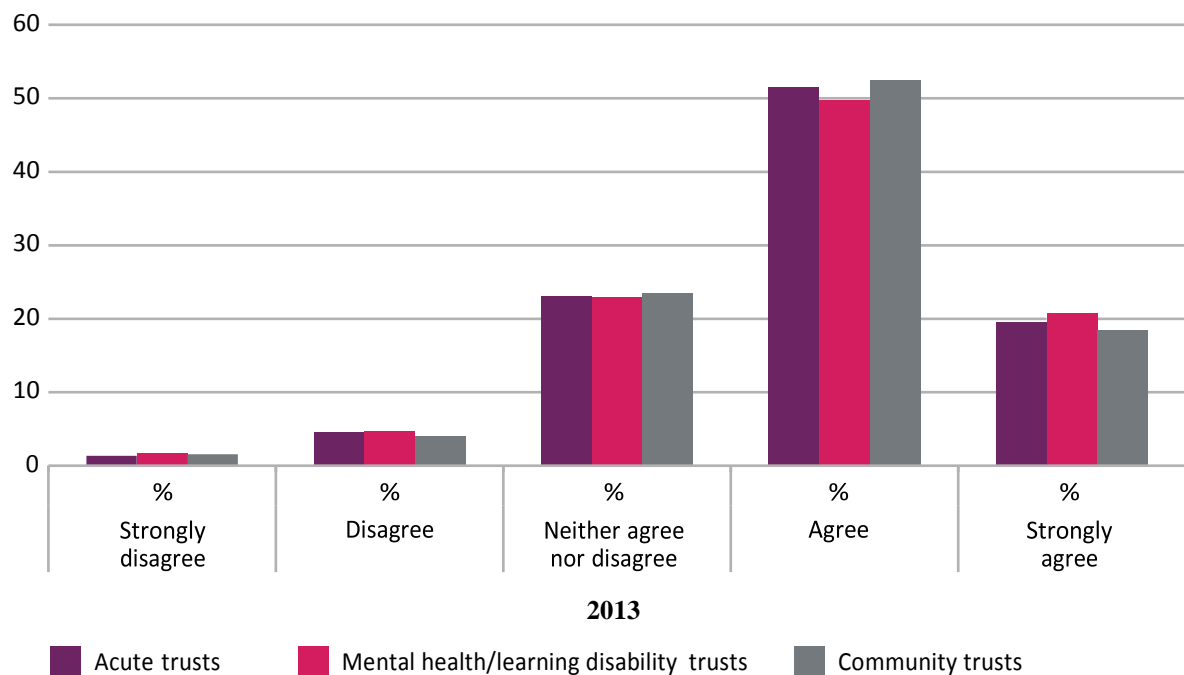
**FIGURE 13: CQC AND PATIENTS ASSOCIATION SURVEY OF COMPLAINANTS, MARCH 2014**



**FIGURE 14: 2013 ACUTE INPATIENT SURVEY – WEIGHTED PERCENTAGE OF RESPONDENTS THAT SAID THEY SAW OR WERE GIVEN INFORMATION EXPLAINING HOW TO COMPLAIN**



All trusts, CQC inpatient survey 2013/14

**FIGURE 15: NHS STAFF SURVEY – MY ORGANISATION ACTS ON CONCERNS RAISED BY PATIENTS/SERVICE USERS**

#### NHS staff surveys 2013

There is a discrepancy between the views of staff and the experience of people who have made complaints. This needs further investigation. More thorough methods of reviewing complaints handling are now a part of CQC's inspection process and we will soon have a more accurate picture of the state of complaints handling.

We also reviewed 2013/14 data supplied by the Parliamentary and Health Service Ombudsman on the proportion of complaints they investigated that were partially or fully upheld. Nationally, 43% of complaints investigated by the Ombudsman regarding care in acute trusts were fully or partially upheld. In NHS mental health trusts this figure was 36% and in NHS community trusts it was 30%. However, the data also showed great variability between organisations in the proportion of complaints being upheld. Organisations that have high rates of complaints being upheld by the Ombudsman may have inadequacies in their complaints handling processes.

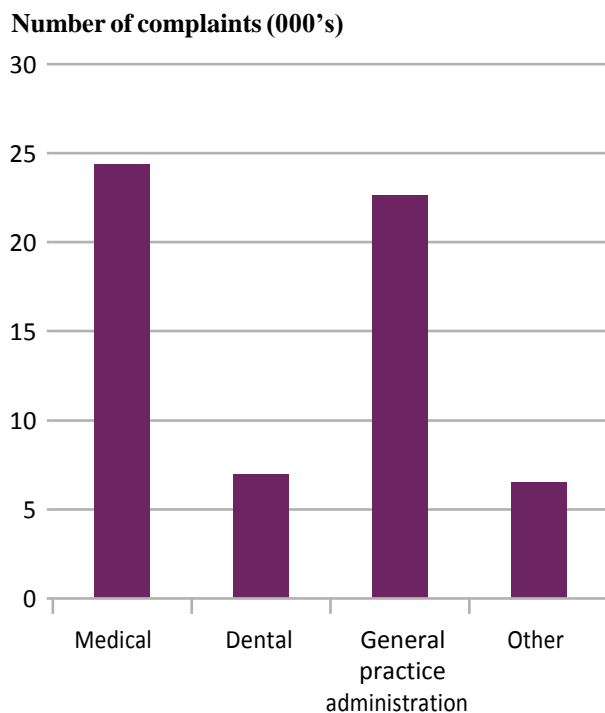
## Adult social care and primary care services

### Complaints received

Many complaints in adult social care are about funding and assessment of care, which are local authority issues where CQC has no remit. However, we want to find out about concerns that relate to the care people receive.

Returning data to the Health and Social Care Information Centre regarding the number of written complaints received is mandatory. However, many GP practices and out-of-hours services are not returning this information, so the reported figures are an under-representation (**FIGURE 16**).

The response rate of GP practices to the Health and Social Care Information Centre data collection in 2013/14 was 77%. The return for NHS trusts was near to 100%. In 2013/14, the total reported number of written complaints received across general practice and dental practice was 60,564.

**FIGURE 16: GENERAL AND DENTAL PRACTICE – WRITTEN COMPLAINTS 2013/14**

CQC analysis of Health and Social Care Information Centre data; NHS written complaints, 2013/14

Many organisations in adult social care and primary care settings report low numbers of complaints.

Around 40% of the adult social care providers that we inspected in quarter 2 of 2014/15, and

requested complaints information from, said they had not received any written complaints in the previous 12 months (TABLE 4).<sup>20</sup> We also asked adult social care providers inspected in quarter 3 for additional information about the themes of complaints they receive. Replies revealed three major themes of complaints: staffing and care, laundry, and communication.

Almost 30% of GP and dental practices that returned data to the HSCIC had not received any written complaints in the previous 12 months.

The number of concerns received by CQC regarding adult social care services has increased since the beginning of 2012/13, but this has been at a slower rate than for NHS services (FIGURE 17).

We have seen a large increase in concerns we receive about primary care, but some of the increase will be because CQC's regulation of the sector is

fairly new (FIGURE 18).

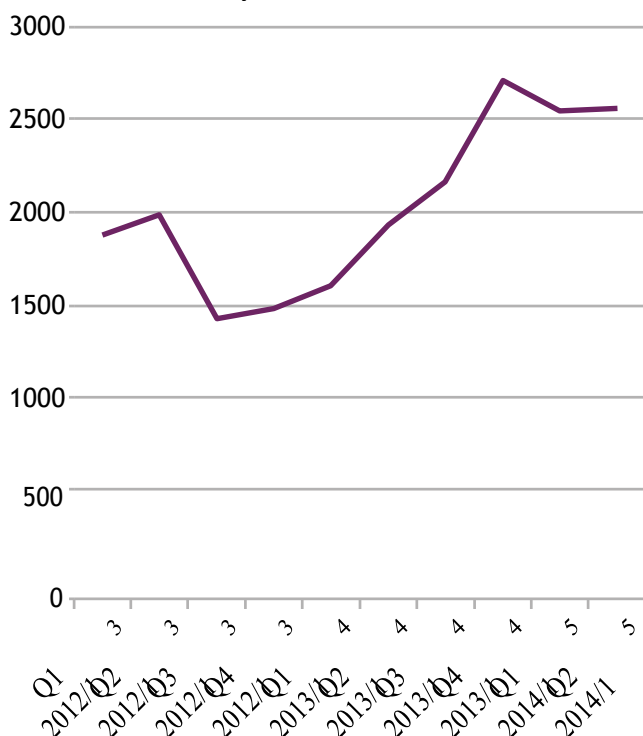
20. As part of CQC's new approach to inspections, information is requested directly from health and adult social care providers that are scheduled to be inspected. This helps guide the inspection and inform our findings. There are concerns over the accuracy of the information that has been returned to date and CQC is seeking solutions to ensure that future returns are more robust.

**TABLE 4: RETURNS FROM PROVIDER INFORMATION REQUESTS (PIRS) IN QUARTER 2, 2014/15**

Service type	PIRs with zero complaints	%	PIRs with complaints	%	Total PIR returns	Total number of complaints in PIRs
Community	75	40	114	60	189	984
Hospice	7	37	12	63	19	53
Residential	165	40	247	60	412	1112
Shared Lives	4	50	4	50	8	4
Total	251	40	377	60	628	2153

**FIGURE 17: CONCERNS RECEIVED BY CQC – ADULT SOCIAL CARE SERVICES 2012/13 TO Q2 2014/15**

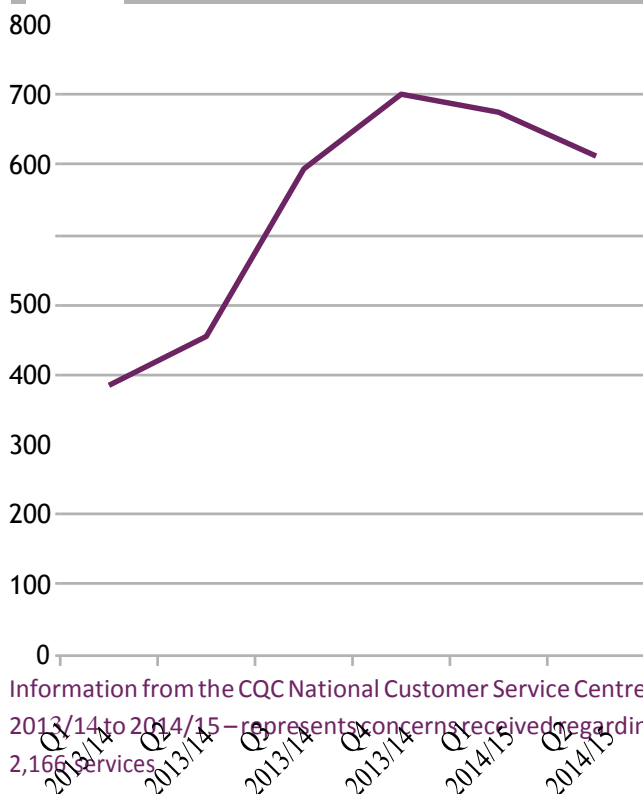
**Concerns received by CQC**



Information from the CQC National Customer Service Centre 2012/13 to 2014/15 – represents concerns received regarding 10,315 services

**FIGURE 18: CONCERNS RECEIVED BY CQC – PRIMARY CARE SERVICES 2013/14 TO Q2 2014/15**

**Concerns received by CQC**



Information from the CQC National Customer Service Centre 2013/14 to 2014/15 – represents concerns received regarding 2,166 services

## Complaints handling

We analysed a number of data sources to understand how well providers are handling complaints and concerns.

Qualitative analysis of published inspection reports (using CQC's new approach in adult social care providers, GP practices and out-of-hours services) showed high levels of positive practice at all stages of the journey of making a complaint (FIGURE 19).<sup>21</sup>

To provide additional evidence for this report, we asked inspectors to complete a survey about complaints handling in the services they inspected

between August and October 2014.<sup>22</sup> Many adult social care and GP practice inspectors felt that they did not have enough evidence to answer the questions, often because the locations inspected had received no or very low numbers of complaints.

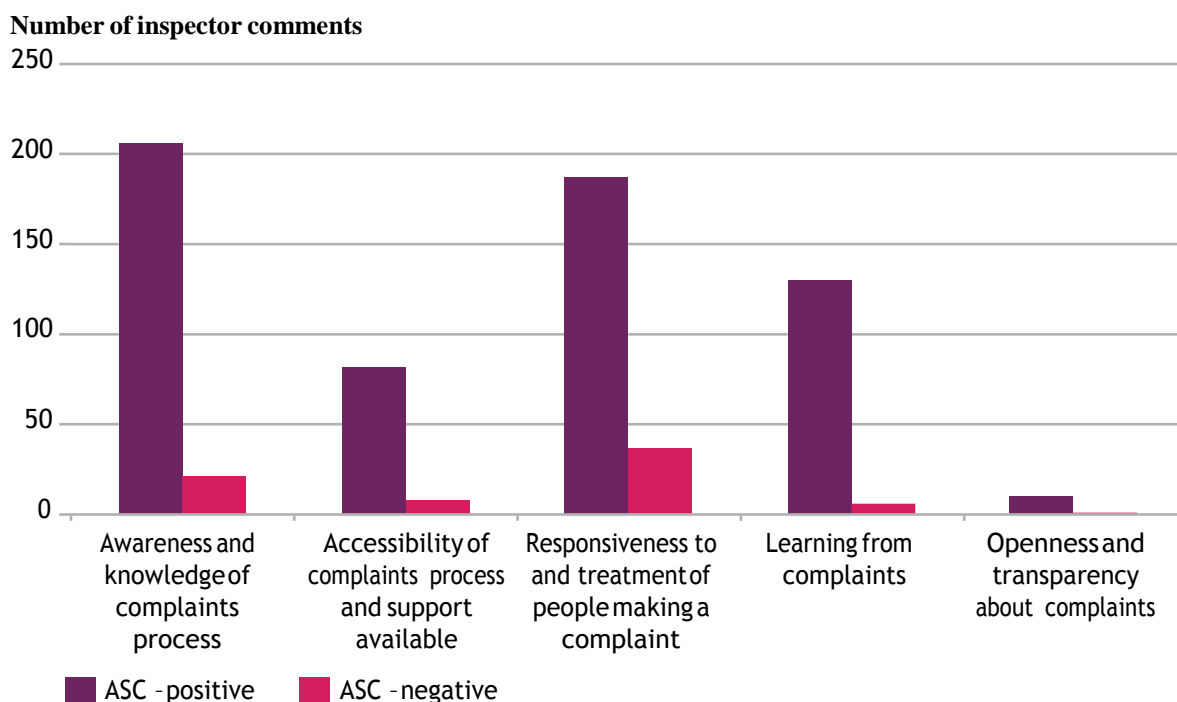
Where inspectors could provide an answer, it was generally positive about how providers were

handling complaints. However, the responses did indicate variation in the provision and awareness of advocacy and support to assist people who wanted to complain. There was also variability in ensuring that a complaints process was accessible to vulnerable groups and children. Inspectors also found variation in what information services

provide about complaints processes. In GP practices, inspectors showed that people do not always know how to make a complaint.

21. We reviewed inspection reports from CQC's new approach for 165 adult social care locations, from which 688 comments about complaints handling were analysed. We reviewed reports for 59 primary medical service locations and 24 out of hours services, from which a total of 479 comments about complaints handling were analysed. The taxonomy that we have used to categorise inspector's comments has been applied retrospectively to the inspection reports. At the time of undertaking these inspections, inspectors were not working to the detailed methodology around complaints handling that has since been rolled out, and may not therefore have reported on all aspects of complaints handling that they do now.

22. Just under 100 responses were received. Responses related to 54 adult social care providers and 35 providers of primary medical services. Inspectors of five NHS acute hospitals, one NHS ambulance trust and one independent hospital also provided responses. However, these have not been included in analysis due to the low numbers.

**FIGURE 19: ADULT SOCIAL CARE INSPECTION REPORTS – COMPLAINTS HANDLING THEMES**

## CQC inspection reports

In a CQC survey, a large majority of people who use home care services (that were due to be inspected in quarter 2 of 2014/15) reported that they knew how to raise concerns. They were very positive about the actions of care agencies in response to any

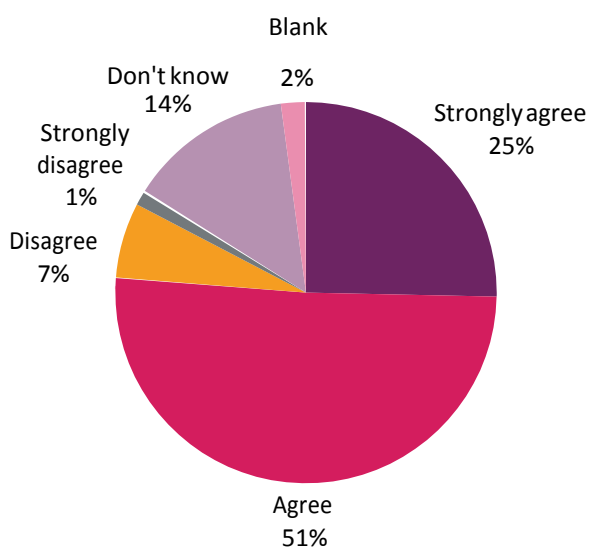
complaints made. More than 75% of those people said they knew how to make a complaint and over 70% said that care agencies and staff responded well to complaints or concerns raised (TABLE 5 AND FIGURES 20-21).

**TABLE 5: ADULT SOCIAL CARE SURVEY RESULTS 2014 – PEOPLE USING HOME CARE AGENCY SERVICES**

	I know how to make a complaint about the care agency		The care agency and its staff respond well to any complaints or concerns I raise	
Strongly Agree	444	25%	444	25%
Agree	893	51%	818	47%
Disagree	112	6%	118	7%
Strongly Disagree	23	1%	34	2%
Don't know	244	14%	302	17%
blank	37	2%	37	2%
<b>Total</b>	<b>1753</b>		<b>1753</b>	

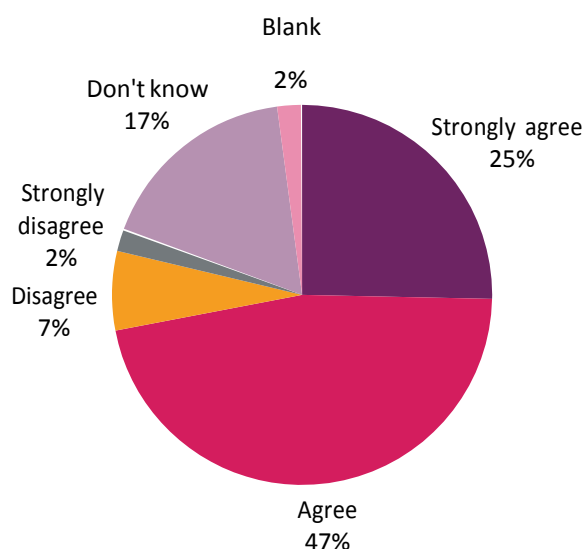
CQC survey of 133 home care agency services 2014

**FIGURE 20: ADULT SOCIAL CARE SURVEY – “I KNOW HOW TO MAKE A COMPLAINT ABOUT THE CARE AGENCY”**



CQC survey of 133 home care agency services 2014

**FIGURE 21: ADULT SOCIAL CARE SURVEY – “THE CARE AGENCY AND ITS STAFF RESPOND WELL TO ANY COMPLAINTS OR CONCERNS I RAISE”**



CQC survey of 133 home care agency services 2014

We analysed a sample of qualitative data from a number of sources that collect people’s feedback, including CQC’s own ‘Share your experience’ web form, between 2011 and 2014 (**FIGURE 22**).<sup>23</sup>

Importantly, this type of feedback is less reliable for informing a true picture. A negative slant is likely because people are more likely to report bad experiences than acceptable or good care. As in acute and mental health services, feedback highlighted issues with the timeliness of

investigations of complaints and responses. People felt that their concerns were not taken seriously or adequately addressed.

There are a number of potential interpretations of this data. The fact that a large number of adult social care

and primary care providers did not report receiving any written complaints suggests that more could be done to encourage feedback and build a culture in which concerns are welcomed as opportunities to improve. The positive picture from our inspection reports and our user survey in adult social care may

reflect the fact that in many locations we inspected, there were few complaints or none at all.

However, feedback from websites and other sources highlights that there are issues with the handling of complaints in these sectors. Combined with our survey that showed inspectors often had insufficient evidence to answer questions, we believe that the partial picture we are able to pull together is not accurately capturing how well providers encourage, listen to and respond to complaints and concerns in adult social care and primary care.

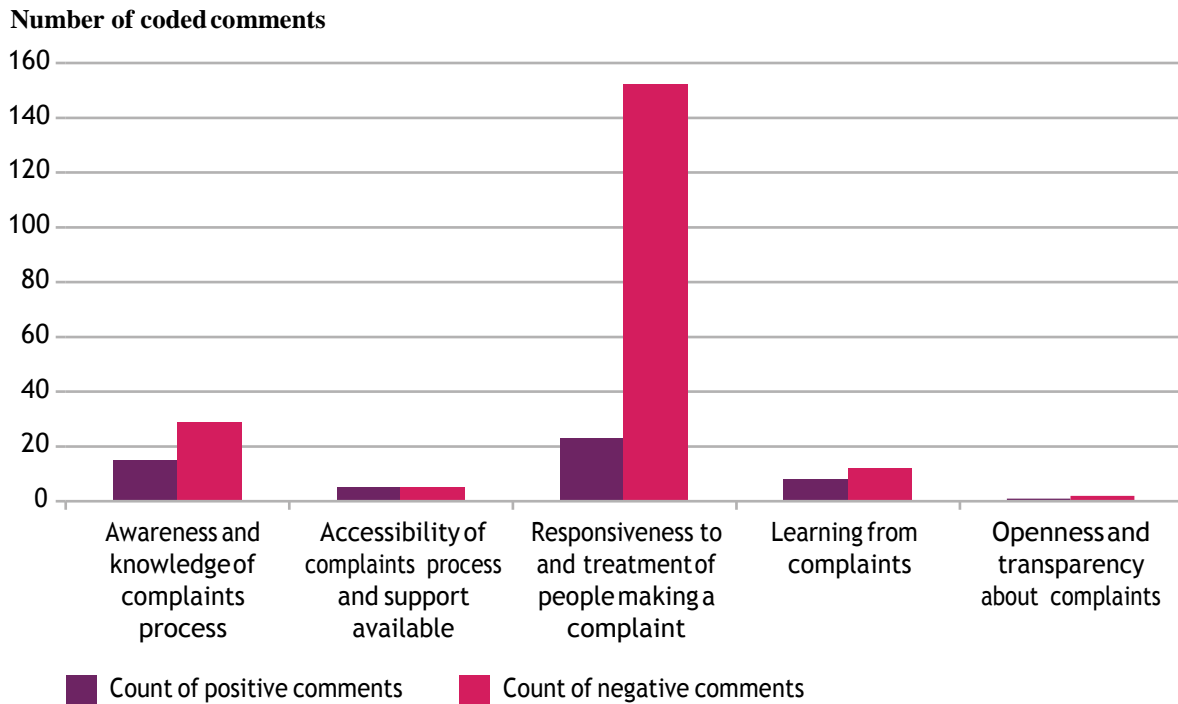
We believe that the more thorough methods of reviewing complaints handling that we are now rolling out will help inspectors to gain robust evidence of the state of complaints. We will continue to review inspection findings and refine our methods if necessary.

23. This data was categorised against the regulation relating to complaints handling in our outgoing (‘old approach’) regulatory framework. We reviewed 243 comments about adult social care and 25 comments about primary care. We only reviewed a sample of comments for adult social care. The total number of available comments for primary care organisations was low.

CQC understands that the next stage of reform to the HSCIC data collection will focus on improving response rates and quality of primary care returns, and will consider the extension of the collection

to adult social care. Improving the data available in these sectors will be crucial to presenting a true picture of the state of complaints and we hope these reforms will be implemented as a priority.

**FIGURE 22: ADULT SOCIAL CARE PROVIDERS - 'USER VOICE' FEEDBACK ON COMPLAINTS HANDLING**



## 4. CONCLUSION

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This report paints a partial picture of the state of complaints in health and social care services, but one in which some things are clear. There is wide variation in the way complaints are handled and much more could be done to encourage an open culture where concerns are welcomed and

learned from. While most providers have complaints processes in place, people's experiences of the system are not consistently good.

This must change. Services should encourage and embrace complaints. They are valuable because every concern is an opportunity to improve. Making this cultural shift will require everyone involved in health and social care to stop seeing complaints as a negative. As long as we do, there is an incentive for services to be less open about seeking feedback.

CQC has a big role to play in supporting this change. We have set out what we expect from providers when it comes to encouraging, listening to and responding to complaints, and how we will look at this through our inspections. We have aligned our approach with the universal expectations of good complaints handling set out by the ombudsmen

and Healthwatch England, to ensure that there is a single shared vision.

We will take action on services that do not take complaints seriously. From now on, all our inspection reports will include a description of

how complaints and concerns are handled. We will recognise and celebrate good practice and set out where improvements need to be made.

As we hold providers to a higher standard, we know we need to deliver that same standard ourselves.

We are working to make it easier for people to share their experiences with us, to use that information effectively in our regulation, and to report back to people on what action we have taken. We know this should create a virtuous circle where more people share information with us, and our regulation becomes more effective.

We will continue to work with the Department of Health, the ombudsmen, patients' organisations, Healthwatch England and NHS England to make it easier for people to raise concerns. And we

will continue to test and develop our inspection approach to complaints handling.

This report demonstrates why complaints matter – to people who use services, to organisations providing services and to CQC. Every concern is an opportunity to improve. Complaints may signal a problem, but this information can help save lives and learning from concerns will help improve the quality of care for other people.



