Public Document Pack

HEALTH AND WELLBEING BOARD

Thursday, 10 December 2015 at 6.15 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 (Vice Chair)
Healthwatch Representative – Deborah Fowler
Clinical Commissioning Group (CCG) Chief Officer – Paul Jenkins
NHS England Representative – Dr Henrietta Hughes
Director of Public Health – Dr Shahed Ahmad
Director of Health, Housing and Adult Social Care – Ray James
Interim Director of Children's Services – Tony Theodoulou
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 FOR ABSENCE

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. ROYAL FREE VANGUARD (6:15-6:30PM) (Pages 1 - 2)

To receive a briefing note containing details of the Royal Free Vanguard Bid for acute care.

4. CYCLE ENFIELD (6:30-6:35PM) (Pages 3 - 6)

To receive a report from Ian Davis, Director of Regeneration and Environment, updating the board on the implementation of the Cycle Enfield proposals.

5. SYSTEM LEADERSHIP PROPOSAL/SUGAR REDUCTION (6:35-7:05PM) (Pages 7 - 20)

To receive a report on the Sugar Reduction System Leadership Proposal for the board.

6. LONDON BOROUGH OF ENFIELD BUDGET CONSULTATION 2016/17 (7:05-7:20PM) (Pages 21 - 34)

To receive a presentation on the London Borough of Enfield 2016/17 budget proposals.

7. FUTURE IN MIND TRANSFORMATION PLAN - CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (7:20-7:35PM) (Pages 35 - 38)

To receive a report from Graham MacDougall (Director of Strategy and Partnerships - Enfield Clinical Commissioning Group) on the Child and Adolescent Mental Health Services (CAHMS), Future in Mind Transformation Plan.

8. DEVOLUTION (7:35-7:40PM) (Pages 39 - 50)

To receive for information some information on health devolution proposals for London.

The update has been taken from the health and care section relating to devolution from the London Proposition Report. This was submitted to Her Majesty's Treasury on 4 September 2015 and is the starting point for the devolution ideas that London boroughs (through London Councils) pitched to government with partners including the National Health Service, Clinical Commissioning Groups, Greater London Authority and Public Health England.

9. STROKE AND DEMENTIA PREVENTION UPDATE (7:40-7:45PM) (Pages 51 - 64)

To receive an update from Dr Shahed Ahmad, Director of Public Health, on stroke and dementia intervention and prevention in the borough.

10. SUB BOARD UPDATES (7:45-8:00PM) (Pages 65 - 120)

To receive updates on the following:

- Health Improvement Partnership Board
- Joint Commissioning Board (To Follow)

- Primary Care
- Better Care Fund

11. FEEDBACK FROM THE HEALTH AND WELLBEING BOARD DEVELOPMENT SESSION (8:00-8:05PM) (Pages 121 - 122)

To receive feedback on the housing item discussed at the Board Development Session held on 4 November 2015.

12. MINUTES OF THE MEETING HELD ON 15 OCTOBER 2015 (8:05-8:10PM) (Pages 123 - 134)

To receive and agree the minutes of the meeting held on 15 October 2015.

13. FUTURE ITEMS (8:10-8:15PM)

To consider items for discussion at future board meetings:

11 February 2016

- Health and Wellbeing Board Terms of Reference
- Leisure and Culture Strategy

21 April 2016

To note the items agreed for discussion at future board development sessions:

6 January 2016

- Tower Hamlets Vanguard
- Cancer Vanguard
- Sport England

2 March 2016

- Diabetes

14. DATES OF FUTURE MEETINGS

To note the dates agreed for future meetings as follows:

- Thursday 11 February 2016, 6.15pm
- Thursday 21 April 2016, 6.15pm

To note the dates agreed for board development sessions as follows:

- Wednesday 6 January 2016, 2pm
- Wednesday 2 March 2016, 2pm

15. EXCLUSION OF PRESS AND PUBLIC

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

There is no part 2 agenda.

Agenda Item 3

Royal Free London NHS
NHS Foundation Trust

Report to Enfield Health and Wellbeing Board

Royal Free London NHS Foundation Trust Vanguard bid

At the start of October NHS England announced that the Royal Free London NHS Foundation Trust was one of 13 successful bidders to become vanguard sites. Following the launch of the NHS Forward View, which looks at what change is needed over the next five years, NHS England invited individual organisations or partnerships of trusts to apply to become vanguard sites.

These sites were chosen on the basis of their plans for changing the way healthcare will be delivered in the future, which may attract funding to accelerate the development and implement of the plans. Successful approaches to change may then be rolled out to the wider NHS.

At the end of July, the trust submitted a vanguard bid to become the heart of a group that other organisations will want to collaborate with. This bid was successful, allowing us to consider options including buddying, merging specific office functions and other innovative models such as joint clinical and corporate ventures.

The key benefits of this approach are that it would reduce the variation patients can experience in care, increase efficiency and can be delivered at reduced cost to the healthcare economy.

Potential partners will be identified as the proposal is developed, but the trust plans to work with Salford Royal NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust to develop plans for a group model.

The trust will be happy to provide future updates to the board as more detailed proposals are developed.

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Agenda Item 4

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **10 December 2015**	**Agenda - Part: 1** **Item: 5** **Subject: Update on Cycle Enfield** **Wards: All**
Director of Environment and Regeneration	**Cabinet Member consulted:**
Contact officer and telephone number: E mail: bob.griffiths@enfield.gov.uk 0208 379 3676	**Approved by:**

1. EXECUTIVE SUMMARY

This paper updates the HWB on progress on the implementation of Cycle Enfield and outlines the potential health benefits of the programme.

2. RECOMMENDATIONS

It is recommended that the Board notes progress to date and the potential health benefits to the borough.

3. BACKGROUND

The Council was one of only three outer London Boroughs awarded £30m 'mini-Holland' funding to help implement the Mayor's Vision for Cycling. The funding will enable Enfield to implement high quality cycling facilities, on a par with what can be found in cities such as Amsterdam and Copenhagen. The aim to increase cycling levels from just 1% at present to 5% at the end of the project.

There are several strands to the project, but the flagship schemes are the introduction of segregated cycles facilities on several of the borough's main roads. These schemes are not like the 'Cycle Super Highways' in Central London, which are primarily aimed at commuter cyclists. Instead , Enfield's schemes are aimed at encouraging local people of all ages and abilities to cycle

to their town centres and to cycle rather than drive the significant number of short distance trips that are currently being made by car.

Consultation on the A105 (Green Lanes) route between Enfield Town and Palmers Green has recently finished, with the majority of people the 1,600+ responses in support of the scheme. All of the consultation comments are currently being carefully assessed to help inform the final design and, subject to final approval early in the New Year, it is anticipated that works will start on site in June 2016.

Consultation is ongoing (until 18 December) for the plans to transform Enfield Town itself, removing traffic (expect buses) from Church Street, providing two-way cycle lanes and public realm improvements to make the town centre less car dominated. The plans for segregated cycle lanes on Southbury Road, Nags Head Road and Lea Valley Road are also out to consultation until 18 December.

The final main road scheme is for the A1010 (Hertford Road/Fore Street) corridor, which again provides segregated cycle lanes and town centre improvements along its length. Consultation on the section south of Ponders End will commence later this month, with the northern section planned for May 2016, after the Mayoral election.

4. ALTERNATIVE OPTIONS CONSIDERED

None

5. REASONS FOR RECOMMENDATIONS

Compared to those who are least active sufficient physical activity reduces all-cause mortality and the risk of heart disease, cancer, mental health issues and musculo-skeletal disease by approximately 30%. Guidelines on physical activity have been published by (amongst others) the World Health Organisation (WHO) the US Department of Health and Human Sciences and the Chief Medical Officers of the Four Home Countries.

Both self-report and objective measurements of physical activity indicate that population levels of physical activity are below those necessary to maximise health. Health Survey (HSE) 2012 data indicates that 33% males and 44% of females aged 16+ report not meeting the current Chief Medical Officer (CMO) guidelines of 150 minutes of physical activity per week.

There is strong evidence for a clear inverse relationship between physical activity and all-cause mortality, cardiorespiratory health, metabolic health including Type 2 diabetes, muscle mass and function, breast and colon cancer and poor mental health including depression and cognitive decline. There is limited, moderate or weak evidence for a positive effect of physical activity on weight loss, musculo-

skeletal health including hip and vertebrae fracture and osteoporosis. Precise effects of physical activity are dependent upon the type, intensity and length of the activity as well as the person including their age, gender and ethnicity but risk reduction is approximately 30% for all-cause mortality, 20-35% for cardiovascular disease, 30-40% for metabolic syndrome and type 2 diabetes, 36-68% for hip fracture, 22-83% for osteoarthritis, 30% risk reduction in prevention / delay in decline of physical functional health, 30% risk reduction of falls, 30% of colon cancer, 20% for breast cancer and 20-30% risk reduction of depression and dementia.

Both self-report and objective data indicates that population levels of physical activity are insufficient to maximise population health. Active transport has the potential to integrate physical activity as part of everyday life, increase population levels of physical activity and improve both individual and societal health. Forthcoming evidence (Journal of Public Health, unpublished) shows that those who cycle for utility purposes are 4x more likely to meet physical activity guidelines than those who do not. A modal shift in transport towards walking, cycling and public transport is called for by the World Health Organisation (WHO), the Chief Medical Officer (CMO) and the Faculty of Public Health.

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

6.1 Financial Implications

The financial implications of Cycle Enfield have been outlined in other reports.

6.2 Legal Implications

The financial implications of Cycle Enfield have been outlined in other reports.

7. KEY RISKS

If Cycle Enfield is not implemented in full the potential health benefits outlined above will be missed.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Ensuring the best start in life
8.2 Enabling people to be safe, independent and well and delivering high quality health and care services
8.3 Creating stronger, healthier communities
8.4 Reducing health inequalities – narrowing the gap in life expectancy
8.5 Promoting healthy lifestyles

The health impacts of cycling have been summarised by the Transport and Health Study Group:

Health Promoting	Health Damaging
Enables access to:	Injuries
employment	Pollution:
education	particulates
shops	carbon monoxide
recreation	nitrogen oxides
social (support) networks	hydrocarbons
health and other services	ozone
countryside	carbon dioxide
recreation	lead
physical activity	benzene
	Noise and vibration
	Odour
Active travel	Climate change
	Stress and anxiety
	Danger
	Loss of land and planning blight
	Severance of communities by traffic

9. EQUALITIES IMPACT IMPLICATIONS

The impact of modal shift towards cycling will be overwhelmingly positive; it will improve health, reduce residents travel costs, reduce the external costs of transport (pollution, road traffic injuries), make transport more accessible to all (in Holland women cycle as much, or more than men) and reduce health inequalities.

Background Papers

None

Agenda Item 5

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **10 December 2015**	**Agenda - Part: 1** | **Item: 3** **Subject:** Recommendations on sugar consumption **Wards: All**
Report of: Ian Davis Director of Regeneration and Environment Contact officer and telephone number: E mail: **glenn.stewart@enfield.gov.uk**	**Cabinet Member consulted:** **Cllr Daniel Anderson** **Approved by:**

1. EXECUTIVE SUMMARY

Sugar consumption has been a controversial issue for a number of years but the Scientific Advisory Committee on Nutrition (SACN) has now made a number of recommendations which have been accepted by the Government. These are:

- no more than 19g/day of free* sugars for children aged 4 to 6
- no more than 24g/day for 7 to 10-year olds
- no more than 30g/day for children from age 11 and adults

2. RECOMMENDATIONS

The Board is asked to note the recommendations made by SACN and consider how these recommendations may be implemented.

3. BACKGROUND

Introduction
In September 2015 the HWB asked for a paper to come to the Board on system leadership. Obesity represents a considerable cost to the health and social care economy (some £84m) and sugar consumption is associated with this. Equally Enfield has some of the worst dental public health figures in London. Sugar is an issue upon which the respective partners of the HWB have various levers and through which the HWB can demonstrate both internal and external leadership. This paper seeks to outline the rationale and options that the HWB might like to explore in this role.

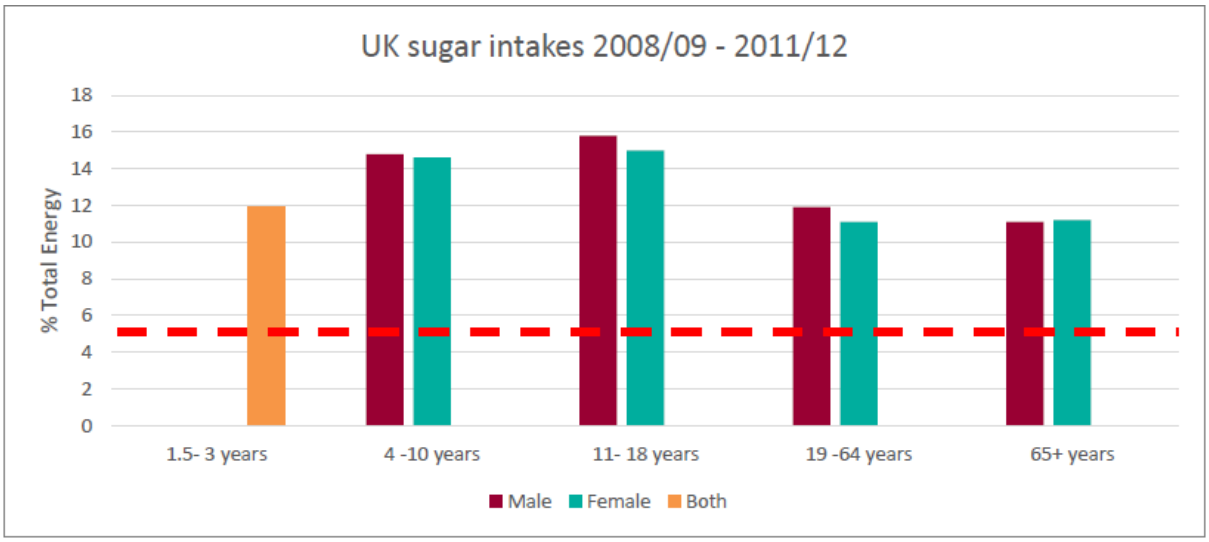
Background
Sugar consumption has been a controversial issue for a number of years. The Scientific Advisory Committee on Nutrition (SACN) was asked by the

Government to examine the relationship between dietary carbohydrates (sugars, starches and fibre) and health. A draft report for consultation was produced in June 2014 and a final report in July 2015.

SACN found that a high intake of free sugars is detrimental to several health outcomes including tooth decay, obesity and type 2 diabetes. It also found that in adults consuming an unrestricted diet that increasing or decreasing the proportion of calories consumed as sugars leads to a corresponding increase or decrease in energy intake and that children and adolescents who drank sugar-sweetened drinks compared to low calorie drinks experienced greater weight gain and increases in Body Mass Index (BMI).

SACN therefore recommended that average sugar intake should not exceed 5% of total energy dietary intake in all age groups from 2 years of age. No quantitative recommendations are made for children under the age of 2 years due to the absence of information. But from about 6 months of age, gradual diversification of the diet to provide increasing amounts of whole grains, pulses, fruits and vegetables is encouraged. Current average dsugar intakes in all age groups are at least twice the new recommendations and three times higher in 11 to 18-year olds (Fig 1). The main sources are sugars-sweetened drinks (including carbonated drinks, juice drinks, energy drinks, squashes and cordials); cereal-based products (biscuits, cakes, pastries and sweetened breakfast cereals); table sugar and confectionery; and fruit juice.

Fig 1: UK sugar intake compared to the recommended maximum of 5% energy, by age.



The new dietary recommendation for free sugars is designed to minimise the health risks associated with high free sugars intakes and to result in improved management of energy intake, reducing this across the population by an average of 100kcal/day (418kJ/day). This is expected to beneficially influence the risk of obesity and also to improve dental health.

SACN therefore made the following recommendations:

- Free sugars should account for no more than 5% daily dietary energy intake.
- The term free sugars is adopted, replacing the terms Non Milk Extrinsic Sugars (NMES) and added sugars. Free sugars are those added to food or those naturally present in honey, syrups and unsweetened fruit juices, but exclude lactose in milk and milk products.
- The consumption of sugar-sweetened beverages (e.g. fizzy drinks, soft drinks and squash) should be minimised by both children and adults.

Public Health England (PHE) has translated the above recommendations into:

- no more than 19g/day of free sugars for children aged 4 to 6 (5 cubes / teaspoons of sugar)
- no more than 24g/day for 7 to 10-year olds (6 cubes / teaspoons of sugar)
- no more than 30g/day for children from age 11 and adults (7 cubes / teaspoons of sugar)

It is estimated that per year benefits of achieving a 5% energy intake from sugar would be to avert 4700 deaths, 242,000 dental caries and save the NHS £576 million.

How this might be implemented in Enfield.

Whilst a number of nationals actions may or may not be implemented the following actions may be considered in Enfield:

- Distribute more widely the LBE poster indicating the amount of sugar in various drinks etc (Appendix 1)
- Promoting alternatives to sugary drinks such as water, milk, ‘diet’ and sugar-free alternatives
- Work with the Local Authority workforce to reduce the amount of sugary food that is brought in (for example – only bring in celebratory food on a Friday)
- These recommendations to be considered in future school catering contracts
- Ensure water fountains in parks
- Improving the food and drinks on offer in public buildings and spaces
- Building good food and drinks offers into contacts with local authority venues such as leisure centres, parks and swimming pools
- Implement government buying standards for food and catering services
- Support local food businesses, such as takeaways, to promote healthier eating through training as well as incentives and reward schemes
- Brighton and Hove has introduced a voluntary 10p sugar tax on all sugary soft drinks with the proceeds going to a children’s health and food education Trust

- Action on vending machines in Local Authority and health care setttings to provide healthy options
- Ensure that Voluntary and Community groups that receive funding through the Local Authority have a nutrition policy

Potential impact in Enfield

Enfield has the 4th highest rate of adult excess weight in London (64.8%) and obesity doubles between Reception Year and Year 6 (from 12% to 24%). Sustain has estimated the potential impact of 5 - 20% sugary drinks duty at a local level. In Enfield it is estimated that a 20% levy would result in:

- 264 fewer cases of diabetes
- 180 fewer cases of CVD & Stroke
- 47 fewer cases of bowel cancel
- £1,608,894 in healthcare cost savings

4. ALTERNATIVE OPTIONS CONSIDERED

None

5. REASONS FOR RECOMMENDATIONS

The above are recommended to the Board for consideration.

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

6.1 Financial Implications

None until any recommendations are implemented

6.2 Legal Implications

None until any recommendations are implemented

7. KEY RISKS

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Ensuring the best start in life
8.2 Enabling people to be safe, independent and well and delivering high quality health and care services
8.3 Creating stronger, healthier communities
8.4 Reducing health inequalities – narrowing the gap in life expectancy
8.5 Promoting healthy lifestyles

The report from SACN indicates that all the above priorities will be positively impacted by a reduction in sugar consumption

9. EQUALITIES IMPACT IMPLICATIONS

The worst rates of obesity and tooth decay are in wards and areas of health inequalities, a reduction in sugar consumption would impact positively on these.

Appendix 1:

Be part of a healthier Enfield:
Cut out sugary drinks

www.enfield.gov.uk/meds

ENFIELD Council

Sugar and what might be done about it

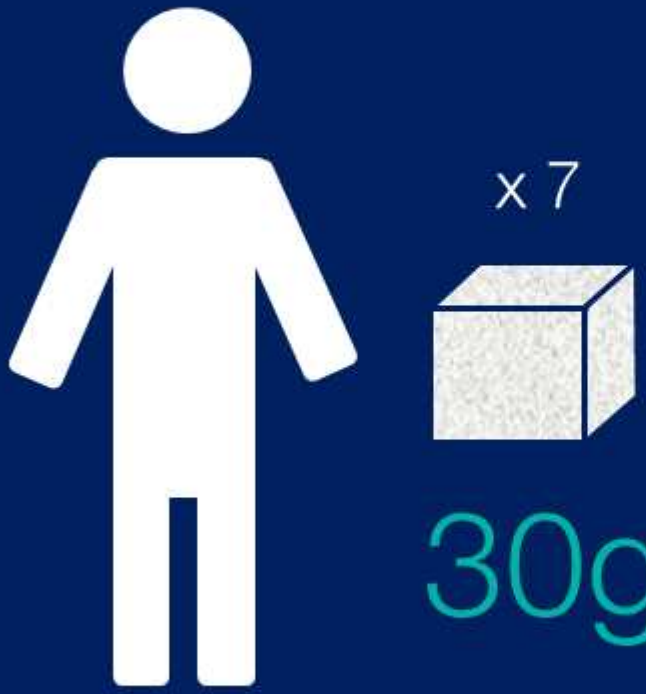
Glenn Stewart
Assistant Director of Public Health

Background

- Scientific Advisory Committee on Nutrition (SACN) asked by Government to look at relationship between dietary carbohydrates and health
- Final report July 2015
- Sugar linked to tooth decay, obesity, type 2 diabetes
- Recommendations made

ENFIELD Council

New recommended maximum daily sugar intake



x 7

30g

Adults & 11+

x 6

24g

7-10 years

4

*Scientific Advisory C

What does this mean in practice?

- Current sugar intake is approximately 3x higher than recommended in school-aged children and teenagers and twice that recommended in adults

What would reduction to 5% achieve?

- 4700 deaths, 242,000 dental caries per year
- The NHS £576m per year

Why Enfield

- 4th highest rate of excess weight in London (64.8%)
- Obesity doubles between Reception and Year 6 (12 – 24%
- Xx highest rate of decayed, missing or filled teeth (DMFT) in London

So what could we do at a local level?

- Display the LBE sugar poster more widely (next slide)
- Work with the Local Authority workforce to reduce the amount of sugary food that is brought in (for example – only bring in celebratory food on a Friday)
- Improve the food and drinks on offer in public buildings and spaces
- Build good food and drinks offers into contacts with local authority venues such as leisure centres, parks and swimming pools
- Implement government buying standards for food and catering services
- Support local food businesses, such as takeaways, to promote healthier eating through training as well as incentives and reward schemes
- Brighton and Hove has introduced a voluntary 10p sugar tax on all sugary soft drinks with the proceeds going to a children's health and food education Trust
- Action on vending machines in Local Authority and health care setttings to provide healthy options

LBE sugar poster / Over to you / Questions

Budget Consultation
Health and Wellbeing Board

2016/17

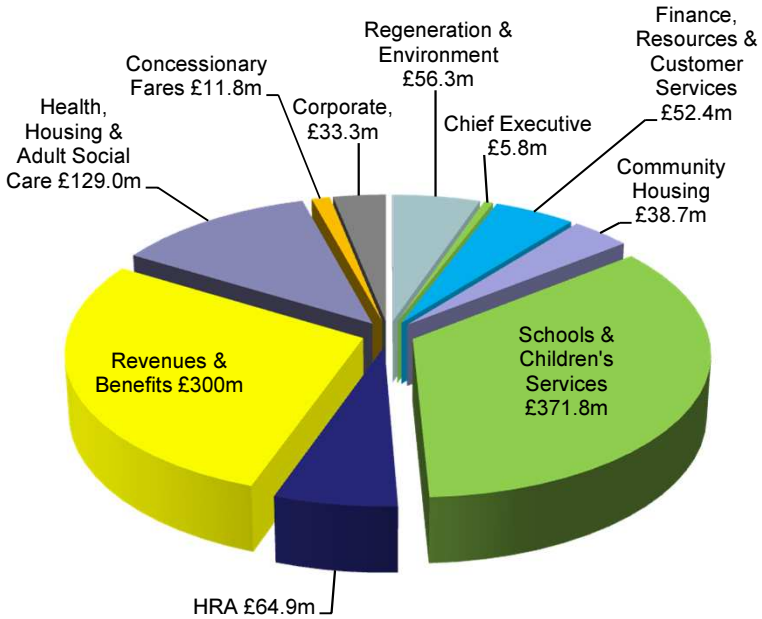
ENFIELD Council

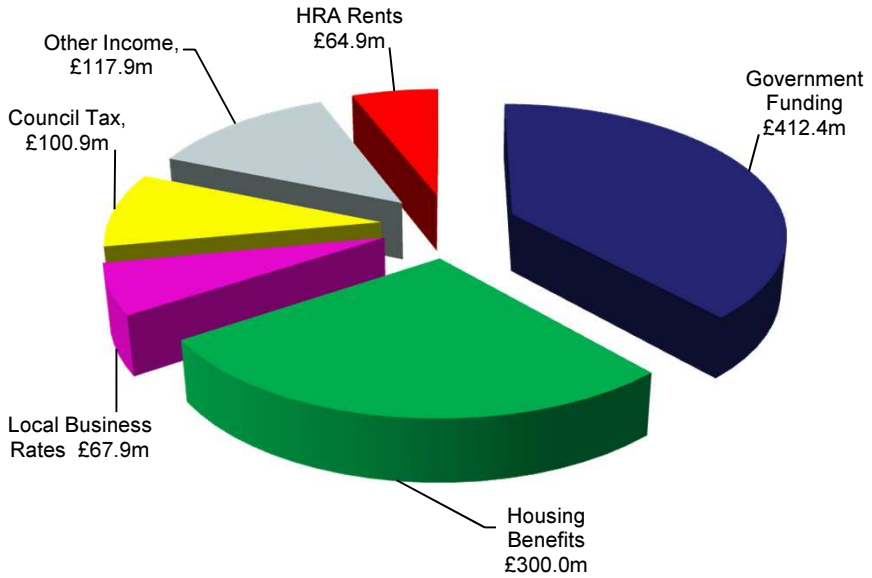
Agenda

- Where the Council's money comes from and where it is spent
- Our approach to financial management
- Pressures and risks
- Budget Gap
- Council Services included in the consultation
- Council Tax information
- Questions

