Public Document Pack

HEALTH AND WELLBEING BOARD

Tuesday, 12 July 2016 at 6.15 pm
Room 1, 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 Community Safety & Public Health – Councillor Krystle Fonyonga
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 – Sarah Thompson
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 Foundation Trust – Peter Ridley
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 (6:15 - 6:20PM)

2. DECLARATIONS OF INTEREST

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

3. SUSTAINABILITY AND TRANSFORMATION PLAN (STP) SUBMISSION (6:20 - 6:35PM) (To Follow)

To receive a submission on the Sustainability and Transformation Plan (STP) from Deborah McBeal (Deputy Chief Officer, NHS Enfield CCG).

4. CO-COMMISSIONING OF PRIMARY CARE SERVICES (6:35 - 6:50PM) (Pages 1 - 26)

To receive a report on the Co-Commissioning of Primary Care Services.

5. CHILD HEALTH (6:50 - 7:05PM) (Pages 27 - 48)

To receive a briefing on Child Health by Allison Duggal (Consultant in Public Health).

6. ENFIELD HEALTH & WELLBEING BOARD SUB BOARDS & PARTNER UPDATES (7:05 - 8:00PM) (Pages 49 - 158)

To receive an update on the following:

1. Health & Wellbeing Board Sub Boards, namely Joint Commissioning Board (Pages 49 – 78) and Health Improvement Partnership Board (Pages 79 – 84).

2. Better Care Fund 2016/17 Plan (Pages 85 – 158).

3. Specific local service developments by providers:

    a) Richard Gourlay, Director of Strategic Development to provide an update on North Middlesex Hospital service developments.
    b) Barnet, Enfield & Haringey NHS Mental Health Trust to provide an update on progress following a recent CQC visit.

7. ITEMS FOR INFORMATION (8:00 - 810PM) (Pages 159 - 230)

To receive the following items for information:

1. Annual Public Health report (attached for information and can also be viewed on the following link):-

https://new.enfield.gov.uk/services/health/public-health/health-publications/annual-public-health-report/public-health-information-enfield-annual-public-health-report-2015_infant-mortality-in-enfield.pdf

8. MINUTES OF THE LAST MEETING (8:10- 8:15PM) (Pages 231 - 242)

To receive and agree the minutes of the meeting held on 24th April 2016.

9. DATE OF NEXT MEETING

Dates for future Health & Wellbeing Board meetings are as follows:

Wednesday 5th October 2016 – Room 1 – 6:15pm
Thursday 8th December 2016 – Conference Room – 6:15pm
Thursday 9th February 2017 – Conference Room – 6:15pm
Wednesday 19th April 2017 – Conference Room – 6:15pm

For information the future Health & Wellbeing Board Development Sessions are as follows:

Tuesday 6th September 2016 – Room 1 – 2-5pm
Thursday 24th November 2016 – Conference Room – 2-5pm
Wednesday 11th January 2017 – Conference Room – 2-5pm
Tuesday 21st March 2017 – Room 1 – 2-5pm

10. EXCLUSION OF PRESS AND PUBLIC

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

There is no part 2 agenda.

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Agenda Item 4

MUNICIPAL YEAR 2015/2016 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board**	**Agenda - Part:** **Item:** **Subject: Primary Care Co-Commissioning** **Wards: All** **Cabinet Member consulted:** **Approved by:**

Dr Mo Abedi, Chair
NHS Enfield CCG
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1. EXECUTIVE SUMMARY

Under plans released in early November 2014 in the report *Next Steps towards primary care co-commissioning,* NHS England offered CCGs across England the opportunity to adopt one of three commissioning models should they wish to take on board greater powers for Primary Care Commissioning.

Co-Commissioning is seen as an essential part of moving to place-based commissioning and a way of implementing new models of care. The five CCGs in North Central London (Barnet, Camden, Enfield, Haringey and Islington) submitted an application to undertake joint co-commissioning of primary care services with NHS England and have since operated as Joint Commissioners of Primary Care Services, having made the governance changes required to do so.

Nationally sixty-three CCGs opted for delegated commissioning in April 2015 and a further five became delegated in April 2016. In London, six CCGs took on delegated powers in April 2015 with a further five taking on delegation in April 2016.

There is an expectation that all CCGs will become delegated commissioners at some point in the future and in May 2016, the current North Central London (NCL) Primary Care Joint Committee tasked a steering group with the responsibility for overseeing an engagement and options appraisal process for assessing whether or not to apply for delegated commissioning powers. The perceived benefits for NCL of becoming delegated commissioners of primary care are as follows:

- Collaborative primary care commissioning;
- Ability to influence local primary care transformation;
- Local input in decision making;
- Ability to redesign local incentive schemes;
- Clinical leadership and decision making;
- CCG insight into practices and ability to harness CCG expertise to drive up quality;
- Control of primary care medical budgets;

- Greater control of workforce and processes supporting co-commissioning.
- Expectation nationally that CCGs take on level 3 delegated commissioning at some point in the future

The CCGs in NCL need to determine whether to move to delegated commissioning, with applications due in October 2016 for interested CCGs. This report and its appendix form part of an engagement process scheduled to run from June – August 2016. Following the engagement process, a recommendation will be made to September 2016 CCG Governing Body meetings on whether or not to apply for delegated commissioning.

2. RECOMMENDATIONS

The Enfield Health and Wellbeing Board is asked to comment on the opportunity for the CCG, along with the other CCGs in North Central London, to apply for delegated commissioning of Primary Care Services.

3. SUPPORTING PAPERS

Appendix A – Primary Care Commissioning stakeholder pack

NHS
Barnet Clinical Commissioning Group

NHS
Camden
Clinical Commissioning Group

NHS
Enfield
Clinical Commissioning Group

NHS
Haringey
Clinical Commissioning Group

NHS
Islington
Clinical Commissioning Group

North Central London Primary Care Co-Commissioning Options

Stakeholder Engagement Pack June 2016

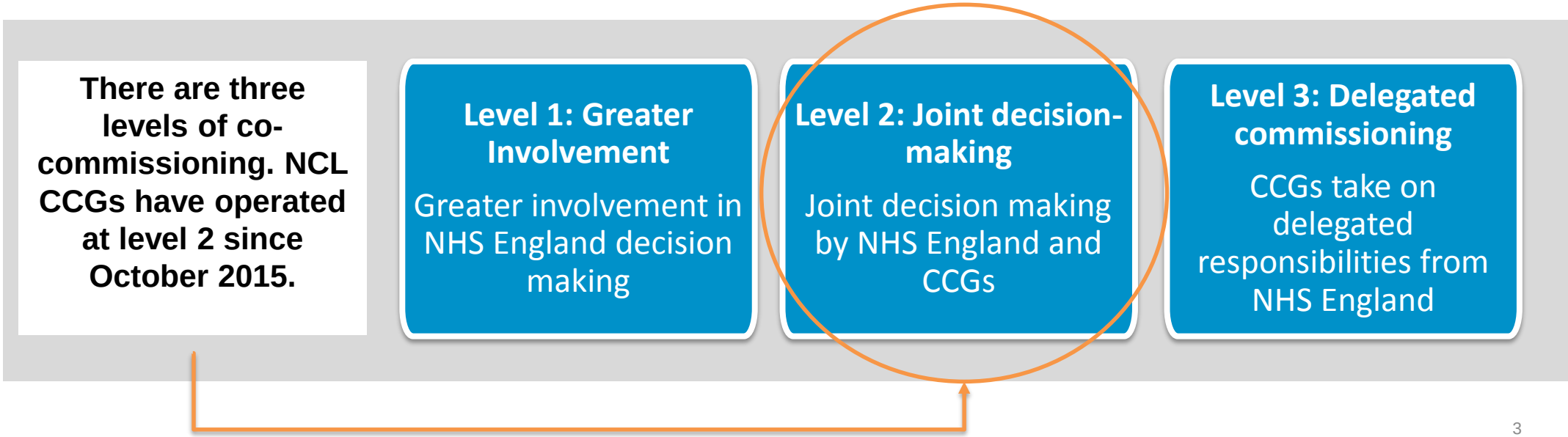
Different levels of Primary Care Co-Commissioning

Level 1 – Greater involvement	• CCGs collaborate more closely with NHS England (Lodnon region)
Level 2 - Joint Commissioning	• Jointly commissioning services alongside other CCGs and the NHS England, London regional team • Joint Committee or Committee in common make decisions • NHS England, London regional team has the casting vote
Level 3 - Delegated Commissioning	• CCGs have full responsibility for commissioning GP services • CCGs make all decisions and NHS England, London regional team do not have a casting vote on decisions • CCGs will need to create individual Primary Care Committees or a Committee in Common

Where we are now

- The CCGs in Barnet, Enfield, Haringey, Islington and Camden need to determine whether to move to delegated commissioning (the level of Co-Commissioning with the greatest responsibility for CCGs)

- Applications are due in October 2016 for interested CCGs



Functions under different levels of co-commissioning

Primary Care Function	Level 1: Greater Involvement	Level 2: Joint Commissioning	Level 3: Delegated Commissioning
General practice commissioning	Potential involvement in discussions but no decision making role	Jointly with NHS England (London region)	Yes
Pharmacy, eye health and dental commissioning		Potential involvement in discussions but no decision making role	Potential involvement in discussions but no decision making role
Design and implementation of local incentives schemes		Subject to joint agreement with NHS England (London region)	Yes
General practice budget management		Jointly with NHS England (London region)	Yes
Contractual GP practice performance management		Jointly with NHS England (London region)	Yes
Medical performers' list, appraisal, revalidation		No	No

Source: NHS England, *Next steps towards primary care co-commissioning*, November 2014

Benefits and issues of different levels of co-commissioning

Greater Involvement (Level 1)

- Reduced governance structure and CCG responsibilities

- Would require dismantling of current level of governance structure;
- Lack of localisation of decisions and ability to influence local decision making, strategy and implementation of new models of care;
- Limited clinical leadership and access to contracting expertise;
- Limited insight into performance of practices locally and ability to influence management of quality;
- Limited ability to redesign incentives and contracting approaches;
- Limited management of primary care staff and financial resources to support strategic drivers for change.

Joint (Level 2)

- Collaborative primary care commissioning;
- Acceleration of local primary care transformation;
- Local input in decision making;
- Ability to redesign local incentive schemes;
- Clinical leadership and decision making;
- Increased local appetite and energy to transform primary care;
- CCG insight into practices and ability to harness CCG expertise to drive up quality.

- Limited access to timely and complete information;
- Limited influence of historic processes of contracting team;
- Contracting expertise still an NHS England (London) resource – lack of local capacity;
- NHS England (London) have the casting vote in decision making.

Delegated (Level 3)

- Collaborative primary care commissioning;
- Ability to influence local primary care transformation;
- Local input in decision making;
- Ability to redesign local incentive schemes;
- Clinical leadership and decision making;
- CCG insight into practices and ability to harness CCG expertise to drive up quality;
- Control of primary care medical budgets;
- Greater control of workforce and processes supporting co-commissioning.
- Expectation nationally that CCGs take on level 3 delegated commissioning at some point in the future

- Additional contracting staff cost to ensure capacity is increased to levels where improvements can be realised;
- Budgetary pressures derived from commissioning primary care are the responsibility of the CCG (QIPP);
- CCGs will take on the responsibility of sole decision making of GP constituents

Frequently Asked Questions

How would we deal with conflicts of interest if the CCGs are in charge of Primary Care Commissioning?

- The governance structure would be set up to avoid conflicts. Provisions could include use of independent clinicians, a lay chair and register of interests.
- Making decisions beyond individual CCG groupings would also help mitigate conflicts.

Why have we grouped as North Central London?

- NCL are able to work collaboratively to improve health outcomes, share best practice and improve quality
- As NCL CCGs move to strategic planning through our Sustainability and Transformation Plan, working as a Strategic Planning Group (SPG) will be important for applying for central funding.

What would delegated commissioning mean in terms of budgets?

- We would take more responsibility for the way funds are used and would have greater transparency.
- There is no intention to pool core Primary Care budgets across NCL. We could be allocated some funding at Strategic Planning Group (SPG) level which the CCGs would agree together how it was used.

Would the CCG be responsible for performance monitoring practices?

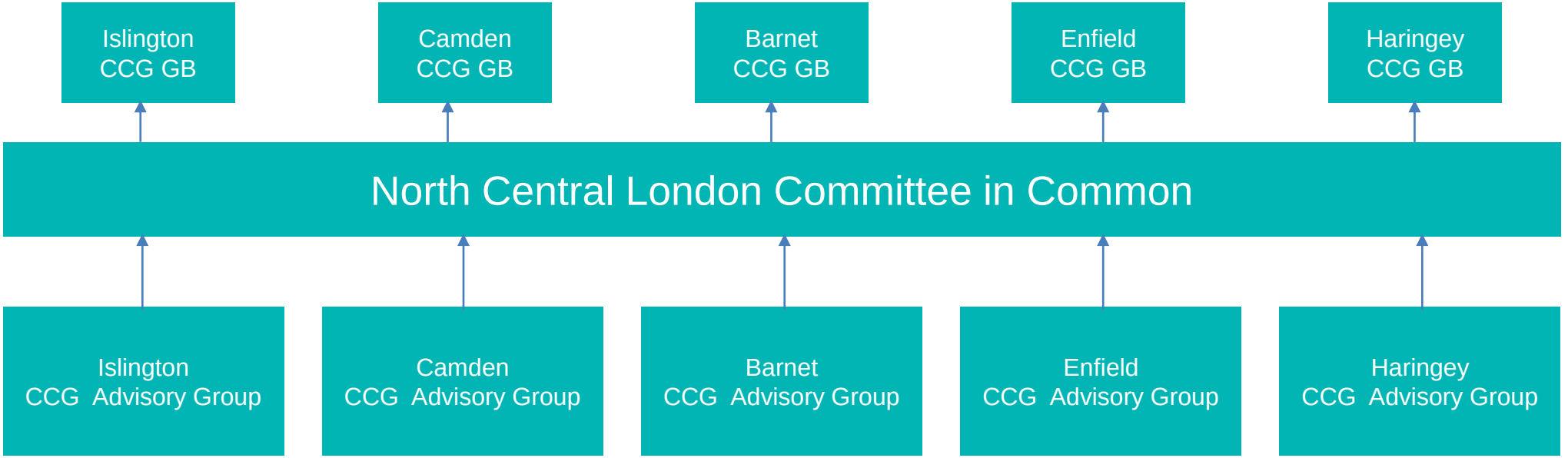
- Yes, the CCG would have a role in performance monitoring practices.
- This would help the CCG fulfil its role of driving up the quality of local primary care. The approach taken would be informed by the CCG's conflicts of interest policy. CCGs could use GPs from outside the local area to assist with this work.

There is a perception that NHS E (London) have not been resourced to a level where they can perform the function well, why we would take this on without additional resource?

- There is no expectation that by becoming delegated commissioners we will be able to apply for, or receive, additional resource. However, we will have the ability to influence the way in which the existing team carries out the function and add resource so that we have a function that supports our CCG goals related to improvements in quality and patient care.

Changes to the current governance structure that would take placed if NCL moved to Delegated Commissioning

If North Central London CCGs decided to become Delegated Commissioners, having considered other options, it is recommended that **a Committee in Common** be established to support decision making and to manage conflicts of interest, however comments are welcome on this recommendation.



- Each CCG would establish its own Primary Care Commissioning Committee but they would all meet together at the same time and in the same place.
- Having the Committees meeting in common would:
  - promote information sharing and benchmarking across North Central London;
  - support management of conflicts of interest by creating more transparency and supporting non-conflicted clinical input;
  - Help to identify areas for collaborative working

Experiences from existing Delegated Commissioners…

Forced the CCGs to work together and brought in some independent GPs who have a different perspective to the local ones, e.g. new ideas and challenge…..

We have greater control over decisions locally. NHS E had wanted to tender for a new practice, we decided to disperse the list….

Its still not clear what we are responsible for vs NHS England (London)…

With more lead in time we would have been a bit more ambitious in our DES and QOF arrangements this year – which are now in our gift. We have offered an alternative DES, but would have done more with time……

There is a feeling that the impact of level 3 delegated commissioning has yet to be fully felt by the CCGs as responsibilities are slowly coming back to us…

There is not enough NHS E resource..

The primary care resource has remained within NHS E and the bulk of the workload is still being done by NHS E teams, with them coming to the CCG for us to for a decision / sign off. This will slowly change as the year progresses…

One year in we are beginning to experience some local benefits of delegated commissioning e.g. Setting our own agenda, making some decisions ourselves about what to do if there is a service gap, resignation etc. before we felt we had no real local say……

Timeline and next steps

Date	Planned activity
June 16	Enfield CCG has sought and been granted permission from NHS England to proceed with the NCL wide programme, as we were placed under legal directions by NHS England from 10th August 2015. Whilst Enfield CCG remains under legal directions, NHS England retain responsibility for commissioning primary care services.
June – August 16	Engagement on options for Co-Commissioning (Level 1, 2 or 3). Gathering feedback from engagement sessions to inform Governing Body decisions in Sept. Voting, where applicable, with member practices takes place.
August 16	24th Extraordinary NCL Joint Committee to review due diligence and engagement feedback Preparation of report for Sept Governing Body meetings, setting out feedback on options and a recommendation of the preferred option
September 16	Outcome of Extraordinary NCL Joint Committee to be considered at GP Transformation Sub-Group and Executive Committee Decision made on next steps for Co-Commissioning by Governing Bodies
October 16	Submit application or inform NHS England of outcome of engagement and intention for Co-Commissioning

Key questions for stakeholder consideration

- Do you think NCL CCGs should move to level 3 delegated commissioning to help achieve primary care transformation?

- Do you have any comments about the proposed governance structure?

- Is there additional information needed to better inform your understanding?

Additional Information

Background and Context

- NHS England offered CCGs the opportunity to adopt one of three commissioning models should they wish to take on board greater powers for primary care commissioning. Co-Commissioning is seen as an essential part of moving to place-based commissioning and a way of implementing new models of care;

- The five CCGs in North Central London currently undertake joint co-commissioning of primary care services with NHS England;

- Take on of delegated commissioning will bring resource from NHS England (London) closer to CCG teams, however investment will be required locally to fully realise the benefits of delegated commissioning as there is currently limited primary care contracting capacity;

- The CCGs in North Central London continue to work together to transform services for local people and increasingly investment will be delivered to Strategic Planning Groups (SPG) through Sustainability and Transformation Plans. A move to delegated commissioning strengthens the SPGs case for collaboration when applying for new investment.

Level 1 – Greater involvement in Commissioning

What is Greater Involvement in Co-Commissioning?

- Greater involvement in primary care co-commissioning is an invitation to CCGs to collaborate more closely with NHS England (London region) to ensure that decisions taken about healthcare services are strategically aligned across the local health economy
- There is no formal approval process for greater involvement; arrangements are taken forward locally

What are the responsibilities?

- CCGs whose role is to have greater involvement may be consulted on decisions made by NHS England
- With the exception of existing responsibilities for Primary Care Strategy Development, CCGs have limited responsibility under this level of Co-Commissioning

Level 1 – Greater involvement in Commissioning

Where are decisions made?

- Decisions are made by NHS England

What governance is required?

- No formal changes to CCG governance are required

Are there other CCGs in London with this level of Co-Commissioning?

- In London, only City and Hackney CCG in London have this level of Co-Commissioning

Level 1 – Greater involvement in Commissioning

Advantages

- No change to governance or existing CCG responsibility in terms of set up cost or capacity

Disadvantages

- Lack of influence over decision making
- Lack of localisation of decisions
- Lack of ability to influence local strategy and implement new models of care
- Limited clinical leadership and access by the CCG to contracting expertise
- Limited insight in to the performance of practices locally and ability to influence management of quality
- Limited ability to redesign incentives and contracting approaches
- Limited management of primary care staff and financial resources to support strategic drivers for change

Level 2 – Joint Commissioning (Current arrangement)

What is Joint Co-Commissioning?

- A joint commissioning model enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with NHS England (London region).
- Within this model CCGs also have the option to pool commissioning and GMS/PMS funding for investment in primary care services, although in NCL this is not something that the CCGs chose to do
- Joint commissioning will require a joint committee or “committees in common” to make commissioning decisions. This could be with one or more CCGs and NHS England (London region). It is for NHS England (London region) and CCGs to agree the full membership of this Committee. Representatives from the local HealthWatch and Health and Wellbeing Board also have the right to join this committee as a non-voting member. The NCL Joint Committee is made up of a variety of local stakeholders and has a lay chair and a lay/ exec majority

What are the responsibilities?

- CCGs as Joint Commissioners have a joint responsibility for Commissioning GP services, Local Incentive Schemes, Budget Management and Contracting of GP services. In practice the day to day operation of responsibilities is carried out by NHS England (London Region) staff with decisions made at the NCL Joint Committee

Level 2 – Joint Commissioning (Current arrangement)

Where are decisions made?

- Decisions are made in a Joint Committee which has a lay/exec majority with representatives from each of the CCGs in NCL. NHS England has the power to veto a decision made by CCGs

What governance is required?

- For NCL, the governance is already in place and therefore no changes are required

Are there other CCGs in London with this level of Co-Commissioning?

- The CCGs in North West London and South East London are currently Joint Commissioners and are considering the option of moving to level 3 delegated commissioning

Level 2 – Joint Commissioning (Current arrangement)

Advantages

- Integrated primary care commissioning
- Acceleration of local primary care transformation
- Local input in to decision making
- Ability to redesign local incentive schemes
- Clinical leadership and decision making
- Increased local appetite and energy to transform primary care
- CCG insight into practices and ability to harness CCG expertise to drive up quality

Disadvantages

- Access to timely and complete information challenging
- Limited influence of historic processes of contracting team
- Contracting expertise still an NHS England (London) resource – lack of local capacity
- NHS England (London) have the casting vote in decision making

Level 3 – Delegated Commissioning

What is Delegated Co-Commissioning?

- Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning general practice services
- CCGs continue to remain responsible for discharging their own statutory duties, for instance, in relation to quality, financial resources and public participation
- Within this model CCGs also have the option to pool commissioning and GMS/PMS funding for investment in primary care services, however this is not mandatory and is to be decided by CCGs prior to applying to become delegated commissioners

What are the responsibilities?

- CCGs as Delegated Commissioners have sole responsibility for Commissioning GP services, Local Incentive Schemes, Budget Management and Contracting of GP services

Are there other CCGs in London with this level of Co-Commissioning?

- The CCGs in BHR, WEL and SWL are delegated commissioners

Level 3 – Delegated Commissioning

Where are decisions made?

- Delegated commissioning requires CCGs to create a ‘primary care commissioning committee’ to oversee the exercise of delegated functions. It is for CCGs to agree the full membership of this Committee. However, this Committee will be required to have a lay Chair and lay and executive majority. Representatives from the local HealthWatch and Health and Wellbeing Board will also have the right to join this committee as a non-voting member. Decisions are made by this committee. NHS England does not have the power to veto decisions made by delegated commissioners

What governance is required?

- CCGs will need to decide whether to establish a Committee-in-Common to manage decisions across NCL or whether to establish individual primary care committee meetings, both of which report to CCG Governing Body meetings

Level 3 – Delegated Commissioning

Advantages

- Integrated primary care commissioning
- Acceleration of local primary care transformation
- Local input in to decision making
- Ability to redesign local incentive schemes
- Clinical leadership and decision making
- Increased local appetite and energy to transform primary care
- CCG insight into practices and ability to harness CCG expertise to drive up quality
- Greater control of workforce and processes supporting co-commissioning
- Control of primary care medical budgets and any head room

Disadvantages

- Additional cost to ensure capacity is increased to levels where improvements can be realised
- Budgetary pressures derived from commissioning primary care are the responsibility of the CCG (QIPP)

What would NCL need to do to become Delegated Commissioners?

The CCGs will need to:

- Review CCG Constitution, Scheme of Delegation and Conflicts of Interest Policies and update where required
- Submit Delegated Commissioning Governance documents such as the CCG IG toolkit, the Committee(s) ToR and a completed application for delegated commissioning to NHS England.
- Prepare a due diligence report prior to ‘take on’ which analysis the current state of contracts and finances related to the areas to be delegated by NHS England (London Region)
- Understand the implications for CCGs categorised as ‘under directions’
- Prepare an options appraisal of potential approaches to staffing*
- Engage stakeholders – where required there needs to be a member vote

* As part of the London OD review, NCL are expected to get a fair share of the NHS England (London) Primary care contracting staffing resource. NCL will not receive additional staff and will therefore need to consider how best to configure staff across CCGs and NHS England (London region), along with any need for further investment in staffing

Further information

For more information or to ask a question of the programme team please email the Primary Care Team at the CCG: PrimaryCare@enfieldccg.nhs.uk

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BRIEFING ON THE LOCAL CHILD HEALTH PROFILES AND HEALTH BEHAVIOURS IN YOUNG PEOPLE FOR ENFIELD

APRIL 2016

THE PHE CHILD HEALTH PROFILE AND THE HEALTH BEHAVIOURS IN YOUNG PEOPLE HAVE NOW BEEN PUBLISHED FOR 2016. THIS PROFILE ALLOWS COMPARISON WITH NATIONAL AND REGIONAL DATA ON CHILD HEALTH AND ALLOWS THE TARGETING OF AREAS FOR LOCAL IMPROVEMENT.

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INTRODUCTION

Enfield has a mixed picture of health and wellbeing of children. This is probably, at least in part, due to the contrasts seen across the east and west of the borough in terms of ethnicity and socioeconomic status.

Children and young people under the age of 20 years make up 27.7% of the population of Enfield and 18.6% of school children are from an ethnic minority group. There are almost 5,000 births[1] per year and the life expectancy at birth in 2012-2014 was 80.7 for boys and 84.1 for girls.

Levels of child poverty are worse than the England average with over one quarter (25.5%) of children aged under 16 years living in poverty. However this is a considerable improvement on the levels of child poverty 10 years ago when 36.6% of children under 16 were living in poverty. Levels of obesity and tooth decay continue to cause concern as they are higher than both the England and London averages.

PREMATURE MORTALITY

INFANT AND CHILD MORTALITY

Due to the small numbers of infant deaths, it is recommended that 3-rolling year averages are used for monitoring purposes. This allows the data to be 'smoothed over' and improves the interpretation of the data.

There was an average of 20 deaths of babies under 1 year in Enfield in 2012-14. In 2012-14 the mortality rate of 4.0 per 1,000 live births (aged less than 1 year) in Enfield was the same as the England average and lower than the London average. This is considerably better than the previous rate of 5.6 per 1,000 live births in 2010-12 and a further improvement on the 2011-13 rate of 4.6 per 1000 live births.

The child mortality rate of 15.3 per 100,000 children aged 1-17 in 2012-14 is an increase on the previous rate of 13.7 in 2011-14. This was worse than the England average of 12.0, but the difference between the local and England values is not statistically significant.

Factors affecting infant mortality include low birthweight, teenage pregnancy, breastfeeding and smoking in pregnancy. An infant mortality report and action plan was produced in March 2015 to address the borough's high infant mortality rate.

[1] ONS data.

Factors affecting child mortality include injuries, mental health conditions including self-harm and substance misuse and immunisation rates.

LOW BIRTHWEIGHT BABIES

Enfield's rate of low birthweight term babies is now lower than the England average at 2.7 compared to 2.9. Figure 1 demonstrates what a considerable achievement this rate is.

ACTION TO ADDRESS LOW BIRTHWEIGHT

Poverty, ethnicity and early access to maternity services affect the rates of low birthweight births. The reduction in the rate of low birthweight term babies probably reflects the considerable work done to reduce late access to maternity services and to increase smoking cessation rates in pregnancy. This includes the Council's 'As Soon As You're Pregnant' (ASAP) campaign which encourages women to attend for antenatal care at the earliest opportunity, before the thirteenth week of pregnancy and targeted work in communities which have historically been reluctant to engage with health professionals early on in pregnancy. In addition, the borough has enrolled and trained Parent Engagement Panel (PEP) volunteers to work as Community Health Champions.

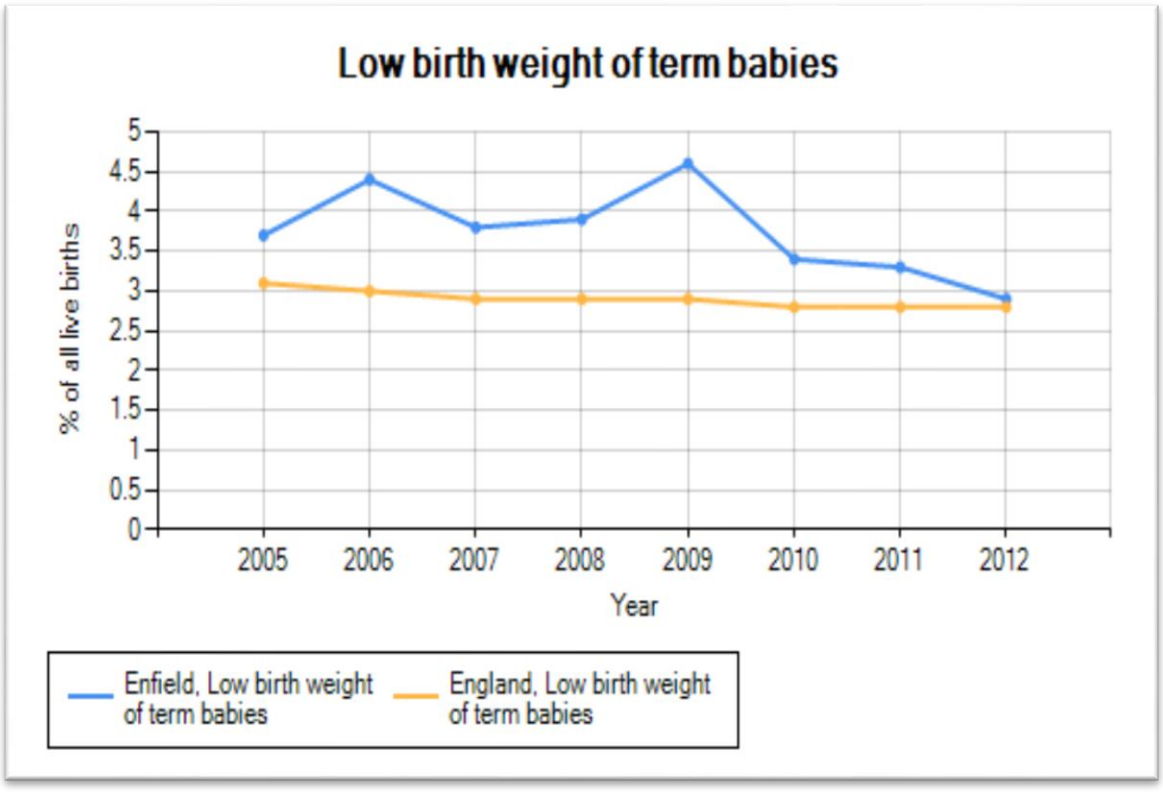

Figure 1 Low birthweight of term babies 2005-2012

SMOKING DURING PREGNANCY

Enfield's rate of recorded smoking status at the time of delivery is significantly better than the England average and approximately the same as the London average.

These smoking figures suggest that Enfield is performing well in terms of women ceasing to smoke during pregnancy. However, the smoking data is collected by asking women if they smoke, and is therefore subject to recall bias.

ACTION TO ADDRESS SMOKING DURING PREGNANCY

The Public Health team is planning a study to pilot testing for metabolites of nicotine to see whether the smoking rate is actually higher than these data suggest, and whether further interventions are therefore needed in this population.

BREASTFEEDING

The borough has a higher breastfeeding initiation rate than the England average, but breastfeeding prevalence at 6-8 weeks after birth is not recorded as the data does not meet PHE's validation criteria.

Of our closest statistical neighbours (as defined by CIPFA), only two of four boroughs met the validation criteria for this measure. Further work is required to establish where the problem lies in Enfield. In other areas, a common reason for lack of submission was difficulty obtaining data from GP practices; our statistical neighbour Haringey was unable to submit as some GP practices had not submitted their data returns. Further investigation is required to identify the root of the problem in Enfield. It is hoped that when the work has been completed to improve the health visiting data set that this will solve the problem with the 6-8 week prevalence data.

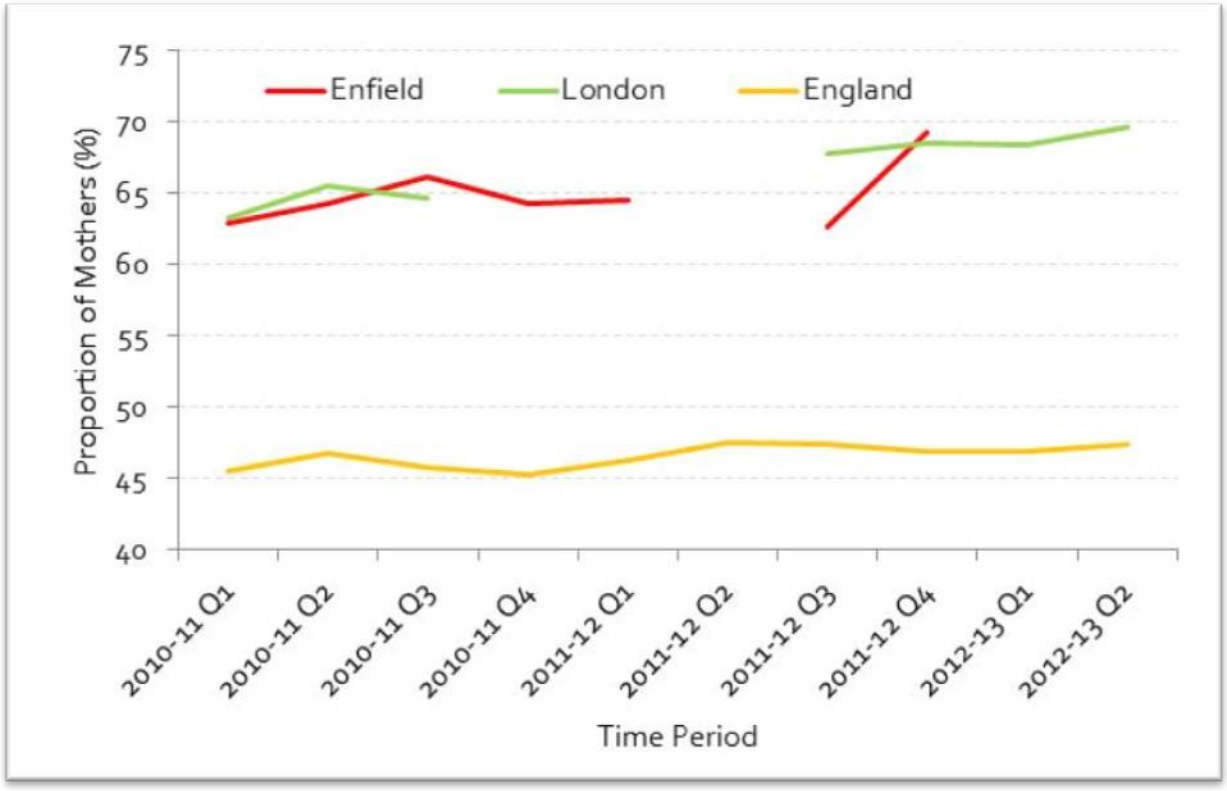

Figure 2 **Breastfeeding for 6-8 weeks 2010/11 to 2012/13**

ACTION TO ADDRESS BREASTFEEDING

A breastfeeding app has been developed which gives mothers information about breastfeeding and lets them know where the nearest breastfeeding-welcome business venue is.

The number of breastfeeding-welcome businesses (those that welcome mums and babies in their premises and agree that mums can breastfeed in all areas of their business that are open to the public) has increased to over 200.

HEALTH PROTECTION

IMMUNISATIONS

The report shows that Enfield has recorded rates of children immunised against MMR by the age of two of 88.6% (below 90%). This is well below the England average of 92.3, above the London average (87.3%), but below the 90% that is needed to protect the population. However, the average recorded rates of Dtap/IPV/Hib vaccination at 2 years was 92.8%, which while lower than the England average was above 90% coverage which is the goal.

ACTIONS TO ADDRESS IMMUNISATION RATES

There remain issues with the transfer of data from one system (Child Health Information System) to another (COVER which is the National Immunisations system). However, a lot of progress has been made and a protocol has been developed which allows the reporting of reliable data on local immunisation rates to COVER .

Immunisation is a standing item at Health Protection Forum meetings and the public health team is working with NHS England to improve rates of childhood immunisations. The Council is co-commissioning a school-aged immunisations service with NHS England which will provide a 'catch-up' service for children that have missed primary immunisations.

The rates of immunisations for children in care has been identified as an area where performance has been dipping and the public health team is working with the looked after children team to improve immunisation rates in this cohort.

Table 1 Enfield Immunisation Coverage 2014/2015

Immunisation	**N°. immunisations given**	**Enfield Coverage (%)**	**London Coverage (%)**	**England Coverage (%)**
Primary immunisations at 12 mths[1]	3962	90.8	90.3	94.2
MenC at 12 mths	4066	93.2	-	-
PCV at 12 mths	3954	90.6	90.6	93.9
Rotavirus at 12 mths	3348	76.8	-	-
MMR (second dose)	3723	86.1	81.1	88.6
HiB/MenC booster by 24 months	3964	88.6	86.8	92.1
PCV booster	3895	87.1	86.4	92.2
DTaP/IPV booster	4063	93.9	92.5	95.7

[1] Diphtheria, Tetanus, Pertussis, Pneumococcal and Haemophilus influenza (DTaP/IPV/HiB)

WIDER DETERMINANTS OF HEALTH

POVERTY AND HOMELESSNESS

While Enfield's child poverty rate[2] has reduced from the 2012 figure of 29.6% to 25.5%, it remains significantly higher than the London and England averages. This is partly due to families being housed in the borough by other authorities (owing to the relatively cheap housing) and partly because of difficulties obtaining well-paid job opportunities in the borough.

Enfield has a similar rate of family homelessness to London. The number of statutory homeless households with dependent children or pregnant women in Enfield has reduced very slightly from 4.3 to 4.2 per 1000 households, but this is still more than double the England average of 1.7 per 1000 households. However, this measure relates to statutory homeless households with dependent children or pregnant women per 1,000 households in 2013-14 and is likely to be an underrepresentation of the true number.

ACTION TO ADDRESS CHILD POVERTY

In November 2014 the Council's Public Health team held a child poverty conference to raise awareness of the high levels of poverty and to generate new ideas for how to tackle the problem. These ideas contributed to the child poverty action plan which was approved by CMB, and which was taken to the Enfield Strategic Partnership (ESP) for comments in early June 2015. The ESP agreed the action plan, but due to the in-year cuts to the public health ring-fenced budget the action plan was put aside until monies became available.

EDUCATION

Enfield has good outcomes above the regional and national averages for GCSE results. In 2014/15, 55.6% of young people in the borough achieved 5 or more A*-C GCSE results, including English and Maths. This was not significantly different to the London or England average and corresponds to over 2,000 young people in the borough achieving this level of education.

[2] Children aged 16 and under living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income

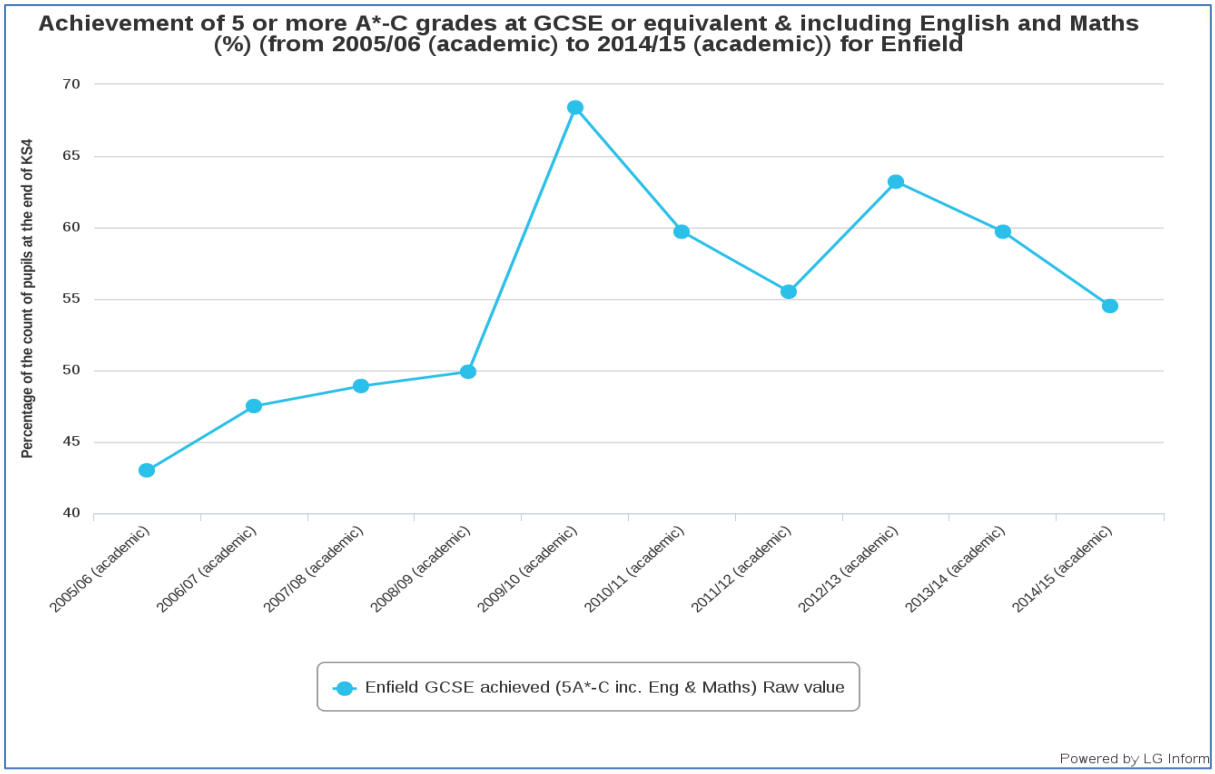

Figure 3 GCSE Achievement in Enfield, 2005/6 to 2014/5

In addition, the borough has a lower rate of young people Not in Education, Employment or Training (NEETs), 3.1% of the total cohort of 16-18 year-olds in 2014, compared to an England average of 4.7%.

However, Enfield has slightly below average results for children achieving a good level of development at the end of reception at 63.9% compared to an England average of 66.3%.

ACTION TO ADDRESS EDUCATION ISSUES

In response, the Council is working hard to increase funded childcare take-up and is developing a curriculum-focused approach centred on play and communication for implementation in the newly reformed Children's Centres.

YOUNG OFFENDERS

The rate of first time entrants to the youth justice system per 100,000 10-17 year olds has steadily reduced in the borough and is now 471.5 per 100,000 10-17 year olds. This is not significantly different from the England average.

In absolute numbers, the figure has dropped from about 450 first time entrants in 2008 to 155 in 2014.

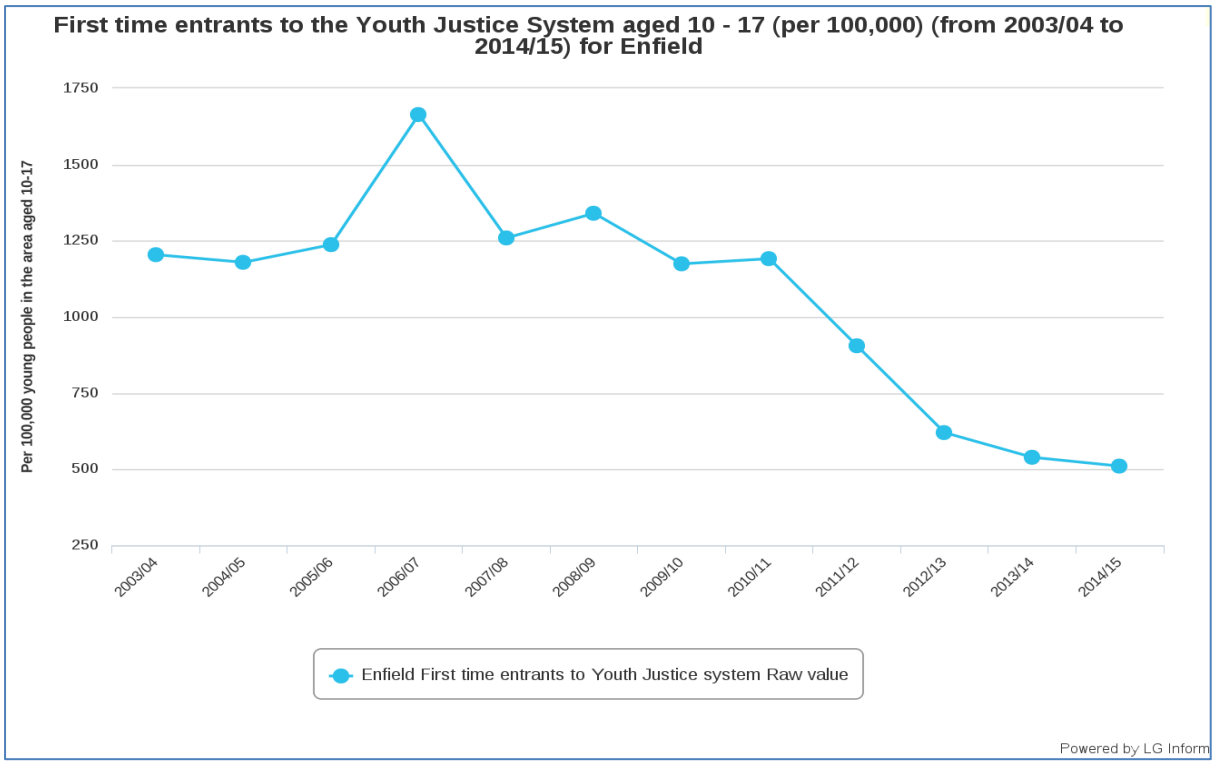

Figure 4 First time entrants to the youth Justice System in Enfield 2003/4 to 2014/15

ACTION TO ADDRESS YOUNG OFFENDER RATE

The falling First Time Entrant (FTE) rate between 2008 and 2014/15 has partly been achieved by a triage programme that targets around 150 young people per year who would otherwise be cautioned or charged. This triage work was carried out by the Youth and Family Support Service prevention team and is funded by Enfield Council. However, because of the reductions in Council funding the future of this service is not certain beyond March 2017.

CHILDREN IN CARE

In 2015, Enfield had a lower rate of children who were looked after (44 per 10,000 aged under 18) than London (52 per 10,000) and England (60 per 10,000).

Area	Value	Lower CI	Upper CI
England	60*	60	60
London PHE centre	52*	-	-
Barking and Dagenham	77*	70	84
Barnet	34*	30	38
Bexley	50*	44	56
Brent	44*	39	49
Bromley	37*	33	42
Camden	43*	37	50
City of London	*	-	-
Croydon	87*	81	93
Ealing	44*	40	49
Enfield	44*	39	49
Greenwich	80*	74	88
Hackney	58*	52	65
Hammersmith and Fulham	55*	47	63
Haringey	75*	68	83
Harrow	29*	25	34
Havering	45*	40	51
Hillingdon	48*	43	54
Hounslow	48*	43	54
Islington	90*	80	99
Kensington and Chelsea	38*	31	46
Kingston upon Thames	32*	26	38
Lambeth	78*	71	85
Lewisham	73*	66	79
Merton	34*	29	40
Newham	52*	47	57
Redbridge	29*	25	33
Richmond upon Thames	22*	18	27
Southwark	82*	75	89
Sutton	50*	44	58
Tower Hamlets	44*	39	49
Waltham Forest	42*	37	47
Wandsworth	37*	32	42
Westminster	44*	38	51

Source: Children looked after in England, Department for Education.

Figure 5 Looked after children per 10,000 population under 18, 31 March 2015.

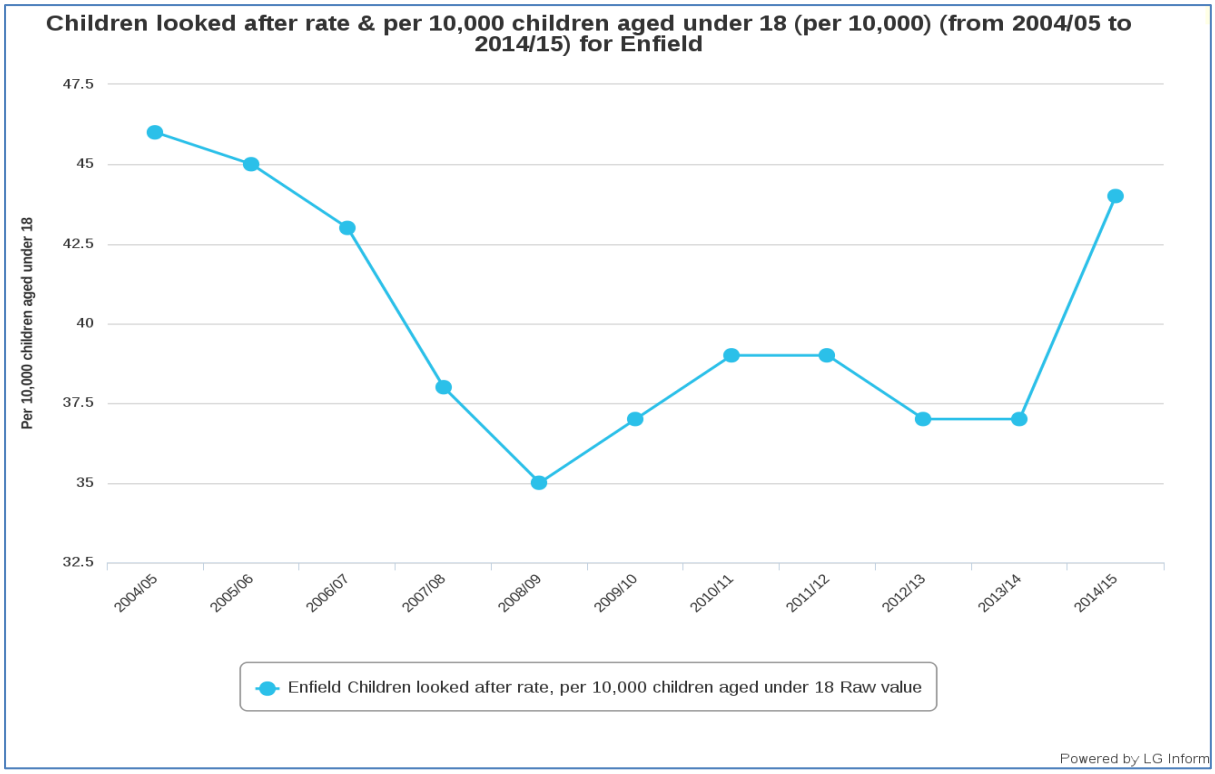

Figure 6 Rate of Looked after children per 10,000 children aged under 18 in Enfield 2004/5 to 2014/15

Enfield Children's Services were scrutinised by OFSTED last year and were awarded a Good status for services including those for looked after children. The OFSTED report noted that the thresholds for intervention in child protection matters were appropriate, but it should be noted that the number of looked after children has increased recently. This is in part due to a change in the law which now confers looked after child status on any young person who has been remanded through the courts. Despite this rise, Enfield still has relatively low levels of children in care when compared to other authorities in London or in the country.