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CQC-269-122014



# **Review of Antenatal and New-Born and Immunisation Screening Programmes in Enfield 2015**



## **Review of Antenatal and New Born and Immunisations in Enfield**

Prepared by: Dr Catherine Heffernan, Principal Advisor for Commissioning Early Years, Immunisations and Vaccination Services and Dr Jane Scarlett Consultant lead for Antenatal and New Born Screening

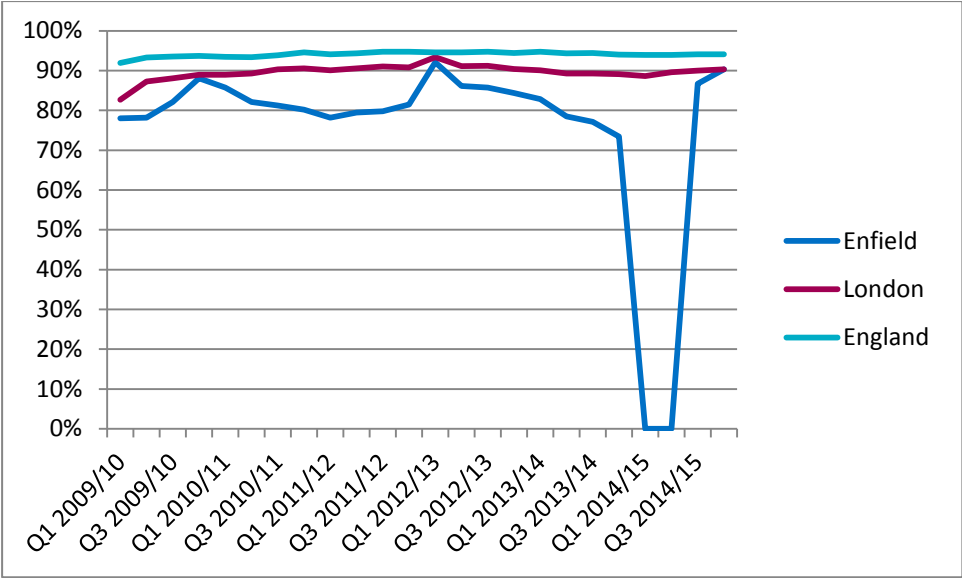
Presented to: Health and Well Being Board, Enfield, July 14<sup>th</sup> 2015.

Classification: OFFICIAL

The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

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## 1 Aim

- The purpose of this paper is to provide the Enfield Health and Well Being Board (HWBB) with an overview of Section 7a immunisation and screening programmes since NHS England assumed commissioning responsibilities on April 1<sup>st</sup> 2015.
- Section 7a immunisation programmes are universally provided immunisation programmes that cover the life-course and comprise of:
  - Antenatal and targeted new-born vaccinations
  - Routine Childhood Immunisation Programme for 0-5 years
  - School age vaccinations
  - Adult vaccinations such as the annual seasonal 'flu vaccination

Section 7a Screening Programmes are;

- Diabetic Eye Screening
- Abdominal Aortic Aneurism (AAA)
- Cancer; cervical screening
- Cancer; Breast Screening
- Cancer; Bowel Screening
- The Enfield HWBB are asked to note and support the work NHS England (London) are doing to increase screening and vaccination coverage and screening and immunisation uptake in Enfield.

## 2 Antenatal Newborn Screening Programmes

### 2.1 Impact of Antenatal Newborn Screening

Screening tests are used to find women & babies at higher risk of a health problem. Early intervention can reduce mortality and morbidity and economic cost of life long treatment and support from health, education and social services. The tests can help in decision making about care or treatment during pregnancy or after the baby is born. Some screening tests are offered within a matter of hours after the baby born to intervention to prevent death or limit the negative outcomes on health and development.

There are six Antenatal and Newborn (ANNB) screening programmes, screening for a total of 30 conditions:

Many of these programmes are funded wholly or partly within the maternity pathway payment, with some aspects directly commissioned by NHSE (e.g. specialist laboratories for newborn bloodspot screening). Women have a choice of maternity unit for booking. Each maternity unit holds a quarterly ANNB screening steering group meeting. ANNB screening programme standards include timescales for referral into other services (e.g. liver services for women who are Hep B positive).

There are quarterly KPIs for the programmes and a very recently established programme of Quality Assurance visits is being rolled out across London. Most of the KPI data is collected by maternity unit rather than borough of residence of

the mother. The NENCL ANNB Screening Performance and Quality Board meets every four months, and reports in to the NHSEL ANNB screening commissioning board, which also meets every four months. Enfield CCGs maternity commissioning lead attends both of these meetings and gives comprehensive feedback.

Maternity services for Enfield are provided by Barnet and Chase Farm Hospital and North Middlesex Hospital. There are no ANNB External Quality Assurance visits planned to either hospital in 2015/16. Following some concerns about the oversight of ANNB screening programmes in North Middlesex Hospital, due to several incidents with the Down's Syndrome pathway, this pathway was reviewed and there is now improved oversight and increased reporting of early alerts as soon as there is any pathway deviation.

## 2.2 Hepatitis B +ve mothers

### **Highest rate of hepatitis B+ve pregnant women is in London.**

- Liver disease is the fifth biggest cause of mortality in England (1/4 due to hep infection).
- Not treated persistent hep B infection can lead to cirrhosis of the liver or liver cancer.
- Mother to baby transmission during birth accounts for 20% of all new cases.

An effective hep B antenatal screening and infant immunisation pathway for babies born to women with hep B will reduce morbidity and mortality. Without this, 90% of babies born to mothers who are highly infectious for hep B will develop hep B themselves, as will 10% of babies born to mothers who have low infectivity.

**Immunisation schedule:** At birth (+immunoglobulin if high risk); at 1 month; at 2 months; at 12 months; Serology check at 1 year

Hospital responsible for 1st dose, Subsequent doses delivered by a number of providers (primary care; hospital; health visitors; GPs)

CHIS responsible for monitoring immunisation for babies of Hep B positive mothers.

### **Timely referral of hepatitis B positive women for specialist assessment**

Women found to be Hep B positive should be referred to a liver disease specialist within 6 weeks, for full assessment, treatment if indicated, and to plan for the birth of the baby. The acceptable standard for this is 70% of women seen within 6 weeks and the achievable standard is 90%. Achieving this standard is a challenge for many units. Due to low numbers of women who are Hep B positive quarterly KPI data is not published for this indicator.

**HIV positive mothers** – Barnet and Chase Farm screened 99.6% of women for HIV, and North Middlesex hospitals screened 99.9% in quarter 2 2014/15. Ensuring all women are screened, and that those who decline screening are aware of the benefits of treatment to both mother and baby, is important here. Recent audits of babies diagnosed with HIV show that all were born to mothers who were not screened antenatally.

Table 1: KPI ID1 - The proportion of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result.

Area	Performance %
England	98.7
London	99.8
Barnet and Chase Farm Hospitals NHS Trust	99.6
North Middlesex University Hospital NHS Trust	99.9
Royal Free Hampstead NHS Trust	100.0
The Whittington Hospital NHS Trust	99.7
University College London Hospitals NHS Foundation Trust	99.9

Source: <https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2014-to-2015>

## 2.3 Sickle Cell and Thalassaemia

### Timeliness of Sickle Cell and Thalassaemia (SCT) testing

Antenatal testing for SCT needs to be done early in pregnancy in order for partners of women who are found to be SCT carriers to be offered testing and to have a result in time for invasive diagnostic testing of the foetus to be offered by 12 weeks gestation. Testing later than this limits options for the future of the pregnancy. Because of this, an acceptable target of 50% of mothers having a result for SCT testing by 10 weeks gestation has been set, with the achievable target 75%. Barnet and Chase Farm (52.9%) met the acceptable target, and performance in North Middlesex improved considerably (8.8% in Q1, 35.7% in Q2) although they do not yet meet the acceptable target. NHSEL are monitoring performance against this target across London in 2015/16, and will also be reviewing the data collection process to ensure the information is correctly measured.

Table 2: KPI ST2 - The proportion of women having antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available by 10 weeks' gestation.

Area	Performance %
England	51.6
London	40.2
Barnet and Chase Farm Hospitals NHS Trust	52.9
North Middlesex University Hospital NHS Trust	35.7
Royal Free Hampstead NHS Trust	67.1
The Whittington Hospital NHS Trust	44.0
University College London Hospitals NHS Foundation Trust	62.3

Source: <https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2014-to-2015>

## 2.4 Foetal anomaly screening including Down's Syndrome

Down's syndrome screening consists of an ultrasound scan and biochemical markers, results from which are combined to give the risk of a pregnancy being affected with Down's Syndrome. The Down's Syndrome KPI measures completeness of the information provided which is needed for the risk calculation. The acceptable target is 97.0% and achievable is 100%. In Q2 2014/15, Barnet and Chase Farm achieved the target but North Middlesex were below target at 94%.

Table 3: KPI FA1 - The proportion of laboratory request forms including complete data prior to screening analysis, submitted to the laboratory within the recommended timeframe of 10+0 to 20+0 weeks' gestation.

Area	Performance %
England	96.5
London	96.4
Barnet and Chase Farm Hospitals NHS Trust	98.4
North Middlesex University Hospital NHS Trust	94.6
Royal Free Hampstead NHS Trust	98.2
The Whittington Hospital NHS Trust	94.8
University College London Hospitals NHS Foundation Trust	99.5

Source: <https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2014-to-2015>

## 2.5 Newborn Hearing screening

Newborn hearing for Enfield is provided by the North Central London programme, which covers all five maternity providers in North Central London. There are two KPIs for newborn hearing. The first is to ensure that babies receive screening soon after birth, and measures the proportion of babies eligible for newborn hearing screening for whom the screening process is complete by 4 weeks. The acceptable target for this is 95% and the achievable target is above 99.5%. In Q2 2014/15, NCL reached 96.5%, close to the overall London performance of 96.8% but below the England performance of 98.0%.

The second KPI measures the percentage of babies referred for assessment after screening who receive audiological assessment within 4 weeks of referral. The acceptable target is above 90% and the achievable target is 100%. Because of low numbers of babies referred, data is not published for individual programmes. In Q2 2014/15, the overall London performance was 91.5% and the England performance was 87.7%.

## 2.6 Newborn Infant Physical Examination

The NHS Newborn and Infant Physical Examination Programme offers parents the opportunity to have their baby screened for abnormalities of the eyes, heart, hips and testes. Newborn clinical examinations have been undertaken as part of routine care for a number of years. In preparation for reporting Key Performance Indicators for the NIPE programme providers are being required to

install IT systems with functionality to meet national specifications and provide failsafe for the NIPE programme by the end of March 2016. Once installed KPI data should be submitted. So far only two London providers are submitting data, both in South London.

## 2.7 Newborn bloodspot testing

The newborn bloodspot now tests for nine conditions, phenylketonuria (PKU), congenital hypothyroidism (CHT), sickle cell disease (SCD), cystic fibrosis (CF), medium-chain acyl Co-A dehydrogenase deficiency (MCADD), Maple Syrup Urine Disease (MSUD), Homocystinuria (HCU), Glutaric Aciduria Type 1 (GA1) and Isovaleric Acidaemia (IVA). The last four conditions were added to the national programme from January 2015, and due to the number of conditions the bloodspot samples are tested for, new standards for the bloodspot samples were set from April 2015. These standards are likely to increase the number of babies who need a repeat sample taken. Many repeat samples are considered avoidable, i.e. are due to either poor sample labelling or inadequate bloodspots. The acceptable standard for avoidable repeats is 2% and the achievable standard is 0.5%. The latest results available date from before the new guidance on sample quality was introduced, so the number and percentage of avoidable repeat tests is likely to increase. In Q2 2014/15 Barnet and Chase Farm Hospital had an avoidable repeat rate of 1.8% and North Middlesex had a rate of 2.4%. Nearly half of the avoidable repeats for both hospitals were due to inadequate samples, but samples taken when babies were too young, wrong NHS number and wrong date of birth were also common reasons for repeat samples to be needed.

NHSEL are monitoring performance against this target across London in 2015/16, in order to reduce the unnecessary distress to babies and families and to reduce unnecessary use of resources and staff time.

Table 4: KPI NB2 - The percentage of babies from whom it is necessary to take a repeat blood sample due to an avoidable failure in the sampling process.

Area	Performance %
England	2.6
London	2.0
Barnet and Chase Farm Hospitals NHS Trust	1.8
North Middlesex University Hospital NHS Trust	2.4
Royal Free Hampstead NHS Trust	0.6
The Whittington Hospital NHS Trust	2.2
University College London Hospitals NHS Foundation Trust	0.8

Source: <https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2014-to-2015>

## 2.8 Incidents and Serious Incidents

Following some reported incidents in 2014 which raised concerns about adherence to the ANNB screening pathways, a quality assurance visit was carried out to North Middlesex Hospital in late 2014. An action plan was developed from this which has been implemented and the concerns have been resolved. Any deviation from any screening pathway is flagged in an early alert. KPI quarterly reports include exception reporting on all women to ensure that all women receive an offer of screening and all those accepting receive a screening result.

## 3 Immunisations; Antenatal and New-born Vaccinations

### 3.1 Pertussis vaccination for Pregnant Women

- In 2012, a national outbreak of pertussis (whooping cough) was declared by the Health Protection Agency. In 2012, pertussis activity increased beyond levels reported in the previous 20 years and extended into all age groups, including infants less than three months of age. This young infant group is disproportionately affected and the primary aim of the pertussis vaccination programme is to minimise disease, hospitalisation and death in young infants. In September 2012 The Chief Medical Officer (CMO) announced the establishment of the *Temporary programme of pertussis (whooping cough) vaccination of pregnant women* to halt in the increase of confirmed pertussis (whooping cough) cases. This programme has been extended for another 5 years by the Department of Health (DH) in 2014. Since its introduction, Pertussis disease incidence in infants has dropped to pre2012 levels.
- Statistics for pertussis vaccine uptake are reported monthly and by region/area. They cover those women who delivered a baby within the survey month at more than 28 weeks gestational age and who are registered on the general practitioner (GP) systems. However the submission is currently optional and 100% of Enfield GP practices submitted reports for the 2014/15 sentinel survey (ImmForm, 2015). Nationally 70% of the population of pregnant women are reflected in the sentinel surveillance data.
- In England, pertussis vaccine coverage in pregnant women reached 62.6% in December 2014 – the highest recorded since the start of the programme. Nationally, the uptake of pertussis vaccine is increasing year on year.
- There are seasonal patterns with the winter months of November and December each year reporting the highest proportion vaccinated whilst there's a drop between April and July
  - Difference attributed to pertussis given with seasonal 'flu vaccination during November and December
- London monthly averages are ~10% lower than national averages and London was one of only two area teams (Birmingham Black Country being the other) that reported coverage rates of under 50% between Oct 2012 and December 2014
- The annual average for London for 2014/15 (April 1st 2014 – March 31<sup>st</sup> 2015) was 46.1%. Enfield CCG reported an average of 32.7% uptake (ImmForm, 2015).

- NHS England has a pan-London action plan to increase uptake amongst pregnant women with a named lead. This includes a project to understand women's reasons for not being vaccinated and an audit on how well the vaccine is prompted by the health professionals involved. A maternity service level agreement (SLA) has been implemented for 2015/16 with Clinical Commissioning Groups (CCGs) specialised commissioning to enable all maternity services to administer seasonal 'flu and pertussis to all pregnant women. We are chasing sign up by Royal Free and North Middlesex Maternity Departments.

### 3.2 Universal BCG vaccination

- The national reporting system is currently under review so no data has been collected since 2012. However, since the London TB Board and the London Immunisation Board both recommended a universal BCG vaccination programme in London, providers of Child Health Information Systems (CHIS) are now contracted to submit quarterly data as part of the Cohort of Vaccination Evaluated Rapidly (COVER) returns. This data will be available from Q1 2015/16 onwards.
- For 2014/15, NHSE (London) commissioned a Commissioning for Quality and Innovation (CQUIN) for BCG and Hepatitis B for maternity units across London. An audit in June 2015 found that Barnet, Enfield and Haringey Mental Health Trust (the local early years provider for Enfield) reported 58% for quarter 3 (above the threshold of 50%) but 42% for Q4 2014/15 (below the 70% threshold).
- NHS England will be rolling out a 100% offer of BCG vaccine to all babies up to the age of one year across London. This offer will primarily be given in the maternity units with a community offer for those parents who missed out on the vaccine in maternity hospitals. Enfield did not have universal BCG vaccination programme prior to 2015, although all babies born at North Middlesex Hospital including those resident in Enfield are offered BCG.
- Since April 2015, there has been a shortage of BCG vaccine nationally resulting in low stocks within London. It is anticipated that providers can reorder the vaccine from September onwards and have been recommended to adhere to the Public Health England advice of prioritising those infants most at risk of TB. Further guidance will be issued from PHE to providers in regard to the lack of supplies in London.
- The current roll out of 100% offer of BCG is temporally on hold until vaccine supplies are in place. NHSE are seeking information on when that is likely to be and will work with providers accordingly on contingency plans.

### 3.3 Neonatal Hep B vaccination

- Babies born to mother who are Hepatitis B positive should receive a course of 4 does of Hepatitis B vaccine and a serology by 12 months of age. Mothers are identified through the antenatal screening programme and babies are followed up through primary care in Enfield.
- Numbers for babies born to mothers who are Hepatitis B positive are small so annual figures are more robust. The latest annual data available is for 2013/14 (year ending March 31<sup>st</sup> 2014). No data was available for Enfield for

the years 2013/14. The collection of data for Hepatitis B at risk babies is experimental and is done via COVER submissions. It is difficult to draw a conclusion that Enfield had no babies deemed at risk of Hepatitis B due to Hepatitis B positive mothers or whether the CHIS system was unable to record the status of the child.

- NHS England's intention is to have all babies vaccinated by their first birthday and serology conducted. This is being enacted through commissioning endeavours (including CQUIN to improve reporting) in 2014/15 and a pan-London action plan being delivered by a Hep B sub-group of the London Immunisation Board. An audit of the CQUIN in June 2015 found that Barnet, Enfield and Haringey Mental Health Trust reported 100% for all Hepatitis B at risk babies who reached the age of one year within the respective quarters had been vaccinated for quarters 3 and 4 2014/15.

## 4 Routine Childhood Immunisation Programme (0-5 years)

### 4.1 COVER Time Trend for Enfield

- Cohort of Vaccination Evaluated Rapidly (COVER) monitors immunisation coverage data for children in UK who reach their first, second or fifth birthday during each evaluation quarter – e.g. 1<sup>st</sup> January 2012 to 31<sup>st</sup> March 2012, 1<sup>st</sup> April 2012 – 30<sup>th</sup> June 2012. Children having their first birthday in the quarter should have been vaccinated at 2, 3 and 4 months, those turning 2 should have been vaccinated at 12/13 months and those who are having their 5<sup>th</sup> birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years.
- London has in recent years delivered significantly poorer uptake than the remainder of the country. Reasons provided for the low coverage include the increasing birth rate in London which results in a growing 0-5 population and puts pressure on existing resources such as GP practices, London's high population mobility, difficulties in data collection particularly as there is no real incentive for GPs to submit data for COVER statistics and large numbers of deprived or vulnerable groups. In addition, there is a 20-40% annual turnover on GP patient lists which affects the accuracy of the denominator for COVER submissions, which in Enfield's case inflates the denominator (i.e. number of children requiring immunisation) resulting in a lower uptake percentage. Like many other London boroughs, Enfield has not achieved the required 95% herd immunity (i.e. the proportion of people that need to be vaccinated in order to stop a disease spreading in the population).
- Figure 1 illustrates the quarterly COVER statistics for the uptake of the six COVER indicators for uptake. The primaries (i.e. completed three doses of DTaP/IPV/Hib) are used to indicate age one immunisations, PCV and Hib/MenC boosters and first dose of MMR for immunisations by age 2 and preschool booster and second dose of MMR for age 5. Quarterly rates vary considerably more than annual rates but are used for monitoring purposes. This graph only contains up to Q3 2014/15 as that was the latest available data in this format at time of writing. However Appendix 1 illustrates the time trend of Enfield compared to London and England from Q1 2009/10 to Q4 2014/15.

- Similar to the general pattern across London where coverage rates decrease as age increases, Enfield's rates decrease as the age cohort goes from age 1 to 2 and to age 5. This decrease in coverage rates is affected by data information systems not capturing movements in population (i.e. transfers in and movers out of borough) and also reflects inadequacies in call/recall systems to bring children in for the remaining vaccinations on the Routine Childhood Immunisation Schedule (i.e. calling parents/guardians for appointments and chasing those who do not attend). This is not unique to Enfield and is common across London boroughs.
- Throughout 2011/12 to 2014/15, London has consistently performed below national on all COVER indicators by ~4% for the age 1 vaccinations, ~6% for age 2 vaccinations and ~10% for the age 5 vaccinations. The rates dipped at the start of 2013/14 but have since increased to the pre-dip levels.
- Appendix 1 shows how Enfield performed comparatively to London and England for the latest published data (Quarter 4 2014/15 – i.e. January 1<sup>st</sup> - March 31<sup>st</sup> 2015). This table compares all vaccinations given within the routine childhood immunisation programme. It can be seen that Enfield performs below regional and England averages and below the World Health Organisation (WHO) recommended of 95%.
- When looking at the age one vaccines (the primaries), Enfield's figures peaked in Q1 2012/13 and have since been in decline. The complete drop for Q2 2014/15 was due to no data being submitted for that quarter. However, since then Enfield's figures have improved with an increase to 90.3% for Q4 2014/15, in line with London's average.
- The age 2 vaccinations – MMR first dose, the PCV booster and the Hib/Men C booster also show improvements for Quarter 4 2014/15 (see Appendix 1). Again all three indicators were in line with London's averages: 85.4% compared to London's 85.7% for PCV booster, 86.4% compared to London's 86.3% for Hib/Men C booster and 86% compared to London's 86.5% for MMR first dose.
- Age 5 vaccinations performed higher than London's averages in the latest available data – 88.3% for preschool booster compared to London's 77% and 82.6% for MMR 2<sup>nd</sup> dose compared to London's 80.1%. England averages were 88.4% and 88.6% for preschool booster and MMR 2<sup>nd</sup> dose, illustrating that Enfield's reported coverage rates for completed immunisation schedules are in line with national averages for Q4 2014/15. This improvement in rates was seen in Q3 2014/15 and it is NHSE (London)'s intention to maintain and continue this improvement.

## 4.2 Enfield compared to Neighbouring Boroughs

- Table 1 shows Enfield compared to its neighbouring boroughs in North East London (data for COVER is still reported as PCT areas) for Quarters 2 and 3 (i.e. October – December 2014). Enfield had a significant increase between Q2 and Q3 for the age 1 vaccinations of 3.2%. The other indicators remained stable with no significant changes (i.e. the confidence intervals for each indicator uptake rate overlapped with the previous quarters). Islington achieved the 95% target for age one vaccinations and for the PCV booster (though the other two age 2 vaccinations are almost there).

- Compared to London, Enfield performs below London average for the age 1 and 2 vaccinations but higher than age 5 preschool booster and slightly lower for the 2nd dose of MMR.
- When compared to quarter 3 2013/14, there are significant increases in three of the indicators for Enfield – a rise from 85.8% to 89.7% for age one vaccinations, 72.7% to 80% for the age 5 vaccination (preschool booster) and 85.8% to 89.7% for the 2<sup>nd</sup> dose of MMR.