ENFIELD Council

Council Spend and Income 2015/16 (£m's)

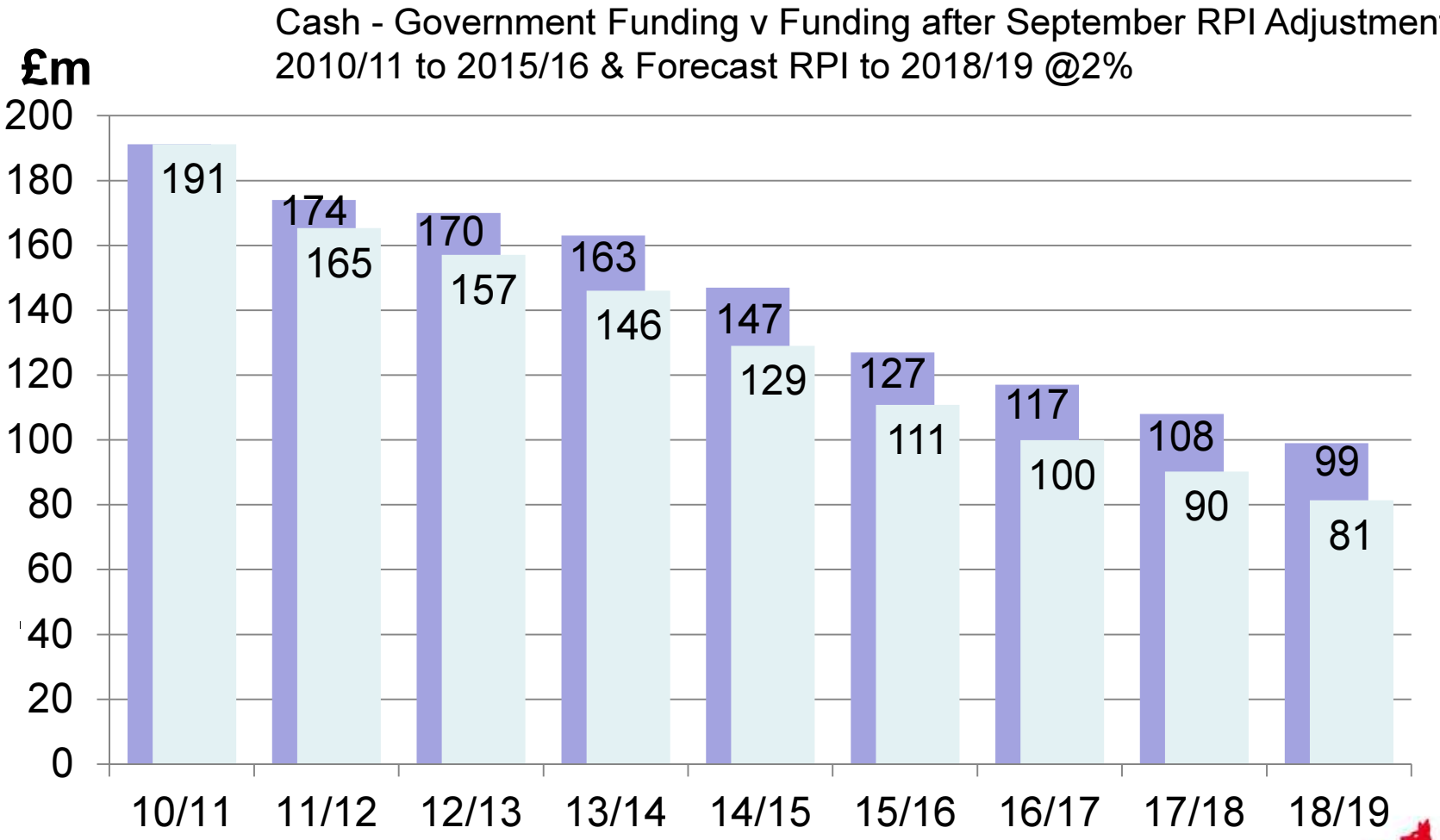




Gross Expenditure £1.064bn or £1,064,000,000

ENFIELD Council

Government Core Funding Reductions 2010/11 to 2018/19



Note: Figures excludes the specific grants of Dedicated Schools Grant, Public Health Grant and New Homes Bonus

ENFIELD Council

Our Approach to Financial Management

- Medium Term Financial Plan:
  - Looks four years ahead
  - Gives as much stability and certainty as possible
  - Brings together all the Council's day to day finances
  - Aiming to put in place a plan to deliver a balanced budget for a four year period
- Firm control on finances:
  - Helps to focus on choices which need to be made
  - Enables delivery of services with minimum interruption

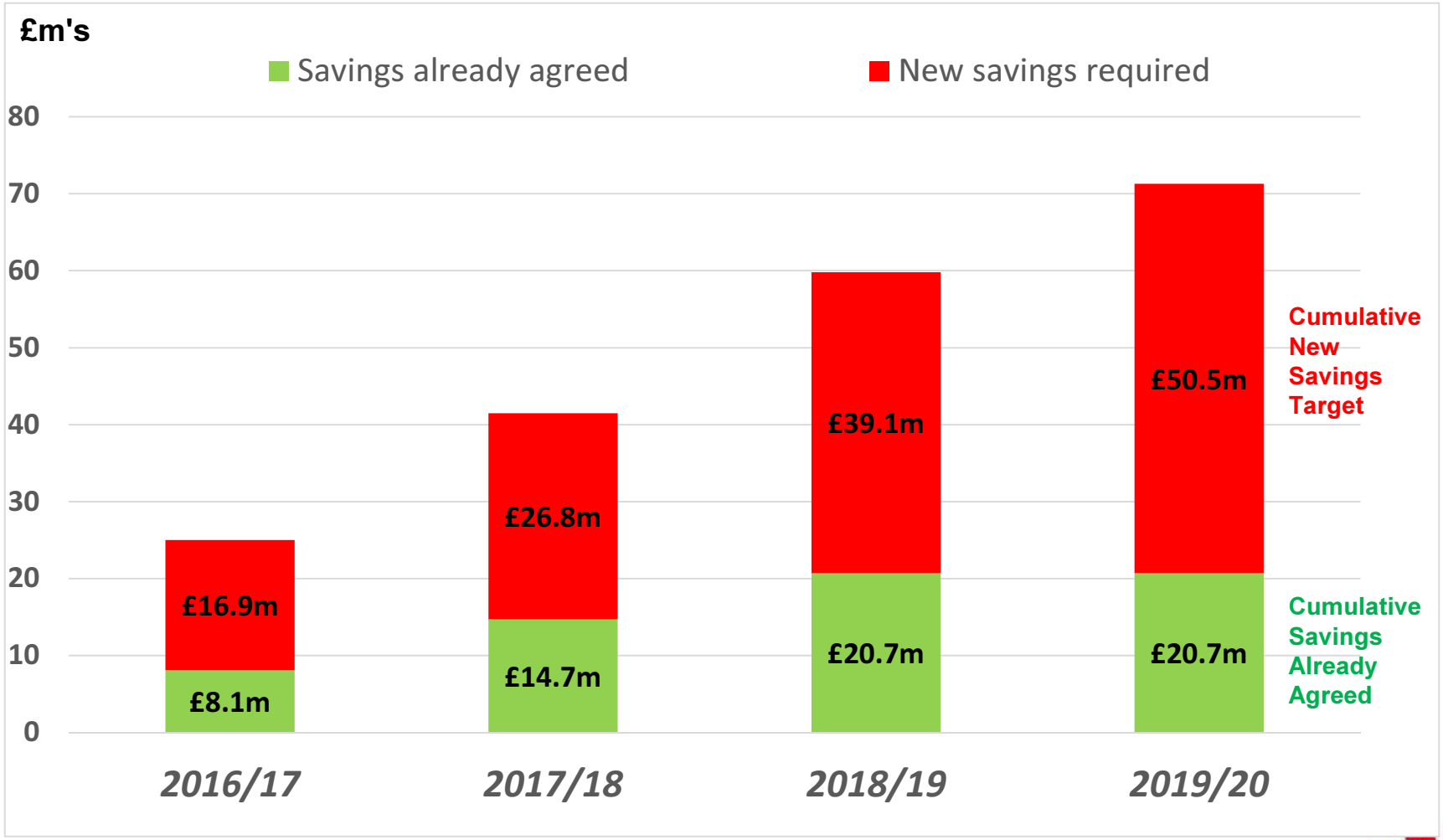
ENFIELD Council

Pressures and Risks

- Spending Review 2015 & Financial Settlement – further Central Government spending cuts.
- Care Act 2014 – potential increase in care costs and additional responsibilities for the Council which are not fully funded.
- Demographics – increase in demand for Council services due to population growth as well as an ageing population
- Borrowing – increases in costs for new borrowing for capital investment (e.g. schools, roads and public realm).
- Inflation / pay – increased cost of running services.
- Upturn in property market – increase in the level of rents paid to landlords for temporary accommodation but not funded by Government under new welfare arrangements.

ENFIELD Council

Cumulative Savings Targets over the Period of the Financial Plan



Note that Budget Pressures over the period 2016/17 to 2019/20 total £71.2m. Saving of £20.7m have already been made from Enfield 2017 (back office savings) and the full year savings effect of prior year decisions, and these are being implemented. Therefore the remaining Savings Target is £50.5m to be met from new savings.

ENFIELD Council

Government Spending Review 2015
25th November 2015

- Government's public spending plans for next four years to 2019/20
- High level so will not know full details for Enfield until the Local Government Finance Settlement in December
- Core central government funding to local government will fall by 24%*
- Including forecasts of other income raised locally by councils, the overall position is a 6.7% reduction*
- Councils to retain 100% of their business rates income (only 50% at the moment) but more work needs to be done to determine the impact of this and the funding reductions on Enfield's current financial plans and saving targets.

ENFIELD Council

* Source: Local Government Association real term percentage over four years to 2019/20

Service areas included in consultation

Savings are being considered from all service areas including:

- Adult Social Care
- Health & Housing
- Services for Children & Young People
- Environment & Regulatory Services
- Neighbourhood & Street Scene
- Regeneration
- Parks, Open Spaces, Leisure & Culture

ENFIELD Council

Summary of Council Tax Options

Options	Potential Saving	Potential Saving	Potential Saving	Potential Saving
	2016-17	2017-18	2018-19	2019-20
	£m	£m	£m	£m
Council tax Increases: Council tax has been frozen since 2010/11 The Council's financial plan currently assumes a council tax increase of 1% in 2016/17 and this is included in figures shown in slide 7 (Budget Gap). Higher increases would generate additional savings as follows:				
Increasing Council Tax by 1.99% each year would bring in an additional :	**1.0**	**2.0**	**3.0**	**4.0**
Increasing Council Tax by 3%* each year would bring in an additional :	**1.5**	**3.5**	**5.5**	**7.5**

*To increase Council tax above 1.99% currently requires a referendum of the local electorate at an estimated cost of £500k. This option includes the cost of the referendum. Lead in time to organise a referendum make it unlikely to be a viable option for 2016/17 unless done retrospectively which incurs a risk of a no vote which would result in re-billing and the associated costs.

ENFIELD Council

Questions?

ENFIELD Council

Budget Consultation (1)

- What are your thoughts on whether the Council should consider raising the level of Council Tax in order to protect services?

- If the Council were to increase Council Tax, by how much do you think it is reasonable for the authority to increase it in order to protect some services?

ENFIELD Council

Budget Consultation (2)

- What are your thoughts on whether the Council should introduce or increase charges for some of the services it provides?

- What other options should the Council explore to help make the anticipated savings of £50mil. by 2019/20?

ENFIELD Council

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Agenda Item 7

MUNICIPAL YEAR 2015/2016	

MEETING TITLE AND DATE Health and Wellbeing Board 10 December 2015	Agenda - Part: 1	Item: 7
	Subject: Enfield CAMHS Future in Mind Transformation Plan	
	Wards: All	
Report of: Graham MacDougall, Director Strategy & Partnerships	Cabinet Member consulted: N/A	
Contact officer - Claire Wright Email: claire.wright@enfieldccg.nhs.uk		

SUMMARY:

In March 2015 the Government published a wide-ranging report on child and adolescent mental health, *Future in Mind – Promoting, protecting and improving our children and young people's mental health and wellbeing*. The report sets out a national ambition to improve mental health services for children and young people. *Future in Mind* stipulates that each CCG area is required to submit a Transformation Plan. Enfield submitted on 16 October 2015. The national timeline required the assurance process to be completed in the first week of November, and feedback was received on the 9th November 2015. Enfield was asked to resubmit our plan to provide additional assurance, and this was done as required on 24th November 2015.

The CCG is awaiting further advice from NHS England following its resubmission and the Transformation Plans formed the basis of the recent Mental Health Stocktake with NHSE across Barnet, Enfield and Haringey CCGs, with the Trust and with local authority representation from LBE. Many CCGs have been required to resubmit with either additional information, ensuring a link between needs assessment, vision, strategic aims and investments with some areas being presentational. NHSE has stated it is confident that plans will be assured following resubmission.

Transformation Plans had to include information on services currently available, levels of local investment, areas for service transformation and arrangements to review implementation of the plan and monitor improvement. We were required to submit a high level template, supported by more detailed plans. A high level template, was submitted with the Joint Commissioning Strategy for Emotional Well-being and Child and Adolescent Mental Health and a *Future in Mind* Transformation Action Plan. Development of the plan was led by the CCG and Council, working closely with our providers and other partners, including children and young people.

Our plans clearly address the five key areas required by *Future in Mind*:

- Accountability and transparency;
- Improving access to effective support;
- Care for the most vulnerable;
- Promoting resilience, prevention and early intervention;
- Developing the workforce

Funding allocations

All CCGs have been allocated three areas of funding which are shown in the table below.

Initial allocation of funding for eating disorders and planning in 2015/16 (Already released)	Additional funding available for 2015/16 when the Transformation Plan is assured	Minimum recurrent uplift for 2016/17 and beyond if plans are assured (includes eating disorders)
£169,378	£423,970	£593,348

Children and Young People's IAPT

In addition to the funding shown above, Enfield has received £426K in the form of training places and funding for backfill so that we can participate in the children and young people's IAPT programme.

Future in Mind recommends implementation of CYP IAPT, as the major transformation programme for existing CAMH services and partner agencies. CYP IAPT aims to:

- Improve access and choice of NICE approved best evidence based therapies
- Create a service culture of full collaboration between child, young person and/or their parent/carer (where appropriate) and therapist
- Improve access through self-referral
- Use of a range of outcome measures to guide therapy and support service monitoring and decisions about service development

Eating Disorder Service

For CCGs who already commission Eating Disorders Services that comply with statutory guidance, then there is provision for the additional investment to be used in improving self harm and crisis intervention services.

The contract with the Royal Free Hospital for the Eating Disorder Service is currently worth £265,817, and in 2013/14, 25 young people were referred to the service and 23 accepted and in 2014/15, 31 were referred and 29 accepted. Outcomes for the service are good and there were no inpatient admissions to Tier 4. There are issues with compliance with statutory guidance for non urgent waiting times, self referrals, and therapeutic mix, but the service has reported vacancies which have impacted on waiting times and indicated that service improvements could be made from existing resources. We believe our current level of investment is consistent with numbers of young people seen, and given the increase in numbers of young people with deliberate significant self-harm leading to admission to hospital, investment into self harm crisis intervention is seen as the greater priority.

Perinatal Mental Health

Perinatal mental health is one of the priorities for 2015/16 identified in Future in Mind, and additional funding is anticipate but has yet to be announced.

NHS Enfield CCG has worked with other NCL CCG's to develop a joint Perinatal Mental Health Strategy and the need for a specialist perinatal mental health service co-commissioned with Haringey and Barnet CCGs at NMUH and Barnet Hospital has been identified as a priority.

The cost options currently being looked at include a specialist psychiatrist sited with the maternity unit (£70k per CCG) and a specialist team sited within maternity services (£200k per CCG). This will be further examined once funding is announced.

Additional priorities for transformation

Many of the elements of *Future in Mind* are already in place, our main CAMH service is well thought of, and is a joint service across the Council and BEH MHT with good working relationships with schools and staff embedded in social care, youth justice, the looked after children team and children's centres.

However there have been increased pressures on the service, and waiting times have grown. The dramatic increase in numbers of young people admitted to hospital with deliberate self-harm in particular is a concern. In 2015/16 we have stated that want to focus on establishing platform for further development. Therefore priorities for investment in 15/16 include continuation of self-harm and crisis intervention work with NMUH and Barnet, a waiting list initiative, infrastructure to support implementation of the plan, and development of a peer mentoring scheme proposal and voluntary sector capacity.

Priorities thereafter are to increase capacity in the service to develop a whole system response to crisis intervention, autism and neuro-developmental/mental health services, and a focus on developments that will support early identification and intervention, such as the parent and infant mental health service.

Implementation

The Transformation Plan has been discussed in detail with a wide range of stakeholders, including the voluntary sector and children, young people, and parents and carers, the level of sign up is good, and implementation has started. Implementation will be the responsibility of the Enfield CAMHs Partnership Group, which meets monthly, supported by the CYP IAPT Steering Group and Task and Finish Groups that will be set up to drive individual work streams. The Partnership Group reports the Joint Commissioning Group, which is a Sub-Committee of the Health and Wellbeing Board. Ultimate accountability is to the Health and Wellbeing Board. It is important to note that this is a jointly developed plan across the CCG, LBE and providers and has strong clinical approval.

SUPPORTING PAPERS:

None

RECOMMENDED ACTION:

Health and Wellbeing Board is asked to note the contents of this report and will receive the full plan following further advice from NHS England

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Health and Care

Strategic Context

This section sets out the broad model for reform of health and care in London that has been agreed in principle by London boroughs, CCGs, the Mayor, PHE and NHS England. It provides a common platform for collaborating to transform outcomes for Londoners and address the sustainability of the health and care system in the capital.

There is commitment across local government and the NHS in London to make progress on reform and transformation within existing powers and responsibilities. But both the ability and incentives to address long-standing, complex challenges will be significantly constrained without clear steps by government and national NHS bodies to devolve funding and powers, and to provide freedoms and flexibilities to support new ways of working and a strategic focus on driving transformative change.

We therefore want to use the CSR to establish a framework for supporting reform of health and care across London throughout the next Parliament. This framework seeks immediate agreement to some national changes, while others would be unlocked as detailed proposals are developed at different levels in London.

There is agreement between all London partners that the scale, complexity and history of health and care issues in the capital mean a single, city-wide approach to reform will not be successful. There is also consensus that London's model of reform must address the whole health and care system – to enable a rebalancing towards prevention, early intervention; supporting independence and wellbeing, as well as addressing the future sustainability of health and care services.

This needs to be developed on three geographical levels: local, sub-regional and regional. A principle of subsidiarity underpins this ensuring decisions are made at the most appropriate level. But there is recognition, including politically, that hospital service transformation will require collaboration across sub-regional footprints and the linkages between locally led out of hospital transformation and sub-regionally co-ordinated hospital network transformation will need to be strong.

The increased focus on prevention and public health will require action not only by NHS and local authority care services, but also by other parts of local and regional government and agencies across a range of areas including employment support, housing and offender management.

There is an ever strengthening track record of collaboration between local government and the NHS in London. But it is recognised that our model of reform will require this to evolve to a new level. Therefore pilots will be set up before the CSR is finalised, through which, sub-regionally and locally, detailed reform proposals and collaborative structures through which to deliver these, will be worked up.

Background

London's population is growing at a faster rate than any other region in England and is transient, accounting for 37% of the nation's short-term residents. The capital also has a 7% higher poverty rate than the rest of England and a substantial inequality gap in healthy life expectancy between boroughs. London also has particularly high and growing populations of both under 25s, where investment in prevention could have significant impact, and over 80 year olds, the biggest users of health and care services.

The unique nature of London's population, the growing health risk factors and organisational challenges will put unprecedented pressure on the health and care system over the coming years. The NHS in London faces a £4.76bn affordability gap between forecast funding levels and the expected rise in demand for healthcare by 2020/21[1]. In a similar time horizon London local government faces a potential funding gap of close to £3.4 billion, of which £1.14bn would be experienced by adult social care.

Lifestyle risk factors are stimulating an increase in health and care demand. London has the highest rate of childhood obesity of any peer global city with consequences for the high proportion of the health budget spent on associated illnesses. Intervention on smoking is thought to be an opportunity to not only address the 8,400 lives lost to smoking each year but also reduce the £1.9-£2.8bn currently spent on smoking related illness.

London's Health Care system has some significant and enduring challenges:

- the variable quality of primary care in the capital and particularly in the inner city
- the poor health of the population in some areas of London
- the over reliance on hospitals for the delivery of health care
- the different patterns of hospitalisation between different areas of the capital and in comparison nationally
- the concentration of hospital services in inner-city areas with higher population growth and demand for services in outer London

There are significant opportunities to radically transform the health and care landscape. Currently a fraction of the budget is spent on prevention and self -management initiatives despite significant opportunities to be achieved from proactively addressing worsening risk factors. Bringing health and social care together provides an opportunity to deliver an integrated system that much better meets the population's varying needs.

[1] £1.74bn Commissioner challenge defined as the difference between available funding and spending based on 'unconstrained demand' and rising cost of provision
£3.02bn Provider challenge defined as current deficits, impact on commissioners constraining demand, price changes from tariff changes and rising cost of provision
£1.74bn London share as announced by the new Conservative government in May 2015. Funding to be directed at transformation.
NOTE: If tariff efficiencies of 4% were to be delivered, this affordability gap reduces to £1.74bn. However this is dependent on productivity increases within the system. The majority of providers have opted for ETO tariff prices which include a 3.5% efficiency.

There is a strong history of collaboration and joint working across health and care and political leadership across London. At local level Health & Well Being Boards are growing in maturity and effectiveness and aspire to develop further to fulfil the full strategic commissioning role envisaged in their creation. At a pan-London level political leadership includes the London Health Board, previously the London Health Improvement Board, which from its inception in 2011 has been chaired by the Mayor of London with representation from elected borough leaders, the NHS and Public Health.

A Shared Vision for Health And Care In London

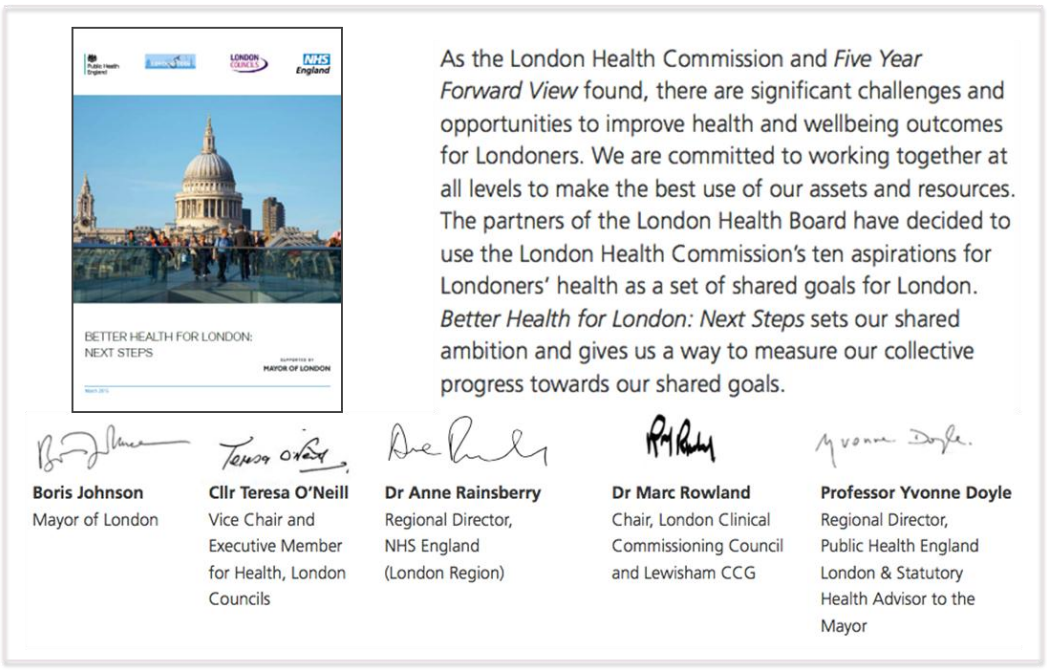
Nationally the NHS published the *Five Year Forward View* in October 2014 setting out a shared vision of how health services need to change, in order to sustainably address three widening gaps, in health and wellbeing, care and quality, and funding and efficiency. Building on the *Five Year Forward View* and the collective high level vision for health and care in London established through the *London Health Commission*, *Better Health for London: Next Steps*[2] was published in March 2015.

This followed a year long journey that started with a conversation with Londoners, through engagement of more than 14000 Londoners at tailored events and through online discussions. The process encouraged collaboration between the organisations that influence health and care; including Local Government, NHS England, Public Health England, London's healthcare commissioners and providers, patient representatives, the voluntary sector and industry.

The recommendations set out directly address issues relating to how to affect the change, such as funding, workforce, information sharing, estates and leadership.

The partners of the London Health Board; London Councils, London CCGs, the Mayor, NHS England and Public Health England have committed to 10 joint aspirations to help London become the healthiest World City.

