HEALTH AND WELLBEING BOARD

Wednesday, 5 October 2016 at 6.15 pm
Room 1, Civic Centre, Silver Street, Enfield, EN1 3XA

Contact: Jane Creer
Board Secretary
Direct : 020-8379-4093
Tel: 020-8379-1000
Ext: 4093
E-mail: jane.creer@enfield.gov.uk
Council website: www.enfield.gov.uk

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 Helene Brown
Director of Public Health – Tessa Linfield
Director of Health, Housing and Adult Social Care – Ray James
Interim Director of Children's Services – Tony Theodoulou
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 – Libby McManus
Barnet, Enfield and Haringey Mental Health NHS Trust – Andrew Wright
Enfield Youth Parliament – Robyn Gardner, Bobbie Webster

AGENDA – PART 1

1. WELCOME AND APOLOGIES (6:15 - 6:20PM)

2. DECLARATION OF INTERESTS

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

3. ENFIELD HEALTH & WELLBEING BOARD REVIEW OF CURRENT SUB BOARDS STRUCTURE (6:20 - 6:40PM) (Pages 1 - 4)

To receive a report from Sam Morris (Strategic Partnerships Manager) containing recommendations relating to the Health and Wellbeing Board sub boards.

4. CLINICAL COMMISSIONING GROUP AND LONDON BOROUGH OF ENFIELD FINANCIAL AND COMMISSIONING INTENTIONS (6:40 - 7:00PM) (Pages 5 - 20)

To receive reports from the Clinical Commissioning Group (attached) and the London Borough of Enfield (to follow) on their financial and commissioning intentions.

To receive a progress update from Enfield CCG: on the Financial Recovery Plan 2016/17 and beyond.

5. FEEDBACK FROM HEALTH AND WELLBEING BOARD DEVELOPMENT SESSIONS (7:00 - 7:15PM) (Pages 21 - 24)

7.1 New Models of Care

7.2 Hospital Chains

7.3 Additional Development Session (04/10/16)

6. UNISON / NHS BURSARY REMOVAL (7:15 - 7:25PM) (Pages 25 - 32)

To discuss the impact of potential changes to the NHS Bursary system.

7. PROGRESS UPDATE ON THE NORTH CENTRAL LONDON (NCL) SUSTAINABILITY AND TRANSFORMATION PLAN (STP) DRAFT - THE CLINICAL CASE FOR CHANGE (7:25 - 7:40PM) (Pages 33 - 110)

To receive a report on the North Central London Sustainability and Transformation Plan draft.

REPORTS FOR INFORMATION

The following reports are for information only.

8. SAFEGUARDING ADULTS AND SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORT 2015-16 (7:40 - 7:45 PM) (Pages 111 - 200)

To receive for information the Safeguarding Adults Board Annual Report 2015-16 from Marian Harrington (Independent Chair of Enfield Safeguarding Adults Board).

To receive for information the Safeguarding Children's Board Annual Report 2015-16 from Geraldine Gavin (Independent Chair of Enfield Safeguarding Children's Board).

9. DIABETES IN ENFIELD ANNUAL PUBLIC HEALTH REPORT (7:45 - 7:50PM) (Pages 201 - 228)

To receive for information a report from Gosaye Fida (Senior Public Health Strategist) published in August 2016.

10. OVERVIEW AND SCRUTINY WORK PLAN 2016-17 (7:50 - 7:55PM) (Pages 229 - 242)

To receive for information a report on the Overview and Scrutiny Committee work plan for 2016/17, approved by full Council.

11. SUB BOARD UPDATES (7:55 - 8:00PM)

To receive updates from the following sub boards:

- Health Improvement Partnership Board – Please note that the September meeting of the HIP Board was cancelled and that the HIP Board meetings will resume with the new Director of Public Health
- Joint Commissioning Board
- Primary Care Sub Board

12. MINUTES OF THE MEETING HELD ON 12 JULY 2016 (8:00 - 8:05PM) (Pages 243 - 254)

To receive and agree the minutes of the meeting held on 12 July 2016.

13. WORK PROGRAMME 2016/17 (8:05 - 8:10PM) (Pages 255 - 260)

To consider the work programme for 2016/17 and to agree any changes.

14. DATES OF FUTURE MEETINGS

Members are asked to note the date of future meetings of the Health and Wellbeing Board:

- Thursday 8 December 2016
- Thursday 9 February 2017
- Wednesday 19 April 2017

All meetings take place at 6.15pm unless otherwise indicated.

Members are asked to note the dates for future Health and Wellbeing Board Development Sessions:

- Thursday 24 November 2016
- Wednesday 11 January 2016
- Tuesday 21 March 2016

The development sessions take place at 2pm unless otherwise indicated.

15. EXCLUSION OF PRESS AND PUBLIC

If necessary, to consider passing a resolution under Section 100A(4) of the Local Government Act 1972 excluding the press and public from the meeting for any items of business moved to part 2 of the agenda on the grounds that they involve the likely disclosure of exempt information as defined in those

paragraphs of Part 1 of Schedule 12A to the Act (as amended by the Local Government (Access to Information) (Variation) Order 2006).

There is no part 2 agenda.

Agenda Item 3

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MUNICIPAL YEAR 2016/2017 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board 05/10/16**	**Agenda - Part:** **Item:** **Subject: ENFIELD HEALTH & WELLBEING BOARD REVIEW OF CURRENT SUB BOARDS STRUCTURE** **Wards: All**
	Cabinet Member consulted: Cllr Doug Taylor
Contact officer and telephone number: Sam Morris (Strategic Partnerships Manager) Email: **sam.morris@enfield.gov.uk**	**Approved by: Cllr Doug Taylor**

1. EXECUTIVE SUMMARY

As part of the ongoing review and development of the EH&WB and its supporting structures a number of key step changes have been agreed, these include creation of work programmes for both the EH&WB Developments Sessions and the Board itself, as well as revised Terms of Reference that have been agreed by the EH&WB and signed off at Council.

The newly revised Terms of Reference (TOR) provide clarity around the purpose of the EH&WB Sub Boards and their mandate to execute EH&WB functions and to report back to the Board.

This report outlines the current link between the EH&WB and its Sub Boards, as well as recommendations to make changes that will improve the lines of accountability, relationship and transparency between the EH&WB and the Sub Boards.

2. RECOMMENDATIONS

This report sets out a number of recommendations to the EH&WB for agreement these include the following;

a) Revision of the EH&WB Sub Board Terms of Reference (TOR) so members of both the EH&WB and Sub Boards are clear about the remit and role of each, as well as clarity on reporting lines and expectation of deliverables

b) Presentation of proposed Sub Boards work programmes to the EH&WB at the beginning of calendar year 2017

c) A twice yearly Sub Boards progress report to be presented and fully discussed at each EH&WB, instead of reports going as items for information to every EH&WB.

d) Agree Health and Wellbeing priority to be the focus of the EH&WB and its

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Sub Boards for calendar year 2017

e) A section of each EH&WB agenda to be dedicated to exploring a specific challenge or issue which is directly related to a Sub Board area

3. BACKGROUND

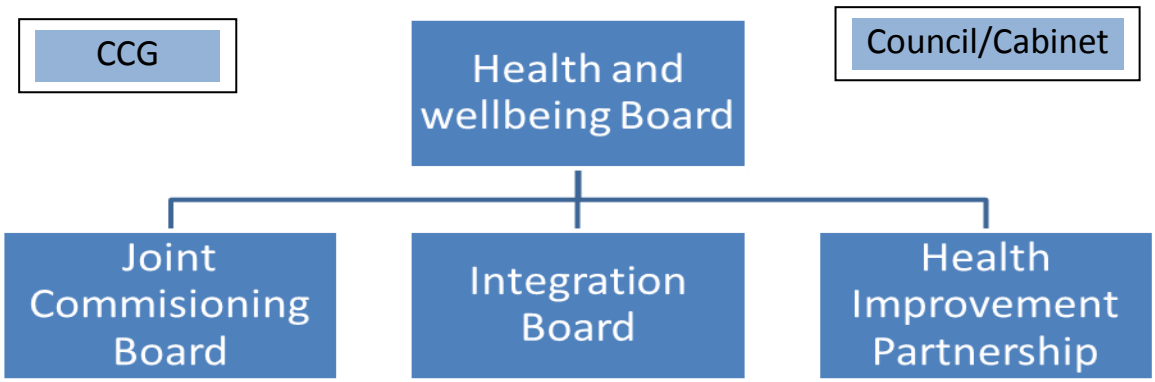
As part of the ongoing review and development of the EH&WB and its supporting structures a number of key step changes have been agreed, these include creation of work programmes for both the EH&WB Developments Sessions and Board itself and revised Terms of Reference that have been agreed by the EH&WB and signed off at Council.

The newly revised Terms of Reference provide clarity around the purpose of the Sub Boards (see the extract below from the revised EH&WB TOR)

> *The EH&WB will be able to appoint sub committees to discharge their functions in accordance with section 102 of the 1972 Local Government Act.*
>
> *All Sub-Boards will have their Terms of Reference and membership approved by the Health and Wellbeing Board and will need to operate in accordance with the requirements of the full board, and be focused on activity that is in line with the ToR and remit of the EH&WB.*

With these recent developments it is timely to set out how the current Sub Boards are interacting with the EH&WB and what modifications could be made in order to improve connectivity, communication and accountability between them. Diagram 1 below shows the current EH&WB and subcommittee structure.

Diagram 1 EH&WB structure:



Currently the only link between the sub committees and the EH&WB is a standing item on the EH&WB agenda which comes as a report and sets out the work of each Sub Board in general terms. The reports make no

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recommendations to the EH&WB and does not annotate how the Sub Boards deliver the priorities of the Enfield Health & Wellbeing Strategy and in turn that of the Board.

Through initial discussions with the EH&WB Chair and Sub Board leads within the Council, it was felt that these update reports to the EH&WB were not sufficient on their own to achieve the aims of the Sub Boards outlined in the new TOR and make them accountable to the Board.

Therefore this report sets out a number of steps that are recommended to the Board for agreement (Outlined in Section 2)

4. ALTERNATIVE OPTIONS CONSIDERED

None

5. REASONS FOR RECOMMENDATIONS

EH&WB Terms of Reference stipulate that the "The EH&WB is to appoint sub committees to discharge their functions in accordance with section 102 of the 1972 Local Government Act".

There has also been feedback from specific members of the EH&WB that there is disconnect between the work of the Sub Boards and the EH&WB, as well as ambiguity regarding lines of accountability.

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

6.1 Financial Implications

None

6.2 Legal Implications

None

7. KEY RISKS

If the recommendations are not agreed and changes not made, then the EH&WB and its Sub Boards could become ineffectual and will not adhere to the EH&WB TOR.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

There would be a positive impact on all Health and Wellbeing Strategy priorities if the EH&WB focussed its work on a specific priority for each year and subcommittees were to focus on the delivery of said priority and held accountable by the EH&WB.

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However it should be noted that if this approach was adopted it would take a five year period for all priorities to be addressed by the EH&WB.

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

9. EQUALITIES IMPACT IMPLICATIONS

N/A

Background Papers

None

Agenda Item 4

MUNICIPAL YEAR 2016/2017 - REPORT NO.

MEETING TITLE AND DATE **Health and Wellbeing Board** **5th October 2016**	**Agenda - Part:** **Item:** **Subject:** **NHS Enfield CCG Commissioning Intentions** **Wards:**
	Cabinet Member consulted:
	Approved by:

Graham MacDougall
Director of Commissioning
NHS Enfield CCG

Contact officer and telephone number:
graham.macdougall@enfieldccg.nhs.uk
020 3688 2823

1. EXECUTIVE SUMMARY

This attached paper presents the Enfield CCG commissioning intentions for 2017-19, which were approved by the Enfield CCG Governing Body on the 21st September. This followed a process of patient and public engagement, which included a presentation to the Health and Wellbeing Board on the 6th September 2016.

The paper outlines the key strategic drivers affecting the development of our commissioning intentions and these include: financial recovery, the development of the NCL Sustainability and Transformation Plan, local plans for health and social care integration, and reducing variation through the Right Care work. The report also includes the process through which patients and the public have been involved, and an update on progress for implementing *New Models of Care,* seen as a vehicle for delivering transformation.

Enfield CCG Commissioning Intentions will be published on 30th September 2016, and included in letters written to all our providers, via North Central London and lead commissioners, to ensure all our providers are fully informed about our intentions for 2017/18 and 2018/19, many of whom will have been involved in their development.

The commissioning intentions are laid out across a number of areas with key changes being signalled. The paper includes NCL wide intentions where these have been developed, whether part of STP or not.