Table 1

*Enfield PCT and Neighbouring PCTs Comparisons between Q2 and Q3 2014/15*

Q2 1415 & Q3 1415 Immunisations		Immunisation rate for children aged 1 who have been immunised for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) - (DTaP/IPV/Hib)- 3Doses			Immunisation rate for children aged 2 who have been immunised for Pneumococcal infection (PCV) - (PCV booster)			Immunisation rate for children aged 2 who have been immunised for Haemophilus influenza type b (Hib), meningitis C (MenC) - (Hib/MenC)			Immunisation rate for children aged 2 who have been immunised for measles, mumps and rubella (MMR) - (MMR)			Immunisation rate for children aged 5 who have been immunised for Diphtheria, Tetanus, Polio, Pertussis (DTaP/IPV) - pre-school booster			Immunisation rate for children aged 5 who have been immunised for measles, mumps and rubella (MMR2)		
PCT Name	PCT Code	Q2 1415	Q3 1415	Signif. change	Q2 1415	Q3 1415	Signif. change	Q2 1415	Q3 1415	Signif. change	Q2 1415	Q3 1415	Signif. change	Q2 1415	Q3 1415	Signif. change	Q2 1415	Q3 1415	Signif. change
North Central & East London (NCEL)		%	%		%	%		%	%		%	%		%	%		%	%	
Barking & Dagenham PCT	5C2	89.5	92.0	➔	86.6	85.9	➔	86.2	86.5	➔	87.1	85.9	➔	83.3	80.9	➔	82.2	78.8	➔
Barnet PCT	5A9	72.5	85.0	⬆	68.6	78.1	⬆	68.9	77.9	⬆	69.6	78.3	⬆	63.9	70.7	⬆	66.4	71.6	⬆
Camden PCT	5K7	92.4	93.2	➔	86.3	86.9	➔	85.3	86.8	➔	85.3	86.1	➔	82.3	83.4	➔	82.1	81.1	➔
City & Hackney Teaching PCT	5C3	85.1	85.5	➔	90.2	88.5	➔	89.8	88.4	➔	90.2	87.6	➔	82.5	83.4	➔	88.8	87.2	➔
Enfield PCT	5C1	0.0	86.7	➔	0.0	86.0	➔	0.0	88.3	➔	0.0	87.1	➔	0.0	85.1	➔	0.0	85.1	➔
Haringey Teaching PCT	5C9	93.1	94.2	➔	87.1	85.3	➔	88.7	87.0	➔	88.0	86.5	➔	84.3	84.9	➔	83.5	84.2	➔
Havering PCT	5A4	91.0	93.8	➔	87.8	88.1	➔	88.1	88.5	➔	86.5	87.0	➔	84.4	82.5	➔	83.4	81.4	➔
Islington PCT	5K8	97.9	96.6	➔	97.6	95.0	➔	97.7	94.8	⬇	95.4	94.6	➔	94.2	90.3	➔	93.2	90.1	➔
Newham PCT	5C5	92.7	92.5	➔	89.7	88.6	➔	90.1	89.0	➔	90.7	89.1	➔	84.3	81.2	➔	85.6	81.8	➔
Redbridge PCT	5NA	91.2	90.5	➔	85.5	84.4	➔	86.1	83.8	➔	85.9	83.3	➔	73.7	76.9	➔	72.4	74.6	➔
Tower Hamlets PCT	5C4	94.3	95.8	➔	93.4	90.3	➔	93.2	96.4	⬆	93.2	89.0	⬇	81.6	84.0	➔	91.7	91.5	➔
Waltham Forest PCT	5NC	85.7	89.7	⬆	82.4	83.5	➔	83.4	83.2	➔	84.2	83.6	➔	80.9	81.0	➔	80.2	80.3	➔
London	London	89.6	90.0	➔	85.8	85.5	➔	86.2	86.1	➔	86.5	86.0	➔	78.2	78.0	➔	80.8	80.5	➔

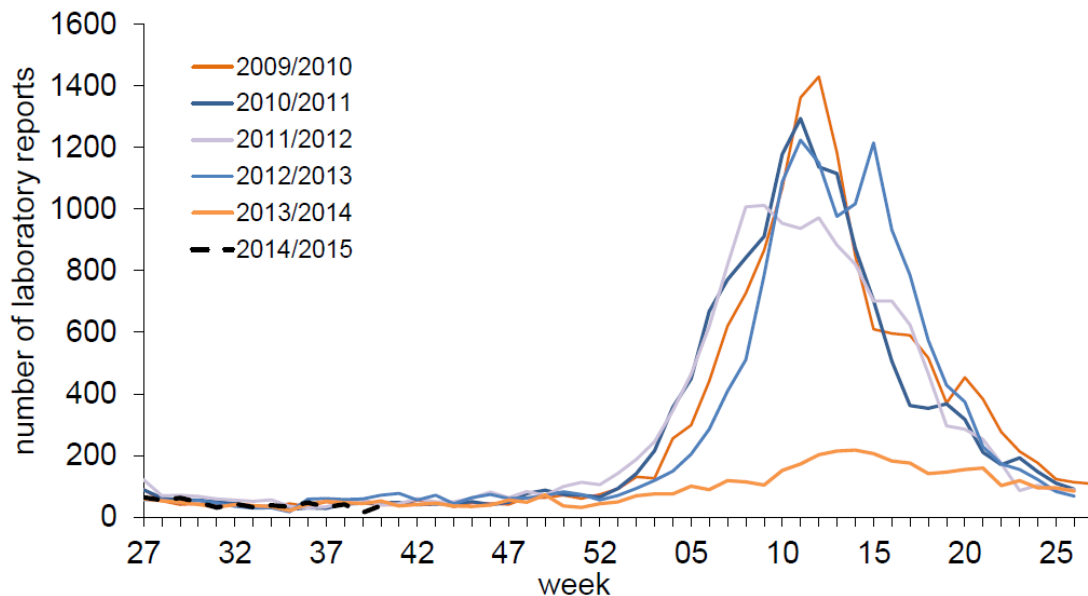
Source: PHE (2015)

### 4.3 Rotavirus

- Rotavirus vaccine was introduced into the Routine Childhood Immunisation Schedule in 2013/14 and is measured monthly. Since June 2014 both London and England averages have been 90% or over.
- The programme has been very successful in reducing incidences of rotavirus with laboratory reports of rotavirus for July 2013 – June 2014 being 67% lower than the ten season average for the same period in the seasons 2003/04 to 2012/13 (See Figure 1).
- The latest available figures for Enfield CCG is for May 2015 whereby 95.3% of babies received the first dose of the vaccine, 89.6% received two doses (ImmForm, 2015). Rotavirus vaccine uptake is monitored monthly and there is no national target.

Figure 1

Seasonal Comparison of Laboratory Reports of Rotavirus 2009/10 to 2014/15 for England



Source: PHE (2014)

## 5 School Age Vaccinations

### 5.1 HPV vaccination

- Human papillomavirus (HPV) vaccination has been offered to 12-13 year old girls (Year 8) since the academic year 2008/09. Originally the course was 3 doses but following the recommendation of the Joint Committee of Vaccinations and Immunisations (JCVI) in 2014 is that two doses is adequate.
- Since 2008/09, there has been a steady increase of uptake both nationally and in London. England has increase from 80.1% in 2008/09 to 86.7% in 2013/14 (the latest published data) whilst London has performed lower but still increasing from 73.8% in 2008/09 to 80% in 2013/14. However, the 2013/14 figures are still below the national target of 90%, the level set for herd immunity. Nevertheless, Data for 2014/15 will be available in December 2015.
- Table 2 ranks the performance of London's Primary Care Trusts (PCTs) comparing 2013/14 to the performance of 2012/13 (data is still published as PCT areas for comparison reasons). It can be seen that Enfield is at the bottom of the ranked PCTs with 68.3% girls completing their course of vaccinations in 2013/14. There is however a jump of 6.2% from 2011/12's 62.1%% for completed courses.
- For both years, the uptake of 1<sup>st</sup> dose was 78.5% in 2013/14 and 80.9% in 2012/13. This means a fall of 10.2% between first and third doses of HPV in 2013/14. Now that the course has been reduced to two doses, this difference

should be smaller resulting in higher reported rates for 2014/15 (second dose of HPV was 71% in 2013/14).

- NHS England (London) has just finished a re-procurement of school age vaccination services for London commencing later this year. As part of this new contracting arrangement, all providers will be required to provide monthly updates on HPV vaccination rates as well as provision of their timetables and action plans to improve uptake rates.
- Surveillance data from Public Health England (PHE) already suggest that the programme is achieving its aims. Reductions in the prevalence of HPV 16 and 18 infections (HPV strains 16 and 18 cause 70% of cervical cancers and precancerous cervical lesions) are consistent with very high vaccine effectiveness among those vaccinated and suggest that herd-protection is also lowering prevalence among those who are not vaccinated. These early findings support confidence in the programme delivering its expected impact on cervical cancer and other HPV-related diseases in due course. It is anticipated that, with the new two-dose schedule, higher coverage of the completed course should be achievable, thus increasing the potential impact of the programme

Table 2

*Ranking of London Primary Care Trusts (PCTs) in relation to percentage of Year 8 girls who completed the HPV course in 2013/14 and 2012/13*

Name of Organisation	% 2013/14	% 2012/13	Difference
NEWHAM PCT	92.3	90.3	2.0
SUTTON AND MERTON PCT	89.4	87.3	2.1
ISLINGTON PCT	87.1	87	0.1
WALTHAM FOREST PCT	86.8	86.5	0.3
BROMLEY PCT	86.8	85.5	1.3
HILLINGDON PCT	86.5	85.4	1.1
HOUNSLOW PCT	86.2	85.3	0.9
HAVERING PCT	86.2	84.8	1.4
SOUTHWARK PCT	85.7	83.9	1.8
HARROW PCT	83.2	83.7	-0.5
LEWISHAM PCT	82.9	83.2	-0.3
RICHMOND AND TWICKENHAM PCT	81.8	82.7	-0.9
KINGSTON PCT	81.6	81.3	0.3
BRENT TEACHING PCT	81.1	80.2	0.9
LAMBETH PCT	80.9	79.1	1.8
BARKING AND DAGENHAM PCT	79.2	78.8	0.4
WANDSWORTH PCT	79.1	78.8	0.3
KENSINGTON AND CHELSEA PCT	78.9	78.7	0.2
WESTMINSTER PCT	77.9	78.5	-0.6
GREENWICH TEACHING PCT	77.6	78.3	-0.7
EALING PCT	77.0	77.7	-0.7
CAMDEN PCT	77.0	77.4	-0.4
BEXLEY CARE TRUST	76.6	76	0.6
HARINGEY TEACHING PCT	76.4	75.7	0.7
CROYDON PCT	76.4	74.7	1.7
TOWER HAMLETS PCT	75.6	74.5	1.1
HAMMERSMITH AND FULHAM PCT	73.3	72.2	1.1
BARNET PCT	69.5	72	-2.5
CITY AND HACKNEY TEACHING PCT	69.4	66.9	2.5
REDBRIDGE PCT	69.2	66.7	2.5
ENFIELD PCT	68.3	62.1	6.2

Source: PHE (2014)

## 5.2 Other school age vaccinations

- To date, data is not routinely collected and published for Meningococcal C (Men C) vaccination programme and for the teenage booster.
- NHS England (London)'s procurement of immunisation services to deliver school age vaccinations will provide provision in sites outside school as well as deliver school-based vaccinations. Through the new contracts, NHS England will be routinely collecting data on coverage and uptake. The new

national Maternal and Child Health Data set Portal which is due later this year will also provide data on uptake.

- From September 2014, it is planned to deliver Meningococcal ACWY instead of Men C in Year 9 with a catch up in years 12 and 13. This is a national programme following the rise in Meningococcal W (Men W) cases in England over the last two years. A sub-group of the London Immunisation Board has been set up to deliver London's action plan to implement the new programme for 2015/16.
- Following two years of piloting delivery of child 'flu vaccination programme in primary and secondary schools, the programme is being rolled out from September 2015. Across London, all year 1 and 2 children will be offered Fluenz within their schools. GPs will continue to be responsible for vaccinating 2- 4 year olds.

## 6 Adult Vaccinations

### 6.1 Shingles

- The Shingles vaccination programme commenced in September 2013.
- Shingles vaccine is offered to people who are 70 years or 79 years old on 1<sup>st</sup> September in the given year. Data on vaccine coverage is collected between 1<sup>st</sup> September and 31<sup>st</sup> August. London has excellent reporting rates with 98.35 of GP practices submitting data returns.
- Although data for 2014/15 only covers up to February 2015, this year London and England appear to be performing lower than last year despite the national trend projecting an increase on last year. London's average for uptake amongst the 70 year old cohort is 28.6% (lower than England's 48.7% and lower than 2013/14 when it was 51.3%). For the same period, London's average for uptake amongst the 79 year old cohort is 39.6% (lower than England's 48.1% and last year's 50.9%).
- For Enfield, 49.8% of the age 70 year olds were vaccinated in 2013/14 which has slightly decreased to 32% for 2014/15. There has been a larger drop for the 79 year old cohort with 48.4% vaccinated in 2013/14 and 28.6% vaccinated so far in 2014/15.
- In 2013/14 London had 35,616 unvaccinated 70 and 79 year olds (48.5% of the total). Within Enfield, 1543 were unvaccinated (48.1% of the overall total 70 and 79 year old population).
- Table 3 illustrates the percentage uptake by CCG in London for both years of the Shingles programme for the two age cohorts. It can be seen that Enfield CCG reports uptake rates lower than London averages – in 2013/14, 49.8% of 70 year olds and 48.4% of 79 year olds had the shingles vaccine compared to 51.3% and 50.9% for London.
- Nationally and within London, there is no difference between ethnic groups in terms of uptake.
- A task 'n finish group has been set up under the London Immunisation Board with the primary aim of driving up the uptake of shingles vaccine in London. The first output of this group is to devise and promote London Shingles Awareness Week (27<sup>th</sup> July 2015 – 2<sup>nd</sup> August 2015).

Table 3

*Uptake of Shingles Vaccine for the 70 and 79 age cohorts by London CCG for 2013/14 and 2014/15*

CCG	% of 70 years age cohort vaccinated 2013/14	% of 70 years age cohort vaccinated 2014/15*	% of 79 years age cohort vaccinated 2013/14	% of 79 years age cohort vaccinated 2014/15*
Barking and Dagenham CCG	51.9	39.7	45.1	45.5
Barnet CCG	56.1	44.9	55.3	52.4
Bexley CCG	47	40.8	39.8	40.9
Brent	51.8	41.7	50.1	43
Bromley CCG	55.6	39.4	57.3	41.5
Camden CCG	50.3	33.2	52.6	33.3
Central London (Westminster) CCG	34.6	26.3	36.7	27.2
City and Hackney CCG	43	31.1	42.5	30.1
Croydon CCG	55.6	41.4	55.1	40.9
Ealing CCG	49.8	32	48.4	28.6
Enfield CCG	52	40.9	51.7	45.2
Greenwich CCG	51.4	40.9	48.7	34.4
Hammersmith & Fulham CCG	36.6	24.7	32.1	19.2
Haringey CCG	47.7	35.8	49.4	36.1
Harrow CCG	51	41.6	53.3	42.7
Havering CCG	54.6	45.5	55.1	45.4
Hillingdon CCG	62	45.7	60.3	48.6
Hounslow CCG	44.6	37.9	44.6	31.7
Islington CCG	51.2	38.7	45.9	42.1
Kinston CCG	52.6	46.9	56.1	42.9
Lambeth CCG	51.2	32.7	50.1	38.6
Lewisham CCG	49	39.3	48.5	43.4
Merton CCG	51.1	40.1	54.3	41.8
Newham CCG	60.7	42.1	59.1	51.5
Redbridge CCG	51.2	39.1	49.4	36.2
Richmond CCG	61.8	40.9	59.8	43
Southwark CCG	45.5	31.2	46	38.3
Sutton CCG	56.2	46	60.1	48.8
Tower Hamlets CCG	50.9	40.8	56.3	42.4
Wandsworth CCG	52	36.9	50.5	42.8

Waltham Forrest CCG	48.7	37.2	45.5	39.4
West London (K&C & QPP) CCG	42.1	19.5	42	17.4
<b>London</b>	<b>51.3</b>	<b>38.6</b>	<b>50.9</b>	<b>39.6</b>
<b>England</b>	<b>61.8</b>	<b>48.7</b>	<b>59.6</b>	<b>48.1</b>

\* Collection of data still ongoing

Source: PHE (2015)

## 6.2 PPV

- Pneumococcal Polysachride Vaccine (PPV) is offered to all those aged 65 and older to protect against 23 strains of pneumococcal bacterium. It is a one off vaccine which protects for life.
- Vaccine uptake and reporting coverage is published cumulatively. The latest published data is for 2013/14. Up to and including 31<sup>st</sup> March 2014, 66.3% of those aged 65 years and older were vaccinated with PPV in Enfield. This is higher than London's average of 63.6% and lower than England's average of 68.9%. Reporting coverage rates are good – 92.6% for London and 92.9% for England and 92.3% in Enfield.

## 6.3 Seasonal 'Flu

- Table 4 illustrates the uptake of seasonal 'flu vaccine for each of the identified 'at risk' groups for Enfield CCG compared to London and England averages for the winter 2014 (September 1<sup>st</sup> 2014 to January 31<sup>st</sup> 2015). It can be seen that London performs lower than England across the groups. In relation to Enfield CCG, it performs better than London average for the 65+ age group – 72.8% compared to London's 69.2% and similar to England's 72.7% - but it is lower than London average for the other 'at risk' groups.
- Overall, the uptake rates for seasonal 'flu vaccination were down from 2013/14's performance. In England, 72.7% of 65+ year olds were vaccinated (down from 73.2% in 2013/14), 50.3% of those aged 6 months to 65 years with one or more underlying clinical risk factors (down from 52.3% in 2013/14). Vaccination rates of pregnant women increased from 39.8% in 2013/14 to 44.1% in 2014/15 for England.
- London, England and Enfield all performed below the recommended 75% uptake level for all at risk groups. This excludes the child 'flu groups of healthy 2 – 4 years olds where there is no target but GPs are encouraged to aim for 40% coverage rates.
- In relation to Health Care Workers (HCW) directly involved in patient care, 43.2% were vaccinated in London. This is a rise from 41.1% from 2013/14 but both are lower than England averages (54.9% in 2014/15 and 54.8% in 2013/14). Uptake in the acute trusts ranged from 19.6% in South London and Maudsley NHS Foundation Trust to 82.7% in Whittington Hospital. For Barnet, Enfield and Haringey Mental Health Trust, 29.5% of all health professionals directly involved in patient care were vaccinated with seasonal 'flu vaccine whilst 46.5% of health care workers were vaccinated in North Middlesex Hospital.
- In April 2015, NHS England (London) undertook a review of how the 2014/15 seasonal 'flu programme was delivered. This review was presented to the

London Immunisation Board in May 2015 and the reflections and recommendations will be incorporated in the planning for the 2015/15 'flu programme.

*Table 4*  
*Uptake of the 'at risk' Groups of Seasonal 'flu for Enfield CCG compared to London and England for Winter 2014 (September 1<sup>st</sup> 2014 – January 31<sup>st</sup> 2015)*

	% uptake 65 years and over	% uptake 6 months – 65 years at risk	% uptake pregnant women	% uptake all 2 year olds combined	% uptake all 3 year olds combined	% uptake all 4 year olds combined	% of practices responding
Enfield CCG	72.8	52	37.7	29.4	33.5	21.9	100
London	69.2	49.8	39.9	30.3	32.7	23.6	100
England	72.7	50.3	44.1	38.5	41.3	32.9	99.8

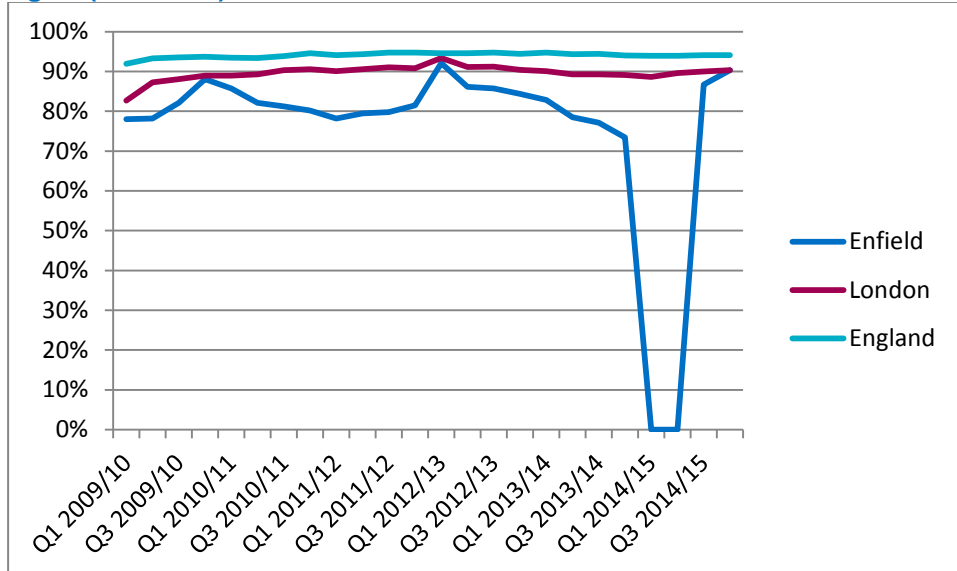
Source: PHE (2015)

## 7 Conclusions and Next Steps

- Enfield and London have performed below national averages on almost all the Section 7A immunization programmes. However, the London Immunisation Board is overseeing pan-London approaches to improve uptake and coverage.
- For 2015/16, each London borough has been assigned an immunisation commissioner who is responsible for delivering a multi-agency borough specific action plan. The aim of each plan is to increase uptake and vaccination coverage within the boroughs, which in turn will increase London averages. The plans will also address health equities in access to immunisations and health inequalities in uptake. Enfield has a borough specific plan and at time of writing, a draft of this plan is currently being agreed and shaped with local partners. It is due to be signed off locally in June 2015.

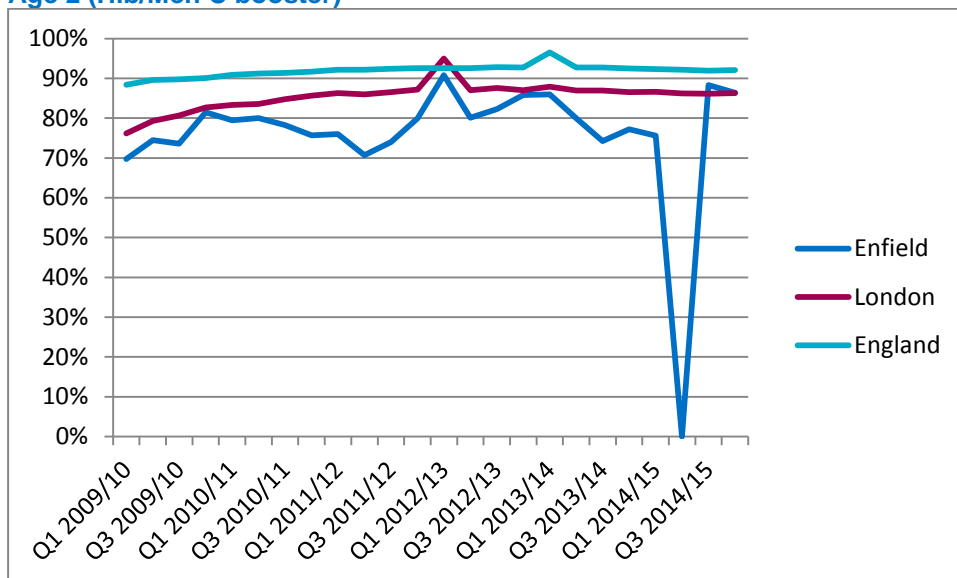
## Appendix 1: Vaccination Uptake in Enfield for Q1 2009/10 to Q4 2014/15 compared to London and England

### Age 1 (Primaries)



Source: PHE (2015)

### Age 2 (Hib/Men C booster)



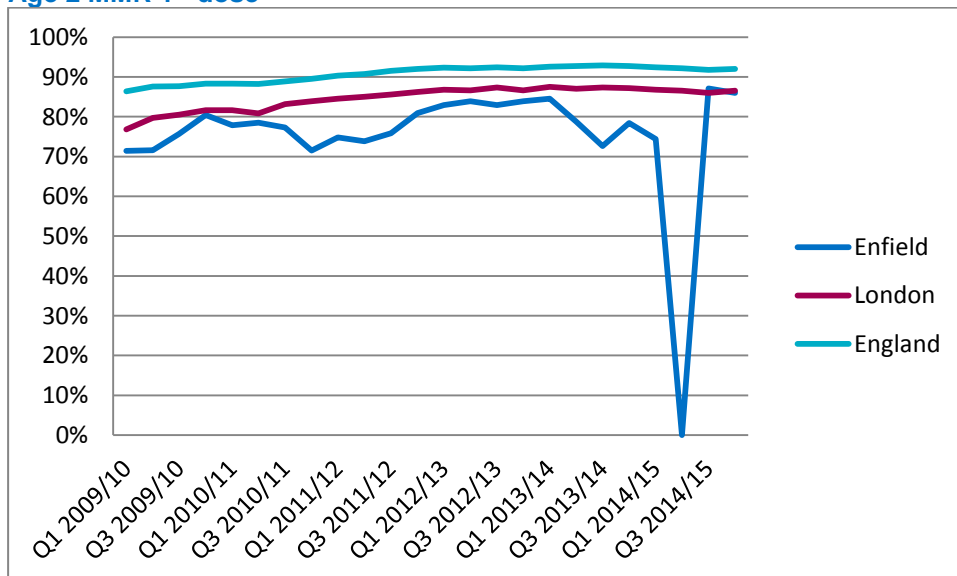
Source: PHE (2015)

### Age 2 (PCV Booster)



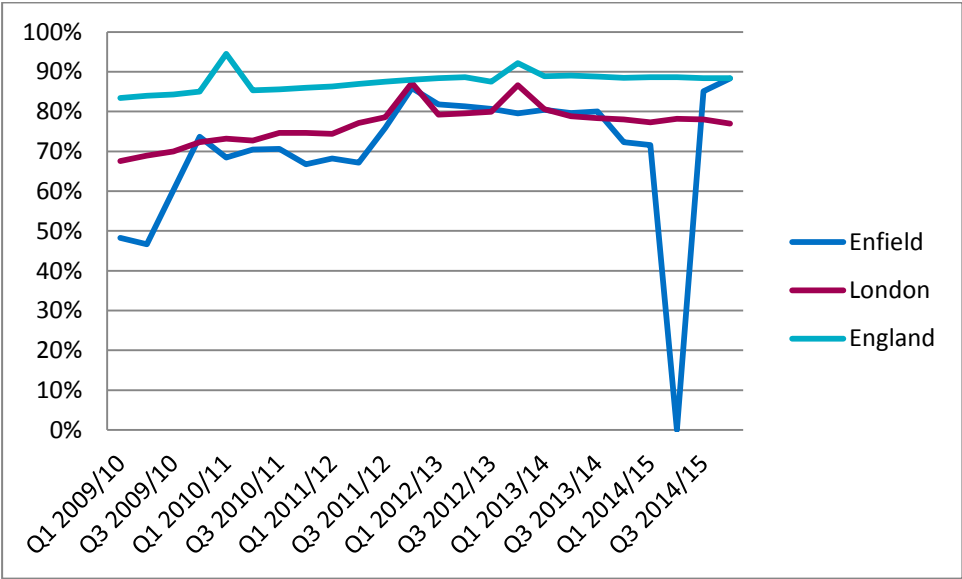
Source: PHE (2015)

### Age 2 MMR 1<sup>st</sup> dose



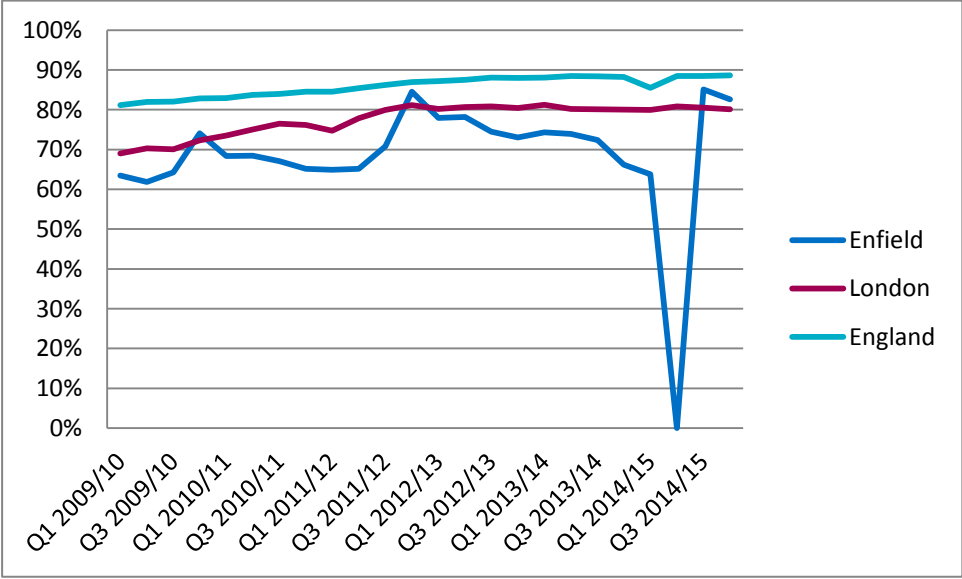
Source: PHE (2015)

Age 5 Preschool booster



Source: PHE (2015)

Age 5 MMR 2<sup>nd</sup> dose



Source: PHE (2015)

<b>MUNICIPAL YEAR 2015/2016</b>	
<b>MEETING TITLE AND DATE</b>  <b>Health and Wellbeing Board</b> <b>14<sup>th</sup> July 2015.</b>	<b>Agenda - Part:1</b>
	<b>Item: 7</b>
	<b>Subject:</b> <b>NHS Enfield CCG Operating Plan 2015/16</b>
<b>Report of: Graham MacDougall,</b> <b>Director Strategy &amp; Partnerships</b>	<b>Wards: All</b>
	<b>Cabinet Member consulted: N/A</b>
<b>Contact officer -</b> Richard Young <b>Email:</b> <a href="mailto:richard.young@enfieldccg.nhs.uk">richard.young@enfieldccg.nhs.uk</a>	

## 1. EXECUTIVE SUMMARY

This paper updates the Health & Wellbeing Board on NHS Enfield Clinical Commissioning Group (CCG) Operating Plan Refresh submissions.