[2] http://www.londoncouncils.gov.uk/our-key-themes/health-and-adult-services/health/better-health-london-next-steps-plan



Aspiration	2020 Ambition
1. Give all London's children a healthy, happy start to life	Ensure that all children are school-ready by age 5 Achieve a 10% reduction in the proportion of children obese by Year 6 and reverse the trend in those who are overweight
2. Get London fitter with better food, more exercise and healthier living	Help all Londoners to be active and eat healthily, with 70% of Londoners achieving recommended activity levels
3. Make work a healthy place to be in London	Gain one million working days in London through an improvement in health and a reduction in sickness absence
4. Help Londoners to kick unhealthy habits	Reduce smoking rates in adults to 13% - in line with the lowest major global city and reduce the impact of other unhealthy habits
5. Care for the most mentally ill in London so they live longer, healthier lives	Reduce the gap in life expectancy between adults with severe and enduring mental illness and the rest of the population by 5%
6. Enable Londoners to do more to look after themselves	Increase the proportion of people who feel supported to manage their long-term condition to the top quartile nationally
7. Ensure that every Londoner is able to see a GP when they need to & at a time that suits them	Transform general practice in London so Londoners have access to their GP teams 8am-8pm, and primary care is delivered in modern purpose-built/designed facilities
8. Create the best health and care services of any world city, throughout London and on every day	Work towards having the lowest death rates for the top three killers Close the gap in care between those admitted to hospital on weekdays and at weekends
9. Fully engage and involve Londoners in the future health of their city	Achieve 10 basis point improvements in poll data
10. Put London at the centre of the global revolution in digital health	Create 50,000 new jobs in the digital health sector & ensure that innovations help Londoners to stay healthy and manage their conditions

Opportunities and Benefits Of Devolution In Meeting These Ambitions

Our goal is to secure improved care across the spectrum of health and care services, reducing hospitalisation through proactive, co-ordinated and personalised care that is effectively linked up with wider services to help people maintain their independence, dignity and wellbeing. When Londoners need acute or emergency physical or mental care they should all be able to access consistently world class services, seven days a week. But they should be just as confident about being able to access consistently high quality support to address lower level health issues and manage ongoing conditions to minimise the impact on their wider lives and families.

Achieving this integration of services across providers can be significantly accelerated as a result of the opportunity presented by devolution:

Benefit	Outcomes	Additional opportunity from devolution
Addressing the health and wellbeing gap	• All children are school-ready by age of 5 • Reduction in proportion of obese children • Increased proportion of Londoners achieving recommended activity levels • Reduction in workplace sickness and associated absence • Reduction in smoking rates to level of lowest global city	• Ability to strengthen and support actions taken by many Health and Wellbeing Boards by working in partnership across the health and care system and by other industries and sectors. • Opportunity to embed health promotion and prevention throughout health and care services, and develop new partnerships between the public, third and business sectors to promote health in innovative settings across London • Strengthening strategic alliances e.g. on illegal tobacco
Addressing the care and quality gap	• Reduction in gap in life expectancy for adults with severe & enduring mental illness • Public supported to self-manage long-term conditions • Public able to access care in the right place at the right time • Reduction in the gap in outcomes for weekend vs weekday admissions	• Integration of health and care budgets in a place to maximise potential for new models of care and reducing the reliance on hospitals. • Build on examples of local collaboration pilots to provide early intervention and re-ablement services rather than a crisis based system • Enable investment in partnership working between primary care and local services to coordinate care around the needs of patients • Enable investment in partnership working between primary care, social care and the community sector to roll-out integrated personal commissioning • Use transformation funding to invest in fit for purpose facilities for the provision of health and care services
Addressing the funding and efficiency gap	• Improved value delivered within available health and care funding	• Allows for increased investment in out of hospital settings to deliver care in the most appropriate settings for the patient • Integrates services improving patient flow through the system and associated productivity

London's Devolution Proposition for Reforming Health And Care Services

Our model of reform to achieve this recognises that collaboration and new ways of working will be needed between commissioners, providers, patients, carers and wider partners at multiple levels.

We are committed to ensuring wide ranging engagement to support development of this model. Political leadership and oversight at the borough level through Health and Well Being Boards and at the pan-London level through the London Health Board will need to develop; further strengthening its connections to all London partners. New leadership and collaboration capability at the sub-regional level will also be required.

We recognise the ultimate accountability of existing statutory organisations to parliament and electorates. In our model, geographies would be accountable for upholding national standards, delivering statutory requirements including, but not limited to, the NHS Constitution and would have to account to the Chief Executive of NHS England for the financial performance of the NHS within the local geography. We are committed to this accountability and upholding national standards and requirements.

Our model will be developed on three geographical levels: local, sub-regional and pan-London. A principle of subsidiarity underpins this ensuring decisions are made at the most appropriate level. There is recognition that acute service transformation will require collaboration across sub-regional footprints and place based budgets will support the linkages between locally led out of hospital transformation and sub-regionally co-ordinated hospital network transformation. Core components of the London approach across the three geographical levels for action will include:

<u>Locally:</u>

- joint multi-year local integration planning, supporting Health and Well Being Board strategies, to secure increased prevention, early intervention, personalisation and integrated out of hospital health and care services – and alignment of provider plans
- full pooling and joint commissioning of NHS, social care and public health commissioning budgets through s75 agreements
- local public asset plans and scheme development to secure facilities to deliver accessible, multi-purpose, integrated out of hospital services

<u>Sub-regionally:</u>

- Delivery of local Health and Well Being Board aspirations through accountable strategic partnerships based on joint committees established to lead transformation at sub-regional scale
- joint health and care strategies to develop new models of care across acute, primary and social care settings
- joint commissioning to secure delivery of sub-regional plans that are clinically and financially sustainable for all parts of the health and care system within the geography

- sub-regional estate plans and scheme development to unlock redevelopment of un- or under-used NHS estate, aligned with local public asset planning

Pan-London:

- The London Health Board, chaired by the Mayor of London, will provide political leadership, oversight and support for the London strategy including delivery of the ambitions of Better Health for London and commitment to the vision set out in the *Five Year Forward View*
- A pan-London joint executive committee, accounting to the London Health Board and with ability to act on behalf of regional and local partners to agree strategic priorities and to create frameworks that support devolved working at all levels
- Partnerships for strategic estate planning, allied to the London Land Commission and sub-regional strategies
- Workforce planning and skills development to match the pace of health system transformation
- Collaboration to develop city level public health improvement actions, including both regulatory and fiscal interventions
- Development of London wide financial and other frameworks, such as new payment models, for use at sub-regional and local level.

To deliver this strategy, three types of action and agreement will be required:

1. **Action by London**: London will build on its record of collaboration and joint working by developing the leadership and delivery arrangements that are required at local, sub-regional and pan-London levels. This will include the swift setting up of pilot collaborations at local and sub-regional levels;
2. **Devolution Unlocked as London Becomes Ready:** Agreement is needed between London government and its NHS partners on the one hand, and Government and the NHS at national level on the other, on a menu of new devolved flexibilities, opportunities and authority that would become available to London and parts of London upon the development of robust joint governance, strategies and delivery arrangements.
3. **Requirements of NHS and Government:** Agreement is also needed on a set of reforms to unlock health improvement and system transformation as part of the CSR decision-making process. This requires action by the NHS, Department of Health and other government departments including CLG

We describe the detail of these three tasks in the next section.

London's Devolution 'Offers':

Actions and Agreements Sought

Action by London

London Leadership: collaborative transformation

Partners recognise that a number of immediate actions will need to be taken to maximise the opportunity afforded by the shared model described. Implementation of this model would require:

- Partners would rapidly establish the governance by which a pan-London joint committee can act on behalf of regional and local partners, account to London's political leadership and meet the statutory requirements of the NHS.
- This is expected to result in the development of a MoU similar to the spirit of the Manchester MoU to be published in autumn 2015, but reflecting London's larger population and need for sub-regional working in addition to pan-London and local levels
- Immediate contribution of resources, capacity and capability from each of the parties to deliver a joint business case and plan across boroughs, the GLA, NHS England, PHE, CCGs and Providers. This would include an articulation of the benefits to be achieved and a plan for their realisation.
- Development of a business plan and associated business case for delivering sustainable transformation through the use of devolved funding to be completed by summer 2016

London Pilots: collaborative transformation

London boroughs have embraced their new public health roles and are innovating to find better ways of engaging with their communities on health and healthy lifestyles, improving public health services, using their regulatory powers to shape healthier places, making links with other services to impact on wider determinants of health and helping embed more preventative approaches into mainstream service planning. They are collaborating to spread best practice and work together on common challenges. This includes collaborative commissioning, often supported by PHE London, both through boroughs working together in small numbers and through pan-London approaches to HIV Prevention and the impending commissioning of sexual health services. Many of these collaborations are supported regionally by the Mayor's public health-related initiatives such are London healthy schools, TfL's huge investment in cycling and its health transport plan, and a pan London community sports programme, amongst others.

We will continue to build on our existing platforms, including by increasing collaboration on prevention between local government, regional government, PHE and the NHS and by mainstreaming prevention into integrated health and care.

To create a platform for the swifter transformation described in our proposals London will build on this record of collaboration by developing a range of pilot collaborations at both local

level for boroughs and CCGs through Health and Well Being Boards and at sub-regional level:

- at least one Borough/CCG level fully integrated strategy where care, public health and CCG budgets are fully shared;
- at least one sub-regional collaboration across health and local government able to develop a full service transformation strategy;
- at least one sub-regional collaboration producing a strategy to transform the health and care estate and release resources from under-used estate to support investment.

These partnerships will be identified during the autumn of 2015 working up their plans in the months afterwards. As their strategies are established these partnerships should be able to draw down a range of further powers from a menu agreed with government as part of the CSR London proposition process.

Devolution Unlocked as London Becomes Ready

This menu of devolution opportunities to be unlocked subject to certain conditions should include the following proposals:

1. **Supporting local integration:** subject to the approval of joint local multi-year integration plans to transform prevention and out of hospital services, underpinned by pooling of budgets, s75 agreements and robust collaborative delivery mechanisms with clear provider engagement:

    - full devolution of primary care commissioning to Borough/CCG level
    - transformation funding
    - the ability to adopt new payment models and vary national contracts, within a regionally developed framework
    - a streamlined single performance management approach for NHS spend

Case study:
In Greenwich, teams of nurses, social workers, occupational therapists and physiotherapists jointly respond to community emergencies. Immediate intervention has avoided over 2,000 patient admissions and saved over £1m in social care spend

2. **Supporting sub-regional transformation**: subject to the establishment of local government/NHS sub-regional partnerships with a robust business case for transformation of their local health economy and clear governance and implementation structures:

    - NHS England specialised commissioning budgets suitable for managing at the sub-regional level
    - transformation funding

Case study:
King's Health Partners and Southwark and Lambeth Integrated Care are working to improve education, prevention, care outcomes and patient experience across the care system. One project, TALK, gives GPs access to 24/7 consultant geriatrician advice and aims to reduce the burden on urgent care. 56% of calls have resulted in planned rapid access appointments, preventing admissions

- the ability to draw down new payment models and variations to national contracts from a menu of regionally developed alternatives
- a role in decision-making on 'cash support' for providers

3. **Supporting sub-regional estates strategy:** subject to agreement of a sub-regional estates business plan and establishment of robust governance mechanisms:

    - access to NHS capital on the basis of a joint capital strategy between London partners, as is currently being discussed in Manchester
    - power to make capital funding decisions up to a threshold within their envelope
    - make variations in capital charges and the capital tariffs to unlock redevelopment of under-utilised NHS estate
    - Devolved authority to make joint decisions on disposal of NHS estate in line with the sub-regional capital strategy and NHS accounting officer requirements
    - Right to retain the uplift in the value of NHS disposals created through increases in land value that result from the joint capital strategy (allied to pan-London governance to ensure retained income will address need in all parts of London).

4. **Supporting pan-London health and care system transformation:** subject to the establishment of appropriate joint NHS England, CCG and London government structures:

    - NHS England commissioning budgets and responsibilities that are not suitable or for holding at sub-regional level or local levels
    - a joint role in decision-making on 'cash support' for trusts subject to clear and robust plans that link the support to financial recovery and strategic change, with applications being submitted from the London system to DH
    - a role in jointly developing a tariff with NHS England that reflects the cost of NHS services in London and ensure partners have full involvement in proposals to vary the national tariff
    - powers and national resources for developing payment and contracting models
    - An integrated approach to workforce strategy across London with devolved authority for joint design of co-commissioning training to London level and consideration of devolution of HEE budgets consistent with government's wider demand led approach to skills provision
    - making best use of London's share of available improvement resource and funding e.g. NHS IQ

Case study:
A London Prevention Board has been established involving local authorities, CCGs, NHS England, Public Health England and the GLA, which is shaping up proposals for collaborative innovation and work with wider partners to accelerate progress on key population health priorities for the

5. **Supporting pan-London estates strategy**: subject to the establishment of suitable joint NHS and London government governance and management arrangements, aligned with the London Land Commission:

- Protection of London's share of the NHS capital budget for planning purposes as described under *"Requirements on NHS and Government"* below (estimated to be around £1.2 – 1.4 billion per annum for NHS Trusts and primary care estates)
- Power to make capital funding decisions up to the London budget
- London Land Commission (LLC) to have "right of first refusal" on land assembly and disposal in order to increase value in estate disposals with an allied expectation that sub-regional capital strategies are aligned to the wider LLC strategic plans

6. **Supporting pan-London public health improvement**: subject to the establishment of suitable joint GLA and local government governance and management arrangements:

    - The ability to raise the minimum age for purchasing tobacco, alcohol and other harmful substances.
    - The ability to use fiscal measures to reduce the purchasing of tobacco, alcohol and other harmful substances.
    - Power for the Mayor to make health improvement interventions to complement his statutory health inequality duty and functional responsibilities for transport, housing, planning, environment and economic strategy.

Clear joint mechanisms between the government, national NHS bodies and London partners should also be established to work through the detail of conditional devolution. This route should also be prepared to consider further potential devolution or delegation proposals for any level that arise through the development of detailed transformation business cases.

Requirements of NHS and Government

To enable and incentivise partners across London to make accelerate progress on health and care reform in London, we are seeking agreement through the CSR to the following measures:

1. *Financial Levers:*
    - Agreement to future years financial allocations and planning assumptions to give visibility and assurance of funding over a 3 – 5 year period.
    - London's share of all national NHS transformation funding devolved, ring-fencing London's share of the £8 billion additional NHS funding [estimated to be £1.74bn] and delegation of London's share [£38m-£45m per annum] of the £750 million Primary Care Infrastructure Fund subject to a clear agreement on expenditure accountability
    - Agreement to develop a joint capital strategy between NHS England, CCGs and London partners, with joint decision-making and full visibility of the capital budget.
    - Access to NHS capital based on the joint capital strategy and agreed for a 5 year period with the capital strategy being refreshed every two years.

2. *Regulatory and Service Levers:*
    - Full involvement in decisions about provider performance by London partners and the relevant regulatory bodies and delivery of a financial envelope for providers. This to include a commitment to explore with the DH, NHS England

and NHS Improvement a mechanism for devolving the approval of cash support linked to financial recovery and strategic change with applications being submitted from the London system to the DH.

- A process for agreeing with government, NHS England and NHS Improvement how provider regulation in London can better contribute to whole system transformation ambitions
- Agreement by NHS England and Monitor to arrangements where London partners have full involvement in proposals to vary and otherwise reach local agreements related to the national tariff in order to develop innovative payment mechanisms that support the delivery of new models of care.
- Agreement from NHS England and NHS Improvement to consider a single joint appointment across both organisations for activities across London.
- Agreement to streamlining national programmes and devolving NHS England decision-making and powers to the regional level as much as possible.

3. *Public Health Issues Involving other Government Departments:*
   - Agreement to devolve the Work Programme Plus to enable integration of employment support and health, and strengthen the focus on employment outcomes in the NHS mandate (see Chapter 2)
   - Make health a key consideration in the National Planning Policy Framework (Section 2 – Ensuring the Vitality of Town Centres) to strengthen local authorities' ability to reflect health issues in their local plans.
   - Update Planning Policy Guidance, reflecting examples of case law, to embed health and wellbeing eg establishing exclusion zones around infant, children or young person facilities for fast food, alcohol, betting and payday loan outlets.
   - Ensure consistency of approaches by Planning Inspectors to appeals against refusal of permissions on public health grounds.
   - Make health a fifth licensing objective to enable councils to take public health issues into account when making licensing decisions.
   - Amend the Late Night Levy so that the charges are put into a pool under the joint control of the local authority and police, to increase the incentive for areas to use these powers because they will be able to determine locally the appropriate balance of spending on prevention and policing.
   - Additional regulatory powers for London boroughs and the London Mayor including:
     - Give councils power to determine permitted development rights – to enable them to balance local considerations, which would enable them to consider health alongside growth and other factors.
     - Give councils the power to set regular review periods for alcohol licences.
     - Give councils the power to vary business rates, to enable them to consider health implications alongside growth and other local factors, eg to incentivise the provision of healthy food options.
     - Agreement to continue to work with London partners to develop additional powers as required

Agenda Item 9

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **10 December 2015**	**Agenda - Part: 1** | **Item: 9** **Subject: Stroke and Dementia Prevention** **Wards:**
Dr Tha Han Mr Gosaye Fida	**Approved by:** Dr Shahed Ahmed

1. EXECUTIVE SUMMARY

Colleagues from Public Health and CCG met to discuss the potential bid for health devolution for prevention of stroke and dementia. Although the bid was not submitted, it was felt that the HWB would be interested in the thinking.

Cardiovascular disease (CVD) is the biggest contributor to the life expectancy gap in Enfield; and the burden of stroke and dementia on the individuals, community, health and social care sector, is increasing. However, substantial proportion of stroke and dementia can be avoided by prevention, early detection and effective treatment. Moreover, preventing stroke and dementia will be in line with Health and Wellbeing Board strategic priorities. This paper will discuss the evidence around what could be done to prevent stroke and dementia with limited resources that will bring maximum return on investment for Enfield's health and social care economy.

In Enfield, the over 65 year-old population is likely to rise to 50,000 by 2025. In addition, the premature mortality rate from stroke in Enfield is higher than London and England average. Evidence suggests that substantial proportion of stroke and dementia can be avoided by early detection and effective treatment of their risk factors such as high blood pressure (hypertension), high cholesterol and atrial fibrillation (AF) alongside effective lifestyle interventions at a population level.

In Enfield around 650 people with known atrial fibrillation (AF) are not on anti-coagulants although they are clinically eligible. A further 2,700 people are estimated not to know they have AF. Likewise about 30,000 people are living with high blood pressure without knowing they have the condition.

Currently there are 1,888 people recorded as having dementia in Enfield. The analysis of Alzheimer society suggested that the economic impact of dementia in Enfield is likely to be about £60.9 million annually.

Enfield has also financial challenge as ECCG allocation in 2015/16 is 4.34% below target, which is equivalent to a £16.369m shortfall. Enfield Public Health is also faced with similar under allocation of budget. In 2014/15 Enfield's public health allocation was £43 per person, lower than the London average of £68 per person. These factors will inevitably limit the resources available for primary (lifestyle interventions) and secondary preventions.

Despite the challenges, Enfield has had a good track record in managing risk factors for cardiovascular disease, implementing healthy lifestyle initiatives for physical activity, smoking cessation, diet and nutrition, and tackling excess alcohol

consumption whilst also managing complex case of cardiovascular disease within the community.

RECOMMENDATIONS

Members of the Health and Wellbeing Board (HWB) are asked to note the content of this report.

3. BACKGROUND

Stroke and vascular dementia are the largest causes of disability and suffering in England. Nevertheless, substantial proportion of cardiovascular disease including stroke and dementia can be avoided by prevention, early detection and effective treatment.

Reductions in smoking prevalence and improvements in the detection and management of risk factors for cardiovascular diseases (CVD) have undoubtedly made a major contribution to the observed reductions in cardiovascular mortality. Despite reduction in cardiovascular mortality in recent years, Enfield still has higher rates of obesity and overweight than statistical neighbours, and higher prevalence of diabetes, making it a good ground for new incidences of stroke and vascular dementia in the years to come.

Enfield is also 14th of most deprived of the 32 London boroughs. 12 of Enfield twenty-one wards are the most deprived wards in England.

Enfield is also faced with a number of challenges to tackle the gap in life expectancy and health inequalities**.** Amongst the challenges include high levels of poverty, high levels of population mobility, and low public health and ECCG allocation that has all had impact on the depth and breadth of investment in preventive interventions.

2.0 Risk factors for stroke and dementia

Hypertension, diabetes, atrial fibrillation, smoking, poor diet, obesity and unhealthy workplaces are all risk factors for stroke and dementia. There is an excellent evidence base for stroke prevention in the short, medium and long term. Most of these risk factors are modifiable with sustained investment in lifestyle and secondary preventions in the primary care.

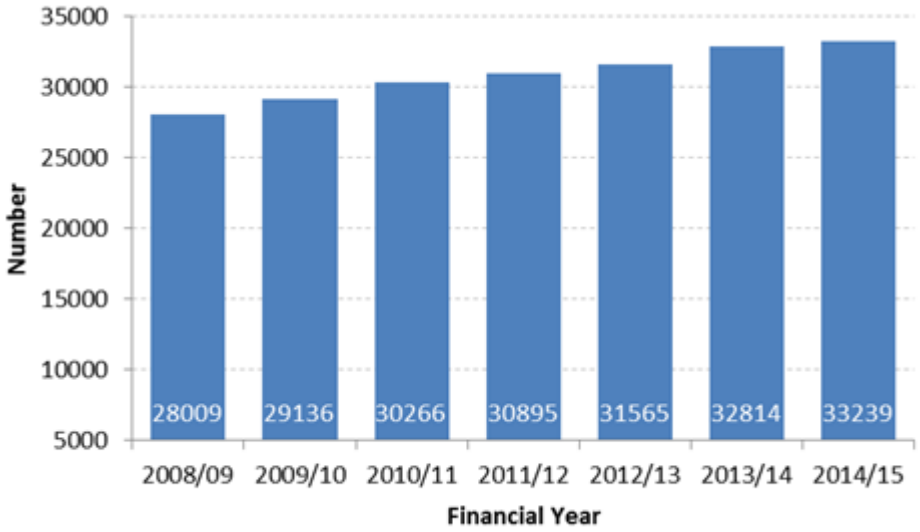
3.0 Track record of success

Enfield has a track record in managing risk factors to stroke and cardiovascular disease that would otherwise lead to increased risk of vascular dementia.

3.1 Hypertension

- In Enfield, is making a good progress over the years in identifying and controlling those with blood pressure. In 2014/15 there were additional 5230 people compared to the baseline year (2008.09) who had their high blood pressure controlled making the total number of patients with early detection and management of their blood pressure to 33,239 in the borough (figure-1).

Figure-1 The number of people whose blood pressure is controlled

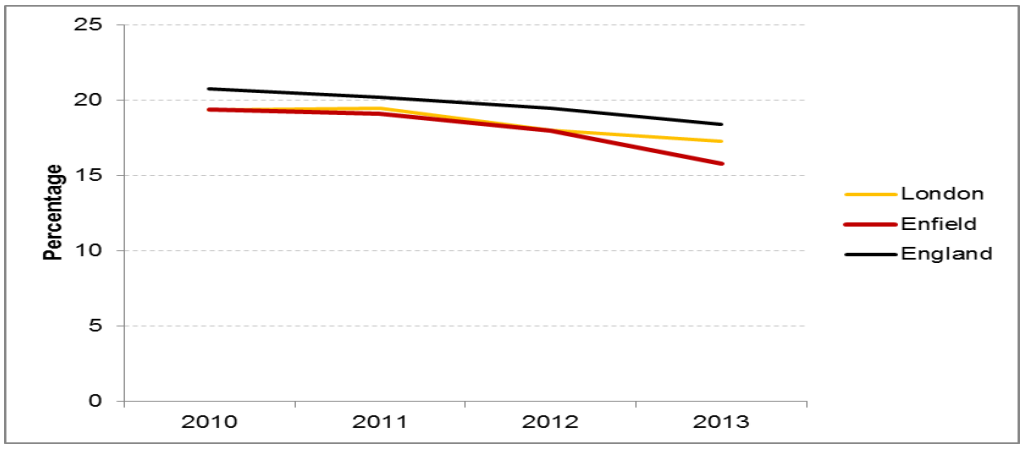


Source: Quality and Outcomes Framework (QOF), Health and Social Care Information Centre

3.2 Smoking

- Following the establishment of a Tobacco Control Alliance in 2010, Enfield's adult smoking prevalence is down to about New York levels. Smoking prevalence in Enfield continues to decrease – it is now 13.6% compared to 17% in London and 18% in England.
- Smoking prevalence amongst 15 year olds is 3.5%; the second lowest in 32 London boroughs

Figure-2 Declining trend in smoking prevalence in Enfield

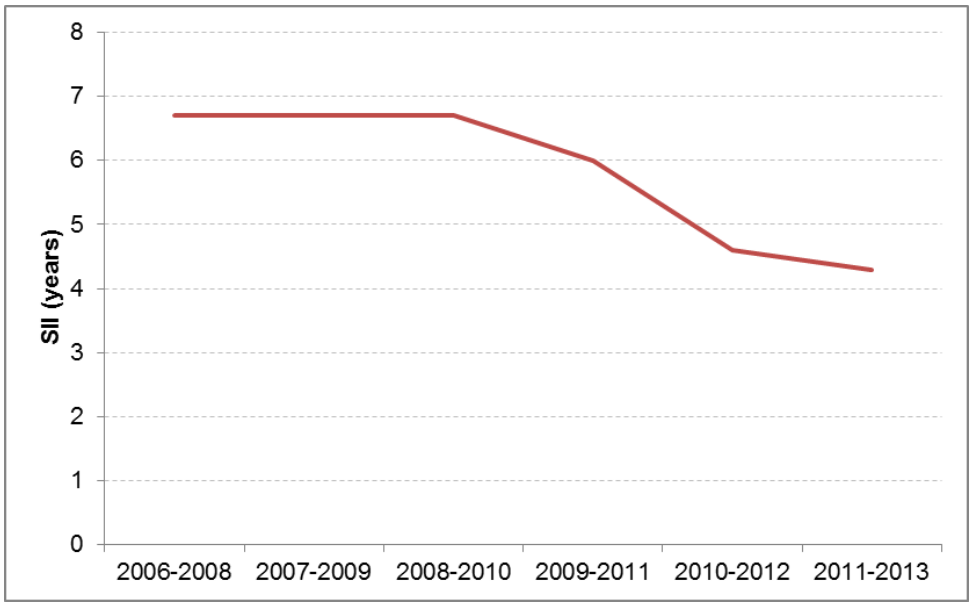


Source : Enfield Public Health

3.4 Reduction in Inequality

Life expectancy in Enfield has improved and there has been a major decrease in inequality for women. The measure of inequality called “Slope Index of Inequality” for Enfield shows a decrease in life expectancy in female population from 6.7 years, in 2008-2010, to 4.3 years in 2011-2013 (*Figure 3*).