ACTIONS TO ADDRESS THE RATES OF LOOKED AFTER CHILDREN

The rates of looked after children are maintained at a lower rate than London and England averages by a range of preventive services which have focused on supporting families to stay together wherever this is in the child's best interest. These include:

- Extensive support services for disabled children (allowing more families to cope in the community);
- Children's Centres and family support services which allow difficulties to be addressed as they arise;
- Family Group Conferences which allow alternative support from within the network to be identified;
- A Placements Panel made up of senior officers which ensures children only become looked after when all safe alternative options have been explored.

HEALTH IMPROVEMENT

OBESITY AND PHYSICAL ACTIVITY

Enfield has statistically significant higher rates of childhood obesity and overweight children at both reception and year 6. Enfield has higher rates than England average rates and the average rate for London. Enfield also has higher rates of obesity and overweight than statistical neighbours, with the exception of the rates in Greenwich for reception-aged children.

Table 2 Result of NCMP, Enfield, London and England, 2014/15 (academic year)

	Reception Year					Year 6				
	No of children measured	Participation rate	% Underweight	% Overweight	% Obese	No of children measured	Participation rate	% Underweight	% Overweight	% Obese
Enfield	4,106	89.5%	1.5%	12.7%	10.5%	3761	93.2%	1.5%	15.7%	25.4%
London	97,219	94.9%	1.6%	12.0%	10.1%	81,177	94.7%	1.7%	14.6%	22.6%
England	610,636	95.5%	1.0%	12.8%	9.1%	531,223	93.9%	1.4%	14.2%	19.1%

Source: Health and Social Care Information Centre (HSCIC)

There is a strong link between childhood obesity and poverty, so this is unsurprising given the high levels of child poverty in the borough. There is also a correlation between childhood obesity and ethnicity which needs further investigation in our borough.

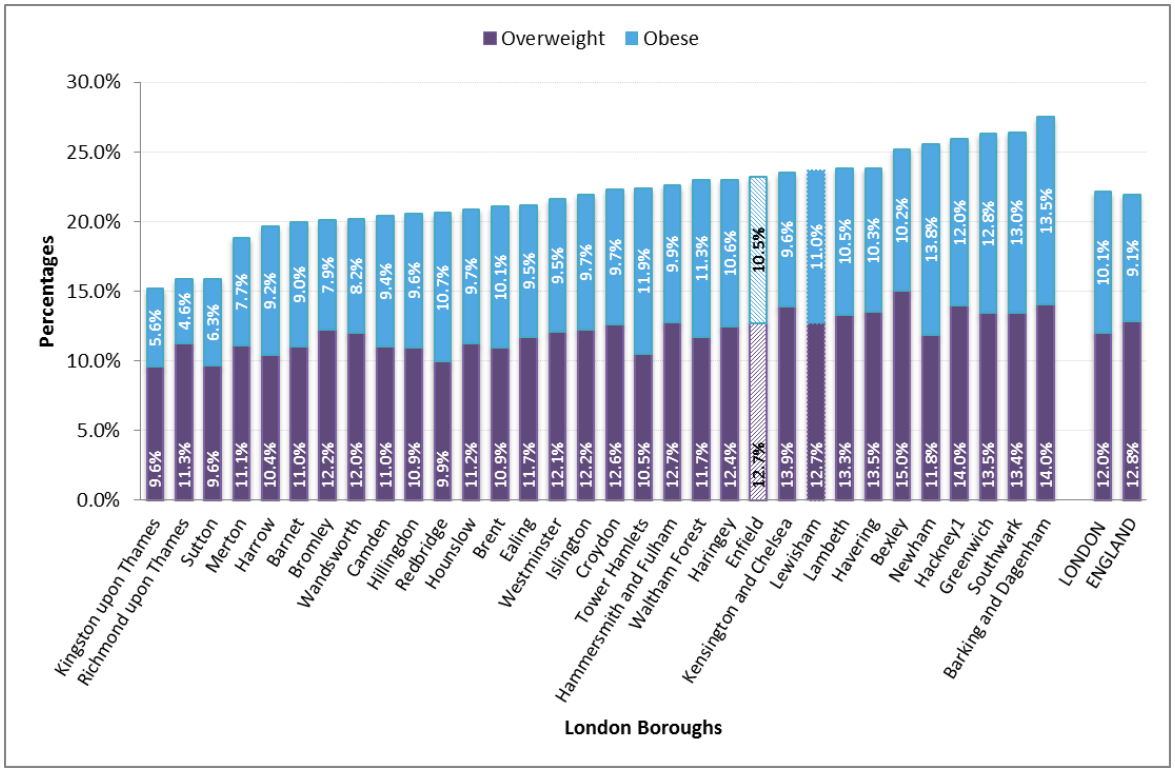

Figure 7 Prevalence of combined Overweight and Obesity in Reception Year pupils (aged 4-5 years) London boroughs; 2014/15
Source: Health and Social Care Information Centre

In Enfield, 58.7% of 15-yr olds reported that they ate the recommended amount of fruit and vegetables each day (at least 5 portions).This was better than England (52.4%, London (56.2%) and statistical neighbours.

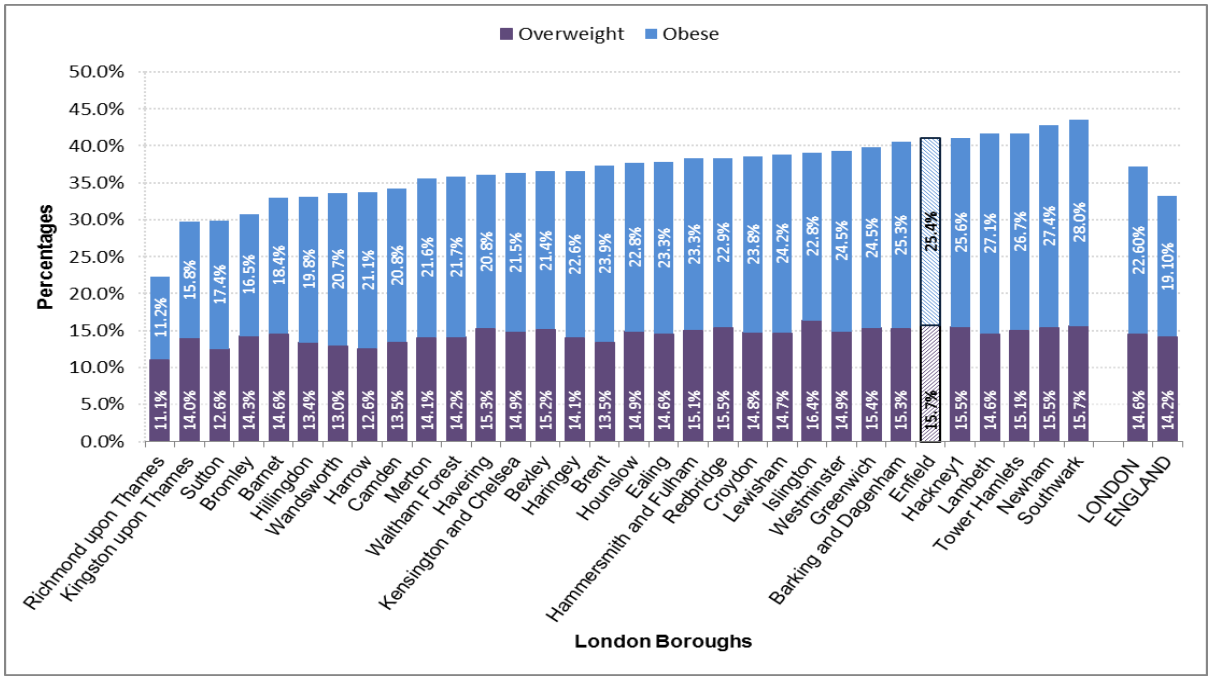

Figure 8 Prevalence of combined Overweight and Obesity in Year 6 pupils (aged 10-11 years) London boroughs; 2014/15
Source: Health and Social Care Information Centre

12.4% of our 15 year-olds meet the WHO guideline of an hour of moderate-to-vigorous physical activity per day. This is similar to the England average of 13.9%.

ACTION TO ADDRESS OBESITY AND PHYSICAL ACTIVITY

The following have been delivered in the borough:

- Delivering the Change 4 Life programme in Children's Centres;
- Supporting the Healthy Schools London programme, this awards schools for helping their pupils to maintain a healthy weight and lifestyle;
- Ensuring school playgrounds are designed to encourage varied and active play;
- Addressing parental concern around the perceived safety of walking and cycling;

The following are planned for the next year:

- Work to reduce consumption of sugary drinks by children.
- Development of a healthy eating programme to be delivered to children prior to their entry into reception year
- Further work to implement Cycle Enfield;
- Offering free places for the summer at local leisure centres for children identified as overweight or obese

ORAL HEALTH

Enfield has a significantly higher than London and National average rates of children with decayed, missing or filled teeth with 43.9% of children aged 5 with one or more decayed, missing or filled teeth. This is one of the highest rates of dental disease in London and compares to 27.9% nationally and 32.9% of children aged 5 for London.

In addition, as can be seen in the figure below, the oral health of 3-year olds in the borough is also a cause for concern.

Oral health, like obesity, is linked to poverty. Other reasons the rate is high may include: consumption of sugary drinks; families' lack of understanding of dental care in the UK and how to access NHS dentistry; parents who do not speak English may find it difficult to access services; and parents may not be getting the right information when their children are very young, so their first trip to the dentist occurs when they are already school age (this is too late).

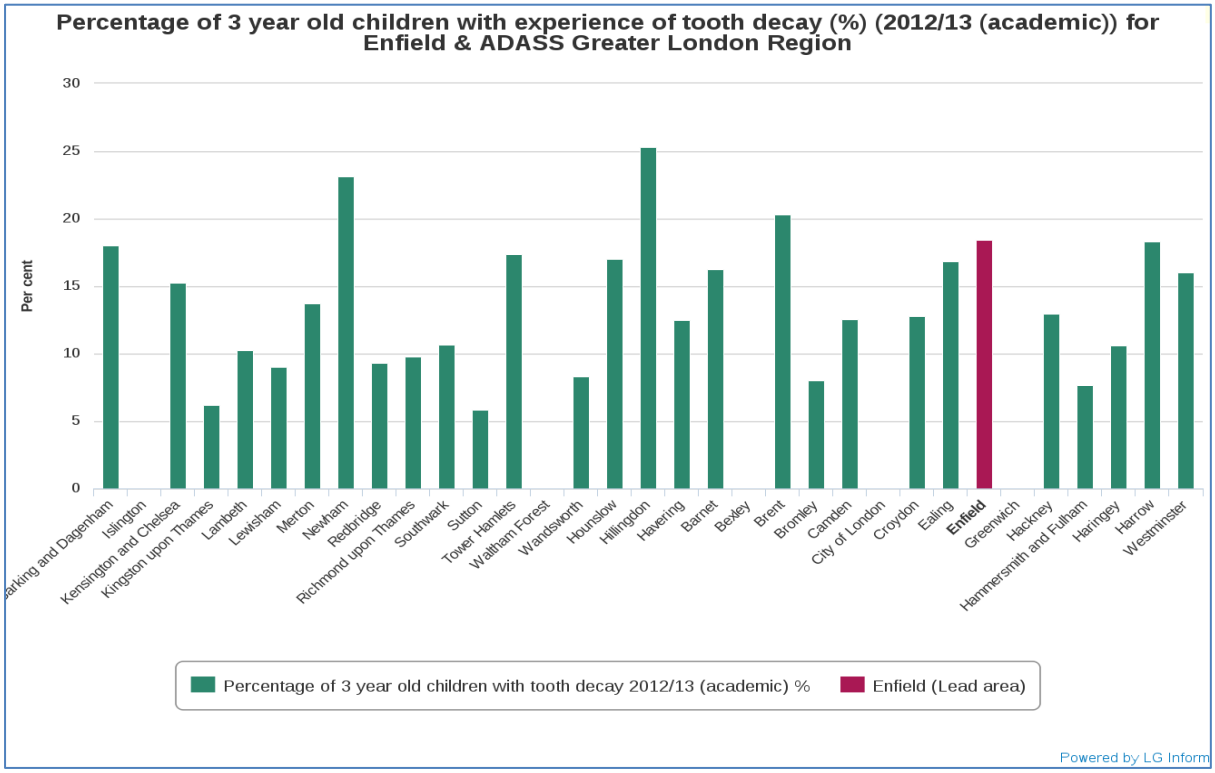

Figure 9 Oral health of 3 year olds in Enfield 2012/13. Source LGInform

ACTION TO ADDRESS ORAL HEALTH

There has been a significant programme of work to address this over the past year, including the distribution of 'Brushing for Life' packs, signposting to dentists, an outreach programme for special schools and oral health promotion training to primary school, community and frontline health staff and the training of parent dental advisors.

A number of schools are also engaged in a fluoride varnish pilot. This is a well-evidenced programme to apply varnish to the teeth of young children and is recommended by Public Health England's public dental health consultants.

TEENAGE PREGNANCY

Enfield's rates of under-18 conceptions was 24.6 per 1,000 females aged 15-17. This is above the national rate (22.8) and the London rate (21.5), but marks considerable improvement made over the last 5 years. The number of women aged less than 18 who delivered a baby in 2014/15 (teenage mothers) is lower than the English rate at 0.8% of deliveries, but higher than the London rate of 0.5%.

The rate of repeat abortions for under 25 year olds is higher than the England and London averages at 35.8% (compared to 27.0% for England and 32.3% for London). However, the percentage of terminations performed under 10 weeks is 82.7% which is higher than the England average of 90.4% and similar to the London average of 83.7%.

ACTION TO ADDRESS TEENAGE PREGNANCY

The teenage pregnancy rate was previously very high but a concerted campaign to make this a priority in the borough over a number of years has reaped rewards.

The falling rate is thanks to a number of interventions and programmes, including:

- The Enfield Young People's Project;
- Dedicated sexual health outreach nurses for under 19s;
- A condom distribution scheme;
- An emergency contraception scheme;
- Social networking;
- Youth Enfield website;
- Accessible clinics;
- Workforce training for professionals and volunteers working with young people.

SEXUALLY TRANSMITTED INFECTIONS

Enfield has a higher rate (1039 per 100,000 15-64 year olds) than the England average for new sexually transmitted infections among 15-24 years olds. This is lower than the London average of 1534 per 100,000.

There is a low proportion of 15-24 year olds in the borough that have been screened for chlamydia (18.1%) compared to London (27.9%) and England (24.3%) and the rate of chlamydia detection in young people is low at 1705 per 100,000 people aged 15-24 years.

ACTION TO ADDRESS SEXUALLY TRANSMITTED INFECTIONS

Enfield Council has procured a new sexual health service, to be delivered by North Middlesex University Hospital, to ensure that residents have the best possible access to testing and care. This included a substantial review of locations and delivery methods for Sexual Health services.There are new clinics planned in premises more accessible than the previous settings and plans to work more closely with the voluntary sector.

The Sexual Health Partnership Board is a multidisciplinary group that monitors data on sexual health and provides a forum to discuss and contribute to planning sexual health services in the borough.

The Public Health team has run preventative campaigns to encourage testing for STIs and HIV. It recently ran campaigns to coincide with national HIV testing week in November 2014, World AIDS Day in December 2014 and Valentine's Day 2015. The future of these campaigns, however, is not clear as the funding for public health has been reduced.

ALCOHOL AND SUBSTANCE MISUSE

Enfield's rate of under-18s admitted to hospital for alcohol specific conditions was lower at, 18.5 per 100,000 population for 2012/13-14/15, than the England (36.6 per 100,000) and London averages (23.7 per 100,000)[3].

Enfield's rate of 15-24 year olds admitted to hospital for substance misuse (44.9 per 100,000 15-24 year olds for 2012/13-2014/15) is also lower than the England (88.8 per 100,000) and London averages. This is statistically significant when the rate is compared to the England rate.

ACTIONS TO ADDRESS ALCOHOL AND SUBSTANCE MISUSE

In the past, the Public Health team coordinated an alcohol awareness campaign which encouraged different sections of Enfield's residents to drink sensibly, including young people. To target young people, posters were displayed in family centres, youth centres and cinemas.

There is a large programme of work led by the DAAT team on reducing substance misuse across the borough, including work targeted at young people.

- **Distribution of substance misuse information to maternity services** that midwives can hand out to patients where appropriate. This will include information for mothers to take away where there may be substance misuse needs with the father.

An evaluation of the impact and outcomes achieved by the joint maternity clinic will take place in early 2016.

[3] This is a different rate to that shown in the Child Health Profile, as it is based on more recent data. In fact this shows that the rate is coming down from 19.2 in 11/12-13/14 to 18.5 in 12/13-14/15.

Enfield's Drug and Alcohol Team commission Compass to provide an adult and young people's drug and alcohol service. The young people's service delivery includes a Hidden Harm service to support children and young people affected by parental substance misuse.

Enfield's Hidden Harm Parental Substance Misuse Service and North Middlesex Hospital's Maternity Services have been developing and implementing joint working arrangements to help improve engagement of pregnant women in both services and offer them the best care possible.

The joint working in place and currently being further developed include:

- A Care Pathway for pregnant women with substance misuse needs. This pathway is already in place and there have been a number of women who have been successfully care coordinated using this care pathway.
- The introduction of a lead role for pregnancy in Compass the adult drug and alcohol service, who will help draw together operational working between the adult drug and alcohol services, NMUH maternity services and the Hidden Harm Service. This lead role is already operational.
- Flexibility in the location in which appointments are delivered by both services to ensure they are as accessible as possible to encourage and increase engagement.
- Pregnant women with substance misuse needs have a named midwife for contact and a named substance misuse worker to support with care coordination and communication between the two services.
- The lead worker for pregnancy in Compass began a weekly Friday drug and alcohol clinic from NMH maternity services from August 2015. This coincides with the Consultant's clinic that takes place on a Friday morning. The lead worker for pregnancy from Compass is present at NMH maternity services all day on a Friday to enable them to deliver:
    - One to one sessions with patients
    - Group work sessions with patients
    - Joint sessions with midwives (on site or home visits)
    - Surgery space for midwives and other maternity staff to discuss cases
    - Bite size training programme to be developed and potentially delivered at the same time each week for professionals to attend

- Distribution of substance misuse information to maternity services that midwives can hand out to patients where appropriate. This will include information for mothers to take away where there may be substance misuse needs with the father.

HOSPITAL ADMISSIONS

Enfield has a higher rate of A&E attendances for 0-4 year olds (847.8 per 1000 children aged 0-4 years) than the London and England averages (540.5 per 1000 children aged 0-4 years).

It is not possible to identify all reasons why children attended A&E, but it is known that most of the children who were subsequently admitted attended for ear, nose and throat infections or upper airway infections. Some of these could be prevented by hand-hygiene of parents and carers and immunisation with pneumococcal vaccine, Hib vaccine and influenza vaccine. In addition, most viral bronchiolitis cases can be dealt with by GPs, out-of-hours GPs and urgent care centres. Appropriate triage by 111 services should help avoid unnecessary A&E attendance.

ACTION TO ADDRESS HOSPITAL ADMISSIONS

Actions already taken to reduce A&E use:

- To promote GP registration, Enfield Council distributed leaflets door-to-door informing where the nearest GPs are in Enfield Chase and Enfield Lock.
- The CCG has made additional investments into Urgent Care Centres, and arrangements have been made to employ GPs in the A&E department.
- In addition, an app was commissioned by the CCG for users of iPhones and Android phones to inform them of where to go to if they feel unwell.
- A booklet on common childhood illnesses was published last summer. This signposts parents to appropriate self- care, advises when professional help is needed and provides information on immunisations. The booklet was translated by public health into the main community languages with a web-based spoken word version for the Somali community.

HEALTH BEHAVIOURS IN YOUNG PEOPLE

The What About YOUth (WAY) survey is a lifestyle study of 15-year olds in England that collects data on risky behaviours, health and wellbeing.

The vast majority of children (84.1%) reported that their general health was excellent or good, a similar percentage to the England average of 85%. Enfield has a lower proportion of children with a long term illness, disability or condition and only 6.6% of children engaged in three or more of the risky behaviours they were asked about, much lower than the England average of 15.9%

HEALTHY WEIGHT

Over 50% (53.6%) of children reported that they felt their body was about the right size. This was similar to the England average and similar to the borough's statistical neighbours. The percentage of children reporting that they eat five portions of fruit and vegetables per day was 58.7% for Enfield which compares favourably with 56.2% in London and 52.4% in England. Physical activity levels among Enfield youth are below the England average with 12.4% of young people reaching the WHOs guideline of an hour of moderate to vigorous physical activity per day. The England average is 13.9% of young people.

MENTAL HEALTH AND WELLBEING

The mean Enfield score on the Warwick-Edinburgh Mental Wellbeing scale was 48.4, which is higher than the England mean score of 47.6. Additionally Enfield had high rates of bullying with 48.1% of children reporting that they had been bullied in the past couple of months. However, although this was a high percentage this was lower than the England and London averages.

E-CIGARETTES, SMOKING AND DRINKING

Only 2% of Enfield 15-year olds are regular smokers and this is lower than the England average of 5.5%.E-cigarettes have been tried at least once by 10.5% of 15-year olds, lower than the England value of 18.4%. In Enfield 1.8% of 15-year olds are regular drinkers, much lower that the England average of 6.2%. This may reflect ethnicities in the boroughs, as many cultures refrain from alcohol.

Agenda Item 6

HEALTH and WELLBEING BOARD

REPORT OF:

Bindi Nagra

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Agenda – Part:	**Item:**
Subject: Joint Commissioning Board Report	
Date: Tuesday 12th July 2016	

1. EXECUTIVE SUMMARY

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

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

1.3 This report notes:

- Updates on Section 75 Agreements with BEH MHT and the CCG [p.3]
- Housing Gateway pilot project to purchase accommodation from the open market to meet the specific needs of adults with disabilities [p.3-4]
- Enfield Integrated Care for Older People Programme:
  - Enfield Council, Enfield CCG and Enfield Community Services agree to a joint approach in developing Phase II of the Independent Locality Team [p.4]
  - The Council and CCG's joint commissioning of two voluntary care services [p.4-5]
  - Outline of the Community Crisis Response Team [p.5]
- Update on the success of the first cohort of clients serviced by the Family Nurse Partnership service [p.6]
- The CCG working with GPs to identify patients who may need to be assessed and added to Dementia Registers [p.8]
- Mental Health:
  - The CCG and BEH MHT has set up a Steering Group to explore opportunities for patients who are currently placed in Complex Care out of borough [p.9]
  - Scoping the potential of the borough's Mental Health Wellbeing Centre [p.9]

1. EXECUTIVE SUMMARY (CONTINUED)

- Learning Disabilities – Enfield Council received a Highly Commended Award at the Municipal Journal Local Government Achievement Awards 2016 and has been shortlisted as a finalist for the Health Transformation Awards [p.10]
- Introducing the draft Early Help Strategy 2016-19 [p.13]
- Work being carried out to launch the tender to secure a provider to deliver Residential and Nursing Care services from the former Elizabeth House site in eastern Enfield [p.15]
- Update on the recommissioning of Voluntary & Community Sector services [p.16-17]
- The Safeguarding Adults Board's Annual Report 2015-16 has been completed and is scheduled to be presented in full to the H&WB 5th October [p.17]
- The Multi-Agency Safeguarding Hub (MASH) is now fully operational [p.18-19]
- Update on Carers Week – 6th to 12th June
-
- Partnership Board updates [p.21-24]
  - Safeguarding Adults Board [p.21]
  - Carers Partnership Board [p.22-23]
  - Learning Difficulties Partnership Board [p.23-24 and Appendix 2]

2. RECOMMENDATIONS

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

3. INTEGRATED & PARTNERSHIP WORKING

3.1 SECTION 75 AGREEMENT

3.1.1 s75 Agreement between LBE and BEH MHT

Enfield Council and Barnet, Enfield and Haringey Mental Health Trust has revised the Section 75 agreement for Integrated Mental Health Services. The Council and Trust have a history of joint working, which was formalised in a Section 75 Agreement in 2008.

This partnership agreement enables the Trust and the Council to establish and maintain integrated provision for delivery of services to adults with mental health difficulties for whom the Trust and Council have a responsibility to provide health and social care. The Council and Trust managers ensure that their respective community mental health staff, work together to meet the assessed needs of Enfield residents, whose lives are affected by severe mental illness including dementia.

The creation of a new Section 75 Agreement will allow the two partners to build on work to date, providing an updated framework within which the service can be provided. The partnership arrangement will continue to delegate responsibility for management to the lead organisation - Barnet, Enfield and Haringey Mental Health Trust.

The Trust approved the revised agreement on 20th June and work is now underway to formally issue the agreement for signing.

3.1.2 s75 Agreement between LBE and Enfield CCG

Enfield Council and Enfield Clinical Commissioning Group (CCG) are currently renewing the Section 75 agreement for Adults. It is intended that this will include Children's services joint arrangements going forward. Agreements have been reached regarding the Better Care Fund (see separate report). Agreements are also proposed regarding some continuing healthcare within the Reprovision project (a new dual registered care home). The signing of a new Agreement for 2016/17 is expected to take place by the end of July 2016.

4. SPECIALIST HOUSING

4.1 Following development of the **Parsonage Lane** shared ownership pilot project (now near completion), a feasibility study is now underway to explore opportunities for the Council to offer mortgages to enable the purchase of fully wheelchair accessible shared ownership homes for people with long term disabilities. Assuming the outcome of this study is positive, this approach will provide an innovative solution to maximise the appropriate use of new build accessible homes for sale, whilst meeting escalating need for wheelchair accessible homes.

4.2 A pilot project with the **Housing Gateway** to purchase accommodation from the open market to meet the specific needs of adults with disabilities wishing to live independently in the community is progressing well. A multi-disciplinary project board has been established and property searches are now underway.

4.3 Following the announcement of additional funding from the Mayor's Care & Support Specialist Housing Fund, Health & Adult Social Care have worked in partnership with Housing Development Services to submit three bid applications in May 2016 for local housing development. This includes grant funding applications for:

- the development of Enfield's third Extra Care Housing Scheme for older people with care and support needs;
- the development of accessible and flexible respite accommodation for older people with dementia care needs.

Bid applications are now being assessed – an update on outcome shall be provided thereafter.

5. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

5.1 Identification and Primary Care Management

The first phase of development of the Integrated Locality Teams (ILT) – bringing together professionals across community health and social care to support GPs in their practices without organisational changes – was completed in 2014/15 and early indications are that this approach was successful in managing more complex cases of older people are at risk of hospitalisation.

An evaluation was undertaken in 2015/16 and it showed a clear reduction in the number attending A&E and being admitted to hospital from sample group:

- 31% reduction in A&E attendances;
- 28% reduction in emergency admissions, but 4% reduction in bed days
- 57% of people had reduced A&E attendances or no attendance post-intervention, 70% of people had reduced emergency admissions or no emergency admissions post-intervention.
- In general, patients were very much satisfied with the joined up health and social care they received at home. 96% of patients were 'very satisfied' or 'satisfied' with the range of services they received from the ILT. In addition, about 90% reported they are involved as much as they want to be in decisions about their health and social care
- 27% increase from 2014/15 in the number of patients discussed at ILT meetings.

Given the success of Phase 1, Enfield CCG, London Borough of Enfield and Enfield Community Services have agreed to a joint approach in developing Phase II which involves a jointly managed, co-located ILT team working across the 4 localities by Qrt.4 of 2016/17.

5.2 Voluntary Care Sector Services

Enfield CCG and LBE have jointly commissioned two voluntary care services, one to enable post-diagnostic support for people with dementia, the other to promote falls prevention, aligned to the new partnership approach to working with the sector. Age UK Enfield and its partners were awarded the contract to deliver both services following a tender process.

Falls prevention Service is focused around primary prevention for frail/older patients who at risk of (or those who have had) a fall/ fracture. The model sits within the Integrated Locality Teams to support the GPs and MDT meetings where possible and work closely with the Bone Health and Fracture Liaison Service

The service will provide drop in sessions which will be flexible for older people to attend within the community. There will be structured programmes such as Tai-Chi/Otago which will be jointly delivered by the 'Everybody Walks' Programme with LBE. The service, (which is non-clinical) has also been developed in collaboration with Enfield community falls and therapies teams as experts of Falls and Fractures.

The post diagnostic support for people with dementia service is delivered by Age UK in collaboration with partners from the voluntary sector, health and social care as part of the Integrated Locality Teams within the integrated care network.

The service supports people with dementia & their carers to navigate the care system and make choices both now and in the future about the help, care and support available to them from diagnosis onwards providing advice, information, signposting and/or advocacy.

5.3 **Crisis Response Team**

The Community Crisis Response Team (CCRT) provides a rapid assessment and immediate treatment/care for (>65) patients within their own homes, and care homes. It ensures that patients have access to an alternative treatment to prevent hospital admission where it is clinically appropriate.

CCRT covers unscheduled and/or enhanced care needs between the hours of 17:00 and 2:00 Monday to Sunday 365 days a year. Response is initiated between 20 minutes to two hours (depending on triage) of the referral being made; referrals can be made by LAS, Barndoc, NHS 111, the patient's GP, Social Services, Community Matrons, NHS Trusts or other health care professionals.

The team is made up of nurses and technical instructors (TIs) augmented by social services, telecare Safe & Connected services and home care support workers, providing short term care, treatment and rehabilitation support for a range of complex and enhanced care needs in the community. The service is able to prescribe and issue medication and equipment and where necessary make onward referrals to other services. The service has seen a total of 138 since April 2016.

5.4 **Dementia Diagnosis Rate**

Improving the rate of dementia diagnosis is a key performance indicator in Enfield's Better Care Fund Plan,. Enfield CCG works very closely with our GPs to continue to improve dementia diagnostic rates and ensure that patients are able to access the help and support they need. There has been a significant improvement from 45% in 2014/15 to 66.6% as of May 2016/17.

6. PUBLIC HEALTH

6.1 Family Nurse Partnership (FNP) service

On the 14th June the Council's first cohorts, that received support from the Family Nurse Partnership team, graduated - 18 young Mothers and toddlers.

This specialised service works with 100 vulnerable young Mothers under 20 years old from pregnancy until the child is two years old and their family (if possible). They are supported in parenting and interpersonal skills, accommodation, education and employment.

To date there have been 4 young mothers in the programme that were LAC and under section 20 (In voluntary care or no family in the UK).

A cost/savings analysis was carried out on a sample of the recent graduates:

- If, say, 50% of those that had graduated had not enrolled on the programme and had been taken into foster care this would have cost the Local Authority in the region of £280,800 per year. (This is averaged out at £600 per placement per week)

- If each of the sampled 9 had been accommodated in a mother and baby foster placement this would have cost £421,200 per year. (Average cost being £900 per week per placement)

- If all sampled 9 had been placed into Local Authority residential care this would have cost £1.17million per year (average being £2,500 per week per placement).

These samples do not take into account any issues that may raise the cost of Specialist Foster care for those with serious mental health, sexualised or aggressive behaviours.

Other services that FNP work with during the young person enrolment are:

- Housing, social care, YOT, Solace, police, substance misuse, sexual health services, CAMHS, IAPT, acute mental health services, School Nurses, Education Welfare.

As evidenced in the recent 'Building Blocks' trial (RCT, Oct 2015), FNP is known to identify safeguarding risks early and prevents child maltreatment through the intensive work of the Programme.

It could, therefore, be presumed that enrolling onto the FNP programme assisted in keeping these vulnerable young parents away from gangs, youth offending, improving their health and that of their child.

Educational attainment levels of children born to mothers who are enrolled onto the FNP programme are known to achieve at least that of their peers' average, but early signs are that they are achieving above average levels.

Raising aspirations within this vulnerable group of parents is key to changing the life chances of these babies.

There are currently 98 young women either fully enrolled or preparing to enrol onto the programme.

6.2 **Sexual Health – Condom distribution in-borough**

The borough's condom distribution scheme is currently being reviewed. The service was launched in 2009 and during its tenure has been relocated two times, which has affected activity.

During a survey, young people told staff that they do not go to clinics for condoms because they have a long wait, fill out too many forms and answer too many questions just to get free condoms. They also don't like 'hanging around' in waiting rooms as they don't know who is going to see them and make judgements about why they are at the clinic – they just want to be able to access condoms quickly.

The service has to be easily accessible i.e. open after school until 5pm every day with a late night openings. Registration should be quick and easy to understand.

The Teenage Pregnancy Team reported that the service has significantly declined since being moved to the Claverings site.

Year and location	Total Registrations for Enfield	Total no. of Condoms for Enfield
2009/10 1st year of scheme Ponders End High St	256	3,053
2010/11 Ponders End High St	554	10,305
2011/12 Ponders End High St	678	12,580
2012/13 Enfield Highway Library	367	8,517
2013/14 Enfield Highway Library	480	10,987
2014/15 Claverings	393	8,082
2015/16 Claverings	249	5,861

As the sexual health lead provider for the borough, North Middlesex has taken all of this feedback on board and is working with the Teenage Pregnancy team, designing a delivery model for Enfield clinics that will make registering and accessing condoms easier.

7. SERVICE AREA COMMISSIONING ACTIVITY

7.1 Older People – Dementia

7.1.1 NHS Enfield CCG has been working with GPs to identify those patients with a formal diagnosis of dementia who need to be added to individual GPs Dementia Registers, as well as those individuals who may need to be assessed for a formal diagnosis from the Memory Service. The Review indicated an improvement area was post-diagnostic support for people with dementia, and a voluntary sector service linked to the Memory Service is being mobilised (see Integrated Care).

7.1.2 The post-diagnostic service will support Enfield to increase the proportion of older people likely to have dementia in Enfield (estimated at around 3,000) who were known to be on GPs' Dementia Registers to increase.
The BEH-MHT led Memory Service for dementia diagnosis has achieved the appointment of an additional Consultant Psychiatrist to support the achievement of the national dementia diagnosis target, including bringing the service in line with 6 weeks to diagnosis. BEH-MHT and Enfield CCG have developed at Steering Group which is working through issues around the clinical pathway including imaging for diagnostic testing.

7.1.3 As at June 2016 the service is now achieving referral to diagnosis within 6 weeks. The steering group is currently working on a revised and updated service specification including clinical pathways and from this it is expected that further opportunities for enhancing support and guidance for service users within the framework of a system wide/partnership approach can be identified and developed.

7.1.4 The current diagnostic performance for people with dementia has improved and is currently at 58% against target. It is expected that this figure will improve further to achieve the target of 66.7%. A trajectory for this is being developed by the Steering Group.

7.2 Mental Health

7.2.1 The CCG has appointed a Head of Mental Health Commissioning who commences on 4th July 2016.

7.2.2 An updated National Mental Health Crisis Care Concordat (MHCCC) has been developed and will continue to focus on the four pillars of the Crisis Care Concordat

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well

Next Steps – Continue to work with all stakeholders across the health and social care system to ensure that clinical pathways, timescales and social/housing pathways are aligned to ensure appropriate and effective

communication processes to develop solutions to enable timely and sustainable discharge from inpatient beds.

The current crisis concordat plan is being formally reviewed in a system wide (Tri borough, Barnet Enfield Haringey) workshop led by Enfield CCG to be held in 18th July 2016. This workshop will focus on the 4 pillars of the concordat identified above.

The workshop will determine

- Where are we now
- Where are there gaps in the current plan
- Way forward and reporting governance structure.

7.2.3 Mental Health Complex Care Rehabilitation - Enfield CCG with BEH-MHT has commenced a Steering Group to explore opportunities for this cohort of patients who are currently placed in care environments out of borough. Further detail will follow as this project is currently in its scoping stage. It is also envisaged to develop community services as part of the clinical pathway aimed at achieving independent living, including a walk in community safe haven facility.

7.2.4 Enhancing Mental Health Support in Primary Care - Enfield CCG is currently scoping what enhanced support for GP's should look like to achieve the strategic goals of more persons being able to be cared for in primary care and reducing dependency on secondary care services.
We envisage this to be in the form of mental health link workers from secondary care supporting GP's and a safe haven/crisis café type facility within Enfield.

7.2.5 Mental Health – Wellbeing Centre
Initial work on scoping the potential of the Mental Health Wellbeing Centre has begun with a work plan devised for development.

Desk research is currently being undertaken looking at similar Centres around the country and the costs associated. Also researching the 'Safe Haven' model and have the Centre will dual usage, being used as a Safe Haven in the evenings and possibly weekends.

A number of organisations have expressed an interest in the development of the Centre and how they can provide support and service. Most notably The Ark (ECYPS) and North London Hospice could possibly offer their buildings for use as needed. The North London Hospice in Barrowell Green is a good model for a Wellbeing Centre in design and layout and their management have been very generous in providing information about their build and their advice.

Discussion is also taking place about the service model we wish to see implemented. A steering group will be set up for September to govern the Centre's development.

7.3 **Learning Disabilities**

7.3.1 Transforming Care for adults with learning disabilities (Winterbourne View)

Enfield continues to be one of the leading areas in terms of implementation of the Transforming Care programme and the Concordat.

All age health and care Commissioners from the North Central London (NCL - Barnet, Enfield, Haringey, Islington and Camden) area are working together to develop the NCL Transforming Care Plan for people with learning disabilities.

The aim of the transformation plan is to develop a sustainable system and new model of service delivery for the NCL area that is focussed on supporting people with learning disabilities to remain healthy and well in the community and reduce avoidable admissions to assessment and treatment and inpatient services. The NCL commissioners have worked together to set a baseline for assessment and treatment and inpatient activity and we have developed key objectives that outline how we intend to reduce activity by 50% in line with the new national service delivery model. The key aims of the new national service model are:

- more choice for people and their families, and more say in their care;
- providing more care in the community, with personalised support provided by multi-disciplinary health and care teams;
- more innovative services to give people a range of care options, with personal budgets, so that care meets individuals' needs;
- providing early more intensive support for those who need it, so that people can stay in the community, close to home;
- but for those that do need in-patient care, ensuring it is only for as long as they need it.

Enfield handed over SRO lead for delivery of the NCL Transformation plan at the beginning of May and we continue to share our good practice with our NCL partners.

Municipal Journal (MJ) Local Government Achievement Awards 2016

Enfield Council was short listed as a finalist for the Municipal Journal (MJ) Local Government Achievement Awards 2016. We outlined our approach to delivering our Transforming Care Programme for people with learning disabilities in the "Delivering Better Outcomes" category. We received a Highly Commended Award at the ceremony on the 16th of June 2016. We have also been shortlisted as a finalist for the Health Transformation Awards. The ceremony is being held on 29th of June 2016.

7.3.2 **Collaborative contract framework for people with learning disabilities**

Waltham Forest, Hackney and Enfield have collaborated to establish a contract framework for people with learning disabilities who require health, care and support to live independently.

The tender commenced in October and closed at the beginning of November. Commissioners from Waltham Forest, Hackney and Enfield have evaluated all the 24 bids that were submitted and shortlisted to 12 organisations. We are currently developing internal processes with a view to start drawing off of the contract framework by the end of June 2016. Experts by Experience (Parent / Carers and people with learning disabilities) were supported to take part in the procurement and the interview process, and actively contributed towards evaluation.

The aim of the contract framework is to diversify the local supported living market and improve quality, safety and efficiency outcomes for people with learning disabilities who meet the eligibility criteria for specialist health and care. Enfield CCG will be able to utilise this contract framework also.

Islington has expressed an interest to join the contract Framework. Following a presentation by Enfield's LD commissioner at a meeting in May of the NCL learning disabilities commissioner's network, Camden and Barnet are also considering joining the framework.

7.3.3 **New developments**

Commissioning is currently working in partnership with the Council's Housing Gateway to develop a process for accessing accommodation through this means. We are also in communication with the Housing Policy team to ensure that people with learning disabilities can access housing and housing advice, advocacy and support where necessary.

7.3.4 **Implementation of the Joint Strategy for People with Autism**

Commissioning is working with a local voluntary and community sector provider - One-2-One - to implement the strategy for adults with autism.

a. We are developing a set of standards and principles for practitioners to work towards when supporting someone with autism. Membership includes: ILDS, BEHMHT, Royal Free London, Social care workforce, Children's and young people clinicians and experts by experience.

b. The Peer Support Group network that is jointly facilitated by One-to-One and the National Autistic Society (NAS) now have over 60 members. The peer support group is arranging drop in sessions across Enfield and an event that is funded by Enfield Council's Autism Innovation fund where self- advocates will be testing technology and apps that are designed to support people with autism to self- manage and prevent episodes of low level anxiety and depression. The peer support group are aiming to prepare an overview of this research in a report that summarises their views of how effective this technology is. This report will be transposed into accessible formats and will be shared with the Council and MH Trusts and special interest groups with a view to contributing towards providing information about the different options and assistive technology available to support people with autism to remain healthy and well in the community.

c. Commissioners from across Barnet, Enfield and Haringey are working together to identify existing demand, access, trends, activity and expenditure for people with autism. This information will inform pathway redesign with a commitment to commissioning more local provision for diagnosis and post-diagnostic support. The Enfield Practitioners working group have drafted a model for delivering local autism diagnostic and post-diagnostic support options and Commissioners are now considering options for taking this forward. The draft model includes:

- screening and self- management tools that can be used by individuals, GP's, Health and Care Navigators and support workers

- health and care professionals for people who meet the eligibility criteria for health and / or care services

- VCS support hub and peer support networks

d. The Autism Steering Group hosted a very successful conference on the 6th April. This was very well attended and feedback has been very positive. The Autism Team (Practitioners Working Group) has been established and three meeting have been held. The monthly drop in session is now up and running and well attended.

7.4 **Children's Services**

7.4.1 Joint Enfield Council and CCG Strategy for Emotional Wellbeing and Child and Adolescent Mental Health for 0-18 year olds in Enfield
Implementation of the plan is being progressed through the CAMHS Partnership Group, which is in in turn accountable to the Joint Commissioning Board. The recruitment has begun for STAY (Strengthening the Team Around You) and SCAN (Neurodevelopmental conditions).

7.4.2 Transforming Care -
The Transforming Care work focuses on CYP with mental health, autism and learning disabilities conditions and at risk of mental health inpatient or other out of borough residential placements. A Transforming Care North Central London Wide Implementation Group has been set up to coordinate the work. A local Enfield working group will be set up shortly. There are monthly discussions about young people is held at the Complex Issues Panel.

7.4.3 Strengthening the Team Around You (STAY) (formerly the Enhanced Behaviour Support Service)
This service will work closely with the Joint Disability Service, education services, and adult and transition services. As above, BEH Mental Health Trust is re-advertising posts.

7.5 **Early Help Strategy 2016-19 (Age coverage: 0 – 19/25)**

Early Help in Enfield is defined as:

"Intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population most at risk of developing problems. Early intervention may occur at any point in a child or young person's life".

The Draft Early Help Strategy 2016-19 (the 'Strategy'), sets out the role and purpose of Early Help in Enfield, providing 16 recommendations to address the urgent need for a renewed focus and alignment of services because of the changing context within which all partners are working.

This would ensure our Early Help offer remains sustainable, effective and continues to meet the needs of service users.

As well as key challenges and areas of improvement identified with the support of partners, drivers for creating the Strategy include:

- Financial pressures and reduced resourcing levels across all partner organisations
- The transformation agenda across public services
- The recommendations of the Munro, Family Justice and Allen Reviews
- Ofsted recommendations
- Government focus on "Troubled Families"
- Review of Early Help for Under 5s

There is further work to be completed in order to produce an action plan and ensure continued strategic alignment of the Strategy. We are currently conducting analysis of our mapping and anticipate having an action plan and final Strategy by October 2016.

The Strategy will be owned by the Enfield Safeguarding Children Board (ESCB) and has been reviewed by the Children's and Education DMT. It is recommended given the role and remit of the Health and Wellbeing Board, that the Board also have some oversight of the Strategy (see Appendix 1 for further information).

7.6 DRUG AND ALCOHOL ACTION TEAM (DAAT) –

7.6.1 <u>Performance for Drug Users in Treatment</u>

The NDTMS ratified data for the 12 month rolling period April 2015 to March 2016 has confirmed that:

- The DAAT has seen 1077 Drug Users In Treatment during the year; 63 more than the end of year target.
- The Successful Treatment Completion Rate for the end of the year was 26.0% which is 4.6% above the target. It is 6.7% above the London average and 10.8% above the National average.
- Our ranking for Successful Treatment Completions for the end of year performance confirmed that Enfield reached 6th place in London.

The Numbers of Drug Users in Treatment and the Successful Treatment Completion rate for Enfield DAAT is summarised in Fig.1 below:-

Fig. 1: Successful Completions All Drug Users (Partnership)

Partnership	Apr 2014 to Mar 2015 Baseline	Apr-15 to Mar-16 Actual	Apr 2015 to Mar 2016 Target
Number of Successful Completions	177	280	**217**
Numbers in Treatment	977	1077	**1014**
% Successful Completions	**18.1%**	**26.0%**	**21.4%**
% London Average	19.6%	**19.3%**	
% National Average	15.8%	**15.2%**	

7.6.2 Numbers of Alcohol Users in Treatment

The Alcohol performance has remained good with 338 users In Treatment for the latest ratified NDTMS period for April 2015 to March 2016.
There has been a marked improvement in quality from the Baseline with Alcohol Successful Treatment Completions now at 50.0%. This is 7.9% above the London and 10.8% above the National averages. The London ranking now stands at 7th for this measure.

The Numbers of Alcohol Users in Treatment and the Successful Treatment Completion rate for Enfield DAAT is summarised in Fig. 2 below:-

Partnership	Apr 2014 to Mar 2015 Baseline	Apr-15 to Mar-16 Actual	Apr 2015 to Mar 2016 Target
Number of Successful Completions	113	169	**122**
Numbers in Treatment	326	338	**326**
% Successful Completions	**34.7%**	**50.0%**	**37.4%**
% London Average	39.3%	**42.1%**	
% National Average	39.2%	**39.2%**	

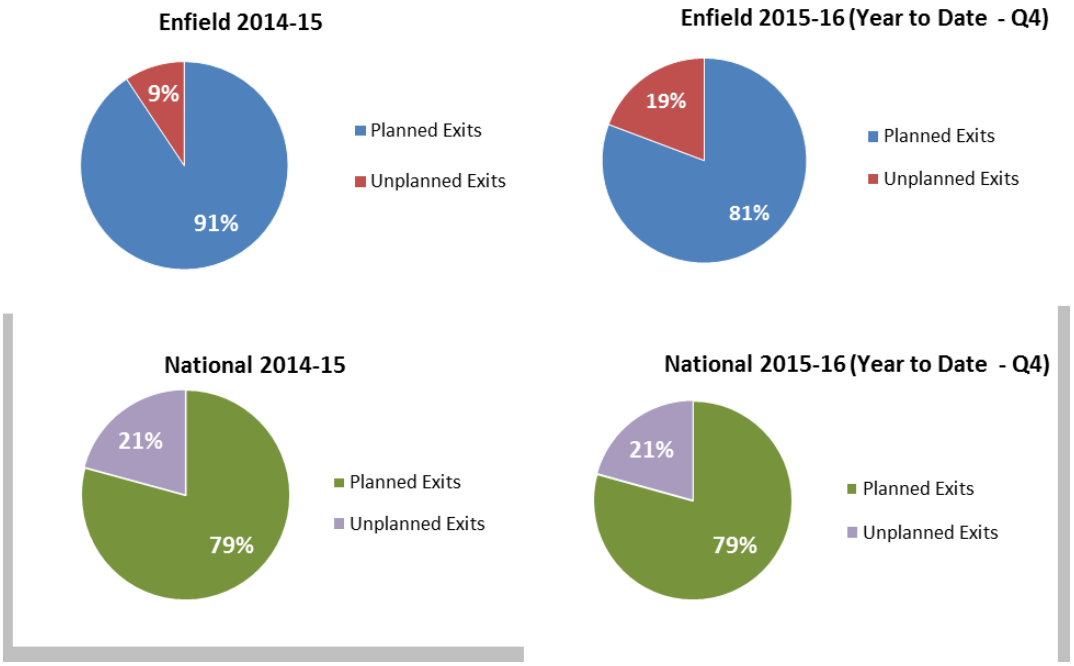
7.6.3 Number of Young People in Substance Misuse Treatment

The NDTMS ratified data for the number of Young People In Drug or Alcohol Treatment for Q4 2015/16 has further increased to an all-time high of 208. This increase corresponds to a 14% improvement while Nationally the number of Young People in Treatment has declined in the same period by 7%.

The Planned Treatment Exit rate has slightly decreased to 81% but this is still 2% above the National average which shows acceptable progress in

young people's substance misuse provision given the overall achievement in quantitative growth.

DAAT Young People Planned Treatment Exits



8. REPROVISION PROJECT

8.1 Building works continue on the build of a new 70 bed care home on the former Elizabeth House site in eastern Enfield. Morgan Sindall is now in week 43 of the build programme and practical completion remains on target for 28th October 2016. The roof structure has been completed and internal room partitions are ongoing on ground and first floors; this month brickwork and window installation is due to commence.

8.2 Communication and Engagement activities continue:

- Regular newsletters circulated to local neighbours
- The topping out ceremony was held on 12th May.
- Update briefings were held with residents, families and friends at both Coppice Wood Lodge and Bridge House.

8.3 The Planning & Commissioning hub are working to launch the tender to secure a provider to deliver Residential and Nursing Care services from this home. The Council has actively engaged with the Market to better understand why previous attempts to secure a Provider have been unsuccessful. As a result, the team are working to refine and modify requirements where practical to make this opportunity as attractive as possible to potential providers. Contract award is anticipated October/November 2016.