Owing to difficulties agreeing the national tariffs, a revised timetable for contracting and planning submissions was issued. The final submission date for CCG operating plans was moved from 7<sup>th</sup> April to 14<sup>th</sup> May 2015.

The CCG has successfully submitted the Operating Plan Finance and Activity Plan and the UNIFY submission in accordance with the guidance and the revised timetable. However, due to delays in NHS England feedback on the Operating Plan Narrative document, the submission on that part of the Operating Plan has been deferred.

As part of the submission on 14<sup>th</sup> May, the CCG has submitted measures approved at a previous meeting of the Health & Wellbeing Board.

The Plan includes the assurances for acute activity plans to ensure commissioned activity is able to deliver the NHS constitution standards.

## 2. RECOMMENDATIONS

The Health & Wellbeing Board is asked to:

- Note the requirements of the process and the overview of the CCG submissions within the report.
- Endorse NHS Enfield CCG Operating Plan.

## 1. INTRODUCTION

Each CCG has been required to undertake a “refresh” of its Operating Plan for 2015/16. However, the process undertaken by NHS England has been significantly more substantial than originally indicated.

The CCG was required to submit a ‘Full Final Plan’ of the refreshed Operating Plan 2015/16 by 14<sup>th</sup> May 2015 (This was a different deadline to that previously published – see section 3). However, the submission of the revised Narrative Document has been deferred.

This paper updates the Health & Wellbeing Board on the submissions that have been made to date; an overview the final submission of the Finance and Activity Plan and also the chosen Quality Premium Measures for 2015/16 as appendices to this report.

## 2. BACKGROUND

NHS England (NHSE), working with Monitor and the NHS Trust Development Authority, produced joint guidance on the 2015/16 NHS planning process for commissioners, NHS Trusts and Foundation Trusts. The guidance was published in December 2014, setting out details of the planning process for 2015/16 with further supplementary guidance published in mid-January.

For 2015/16, each CCG must submit a one-year Operating Plan, consisting of:

- i. A Finance and Activity Plan.
- ii. A UNIFY submission covering NHS Constitution standards, performance trajectories and other requirements.
- iii. A full narrative setting out the CCG’s approach to achieving the national and local targets.

Alongside these processes has been a detailed and meticulous approach to ensure system-wide alignment of plans through a “Triangulation” process involving providers and other commissioning organisations.

## 3. CHANGES TO THE NATIONAL TIMETABLE

In light of the difficulties in agreeing the tariff structure for NHS PbR (Payment by Results) activity, the original timetable was significantly altered. A copy of the revised timetable is attached at appendix 1.

However, as indicated above, the submission of the revised Narrative Document has been deferred and it appears that a resubmission is not required.

#### **4. NHS ENFIELD CCG OPERATING PLAN 2014/15-2015/16**

Enfield CCG has successfully submitted the 2015/16 Operating Plan. As part of a detailed and iterative assurance process, NHSE have undertaken a forensic examination of every element of the Operating Planning submissions – frequently requiring additional information in order to assure the local health economy plans as compliant. The CCG has worked with Public Health colleagues and the Enfield Health & Wellbeing Board to complete the required returns.

The focus of this draft of the Operating Plan has been to ensure that CCGs have commissioned sufficient activity to meet the local requirements of the NHS Constitution standards (e.g. max 4 hour waits in A&E, 18 week referral to treatment times (RTT), cancer waiting times etc). Following a series of assurance exercises concerning planned levels of commissioned activity, Enfield CCG has increased the levels of activity planned to be commissioned in some areas. The key messages are:

- Increased levels of first outpatients on the basis of an 11% rise in primary care referrals in 2014/15.
- Increased levels of A&E attendances.
- Commissioned at out turn for most elective activity. This includes a substantial element of “RTT catch-up” work to reduce / eliminate waiting list backlogs. (NB: there remains an issue with establishing accurate levels of RTT waiting lists at Barnet & Chase Farm Hospitals).
- Commissioned at outturn for non-elective activity. This accommodates the significant rise in non-elective admissions at the CCG’s main providers.

QIPP reductions have then been applied to these investments which will reduce some of the levels of activity. This means that an average of 3.9% of activity related growth has been applied to contracted activity. Demographic growth has been applied at 1.5% across the board. (See appendix 2 for detail).

As a result, NHS England has now assured Enfield CCG 2015/16 activity plan.

Previous versions of the draft Operating Plan Narrative have been shared with the Health & Wellbeing Board (H&WBB) including a detailed consideration at one of its development sessions. Specific agreement has been given by the H&WBB in relation to areas concerning the Better Care Fund plan and the non-elective admissions reduction target. The Operating Plan refresh will actively support and delivery the Health & Wellbeing Strategy.

#### **5. QUALITY PREMIUM**

The Quality Premium is intended to reward Clinical Commissioning Groups for improvements in the quality of the services that they commission; for associated improvements in health outcomes and reducing inequalities in achieving the main objectives of the NHS Outcomes Framework and CCG Outcomes Indicator Set.

The quality premium paid to CCGs in 2016/17 – to reflect the quality of the health services commissioned by them in 2015/16 – will be based on the following measures that cover a combination of national and local priorities.

At its development meeting on 29<sup>th</sup> April, the Health & Wellbeing Board considered the measures for inclusion in the Quality Premium 2015/16. Alongside the mandatory requirements, the Health & Wellbeing Board approved local measures (see Appendix 3) for:

- Reducing potential years of lives lost through causes considered amenable to healthcare (10 per cent of quality premium);
- Urgent and emergency care:
  - Option 1: Reducing avoidable emergency admissions (composite measure) and
  - Option 2: Reducing NHS-responsible DToCs rates per 100k pop.;
- Mental health: Option 1: Reducing mental health- related A&E 4hr wait breaches;
- Improving antibiotic prescribing in primary and secondary care (10 per cent of quality premium);
- Two local measures:
  - (1) Further improving dementia diagnosis and
  - (2) Reducing emergency admissions from care homes.

These have been included in the CCG submission.

## **6. NEXT STEPS:**

The CCG has submitted its plans in accordance with the original guidance and the further requirements issued by NHS England. As stated earlier, the CCG was required to submit a 'Full Final Plan' of the refreshed Operating Plan 2015/16 by 14<sup>th</sup> May 2015. However, the submission of the revised Narrative Document was deferred and now appears to have been replaced with on-going assurance via quarterly NHSE meetings. CCGs can expect the forensic examination of achieving NHS Constitution standards to continue through the NHSE quarterly assurance process.

Notwithstanding the above, the CCG is updating the narrative document for organisational purposes. Alongside forthcoming commissioning intentions this could form part of the basis for a public facing document.

## **7. RESOURCE IMPLICATIONS:**

The resource implications of the operating plan are now included within the contracts agreed with providers. All of the financial implications are set out within the CCG Finance and Activity Plan.

## **8. EQUALITY IMPACT ANALYSIS:**

There has been no EQIA on this document. Equality Impact Assessments and Quality Impact Assessments are undertaken routinely as part of each project under the CCG Transformation Programme, and reported to the Transformation Programme Group as part of business as usual.

## **9. RISKS:**

There are no risks directly arising from this document. However, several of the projects contained within the Operating Plan will require further risk assessment if commissioned.

## **10. PATIENT & PUBLIC INVOLVEMENT (PPI):**

There has limited direct PPI on this document. However, many of the individual elements of the Plans (including commissioning intentions for 2015/16) have been the subject of extensive engagement.

## **11. RECOMMENDATIONS**

The Health & Wellbeing Board is asked to note the 2015/16 Operating Plan requirements and submissions to date within the report and endorse the NHS Enfield Operating Plan.

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## Appendix 1

## Revised Contracting and Planning Submission Timetable

Timetable item (applicable to all bodies unless specifically referenced)	Original timetable	Revised timetable
Contract negotiations	Jan – 11 Mar	Jan – 31 Mar
Weekly contract tracker to be submitted each Thursday	From 29 Jan	From 29 Jan
Submission of draft activity plan data (NHS Trusts, NHS FTs (except distressed NHS FTs))	n/a	27 Feb
Submission of draft finance and activity plan data (CCGs, NHS England and distressed NHS FTs)	n/a	27 Feb
Confirmation by providers of chosen tariff option - ETO or DTR (NHS Trusts and NHS FTs)	n/a	By 6pm on 4 Mar
Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)	13 Feb	20 Mar
National contract stocktake – to check the status of contracts	20 Feb	27 Mar
<b>Contract Signature Deadline</b>	<b>11 Mar</b>	<b>31 Mar</b>
CCGs	n/a	By 31 Mar
Draft plans approved by NHS Trusts and NHS FTs		
Post-contract signature deadline: where contracts not signed, local decisions to enter mediation*	By COP 25 Feb	By COP 1 Apr
Submission of full commissioner plans (CCGs, NHS England)**	27 Feb (noon)	7 Apr (noon)
Submission of draft plans (NHS Trusts & NHS FTs)		
Assurance of most recent plan submissions by national bodies	27 Feb – 30 Mar	7 Apr – 13 May
Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)	6 Mar	14 Apr
Contracts signed post-mediation	11 Mar (by noon)	17 Apr (by noon)
Entry into arbitration where contracts not signed; and submission of Dispute Resolution Process paperwork*	11 Mar (noon)	17 Apr (noon)
Contract arbitration panels and / or hearings*	13 – 24 Mar	20 – 29 Apr
Arbitration outcomes notified to commissioners and providers*	By 25 Mar	By 30 Apr
<b>Plans approved by Boards of NHS Trusts and NHS FTs</b>	<b>By 31 Mar</b>	<b>By early May</b>
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties*	By 31 Mar	By 7 May
<b>Submission of final plans (NHS Trusts &amp; NHS FTs) Commissioner plan refresh if required (CCGs and NHS England)**</b>	<b>10 Apr (noon)</b>	<b>14 May (noon)</b>
Assurance and reconciliation of operational plans	From 10 Apr	From 14 May

## Summary Bridging Analysis for Planned Activity in 2015/16

		ACTIVITY TYPE (e.c denotes technical guidance code - SUS data to be used unless specified otherwise)							
NHS ENFIELD CCG	All Trusts	Non-elective spells - all specialities (E.C.23)	Daycase Elective Spells - all specialities (E.C.32)	Ordinary Elective Spells - all specialities (E.C.21)	Total - all spec elective spells (E.C.22)	All First Outpatient Attendances - all specialities (E.C.24)	All subsequent outpatient attendances - all specialities (E.C.6)	A&E attendances all types (E.C.8)	GP Written Referrals for a first outpatient appointment - G&A (E.C.9) (MAR DATA)
<b>2013-14 Out-Turn</b>									
M10 SUS FOT		34,359	35,288	6,146	41,434	124,099	269,479	151,715	58,233
Seasonality		0	0	0	0	0	0	0	0
Other (POD Remapping)		0	0	0	0	0	0	0	0
Remove non-recurrent activity		997	2,540	1,771	4,311	0	0	0	0
<b>Restated FOT</b>		<b>33,362</b>	<b>32,748</b>	<b>4,375</b>	<b>37,123</b>	<b>124,099</b>	<b>269,479</b>	<b>151,715</b>	<b>58,233</b>
Pop Growth (1.5%)		515	529	92	622	1,861	4,042	2,276	873
Non-Demographic Growth		996	423	74	497	13,651	3,638	5,538	6,406
Service developments (Pathway Design)		0	0	0	0	0	0	0	0
Other (Other)		997	0	0	0	0	0	0	0
Other (Reversals Metrics & Challenges)		0	0	0	0	0	0	0	0
Less QIPP		0	(514)	0	(514)	(5,450)	(318)	(2,500)	(4,814)
Less BCF		0	0	0	0	0	0	0	0
Plus RTT		0	2,876	2,014	4,890	0	0	0	0
<b>Net Adjustments</b>		<b>2,509</b>	<b>3,315</b>	<b>2,180</b>	<b>5,495</b>	<b>10,062</b>	<b>7,362</b>	<b>5,313</b>	<b>2,465</b>
<b>2015/16</b>		<b>35,871</b>	<b>36,062</b>	<b>6,555</b>	<b>42,618</b>	<b>134,161</b>	<b>276,841</b>	<b>157,028</b>	<b>60,698</b>
<b>Revised year on year growth (%)</b>									
Growth in 2014/15 (%)		6.1%	13.3%	1.6%	3.2%	11.8%	3.5%	10.2%	11.3%
Growth in 2015/16 (%)		4.4%	2.2%	6.7%	2.9%	8.1%	2.7%	3.5%	4.2%

## Appendix 3

## 2015-16 Quality Premium- Enfield CCG

**Quality Gateway**

No cases of serious quality failures at a local provider where CCG is not considered to have made appropriate, proportionate response with its partners to resolve failures. Payments will be discretionary and subject to CCG assurance process criteria in relation to quality failures where gateway is not

**Financial Gateway**

Operate in a manner consistent with Managing Public Money; does not incur unplanned deficit in 2015/16, or require unplanned support to avoid unplanned deficit; and does not incur a qualified audit report in respect of 2015/16.

National Measures		Target	% Allocation	Maximum Available	Reporting Frequency
Reducing Potential Years of Life Lost (PYLL) through causes considered amenable to healthcare over time		No less than 1.2%	10%	£162,423	Annual
Urgent & Emergency Care Option 1: Reducing avoidable emergency admissions (composite measure)	at least 0% change over 4 years; or rate of less than 1k per 100k pop. (ISR)	30%	£487,268	Monthly	
Urgent & Emergency Care Option 2: Reducing NHS-responsible DToCs rates per 100k pop.	Less than 2014/15 Rate			Monthly	
Mental Health Option 1: Reducing mental health- related A&E 4hr wait breaches		% mental health breaches no greater than average for all patients; OR less than 5%	30%	£487,268	Monthly
Improving antibiotic prescribing in primary and secondary care:	(i) Reducing the number of antibiotics prescribed in primary care	Reduction from 1.144% to 1.133%	5%	£81,211	Quarterly
	(ii) reducing the proportion of broad spectrum antibiotics prescribed in primary care	Reduction from 12.5% to 11.3%	3%	£48,727	
	(iii) secondary care providers validation their total prescription data	Compliance at RFL and NMUH (providers with 10% or more of their activity commissioned by CCG)	2%	£32,485	

Proposed Local Measures		Target	Adjustment Value	Maximum Available	Reporting Frequency
Emergency admissions from care homes		6% Reduction	10%	£162,423	Monthly
Dementia Diagnosis Rates		66.7%	10%	£162,423	Monthly
<b>Sub total</b>			<b>100%</b>	<b>£1,624,225</b>	

Constitutional Measures		Target	Potential % Adjustment	Potential Adjustment	Reporting Frequency
18 Week RTT (Admitted Pathway)		90%	-10%	-£162,422.50	Monthly
18 Week RTT (Non-Admitted Pathway)		95%	-10%	-£162,422.50	Monthly
18 Week RTT (Incomplete Pathway)		92%	-10%	-£162,422.50	Monthly
A&E waits (CCG mapped from HES provider data)		95%	-30%	-£487,267.50	Monthly
Cancer waits - 14 days (Urgent GP referral for Suspected Cancer)		93%	-20%	-£324,845	Monthly
Cat A red 1 ambulance calls (LAS performance)		75%	-20%	-£324,845	Monthly

**Grand Total****-100%**

**MUNICIPAL YEAR 2015/2016**

**MEETING TITLE AND DATE**  
**Health and Wellbeing Board**  
**14 July 2015**

Dr Tha Han  
 Consultant in Public Health  
 Tel: 0208 379 1269  
 Email: tha.han@enfield.gov.uk

<b>Agenda - Part: 1</b>	<b>Item: 8a</b>
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<b>Subject: Health Improvement          Partnership Board Update</b>
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<b>Approved by: Dr Shahed Ahmad</b>
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**1. EXECUTIVE SUMMARY**

This is a report to the Health and Wellbeing Board, providing an update regarding the work of the Health Improvement Partnership Board.

**2. RECOMMENDATIONS**

The Health and Wellbeing Board are asked to note the contents of this Report.

**3. PUBLIC HEALTH OPERATING MODEL**

A new model of Public Health delivery started on 1 April. Public Health staff have been embedded in other council departments. The expectation is that this will build public health skills, capacity and capability across the council.

**4. WORK WITH PUBLIC HEALTH ENGLAND**

Public Health England (national) has asked its centres whether they wish to express interest for holding a hypertension workshop. We have supported PHE London to express interest.

**5. WORK WITH THE LONDON PRIMARY CARE TRANSFORMATION OVERSIGHT GROUP**

We have advised the above London-wide group that GP Federations should continue to collect and report data at sub-borough level to help tackle health inequalities and that their management boards should have access to public health expertise.

## **6. CHILD HEALTH PROFILE**

The 2015 child health profiles are now available at: <http://www.chimat.org.uk/profiles> . These are profiles that provide a snapshot of child health and wellbeing for each local authority using key health indicators.

## **7. INFANT MORTALITY**

Although Enfield has an infant mortality rate slightly worse than the London and England averages, with an average of 23 deaths of babies under 1 years of age in the borough, the rate is considerably improved on last year.

## **8. PARENTING PROGRAMMES**

The Consultant in Public Health (CPH) is working with colleagues in SCS to co-design parenting programmes to be delivered in the borough, including in the borough children's centres.

## **9. ANETENATAL PROJECTS**

The breastfeeding phone app for Enfield is now available at Breaststart.

There are now 6 PEP volunteers who are completed health training programmes and are volunteering at North Middlesex University Hospital maternity service and a further 10 volunteers are about to start their training. The focus of the work of the PEP volunteers is maternal and child health, including breastfeeding and early access to maternity. There are additional plans for the PEP volunteers to work with children's centres.

In May 2015 a local campaign to improve early access to maternity was launched and materials are still visible in the borough.

## **10. LOW BIRTH WEIGHT BABIES**

Enfield's rate of low birthweight babies is higher than the London and England averages and it is suspected that this is primarily due to women smoking during pregnancy, as the number of premature births is generally small. It is also worth noting that poverty, ethnicity and early access to maternity affect the rates of low birthweight births.

There is work planned in 2015/16 to examine the true prevalence of smoking in pregnancy, rather than relying on self-reporting, in the borough.

## **11. HEALTH VISITOR TRANSITION/SCHOOL NURSING**

The transition of the health visitors and FNP programme from NHS England to the local authority is progressing. A traded service for school nursing is being developed for the local Academies, Free Schools and Independent schools.

## **12. CHILDHOOD OBESITY**

Enfield has significantly high rates of childhood obesity and overweight at both reception and year 6. Enfield has higher rates than England average rates and the average rate for London. Enfield also has higher rates of obesity and overweight than statistical neighbours, with the exception of Greenwich reception-aged children.

There is a strong link between childhood obesity and poverty, so this is unsurprising given the high levels of child poverty in the borough. There is also a link between childhood obesity and ethnicity which needs further investigation in our borough.

Proposed work for coming year includes:

- Delivering the Change 4 Life programme in children's centres;
- Supporting the Healthy Schools London programme;
- Ensuring all school playgrounds are designed to encourage varied and active play;
- Addressing parental concern around the perceived safety of walking and cycling.

## **13. ORAL HEALTH**

The rate of diseased, missing and filled teeth is high in Enfield. Oral health, like obesity, is due to many factors. These include poverty, lack of understanding of how to access dental care in the UK including NHS dentistry; difficulty accessing services due to language barriers; and parents not getting the right information when their children are very young, so their first trip to the dentist occurs when they are already school age (this is too late).

There has been a significant programme of work to address this over last year, including:

- 801 under-5s signposted to dentists;
- 1068 'Brushing for Life' packs distributed;
- 6 parent dental advisors trained;
- 10 high-risk schools engaged in fluoride varnish pilot (2088 children had varnish applied);
- An outreach programme for special needs schools.

Additional work for the coming year will include:

- Providing oral health promotion training to primary school,
- Community and other frontline staff;
- Developing links and partnerships with other health organisations and voluntary and community groups.

## **14. SEXUAL HEALTH PROCUREMENT**

The Sexual Health Needs Assessment for Enfield has been completed and has been used to inform the procurement of a new service for the borough.

## **15. FGM**

Presentation to CCG Governing Body Safeguarding session on FGM needs assessment. GPs found the needs assessment useful. The CPH has been invited to attend a Home Office stakeholder group on FGM.

## **16. HEALTH PROTECTION**

### Immunisation

The CPH is liaising with NHSE and colleagues in the CCG to improve the data flows for immunisation performance data. IT issues have resulted in the appearance of poor immunisation performance, but there is confidence that this is an artefact.

### Tuberculosis

Community development work has been commissioned from a voluntary sector organisation to improve TB awareness and reduce the stigma associated with TB.

### Communicable Disease

The CPH for health protection receives regular updates from partners on emerging issues so that the Council can maintain operational readiness.

Currently the CPH is monitoring the Ebola Virus Disease outbreak in West Africa. To date, there have been 27,305 confirmed, probably or suspected cases of Ebola in the current outbreak with 11,169 deaths due to the disease. The outbreak in Liberia was declared over in May and just 24 new cases have been reported in the 7 days to 14 June 2015.

There is also an emerging Middle Eastern Respiratory Syndrome Coronavirus (MERS-CoV) situation in South Korea and China where there have now been 175 cases of the disease, including the initial case who returned from the Middle East to S Korea and 27 deaths.

### Health Protection Forum

The CPH is working with partners to initiate work on hepatitis in the borough. This is one of the priority areas for the Enfield Health Protection Forum which meets quarterly to improve partnership working between the NHS, Public Health England, Council teams and other partners on matters of health protection. Cycle Enfield (formerly mini-Holland) is likely to be the most significant influence on improving levels of physical activity in the near future in Enfield. This will result from incorporating physical activity into everyday life. Work on Cycle Enfield is progressing; a number of consultation events have been held and will continue to be held on proposed routes with 'spades in the ground' expected in April 2016.

Enfield Health Trainers provide practical support to people wishing to improve any aspect of their lifestyle. Approximately 80% of referrals to the service are related to obesity, physical activity or food. Between April 2014 and March 2015 Health Trainer service had 901 referrals from GP practices and worked with 1598 clients.

Active People Survey (APS) data indicates that 34.8% of adults (16+) reported undertaking 1\*30 min of sport per week between October 2013 and October 2014.

## **17. SMOKING**

Smoking prevalence in Enfield in 2013 was 15.8% (latest data available). This compares to 18.0% in 2012 which equates to difference of approximately 5000 fewer smokers.

In 2014-15 Enfield helped 1603 people to stop smoking, this compares to 1582 in 2013-14.

In response to research indicating that approximately 50% of the Turkish community smokes Enfield Public Health facilitated run a workshop to reduce prevalence in May 2015. A number of groups and community representatives attended with publicity in the Londra Gazette, Olay and Acik Gazette (internet paper). A cardiologist from the North Middlesex and a Consultant in Public Health were also interviewed on Turkish TV. A Turkish working group will now be established to continue this work, reporting into the Tobacco Control Alliance.

PH worked with a parent / Governor with Carterhatch junior school to implement no smoking at the school gates with a launch event in June 2015 attended by the Council leader, deputy Mayor and PH England. The event was complimented by other health activities on the day. This programme will be rolled out to other schools across the borough.

The Public Health budget for smoking in 2015-2016 has been reduced compared to 2014-2015 which has implications for the number of quitters as well as work in the Turkish community, the Mental Health Trust, Forensics and schools.

## **18. HEALTHCHECKS**

Healthchecks are essentially a 'health MOT' designed to detect vascular disease in those who are not already on GP disease registers. In 2014-15 Enfield delivered 8083 healthchecks with a range of between 0 and 22%.

## **19. SUPPORTING CCG COMMISSIONING**

CPHM actively participated and gave public health, research and clinical input to multiple planning groups at CCG such as Clinical Reference Group, Primary Care Quality Improvement Group, Transformation Programme and Recovery Group. By participating in these strategic groups CPHM ensures health inequalities are not widened due to the efficiency savings and evidence-based approaches are used in the QIPP programmes. The CCG is in £19M financial deficit and is prioritising cost-saving interventions over simply cost-effective interventions. In this situation CPHM reviews evidence around the thresholds of procedures of low clinical effectiveness. CPHM also supports Better Care Fund working group. A newsletter was sent to GPs in April to improve hypertension recognition and evidence based control. A new newsletter will be released in July

around smoking as 9,500 people with long-term condition are recorded to be smokers.

## **20. LIFE EXPECTANCY GAP**

CPHM working with major stakeholders is developing first draft of plan to tackle life expectancy gap in five wards. Health intelligence team is providing local evidence by drafting ward profiles of these wards. Mosaic social marketing data is also used as evidence to derive activities to reach disadvantaged communities. The plan also will also be informed by National Health Inequality Support Team recommendations set out in the Annual Public Health Report 2014.