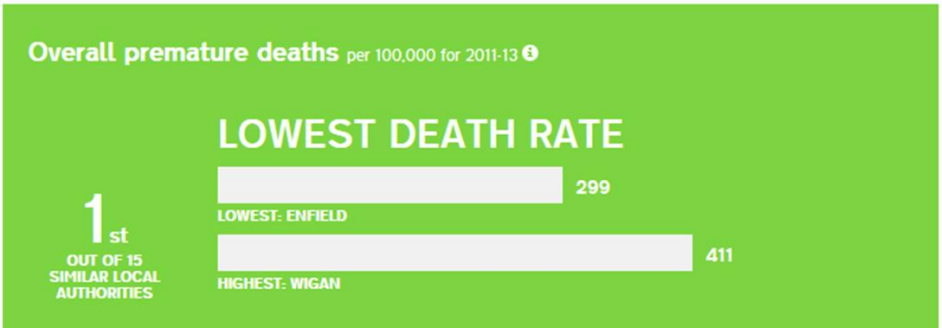
Figure-3 Trend of Slope Index of Inequality for Females, Enfield, 2006-2008 to 2011-2013



Source: Public Health Outcomes Framework, Public Health England

3.5 Best Premature Mortality in our peer group

All cause mortality for people aged under 75 years (referred as premature mortality) in Enfield is the lowest amongst the 15 local authorities with similar characteristics.



Source: Longer Lives, Public Health England

Other areas of performance where Enfield has made a good progress and in some respect exceeded performance of statistical peers:

- Best performing among statistical peers in premature mortality from Coronary Heart Disease, acute Myocardial Infarction and lung, colorectal cancer and survival of breast, lung and colorectal cancer.
- Reduced risk of stroke in patients with diabetes
- Reduced mortality from Chronic Obstructive Pulmonary Disease (COPD) for over 75 years old.
- One of cost effective stop smoking service that has higher success rate (61%) of quit than London and England average and has achieved the national quit target.

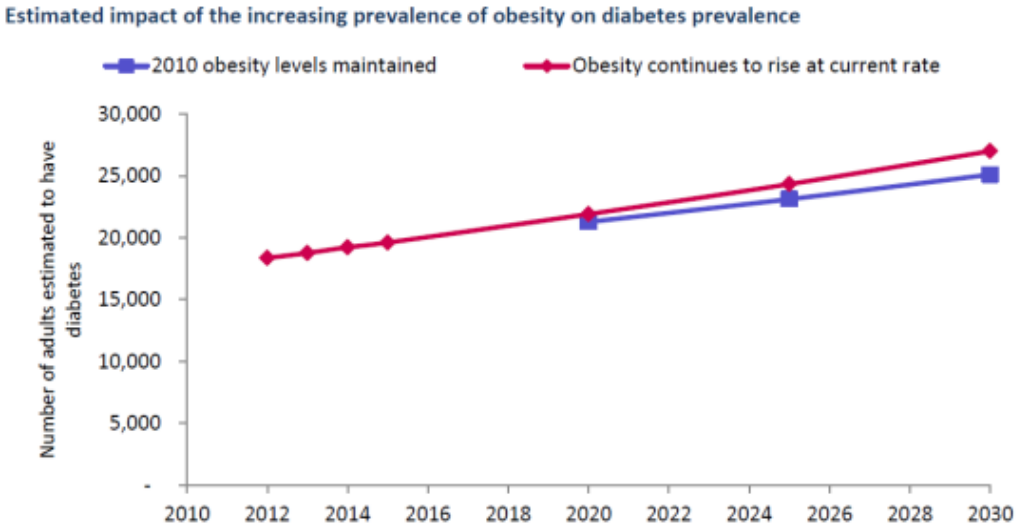
4.0 Case for change

Whilst Enfield is making a good progress in its commissioning of primary and secondary prevention to reduce the risk of cardiovascular disease, there are areas of concern that needs attention:

- Enfield has a population of about 324,000 and eighth of whom are 65 years or older (around 42,000 people), which is higher than London average of 11.5%.

- In the coming years, the number of people over 65 year old population likely to rise to 50,000 by 2025 and people with diabetes to almost double from the current 18,000 to 30,000 by 2030. Evidence suggests obesity account for 80-85% of the risk of developing type 2 diabetes; and it is likely that the rise in obesity in Enfield will contribute to the number of diabetes cases over the years (*figure-4*).

Figure-4 Estimated prevalence of diabetes



Source: National Diabetes Information Service using data from YHPHO diabetes model

We need to control the level of obesity in our population to maintain the prevalence of diabetes at the current level or below. Patients with cardiovascular risk factors such as diabetes and hypertension are likely to have the most complications and cost health and social care the greatest amount of money.

In Enfield, the prevention, early detection and management of many risk factors are improving however; they are long way away from having optimum impact on the burden of cardiovascular disease ;

For example,

- We have 41,041 people diagnosed with hypertension, and 9,476 of these patients blood pressure are not controlled properly adding 26,000 people living with undiagnosed hypertension.

- There were 309 emergency admissions due to stroke in Enfield in 2012/13. This equated to standardised rate of 120.4 per 100,000, as compared to England average of 125.2 per 100,000.

- In Enfield there are around 3,700 people who have previous history of stroke or Transient Ischemic Attack (TIA) and 7,700 people with Coronary Heart Disease and 1,800 people living with undiagnosed diabetes.

- Enfield's recorded prevalence of Diabetes is 7.1%, the 7th highest rate amongst London boroughs. The prevalence is above both London (6.1%) and England (6.4%) averages.

- Enfield has (80.9%) patients with hypertension whose BP is managed effectively. Although we are making good progress, our achievement to date is lower than the London average of 82.1% and 83.6% England average figure.

- Percentage of patients with diabetes in Enfield who has controlled blood pressure (89.4%) was the 5th lowest in the London boroughs, and below London (90.6%) and England (91.4%) averages.

- Whilst our performance in managing blood glucose (HbA1c<7) is reasonable; Data from 2013/14 a shows, there are about 2700 patients with HbAlc >9 in Enfield.

- Enfield has the 4th highest hospital admissions rate for diabetes in female in London and the most deprived part of the borough being 2.5 times likely to have diabetes.

- In Enfield there are around 3,700 people who have previous history of stroke or Transient Ischemic Attack (TIA) and 7,700 people with coronary heart disease and 1,800 people living with undiagnosed diabetes.

- There were 309 emergency admissions due to stroke in Enfield in 2013/14. This equated to standardised ratio of 120.4, which means that the rate in Enfield was 20.4% higher than expected based on the England average.

- Every year, around 130 people die from stroke in Enfield, around 35 of those are residents aged under 75 year olds.

- In Enfield around 650 people with known atrial fibrillation are not on anti-coagulants although they are eligible. A further 2,700 people are estimated not to know they have AF.

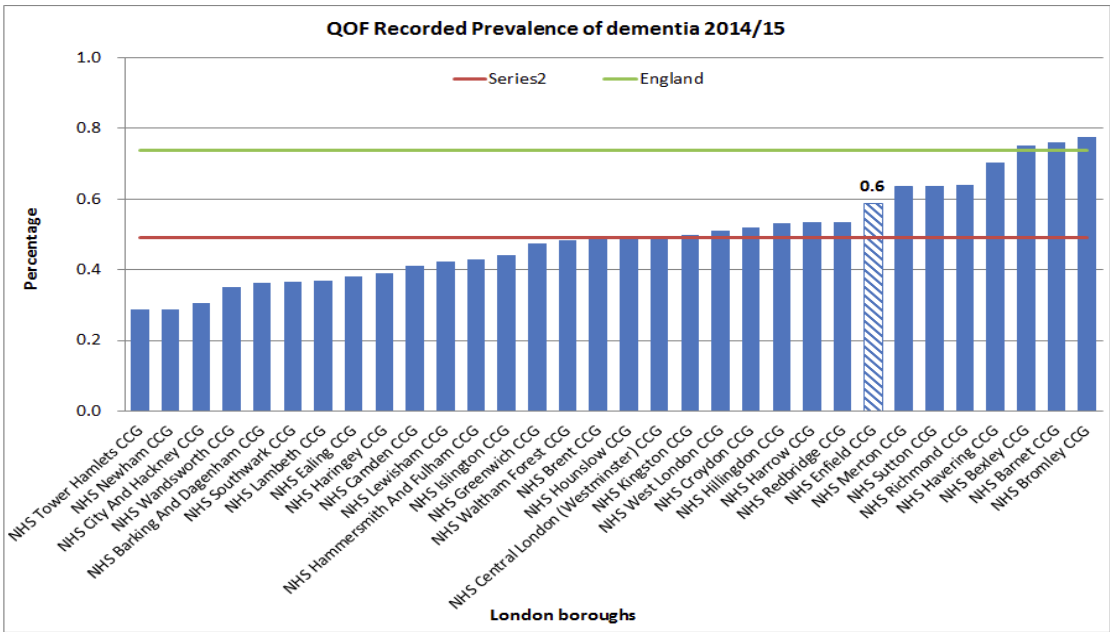
NHS England published commissioning guide in which it indicate the opportunities for CCG's to improve their commissioning outcomes, quality and efficiency if in ten areas of programme expenditure with highest spend. For Enfield, there is an opportunity to improve, may be increase efficiency savings, in cardiovascular disease commissioning if the ECCG were to equal it's commissioning to England average or bench mark.

5.0 Dementia diagnosis

Dementia is a term for a range of progressive, terminal organic brain diseases. Symptoms include loss of memory, a decline in reasoning and communication skills as well as a gradual loss of skills needed to carry out daily functions and activities. Vascular dementia is the second most common form of dementia and can develop following a stroke.

The number of people with dementia is expected to increase in Enfield by approximately 20% over the next 8 years. In addition, there is an growing concern with undiagnosed dementia in the high risk group. Dementia prevalence in Enfield is higher than England average and most of our statistical neighbours (*figure-5*)

Figure-5 Dementia prevalence, 2014/15



Source: Public Health Outcomes Framework, Public Health England

There are however, a number of measures that can be used to help people cope with the symptoms of dementia and slow down the symptoms. Early diagnosis is therefore important in managing the disease and assists in getting appropriate support.

Recent evidence suggests that up to 72% of patients have some form of cognitive impairment after a stroke and secondary stroke prevention could reduce the incidence of vascular dementia. Thus, living healthy lifestyle can protect against the risk of developing cardiovascular disease and reduce the risk of developing vascular dementia. With early diagnosis and treatment it's possible to improve the quality of life for people affected by dementia.

6.0 Progress to date on tackling risk factors for Stroke and Dementia

In the section below we have outline some of the initiatives which have contributed to Enfield CCG and Council success in recent years could benefit with sustained investment to continue;

- Working with University College London Partnership (UCLP) in Enfield set up a pilot scheme called HILO' to facilitating High blood pressure control and lipid lowering prevention programme in patients at high risk of cardiovascular disease. The results are promising and the lesson from this if rolled out could benefit to tackle the raise of blood pressure in Enfield and beyond.

- Working with UCLP we have established an atrial fibrillation pilot to identify those at risk and provide medication for eligible patients to reduce risk of stroke.

- We have established in South East Enfield Diabetes Multi-disciplinary Team (MDT) meetings which are beginning to show real improvements to management of complex diabetes cases.

- We have established structured patient education programmes for diabetes called “conversation maps”, particularly targeted at deprived ethnic minority populations.

- We have placed health kiosks in virtually every GP practice to encourage assessment of risk of blood pressure.

- We have funded hypertension training provided by British Heart Foundation (BHF) for primary care professionals in Enfield.

- On the back of our Upper Edmonton Life Expectancy Conference, Health Education England funded (via NUMH) a health bus which visited our most deprived areas and identify numerous cases of undiagnosed hypertension cases.

- We have secured Haringey & Enfield North Central London (HENCL) funding for diabetes training for healthcare professionals in Enfield

- We have 1 Gold, 2 Silver and 17 bronze healthy schools awards; one of the best amongst the most in London Borough of Enfield

- We are the first local authority in the London to achieve GLA healthy workplace award and are rolling this out to other employers in the borough.

- Both Enfield CCG and previously Barnet and Chase Farm Hospitals have participated in the Global Corporate Challenge to improve staff health pilot.

- We work with local voluntary organisations and community groups, to identify the local community health and social care needs, develop and deliver strategies. e.g., work with Tobacco Control Alliance.

- Working in partnership with academic, voluntary sector, London and national NHS commissioning organisations to tackle risk of cardiovascular disease and stroke.

- NHS Health check is an intervention designed to detect ten year risk of vascular disease of adults aged 40 to 74 years old. In 2014-15 Enfield delivered 8083 health checks and identified at risk of cardiovascular disease (ten year risk ranging from 0 to 22%) and referred them to receive appropriate medication sign up to life style interventions.

- Enfield Health Trainers provide practical support to people wishing to improve their lifestyle. Approximately 80% of referrals to the service are related to obesity, physical activity or healthy eating. In 2014/15 financial year the service had 1598 clients' cases of which 901 were referrals GP practices.

- We have maintained funding for Smoking Cessation programme which has delivered 1604 quit in 2014/15.

- We are aiming to reach for 2 million in leisure centre Sports attendances this year.

- Enfield has received £30million grant from Greater London Authority to improve cycling in the borough.

7.0 Financial Implications

There is no specific financial implication for HWB to consider in this report; however, it will be important for the board to be aware of the possible impact of any savings made in the future on stroke and dementia prevention. The points below highlight some of the resource implications worth taking a note;

- NICE estimated that by providing anti-coagulant for eligible patients with Atrial Fibrillation (AF), £224,000/100,000 could be saved from stroke treatment. In Enfield, this could be about £552,124 per annum.

- The overall economic impact of dementia in the UK is estimated at an average annual cost of £32,250 per person (Alzheimer's Society).Given the number of people with dementia in Enfield (1880) the current economic impact of dementia is likely to be about £60.9 million annually in the borough.

- Evidence from 2013/14 data shows that diabetes related complications (Myocardial Infarction, Heart Failure, Stroke (Chronic Kidney and Renal Replacement) cost as high as £5,948,466 in Enfield.

- AF is a major risk factor for stroke and is a contributing factor to one in five strokes. Early detection and treatment could prevent irreparable damage to the heart and reduce the risk of stroke, heart failure and other long-term complications.

- Evidence from UK Stroke Association shows in Enfield 657 patients with AF eligible for ant-coagulant didn't receive the treatment.

- We have 26,000 people living with undiagnosed hypertension and Enfield's has diabetes prevalence (7.1%), the 7th highest rate amongst London borough; a prevalence.

HWB are asked to take a note that the long term risks of under investment in the above preventive interventions (both lifestyle and secondary prevention) will result in further increase in the number of patients who would need a complex

package of care at later stage and may increase unnecessary hospital admissions and social care cost.

For further details on Enfield Health and Wellbeing Board (HWB) priorities for cardiovascular disease and healthy lifestyle please see appendix-1

Appendix-1

Impact on priorities of Health and Wellbeing Board (HWB)

1) Reducing health inequalities – narrowing the gap in life expectancy

Department of Health Cardiovascular Disease (CVD) Outcomes Strategy (2013) identified for commissioners and providers of Health and Social Care services ten key actions that will make a difference in improving outcomes for CVD patients in line with the NHS, Public Health and Adult Social Care Outcomes Frameworks. These were;

1) Managing CVD as a single family of diseases;
2) Improve prevention and risk management;
3) Enhancing case finding in primary care;
4) Better identification of very high risk families/individuals;
5) Better early management and
6) secondary prevention in the community and acute care
7) Improving care for patients living with CVD;
8) Improve end of life care for patients with CVD;
9) Improve intelligence, monitoring and research and support commissioning.

In addition, cardiovascular disease such as stroke and vascular dementia contributes to significant reduction in the gap of life expectancy and health inequalities.

2) Promoting healthy lifestyles and making healthy choices

Promoting healthy lifestyle and making healthy choices by all section of Enfield populations is one of the five key priorities of Enfield HWB. To this end Enfield Public Health has commissioned successful interventions to improve healthy lifestyle.

Cardiovascular disease (CVD) is addressed by several of the priority outcomes of Enfield Health and Well Being Strategy. The key aspirations of the priority outcome are; to work with primary and community care provisions to prevent unnecessary use of services and hospital admissions. More importantly, HWB support the prevention to be at the core of health and social care provisions and encourage services to provide opportunities to increase individual and group to consider changes in behaviours that we know have negative consequences for their health.

Enfield HWB also recognises that in many cases poor health can be avoided through better lifestyle choices and recognising risks to health. HWB advocates that early diagnosis of risks of disease, positive interventions and good quality service delivery will lead to people in Enfield enjoying better health and wellbeing into the future. It also acknowledges the lifestyle choices that people make about diet, exercise, alcohol consumption, smoking and drug use can affect their health and wellbeing.

Appendix-2 Background Papers

1) Public Health Outcome Framework, 2015
2) Department of Health, Cardiovascular Disease strategic outcome, 2013
3) Health and Social Care Act, 2012
4) National Diabetes Audit , Secondary Users Service (SUS) data 2013/14
5) Health and Social Care Information Centre (HSCIC), 2015a)
6) Alzheimer's Society, Dementia 2014. Opportunity for change.
7) Enfield Dementia Strategy 2011-2016
8) Alzheimer society http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=418
9) Enfield Health and Wellbeing Board Strategy, 2014-2019
10) Cognitive Impairment after stroke , 2015 published evidence
11) National Cardiovascular Network for prevalence data , March 2015 PHE
12) Commissioning for value focus pack. Cardiovascular disease (CVD) pathway, Dec, 2014

Glossary of terms

CVD	Cardiovascular Disease
ASC	Adult Social Care
AF	Atrial Fibrillation
RCA	Route Cause Analysis
TIA	Transient Ischemic Attack
HWB	Health and Wellbeing Board
A&E	Accident and Emergency
JSNA	Joint Strategic Needs Assessment
NUMH	North University of Middlesex Hospital
BHF	British Heart Service
HENCL	Haringey Enfield North Central London
HbA1c	Hemoglobin A1c
MDT	Multi-disciplinary Team
ECCG	Enfield Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
UCLP	University College London Partnership

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Agenda Item 10

MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **10 December 2015** **Report of: Director of Public Health** Contact Officer: Miho Yoshizaki Tel: 0208 379 5351 Email: miho.yoshizaki@enfield.gov.uk	**Agenda - Part: 1** | **Item: 10 a** **Subject: Health Improvement Partnership Board Update** **Approved by: Dr Shahed Ahmad**

1. EXECUTIVE SUMMARY

This report summarises the work of the Health Improvement Partnership Board.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to note the contents of this report.

The Health Improvement Partnership is due to meet on Thursday, 10th December 2015.

1.0 HEALTH INEQUALITIES IN THE FIVE PRIORITY WARDS

The Public Health Core offer team coordinates the measures aimed at reducing health inequality. There has been a significant improvement in reducing the health inequality gap, but there have remained significant challenges to life expectancy across the borough. It was determined that 5 wards (Upper Edmonton, Chase, Ponders End, Enfield Lock and Jubilee) should receive discrete interventions in order to tackle this.

Health Intelligence team has been actively supporting programme by providing analyses and evidence. Recently mortality rates by wards were analysed which highlighted the consistently higher mortality rates amongst those five priority wards, in particular, the wide variation in mortality due to cardiovascular disease within Enfield. This gives all the more importance to promote prevention and effective management of the cardiovascular diseases in Enfield to reduce inequality.

2.0 SUPPORTING PRIMARY CARE IMPROVEMENT

2.1 GP practice visits

The Public Health team is meeting with the GP practices in the five wards as a measure to facilitate primary care improvement.

Dean House surgery was visited in mid-October and Evergreen surgery in early November. Three more practices either within or directly related to the 5 high-priority wards are to be visited in December.

Information reviewed / discussed at the meetings –

- Highlighted health issues of the residents of Ponders End, Upper Edmonton and Jubilee.
- Discussed how Public Health and the surgeries can work together to help improve the residents' health status.
- Public Health services currently delivered in Enfield were promoted. These include NHS Smoking Cessation, NHS Healthcheck, and lifestyle services.
- The importance of reducing the variation in primary care performance including screening and immunisation was highlighted.
- How a single-handed GP can tackle diabetes and other long-term condition management: teamwork and dedication to holistic health.
- How challenging cases of high blood pressure and cholesterol were managed with innovative support.
- Exchanged information and ideas on how to improve health of the population and reduce inequality.
- Discussed the challenge of "Population Churn" or turnover in Upper Edmonton.
- Noted the challenge of DNA's both in terms of increasing waiting times for appointments and as a misuse of resources.
- Discussed the challenge of lack of awareness of new customers of the NHS of the mechanism of referral for secondary and other health care.
- Spoke at length about the difficulty of recruiting staff of all grades to work in the Edmonton Green and Upper Edmonton area.

2.2 GP Newsletter

A newsletter on diabetes in Enfield will be sent to GPs in December. This will be used to inform the GPs of progress made so far with diabetes, the challenges ahead and the services available to their patients in Enfield to enable them to live well with diabetes. It should be noted that, although recognition of Enfield GPs is better than London average, there is an increasing demand and higher admissions from complications of diabetes such as renal failure and consequent Renal Replacement Therapy such as dialysis.

3.0 DIABETES

Long term conditions represent a significant cause of morbidity across the borough, and can be greatly influenced by a range of lifestyle factors. There are currently 16,291 patients aged 17 years and older diagnosed with Diabetes in Enfield.

3.1 Diabetes Locally Commissioned Service (LCS)

A pilot to deliver integrated care package within primary care for patients with Type 2 Diabetes was commissioned in South East Enfield Locality. 14 out of 16 practices in the South East Enfield Locality participated in this pilot which ran from December 2014 to September 2015. One of the key elements of this pilot was Multi-disciplinary Team support including Consultant diabetologist and the community diabetes specialist nursing team. Various learning points were raised and recommendations made based on these points.

3.2 National diabetes prevention programme – expression of interest bid

Enfield CCG and Enfield Public Health made a joint expression of interest bid on the National diabetes prevention programme in September and we are still awaiting results from the NHS England.

3.3 Diabetes education in primary care

Using HE NCEL fund, Enfield CCG offered diabetes education in primary care to GP practices across Enfield (January – March 2015). Over 50 delegates (GPs/Practice Nurses/Health Care Assistants) attended the courses and the feedback was excellent.

Patient Structured Education using the Conversation Maps approach will continue to work closely with BME patients with diabetes in Enfield.

4.0 ENHANCING CARDIOLOGY IN PRIMARY CARE LOCALLY COMMISSIONED SERVICE (LCS)

Long term conditions represent a significant cause of morbidity across the borough, and can be greatly influenced by a range of lifestyle factors. The Enfield Joint Health and Wellbeing Strategy 2014-2019 highlight that the largest cause of death in the borough is Cardiovascular Disease (CVD).

4.1 Cardiovascular Disease (CVD) retrospective case review

CVD retrospective case review is in process to better understand the current status in secondary prevention of Cardiovascular Diseases (CVD) following a CVD event such as heart attack or stroke.

450 cases are to be reviewed by the end of this year and report will be prepared for shared learning early next year. Enfield Public Health team will be supporting the analyses.

4.2 Atrial Fibrillation Pilot

AF pilot project in the South East locality is aimed to decrease stroke rates and reduce costs associated with stroke care in the South East Enfield locality. This project intended to improve detection and management of AF in line with the 2012 European Society of Cardiology (ESC) guidelines.

The participating practices identified 61 additional patients with AF thorough the project and saw an overall increase in the percentage of patients who are receiving anticoagulant therapy.

5.0 MAYOR'S CHARITY EVENT ON DEMENTIA

Public Health will be participating in a Dementia Event on the 28th November. The event is intended to focus on the immediate needs of those who are suffering from dementia and their carers, but Public Health will be publicising the entirely practical means of reducing the risks of developing dementia, particularly vascular dementia, through both lifestyle changes and medical interventions.

6.0 EFFICIENCY PROGRAMME (QIPP)

This programme is designed to deliver better quality healthcare at reduced cost. Enfield CCG has a target to save £12.5M through 19 QIPP schemes.

A Public Health consultant and the core offer team support the CCG in the areas of long-term conditions and also works to address clinical pathway issues through the Transformation Programme Board, Clinical reference Group, Long-term Condition Steering Groups and the Quality and Safety Group.

7.0 PUBLIC HEALTH CAMPAIGN

7.1 GP registration promotion campaign

Following a Healthwatch report on GP registration, a GP registration promotion campaign is being undertaken in November in the form of distribution of leaflets across Enfield. A generic leaflet with information on how to register will be distributed across Enfield using a housing newsletter mail drop. Leaflets with schematic ward maps will be distributed, by door-to-door drop, to all households in the 5 priority wards. The maps show the location of the GPs in the wards and the immediate vicinity and relevant bus routes. Active travel is also encouraged by putting walking distance times around GPs. Adverts will also be distributed at libraries and groceries.