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

Further to the update provided in the last report:

Two consultation events were held, in partnership with Enfield Voluntary Action, in January this year where the sector was asked for its views over areas for investment and commissioning. From those workshops the following outcomes for recommissioning were agreed:

- Helping People Continue Caring
- Supporting vulnerable adults to remain living healthily and independently in the community including avoiding crises
- Supporting people to improve their health and wellbeing/improving self-management
- Helping Vulnerable Adults to have a voice
- Preventing Social Isolation
- People recover from illness, safe and appropriate discharge from hospital
- Increased and improved information provision

A follow up event was held in April and these intentions were communicated to the sector along with the following information on how the commissioning will be structured:

- One contract will be awarded for each outcome
- Partnership/consortia bids are strongly recommended and will be weighted in the tender process
- Outcome based events are organised for mid/late July prior – a chance to meet others interested in each outcome and work together. These sessions will be chaired by the Institute of Public Care and will look at forming successful consortiums as well as the outcomes themselves.
- Support around bid writing and tender process will be organised from September
- New monitoring arrangements with guidance published alongside new contract to demonstrate effectiveness and impact
- Specifications will be published by the end of July/beginning of August
- New services commissioned by 2017/8 financial year
- In addition, each lead partner of the successful bid will be offered additional funding for leadership costs (as part of the strategic funding for Age and Disability). Amounts to be confirmed but likely in the region of £10,000 per annum

The intention is to commission intervention services to meet all needs from all communities. Discussion is still on-going with Enfield CCG about joint commissioning arrangements, something HHASC is very keen on. Commissioners will be looking at how to spend the limited resources available in order to achieve the greatest impact. This will require collaborative and joined up working from the voluntary and community sector in order to meet the requirements of the commissioning process.

In addition to prevention services, HHASC is also exploring additional opportunities to commission services that support the strategic voice of the differing age groups in the borough as well as disabled communities. The concept of a Mental Health Hub (physical or virtual) is being explored as a joint venture with the Enfield CCG which may be staffed by VCS organisations whom we grant fund. Additional opportunities for the VCS include brokerage, support planning and provision of Personal Assistants. These services will be commissioned separately to the prevention services and will not be grant aided.

10. SAFEGUARDING

10.1 Annual Report

The Safeguarding Adults Board's Annual Report 2015-2016 has been completed and is scheduled to be presented in full to the Health and Wellbeing Board on the 5th of October 2016.

This document is a statutory requirement under the Care Act 2014 and sets out what the Board has done to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area.

The report provides a summary of key areas: this includes the Boards accomplishments, quality assurance and organizational learning, outcome of Safeguarding Adult Reviews, the difference which has been made to adults at risk, performance data and contribution of partner statements. The future aims of the Board have been set out based upon consultation with partners and those whom use services and carers in early 2016.

10.2 Quality Checker Project Update

The Quality Checker project moved its base from Park Avenue Disability Centre to The Lancaster Centre, which is a community hub housing charitable organisations that provide a range of outreach services. This move aims to raise awareness of the project and strengthen links and promote joint working with other volunteer projects. The volunteers of the project are looking forward to being community based and enjoying opportunities to network with volunteers from partner organisations.

10.3 Dignity in Care Panel

The Dignity in Care Panel are Quality Checkers Volunteers who focus their visits and service reviews on LBE in-house services and whether or not they are meeting the recognised Dignity in Care Standards. The panel are working on the following service reviews and will provide feedback at the next Quality Improvement Board:

- Mystery shopping calls to Adult Abuse Line
- Review of Enablement Services
- Review of Brokerage services
- Review of LBE Mental Health Drop In Service

The work of the Dignity in Care panel is to give feedback on the customer experience and make recommendations for service improvements and highlight

good practices noted. The Dignity in Care panel work with the guidance of an independent Chair and the Volunteer Co-Ordinator

10.4 **Quality Checker Activities**

10.4.1 Meaningful Activities in Care Homes

The Quality Checker volunteers are continuing to make visits to care homes to gather feedback on the quality of the activities provided to residents and their level of engagement with the community and residents families and friends. This piece of work is expected to take a number of months due to the in-depth nature of visits made by the volunteers.

10.4.2 Hydration Working Group

The Quality Checkers continue to contribute to the work of the Hydration Working Group and have conducted a further series of visits to care homes across the borough to identify how people without verbal communication are kept adequately hydrated. The Quality Checker volunteers are also reviewing an information card being developed for care home staff giving top tips to spot signs of dehydration.

10.4.3 Awareness of Safeguarding in BME Communities

It is acknowledged that it is highly likely that safeguarding alerts are under reported from people from BME communities and this has raised an opportunity for the Quality Checker project to use their skills to help to close this gap.

The Quality Checker project has successfully recruited a number of volunteers from BME communities. These volunteers will be invited to support the development of a plan to raise awareness of safeguarding in BME communities. This will include raising awareness of the safeguarding process and identifying the barriers to raise appropriate alerts and reassurances that the process is fair and non-discriminatory. This supports the Making Safeguarding Personal agenda and promotes the person centred process now operating.

10.5 **Safeguarding Information Panel.**

The SIP continues to meet regularly to discuss the level of safeguarding alerts raised in the borough together with soft intelligence received. This data is used to assess the performance of providers in the borough and where necessary implement further fact finding or initiate the Provider Concerns process. The data collection and presentation for this his being reviewed to ensure that the data relied on is accurate and able to demonstrate themes of quality issues that are contributing factors to poor performance of providers. This information can then be effectively used to support the prevention of provider failure and increased safeguarding alerts being raised and allow early interventions to be deployed.

Currently working groups have been established to support the prevention of safeguarding alerts and provider failures. These outcomes of these work streams will feed in to the SIP to measure the impact of prevention strategies implemented.

10.6 The Adult **Multi-Agency Safeguarding Hub (MASH)**

10.6.1 The Multi-Agency Safeguarding Hub is operating from the refurbished 7th floor civic centre and has a full complement of permanently appointed staff.

10.6.2 **Referrals -** The MASH continues to receive approximately 300 referrals per month. Police risk assessments continue to be received in batches and this is causing both delay in responding to cases but also some duplication of work as the risk assessments are also being sent to Mental Health Services for action. This and other issues identified within this briefing will be addressed as part of the MASH implementation review

10.6.3 **North Middlesex Hospital -** all safeguarding concerns are now being referred directly to the MASH. North Middlesex has provided a dedicated email address for correspondence and in addition to a Safeguarding Co-ordinator, has identified Matrons to attend strategy meetings and to share information.

10.6.4 **Statistics –** A full suite of performance and activity measures had been agreed and electronic forms developed to support the MASH and its information and reporting requirements. There continue to be some delays in embedding this due to system access and reporting issues. The MASH manager does have access to system generated reports but as part of the review further work will be done to ensure performance and activity measures remain appropriate and proportionate.

10.6.5 **Partner Agencies –** MASH has continued to share and exchange information with partner agencies using the information sharing protocols in place. Response times from different agencies continue to be monitored. Communication and information sharing between children's services and the police has improved since the physical co-location on the 7th floor of the civic centre.

10.6.6 **Technology -** OLM has provided a further demo of MASH solution (Guardian) and delivery of this option to support the MASH will be wrapped up on ongoing discussions with the IT provider.

10.6.7 **Current Pressure Areas –**

- discussion underway to agree dedicated operational support hub support to process incoming referrals and minute taking duties;
- The volume of police risk assessments

10.6.8 **Interface Meetings: these are still in place and working well:**

Interface meetings have been set up to discuss cases, to avoid drift and to agree case responsibility.

- North Middlesex Hospital – fortnightly (alternate sites – MASH room/North Middlesex Hospital)
- Enfield CCG – weekly (MASH room)
- Weekly case management meeting with MASH managers re complex cases, receive support and guidance from seniors in MASH, CMS or Central Safeguarding (depending on the case)
- Crime Consultation (DV and police) – Civic Centre

11. CARERS

11.1 The Care Act and Carers Assessments

Enfield Carers Centre is carrying out a one year pilot programme to undertake standalone Carers Assessments and have employed two members of staff to implement the programme. This contract began on the 1st December 2015. The newly appointed Officers have undergone all their training and shadowing and assessments started in January 2016.

Data indicates that performance on Carers Assessments seems to have decreased in 2016/7. A review is underway to review performance and assess.

11.2 Carers Week (6 to 12 June)

Carers Week took place in the week beginning 6th June this year. The theme this year is 'Creating Carer Friendly Communities'.

Enfield Carers Centre undertook their usual outreach work in local supermarkets and shopping centres throughout the week. This was to increase the public awareness of carers and to fundraise. There seemed to be an increased level of support from supermarkets this year with the Centre able to be presence in the large Sainsbury's on the A10 and Ponders End Tesco. There was also outreach at North London Hospice Barrowell Green site.

Enfield Carers Centre hosted their annual Family Fun Day on Saturday 11th June outside Enfield Town Library. There were a variety of stalls, activities and entertainment. The day itself was very busy, with a bigger turn out than previous years, probably due to the good weather. There was lots of new interest in the Centre and a very positive day.

Enfield Council hosted two events – both poorly attended. The first was training for school governors around young carers where only three people attended. This highlights the need to continue to promote the young carers agenda to schools. A Question and Answer session with Ray James and other senior managers from Enfield CCG, BEH Mental Health Trust and Enfield Carers Centre attracted only four carers but a good discussion was held nevertheless. Reasons for the poor attendance when compared with last year's event have been suggested as the venue and no lunch provided. More positively, it has been stated that the Q&A sessions are usually well attended when people wish to complain so perhaps a low turnout is a positive thing!

11.3 Enfield Carers Centre

Statistics are from Quarter 4 – January –March 2016. Q1 2016/7 are due in July 2016.

The Centre now has 4,529 carers on the Carers Register. In addition, 1,002 carers hold a Carers Emergency Card. In this quarter the Centre registered 266 new carers.

The Carers Centre respite programme has allowed 286 carers to receive a break between January-March

In the Jan-March quarter, 70 carers received benefits advice from the ECC Benefits Advisor. This has highlighted the real need for benefit advice specifically for carers and is an excellent addition to the range of support the Centre provides.

The Hospital Liaison Worker continues to work on the wards at North Middlesex, Chase Farm and Barnet Hospital. Leaflets and posters are distributed and supplies kept topped up throughout all hospitals. Barnet Hospital has also a permanent pop up banner advertising Enfield Carers Centre near the lifts next to the outpatients department. In the quarter of January-March 2016 the Hospital Worker identified 60 new carers.

The Advocacy Worker has been taking up cases and has continued to promote the services within the VCS and with practitioners. In this quarter they provided support to 76 carers.

The newly established Transition project for young carers and young adult carers is running well, although funding is currently being sought to continue this work. In this quarter of operation the Young Adult Carer Project has identified 22 young adult carers.

The Centre's training programme has seen 157 carers attend a training sessions over this quarter. A further 24 carers have received one to one counselling during this period.

12. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

12.1 Safeguarding Adults Board (SAB)

At the Enfield Safeguarding Adults Board June 2016 a number of key areas were discussed. The year-end performance data was considered for 2015-2016 and highlights as follows:

- 3,511 referrals and reports were made into the Multi Agency Safeguarding Hub
- Of these 1,602 were Police Merlins. A high proportion related to adults with mental health needs
- There were 655 referrals from partners which were not referred as safeguarding. These included reports from Care Quality Commission, NHS 111 and the largest number from the London Ambulance Service
- There were a total of 1,244 safeguarding concerns raised to the Council. This compares with 996 last year and represents a 27.8% increase from the previous year

In relation to the safeguarding concerns we recorded as Section 42 Care Act criteria, we found that neglect (34% of cases) and multiple abuse (29%) of cases are the most reported. National trends from previous years also found similarly that neglect is the most predominantly reported type. Abuse was alleged to have happened in peoples in own homes in 37% of referrals and 30% in residential or nursing homes. Ethnicity of adult at risk continues to be predominantly from White British or White Other. This is a national issue and was discussed at the Board, to consider what action could be taken to address this concerning trend.

In 84% of cases a nominated advocate was involved. Finally, 59% of the cases which had a conclusion at the time of reporting were substantiated or partially substantiated. The performance data concluded with information from the Care Quality Commission related to providers and summary of latest published new approach ratings on active social care organisations in Enfield, including compliance actions, requirements notices and published warning notices. It was acknowledged that Enfield Council worked with 17 care provider under the Provider Concerns Process during the last financial year.

The Board agreed in March 2016 the ratification of London Multi Agency Adult Safeguarding Policy and Procedures from April 2016. This will significantly impact on the performance data to be reported during the next financial year. The most significant change is that outcomes recorded will relate to adult at risk identified outcome and to what extent these were met; we want to know the difference safeguarding made to the individual and if they felt safer. There is no longer recording using the classifications of substantiated, partially substantiated, inconclusive or not substantiated.

The Board received assurances from the Chair of the Quality, Performance & Safety sub-group of the Board with respect to work undertaken and the plan in progress for 2016-2017. The Board's updated strategy action plan for 2016-2017 was presented following consultation in early 2016 with service users, carers and organisations. This will be updated following the Boards suggestions and implemented immediately via the partnership, with quarterly reporting to the Board on progress. The Board will also receive action plans and progress reports on the two statutory Safeguarding Adult Reviews completed during 2015-2016; both action plans were agreed at Board level.

Two presentations were delivered to the Board:

- The first from the Central Metropolitan Police Service on how they have increased recording of disability hate crime. This presentation provided opportunity to discuss how this can be developed and improve local response to disability hate crime, which is currently under reported in safeguarding.
- The Board secondly received assurance from Barnet Enfield and Haringey Mental Health Trust with respect to their comprehensive Care Quality Commission Inspection.

12.2 <u>Carers Partnership Board (CPB)</u>

The Carers Partnership will now be chaired by Doug Wilson, Head of Strategy and Commissioning going forward.

The Carers Partnership Board held its away day in April and the focus was the priorities for the forthcoming year. The priorities identified were:

1. Young carers
2. Timely access to information and advice (with a particular focus on support for self-funders and financial information)
3. Protecting Carers Health and Wellbeing (including carers breaks)
4. Carers involved in care planning

These priorities will be written up into a Carers Multi Agency Action Plan (MAAP) and become a focus for the work of the Board over the next 2-3 years, being annually reviewed.

In addition the Board discussed the issue of social inclusion and the need for better adult changing facilities around the Borough. It was raised that many carers become socially isolated as they are only able to take the person they care for out for a short period of time due inadequate personal care facilities. This is likely to be a piece of project work for the Board going forward to try and influence social spaces to think about adult personal care facilities.

Again new carer representatives are needed for the partnership board and promotion will begin after the summer.

12.3 <u>Learning Difficulties Partnership Board (LDPB)</u>

The LDPB last met on the 16th May. The Big Issues for this meeting were the Financial Situation and The Learning Disability and Autism Council.

12.3.1 Bindi Nagra attended to the meeting to discuss the financial situation.
Bindi explained the situation in relation to reduced funding from central government, and the significant efforts made by the council to reduce 'Back Office' costs. Bindi further explained that the level of cuts were now such that there we need to look at reducing care purchasing budgets.

The board had an open and wide ranging discussion about how this could be done, focusing on partnership working between the local authority, the people we support and their carers.

Many carers still have significant concerns. Many carers were concerned about the wording of a recent cabinet report, suggesting the use of out of borough residential placements as a savings option for people with high community based packages. Binda acknowledged this was poorly worded. The board has written a response to this statement for the Health and Wellbeing board (see Appendix 2).

12.3.2 Leyla Cag, from One-to-One gave a presentation on the Learning Disabilities and Autism council.
There will be 10 councillors, with two places reserved for people with Autism. Councillors will be elected, and trained in their roles. Anyone who lives in Enfield and has a learning disability will have a vote and be eligible to stand.
The board decided that councillors will represent a geographic area, and each councillor will represent four of five council wards. Councillors will represent their constituents on local matters and issue that effect people with learning disabilities.
People who are currently members of the partnership board and its sub groups who are not elected to council will act in an advisory role.

Future members of the Partnership Board will be nominated by the council.

12.3.3 Marc Gadsby gave an update to the board on the future of the independence and wellbeing service.

Marc explained what the options were, and the reasons the council chose to create a Local Authority Trading Company.

Marc explained there will be a series of communication events over the next few weeks, and information on these was sent out with the minutes.

12.3.4 Peppa Aubyn spoke to the board about the Transforming Care Programme.
A Central and North West London Transforming Care Board is being developed.
Peppa explained that Enfield had achieved its targets, but this was an opportunity to provide a regional lead in promoting best practice.

People with experience of moving from Assessment and Treatment Units into the community, and their cares are invited to be part of this board. Anyone interested will contact Peppa.

12.3.5 Other business.
This was Peppa Aubyn's last Partnership Board before she moves on to her new role as Head of Mental Health Commissioning at the CCG, and the board thanked her for her excellent work.

There had not been a Focus Group meeting for some time. It was agreed that Chris O'Donnell will take on facilitating this.

Carers and Parents Enfield have yet to secure funding. They will be meeting with the carers centre to discuss.

The Health Sub Group has delivered training on annual health checks at a recent GP protected learning time event. The Community Nurses will be hosting a Diabetes Awareness Day at the Dugdale Centre on the 13th June.

The End of Life Care Steering Group has delivered two pilot courses on its revised End of Life Care training session, and will now roll out to providers.

The Transport Sub Group has completed its travel survey and launched it at an event attended by TFL, Safer Transport Police and local transport services.

Early Help Strategy 2016-19 (0 – 19/25)

Summary

The Draft Early Help Strategy 2016-19 (the 'Strategy'), sets out the role and purpose of Early Help in Enfield, providing 16 recommendations to address the urgent need for a renewed focus and alignment of services because of the changing context within which all partners are working.

This would ensure our Early Help offer remains sustainable, effective and continues to meet the needs of service users.

As well as key challenges and areas of improvement identified with the support of partners, drivers for creating the Strategy include:

- Financial pressures and reduced resourcing levels across all partner organisations
- The transformation agenda across public services
- The recommendations of the Munro, Family Justice and Allen Reviews
- Ofsted recommendations
- Government focus on "Troubled Families"
- Review of Early Help for Under 5s

There is further work to be completed in order to produce an action plan and ensure continued strategic alignment of the Strategy. We are currently conducting analysis of our mapping and anticipate having an action plan and final Strategy by October 2016.

The Strategy will be owned by the Enfield Safeguarding Children Board (ESCB) and has been reviewed by the Children's and Education DMT. It is recommended given the role and remit of the Health and Wellbeing Board, that the Board also have some oversight of the Strategy.

1. Background

1.1. Early Help in Enfield is defined as:

"Intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population most at risk of developing problems. Early intervention may occur at any point in a child or young person's life".

1.2. Working Together to Safeguard Children (2015) sets out a clear expectation that local agencies will work together and will collaborate to identify children with additional needs and provide support as soon as a problem emerges.

1.3. Providing early help is far more effective in promoting the welfare of children – and keeping them safe – than reacting later when any problems, may have become more entrenched.

1.4. In May 2016, following a mapping exercise and a series of thematic workshops with partners, **a Strategy was drafted to address the urgent need for a renewed focus and alignment of services because of the changing context within which all partners are working**.

1.5. **The key drivers** for such change are:

1.5.1. Financial pressures and reduced resourcing levels across all partner organisations
1.5.2. The transformation agenda across public services
1.5.3. The recommendations of the Munro, Family Justice and Allen Reviews
1.5.4. Ofsted recommendations
1.5.5. Government focus on "Troubled Families"
1.5.6. Review of Early Help for Under 5s

1.6. The Strategy comprises of 16 recommendations and recognises that with the pressing financial challenges that currently prevail, there is the need for a more keenly focused business case for early intervention, pre-empting and preventing the ever more costly levels of care and support of children and families that have reached crisis point.

1.7. The Strategy also aligns with the priorities and commitment to early intervention as set out in the *Enfield Children's Plan 2016-19.*

2. Aims

- Preserve family life wherever feasible
- Reduce family dependence on intensive/specialist services
- Get it "Right First Time"
- Deliver value for money services
- Encourage participation and engagement
- Reduce social exclusion
- Protect children from significant harm
- Narrow achievement gaps
- Prevent crime and anti-social behaviour
- Reduce exclusion and improve attendance at school
- Promote readiness for school
- Improve life opportunities for young people and their pathways into education, employment and training

3. Strategy Recommendations

3.1. Further analysis of mapping to identify priority needs
3.2. Continued communications through consultation, participation and co-design to ensure raised awareness
3.3. Urgent and prioritised work within the Council's IT work plan

3.4. Protocols to access specialist advice and guidance should be regularly reviewed and updated.

3.5. SoS training delivered to all partners and principles adopted

3.6. Regular information and training for partners on pathways and thresholds

3.7. Partners agree common mechanisms for recording information, actions and outcomes

3.8. Further explore evaluation tools in harmony with data collection requirements. ESCB should regularly monitor/review

3.9. Evidence based work to improve outcomes and analyse need to inform commissioning

3.10. Improve information sharing and review current protocols as part of ESCB work programme

3.11. Need a more formalised data and performance forum for Early Help services

3.12. Regular communications to all partners to achieve clarity and consistency

3.13. Parents/carers must give their explicit consent for information to be shared with other agencies in order to support need and offer additional Early Help services. The only exception is where there are explicit child protection concerns.

3.14. All referrals for Early Help services to be assessed against vulnerability scale at appropriate intervals until closure

3.15. Work towards a single standardised Early Help form

3.16. Continue developing Local Offer page to incorporate full Early Help offer

4. Progress to date

4.1. The Strategy has been approved by the Children's and Education DMT and has also been reviewed by the ESCB. We continue to collate any feedback.

4.2. In a 2015 report, Ofsted recommended that we ensure that the ESCB robustly monitors, evaluates and influences the effectiveness of early help services. As such, it has been agreed that the ESCB will have ownership of the Strategy.

4.3. We are currently conducting a needs assessment and further analysis of our mapping in order to produce an action plan later this year. We anticipate having the final Strategy and a plan by October 2016.

4.4. Given the role and remit of the Health and Wellbeing Board, it has also been recommended that the Board have some oversight of the Strategy, providing input and feedback as part of reviews and monitoring once the Strategy is finalised.

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Members of the Learning Disability Partnership Board were distressed to read the recent Cabinet Report under New Saving Proposals 2016/17 stating the following –

> *"Additional net reduction of £1.750m in personal budget allocations for LD clients. Including previous years MTFP the total savings will be £3.04m (15% of total purchasing budget)*
>
> *Reducing personal budgets by an average of 15% will significantly impact on the quality of life and additional burdens placed on informal and family carers. Some individuals not be able to be supported within the community within the existing budgets so will need to have their needs met in lower cost residential placements including out of borough. This approach is consistent with the National picture and approach in Adult Social Care."*

This has caused significantly increased anxiety for many family carers and service users and they strongly oppose this move.

The Partnership Board were disappointed that they and councillors appear to have been misled on the national position as there is no clear definition of the National picture and approach in Adult Social Care stated above.

The Partnership Board also felt that the statement that "personal budgets would be reduced by an average of 15% and that some individuals who were not able to be supported within existing budgets within their community will need to have their needs met in 'lower cost residential placements' including out of borough" was either badly drafted at best or ill judged and possibly in breach of the 2014 Care Act at worst.

The Partnership Board understand the financial position that the council faces, but would like reassurance that there will not be an arbitrary cut to people's personal budgets of 15%, and that the council will continue to support people to live as independently as possible in the local community in line with the real national agenda.

Carer representatives on the Board had written to Cllr. Taylor (copying Cllr. Cazimoglu and Ray James), detailing their concerns, and a response had been received from Bindi Nagra. This response was discussed at the LDLB, and it was felt that it did not fully address the Board's concerns. Mr Nagra has offered to attend the next LDPB meeting and his presence would be much appreciated, so that this matter may be clarified further.

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For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

MUNICIPAL YEAR 2015/2016 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board**	**Agenda - Part:** **Item:** **Subject: Health Improvement Partnership Board Update** **Approved by: Dr Shahed Ahmad**

Contact Officer:
Shahed Ahmad
Tel:
Email: Shahed.Ahmad@enfield.gov.uk

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 Board met on the 16th June 2016.

1.0 Annual Public Health Report 2015

The Annual Public Health Report (APHR) for 2015 was published on the Enfield Council website.

The APHR is a statutory duty for the Director of Public Health to report on the health of the local population. This year's report focussed on infant mortality and highlights the importance of evidence-led interventions that can improve infant mortality rates and includes joint working with Enfield's Children's Centres, Teenage Pregnancy Unit; and the Health Visiting and Family Nurse Partnership teams which have just come under Local Authority commissioning.

The report is available at: https://new.enfield.gov.uk/services/health/public-health/health-publications/annual-public-health-report/public-health-information-enfield-annual-public-health-report-2015_infant-mortality-in-enfield.pdf

The 2016 APHR will be on the topic of diabetes (a condition whose prevalence we expect to increase substantially over the next fifteen years) and should be available in the near future.

For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

2.0 NHS Planning guidance 2016/17-2020/21: Developing the North Central London Sustainability & Transformation Plan

The NHS England Planning Guidance 2016/17–2020/21 published on 22 December 2015 confirmed that as part of the 2016/17 annual planning process, we would also be required to a five year Sustainability and Transformation Plan (STP), driving delivery of the NHS England Five Year Forward View based on a the North Central London strategic planning footprint.

The Sustainability & Transformation Plan final submission to NHS England is 30th June 2016. The NHS England Planning Guidance makes it clear that in order to become sustainable we need to accelerate the work on prevention and care redesign. The guidance also sets out a requirement for local systems in order to achieve future sustainability they must accelerate their work on prevention and care redesign and expect acceleration in transformation in a few priority areas, in order to build momentum. These plans focus on delivery of the Five Year Forward View (FYFV) and an acceleration of service transformation as well as a shared approach to planning through system wide Strategic Planning Groups (SPG) including specialist commissioning, providers and local government.
Therefore the STP must deliver against the national direction of:

- A radical upgrade in prevention and public health;
- A concerted effort to improve the quality of care, aligned to the introduction of new models of care;
- A focus on getting finances back in balance; and
- A place based system wide vision for transformational change to address local and national challenges and priorities

3.0 Reducing burden of hypertension – Enfield's contribution to London wide initiative

In Enfield, around 74,000 people are estimated to have hypertension, yet almost half of those are not aware of their condition; and of those diagnosed, around 9,000 people do not have their blood pressure controlled to adequate levels. If we can match the level of detection and management of hypertension achieved in Canada, we could, over a five year period, prevent over 150 strokes and around 70 heart attacks in Enfield. Furthermore, cardiovascular disease including stroke and heart attack is the leading cause of death contributing to the life expectancy gaps in Enfield. Hypertension is therefore a priority for Enfield in improving population health as well as in reducing inequality in life expectancy.

The Enfield Council is working with CCG and partners to reduce variation in the level of hypertension management across GP practices, disseminating the latest intelligence, results of local pilot works to improve hypertension management and examples of best practice achieved locally with primary care professionals through Public Health newsletters for professionals and by meetings including Locality Business Meetings, pushing forward hypertension agenda.

Hypertension presents great opportunities in improving population health not just in Enfield but in London as a whole. For the system improvement to help reduce the burden of hypertension, it requires a regional and national leadership.

For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

Enfield took initiative in establishing and facilitating London Hypertension Leadership Group. The group was established in January 2016 with the aim of pushing forward the hypertension agenda at the London level by raising the profile of hypertension including in the NHS Sustainability and Transformation Plan (STP) and by pursuing a range of work to support and influence primary care practitioners, commissioners, and other stakeholders to increase levels of hypertension prevention, detection and management in London. The membership includes local public health representatives, voluntary sector, Academic Health Science Network, PHE and NHS England Healthy London Partnership. The group is now officially accepted as a reference group of the Healthy London Partnership Proactive Primary Care Programme.

Series of intelligence tools and evidence reviews have been delivered by this leadership group, which inform local authorities, CCG and SPG of the best practices. The group is now preparing for its first workshop in July, aiming to share best practices and evidence identified through the above activities as well as to facilitate effective networking between primary care practitioners, commissioners and voluntary sector organisations to create system for improved prevention, detection and management of the hypertension in London.

4.0 Atrial Fibrillation Update

Atrial fibrillation (AF) is a common arrhythmia and a major risk factor for ischemic stroke, especially in the elderly.

In Enfield AF prevalence is 1.07% (3,424 in number) (QOF 14/15). GP records show that 544 patients have been diagnosed with AF but not been offered eligible treatment. It is also estimated that 2,700 people in Enfield have AF without knowing they have it, increasing their preventable risk of stroke.

It is therefore important to identify patients with undiagnosed AF early as well as providing appropriate treatment (anti-coagulation) for those diagnosed and eligible but not yet offered the intervention. Providing early treatment to patients will have significant impact on the reduction of the risk of stroke attributable to AF and the complications due to a stroke event.

Public Health have been working with the Enfield Clinical Commissioning Group (ECCG) clinical leads and commissioners on the development and the production of the combined AF and pre-diabetes (precursor stage of type 2 diabetes) business case aimed at improving early detection and management of patients at risk of stroke and diabetes. The business case plans to detect in 3 years 2700 new undiagnosed patients with AF in addition to treating (anticoagulating) 544 eligible but not been provided with this treatment.
We hope, the successful delivery of this business case (AF) could avert at least 30 stroke which would otherwise result in about 9 deaths (31%), 28% (14/30) with moderate to severe disability, and 6 (20%) with minor or no disability.

5.0 Leisure and Sport / Physical Activity Update

The Council's Leisure and Sport Service was one of 17 local authorities in England to be selected for the National commissioning project. The project aim

For more guidance check Enfield Eye: http://enfieldeye/downloads/file/9380/report_writing_guidance

was to raise the profile and potential of leisure and sport services to support strategic objectives, in this instance specifically around health.

Various developments have been made in the following area:

- Communication and marketing
- Physical activity pathway
- Voluntary Community Sector
- Childhood Obesity – pilot on free summer holiday membership for reception and Year 6 identified as overweight or very overweight.

6.0 Update from Regeneration & Environment

An important step in tackling the social determinants of health at a local level can be achieved through a greater integration of health, planning, transport, and environment and housing departments. These include such areas as the built and natural environment, air quality, food safety, housing quality and tobacco control, consumer protection, health and safety, noise, pollution control and environmental problems as part of our responsibilities to improve and protect the health and wellbeing of communities.

<Air Quality>
The Council was successful in a joint bid with Camden and Islington for funding to increase business at the consolidation centre and in a and in a joint bid with Barnet, Haringey and Waltham Forest to have an officer, shared between the boroughs over the next 3 years to check construction sites for compliance with construction management plans and the non-road mobile machinery low emission zone. We have also joined a successful bid led by City of London to hold some Air Quality Action days over the three year duration of the project, which includes reducing the amount of time people spend idling their vehicles.
The Council has also commissioned ‘air aware’ projects in 5 schools with the intention of commissioning more should these be successful.

<Cycle Enfield>
Consultations on the A105, Enfield Town, Southbury Road and A1010 south have now closed. Consultation on the A1010 North will open shortly.
The latest information can be found at: http://cycleenfield.co.uk/

<HealthChecks>
We have successfully achieved our target of delivering over 8000 Health Checks to for 2015/16. GPs have been issued targets for the number of healthchecks to be delivered in 2016/17. Targets were issued according to a) the number of people aged 40-74 on their registers and b) deprivation. It is expected that this will make the scheme both more effective and more equitable.

<Tobacco Control>
A Turkish Smoking Conference was held on Saturday 21st May with presentations from Turkish doctors, cardiologist and community leaders. The aim of the conference was to highlight the issue of tobacco use in the Turkish community and engage the community in a) ensuring that people do not start to smoke through making smoking an unusual behaviour (denormalising) b)

promoting different methodologies people could use to stop smoking and c) promote the Stop Smoking Service.

Following budget cuts a new model of stop smoking is being established with the Stop Smoking Service. This will involve more encouragement of people to stop smoking by themselves, promotion of e-cigs and alternative means of stop smoking. The Service will target as a priority the Turkish Community, pre and postnatal women, young people and people with long-term conditions.

<Mental Health>
It has been decided to take a more focussed approach with regard to Mental Health Promotion. Public Health is focussing their efforts on developing a Suicide Strategy and toolkit for Clinicians and other professionals to assist those found to be in distress. This is being undertaken in collaboration with Enfield Mental Health Users Group (EMU).

<Public Realm>

- Maintaining the 17 outdoor gyms that provide free access to exercise equipment for a high proportion of the residents within the borough
- On May 11th the Council opened a new multi-use games area at Hazelwood Recreation Ground
- A new play area and multi-use games area have recently been installed at Millicent Grove / Cherry Blossom Close
- LBE has refurbished play areas at Ponders End Park, Tatem Park and Lee Road Open Space
- New marked walking routes have been created at Trent Park
- The Parks Service has recently secured £150,000 of external funding for the installation of a fully accessible play area at Albany Park.

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MUNICIPAL YEAR 2016/2017

MEETING TITLE AND DATE **Health and Wellbeing Board** **12th July 2016**	**Agenda – Part: 1**	**Item:**
	Subject: Better Care Fund: **For information - The 2016-17 Better Care Fund plan**	
	Wards: All	
REPORT OF: Bindi Nagra, Asst. Director, Health, Housing and Adult Social Care, LB Enfield, and Graham MacDougall, Director of Strategy and Partnerships Enfield CCG	**Cabinet Member consulted:** Cllr. Doug Taylor, Leader of the Council	
Contact officer: Keezia Obi, Head of Service, Enfield 2017 (BCF Lead) **Email:** Keezia.Obi@enfield.gov.uk **Tel:** 020 8379 5010		

1. EXECUTIVE SUMMARY

This report provides an update on the completion of 2016/17 Better Care Fund (BCF) plan including:

- a summary of the investment plan and the scheme / project changes
- the NHS England submission and assurance rating
- governance arrangements and delivery of the plan

Also included in the report is:

- an update on the implementation of audit recommendations
- BCF Quarter 4 2015/16 data and performance information

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- **Note** that subject to final confirmation by NHS England on July 7th, the local plan is 'fully approved'
- **Receive and note** the contents of the final narrative plan submitted to NHS England
- **Note** the schemes / projects included in the 2016/17 plan and the investments / disinvestments compared to 2014/2015
- **Note** the progress made to date with the audit recommendations
- **Receive and note** the contents of the 2015-16 Quarter 4 end of year data and performance return to NHS England.

3.0 2016-17 BCF PLAN AND NHS ENGLAND (NHSE) ASSURANCE RATING

3.1 The BCF Plan

3.11 As a reminder, whilst the majority of the national conditions for BCF plans remain the same as 2015/16, the £1 billion payment for performance framework has been removed and replaced by 2 new national conditions:

- Agreement to invest in NHS commissioned out-of-hospital services (which may include a wide range of services including social care services), or retained pending release as part of a local risk sharing agreement.
- Agreement on clear and focused, local action plans and agreed targets to reduce delayed transfers of care (DTOCs)

3.12 To summarise, the allocations for Enfield are as follows:

- Revenue funding from CCG - £19,185,445
- Local Authority contribution (Disabled Facilities Capital Grant) - £2,540,000

Total - £21,725,445 (2015-16 total was £20,586,000)

The allocation includes the following:

- Protection of Adult Social Care Services - £6,055,000
- Care Act monies - £734,000
- Funding held as a contingency as part of a local risk sharing agreement - £1,500,000

3.13 For 2016-17, the majority of the BCF schemes build on the existing 2015-16 activity. However some new schemes have been included in the following areas:

- The existing Integrated Care programme now includes new schemes:
    - GP integrated care local incentive scheme – funding for GPs to support complex and ‘at risk’ patients
    - Integrated Locality Team Management – funding for a joint post to manage and further develop the integrated locality team services
    - Resources to provide dementia nursing care, stepdown service and continuing healthcare support to the new build nursing home

- The existing Mental Health schemes include an additional project, which is to set up a pilot that will provide trained MH practitioners integrated into GP teams to support the management of patients presenting with MH issues.

- A new Children's Services project to support young people with severe and enduring mental health issues - an enhanced support service to support 'Future in Mind' implementation.

3.14 For further information, the detailed scheme plan is attached – please see appendix 1. A copy of the narrative plan is also attached – see appendix 2

3.15 The narrative plan includes the local vision for health and social care services, the evidence base that supports the case for change and an agreed approach to financial risk sharing and contingency. Our plan is in line with and supports all the following national conditions:

- Maintain provision of social care services
- Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions (physical and mental health) to acute settings and to facilitate transfer to alternative care settings when clinically appropriate
- Better data sharing between health and social care, based on the NHS Number
- A joint approach to assessment and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans
- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care
- An agreed approach to financial risk sharing and contingency

3.2 NHSE Submission and assurance rating

3.21 The Enfield submission has now been signed off by the Chair of the HWB and senior officers on behalf of both the Council and the CCG.

3.22 Feedback received from NHS England has been very positive in terms of the quality and comprehensiveness of the plan throughout the assurance processes. Draft assurance ratings were issued on 12th June and the rating for Enfield was 'Approved with Support'. It was noted that there were no fundamental areas of concern and that we had a strong plan that was viewed as being under development

3.23 Final ratings will be confirmed on July 7th and NHS England has advised that Enfield's rating is expected to be 'fully approved'.

3.3 Governance and delivery of the local plan

3.31 In recent months, the governance arrangements supporting the plan have been strengthened. This has been necessary to ensure that closer monitoring occurs, particularly in relation to the delivery of outcomes of funded schemes, financial activity, data reporting and performance, and in response to audit

recommendations. To achieve this, colleagues across the council and CCG are working in close partnership.

3.32 The outcomes of this will result in the production of regular updates to outline progress, performance, expenditure against funded schemes and forecast spend by year end, plus the required reporting to key stakeholders.

3.33 Part of the review of governance incudes an agreement by the Integration Board to review its Terms of Reference. With changes taking place at regional level e.g. North Central London and Sustainability and Transformation Plans (STP's), it is an opportunity for partners represented on the Integration Board to consider what might work best in this context. This includes the development of a local strategic plan for 2017, to support Health and Social Care Integration for 2020. Colleagues will be contacted to discuss their views about this.

3.34 In addition, NHS E and ADASS have recently published their ongoing offer of support to local areas which will be explored in conjunction with these discussions. Meanwhile, any further procurement of external facilitation is on hold.

4.0 AUDIT REPORT RECOMMENDATIONS AND ACTION TAKEN TO IMPROVE BCF IMPLEMENTATION

4.1 An action plan has been produced combining the recommendations from the following 3 audit reports:

- Ernst Young (EY) Deliverability Review - August 2015
- PA Consulting Supporting Enfield to Accelerate Personalised, Co-ordinated Care - December 2015
- Pricewaterhouse Cooper (PwC) LBE internal audit - December 2015

4.2 Very good progress has been made in implementing the actions, with the majority complete. Key areas of improvements can be summarised as follows:

Governance and partnership working – as noted above a review of the BCF programme governance and remit/membership of the sub groups has taken place, including ensuring that the BCF implementation reports to the Joint Commissioning Board.

Programme and project management – a revised business plan template has been produced which focuses on: scope and objectives, fit with the NHSE national conditions and BCF performance indicators, outcomes, benefits and milestones and breakdown of costs. Both delivery of outcomes and spend will be regularly monitored.

Service delivery - recommendations relating to the meeting of the NHSE national conditions and Key Lines of Enquiry (KLOE's) were reviewed as part of the BCF planning process for 2016/17. This is to ensure that we are meeting necessary funding requirements.

5.0 NHS England quarterly data reporting

5.1 The NHS England quarter 4 data report (for the period January to March 2016) was submitted on May 27th. A copy is attached for information – see appendix 3

5.2 The report helpfully summaries the key successes for 2015/16 and challenges for 2016/17, which are noted as follows:

Successes 2015-16:

- Admissions to residential and nursing care continued to reduce throughout the year and our target, already very ambitious, was exceeded

- Seven day working is in place across health and social care and our integrated locality teams are working well to bring a multi-disciplinary approach to supporting people who need our help. The community-based rapid response services work together to help / support and treat people in their own homes to avoid unnecessary hospitalisation and facilitate safe and timely discharge at the weekend and out of hours.

- Our enablement service continues to deliver excellent outcomes with over 71% discharged with no further need for support.

Challenges 2016-17:

- Non- Elective Admissions (NEA's). The work undertaken in 2015/16 to reduce admissions for older people (65+) needs to be extended into pediatrics and our 50+ population, as these have shown themselves to be areas of increased pressure during 2015-16. Noted that the extension to the 50+ population and the Older People's Assessment Unity (OPAU) dealing with under 65s commenced during Quarter 4 2015-16.

- The increase in the number of people whose discharge from hospital was delayed in 2015-16 has been identified with particular issues including: a) non acute mental health discharge and support arrangements, b) shortage of residential/nursing stepdown provision, c) patient choice (for residential/nursing care). An action plan is in place and has been implemented with a 45% reduction in delays achieved in January 2016 compared to September 2015. This remains an area of priority for 2016-17. This is supported by the System Resilience Groups and focused around our two main acute providers.

- To develop, with the Enfield Integration Board and key stakeholders, a shared vision and strategic direction for the integration of health and social care in Enfield.

5.3 The 2016-17 first quarter report is not yet available and will be brought to the next HWB.

End of Report.

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Enfield Better Care Fund – 16/17
May 3rd Submission Template Scheme Plan (final)

Scheme Name	Scheme Type/Comments	2016 / 2017 planned expenditure	Change from 2015/16	2015 / 2016 expenditure	Changes from 2015/16 plan
Older People's Assessment Unit	Rapid access to multi-disciplinary geriatrician led acute-based diagnostics & treatment day service	£708,000	-307,000	£1,015,000	Improved re-commissioning of OPAUs in Enfield in 2015/16. Lower cost also due to other CCGs contribution using facility improving value for money.
Care Homes Assessment Team	Improving healthcare services to care homes	£479,000	+52,000	£427,000	Given success of CHAT in improving quality outcomes & reducing care home admissions, service expanded to cover all Enfield care homes in latter part of 2015/16: funding to sustain coverage
Risk Stratification Tool	Technology to support GP identification of high-risk patients to be managed on multi-agency basis Bringing together both health and social care data to support GPs and MDTs, the tool is being widely and successfully used. Work is underway to develop the algorithm further as an "at risk of social care" function	£30,000	0	£30,000	No change
Integrated Locality Teams (Delivery)	Integrated Care Teams - personalised care/support at home via integrated care teams	£350,000	-25,000	£375,000	£375k included. £25k one-off payment to support mobilisation of Phase II development in 2015/16
Assistive	Assistive technologies	£40,000	-20,000	£60,000	Better re-commissioning of

Technology (Tele-Health)					technology in 2016/17 planned.
Intermediate Care at Home – Promoting 7 Day Working	7 Day Working Support for people at home and hospital avoidance.	£200,000	0	£200,000	No change
Dementia-Friendly Communities	Post-diagnostic support linked to primary & community healthcare for people diagnosed with dementia & their families	£45,000	+10,000	£35,000	Costs of joint CCG/LBE procured services slightly higher than originally planned, and 2016/17 makes an adjustment to this
Social Care Capacity in Hospital - Promoting 7 Day Working	7 Day Working - Combines reablement (hospital avoidance) and 7 day working This scheme has demonstrated real benefits with reductions at year end 15/16 in both health and social care delays	£100,000	0	£100,000	No change
Social Care Hospital-Home Liaison & 7 Day Working	7 Day Working - Combines personalised care/support at home, reablement (hospital avoidance) and 7 day working Linking in with the voluntary sector this service has been successful in supporting both hospital avoidance and facilitating speedy and appropriate discharge to home from hospital	£190,000	0	£190,000	No change
OOH 365/7 Day Community Crisis Response Team	Combines personalised care/support at home (hospital avoidance) and 7 day working Integrated Falls Service	£350,000	+40,000	£310,000	To increase investment in Community Crisis Response service in 2016/17 as service started mid-year in 2015/16
Integrated Falls Service	Integrated care teams - personalised care/support at home via integrated care teams	£180,000	0	£180,000	No change
Falls Prevention - Voluntary Sector	Integrated care teams	£80,000	+20,000	£60,000	Costs of joint CCG/LBE procured services slightly higher than originally planned,

					and 2016/17 makes an adjustment to this
Tissue Viability Service	Improving healthcare services to care homes	£70,000	0	£70,000	No change
Memory Service	Investment in specialist MH assessment, diagnoses & treatment for people with dementia	£551,000	0	£551,000	No change
Palliative Care Rapid Response Service (via Hospice)	Personalised support/ care at home	£150,000	0	£150,000	No change
Community Matrons as part of ILT Delivery	Integrated care teams - personalised care/support at home via integrated care teams	£541,000	0	£541,000	No change
District Nurses as part of ILT Delivery	Integrated care teams - personalised care/support at home via integrated care teams	£895,000	0	£895,000	No change
Enhanced Out of Hours District Nursing	To support implementation of seven day working	£277,000	0	£277,000	No change
Intermediate Care at Home as part of ILT Delivery	Integrated care teams - Personalised care/support at home via integrated care teams	£1,501,000	0	£1,501.000	No change
Nursing home capacity	Improving health care services to care homes.	£777,000	**New**	£0	New build nursing home which will provide dementia nursing care for the local authority, stepdown and continuing healthcare capacity for Enfield CCG
Project Management Costs for IC Programme	Overhead costs to deliver IC Programme	£100,000	-80,000	£180,000	Jointly funded commissioner posts across the CCG and Council to provide a more

					joined up approach to service development
GP Integrated Care Local Incentive Scheme	Integrated care teams - personalised care/support at home via integrated care teams	£150,000	**New**	£0	GP funding to support complex and 'at risk' patients
Integrated Locality Team Management	Integrated care teams - overhead costs to deliver ILTs	£80,000	**New**	£0	Pooled management – joint post for ILT
Shared Record Solution	Costs of IT enabler of integrated working	£66,755	-33,245	£100,000	Joint funding agreed across the CCG and the local authority to deliver a shared care record solution across health and social care. 15/16 funding being rolled forward into 16/17 in addition
Psychiatric Liaison at hospital (RAID)	Support to improve quality of health experience & outcomes for people with MH issues in acute hospital	£400,000	0	£400,000	No change
Improving Access to Psychological therapies (IAPT)	Reablement services The IAPT team (therapists, counsellors and psychologists) offers free confidential and evidence based talking therapy for those aged 16 and over.	£486,000	0	£486,000	No change
Children's early intervention / psychosis	Service for young people with severe and enduring mental health issues.	£210,000	**New**	£0	To support Future in Mind implementation
CYP Enhanced Behaviour Support Service	CYP Enhanced Behaviour Support Service – positive community interventions to avoid residential placements	£175,000	0	£175,000	No change
Enhanced MH Support for Primary Care	Responsive and practical support at GP surgeries to GPs dealing with MH patients	£250,000	**New**	£0	Development of a pilot that provides trained MH practitioners integrated into general practice teams to enhance confidence and support the management of

					patients presenting with MH issues
Personal Health Budget	Personalised support/ care at home	£25,000	0	£25,000	No change
Safeguarding Nurse Assessor	Investment in safeguarding Continuation of a programme which has successfully contributed to the support of improved safeguarding practice across health and social care providers	£70,000	0	£70,000	No change
Pool Fund Management	Programme overheads costs for BCF Programme	£100,000	0	£100,000	No change
Wheelchair Services	Assisted Technologies This service will be run through the integrated community equipment service already in place through the Local Authority Trading Company (LATC)	£798,690	+8,690	£790,000	Estimate for cost of service through LATC
Quality Checker	Improving healthcare services to care homes A user by experience programme in place to drive improvement in quality within service provision across both health and social care which continues to deliver improved outcomes for users of both health and social care services	£80,000	0	£80,000	No change
Social workers (Safeguarding)	Support for safeguarding investigations Enfield recognised as an exemplar of good practice. This investment continues to support the MASH for adults and implementation of the new PAN London procedures	£269,000	0	£269,000	No change
Enhanced support	Support for carers	£300,000	+200,000	£100,000	Enfield Carer Centre now has delegated authority to complete statutory assessments and reviews for

					carers through Care Act 2014 Duties. Pilot programme into month 5 and working well with full evaluation due in July 16
Respite	Support for carers	£189,000	+89,000	£100,000	Delivery of preventative support through the voluntary sector working with carers to provide direct payments for care and support which helps carers to continue caring
Primary care premises		£0	-80,000	£80,000	BCF funding no longer required
Preventative services	Prevention, reduction & delaying of need CCG investment in delivering early intervention/prevention support through the Voluntary Sector and in partnership with the Local Authority	£410,000	0	£410,000	No change
Care Act	Carers & advocacy services Increased support for carers through provision of regular breaks and meeting the statutory duties for provision of advocacy across the Care Act and the Mental Capacity Act with significantly increased activity in this area already in 2015/16	£734,000	0	£734,000	No change
Protection of social care monies	Social care pressures	£6,055,000	+103,000	£5,952,000	Increased demographic pressures continue within Adult Social Care at around 3.5% per year with particular areas of growth in Adults with learning disabilities, mental ill health and older people with dementia

Risk-Sharing Contingency Arrangements	The contingency has been calculated per cost of non-elective admission at £2039 per admissions x 736. The agreed trajectory represents a reduction against this year's baseline, but with the expectation that demand will continue to increase. The operating plan assumes 1.6% increase and the BCF a 3.4% reduction on that baseline	£1,500,000	0	£1,500,000	The CCG and LBE have accepted that the £1.5m contingency is likely to be used to fund emergency admissions given that the current BCF target is a stretch based on performance during 2015/16. (as per Risk Share and Contingency Confirmation template completed and submitted to NHSE)
Disabled facilities grant	To support independent living & enabling people to stay at home for longer	£2,540,000	+1,195,000	£1,345,000	This amount also includes the capital grant of at least £460k which will be used to fund completion of a new Health & Wellbeing Centre. Planning for this has begun in 2015/16 with plans to work across both statutory and VCS organisations. DFG investment in accessible homes which promote independent living for longer within people's own homes in order to reduce the number of residential admissions into provision for people who are physically frail.