The Governing Body agreed that the following caveat should be included in Commissioning Intention letters ‘Enfield CCG remains a financially

challenged organisation and will need to identify additional recurrent and non-recurrent initiatives and savings as part of our overall Recovery Plan. At this time the full extent of the Recovery Plan is still being worked up and therefore the detail within these Commissioning Intentions are subject to revision and more importantly the addition of new schemes and initiatives designed to bring Enfield CCG and the wider health economy back into financial balance. Whilst Enfield CCG is committed to giving providers and the public we all serve the requisite notice of changes, where appropriate we reserve the right to introduce new schemes that are not currently heralded within this document at any point.'

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to NOTE the attached paper and caveat included in the above summary.

Objective(s) / Plans supported by this paper: Commissioning intentions aim to address all of our strategic objectives.

Audit Trail:

Transformation and Financial Recovery Group 1 September 2016
Health and Well-being Board 6 September 2016
Patient Participation Groups Network 6 September 2016
Clinical Reference Group 7 September 2016
Transformation and Financial Recovery Group 8 September 2016
West Locality Commissioning Group 8 September 2016
Enfield Racial Equality Committee 9 September 2016
Patient and Public Event 14 September 2016
Enfield CCG Governing Body 21st September 2016

Patient & Public Involvement (PPI). As outlined above and further engagement takes place throughout September

Equality Impact Analysis: Undertaken for each commissioning area

Risks: Deliverability will continue to be a significant challenge

Resource Implications: Resource allocation discussions occur for each area to ensure capacity and capability to deliver

Next Steps: Detailed Commissioning Intentions were published on 30th September 2016
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Enfield CCG Commissioning Intentions 2017-18

1. Introduction

The publication of commissioning intentions is an annual process to signal to our public and our providers any changes to service delivery, which are published on 30th September each year, giving the standard NHS 6 months' notice of any changes.

There are a number of drivers affecting the development of Enfield's commissioning intentions and these are detailed in the paper; together with the process through which the patients and the public have been involved and the specific intentions.

2. Strategic Drivers

There are a number of strategic drivers which shape and influence our intentions.

a. CCG Special Measures and Financial Recovery

Enfield CCG is one of 7 CCGs national that have been placed under special measures, particularly due to our financial position. Currently the CCG is spending more that its allocated funding and therefore the CCG is in a state of financial recovery. The CCG needs to be able to make recurrent savings in order to achieve financial balance. This will have an impact across all our providers.

b. Local Integration of Health and Social Care

All local health and social care areas are required to have an integration plan by the end of 2016/17 which describes the local ambition for the integration of health and social care by 20120. Enfield has had an Integration Board for some time now and developmental sessions have been undertaken. LBE and CCG have agreed to describe the many examples of integrated health and social care teams operating within Enfield as its starting point. This includes integrated learning disabilities, integrated health and social care mental health teams, integrated multidisciplinary teams for managing complex older people. We will then build up our integration agenda from these examples.

c. CCG Improvement and Assessment Framework

2016 saw the introduction of a new Improvement and Assessment Framework for CCGs as part of NHS England's assurance process for CCGs. The four domains are: Better Health, Better Care, Sustainability and Leadership. Included in each of these are the following:

1. **Better Health**: includes prevention, maternal smoking rates, childhood obesity, HbA1c for diabetes, reducing falls, % deaths occurring in hospital

2. **Better Care**: early cancer diagnoses, cancer survival rates, new waiting

times for psychological therapies and first episode of psychosis, mental health crisis care, choice in maternity services and provider, reducing long stay hospital beds (transforming care programme), delayed transfers of care (DTOCs) and primary care experience.

3. **Sustainability:** financial recovery, delivery through new models of care, local strategic estates plan

4. **Leadership**: involvement in the development of the Sustainability and Transformation Plan, governance, system leadership

d. Right Care

Right Care is a national transformation programme established by NHS England which uses national data on activity, spend and outcomes to compare a peer group of CCGs. This activity is across a range of programme areas including cardiovascular cerebrovascular, mental health and musculoskeletal. The data indicates where a CCG is an outlier in terms of activity, spend and outcomes.

The aim of right care programme is to reduce this unnecessary variation so that we improve the value that the patient receives from their own care and to improve the value the whole population receives from the investment in healthcare. For example, Enfield has much higher rates of surgical intervention for musculoskeletal conditions relative to its peer group, by as much as £800K. The reduction of significant activity and spend where we are an outlier is viewed as a critical part of the CCG's financial recovery.

e. Sustainability and Transformation Plan

North Central London is the agreed footprint to develop a 5 year strategic plan which is a collaboration between CCGs, all main providers and all local councils which aims to address three gaps: health and wellbeing gap, care and quality gap and the efficiency and financial gap. This means that transformation needs to occur at scale and pace to delivery multi-provider care systems using some of the new models of care. Transformation will include all parts of the care system including elective, urgent and emergency care, mental health, out-of-hospital care, primary care. The STP 5 year plan will therefore have a significant effect on local commissioning intentions for Enfield.

3. <u>New Models of Care</u>

New models of care were signalled in the 5 Year Forward View as a vehicle for testing out transformation of services and systems of care. A series of vanguards were approved by the NHS to test them out. The current make up of this is as follows:

a) 50 vanguards nationally
b) 9 Primary and Acute Care Service (PACS)
c) 14 Multi-Speciality Community providers (MCPs)
d) 6 Enhanced Care Homes

e) 8 Urgent and Emergency Care Providers
f) 13 Acute Care systems

PACS are mainly focussing on the transformation of elective pathways across a wide range of specialities. MCPs are tending to focus on out of hospital care for complex populations including older people and people with long term conditions. New models of care are still fairly embryonic in terms of being fully operational and therefore assessing impact. Different governance arrangements are being tested as part of the vanguards. It is expected that more information about the current vanguards will be made public over the next few months. There is a considerable role for primary care, particularly general practice, in the development of those new models and in the delivery of care though those new models.

4. Commissioning Intentions

Enfield CCG is currently spending more that it's funding allocation year on year and this needs to stop. The CCG is under special measures and as such it is expected to deliver recurrent savings and efficiencies to get back into financial balance. This means that there may be very difficult decisions the CCG has to make in order to balance its book.

The CCG therefore needs to:

a) Recover its financial position
b) Maximise the impact of its current investment has on improving patient outcomes and delivering value for money and maximise productivity
c) Ensure that we maximise the impact of our current contracts and that contract management is robust
d) Work with providers to reduce unnecessary activity from elective specialties as outlined in the right care programme to reduce costs
e) Work with the other CCGs on NCL to aim to reduce commissioner costs from the system
f) Review and strengthen our systems and processes for assessing, approving or rejecting individual treatment requests in line with other CCGs
g) Review its currently commissioned service to determine if any changes to eligibility criteria need to be reviewed
h) Review its currently commissioned services to determine if any of those need to be decommissioned, subject to consultation with our public.

Enfield CCH has been undertaking a number of sessions with patients and public, local clinicians and Health and Wellbeing Board as part of developing our commissioning intentions as outlined in the audit trail above.

The following table outlines the key commissioning intentions:

Programme Area	Commissioning Objective	Commissioning Intent	Timescale
Elective Care	**Approval Process for Procedures**	ECCG will be reviewing the clinical criteria and referral processes for a wide range of services and where appropriate introducing new referral templates. This will include the introduction of prior approval processes for some services (e.g. Individual Funding request)	Q1
	Approval processes for Consultant to Consultant Referrals	ECCG expects providers to abide by the NCL Internally Generated Demand (IGD) Policy (for consultant to consultant referrals) and will be challenging referrals and costs related to activities in breach of this policy	Q1
	Elective Activity	ECCG will reduce the number of Outpatient First Appointments that result in discharge by risk and gain share arrangements with providers.	Q1
		ECCG will be seeking to reduce activity per 1000 population to the NCL average where appropriate for key specialities including gastro, urology, neuro, ENT, MSK (Trauma and orthopaedics and pain), general medicine and general surgery. We expect the providers to work with us on developing new models of care which better triage referrals , reduce unnecessary activity and reduces length of stay.	Q2
	Ambulatory Care	We will be working with providers to increase the number of patients going through ambulatory care across medical and surgical specialties and for all ages, with the aim of reducing non-elective admissions (where appropriate and safe) and also reducing the overall costs associated with non-elective activity.	Q2

	Improving Discharge Processes	ECCG will be seeking to work with providers to improve discharge planning across both elective and non-elective areas.	
	Right Care a) MSK: reduce high levels of surgical intervention b) Respiratory: reduce high levels of emergency admissions for COPD and Asthma c) Reduce higher levels of prescribing in mental health d) Reduce higher elective length of stay for some CVD patients e) Reduce higher levels of emergency admissions for cerebrovascular events f) Reduce higher levels of multiple emergency admissions and A&E attendances	ECCG gives notice to providers that outlier areas within *right care* programmes need to be addressed. The CCG is open to different routes to reduce this variation including delivery through new models of care. This will reduce surgical rates at our acute providers.	Q2
	Dermatology	The CCG will commission a tele dermatology service from RFH to support a streamlined patient journey and maximise best use of consultant time. This will reduce the level of dermatology first outpatients through contractual removal of the unnecessary capacity.	Q1
	Shared Care between General Practice and Acute Provider	ECC will commission shared care across general practice and acute providers to include methotrexate, expanding anticoagulation, and other areas identified through new pathways. This will reduce outpatient activity within our acute providers, and six months' notice is given.	Q2

	Elective Procedures	The CCG will give notice to providers that it is reviewing all processes for the assessment, approval and rejection of those procedures outlined below. The CCG needs to reduce its current high level of approval for the following areas: 1. Procedures of Limited Clinical Effectiveness 2. Criteria for hip & knee replacements 3. Hearing aids 4. IVF 5. Hernias 6. Haemorrhoids 7. Sterilisations 8. Homeopathy	Q1
	Pathology	Enfield CCG is working with CCGs and providers to standardise pathology costs across NCL. Notice will therefore be given to all current providers of the need to agree standard pricing and quality KPIs. A re-procurement of pathology services may be undertaken where standardisation of pathology costs is not agreed.	Q3
	Other Elective Pathways	Enfield CCG will aim to introduce pathways which streamline patient care and reduce unnecessary activity within acute providers	Q1
Cancer	**Reducing Variances**	ECCG will work with providers to understand variances and issues associated with the coding and activity within cancer services with a view to standardisation.	Q1
Stroke	**Enhancing Stroke Pathway**	Enfield CCG will work with providers to review the current stroke pathway and rehabilitation including the effectiveness of early supported discharge. Providers should expect a change to the pathway from 1 April 2017.	Q1
Neurological Conditions	**Improved Community Support**	ECCG wishes to explore the possibility to improve support to neuro patients, including Parkinson's, with the potential	

		development of community neuro rehab service.	
Long Term Conditions	**Integrating Service Delivery**	ECCG will work with providers the develop integrated services for patients with long term conditions (including respiratory, cardiology and diabetes) where the impact can be measured with the aim of reducing secondary care activity and improving patient outcomes.	Q1
Acute Medicines Management	**Reduce expenditure of high costs drugs**	Enfield CCG notifies its acute providers that there are a number of changes it wishes to see: use of avastin, repatriation of specialist drugs in scope of the NHSE manual for prescribed services, and ensuring NICE compliance	Q1
Urgent and Emergency Care	**Integrated Urgent Care Service**	Enfield as lead commissioner will maximise the impact of the new integrated 111 and GP Out of Hours service to ensure that it delivers to its full potential, that the public are full aware of its new capabilities and that the new service contributes to system resilience by reducing patient access to A&E..	Q2
	Urgent and Emergency Care Network	Enfield CCG will continue to work with its other NCL CCGs and stakeholders to substantially contribute to the development of the Urgent and Emergency Network, its workplan and part of the STP and the designation process for Urgent Emergency Care facilities.	Q2
	Frequent A&E and LAS Attenders	CCG is currently working with providers and general practices to identify patients that are frequent callers to LAS and/or attenders to A&E. Patient discussions around alternatives for care to take place to offer other options. Aim is to reduce A&E and LAS activity in acute providers where other alternatives are available	Q1
	GP See, Treat and Direct	ECGG want to maximise the impact of the pilot GP See and Direct to provide treatment and be	Q2