8.0 JOINT STRATEGIC NEEDS ASSESSMENT UPDATE

Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (JHWSs), through the health and

wellbeing board. The purpose of the JSNA is to inform the way in which decisions about health, wellbeing and social care services are planned and arranged.

The Enfield JSNA is available on the Enfield Health and Wellbeing website at http://www.enfield.gov.uk/healthandwellbeing/jsna.

The contents are being reviewed and updated to ensure it remains relevant and a useful tool and resource for commissioners, policy makers, local people and other key stakeholders.

The maintenance of Enfield JSNA is led by the Public Health Intelligence team, and the maintenance process is overseen by the JSNA steering group which membership includes Local Authority, CCG and Community and Voluntary sector colleagues. The JSNA steering group meets quarterly and the last meeting was in October 2015.

Data and contents update is progressing well with the support from various stakeholders at LBE and Enfield CCG. We will continue to update the data and contents as appropriate. Since September 2015, following sections are either being updated on the web or being reviewed by lead consultant.

- Child Poverty
- HIV and Sexual Health
- Learning Disability and Autism
- Circulatory Disease
- All Respiratory Disease
- Cancer
- Health Inequalities
- Prevention - Immunisations, Screening, and Health Checks

9.0 QUALITY AND OUTCOMES FRAMEWORK (QOF) 2014/15 HEADLINE REPORT

QOF is the annual reward and incentive programme detailing the GP practice achievement results. The data for 2014/15 was published at the end of October 2015. Health Intelligence team produced a Headline Report summarising Enfield's achievements and analysing trends. The report highlighted increasing demand for major Long Term Conditions (increasing prevalence) and further opportunities for improvements in managing these conditions such as effective control of blood pressure.

10.0 PUBLIC HEALTH SERVICES FOR 0-5 YEARS

From 1 October 2015, the responsibility for commissioning Health Visiting and Family Nurse Partnership services transferred from NHS England to local authorities. The rationale behind this move is that local authorities know their communities and have a better understanding of local needs so they are in a more informed position to commission the services.

Funding for the 0-5 budget will sit within the overall public health budget and is ring-fenced to March 2017.

A review at twelve months, involving Public Health England (PHE) will inform future commissioning arrangements.

Child Health Information Systems (CHIS) and the 6-8 week GP check (Child Health surveillance) have not transferred to local authorities, although the CHIS service is expected to transfer in 2020.

Health Visitors and Family Nurses continue to be employed by the provider, which is currently Barnet Enfield and Haringey Mental Health Trust.

10.1 Health Visiting

Health visiting is a universal service that provides a professional public health service based on evidence of what works for individuals, families, groups and communities.

Health visitors are highly trained specialist community health nurses, skilled at spotting early issues that may develop into problems or risks to the family if not addressed.

The service will vary according to the personalised assessment of each particular family and what will work for them. They lead the delivery of the 0-5 elements of the Healthy Child programme in partnership with other social care colleagues, which places them in a strategic position to tackle and reduce infant mortality because they work closely with the parent and family from pre-natal, during pregnancy, post- natal until the child starts school at 5 years.

Health visitors are mandated to undertake:

- an antenatal visit,
- visit new born babies at home between 10 and 14 days, and
- undertake a 6-8 week review, followed by
- another review at one year and
- a further review at 2 - 2½ years,

and focus on six early year's high impact areas including;

(i) maternal mental health,
(ii) transition to parenthood,
(iii) breastfeeding,
(iv) healthy weight,
(v) managing minor illnesses / accident prevention and health and wellbeing.

This facilitates regular contact with families and their children at the most challenging times of their lives and plays a key role in early detection of potential risk factors of infant mortality and child development.

One of the strengths of health visiting is that by visiting families in their homes, they are able to take a holistic view of the family and their needs. Through regular contact and with appropriate training, health visitors can influence mothers, fathers and family members to develop healthy behaviours (including increasing physical activity and maintaining a healthy weight) associated with improved wellbeing. In addition, health visitors can encourage greater physical activity among children by providing relevant information to families and working with partners to develop greater opportunities to be physically active within

10.2 Family Nurse Partnership (FNP)

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

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

The criteria for eligibility to be offered the programme are:

- All first time mothers aged 19 and under at conception;
- Enfield residents;
- Eligible if previous pregnancy ended in miscarriage, termination, still birth;
- Enrolment should be as early as possible in pregnancy and no later than the 28th week of pregnancy. 60% should be enrolled by the 16th week of pregnancy.
- Women who plan to have their child adopted or have had a previous live birth are excluded from the programme.

The FNP programme is overseen by a FNP Advisory Board (FAB) chaired by the Assistant Director Commissioning and Community Engagement, Schools and Children's Services.

In the last 12 months:

- 37 clients were enrolled, of whom 41% were enrolled by the 16th week of pregnancy (the target is 60%);
- 75% of those who were offered the programme enrolled, which meant that the target of 75% was achieved;
- 44 pregnancies, 19 infancies and 5 toddlerhood graduations were completed.

There are an increasing number of vulnerable, complex and safeguarding issues within the families enrolled onto the programme.

A strategic vision for FNP in Enfield is being developed as part of the borough's wider maternity and children's services. FNP aligns with the Healthy Child Programme and will be included in future commissioning plans for the wider Health Visiting service.

11.0 SCHOOL NURSING

School nursing service provides a service to all the Council-funded schools in the borough. School nurses assist with safeguarding, health promotion, can advise on health matters and help with training on long term medical conditions (e.g. how to use EpiPens) to help every child attend school and reach their potential. School nurses also deliver the school aged national immunisation programme to all schools in the borough.

Children can self-refer to school nursing or can be referred by school staff, social services, the looked after children nurse specialists, child protection nurses or medical colleagues.

There are plans to co-commission an immunisations service with NHSE and to develop a traded service for school nursing to be offered to academies, free schools and independent schools in the borough.

School nursing will be reviewed in the next year to ensure value for money and assure clinical quality and governance.

12.0 SCREENING AND IMMUNISATION

The latest immunisation data suggest an increase in coverage, but these have not been validated and are not available for dissemination yet. Flu vaccination has commenced in schools, but uptake so far has been very low. It is thought that this is due to the use of gelatine in the nasal spray and we have a meeting with NHSE to discuss this and explore what other boroughs have done to address the issue.

The team is working with NHS England to assure the Council of screening programmes in the borough and have invited NHSE to attend the upcoming Scrutiny sessions. The new public health practitioner has also been discussing antenatal and newborn screening with the local maternity units and with NHSE.

13.0 HEALTH PROTECTION

Guinea reported its last case of Ebola virus disease on 29th October and that case has now tested negative. There have not been any cases in November. Sierra Leone was declared Ebola free on 7 November and is now in a 90-day period of enhanced surveillance. Liberia was declared Ebola free, but has unfortunately reported cases in the last few weeks.

There have been cases of Polio in Ukraine, but no instances in European countries. We remain vigilant for the signs of infectious diseases in the borough.

14.0 AIR QUALITY – SEEK TO REDUCE EMISSIONS FROM VEHICLE IDLING

A bid was submitted to the Mayor's Air Quality Fund with the ambition of making Enfield idle-free by 2020. There are several strands to this project which include engagement with schools, the community and local businesses. Specific campaign/target areas include level crossings, outside schools, air quality hot spots, taxi ranks, stations and at key junctions where people are likely to be waiting for over a minute for the lights to change.

Commissioning some "Air Aware" lessons within schools, separate to the bid but will complement it, if it is successful.

15.0 CYCLE ENFIELD

Plans for a pedestrian and cycle-friendly transformation of Palmers Green and Winchmore Hill have received a major boost after they won the backing of local people.

The plans for Palmers Green, which are being funded through the Mayor of London's £30 million Mini Holland fund, will see the town centre improved with wider pavements, more trees, bike lanes, landscaping, and more car parking.

There will be extra parking spaces serving the shopping area and there will also be major improvements to the Winchmore Hill area with a safe, separated cycle track running from Palmers Green to Enfield Town allowing people to make local journeys by bike instead of car.

In all, 60 per cent of the 1,646 people consulted said they supported the plans, while just 40 percent were opposed to them. The Palmers Green proposals will be submitted to Transport for London for approval, and, if obtained, work will start in the Spring of 2016.

16.0 HEALTHY WEIGHT STRATEGY

The Healthy Weight Strategy will be presented to the CCG and Health Improvement Partnership in December.

17.0 HEALTH CHECKS

Backdated health check data indicates that the number of health checks received in Q1 has risen from 1,297 to 2,416. In Q2 data indicates 1604 were received with a cumulative Q2 total of 4020.

18.0 TOBACCO CONTROL

Two surveys appear to indicate that smoking prevalence in Enfield is falling;

- the What about YOUth survey of 298,080 15 year olds showed that Enfield has the second lowest rate of current 15 year old smokers in the country (3.5%)

- the Integrated Household Survey (HIS) (340,000 respondents) has indicated that smoking prevalence in the borough has fallen from 15.8% in 2013 to 13.6% in 2014. This represents approximately 5,000 fewer smokers than we'd expect given the 2013 prevalence.

The most recent national campaign was Stoptober. An event for Stoptober took place on 10th September 2015 at Edmonton Green Shopping Centre (outside Asda) which was covered in the local press and supported by Cllrs Keazor and Brett. This year's themes was humour and 3 comedians (two English and one Turkish), distributed stop smoking materials. 39 client's and seven staff signed up for Stoptober.

The Christmas / New Year campaign is being developed but is likely to focus on finance.

19.0 BUSINESS AND ECONOMIC DEVELOPMENT

Three young people who had all recently experienced severe mental health problems were referred to JOBSnet for structured work placements from the Public Health department. These included working in Business and Economic Development, Legal Services and Serco within the Council. The placements all responded well to individual 1:1s, mentoring and support and employability workshops based around their CV, applications and interview skills.
They all had a very enjoyable and beneficial experience and felt that they had received a lot of useful information. Through this intervention one of the placements has now been recruited as an apprentice in the Council's IT department.

The job brokerage team has been trained in giving health advice on smoking, diet and exercise as part of the offer to support people towards the labour market. Staffs are working together on an ESF bid aimed at supporting people with common mental health problems towards employment as part of a 10-boorugh sub-regional submission led by Hackney Council.

20.0 MENTAL HEALTH

Environment & Regeneration Public Health are producing a draft Mental Health Promotion Action Plan and this should be available by the end of the year, which will identify the top three indicators.

21.0 PUBLIC REALM

- The Council have 17 outdoor gyms that provide free access to exercise equipment for a high proportion of the residents within the borough
- We will soon begin a consultation on the installation of a new outdoor gym within Town Park
- We have two community food growing schemes in the borough, which have started to provide healthy food for the community
- We support a range of running and walking events in the borough, some of which are free of charge, which enables the community to both exercise and socialise.
- This year we have invested over £80,000 in new equipment and pitch enhancements

22.0 DAAT

The latest data for the 12 month rolling period October 2014 to September 2015 is confirming that Enfield has seen 1055 drug users for treatment during the year. This is a marked improvement over the previous excellent performance already achieved. Enfield remains strong in respect of its London ranking for the Numbers of Drug Users in Treatment as it is currently placed 13th; against an investment ranking of 20th. The Number of Successful Treatment Drug Completions has improved even further and now reached 25%; 5.1% above the London average and 9.7% above the National average. The DAAT is currently ranking 8th in London for Successful Treatment Drug Completions.

The number of alcohol users in treatment has remained stable and is consistently good with 354 alcohol users taking up Treatment during the latest 12 month rolling period. It is pleasing to note that the quality in provision has also continued to improve as the Successful Treatment Completion rate is 45.2% which is 3.9% above the London average and 6.1% above the National average. The Enfield ranking for Alcohol Successful Completions is now 7th in London.

The Number of Young People in drug or alcohol treatment for the full year 2014-15 was 175. The Planned Treatment Exit Rate remains very good at 93%; which is 13% above the National Average and 16% above the performance achieved to the same period last year.

The most recent performance for young people has confirmed that 175 young people received substance misuse treatment for the 12 month period up to June 2015. 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.

Enfield DAAT Partnership Board has to also prioritise drug and alcohol related crime reduction initiatives and it receives designated funding from the Mayor's Office for Police and Crime (MOPAC) for this purpose. The performance measures for drug and alcohol crime reduction are as follows:-

- The key target is the Percentage of Drug and Alcohol Offenders with Reduced Offending and Q2 is showing that Enfield has achieved 26.2% against a target of at least 20%;
- The target for Successful Treatment Drug Completions has to be above the London average of 19.6% and Enfield is currently achieving 35.1%;
- The target for the Numbers of Drug and Alcohol Users in Treatment in the crime reduction service was based upon the 2013/14 Baseline of 149 with a 40% minimum growth factored in to equal 208. Enfield is currently achieving 319 for the latest 12 month rolling period.

23.0 SEXUAL HEALTH

The Council has the responsibility for:-

- Integrated Sexual Health Community Services, which is delivered by NMUH; and
- LARC, which is delivered by the borough's GPs

The Integrated Sexual Health Community Services contract delivers GUM treatment for all Enfield residents and Contraception for those not registered with an Enfield GP.

The contract includes specialised Sexual Health Outreach Nurses for young people (4YP) and will be working with voluntary organisations to improve relations with the population identified as 'hard to reach' – sex workers, DAATrs as well as the LGBGTT and BME population.

The opening hours will increase by 25%:-

- Monday – Friday 8am – 7pm;
- Weekends 9am – 2pm

The new service model will commence on a phase basis based on the service moving to the new locations:-

- Burleigh Way: 01 January 2016 commencement;
- Enfield Highway: 01 April 2016 commencement,

The Council has contractual agreements with 27 of the Borough's GPs to deliver Long Active Reversible Contraception (LARC). Activity is steadily increasing and is expected to continue to grow as the new contractor for Integrated Sexual Health Community Services will be training and supporting the GPs with this service.

24.0 UPDATE ON PUBLIC HEALTH GRANT

Public Health England (PHE) consulted on the formula for the future *target* grant allocation and Enfield Council has submitted a response. Since then the comprehensive spending review announced reductions to the national public health budget. No proposals about how this will be implemented have been produced by government.

25.0 ROYAL FREE UPDATE

Following the acquisition of Barnet and Chase Farm (BCF) by the Royal Free London NHS Foundation Trust (RFL) the Clinical Pathway Redesign Programme seeks to align pathways across the local health economy between the 5 CCGs (Barnet, Camden, Enfield, Herts Valley and E&N Herts) and RFL to ensure that services are financially and clinically sustainable.

There are a total of 45 pathways which were designed across 8 specialities.

25.1 Pathways

The Trust has agreement to roll out all clinical pathways in Enfield CCG. Meetings have begun to look at launching the Dermatology pathways and associated services in the New Year. To date the Trust has also launched pathways in Barnet and East and North Herts CCGs with agreement to launch all pathways in Herts Valley CCG, which will begin the early 2016.

Pathways will be launched in phases working with local CCGs and GPs to identify areas of need that the pathways can help address.

In order to compliment the pathways the trust has started an internal transformation programme ensuring that it has the right services in place to meet the changing demand.

25.2 Cancer

An internal piece of work is underway to map all the cancer pathways across the expanded trust. The aim is to ensure that pathways are integrated and streamlined and that services adapt in order to meet the changing demands. This is reflected in the rebuild of Chase Farm with the expanded Breast, Endoscopy and Chemotherapy services on site.

25.3 Clinical Advice and Navigation (CAN)

A key component to ensuring that GPs have access to fast consultant opinion on patients being managed in primary care, CAN is one of the key enablers to the pathway work. To date the following services have been launched:

- Email advice for Gastroenterology and Cardiology in Enfield, Barnet and East and North Herts CCGs.
- Telephone advice for Respiratory in Enfield, Barnet and East and North Herts CCGs.
- Teledermatology service in East and North Herts CCG.

25.4 MSK tender

The Royal Free has formed a partnership to respond to a tender for an integrated MSK service in Enfield with a number of other local providers. The partnership was successful at Pre-Qualification Questionnaire stage, and is awaiting the issuing of the Invitation To Tender.

25.5 Health Information Exchange (HIE)

HIE's allow for the seamless transfer of data and patient information between existing healthcare systems. i.e. primary care records can be reviewed in secondary care and vice versa.

The benefits of HIE include:

- The system will allow patients to be tracked along pathways ensuring they are receiving the right diagnostics, appointments and treatments at the right time and in the right place.
- Clinicians will be able to see older information about patients (e.g. discharge letters) without having to request copies of letters.
- The system allows for various levels of access ensuring that only certain health professionals can see specific information about patients, protecting confidentiality and sensitive information.

HIEs are a key enabler of the pathway work and the Trust will be rolling out the systems in collaboration with Enfield GP federations in early 2016.

26.0 DEVELOPING ENFIELD COUNCIL'S PUBLIC HEALTH CAPABILITY

26.1 **Public Health Delivery Meetings** are being held with each Enfield Council team who have received Public Health staff or financial allocations

26.2 **Wider Public Health** group meetings have been held with Schools and Children's Services and with Environment to discuss how they can be best supported to improve the health of Enfield's population. A council-wide meeting will be held in the new year to strengthen knowledge exchange.

26.3 **Community Health Wellbeing Fund** has gone live.

26.4 **Public Health and Community Resilience Outreach Office** has been recruited.

27.0 REGIONAL AND NATIONAL ACTIVITIES

27.1 We continue to act as Professional Appraisers for Public Health England and benefit from the national Revalidation system for doctors.

27.2 We continue to provide mentoring support for new and aspiring Directors of Public Health and to support Public Health workforce development in London.

27.3 We support the London Primary Care Transformation group and will be supporting them to develop London-wide standards for primary care.

27.4 We have been working with Public Health England to deliver the London Hypertension Workshop.

27.5 We have been providing Public Health advice to the Board of London Cancer and to Cancer Commissioning Board for London.

27.6 We have been invited by Healthy London Partnerships to present Enfield's work on hypertension to their Commissioning for Prevention Event in January.

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MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **10 December 2015**	**Agenda - Part: 1** **Item: 10c** **Subject: Primary Care Update** **Wards: All**
Report of: Dr Mo Abedi, Chair NHS Enfield CCG	**Cabinet Member consulted:**
Contact officer and telephone number: E mail: Jenny.Mazarelo@enfieldccg.nhs.uk Tel: 020-3688-2156	**Approved by:**

1. EXECUTIVE SUMMARY

This paper updates the Health and Wellbeing Board on Primary Care matters across the borough of Enfield, in particular:

- Update on joint commissioning of GP services arrangements with NHS England with effect from 1st October 2015;
- Development of a strategic estates plan
- Update on the additional capacity being provided by two Primary Care Urgent Access hubs on a pilot basis until 31st March 2016
- Progress of Vision migration to EMIS Web
- Development of a primary care transformation framework and patient offer for Enfield

2. RECOMMENDATIONS

The Enfield Health and Wellbeing Board is asked to note the contents of this report and comment on the patient offer and Local Authority deliverables reflected in the patient offer.

3. CO-COMMISSIONING OF PRIMARY CARE SERVICES

From 1st October 2015, Clinical Commissioning Groups (CCGs) in north central London (Barnet, Camden, Enfield, Haringey and Islington) formally took on shared responsibility for commissioning GP services, in partnership with NHS England, bringing a local approach to this area of health care commissioning. These arrangements do not affect commissioning of primary care dental, ophthalmic and community pharmacy services. The NCL CCGs will continue to work with local patient groups, GP practices, HealthWatch and Health and Wellbeing Boards, to buy and plan the best possible GP services for the local population and believe that this approach will allow us to do more in areas like developing the

primary care workforce, and take advantage of our understanding of the needs of our local populations to better join up services.

Nationally, the move to allow CCGs to take on greater commissioning responsibility for GP services follows plans set out by NHS England Chief Executive Simon Stevens in 2014 aimed at giving patients, communities and clinicians more scope in deciding how local services are developed. NHS England will continue to hold responsibility for contracting GP practices, and for areas of commissioning including performance monitoring.

Co-commissioning arrangements are overseen by the NCL Primary Care Joint Committee which met for the first time, in public, on 5th November 2015. At the meeting:

- Terms of Reference, Standing Orders, Conflicts of Interest policy, Governance Structure and Co-Commissioning Operating Model were approved;
- Primary care co-commissioning performance report was reviewed
- Month 6 finance report received and discussed.
- Correspondence from NHS England regarding applying for full delegation of primary care services by 6th November 2015 was discussed. It was agreed that NCL wished to see current joint arrangements established before considering full delegation.

The next meeting in public is scheduled to take place on Tuesday 19th January 2016 3-4.30 pm at St Pancras Hospital Conference Suite, 4 St Pancras Way, London NW1 0PE.

4. PRIMARY CARE ESTATES

In June 2015, the Department of Health published 'Local Estates Strategies – a framework for commissioners'. This places an obligation on CCGs to develop a local estates strategy in collaboration with a wide range of local stakeholders by the end of December 2015. The development of a strategic estates plan is being overseen by a Local Estates Forum and will inform the completion of a NCL estates plan by 31st March 2016.

5. ENFIELD PRIMARY CARE TRANSFORMATION PROGRAMME 2015/16

Primary Care Urgent Access Pilot

As planned, two primary care access hubs were established as a pilot on 1st October 2015 for the six months to 31st March 2016 on weekday evenings and Saturdays.

- Since 1st October 2015 to 12th November 2015, 1,229 patients have been seen at the hubs;
- Patients from 50% of practices not signed up are accessing the service via 111
- 476 patients have completed a survey of their experience

- 38% of patients said they would have gone to their own GP Practice if they had not used the service
- 27% of patients said they would have gone to A&E if they had not used the service
- 89% patients rated their experience of the service as positive
- 80% of patients surveyed said they were very likely/likely to recommend the service.

Vision Migration to EMIS Web

Phase 1 of migration of GP practices from Vision to EMIS Web to deliver IT inter-operability between practices across Enfield will be completed on 9th December 2015. At this point, 94% of Enfield's patient population will be covered by EMIS Web. A further phase of migrations will commence in April 2016 increasing this coverage to 97%. This will also facilitate NCL and London Borough of Enfield's implementation of a digital care record.

Transforming Primary Care in Enfield

Since September 2015 the CCG has been developing a primary care transformation framework (Appendix 1) and patient offer (Appendix 2) with its member practices for wider consultation and implementation in early 2016. The framework focusses on the four priority areas of:

- Primary care development
- Network development
- Locality commissioning
- Joint Co-commissioning

In addition to developing the transformation framework, an online survey was undertaken to provide GP practices in north central London with the opportunity to share their views about how effectively they feel they are currently able to offer coordinated care to patients, supporting them to be proactive about their own health and wellbeing, and offering them care that is accessible – the patient offer described in Transforming Primary Care in London.

The survey, ran from 21st October to 17th November 2015 and will provide Enfield and NCL with a picture of where we are doing well, clarify what is particularly challenging and may need collective problem solving. It will also help to inform future investment priorities over the next three to four years.

The information gathered through this survey will be used to inform service planning and benchmarking for NCL and not as part of any performance reviews. At the Local Medical Committee's request, the data will be collated and held by NEL CSU and CCGs will only receive anonymised data at locality level, i.e. CCGs will not be able to identify individual practices.

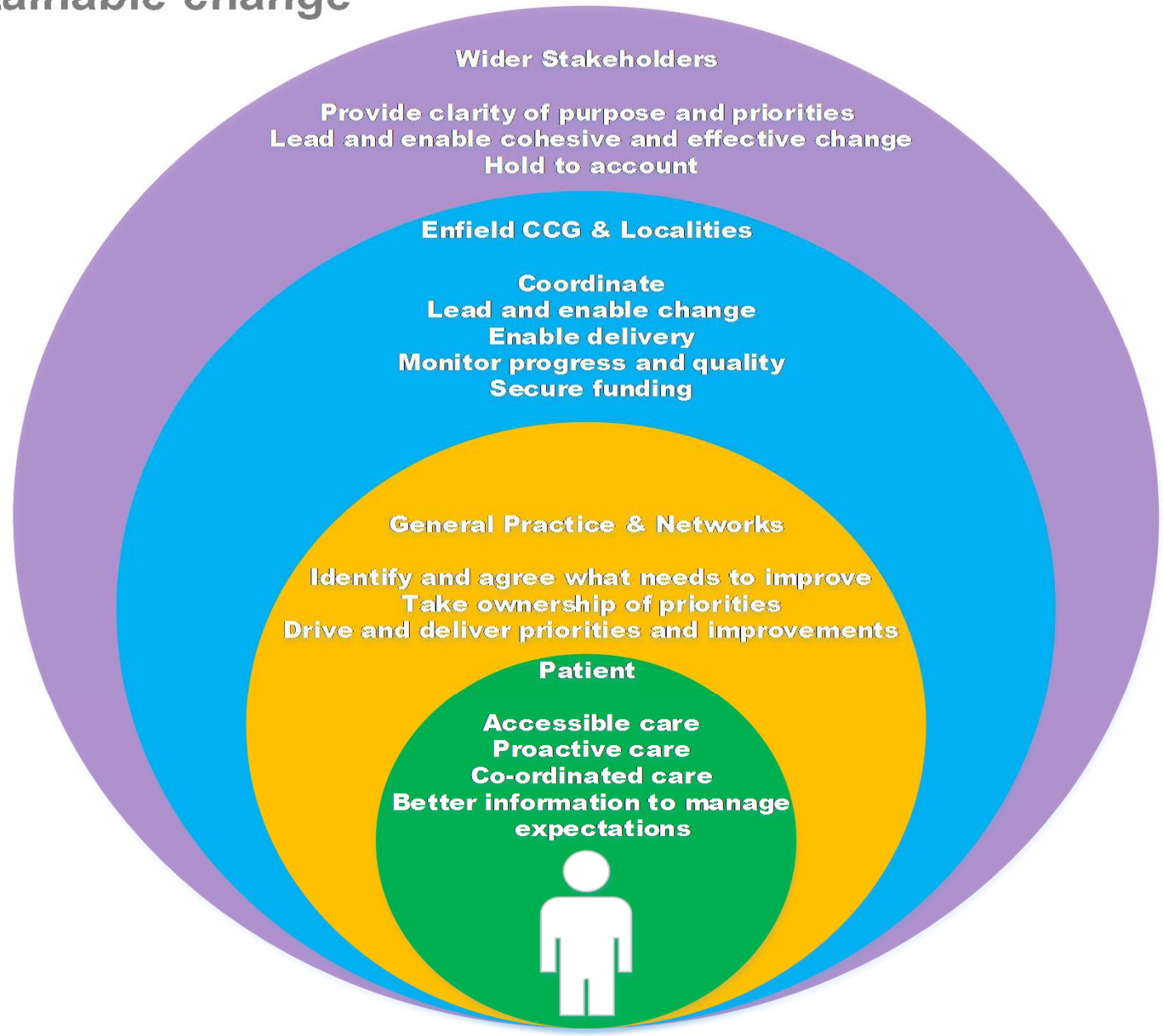
4. CONCLUSION

This report provides an update on Primary Care matters in Enfield.