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Better Care Fund 2016/17

Enfield Narrative Plan – 3rd May 2016

NHS
Enfield
Clinical Commissioning Group

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1. Local Vision for health and social care services

In Enfield our vision for integration of health and social care continues to be:

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

As previously stated at the start of our plan for 2014/15, Enfield has already embarked upon its journey toward the integration of health and care services, which is a key component of our Health and Wellbeing Board's vision of enabling local people to 'live longer, healthier, happier lives in Enfield.

Our Health and Wellbeing Strategy that is based upon our Joint Strategic Needs Assessment (JSNA), sets out the following priorities:

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

We remain committed to the Better Care Fund as a major opportunity to develop our work across the Health and Wellbeing Partnership and support delivery of our priorities. Accordingly our BCF plan continues to be based on a broad programme of activity which spans the key issues affecting our residents' health and outcomes.

Despite significant challenges across our health and social care services in Enfield the implementation of our Better Care Fund programme of work has seen some success in 2015/16:

- Admissions to residential and nursing care continue to reduce and our target, already very ambitious, will be met this year.
- Our enablement service continues deliver excellent outcomes with over 71% discharged with no further need for support;
- On track to achieve 88% of people living independently after receiving the service upon discharge from hospital;
- Our satisfaction measure shows good performance against continuity of care co-ordination (continuity of support and telling your story once);
- Seven day working is in place across health and social care and our integrated locality teams are working well to bring a multi-disciplinary approach to supporting people who need our help.

However, we are not complacent and know that the number of emergency admissions from our adult and child populations has increased this year; the number of days lost to delayed discharges has increased with more people in hospital due to mental ill health. We also know that we must improve access to good information which keeps people well informed and supports good, informed decision making.

The context in which we are working is equally important. Enfield is a borough which continues to experience significant population growth with many of its wards amongst the most deprived in the country. With annual population increases averaging around 3,500 people per year, growing numbers of children and adults under 65 and an increasingly older and frail older people population, there continues to be an upward movement in the numbers of people who access health and social care services. This is in addition to increased numbers of children and adults admitted as emergencies to hospital, greater demand upon all areas within social care, particularly within learning disabilities and older people with dementia. Our work to deliver more joined up and enabling services has contributed to our management of this demand, reducing the rate of increase most specifically across our older people population.

Nevertheless, there is a shared ambition and acknowledgement of the challenges which we are facing as a partnership. We are already expanding the work we do across integrated pathways to improve our response for children and for adults to ensure we have the right services in the right place at the right time.

- An action plan is in place to reduce our delayed discharges with a reduction of 45% already achieved in January 16 compared to September 15. This plan has been reviewed and strengthened to respond to our local challenges
- Our success at reducing emergency admissions for older people will be used to address increases in paediatrics and adults
- We are jointly recommissioning our voluntary sector activity with a focus on integrated hub based approaches which will see Voluntary and community sector (VCS) organisations both working together and with statutory services to deliver early intervention support which is evidence based. This will see an increased focus on enabling support, self-management of long term conditions, increased support for carers and ensuring that our most vulnerable people continue to have a voice both through service development and advocacy support.
- We are jointly commissioning a Strengthening the Team Around You service for children and young people with challenging behaviour at risk of admission to hospitals or residential units

As we explained in our original submission, Enfield CCG has been working with the other CCGs of North Central London to develop Value Based Commissioning and as part of that we have been working with patients to develop a set of outcomes which will be a series of patient ‘’I’ statements’’ which will be translated into a set of measurable key performance indicators for the future. We have considered the substantial work undertaken by ‘’National Voices’’ and have underpinned our vision for planned care delivery with the following:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me”

We therefore expect the difference to our patients and service users’ outcomes to include:

- Patients are as resilient as they can be for as long as they can be but will know when to seek help quickly and from where
- Patients will tell their narrative once and multidisciplinary teams will use that narrative to plan care around the needs of the patient and the goals that are important to them
- Patients will fully understand their care plan and will achieve their goals in the least amount of time possible
- Patient experience of care delivery will be consistently high
- A range of clinical outcomes will be improved and variation reduced: e.g. HbA1c, BP Cholesterol, COPD exacerbations, Depression and Anxiety, actual disease prevalence
- Planned care, both urgent and routine, will become optimal with minimal emergency care required

We started to develop this network in 2014, and have used the BCF Plan funding, with agreement of all partners, to gradually expand its function and scope over the last year through feedback from people with frailty themselves. For example, one of the key issues people highlighted to us was that they did not always feel as though their care was well-coordinated across the system. However, we are making progress on this, and a range of other issues: for example, 65% of people told us they felt their case was well-coordinated in 2014, and this figure has increased to nearly three-quarters in 2015/16. Our aim is for *all* people to feel this is the case by the end of the next three years, as a greater number of people will be able to access our network.

Our engagement activity with the community endorses our direction of travel. People do expect us to share information appropriately, provide good continuity of support and consider their situations holistically. We have also been clear about the challenges too. In order to deliver sustainable services and support to the people who need our help, we need to do much more with much less. This requires significant system and process change and a shared understanding of and participation in the design, development and delivery of the kinds of high quality support which people need and want. This will ensure that our most vulnerable people continue to have a voice. We have also continued to develop and expand our quality checker service with an eye on maintaining good quality and delivering improvement where it is needed. Working with people who have experience of care (carers as well as service users) and service providers have welcomed this approach. The feedback provided by the quality checkers also contributes to improved services.

There remains much still to do but we have made good progress this year on our journey towards fully integrated health and social care services. Our 2016/17 plan is more ambitious and will enable us to make further progress in integrating our plans and services.

2. An evidence base supporting the case for change

Enfield's population is increasing rapidly and the demographics and characteristics of the population are changing. Taken together, this is having a significant impact on the services that local people need and the way in which these services need to be delivered.

Between 2001 and 2014, Enfield's population has grown from 273,559 to 324,574 – an increase of over 50,000 people or 18.6% since 2001. This is well above the level of population growth in England of 9.8% and is also above the growth rate in London as a whole.

Projections from the Greater London Authority and Office for National Statistics all predict that Enfield's population will continue to rise significantly. According to the ONS, Enfield's population could reach 421,000 by 2037, which would represent an increase of over 100,000 people in a 25 year period.

22.6% of Enfield's population are under 16. This is above the average for London (20.2%) and very nearly twice the proportion in the UK (11.5%). Children in Enfield live disproportionately in the less wealthy east of the borough, and this is reflected in the fact that 29% of children are in poverty (compared with 23.5% in London and 18.7% across the UK.

12.8% of Enfield's population are over 65, which is a greater proportion than London as a whole (11.5%).

Enfield's population is increasingly diverse. Enfield Council estimates that around 35% of residents are white British (2015 local estimate). Some communities have grown substantially – the 'white other' group (including Greek, Turkish, Cypriot and Eastern Europeans) has grown from less than 13% in 2001 to over 23% by 2015. Altogether, the number of Greek, Greek Cypriot, Turkish, Turkish Cypriot and Kurdish residents numbered around 55,000 in 2015.

A large proportion of Enfield's population are born outside of the UK, and there are high levels of mobility and transience. At the 2011 census, 10.9% of Enfield residents had moved into the area in the previous year

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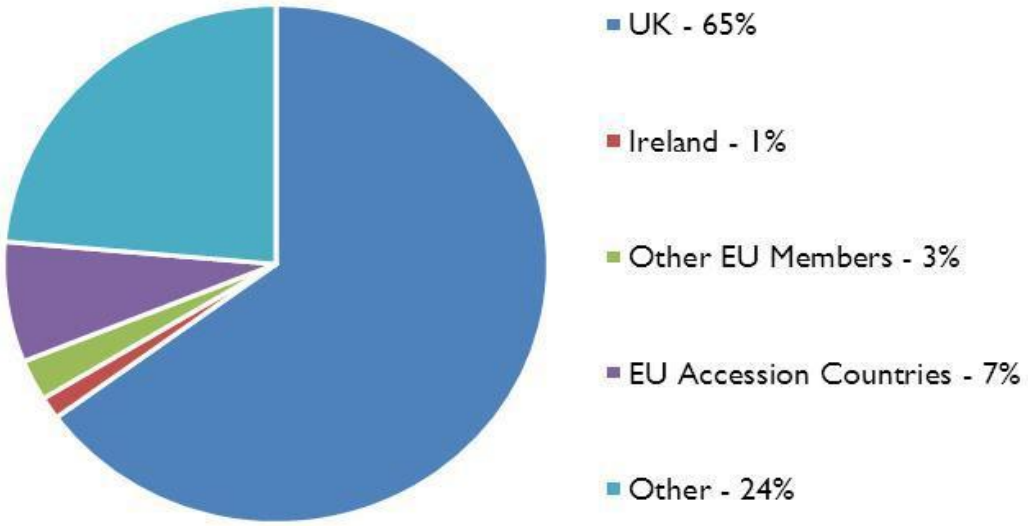
Country of Birth of Enfield Residents: 2011



Source: 2011 Census

This is reflected in the languages spoken within Enfield's communities. At the 2011 census, 14% of households did not have any occupants whose main language was English. A further 3.6% of households had no adults whose main language was English, but a child under 16 did have English as their main language.

Enfield has high levels of deprivation and poverty by both national and regional standards and significant economic challenges. Enfield is the 12th most deprived London Borough according to the 2015 Indices of Multiple Deprivation. It was the 14th most deprived in 2010 so has become more deprived relative to other parts of London.

In August 2015, 26,000 Enfield residents were claiming an out of work benefit - 12.6% of the working age population. This compares with 10.7% in London and 12.0% in Great Britain.

12,870 16-64 year olds were claiming either Employment Support Allowance or incapacity benefits, meaning that a large proportion of those claiming an out of work benefit had a disability, illness or limited mobility.

The above statistics are a clear demonstration supporting the case for change and resulting in the following health headlines:

- A life expectancy gap of almost 9 years between the most affluent and deprived wards
- A potential years of life lost (PYLL) score for women over 50 living in the south east of the borough significantly higher than the male population and for London as a whole.

- Deprivation scores which show Enfield wards in the east and south of the borough to be amongst the top 10% in England
- Significant levels of undiagnosed and debilitating long term conditions
- A reduction in healthy years lived as people live longer and marked differences between the potential years of life lost where good healthcare could have made a difference.

Enfield has increasing numbers of people living with long term conditions or disabilities and a challenging financial context which means that the case for change has never been stronger. Feedback from the people who work within our services and from those people with whom we work is equally clear. Joined up services which are efficient, easily accessible and which provide care and support closer to home are what everyone wants. The integration of health and social care economies is happening but needs to progress more quickly if we are to meet the challenges facing us. The purpose of the better care fund plan is to accelerate progress towards our key goals:

- Effective case finding which enables professionals and patients/service users to work together at an earlier stage to prevent deterioration and crisis
- Integrated health and social care locality teams providing access to good community services 7 days a week
- Reducing A&E attendances by providing good support in the community to prevent crisis
- Supporting more people to help themselves by giving them good information, advice, support and the tools to self-manage where they can appropriately do so
- Strong community enabling services which prevent hospital admission and facilitate speedy and safe discharge to the community

We are clear that the work we have done in 2015/16 to reduce emergency admissions for older people (65+) needs to be extended into paediatrics and our 50+ population as these have shown themselves to be areas of increased pressure this year.
The increase in the number of people whose discharge from hospital was delayed in 2015/16 has been identified as a priority with particular issues around:

- non acute mental health discharge and support arrangements
- shortage of residential/nursing stepdown provision
- patient choice (for residential/nursing care)
- completion of assessment

An action plan is in place and has been implemented with a 45% reduction in delays achieved in January 16 compared to September 15. This remains an area of priority for 2016/17. This is supported by the System Resilience Groups focussed around our two main acute providers.

Improving the availability of good accessible information which supports informed decision making and self-management of long term conditions is key to our vision of integrated care. Access to good quality information has been improved as a result of

the Care Act implementation. Work has also started this year on recommissioning the VCS in partnership across the Council and the CCG with a view to commissioning evidence based support and services which will work jointly with statutory services. This will enable us to increase our focus on early intervention and preventative services which engage with people at an earlier stage to increase resilience, self-care and to provide single points of access for information/advice/practical low level support as appropriate.

We are also increasing our nursing home capacity to support timely discharge from hospital (and to ease pressure on the rate of emergency admissions), in particular at North Middlesex Hospital. We are working within a very challenging care market and the 2016/17 BCF plan needs to demonstrate that we are putting in place new initiatives and services to improve the system as a whole.

The case of change was described in the Better Care Fund Plan 2015/16 and key issues to be addressed are taken forward in our joint Better Care Fund approach in 2016/17. The table below summarises the case for change across our populations.

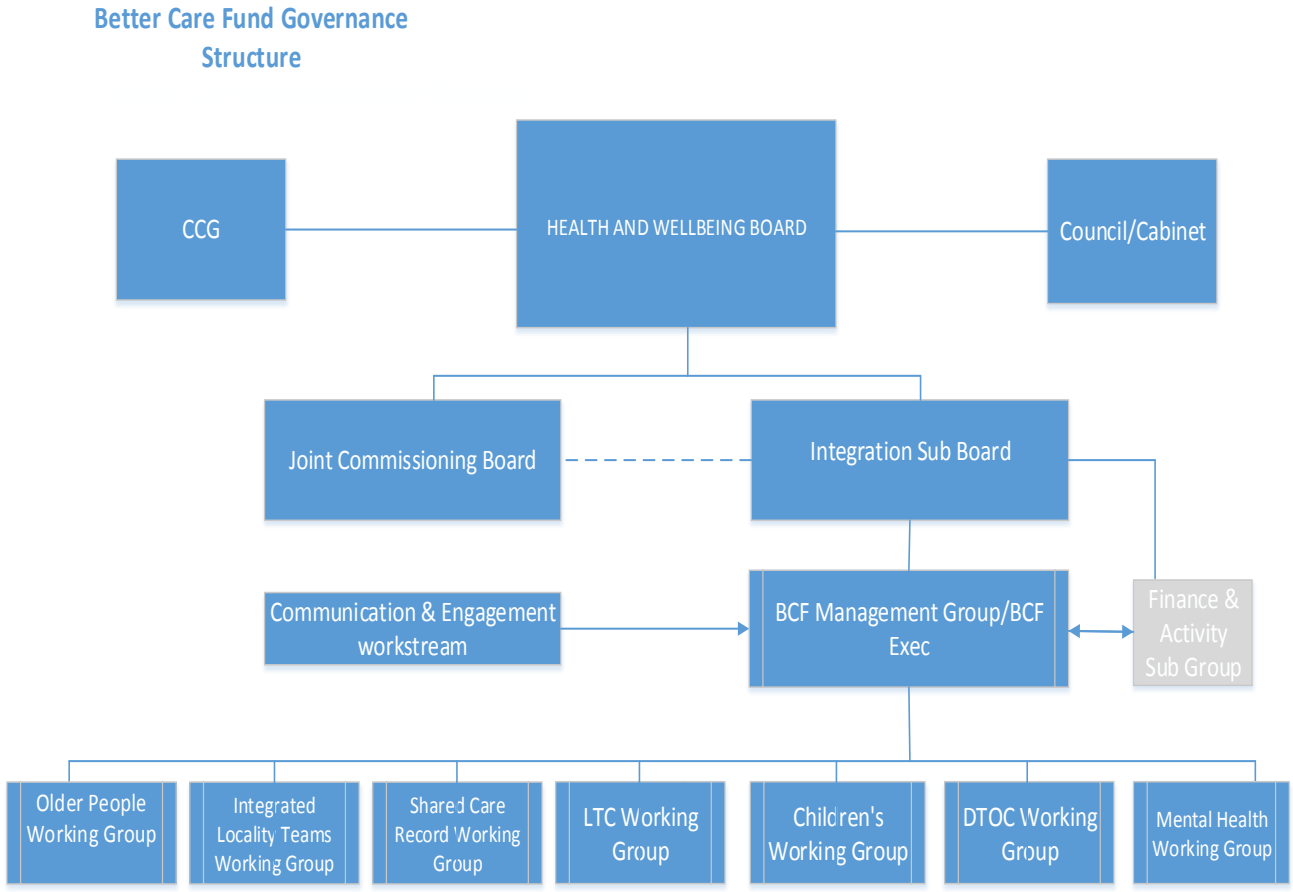
CASE FOR CHANGE ISSUE SUMMARY	**Population Groups**			
	Integrated Care for Older People	**Mental Health**	**Working Age Adults & LTC**	**Children with Health Needs**
	All above have cross-cutting theme: Supporting Carers			
Population Needs: The health of population continues to improve, but there remain many issues to address				
Larger than London average population sizes	✓	☐	✓	☐
Evidence high number of complex cases in general population	✓	✓	✓	☐
Known health inequalities & differences (including those linked to deprivation) across localities	✓	✓	✓	✓
Adverse outcomes affected by holistic issues, e.g. social isolation, nutrition, access to work etc.	✓	✓	✓	✓
Prevalence in population on upward trajectory over next 5 years	✓	✓	✓	✓
Evidence impact on longer-term life chances	✓	✓	✓	✓
Quality & Outcomes: Care services have strengths, but can be better integrated & people's cases better managed				
Evidence too many people are hospitalised as part of unscheduled care compared to England	✓	☐	✓	✓
Evidence planned primary care management of population could improve, including diagnosis	✓	✓	✓	✓

Evidence care service response fragmented with inconsistencies in response	✓	✓	✓	✓
Evidence outcomes important to individuals are not always realised in the current system	✓	✓	✓	✓
Evidence quality of care & safeguarding could improve & made more consistent for individuals	✓	✓	✓	✓
Evidence people's choice and resilience could improve, including in self-management	✓	✓	✓	✓
Evidence better rapid response could be planned to support individuals	✓	✓	✓	✓
Evidence people's carers could be better supported	✓	✓	✓	✓
Finance & Sustainability: 'No Change' scenario is unsustainable over next five years given financial pressures				
Population need changes likely to mean significant financial pressures on care system	✓	☐	✓	☐
Opportunities to identify significant cashable and non-cashable efficiencies from transformation	✓	✓	✓	☐
Opportunities to commission and incentivise outcomes as part of medium-term development	✓	☐	✓	☐
Opportunities to commission and incentivise outcomes in the longer-term	✓	✓	✓	✓
Consequences of transformation has potential to provide significant challenges to acute providers	✓	☐	✓	☐
Opportunities to build health and social care partnerships to deliver collective efficiencies and manage more sustainably	✓	✓	✓	✓
Opportunities to develop infrastructure to support and sustain transformation	✓	✓	✓	✓

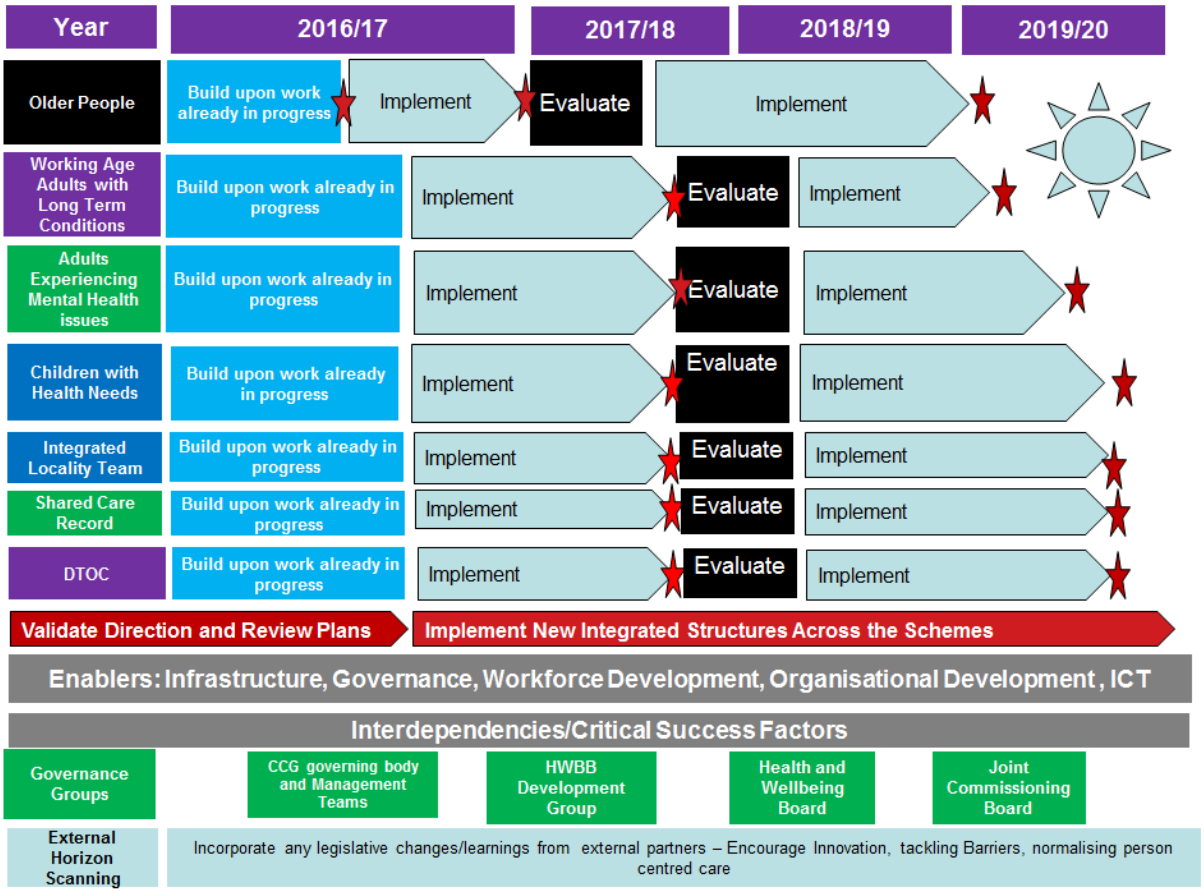
3. A coordinated and integrated plan of action for delivering that change

We recognise that in order for the implementation of the Better Care Fund to be successful and enable us to move towards 2020 health and social care integration, it needs to be recognised as a distinct programme of delivery, yet interwoven within our wider local commissioning arrangements. Furthermore, the governance arrangements must be such that it drives integration at both operational and strategic level. In response to the outcomes of NHS England support (PA Consulting) and our own audit activities, a review of our governance arrangements has taken place and

the structure that has been operating in 2015/16 is currently under review, as is the terms of reference of our BCF Management Group and Integration Board. The following diagram illustrates our governance structure, although this is subject to further change to ensure it continues to be fit for purpose.



Included here is a summary of the BCF work plan with delivery of each part of the programme managed within separate working groups. The working groups report into the BCF Management Group/Executive, each with their own programme lead. The BCF programme of work itself is overseen by a Head of Service located within the Council's Transformation Office who then reports to the Assistant Director for Adult Social Care within the Council and the Director for Strategy and Engagement within the CCG.



Supporting the BCF Programme of work is a 'wrap-around' sub-group – Finance and Activity Group. Individual programme leads along with finance and performance representatives (Council and CCG) are the main officers of this group and attend regular meetings. The remit of this group is to monitor performance against individual programme targets, to assess the impact of schemes on the overarching performance measures and to monitor the pooled fund which, as agreed within the Section 75 agreement, is currently managed by the Council.

At strategic level, it has been established that partners would benefit from focused time and support to help shape the future of integration in Enfield. We have engaged independent external support to do this as we acknowledge that integration presents many challenges for individual organisations and as a whole. An approach which supports change across the system, whilst recognising the impact this will have on patients/service users, carers, organisations and providers is an approach that requires mature thinking, challenge and ultimately collaboration. We have identified a number of outcomes we wish to achieve as part of this external support, but ultimately the key one is shaping what integration in Enfield looks like, how we are going to get there and what success looks like.

The Joint Intermediate/Reablement Care Strategy had as its key priorities:

- Prevent avoidable admissions to hospital and support timely discharge
- Decrease the number of people unnecessarily admitted to long-term care following a hospital stay
- Improve quality and maximise independent living

- Improve the skills and competencies of the workforce
- Deliver more cost effective services in order to meet current and future demand within existing resources
- Robust performance management and governance

This is reflected in the performance figures for 2015/16 for our admissions to residential care. There was good performance with the number reduced to 166 against an ambitious target of 185. The 16/17 trajectory has been set below the 15/16 target but above the end of year outturn position to reflect increasing numbers of older people, particularly with dementia, coming through the system. The target set nevertheless still reflects a level of ambition in Enfield around managing demand across all areas down.

The effectiveness of enablement – the ambition in Enfield continues to be to increase the numbers of people able to access our enablement service both to avoid hospital and to facilitate speedy and appropriate discharge from hospital. The target for 15/16 was not achieved as the service was significantly impacted by some supply issues within the domiciliary care market generally and as a result it was necessary to utilise enablement capacity to fill a long term service provision gap. This issue has been resolved now and the target in Enfield for 16/17 is reflective of a continued ambition to increase capacity and access to the enablement service and to increase the number of people who receive support in this way to continue living independently both with and without support.

And whilst work to prevent avoidable admissions to hospital and support timely discharge has been successful with increased capacity across the health and social care system, there remains further work to do. Enfield is a borough experiencing population growth in excess of both London and National averages and our population is getting older with increasing numbers of people living into old age with frailty and illness. In order to ensure more people are enabled to live independently within their own homes and manage the increased demand for services, the Council, together with Enfield CCG, is currently completing and will shortly be consulting on a new overarching strategy which pulls together its priorities for supporting more people, including carers, through the delivery of services which promote early intervention and prevention. This includes recommissioning the Voluntary Sector activity which both the Council and the CCG fund. Where strategies remain current, the overarching strategy will reference them. Where strategies are due for refresh, the priorities within them are being reviewed and included, where appropriate, within the new strategy.

The risk log for the overall Better Care Fund programme is attached as Appendix 3, this has been developed with feedback from the Enfield Integration Board and with input from the is BCF Management Group and the Finance and Activity sub group. This will be reviewed for 2016/17 following formal sign off of the investment plan and supported by quarterly monitoring and review.

Also attached, as Appendix 4, is the risk log for the Integrated Care Programme which is reviewed at each meeting of the Older People's Working Group, and reported to the BCF Management Group.

The Integrated Care Programme

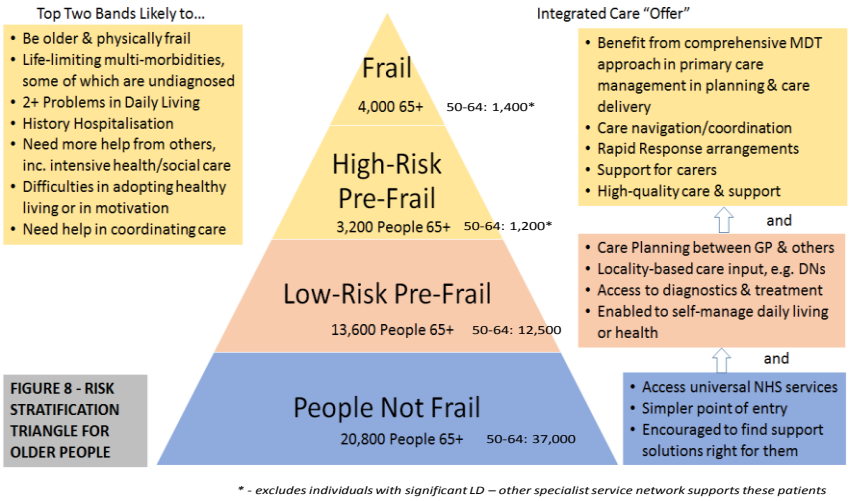
The aim of our integrated care programme is to develop a person-centred response to planning and delivering care to individuals so local people will be able to say: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve outcomes important to me". As noted in an earlier section, our principles are in line with the NHS Five Year Forward View:

- Patient & carers at the heart of care planning & delivery – services are integrated around them;
- Components of the model therefore need to act as a single system – a network of care;
- Enabled via joint assessment, care planning and interventions with patients and across the system;
- High-quality care delivered in the most appropriate settings including out-of-hospital settings;
- All the above will mean unnecessary activity and costs incurred in the system will be avoided and this will help achieve long-term sustainability.

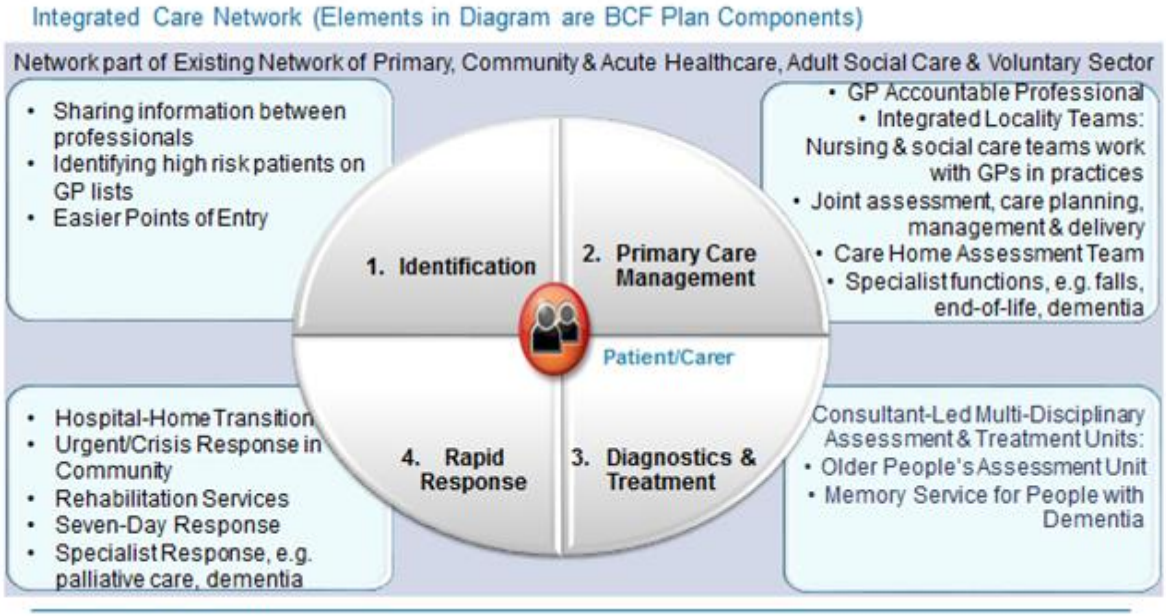
Priorities and Scope: Integrated Care Programme Aimed at 50+ Population
Our JSNA Factsheet[1] suggested older people with complex needs were most likely to benefit from an integrated approach to care planning and delivery. Last year's BCF Plan focussed on developing and implementing our integrated care network for people aged 65+ who were pre-frail or frail[2] including those with dementia. As a result of its success, we will extend our model to those with frailty 50+ using the same resources in 2016/17. The model's resources are tailored to need, with the greatest level of resources targeted on those identified as "high-risk pre-frail" or "frail" individuals.

[1] http://www.enfield.gov.uk/healthandwellbeing/info/18/the_health_and_wellbeing_of_older_people/57/older_people_with_complex_needs

[2] Frailty" is "the impact of a combination of (often multiple) conditions including musculoskeletal, neurological, functional and organic mental health, respiratory and cardiovascular conditions & syndromes and their impact that collectively results in a person's vulnerability to sudden health changes triggered by minor stressor events." (Department of Health, 2013).



Integrated Care Network Model



The diagram shows how our community-based model delivers person-centred care to people with frailty to enable them to access the right solutions according to need. Our model operates in the wider context of the current health and social care system in Enfield and contains the following functions:

- *Identification and Filtering of Response Based on Patients' Needs:* We streamlined the number of access points for people with frailty in 2015/16. Individuals are now identified either via self/carer identification of a social need to LBE, the multi-agency hospital discharge process or care professionals working with GPs in their practices (including using risk stratification to identify high-risk patients). Our response is then matched to the patient's level of need;
- *Joint Assessment & Care Planning:* Some individuals will need a comprehensive assessment and the number of professionals involved is tailored to need – from 1 or 2 (e.g. a GP and/or social worker) through to a

larger team of multi-sector professionals (including the voluntary sector) working together and with the individual to plan and coordinate care in the short- or longer-term;

- *Care Delivery* is based on individuals' needs and their plan but may include multi-disciplinary:
    - *Time-Limited Bed- or Community-Based Rehabilitation* to help people recover post-illness, maximise independence, avoid hospital or care home admission or facilitate hospital discharge;
    - *Arranging or Delivering Ongoing Social and Healthcare & Support* to help people who might need health and/or social care support following their rehabilitation;
    - *Specialist Diagnosis, Treatment and Intervention* for individuals whose conditions have changed and whose cases need to be managed pro-actively to help reduce risk of crisis in the near future;
    - *Rapid Response* for those who need an urgent or crisis response in the community to avoid unnecessary hospitalisation or need to be discharged from hospital safely in a timely way.

Our model is underpinned by an ethos of promoting individuals' autonomy, independence and self-care tailored to individual's needs. We are investing in training to ensure multi-agency staff (including in the voluntary sector) are able to successfully promote this ethos regardless of their role.

All of our model's components were implemented or commissioned in 2015/16, with further refinements in 2016/17, learning from the previous year and ensuring some of its enablers are implemented, e.g. Shared Care Record Solution and integrated workforce planning. We are evolving our network towards the new models outlined in the *Five Year Forward View*. Our co-location plans for the multi-sector, multi-disciplinary Integrated Locality Teams working at GP practice/locality level for people with frailty is a step towards a Multi-Speciality Community Provider model; whilst our Care Homes Assessment Team working with GPs delivers many functions of the Enhanced Support for Care Homes model.

Our model is designed to raise the quality of care and patient experience through its person-centred approach (which is what patients tell us they want) but also help reduce non-elective admissions. The table below describes the different components of our model, evidence of how they improve or are likely to improve the quality of care and their contribution to reducing to non-elective admissions.

For children, the Better Care Fund supports a much wider programme of partnership working across children's services. The focus for the BCF programme in 2015/16 has been on developing the STAY project, and enhanced behaviour support team, that will work with children with challenging behaviour to prevent admission to residential and inpatient units and support implementation of the Transforming Care Programme. For 2016/17, we are looking to support implementation of the Future in Mind Programme focussing on the team that works with early intervention in psychosis and young people with severe and enduring mental health problems. Work to address non elective activity at our acute hospitals will also take place with a focus on short stay non elective admissions.

Model Component		Funding Partially or Fully From BCF Plan	Model Functions Covered	Changes in 2016/17 from 2015/16	Conditions Supported							
					Reduce Pressures on Social Care	Known to Improve Quality of Care	Directly reduces emergency admissions	Joint Assessment & Care Planning	Supports People with Dementia	Includes 7 Day Working	Supports Hospital Discharge / Prevents Re-Hospitalisation	Benefit From Shared Record?
Risk Stratification Tool		Partially	Identification									
GP Local Incentive Scheme to Support Integrated Care		Fully	Identification; Assessment & Care Planning; Delivery	New scheme in 2016/17	✓	✓	✓	✓	✓			✓
4 x Integrated Locality Teams (ILTs), working GPs and others in their practices and in community	Co-located & jointly managed ILTs. Input from:	Partially	Identification; Assessment & Care Planning; Delivery	Will move from virtual to physical teams in Phase II							✓	
	- Social Care Professionals, including BCF funded hospital-to-home liaision	Partially									✓	
	- Community Matrons	Fully										
	- District Nurses	Partially			✓	✓	✓	✓	✓			✓
	- Intermediate Care at Home & LBE Enablement	Partially								✓	✓	
	- Falls Specialists/Fracture Liaison Nurse	Fully									✓	
	- Geriatricians input	Fully									✓	
	- Palliative Consultant	Fully		New - supports EOL care								
	- Joint ILT Manager of Service	Partially		New - will manage service	Infrastructure							
Assistive Technology (Tele-Health)		Fully	Assessment & Care Planning; Delivery	Expansion of service		✓	✓	✓			✓	
Bed-based Community Rehabilitation Investment		Partially	Delivery - Rapid Response		✓	✓	✓	✓		✓	✓	✓
Wheelchair Services		Fully	Delivery		✓	✓						
Voluntary/ Community Sector (VCS) Hub Phase I	Multi-agency VCS navigators working in integrated care network. Phase I focussed on 2 priorities:	-	Assessment & Care Planning; Delivery	Phase I development in late 2015/16 - full effect in 2016/17	✓	✓		✓	✓			
	- Post-Diagnostic Support for People with Dementia;	Fully			✓	✓		✓	✓			
	- Falls Prevention	Fully			✓	✓		✓				
Multi-disciplinary Care Homes Assessment Team (CHAT)		Fully	Assessment & Care Planning; Delivery	Expanded to cover all older people's care homes		✓	✓	✓	✓		✓	✓
Older People's Assessment Unit (OPAU)		Fully	Assessment & Care Planning; Delivery - Specialist Intervention	Expanded to cover 50-64 population.	✓	✓	✓	✓	✓			✓
Memory Service		Fully	Assessment & Care Planning; Delivery			✓		✓	✓			✓
Nurse-led 7-Day Out-of-Hours Community Crisis Response Team		Fully	Delivery - Rapid Response	Function implemented in Q4 2015/16 - full effect 2016/17		✓	✓		✓	✓	✓	✓
Out-of-Hours Enhanced Nursing Service		Partially	Delivery - Rapid Response			✓	✓		✓		✓	✓
Palliative Care Rapid Response		Partially	Delivery - Rapid Response			✓	✓		✓			✓
Additional Investment in Hospital-Based 7 Day Social Care		Partially	Assessment & Care Planning; Delivery - Rapid Response	Expanded service in 2016/17	✓	✓		✓	✓	✓	✓	✓
Consultant-led Psychiatric Hospital Liaison Service		Partially	Assessment & Care Planning Delivery - Rapid Response			✓		✓	✓		✓	✓

4. NHS England National Conditions

4.1. Plans to be jointly agreed

The Better Care Fund pooled fund amount for 2016/17 is £21,725,445 comprising £19,185,445 from the CCG and £2,540,000 from the Council. The financial allocations within this pool are subject to sign off by the Health and Wellbeing Board once work to verify and validate has been completed by Council and CCG officers.

The Enfield Health and Wellbeing Board has established a sub-board called the Enfield Integration Board and a BCF Management Group. The Board is responsible for overseeing and governing the progress and outcomes associated with the Better Care Fund plan. It comprises senior offices from both Enfield CCG and the London Borough of Enfield; additional members may be appointed to the Group by the agreement of all current members prior to approval by the Health and Wellbeing Board.

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

The Health and Wellbeing Board has agreed that the Enfield Integration Board provides the overall Assurance to the Health & Wellbeing Board supported by the Joint Commissioning Board arrangements for managing commissioning arrangements across health & social care in Enfield.

Discussion and agreement of the plans is taking place at the Integration Sub Board which includes representation from the CCG, Council, acute trusts, community and mental health trust and the VCS. Subject to agreement of performance targets for 2016/17 and the associated impact on all partners, discussion regarding the impact on providers will take place at the Integration Sub Board. This will include reaching agreement on what the impact on providers will be and how this will be managed. Specifically within the context of our two hospital trusts in Enfield, this will be related to a reduction in emergency admissions of 736 next year and a reduction in delayed discharge days lost of 300.

All our NHS providers have been advised of the CCG commissioning intentions and have been involved in the development and delivery of new services during 2015/16 as part of our integrated care programme. Furthermore, there have been embryonic discussions with our main NHS providers about developing new models of care to support integrated delivery. This has taken place at both operational and strategic level to identify how the BCF contributes to a longer term strategic plan. This will need to be substantially developed during 2016/17 as part of delivering the 5 Year Forward View. As part of this we are seeking greater system, ownership of both reductions of emergency admissions and reductions of delayed transfers of care to support system resilience.

Within the context of change, a key part of the development of the Integrated Care programme has been to understand the future workforce requirements and assess

capacity. The Council and CCG are also working jointly on a workforce development plan with key points to include:

- Moving towards enabling and self-care
- Recruitment and retention of qualified practitioners (nurses, social workers, occupational therapists) to address local shortages
- Working in integrated care settings to support new ways of integrated working

A more detailed Community Education Provider Network (CEPN) Workforce Planning and Development Plan also addresses the integrated workforce needs, both current and future. A five year plan, this is currently in development with a target date of December 2016 for completion. This timeline allows us the opportunity to consult widely on emerging findings (between April and December).

The plan will also take into account the regional NCL STP workstream on workforce development and further work and consultation includes the interface with plans and outcomes being undertaken by BCF subgroups and other stakeholders. The plan is in draft, but available on request.

The Council is also in discussion with colleagues within housing to agree the spending plan and business case for the disabled facilities grant for 2016/17 with a view to maximising independent living options for people living with disabilities and illness. Included within the DFG allocation for 16/17 is the DOH capital grant and discussions are underway currently between the council, CCG and voluntary sector with a view to commissioning a mental health and wellbeing hub. This hub will be developed on the basis that it will be fully integrated with an agreed shared ambition.

4.2. Maintain provision of social care services

In line with DH guidance £6,055m has been allocated within the Better Care Fund to maintain the provision of social care services in 2016/17 compared to £5,952 for 2015/16. Our plans protect local social care services in three main ways:

- Funding for personal budgets/care packages, recognising unavoidable demand and demographic growth;
- Funding increased capacity to meet growing demand for enablement, telecare, and associated interventions to reduce ongoing demand and cost; and
- Funding increases in capacity/infrastructure to ensure more integrated case management and, crucially, to protect the supply of locally available high quality services.

With a focus on improved access to better care and support services in the community the schemes within Enfield's Better Care Fund will provide the necessary capacity to:

- Work proactively to prevent crisis
- Reduce the number of people admitted to hospital as emergencies

- Maintain the low number of people admitted to residential care from hospital (the bulk of placements are made from hospitals with 80% of those people not previously known to social services).
- Reduce the number of people admitted to hospital from residential/nursing care
- Promote self-management for people with long term conditions with improved access to support when needed at any time reducing dependency on long term support
- Integrate and improve access to community equipment and assistive technology solutions to promote independent living for carers, patients and service users
- Further increase capacity within the enablement service in order to provide more rehabilitative options for people both in the community and from hospital.

Now London's fourth largest borough by population, Enfield has experienced significant population growth. With a population figure of 312,466 at the 2011 census, this has now increased to an estimated 327,000 in 2015, an increase of 4.6% or more than 3,500 people per year.

Within this population, the number of people living with long term illness or disability is also increasing. Between 2011/12 and 2014/15 the number of people receiving Adult Social Care services in Enfield has increased by 6.3% (over 8% when the increased number of people accessing enablement services is included) (local service intelligence) with the most significant percentage increase in the Integrated Learning Disability service at over 15%. Between 2014/ and 2016 the proportion of people with a long term illness or disability is projected to increase by a between 2.7% and 3.6%. Within this increase the most significant increases are likely to be within learning disability and dementia.

In summary between 2015 and 2018 in Enfield there will be (Source POPPI/PANSI):

- 5.3% more people predicted to have two or more psychiatric disorders,
- 7.7% more older people with a limiting long term illness,
- 4.2% more adults with a moderate or severe learning disability and
- 8.4% increase in the number of people with a serious physical disability

There are over 29,000 carers living in Enfield, almost 7,000 of whom provide more than 50 hours of support a week. Adult Social Care works with around 10,000 service users a year providing support through Voluntary Sector Care services to a further 4,000 carers through the provision of information, advice, access to regular breaks, direct payments and therapeutic services which help people to continue in their caring role. Our new direct payments scheme for carers, implemented in 2014, has had a positive impact on support and outcomes for carers with very positive outcomes reported. The direct payment scheme is administered on the Council's behalf by our VCS run Carer Centre and the Council has entered into agreement in 15/16 to delegate the assessment of carers to the Carer's Centre. This is also progressing well with over 180 carers accessing the direct payment with no further need for support (for their cared for person) from the Council.

Significant work has been done to reduce the number of residential admissions for people aged 65 and over and whilst we have anticipated and are experiencing growth in the number of placements supporting dementia with nursing care the number of placements for people with physical frailty has been reduced through improved partnership approaches between health and social care. We believe that overall this approach will continue to deliver reductions in residential placements but anticipate also that with population growth and a 65+ population getting older with increasing numbers of people with dementia generally and being identified/diagnosed, that we will be able to manage increased demand and reduce the number of placements in absolute terms (given population increase and dementia prevalence/diagnosis rates). The most significant contributing factors in reducing numbers overall has been increased 7 day presence within hospital settings, establishment of integrated locality teams and increased capacity of stepdown and enablement/intermediate care support with increased capacity available.

Increased capacity within the enablement service (+50% over 3 years) has resulted in a wider offer with an additional 800 people passing through the service annually compared to 2012/13. The proportion of people passing through enablement with no further need for support is now up to 72%. Performance against NI125 has dipped slightly due to increased numbers of deaths of service users post discharge. Disregarding deaths the proportion of people continuing to live independently three months following discharge is at around 88%. The health and social care partnership believes that our target should continue to reflect a significant level of ambition with further work being undertaken to improve the partnership enablement offer.

Within the BCF allocation £747k has been allocated to Care Act responsibilities. We continue to assess the impact of the Care Act, including the increased demand for support from carers and for advocacy support services. The VCS will be key partners in the delivery of early intervention services which promote hospital avoidance, speedy and appropriate hospital discharge, self-management of long term conditions, advocacy support and our work with carers.

4.3. Agreement for the delivery of 7-day services across health & social care to prevent unnecessary non-elective admissions (physical and mental health) to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

Our original business case estimated that delivering the entire integrated care network at a weekend would cost an additional 25% for all such services (£2m). We decided to focus our 7-day BCF Plan investment on rapid response solutions that immediately prevent an individual's hospitalisation as the model's other components were pro-active, scheduled care that could be delivered Monday to Friday. These rapid response solutions therefore include measures that would support system resilience more generally. We have also funded a range of health and social care to support 7-day service and system resilience from the Better Care Fund in 2015/16 and continued this investment in 2016/17. Most of our 7-day working in the

integrated care model was in place for late 2015/16, with the latest addition being the Community Crisis Response Team - most of our focus for development in 2016/17 is on re-commissioning the 111/out-of-hours services, which is funded outside of the BCF Plan (see below).

Our network's rapid response solutions support / help people avoid unnecessary hospitalisation and facilitate safe and timely hospital discharge at the weekend. These services are funded partly via BCF (Section 2) with the remaining investment from mainstream commissioning budgets including System Resilience funding. We see the Shared Record Solution as a key enabler of weekend/OOH working.

The Community Crisis Response Teams will aim to assess and treat patients in their own home providing patient care out of hours, 7 days a week, reducing the need for unnecessary A&E Attendance & emergency hospital admissions. This will be phased with initial provision of service for 15/16 **out of hours** 7 days a week. The operating hours will be reviewed following an initial pilot phase to review provision in line with demand for evenings and weekends.

Aims of Community Crisis Response Service (< 2 Hours Response)

- Rapidly respond (and on a multi-disciplinary footing) to address health & social crises that do not require acute hospital-level care experienced by older patients, which would otherwise lead to adverse health outcomes through providing appropriate treatment, intervention and support tailored to them in patients' home safely, including those in care homes;
- Providing rapid access to equipment and required medication as needed to maintain the patient in the community
- Reduce avoidable hospital admissions – from community and residential homes
- Work with the integrated care network post-crisis to ensure joined-up working with community teams to ensure patients are subsequently safely managed in the community across care sectors;
- To provide short term care packages for patients under the care of the CCRT service who need a care package for hospital avoidance.

This is a nurse led service with access to medical cover provision from BARNDOC for clinical governance, medical support and leadership.
The team provides an assessment service for falls, worsening health and social problems, minor injuries and illnesses and will work closely with GPs and residential /care homes including other services within the Integrated Care Network to ensure patients are supported in a home environment wherever possible.

Other areas of focus for 16/17 for 7 day working are detailed in Appendix 6.

In Hospital Settings

Our multi-disciplinary hospital-based community health and social care services facilitate discharge (including from A&E) at weekends. These professionals work with acute staff to assess and discharge suitable patients either home or to bed-based

step-down facilities to start, or continue, patients' out-of-hospital rehabilitation over the weekend. Although this investment helps underpins many of the NHS 7-day service clinical standards, it particularly fulfils Standard 9.

In addition to this, System Resilience funding is also committed to increase 7-day working for specific hospital-based services specifically weekend working in paediatrics and A&E doctors and nurses, clinical support staff, pharmacy, therapies and discharge nurses. (In addition, System Resilience also funded the provision of a Mental Health Crisis lounge, a designated hospital place of safety, an area that provides privacy and dignity for someone in mental health crisis).

Out-of-Hospital Settings
Our community-based rapid response services work together to ensure people avoid hospitalisation where this is unnecessary at weekends and out-of-hours:

- *GP Urgent Access Hub* established in 2015/16 to enable professionals to schedule GP appointments for patients with clinical needs who need to be seen quickly in the evening or at the weekend at a local practice;
- *Re-commissioned 111 and GP Out-of-Hours Service* to be implemented Oct-16 which will strengthen our primary care out-of-hospital "offer" out-of-hours and at weekends;
- *Community Nursing & Rehabilitation Out-of-Hours services* (Section 2) include 7-day working, with the latest addition being the nurse-led Community Crisis Response Team to support people in the community and in care homes to avoid hospitalisation, a service linked to the Council's 24/7 Safe & Connected Service which ensures a rapid response is mobilised should a user's alarm be triggered. This means the Intermediate Care Service in which the Crisis Response Team is situated, is now funded to provide a 7-day and out-of-hours service.
- *Other Out-of-Hours services*: The integrated care model includes access to out-of-hours and weekend social care duty and community mental health services as appropriate.

These activities will continue to be monitored and adapted in our 2016/17 plan.

4.4. Better data sharing between health & social care, based on the NHS Number

The NHS number is now being used across both health and social care as the primary identifier for individuals with whom we interact. We have implemented the Shared Care Record Summary and have been working across health and social care services and commissioners to implement a shared record solution across primary, secondary, community health and mental health care and adult social care sectors. The NHS number will be used as the primary identifier in this solution.

Implementing a Shared Record solution across North Central London is a key priority in the NCL Digital Footprint Roadmap. With a view to implement in Q4 2016/17, we have identified options for delivery, which will meet the functional requirements specification for the Enfield shared care record. The decision about which solution we implement will be made in collaboration between NHS and Council operational

and IT staff working in Enfield assessing each solution's fit against our system requirements (developed in collaboration between partners).