		an integral part of the Urgent Care Centre at NMUH. This aims to reduce patient flow into the urgent care centre and in to A&E at NMUH. Service evaluation will inform the way forward.	
Primary Care	**Cardiovascular Disease**	ECCG will continue to commission services for atrial fibrillation and pre-diabetes during 2017/18 and with a view to including the identification and management of people with high blood pressure.	Q1
	Primary Care Hubs	ECGG has been reviewing its urgent care services with a view to determining how primary care hubs could offer patients additional capacity as part of developing 8-8, 7 days per week general practice. Four primary care hubs are planned to be in place.	Q3 months
	Primary Care Prescribing	The CCG would like to ensure that there are robust medication reviews in place for repeat prescribing to reduce any unnecessary wastage and simply patient concordance	
	Primary Care Delegated Commissioning	NCL CCGs will take on full delegated responsibility for the contracting and commissioning of general practice	1 months
	Advice and Guidance	ECCG wishes to expand the access to specialist advice and guidance available to GPs to improve the quality of care and reduce the number of inappropriate referrals to secondary care	1 month
Mental Health	**Provision of Complex Rehabilitation for patients with severe mental health issues**	ECCG currently spot purchases long term inpatient mental health rehabilitation from a range of providers nationally. The CCG will commission a local service from BEHMHT to provide more local service for patients and reduce costs.	3 months
	Provision of long term care for people with severe dementia	ECCG will commission a range of care options for patients currently in long term hospital beds within BEHMHT to include home packages and care homes. CCG is still assessing the number of ward	3 months

		patients who are eligible for Continuing Health Care. On completion of individual patient assessment the re-commissioning of a range of services will be implemented.	
	Provision of Perinatal Mental Health service	NCL CCGs have submitted a bid against national funding to develop a perinatal mental health service which will be fully commissioned for 2017/18. The mental health provider will support maternity providers.	3 months
	Review Provision of CAMHS	Enfield CCG will need to review its agreed Future in Mind strategic plan, and reassess the supporting financial plan against reductions in local authority CAMHs funding.	Q1
	Provision of Female Psychiatric Intensive Care Unit (PICU)	NCL CCGs will commission a local Female PICU service from one of our local providers via NCL STP process.	Q2
	Psychological Therapies	ECCG wishes to ensure the maximum productivity for our investment in psychological therapies.	Q2
Integrated Care	**Assessing impact of integrated care system**	All providers will be expected to participate in a significant review of our integrated care system to inform any future commissioning and decommissioning approach	Q2
Community Services	**Productivity and Value for Money**	The CCG has already begun a rebasing of the community services contract with BEHMHT. Notice is therefore given of any material changes to the community services contract as a result of this work.	Q1
	Systematic review of adult and paediatric services	ECCG and LBE commission a range of adult and paediatric services from BEHMHT. It is critical that those services are productive and deliver the right care at the right time. These services also need to substantially contribute to system resilience. Enfield CCG will be undertaking systematic review to determine their effectiveness and this may impact on commissioning of community services	Q2

	System Resilience	We will be seeking to increase the productivity of existing Community Services and Mental Health Services and identifying how they can contribute more effectively to managing activity Out of Hospital and improving outcomes for patients. Initially this will focus on improving the productivity within the existing spend.	Q2
Contract Form, Reviews and Currency	**Contract Form**	Enfield CCG will work with acute providers on a new, more sustainable contract model that reduced the burden of challenges and support the long term financial health of all partners	Q2
	Contract Currency	ECCG will work with BEHMHT to introduce true Service Line Costing and accurate Activity Monitoring to enable effective capacity and demand to be undertaken going forward. This applies to both the mental health and the community services contracts led by Enfield CCG.	Q2
	Contract Levers and Metrics	Enfield CCG, as lead commissioner, will work with other lead commissioners to ensure that we maximise the benefit of national contracts including any penalties, metrics, KPIs etc	Q1
		Enfield CCG will ensure that acute providers have a Length of Stay within normal range	Q1
Procurements	**Elective Care**	Enfield CCG must signal any intention it has to market test services as part of competition and opening up the market. The CCG will be testing a number of services through Any Qualified Provider with ophthalmology, urology, gynaecology. ENT, termination of pregnancy, audiology	Q1

5. Conclusion

The above represents the current commissioning intentions prior to submission on 30th September 2016. NCL commissioning intentions falling out of the STP are still being developed and there may be some changes to our intentions up to submission of the STP on 21 October.. The Governing Body is asked to approve the commissioning intentions for both our public and our providers in the knowledge that further intentions may be required to support financial recovery.

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Agenda Item 5

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

MUNICIPAL YEAR 2016/2017 - REPORT NO.

MEETING TITLE AND DATE
Health and Wellbeing Board

05/10/16

Agenda - Part:	**Item:**
Subject: FEEDBACK FROM HEALTH AND WELLBEING BOARD DEVELOPMENT SESSIONS **Wards:**	
Cabinet Member consulted: Cllr Doug Taylor	
Approved by:	

Contact officer and telephone number:
E mail: **Sam Morris (Strategic Partnerships Manager) Ext: 4245**
Sam.morris@enfield.gov.uk

1. EXECUTIVE SUMMARY

This report provides a short summary of the topics presented at the Enfield Health and Wellbeing Board Development Session (EH&WB) which took place on the 6th Sept 2016.

The purpose of this report is to allow EH&WB members to reflect on the topics presented at the Development Session and the subsequent discussions and decide if any action should be taken by the Board.

- **Please refer to the Developments Session minutes which have been circulated to EH&WB members but have not been included in this report as the EH&WB Development Sessions are not public meetings.**

2. RECOMMENDATIONS

To note the summary of topic discussed at the last EH&WB Development session.

3. BACKGROUND

COMMISSIONING INTENTIONS AND NEW MODELS OF CARE

RECEIVED a presentation from Graham MacDougall (Director Commissioning, CCG) providing information on Commissioning Intentions and New Models of Care within the CCG.

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

Local Integration of Health and Social Care
All local health and social care areas in Enfield need to have developed integration plans for 2020 by the end of this financial year.

CCG Improvement and Assessment Framework
There are four key areas for the improvement and assessment framework. These are:

1) Better Health, including preventions for childhood obesity, smoking
2) Better Care includes early cancer diagnosis, new waiting times, and choice in maternity services. Overall it looks at experience whilst in care, reducing long hospital stays and crisis care.
3) Sustainability includes financial recovery and delivery though new models of care
4) Leadership includes the involvement in developing the Sustainability and Transformation Plans (STP).

Right Care
Discussion is taking place to look into the reduction of the level of variation within service providers which will provide greater collective responsibility and reduce overall costs.

Sustainability and Transformation Plans (STP)
The North Central London (NCL) is developing a 5 year strategic transformation plan to bridge the health and wellbeing gap, care and quality gap and efficiency and finance gap.

HOSPITAL CHAINS AND GROUPS

Ron Agble, Director of Partnerships and Transactions – Royal Free Hospital, presented this item on behalf of Peter Ridley.

The Royal Free London has three main hospitals: Barnet, Chase Farm and the Royal Free. Combined this hospitals have 1.6 million patient visits year and a turnover of over £950m. The hospitals have a large portfolio of specialist services.

The Royal Free strategy for 2015 to 2020 is to focus on world class expertise and local care.

The NHS invited organisations to apply to become vanguard sites for the new care model programme. There are 5 five types of vanguard: Integrated Primary and Acute Care Systems, Multispecialty Community Providers, Enhanced Health in Care Homes, Urgent and Emergency Care, and Acute Care Collaboration. The Royal Free Hospital was selected as an Acute Care Collaborations Vanguard which will link hospitals together to improve their clinical and financial viability.

In August 2016, NHS Improvement accredited The Royal Free London to lead the development of Foundation Trust groups. The group will have a Group

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Centre which will provide strategic direction, help set standards, facilitate sharing of best practise and manage Shared Support Services.

The Royal Free London is currently having conversations with service providers to look into how partnerships with primary care could be developed. Decisions are still yet to be made regarding operational structures and decision making responsibility for the group.

4. ALTERNATIVE OPTIONS CONSIDERED

None

5. REASONS FOR RECOMMENDATIONS

To ensure the topics presented at the EH&WB Development Sessions are referenced and considered at following formal public EH&WB.

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

None

6.2 Legal Implications

None

7. KEY RISKS

None

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

N/A

9. EQUALITIES IMPACT IMPLICATIONS

N/A

Background Papers

Enfield Health and Wellbeing Board Development Session Minutes (Sent to all EH&WB Members on the 27/09/16).

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UNISON
Health Care

12 September

UNISON Centre
130 Euston Road
London
NW1 2AY
Direct Tel: 020 7121 5232
j.randall@unison.co.uk
www.unison.org.uk

Mr Ray James
Director of Health, & Adult Social Care
London Borough of Enfield
Civic Centre
Silver Street
Enfield
Middlesex
EN1 3XA

Dear Mr James,

NHS bursary removal will reduce nursing supply in social care

UNISON is writing to all councils that have a responsibility to provide or commission adult social care services in England to warn them about the impact the Government's plan to remove NHS bursaries could have on the future nursing supply in the social care sector.

According to Skills for Care, there are approximately 51,400 registered nurses in adult social care. The importance of nurses to the social care system and the wider healthcare system has recently been highlighted by the pressures on Accident and Emergency Departments in hospitals across England. It has been reported that on the 30th November 2014 there were 5,200 patients in hospital who were ready for discharge but were not able to because there were not suitable care arrangements in place.

Some of this pressure on the health and social care system has been attributed to a shortage of nursing staff. The nursing vacancy rate in the social care sector is estimated to be around 7.6%. Experts predict that the shortage of nurses in the UK will continue for years to come and could get worse because of an ageing workforce, increasing demand and the uncertainty caused by leaving the EU.

In an attempt to create 10,000 additional training places by 2020, the Government plan to remove NHS bursaries in England and replace them with tuition fees and loans by September 2017. However, following this change, a student undertaking a full-time degree in nursing will see their total debt increase from approximately £6,930 to approximately £48,788 on graduation. London Economics predict that the increased cost to students will deter people from becoming a nurse and the changes may reduce current participation levels by 6-7% (or almost 2,000 students a year). Fewer nurses qualifying in 2020 will exacerbate the current shortage and have disastrous consequences for the local population, including vulnerable adults and elderly people in care homes, as patient safety is compromised.

With the decline in the number of students, dependency on agency and overseas staff will increase. Councils with responsibility to provide or commission adult social care services and social care providers will see their staffing costs increase as they struggle to maintain safe staffing levels. At a time when the Nuffield Trust estimates that there will be a social care funding gap of between £2 billion and £2.7 billion in 2019/20 because of the Government's austerity agenda, further spending on expensive agency and overseas staff is an additional cost that councils and social care providers can ill afford.

UNISON, Britain's largest public service union, is not alone in having concerns about the scrapping of NHS bursaries. Other organisations and individuals have publicly raised their concerns about the changes too, including:

- The Mayor of London and the London Assembly
- Nursing Times
- Nursing Standard
- Nursing Practice
- King's Health Partners
- Association of District Nurse Educators
- Royal College of Nursing
- British Dental Association
- British Kidney Patient Association
- British Medical Association
- British Health Professionals in Rheumatology
- The Society of Chiropodists and Podiatrists/The College of Podiatry
- Foundation of Nursing Studies
- Institute of Health Visiting
- National Union of Students
- Neurological Alliance
- Patients Association
- Parkinson's UK
- The Queen's Nursing Institute
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Paediatrics and Child Health
- Royal Mencap Society
- The Society and College of Radiographers
- Unite.

Nurses play a critical role in adult social care. It is imperative that the sector can be confident of the supply of nurses to meet future demand. If you share our concerns and those of many other organisations, UNISON urges your council and the Director of Social Services on your local health and wellbeing board to use our enclosed letter template to write to the Minister of State calling on the Government to put an immediate halt to the proposals to end NHS bursaries, until a long term and viable option has been identified which promotes the value of graduate and university degree educated health professions.

Your council and the Director of Social Services on your local health and wellbeing board should also call on the Government to consult properly and openly on how to improve the support available to nursing students, recognising the unique aspects of nursing degrees, and to increase the number of nurses, midwives, and allied health professionals.

If you would like UNISON to come and talk to you or your council and/or health and wellbeing board in more detail about the impact these changes will have on the future supply of nurses in social care, please contact James Randall by email j.randall@unison.co.uk or call on 0207 121 5232.

Yours faithfully

Gail Adams

Gail Adams
UNISON Head of Nursing

TEMPLATE LETTER

Philip Dunn MP
Minister of State at the Department of Health
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

[Date]

Dear Philip,

We are writing in response to the Government's changes in healthcare education funding.

We note the Government's plan to end NHS bursaries for training nurses, midwives and allied health professionals from September 2017. The bursaries will be replaced with student loans.

Student nurses are unlike other students. Often they are 'mature students' with dependents and spend 50% of their time in clinical placements as part of their qualification. This reduces their ability to access paid employment while in training. Nursing attracts a large number of mature students already saddled with debt from a first degree.

The Chancellor's claim that replacing bursaries with interest-bearing loans will free-up 10,000 new places for nurses is based on the demand for places under the current system. The current applicant to place ratio is an argument in favour of the Government financing more nursing bursaries, not an argument for the introduction of loans.