Transforming Primary Care in Enfield

1. The framework for transformation
2. How we will build the transformation programme
3. Mobilising Enfield to deliver

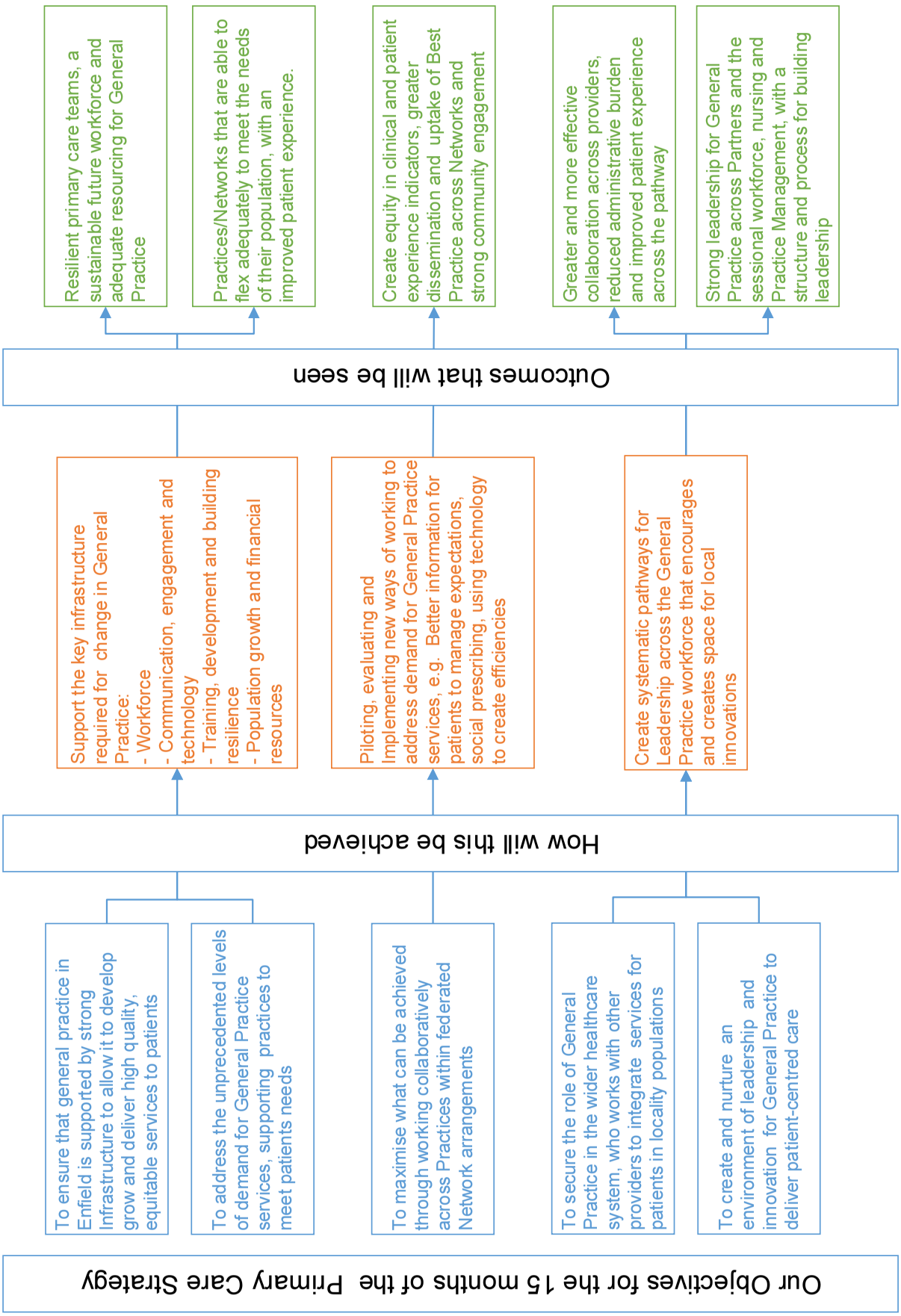
The roles in developing and delivering transformation – working together to drive sustainable change



The framework: four priorities

1	Primary care development	Reducing variation and improving IT, estates and workforce
2	Network development	Supporting networks to become accountable organisations and deliver services to locality populations
3	Locality commissioning	Improving commissioning performance and outcomes for patients, including referral and medicines optimisation; Identify areas for service redesign
4	Joint co-commissioning	Implementing the Commissioning Strategic Framework, overseeing the management of GP contracts, performance and developing new models of care

➢ Are these the right priorities?


Our Objectives for the 15 months of the Primary Care Strategy
To ensure that general practice in Enfield is supported by strong Infrastructure to allow it to develop grow and deliver high quality, equitable services to patients
To address the unprecedented levels of demand for General Practice services, supporting practices to meet patients needs
To maximise what can be achieved through working collaboratively across Practices within federated Network arrangements
To secure the role of General Practice in the wider healthcare system, who works with other providers to integrate services for patients in locality populations
To create and nurture an environment of leadership and innovation for General Practice to deliver patient-centred care
How will this be achieved
Support the key infrastructure required for change in General Practice:
- Workforce
- Communication, engagement and technology
- Training, development and building resilience
- Population growth and financial resources
Piloting, evaluating and Implementing new ways of working to address demand for General Practice services, e.g. Better information for patients to manage expectations, social prescribing, using technology to create efficiencies
Create systematic pathways for Leadership across the General Practice workforce that encourages and creates space for local innovations
Outcomes that will be seen
Resilient primary care teams, a sustainable future workforce and adequate resourcing for General Practice
Practices/Networks that are able to flex adequately to meet the needs of their population, with an improved patient experience.
Create equity in clinical and patient experience indicators, greater dissemination and uptake of Best Practice across Networks and strong community engagement
Greater and more effective collaboration across providers, reduced administrative burden and improved patient experience across the pathway
Strong leadership for General Practice across Partners and the sessional workforce, nursing and Practice Management, with a structure and process for building leadership

Timeline - how we will build and agree the Transformation Programme

	Develop Draft Transformation Framework	Share with Key Stakeholders	Agree Transformation Framework	Develop Strategy and delivery plan	Engage on Strategy	Approve strategy and delivery plan
When	*Sept 2015*	*Sept – Oct 2015*	*Oct 2015*	*Oct – Nov 2015*	*Nov – Dec 2015*	*February 2016*
What and how	• Agree scope and objectives of Programme • Agree the key deliverables that will drive the change • Agree where support is needed to accelerate	• 10,14,17/9 – Locality Commissioning meetings • 8/10 and 22/10 PLT meetings • 30/09 – GP Quality Improvement Sub-Group • 04/11 – GP Member event	• 26/10 - Enfield LMC	• 28/10 GP Quality Improvement Sub-Group • 4/11 GP Engagement Event • 16/19/26/11 Locality Commissioning Business meetings • 30/11 Enfield LMC	• 03/12 Practice Managers Forum • 10/12 Health Improvement Programme Partnership Board • 10/12 HWBB Board • 23/12 Executive Committee	Launch programme following GB development seminar and GB approval February 2016 - March 2017 (14 months transformation programme)

➢ We need to understand where our plans will get us and by when!

The Patient Offer (summary)

- Your practice will be open during routine hours of 8 am – 6.30 pm Mondays - Fridays
- You will have a choice of appointment including flexible length of appointment time appropriate to your needs – named/same doctor for continuity of care or with a GP/Nurse for rapid access for urgent problems
- You will have access to extended opening hours of 8 am – 8 pm 7 days a week across Enfield
- You will only need to make one contact to make an appointment - in person/by phone or on-line
- You will have on-line access to view your medical record, order repeat prescriptions and make appointments
- You will have access to a greater range of services nearer home, reducing the need to travel to hospital
- You will be expected to self care and purchase medicine over the counter where this is available
- You will be prescribed the most clinically and cost effective medicine
- You will received care in safe and suitable premises that support your well-being
- Your practice will identify patients who would benefit from co-ordinated health and social care with a named clinician and will proactively review you on a regular basis
- Clinicians across local health and social care will have access to a sub-section of your medical record to provide seamless and co-ordinated care

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
Primary Care Development						
(A2: Contacting the practice) **IT - improved access to online booking, repeat prescribing and of viewing medical records**	▪ All practices to provide a minimum of 50% of total practice registered population have online accounts. ▪ All practices to provide a minimum of 50% of total practice bookable slots are made available online. ▪ All practices to work collaboratively with their PPGs to cultivate and 'polish' online access to best fit the expectations of their patient population	▪ Contribute to delivery at scale ▪ Exchange information – work collaboratively to refine, develop and trial new ideas to increase and enhance patient online features	▪ Share knowledge and experiences (bi-directional ebb and flow) to ensure any emerging experiences and good practices are cascaded to a wider audience.	▪ Supporting the uptake and utilisation of patient online access services ▪ Raise the profile of online access to patients and key stakeholders to improve awareness and interest ▪ Celebrate successes	▪	▪ Produce a dashboard scoring individual, borough and regional utilisation ▪ Develop national metrics for assessing optimum baselines ▪ Identify exemplar practices nationally and cascade learning.
(A1: Patient choice of access and A2: Contacting the practice) **IT - Patient record (view only) – patient can expect clinicians**	▪ Champion and actively promote the patient record function so patients can make an informed decision either to	▪	▪	▪ Co-develop the system architecture solution to enable sharing of patient records throughout the health economy.	▪	▪

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
across the local health economy to have access to a subsection of their patient records.	opt in and out. ▪ Signup to the data sharing agreements ▪ Ensure all patient correspondence and relevant information is recorded and accepted to the patient record within 48 hours. ▪ Comply with all Information Governance policies and duties.			▪ Ensure the safe and effective delivery ▪ Work collaboratively with the remaining LC CCGs to develop programmes that meets the 5 year forward view and Personalised Heath and Care 2020 agendas.		
(A2: Contacting the practice) **IT - Patients will be required to only make one call, click or contact in order to make an appointment. Primary care teams will maximise the use of technology and actively promote online services to patients including appointment booking, prescription ordering, viewing**	▪ Practices actively participate in training and learning opportunities ▪ Implement and use the IT solutions available to facilitate appointment booking, prescription ordering, viewing medical records and email consultations. ▪ Implement and	▪ Identify Information Management and Technology (IM&T) opportunities and communicate these to the relevant commissioning leads. ▪ Standardising clinical coding	▪ Promote and champion the use of IT solutions.	▪ Purchase IT solutions that support the exploitation and optimisation agenda of Primary Care IM&T ▪ To put on a range of EMIS training aligned to training needs identified from membership feedback ▪ Develop EMIS Enterprise to support practices improve quality outcomes.	▪	▪ GPSoC Framework

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
medical records and email consultations.	utilise the Enfield Global Library. ▪ Create or use EDT Docman email accounts as the practice generic email account. ▪ Signup to and comply with the new CCG practice-agreement ▪ Improve performance of: - EPS - SCR - GP2GP			▪ Work collaboratively with practices to ensure optimal exploitation of Docman ▪ Co-author with service delivery partners the CCG Practice agreement offer. ▪ transfer the of ownership of Iplato to practices ▪ Support practices maximise QoF attainment via business intelligence.		
(Strategic Commissioning Framework Enabler) **Primary Care Workforce Development**	▪ Offering time and commitment to primary care staff to complete mandatory training and continuing professional development to meet CQC and revalidation requirements ▪ Offering time and commitment to	▪ Deploying primary care staff with skills that can be utilised across localities, accessible to all patients within the area;	▪ Developing a range of skilled primary care staff to deliver high quality, primary care based services to local patents;	▪ Working with new initiatives, such as CEPN GP nurses, to recruit and retain a better range of primary care staff within the borough;	▪ Supporting new initiatives to develop staffing within, and allied to, primary care within Enfield;	▪ To support the improvement of the primary care workforce within Enfield;

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
	develop additional primary care staff to provide improved services to patients; ▪ Participating in workforce and skill mix initiatives to offer new models of care					
(Strategic Commissioning Framework Enabler) **Primary Care Estate**	▪ Provide safe and suitable of premises that people receive care in, work in, or visit safe surroundings that promote their wellbeing ▪ Support Practices in developing their premises to enable CQC, Infection Control and DDA compliance. ▪ All practices to prepare and provide an access statement in support that their premises comply with the Equality & Diversity Act 2010.	▪ Contribute to the development and production of the Strategic Estates Plan.(SEP) ▪ Promoting system transformation, new models of care and support commissioning and integration within the SEP. ▪ Pledging to working collectively with practices and patient groups to provide services from clean and safe environments that are fit for purpose based on and the current regulatory	▪ Work with practices, other providers and the CCG to ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice. ▪ Business case proposals should demonstrate they will enable new service models to be delivered ▪ All newly approved space should be available for use as a minimum of 84 hours per week and ideally 7 days	▪ CCG will ensure commissioning and delivery of such services will take place in viable, "fit for purpose" premises ▪ CCG will wherever possible and where circumstances allow, ensure that the delivery of high quality care will be delivered from available, accessible safe, CQC and H&S compliant environments. ▪ Strategic Estate plan to reflect the need and demand for local care hubs,	▪ To support and work with CGG and local GPs and other providers to enable the development of new premises that meet the health and social care needs of local population and accessible to all.	▪ Robust management of GP contract compliance ▪ To manage the Primary Care Transformation Fund (PCTF) process efficiently and in a timely manner that supports the implementation of the SEP and new developments and improvements to premises. ▪ Priority will be given to business cases where the premises for delivering services are more than 50% over-utilised or where suitability (condition and function) is not

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
		requirements to ensure " service users" are protected against risks associated with unsafe and unsuitable premises	a week to primary and community contractors.	including where appropriate, new developments that enable complete delivery of the Patient Offer. ▪ Use the estate as an enabler to improve accessibility and reach of services. ▪ Priority will be given to business cases where the premises for delivering services are more than 50% over-utilised or where suitability (condition and function) is not to an appropriate standard. ▪ SMART objectives will be agreed with practices linking funding approval to the realisation of intended benefits		to an appropriate standard

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
Network Development						
(P1: Co-design) Improving access for patients to a greater range of services and care, closer to home, provided by local primary care staff	▪ Referring to local primary care-led services ▪ Working together to reduce the workload of individual practices by delivering more effectively together ▪ Offering practice personnel a chance to specialise as potential aid to recruitment & retention of excellent clinical staff in Enfield.	▪ Contributing to the development of priority services that meet the needs of local patients ▪ Committing to working together locally from accessible and appropriate care hubs for patients ▪ Work with the CCG to develop a persuasive case to migrate the remaining 4 practices onto a single clinical system	▪ Designing and delivering better healthcare for Enfield patients ▪ Work with the CCG to develop a persuasive case to migrate the remaining practices onto a single vendor solution	▪ Supporting the Network's continuing development as a key component to transforming primary care for patients ▪ Co-designing and improving services for Enfield patients ▪ Support and develop a persuasive case to migrate all practice onto a single vendor solution.	▪ Working with the GP Networks to improve the health of the local population utilising them to support the delivery of key health promotion and prevention strategies	▪

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
(A4 Extended opening hours) Patients will be able to access pre-bookable routine appointments with a primary health care professional 8am – 6.30pm Monday to Friday and 8am to 12 noon on Saturdays.	▪ All practices to provide in person (doors open) and telephone access during core hours of 8am to 6.30pm Monday to Friday ▪ All practices to provide a minimum of 72 pre-bookable GP appointments per 1,000 patients ▪ All practices to provide a minimum of 25 Nursing appointments per 1,000 patients	▪ Commit to collaborating with neighbouring practices and Networks to ensure patients have access to care delivered by Networks beyond core hours.	▪ Contribute to the development of priority services that meet the needs of local patients ▪ Ensure clinical and managerial expertise established to mobilise and deliver pan-Enfield services	▪ Support the delivery of 7 day working (8am – 8pm, 7 days a week) by commissioning pan-Enfield urgent primary care as part of the urgent care network	▪	▪ Robust management of GP contract compliance

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
Locality Commissioning Development						
(A1: patient choice of access) Patients will have one visit for all consultations/ tests/ procedures etc where appropriate (one stop service)	▪ Refer into one stop services where exists via Enfield Referral Service ▪ Share feedback and ideas at Practice Visits and Locality Meetings	▪ Identify and assess ideas/opportunities for one stop services ▪ Develop models of care for one stop services	▪ Networks will engage with Enfield CCG procurement opportunities and develop suitable working relationships with secondary care in order to provide high quality one stop services	▪ Locality Manager capacity committed to develop one stop services in partnership with the Locality ▪ One stop approach will be considered in all Enfield CCG service redesign opportunities	▪ Jointly develop the evidence base for new services	▪ Provide support and approval of primary care delivered services
(C1-C5: Co-ordinated care) Patients will receive clinically robust services avoiding multiple visits to different clinicians i.e. right care, right place, first time Patients will experience an efficient and seamless pathway between primary and secondary care services	▪ Escalate issues and examples of poor patient pathways to Locality Manager ▪ Share feedback and ideas at Practice Visits and Locality Meetings	▪ Agree focus for 2016/17 and what can realistically be achieved ▪ Design and develop new models of care ▪ Develop good working relationship with secondary care clinicians in order to agree service redesign and issues resolution	▪ Networks will engage with Enfield CCG procurement opportunities and where successful will deliver services that direct patients to the right setting first time	▪ Locality Manager capacity committed to develop robust services in partnership with the Locality ▪ CCG will ensure that providers are held to account on transfer of care arrangements, timely and high quality discharge summaries, and availability of results ahead of consultations	▪ Jointly develop the evidence base for new services ▪ Identify greatest are of need based on Locality health and demographic profiles	▪ Provide support and approval of primary care delivered services

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
(P3 Personal conversations) Discussions with patients will be backed by a strong robust evidence base and further information can be provided where requested *[Examples: POLCE, Antibiotic prescribing, demands for brand names]*	▪ Strong and honest conversations with patients ▪ Understand the justification behind policies that restrict referral/treatment i.e. POLCE ▪ Share feedback and ideas at Practice Visits and Locality Meetings	▪ Design and develop material to support patient to clinician conversations *[Example: laminated list explaining CCG has limited the prescribing of the following items]*	▪ Not applicable	▪ Support Locality in development of information/ policy statements ▪ Review policies in line with feedback from Practices/ Localities ▪ Ensure policies are robust and well justified	▪ Jointly develop the evidence base for policies that limit available treatments and medications ▪	
(A1 patient choice of access) Patients will receive enhanced care in GP Practices as an alternative to hospital-based services *[Example for reference is minor surgery, physio, Telederm, patients on long-term follow-up programmes]*	▪ Share feedback and ideas at Practice Visits and Locality Meetings	▪ Identify and assess ideas/opportunities for primary care services ▪ Develop models of care for primary care services ▪ Develop good working relationship with secondary care clinicians in order to agree service redesign and transfer of care to primary care services	▪ Networks will engage with Enfield CCG procurement opportunities for primary care services	▪ Locality Manager capacity committed to develop robust services in a primary care setting ▪ CCG will ensure that providers are engaged with new models of care and hold providers to account on transfer of care agreements ▪	▪ Jointly develop the evidence base for new services ▪ Identify greatest are of need based on Locality health and demographic profiles	▪ Provide support and approval of primary care delivered services

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
(Strategic Commissioning Framework Enabler) Ensuring local providers are charging for services appropriately to ensure the best possible use of tax payers funds	▪ Validation of activity datasets ▪ Escalate issues and examples to Locality Manager	▪ Identify opportunities for challenging providers on appropriate pricing ▪ Review pricing models to determine alternatives *[Example: package price or price cap for A&E Frequent Fliers]*	▪ Networks will engage with Enfield CCG procurement opportunities ensuring best possible use of tax payers funds	▪ Challenge local providers where pricing has been inappropriately applied, using examples from practices activity validation		

Patient Offer	Practice Deliverables	Locality Deliverables	Network Deliverables	CCG Deliverables	Local Authority Deliverables	NHS England Deliverable
Joint Co-Commissioning						
Strategic Commissioning Framework (Proactive, Accessible & Co-ordinated care)	▪ Ensuring that all patients are able to access the same high-quality services that are available, proactive and co-ordinated around their needs;	▪ Practices working together to deliver more accessible, proactive and co-ordinated services for their local patients;	▪ Ensuring that their member practices are delivering the services that patients should expect and supporting those members to achieve this;	▪ Supporting and enabling practices to provide improved services to ensure that patients can	▪ Supporting the delivery of the Framework locally to benefit Enfield citizens;	▪ Reviewing progress on the CCG's delivery of the Framework enabling better local primary care services for patients;
Personal Medical Services (PMS) Reviews	▪ Offering patients access to an agreed ranges of high-quality primary care services;	▪ Working together to deliver the new PMS services to patients and any new primary care services derived from any released	▪ Working with members to offer responsive services, that may arise from PMS savings, to all patients in Enfield;	▪ Ensuring that any resources released from the review are reinvested to improve local primary care services;	▪ Supporting the aims and objectives of the review locally;	▪ Completing the PMS Review as efficiently and equitably as possible;
NHS E Contracts	▪ Delivering patient services to the agreed standards of the practice's contract with NHSE;	▪ Where appropriate, co-ordinate care for local patients to enable all patients to have access to high quality primary care services;	▪ Working in partnership to support members in the delivery of their NHS E contracts thus improving services for all patients;	▪ Working with NHS E to ensure that services are delivered to agreed standards and assist with improving the quality of primary care services for all local patients;	▪ Working with the CCG to support the development of local health services for the borough's citizens;	▪ Ensuring that practices are delivering their contractual services to patients;

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MUNICIPAL YEAR 2015/2016

MEETING TITLE AND DATE **Health and Wellbeing Board** **10th December 2015**	**Agenda – Part: 1**	**Item: 10 d**
	Subject: Better Care Fund Update	
	Wards: All	
Report of: Bindi Nagra and Graham MacDougall	**Cabinet Member consulted: N/A**	
Contact officer - Hayley Coates **Email:** Hayley.coates@enfield.gov.uk		

1. EXECUTIVE SUMMARY

This report provides an update on the Better Care Fund and the latest performance and financial position.

NHS England reporting – the Q2 report was submitted to NHS England on 27th November.

Development sessions – the first of the development sessions was delivered by the Leadership Centre on 25th November. Further sessions are being arranged for January 2016.

External Support – NHS England has offered Enfield the opportunity to participate in a support scheme with PA Consulting. The review commenced in November 2015 and is expected to be concluded by December 2015 and will assist with strategic planning.

Better Care Fund Audit – PWC undertook an audit of the Better Care Fund in Summer 2015 as part of the Council's internal audit programme. A draft report has been issued and an action plan is being developed to respond the areas for consideration that haven't already been addressed.

Governance and management – The Better Care Fund Management Group is now meeting on a monthly basis. Overall management of the fund has transferred to Enfield 2017 to improve links with dependent projects.

Finance - based on Q2 financial reports there is an expected underspend of £51,900 due to delayed or phased starts to projects, which has reduced from £253,750 as reported in October 2015. The financial position of all projects and programmes is being further reviewed.

Performance – the performance report is attached as Appendix 1. An action plan has been developed to improve performance across the key metrics, particularly non elective admissions, and this is outlined in the report.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- Note the contents of the report, including the current performance metrics and actions being taken to improve performance and respond to findings from recent reviews.

- Note that the Q2 return was submitted to NHS England on 27th November 2015 as required.

- Note that further development sessions will be held in January 2016 with the Integration Board and wider stakeholders, to inform planning for the Better Care Fund in 15/16.

3. NHS England Reporting

3.1 The Better Care Fund Q2 return was submitted to NHS England on 27th November 2015, to report the latest progress. This was approved by the Assistant Director of Strategy and Resources and the Director of Strategy and Partnerships prior to submission.

4. Development Sessions

4.1 As previously agreed by the Health and Wellbeing Board, the Leadership Centre has been appointed to lead a number of focused development sessions, to reflect on achievements to date and agree priorities for 15/16 for the Better Care Fund and health and social care integration more widely. In particular, the sessions will focus on:

- Defining a shared vision for integration for the future
- Priorities for 15/16
- Opportunities for 'invest to save' initiatives.

4.2 The sessions have been organised into three phases:

- **Phase 1** –senior leaders at the Council and Enfield Clinical Commissioning Group.

- **Phase 2** – the second session will be for the Enfield Integration Board and will be scheduled for January 2016, to follow announcements about the Better Care Fund for 15/16 and the initial session.

- **Phase 3** – further sessions will be scheduled with wider stakeholders (e.g. front line staff and voluntary groups) building on the work of the first two

sessions. This session is expected to take place in late January/early February 2016.