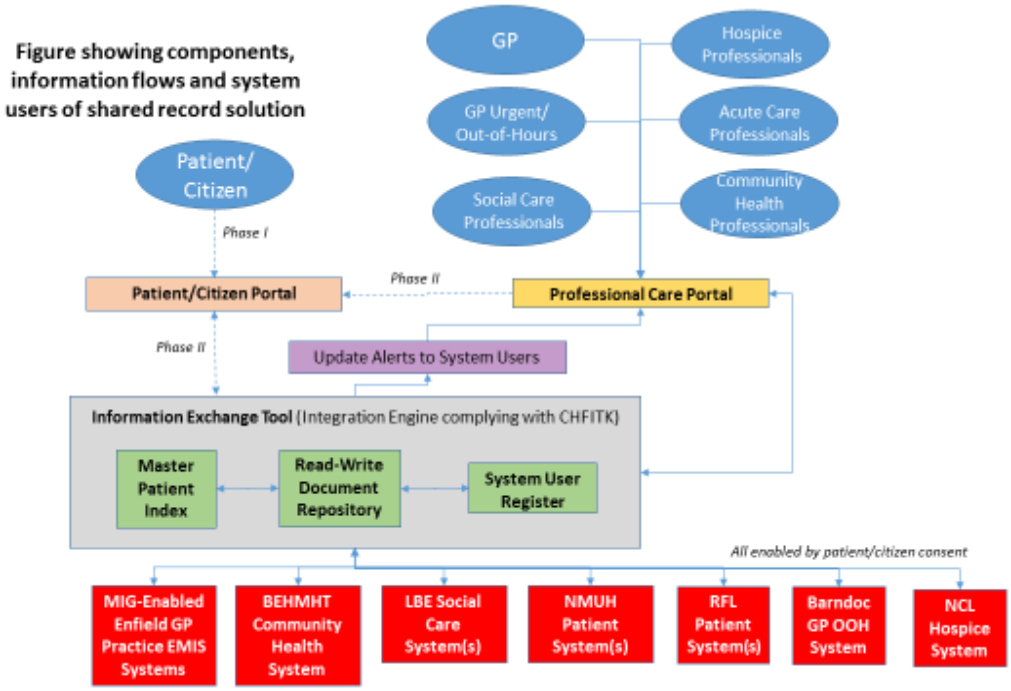
Key organisations operating in Enfield who have agreed in principle to implement an NCL Shared Record Solution are:

- Enfield CCG;
- London Borough of Enfield;
- North Middlesex University Hospital and Royal Free London;
- Enfield Community Services: Barnet, Enfield & Haringey Mental Health Trust;
- Barndoc GP Out-of-Hours Service;
- North London Hospice

Our project scope is to deliver a multi-agency professional and a patient-held record view to support adults with frailty/long-term conditions in the first instance. This will mean professionals and patients will be authorised and authenticated system users, the latter to their own records only.

We will ensure any additional national, regional or local good practices are incorporated in development, e.g. pan-London information standards, or Council solutions including Enfield Connected. This will be enabled through our solution having open Application Programme Interfaces (APIs) which is included in our systems requirements. Both of the solutions we are exploring have open APIs and have already interfaced with another solution (Coordinate My Care). This capability will enable our system to interface with any further systems or open API solutions in the same way.

Partners are in discussion about the following system architecture with sharing enabled through open APIs. The following diagram indicates the current thinking:



In line with data protection requirements, where required explicit consent will be obtained from the patient to share information across agencies and to develop patient-held records; if no consent is given, the solution will not present that patient's records.

The first phase of the rollout will be to support adults with frailty / ongoing conditions. Phase 2 will be to deploy to the wider adult population during 2017/18, in line with requirements in the NHS Personalised Health and Care Framework.

We already have a multi-agency Shared Record Group to take forward this project and have established an Information Governance Sub-Group. This Sub-Group is currently developing communication plans with stakeholders about the Shared Record Solution, and this includes with patients and citizens prior to its implementation. Alongside describing the benefits of sharing the data, key messages are being formulated including:

- Consent arrangements including who will see records about them and why (with documentation about data-sharing left with the individual);
- Specific arrangements will be put in place for those who lack capacity to consent in line with legal and good practice requirements;
- How patients can access their Patient Held Record;
- What individuals' legal rights are, incorporating including what to do if they believe the data about them on their PHR is incorrect or out-of-date;
- How individuals can access further records about their care through, for example, GP Access to Records procedures.

We routinely advise patients and service users of their rights in relation to data protection and access to information, so we will be building on this as we develop the Shared Care Record solution.

Our existing IG protocols to define patient-related information flows between partners are currently being updated to reflect the project's requirements, e.g. details of system user role-based access. With patient consent, the protocols will enable system users to view a (read-only) pre-defined dataset and documents bringing together information from multiple systems as far as possible in real-time to support high-quality care delivery (including unscheduled care) for individuals. The system will include a read-write Joint Care Plan Summary which multiple professionals will update to support integrated care.

4.5. Ensure a joint approach to assessment and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Our joint assessment, care planning and allocation process will be the same as that in 2015/16 until implementation of the Shared Record Solution in Q4 2016/17. Our GPs are responsible as Lead Accountable Professionals for joint development of individuals' Care Plans on their Case Management Registers as part of NHSE Enhanced GP Service to support individuals at risk of unplanned hospital admission. GPs have implemented 5,800 plans for people with frailty since September 2014.

This represents 14% of the population of people aged 65+ and 60% of the 9,800 population who are frail or high-risk pre-frail in the Borough (see diagram in the *Priorities and Scope: Integrated Care Programme Aimed at 50+ Population* Section). This number covers the vast majority of the individuals who are identified on GPs Case Management Register as amongst the "top 2%" of those most at risk of admission (4,600) and also extends into the "top 5%" category. Our aspiration is for all of the frail or high-risk pre-frail population (all 9,800) to have an individual Care Plan by the end of Sep-17 (as these individuals are at enhanced risk of hospitalisation). This will be achieved through gradual progress in developing plans through our existing mechanisms (which will add a further 1,500 cases by Mar-17); and then a further 2,500 in Apr-Sep-17 with progress accelerated through implementation of our Shared Record Solution which will more professionals will be able to contribute to development of plans.

The degree of coordination across agencies depends on individuals' needs, with greater multi-disciplinary coordination of assessments and outcome-based planning for those with more complex needs. Our existing multi-disciplinary hospital discharge teams, Integrated Locality Teams (ILT) and Care Homes Assessment Teams (CHAT) all facilitate joint assessment and care planning process to support GPs to fulfil their responsibilities and their support has proved popular with practices and patients (Section 2).

Phase II of the ILT development means community health & adult social care staff will be jointly managed and co-located from Oct-16 which our staff told us was an important enabler of joint working. We are re-designing ILT business processes to ensure each pre-frail or frail individual has a named community-based lead social care or health professional (if they need one) who they can contact and who will coordinate their care plan(s) and its delivery in the short- and/or longer-term. This is what our patients and service users told us they would prefer when we consulted with them in 2015.

ILTs and CHAT support assessment and care planning for people with dementia and have access to Community Mental Health Teams for specialist support in individual cases. Due to this improved care management and increased resources and training in primary care and the Memory Service, the proportion of Enfield residents living with dementia who had formal diagnoses increased from 50% to 67% over the last 18 months. We established a voluntary sector role of dementia navigator to support people post-diagnosis in 2015/16, a role linked to joint planning in our integrated care network, in particular, the Memory Service and ILTs (Section 2).

We plan to implement a Shared Record Solution to enable professionals to create and update an individual's Joint Care Plan Summary. This document will show who is involved in the case and their contact details (including the named lead professional) and will contain a high-level plan summary to support professionals to jointly coordinate care, building on relationships established in the integrated care network. The solution will also support a Patient-Held Record in Q1 2017/18 to enable individuals to access their records and documents to support them to take control over their care.

Our approach prevents duplication in documenting assessment and care plans for professionals, as the Solution will enable them a single view of pre-defined data and documents from multiple host systems, whilst fulfilling individual agency's statutory responsibilities to have dedicated health or social care plans.

4.6. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The Integration Board, which ultimately agrees the level of emergency admissions, includes membership of all our main acute, community and mental health providers. The agreements from the Integration Board are then discussed as part of the contract negotiations with our main providers. The impact of the better care fund on our providers is therefore clearly signalled during those contract negotiations. This includes the impact on acute providers of reductions of emergency admissions and outlined both in the better care fund and the CCG operating plan. Members of the Health and Wellbeing Board either attend or are represented on the Integration Board, so in addition to the contract negotiations, the impact of change to providers is known as plans and associated schemes are discussed and identified.

The details of the initiatives within the 2015/16 Better Care Fund are not substantially changing for 2016/17 but we expect the impact of those services to have great impact as they become joined up and offer integrated delivery. The Integration Board has been fully sighted on all those initiatives throughout 2015/16 and on newly commissioned initiatives during 2015/16.

The CCG, Local Authority and provider partners are already committed to developing integrated care for older people and for people with long term conditions which focuses on delivering a shift from crisis management and unscheduled care to an emphasis on prevention, early intervention and wellbeing and a more planned care approach to this client group.

We have taken an integrated approach to implementing personal health budgets for older people and people with physical and learning disabilities that are eligible for healthcare services. The Council's Personalisation journey started in 2006 and we now offer a range of support, information (including our e-market place), navigation, brokerage and management options for people with direct payments and their own budgets. Our infrastructure is already well established in this area. Through section 75 partnership arrangements, the Council on behalf of the CCG have set up a pilot to introduce Personal Health Budgets for people who meet the Continuing Healthcare criteria and want to manage their own budget. This will be extended further through implementation of the Better Care Fund plan.

We view the Care Act as an extension of Personalisation wherein the principles of good information for all, access to universal services, the focus on early intervention and prevention and maximising individual choice and control whilst safeguarding individuals, are all promoted. Our integrated approach will provide personalised early interventions to this population whilst also fulfilling the requirements of the Care Act by developing joined up and holistic wellbeing plans that make best use of universal preventative services and focus on supporting people to remain independent for as long as possible.

4.7. Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care

Our integrated care programme and out of hours service are clear evidence of our investment in NHS commissioned out of hospital services. We already have community-based rapid response services which work together to ensure people avoid hospitalisation where this is unnecessary at weekends and out-of-hours:

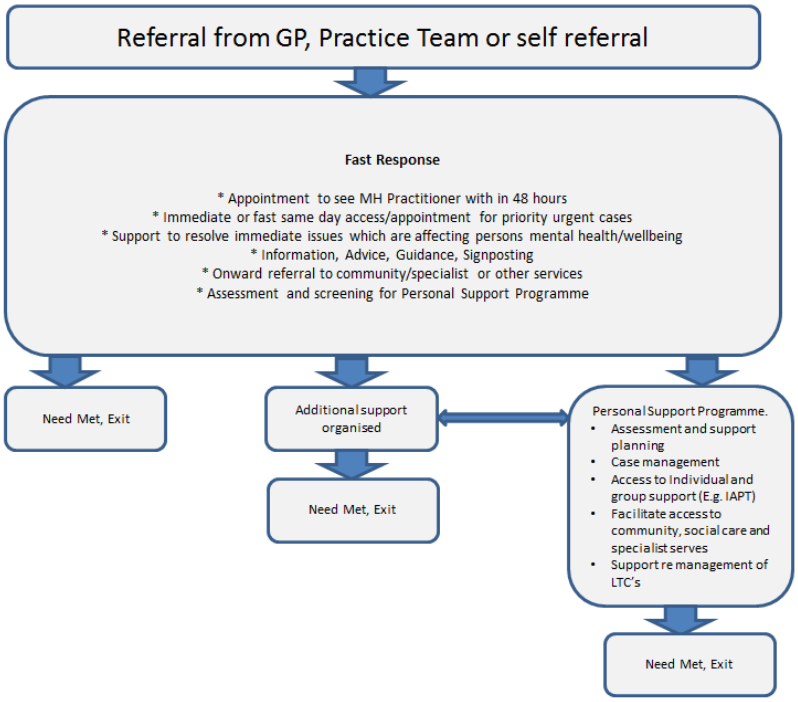
- *GP Urgent Access Hub* established in 2015/16 to enable professionals to schedule GP appointments for patients with clinical needs who need to be seen quickly in the evening or at the weekend at a local practice;
- *Re-commissioned 111 and GP Out-of-Hours Service* to be implemented Oct-16 which will strengthen our primary care out-of-hospital "offer" out-of-hours and at weekends;
- *Community Nursing & Rehabilitation Out-of-Hours services (Section 2)* include 7-day working, with the latest addition being the nurse-led Community Crisis Response Team to support people in the community and in care homes to avoid hospitalisation, a service linked to LBE's 24/7 Safe & Connected Service which ensures a rapid response is mobilised should a user's alarm be triggered;
- *Other Out-of-Hours services:* The integrated care model includes access to out-of-hours and weekend social care duty and community mental health services as appropriate.

Developing enhanced support for GPs managing patients with Mental Health issues

We are developing a proposal to support local GPs in managing patients presenting with mental health issues, which also include patients with physical conditions, as effectively as possible in primary care settings. We have identified funding from the BCF 2016/17 to develop a pilot by offering a trained mental health practitioner integrated into a general practice team, to enhance all the team's confidence and ability to manage mental health presentations, and 'spread the word' that mental health is mainstream health - breaking down barriers. We are proposing the pilot will encompass:

- Responsive and practical support in the GP surgery to the GP dealing with a mental health patient, including signposting to appropriate services and following up with the patient.
- Offer patients presenting in primary care a fast support service for those experiencing social/emotional crisis, anxiety and depression and where appropriate onward signposting and screening for appropriate service, e.g. Improving Access to Psychological Therapies (IAPT).
- Fast signposting to a range of support opportunities (Statutory and voluntary) relevant for a patient at the time of presentation. e.g. Peer support, other community services and support forums, recovery focused programme (Recovery College concepts) and 'Do'.

- Support for patients heading for crisis, crisis support and assessment to signpost rapidly to CRHT.
- Support to practice staff as above and especially for more complex patients.
- Case management for patients who require support to access services related to Long Term Conditions.
- Effective communication 'bridge' between secondary care and the practice as appropriate to ensure as far as possible successful transition from secondary care to primary care. (Discharge from Inpatient services).



4.8. Agreement on local action plan to reduce delayed transfers of care

In Hospital Settings

Our multi-disciplinary hospital-based community health and social care services facilitate discharge (including from A&E) at weekends. These professionals work with acute staff to assess and discharge suitable patients either home or to bed-based step-down facilities to start, or continue, patients' out-of-hospital rehabilitation over the weekend. Although this investment helps underpin many of the NHS 7-day service clinical standards, it particularly fulfils Standard 9. We have had discussions through the System Resilience Groups about developing an Integrated Discharge Hub to better provide consistent system response to discharges.

NCL CCGs are developing a Single Health & Resilience Early Warning Database (SHREWD) for rollout view across the health economy using System Resilience funding. This is a real time information system to help health systems better manage winter pressures on an operational day-to-day basis through presenting more up-to-date information from each acute site at a glance to acute and community commissioners and operational staff.

Direct Access GP Pilot
We introduced a 7-day 10 to 10 “See & Direct” Service at North Middlesex University Hospital (NMUH) as 70% of our residents attending A&E do so at this hospital. Experienced GPs staff this service, with walk-in A&E patients screened and directed to the most appropriate settings outside A&E including to the integrated care network, e.g. the Older People’s Assessment Unit.

Hospital Discharge
We have invested in managing timely and safe hospital discharge together, including weekend working (see 7 day working). Multi-agency services are funded partly via BCF (Section 2) as part of wider investment from mainstream commissioning budgets including System Resilience funding, the latter with the agreement of partners at our two System Resilience Groups.

Acute
Multi-disciplinary hospital-based community health and social care professionals facilitate discharge supported by CCG Continuing Health Care commissioners who agree individual CHC placements, particularly in care homes. These professionals work with acute staff at North Middlesex and Barnet & Chase Farm hospitals (and liaise with out-of-hospital services such as care homes) 7 days per week to assess and manage suitable patients discharge either to return home or to step-down beds to start patients’ out-of-hospital rehabilitation and/or order suitable equipment for individuals as part of transfer.

These professionals meet every day (included at ward rounds) to review more complex cases of patients approaching their expected discharge date and whose discharge may need multi-agency planning and agreement, including those who need to be assessed for CHC (including fast-track cases). In each case, actions with a named professional responsible and expected discharge dates are agreed to address any barriers to timely and safe discharge (e.g. family choice).

Individual cases are escalated to senior managers in each agency for resolution if there are any disputes about the way forward (this is rarely required). Where placement funding isn’t clear at discharge, we will move the patient to the home and continue with the CHC assessment there (with a CHC Panel meeting later) to ensure the patient’s case doesn’t become DTOC.

Non-Acute
A similar multi-disciplinary discharge process is now in place for non-acute discharge, with community health and social care services meeting routinely with CCG CHC commissioners to discuss plans for individual patients in the same way as above.

Hospital Discharge Working Group (HDWG)
Our Hospital Discharge Working Group (HDWG) meets to address strategic and operational issues associated with acute and non-acute hospital discharge processes. The Group is chaired by LBE’s Assistant Director of Adult Social Care and liaises with Barnet and Haringey System Resilience Groups, of which we are members. HDWG includes representatives from those involved in discharge from:

- CCG, including CHC, commissioners
- LBE commissioners and operational functions
- North Middlesex and Royal Free London acute Trusts
- Barnet, Enfield & Haringey MH Trust (who provide both non-acute bed- and community-based Community Health and Mental Health Services
- Care Homes who feedback from and to the wider care home community;
- Voluntary sector representatives running hospital-to-home services (see below)
- Enfield Healthwatch, to provide insight into the patient voice

HDWG shares the same targets for DTOC as those published in the BCF Plan, and the current position on DTOCs against plan is shared with the Group.

The 2015/16 targets and trajectories for Delayed Transfers of Care were not met for most of the year, and were particularly challenging for mental health. It is proposed to maintain the targets for 2016/17.

- Separate workshop sessions have been held to review DTOC plans for both acute and mental health and further sessions are planned.
- DTOC policies are under review and multiagency escalation processes are in place
- For acute care, the number of formal DTOCs are relatively low in Enfield and the focus is on medical optimisation along the whole pathway, with emphasis on ensuring that early discharge planning is the norm for every patient. For example work is underway to:
    - Identify the senior decision makers needed to support effective seven day working, including in out of hospital settings
    - Clarify the role SHREWD (live global patient pathway mapping system)
    - Ensure effective communication of proposals and new systems with patients and staff across all agencies
- For mental health, work to reduce DTOC's is an agreed multiagency priority and for example:
    - BEH MHT have introduced Discharge Implementation Teams onto the acute wards
    - Priority is being given to implementing our enablement strategy
    - Ongoing dialogue with Enfield housing to maximise housing opportunities and improve processes.

5. An agreed approach to financial risk sharing and contingency

We have agreed a risk sharing approach to national condition 7. The proportion of the fund is £1.5m and this has been calculated per cost of non-elective admission at £2039 per admissions x 736 – refer to the BCF Submission Management Information document.

Reducing emergency admissions in Enfield must be seen within the context of a very significant growth in population. Our approach has been system change across

health and social care to manage this increased demand for support. The agreed trajectory represents a reduction against this year's baseline but with the expectation that demand will continue to increase.

The target is for a reduction of 736 in non-elective admissions. The majority is based on modelling of the integrated care schemes for older people, and takes into account a change in age criteria from 65+yrs to 50+yrs.

The 736 reduction sits outside of the CCG Operating Plan assumptions (demographic growth, non-demographic growth, QIPP). Enfield CCG's Operating Plan includes a 1.4% increase in specific acute non-elective admissions. Whilst final operating plan submissions for neighbouring CCG's have not been seen there has been ongoing dialogue through the planning period. Based on previous BCF submissions in March 2016, the target reduction should represent about 2.4% of the non-elective admissions mapped to the HWB, and therefore provide a net reduction on 2015/16 outturn. Providers are involved in the development, implementation and oversight of the Better Care Fund Programme, including the development of individual schemes and impact of the overall programme.

Compared to the previous planned reduction of 1033 for 2015/16, and considering the move to SUS data for monitoring 2016/17 and a more reliable baseline / starting position, the 736 target is still considered to be challenging, but will be closely monitored during the year.

We are still working up the detail of our plans that we'll commission as a result of a release of funds. However, we expect that it will focus on the types of services set out in section 7 and shifting provision which will focus on people receiving support in the community delivered by the VCS working in partnership with acute providers, primary care and social care. In doing so, it will support people to remain at home and as a consequence, increasing the impact of reducing the non-elective admissions further.

The risk of not shifting services away from hospital is of a personal nature to individual wellbeing. People have told us that they want to remain at home, including at the end of their lives. It is a risk to the system as a whole as without more of a focus on this, we will continue to react, rather than intervene early in an individual's health and social care journey and prevent and delay need in the first instance (as clearly set out in the Care Act). It is also likely that our residential admissions will increase as a result of continuing to provide a reactive service.

Discussions continue with our providers about the case for change. As noted in earlier sections of this narrative, the targets set out in the BCF plan support our approach with providers and for the VCS we are recommissioning in order to focus on early intervention and prevention.

End.

6. Appendices

Better Care Fund Better Care Fund Related documentation

6.1 Published documents (including website links)	
Document or information title	**Synopsis and links**
Enfield JSNA	Setting out our changing demographic pressures and arranged according to a series of themes, in order to make it accessible. www.enfield.gov.uk/healthandwellbeing/info/3/joint_strategic_needs_assessment_jsna
Enfield JHWS (for link to consultation survey)	Setting out our agreed priorities for the area. www.enfield.gov.uk/healthandwellbeing/info/4/health_and_wellbeing_strategy
Enfield CCG – Plan on a Page	Providing the basis for our strategic planning and work with neighbouring CCGs. www.enfieldccg.nhs.uk/Downloads/Policies/ECCG%20Plan%20FINAL%204%20280313.pdf
North Central London Primary Care Strategy	Setting out the acute commissioning landscape and changes agreed across Boroughs. www.enfieldccg.nhs.uk/Downloads/Policies/Primary%20care%20strategy.pdf
Enfield's Joint Commissioning Strategy for End of Life Care 2012-16	Our priorities and plans for this important group. www.enfield.gov.uk/downloads/file/8457/enfields_joint_commissioning_strategy_for_end_of_life_care_2012-16
Enfield's Joint Stroke Strategy, 2011-2016	Explaining our priorities in this condition-specific area. www.enfield.gov.uk/downloads/download/2627/enfield_joint_stroke_strategy_2011-16
Enfield's Joint Dementia Strategy, 2011-2016	Setting out our initial plans for dementia sufferers in the Borough. http://www.enfield.gov.uk/downloads/download/1317/joint_dementia_strategy_2011__2016
Enfield's Joint Carers Strategy, 2013-2016	Explaining our joint plans for carers, working across health and social care. www.enfield.gov.uk/downloads/download/2429/enfield_joint_carers_strategy_2013-2016
Enfield's Joint Intermediate Care and Reablement Strategy, 2011-2014	This important strategy sets out our approach to increasing the numbers of people supported through our intermediate care work as well as continually improving outcomes as a result of our interventions. www.enfield.gov.uk/downloads/download/1319/joint_intermediate_care_and_re-ablement_strategy_2011-2014
Adult Social Care - Voluntary and Community Sector Strategic Commissioning Framework 2013-2016	This document has been shaped by our partners in the voluntary and community sector and explains our plans for supporting them to meet need in the community. www.enfield.gov.uk/downloads/file/8459/voluntary_and_community_sector_strategic_commissioning_framework_2013-2016

JSNA Older People with Complex Needs Factsheet	http://www.enfield.gov.uk/healthandwellbeing/info/18/the_health_and_wellbeing_of_older_people/57/older_people_with_complex_needs
Child & Adolescent Mental Health	http://www.enfieldccg.nhs.uk/about-us/child-and-adolescent-mental-health-services-camhs-strategy.htm
Hospital Discharge Action Plan	No link available, see document included in submission files

6.2 BCF programme documents – list of the documents attached as separate appendices		
Appendix number	**Document or information title**	**Synopsis**
1	Scheme plan summary	A list of all the schemes in the investment plan and the changes from 2015/16
2	Performance dash board	This is a monthly activity dash board that reports on the performance of the national and local metrics
3	Enfield Integration Board Programme risk log	This is the overall programme risk log that is owned by the Enfield Integration Board
4	Integrated Care Programme risk log	A separate risk log for the Integrated Care programme
5	Integrated Care programme plan	A detailed plan of the individual schemes and how they support reduction in admissions and improved quality of care
6	Seven day working plan	Action plan including key milestones and target dates

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 27th May 2016.

The BCF Q4 Data Collection

This Excel data collection template for Q4 2015-16 focuses on budget arrangements, the national conditions, non-elective admissions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 9 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Non-Elective Admissions - this tracks performance against NEL ambitions.

6) Supporting Metrics - this tracks performance against the two national metrics, locally set metric and locally defined patient experience metric in BCF plans.
7) Year End Feedback - a series of questions to gather feedback on impact of the BCF in 2015-16

8) New Integration metrics - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care
9) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 9 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the previous quarterly submissions and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously the 2 further questions are not applicable and are not required to be answered.

If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance have been met through the delivery of your plan (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Forecasted income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1 to Q4
Forecasted expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure from the pooled fund in Q1 to Q4

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

5) Non-Elective Admissions

This section tracks performance against NEL ambitions. The latest figures for planned activity are provided. One figure is to be input and one narrative box is to be completed:

Input actual Q4 2015-16 Non-Elective Admissions performance (i.e. number of NEAs for that period) - Cell P8
Narrative on the full year NEA performance

6) Supporting Metrics

This tab tracks performance against the two national supporting metrics, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:
An update on indicative progress against the four metrics for Q4 2015-16
Commentary on progress against the metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

7) Year End Feedback

This tab provides an opportunity to provide give additional feedback on your progress in delivering the BCF in 2015-16 through a number of survey questions. The purpose of this survey is to provide an opportunity for local areas to consider the impact of the first year of the BCF and to feed this back to the national team review the overall impact across the country. There are a total of 12 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund
There are a total of 10 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Disagree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. Our BCF schemes were implemented as planned in 2015-16
2. The delivery of our BCF plan in 2015-16 had a positive impact the integration of health and social care in our locality
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan

Part 2 - Successes and Challenges
There are a total of 2 questions in this section, for which up to three responses are possible. The questions are:
11. What have been your greatest successes in delivering your BCF plan for 2015-16?
12. What have been your greatest challenges in delivering your BCF plan for 2015-16?

These are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Leading and managing successful Better Care Fund implementation
2. Delivering excellent on the ground care centred around the individual
3. Developing underpinning, integrated datasets and information systems
4. Aligning systems and sharing benefits and risks
5. Measuring success
6. Developing organisations to enable effective collaborative health and social care working relationships
7. Other - please use the comment box to provide details

8) New Integration Metrics

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 / Q3 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

9) Narrative

In this tab HWBs are asked to provide a brief narrative on year-end overall progress, reflecting on a first full year of the BCF, with reference to the information provided within this and previous quarterly returns.

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Better Care Fund Template Q4 2015/16

Data collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Funds pooled via a S.75 pooled budget, by Q4? If no, date provided?
Yes

3. National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the annual totals and the pooled fund
Income to	Forecast	Yes	Yes	Yes	Yes	Yes
	Forecast					
	Actual	Yes	Yes	Yes	Yes	
	Actual					
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Forecast					
	Actual	Yes	Yes	Yes	Yes	
	Actual					
	Commentary	Yes				
	Commentary					

5. Non-Elective Admissions

Actual Q4 15/16	Comments on the full year NEA performance
Yes	Yes

6. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
	Admissions to residential Care	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Reablement	Yes	Yes
		Please provide an update on indicative progress against the metric?	Commentary on progress
	Local performance metric	Yes	Yes
	If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Patient experience metric	Yes	Yes	Yes

7. Year End Feedback

Statement:	Response:
1. Our BCF schemes were implemented as planned in 2015-16	Yes
2. The delivery of our BCF plan in 2015-16 had a positive impact on the integration of health and social care in our locality	Yes
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions	Yes
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care	Yes
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Yes
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Yes
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality	Yes
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality	Yes
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality	Yes
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan	Yes

11. What have been your greatest successes in delivering your BCF plan for 2015-16?	Response and category
Success 1	Yes
Success 2	Yes
Success 3	Yes

12. What have been your greatest challenges in delivering your BCF plan for 2015-16?	Response and category
Challenge 1	Yes
Challenge 2	Yes
Challenge 3	Yes

8. New Integration Metrics

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Yes	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Yes	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes
Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

9. Narrative

Brief Narrative	Yes

Cover

Q4 2015/16	
Health and Well Being Board	**Enfield**
completed by:	Sue Glandfield
E-Mail:	sue.glandfield@enfield.gov.uk
Contact Number:	020 8379 3913
Who has signed off the report on behalf of the Health and Well Being Board:	Bindi Nagra (Assistant Director Strategy and Resources, LBE) and

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	16
4. I&E	19
5. Non-Elective Admissions	2
6. Supporting Metrics	9
7. Year End Feedback	16
8. New Integration Metrics	67
9. Narrative	1

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Budget Arrangements

Selected Health and Well Being Board:	Enfield

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you now confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

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National Conditions

Selected Health and Well Being Board: Enfield

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q4 Submission Response	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?
1) Are the plans still jointly agreed?	Yes	Yes	Yes	Yes	Yes	
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes	Yes	Yes	
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	Yes	No - In Progress	Yes	Yes	
4) In respect of data sharing - please confirm:						
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	Yes	Yes	Yes	Yes	
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Yes	Yes	Yes	Yes	
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	Yes	Yes	Yes	Yes	
6) Is an agreement on the consequential impact of changes in the acute sector in place?	No - In Progress	Yes	Yes	Yes	Yes	

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Enfield

Income

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£6,697,500	£4,629,500	£4,629,500	£4,629,500	£20,586,000	£20,586,000
	Forecast	£6,697,500	£4,629,500	£4,629,500	£4,629,500	£20,586,000	
	Actual*	£6,697,500	£4,629,500	£4,629,500			

Q4 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£6,697,500	£4,629,500	£4,629,500	£4,629,500	£20,586,000	£20,586,000
	Forecast	£6,697,500	£4,629,500	£4,629,500	£4,629,500	£20,586,000	
	Actual*	£6,697,500	£4,629,500	£4,629,500	£4,629,500	£20,586,000	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	N/A

Expenditure

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,146,500	£5,146,500	£5,146,500	£5,146,500	£20,586,000	£20,586,000
	Forecast	£4,896,500	£4,896,500	£5,396,500	£5,396,500	£20,586,000	
	Actual*	£4,892,750	£4,896,500	£5,396,500			

Q4 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,146,500	£5,146,500	£5,146,500	£5,146,500	£20,586,000	£20,586,000
	Forecast	£4,896,500	£4,896,500	£5,396,500	£5,396,500	£20,586,000	
	Actual*	£4,892,750	£4,896,500	£5,396,500	£4,869,250	£20,055,000	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	The actual total for the year shows an underspend of £531k, which relates to CCG commissioned schemes, as reported to the April CCG Finance Committee. This is minimal and represents only 2.6% of the total pooled fund & 50% will be carried forward into the 2016/17 pooled fund

Commentary on progress against financial plan:	£194k of contingency was released in quarter 1 of 15/16 to reflect the reduction in emergency activity between the first quarter of calendar year 2015 and the first quarter of calendar year 2014 as per NHSE BCF guidance. There is no expectation for further reductions in emergency activity in 2015 so no further contingency releases are assumed. A decision has yet to be taken regarding how the underspend will be allocated in the 2016/17 plan.

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

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Non-Elective Admissions

Selected Health and Well Being Board: Enfield

	Baseline				Plan					Actual				
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
D. REVALIDATED: HWB version of plans to be used for future monitoring. Please insert into Cell P8	7,258	7,122	7,377	7,751	6,970	6,874	7,133	7,498	6,726	7,128	7,695	7,765	7,890	8,236

Please provide comments around your full year NEA performance	Over the 5 quarters shown above, performance has been 3513 admissions (or 10%) above plan. Over the last 4 quarters, performance has been 3355 admissions (or 11.9%) above plan.

Footnotes:

Source: For the Baselines and Plans which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs, as of 26th February 2016.

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National and locally defined metrics

Selected Health and Well Being Board:	Enfield

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Overall the number of placements into residential and nursing care is down this year compared to last year and ahead of target. However, there has been an increase in the number of people with dementia being placed, particularly within a nursing care setting.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Data to support this return is still being reviewed. It is unlikely that the target of 88% will be met. However, anticipated outturn is likely to be between 85%-87%

Local performance metric as described in your approved BCF plan / Q1 / Q2 / Q3 return	Diagnosis of Dementia
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Performance has been maintained above the BCF target level in 2015/16. Early detection and referrals by GPs to the Enfield Memory Service were encouraged resulting in an increase in number of assessments and diagnoses rates.

Local defined patient experience metric as described in your approved BCF plan / Q1 /Q2 return	A composite metric was included in our plan as submitted and approved. The Local Composite Measure (%) Includes : Proportion of carers who find it easy to find information about services (Carer survey); Proportion of people who use services who find it easy to find information about services (ASC User Survey); Last 6 months, enough support from local services/organisations to help manage long-term conditions (GP Patient
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	The latest average across all metrics has improved compared with 13/14 baseline information but is slightly short of the target if the latest average is considered. Surveys are annual & this measure will continue to be monitored as more detail from the surveys becomes available

Footnotes:

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

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Year End Feedback on the Better Care Fund in 2015-16

Selected Health and Well Being Board:	Enfield

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. Our BCF schemes were implemented as planned in 2015-16	Agree	
2. The delivery of our BCF plan in 2015-16 had a positive impact on the integration of health and social care in our locality	Agree	The schemes in the plan have encouraged & enabled officers (both in operational & strategic services) to work together.
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions	Disagree	Overall NEAs increased in 2015/16 on the previous year. The BCF schemes targeted the elderly and frail population where NEAs were avoided.
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care	Disagree	The main area where an increase was observed was non-acute relating to the BEHMHT paptients
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Agree	The wording is incorrect here. The positive impact is that more people were supported to continue liviing indpendently at home following input from enablement services - agreed that the plan had a positive impact & on track to achieve the target.
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Agree	There was an overall reduction in the number of older people admitted to residential/nursing care in the year though there has been an increase in the number of older people with dementia admitted to placements
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality	Agree	BCF schemes have encouraged local partnership working e.g. Integrated Locality Teams, 7 Day working and the OPAU - all of which are making noticeable improvements to patient care.
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality	Agree	
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality	Agree	£194k of contingency was released in quarter 1 of 15/16 to reflect the reduction in emergency activity, as per NHSE BCF guidance. A proposal for how this will be utilised during 2016/7 is yet to be agreed & approved by the HWB.
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan	Agree	

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

11. What have been your greatest **successes** in delivering your BCF plan for 2015-16?	Response - Please detail your greatest **successes**	Response category:
Success 1	Seven day working is in place across health and social care and our integrated locality teams are working well to bring a multi-disciplinary approach to supporting people who need our help. The community-based rapid response services work together to help / support & treat people in their own homes to avoid unnecessary hospitalisation & facilitate safe & timely discharge at the weekend & out of hours.	1.Leading and Managing successful better care implementation
Success 2	Admissions to residential and nursing care continue to reduce and our target, already very ambitious, was met this year.	2.Delivering excellent on the ground care centred around the individual
Success 3	Our reablement service continues deliver excellent outcomes with over 71% discharged with no further need for support and on track to achieve approx 86/86% of people living independently after receiving the service upon discharge from hospital.	2.Delivering excellent on the ground care centred around the individual

12. What have been your greatest **challenges** in delivering your BCF plan for 2015-16?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	The work done in 2015/16 to reduce emergency admissions for older people (65+) needs to be extended into paediatrics and our 50+ population as these have shown themselves to be areas of increased pressure this year. Noted that extension to 50+ population & OPAU dealing with under 65s commenced during Q4. (NEA - qualification: there has been a reduction for the target population but not the wider NEA activity)	2.Delivering excellent on the ground care centred around the individual
Challenge 2	The increase in the length of delay (i.e. number of days) for paptients to be discharged from hospital in 2015/16 has been identified as a priority with particular issues around: • non acute mental health discharge and support arrangements • shortage of residential/nursing stepdown provision • patient choice (for residential/nursing care) •	2.Delivering excellent on the ground care centred around the individual
Challenge 3	To develop, with the Enfield Integration Board & key stakeholders, a shared vision & strategic direction for the integration of health & social care in Enfield	6.Developing organisations to enable effective collaborative health and social care working relationships

Footnotes:
Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Leading and managing successful Better Care Fund implementation
2. Delivering excellent on the ground care centred around the individual
3. Developing underpinning, integrated datasets and information systems
4. Aligning systems and sharing benefits and risks
5. Measuring success
6. Developing organisations to enable effective collaborative health and social care working relationships
7. Other - please use the comment box to provide details

New Integration Metrics

Selected Health and Well Being Board: Enfield

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Hospital	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	40
Rate per 100,000 population	12

Number of new PHBs put in place during the quarter	3
Number of existing PHBs stopped during the quarter	1
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	71%

Population (Mid 2016)	336,359

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - throughout the Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014).
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html
Q4 15/16 population figure has been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Enfield

Remaining Characters	30,235

Please provide a brief narrative on year-end overall progress, reflecting on the first full year of the BCF. Please also make reference to performance on any metrics that are not directly reported on within this template (i.e. DTOCs).
Despite significant challenges across our health and social care services in Enfield the implementation of our Better Care Fund programme of work has seen some success in 2015/16: Admissions to residential and nursing care continue to reduce and our target, already very ambitious, will be met this year. Our enablement service continues to deliver excellent outcomes with over 71% discharged with no further need for support and we are on track to achieve approx 86/87% of people living independently after receiving the service upon discharge from hospital. Our satisfaction measure shows good performance against continuity of care co-ordination (continuity of support and telling your story once). Seven day working is in place across health and social care and our integrated locality teams are working well to bring a multi-disciplinary approach to supporting people who need our help. We are clear that the work we have done in 2015/16 to reduce emergency admissions for older people (65+) needs to be extended into paediatrics and our 50+ population as these have shown themselves to be areas of increased pressure this year. The increase in the number of people whose discharge from hospital was delayed in 2015/16 has been identified with particular issues around: a) non acute mental health discharge and support arrangements, b) shortage of residential/nursing stepdown provision, c) patient choice (for residential/nursing care) and the completion of assessments. An action plan is in place and has been implemented with a 45% reduction in delays achieved in January 16 compared to September 15. This remains an area of priority for 2016/17. This is supported by the System Resilience Groups focussed around our two main acute providers. Improving the availability of good accessible information which supports informed decision making and self-management of long term conditions is key to our vision of integrated care. Access to good quality information has been improved as a result of the Care Act implementation. Work has also started during 2015/16 on recommissioning the VCS in partnership across the Council and the CCG with a view to commissioning evidence based support and services which will work jointly with statutory services. This will enable us to increase our focus on early intervention and preventative services which engage with people at an earlier stage to increase resilience, self-care and to provide single points of access for information/advice/practical low level support as appropriate.

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INFANT MORTALITY IN ENFIELD

Annual Public Health Report: 2015

www.enfield.gov.uk

ENFIELD Council

WELCOME

I would like to welcome you to the Annual Public Health Report for 2015/16. This report focuses on infant mortality and what can be done to reduce it as well as ensuring all children in Enfield have the best chances for a long and healthy life.

Infant mortality has been a long standing concern for Enfield. Despite recent improvements, it remains a priority for the Health and Wellbeing Board. It is associated with a number of risk factors; low socio-economic status, late booking for antenatal care, smoking during and/or after pregnancy, alcohol and/or substance misuse during and after pregnancy, maternal obesity, domestic violence, low birth weight, not breastfeeding and inappropriate infant sleeping position. Enfield has been able to consider these factors and has, in collaboration with partners, developed interventions and campaigns to tackle them including the "Back to Sleep" campaign promoting safe sleep practices for babies, breastfeeding support programmes, and the "ASAP – As Soon As you are Pregnant" campaign aimed at encouraging pregnant women to notify health services as soon as they find out they are pregnant.

This Annual Public Health Report highlights the importance of evidence-led interventions that can impact on improving infant mortality rates. It includes examples of work across the borough that contributes to reducing infant mortality. This includes joint working with Children's Centres, Teenage Pregnancy Unit, with the Health Visitor and Family Nurse Partnership services, and Perinatal Mental Health services. Ultimately, it is only by engaging fully with our partners and especially with the Enfield community that we can have an impact on reducing the rate of infant mortality in Enfield further.

I would like to thank the Public Health team for their hard work in producing this report which will help to guide and shape future work in reducing infant mortality and ensuring all children have the best start in life.

Cllr Nneka Keazor
Cabinet Member for Public Health and Sport

FOREWORD

My report this year focuses on infant mortality and what is being done in Enfield to address it. In 2010, Enfield had the worst infant mortality rate in London (5.76 per 1,000 live births). Whilst I am pleased to say that the rate has decreased (4.56 per 1,000 live births) we cannot afford to be complacent especially as Enfield's rate is still higher than the London average (3.8).

We know that a number of factors are associated with a higher risk of infant mortality and Enfield has developed a number of campaigns to address these factors. However, it is important that we continually promote messages to protect both babies and unborn children, for example, encouraging women to make sure they make contact with health services as soon as they think they are pregnant and see a midwife preferably within 10 weeks but certainly within 12 weeks of becoming pregnant, supporting women to access smoking cessation services, give advice regarding healthy eating in pregnancy, raising the awareness of the importance of breastfeeding and safe sleep positions, and promoting the antenatal screening programmes available to all pregnant women. I am also delighted that North Middlesex University Hospital NHS Trust is planning a programme for monitoring foetal growth with ultrasound.

This report highlights the relationship between child poverty and levels of infant mortality. Reducing both child poverty and infant mortality are key priorities for Enfield Council and feature in Enfield's Health and Wellbeing strategy (2014-2019), there are a number of work steams associated with this aimed at ensuring all children in Enfield have the best start in life.

I would like to thank Dr Allison Duggal, her team and partners for their work on tackling infant mortality. I would also like to thank Dr Cath Fenton and her team for the work they carried out prior to transition on moving this agenda forward. Finally I would like to thank those who produced this report; Dr Allison Duggal, Dr Chinelo Nwajiobi, Estella Makumbi, Miho Yoshizaki, Emily Rainbow, Lisa Luhman and all the Enfield Public Health Team for their clear description of the situation.

Dr. Shahed Ahmad
Director of Public Health

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EXECUTIVE SUMMARY

This year's Annual Public Health Report focusses on infant mortality and what is being done in the borough to ensure that all children in Enfield have the best chance for a long and healthy life regardless of the circumstances of their births.

Infant mortality refers to the death of a live-born baby in the first year of life. It does not include stillbirths, miscarriages or terminations and is more common in the first eight months of life. Infant mortality is usually expressed as a population rate (the number of infant deaths per 1,000 live births) which allows comparison with other populations or areas. Common causes of infant death include physical immaturity e.g. in premature births; low birth weight; congenital anomalies; maternal complications; infections; SUDI or "cot deaths".

In England and Wales, 130 out of every 1,000 children born in 1911 died before their first birthday. Now, the infant mortality rate is a fraction of this (4.1 per every 1,000 live births in 2011-13). The decrease in infant deaths is due to advances in public health and healthcare, including the control of infectious diseases and improved public health infrastructure, as well as specific improvements in midwifery and neonatal intensive care. However, infant mortality levels in Enfield were the sixth highest in London for the years 2011-13 (4.6 per 1,000 live births), this was a reduction from the 2010-12 rate of 5.76.

This report explores some of the contributing factors to infant mortality and the interventions that Enfield are delivering with partners to tackle infant mortality.

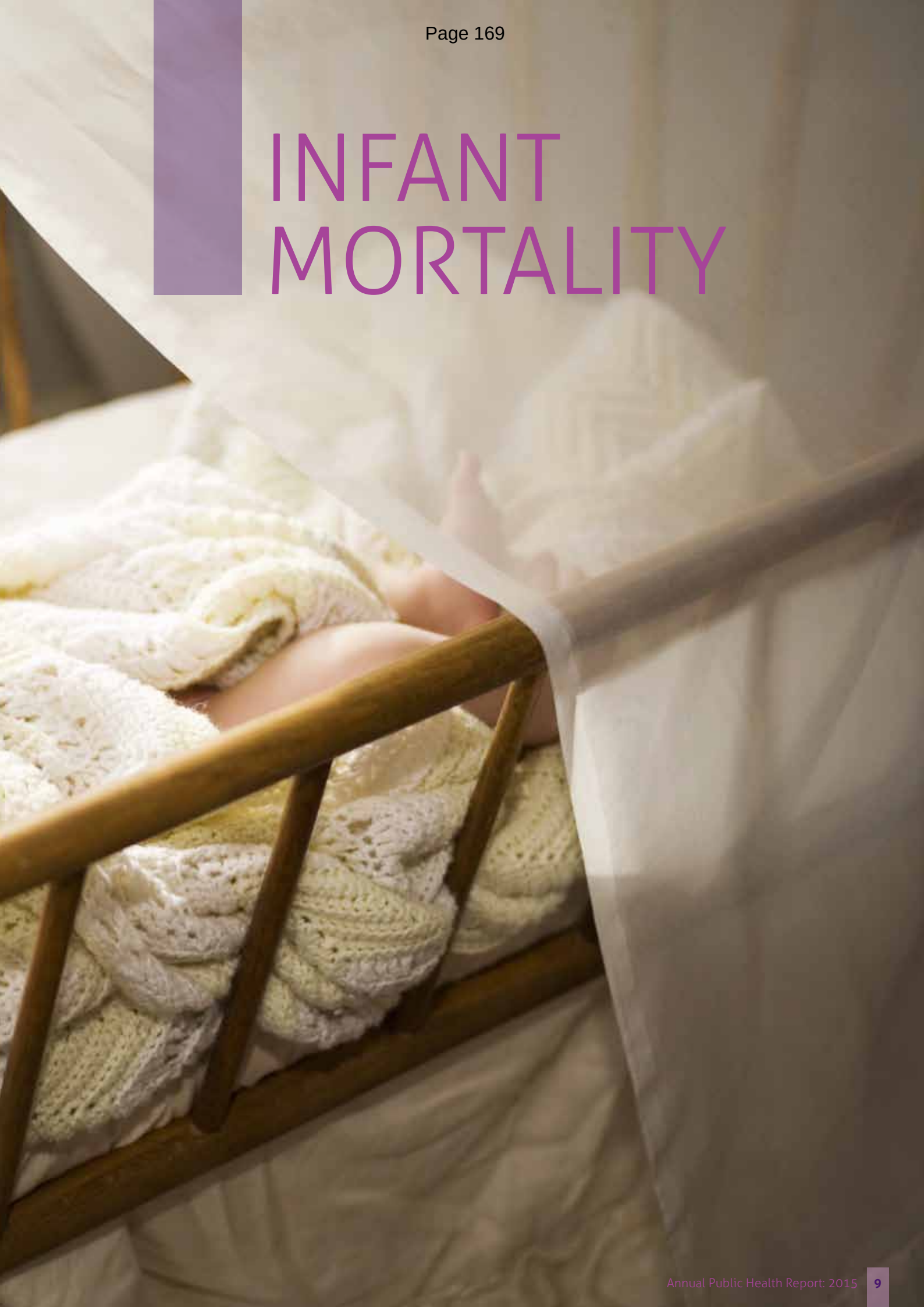
The first section describes infant mortality, current data and why early years are important to the health of a child. This section also explores the relationship between child poverty and inequalities; it identifies the risk factors associated with infant mortality and describes the current antenatal, maternity and screening services available to all women in Enfield.

There is a body of evidence, both national and international, that demonstrates that infant mortality rates can be successfully reduced. The next section of the report explores this evidence and how it has been used to inform our services, interventions and campaigns.

This is followed by a section which describes how services are working in partnership to tackle infant mortality. This includes examples from Children's Centres, Health Visitors, Family Nurse Partnership, Perinatal Mental Health services, Enfield Safeguarding Children Board and the Teenage Pregnancy Unit.

The final section of the Annual Public Health Report illustrates how Enfield will know it is making a difference, and describes the various data sources and tools available that can be used to measure the difference Enfield is making.

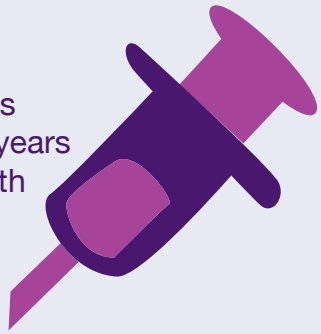
INFANT MORTALITY



INFANT MORTALITY: KEY MESSAGES

Every year in England about **3,000 babies die** before their first birthday.

Infant mortality has reduced over the years due to public health efforts such as **immunisations.**



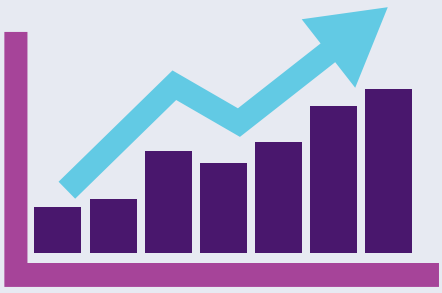
Babies born to **mothers who smoke** (or have partners that smoke) during pregnancy are more likely to die during the first weeks of life.

Depression and anxiety are common in pregnancy and once the baby has arrived. Current data suggest that **10-20%** of maternities in Enfield are affected by **mental health issues**.

Breastfeeding is known to reduce the chances of a child suffering from diarrhoea and vomiting, chest infections, ear infections, constipation, and obesity.

In 2013, **8.5%** of babies born in Enfield were identified as being of a **low birth weight**. Low birth weight infants are at higher risk of mortality than babies of normal weight at birth.

Infant mortality levels in Enfield were the **sixth highest** in London for the years 2011-13 (4.6 per 1,000 live births), this was a reduction from the 2010-12 rate of 5.76.