Research has not been conducted into how the introduction of fees will impact upon the application rate for nursing places. The Government does not know if the introduction of fees will exacerbate the current nursing shortage. There is a high risk that a loan system will be an obstacle to people from poorer backgrounds and those changing careers later in life.

If the increased cost to students deters people from becoming a nurse and fewer nurses are trained, it is reasonable to assume that social care will be impacted heavily by the decision to end the bursary system. According to Skills for Care, the vacancy rate for nurses in social care in England was 8% in September 2014. BUPA, who employ 5,000 nurses and senior nurses in 280 care homes and five care villages across the UK, caring for over 40,000 people, reported a vacancy rate of 13% for nurses nationally across the UK. Additionally, Four Seasons Healthcare reported carrying around 500 vacancies for nurses at any one time, a vacancy rate of around 10%.

Therefore, we believe recruitment and retention of nurses in social care will be made harder by the scrapping of student nurse bursaries.

If the number of qualified nurses declines, dependency on agency and overseas staff will increase in social care. At a time when the Nuffield Trust estimates that there will be a social care funding gap of between £2 billion and £2.7 billion in 2019/20, this is an additional cost that councils with responsibility for providing or commissioning adult social care services and care providers can ill afford.

We believe that the decision to scrap bursaries is driven by the desire to save money in the short-term and that, over the long-term, costs will be higher for social care both financially and in terms of UK trained workforce working in social care.

We call on the Government therefore to put an immediate halt to the plan to end NHS bursaries until a long term and viable option has been identified which promotes the value of graduate and university degree educated health professions. We also call on the Government to consult properly and openly on how to improve the support available to nursing students, recognising the unique aspects of nursing degrees, and to increase the number of nurses in social care.

Yours sincerely,

[Signature]
[Name]
[Job title]

North Central London
Sustainability and
Transformation Plan

North Central London Sustainability and Transformation plan

Progress report – September 2016

NHS England
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
BARNET LONDON BOROUGH
Camden
ENFIELD Council
Haringey LONDON
ISLINGTON
Barnet, Enfield and Haringey NHS Mental Health NHS Trust
A University Teaching Trust
Camden and Islington NHS Foundation Trust
Central and North West London NHS Foundation Trust
Central London Community Healthcare NHS Trust
Your healthcare closer to home
Moorfields Eye Hospital NHS Foundation Trust
North Middlesex University Hospital NHS Trust
Royal Free London NHS Foundation Trust
The Tavistock and Portman NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
Whittington Health NHS

Contents

1 Executive summary

North Central London (NCL) has a complex health and social care landscape, with a diverse and growing population. 5 CCGs, 5 local authorities, 4 acute trusts (including 5 A&E sites), 2 mental health trusts and 2 community trusts make up the scope of our footprint. There are also 4 single specialist trusts in the area. Whilst there are good examples of organisations collaborating over the past few years, working collectively at a pan-NCL level is still relatively new, and we are building the trust required to deliver our Sustainability and Transformation plan (STP).

NCL is a vibrant part of the country's capital – there is rich cultural and economic diversity. Every borough has its own unique identity and local assets that we can build on. Many people in NCL lead healthy lives, but if people do get sick we can offer some of the best care in the country. We have a reputation for world class performance in research and the application of innovation and best practice, and can harness the intellectual capacity amongst our people to deliver outstanding outcomes. However, we are still not able to deliver universally for everyone to the standards we would like. Deprivation and inequalities exist across NCL, and poor health and wellbeing outcomes are often linked to this. There are particularly high levels of mental health problems in our population. Obesity levels are high for children, whilst immunisation levels are low. Our analysis tells us that too many people stay longer in hospital than is medically necessary. There are challenges with meeting acute standards, as well as issues workforce sustainability. Some of our estates aren't fit for purpose. Additionally, we face a financial challenge of £876m across health commissioners and providers by 20/21 if we do nothing.

We want people to be able to get the care they need when they need it, and this means supporting people to live full and independent lives in their communities to maximise health and wellbeing. When people do need specialist care, they should get it quickly and in the most appropriate setting, and be supported in their recovery. To deliver on our vision, we have created a programme of work that will meet the triple aim of health and wellbeing; care and quality; finance and efficiency. The programme includes a focus on: population health; transforming primary care; mental health; urgent and emergency care; optimising the elective pathway; consolidation of specialties; organisational-level productivity and system productivity. Delivery in these workstreams will be underpinned by a number of system enablers including: health and care workforce; health and care estates; digital and information; commissioning models; new care models and new delivery models. We recognise that there are a many significant and complex interdependencies across these workstreams and are currently in the process of identifying these and establishing the best possible process for effective management. We have developed a governance structure that has enabled us to mobilise the programme and engage all organisations across the system in developing our plan.

Our aim is to transform the way that healthcare is commissioned and provided in NCL through this STP, ensuring the system is both high performing, and clinically and financially sustainable in the future. Key decisions going forward will include how we design care for the specific needs of population groups, the delivery vehicles for care (and thus the shape of the provider landscape in NCL as a whole), and the way we can optimally commission services. We are committed to being radical in our approach and delivering the best care in London. Our population deserves this, and we are confident that we can deliver it.

2 North Central London has a complex health and social care landscape

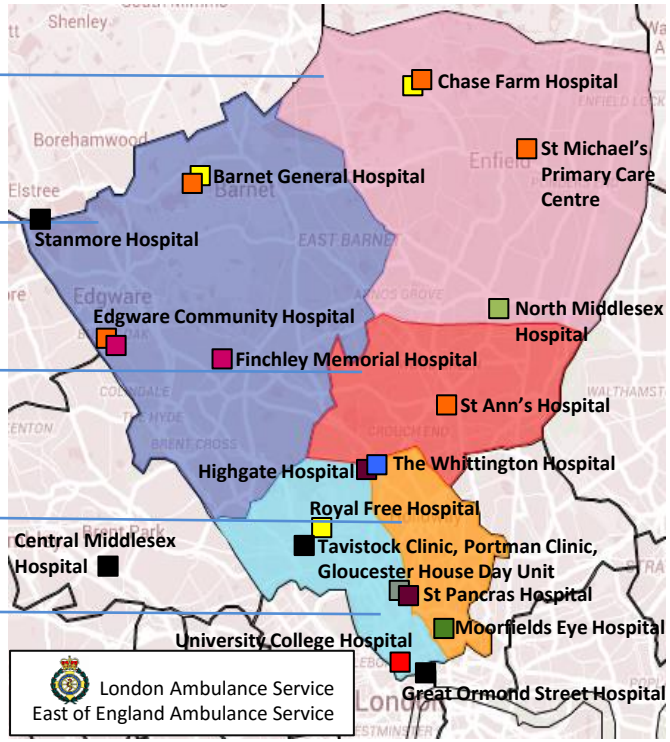
Enfield CCG / Enfield Council
~320k GP registered pop, ~324k resident pop
48 GP practices
CCG Allocation: £362m (-£14.9m 15/16 OT)
LA ASC, CSC, PH spend: £184m

Barnet CCG / Barnet Council
~396k GP registered pop, ~375k resident pop
62 GP practices
CCG Allocation: £444m (£2.0m 15/16 OT)
LA ASC, CSC, PH spend: £158m

Haringey CCG / Haringey Council
~296k GP registered pop, , ~267k resident pop
45 GP practices
CCG Allocation: £341m (-£2.8m 15/16 OT)
LA ASC, CSC, PH spend: £163m

Islington CCG / Islington Council
~233k GP registered pop, , ~221k resident pop
34 GP practices
CCG Allocation: £339m (£2.7m 15/16 OT)
LA ASC, CSC, PH spend: £138m

Camden CCG / Camden Council
~260k GP registered pop, , ~235k resident pop
35 GP practices
CCG Allocation: £372m (£7.2m 15/16 OT)
LA ASC, CSC, PH spend: £191m



Total health spend **£2.5b**

Total care spend **c.£0.8b**

NHS England
- Primary care spend **~£180m**
- Spec. comm. spend **~£730m**

15/16 OT		
£185m	-£12.4m	BEH Mental Health NHS Trust (main sites, incl Enfield community)
£136m	£0.7m	Camden and Islington NHS FT (and main sites)
£249m	-£8.3m	North Middlesex University Hospital NHS Trust
£951m	-£51m	The Royal Free London NHS FT
£940m	-£31m	University College London Hospitals NHS FT
£293m	-£14.8m	Whittington Health NHS Trust (incl Islington and Haringey Community)
£202m	£2m	Moorfields Eye Hospital NHS FT
N/A – not in scope for NCL STP finance base case		Central and North West London NHS FT (Camden Community)
		Central London Community Healthcare NHS Trust (Barnet Community)

The specialist providers are out of scope: GOSH and RNOH
Tavistock and Portman NHS FT is out of scope financially but within scope for mental health

Note: all OT figures are normalised positions

Vanguards in scope
- Royal Free multi-provider hospital model
- Accountable clinical network for cancer (UCLH)

NCL CCGs activity stats

A&E	522,838
Elective	134,513
Non-elective	163,487
Critical Care	25,718
Maternity	45,528
Outpatients	1,803,202

Total GP registered population 1.5m

Our population
- Our population is **diverse and growing**.
- Like many areas in London, we experience **significant churn** in terms of people using our health and care services as people come in and out of the city.
- There is a **wide spread of deprivation** across NCL – we have a younger, more deprived population in the east and south and an older, more affluent population in the west and north.
- There are high numbers of households in **temporary accommodation** across the patch and around a quarter of the population in NCL **do not have English as their main language**.
- Lots of people come to settle in NCL from abroad. The largest **migrant communities** arriving during 2014/15 settling in Barnet, Enfield and Haringey were from Romania, Bulgaria and Poland. In Camden and Islington in 2014/15 the largest migrant communities were from Italy, France and Spain.

2 We are building on our local strengths

Who we are

North Central London (NCL) comprises 5 CCGs: Barnet, Camden, Enfield, Haringey and Islington, each coterminous with the local London Borough. The population of NCL is c.1.44m and has a £2.5bn health and c.£800m social care budget. There are four acute trusts: The Royal Free London NHS Foundation Trust (sites in scope including Barnet Hospital, Chase Farm Hospital and The Royal Free hospital in Hampstead), University College London Hospitals NHS Foundation Trust (University College Hospital site*), North Middlesex University Hospital NHS Trust, the Whittington Health NHS Trust and three single specialist hospitals: Moorfields Eye Hospital NHS Foundation Trust, Great Ormond Street Hospital for Children NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust. Community services are provided by Central and North West London NHS Foundation Trust, the Whittington Health NHS Trust, and Central London Community Healthcare NHS Trust. Mental health services are provided by the Tavistock and Portman NHS Foundation Trust, Camden and Islington NHS Foundation Trust, and Barnet, Enfield and Haringey Mental Health Trust. There are over 200 GP practices, and the out-of-hours services contract was recently awarded to the London Central and West Unscheduled Care Collaborative.

Our history

Historically, neither local residents nor health and care professionals have identified NCL as a "place". Whilst there are good examples of strong partnership working where areas have come together, we have not generally operated on a 5 borough footprint in recent years. The disparities (in terms of population, geography, provider landscape and finances) between the different boroughs in NCL mean that it can be difficult to align around a common vision. The STP process has helped us to realise that we need to do something radically different in order to deliver the quality of care that we want for our population – and that we can only do so by working together collaboratively and at scale, across the whole footprint. However, we have individual and collective achievements that can be built on.

Building on our strengths

We know we have the capability to deliver significant change, for example:

- All of our boroughs are already working in GP federations. In Islington, practices are working together to make sure that people can see a doctor when their surgery is closed: with individuals' consent, the entire GP record is available.
- Our delivery of the national Transforming Care programme in Enfield has significantly improved the lives of people with learning disabilities and autism: through diverting funding away from clinical assessment and treatment services, we have set up a community intervention service which uses combination of proven holistic therapies and Positive Behaviour Support techniques. As a result, hospital bed days per month for this cohort in Enfield have reduced from 188 to 30 between 2012 and 2015.
- We can build on the UCLP work on atrial fibrillation which many CCGs have collaborated on leading to an increase in anticoagulation rates in primary care and reduction in strokes.
- We have developed an Ambulatory Care Network at Whittington Health to address the issues of inappropriate admissions and long length of stay, through providing a safe alternative and an improved experience for patients.
- We can further develop the new model of care for CAMHS which is now referenced in 50% of CAMHS transformation plans nationally and being piloted in Camden.
- Barnet, Enfield and Haringey Mental Health Trust's Enablement Programme launched in April 2015 is helping people who use our services to "Live, Love and Do".
- The first Multidisciplinary Diagnostic Centre for cancer in England opened in NCL at UCLH.