## **21. JSNA**

Following sections have been updated on the web between January 2015 and June 2015:

- Coronary Heart disease (Health and Wellbeing of Adults Chapter)
- Obesity (Health and Wellbeing of Adults Chapter)
- Diabetes (Health and Wellbeing of Adults Chapter)
- CVD (Health and Wellbeing of Adults Chapter)
- Sensory Impairment (Health and Wellbeing of Adults Chapter)
- Vulnerable Children (Health and Wellbeing of Children, Young People and their Families)
- Child Sexual Exploitation – new information added to the Vulnerable Children section
- FGM – new information added to the Vulnerable Children Section
- Population Numbers and Projections (Enfield People Chapter)
- Life Expectancy (Enfield People Chapter)
- Hospitals and GP Practices (Enfield People Chapter)
- Demographics (Health and Wellbeing of Children, Young People and their Families)

There are several sections which are either being reviewed by leads or in the final stage of being uploaded to the JSNA website. These will be made available online as soon as they have been signed-off. These include:

- Child Poverty (Health and Wellbeing of Children, Young People and their Families)
- COPD (Health and Wellbeing of Adults Chapter)
- HIV and Sexual Health (Health and Wellbeing of Adults Chapter)
- Infant Mortality (Health and Wellbeing of Children, Young People and their Families)
- Oral health of Children (Health and Wellbeing of Children, Young People and their Families)
- Circulatory Disease (Health and Wellbeing of Adults Chapter)

- Cancer (Health and Wellbeing of Adults Chapter)

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**Health and Wellbeing  
Board – 14 July 2015**

**REPORT OF:**

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**Agenda – Part: 1**

**Item: 8b**

**Subject:**

Joint Commissioning Board Report

**Date: Tuesday 14<sup>th</sup> July 2015**

**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 notes:

- The status of the Care Act 2014 and preparations for the 2016 funding reforms [p.3]
- Partnership working between LB Enfield, NHS Enfield CCG and Enfield Community Services to form virtual Integrated Locality Teams supporting GPs for people with frailty [p.4]
- Update on the Sexual Health Community services procurement [p.5]
- The development of a draft action plan that has been uploaded on the Mental Health Crisis Care Concordat (March 2015). This is a shared Barnet and Haringey [p.7]
- Enfield on target to achieving the NHSE implementation date of September 2015 for phase two re moving all people with Learning Disabilities to community services [p.7]
- The Care Act gives a clear vision to proactively identify Carers, which has been logged as a priority area of work for 2015 [p.10]
- Carers Week (8<sup>th</sup> -14<sup>th</sup> June) activities [p.13]
- The Better Care Fund Executive has agreed to prioritise development of a business case for a Children's Services Enhanced Behaviour Support Service [p.13]

## **1. EXECUTIVE SUMMARY (CONTINUED)**

- The introduction of the Government's report on children and adolescent mental health – Future in Mind, March 2015 [p.14]
- The number of DAAT successful treatment completions has started to increase [p.14]
- The authorisation for the signing of the Provision Project building contract has been agreed by Cabinet [p.16]
- A provider forum was held for funded organisations [p.17]
- The ratification of the Safeguarding Adults Strategy, 2015-18 [p.17]
- The definition of the Deprivation of Liberty Safeguards (DoLS), which is part of the Mental Capacity Act 2005 [p.19]
- The achievements of the Adult Multi-Agency Safeguarding Hub (MASH) went live on the 20<sup>th</sup> April 2015 [p.20]
- The updates on Specialist Accommodation [p.22]
- Board updates:
  - Learning Difficulties Partnership Board (LDPB)
  - Carers Partnership Board (CPB)
  - Physical Disabilities Partnership Board (PDPB)
  - Sexual Health Partnership Board (SHPB)
  - Safeguarding Adults Board (SAB)
  - Noting the reformation of the Joint Commissioning Board [p.27]

## **2. RECOMMENDATIONS**

- 2.1** It is recommended that the Health & Wellbeing Board note the content of this report (with appendices).

### **3. THE CARE ACT 2014**

- 3.1 The first major reforms under the Care Act 2014 came into force on April 1<sup>st</sup>. The Council has successfully implemented the key requirements and as with all local authority areas are in the process of embedding the new duties.
- 3.2 We have processes and arrangements in place to respond to new duties for prevention and wellbeing which comprise a range of information and advice including universal services, signposting to financial advice and an on-line support tool AskSara. Planning and activities are also underway to ensure that council and partners are embedding the wellbeing principles. This includes through commissioning arrangements, our work with housing partners and other key partnerships. Additional capacity has been built into the Adult Social Care front line services to manage the new assessment requirements including new duties to assess and provide support to carers.
- 3.3 The new national eligibility criteria based on 'significant impact' on wellbeing and outcomes is being applied. Although it is early days, since 1<sup>st</sup> April the council has seen an increase in activity as a result of the new duties including assessments and support planning, provision of information and advice and support to carers. Access to advocates has also been improved to ensure that where required an individual is independently supported as set out in the Act. We have a new deferred payment arrangement in place, processes for undertaking serious case reviews have been reviewed and a number of reviews are taking place.
- 3.4 We continue to prepare for the 2016 funding reforms for which the final regulations and statutory guidance are due in October. This includes preparing for the reforms and early assessments and the financial modelling to understand the financial impact to the council.
- 3.5 As well as the financial considerations, it is essential that we understand the impact of the Care Act on the outcomes experienced by individuals. The Care Act Board is currently developing a performance and monitoring framework to enable the impact to be measured on a qualitative and quantitative basis.
- 3.6 The implementation of the Act is taking place at a time of considerable change for the council as we move forward with the Enfield 2017 transformation programme. Several aspects of the Act require changes in how we work which are consistent with the developments taking place across the council including the new Gateway Service, Assessment Hub and changes to our finance and IT systems. In view of this, the ongoing implementation will form part of the Enfield 2017 programme.

### **4. BETTER CARE FUND**

Please note: There will be a separate BCF Report to H&WBB

## 5. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

5.1 The integrated care network aims to establish an approach to delivering self-management, care and support of older people with frailty that is more patient-centred, multi-disciplinary and makes most effective use of existing and new resources to deliver care in the most appropriate clinical setting, a key element of which is in primary care, with the GP as Lead Accountable Professional. This will support patients, professionals and organisations to deliver patient-defined and clinical outcomes through a joined-up & holistic approach to meeting needs & preferences and coordinating assessment, care planning & delivery. Its Operating Model has a number of inter-related components discussed below.

### 5.2 Identification and Primary Care Management

Working in partnership between NHS Enfield CCG, London Borough of Enfield and Enfield Community Service, virtual Integrated Locality Teams formed composed of social workers, community matrons & therapists, to deliver a multi-disciplinary, approach to supporting GPs as Lead Accountable Professional in their practices. Future plans include working with the voluntary sector to develop pan-sector support for healthy ageing for older people with frailty. The Care Homes Assessment Team (CHAT) is a nurse-led team with geriatrician input to manage the individual cases of older people in care homes, help develop lasting nursing staff skills in these homes and engage with GPs of residents.

Update	Achievements	Next Steps
Initial <b>GP Care Plans</b> were developed for “top 2%” of cases	5,800+ plans developed between since Jul-14 (target was 4,500 for 2014/15)	NHS England Enhanced Service which supports this care planning extended to 2015/16
<b>Integrated Locality Teams:</b> Plan for Phase II development of Teams now agreed across ECS/LBE. Phase II configuration of ILT roll out for 2014/15 underway	850+ ILT case conferences developed compared (target of 750 for 2014/15) 69% of practices had reduction in emergency admissions of patients 65+ via CCG Locally Commissioned Service (8% fall overall) between Dec-Mar 13/14 & 14/15	<b>Locality Teams:</b> Development plans for co-located, co-managed teams agreed for implementation in 2015/16 <b>Locally Commissioned Services:</b> No funds as yet identified to continue scheme in 2015/16. Recommendation is that it continues
<b>Falls Service</b> currently supporting patients at falls risk, and facilitating professionals’ access to support	Falls Service resulted in net cost-benefit analysis; & significant reduction in re-fractures from pilot	<b>Falls Service</b> specification agreed clinically and voluntary sector falls prevention specification submitted to IC Working Group Jun-15
<b>Tele-Health</b> pilot involving 41 patients with COPD/CHF to help manage their condition	Positive feedback from patients & GPs. Evaluation shows >50% with reduced hospital visits (A&E, Outpatients etc.)	<b>Tele-Health</b> pilot expanded to 60 patients and one provider selected to continue with pilot; next review scheduled for late 2014
<b>CHAT</b> expanded to work in 31 care homes at same time as developed “stretch strategy” to reduce costs	8% reduction in emergency admissions between 2013/14 and 2014/15 from those homes in which CHAT worked	Funding outside BCF Plan identified to expand <b>CHAT</b> function to all 45 homes in second half of 2015/16 (subject to evaluation)

### 5.3 Diagnostics & Treatment

The *Older People's Assessment Units* (OPAU) are consultant-led, multi-disciplinary non-inpatient units to facilitate GPs same or next day access to assessment, diagnostics, treatment and intervention to support primary care case management. The Chase Farm OPAU will continue, but partners are working with NNUH to re-develop its ambulatory care "offer" for older people as an alternative mechanism to deliver the same clinical function as its current OPAU (together with other unscheduled care functions such as admission avoidance in A&E) in a more effective and efficient way for patients.



1,900 people used OPAU last year, with 60% seen by therapists & 15% by social workers



Over 50% of patients visited because of falls, breathing problems or deteriorating conditions



All patients told us they were happy with outcome of their visit



Estimated 70% of patients likely to otherwise go to A&E in next few days, and 25% admitted to hospital



CF OPAU saves £1.16 in preventing people attending hospital as an emergency for every £1 spent

### 5.4 Rapid Response

This function includes a range of services with a focus either on time-limited help for people to return home safely after hospital or providing a crisis management response in the community to help people avoid hospitalisation 7 days a week. This help might include time-limited community rehabilitation, and a draft Service Specification incorporating hospital & community bed-based and home-based rehabilitation is being finalised, including an analysis of the likely need for fast- and slow-stream rehabilitation beds. Plans are also well-advanced in developing a community crisis/urgent response functions and options will be discussed at the Jun-15 Integrated Care Working Group.

## 6. PUBLIC HEALTH GRANT

### 6.1 Sexual Health Community Services Procurement

6.1.1 The OJEU was published 29<sup>th</sup> May and the ITT closing date is 25<sup>th</sup> June 2015.

6.1.2 24 Organisations registered interest of which:

- Private Organisations	3
- Charity Organisations	3
- IT/Test Kit Solutions companies	3
- CIC	3
- NHS Trusts / Acute	12

6.1.3 Over 100 questions have been submitted by the registered interested parties and answered

6.1.4 The envisaged timetable for the selection of the successful Provider to enter into the Contract is as follows:

Activity	Date / Time
Issue ITT	29 May 2015
Deadline for receipt of Providers questions	12 June 2015
Deadline for responses to Providers questions	16 June 2015
Deadline for receipt of Tenders	4pm, 25 June 2015
Evaluation of written submissions	1 July 2015
Clarification Meetings (if required)	2 July 2015
Presentation to CMB	7 July 2015
Approval of decision to award by Cabinet	22 July 2015
Notification of outcome to Providers	3 August 2015
10 day standstill period	4 – 13 August 2015
Final contract award	14 August 2015
Contract start	1 November 2015

6.1.5 The service will be delivered from three/four locations across the borough:

- Enfield Town
- Enfield Highway
- Bowes/Palmers Green
- Edmonton Green

6.1.6 The redesigned Sexual Health Community service will offer increased access via locations and hours (seven days opening).

6.2 **Health Visiting and Family Nurse Partnership Services** will be transferred to local authorities from NHS England on the 1st October 2015. The funding will be added to the Public Health grant and ring-fenced for 18 months (to 31 March 2017).

These services will be part of the Community Services block contract with the Council's School Nursing services and Children's' Therapies services. The lead on the block contract is the CCG with Enfield Council as an Associate. These services have been kept within the block contract arrangement to ensure joint working with the CCG on all children's services. The Council is will co-manage and monitor the HV and FNP services with NHSE until 30<sup>th</sup> September and will continue to manage and monitor the services thereafter.

## 7. SERVICE AREA COMMISSIONING ACTIVITY

### 7.1 Older People – Dementia

NHS Enfield CCG has been working with GPs to identify those patients with a formal diagnosis of dementia who need to be added to individual GPs Dementia Registers, as well as those individuals who may need to be assessed for a formal diagnosis from the Memory Service. The Review indicated a key improvement area was post-diagnostic support for people with dementia, and a Service Specification has been drafted for this voluntary sector service linked to the Memory Service, with funding via the BCF Plan.

As a result of the End-to-End review of the Dementia Pathway and the Memory Service (from referral to assessment, assessment to diagnosis) initiatives, the proportion of older people likely to have dementia in Enfield (estimated to be around 3,000) who were known to be on GPs' Dementia Registers increased from 46% (around the national average) to 59% between the end of Mar-2014 & Mar-2015, and Enfield achieved its agreed target. The target for end Mar-2016 is 66%.

## 7.2 **Mental Health**

7.2.1 The Enfield Joint Adult Mental health Strategy (2014-2019) will be further informed by the Public Health Needs Assessment for adult mental health which will be completed during the summer 2015. The needs assessment will be led by Enfield Public Health in partnership with statutory and other stakeholders. The assessment report will afford a refreshed understanding of mental health needs and opportunities to further develop co-produced services and interventions to meet the needs of persons who access mental health services and their carers.

7.2.2 The Mental Health Crisis Care Concordat - Published by the Government in 2014. It is a commitment by 22 national bodies to work together to improve the system of care and support for persons at the point of crisis.

A draft Enfield action plan has been developed and was uploaded on to the Crisis Care Concordat website in March 2015. This is a shared overarching document for Barnet Enfield and Haringey as all three boroughs have the same main NHS provider of secondary care mental health services and is work in progress. Following agreement on updating the present plan at a workshop held on 21/05/15 the revised content of this plan will be uploaded and each borough will progress a local borough action plan working together locally to put in place the principles of the concordat to improve the system of care and support so that people in crisis because of a mental health condition are kept safe with appropriate support to find the help they need from whichever of our services they turn to first.

7.2.3 2015-16 National RTT NHS Waiting time targets for IAPT (Individual Access to Psychological Therapy) and EIP (Early Intervention Psychosis).

Both national targets will be reported on for the September Board following the Q1 submission to NHS England in July 2015. Activity monitoring to date indicates that Enfield is on target.

## 7.3 **Learning Disabilities**

7.3.1 Work continues on implementing the Transforming Care Programme locally. We are well on target to achieving the NHSE September 2015 target for moving all people identified in the second phase target to community services and to date we have delivered the following:-

- Moved people with learning disabilities from a hospital environment into the community in a planned, measured and clinically robust and appropriately

way with a view to the long term sustainability of each and every placement made.

- Invested in a local integrated community intervention service that offers holistic therapies and support which has actively contributed to significantly reducing admissions to our in borough assessment and treatment service for people with learning disabilities. This reduction in admissions has been significant; causing our service provider to notify us of their intention to complete a review of the long term viability of the service.
- Invested in Positive Behaviour Specialists that are working with our learning disabilities integrated multi-disciplinary community service to provide training and support to our complex needs services with a view to a) upskilling them in PBS techniques and b) developing resilience strategies with a view to minimising crisis episodes
- Enabled our clinical leads (psychiatry) to work in partnership with the community intervention service to develop holistic approaches to minimising use of medication to manage episodes of challenging behaviour – our clinicians were invited to present our approach at the Royal College of Psychiatry London Leadership Network on the 12<sup>th</sup> November 2014.
- Provided awareness training to London Learning Disabilities Leadership Network with a view to presenting our model and approach to minimising admissions on 24<sup>th</sup> of April 2015.
- Provided mental health support and minimising challenging behaviour training to service providers of people with complex needs and behaviour that can prove challenging. The most recent event took place on the 4<sup>th</sup> of June 2015 with another planned for September 2015.
- Working in partnership with children's services to develop a multi-disciplinary intervention service that supports young people in transition with learning disabilities with emotional issues and behaviour that challenges at times and seeks to reduce out of area educational residential placements.

7.3.2 Commissioning are working in partnership with the Council's property services, housing enabling and the Integrated Learning Disabilities services to commission a wide range of supported accommodation over the next 12-18 months. These services are:

- A small supported accommodation service for people with severe autism who may also have complex needs and behaviour that proves challenging at times

- A 24-hour health and care supported living service for 5 people with profound and multiple learning disabilities and physical health care needs on Baker Street
- Reprovision of 2x residential care home services with a view to replacing this provision with supported accommodation services for people with complex needs. This is in line with the Personalisation agenda and the Transforming Care for people with learning disabilities programme

#### 7.3.3 Autism (under the mental health section):

- Our Autism Strategy implementation and co-ordination service has re-established the Autism Steering Group. The first meeting of the Steering Group will take place on 16<sup>th</sup> of June 2016 and includes representation from relevant stakeholders. This Steering Group will be responsible for overseeing the delivery of Enfield's Joint Adults with Autism Strategy and the key objectives within.

### 7.4 Carers

#### 7.4.1 The Care Act and Children and Families Act

Work is being undertaken to look at new Carer Pathways in both Adult and Children's Services in line with the new requirements in both acts.

HHASC are in the process of delegating authority for Carers Assessments to Enfield Carers Centre, who are best placed to reach hidden carers with the expertise and quality needed. This will also introduce a formal support plan and a Resource Allocation System (RAS) for carers direct payments. It is hoped this will lead to earlier support to carers and provide better quality outcomes.

Adult Social Care assessments forms have been updated in line with the Acts.

Children's Services are currently designing a new pathway for young carers, including increased awareness raising for schools and will be undertaking a consultation, led by the Carers Trust, to review support for young carers.

#### 7.4.2 The Employee Carers' Support Scheme

Meetings have recently been held between the Chairs of all the Equality groups to look at their impact and influence. There has been disappointment that the Carers Action Group has not been able to make changes or influence as desired.

A business case for the continuation and support of the groups is being prepared for the Corporate Equalities Group.

#### 7.4.3 Enfield Carers Centre

The Centre now has 3808 carers on the Carers Register. In addition, 860 carers hold a Carers Emergency Card. In the October-December 2014 quarter the Centre registered 289 new carers.

The Carers Centre respite programme has allowed 223 carers to receive a respite break or activity between January and March.

Enfield Carers Centre has now recruited a full time Benefits Advisor who took up their post in April 2014. In the Jan-March quarter, 86 carers received benefits advice. This has highlighted the real need for benefit advice specifically for carers and is an excellent addition to the range of support the Centre provides.

The Hospital Liaison Worker continues to work on the wards at North Middlesex, Chase Farm and Barnet Hospital. Leaflets and posters are distributed and supplies kept topped up throughout all hospitals. Barnet Hospital has also a permanent pop up banner advertising Enfield Carers Centre near the lifts next to the outpatients department. In the quarter of Jan-March the Hospital Worker identified 57 new carers.

The Advocacy Worker has been taking up cases and has continued to promote the services within the VCS and with practitioners. In the Jan-March quarter they provided support to 84 carers.

The newly established Young Adult Carers project for young carers and young adult carers is running well, although funding is currently being sought to continue this work. In the second quarter of operation the Young Adult Carer Project has identified an additional 16 young adult carers.

The Centre's training programme has seen 151 carers attend a training sessions over this quarter. A further 18 carers have received one to one counselling during this period.

#### **7.4.4 Identification of Carers**

In the Care Act 2014 there is a clear vision to proactively identify carers. This will be a priority area of work for 2015 – in February pharmacies in Enfield received 1000 prescription bags, branded with the 'I am a Carer' design with contact details for the Council and the Carers Centre. We hope to reach carers that otherwise do not access services.

Prior to Carers Week in June, there will be a two week billboard campaign, again using the 'I am a Carer' brand, to advertise Carers Week and to, again, try and reach those hidden carers.

#### **7.4.5 Primary Care\***

##### **7.4.5.1 Referrals and Practice Engagement**

The GP project has now seen 320 new carers registered through either the GP or the self-referral method from the surgery information. 14 surgeries have a permanent carers noticeboard. 15 surgeries are now hosting regular carers information stands and 26 practices now have carers post boxes on reception. All 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. 47 practices are now actively engaging in the project. All pharmacies have been written to in the reporting period and three are now actively engaging in the project. A bimonthly

E- bulletin is sent to all the practices that have been visited with a project update and a request for further engagement.

#### 7.4.5.2 Marketing Promotion and Project Activity

Following the meeting last quarter with a business analyst from NEL Commissioning a questionnaire was sent out to all GP practices in the borough asking how and if they read code carers on Emis and Vision and if they would be willing to work with ECC to improve their carers registers and have a focused drive on identifying more carers in their practice. The aim of this is to increase the number of carers on practice registers. Seven practices have responded saying they would be willing to do this and the GPLM is now contacting them to make appointments to discuss how to move forward with each practice.

One practice (Green Lanes) has confirmed that they are willing to hold Carers Health Check clinics and this is being set up by the GPLM currently. Three other practices have indicated that they would be willing to hold the clinics and the GPLM hopes to have more in place by the end of the next quarter.

Three new practice Carers Champions were trained and began the role in the reporting period.

#### 7.4.5.3 Enfield Carers Centre GP Health Forum

Fifteen Carers attended the Carers GP and Health Forum in March. The first half of the session was an information session presented by the GPLM about general healthcare services in the borough. Topics covered and issues raised included on line appointment booking, health checks for over 40's and the confusion many people feel about whether to use Urgent Care Centres (UCC), A&E, or their GP. The Primary Care Liaison Officer from UCC at Chase Farm was present and discussed with the group the high number of patients that they see who are not suitable for treatment there. She has agreed to come along to the next forum with the UCC Service Manager to talk to Carers about UCC and when it is appropriate to use it and when to go to A&E

The second half of the session was a presentation by a GP Dr Ujjal Sarkar from Lincoln Road Practice. Dr Sarkar talked about GP services in Enfield and the role of the CCG as he is a governing body member. He detailed the CCG's vision and goals and discussed the challenges of delivering primary healthcare services in Enfield. Carers found the section on GP services interesting as Dr Sarkar explained which services GPs must provide and which are discretionary.

Feedback from carers included:

- 100% said they found the meeting to be very worthwhile
- 80% said they had found it useful to their caring role
- 28% said they had never discussed their caring role with their GP and 60% said they had. 12% had discussed it a little but not often.

Comments included:

*'Very informative and better understanding of GP's responsibilities'*

*'Some of the information given I was not aware of'*

In response to the question:

'What services could your GP provide that would help you and the person that you care for?' Responses include:

*'Provide more appointments for carers'*

*'Provide information quicker I had to wait two months for feedback on test results, this is a long time if you are unwell'*

*'Support emotional and physical'*

#### 7.4.5.4 Awareness Raising

Surgery visits continue to be undertaken to keep practice literature up to date and to ensure that posters leaflets and flyers are available for carers.

Two volunteers work with the GPLM to help with this role.

In conjunction with London Borough of Enfield, all the pharmacies in Enfield were sent 1000 printed prescription bags with ECC details printed on them and sent a letter from ECC containing referral cards.

#### 7.4.5.5 Individual Support

Eight individual Carers were supported with primary care related problems through the project in this quarter. These included: helping them to sort out problems with hospital transport transfers; supporting a carer to write to her GP about her parent being removed

#### 7.4.5.6 Project Challenges and Shortfalls

Communication with some of the practices is still a big challenge. Many of them have to be chased many times before a reply is given and many of the practice managers are rarely available by telephone. This is mainly due to work load and the time constraints they face but it can be very frustrating and time consuming for the GPLM. Some of the smaller practices do not really engage with the project, other than displaying posters and leaflets, despite this, we are seeing a gradual increase in referrals coming directly from the GP's themselves which is encouraging.

Project plans for the next quarter include:

- Increasing the number of surgeries hosting volunteer- run information stands on a regular basis
- Continuing to raise the number of Carers identified through the project
- Placing articles and external links on as many surgery websites as possible
- Undertaking an increased number of staff training sessions in practices
- Hosting another Carers GP Forum at ECC
- Increasing the number of Carers Champions in Enfield
- Working to embed some sustainable policies in GP Practices in Enfield.

- Continuing to work towards permanent Carer prompts on GP computer system

(\*All statistics are to the end of March 2015)

#### 7.4.6 Carers Week (8th June-14th June)

- Tuesday 9<sup>th</sup> June is Information Day at the Dugdale Centre. The day will be made up of presentations, information stalls, lunch and a Question and Answer session with a HHASC Assistant Director.
- Friday 12<sup>th</sup> June is National Young Carers Day Enfield Carers Centre are planning a day trip for adult carers and activities for young and young adult carers.
- Saturday 13<sup>th</sup> June - Enfield Carers Centre will be hosting a Family Fun Day outside Enfield Town Library. This will be a combination of information stalls, entertainment and food and drink. The purpose is to raise awareness of carers' issues and the Centre itself.

### 7.5 Children's Services

#### 7.5.1 Child Health and Wellbeing Networks

A paediatric integrated care work stream was initially established to support implementation of the Barnet, Enfield and Haringey Clinical Strategy, and is now supporting the development of the Child Health and Wellbeing Networks included in the Better Care Fund submission. The new networks will enable care to be designed around the needs of children and families taking account of both their physical, social, and emotional, circumstances and providing access to expertise from across the professional spectrum, but most importantly from children and families themselves.

#### 7.5.2 Joint Enfield Council and CCG Children and Adolescent Mental Health Service (CAMHS) Strategy

The Strategy is being finalised to incorporate the *Future in Mind* Report. The Strategy will be going out for consultation shortly.

#### 7.5.3 Enhanced Behaviour Support Service

The Better Care Fund Executive has agreed to prioritise development of a business case for an Enhanced Behaviour Support Service. The aim of the service is to prevent, where possible, long-term residential care for children and young people with learning disabilities and challenging behaviour, enabling them to remain within their family/community. It is proposed to model the Team on the Ealing Intensive Therapeutic and Short Breaks Service (ITSBS), which has been cited by the Department of Health as an example of Good Practice. The Ealing model consisted of a Clinical Psychologist, Therapeutic Nurse, who provide positive behavioural support and therapeutic interventions, access to regular planned short breaks, and an administrator. The team worked with 21 young people between October 2008 and April 2014 all of whom were referred due to high levels of challenging behaviour and because families/other professional were concerned about home breakdown. 20/21 of the cases seen by the service

have continued living at home and there have been significant improvements in challenging behaviour.