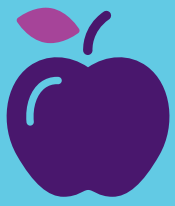


The following factors can help to reduce infant mortality:

Routine enquiry and support regarding domestic violence and mental illness

Ensuring early access to antenatal care

Providing information and education on the antenatal and newborn screening programme



Promoting healthy and maternal nutritional status

Provision of specialist services for obese pregnant women

Reducing smoking before during and after pregnancy

Promotion of safe sleeping

Promotion and support of breastfeeding

Ensuring high coverage of childhood immunisations

Enfield has, in collaboration with partners, developed interventions and campaigns to tackle infant mortality including:

the “Back to Sleep” campaign promoting safe sleep practices for babies

breastfeeding support programmes

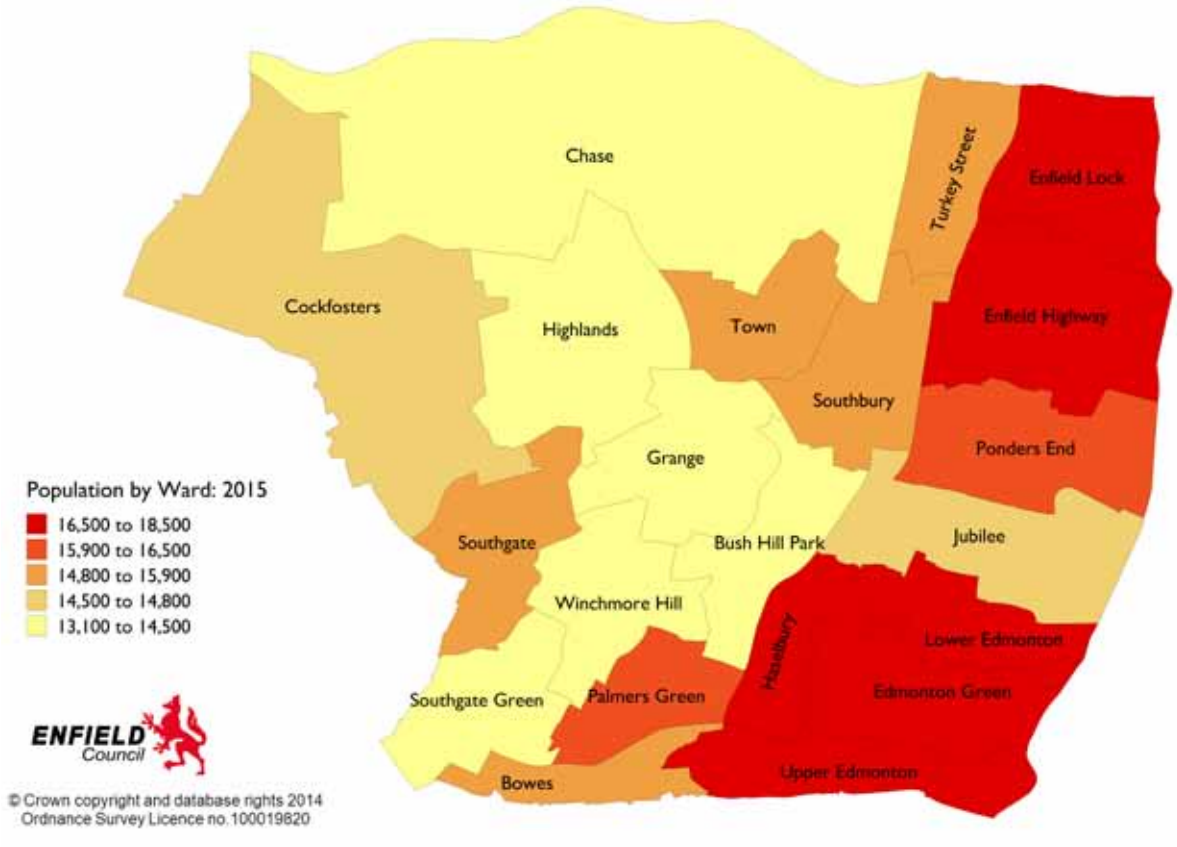
the “ASAP – As Soon As you are Pregnant” campaign aimed at encouraging pregnant women to notify health services as soon as they find out they are pregnant

CHILDREN AND YOUNG PEOPLE IN ENFIELD

Enfield is a very diverse borough with over 324,000 residents (Mid-2014 population estimates, Office for National Statistics (ONS), around two thirds of whom were born in the UK (2011 Census, ONS). In 2010 it was estimated that new community groups made up about 12% of the total population. These included Somalis, Nigerians, Ghanaians, Congolese, Turkish, Kurdish, Albanian and migrants from the A10 accession countries following the 2004 enlargement of the European Union (EU)[1].

Enfield has a mobile population with many residents moving in from other parts of London and moving out to other UK locations. There is also net inward migration from outside the UK. The population is higher on the eastern side of the borough than the west, particularly in Enfield Lock, Enfield Highway, Lower and Upper Edmonton, Edmonton Green and Hazelbury.

FIGURE 1: Enfield population by Ward

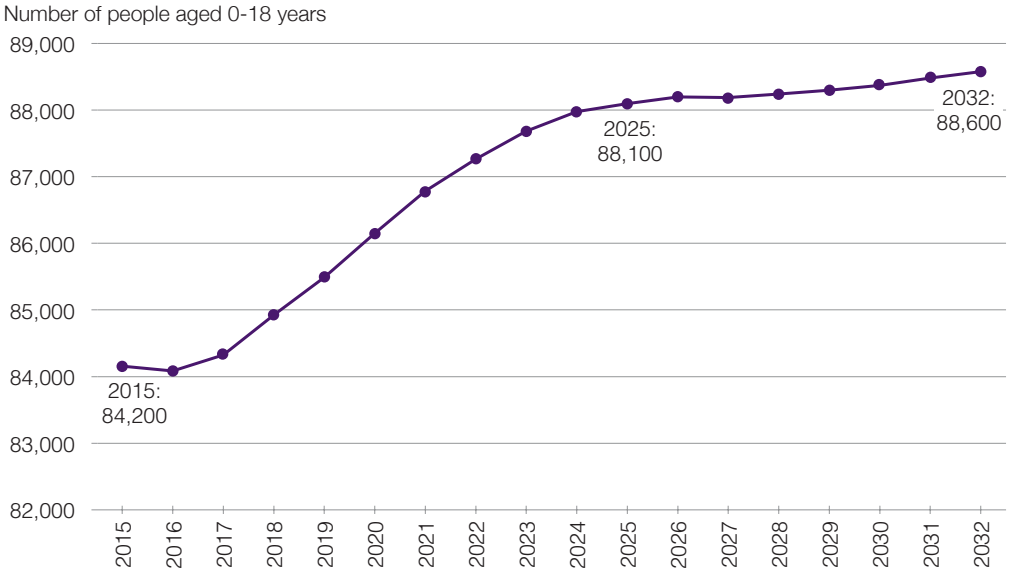


Source: GLA2013 Round of Demographic Projections, Greater London Authority (GLA)

1 Source: Office for National Statistics

An unusually large proportion of the Enfield population is made up by younger people. In 2013, just over one fifth (21.3%) of residents were aged under 15, the 4th highest proportion in England and well above the England average of 17.8%. Current estimates suggest that the total number of people under 18 years old and resident in Enfield was 84,200 in 2015. This is predicted to increase to 88,100 by 2025 and 88,600 by 2032.

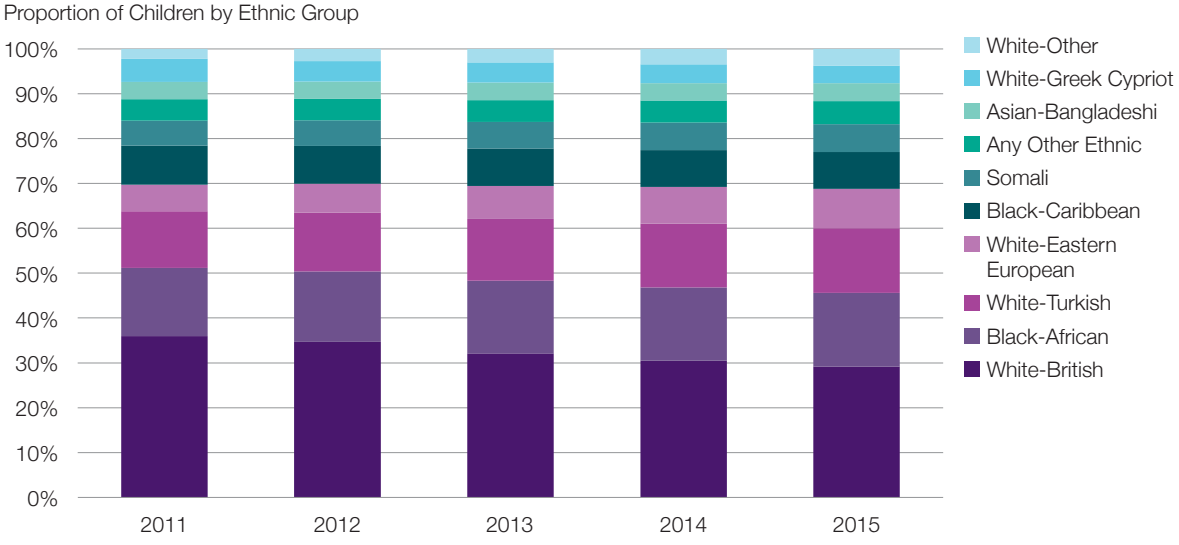
FIGURE 2: Children and Young People Population Projections for Enfield: 2015-2032



Source: GLA2013 Round of Demographic Projections, GLA

Between 2011 and 2015, the largest ethnic group amongst Enfield school pupils was White British (21.5%). The second largest group was Black-African (12.1%). There is a large Turkish community in Enfield and more than 10% of pupils are White-Turkish.

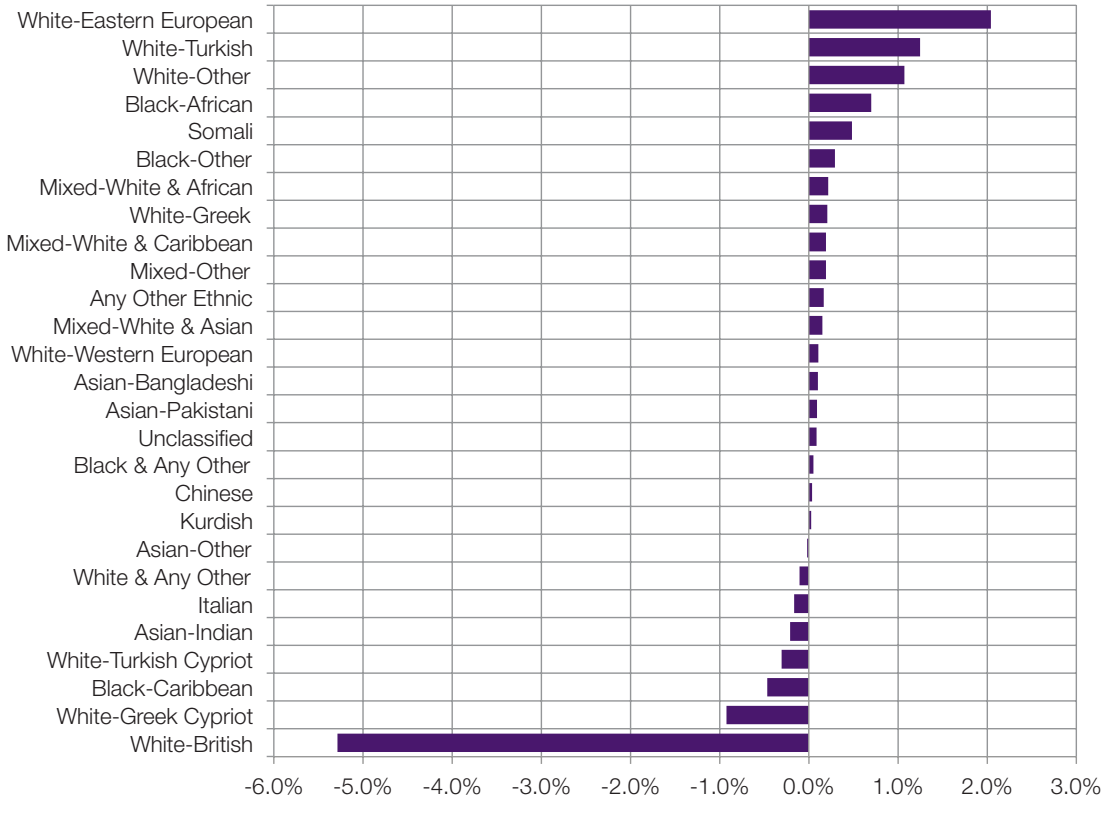
FIGURE 3: Pupil ethnicity in Enfield. Ten largest groups: 2011-2015



Source: Enfield School Census, London Borough of Enfield

The proportion of pupils belonging to the White British group fell substantially by 5.3% between 2011 and 2015. In contrast, the proportion of pupils identified as White Other, White Turkish and White Easter European increased (7%).

FIGURE 4: Change in size of pupil ethnic groups: 2011-2015



Source: Enfield School Census, London Borough of Enfield

THE IMPORTANCE OF THE EARLY YEARS IN THE HEALTH OF A CHILD

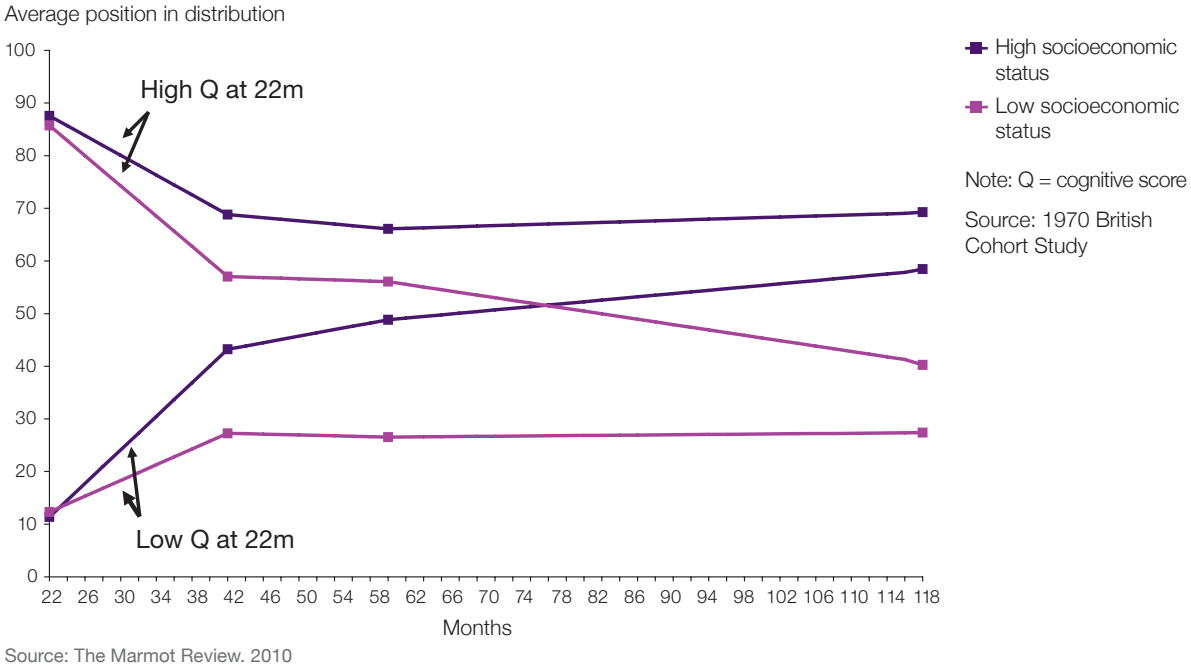
Pregnancy, birth and the first 24 months of a baby's life are seen as critical to the health of the child. It is a time when parents are very busy, but are receptive to help and advice from different sources.

A baby's brain is developing at an incredible rate during this period. From birth to 18 months, the synapses (connections in the brain) are forming at a rate of 1-2 million per second. It is this rapid and incredible brain development that makes the early years such an important time to ensure that a child lives a healthy, happy and successful life.

The attachment between babies, parents caregivers is crucial and there is long-standing evidence that the baby's social and emotional development is strongly affected by the quality of this attachment[2].

It is crucial that help and support are available to families with children under two years old. If a child falls behind in the first year, there is good evidence that they are more likely to fall further behind in subsequent years. Figure 5 shows the differences in changes to cognitive development in children according to socioeconomic differences. This shows that where a child has a higher cognitive score at 22 months, then those children who have low socioeconomic status (i.e. poorer children) start to lag behind their peers with higher socioeconomic status (richer children) by 42 months. Where children have a lower cognitive score at 22 months, there is again a difference according to socioeconomic status. In this case, the richer children show increases in cognitive status whereas the poorer children do not see any gains past 42 months.

FIGURE 5: Inequality in early cognitive development of children in the 1970 British Cohort Study at ages 22 months to 10 years[3]



Source: The Marmot Review. 2010

2 1001 Critical Days – web
3 Fair Society, Health Lives. The Marmot Review. February 2010.

WHAT IS INFANT MORTALITY?

Introduction

Infant mortality refers to the death of a live-born baby in the first year of life. It does not include stillbirths (a stillborn baby is a baby who is born dead after 24 completed weeks of pregnancy), miscarriages (the loss of the pregnancy in the first 23 weeks) and terminations (abortions) and is more common in the first eight months of life. Infant mortality is usually expressed as a population rate (the number of infant deaths per 1,000 live births) which allows comparison with other populations or areas. Common causes of infant death include physical immaturity e.g. in premature births; low birth weight; congenital anomalies; maternal complications; infections; injury and Sudden Unexpected Death in Infancy (SUDIor 'cot death').

Although infant mortality refers to the death of a live born baby in the first year of life, a variety of infant mortality statistics are available. The most common ones are:

- Perinatal Mortality (still births and deaths less than seven days after birth)
- Neonatal Mortality (infant deaths less than 28 days after birth)
- Post-neonatal Mortality (infant deaths 28 days to one year after birth)

In England and Wales, 130 out of every 1,000 children born in 1911 died before their first birthday. Now, the infant mortality rate is a fraction of this (4.1 per every 1,000 live births in 2011-13). The decrease in infant deaths is due to advances in public health and healthcare, including the control of infectious diseases and improved public health infrastructure, as well as specific improvements in midwifery and neonatal intensive care. Infant mortality is often used as a proxy for population health as there is good correlation between infant mortality and the health of a population worldwide[4].

The factors that are associated with a higher risk of infant mortality include:[5]

- Low socio-economic status (usually associated with living in a more deprived area)
- Maternal age (under 20 years and 35 years and over)
- Birth outside marriage/sole parental registration
- Late-booking for antenatal care
- Smoking during and/or after pregnancy
- Alcohol and/or substance misuse during and after pregnancy
- Maternal obesity
- Maternal morbidity, for example diabetes, mental illness
- Domestic violence
- Low birth weight (<2,500g)
- Not breast feeding
- Inappropriate infant sleeping position and environment
- Congenital abnormalities

In addition to addressing the factors listed above, infant mortality rates can be decreased by: reducing child poverty; reducing the levels of obesity in pregnancy; increasing breastfeeding rates; reducing smoking in pregnancy; reducing sudden unexpected death in infancy (cot deaths); and reducing unwanted teenage conceptions.

4 Infant Mortality Rate as an Indicator of Population Health. D. D. Reidpath and P. Allotey. Journal of Epidemiology and Community Health Vol. 57, No. 5 (May, 2003), pp 344-346

5 Tackling health inequalities in infant and maternal health outcomes – report of the infant mortality national support team. December 2010

Why is it important?

Every year in England, about 3,000 babies die before their first birthday and many more are stillborn or have long-term disabilities. The death of a baby is a devastating experience for families and many of these deaths are preventable. Infant mortality varies considerably between countries, particularly between developing countries and the more developed world such as North America and the UK. In 2010, the infant mortality rate for England and Wales was 3.2 per 1,000 live births after 24 weeks gestation, compared to 2.1 per 1,000 in Finland and Sweden and 2.5 in Norway. The infant mortality rate was higher in Scotland (3.3 per 1,000), the USA (4.2 per 1,000) and Northern Ireland (4.5 per 1,000).

Infant mortality is an important indicator of the health or pregnant women, infants and children. These statistics are also an important measure of the overall health of a population, in part because the risk factors for infant mortality are likely to be the same influence the health status of the population[6]. Further, there is a growing body of evidence that shows the importance of health and wellbeing in the early years, and in particular the first two years of life, and the long-term benefits of ensuring all children have access to the best start in life.

The main causes of infant deaths are immaturity related conditions (babies born less than 37 weeks gestation), congenital anomalies (conditions or malformations present before or at the time of birth) and sudden and unexpected death in infancy, normally occurring within the first eight months of life (Oakley et al. 2009). Most causes of infant deaths show a socio-economic gradient.

Infant mortality and inequalities

Infant mortality has reduced over the years due to public health efforts such as immunisations, but not everyone in society benefits equally and significant health inequalities persist. There are higher rates of infant mortality in some population groups, including those working in routine and manual occupations, births registered by the mother alone, and births where the registered occupation group is 'other'; which includes people who are unemployed[7]. Infant mortality is strongly linked with lower socio-economic status, and hence with child poverty, both nationally and internationally.

Infant mortality has reduced over the years due to public health efforts such as immunisations

6 Health Inequalities Unit. Review of the Health Inequalities Infant Mortality PSA Target. Department of Health February 2007 see http://tinyurl.com/o86acry (accessed 22 July 2013)

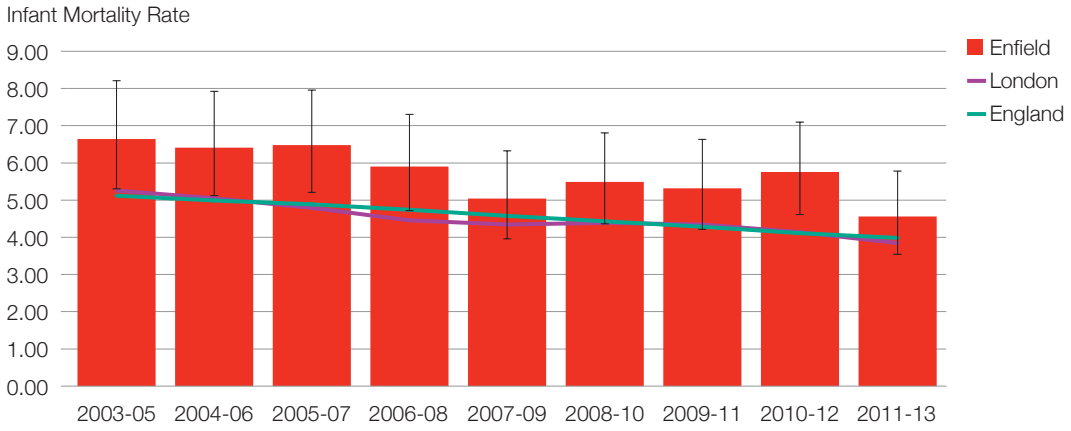
7 Fair Society, Health Lives. Marmot M. 2010. http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

INFANT MORTALITY IN ENFIELD

Infant mortality levels in Enfield were the sixth highest in London for the years 2011-13[8] (4.6 per 1,000 live births), the most recent period for which data are available. This is shown in Figure 6.

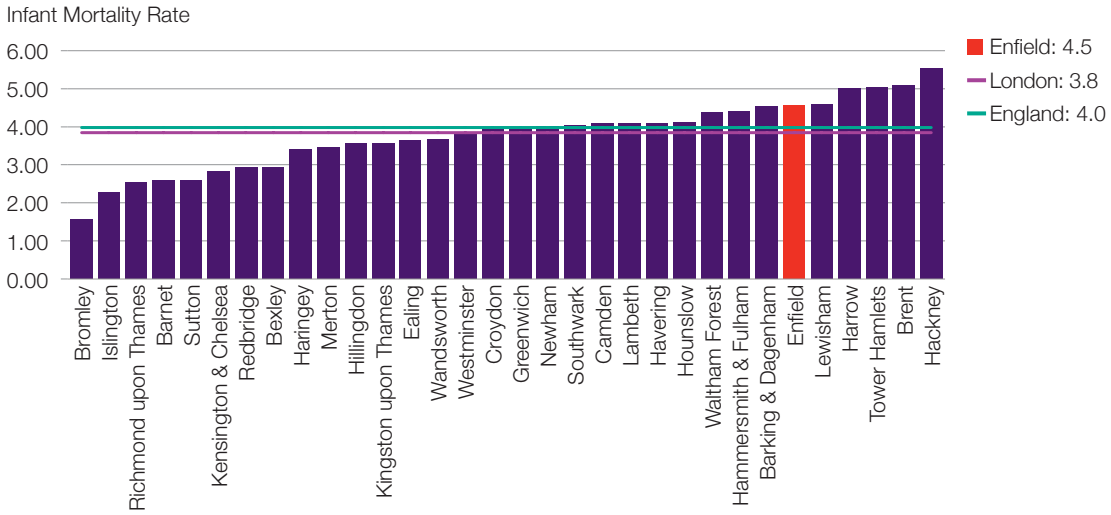
The numbers of deaths are relatively small, but an average of 27 babies are still dying before their first birthday each year in Enfield and the rate each year has dropped very little.

FIGURE 6: Infant mortality rates in Enfield, London and England. Three-year rolling averages from 2003-05 to 2011-13



Source: Office for National Statistics

FIGURE 7: Infant Mortality Rate, per 1,000 Live Births: 2011-13 Pooled

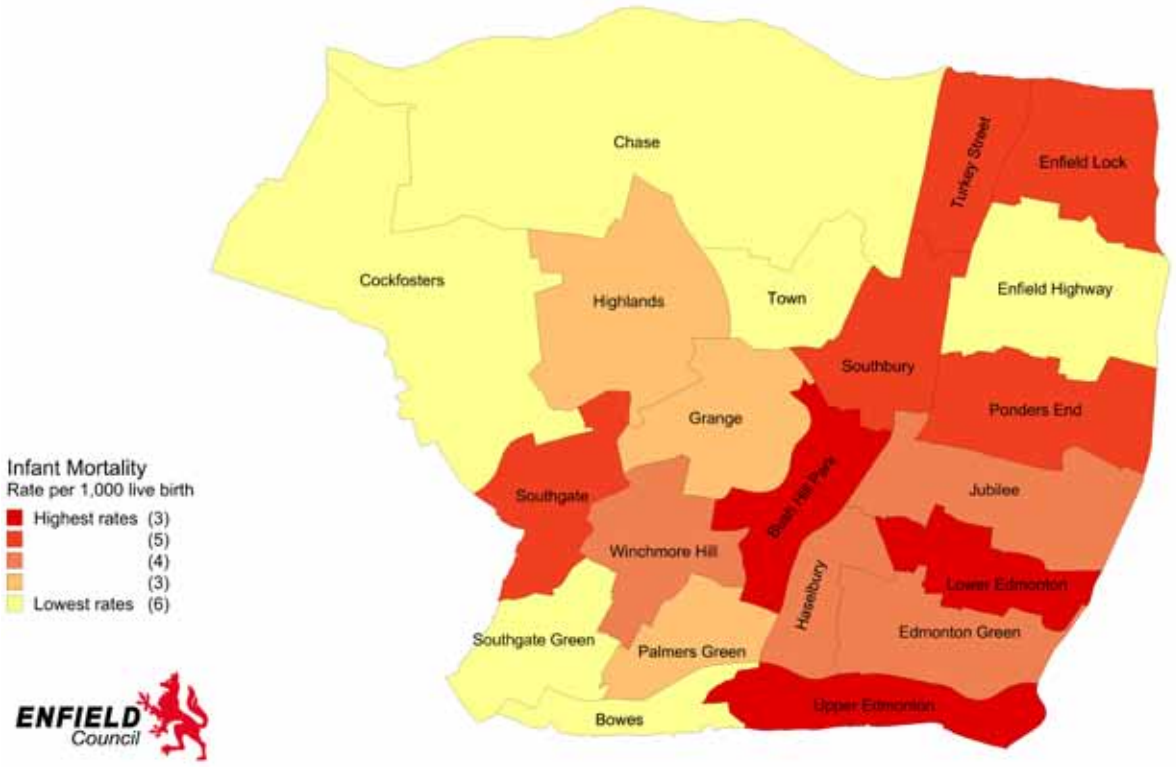


Source: Office for National Statistics

8 Infant mortality data is calculated as a 3-year average. This is because the numbers of deaths is small and so small changes can seem significant. By averaging these out over 3 years, the data is more meaningful.

Within Enfield, the highest rates of infant mortality are in the east of the borough, particularly in Upper Edmonton, Lower Edmonton and Bush Hill Park. However, it should be noted that these are based on small numbers of events and the data should be treated with caution.

FIGURE 8: Infant Mortality Rate per Ward, Enfield, 2006-2013



Source: Enfield Public Health Intelligence based on Primary Care Mortality File, ONS

Sudden Unexpected Death in Infancy (SUDI)

Sudden Unexpected Death in Infancy (SUDI) refers to all unexpected deaths in infants of up to one year of age without a clear diagnosis of cause of death. All deaths in the first year of life are investigated and categorised, these are usually divided into those deaths for which there is a clear diagnosis and those for which there is no diagnosis. Those deaths without a diagnosis after investigation are referred to as Sudden Infant Death Syndrome (SIDS).

Sudden unexpected death in infancy (SUDI)[9] is a significant cause of infant mortality and usually occurs within the first eight months of life. There is a higher risk of SUDI for male, preterm and/or low birth weight babies and for babies sleeping on their fronts or sides (that is, not sleeping on their back). Although SUDIs occur in all socioeconomic groups, it is more common amongst people living in deprived areas (Gray et al., 2009). Overcrowded living conditions are associated with health problems such as stress and depression, poor educational achievement of children and family breakdown. Although the exact mechanisms are unknown, there appears to be a link between overcrowding and SUDI; but it should also be noted that smoking and obesity and teenage pregnancy are also more common in more deprived areas.

In Enfield there were 4.3 homeless households with dependent children or pregnant women per 1,000 total households. This compares to 1.7 nationally

In Enfield there were 4.3 homeless households with dependent children or pregnant women per 1,000 total households. This compares to 1.7 nationally.

FIGURE 9: Rate of unexplained deaths in infancy per 1,000 live births 2004-2012

Source: CHIMAT

9 SUDI refers to sudden infant death syndrome. When the death has been investigated and no cause can be found, it will be recorded as Sudden Infant Death Syndrome and known colloquially as a cot death.

RISK FACTORS FOR INFANT MORTALITY

Child Poverty

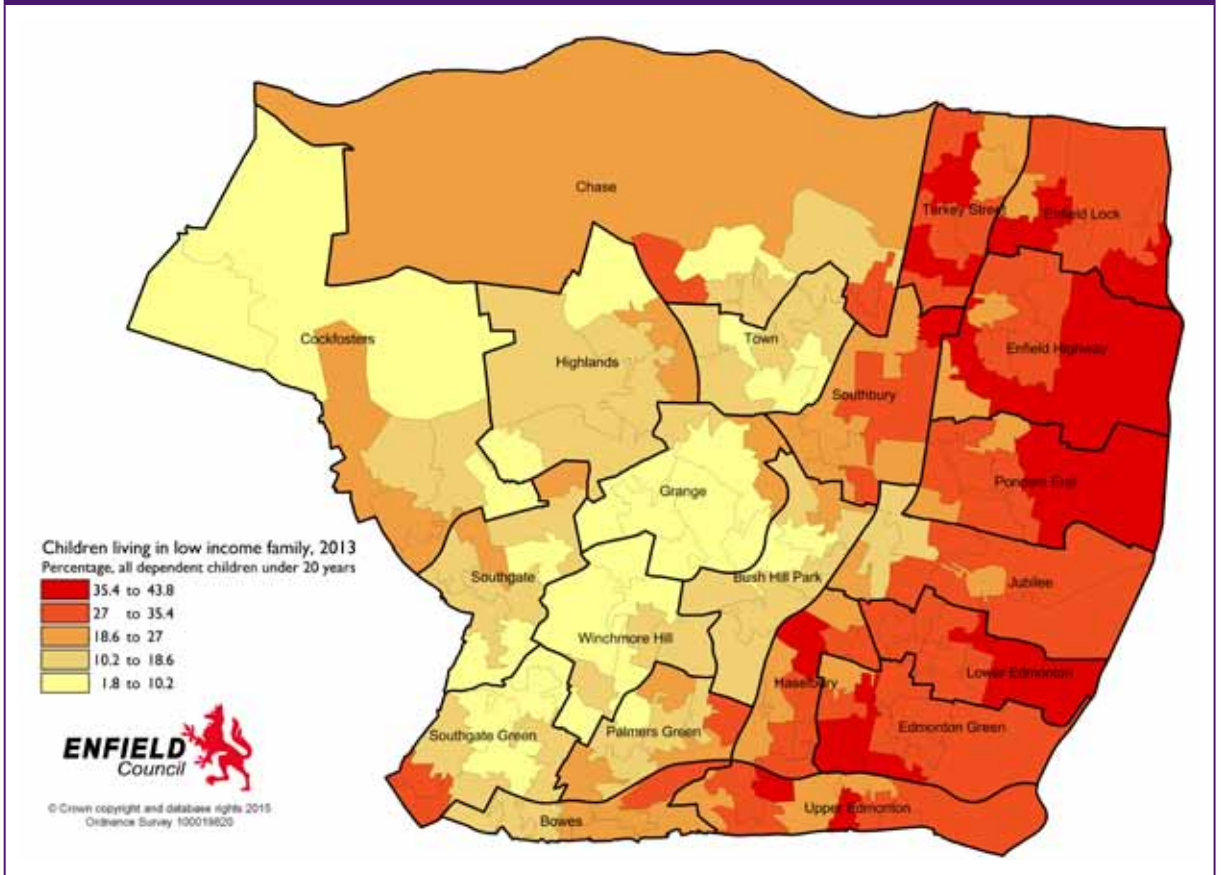
Enfield is a borough of contrasts. The Western side of the borough is affluent, but almost one in four (24.9%) children in Enfield live in poverty – the 11th highest rate in London – and over 21,000 children live in houses blighted by poverty. The large number of children living in poverty in Enfield is set against a backdrop of significant demographic changes in the borough. The population of 0-4 year olds has risen over 30% in the last 10 years, child poverty rates are constantly above London and England averages and the number of lone parents claiming benefits rose by 14% between 2,000 and 2010, bucking the trend for the rest of London where it fell by a quarter.

The child poverty rate varies widely within Enfield, with the highest rates in the east of the borough as Figure 8 shows. It is worth comparing this to Figure 10 which shows the rates of infant mortality by ward and shows the relationship between poverty and infant mortality.

The wards with the highest rates of child poverty are Edmonton Green, Turkey Street, Enfield Lock, Lower Edmonton, Ponders End, Enfield Highway, Haselbury and Upper Edmonton.

More than two in five children are living in poverty in the following wards: Edmonton Green, Turkey Street, Enfield Lock, Lower Edmonton, Ponders End, Enfield Highway, Haselbury and Upper Edmonton. Even in the wards with the lowest child poverty rates, more than one in ten children live in poverty.

FIGURE 10: Percentage of dependent children under 20 year olds living in poverty, by lower super output area, 2013



Source: HM Revenue and Customs

Children from low-income families are more likely than those from higher-income families to live in inadequate housing. Poor housing has been shown to have an adverse impact on childhood health and has been associated with:

- An increased risk of contracting respiratory infections, asthma and hypothermia;
- Reduced immunity;
- An increased likelihood of developing skin conditions;
- Developmental delay; and
- Stress and depression.

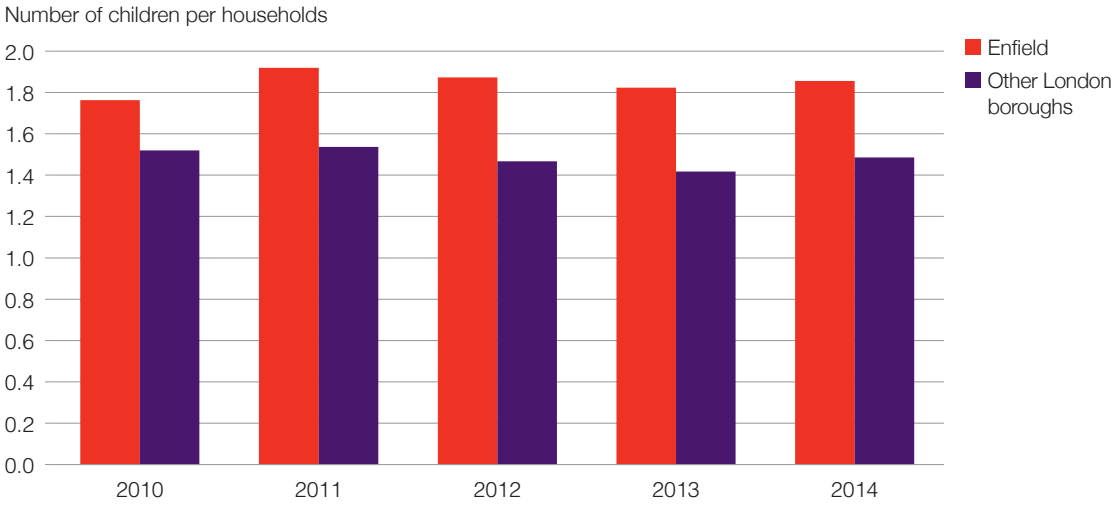
As of May 2014, more than 35,000 households in Enfield were claiming housing benefit. More than half of these households (54.3%) had at least one dependent child – this is above both the London (42.4%) and England (37.3%) averages. Around half of households claiming housing benefit are renting from the private rental sector. These tenants are at a higher risk of living in poor housing conditions than those who rent from the Council.

Enfield also has a higher proportion of households with children living in temporary accommodation than the London average. This is partly because of increased demand in the borough – other local authorities place households in Enfield due to the relatively cheaper housing market. As of March 2014, Enfield had by far the highest number of households placed by other local authorities (1,659 households) among London boroughs. Redbridge was the second highest with only 1,092 households.

The number of children living in temporary accommodation in Enfield was 4,362 in June 2014

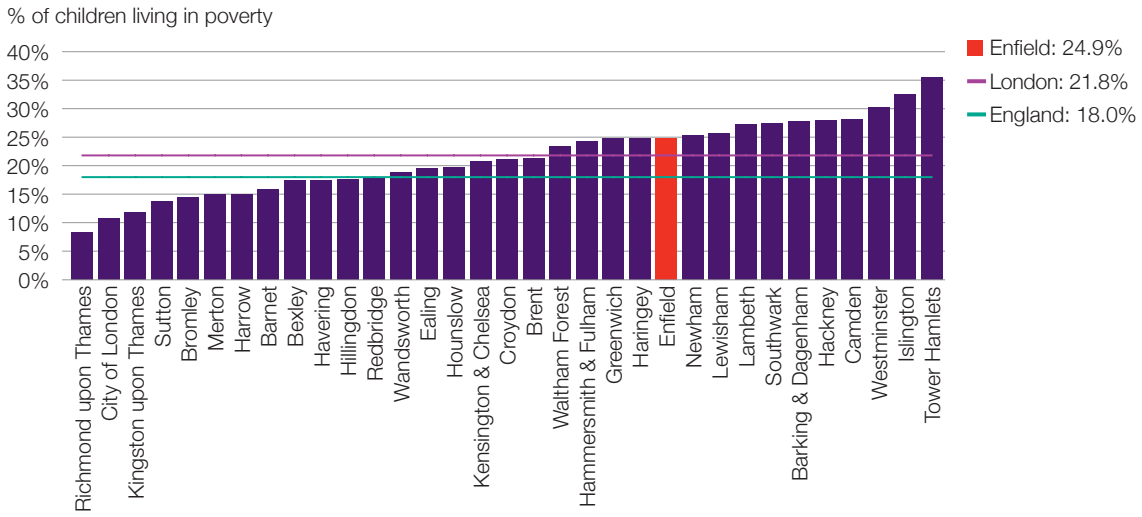
The number of children living in temporary accommodation in Enfield was 4,362 in June 2014. This equates to almost two children per household in temporary accommodation, compared to 1.5 in other London boroughs.

FIGURE 11: Number of children per all households living in temporary accommodation



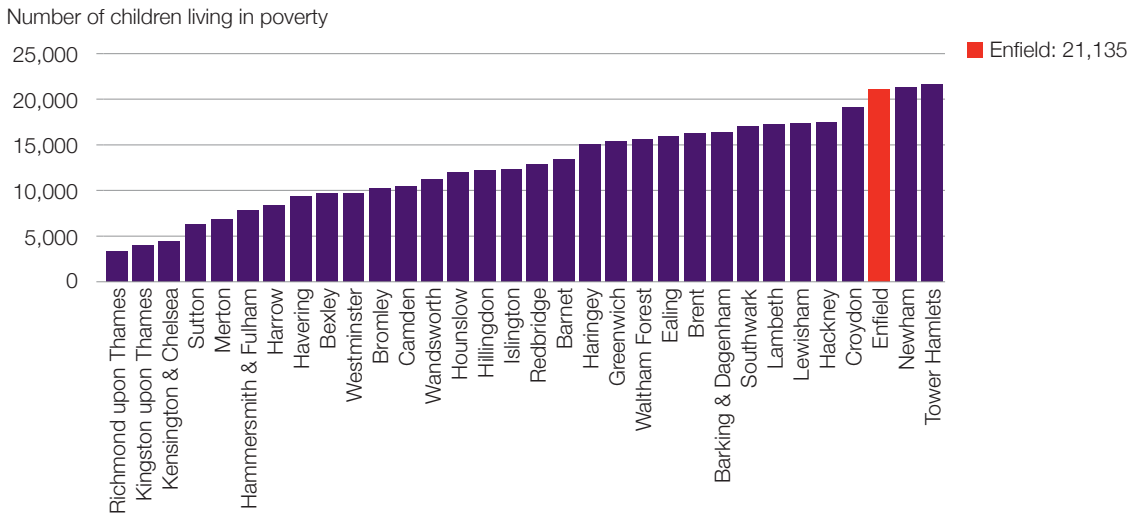
Source: Department for Communities and Local Government (DCLG)

FIGURE 12: Percentage of children living in a low-income family, all dependent children aged less than 20 years, London Boroughs, 2013



Source: HMRC

FIGURE 13: Number of children living in low-income family, all dependent children aged less than 20 years, London Boroughs, 2013



Source: HMRC

Smoking and tobacco use

Smoking in pregnancy is the single greatest modifiable risk factor for adverse outcomes in pregnancy, including miscarriage and stillbirth. This includes passive smoking by the mother or infant if their partner smokes. Smoking during pregnancy increases the risk of infant mortality and can lead to chronic conditions in later life.

Babies born to mothers who smoke (or who have partners that smoke) during pregnancy are more likely to die during the first weeks of life

Babies born to mothers who smoke (or who have partners that smoke) during pregnancy are more likely to die during the first weeks of life than babies of mothers who do not smoke. Smoking exposes the baby to more than 4,000 chemicals present in cigarette smoke[10] and the babies of mothers who smoked during pregnancy are more likely to be born prematurely, twice as likely to have a low birth weight and are up to three times as likely to die from sudden unexplained death (Green et al., 2005). Smoking is associated with inequalities; smoking in pregnancy is much higher in routine and manual socio-economic groups. Nationally, 38% of mothers in England lived in a household where at least one person smoked during their pregnancy[11].

NHS maternity services record the smoking status of women when they book for antenatal care and women that smoke are offered a referral to smoking cessation services. Enfield's rate of smoking amongst pregnant women at the time of delivery has fallen steadily over the course of the last five years, mirroring the regional trend. In Enfield, the levels of smoking during pregnancy are low at 5.5% of pregnant women compared to 12% in England. There are, however, likely to be considerable inequalities in the prevalence of tobacco use during pregnancy, as recent local evidence suggests high levels of tobacco use in the Turkish community.

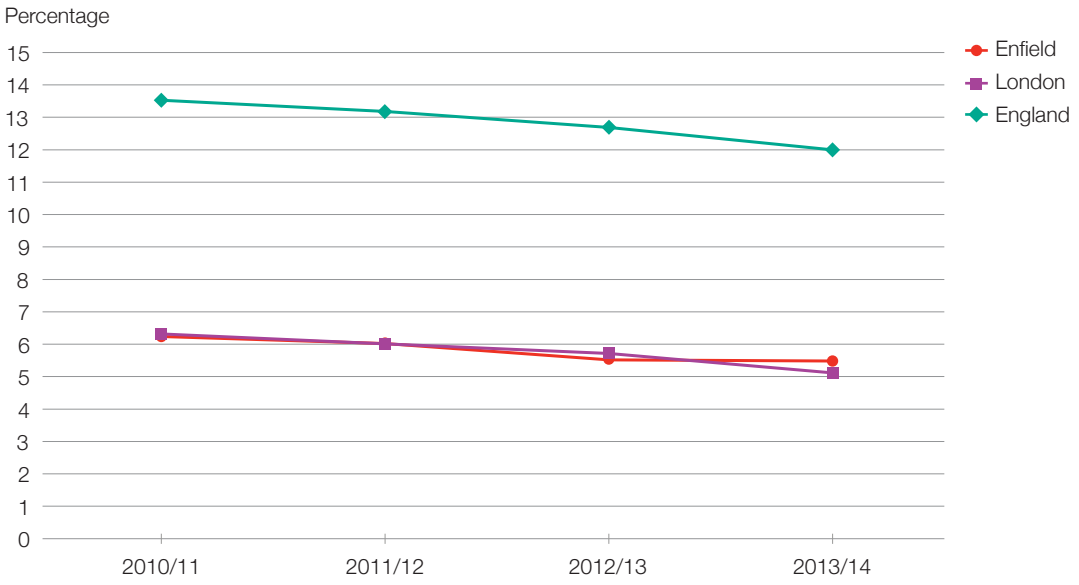
10 See http://tinyurl.com/8araqzz (accessed 23 July 2013)
11 NICE Smoking: stopping in pregnancy and after childbirth. NICE guidelines [PH26] Published date: June 2010

The Department of Health's Tobacco Control Plan sets out a target that the proportion of mothers smoking at the time of delivery should fall below 11% by the end of 2015. In 2013/14, Enfield's rate was already half this, at 5.5%. This was marginally above the London average of 5.1% but well below the national average of 12%.

Ensuring this figure remains low is key to promoting child health and reducing the chances of issues such as premature births and low birth weights, both of which can significantly affect rates of infant mortality and the long-term health and educational attainment of a child. As can be seen in Figure 14, smoking prevalence amongst women at delivery in Enfield is low compared to the English prevalence. However, it should be noted that these data refer to women that self-report smoking and are not based on an objective measurement such as nicotine metabolites.

E-cigarettes are increasingly being used by people trying to stop smoking. E-cigarettes are not risk free and although the vapour contains fewer toxins, they are not recommended for pregnant women as they are not regulated and the effects on the unborn child are not known. If a pregnant woman wants to stop using e-cigarettes or smoking there are a number of sources of support they could use including the national quitline and a local stop smoking service that can help and prescribe nicotine replacement therapy if appropriate.

FIGURE 14: Smoking at time of delivery – Enfield



Source: Public Health Outcomes Framework

FIGURE 15: Smoking at time of delivery 2013/14

Source: Public Health Outcomes Framework

Maternal Obesity

Maternal obesity is associated with greater health risks to both the mother and baby. For the baby, there is a higher risk of stillbirth, congenital abnormality and prematurity.

Obesity is linked to socioeconomic group, and is more common in those working in routine and manual work than in professional and managerial groups and some BME communities. Maternal obesity is associated with many issues for the baby, including:

- stillbirth
- neonatal death
- congenital anomalies, including neural tube defects and cardiovascular anomalies
- prematurity.

There are issues for the mother as well. It can be difficult to perform ultrasound examinations on obese women, blood pressure cuffs might not fit the larger arms of obese women and there may be issues if the woman needs to have an anaesthetic.

In the Confidential Enquiry into Maternal and Child Health (CEMACH) maternal death enquiry, it was found the 30% of the 261 maternal deaths in the UK between 2,000 and 2002 were in obese women (BMI of at least 30kg/M2). In the period 2003-2005, 22% of the 295 maternal deaths involved women who were obese and of those women, 19 were morbidly obese (BMI greater than 40kg/M2). In 2003-2005 there were 48 maternal deaths due to heart disease and 60% of those women that died from heart disease during their pregnancy were overweight or obese[12].

The same enquiry found the following risks related to maternal obesity in pregnancy:

- maternal death or severe morbidity
- cardiac disease
- spontaneous first trimester and recurrent miscarriage
- pre-eclampsia
- gestational diabetes
- thromboembolism
- post-caesarean wound infection
- infection from other causes
- postpartum haemorrhage
- low breastfeeding rates.

Maternal obesity can lead to complications associated with pregnancy including:

- increases in caesarean and operative deliveries
- admission to hospital for complications
- length of hospital stay
- requirements for neonatal intensive care
- a need for appropriate equipment to manage safely the care of obese mothers.

There is a clear need for care pathways for the management of obese pregnant women and women at clear risk of obesity. Such care is likely to result in improved life chances for the child and improved health and wellbeing for the mother.

12 CEMACH – http://www.noo.org.uk/NOO_about_obesity/maternal_obesity/maternalhealth

ANTENATAL AND MATERNITY SERVICES AND SCREENING

Access to antenatal and maternity services

Early access to antenatal care is particularly important for women as it provides various opportunities to identify and manage potential problems, such as gestational diabetes or smoking during pregnancy, before they become serious issues.

Late access to antenatal care can be more common amongst some minority ethnic groups because of deeply-held cultural beliefs and multi-generational teaching. For example, there is evidence that irrespective of educational background, a sizeable proportion of women from Black African ethnic groups deliberately do not reveal that they are pregnant until sometime after 12 weeks of pregnancy[13]. A number of immigrants, especially refugees and asylum seekers, are reluctant to engage with any people or organisations they associate with 'state control' because of experiences that they may have had elsewhere, and thus often substantially delay seeking help with pregnancies. In addition, pregnant women who have complex social factors (for example, housing problems, not being fluent in English, being unfamiliar with the NHS system) have been found to be deterred from using antenatal services for a range of reasons, including:[14]

- feeling overwhelmed by the involvement of multiple agencies
- not being familiar with ante-natal care services
- having practical problems which prevent them attending antenatal appointments
- finding it hard to communicate with healthcare staff
- feeling anxious about the attitudes of health care staff, especially if they already have a number of children.