What next

The next step is to build on this to complete the pan-NCL strategic plan for health and care services to improve outcomes and ensure whole system viability for the population, drawing on the Better Health for London Next Steps. We have started to build the trust between organisations that will be required to deliver this kind of plan. Providers have a good relationship and local authority engagement has been notably strong. The CCGs in NCL have extensive experience of commissioning: clinical leadership is embedded in what we do and we are knowledgeable about what patients and local residents need and want. However, we recognise that no single organisation or sector can do this alone. We have committed to working together to develop a plan that considers services at scale, but that takes into account the unique characteristics of local areas.

*UCLH also have a number of specialist hospitals including the Royal London Hospital for Integrated Medicine, the National Hospital for Neurology and Neurosurgery, the Royal National Throat, Nose and Ear Hospital, and the Eastman Dental Hospital

3 Case for change: health and wellbeing

People in NCL are living longer but in poor health
The number of older people is growing quickly, and older people have higher levels of health and care service use compared to other age groups. Older people in NCL are living the last 20 years of their life in poor health, which is worse than the England average.

There are different ethnic groups with differing health needs
There are large Black and Minority Ethnic (BME) groups in NCL. These groups have differing health needs and health risks. In addition, a quarter of local people do not have English as their main language, which creates additional challenges for effective delivery of health and care services.

There is widespread deprivation and inequalities
Poverty and deprivation are key drivers of poor health and wellbeing outcomes. Many local children grow up in poverty and many adults are claiming sickness or disability benefit. There are stark inequalities in life expectancy in NCL; for example, men living in the most deprived areas of Camden live on average 10 years fewer than those in the least deprived areas.

There is significant movement into and out of NCL
Almost 8% of local people move into or out of NCL each year, which has a significant impact on access to health services and health service delivery, such as registering with a GP and delivering immunisation and screening programmes. Large numbers of people also come into NCL daily to work.

There are high levels of homelessness and households in temporary housing
There are increasing levels of homeless households in NCL. Four of the five boroughs are in the top 10% of areas in England for number of homeless households with a priority need, and all five are in the top 10% for number of households in temporary accommodation. Poor housing is one of the main causes of poor health and wellbeing (especially for children), and housing locally very is expensive.

Lifestyle choices put local people at risk of poor health and early death
Almost half of people in NCL have at least one lifestyle-related clinical problem (e.g. high blood pressure) that is putting their health at risk, but have not yet developed a long term health condition. The biggest killers in NCL are circulatory diseases and cancer; these diseases are also the biggest contributors to the differences in life expectancy across NCL.

There are poor indicators of health for children
The number of children living in poverty is high, particularly in Camden and Islington. Childhood obesity is high, whilst immunisation levels are low.

There are high rates of mental illness among both adults and children
The rates of mental illness are high in Enfield, Haringey and Islington, and many mental health conditions go undiagnosed. Just c.72k of the estimated c.194k people who have common mental health problems or severe mental health illness in NCL are known to GPs, and only 4% of adults on Care Programme Approach are in employment, compared to the London average of 5% and England average of 7%. In addition, up to a third of people with dementia in Camden and Enfield are thought be undiagnosed. People with mental health conditions are also more likely to have poor physical health.

There are differing levels of health and social care needs
The majority of people are largely healthy, but there is high use of health and social care by those with long term conditions, severe mental illness, learning disabilities and severe physical disabilities, dementia and cancer.

This suggests that the priority groups for focus are **people with mental illness and people at risk of poor mental or physical health**. It is also important to make sure **high quality services are available when required** for the majority of local people who are **not high users of services**. Consideration needs to be given to **reducing health inequalities**, the **requirements of different ethnic groups** and **the significant movement of people** into and out of NCL.

3 Case for change: care and quality

There is not enough focus on prevention across the whole NCL system (including health, social care and the wider public sector). Many people in NCL are healthy and well, but still at risk of developing long term health conditions. There is therefore an important opportunity for prevention of disease among these people. Between 2012 and 2014, around 20% (4,628) of deaths in NCL could have been prevented. In addition, the wider determinants of health such as poverty, housing and employment have a significant impact on individuals' health and wellbeing.

Disease could be detected and managed much earlier. There are people in NCL who are unwell but do not know it. For example, there are thought to be around 20k people who do not know they have diabetes, while 13% of local people are thought to be living with hypertension. There are opportunities for better, more systematic management and control of long term health conditions in primary care.

There are challenges in provision of primary care. There are low numbers of GPs per person in Barnet, Enfield and Haringey, and low numbers of registered practice nurses per person in all CCGs, but particularly in Camden and Haringey. Satisfaction levels and confidence in primary care is mixed across NCL. There are high levels of A&E attendances across NCL compared to national and peer averages, and very high levels of first outpatient attendances, suggesting that there may be gaps in primary care provision.

Lack of integrated care and support for those with a LTC. Levels of non-elective admissions are similar in NCL to other areas of London. However, there are high levels of hospitalisation for the elderly and those with chronic conditions. Many people with long term health conditions – over 40% in Barnet, Haringey and Enfield – do not feel supported to manage their condition.

Many people are in hospital beds who could be cared for at home. The majority of people with long hospital stays are elderly. This can be harmful to health, and not what people want. Delayed discharges are high in some hospitals in NCL and hundreds of people could potentially be cared for closer to home or in their home. There is also a large number of people whose admission to hospital might have been avoided.

There are differences in the way planned care is delivered. This may be because of levels of patient need, or differences in clinical practice. The number of people seen as outpatients is high and there is variation in the number of referrals between consultants in the same hospital, the number of follow-up outpatient appointments and the proportion of planned care that is done as a day case.

Challenges in mental health provision. There is still stigma associated with mental illness, and many people either do not know how, or do not want, to access mental health services. At the same time demand for mental health services has increased due to reduced funding for other public services, increasing population, higher public expectations and changes to legislation. There are high levels of mental illness in NCL, and high rates of early death, particularly in Haringey and Islington. High numbers of people are admitted to hospital: the rate of inpatient admissions in NCL is 828 per 100k, compared to 587 England-wide. Many people receive their first diagnosis of mental illness in Emergency Departments. There is variable access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services within urgent care.

Challenges in the provision of cancer care. There are many opportunities to save lives and deliver cancer services more efficiently. Late diagnosis is a particular issue, as is low levels of screening and low awareness of the symptoms of cancer in some groups. Waiting times to see a specialist and for diagnostics are long, with referrals to specialists having almost doubled in five years. There is a shortfall in diagnostic equipment and workforce, and a lack of services in the community. Some hospitals are seeing few patients with some types of cancer, in some cases less than 2 per week.

Workforce challenges. There is a significant shortfall predicted in GPs, nurses, allied healthcare professionals, with an aging workforce and increasingly attractive career opportunities elsewhere. Many people are leaving the NHS entirely. There is a high vacancy and turnover rate locally in health and social care. The number of GPs and practice nurses per person in parts of NCL is low.

Some buildings are not fit for purpose. Many of the local buildings are old and not fit for purpose, although there have recently been a number of major developments locally. It is estimated that 15% of NHS building space is not being used, incurring £20-25m a year in running costs. A large number of primary care buildings are also not fit for purpose – around 33% of GP premises in London need replacing.

Information technology needs to better support integrated care. The level of digital maturity of providers across NCL is variable, with most below the national average for digital capabilities, particularly their capability to share information with others. There is no NCL-wide governance structure or leadership team to implement digital transformation, resulting in fragmentation of information flows and duplication of effort.

3 Case for change: finance

- In 2015/16 the health system across NCL had an underlying deficit of around £120m deficit.
- If we do nothing that deficit will continue to rise over the next 5 years as a result of population growth and demand for healthcare, together with the forecast costs of delivering care exceeding the funding increases over the period to 2020/21.
- There is an increased demand for specialised services driven by advances in science and an ageing population. This has caused spending to rise more quickly than in other areas of the NHS, resulting in a financial challenge
- The scale of the financial pressures are still being validated but early analysis suggests that without action the NCL system will have a significant financial problem

4 In response to the case for change, we have collectively developed an overarching vision for NCL which will be delivered through the STP

Our vision is for North Central London to be a place with the best possible health and wellbeing, where no-one gets left behind. It will be supported by a world class, integrated health and social care system designed around our residents.

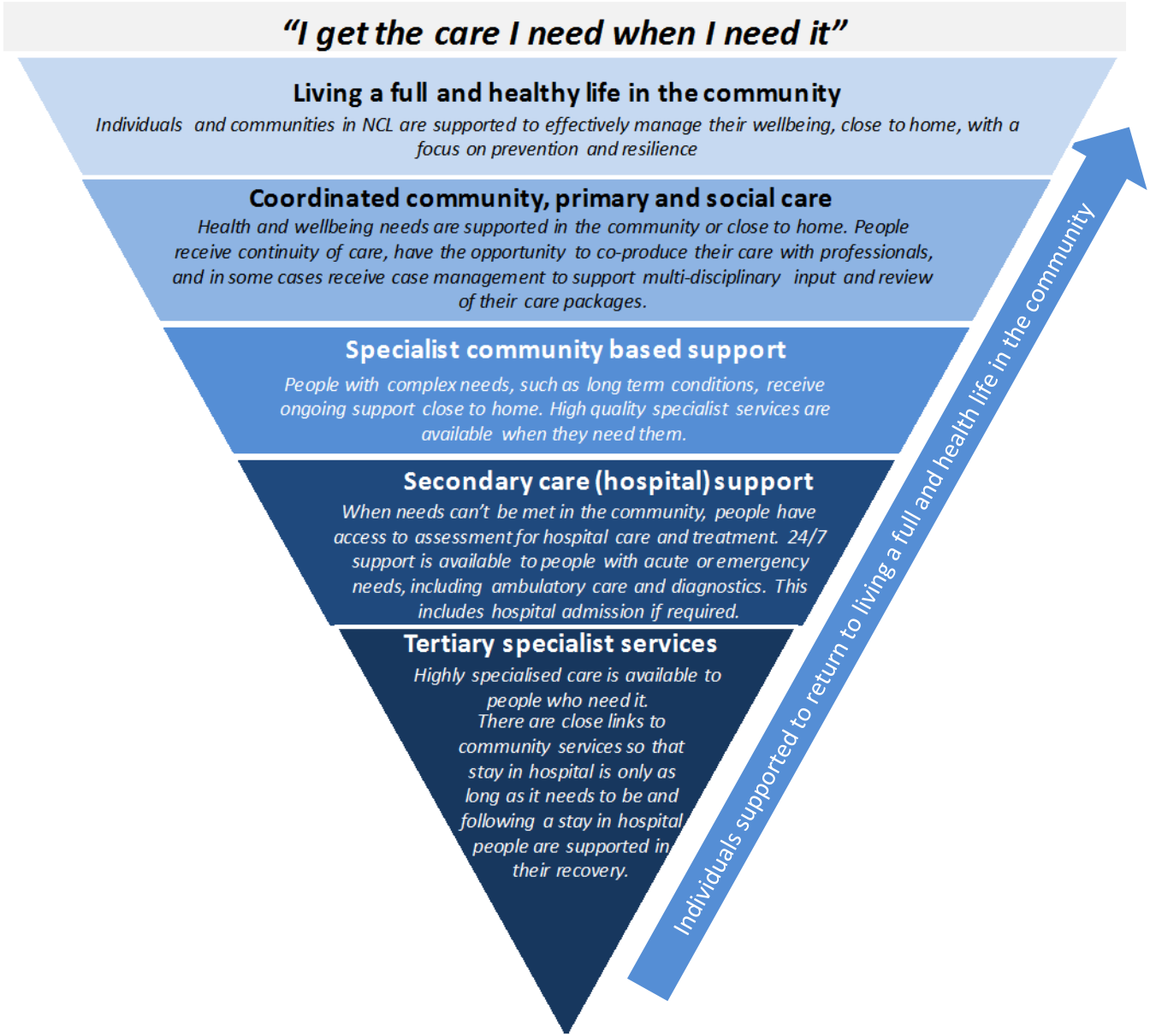
This means we will:

- help people who are well, to stay healthy
- work with people to make healthier choices
- use all our combined influence and powers to prevent poor health and wellbeing
- help people to live as independently as possible in resilient communities
- deliver better health and social care outcomes, maximising the effectiveness of the health and social care system
- improve people's experiences of health and social care, ensuring it is delivered close to home wherever possible
- reduce the costs of the health and social care system, eliminating waste and duplication so that it is affordable for the years to come
- at the same time we will ensure services remain safe and of good quality
- enable North Londoners to do more to look after themselves
- have a strong digital focus, maximising the benefits of digital health developments.