#### **7.5.4 Future in Mind Report**

The Government's wide-ranging report on children and adolescent mental health, *Future in Mind*, March 2015, stipulates that each CCG area is required to produce a Transformation Plan. These Plans should cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services. Plans are expected to clearly articulate the local offer of mental health services. Once the Government guidance is issued on the Transformation Plans, partners will be consulted before submission. It is expected that the Health and Well-Being Board will provide strategic leadership and approve these plans.

The 'Future in Mind' report addressed five key themes (see attached briefing note):

- Promoting resilience, prevention and early intervention
- Improving access to effective support - a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

## **7.6 Drug and Alcohol Action Team (DAAT)**

### **7.6.1 Successful Completions (Drugs)**

The DAAT has now set the targets for 2015/16 for the *Number of Successful Treatment Completions* and *Numbers in Treatment* which are included in the Table below. In setting the targets the DAAT has aimed to be within the top 50% of best performing DAAT's in London which is considered stretching.

The local forecast for the 12 month rolling period March 2014 to February 2015 is indicating that 995 drug users have been in treatment during the year. The direction of travel for the Numbers in Treatment remains positive and needs to be sustained to reach the end of year target. The Number of Successful Treatment Completions has also started to increase upwards and remains acceptable given the rise in the Numbers in Treatment. The DAAT is currently ranking 0.5% above the London Average for Successful Treatment Completions and 4.1% above the National Average.

## Enfield Providers - Successful Completions (Drugs)

Fig. 1: Successful Completions All Drug Users (Partnership)

Partnership	Jan 2014 to Dec 2014	Feb 2014 to Jan 2015	Mar 2014 to Feb 2015	Apr 2015 to Mar 2016
Number of Successful Completions	227	220	199	217
Numbers in Treatment	963	969	995	1014
% Successful Completions	23.6%	22.7%	20%	21.4%
% London Average	19.9%	19.7%	19.5%	
% National Average	16.4%	16.1%	15.9%	

### 7.6.2 Drug Intervention programme Performance

The end of 2014/15 year MOPAC Performance for the adult drug offender element of the Grant is outlined below. The total number of convictions at year end was below the Baseline by 6 convictions. The Number of Offenders in the Cohort who Achieved Reduced Offending was very positive at 26.2%. The Successful Treatment Completion rate for the Cohort was 6.7% above the London Average and the growth in Numbers In Treatment was 71.2%.

The DAAT has proposed setting a target of 20% to MOPAC for the Numbers Achieving Reduced Offending and that the rates for Successful Treatment Completions should be 21.4% and Numbers in Treatment should increase by 40% over the Baseline. The DAAT will continue to report on the Number of Convictions as well as part of the Quarterly monitoring process but this measure will not be used under the PbR element of the Grant allocation. The proposed amended Grant Agreement has been sent to MOPAC to confirm the 2015/16 targets going forward.

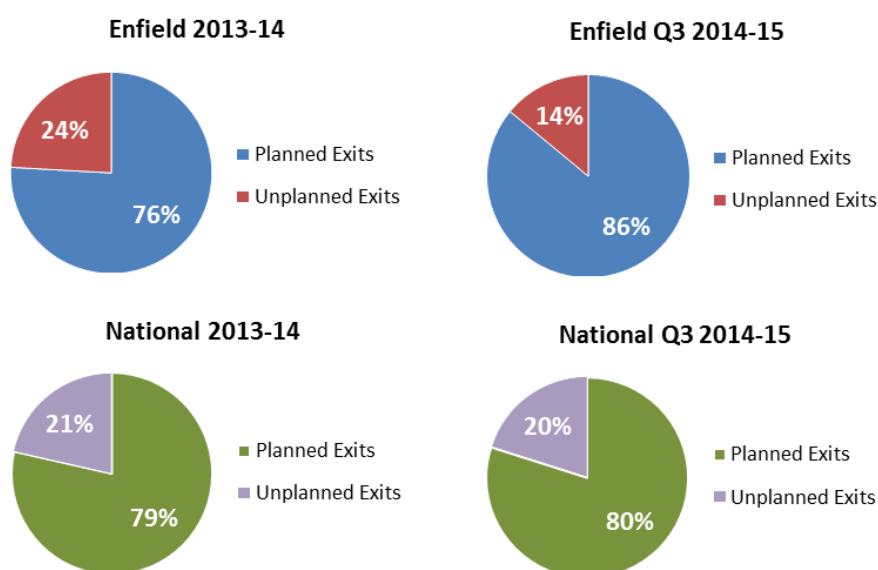
MOPAC Re-offending Cohort: 42	2013-14					2014-15				
Category	Q1	Q2	Q3	Q4	Total Y/E	Q1	Q2	Q3	Q4	YtD
Total Number of Convictions	62	33	75	51	221	64	46	58	47	215
Cumulative Number of Convictions	62	95	170	221	221	64	110	168	215	215
Clients with Increased Conviction Rate YTD	N/A	N/A	N/A	N/A	N/A	16	13	14	8	8
Clients with Static Conviction Rate YTD	N/A	N/A	N/A	N/A	N/A	16	15	7	23	23
Clients with Decreased Conviction Rate YTD	N/A	N/A	N/A	N/A	N/A	10	11	21	11	11
IMPROVED MOPAC TARGET % of Cohort Achieving Reduced Offending Behaviour	N/A	N/A	N/A	N/A	N/A	23.8%	26.2%	50.0%	26.2%	26.2%
NDTMS Successful Completions DIP 12 Month Rolling					N/A	34.3%	35.0%	24%	25.4%	25.4%
NDTMS In Treatment DIP 12 Month Rolling					N/A	193	210	255	271	271

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

The Number of Alcohol Users in Treatment has remained consistent with the previous 12 month rolling period at 324. The Numbers Successfully Completing Treatment has reduced though and the DAAT has commenced work with the two main providers to introduce a positive re-engagement service to improve this performance in the direction of travel required.

### 7.6.4 Young People's Substance Misuse Performance

The most recent PHE ratified performance for young people has confirmed that 181 young people received substance misuse treatment for the 12 month period up to December 2014. This performance is relatively consistent with the previous year's data and remains good compared to the level of investment afforded to the young people's substance misuse provision. The Planned Exit rate is very good as the following Pie Charts demonstrate.



## 8. Reprovision Project

The Reprovision Project continues to progress generally positively. A challenge has been obtaining a firm cost for construction, which has taken longer than expected due to a number of reasons including changes made to the design, difficulty in obtaining acceptable quotes in terms of sub-contractor packages – this process is now complete.

As expected building costs have been subject to increase due to the construction industry experiencing major inflation due to scarcity of labour, materials and equipment, the Council is facing a similar situation with other construction projects e.g. schools building programmes.

A report to seek authorisation for the signing of the building contract with the contractor was agreed by Cabinet on the 17<sup>th</sup> June and will now go to full Council. Subject to that being agreed the schedule is envisaged as:

Work Begins on Site	July 2015
Building Completed	September 2016
Building occupied and operational	September 2016

Once the building construction has started, a competitive Tender exercise will be initiated to select and appoint a service provider to deliver care to the future resident group.

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

A provider forum with funded organisations was held on 18<sup>th</sup> May 2015 to update the sector on a number of key areas. The broad context was set out: reaffirming the Council's commitment to working with the VCS: the challenging financial context and scale of required efficiencies required as a whole by the Council and department set out. Those present acknowledged the need to for current arrangements to be refreshed and modernised particularly around commissioning, procurement and monitoring practice. The shared principles to future commissioning set out in the original framework document were confirmed, underpinned by the need to ensure consistency with Council strategy and duties, working to Enfield 2017 principles.

Commissioning priorities and an indicative timeline were set out as follows:

- Evidenced based prevention / universal offer / risk based targeted interventions (e.g. falls prevention)
- Support for carers
- Increasingly integrated statutory services
- Advocacy services (particularly safeguarding)
- Information & advice across health & social care
- Prevent admission and support safe & timely discharge (residential / hospital)
- Providing employment / work experience/ volunteering and opportunities for care leavers and people eligible for adult social care

New opportunities for local VCs organisations were shared including the Home Based Support Service strategy and signalling the forthcoming consultation of the Council's new approach to Transport provision. An ongoing commitment was given to continue supporting the VCS with advice and guidance and capacity building.

## 10. **SAFEGUARDING**

- 10.1 The **Safeguarding Adults Board Safeguarding Adults Strategy 2015-2018** has been ratified by the Board and action plan is now being implemented by the partnership. A consultation held from February to April 2015 had 113 individual responses to a questionnaire, 8 responses on the whole strategy document, and 16 individuals responded through group presentations and discussions. We also took the consultation to the Health and Wellbeing Board.

Out of the 113 who responded to the questionnaire 50% identified themselves as a carer, 15% considered themselves to be carers and service users, and 8% considered themselves to be service users. The remaining respondents were local residents, carers who were also employed and individuals employed in health and adult social care or other occupations. Of those who chose to respond as to their gender, 41 of the respondents were male, 63 were female and 2 were transgendered. Additionally, 58% felt their day to day activities were limited a lot or a little because of a health problem or disability. Usefully 58% were able to suggest actions which could be taken to meet the Safeguarding Adults Board's aims.

The two areas that people felt fit most in safeguarding adults were **financial abuse** and **abuse in care settings**. When we asked people about the aims of the Board that was most important to them the answer was **preventing abuse** followed by **keeping people safe in a way that improves health and wellbeing**.

Some of the points raised by respondents were:

- Quite a few respondents wanted more publicity and suggested a single point to report abuse.

*"everyone needs to be made aware of what abuse is and where the boundaries of acceptable behaviour lies. Many who have lived in abusive environments don't really realise what abuse is and will deny that it's happening..."*

- Use of technology to help detect abuse and keep a person safe if harm is occurring
- Keep contact with people at risk and not just during times of difficulty
- Ensure Dignity in Care and that we work to prevent issues such as dehydration

*"no patient on any hospital ward should ever die, or even suffer, from dehydration or malnutrition...the common factor in all these scenarios is that they involve basic care and not high-tech medical nursing."*

- All departments should cooperate and share information with each other
- More prevention – to listen to what people want

The Safeguarding Adults Board will now publish the Safeguarding Adults Strategy and the action plan for the coming three years 2015-2018. We have reviewed all of the responses from the consultation and identified key actions we will take, including a very clear emphasis on prevention, both in our strategy document and our action plan and to set ourselves actions to facilitate interventions which prevent dehydration, particularly for those receiving care in the community and care homes. A number of people wanted a single number to report abuse and as the Enfield Adult Abuse Line (tel: 020 8379 5212) already exists we clearly we need to do more to publicise this contact point. Further, we want to share information to support an adult at risk to receive a quick response and work with them in partnership. We have set up a Multi-Agency Safeguarding

Hub to help with the sharing of information and will work to support this develop over the coming year.

- 10.2 **Making Safeguarding Personal (MSP)** is a national initiative set out by the Local Government Association and Association of Directors of Adult Social Services to improve safeguarding practice through a person centred approach. The overarching intention of MSP is to facilitate person-centred, outcome-focused responses to adult safeguarding situations. Enfield is operating at the Gold Standard level for Making Safeguarding Personal in March 2015.

All partners on the Board are expected for the coming year to have an action plan around how Making Safeguarding Personal will be implemented and this is being assured through the 'Care Act Implementation for Safeguarding Adults' sub-group of the Board. Enfield Council is supporting partners with implementation through commissioning bespoke training from Bournemouth University, College of Social Work, to support the development and implementation of Making Safeguarding Personal (MSP) agenda.

The Course is titled 'Senior Management Programme The College of Social Work - Improving Personal and Organisational Performance (IPOP)'. The aim of this training is to support and build on the work already undertaken in achieving the gold standard in MSP. MSP is a major feature in the Adult Safeguarding Boards three year safeguarding strategy and included in the Care Act.

- 10.3 The **Deprivation of Liberty Safeguards (DoLS)** are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. Where someone needs to be detained in a care home or hospital to keep them safe, a DoLS can be authorised which outlines the safeguards for that particular individual.

There are six assessments which have to take place before a standard authorisation can be given. The Association of Directors of Adult Services (ADASS) and the Department of Health have now created new application forms to simplify the application process to Local Authorities.

If a standard authorisation is granted, one of the most important safeguards is that the person has someone appointed with legal powers to represent them, to ensure that their placement or treatment stay remains in their best interests. This is called the relevant person's representative and will usually be a family member or friend. If a person is un-befriended or has no family, they will have a paid representative appointed for them and they can access the services of an Independent Mental Capacity Advocate (IMCA) if they need this level of representation.

Other safeguards include rights to challenge DoLS Authorisations in the Court of Protection. There is also a streamlined process for having such safeguards put in place for people in Supported Accommodation or other settings than a care

home or hospital. These judicial DoL Safeguards have to be authorised by the Court of Protection who have now streamlined the application process for these cases.

In the last year there have been 585 requests for a Deprivation of Liberty Safeguard and 66 the year prior, which is a 786% increase.

These DoLS requests can be broken down further:

- 439 were authorised
- 88 were not authorised (declined)
- 10 were found to not be appropriate to be referred for a DoLS
- 48 of the cases are still in progress

10.4 The **Dignity in Care Panel** has successfully recruited additional volunteers to contribute to the work of the project. With the continued support of Marian Harrington, the independent chair, the panel has developed a detailed work plan. The panel will review the work of the Complaints and Brokerage teams to gather customer feedback to influence service development and improvement and identify and share good practice.

10.5 **Quality Checker Project** - The Volunteer Co-ordinator has planned a recruitment drive to increase the number of volunteers and to ensure the volunteer team are representative of the community that they serve.

The project works closely with the Safeguarding Adults Team and takes actions from the Safeguarding Information Panel and other strategic working groups to carry out targeted visits to collect customer feedback. In addition the project is working with Bournemouth University and The Three Sided Cube company to develop a dignity focused social care APP; this is to be used by officers and volunteers visiting care homes and care providers delivering social care support.

The purpose of the APP is to support the gathering of feedback and soft intelligence consistently so that the performance of social care providers can be compared and monitored. A prototype of the APP is currently being developed which will be trialled and evaluated by a group of Quality Checker volunteers. Once completed the APP will be available to be downloaded on both android and Apple hand held devices.

10.6 **Safeguarding Information Panel (SIP)** - Further developments have been made to enhance the data collection to demonstrate trends of abuse and failing providers. This includes centralising multi agency key information and soft intelligence that is gathered on a regular basis. The Safeguarding Information Panel continues to be an integral part of the strategic safeguarding function.

10.7 The Adult **Multi-Agency Safeguarding Hub (MASH)** went live on the 20<sup>th</sup> of April. The interim location for the MASH is Committee room 2.

Staff within the Adult MASH have settled in quickly and members of the team are working together well and creating strong links with the SPOE which includes the MASH run by children's services. All posts out for recruitment have been filled with the final social work post due to be filled on 22<sup>nd</sup> June 2015.

#### **10.7.1 Activity**

Between 20<sup>th</sup> April 15 and 4<sup>th</sup> June 15 – 449 safeguarding concerns including 180 police risk assessments have come through the Adult MASH. As a result, caseloads are currently high – on average (12), which is to be expected. This is presenting some issues but with a full complement of staff in place, will be manageable and the transfer and closure process is constantly under review.

This compares to 260 referrals between 1st April 2014 and 30th June 2014 (quarter 1) so there has been a significant increase in the volume of activity coming through the Adult MASH.

#### **10.7.2 Wellbeing and Prevention**

In addition to dealing with the safeguarding issues, cases are also passed to relevant teams for care management with requests to undertake reviews and assessments. There has been a marked increase in Police Risk Assessments (PRAs) received into the MASH during w/c 1<sup>st</sup> June 2015. This may result in relevant teams such as Care Management, Enablement, Mental Health, Learning Disabilities and Access receiving increased requests for assessments/re-assessments/reviews. Senior managers in Health and Mental Health Services have been fully briefed and are aware of this.

#### **10.7.3 Mental Health**

People that are known to mental health services or have complex mental health needs are being transferred and accepted by this team. So far, information provision and advice from Mental Health Triage and the relevant complex teams has been timely and relevant. As a result, not having a mental health professional in the MASH has not had an adverse impact on day to day work in terms of decision making, but has still generated a lot of work for our staff.

Approx. 60% of the police risk assessments and 50% of our safeguarding concerns, are mental health related, it has been time consuming (for our admin staff) to forward the information to either Mental Health Triage or the relevant Complex Mental Health team.

#### **10.7.4 Sharing of Information**

Obtaining information from some partner agencies (police and community nursing in particular) in a timely manner is still presenting some challenges and the need to chase information does require significant time and resource within the MASH. Although, in preparation for the MASH, information/advice/training sessions with care teams, partner agencies have been provided to raise the profile of MASH and to clarify responsibilities under the Care Act, there is clearly a need for this to continue. Information sharing will improve with the introduction of an Information Sharing Form which commenced on 25<sup>th</sup> May 2015.

#### **10.7.5 Virtual Partners**

Good working relationships have been developed with our virtual partners (not physically located within the MASH itself) – hospital and Learning Disability

services are having ongoing discussions about how to improve our communication strategy in relation to RAG rating and team responsibility for gathering information. The Care Assess form (IT system for information collection) has been revised to reflect the team responsible for completing the work.

#### **10.7.6 Mash Profile and Branding**

We are also working well with the Care Act, Web team to raise the profile of MASH and will be undertaking further work for MASH to be publicised on Enfield Eye, road shows and other events in the near future. Text for a leaflet and booklet has been created (aimed at both the public and professionals) and hopefully, should be in production and available shortly.

### **11 SPECIALIST ACCOMMODATION**

- 11.1 Work continues on the redevelopment of outdated specialist accommodation located off Carterhatch Lane, to provide 14 accessible homes for older people with learning disabilities and dementia, in the form of an Extra Care service. The build is progressing well, and suitable tenants are now being identified. A flexible support and care model is now being developed, which will maximise service-user choice and control over services received. With 24-hour staff cover, the scheme will also act as a 'hub' service, offering out-of-hours and on-call support to people with low level support needs living in surrounding services. The service is expected to open this autumn.
- 11.2 As part of the Council's ongoing commitment to improve accommodation services for adults with disabilities, planning permission has now been submitted for the redevelopment of a further outdated building within the Carterhatch scheme, to modernise accommodation and increase capacity. The new service will provide quality move-on accommodation for adults with learning disabilities and will link into the new 'hub' service via assistive technology.
- 11.3 The development of wheelchair accessible homes for people with disabilities on Jasper Close (for social rent) and Parsonage Lane (for home ownership) is well under way. Off-site pod construction methods have been employed by the developer. The pre-constructed pods are now being fitted on site. Expressions of interest from people in receipt of support and care services who are interested in home ownership are now being sought. The schemes are expected to complete in autumn this year.
- 11.4 Joint work between Commissioners, Housing and the Integrated Learning Disabilities Service has led to the successful relocation of 18 tenants from Old Church Court. Many service users have now moved on to live independently within the community with floating support services tailored to their needs

### **12. PRIMARY CARE PREMISES STRATEGY GROUP**

The 'Primary Care Premises Strategic Group' meets on a quarterly basis providing a forum for key partners to meet and supply long term strategic oversight to current and future primary care premises developments in the

borough. The purpose of this group is solely to consider the development and sustainable supply of primary care premises, in line with regeneration programmes being delivered by Enfield Council. The stakeholders (NHS England, NHS Enfield Clinical Commissioning Group, NHS Property and Enfield Council) continue to share intelligence and discuss primary care premises development opportunities across the borough. The next meeting is 5<sup>th</sup> August 2015.

### **13. SECTION 75 AGREEMENT FOR ADULTS**

The Council and NHS Enfield Clinical Commissioning Group have had a Section 75 Agreement for commissioned services for adults since 2011. The current agreement has continued to work well during 2014-15 and both parties have confirmed the intention to continue the agreement for 2015-16, with some amendments in order to facilitate the inclusion of the Better Care Fund pooled budget and support further effective collaborative working across health and social care.

The end of year review for 2014-15 is currently underway and the report will be shared with both parties once complete.

### **14. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)**

#### **14.1 Learning Difficulties Partnership Board (LDPB)**

14.1.1 The Learning Disabilities Partnership Board met on the 18<sup>th</sup> May. The big issue for this meeting was Workforce Development, focusing on the Care Certificate.

14.1.2 Helen Ugwu (Learning and Development Consultant, LBE) and Voyta Camek (Skills for Care) gave presentations on the Care Certificate, and how it is being implemented locally. Implementation of the Care Certificate will be monitored by the Care Quality Commission (CQC). The Board felt it is important that the standards are also rolled out across non-regulated services. The Board was especially concerned that Personal Assistants should be able to achieve their Care Certificate. The Board also thought that on-going learning and continued professional development should be coordinated.

14.1.3 The Board agreed to set up a Workforce Development Sub Group. Niel Niehorster (Chair) and Sheila Barry (Co-Chair) will write to people who may be interested in joining, and invite them to a first meeting before the next Partnership Board. This will be for representatives of any organisation that works with people with learning disabilities.

14.1.4 The Board had received the final Care Charging Policy for this year. The Board were pleased that the fixed fee for transport was not included. The Board did note that other elements of their feedback were not included, and detailed reasons were not given.

14.1.5 Chris O'Donnell (PCP coordinator) is now looking after the Learning Disability Website. He is working with team leads to update the page contents.

He will also circulate a consultation document to the board, asking for views on what content people would like to see, and any other ways they would like to access this information, for example, via a Facebook page.

14.1.6 The Autism steering group reported they will be having their first meeting on the 16<sup>th</sup> July.

14.1.7 The Employment sub group report that as of the end of March there were 153 people in employment.

They are also beginning work with the New Opportunity Centre and Transport for London to develop a 'Travel Buddy' scheme.

The Park Avenue Café has been redesigned and is available as an employment opportunity for people with increased support needs.

Shirley-Anne Wheeler (Equals Employment) has presented to the Council Employment Group, and one job in the Finance Department has been offered to a person with a Learning Disability.

14.1.8 The Equalities and Inclusion sub group have applied for lottery funding to forward the 'Learning Disability Parliament' proposal.

14.1.9 The Hate Crime sub group reported that there was a very successful Hate Crime conference in May. A new video resource has been produced which will be hosted on the One-to-One website.

14.1.10 The Health Sub Group reported the Dr Sarkar has now stepped down as Learning Disability lead for the Clinical Commissioning Group.

The Health Sub Group also reported that they have started a Diabetes group, in partnership with One-to-One, which has been well attended.

The Sub Group also report excellent progress with the Winterbourne Concordat Actions. Only four people are waiting to move, and all have said they would like to remain near the areas where they now live.

A new Acute Liaison Nurse (Tamara McNamara) has been appointed to Barnet and Chase Farm hospitals. Jon is still negotiating with the North Middlesex hospital about their post.

14.1.11 The Housing sub group report there are now 2 shared ownership properties available at Parsonage Lane for people with learning Disabilities.

Work is on-going remodelling the Carterhatch Service to improve accommodation, including the development of purpose built extra care accommodation for older people with learning disabilities who may also have dementia.

There is also work at Linwood Crescent to improve quality of accommodation, providing self-contained homes with communal lounge/kitchenette facilities.

The sub group has also set up an Accommodation Board, to oversee new developments and help ensure that the needs of people requiring a change in accommodation are appropriately 'matched' with new services, to improve transition planning and make best use of resources.

14.1.12 The transport sub group have completed a survey on the accessibility of local busses, trains and tubes for people with learning disabilities. However, there is a possibility the Enfield Transport Users Group will not continue, and the sub group may not have anyone to report this to.

14.1.13 The Services for people whose Behaviour can be challenging Sub Group have produced information on support available, and referenced the Challenging Behaviour Charter as the standards expected from all local providers.

The group is currently finalising a self-assessment tool for local providers, and a training programme to be offered.

The group have also started looking at best practice information of behavioural risk assessments, and hope to produce local guidance signposting providers to national best practice. The ILDS will be giving a presentation at the DoH positive and Safe network meeting to share its excellent work around physical interventions.

14.1.14 The Board was also appraised of the current financial situation and strategies in place to attempt to meet budget pressures.

#### 14.2 **Carers Partnership Board (CPB)**

The Board had its annual away day in April. The day included presentations from Enfield CCG and BEH Mental Health Trust about the work they are doing with carers and feedback from both Adult and Children's Services on the progress with the Care Act and Children and Families Act. The afternoon was spent looking at the priorities for the coming year and consultation for the refresh of the Joint Carers Strategy.

Pauline Kettless, Head of Brokerage, Commissioning, Procurement and Contracting, will be taking over the Chair from July 2015.

#### 14.3 **Physical Disabilities Partnership Board (PDPB)**

23<sup>rd</sup> March PDP Board – following our successful 'new members' campaign at Christmas, the Board was well attended and included new members. We have a number of 'virtual' members, who are unable to attend quarterly, but wish to be kept informed and will attend when possible. This is a very positive step forward; our new members include carers and young people.

The meeting spent some time getting to know each other. The Board was informed of the Safeguarding Adults Strategy consultation which generated helpful discussion and comments. We had a presentation from the Chair of the LD Partnership Board - as it is a successful Board and we are a relatively new cohort of members, it was helpful to understand their format and why it is successful.

Following this, the Board agreed the outline ToR and general work plan for the year. This will include themed Board meetings to be agreed at the next meeting.

#### 14.4 **Sexual Health Partnership Board (SHPB)**

The Sexual Health Partnership Board meeting was held on 9 June 2015 and was well attended with new members from North Middlesex Hospital sexual health team.

The meeting discussed the Terms of Reference for the Board which were agreed with some minor revisions to reflect the strategic nature of the Board; services for Long Acting Reversible Contraceptives (LARC); and how to ensure that all women in the borough have access to this method of contraception and the Sexual Health Needs Assessment which is now complete and being used as part of the commissioning cycle for sexual health in the borough.

The meeting was not able to discuss the Sexual Health Community Services Tender, as the Commissioner felt there was a high level of conflict of interest due to two members of the Board representing organisations that had registered an interest.