Despite some seasonal variation, over the last two years the proportion of expectant mothers being seen by 12 weeks six days of pregnancy has gradually increased. However, as can be seen in Table 1, North Middlesex Hospital was not performing as well as other maternity units in the sector. In 2014/15 67% of women booked for maternity care were less than 12 weeks pregnant at North Middlesex University Hospital. Of those bookings that took place over 12 weeks gestation, 5.2% were due to a late referral from the GP and 6% were due to patient choice. For the same timeframe, in Barnet and Chase Farm Hospital NHS Trust (now Royal Free Barnet General) 81.6% of those booked for maternity care before 12 weeks. Since these data were released, there have been changes to maternity services in Enfield, including the closure of the maternity unit at Chase Farm Hospital.

TABLE 1: Early Booking at Maternity Services – Enfield CCG 2014/15

	Number of Maternities	% booked before 12 completed weeks of pregnancy
Barnet and Chase Farm	914	79.1
North Middlesex	2,192	67.0
Royal Free	54	96.4
UCLH	174	76.0
Whittington	140	73.3
Total Enfield Maternities	**3,474**	**70.9**

13 Chinouya M, Madziva C. *Black African women and the antenatal booking appointment in Haringey*. Public Health Department. Haringey Council. London. 2013
14 NICE CG 110, 2010

Antenatal and Newborn Screening

When a woman is pregnant and accesses antenatal and maternity services, she will be offered a number of screening tests. Every woman can choose which maternity service she uses and all maternity units provide the same screening tests and employ a screening coordinator.

There are six antenatal and newborn screening programmes, which screen for a total of 30 conditions:

1 Infectious Diseases in Pregnancy (HIV and Hepatitis B)

Early diagnosis of these infections in the expectant mother allows the mother to be treated. Some of the treatments reduce the chances of the unborn child being infected in the womb.

2 Sickle Cell and Thalassaemia Testing

Early screening for sickle cell trait or thalassaemia in the pregnant woman allows the risk of the baby having these serious blood disorders to be calculated and appropriate action taken.

3 Foetal Anomaly Screening including Down's Syndrome

Screening for foetal anomalies includes screening for problems with the baby's heart, kidneys or other organs. It also allows identification of syndromes such as Down's. This allows the medical team to be prepared to treat the baby appropriately during and after birth and reduces the risks to both mother and child.

4 Newborn Hearing Screening

Identification of hearing problems as soon as possible allows appropriate actions to be taken to ensure that the baby can develop properly.

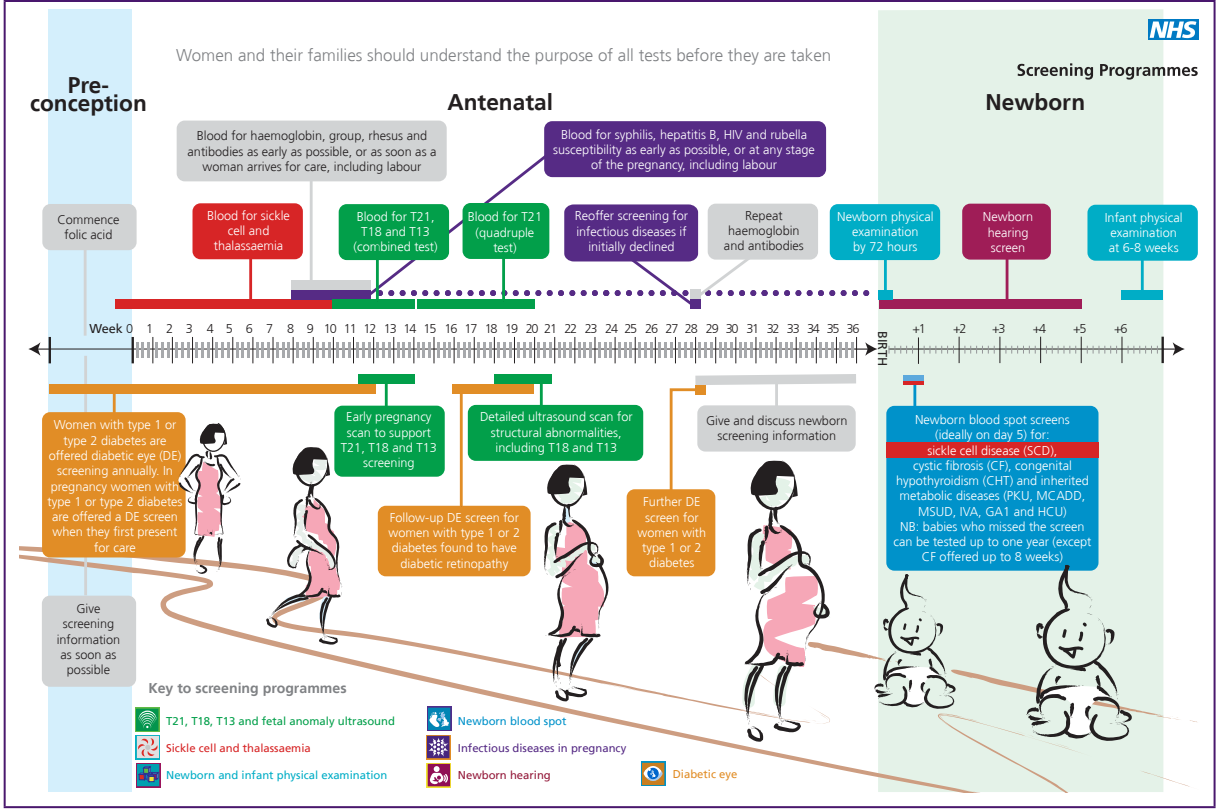
5 Newborn Infant Physical Examination (NIPE)

The Newborn Infant Physical Examination takes place within 72 hours of birth and then again at 6-8 weeks. The examination checks the baby's hearing, hips, eyes and boys' testes.

6 Newborn Bloodspot Testing

Newborn Bloodspot testing tests for Phenylketonuria (PKU), congenital hypothyroidism (CH), sickle cell diseases, cystic fibrosis (CF), medium-chain acyl Co-A dehydrogenase deficiency (MCCAD), maple syrup urine disease (MSUD), homocystinuria (HCU), glutaric aciduria Type 1 (GA1) and isovaleric acidaemia (IVA). Early diagnosis of these conditions allows treatment before the baby's health is damaged. For instance, congenital hypothyroidism (being born without a thyroid gland) can lead to poor growth and learning disabilities, but if it is identified early the baby can be given thyroxine (the hormone produced by the thyroid).

FIGURE 16: Antenatal and Newborn Screening Timeline



Breastfeeding

Exclusive breastfeeding is recommended for the first six months of life. This is based on international evidence and has numerous benefits for both mother and child.

Maternal age, educational attainment and socio-economic position have a strong impact on patterns of infant feeding. The NHS infant feeding survey 2010 showed that breastfeeding was most common among mothers who were aged 30 or over from minority ethnic groups, left education aged over 18, in managerial and professional occupation and living in the least deprived areas. While association between maternal breastfeeding for four months or more is independent of family income level, low income mothers breastfeed less often and for shorter periods of time[15].

It was also noted that Infants who were breastfed longer had fewer bouts of sickness and reported use of fewer medications[16].

TABLE 2: Advantages of Breastfeeding

Advantages for mother	Advantages for Baby
Cheap	Lower risk of GI infections
Convenient	Lower risk of respiratory infections
No risk of error in preparation of milk	Lower risk of atopic disorders (allergy)
Promotes weight loss	Lower risk of SIDS
Lower risk of breast cancer and possibly some other diseases	Lower risk of heart disease in later life
Promotes bonding	Lower risk of obesity

15 Maternal childbirth J 2006, Nov; 10(6) 537-543
16 Birth 2002 June29 (2) 95-100

Historical prevalence data for breastfeeding rates at 6-8 weeks after birth – accepted as good practice in reducing the chances of poor health in infants across a number of conditions – suggest that mothers in Enfield continue to breastfeed at a level in line with the London average and significantly above the England average. In the fourth quarter of 2011/12 (the latest available local data), 69.26% of mothers were breastfeeding at 6-8 weeks after birth. This compared with a London figure of 68.55% and an England figure of 46.88%.

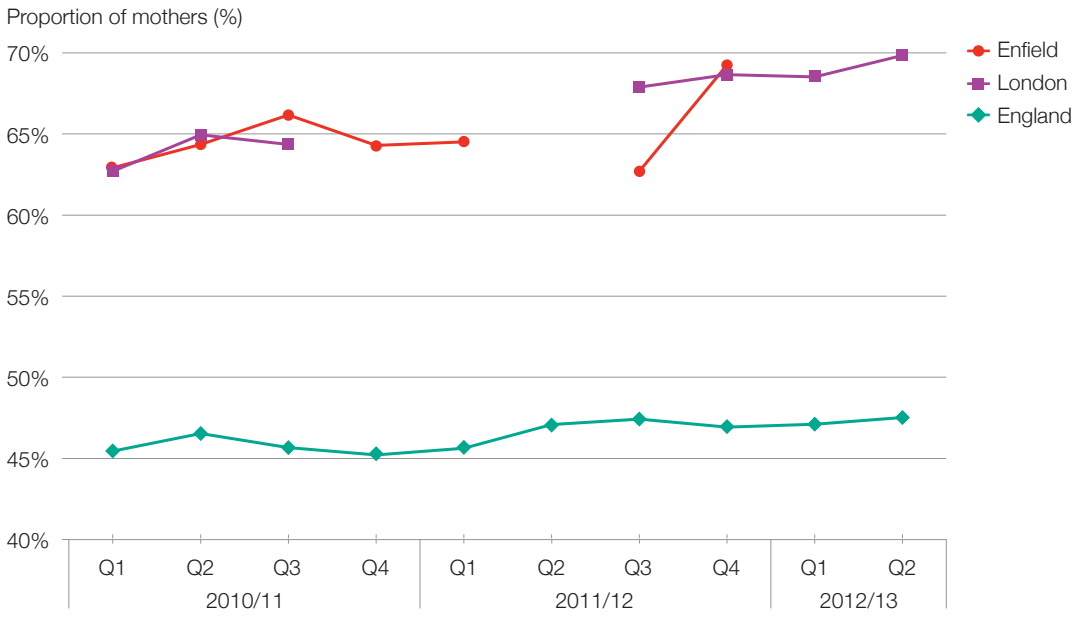
At a national level, there has been a significant improvement in breast feeding initiation and prevalence at six weeks to eight weeks as shown in Table 3 below.

TABLE 3: Breastfeeding in UK

Indicator	2005	2010
Proportion of babies breastfed at birth	76%	81%
Mothers breastfeeding exclusively at three months	13%	17%
Breastfeeding rates at six weeks	48%	55%
Introducing solids by four months	51%	30%

Source: NHS infant feeding survey 2010

FIGURE 17: Breastfeeding for 6-8 weeks, 2010/11-2012/13



Source: Public Health Outcomes Framework

NB. Data are not available for Enfield between Q1 and Q4 2011 and between Q3 2010-11 and Q3 2011-12 due to problems with data transfer

By breastfeeding their new-borns, mothers contribute to the health of both their child and themselves in the short and long term. Breastfeeding is known to reduce the chances of a child suffering from diarrhoea and vomiting, chest infections, ear infections, constipation, and obesity and, consequently, Type 2 Diabetes in later life.

Maternal morbidity e.g. diabetes or mental illness

Perinatal mental health

Having a baby is very rewarding but can be hard, physically and emotionally. Parents are often deprived of sleep and have to adjust to a very different way of life. This is always a challenge, but for some parents it is more challenging and the chemical changes taking place in the body, along with emotional upheaval can lead to mental health problems.

10-20% of maternities in Enfield are affected by mental health issues

Depression and anxiety are common in pregnancy and once the baby has arrived. Current data suggest that 10-20% of maternities in Enfield are affected by mental health issues[17]. The majority of these would be expected to be mild to moderate depression and estimates based on national prevalence data would suggest a minimum of 470 cases per year in the borough. In addition, over 100 women would be expected to be suffering from post-traumatic stress disorder and severe depression and we would expect 10 cases of post-partum (puerperal) psychosis, a severe mental illness and psychiatric emergency, per year in the borough. Whilst some women may develop a psychotic illness during the perinatal period, some women with severe mental health illness such as bipolar disorder or schizophrenia may suffer relapses and suicide is one of the leading indirect causes of death in the perinatal period[18].

TABLE 4: Estimated numbers of women in Enfield affected by mental illness during pregnancy and the postnatal period

Condition	Estimated number of Women
Postpartum psychosis 2013/14	10
Serious Mental Illness (SMI) 2013/14	10
Mild-moderate depressive illness and anxiety (lower and upper estimates) 2013/14	470-700
PTSD 2013/14	140
Adjustment disorders and distress (lower and upper estimate 2013/14	700-1400

Source: Hospital Episode Statistics, Health and Social Care Information Centre

Recently, the Department of Health and Public Health England released Future in Mind[19] which set out proposals to support improvements in children and young people's mental health and had recommended that all maternity units should have a specialist mental health clinician. This has been echoed by the Royal College of Midwives. Currently, in North Central London, only the Whittington Hospital can offer a comprehensive specialist perinatal mental health service.

Most mental health services in the borough are provided by Barnet Enfield and Haringey Mental Health Trust.

17 Mental health in pregnancy, the postnatal period and babies and toddlers. CHIMAT
18 Centre for Maternal and Child Enquiries (CMACE) 2011
19 Future in Mind: https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

Low birth weight

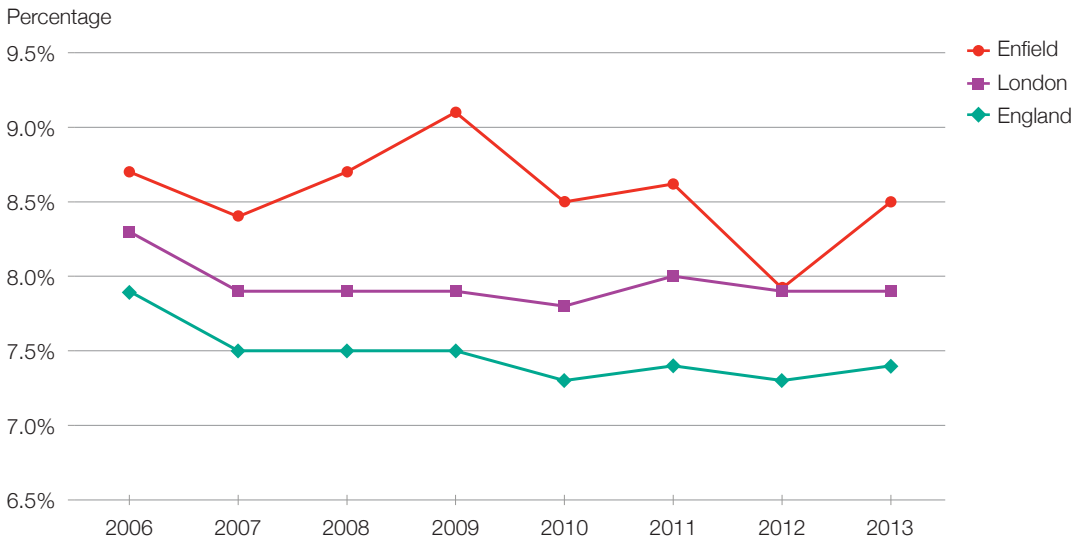
Low birth weight infants (defined as <2,500g weight and birth at term) are at higher risk of mortality than babies of normal weight at birth. Most of the deaths in these children are in the neonatal period, but low birth weight children remain at higher risk into infancy and early childhood.

There are many risk factors for low birth weight, but the most important ones are smoking in pregnancy, ethnicity and socioeconomic factors. Prematurity is also associated with low birth weight.[20, 21]

In 2013, 8.5% of babies born in Enfield[22] were identified as being of a low birth weight.

In 2013, 8.5% of babies born in Enfield were identified as being of a low birth weight

FIGURE 18: Percentage low birth weight babies 2006-2013



Source: CHIMAT

20 N Engl J Med. 1985 Jan 10;312(2):82-90. Mc Cormick
21 Public Health Rep. 1987 Mar-Apr;102(2):182-92.Sappenfield et al.
22 CHIMAT – % Live births and stillbirths with a low birthweight

Stillbirths

A stillbirth is a baby born dead after 24 completed weeks of pregnancy. There are more than 3,600 stillbirths every year in the UK, and one in every 200 births ends in a stillbirth.

What causes stillbirth?

- About 50% of all stillbirths are linked to complications of the placenta (the organ that links the baby's blood supply to the mother's and nourishes the baby in the womb).

Other conditions that can cause stillbirth or may be associated with stillbirth include:

- Bleeding (haemorrhage) before or during labour
- Placental abruption –where the placenta separates from the womb before the baby is born
- Pre-eclampsia – a condition that causes high blood pressure in the mother
- the umbilical cord slipping down through the entrance of the womb before the baby is born (cord prolapse) or wrapping around the baby's neck
- Genetic disorders
- Diabetes
- Infections – these include bacterial and viral infections
- A liver disorder, intrahepatic cholestasis of pregnancy (ICP) or obstetric cholestasis
- Multiple pregnancies
- Mother's age – those aged 35 years and above are more at risk
- Maternal obesity – those with a body mass index (BMI) over 30 are more at risk
- Smoking, drinking alcohol or substance misuse.

The Enfield stillbirth rate pooled between 2011and 2013 is 6.0 (per thousand total births) compared to an England rate of 4.9.

The earlier a woman accesses maternity services, the earlier they can be assessed and referred or treated for some of these conditions. In 2013, only 65.7% of women in England who had a stillbirth booked by 12 weeks gestation[23]. In the UK, women are recommended to engage with maternity services and establish a plan of care prior to the 12th completed week of pregnancy[24], and ideally by 10 weeks[25].

Reducing stillbirths

Maternity services record the smoking status of women at the time of booking for antenatal care. Those that smoke are offered referral to smoking cessation services.

Pregnant women are also offered at least 2 ultrasound scans during their pregnancy:

- at 8 to 14 weeks, and
- between 18 and 21 weeks

In Enfield the North Middlesex Hospital is planning a programme for monitoring foetal growth with ultrasound.

23 Health Equity Audit of Booking for Antenatal Care in London. Neil S P Smith. 2015.
24 Predictors of the timing of initiation of antenatal care in an ethnically diverse urban cohort in the UK. Cresswell et al. BMC Pregnancy and Childbirth 2013, 13:103.
25 National Institute for Health and Care Excellence. Antenatal Care: NICE Clinical Guideline 62. 2008. https://www.nice.org.uk/guidance/CG62

Immunisation coverage

Immunisation ranks only just below clean water as the most important intervention for children's health. This is reflected in the national schedule of immunisations, which begin at just eight weeks old and continue for the rest of life.

Enfield has had challenges trying to maintain immunisation rates and although they are still generally low compared to National rates, there have been general improvements. There are a number of reasons for this. As in the rest of London, there is a growing 0-5 population and this is likely to put pressure on existing resources such as GP practices. The mobility of the local population also contributes to difficulties contacting families and arranging immunisations.

In recent years there have been further challenges for Enfield due to problems with the reporting system for immunisation data. This resulted in the rates of immunisation in the borough being under-reported. These technical difficulties in reporting have now been resolved and the interim data show that reported Enfield immunisation rates have improved even if rates are not yet up to the 95% recommended by the World Health Organisation (WHO).

TABLE 5: Enfield Immunisation Coverage 2014/2015

Immunisation	Number immunisations given	Coverage (%)
Primary immunisations at 12 months[23]	3,962	90.5
PCV at 12 months	3,954	90.4
MMR (second dose)	3,723	86.1
HiB/MenC booster by 24 months	3,964	91.2
PCV booster	3,895	88.6
DTaP/IPV booster	4,063	93.6

Source: HSCIC NHS Immunisation Statistics England, 2014-15

26 Diptheria, Tetanus, Pertussis, Pneumococcal and Haemophilus influenza (DTaP/IPV/HiB)

Teenage pregnancy

Children born to teenage mothers are more likely to experience negative outcomes in life. Pregnant teenagers are less likely to access antenatal services early in the pregnancy, more likely to smoke and less likely to breastfeed. Teenage mothers are three times more likely to develop post-natal depression, more likely to end up in poverty, poor housing and poor health. Nationally, infant mortality rates are 60% higher for teenage mothers than they are for women aged 20-39 years[27]. There is also a 25% greater likelihood of prematurity and low birth weight amongst teenage mothers compared with older mothers.

Enfield's Teenage pregnancy rate in 2013 was 23 per 1,000 females aged 15-17 years. This was higher than the London rate of 21.8 but lower than the England rate of 24.3. It was a 12.9% reduction from the Enfield rate in 2012 of 26.4 and a 50.4% reduction from the baseline rate in 1998 of 46.4 per 1,000 females aged 15-17 years. Teenage pregnancy rates in Enfield have been decreasing since 2007.

In Enfield, 35.8% of abortions for women under-25 years were repeated abortions in 2014, the 8th highest rate amongst 32 London boroughs and significantly higher than the England average of 27%.

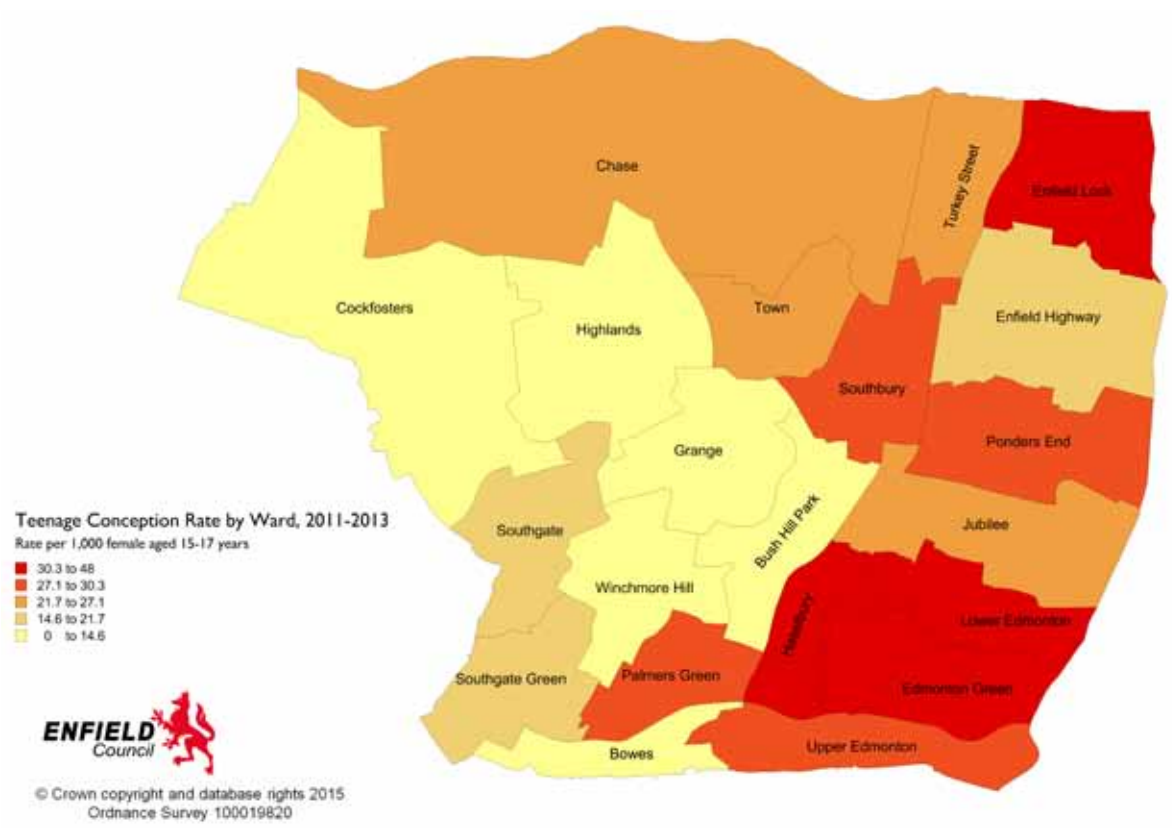
FIGURE 19: Percentage of all deliveries that were to mothers aged under 18 years

Source. Hospital Episode Statistics (HES), HSCIC

Even though the teenage pregnancy rates in Enfield have been reducing, there is still a disproportionate rate of teenage conceptions taking place in Upper Edmonton, Lower Edmonton and Haselbury which are within the most deprived areas of Enfield. The rates in these areas are more than five times higher than the teenage conception rates in the areas of the borough with the lowest rates. This geographical variation across the borough mirrors the geographical variation of child poverty and this is in line with national evidence which demonstrates that young women from the poorest backgrounds are more likely to become teenage mothers.

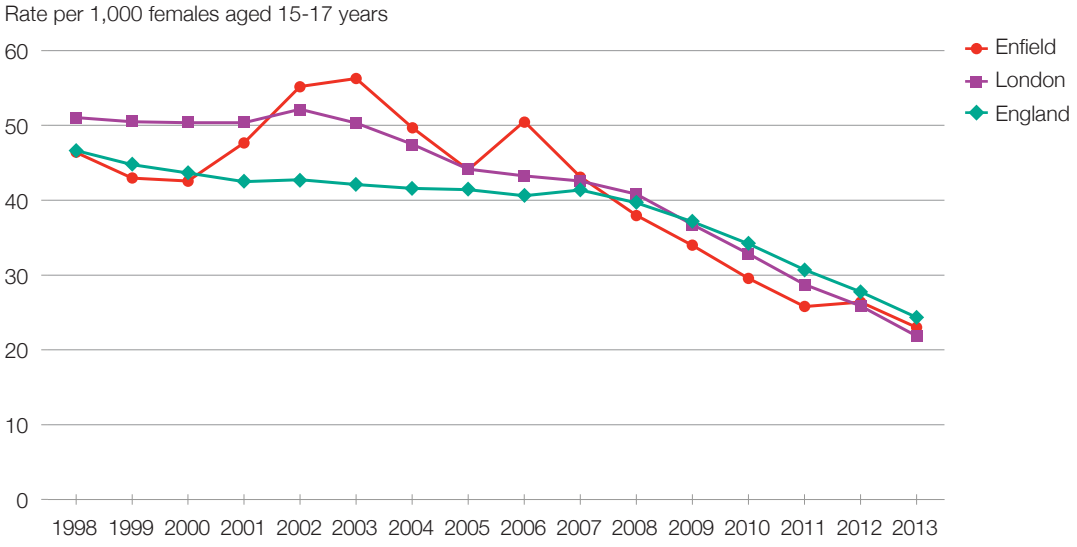
27 Department for Children, Schools and Families and Department of Health, 2010. Teenage Pregnancy Strategy: Beyond 2010. [online] Available at Teenage Pregnancy Strategy Beyond 2010

FIGURE 20: Map showing teenage conception rate by Ward in Enfield, 2011-2013



Source: Teenage Conception Unit

FIGURE 21: Under-18 Conception Rate in Enfield, London and England: 1998 to 2013



Source: The Office of National Statistics (ONS), 2014

Older mothers

The percentage of births to mothers over the age of 35 years in Enfield (22.6%) is higher than the national average (19.2%), but lower than the regional average (24.9%). This may be in part due women waiting to start a family due to the extra cost of working and living in Greater London.

FIGURE 22: Percentage of all deliveries that were to women aged 35 years and above

Source. Hospital Episode Statistics (HES), HSCIC

Female Genital Mutilation

Female Genital Mutilation (FGM) is a form of child abuse and violence against women and girls. It is illegal in the UK and is prohibited in 24 of the 29 countries in Africa and the Middle East where it is most prevalent.

FGM is a cultural practice and can be performed at different times in a woman's life depending on which culture she was born in to: it can be performed on newborns, during childhood, adolescence, just before marriage or during first pregnancy. The majority of cases are thought to be performed when the girl is between five and eight years of age. FGM involves procedures that include the partial or total removal of the external female genital organs for non-medical purposes.

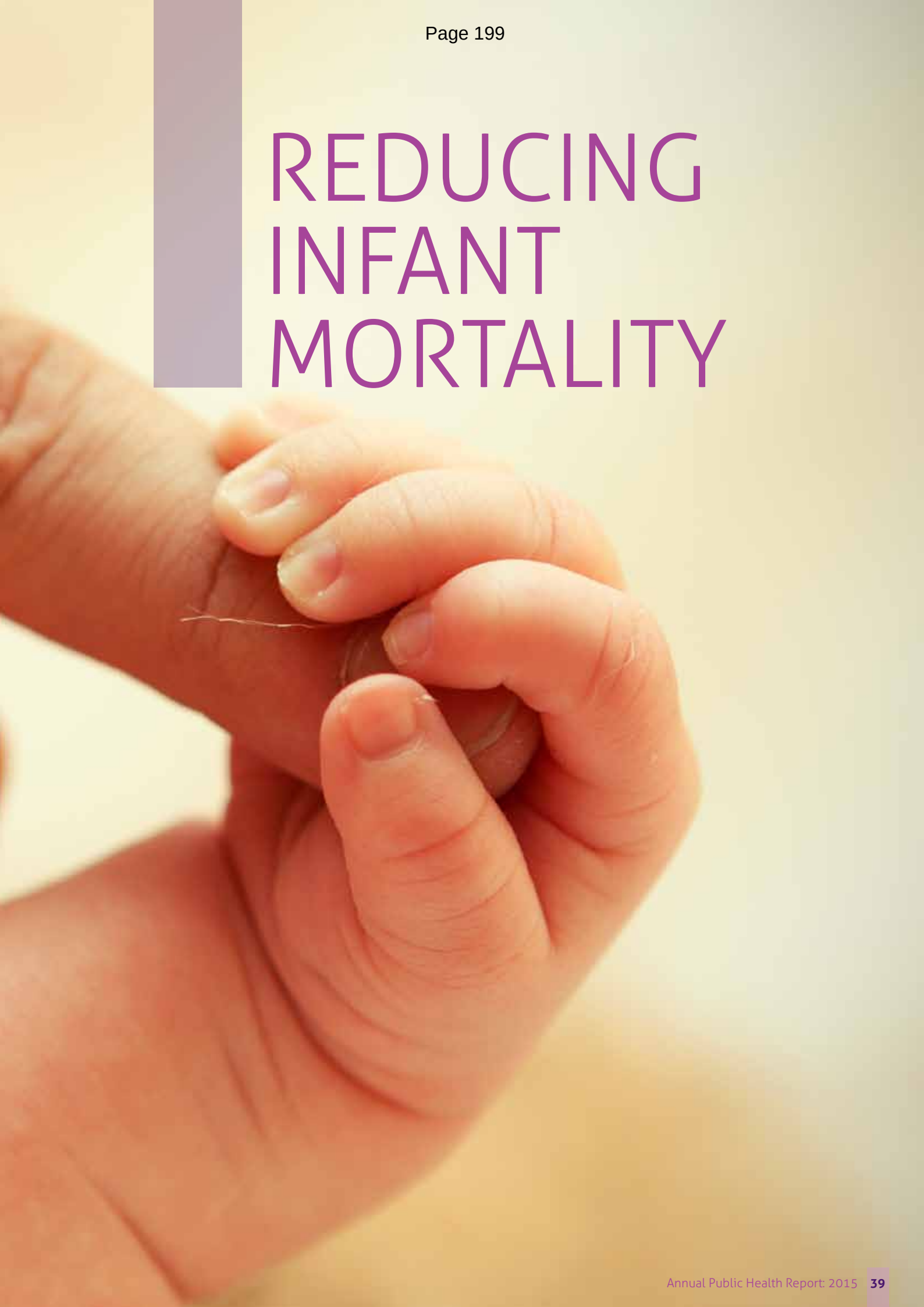
FGM is a practice that is medically unnecessary, painful and often results in serious physical and mental health consequences. Women are often cut with crude implements such as razor blades, glass or scissors. Needless to say, this is done by lay cutters with no anaesthetic and the articles used are not sterile. Infection is a major problem, including lifelong problems such as hepatitis and HIV infections.

Women that have been victims of FGM may have difficult pregnancies and deliveries due to the damage done by FGM. This puts the life of the woman and her child at risk.

TABLE 6: The Health Consequences of FGM

In the short term the consequences may include:	In the longer-term, the consequences may include:
▮ Death	▮ Chronic vaginal and pelvic infections
▮ Shock and severe pain	▮ Difficulties passing urine and chronic urinary tract infections
▮ Haemorrhage	▮ Kidney disease
▮ Wound infections, including tetanus, HIV, hepatitis B, hepatitis C	▮ Damage to the reproductive system including infertility
▮ Urinary retention	▮ Infibulation cysts, neuromas and keloid scars
▮ Fractures or dislocations as a result of the girl being restrained	▮ Psychological damage including depression, anxiety and sexual dysfunction
▮ Injury to other tissues	▮ Increased risk of HIV and other infections
▮ Damage to other organs	▮ Fistula formation
	▮ Complications in pregnancy
	▮ Maternal or foetal death

REDUCING INFANT MORTALITY

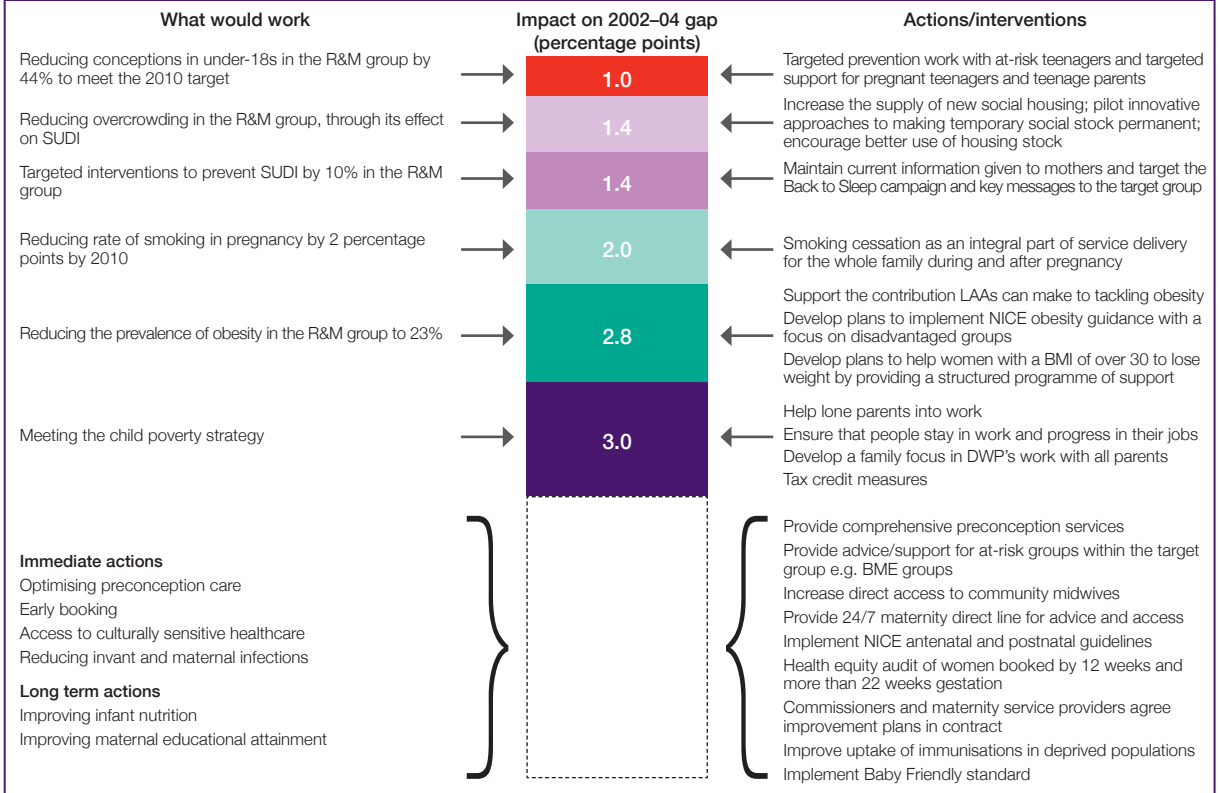


WHAT DOES THE EVIDENCE TELL US ABOUT HOW TO TACKLE INFANT MORTALITY?

There is a body of evidence, both national and international, that demonstrates that infant mortality can be successfully reduced.

The figure below shows which interventions have evidence that they work and what the impact would have been in 2002-2004 if they had been implemented nationally. This gives us a useful guide as to what we should do locally to address infant mortality rates.

FIGURE 23: Nationally identified interventions to reduce inequalities in infant mortality



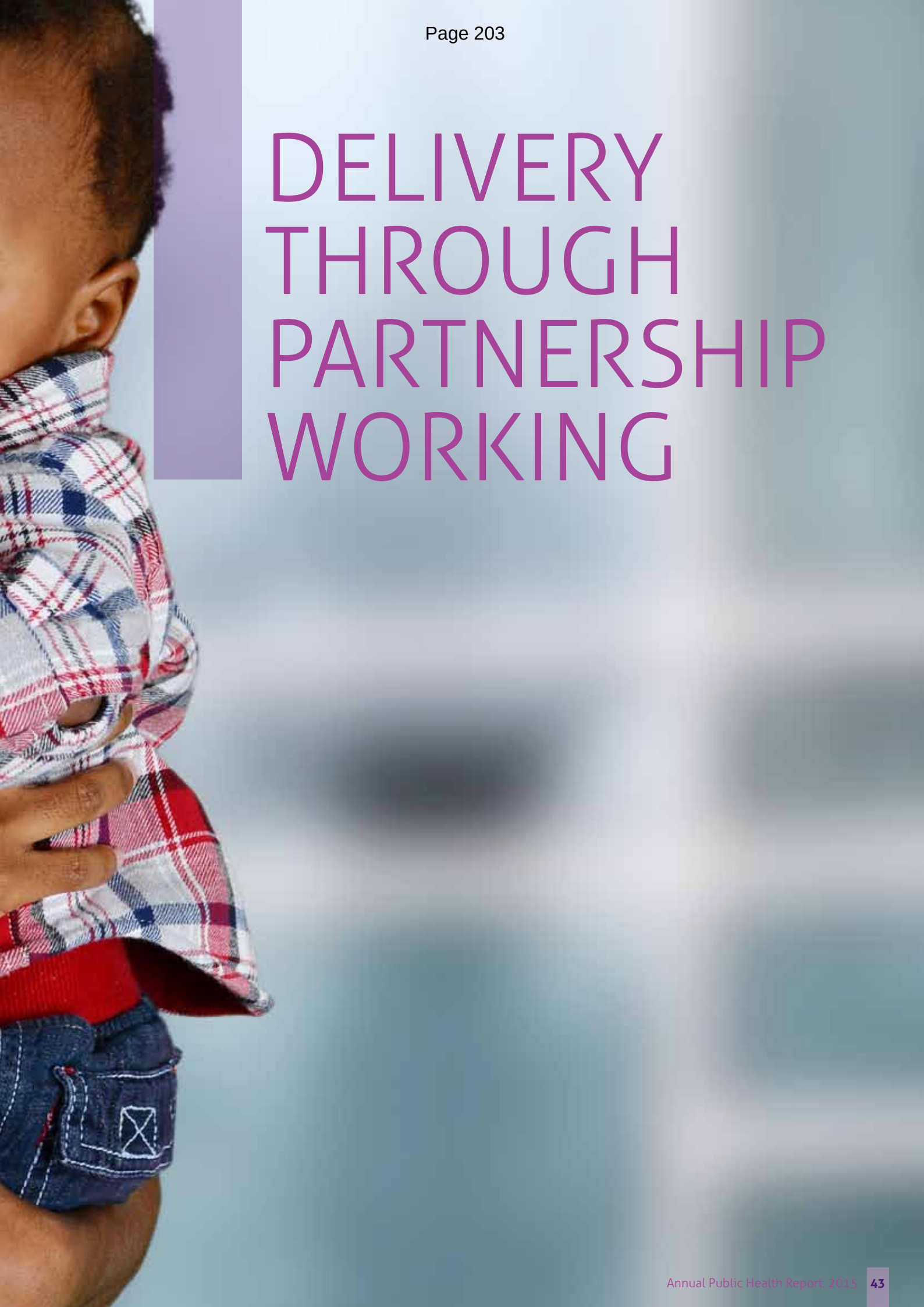
Source: Department of Health – Infant National Support Team Report 2010

In addition to the points in Figure 23, the Department of Health has identified the following additional factors that can help to reduce infant mortality:

- Improving maternal educational attainment
- Routine enquiry and support regarding domestic violence and mental illness
- Providing more intensive parenting support for women with complex needs
- Ensuring early access to antenatal care
- Providing information and education on the antenatal and newborn screening programme
- Promoting health and maternal nutritional status
- Provision of specialist services for obese pregnant women
- Reducing smoking before during and after pregnancy
- Reducing exposure of infants to environmental tobacco smoke
- Providing information and education on risks associated with consanguinity[28]
- Promotion of safe sleeping
- Promotion and support of breastfeeding
- Ensuring high coverage of childhood immunisations

More recently Sir Michael Marmot published a review 'Fair society, healthy lives (2010)' in which six policy objectives were identified which would reduce health inequalities. The first of these was the need to give every child the best start in life. This influenced national policy and in recent years public health has adopted a life course approach. This approach stresses the impact that early experiences can have on the entire life of an individual.

28 Everybody carries rare 'recessive' genes in their cells that can cause serious diseases and/or congenital abnormalities, some of which are incompatible with life. (It is important to remember that the most common direct cause of infant death is congenital abnormality). These recessive genes are usually rendered inoperative by the presence of other genes which 'override' them. However, if a couple who are closely related (such as first cousins, who share a set of grandparents) have a baby together there is an increased risk of each giving the baby the same recessive gene and these two genes together can cause a congenital abnormality or rare, serious disease. Normally, relationships between more distant relatives leading to pregnancy carry lower risks. However, some families carry specific genetic disorders and the risk of a relationship between more distant relatives (such as third cousins) in such circumstances carries a much higher risk of any consequential child suffering from that condition.



DELIVERY THROUGH PARTNERSHIP WORKING

PARTNERSHIP WORKING WITH CHILDREN'S CENTRES

Children's centres in Enfield

Enfield has five hub children centres which deliver stay and play sessions known as the 'Universal Core Offer'. These central 'hubs' also deliver sessions from other local venues like schools, churches and other community buildings. These universal programmes will be widely used by the community; especially families with children aged 0-2. This approach will enable centres to identify families with particular needs, in a non-stigmatising way. They will then be able to offer timely support or signpost to other more targeted individual services, 'The Target Core Offer' as required. There are three stay and play sessions which are a balance of both play and communication focused sessions. These include:

- **Baby Talk** for first time parents with babies aged three months to 12 months. Health visitor will write to all parents when their child is approximately eight weeks old and invite them for a session at their local centre. The programme will be delivered by children centre staff but supported from a range of different professionals. Each session will have a different theme like safe sleeping, baby massage etc. and it will be followed by health advice like breastfeeding, weaning, healthy snacks and others. There will be opportunities for baby weighing and meeting other professionals.

- **Toddler Talk** for families with two or more children aged three plus months. This is a 12-week rolling programme. Parents will be invited to attend six weeks prior to the start of the session each school term. The session starts with interactive play where parents will be encouraged to use the Enfield Play and Communication profile to assess their own child's personal, social and language development. This will be followed by health advice and support. Those families who may need additional access to services from speciality professionals like speech therapists, educational psychologists or family workers will have the opportunity to book an appointment to meet a specialist or attend other activities. Information about local adult learning, volunteering and employment support will be available.

- **Child Talk** for families with children who will be starting nursery or school within the next 12 months. This a six-week programme where the early intervention workers will work with parents to complete a play and communication profile of what their child is able to achieve. This aims at helping parents to understand and explore what the anticipated next steps are for their child.

Other significant services include support from volunteer community health workers, who are part of Enfield Parent Engagement Panel (PEP). These are community members who act as a link between their communities and the children's centres. They reach out to their communities and chaperone individuals who may need to be supported while in the centres to ensure that they get a good experience and continue to access the service. They raise awareness of the services offered by the children's centres and encourage parents to use the service. They have been trained to support, sign post and offer basic health advice to members of the community. They are stationed in some of the children's centres on specific days and they also work with individuals in their respective communities. They also support health promotion events.

Volunteer breastfeeding peer support workers are placed in the different centres. They are National Childbirth Trust (NCT) trained to support breastfeeding without putting pressure on mothers who do not wish to breast feed. They also support families through weaning and introducing solid food. They empower women to make the best decisions for their babies. The infant mortality review and action plan (which was developed in 2015) identified breastfeeding as a key factor in reducing Infant mortality. Increasing the rate of breastfeeding initiation in the (Routine and Manual) R&M group to those of the non-R&M group from 67% to 83% – would contribute four percentage points. (Tackling health inequalities in infant and maternal health outcomes, 2010)[29]

29 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215869/dh_122844.pdf

Outreach and Home Visit

Some families need more convincing and encouragement than others to use Sure start services. Reaching out into the community is essential if Sure Start children's centres are to support the most disadvantaged families. Outreach and home visiting can involve staff from the whole spectrum of Sure Start services including health professionals, family support workers and a range of specialists targeting specific issues. A structured programme of outreach of work enables centres to:

- Inform families about support available to help them
- Make services easier to reach and use
- Provide a gateway to persuade families to access services
- Deliver services through home visit particularly relating to child health and communication and social and emotional development
- Target resources at the families who need the most support and so improve outcomes for the most disadvantaged children.

Conclusion

All five Enfield hubs have access to the following professionals who are part of the stay and play sessions. These give general information, advice and guidance and sign post to targeted offer where necessary. They can all contribute to early detection and intervention as well as resilience, health and wellbeing of families which mitigates the risks linked to Infant mortality and contributes to better outcomes for children and their families. These include:

- Speech therapy
- Social workers
- Educational Psychologists for under 5's
- Health visitors
- Special Educational Needs advisors
- Family support workers
- Jobcentre Plus or Benefit workers

PARTNERSHIP WORKING IN HEALTH PROTECTION

Immunisation

Newborn children are at higher risk from infection than older children and adults. This is partly due to the immaturity of their immune systems, which rely for the first few months on immunity passed on from their mother. This is one of the reasons that immunisation against childhood illnesses is so important and indeed, after clean water and sewage, immunisation is the most important public health measure that can be taken to protect a population.

Following the transition of public health to the local authority, the arrangements for immunisation and screening have changed. NHS England commissions both screening and immunisations, with public health advice from Public Health England (PHE), while local authorities provide an assurance function.

The Enfield Public Health team have excellent working relationships with both the NHSE Immunisation Commissioner for London region and the Child Health Information Team at Barnet, Enfield and Haringey Mental Health Trust (BEH MHT). This has enabled the team to receive regular data on the uptake of all childhood immunisations. The team also receive quarterly uptake data on the entire immunisation programme via PHE.

There has been a recent policy change and universal BCG vaccination for newborns is being made available across London. This has been implemented at North Middlesex Hospital and The Royal Free Hospital Trust has recently agreed to implement this at Barnet Hospital as well as providing flu and pertussis vaccinations to pregnant women. It is hoped that this will start in 2016.

Recent PHE data indicates that the take up of 'flu and pertussis vaccination amongst pregnant women is low in Enfield compared to national and regional levels. This results in their newborn children not being protected from these infections and there are current plans to promote these vaccinations in maternity units and in the community. It appears that Enfield does not perform as well as well as London or England in either prenatal pertussis vaccination or influenza vaccination. Published provisional flu vaccine data show that 30.3% of pregnant women in Enfield received 'flu vaccination compared to 37.2% in London and 41.4% for England. Pertussis vaccination data are shown in Table 7.

TABLE 7: Prenatal pertussis vaccine coverage Enfield Clinical Commissioning Group as of November 2015

	1 April 2015 to 31 September 2015					
	April	May	June	July	August	September
NHS Enfield CCG	32.0	34.1	32.4	31.4	33.2	28.2
London Area Team	46.0	45.8	44.3	45.4	46.8	46.6
England	56.1	55.2	55.1	55.6	56.6	57.7

Source: NHS England

Communicable disease

The control of communicable disease is provided in partnership between Public Health England (PHE), local authorities and the NHS. In Enfield we have a Health Protection Forum which is attended by representative from many teams in the local authority including environmental health and emergency planning, plus representatives of NHS England, the Clinical Commissioning Group (CCG) and PHE. The forum provides a mechanism for sharing information on communicable diseases including any local incidents and outbreaks.

PARTNERSHIP WORKING ON TEENAGE PREGNANCY

Enfield's teenage pregnancy unit works to implement the national teenage pregnancy strategy. It is funded from Enfield's Public Health grant and works in partnership with services such as the sexual health service, schools and youth services to reduce the overall borough rate of teenage pregnancies while specifically targeting the areas with high and increasing rates.

Accountability for achieving the reduction in teenage conceptions lies with the Enfield Targeted Youth Engagement Board (ETYEB) through the work of the Teenage Pregnancy Partnership Board (TPPB). Achieving reductions in the rates of teenage pregnancy depends on effective partnerships between key agencies such as Enfield Council, Enfield CCG, other NHS bodies and the voluntary sector. Local and national data are used to identify and prioritise programmes of work and groups to support with targeted services within the borough. The two measures for which there is the strongest evidence of impact on teenage pregnancy rates are: comprehensive information advice and support – from parents, schools and other professionals – combined with accessible, young people-friendly sexual and reproductive health (SRH) service[30].

In order to reduce teenage pregnancy in Enfield, the following schemes have been put in place:

- **Enfield Young People's Project (EYPP)** is a youth development programme designed to support young people at high risk of social exclusion or disengagement from education, low attainment, behavioural and/or emotional problems, teenage pregnancy and poor sexual health. The programme is also designed to empower young people with low self-esteem to make positive decisions for themselves. To date 222 selected students have participated in the programme since 2011.

- **Txtm8** – Offered a completely free text messaging service for young people aged 13-19. They could text in with any question about sex and relationships to 89868 and a trained team of operators would respond within 30 minutes. Young people could text as many times as they wanted and could carry out 'conversations' via text with operators to get more information and advice[31]. This service was available to all young people in Enfield 24 hours a day, seven days a week, but has recently been discontinued as a new, improved service – the Well Happy telephone app is about to be introduced.