Our core principles are:

- residents and patients will be at the heart of what we do and how we transform NCL. They will participate in the design of the future arrangements.
- we will work together across organisational boundaries and take a whole system view
- we will be radical in our approach and not be constrained by the current system
- we will harness the world class assets available to us across the North Central London communities and organisations
- we will be guided by the expertise of clinicians and front line staff who are close to residents and patients
- we will build on the good practice that already exists in North Central London and work to implement it at scale, where appropriate
- we will respect the fact that the five boroughs in NCL have many similarities, there are significant differences which will require different responses in different localities.

4 The vision will be delivered through a consistent model of care



5 We have made a start on the journey towards realising our vision…

Establishing effective partnership working
Recognising that NCL-wide collaborative working across NCL is a relatively new endeavour, we are continuing to build relationships across the programme partners to ensure that health and care commissioners and providers are aligned in the process of transforming care. The STP Senior Responsible Officers (SROs) are working to bring CCGs, providers and local authorities together across the 5 boroughs recognising the history and context that underlies working together in a new way. We have established a governance framework that supports effective partnership working and will provide the foundation for the planning and implementation of our strategic programme going forward.

Understanding the size and nature of the challenge
We have undertaken analysis to identify the gaps in health and wellbeing, and care and quality in NCL in order to prioritise the areas we need to address. The clinical cabinet has finalised our case for change, which sets out a narrative in support of working in a new way and provides the platform for strategic change through identifying key areas of focus.

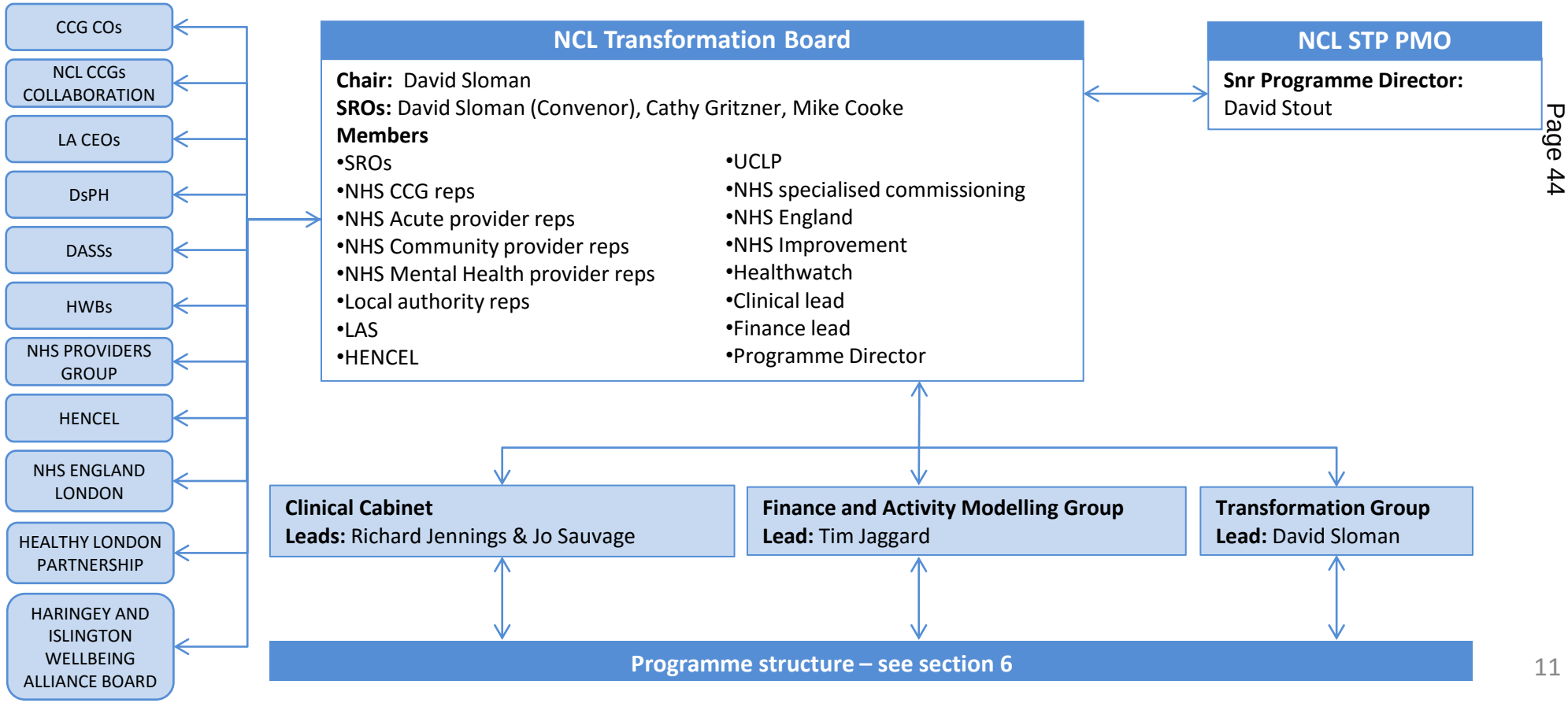
Finance directors from all organisations have been working well together to identify the projected NCL health and care position in 20/21 should we do nothing. We are working closely with NHS England to address the challenge around specialised commissioning, which is particularly relevant in our footprint given the specialist trusts that fall within the NCL geography.

Building the foundations of a major transformation programme
We have confirmed a budget which we feel reflects the scale of the challenge ahead of us. This funding will sustain the key roles we have already appointed to drive delivery – a senior programme director, two clinical leads and a communications and engagement director – as well as support the provision of additional resource across the various programme workstreams.

Delivering impact from year one
There is already work in train that will ensure delivery of impact before next April. CCG plans are being implemented which will build capacity and capability in primary care and delivering on the 17 specifications in the London Strategic Commissioning Framework (SCF). However we recognise that we will need to broaden our out of hospital strategy to ensure that it is co-produced and integrated with social care. Our case for change highlights some urgent issues that need addressing to ensure the short-term sustainability and viability of general practice, and our plans will ensure this as well as reducing variation and improving the offer to people across the patch. Specifically we are on track to deliver 8am – 8pm access across 100% of practices by 17/18 to deliver 135,000 additional GP and practice nurse appointments across NCL. Leveraging the opportunities afforded to us through our status as a London estates devolution pilot will potentially free up capital to provide much needed investment for primary care to deliver the larger-scale transformation required in line with our aspirational model of care. The implementation of our Local Digital Roadmap will support the delivery of the mental health, primary care and estates work, and our two Vanguards are continuing to progress with their plans.

5 We have developed a robust governance structure that enables collaborative input and steer from across the STP partners

The NCL STP **Transformation Board** meets monthly to oversee the development of the programme and includes representation from all programme partners. It has no formal decision making authority, but members are committed to steering decisions through their constituent boards and governing bodies. There are three subgroups supporting the Transformation Board. The **Clinical Cabinet** provides clinical and professional steer and input with CCG Chair, Medical Director, nursing, public health and adult social services and children's services membership. The **Finance and Activity Modelling Group** is attended by Finance Directors from all partner organisations. The **Transformation Group** is a smaller steering group made up of a cross section of representatives from organisations and roles specifically facilitating discussion on programme direction for presentation at the Transformation Board. Every workstream has a senior level named SRO to steer the work and ensure system leadership filters down across the programme.



6 We are in the process of designing a cohesive programme that is large scale and transformational in order to meet the challenge

Development of programme structure

- *Programme designed to meet the triple aim and the enablers needed to achieve this*
- *Senior NCL leaders performing SRO role for each workstream*
- *Scope of workstreams agreed*
- *Development of detailed delivery plans for each workstream based on logic model approach: reviewing inputs, activities, outputs and outcomes*

	A Health and wellbeing	B Care and quality	C Productivity	D Enablers
High level impact	• Improves population health outcomes • Reduces demand	• Increases independence and improves quality • Reduces length of stay	• Reduces non value-adding cost	• Facilitates the delivery of key workstreams
Initiatives	1. Population health including prevention *(David Stout, STP PD)* 2. Primary care transformation *(Alison Blair, ICCG CO)* 3. Mental health *(Paul Jenkins, TPFT CEO)*	4. Urgent and emergency care *(Alison Blair, ICCG CO)* 5. Optimising the elective pathway *(Richard Jennings, Whittington MD)* 6. Consolidation of specialties *(Richard Jennings, Whittington MD)*	7. Organisational-level productivity including: a) Commissioner b) Provider *(FDs)* 8. System productivity including: a) Consolidation of corporate services b) Reducing transactional costs and costs of duplicate interventions *(Tim Jaggard, UCLH FD)*	9. Health and care workforce *(Maria Kane, BEHMHT CE)* 10. Health and care estates *(Cathy Gritzner, BCCG CO and Dawn Wakeling, Barnet Council DASS)* 11. Digital / information *(Neil Griffiths, UCLH DCEO)* 12. New care models & new delivery models *(David Stout, STP PD)* 13. Commissioning models *(Cathy Gritzner, BCCG CO)*

Identifying and managing interdependencies across all workstreams, e.g. estates and digital enablers on population health, primary care transformation and mental health

6 Health and Wellbeing – Population health including prevention workstream

Development of a NCL approach to population health to achieve better health and better care at lower cost, with a reduction in health inequalities. Co-designing new models of care with residents and making best use of community assets including the voluntary and community sector. This includes a focus on preventing disease in the first place (primary prevention), preventing the deterioration/progress of disease (secondary prevention), earlier diagnosis and proactive management (including self-management) of certain conditions (e.g. diabetes), addressing the wider determinants of health such as homelessness and employment, and developing new models of care for particular population groups. The alignment of population health approaches to wider determinants of health through place-based and system leadership will drive improvement in outcomes.

Key features within scope include using population level data to understand needs across population groups (including children) and track health outcomes; aligning financial incentives with improving population health; development of different strategies for different population groups, including a whole system approach to prevention; delivering cost-effective interventions at a much larger scale to have a demonstrable impact on outcomes (e.g. smoking cessation and others from Better Health for London); developing integrated health and care records to co-ordinate services; scaled-up primary care systems; and close working with individuals to support and empower them to manage their own health and wellbeing.

6 Health and Wellbeing – Primary care transformation workstream

Focused on reducing demand by providing radically upgraded out of hospital care and support for individuals with different levels and types of needs. Close links with the urgent and emergency care workstream to achieve this. Investment in NCL GP capacity through additional staff and making time for patients initiatives to address immediate and long-term sustainability and transformation of GP practice capabilities. Particular focus on services for people with long term conditions and complex needs requiring continuity and planned care.

Development of primary care hubs to enable extended access and range of services to the community, integrating a range of health and wellbeing services around the individuals to support early intervention and prevent demand.

Development of federations of GP practices to deliver an enhanced, equitable offer to all patients, extending a range of primary care specialities across locality patient lists so residents can access the right service at the right time.

6 Health and Wellbeing – Mental health workstream

Transformation of mental health services to ensure needs are being met holistically across mental and physical health, addressing the social determinants of mental health problems and supporting our population to live well.

Areas of work include: building community resilience, strengthening of integrated out-of-hospital mental health teams, investing in the acute care pathway, developing a female Psychiatric Intensive Care Unit (PICU) and rehab housing, taking a population segmentation approach to Child and Adolescent Mental Health Services (CAMHS) supporting the delivery of Children and Young Person (CYP) plans, and scaling up of 24/7 all age liaison services

Through these workstreams the variations in mental and physical health outcomes across NCL will be addressed, including those for people with medically unexplained symptoms, depression, dementia and co-morbid physical issues such as diabetes.

Strong links with enabling workstreams including workforce, digital and estates.

6 Care and Quality - Urgent and Emergency Care (UEC) workstream

Focused on improving quality of urgent and emergency care and meeting standards, rather than improving out of hospital care which is covered in the primary care transformation workstream. Taking an integrated approach across health and social care will be key to transforming urgent care.

Improvement in NCL UEC services to reduce variability and improve quality and sustainability within the services currently named Emergency Departments, London Ambulance Service, East of England Ambulance Service, Urgent Care Centres and Walk-In Centres. Stabilisation of immediate issues in UEC services across NCL. Complete London-wide designation of UEC services work, and any necessary consolidation/ reconfiguration for all services within NCL, including Walk-In Centres. Implementation of Integrated Urgent Care.

Redesign of Urgent and Emergency Care pathways (including paediatric pathways) across NCL to include areas such as 7 day hospital development, transformation of UEC front door, and increasing the service offer for treatment at home by ambulance services. Implementation of digital urgent and emergency care, including direct booking to primary care. Review of workforce demand, capacity, roles and training.

6 Care and Quality – scope of workstreams and deliverables

Optimising the elective pathway

Understanding the variation in delivery of planned care between all acute providers in NCL and ensuring, where appropriate, pathways are consistent to ensure patient safety, quality and outcomes, and efficient care delivery. Focused on specialties with high volume or high variability, where there is opportunity to achieve high impact and realistic implementation.