#### 14.5 **Safeguarding Adults Board (SAB) – Annual Report**

14.5.1 The Safeguarding Adults Board met on 8<sup>th</sup> June 2015 and data was presented for Q4 2014-2015. Some key points of note include:

- During 2014/15 there were 996 alerts raised to adult social care, compared to 957 in 2013/14 (4% increase)
- Most alerts relate to Multiple Abuse (34%) with Neglect at (28%).
- 40% referrals are in relation to alleged abuse in the Adult at Risk's own home and 26% are in a residential/nursing home
- The largest referral source continues to be Hospital Staff at 23%, followed by Private / Independent Provider at 19%.
- Family members and paid staff continue to be the highest proportion of those alleged to have caused harm. Other vulnerable Adults make up 8% of those alleged to have caused harm, this is compared to 14% in 2013/14 (69 to 35).
- The outcome of the initial alert is 73% 'proceed with Safeguarding' and 5% 'require further information gathering' (at time of reporting).
- There is an increase in the number of adults at risk whom have a nominated advocate involved 31% (433 to 567) since 2013/14. 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.
- 45% of closed cases were substantiated or partially substantiated (48% in 2013/14). The outcome in 29% of referrals concludes 'The allegation has not been substantiated' and this is an increase from 2013/14 with 24%.
- 38% of alerts raised during 2014/15 were closed within 7 weeks, this is a decrease when compared to 2013/14 with 48%.

14.5.2 The Safeguarding Adults Board Annual Report 2014-2015 has been agreed, and sets out in relation to the above data the strategic and operational activities which need to take place to address themes and trends identified. The Annual Report of the Board will be presented at the July Health & Wellbeing Board.

14.5.3 The Board has received a report on Female Genital Mutilation by Public Health and are working in partnership on this important issue. This will include actions such as development within health and adult social care to understand this issue, how children affected by FGM will become adults who may need to access adult services and the support needs and service options available.

14.5.4 The Care Act statutory guidance encourages partners to make a resource contribution to recognise the corporate partnership accountability and to ensure the SAB can carry out its functions. A paper was presented to the Safeguarding Adults Board which set out expected cost for 2015-2016 and request was made for partner contributions to this cost. At the June meeting the contribution from partners was confirmed and set out the current deficit in the budget to meet the expected costs for this financial year. The position of Board Officer will therefore not be recruited to until such a time as resources are identified and this may have an impact on the effective running of the Board's sub-groups. The Board also took note of a report which set out the sub-groups of the Board and current challenges in terms of attendance, partnership and chairing.

14.5.5 The Board received a report from the Fatal Fire Working Group, which was set up in response to the deaths of two individuals. The aim of this group was to ensure that a multi-agency approach to organisational learning is promoted and key messages and enhanced working practices are embedded. The Group identified where partnership working could improve prevention and response, as well as areas of current risk mitigation which included:

- Sprinkler systems provided for new builds for Enfield Homes
- System in place to allow British Oxygen Company to notify London Fire Brigade of addresses that receive highly flammable oxygen cylinders
- LBE ICES team notify LFB of addresses with air mattresses
- Hoarding policy tool box for practitioners to identify hoarders
- Fire safety awareness information available from LFB website
- OT referral system in place for sign posting to telecare suppliers

14.5.6 A number of recommendations were made to the Board and partnership, which included areas such as information sharing at 'Board' level; development of evidenced referral criteria and pathway for frontline LBE and Mental Health visiting practitioners to make appropriate referrals to the London Fire Brigade for fire safety assessments; information on websites; working with housing to identify those who are high risk for fire safety checks; further work on Hoarding; training and links to risk assessments; and development of criteria and process for high risk and sprinkler system consideration.

## 14.6 JOINT COMMISSIONING BOARD

14.6.1 6<sup>th</sup> May was the first meeting of the reformed Joint Commissioning Board. The membership consists of senior managers and clinicians within the Council and CCG.

The Joint Commissioning Board (JCB) will report to the Health & Wellbeing Board

### 14.6.1.2 JCB Proposals:

- set the commissioning intentions and the strategic direction
- obtain an understanding of the current commissioning gaps at a joint (LA and CCG) level

### 14.6.1.3 The Board's areas of priorities will be:

- Mental Health - children and adults
- Children - Health Visitors, School Nursing, Family Nurse Partnership and the universal population
- Sexual Health (June meeting)
- Younger adults – long term conditions
- Long term conditions – including diabetes
- Early intervention approach, use Learning Difficulties/Mental Health example of system impact
- Drug & Alcohol – resources
- Dementia
- Care homes, Domiciliary Care, Continuing Health Care

### 14.6.1.4 Business Items:

- Section 75 – Key issues
- Commissioning Intentions
- Integrated locality teams
- Autism (June meeting) – concerns from Heads of schools over diagnosing
- Autism Strategy

14.6.2 At the 18<sup>th</sup> June meeting the following presentations were made:

### 14.6.2.1 Community Education Provider Networks (CEPN)

- Local networks of health and social care partners who come together to
  - Understand the needs of the patients across health and social care
  - Identify the training, education and development needs of the current workforce
  - Map out the future development needs of the workforce as the landscape continues to develop – particularly in response to strategic plans e.g. the 'Five Year Forward View'<sup>1</sup>
  - Bring partners and stakeholders together to facilitate the effective and efficient delivery of training and education to support the workforce to meet the identified needs of patients in

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<sup>1</sup> The six major stakeholders in the health economy have come together to establish the 'Five Year Forward View' (5YFV): NHS England, Monitor, Public Health England, Trust Development Agency, Care Quality Commission, Health Education England

clinical and non-clinical, community, primary and social care settings

- The JCB noted the work and agreed to engage with this national model

#### 14.6.2.2 Sexual Health Community services Tender

- Services that are part of the tender are:
  - Family Planning
  - Genitourinary Medicine (GUM)
  - Sexual Health OUTreach (SHOUT) Nurse
- The service redesign was outlined
- Risks were discussed
- Projected outcomes
- Procurement timetable and update

#### 14.6.2.3 Autistic Spectrum Disorder Overview

- Children & Young People
  - Evidence of increasing need
  - The five strands from the Autism Action Plan
    - (i) Increasing support to mainstream schools
    - (ii) Addressing the number of pupils who are not having their needs met
    - (iii) Meeting the long term need for more specialist provision
    - (iv) Assessment and diagnosis
    - (v) Working with and support parents
  - Progress to date:
    - ✓ Increasing levels of provision in mainstream and special schools
    - ✓ Autism symposium held in November 2013 that led to establishment of an Autism Strategy group
    - ✓ Establishment of Autism Advisory Service
    - ✓ Implementation of the Children & Families Act
    - ✓ Additional investment in children's therapy services
    - ✓ Better Care Fund proposal for an Enhanced Behaviour Support service
- Adults
  - Implementation of Joint Adults with Autism Strategy (2013-2018)
  - Framework:
    - ✚ Increasing awareness and understanding
    - ✚ Developing a clear and consistent pathway for diagnosis
    - ✚ Improving access for adults to the support and services they require to meet identified needs and priorities

✚ Supporting adults to engage in meaningful activities including employment

- Needs of defined as HFA/Asperger's will have a range of needs split into three broad groups:
  - (i) Those with high needs and are generally able to access services at present
  - (ii) Those with low needs who require preventative services from time to time and are currently not receiving services
  - (iii) Those with no need for services
- Progress to date:
  - ✓ IFR panel for primary care referrals
  - ✓ Identified clinical lead
  - ✓ Completed procurement process to award the £70k NHS Social Care Grant funding to a VCS organisation
  - ✓ Re-established the Autism Steering Group
  - ✓ Awareness training to libraries, leisure services

## MUNICIPAL YEAR 2015/2016

**MEETING TITLE AND DATE**  
**Health and Wellbeing Board**  
**14 July 2015**

Dr Mo Abedi, Chair  
 NHS Enfield CCG  
 Contact officer and telephone number:  
 E mail:  
[Jenny.Mazarelo@enfieldccg.nhs.uk](mailto:Jenny.Mazarelo@enfieldccg.nhs.uk)  
 Tel: 020-3688-2156

<b>Agenda - Part:1</b>	<b>Item: 8c</b>
<b>Subject: Primary Care Update</b>	
<b>Wards: All</b>	
<b>Cabinet Member consulted: N/A</b>	
<b>Approved by:</b>	

## 1. EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board on Primary Care matters across the borough of Enfield.

### **NORTH CENTRAL LONDON PRIMARY CARE TRANSFORMATION PROGRAMME:**

Since the original Primary Care Strategy was finalised in 2012, there have been changes to NHS Policy, most notably the publication of the 'Five Year Forward View' and release of 'Transforming Primary Care in London: a Strategic Commissioning Framework'. The Framework sets out a new way of delivering General Practice and this is a key facet of the strategy refresh and the proposed projects for 2015/16. CCGs across NCL have signed up to seven high level objectives:

- implementing co-commissioning arrangements
- implementing the PC commissioning strategic framework,
- development of federated care networks,
- IT interoperability,
- development of an estates strategy,
- quality improvement of general practice, and
- development of a programme of workforce development

The sum of £6m investment (£1.134m per CCG) has been made available from the NCL transitional fund. The following three areas have been prioritised for investment in Enfield:

- An additional 15,000 urgent appointments delivered from two primary care hubs between 1<sup>st</sup> October 2015 and 31<sup>st</sup> March 2016 on weekdays and Saturdays.
- Migration of GP practices from Vision to EMIS Web to deliver IT inter-operability between practices across Enfield. This will also facilitate London Borough of Enfield's implementation of a digital care record.
- On-going funding of a Primary Care Team function at the CCG

**CO-COMMISSIONING OF PRIMARY CARE SERVICES:**

At its meeting on 10<sup>th</sup> June 2015, the Governing Body approved the submission of an updated proposal to NHS England on 24<sup>th</sup> June 2015 to establish joint commissioning arrangements from 1<sup>st</sup> October 2015. Discussions are ongoing with Local Authorities and the LMC to decide how both groups want to be represented on the Committee, however initial conversations have been positive and it is expected that both groups will be represented at the first Joint Committee meeting in October 2015. Islington Health Watch will coordinate input with contributions from the other four Healthwatch, particularly on issues of local significance.

**2. RECOMMENDATIONS**

The Enfield Health and Wellbeing Board is asked to note the contents of this report.

**3. CO-COMMISSIONING OF PRIMARY CARE SERVICES**

Following the submission of the North Central London CCGs' Co-Commissioning application in January 2015, the CCGs in NCL have been working to sign off changes to their constitution. The changes allow the CCGs to collaborate within the Joint Committee arrangements set out by NHS England.

Whilst the Joint Committee is not fully operational, all but one of the voting members are in place, as is shown in the list of roles and member names below. At the first development session of the Committee on 27<sup>th</sup> May, it was proposed that an additional practice nurse member be added to the list of members on the Committee.

The current list of Committee members is as follows:

<b>NCL Primary Care Joint Committee Membership</b>		
<b>Position on Committee</b>	<b>Voting/ Non-Voting</b>	<b>Names</b>
Lay Chair	Yes	Cathy Herman (Haringey)
Lay Vice chair		Sorrel Brooks (Islington)
Additional Lay member		Bernadette Conroy (Barnet)
NHS England Representation x3	Yes	David Sturgeon
		Paul Bennett
		Dr Henrietta Hughes
CCG Executive Member Representation x5	Yes	Alison Blair (Islington)
		Jennie Williams (Haringey)
		Rob Whiteford (Enfield)
		Susan Achmatowicz (Camden)

		Maria O'Dwyer (Barnet)
CCG Clinical Member Representation x5	Yes	Dr Katie Coleman (Islington) Dr Alpesh Patel (Enfield) Dr Beth Macmillan (Haringey) Dr Ammara Hughes (Camden) Dr Michelle Newman (Barnet)
Practice Nurse Member	Yes	TBC
Healthwatch, HWBB and LMC Representation	No	Emma Whitby (Health Watch) Tbc (Local Authority/ HWBB) Tbc (LMC)

Discussions are ongoing with Local Authorities and the LMC to decide how both groups want to be represented on the Committee, however initial conversations have been positive and it is expected that both groups will be represented at the first Committee meeting. Islington Health Watch will coordinate input with contributions from the other four Healthwatch, particularly on issues of local significance

At its meeting on 10<sup>th</sup> June 2015, the Governing Body approved the submission of an updated proposal to NHS England on 24<sup>th</sup> June 2015 to establish joint commissioning arrangements from 1<sup>st</sup> October 2015.

Operationally, for the first year of Co-Commissioning (2015/16) at least, NHS England have made clear that their intention is to maintain a steady state. Maintaining a steady state means that NHS England will continue to manage the contracting of primary care, delivering this as a service to CCGs whichever level of Co-Commissioning they have opted for, much in same way that CSUs provide commissioning support for acute contracts, NHS England will offer a commissioning support service for managing primary care contracting.

Therefore, the majority of the day-to-day delivery of primary care contracting activities will continue to be managed by NHS England, with David Sturgeon leading the NHS England team at Southside. NHS England are recruiting to co-commissioning posts assigned to NCL. The Co-Commissioning posts will provide a link between the work of the contracting team at NHS England and CCG primary care management leads.

#### 4. **NORTH CENTRAL LONDON PRIMARY CARE TRANSFORMATION PROGRAMME 2015/16**

Since the original Primary Care Strategy was finalised in 2012, there have been changes to NHS Policy, most notably the publication of the 'Five Year Forward View' and release of 'Transforming Primary Care in London: a Strategic Commissioning Framework'. The Framework sets out a new way of delivering General Practice and this is a key facet of the strategy refresh and the proposed projects for 2015/16.

Whilst the CCGs in NCL have seen improvements in Primary Care since the original strategy in 2012, it is important looking ahead to the refreshed Primary Care Strategy that the programme of work fully demonstrates benefits on a project by project basis. In identifying projects, CCGs have been clear about the benefits in terms of quality, value for money and patient care and satisfaction with services. This will be further emphasised in the way in which we monitor projects, to ensure we are focused on the outcomes and value to be derived from the investment secured by CCGs.

CCGs across NCL have signed up to seven high level objectives:

- implementing co-commissioning arrangements
- implementing the PC commissioning strategic framework,
- development of federated care networks,
- IT interoperability,
- development of an estates strategy,
- quality improvement of general practice, and
- development of a programme of workforce development

All of the projects put forward by CCG leads must contribute to delivery of one of the seven objectives listed above. Lessons having been learnt from the programme which delivered the Primary Care Strategy (2012-2015), the intention is to initiate the NCL Primary Care Transformation Programme with clear expectations about ongoing monitoring with regards to value for money, benefits and anticipated outcomes so that projects that do not deliver against the objectives and which do not deliver improvements, are closed down or do not get to full roll out.

The sum of £6m investment (£1.134m per CCG) has been made available from the NCL transitional fund. The following three areas have been prioritised for investment in Enfield:

- An additional 15,000 urgent appointments delivered from two primary care hubs between 1<sup>st</sup> October 2015 and 31<sup>st</sup> March 2016 on weekdays and Saturdays. If additional funding can be secured and a need identified, this will be extended to include Sundays.
- Migration of GP practices from Vision to EMIS Web to deliver IT inter-operability between practices across Enfield. This will also facilitate London Borough of Enfield's implementation of a digital care record.
- On-going funding of a Primary Care Team function at the CCG comprising 3.6 WTE (Head of Primary Care, Estates Manager (previously jointly funded by LBE and the CCG), Primary Care Development Manager and Primary Care Development Facilitator).

In addition, three areas have been prioritised for investment at a Strategic Planning Group (NCL) level:

- Implementing NCL co-commissioning arrangements
- High level (CCG) and practice baseline audit of strategic commissioning framework delivery
- Development of a NCL Balanced Scorecard.

5. **CONCLUSION**

This report provides an update on Primary Care matters in Enfield.

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<b>MUNICIPAL YEAR 2015/2016</b>	
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<b>MEETING TITLE AND DATE</b>  <b>Health and Wellbeing Board</b> <b>14<sup>th</sup> July 2015.</b>	<b>Agenda - Part: 1</b>	<b>Item: 8d</b>
	<b>Subject: Report From</b> <b>Enfield Integration Board</b>	
	<b>Wards: All</b>	
<b>Report of: Dr M Abedi</b> <b>Chair: Enfield integration Board</b>	<b>Cabinet Member consulted: N/A</b>	
<b>Contact officer -</b> Richard Young <b>Email:</b> <a href="mailto:richard.young@enfield.gov.uk">richard.young@enfield.gov.uk</a> <b>Email:</b> <a href="mailto:richard.young@enfieldccg.nhs.uk">richard.young@enfieldccg.nhs.uk</a>		

## 1. EXECUTIVE SUMMARY

- The Enfield integration Board (EIB) has met twice since the last meeting of the Health & Wellbeing Board
- The key discussion and action points are set out within the body of this report and include:
  - An overview of the BCF programme
  - Approval of the clinical model of care for the Older People / Integrated Care Programme
  - Presentations from provider organisations on current work to reduce non-elective admissions.
  - Approval of the BCF Programme Risk Report
- The members of the EIB have requested that externally facilitated development sessions are set up to consider opportunities for service integration in the future. These will contribute to commissioning intentions within the NHS planning system for 2016/17. A programme brief has been developed and an appendix to this report sets out the proposed brief programme and recommendations to take this work forward.
- As part of the national BCF monitoring regime, NHS England required a routine return setting out current progress. This was completed in May and is being reported to this HWB in line with national guidance. (See Appendix 1).

## **2. RECOMMENDATIONS**

The Health and Wellbeing Board is asked to:

- Receive the report outlining the Integration Board meetings and actions.
- Approve the plans for a short facilitated development programme for the Integration Board.
- Approve the Quarterly BCF Data Return.

## **3. BACKGROUND PAPERS**

- Enfield Integration Board Forward Plan. (Attached).
- Quarterly BCF Data Return. (Attached).

## **4. Report from Enfield Integration Board**

Meetings of 22<sup>nd</sup> April and 20<sup>th</sup> May, 2015.

### **I. Terms of Reference for Integration Board**

The Terms of reference for the Integration Board were formally adopted. The Terms of Reference for the Sub-groups to the Integration Board were considered. The constituted sub groups are:

- Finance & Activity Sub Group
- Programme Delivery Group

The ToR for each group was noted and members agreed to offer feedback to officers before the next meeting. It was noted that EIB is a sub-Board of Health & Wellbeing Board and HWB being a sub group of full Council, all changes will need to be reported to full Council via Health & Wellbeing Board.

### **II. Better Care Fund Programme**

An overview of the BCF programme was presented. In response to questions and comments, it was noted that:

- There were currently not any BCF programmes / initiatives awaiting approval (many schemes had started in 14/15 or were existing services).
- A small number of schemes were still being developed by working groups. These would come to the Board for approval in due course.
- Stakeholder engagement options required.
- Important to note that BCF is intended to be a catalyst for change and reshaping existing services.
- EIB felt strongly that dedicated time and support should be given to developing a work plan for the future. It was agreed to explore arrangements for facilitated

sessions to further develop the vision for integration and produce an outline work plan for the next 2-3 years.

- Detailed development work will take place in working groups, final decision to the EIB.
- In regards to the 3.5% acute admissions reduction target, the monthly return is quite pivotal. Important that the Finance & Activity Sub Group focus on the 3.5% info. We need local, reliable data.
- The primary focus of the BCF was to shift money from Acute to Social and Primary Care. The Integration Board was the vehicle to make this happen.
- Understanding the evidence around service change is important. Developing more clinician-to-clinician conversations would be powerful.
- A Performance dashboard is being developed and will be brought to a future meeting.
- If reduction of emergency admissions is successful, the EIB can identify areas of further investment elsewhere.
- BCF provides opportunities for acute providers to move out of traditional ways.
- Business cases need to explicitly include public engagement.
- A discussion on the EIB approach to stakeholder engagement would be welcome

### **III. Clinical Model for the Integrated Care Programme – Older People**

An overview of the Integrated Care Programme – Older People was presented. In response to questions and comments, it was noted that:

- This discussion will focus on the clinical model – full business plan at future meeting.
- In the aims, include something more explicit about improving the patient experience.
- The programme is a network of care for individuals. The Golden thread is the patients themselves.
- Biggest challenge - cultural change for organisations and workforces.
- Organisations need to invest in workforce development for staff.
- Discovered opportunities for cost reduction, e.g. CHATs, reduced their costs and increased their service coverage.
- Concerns were expressed that behaviours of people will frustrate these schemes, e.g. contacting 999 ambulance services rather than calling local rapid response services.
- Critical to 'right-size' the teams (ILTs).
- ILTs are based on population and known patient numbers for each locality
- OPAU. The evidence suggests we may need a single unit (not at both acute hospitals).
- CHATs. Should have seen a correlation of improved quality and a reduction in safeguarding issues raised, but haven't. Suggests something is not working
- Falls programme. Concern about lack of interventions to prevent primary falls. (Fracture liaison nurse, model is about what happens after they've fallen rather than prevention).
- OP frailty. Improving dementia diagnosis is a priority and therefore important to offer more services for GPs to refer patients / carers and families to post diagnosis.

- Functional mental health: There is an ongoing dialogue. The issue of Mental health for Older People has been raised but requires further work.
- It was noted that all partners have bought into the clinical model.

It was agreed that the clinical model as presented was approved – subject to some further work on some elements of the programme.

#### **IV. Financial Report / Overview**

The BCF schedule within the draft section 75 agreement and the financial programme associated with it was considered and agreed.

It was also agreed that a three-year budget plan would be constructed and discussed at a future meeting. It was noted that there was no certainty over planning assumptions beyond 2015/16 in regards to BCF and that policy may change after the forthcoming election. However, it was also recognised that there was a genuine intention to continue this work – irrespective of policy mandate following the election result.

#### **V. Re-setting / Confirming Emergency Admissions Reductions Target**

Agenda item for information only (Reaffirmation of the 3.5% reduction target previously agreed by H&WBB).

#### **VI. Sub-Acute Beds at Chase Farm Hospital**

It was agreed, that the issue of resolving the issue of the (sub-acute) beds at Chase Farm Hospital that remain open is considered by, and will remain, the purview of this Board.

It was agreed to expedite this issue by asking CCG and RFL colleagues to find the most appropriate forum for addressing the details within this issue. It was noted that this matter had been previously discussed at the System Resilience Group. The matter may also need wider discussion in several fora – this would be closely managed for consistency.

#### **VII. Presentation: Provider Trust Representatives**

Representatives from provider organisations were invited to present their current and future plans to ensure the avoidance of emergency admissions and promote integrated services.

- a) Fran Gertler from Royal Free London Hospital presented on behalf of the Trust. Key Messages included:
  - OPAU: evaluation of the OPAUs has shown many positive achievements within integrated care. They have proved popular with GPs and patients, and their positive contribution to key outcomes including a reduction in the number of emergency hospital admissions for patients aged 65+.

- Post-Acute Care Enablement (PACE): This integrated team brings together staff from seven organisations. PACE team manages all onward referral arrangements with social care teams, and has access to rapid response enablement /home care packages as required. The service operates 7 days a week until 10pm. The patients usually go home within four hours of the clinical decision to accept onto a PACE pathway
- TREAT: actively pulls patients from A&E and provides consultant led rapid access investigations, interventions, emergency social packages and, with the support of PACE, a safe return to the community.
- Super MDTs for discharge planning
- 7 day social worker support
- Enablement wards at Chase Farm

b) Richard Gourlay from North Middlesex Hospitals presented on behalf of the trust. Key Messages included:

- Ambulatory Emergency Care: Consultant led service to be provided between 08:00 & 20:00; 7 days a week. Pull through from Emergency Department and redirection from GPs to AEC.
- Care Home assessment team & teleconferences: Consultant geriatrician input into care homes working with community matrons and other stakeholders
- Admission avoidance team: Multi-disciplinary team to review patients in ED & assessment units with a view to supported discharge home. Predominantly Monday to Friday – some coverage on Saturday & Sunday
- “Hot Phones”: Acute Medicine; Care of Elderly; Surgery; Gynaecology; Paediatrics hot phones. Immediate consultant advice available
  - Manage at home
  - Manage in ambulatory model
  - Manage in assessment unit

c) Kathryn O'Donnell from BEHMHT presented on behalf of the Trust. Key Messages included:

- NMUH Mental Health Liaison Service (MHLS): have performance targets set up to ensure avoidance of non-elective admissions, re-admissions, re-attendance and length of stay for patients
- MHLS Crisis Lounge Project enabled better patient flow through A&E exploring alternatives to admission.
- Discharge Intervention Team (DIT) developed to support managing to the contracted bed base rather than depending on independent sector placements. Won a BEHMHT special achievement award and enabled more appropriate use of recovery house beds.
- Contributions to:
  - Care Home Assessment Team (CHAT)
  - Integrated Locality Team
  - Intermediate Care Team (ICT)

Key areas of comment and debate included:

- Royal Free and North Middlesex models of care appeared similar but different. How do we know which is better (if either) and we need to understand the gaps between them.

- System really has come together well. significant impact to DToC
- Presentations have focussed on current plans. We need to be more forward looking
- Development sessions for the EIB are being planned. This will be fertile ground for identifying new opportunities for the future.

d) Presentation: GP Networks Representatives

Manuel Antony from Enfield GP Network presented on behalf of the Network. Key Messages included:

- Care for frail older people using integrated pathways
- Provide quality care around their needs within their community
- Embrace current & emerging technologies to achieve the above
- Risk Stratification - Setup "At Risk" register
- Perform pre assessment investigation
- Perform Assessments and produce Integrated care plan

Key areas of comment and debate included:

- Concern that this was already happening within ILTs
- Risk stratification still embryonic and unsophisticated at the moment
- It was beneficial to share good practice, collaborative working between providers, and we should include in development session
- Presentations show how far we've come. Enfield focus, there isn't another forum that shows this

## **VIII. Better Care Fund Risk Report**

It was noted that these risk were focussing on the implementation of the Better Care Fund – and not those identified in the preparation of the BCF plan or the wider integration agenda. The risk register would be managed in the Finance & Activity Sub Group and reported to the Board.