- **Dedicated sexual health outreach nurses for under 19s** – There is a dedicated team of two highly experienced sexual health nurses, who deliver service for young people branded as SHOUT 4YP. They work in schools and colleges in the borough in addition to running the 4YP clinics for young people. They offer advice including contraception to help young people make healthy choices and reduce the risk of unplanned pregnancies and sexually transmitted infections (STIs). The programme also offers free condoms, free pregnancy testing and free Chlamydia testing. The sexual health nurses also train providers and run two young people friendly clinics in Edmonton and Chase Side, which are close to the teenage pregnancy hot spot areas in the borough.

- **Sexual Health Clinics** – The two sexual health clinics in Enfield provide young people specific clinics (4YP) clinics. In addition, the clinics have good accessibility with a clinic available every week day, with late opening hours and Saturday opening.

- **Condom distribution scheme** – Young people can access free condoms and advice via a C-Card scheme[32].

- **Emergency contraception scheme and Chlamydia testing** – Selected 4YP pharmacies in Enfield provide free emergency hormonal contraception (morning after pill). This service is free and confidential for all females aged 24 and under. They also provide free Chlamydia testing services[33].

30 Department for Children, Schools and Families and Department of Health. (2010) Teenage Pregnancy Strategy: Beyond 2010. [online] Available at www.yor-ok.org.uk/Teenage-Pregnancy/Teenage%20Pregnancy%20Strategy%20Beyond%202010.pdf
31 www.txtm8.com
32 www.enfield.gov.uk/youth/info/64/free_condoms_and_txtm8
33 www.enfield.gov.uk/youth/info/61/emergency_contraception

- **Social networking** – 4YP also has an Enfield Facebook page[34] as well as a twitter page[35] to ensure that young people can access the latest Sex and Relationships Education (SRE) information as well as local information about teenage pregnancy.
- **Youth Enfield website** – This has a dedicated section for information on sex and relationships[36].
- **Training** – Workforce training is provided for professionals and volunteers working with young people. A variety of training is offered to professionals to ensure that everybody working with children and young people are equipped with the knowledge, understanding, skills and confidence to support the SRE needs of young people and therefore contribute towards the Teenage Pregnancy Prevention Strategy.

Many of the services for young people such as local contraception services and sexual health services gained You're Welcome accreditation this year and the certificates were given to the services by Cllr Nneka Keazor at a ceremony in September 2015.

FIGURE 24: Partners receiving their certificates for You're Welcome accreditation from Cllr Keazor, Cabinet Member for Public Health, Autumn 2015

34 www.facebook.com/pages/4YP-Enfield/115709038492949
35 www.twitter.com/4ypenfield
36 www.enfield.gov.uk/youth

PARTNERSHIP WORKING WITH HEALTH VISITING AND FAMILY NURSE PARTNERSHIP

Introduction to health visiting

Health visiting is a universal service that provides a platform from which to reach out to individuals and vulnerable groups, taking into account their different dynamics and needs. Health visitors provide a professional public health service based on evidence of what works for individuals, families, groups and communities, enhancing health and reducing health inequalities through proactive universal service for all pre-school children and vulnerable population targeted according to need. The different national policy drivers give them the mandate to undertake antenatal visits and do health promotion at this stage, visit new born babies between 10 and 14 days, undertake a 6-8 week review followed by another review at one year. This facilitates regular contact with families and their children at the most challenging times of their life and plays a key role in early detection of potential risk factors of infant mortality.

Why health visiting matters

The period from pre-natal development to age three is recognised as a key determinant of health and health inequalities[37]. Health visitors have always focused primarily on this age range, and still use this base to reach out to the wider community in which children and their parents and families live in order to influence the structural determinants of health[38]. Health visitors influence the wider determinants of health through their work with parents who have new babies, offering support and informed advice from the ante-natal period until the child starts school. They play an important role in supporting families to make informed decisions about safer sleeping[39]. They visit parents at home, invite them to join groups, clinics and networks run by the health visitors or colleagues like nursery nurses or community mothers. They can also have a role in community asset mapping, identifying whether a particular community has any specific needs.

Health visitors are highly trained specialist community public health nurses, skilled at spotting early issues, which may develop into problems or risks to the family if not addressed. The wider health visiting team may also include nursery nurses, health care assistants and other specialist health professionals. They offer a universal family service which means that all new parents are entitled to health visiting services irrespective of their situation and number of children. 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 five years. It is therefore imperative to have a strong health visiting service that can effectively identify risks and early intervention which is critical in reducing infant mortality.

Through regular contact and with appropriate training, health visitors can influence mothers, fathers and family members to develop healthy behaviours (including not smoking, 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.

37 Irwin L, Siddiqi A, Hertzman C, 2007
38 Cowley S, Caan, W, Dowling S, Weir, H 2007
39 Journal of health visiting, vol 3, Issue 3, 17 Mar 2015 pp 152-158

The Health Visiting Programme

The Health Visiting Programme which started in 2011 is a national programme of work to deliver the government's commitment of transforming the health visiting service by 2015. The programme sought to increase the number of health visitors by 4,200 and create a transformed, service providing improved outcomes for children and families, with more targeted and tailored support for those who need it. This meant moving from 8,092 health visitors in May 2010 to 12,292 health visitors by April 2015.

Breastfeeding initiation and duration rates can be improved by health visitor intervention. They can ensure whole system approach to promoting breastfeeding by implementing the UNICEF baby friendly standards and supporting other settings such as children's centres to become baby friendly and training for early year staff. Health visitors are well positioned to support mothers with breastfeeding as they continue active engagement with mothers after birth. There is evidence that not breastfeeding is one of the risk factors of infant mortality.

Health visitors can provide help and support to new parents on a range of minor childhood illness such as fever, cold and coughs as well as guidance on the signs of more serious diseases such as meningitis, bronchitis and chicken pox, both to families and in settings such as children's centres. Health visitors are in a strong position to raise awareness of the biggest risks and offer practical and accurate safety advice at universal contacts such as child developmental checks and during targeted follow up after A & E attendance.

Changes in commissioning

To support the transformation, from 1 October 2015, the responsibility for commissioning health visiting services will transfer from NHS England to Local authorities. This is because of the overall change in arrangement to transfer commissioning of public health services for children aged 0-5. The 0-5 Healthy Child Programme is led by the health visiting services. The rationale behind this move is that local authorities know their communities and understand local needs so they are in a better position to commission the services. Funding for the 0-5 budget will sit within the overall ring-fenced public health budget. A review at twelve months, involving PHE will inform future commissioning arrangements. Child health information systems and the 6-8 week GP check (Child Health surveillance) will not transfer to local authorities.

Work has been done to ensure local authorities are well prepared to take on their new commissioning role and understand the leadership role of health visitors, the new service model for health visiting and the Healthy Child Programme. At national level, the Department of Health, NHS England, Public Health England and Health Education England are working with key partners including Local Government Association, Society of Local Authority Chief Executives (SOLACE), The Association of Directors of Children's Services (ADCS), The Association of Directors of Public Health (ADPH) and others to ensure a smooth transition. Only the commissioning responsibility will transfer. Health visitors will continue to be employed by their current provider, the NHS.

Conclusion

Infant mortality has declined significantly in recent years; yet many preventable deaths still occur (Child mortality statistics: childhood, infant and perinatal, 2012 Office for National Statistics 2014). A number of factors affect risk of infant mortality and contribute to health inequalities. These include poverty and housing quality as well as maternal smoking and obesity and teenage pregnancy[40].

Two causes of premature deaths and illness are unintentional injuries and less commonly, infectious disease ('Chief Medical Officer's annual report 2012: our children deserve better: prevention pays'). Health visitors have an important role to play in educating families on assessing and maximising their home safety and working with other agencies (for example the fire and rescue service) to prevent unintentional injuries. They can also help improve local uptake rates of immunisations to reduce the occurrence of vaccine-preventable illness. They can also be instrumental in safeguarding children from harm within the home (such as maltreatment and neglect), allowing early identification and intervention for those at risk.

40 Tackling health inequalities in infant and maternal health outcomes Department of Health 2010

Family Nurse Partnership

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.

It is a 'licensed' programme with structured inputs and well-tested theories and methodologies. It has a strong and rigorous US evidence base, developed over the last 30 years and has been shown to benefit the most needy young families in the short, medium and long term across a wide range of outcomes, helping to improve social mobility and break the cycle of inter-generational disadvantage and poverty[41].

41 Department of Health., 2012. The Family Nurse Partnership Programme – Information Leaflet. [online] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216864/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf

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 programme shows:[42, 43]

- Improved prenatal health
- Fewer childhood injuries and reduced child neglect and maltreatment
- Fewer subsequent pregnancies
- Greater intervals between births
- Increased maternal employment
- Improved school readiness
- There are also effects on child and maternal mortality[44, 45, 46]

FNP Teams have caseloads of up to 25 families per practitioner, and therefore the work is much more intense, and relies heavily on the ability of the practitioner to build a trusting and lasting therapeutic relationship with the mother. The FNP programme in Enfield commenced enrolling clients on 1st November 2013 and has one WTE supervisor, four WTE family nurses and one WTE quality support officer (job share). They offer 'show and tell' sessions to individuals, teams, other professionals and agencies and including invitations to attend their team meetings in order to showcase their practice and promote the programme to a range of services.

As of June 2015, Enfield FNP had a caseload of 70 cases. In the last 12 months 37 clients were enrolled, of whom 41% were enrolled by the 16th week of pregnancy (the target is 60%). In the same period, 75% of those who were offered the programme enrolled, which meant that the target of 75% was achieved. In addition, 44 pregnancies, 19 infancies and five toddlers were completed within the FNP programme. The percentage attrition for pregnancy was 0%, for infancy 10.5% and for toddlerhood 60%.

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

FNP will be fully funded for the first two years during which time commissioners will be expected to develop a strategic vision for FNP in Enfield as part of 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. An early years needs assessment, which includes the FNP programme is due to be carried out in the autumn of 2016.

42 Social Programs That Work – Family Nurse Partnership. *Social Programs that Work*
43 Intervention Summary – Family Nurse Partnership. *National Registry of Evidence-based Programs and Practices*
44 Olds, D. L. et al. Effects of Nurse Home-Visiting on Maternal Life Course and Child Development: Age 6 Follow-Up Results of a Randomized Trial. Pediatrics 114, 1550–1559 (2004).
45 Olds DL, Eckenrode J, Henderson CR, Jr & et al. Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized trial. JAMA 278, 637–643 (1997).
46 Olds, D. L. et al. Effect of Home Visiting by Nurses on Maternal and Child Mortality: Results of a 2-Decade Follow-up of a Randomized Clinical Trial. JAMA Pediatr. 168, 800 (2014).

PARTNERSHIP WITH THE NHS – PERINATAL MENTAL HEALTH

There is current, ongoing, work in North Central London to ensure that all women in the region have access to appropriate timely, high quality, universal and specialist mental health services. One recent initiative is the new service in Enfield to improve the development of strong and positive bonds between parents and their babies. This service is called EPIP (Enfield Parents and Infant Partnership) and is available for the first 18 months of baby's life. This service is funded by the Council, the NHS, Enfield Parents and Children, Enfield Children's Centres and PIPUK (Parent and Infant Partnership UK)[47].

The team is made up of a number of specialist staff including a health visitor and counselling therapist who can help if parents are worried about their relationship with their babies, have difficult feelings about parenthood and might be finding parenthood difficult, or who have concerns about baby's development and behaviour. Therapeutic support available might include Parent Infant Psychotherapy sessions, Specialist Health Visitor support, Group Work with other parents and babies, Individual Counselling.

This does not have to be the first child, if difficulties have been experienced with the antenatal and postnatal period of other pregnancies, then the family can be referred. The service is based at the CAMHS premises in Edmonton, but families can also be seen at children's centres and sometimes at their own home. The team is made up of parent infant psychotherapists, a specialist health visitor and a counselling therapist. They can advise on concerns such as worries about baby's development, bonding with baby and where families are finding parenthood difficult.

Parents need a referral to access EPIP and this can be done by a variety of professionals such as midwives, health visitors and GPs, social care and some voluntary organisations. Once referred, parents can be offered a range of therapeutic support such as parent infant psychotherapy sessions, specialist health visitor therapeutic support and guidance, group work and individual therapeutic counselling support.

The new health visiting guidance includes an antenatal visit for all pregnant women so that they have met a health visitor, know what to expect and can answer questions and highlight any issues. This is addition to the service available across North Central London offering targeted antenatal visits to women with mental health concerns.

In Enfield there is a specialist Health Visitor for perinatal and infant mental health (PIMH) who is also part of the Enfield Parent Infant Partnership (EPIP) team. The SpHV PIMH offers consultation and support to the HVs in their work with families who have mental health issues and challenges to the earliest relationships with their infants.

The Enfield HV PIMH working group have developed an antenatal and postnatal PIMH pathway with additional guidance on identification and risk assessment of parental mental health illness. All the Health Visitors, Early Years Practitioners and Health Visiting Assistants are trained in the Solihull Approach and Health Visitors have had the Institute of Health Visiting perinatal mental health training.

47 www.pipuk.org.uk A charity that provides services to local communities to babies who are struggling to develop a secure attachment relationship with their primary caregiver (usually the mother)

PARTNERSHIP – BEREAVEMENT SUPPORT

Parents who have suffered a sudden and unexpected death of a baby often feel anxious when they have another child. The Lullaby Trust runs the Care of Next Infant (CONI) programme with the NHS. The CONI programme can be run from hospitals and community health centres and involves many professionals such as paediatricians, GPs, health visitors and specialist midwives.

Each area has a CONI co-ordinator and a CONI paediatrician. The family will have regular contact with their health visitor and any concerns about the baby can be fast-tracked for expert advice. Parents receiving CONI can choose to receive a symptom diary, weighing scales, a breathing monitor, resuscitation training, a room thermometer and a baby check book.

Parents that have lost an older child can access bereavement support by speaking to their GP. There are also a number of charities that can assist and these are listed in the Appendix 2.

Where a child or young person has lost a sibling, specialist services can be accessed via an NHS referral or via one of the bereavement charities.

HEALTH IMPROVEMENT AND HEALTH PROMOTION

Smoking cessation

There is a smoking cessation advisor in maternity services and all maternity staff are able to refer pregnant women for smoking cessation advice and (where appropriate) for nicotine replacement therapy. Often women are not willing to admit that they use tobacco when pregnant and so there is ongoing partnership work with local hospitals to better identify pregnant women that smoke and on getting a better estimate of the prevalence of tobacco use in pregnant women.

Healthy eating and pregnancy

Women are often confused about eating healthily in pregnancy. There are a number of foods that should be avoided such as soft cheeses and there are a number of confusing messages about how many extra calories a woman needs during pregnancy and which vitamins she should take. Being overweight or obese before and during after pregnancy are associated with poorer outcomes for both the mother and baby. We are working in partnership with a local maternity unit to provide health trainer support to obese pregnant women.

Early Access to Maternity

The Early Access to Maternity campaign was launched earlier this year with displays on the back of buses, in telephone booths and around the borough on billboards. This was accompanied by a press release in local papers.

In July 2015, a one week roadshow was held in Edmonton Town Centre where a commercial on early access to maternity and breastfeeding was shown to the public, leaflets were distributed and a questionnaire was randomly given out to people to evaluate the effectiveness of our campaigns. Local volunteers from the Parent Engagement Panel helped with the campaign and we received positive feedback from both people approached at the roadshow and the volunteers participating.

300 copies of the commercial used at the roadshow have been produced and have been distributed to all GP surgeries, children' centres and relevant community groups and relevant children's services.

PARTNERSHIP WORKING ON BREASTFEEDING

Enfield Public Health continues to raise awareness of the importance of breastfeeding, its benefits and how to overcome barriers to breastfeeding using social marketing campaigns. One of our main commissioning challenges is recruiting peer supporters as part of a multi-disciplinary team and ensuring that they are integrated within the health care setting and the community.

Enfield Public Health has embarked on delivering a coordinated programme of interventions across different settings to improve breastfeeding rates. The National Child birth Trust (NCT) were commissioned to train a cohort of 12 breastfeeding peer supporters who graduated on 25 February 2015 and have been given volunteer placements in children's centres across Enfield, to support mothers who need help. An award ceremony was held and was led by Cllr Ayfer Orhan, the Cabinet member for Children and Young People and attended by health professionals from maternity, universal health visiting services and senior managers from both public health and children's services.

We have launched the Parent Engagement Panel (PEP) Antenatal project which is a strategic partnership project across a number of different services. Twelve PEP members formed our first cohort of volunteers and now work as Community Health workers to engage parents and families from pregnancy, through the pregnancy and child birth and in the development of children from the onset in order to improve life opportunities for children and their families. We are currently training further volunteers and exploring ways that the breastfeeding volunteers can deliver support to women in children's centres.

PEP volunteers support, advise and give information as well as signposting families to relevant services. They will work closely with children's centres, health visitors, midwives and education services. The group undergoes an intensive training programme which will enable them to work effectively and safely with both health professionals and people in the community, using the health trainer model of delivery. This will enable us to provide sustainable universal support as well as targeted support for mothers who are least likely to breastfeed and who are at risk of poor health outcomes.

The programme is designed to give them skills to move on into paid employment hence we have to recruit new recruits each year if the service is to be sustainable. We also face the challenge of ensuring that we target the women who are least likely to start and continue breastfeeding and engage them from the onset of pregnancy. This requires innovative outreach work to ensure we are not 'preaching to the converted'. This project is one of the initiatives laying the foundation for delivering the UNICEF Baby Friendly Initiative in the community in Enfield.

The Breastfeeding welcome scheme is in progress and the number of businesses that have signed to the scheme has increased to 200. We have rolled out a new sticker for businesses to display at their counters and in their windows, to let customers know that they are welcome to breastfeed whilst on those premises. We have developed, with NHS Wirral, a 'Breastfeeding App' which will carry the details of Enfield businesses that welcome breastfeeding and list the sources of breast feeding support available Enfield. It also includes general information about breastfeeding and its benefits. The app will target mainly young parents and those who wish to breastfeed whilst out and about in the borough.

FIGURE 25: Breastfeeding Health Promotion at All Saints Church, Edmonton

PARTNERSHIP WITH ENFIELD SAFEGUARDING CHILDREN BOARD AND THE CHILD DEATH OVERVIEW PANEL

Enfield Safeguarding Children Board

Babies are particularly vulnerable to abuse and neglect. Children under one years old have eight times the average risk of child homicide[48] and around 26% of babies in the UK are estimated to be living within complex family situations that may increase the risk e.g. parents misusing drugs or alcohol or domestic violence in the family[49].

The Children Act 2004 placed a statutory duty on Local Authorities to establish a Local Safeguarding Children Board (LSCB) and the Enfield Safeguarding Children Board was set up in 2006. The Board meets every two months and is made up of partners including health, social services, voluntary sector and the police, along with two lay members. The Board brings together local agencies to promote the health and wellbeing, and ensure the safety of children in the Borough.

Enfield Child Death Overview Panel (CDOP)

The Child Death Overview Panel (CDOP) meets to review the deaths of Enfield infants and children. The panel is chaired by a Consultant in Public Health and attended by Consultant Paediatricians, Social Workers, Police and midwifery staff.

Child deaths are reviewed and assessed as to whether there are any modifiable factors i.e. could anything have been done or be done in the future to prevent such deaths. As a result of this, annual professional update sessions are held, for example to discuss the evidence around sudden unexplained deaths in infancy (SUDI) and safer sleeping.

Each local authority will have a CDOP, and learning from meetings is coordinated between authorities. There is also current work exploring the production of a national system to allow shared learning and better analysis of risk factors for sudden unexpected death in infancy.

FGM group

There is a Council-led FGM group which aims to help survivors access appropriate services and prevent FGM. The group held a successful conference – 'Standing up to FGM' in March 2015, has engaged in community development with the Somali community and helped train social workers on this issue.

There is an action plan for the group which includes health promotion work, clinical pathway development and further community development. Members of the group also operate at a regional, national and international level.

48 NSPCC. All Babies Count. Chris Cuthbert, Gwynne Rayns and Kate Stanley 2011.
49 1001 Critical Days – website

HOW WILL WE SEE THE RESULTS?

Infant mortality is a multifactorial issue and there are a number of outputs and outcomes that need to be monitored to ensure that we are having a true effect on infant mortality rates. This will be achieved by using strategies and functions already in place across the Council and the health economy.

Nationally, the following can be used to track progress towards reducing infant mortality:

- Deaths of infants under the age of one year per 1,000 live births
- Breastfeeding at six to eight weeks
- Smoking at time of delivery
- Teenage conceptions
- Sudden unexpected deaths in infancy
- Booking by 12 weeks and six days.

Additionally, we will also be locally monitoring progress in the following areas:

- Breastfeeding initiation
- Body Mass Index at booking.

JSNA and Public Health Intelligence Function

Public Health Enfield has a small Health Intelligence Team which produces various intelligence products and reports as part of the statutory Public Health function to support the local authority and the NHS, and to support the Public Health priority of reducing health inequalities and improving the outcomes of Long Term Conditions.

In addition, the team supports the Health and Wellbeing Board and can provide local data to support the implementation of the infant mortality action plan and can help source national data such as the child health profiles available from Public Health England.

The team also leads on the update and maintenance of the statutory Joint Strategic Needs Assessment (JSNA). 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. It holds all the health and demographic information needed to assess local health and plan services. The contents are continually reviewed and updated to ensure the document remains a relevant and 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 includes Local Authority, CCG and Community and Voluntary sector colleagues. The Enfield JSNA is available on the Enfield Health and Wellbeing website at www.enfield.gov.uk/healthandwellbeing/jsna

Enfield Joint Health and Wellbeing Strategy

Enfield Health and Wellbeing Board developed the Enfield's Joint Health and Wellbeing Strategy (JHWS), providing a strategic steer to encourage integrated working between health and social care commissioners, as well as between other health-related services such as housing, transport, the economy and environment. The JHWS also sets out outcomes and high-level actions for the period between 2014 and 2019.

Outcomes in the strategy that require close monitoring include:

- Child immunisation coverage
- Childhood obesity
- Excess weight (overweight and obesity) in adult
- Reducing smoking prevalence
- Increasing levels of physical activity

National data sources

The Child and Maternal Health Intelligence Network (CHIMAT) has a number of tools allowing professionals to interrogate national and local data to improve decision making. The data supports policy makers and commissioners in all areas of children's health and the team at CHIMAT produce a number of benchmarking tools and health profiles.

Additional data are available from Public Health England via the Public Health Outcomes Framework and data are available on maternity services through the performance management of the service by the local Clinical Commissioning Group. There are also data available from the Office for National Statistics, and this is a particularly important source for national statistics such as births and deaths.

APPENDICES

APPENDIX 1
COMPLETE IMMUNISATION SCHEDULE

The safest way to protect children and adults

The routine immunisation schedule

Age due	Diseases protected against	Vaccine given and trade name		Usual site[1]
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenzae* type b (Hib)	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Prevenar 13	Thigh
	Meningococcal group B (MenB)[2]	MenB[2]	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	Meningococcal group C (MenC)	MenC	NeisVac-C	Thigh
	Rotavirus	Rotavirus	Rotarix	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib	Pediacel or Infanrix IPV Hib	Thigh
	MenB[2]	MenB[2]	Bexsero	Left thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
One year old	Hib and MenC	Hib/MenC booster	Menitorix	Upper arm/thigh
	Pneumococcal (13 serotypes)	PCV booster	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMR VaxPRO[3] or Priorix	Upper arm/thigh
	MenB[2]	MenB booster[2]	Bexsero	Left thigh
Two to six years old (including children in school years 1 and 2)	Influenza (each year from September)	Live attenuated influenza vaccine LAIV[4]	Fluenz Tetra[3]	Both nostrils
Three years four months old	Diphtheria, tetanus, pertussis and polio	DTaP/IPV	Infanrix IPV or Repevax	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMR VaxPRO[3] or Priorix	Upper arm
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (two doses 6-12 months apart)	Gardasil	Upper arm
Fourteen years old (school year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y disease	MenACWY	Nimenrix or Menveo	Upper arm
65 years old	Pneumococcal (23 serotypes)	Pneumococcal polysaccharide vaccine (PPV)	Pneumovax II	Upper arm
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	Multiple	Upper arm
70 years old	Shingles	Shingles	Zostavax[3]	Upper arm (subcutaneous)

1 Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart. For more details see Chapters 4 and 11 in the Green Book. All injected vaccines are given intramuscularly unless stated otherwise.
2 Only for infants born on or after 1 May 2015
3 Contains porcine gelatine
4 If LAIV (live attenuated influenza vaccine) is contraindicated and child is in a clinical risk group, use inactivated flu vaccine

Selective immunisation programmes

Target group	Age and schedule	Disease	Vaccines required
Babies born to hepatitis B infected mothers	At birth, four weeks, eight weeks and Boost at one year[1]	Hepatitis B	Hepatitis B vaccine (Engerix B / HBvaxPRO)
Infants in areas of the country with TB incidence >= 40/100,000	At birth	Tuberculosis	BCG
Infants with a parent or grandparent born in a high incidence country[2]	At birth	Tuberculosis	BCG
Pregnant women	During flu season At any stage of pregnancy	Influenza	Inactivated flu vaccine
Pregnant women	28-32 weeks of pregnancy	Pertussis	dTaP/IPV (Boostrix-IPV or Repevax)

1 Take blood for HBsAg to exclude infection
2 Where the annual incidence of TB is >= 40/100,000 – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/393840/Worldwide_TB_Surveillance_2013_Data_High_and_Low_Incidence_Tables____2_.pdf

Additional vaccines for individuals with underlying medical conditions

Medical condition	Diseases protected against	Vaccines required[1]
Asplenia or splenic dysfunction (including sickle cell and coeliac disease)[3]	Meningococcal groups A, B, C, W and Y Pneumococcal Haemophilus influenzae type b (Hib) Influenza	Hib/MenC MenACWY MenB PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Cochlear implants	Pneumococcal	PCV13 (up to five years of age) PPV (from two years of age)
Chronic respiratory and heart conditions[3] (such as severe asthma, chronic pulmonary disease, and heart failure)	Pneumococcal Influenza	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Chronic neurological conditions[3] (such as Parkinson's or motor neurone disease, or learning disability)	Pneumococcal Influenza	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Diabetes[3]	Pneumococcal Influenza	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine
Chronic kidney disease (CKD)[3] (including haemodialysis)	Pneumococcal (stage 4 and 5 CKD) Influenza (stage 3, 4 and 5 CKD) Hepatitis B (stage 4 and 5 CKD)	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine Hepatitis B
Chronic liver conditions[3]	Pneumococcal Influenza Hepatitis A Hepatitis B	PCV13 (up to five years of age) PPV (from two years of age) Annual flu vaccine Hepatitis A Hepatitis B
Haemophilia	Hepatitis A Hepatitis B	Hepatitis A Hepatitis B
Immunosuppression due to disease or treatment[3]	Pneumococcal Influenza	PCV13 (up to five years of age)[2] PPV (from two years of age) Annual flu vaccine
Complement disorders[3] (including those receiving complement inhibitor therapy)	Meningococcal groups A, B, C, W and Y Pneumococcal Haemophilus influenzae type b (Hib) Influenza	Hib/MenC MenACWY MenB PCV13 (to any age) PPV (from two years of age) Annual flu vaccine

1 Check relevant chapter of green book for specific schedule
2 To any age in severe immunosuppression
3 Consider annual influenza vaccination for household members and those who care for people with these conditions

APPENDIX 2
BEREAVEMENT SUPPORT LEAFLET

Useful contacts:

Bliss – Bereavement support for families following the death of a premature baby. Tel: 0500 618140 www.bliss.org.uk

Child Bereavement UK – Supporting families and educating professionals when a baby or child dies, or when a child is facing bereavement. Tel: 01494 446648 www.childbereavement.org.uk

Child Death Helpline – For anyone affected by the death of a child, from pre-birth to adult, under any circumstances. Tel: 0800 282986 www.childdeathhelpline.org.uk

Childhood Bereavement Network – Information and advice about local and national services for bereaved children and young people. Tel: 020 7843 6309 www.childhoodbereavementnetwork.org.uk

The Lullaby Trust – Support for families bereaved through a sudden infant death Tel: 0808 802 6868 www.lullabytrust.org.uk

Sands (Stillbirth and Neonatal Death Charity) – Support for families bereaved through a sudden infant death. Tel: 020 7436 5881 www.uk-sands.org.uk

Winston's Wish – is the largest childhood bereavement charity and the largest provider of services to bereaved children, young people and their families in the UK. Tel: 08452 030405 www.winstonswish.org.uk

Grief Encounter – Support for kids, teens, parents and professionals when someone dies. Tel: 020 8371 8455 www.griefencounter.org.uk

Enfield Child Death Overview Panel
Enfield Safeguarding Children Board
PO Box 59 Civic Centre
Enfield EN1 3BR
Tel: 020 8379 3012 or 2722
Email: CDOP@enfield.gov.uk

ENFIELD Council

Enfield Safeguarding Children Board

When a child dies

Information for Families and Professionals

www.enfield.gov.uk

ENFIELD Council

The death of a child is always tragic. Talking and thinking about a child's death is a particularly sensitive and painful subject. However, it is vital that all child deaths are carefully reviewed, so as much as possible is learned from them to try and prevent future deaths, and to ensure that families are supported. This leaflet provides information that you may find useful.

What the Law requires

From 1st April 2008, the Government introduced a law which requires all local authorities, via their Safeguarding Children Board, to review the death of every child (up to the age of 18 years) in their area. This is because the Government believes that it may help other children and families in the future. This will be done in two ways:

1. Rapid Response

A rapid response by a group of key professionals, who come together for the purpose of enquiring into a sudden and unexpected death of a child.

This may mean a visit, within the first few days, to where the child died, by a police officer and/or health professional.

Most importantly, the rapid response will seek to ensure that support offered to the family is coordinated.

2. Review of all child deaths (under 18 years)

The Child Death Overview Panel, consisting of doctors, other health specialists and childcare professionals, must review and consider information on the circumstances surrounding each child's death. In Enfield, this usually takes place about six months after the child's death.

What is the purpose of a Review?

The Child Death Overview Panel will consider whether they should make any recommendations regarding services for children and their families. Recommend-ations may be reported to local health trusts, children's services and police, and, where appropriate, specialist agencies, such as fire services or traffic authorities. These recommendations may assist in the planning of services for children and families in the future.

Panel Meetings

In Enfield, the Chair of the Panel writes to all parents when the circumstances of their child's death are to be reviewed. Parents are invited to share any information that they want the Panel to know.

Unfortunately, it is not possible for parents or family representatives to attend Panel meetings.

All the information gathered is treated with the deepest respect and in strictest confidence. None of the findings, recommendations or reports will name the child or family.

The Coroner

All sudden and unexpected deaths must by law be reported to the Coroner and the police: for example, when the cause of death is unknown, due to an injury or following an operation.
The coroner may arrange for a post mortem examination to take place and hold an inquest.

For more information on the role of the coroner, please see the leaflet **'When Sudden Death Occurs', available online at: www.dca.gov.uk/corbur/sudden_death.pdf**

The Coroner will be asked to share any relevant information concerning the death of the child with the Child Death Overview Panel.

For further information about the child death processes, visit London Safeguarding Children Board website: www.londonscb.gov.uk

APPENDIX 3
EPIP LEAFLET

WHO CAN BE REFERRED?

- If a parent is struggling with worries about their relationship with their baby as a result of Ante- or Post-natal Depression or anxiety.
- Parents who may have had PND with a previous baby and are concerned that these difficulties may arise again and are anxious about bonding.
- Parents can be referred ante natally if they are worried about how they might manage emotionally with their baby due to previous trauma or circumstances.
- If a parent has had difficulties in forming a bond with a previous child and is worried this may happen again.
- If a baby appears to be struggling more than expected with feeding, sleeping or other issues and parents are worried.

WHO CAN REFER?

We work closely with other professionals and welcome referrals from Midwives, Health Visitors, GPs, Perinatal and Hospital based teams, Children's Centres, Voluntary Organisations, Social Care and many others.

The process for referrals will be to have an initial discussion with someone in the team to think about whether a particular family can be helped by EPIP.

If it is agreed that a referral should be made, the referrer will be asked to complete the referral form and return it to EPIP team.

WHERE ARE WE?

We are based in CAMHS premises at 265 Church Street, Edmonton, N9 9JA.
We also see families at Children's Centres, Enfield Parents & Children's Centre and sometimes at their home.

FURTHER INFORMATION:

If you would like to find out more about our service or would like to discuss a potential referral please do contact:

Carol Levine (Team Lead)
020 8360 6771 or 07815 492535
carol.levine@enfield.gov.uk

Maggie Harris (Specialist Health Visitor)
maggie.harris@nhs.net

www.e-pip.org.uk

EPIP
Enfield Parent Infant Partnership
Developing secure relationships between parents and their babies

A GUIDE FOR PROFESSIONALS

NHS ENFIELD PIPUK

EPIP is a new service which has been set up in recognition of just how difficult it can sometimes be for parents and their babies in those first 18 months.

We see the importance of developing a strong and positive bond between parents and their babies and our aim is to support and facilitate those early attachments and relationships.

WHO ARE WE?

EPIP is a service which has been created, supported and funded by partners from Enfield Local Authority and NHS, Enfield Parents & Children, Enfield Children's Centres, and PIPUK.

We are a small team of parent infant psychotherapists, a specialist health visitor and a counselling therapist, who are able to work with families individually or in groups to help:

- address the worries parents may have about their relationship with their babies;
- address the difficult feelings that may arise on becoming a parent;
- with the concerns parents may have about their baby's development and behaviours;
- work together with parents where they are finding parenthood hard to cope with.

WHAT WE DO:

Consultation:
The team offers consultation to anyone who is working with families in the perinatal period. We aim to help think through with others when there might be a concern or query around a parent's emotional state and/or a baby's behaviours, development or the family's circumstances.
The consultation may lead to a referral to EPIP or may be useful in considering other possibilities for a family.

Our Specialist Health Visitor may also offer to join the allocated Health Visitor for a consultation to meet with the family to help think through in more depth the concerns they may have about their baby.

Therapy:
We work with parents and their babies therapeutically to support the development of a sensitive bond between them. We aim to think together and notice communications between them and work through issues impacting on the relationship.

Sometimes parents may need some time on their own to explore issues that may impact on them being the kind of parent that they want to be. Families will be offered an initial meeting with one of the clinicians in the team, and a range of therapeutic support may be offered.

- Parent Infant Psychotherapy sessions.
- Specialist Health Visitor therapeutic support and guidance.
- Group work with parents and babies around developing positive relationships with each other.
- Individual Therapeutic Counselling Support.

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Public Health
May 2016

ENFIELD Council

MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY, 21 APRIL 2016

MEMBERSHIP

PRESENT Shahed Ahmad (Director of Public Health), Ray James (Director of Health, Housing and Adult Social Care), Deborah Fowler (Enfield HealthWatch), Litsa Worrall (Voluntary Sector), Vivien Giladi (Voluntary Sector), Ayfer Orhan, Alev Cazimoglu, Doug Taylor (Leader of the Council), Mo Abedi (Enfield Clinical Commissioning Group Chair), Julie Lowe (Chief Executive North Middlesex University Hospital NHS Trust) and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

ABSENT Ian Davis (Director of Environment), Dr Henrietta Hughes (NHS England), Nneka Keazor, Kim Fleming (Director of Planning, Royal Free London, NHS Foundation Trust), Tony Theodoulou (Interim Director of Children's Services) and Paul Jenkins (Chief Officer - Enfield Clinical Commissioning Group)

OFFICERS: Bindi Nagra (Joint Chief Commissioning Officer), Andrea Clemons (Acting Assistant Director, Community Safety & Environment), Keezia Obi (Head of Service, Enfield 2017), Jill Bayley (Principal Lawyer - Safeguarding) and Sam Morris (Strategic Partnerships Officer) Penelope Williams (Secretary)

Also Attending: Allison Duggall (Standing in for Tony Theodoulou), Deborah McBeal, Deputy Chief Officer (Standing in for Paul Jenkins), Graham MacDougall, Director of Strategy and partnerships, Enfield CCG.

1
WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting.

Apologies for absence were received from Tony Theodoulou, Nneka Keazor, Henrietta Hughes and Ian Davis.

Andrea Clemons (Head of Community Safety) stood in for Ian Davis, Allison Duggal (Consultant in Public Health) stood in for Tony Theodoulou, Deborah McBeal (Deputy Chief Officer Enfield Clinical Commissioning Group) stood in for Paul Jenkins.

It was noted that Kim Fleming, the representative from the Royal Free had retired from the Royal Free. The Board asked for their thanks to him for his

work on the board to be noted. It was agreed that a letter would be written thanking him for his work on the board.

2
DECLARATION OF INTERESTS

There were no declaration of interests.

3
CLINICAL COMMISSIONING GROUP (CCG) OPERATING PLAN 2016/17

The Board received a report on the Clinical Commissioning Group Operating Plan 2016/17.

Graham McDougall (Director of Strategy and Partnerships- Enfield Clinical Commissioning Group) introduced the report to the Board highlighting the following:

- This was the fourth year of the CCG's NHS Operating Plan (2016/17), produced as part of the NHS annual planning cycle, and has been reported to HWBB.
- The plan covered acute activity, performance and finance.
- Acute activity from acute providers includes accident and emergency, outpatients, day case surgery and emergency admissions.
- The NHS expects performance to be improved in 2016/17 in 4 key areas: accident and emergency, referral to treatment, cancer 62 day treatments and access to diagnostics.
- The NHS expects accident and emergency performance to be at 95% during the fourth quarter of 2016/17 and for treatment to take place within 18 weeks of referral.
- The other focus for 16/17 is to reduce acute providers who are in deficit Acute providers have access to the national Sustainability Transformation Fund which is designed to improve performance as well as financial position.
- CCG's have access to financial incentives via the Quality premium which is set out in the table included in the papers. There were five national measures and three locally determined measures to meet.
- The three local measures involved cancer treatment, dementia reporting and Improving Access to Psychological Therapies.
- The CCG has been given an additional savings target of £7.2m to achieve during 2016/17 which was expected to be a significant challenge. This would mean an overall saving on nearly £17m for 2016/17.

Questions/Comments

1. Meeting the additional savings target would mean that difficult decisions would need to be made. The CCG were currently looking at all expenditure to assess what could be done. A high level list would be provided to NHS England by the end of April.

2. Enfield suffers in comparison with other authorities as they were 4.8% underfunded. Underfunding within 5% was deemed acceptable putting Enfield in a difficult position.

3. A plea was made that local people be involved in deciding what cuts would be made.

4. The multi system (North Central London wide) sustainability and transformation plan was a new requirement for delivering the Five Year Forward View. This meant partners including commissioners, providers and local authorities working together to improve the quality, and reduce the inequality and financial gap across services. In order to obtain the transformation money, the goals in the plan would need to be met. All parts of Health and Social Care were working together to develop a sustainable plan. This will have to be submitted towards the end of June 2016. Governance structures would need to be agreed to enable quick decision making and to make sure that everyone is aligned and all deliverables and key milestones can be met.

5. Schemes to work on include urgent and emergency care, mental health and primary care. The system enablers were estates and workforce. However these proposals were outside the funding deficit and were not designed to close the existing financial gap.

6. The next steps were to provide a high level indication, to be bought together into a high level plan by June 2016. By November 2016 the plan should be complete. Some areas were already being delivered across the five CCGs such as the recently commissioned integrated NHS111 and Out of Hours Service, commissioned for all five North Central London CCGs.

7. There had not been much time to involve the public in the sustainability and transformation plan proposals, but there were plans to develop a communication and engagement strategy. Some engagement strategies were already in place within the workstreams, but it was acknowledged that more could be done. A Healthwatch representative does sit on the Transformation Board. Each workstream will need to develop an engagement plan.

8. Ray James advised that he was the Director of Adult Social Services lead for the five boroughs for the North Central London Sustainability and Transformation Plan.

9. There were issues of democratic deficit and engagement which did still need to be addressed. Some alignment was planned to take place in the near future with full integration in 2017 for delivery in 2020.

10. Developments were welcomed and there was a view that where there have been co-operations in the past they have been successful but there were concerns that changes should make sense to patients and the local population. There would be fears that services were moving away from people.

11. Plans were being developed, looking at population projections and disease profiles. It is currently planned that specialist commissioning would be done at a pan London strategic level.

12. Some concern was expressed that the structure was too much focussed on Camden. It was suggested that this may have been because Camden was better funded than other boroughs and so had more capacity to take on the extra work. The Health and Wellbeing Board was concerned to feel confidence and receive reassurance that the more peripheral areas were being understood. Ray James agreed to feed the board's concerns back to the North London Strategic Planning Group.

4
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST UPDATE

The Board received a presentation from Julie Lowe, Chief Executive, of the North Middlesex University Hospital NHS Trust, updating them on the current situation at the hospital.

1. Presentation

Julie Lowe highlighted the following:

- The hospital had not been able to hit the 95% weekly 4 hour standard target on accident and emergency since July 2015.

- This was due to long term issues. There were huge problems recruiting senior doctors as there were not enough in England. North Middlesex had also struggled as it was not a major trauma centre.

- The problems had been triggered as a result of a critical Care Quality Commission inspection of junior doctor training last July which led to a need to provide more junior doctor training and supervision and reduce the hospital's previous reliance on them to fill the more senior positions.

- Overnight this had a dramatic impact on waiting times and led to the failure to achieve the 4 hour target. At times patients have had to wait

for a long time, leading to patient safety concerns. To put this in context performance as a whole had also dropped by 10% nationally.

- A recent re-inspection had approved the changes in training and a new clinical director was due to start in June 2016 which should lead to improvements.

- The NHS and other partners had been asked to help to provide senior doctors but this had not been successful because of national shortages.

2. Questions/Comments

2.1 When the closure of the accident and emergency unit at Chase Farm Hospital had taken place, it had been planned that North Middlesex would have fourteen senior doctors. Since then three new doctors had been recruited and the hospital now had nine in total. Unfortunately two of those were close to retirement and did not want to continue working full time.

2.2 At the time of the Chase Farm closure, it had been thought that the number of qualified emergency department doctors would increase, but the situation had changed: some doctors had been recruited to the air ambulance service and others had emigrated to Australia. It would be two years before the situation was back in balance. It would not necessarily follow even then that there would be enough doctors and different solutions would need to be found. One possibility was to consider the way that GP's make referrals.

2.3 It was also felt that more needed to be done to improve the pathways through the hospital. Strong clinical leadership would be needed to bring this about but this would be provided by the new clinical director when they took up their post in June. The CCG offered their support to help look at ways to improve the pathways.

2.4 In public health, work was being done to help bring down the number of people visiting the emergency department. This included the winter vaccination programme and the Winter Warm Scheme.

2.5 Regular meetings were held with representatives from Haringey and Barnet to address concerns.

5
BETTER CARE FUND REVIEW 2015-16 AND BETTER CARE FUND PLAN FOR 2016-17

The Board received a report from Bindi Nagra, Assistant Director of Strategy and Resources – Health, Housing and Adult Social Care and Graham MacDougall, Director of Strategy and Partnerships, Enfield CCG.

Keezia Obi, Head of Service Enfield 2017 (BCF Lead), presented the report to the Board highlighting the following:

- The report was in two parts. A review of 2015/16 and the plan for 2016/17.

- The Overview of 2015/16 highlights the achievements in relation to admissions to residential and nursing care, integrated locality team working and community based rapid response working as well, as the challenges faced over delayed transfers of care and in Non-Elective (emergency) admissions (NEA's) to hospital.

- In response to recent audits, governance and management of the fund had been strengthened recently. The financial issues were mainly historic and were in the process of being resolved.

NOTED

1. Activities had been put in place for improving integrated care for the over 50s.
2. The new Older People's unit at Chase Farm had been successful and was well used.
3. Work was continuing with GPs to expand 7 day working using the integrated locality teams.
4. Funding for IAPT (Improving Access to Psychological Therapies) had been expanded.
5. A programme had been set up for enhanced behavioural support which would be continued into the next year.
6. Much had been achieved in the past year although there was still more to be done.
7. The guidance from NHS England for developing the new plan had only recently been received. The conditions were in the main the same as last year, except for two which are noted in the report – a plan for DTOC's and removal of performance payments related to NEA's which has been replaced by the consideration of a risk sharing agreement..
8. The final submission was due by 3 May 2016.
9. The narrative plan had been included with the agenda pack and included agreement on issues such as the alignment and extension of memory clinics, 7 day working and support for mental health.
10. Ninety five percent of the investment plan had been agreed, but discussions were continuing on the final 5 %. It was noted that the area that remains unresolved is due to the CCG being unable to commit further funds due to financial pressures and the Council wanting to see further investment in the community funded by the BCF.

11. Outstanding issues were around the investment plan funding and the risk share agreement. Both the local authority and the NHS were suffering from severe financial challenges. Agreement will be reached by the deadline. If necessary an escalation process will be used to ensure agreement.

12. Acknowledgement that it was disappointing that agreement had not been reached, but it was agreed that the Chair and the Vice Chair would sign off the final submission once an acceptable reconciliation had been brokered.

AGREED:

1. To note the update on the 2015-16 Better Care Fund (BCF) plan, including the current performance metrics and achievements.
2. To note the activity taking place in response to participation in the NHS England support scheme and audits, in particular improvements being made.
3. To note the publication of the 2016-17 planning guidance and timetable, and key changes to last year's guidance.
4. To receive the attached Better Care Fund 2016-17 narrative plan (submission 2 as noted above), noting that this may be subject to change as a result of the final agreement to the investment plan.
5. To agree that delegated authority is given to the Chair and Vice-Chair of the Health and Wellbeing Board to approve that the final 2016-17 Better Care Fund submission. This is in view of the very tight timescale and that the Council and Clinical Commissioning Group have not yet reached agreement on the investment plan.
6. To note at the time of writing that on 11 April 2016 we received verbal feedback from NHS England on the second Better Care Fund submission, but are awaiting the formal feedback. The summary feedback is that we have a good plan but a rating of 'approved with support' has been given at this stage in view of the area awaiting resolution. Further details have been included in the report, but it is noted that it may be subject to change.
7. To note that since the last report to the Health and Wellbeing Board in February, a further development session had been held with the Integration Board.

6
LONDON ASSEMBLY: LONDON ASSEMBLY HEALTH COMMITTEE - END OF LIFE CARE INVESTIGATION

The Board received for information at report from the London Assembly Health Committee on an investigation into End of Life Care.

AGREED that further analysis would be provided to put the information in the context of Enfield for the next meeting.

7
HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

The Board received a report reviewing the Health and Wellbeing Board Terms of Reference.

Sam Morris presented the report to the Board setting out the proposed changes highlighting the following:

- The changes made the terms of reference clearer and legally compliant as a committee of full Council.
- The terms of reference had not been reviewed since being established in April 2013.
- The key amendments were changes to titles, removal of Director of Regeneration and Environment as a full board member, amendment to the reflect the legal responsibilities of the board including the removal of the determination and allocation of public health funds.
- An updated structure had been provided in appendix one with governance information on the Health and Wellbeing Board in the context of it being a council committee.
- It was proposed that the other appendices were removed including the speaking protocol as they were no longer felt to be necessary, now that the board was fully fledged.

NOTED

1. That the Joint Strategic Needs Assessment (JSNA) was published annually.
2. That non statutory appointments should be reviewed annually.
3. The lack of reference to the board's mental health partners.
4. That the term of office of the voluntary sector representatives came to an end in April 2016. An election would need to be held to find replacement representatives.
5. That it would be appropriate to change the titles of the Cabinet members to include instead the Cabinet member with responsibility for the specified remits to avoid having to make changes every year when titles changed.
6. The suggestion that the Enfield Youth Parliament should provide a representative on the board.

AGREED to recommend for agreement to full Council the changes to the Health and Wellbeing Board terms of reference, as set out in the report with the amendment suggested above.

A revised version would be circulated to all board members for final comment.

8
NORTH CENTRAL LONDON SUSTAINABILITY AND TRANSFORMATION PLAN

The Board received and noted the progress update on the North Central London Sustainability and Transformation Plan.

9
ST MUNGO'S HOMELESS HEALTH CHARTER

The Board received a report on the St Mungo's Homeless Charter inviting them to express commitment towards tackling health inequality among people who are homeless by signing up to the charter.

NOTED the Director of Health, Housing and Adult Social Care's comment that the charter was consistent with what the authority aspired to but acknowledged that they sometimes struggled with some of the aspirations. He agreed to appraise the board of any specific issues.

AGREED to note the content of the charter and that the Chair would sign up to the charter on behalf of the Health and Wellbeing Board.

10
SUB BOARD UPDATES

1. Health Improvement Partnership Sub Board Update

The Board received an update from the Health Improvement Partnership Sub Board.

NOTED that the Health Improvement Partnership Board was also looking at performance indicators which they would bring back to a future full board meeting.

AGREED to note the report.

2. Joint Commissioning Board Sub Board Update

The Board received an update from the Joint Commissioning Sub Board.

NOTED

1. Concern about the way that the funding of the NHS Health Checks and the smoking cessation programme had been stopped and the lack of consultation and communication on the decision.

2. The funding of Health checks had been suspended last year due to overspending. It had been discovered that the health check budget had been over spent and spending had had to be stopped midyear. Public Health England had imposed a mid-year £1m cut and this had necessitated cuts in public health budgets.

3. The way the public health function worked was also being reorganised and officers would have been less familiar with the normal protocols and so the communication had not been done as well as it would normally have been done. Lessons would be learnt and improvements implemented.

4. A group is being set up to discuss how to make the best use of the limited resources available. There was a consensus that everyone needed to work more closely to support each other so that difficult decisions can be made in the best way possible.

5. It was felt that more information on this should have been included in the update report.

AGREED to note the report.

3. Primary Care Update

The Board received the Primary Care Update.

NOTED

1. Deborah McBeal (Deputy Chief Officer) reported that the strategic planning group has developed a primary care chapter for the Sustainability and Transformation Plan.

2. Discussions had begun into delegated commissioning arrangements with NHS England. In the short term this would be difficult to sustain because of staffing shortages.

3. A major local strand was the link between GPs and the Sustainability and Transformation Plan on the wider level.

4. It was regretted that the NHS England representative had not attended the meeting to enable the Board to put across their views on the subject.

AGREED to note the report.

11
MINUTES OF THE LAST MEETING (8:10-8:15PM)

The minutes of the meeting held on 11 February 2016 were agreed as a correct record.

12
DATE OF NEXT MEETING

The dates of future meetings would be agreed at Annual Council on 11 May 2016.

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