Specialties in scope for the initial phase of work include: trauma and orthopaedics (T&O), general surgery, ophthalmology, cancer, gastroenterology and ear nose and throat (ENT). Analysis to support understanding of current variability to include: activity volumes by setting of treatments; volumes of activity with and without procedures; ratios of first to follow-up outpatient appointments; daycase rates; and source of outpatient referrals. Identification of potential areas for improvement and appropriate changes to pathways based on this analysis, as well as on national and international best practice such as the Shared Accountability approach (Intermountain Health) and similar value-based care models. Additionally, identification of variability in key NCL-wide cross-cutting themes, such as referral thresholds, pre-assessment, discharge and diagnostics will help inform plans to deliver improvement or standardisation, which might be applied to benefit all pathways of care in general.

Consolidation of specialties

Identification of clinical areas which might benefit from consolidation (bringing multiple services into one), networking across acute providers, or acute providers collaborating and/or configuring in a new way. Identification of areas where planned care services are heavily reliant on locums and where these services can either be consolidated, changed or transferred. Development and implementation of plans for delivering high quality and sustainable services in these areas. Central to this will be understanding activity volumes and workforce requirements at each site under different configurations. Underpinning analysis of volumes of activity, workforce composition, and projected workforce capacity against demand to be undertaken to support and ratify opportunity assessment. Work with the Finance and Activity Modelling Group and NHS England Specialised Commissioning to support identification of the opportunities for specialised commissioning (particularly around consolidation) within NCL. Support the development of delivery plans against the identified opportunities for specialised commissioning.

Close working with the new care models and new delivery models workstream to ensure alignment with overarching strategy for service configuration.

6 Productivity - Organisational-level productivity

Radically improving provider productivity is an essential part of the work to close the financial gap in NCL. Provider plans assume very significant delivery of CIP, improving provider productivity by c.2% per year up to 2020/21). This has been modelled on organisation-level improvements assuming little or no working across organisations: we know that 2% delivery each year will be tough and will required strong local leadership in all providers.

Providers in NCL have committed to delivering around 3% CIP delivery across the organisations, which is clearly an ambitious target but will set the tone for the approach to productivity as part of our STP. Our CIP delivery plans are based around the following schemes which align strongly to the recommendations coming out of the Carter review:

- **Corporate and administrative rationalisation:** minimising back office and administrative processes and streamlining teams and effort
- **Reducing spend on agency staff:** reviewing current spend on agency staff and putting in initiatives that reduce the need to depend on this
- **Prescribing with generics:** ensure this is the standardised approach across the organisation
- **Reviewing inventory and spend:** identifying any areas of high or varying spend and ensuring best value approach is consistent across the organisation
- **Reducing running costs on estates:** looking for ways to save on heating, lighting etc. based on best practice and eliminating any anomalies of high spend
- **Reviewing approach to procurement:** controlling stock levels and approach to procurement to ensure best possible value
- **Improving rostering efficiency:** Ensuring staff skill mix and level is appropriate to need

6 Productivity - System productivity workstream

Business as usual CIPs (defined as those deliverable within organisations, without collaboration or transformation) are already assumed within the organisational-level provider productivity workstream. Building on the learning from the Royal Free vanguard and other work that already exists in NCL, this workstream will specifically explore delivery opportunities beyond BAU CIPs and Carter opportunities through pan-organisational collaboration. As part of this, we will pay close attention to social and environmental impact and will use our powers as employers and purchasers effectively, including maximising social value and eliminating unnecessary resource use. This could include improving supply chains and freight consolidation, and stripping out waste from clinical pathways. In NCL, much work has already been undertaken in this area, for example the development of a shared procurement function across most trusts, outsourcing of payroll functions in several places, and advanced pathology and imaging rationalisation. Additionally many incremental savings are already included in business as usual CIP plans (for example, UCLH's Shelford procurement work, strategies for reducing agency spend. Other opportunities include:

- Workforce management and talent acquisition to reduce total cost of agency and locum staff
- Pharmacy, medical, surgical and food – procurement and distribution
- Digital information – pooled data across organisations irrespective of organisational boundaries
- Corporate finance functions – to create a collective and joined up resource management system

The workstream will also look collectively at structural issues which impact on capacity, capability and cost across the whole system, including the market management of residential and home care.

6 Enablers - Health and care workforce workstream

Development of new workforce models which are person-centred and focused on prevention and self-care, which will enable the delivery of the STP. Implementation of the right numbers of the right workforce, including review of existing roles and requirements for modified and new roles across all settings. Promoting active travel among staff to reduce air pollution and improve physical activity. Close working with the productivity workstream to develop pan-NCL strategies to reduce bank and agency spend, improve retention, and attract registered professionals and support staff into our footprint.

Enabled by the creation of an Improvement Academy building on UCLP's improvement and safety work, where we will harmonise the way we recruit, retain and develop our staff across the footprint. The Local Workforce Action Board (LWAB) will oversee implementation of this work. The workstream will enable local authorities and health to work collaboratively to design a future workforce capable of delivering integrated, person-centred care.

6 Enablers - Health and care estates workstream

The management of One Public Estate across NCL to maximise use of the asset and improve facilities for delivering care.

Development of an overarching estates strategy to deliver this (underpinned by the development of a comprehensive estates database and a pan-NCL estates programme architecture with single governance), with a focus on a number of specific opportunities, including potential site redevelopment at St Ann's, St Pancras and Moorfields.

Development of a detailed plan for capital investment to ensure maximum benefit realisation and enable delivery of benefits in other workstreams. Significant development of out of hospital estates to respond to the planned transformation across the STP programme, including utilisation and efficiency improvement, development of primary care hubs, creating mental health community support, providing accessible urgent care.

6 Enablers– scope of workstreams and deliverables

Digital and information

STP requirements have driven the development of the digital vision: digitally activated population; new and enhanced care delivery models; integrated digital record access and management; insights driven learning health system; workforce integration and enablement; whole system digital delivery model; standards and compliance. These elements have been mapped against each of the STP workstreams. The capabilities required to deliver each theme are included in the local digital roadmap, phased by strategic priority, and based on NCL's current digital landscape and the state of readiness to move towards whole system digital transformation. Digital technologies could play a major role in encouraging behaviour change and self-care. Building on digital excellence and ambition of NCL local authorities, there is the potential to harness big data and analytics across the system to support primary and secondary prevention.

New care models and new delivery models

We are developing our model for population health for NCL. As part of that work we will review the most appropriate organisational delivery models for the effective delivery of our agreed approach to population health. Options which will be explored include the development of accountable care systems/organisations, multispecialty community providers (MCPs), primary and acute care systems (PACS). Through this work we will identify the preferred model(s) and agree an implementation plan for the agreed approach.

6 Enablers - Commissioning models

Developing strong commissioning in order to deliver on the NHS Five Year Forward View and meet the challenges addressed through the STP. Supporting partnership working to develop whole population models of care, improve outcomes for patients and address care, financial and quality gaps. Building on the extensive experience of commissioning, clinical leadership and knowledge about what local residents need and want that is already embedded within NCL CCGs to improve commissioning. Collectively developing plans for a new commissioning system that will implement the STP with the following characteristics:

- Covering a sufficiently large population to commission at scale, driving more ambitious change and productivity improvement
- Clarity and simplicity, speaking with one voice when needed
- Achieving consistency of standards and the reduction of variation in pathways
- Sharing scarce commissioning leadership, capacity and capability
- Managing jointly areas of change requiring consultation, capital/revenue investment etc.
- Take tough decisions when the resources invested do not make the biggest difference to our patients/residents

Our initial new commissioning model balances the importance of local relationships and existing programmes of work with the need to commission at scale.
At the NCL level, the 5 CCGs are developing a single commissioning and financial strategy executed through a single operating model so there is a consistent commissioning approach. We will also enhance commissioning arrangements where we do this across NCL, for example through a proposal for delegated commissioning for primary care. Appropriate governance arrangements will be put in place during 2016/17. At sub NCL level, CCGs will remain as statutory entities in their current configuration.

With our focus on population health systems and outcomes and the transition to new models to deliver these, we will need to consider how we further strengthen strategic commissioning over the next 2 years. In particular we will work with partners to consider how we commission with local authorities for integrated health and social care, as well as commissioning across pathways with NHS England functions. The responsibility for developing strategic place-based commissioning in NCL rests with health organisations and local authorities. We expect national support to ensure rules on procurement and competition do not create barriers to place based systems, as well as support for innovations in commissioning, contracting and payment mechanisms.

7 Over the next few months, we will continue to develop the STP

Next steps
Having established the priority areas to focus on through the case for change and identified immediate actions, we now need to make sure these come together as an overriding strategic plan that will govern the future development of services in NCL, and ensure this is reflected in operating plans and commissioning intentions. We in the process of considering the system as a whole in developing a full STP, rather than piecing together bottom up local plans that may not deliver transformation at scale when put together. However, we understand the urgency and need to move at pace. Between now and September we will have fully scoped and developed a formalised our approach to managing the multiple and complex interdependencies that exist between our transformation workstreams.

	Jul 16 – Oct 16 – *develop STP*	Oct 16 – Jan 17 – *implementation planning*	Feb 17 onwards - *comprehensive implement'n*
Trans-formation Board	• Set the scale of ambition for the STP, including outcomes for population health • Sign off and take ownership of pan-NCL STP • Establish what is best delivered at organisational / borough level as opposed to NCL wide	• Assure ambition is reflected in detailed plans • Sign off implementation plans and obtain endorsement from constituent bodies, ensuring ownership of detailed plan for each workstream	• Ensure plans on track and agree necessary mitigations • Lead engagement with staff, public and politicians
Trans-formation Group	• Develop and take ownership of pan-NCL plan, ensuring no gaps in scope • Ensure plan is aligned and interdependencies mapped	• Oversee management of interdependencies and continue to align existing work / operating plans / commissioning intentions around this	• Oversee STP implementation and ensure alignment with operating plans across NCL • Review plans and add to workstreams / scope if required as any gaps emerge
Clinical cabinet	• Assess workstream plans, ensuring they meet challenges set out in the case for change • Lead broader engagement with clinicians and practitioners across NCL to ensure ownership of case for change and active participation in STP development	• Undertake detailed work with each of the workstreams to achieve clarity on scope and clarify implications from a clinical perspective • Identify and support management of interdependencies	• Review case for change to identify any gaps and progress against the key areas • Support implementation of all workstreams with clinical input
Finance and activity model-ling group (FAMG)	• Develop a whole system finance and activity model, linking into workforce modelling requirements • Articulate quantifiable scale of ambition • Develop investment requirements to implement plans • Ongoing review of in-year delivery across the system to track against projected Status Quo	• Develop whole system productivity plans in detail, ensure 17/18 CIP plans aligned • Set out detailed proposal for transformation funding • Develop granular understanding of where and how benefits accrue, including phasing • Review potential to bring every organisation to financial balance and explore what a NCL system control total might mean	• Support inputs required for business case development where required, and track early impacts of workstreams / initiatives • Support implementation as required • Ensure transformation fund is allocated as required across workstreams
Work-streams	• Further develop plans for each workstream • Map out interdependencies • Provide input to FAMG for impact modelling and investment requirements	• Develop detailed delivery plans for each workstream with benefit phasing • Ensure interdependencies aligned	• Implementation and roll out of plans • Monitoring and evaluation to track impact and iterate plans to ensure continuous improvement

8 We will ensure all our stakeholders and wider programme partners are appropriately involved in the development of the programme

Engagement to date

- Workstreams have been engaging with relevant stakeholders to develop their plans.
- The general practice transformation workstream has worked collaboratively with the London CCGs (and local groups of GPs) to develop pan-London five year plan
- Mental health workstream was initiated at stakeholder workshop in January 2016 and a further workshop in May. Further service user and carer engagement is done via programme updates and specification for a citizens panel is being developed
- Significant engagement was undertaken through reprocurement of 111 process in urgent and emergency care workstream
- The estates workstream has been developed through a working group, with representatives from all organisations in scope
- NCL Digital Roadmap Group meets to define, shape and contribute to the interoperability programme with representation from all key organisations
- Early engagement with Health & Wellbeing Boards and the Joint Overview & Scrutiny Committee

Communications & engagement objectives

- To develop and support the engagement and involvement of STP partners across all organisations at all levels
- To ensure a strong organisational consensus on STP content and the future development of the strategic plan and its implementation. In particular, political involvement and support
- To co-ordinate and support STP partners in their own stakeholder engagement to raise awareness and understanding of:
  - the challenges and opportunities for health and care in NCL
  - how the STP – specifically the emerging priorities and initiatives - seeks to address the challenges and opportunities in order to develop the best possible health and care for our population
  - what the NCL strategic plan will mean in practice and how they can influence its further development and implementation
- To encourage and gather feedback from stakeholders – NHS, local government, local and national politicians, patients and the wider community – that can:
  - influence our emerging plans and next steps
  - help build support for the STP approach
- To ensure equalities duties are fulfilled, including undertaking equalities impact assessments

Delivering the objectives

- Forward planning in place to join up all partners and stakeholders in NCL footprint
- Dedicated communications lead now in place and taking with forward
- Stakeholder mapping underway for external and internal bodies through partnership work with CCG communications and engagement leads to include partners such as local authorities, NHS providers, GP practices and others to be determined as work progresses
- In addition to partners and stakeholders already consulted, we will identify opportunities for more STP partners clinicians/staff to have input into specific work streams, particularly local political engagement which will be key for community leadership of change
- Formal engagement with boards and partners already established and on-going
- Effective communications channels will be established for all stakeholders and partners for transparent contributions to ongoing plans and discussions, including staff, clinicians, patients, politicians etc.
- A core narrative has been created to cover our health and care challenges and opportunities, STP purpose, development, goals, strategic approach and priorities – in person-centred, accessible language
- Review requirements for consultation before March 2017

9 Conclusion and next steps

We know there is more work to do to crystallise our current workstreams plans and complete the wider strategic plan for NCL to ensure that we meet our challenge. Between now and our STP submission in October, we will build on the trust and excellent working relationships we have developed between partner organisations in order to fully define the scope of our plans and set out the tangible impact we expect to have, over specified periods of time. In parallel, we will be further exploring the opportunities that we have not yet quantified in order to show how we plan to close our financial gap. Specific additional opportunities potentially include reducing bed days through reduced length of stay, reducing variation in elective pathways and opportunities around estates. Assessing these will enable us to set out our ask for a fair share of the Strategic Transformation Fund to be used non-recurrently to support sustainability and transformation in our services.