4.3 The first session was held on Wednesday 25th November with senior leaders from the Council and Enfield Clinical Commissioning Group. The facilitator had a telephone conversation with all attendees prior to the group session, to obtain an understanding of the different perspectives and ideas. The session followed a flexible format, to ensure that participants could have an open discussion.

4.4 During the session the attendees started to identify some key achievements to celebrate more widely and some priority areas going forwards. The discussion will inform plans for the Phase 2 sessions and seek the views of a wider group.

5. External Support

5.1 Following the March 2015 Readiness self-assessment, seven Health and Well-being Boards have been offered the opportunity to participate in a support scheme with PA Consulting, of which Enfield is one. The support programme aims to provide tactical support and/or strategic planning in conjunction with NHS England to accelerate personalised, co-ordinated care. This will also support the wider BCF network by providing the opportunity to share examples of best practice and effective issue management across authorities.

5.2 PA Consulting has identified five determinants of successful integrated working:

1) Productive working relationships
2) Open and collaborative cultures
3) Joint performance management processes
4) Developed leadership capabilities
5) Devolved decision making authority.

5.3 The package of support will review the five determinants highlighted above and comprises four elements:

- **Review** – desk based review of relevant documentation
- **Interviews** – to test and validate the findings from the review
- **Analyse** – triangulation of documentation, interviews and observations
- **Report/Feedback** – summary of report and feedback session with recommendations.

5.4 The review aims to provide the Health and Wellbeing Board with further external assurance about progress and delivery of integrated care through the

Better Care Fund and provide recommendations in its progress towards long term excellence in quality of coordinated care.

5.5 The review commenced on 20th November and a 'light touch' approach is being undertaken, recognising that a number of reviews have already taken place. The findings are expected by the end of December 2015, to enable recommendations to be considered in planning for 16/17.

6. Better Care Fund Audit

6.1 Price Waterhouse Coopers, the Council's internal auditors, undertook an audit of the Better Care Fund in Summer 2015 as part of the internal audit programme, approved by the Council's Audit Committee.

6.2 The key findings highlighted that:

- A more defined and documented performance management processes would be of benefit. This has been addressed via the introduction of quarterly updates and performance reports from all leads.

- An action plan should be developed to address any performance risks or emerging issues with performance. This approach is being followed to review non-elective admissions.

- A more robust and structured approach to benefits realisation would enable greater tracking of benefits and to assess individual business cases. This is being addressed via the quarterly reviews of performance and outcomes, with scrutiny planned at the Finance and Activity Sub Group.

- Financial flows were in need of improvement to ensure payments were made between the Council and Enfield Clinical Commissioning Group in a timely manner. This has been addressed by defining payment terms in the Section 75 Agreement.

6.3 A number of the items raised have already been addressed as outlined above and an action plan will be developed to address any remaining areas for consideration.

6.4 Additionally, Enfield Clinical Commissioning Group has commissioned Baker Tilly to undertake an audit to provide assurance on how Clinical Commissioning Group managers are maximising collaborative working and engagement with external groups and maintaining effective financial control. This forms part of the internal audit cycle.

6.5 The Baker Tilly audit has been deferred to Q4 to allow time to implement the agreed actions from previous reviews. The review will consider:

- Separation of responsibilities and duties between the CCG, the local authority and other arm's-length bodies
- Risk-sharing arrangements and contingency plans if targets are not met
- The CCG's individual and collaborative strategic plans and how these link with the BCF agenda
- Management information and reporting to enable effective monitoring and measurement of outcomes
- Arrangements for data sharing between health and social care with due consideration to the Information Governance issues
- Arrangements for ensuring a joint approach to assessments and care planning with the local authority.

7. Governance and Management of the Fund

7.1 Better Care Fund Management Group (BCF MG) has considered the findings of recent reviews and audits to inform the management of the fund going forward, to ensure that the benefits continue to be maximised. This has included the development of an action plan to address the areas of consideration raised in audits.

7.2 To date, the BCF MG has met fortnightly. However, to ensure that these sessions remain focused and effective, it has been agreed that the meetings will now take place on a monthly basis, or more frequently as required when further guidance is issued about the Better Care Fund for 16/17.

7.3 It was agreed that from 2nd November 2015 onwards the programme will be managed as part of the Enfield 2017 portfolio, which is the Council's centralised project and programme management office. This will improve links with dependent projects (for example Shared Care Record) and ensure consistency in approach with other programmes. The transition of management arrangements will also support some of the recommendations raised in recent reviews, to ensure more robust monitoring arrangements are in place.

7.4 Additionally, the scrutiny of the projects and programmes within the Better Care Fund will be enhanced and leads will be required to submit a quarterly update to outline performance, outcomes delivered, actual and forecast spend, to inform management decisions about the fund going forward. Quarter 1 and 2 updates have been requested from all leads and an update will be presented to the next BCF MG meeting.

8. Finance

8.1 The financial position of all projects and programmes is being reviewed; including an estimated forecast spend by 31st March 2015. Based on Quarter 2 financial reports there is an expected underspend of £51,900 due delayed of phased start to projects, which has reduced from £253,750 as reported in October 2015.

9. **Performance**

The performance report is attached as Appendix 1.

Non-Elective Admissions (General and Acute)

9.1 A working group has been established to review non-elective admissions and analysis has been undertaken to better understand the position. This has found that:

- Non-elective Admissions (NEL) are forecasted to increase by over 1.8k (7%) compared to 14/15.
- There is relatively little growth in A&E attendances between M1-5 14/15 and M1-5 15/16.
- The increase of Enfield Clinical Commissioning Group (CCG) activity trends are consistent with the national activity submitted for England.
- The data and trends submitted by the providers for the Monthly Activity Return (MAR) and SUS are consistent but there is lower activity from SUS.
- Admissions at Barnet & Chase Farm Hospital (B&CFH) continue to decline steadily, however main increases for Enfield are being driven by North Middlesex University Hospital (NMUH) which has increased by over 55% compared to 14/15 levels (B&CFH reduced by 35%).
- The increases of NEL activity are mainly being attributed to paediatric and accident and emergency admission specialties. These are due to revised pathways at NMUH which are using beds for observation and triage; this is demonstrated in the A&E conversion rates which have significantly increased since the BEH clinical strategy (particularly for Paedatrics).
- General medicine and geriatric admissions have declined each year; however, there has been a large increase of Respiratory and an increase of Cardiology and T&O which could be linked to improved coding.
- The trends for over 65+ admissions for 15/16 are continuing to increase, with Paedatrics increasing the most (as per the specialty).
- Short stay admissions at B&CFH are decreasing, however NMUH has increased significantly since 12/13. These link to the above points where short stay beds are being used for observations.
- The most common condition for all ages is Acute Abdominal Pain not Requiring Operative Intervention. Paedatrics is Ear, Nose & Throat Infections, Adults is Acute Abdominal Pain and over 65's is UTIs and Community

Acquired Pneumonia. There is also large numbers of falls/head injuries and Mental and Behavioural Disorders for Adults and over.

- There is a general decrease in long stay admissions with a potential link in admission length of stay with the length of time spent in A&E.

- For all ages the most common A&E attendance times are between 7am and 5pm. There are significant peaks for over 65s at 11am and 5pm. The highest proportion of Paedatrics and Over 65s attendances are at 5pm whilst Adults is at 11am. Whilst the proportion of Adults and over decline after 5pm, Paedatrics remains high up to later in the evening up to 10pm.

9.2 A working has therefore been established to explore the data further and advise on potential action.

Residential Admissions

9.3 The Council continues to achieve year on year reductions in the number of people admitted to long term residential or nursing care.

9.4 By October 2015 81 placements had been made against a full year target of 199. Proportionally, dementia placements are increasing for both residential and nursing care and there is a particular shortage of nursing availability within the borough, which has placed an upward pressure on costs both for the Council and for Enfield CCG.

9.5 Strategically, the Council is addressing this through the funding and building of two new nursing homes. The first (70 beds) is already in the construction phase and work is currently underway on a full tendering exercise to secure a provider to run the first of these new homes. It is expected that construction will be complete and the home ready to accept placements by December 2016.

9.6 Authority from the Council to build a second nursing home has also been secured and work is currently underway to identify an appropriate site.

9.7 The Council is also working with other Councils across the North Central London area to explore the option of joint commissioning and procurement of residential and nursing capacity across the region in order to secure longer term sustainable capacity within this area.

Reablement

9.8 Within the Better Care Fund Plan, NI 125 is the metric that has been chosen to monitor the effectiveness of the Enablement Service. This indicator measures the number of people living independently three months subsequent to receiving an enablement intervention following discharge from hospital. Independent means continuing to live in the community (with our

without support). It excludes people who have moved into a residential/nursing placement or people who have died.

9.9 This indicator is a snapshot taken from the winter months but is also monitored throughout the year cumulatively by the Council.

9.10 Current cumulative performance stands at 82.7% against a target of 88% (373 out of 451).

9.11 The Council also monitors the total number of people who pass through the Enablement service and outcomes for them. By September 2015, 802 people had received an enablement service. Of those 575 or 71.7% had been discharged from the service requiring no further support from the Council.

9.12 Work is currently underway within the Council to increase the available capacity of the Enablement Service. Through use of electronic monitoring systems (CM2000), streamlined assessment and review processes and further trusted assessor training to fully utilise the benefits of assistive technology, the service has been able to increase capacity by approximately 8% last year with a further increase expected this year. The roll out of mobile working later this year will bring further efficiencies which will enable the service to work with more people both from the community and from a hospital setting.

Delayed Transfers of Care

9.13 Acute Delays April – September 2015/16 (people):

- Adult Social Care Delays – 3 (12 in 2014/15)
- Health Delays – 57 (98 in 2014/15)
- Joint Delays (health and social care – 0 (0 in 2014/15)

9.14 Assessment delays are the main cause of acute adult social care delays to date. Within health, the main reasons have been the need to await further non acute NHS care, awaiting a continuing healthcare nursing home placement, community equipment delays and patient choice for residential/nursing care.

9.15 Non-Acute Delays April – September 2015/16 (people)

- Adult Social Care – 18 (29 last year)
- Health – 40 (58 last year)
- Joint health and social care – 9 (3 last year)

9.16 The main reasons for a delay within adult social care were assessment completion, funding and residential/nursing placements. Within health the main reasons for a delay were assessment completion, continuing healthcare nursing placements and family choice.

9.17 Number of Days lost to Delayed Discharges

There has been an increase in the number of days lost to delayed discharges for both health and social care, compared to 14/15 performance. The highest number of delays for social care in September 2015 was 'Awaiting Residential Care Home Placement' and for health was 'Completion of Assessment'. To date in 15,16, 53.1% of the total days lost due to delays within the Mental Health Trust.

9.18 An action plan is being developed to reduce mental health delays, to include analysis of the reasons and analysis of the mental health enablement service capacity/accommodation options for people with mental health struggling to maintain tenancy arrangements. Actions are also being explored to address delays in the completion of assessments and the provision of value for money placements for continuing healthcare patients.

Dementia Diagnosis

9.19 Enfield CCG has made good progress on dementia diagnosis in 2015. The latest data published by Health and Social Care Information Centre (HSCIC) is for September 2015, and shows a diagnosis rate of 67.8% (figures for 2 GP practices are estimated, based on their last available data). During November, retrospective figures for April-July will be published. The Direct Enhanced Services (DES) scheme for GP practices and Commissioning for Quality and Innovation (CQUIN) scheme for community services, introduced in 2015/16 for the first time to encourage screening of patients known to community services, are expected to boost diagnosis rates.

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Better Care: Current Period Data

Report Author: admin_Richard Pain

Generated on: 11 November 2015

1. Non-Elective admissions (general and acute)

Indicator	Current Target	Apr 2015 Value	May 2015 Value	Jun 2015 Value	Jul 2015 Value	Aug 2015 Value	Sep 2015 Value	Annual 2015/16	Latest Note
Number of Admissions	2,378	2,355	2,453	2,515	2,546	2,356	2,499		Year to Date (april : 14724 admissions/Target 14,007
Cost of Admissions									

2. Residential Admissions

Indicator	Current Target	Apr 2015 Value	May 2015 Value	Jun 2015 Value	Jul 2015 Value	Aug 2015 Value	Sep 2015 Value	Annual 2015/16	Latest Note
New Admissions to Residential and Nursing Care (65+) per 100,000 pop 65+	283.9	47.4	74.8	102.2	154.6	179.5	201.9	486.6	
Number of admissions to supported permanent Residential and Nursing Care (65+)		19	30	41	62	72	81		
Enfield Population 65+		40,113	40,113	40,113	40,113	40,113	40,113		

3. Reablement

Indicator	Current Target	Apr 2015 Value	May 2015 Value	Jun 2015 Value	Jul 2015 Value	Aug 2015 Value	Sep 2015 Value	Annual 2015/16	Latest Note
(BC) - Achieving independence for older people through rehabilitation/ intermediate care	88.00%	83.95%	80.25%	81.61%	83.00%	82.69%	82.71%	88.00%	
Number of clients living independently 3 months after ICT service		68	130	182	249	301	373		
Number of clients discharged from hospital with ICT		81	162	223	300	364	451		

4. Delayed Transfers of Care

Indicator	Current Target	Apr 2015 Value	May 2015 Value	Jun 2015 Value	Jul 2015 Value	Aug 2015 Value	Sep 2015 Value	Annual 2015/16	Latest Note
Delayed transfers of care (patients) per 100,000 pop	5	5.01	6.89	8.47	8.77	8.68		5	There were 20 patient delays during August, of which 13 were Health Delays and 4 were attributable to Social Care, and 3 were joint delays.
Delayed transfers of care (days)	1903	351	758	1270	1780	2403		4566	There were 2403 days delayed between April and July which is above the cumulative target of 1903 days
Average of all delayed transfers (patients)		12	16.5	20.3	21	20.8			

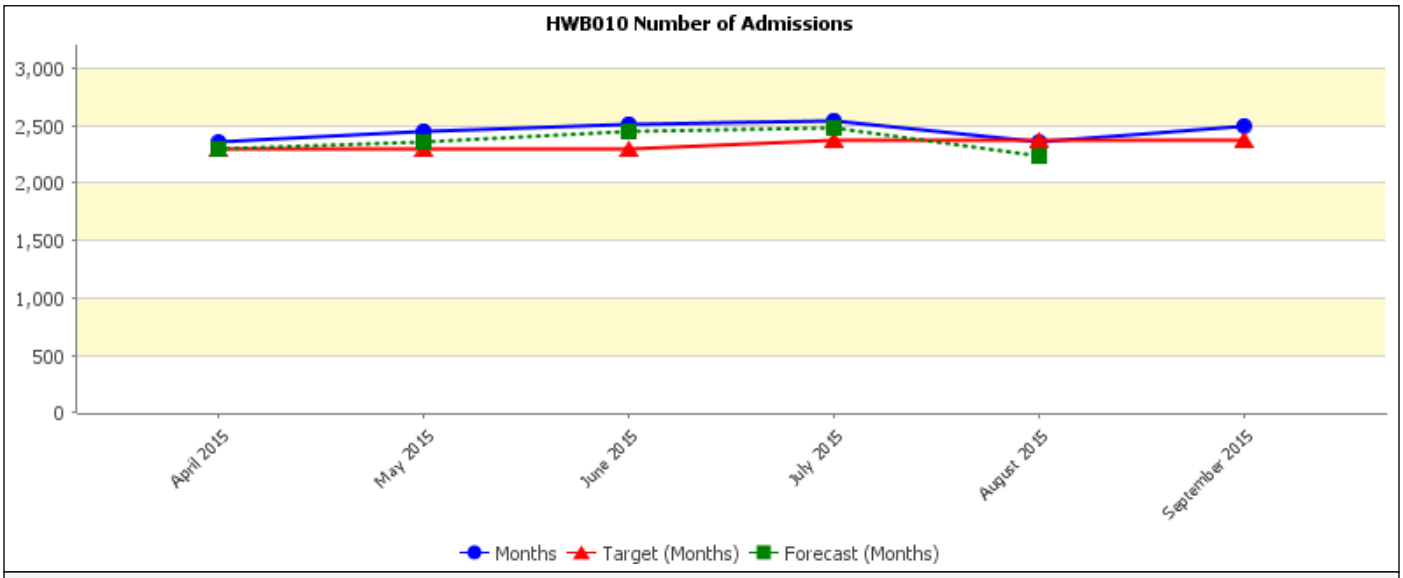
Indicator	Current Target	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Annual 2015/16	Latest Note
		Value	Value	Value	Value	Value	Value		
Population 18+		239,600	239,600	239,600	239,600	239,600			

5. Dementia Diagnosis

Indicator	Current Target	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Annual 2015/16	Latest Note
		Value	Value	Value	Value	Value	Value		
Dementia Diagnosis Rate	60.10%					67.30%	67.80%	60.10%	67.8% is 1901 (QoF dementia register) of 2803 (estimated prevalence). There has been a change of definition for this indicator - data prior to August 2015 awaited from NHS England

Better Care: Number of Admissions

Generated on: 11 November 2015



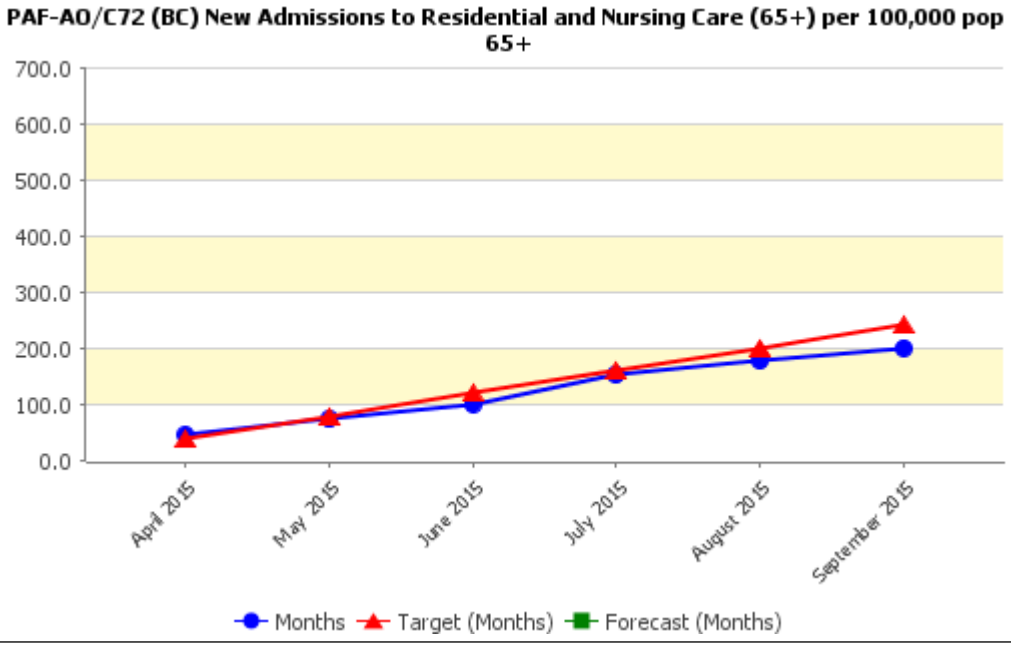
BLUE LINE in the chart: Monthly Activity Report (MAR) trend GREEN DOTTED LINE: Secondary Uses Service data

Monthly Activity Report	Target	Secondary Uses Service
Value		
April 2014	2,374	2,196
May 2014	2,374	2,152
June 2014	2,374	2,088
July 2014	2,459	2,161
August 2014	2,459	2,015
September 2014	2,459	2,100
October 2014	2,583	2,132
November 2014	2,584	2,114
December 2014	2,585	2,253
January 2015	2,323	2,081
February 2015	2,323	1,861
March 2015	2,324	2,083
April 2015	2,291	2,299
May 2015	2,291	2,357
June 2015	2,292	2,451
July 2015	2,378	2,483
August 2015	2,377	2,237
September 2015	2,378	
October 2015		
November 2015		
December 2015		

Notes
Year to Date (april : 14724 admissions/Target 14,007

Better Care: New Admissions to Residential and Nursing Care (65+) per 100,000 population over 65

Generated on: 11 November 2015



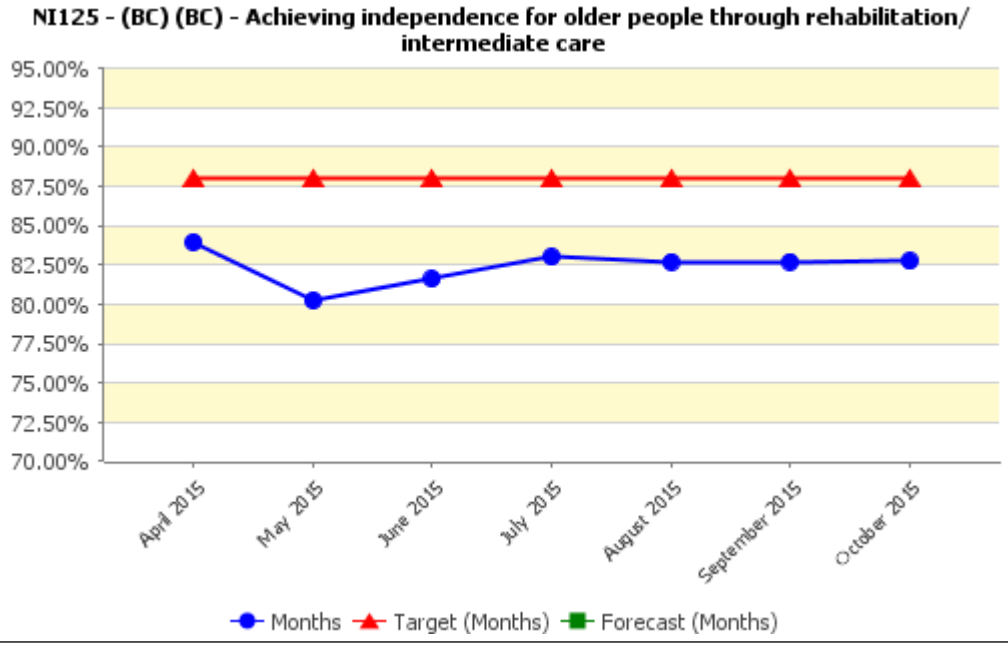
Report Date Ranges

	2014-15	
	Value	Target
June 2014	57.3	108.1
July 2014	87.3	144.1
August 2014	112.2	180.1
September 2014	134.6	216.1
October 2014	162.0	252.1
November 2014	184.5	288.1
December 2014	201.9	324.2
January 2015	239.3	360.2
February 2015	271.7	396.2
March 2015	289.2	432.2
April 2015	47.4	40.6
May 2015	74.8	81.1
June 2015	102.2	121.8
July 2015	154.6	162.4
August 2015	179.5	202.8
September 2015	201.9	243.0
October 2015	211.9	283.9
November 2015		324.5
December 2015		365.0
January 2016		405.5
February 2016		446.1
March 2016		486.6

Notes

Better Care: Achieving Independence for Older People through rehabilitation/ intermediate care

Generated on: 11 November 2015



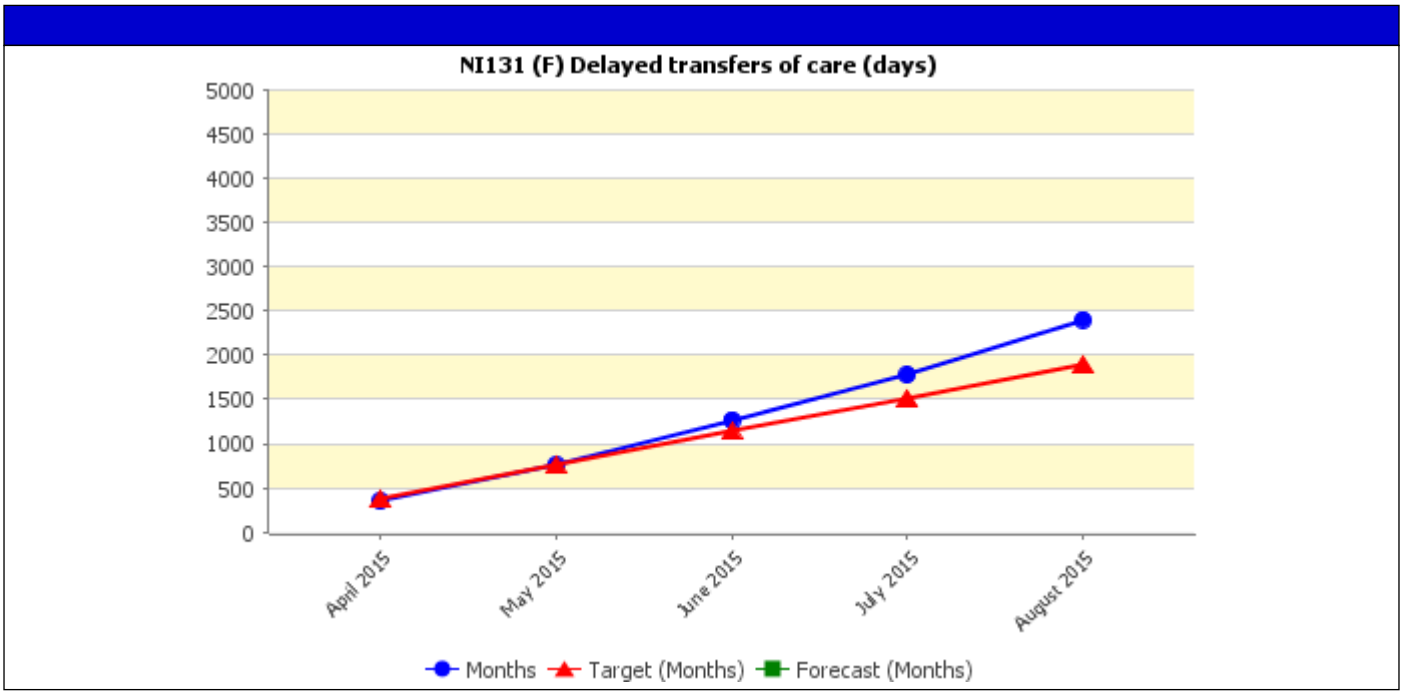
Report Date Ranges

	2014-15	
	Value	Target
April 2014	83.87%	88.00%
May 2014	86.96%	88.00%
June 2014	84.29%	88.00%
July 2014	83.65%	88.00%
August 2014	83.14%	88.00%
September 2014	83.10%	88.00%
October 2014	83.05%	88.00%
November 2014	82.20%	88.00%
December 2014	82.61%	88.00%
January 2015	82.62%	88.00%
February 2015	82.79%	88.00%
March 2015	82.28%	88.00%
April 2015	83.95%	88.00%
May 2015	80.25%	88.00%
June 2015	81.61%	88.00%
July 2015	83.00%	88.00%
August 2015	82.69%	88.00%
September 2015	82.71%	88.00%