The report was approved with a note that some of the risks (as currently identified) required further work on defining the risk more precisely and a wider distribution of the risk owners should be considered.

## **IX. EIB Development Sessions**

At its meeting on 20<sup>th</sup> May, in response to comments made at its previous meeting, the EIB agreed in principle that a project brief should be developed to arrange facilitated development sessions. The suggested project brief could include the following 3 key elements:

- Alignment of commissioner priorities and vision.
- Develop a common understanding of the vision for integration with the Enfield Integration Board and to develop a work plan (potential commissioning intentions) to initiate that work.

- A multi-level / multi-organisational event (from Chief Officers to frontline staff) to realise / implement the vision for integration in Enfield; enabling new ways of working, create platforms for the delivery of the existing programme and develop potential new workstreams for the future.

## **5. Quarterly BCF Data Return**

Under the Operationalisation Guidance published earlier this year, each Better Care Fund Partnership is required to submit performance and assurance data each quarter on a set date.

The guidance states that assurance management for the BCF will be embedded into business as usual processes in NHS England for planning, performance monitoring, assurance, and performance management as far as possible. However, on the most part, this will be at CCG level rather than HWB level.

However, on 11<sup>th</sup> May, the Better Care Support Team issued a revised and much simplified reporting template to report BCF performance for the period 1 January 2015 to 31 March 2015. Meanwhile, NHS England information from other pre-existing sources and data collections has been gathered centrally.

The revised template therefore asks for data returns by Health and Wellbeing Board area to be submitted on the following issues only:-

- Whether Disabled Facilities Grant has been pass-ported to the relevant local housing authority;
- Whether a section 75 agreement is in place to pool BCF funding in accordance with the nationally approved BCF plan; and
- Whether the six national BCF conditions are being met or are on track to be met through the delivery of the national approved BCF plan.
- This will be the only information that we require to be provided from local areas for the return that is due by 29 May 2015.

There will therefore be no collection of data around these metrics through this quarterly return (Jan 15 – Mar 15). This includes forecast performance and actual performance against BCF metrics.

## **6. Calendar of Meetings / Forward Plan**

The Forward Plan was discussed at both meetings – with minor amendments. (Revised version attached at Appendix 2)

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Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics from the Health & Wellbeing Board plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 29th May 2015

This initial Q4 Excel data collection template focuses on the allocation, budget arrangements and national conditions. Details on future data collection requirements and mechanisms (including possible use of Unify 2) will be announced ahead of the Q1 2015/16 data collection.

To accompany the quarterly data collection we will require the Health & Wellbeing Board to submit a written narrative that contains any additional information you feel is appropriate including explanation of any material variances against the plan and associated performance trajectory that was approved.

Content

The data collection template consists of 4 sheets:

- 1) **Cover Sheet** - this includes basic details and question completion
  - 2) **A&B** - this tracks through the funding and spend for the Health & Wellbeing Board and the expected level of benefits
  - 3) **National Conditions** - checklist against the national conditions as set out in the Spending Review.
  - 4) **Narrative** - please provide a written narrative
- To note - Yellow cells require input, blue cells do not.

1) Cover Sheet

On the cover sheet please enter the following information:  
The Health and Well Being Board  
Who has completed the report, email and contact number in case any queries arise  
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 4 cells are green should the template be sent to [england.bettercaresupport@nhs.net](mailto:england.bettercaresupport@nhs.net)

2) A&B

This requires 4 questions to be answered. Please answer as at the time of completion.  
Has the Local Authority received their share of the Disabled Facilities Grant (DFG)?  
If the answer to the above is 'No' please indicate when this will happen.  
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?  
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track for delivery (<http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/>). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please detail in the comments box what the issues are and the actions that are being taken to meet the condition.  
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.  
Full details of the conditions are detailed at the bottom of the page.

Cover and Basic Details

Q4 2014/15

Health and Well Being BoardEnfield

completed by:Richard Young

e-mail:richard.young@enfield.gov.uk

contact number:07850714757

Who has signed off the report on behalf of the Health and Well Being Board:

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to [england.bettercaresupport@nhs.net](mailto:england.bettercaresupport@nhs.net) saving the file as 'Name HWB.xls' for example 'County Durham HWB.xls'

	No. of questions answered
1. Cover	5
2. A&B	4
3. National Conditions	16
4. Narrative	1

Selected Health and Well Being Board:

Enfield

Data Submission Period:

Q4 2014/15

Allocation and budget arrangements

Has the housing authority received its DFG allocation?	No
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If the answer to the above is 'No' please indicate when this will happen	01/04/2015
--	------------

Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?	Yes
---	-----

If the answer to the above is 'No' please indicate when this will happen	01/04/2015
--	------------

Selected Health and Well Being Board:

Enfield

Data Submission Period:

Q4 2014/15

National Conditions

The Spending Round established six national conditions for access to the Fund. Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan. Further details on the conditions are specified below. If 'No' or 'No - In Progress' is selected for any of the conditions please include a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	Comment
1) Are the plans still jointly agreed?	Yes	A s75 agreement is in place between LBE and Enfield CCG. The BCF programme is governed by a subcommittee of the H&WBB (including providers)
2) Are Social Care Services (not spending) being protected?	Yes	Funding is being deployed to support the delivery of services which prevent admission to residential care and hospital and to support timely and appropriate discharge from
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	7 day working is in place across each of the locality teams, including assessment units and hospital teams. Further work is being done on community based crisis response services.
4) In respect of data sharing - confirm that:		
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	The NHS number is being used as the primary identifier. Adult Social Care compliance is currently at 98% and monthly reconciliations are in place to ensure that any gaps are addressed through the MACS system. The council is also a Registration authority and now has access to the summary care record which is also being used to locate NHS numbers.
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	The Council is pursuing open APIs. We have access to the summary care record through N3 and are currently exploring options to deliver a shared care record with GPs, community
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	All information sharing arrangements, including the sharing of data to support Risk Stratification, are in place and agreed by all parties.
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	Multi-disciplinary teams are in place and delivering joint assessment and support planning. There is more work to do with the new locality teams but once these are all in place joint working will be established in all areas of the borough. For support arrangements where there are joint funding arrangements in place, there are accountable professionals. These are at Head of Service level.
6) Is an agreement on the consequential impact of changes in the acute sector in place?	No - In Progress	Plans are in place with appropriate governance and representation from all parties involved including patients and patient representatives. All parties are fully signed up to the BCF plan and key stakeholders are represented at a senior level on our Integration Board. More work is needed on how to address the impact of fewer emergency admissions, how the

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

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 Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)

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 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf)

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

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. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number

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. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:

- confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.

NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable 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.

6) 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, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Selected Health and Well Being Board:

Enfield

Data Submission Period:

Q4 2014/15

Narrative

remaining characters	32,088
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<p>Please provide any additional information you feel is appropriate to support the return including explanation of any material variances against the plan and associated performance trajectory that was approved by NHS England.</p> <p>Enfield BCF partnership is on course to deliver most of the targets and trajectories set out in our BCF plan.</p> <p>We have re-based out Emergency admissions reduction target in line with national guidance and appear to be performing well against that metric. In particular, our programme of interventions for Older People appears to be working well and have had significant impact.</p> <p>Levels of performance against the local target for dementia diagnosis had been achieved at 31/3/15.</p> <p>However, our system continues to have significant challenges around DToCs and re-eablement targets. There are recovery plans in place to address these issues across the health &amp; social care system.</p>
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## Enfield Integration Board (EIB)

### Forward Plan

Monthly Meeting	Date (4pm–5:30)	Key Decisions / Recommendations	Planning Items
<b>January</b>	No meeting		
<b>February</b>	18/02/2015	<ul style="list-style-type: none"> <li>EIB Terms Of Reference (ToR)</li> </ul>	<ul style="list-style-type: none"> <li>Finance Report</li> <li>Re-Setting / Confirming Emergency Admissions Reductions Target</li> <li>Calendar Of Meetings / Forward Plan</li> </ul>
<b>March</b>	18/03/15	<ul style="list-style-type: none"> <li>Meeting postponed</li> </ul>	
<b>April</b>	22/04/15	<ul style="list-style-type: none"> <li>Confirmation of Local Emergency Admissions Reduction Target</li> <li>EIB ToR - finalise</li> <li>Consideration Of Clinical Model for Integrated Care – Older People</li> </ul>	<ul style="list-style-type: none"> <li>Forward Plan</li> </ul>
<b>May</b>	20/05/15	<ul style="list-style-type: none"> <li>ToRs for Programme Delivery and Finance &amp; Activity Sub Groups - approve</li> <li>Risk Report</li> <li>Presentation from Providers</li> </ul>	<ul style="list-style-type: none"> <li>Forward Plan</li> </ul>
<b>July</b>	22/07/15	<ul style="list-style-type: none"> <li>Consideration of Business Cases               <ul style="list-style-type: none"> <li>Integrated Care – Older People</li> <li>Protecting Social Care Services</li> <li>Data Sharing Group</li> <li>Implementing the Care Act</li> </ul> </li> <li>Stakeholder Engagement approach</li> </ul>	<ul style="list-style-type: none"> <li>Finance &amp; Activity Report</li> <li>Report from Programme Delivery Group</li> <li>Forward Plan</li> </ul>
<b>September</b>	16/09/15	TBA	<ul style="list-style-type: none"> <li>Finance &amp; Activity Report</li> <li>Report from Programme Delivery Group</li> <li>Quarterly risk report</li> <li>Forward Plan</li> </ul>
<b>November</b>	18/11/15	TBA	<ul style="list-style-type: none"> <li>Finance &amp; Activity Report</li> <li>Report from Programme Delivery Group</li> <li>Forward Plan</li> </ul>

<b>January</b>	20/01/16	<ul style="list-style-type: none"> <li>• Draft BCF Plan 2016/17</li> </ul>	<ul style="list-style-type: none"> <li>• Finance &amp; Activity Report</li> <li>• Report from Programme Delivery Group</li> <li>• Quarterly risk report</li> <li>• Forward Plan</li> </ul>
<b>February</b>	17/02/16 (TBC due to Half Term)	Detailed consideration of draft BCF Plan 2016/17 (if required)	<ul style="list-style-type: none"> <li>• No routine items</li> </ul>
<b>March</b>	16/03/16	<ul style="list-style-type: none"> <li>• Agree 2016/17 BCF Programme</li> </ul>	<ul style="list-style-type: none"> <li>• Finance &amp; Activity Report</li> <li>• Report from Programme Delivery Group</li> <li>• Quarterly risk report</li> <li>• Forward Plan</li> </ul>

## HEALTH AND WELLBEING BOARD - 14.4.2015

**MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD  
HELD ON TUESDAY, 14 APRIL 2015**

**MEMBERSHIP**

**PRESENT** Shahed Ahmad (Director of Public Health), Deborah Fowler (Enfield HealthWatch), Liz Wise (Clinical Commissioning Group (CCG) Chief Officer), Vivien Giladi (Voluntary Sector), Donald McGowan, Ayfer Orhan and Doug Taylor (Leader of the Council)

**ABSENT** Ian Davis (Director of Environment), Andrew Fraser (Director of Schools & Children's Services), Ray James (Director of Health, Housing and Adult Social Care), Litsa Worrall (Voluntary Sector), Dr Henrietta Hughes (NHS England), Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Kim Fleming (Director of Planning, Royal Free London, NHS Foundation Trust), Julie Lowe (Chief Executive North Middlesex University Hospital NHS Trust) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

**OFFICERS:** Bindi Nagra (Joint Chief Commissioning Officer), Sharon Burgess (Head of Service - Safeguarding Adults, Complaints and Quality Assurance), Allison Duggal (Public Health Consultant) and Richard Young (Interim Programme Manager) Penelope Williams (Secretary)

**Also Attending:** Bindi Nagra (Assistant Director Strategy and Resources, Health Housing and Adult Social Care) standing in for Ray James. Lance McCarthy (Deputy Director of North Middlesex University Hospital NHS Trust) standing in for Julie Lowe.

**1****WELCOME AND APOLOGIES**

The Chair welcomed everyone to the meeting. Apologies for absence were received from Mo Abedi (Chair of the Enfield Clinical Commissioning Group), Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust), Kim Fleming (Royal Free London NHS Trust, Andrew Fraser (Director of Schools and Children's Services), Ray James (Director of Health, Housing and Adult Social Care), Julie Lowe (North Middlesex University Hospital NHS Trust).

Bindi Nagra (Assistant Director Strategy and Resources, Health Housing and Adult Social Care) was standing in for Ray James.

Lance McCarthy (Deputy Director of North Middlesex University Hospital NHS Trust) was standing in for Julie Lowe.

**2**

**DECLARATION OF INTERESTS**

There were no declarations of interests.

**3**

**CLINICAL COMMISSIONING GROUP (CCG) OPERATING PLAN 2015/16 - DRAFT SUBMISSION (6:35-6:50PM)**

The Board received a report on the draft submission of the Enfield Clinical Commissioning Group (CCG) Operating Plan 2015/16 from Graham MacDougall, Director of Strategy and Performance.

1. In Graham MacDougall's absence the report was presented by Liz Wise (CCG Chief Officer) and Richard Young (Interim Better Care Fund Programme Manager/Interim Strategic Planning Programme Manager). The following points were highlighted:
  - Detailed discussion on the Operating Plan had taken place at the Board's last development session.
  - An initial submission had been made on 7 April 2015: the final submission was due on 14 May 2015.
  - The final format has had to be changed to meet new guidance from NHS England including more detail and greater granularity. However the content will be substantially the same.
  - Strategic interventions and issues discussed at the development session would be taken forward by the Integration Sub Board.

**2. Questions/Issues Raised by the Board**

- 2.1 The key changes were in the detail, setting out the underpinning calculations and the figures around accident and emergency admissions. The principles and the discussion still stand.
- 2.2 Some concern was expressed about the proposals for patient and public involvement. It was felt that many of the GP patient groups were not fully developed and as a result too few candidates had been put forward to take part. Richard Young agreed to pick up on this issue and talk to Vivien Giladi outside of the meeting.
- 2.3 The Better Care Fund was reflected in the Operating Plan.
- 2.4 Liz Wise agreed to organise a seminar to explore the financial issues in more detail and to explain how she would be working with the other 4 North Central London CCGs to develop five year plans.

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- 2.5** Working with the other CCGs will enable a more holistic and integrated approach, highlighting the gaps in social care and areas in need of transformation.
- 2.6** After the general election, it is likely that the strategic plans will need to be looked at again.

**AGREED**

1. To approve the 2015/16 Operating Plan in principle as in the draft attached to the report.
2. To delegate the final plan sign off, to the Chair, who will sign the final submission, on behalf of the board.

**4**

**PHARMACEUTICAL NEEDS ASSESSMENT (6:50-7:10PM)**

The Board received the report on the Pharmaceutical Needs Assessment (PNA)

Allison Duggal (Public Health Consultant) presented the report to the Board highlighting the following:

- The PNA has been designed to enable an understanding of current and future pharmaceutical needs. This is the final version.
- It is a statutory requirement that it is published in April 2015.
- The production of the assessment has been overseen by a multiagency steering group.
- A 60 day consultation period taken place and all comments received incorporated in the final document.

**2. Questions/Comments**

- 2.1 It was suggested that the PNA be retitled for the 3 years it covers: 2015-18.
- 2.2 If there were changes in the future, supplementary statements could be issued.
- 2.3 When the assessment has to be renewed, after three years, it should be a much smoother and less expensive process, due to the work put in this time.
- 2.4 Members appreciated the consultation process that had taken place. A summary of the responses has been included as an appendix. The full version could be available if necessary.

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- 2.5 Members welcomed the resource and praised the excellent work that had been done by Alison Duggal and her team.
- 2.6 It was suggested that it would have been helpful to have included percentages in the table on page 32 of the assessment.
- 2.7 The finding that the rate of community pharmacies per population in Enfield is below average for England and that providers in Enfield currently dispense more prescriptions compared with the average community pharmacy in England was telling. Any future gaps in provision would be addressed through additional statements. The NHS will take the PNA into account when looking at extra provision.
- 2.8 Liz Wise felt that the pharmacists could potentially provide an even wider range of health services particularly in the areas such as urgent care and long term illnesses. The pharmacies were an important part of primary care.
- 2.9 Some concern was expressed about the limited range of opening hours in some areas. There were a number of pharmacies that stayed open up until midnight, but none were open 24 hours a day in Enfield.

**AGREED** that

1. The Board approves the publication of the new Pharmaceutical Needs Assessment attached as appendix 1 to the report.
2. Takes into consideration the statutory requirement to meet its obligation to publish the PNA by April 2015.

**5**

**ADJUSTMENTS TO THE BETTER CARE FUND PLAN REDUCING EMERGENCY ADMISSIONS TARGET (7:10-7:25PM)**

The Board received a report setting out adjustments to the Better Care Fund Plan Reducing Emergency Admissions Target.

Richard Young presented the report to the Board highlighting the following:

- NHS England has issued guidance that the ambition for the level of improvement agreed by CCGs and Councils in Better Care Fund plans should be reviewed in the light of the current increased level of emergency hospital admissions.
- In order to achieve the original target of 3.5% (a reduction of 908 from a total of 25,965 admissions) the required reduction would be 18% of an outturn of 30,463 admissions.

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- Two options were considered: to recalculate the activity baseline and generate a new admissions reduction target at 3.5%: to maintain the existing reduction target generating a new percentage target reduction of 1065.

**2. Questions/Comments**

- 2.1 There had been a step change in the numbers of accident and emergency admissions across the country which was difficult to understand. It was unclear whether this was a rectification of clinical behaviour or a new phenomenon. This was not accounted for by the increasing number of people attending accident and emergency departments.
- 2.2 The change had occurred in Autumn 2013 with a 20% rise in the conversion rate. It was noted that this was a national phenomenon and that these figures were not true of North Middlesex University NHS Hospital which has one of the lowest conversion rates in the country.
- 2.3 Enfield is suffering from the same pressures as elsewhere in London and nationwide. More people are presenting at accident and emergency departments, this however is a separate phenomenon, but which also adds to the impact of the target in Enfield.
- 2.4 The reality of the 3.5% target means a reduction of 7% to maintain the levels in the current system and finances, partly due to the growth in the local population and changing demographics.
- 2.5 As part of the CCG planning process, the Health and Wellbeing Board have been asked to agree to revising the target connected to the performance of the Better Care Fund. The choice is to maintain the existing target or deviate from it.
- 2.6 The question was asked that as we did not meet the target last year, why should we meet it this year.
- 2.7 The question had been discussed at length by the Integration Sub Board and they felt that if the target was altered it would also mean making changes to other plans which would be more difficult. Some of the initiatives that had been started as part of the Better Care Fund were having an impact.
- 2.8 The risk of not meeting the target will be managed.

**AGREED** to approve the recommendation from the Integration Sub Board to agree to Option 1 – a new target reduction of 1,065 admissions, based on the existing percentage 3.5% reduction target.

**6**

**ADULT SAFEGUARDING STRATEGY (7:25-7:45PM)**

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The Board received a report on the draft Adult Safeguarding Strategy.

**1. Presentation of the Report**

Sharon Burgess, Head of the Safeguarding Adults, Quality, Improvements and Complaints presented the report to the Board highlighting the following:

- The Care Act which came in on 1 April 2015 requires all local authorities to publish annually an adult safeguarding strategy. Enfield has had a strategy since 2009.
- Key elements of the strategy were that it is free from jargon and written in Plain English.
- The aims of the strategy were to prevent abuse from occurring, to ensure adequate support where dignity is respected and to provide support which is person centred once harm occurs.
- The strategy and its action plan related to the 6 key principles set out by the Government and included in the Care Act.
- The strategy has been developed with partners and those who use the services.
- It has been developed within the “Making Safeguarding Personal in Enfield” agenda and has achieved the gold standard for the partnership work with Bournemouth University and Enfield’s quality checkers.

**2. Questions/Comments**

- 2.1 The service was congratulated on receiving the gold award.
- 2.2 Adults were working together in partnership with Children’s Services and were aware of the need to address the transition gap between the two safeguarding services.
- 2.3 It was felt that it would be helpful to include some higher level actions between the preamble and the tables in the strategy to make a smoother link.
- 2.4 The targets were long term. It was felt that it would be better to make sure that they were achievable and that they could be embedded along with the other measures being brought in by the Care Act.
- 2.5 Enfield was one of the first authorities to adopt a strategy and this had been developed using a successful team based approach which had been widely praised.

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- 2.6 The current strategy had been a refresh of the earlier one including actions over 1,2 and 3 years and incorporating the new safe standards.

**AGREED** to note the content of the strategy and action plan.

**7**

**SUB BOARD UPDATES (7:45-8:25PM)**

**1. Health Improvement Partnership Board Sub Board Update**

The Board received the report updating them on the work of the Health Improvement Partnership Board.

**1.1 Presentation of the Report**

Allison Duggall presented the report to the Board, highlighting the following:

- Work was continuing to address health inequalities, working in partnership in the five key priority wards using a spectrum of different measures to ensure health outcomes are maximised and health inequalities not widened.
- Healthy lifestyles were being promoted, addressing long term conditions, encouraging more physical activity, healthy eating and not smoking. Key initiatives include Cycle Enfield, Active and Creative Enfield, Step Jockey and a bid to Sports England.
- Public Health officers, following training, are now inputting into licensing applications.
- A pilot project providing information and advice in pharmacies is planned, starting in May 2015.
- Work on child poverty is being carried out by Public Health with Price Waterhouse Coopers and the Enfield 2017 team. An action plan had been put in place to address the issues.
- A successful conference on Female Genital Mutilation (FGM) was held on 20 March 2015.
- An assessment of sexual health needs has been carried out which will lead to procurement of the service and a refresh of the strategy.
- Two notable achievements: Ofsted had judged safeguarding services in Enfield as good and Enfield had been awarded excellent by the Greater London Authority as a healthy workplace.

**1.2 Questions/Comments**

- 1.2.1 Members congratulated officers on their excellent work in this area.

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- 1.2.2 Measures were in place to ensure that the child sexual exploitation work being carried out by the Children's Safeguarding Board would be taken account of in commissioning services.
- 1.2.3 The Public Health Team had four statutory duties: those that support the CCG are now based in Holbrook House, approximately 8 officers. Ten other members of staff are embedded in services across the council.
- 1.2.4 Enfield is the only authority in London which has been graded good for child protection services.
- 1.2.5 A new sexual exploitation task group has been set up to look at this area of work. They will be scrutinising all work carried out both internally and externally. This task group is the only one of its kind in London and will ensure that robust procedures are in place to prevent child sexual exploitation taking place in Enfield.
- 1.2.6 The granting of the Healthy Workplace Award to the Council is important for encouraging other employers to become healthy work places.
- 1.2.7 The outcome of the Sports England bid is not yet known.
- 1.2.8 An 8% reduction in hospital admissions has been achieved by the Care Homes Assessment Team as part of the larger Integrated Care target.

**AGREED** to note the content of the report.

## **2. Joint Commissioning Board Update**

The Board received an update report from the Joint Commissioning Board Sub Board.

2.1 Bindi Nagra (Assistant Director Strategy and Resources – Health, Housing and Adult Social Care) presented the report to the Board and asked for questions.

### **2.2 Questions/Comments**

2.2.1 Various reviews had been undertaken on both commissioning and procurement linked to the information and advice requirements of the Care Act and with work being done by Enfield 2017. The front end access point is the Council website. Key is wellbeing in its wider sense.

2.2.2 The Council was considering the best approach to the provision of the work of the Family Nurse Partnership and Health Visitors once the transfer to the Council due in October 2015 has occurred. The Family Nurse Partnership

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had not taken on any new referrals due to the illness of one of the members of staff.

2.2.3 Concern about the growth of the use of Laughing Gas (Nitrous Oxide) by young people was an issue that could be considered by the Drug and Alcohol Action Team and would be referred to them.

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

### **3. Improving Primary Care Sub Board Update**

The Board received an update report from the Improving Primary Care Sub Board.

3.1 Liz Wise, Enfield CCG Chief Officer, introduced the report to the Board:

- The current three year primary care strategy programme ended on the 31 March 2015. From 1 April 2015 a new way of working is being developed by the five North Central London CCGs for joint co-commissioning arrangements with NHS England, to take effect from October 2015. A shadow period will operate between April and October 2015.

#### **3.2 Questions/Comments**

3.2.1 Local Government is involved in the proposals for co-commissioning. The CCG's are currently looking at the best way to engage them and this was discussed at the last meeting of the CCG governing body. Crucial work is taking place on estates and regeneration.

3.3 The aim is that the primary care commissioning framework becomes more proactive, accessible and consistent.

3.4 The CCG is assessing where we are locally and will then look to fill the gaps. Where more services are needed, they will work with NHS England to provide them.

3.5 The benefits of working with Camden and Islington are more than the dis-benefits.

3.6 Some of the Enfield initiatives are being carried forward including the Minor Ailments Scheme, the work with University College London and the IT improvements.

3.7 It was important to take forward what was right for Enfield. The first 6 months will provide an opportunity for a local refresh.

**AGREED** to note the contents of the report.

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**4. Integration Board Update**

The Board received an update from the Integration Board.

4.1 Richard Young (Interim Better Care Fund Programme Manager/Interim Strategic Planning Programme Manager) presented the report to the Board:

- Much of the information about integrated care had been discussed elsewhere on the agenda.
- The business case for integration was discussed at the first meeting and the clinical case will be discussed at the next meeting.
- The old programme board has now been disestablished and replaced by the new board structures.

**4.2 Questions/Comments**

4.2.1 The Older People Working Group will be reformed as part of the programme delivery group. Their work will not be lost, but will be bought in to develop the new group.

4.2.2 Concern was expressed that not all interests were represented on the Integration Board: there was little representation from the secondary care sector. The Sub Board membership had been agreed at the last board meeting with only members of the full board given voting rights. The terms of reference will be reviewed in 3 months. Named substitutes were permitted in the current terms of reference.

**AGREED** to note the report.

**8**

**MINUTES OF THE MEETING HELD ON 12 FEBRUARY 2015 (8:25-8:30PM)**

The minutes of the meeting held on 12 February 2015 were agreed and signed as a correct record.

**9**

**DATES OF FUTURE MEETINGS**

Members noted that dates for next year will be agreed at Annual Council on 13 May 2015.