Notes

Better Care: Delayed Transfer of Care

Generated on: 11 November 2015



Report Date Ranges

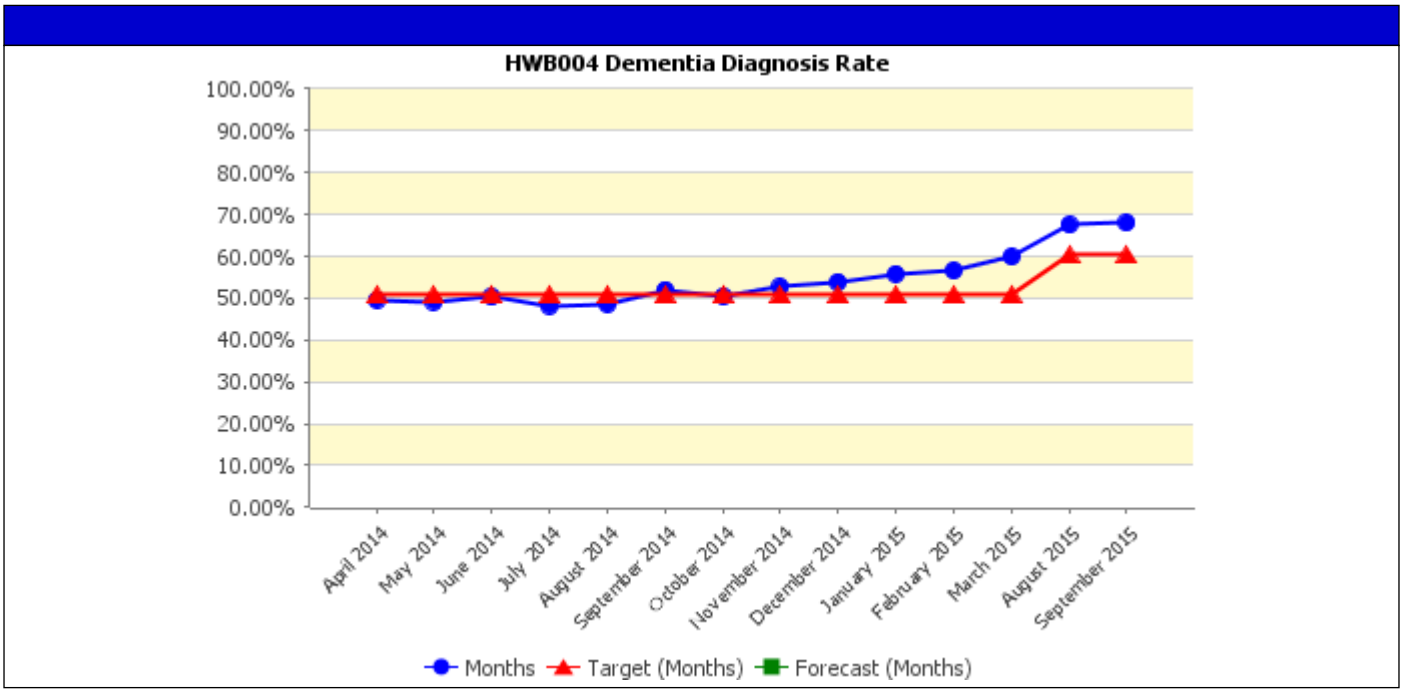
	2014-15	
	Value	Target
June 2014		
July 2014		
August 2014		
September 2014	2278	2432
October 2014	2859	2697
November 2014	3427	3082
December 2014	3875	3648
January 2015	4196	4055
February 2015	4486	4461
March 2015	4778	4866
April 2015	351	381
May 2015	758	761
June 2015	1270	1142
July 2015	1780	1522
August 2015	2403	1903
September 2015		2283
October 2015		2664
November 2015		3044
December 2015		3425
January 2016		3805
February 2016		4186
March 2016		4566

Notes

There were 2403 days delayed between April and July which is above the cumulative target of 1903 days

Better Care: Dementia Diagnoses

Generated on: 11 November 2015



Report Date Ranges

	2014-15	
	Value	Target
April 2014	49.49%	50.58%
May 2014	49.08%	50.58%
June 2014	50.10%	50.58%
July 2014	48.14%	50.58%
August 2014	48.53%	50.58%
September 2014	51.91%	50.58%
October 2014	50.26%	50.58%
November 2014	52.51%	50.58%
December 2014	53.78%	50.58%
January 2015	55.68%	50.58%
February 2015	56.44%	50.58%
March 2015	59.73%	50.58%
April 2015		60.10%
May 2015		60.10%
June 2015		60.10%
July 2015		60.10%
August 2015	67.30%	60.10%
September 2015	67.80%	60.10%

Notes

67.8% is 1901 (QoF dementia register) of 2803 (estimated prevalence). There has been a change of definition for this indicator - data prior to August 2015 awaited from NHS England

Better Care: Survey Data

Generated on: 11 November 2015

Short Name	Source	Frequency	Suggested target	13/14 Baseline	Latest ranking	Latest average	Latest top quartile	2014/15
								Value
Proportion of carers who find it easy to find information about services	Carers survey	Biennial (completed April 2015)	65%	64.3%	17/33	65.6% (notional)	69.3%	61.7%
Proportion of people who use services who find it easy to find information about services	ASC User Survey	Annual (May)	75%	74.30%	13/32	74.4% (notional)	77.9%	73.2%
Last 6 months, enough support from local services/organisations to help manage long-term conditions	GP Patient Survey	annual	60%	56%	18/32 (14/15)	59%	64.3%	57.3%
OPAU - did you have to repeat your clinical history to different members of staff?	OPAU	annual	69%			67%		
Composite Measure			67.3%	64.9%		67.0%		

Health & Wellbeing Board (HWB) Development Session - 4Th November 2015

Context: The HWB Development Sessions are part of the wider HWB structure. They provide an informal forum to explore particular health and wellbeing related themes and broader Enfield Issues. At the November Development Session the theme explored was the relationship between housing and health.

Table top sessions: Table top group sessions were facilitated to give HWB members the opportunity to discuss three questions in the context of housing. Each question directly related to the priorities of the Joint Strategic Health and Wellbeing Strategy. Below is a list of the comments that were made during the table top discussions.

Table 1: Making sure children have the best start in life

- Security of 10 year, not moving around too much
- Most difficulties in private sector – overcrowding, some families move every 6-12 months
- Families that have insecurity of housing – affects mental health, evidence of this.
- Housing should be as health promoted as possible – neighbours mixing, integrating
- Integration – whole devolution debate
- If you live in damp overcrowded conditions – families with young children should be prioritised.
- The point system looks more short term but should be more long term.
- 1000 days of life – anti natal appointments, when visits take place if there are housing issues they should be reported so they are dealt with as soon as possible. This will help identify families that need help early on.
- Could consider moving families out of borough to where there is more space. Better to significantly once then 10 times locally.

Table 2: Creating stronger, healthier communities

- There are two sides when think about "Healthier communities" – physically healthy community and community as in place with social interaction, network of people
- We see nice accommodation, community spaces etc. built and used initially but become not popular / unused / unwelcomed places as a result of residents' turnover etc. Important to think about how can we sustain a) ownership of the community and b) community spirit for a longer term.
- We need to be more creative in using existing spaces / limited resources more effectively, is there any way of utilising school play area for the communities as well?
- Building homes for life – homes that can accommodate different needs at different stages of our life. i.e. designing and refurbishing for health
- Spaces that prevent / reduce social isolation

TABLE 3: Narrowing the gap in life expectancy

- Need to list major determinates in the gap in life expectancy.
- Need to identify factors such as heart disease, diabetes, smoking, lack of physical activities and housing in poor areas.

- Identify how many houses are social housing and affordable to who?
- Most new sites are providing fewer homes
- Most rents are still unaffordable, even for those not on benefits
- Many professionals are choosing to move out of London to afford more affordable homes
- Over occupancy creates problems
- Many rat infested areas
- 25%-30% of private sector rentals are not fit for purpose and this issue is getting worse
- If a child is born in a crowded property, child will develop in that environment, embedding their life opportunities compared to others which will have a direct impact on life expectancy
- Recognise the situation is challenging as it is and need to identify where you can influence to make a difference
- Perhaps change the circle of residents to shift the balance of poverty
- Housing and Public Health need to be linked
- Not good enough to just give people a home if they are struggling with other aspects of their lives
- Employment programmes and access to outdoor space is important
- Access to outdoor activities/opportunities may cause further tensions but also helps provide opportunities too.
- Many Eastern European residents now live in the borough and they would enjoy bbq or picnic areas; this could be a quick win
- Some areas are hilly and unable to be used as a park area. These could be flattened to make better use of the land.
- Growing food is very important. Giving people the responsibility often results in them being more connected to the community they are living in.
- Need to put investment into the core area where people live and then they can take more ownership
- Some boroughs like Hackney, people organise involvement themselves, but some boroughs need more facilitation/guidance to get things moving
- Gardening is key to get people out, grow healthy food and work in communities
- A roof over peoples' heads is important, but an outside environment could also be built into this at the same time
- Plan to use places that can be easily converted – funding spent does not represent work done

Conclusion:

1. **Housing can have significant health benefits both mentally and physically if it's planned in a way that facilitates social engagement, community spaces (shared gardens etc), and takes into account aesthetics as well as cost and functionality.**

2. **There needs to be greater controls in place to improve the quality of housing stock within both local authority owned and private sector housing rental housing.**

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 15 OCTOBER 2015

MEMBERSHIP

PRESENT Shahed Ahmad (Director of Public Health), Deborah Fowler (Enfield HealthWatch), Doug Taylor (Leader of the Council), Nneka Keazor, 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), Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust) and Paul Jenkins (Chief Officer - Enfield Clinical Commissioning Group)

ABSENT Ian Davis (Director of Regeneration and Environment), Ray James (Director of Health, Housing and Adult Social Care), Litsa Worrall (Voluntary Sector), Vivien Giladi (Voluntary Sector), Dr Henrietta Hughes (NHS England), Ayfer Orhan, Alev Cazimoglu and Tony Theodoulou (Interim Director of Children's Services)

OFFICERS: Bindi Nagra (Joint Chief Commissioning Officer), Sam Morris (Participation and Involvement Officer), Natalie Orchard (Partnership Administrator), Jill Bayley (Principal Lawyer - Safeguarding) and Julian Edwards (Interim Assistant Director Children's Social Care) Penelope Williams (Secretary)

1
WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting.

Apologies from Councillors Ayfer Orhan, Alev Cazimoglu, Ian Davis, Vivien Giladi, Tony Theodoulou, Ray James.

2
DECLARATION OF INTERESTS

There were no declarations of interest.

3
BARNET ENFIELD AND HARINGEY MENTAL HEALTH TRUST SUSTAINABILITY REVIEW

The Board received the report from the Enfield Clinical Commissioning Group (CCG) on the outcomes from the recently completed Barnet, Enfield and Haringey Mental Health Services Sustainability Review.

1. Mental Health Sustainability Review

Paul Jenkins, CCG Chief Officer presented the report to the Board highlighting the following:

- The purpose of the review was to find ways to achieve sustainability across the Mental Health Trust, considering both the opportunities and challenges it faces.

- The review was an external review carried out by Carnall-Farrar, and sponsored by the Trust Development Authority. It considered the quality of the services provided, the outcomes required as well as mechanisms for delivery.

- The recommendations are now with the Barnet, Enfield and Haringey NHS Trust. The review was supportive of the Trust and the Trust was pleased that it showed shared values and an understanding of the challenges faced.
- The review judgements on quality and outputs were positive, in comparison with similar trusts in London, and they will provide opportunities for both the commissioners and the trust to improve what they do and for the transformation of services. The full report can be made available on request.

- Areas for improvement include improving the infrastructure – maximising the use of the estate - and making clear changes in the models of care provided, as well as reducing length of stay. As with similar trusts, there is a need to work leaner, smarter and more efficiently.

- It is necessary to understand what is causing the deficit and provide redress linked to the wider transformation programme recognising recognition that efficiencies need to be resolved.

- The interim agency workforce is another area to be addressed.

- Working out how improvements can be carried out will take place over the next few months, working with the regulator, the three boroughs and the three clinical commissioning groups. A more structured action plan is proposed. Enfield will help to facilitate this.

- This is an opportunity for the trust, not just about the finances but about improving quality, responsiveness and outcomes, working on behalf of patients and residents.

2. Questions/Comments

2.1 Andrew Wright, on behalf of the Mental Health Trust, advised members that he welcomed the positives from the review and the support of his

commissioning colleagues. The positives including on performance, staff and most significantly on the long term sustainability of the trust as it exists at present. The potential that the trust might have had to merge with another trust was very unsettling and unhelpful. Now it will be possible to work with the commissioners on the longer term sustainability and to address the underlying funding issues.

2.2 Deborah Fowler asked to be sent copies of the full reports.

2.3 Enfield and the other local authorities have been fully engaged with the review, our Chief Executive was interviewed and Enfield was part of the feedback.

2.4 The review removes some of the speculation and rumour that has been circulating around the future of the trust.

2.5 The work on improving the trust will be carried out in collaboration with the North Central London boroughs and will include the Tavistock Institute. Mental health is a key area for the North Central London boroughs and the intention is to include Camden and Islington. Although these boroughs have different financial circumstances they all face similar challenges. All will be involved in preliminary discussions.

AGREED to note that over the next 6 months, each of the recommended actions will be scoped and a more detailed programme plan developed, with the programme structure and resources put in place. A full stakeholder engagement and communications plan will be developed to ensure that staff, external stakeholders and patients are engaged and kept informed as this important work progresses.

4
NORTH CENTRAL LONDON COLLABORATION OF CLINICAL COMMISSIONING GROUPS (CCGS)

The Board received the report and presentation from Paul Jenkins, CCG Chief Officer containing an overview of the work of the North Central London Collaboration Board.

1. North Central London Collaboration Board

Paul Jenkins presented the report to the Board highlighting the following:

- The collaboration board have considered the options for working collaboratively, supporting the case for change with the aim of improving health and reducing health inequalities.

- The North Central London boroughs have been investigating ways of working collectively together in a similar way to other groups of boroughs in other parts of London.

- The boroughs are hoping to put together a streamlined and systematic health care offer, linking in the outcomes from Carmel Farrar Review, all working against the backdrop of significant financial challenge. Together the bodies are facing a deficit of between £400m to up to £1 billion across North Central London by 2019/20.

- This area includes a very large population - 1.4m residents.

- Staff recruitment and retention issues are variable, but all need to be able to attract and retain the highest calibre individuals to deliver future plans.

- It is a very complex health and social care landscape.

- The full report will be made available.

- Across the region life expectancy and clinical outcomes vary. Adults with long term conditions and mental health illness account for significant proportions of the money spent. The majority of money is spent on acute hospital care, followed by mental health, community and primary care.

- All the five CCG's are in the highest quartile nationally for prevalence of mental health.

- North Central London is facing significant clinical and financial challenges. If nothing is done and the organisations continue to work individually, the cumulative challenge would be £891m by 2019/20. This would be a significant increase in costs with no increase in outcomes or delivery.

- Priorities have been investigated and seven areas for joint improvement have been identified: a programme which looks to realise the opportunities through working with local authorities and other provider colleagues.

- The collaboration board had been set up to support the collective endeavour, making a case for change and setting out strategic objectives.

- Four programme work-streams have been prioritised, based on strategic objectives and the case for change. They are: optimising the use of the estate; prevention and self-care; care for those with chronic complex needs; care for those in child and adolescent mental health services (CAMHS).

- Four programmes have the potential to start immediately: These are redesigning acute services with an immediate focus on urgent and emergency care managing patient expectations and improving

infrastructure, mental health with an immediate focus on transforming inpatient care, care pathways with an immediate focus on primary care, system wide enablers with an immediate focus on estates.

- Various governance models are being considered by partners and stakeholders. Options include everything from a full federation of sovereign CCGs to a formal joint committee. If a new entity were to be created, GP practices will need to be part of the process.

2. Questions/Comments

2.1 A very successful meeting had been held in September, involving all the partners. This has created a good platform to build upon. The clinical case for change will need to be articulated, before any more can be done, alongside a financial piece of work. Both will be needed.

2.3 Other authorities have more money than Enfield, but not significantly better outcomes. It is important to think about how we can meet the standards of the future and there will be a need for consolidation. Personal fiefdoms will not be possible when considering what is affordable. The future will bring different challenges.

2.4 There is likely to be a convergence of funding across the five authorities.

2.5 There is some very successful collaboration in North West London and in Hertfordshire. Where parties are in serious financial difficulty it will be necessary to find a way forward. to find a strategic solution with the commissioners and providers, working closer together, sharing knowledge and ideas. This is beginning to happen. It is important that people are honest and frank.

2.6 Public Health has a strong role to play.

2.7 Before a governance model can be decided upon, the evaluatory framework will have to be considered and key principles identified. Clear principles are essential to ensure transparency when decisions are made in collaboration.

2.8 A voting mechanism will be necessary for conflict resolution.

2.9 There is some growth in the NHS budget but there is no growth in the local government budget. It will be necessary to understand what the reductions in funding will mean in reality.

2.10 There is some concern about special interest groups. Officers are stretched to attend all the various groups and there needs to be some consideration as to whether the groups are doing what they need to do. Are they strategic or operational?

2.11 The appointment of the programme director has to be considered. An experienced interim has been appointed, Janet Soo Chung, who is based in Camden, but all parties would want to be involved in a substantive appointment.

2.12 Governance issues are important to ensure that decisions can be taken at an appropriate level, without unnecessarily slowing down processes. Everyone will need to work differently in the future.

2.13 Ruth Carnell, author of the review, had said that it would not be possible to make major changes, without resources, but there are no resources.

2.14 There is a growing demand for services in primary care, but a decreasing capacity. There will be no new money, but it will be possible to change the application of commissioner spend resources between different areas.

2.15 There are multiple layers of groups and decision makers across the five boroughs including several system resilience groups. There is now an opportunity to improve what we currently have and to make systems more efficient and effective.

2.16 The same report on the procurement of the 111/Out of Hours service went to all five Health and Wellbeing Boards. There is already a joint health overview and scrutiny committee and with the right delegation and structure it could be possible to create one body covering all areas to deal with cross borough issues.

2.17 The aim is that final collaboration proposals will be fully developed and ready for decision in November 2015, but there is a need for further discussion both locally and across all the organisations involved. Special meetings may be necessary to sign off decisions.

AGREED to note the progress achieved towards the collaborative working of the North Central London clinical commissioning groups.

5
OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME

The Board received a report for information on the Overview and Scrutiny Work Programme.

AGREED to note the Overview and Scrutiny Work Programme, particularly the items to be considered by the Health Standing Panel.

6
REPORT BACK FROM DEVELOPMENT SESSION

The Board received a report, updating them on the outcomes from the development session held on 14 September 2015.

NOTED

1. The Board had explored the topic of “influence” and decided that a key issue in terms of system’s leadership was sugar.

2. A full paper would be bought back to the December formal board meeting.

3. The Board had also decided that they would like to communicate more outwardly and would be sending out messages after the meetings in the form of tweets.

4. Bindi Nagra and Shahed Ahmad would draft a tweet to send out on the day following the meeting.

AGREED to note the work undertaken at the development session.

7
DEVOLUTION

The Board received a briefing note on local government devolution.

NOTED

1. The devolution proposals follow on from the agreement for a combined authority in Greater Manchester.

2. London Councils and the Mayor of London have been working on the proposals for London and have been asking for authorities to volunteer for pilot schemes.

3. As part of a devolution programme at the local level, intervention and prevention on dementia and strokes are possible areas for consideration. Bids are being considered.

4. The North Central London estates programmes could also be an area for investigation.

5. London has been divided into 4 sub regions. Enfield falls into the Local London region made up of 8 other boroughs but this is not co-terminus with the North Central London health economy.

6. The Local London Group is developing its own proposals around a number of fields including business, education and skills, employment, housing, health and social care and crime and justice.

7. The Government is due to make announcements in November.

8. A legal identity will need to be created. Form will follow function.

9. All the different groupings are already aggregates of existing structures which have different interests and structures so this should not be threatening.

10. An update will be provided to a future meeting.

11. London councils are looking for expressions of interest for devolution pilot sites. They are looking for borough prevention pilots.

Action: Officers to consider the merit of submitting an expression of interest to be a Stroke and Dementia Pilot.

8
SUB BOARD UPDATES

1. Health Improvement Partnership Board

The Board received the report from the Health Improvement Partnership Board updating them on work of the board.

Shahed Ahmad highlighted the following from the report:

- Enfield is a national lead for blood pressure management. It has been used as a case study by National Public Health England Blood Pressure System Leadership Board and we will be supporting NHS England at a national conference.

- Enfield is supporting the London Care Transformation across the Capital.

- The Royal Society of Public Health held a national conference on Health Trainers which was hosted in Edmonton. Feedback has been very positive.

2. Questions/Comments

2.1 It was suggested that information about our successful blood pressure work could be the subject of a tweet.

2.2 Our immunisation data performance data is not as accurate as it should be and shows poorer performance than was felt to be the case. This was due to past IT problems which are now being rectified. The latest statistics and trends are being sought from NHS England. There is no room for complacency and the council is working with colleagues to improve immunisation rates, but as there have been no disease outbreaks, it is thought that the coverage was better than implied by the data. NHS England are now responsible for immunisation.

AGREED to note the report.

3. Joint Commissioning Board

The Board received an update report on the work of the Joint Commissioning Board.

Bindi Nagra presented the report to the Board and highlighted the following:

- The Integrated Sexual Health and Community services contract will be transferred to the North Middlesex Hospital NHS Trust on 1 November 2015. Several issues are still to be addressed but we are confident that these will be addressed.

- Commissioning responsibility for the Health Visiting and Family Nurse Partnership services has been transferred to the local authority.

4. Questions/Comments

4.1 The Family Nurse Partnership scheme is close to capacity. There have been lots of discussions about these arrangements and the possibility of replacing the scheme, perhaps with a home grown version. It was agreed that there was merit in providing a targeted intensive programme, but as the programme has reached capacity it will need to be reshaped in the future. This is not a priority as we will have to wait until the current agreement expires.

4.2 A transformation plan for the joint Enfield Council and CCG Strategy for the Emotional Wellbeing and Child Adolescent Mental Health for 0-18 years was due to be submitted by 16 October 2015. This will deliver significant new resources for the borough: £170,000 in the first, £500,000 in the second and £500,000 in the third years.

AGREED to note the report and its appendices.

5. Primary Care Update

There was no update for this meeting.

6. Integration Sub Board

The Board received a report from the Enfield Integration Board.

Mo Abedi presented the report to the board and highlighted the following:

- Two meetings had taken place since the last formal board meeting.

- The final business case for the Older People's Integrated Care Programme had been approved by the Integration Sub Board.

- The Integration Sub Board had approved in principle a replacement project within the Children and Young People work stream for bringing the support to young people with learning difficulties and challenging behaviours back into the borough in order to improve the quality of provision and provide value for money.

- One of the risks identified in the better care fund risk report – the risk around the failure to reduce emergency admissions – had occurred. A steering group had been set up to analyse the data and produce a recovery plan.

- Fluctuating delays in the transfer of care was also a problem.

- All board members would be invited to future sub board development sessions.

7. Questions/Comments

7.1 Emergency admissions were increasing but it was felt to be misleading to include the same figures twice on page 33 of the report. It was felt that it would be more accurate to use one set of data.

AGREED to note the report, including the performance report summarised within the main body of the report.

9
MINUTES OF THE MEETING HELD ON 14 SEPTEMBER 2015

The minutes of the meeting held on 14 September 2015 were agreed as a correct record.

10
FUTURE ITEMS LIST 2015/16

NOTED that the following items will be considered at future meetings:

Full Board Meeting - Thursday 10 December 2015

- Devolution
- Better Care Fund
- LBE Budget Consultation
- System Leadership Proposal
- Future in Mind CAHMS Scheme
- Vanguard Bids

Development Session – Wednesday 4 November 2015

- Housing and Health
- Primary Care

The Tower Hamlets Vanguard bid will be discussed at a future development session.

11
COMMUNICATIONS

Communications were discussed earlier in the meeting.

12
DATES OF FUTURE MEETINGS

To note the dates agreed for future meetings as follows:

- Thursday 10 December 2015, 6.15pm
- Thursday 11 February 2016, 6.15pm
- Thursday 21 April 2016, 6.15pm

To note the dates agreed for board development sessions as follows:

- Wednesday 4 November 2015, 2pm
- Wednesday 6 January 2016, 2pm
- Wednesday 2 March 2016, 2pm

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