Our case for change describes where we are now and where differences in the services available to local people can be seen, and is the first step in understanding what is not working so well. This will be used to guide the transformation of local services over the next 5 years. We have built a significant programme to respond to this that covers health and wellbeing; care and quality; productivity (at organisational and system level); and the enablers required to deliver transformation. There is strong leadership in place through senior workstream SROs and the overarching governance framework for the programme that includes clinical leadership, input and ownership from all partner organisations' finance directors, and a triumvirate of SROs representing health commissioners, providers and local authorities to ensure our work is truly led from a whole system perspective. We can build on the high quality work that is going on locally and intend to share best practice in general practice and primary care across all 5 boroughs, promoting learning and continuous improvement (for example, from Camden's prescribing behavioural change methodology).

Our immediate next step will be to work up the strategic plan through a process of co-creation, and to develop a credible proposition for population health and new care models in NCL with tangible options that all partners can buy into, building on the plans already underway for a new commissioning model in NCL. In parallel we will ensure we are addressing urgent issues faced – for example, the sustainability of some of our general practice provision across the patch, and improvement in the provision of mental health services for those with mental health problems – through a whole system, rather than a siloed, response. We will articulate this in terms of concrete, 18-month delivery plans for all of workstreams, particularly in terms of provider sustainability, primary care and mental health services. When we have a better idea of what population health will mean in terms of model(s) of care and delivery vehicles, we will be able to undertake detailed analysis of the impact on activity and patient flows and will articulate this in our next submission.

Difficult decisions lie ahead. These include working through arrangements that will mean that organisationally, the NCL health and care system will look very different following transformation. We are serious about doing something radically different and considering the transformation required across the whole system in NCL, not just individual boroughs or organisations. We are doing this because it is the right thing to do, and the only way forwards to empower people to live healthy and happy lives in NCL in a way that is financially and clinically sustainable. We recognise that we will need to work with all local partners, patients, people who use services, carers and professionals to best understand how to make all of this real over the coming months, and will begin the roll-out and implementation of our programme communications and engagement strategy to enable this.

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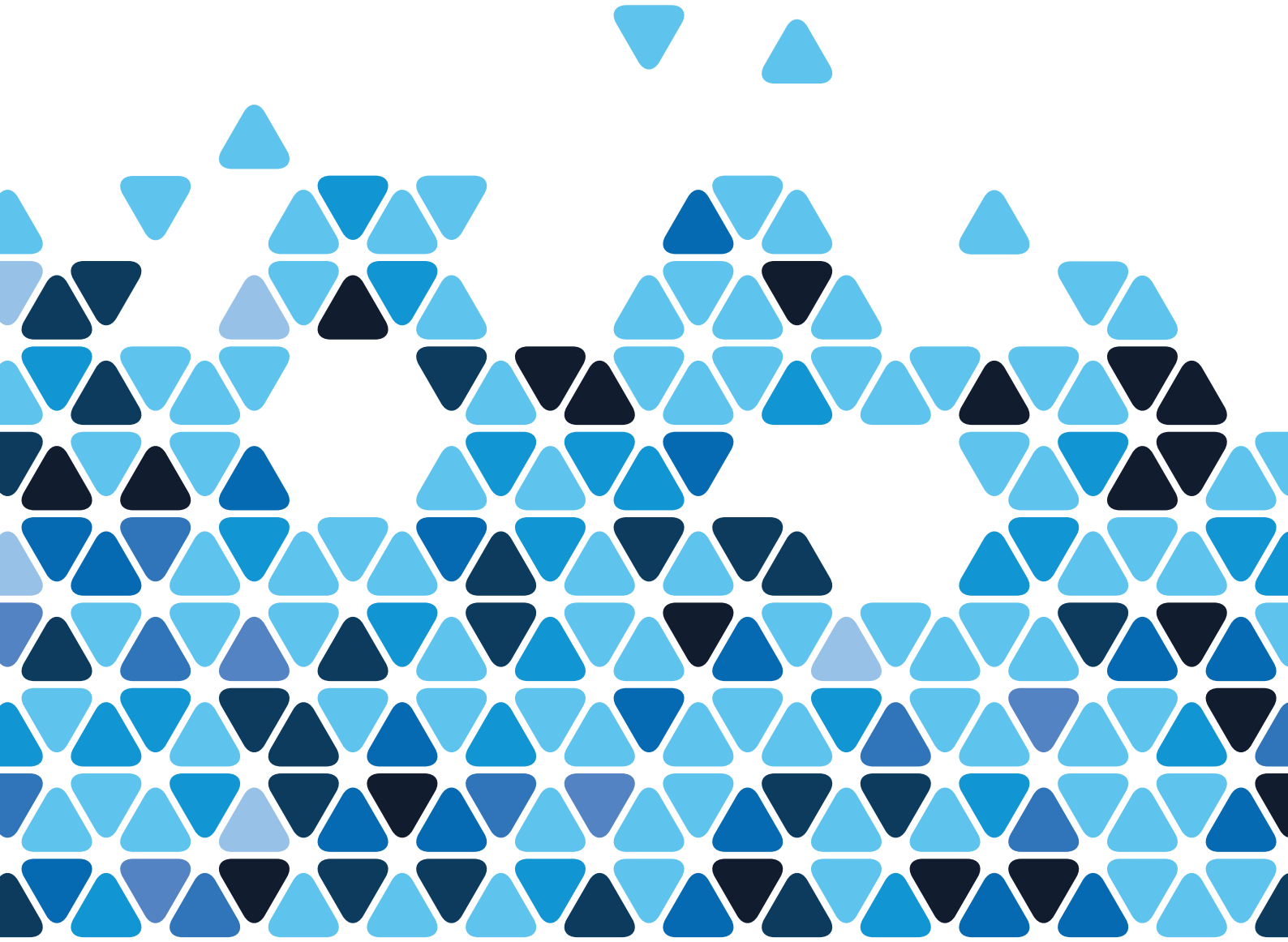
North Central London Sustainability and Transformation Plan

North Central London

Sustainability and Transformation Plan – Case for Change

September 2016



North Central London Sustainability and Transformation Plan

Contents

Foreword

On behalf of all our health and social care partners in North Central London, we present our Case for Change, which tells the story of where we are now. It is important that we recognise our current situation, because we take pride in the services we provide, and it will help us understand where services need to be improved.

We know that there are differences across North Central London; waiting times for services and health outcomes vary, and the quality of care and patient experience of health and social services is sometimes not as good as it could be. This Case for Change is the first step in understanding what is not working so well, and where improvements can be made.

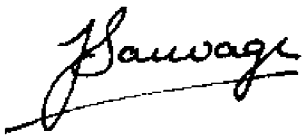
Local doctors, nurses and care workers are committed to working together to ensure we continue to improve. Never before has there been this opportunity to work so closely together to address the most important issues; to plan and deliver health and care for local people, with a strong focus on keeping people well.

In this document we describe the changing health and care needs of local people, and the key issues facing health and care services in North Central London. This document does not contain solutions but will be used to guide our understanding of where we need to transform local services over the next five years. We will work together to address the issues raised and to make sure we are able to provide high value and quality services to all.

We have come together as the North Central London STP Clinical Cabinet – a group of senior doctors, nurses and care professionals to work together to improve care and quality and make local services better. We believe that every person in North Central London should receive the same high quality standard of care. We recognise that we will need to work with all local partners, patients, carers and professionals to achieve this.

Signed by

Dr Richard Jennings, Co-Chair North Central London STP Clinical Cabinet (and Medical Director, Whittington Hospital NHS Trust)



Dr Jo Sauvage, Co-Chair North Central London STP Clinical Cabinet (and Chair, Islington CCG)

North Central London Sustainability and Transformation Plan

On behalf of the North Central London Clinical Board:

Dr Debbie Frost, Chair, Barnet CCG
Dr Caz Sayer, Chair, Camden CCG
Dr Mo Abedi, Chair, Enfield CCG
Dr Peter Christian, Chair, Haringey CCG
Dr Jonathan Bindman, Medical Director, BEH Mental Health NHS Trust
Dr Vincent Kirchner, Medical Director, Camden and Islington NHS Foundation Trust
Dr Joanne Medhurst, Medical Director, CLCH NHS Trust
Dr Alex Lewis, Medical Director, CNWL NHS Foundation Trust
Dr Cathy Cale, Medical Director, NMUH NHS Trust
Dr Stephen Powis, Medical Director, Royal Free NHS Foundation Trust
Dr Geoff Bellinghan, Medical Director, UCLH NHS Foundation Trust
Dr Matthew Shaw, Medical Director, Royal National Orthopaedic Hospital NHS Trust
Flo Panel Coates, Chief Nurse, UCLH NHS Foundation Trust
Helen Donovan, Executive Nurse Lead, Barnet CCG
Clare Johnston, Director of Nursing and People, Camden and Islington NHS Foundation Trust
Dr Julie Billett, Director of Public Health, Camden and Islington Council
Ray James, Director of Adult Social Services, Enfield Council
Jon Abbey, Director of Adult and Children's Services, Haringey Council

1 Executive summary

This Case for Change document describes the changing health and care needs of local people and the key issues facing health and care services in North Central London (NCL). It will be used to guide the transformation of local services to improve care and quality over the next five years.

NCL comprises five CCGs – Barnet, Camden, Enfield, Haringey and Islington – each covering the same area as the local London Borough. There are around 1.44m residents in NCL and the area spends £2.5bn on health care and £800m on social care. There are five acute hospitals, three specialist hospitals, three providers of community services and three providers of mental health services, as well as 237 GP practices.

The needs of local people drive local requirements for health and social care:

1. **People are living longer but in poor health:** the number of older people is growing quickly and older people have higher levels of health and care service use compared to other age groups. Older people in NCL are living the last 20 years of their life in poor health, which is worse than the England average. There are also large numbers of care homes in the north of NCL.

2. **There are different ethnic groups with differing health needs:** there are large Black and Minority Ethnic (BME) groups in NCL. These groups have differing health needs and health risks. In addition, a quarter of local people do not have English as their main language.

3. **There is widespread deprivation and inequalities:** poverty and deprivation are key drivers of poor health and wellbeing outcomes. Many local children grow up in poverty and many adults are claiming sickness or disability benefit. There are stark inequalities in life expectancy in NCL; for example, men living in the most deprived areas of Camden live on average 10 years fewer than those in the least deprived areas.

4. **There is significant movement into and out of NCL:** almost 8% of local people move into or out of NCL each year, which has a significant impact on access to health services and health service delivery, such a registering with a GP and delivering immunisation and screening programmes. Large numbers of people also come into NCL daily to work.

5. **There are high levels of homelessness and households in temporary housing:** Four of the five boroughs are in the top 10% of areas in England for number of homeless households with a priority need, and all five are in the top 10% for number of households in temporary accommodation. Poor housing is one of the main causes of poor health and wellbeing (especially for children), and buying or renting housing locally is very expensive.

6. **Lifestyle choices put local people at risk of poor health and early death:** almost half of people in NCL have at least one lifestyle-related clinical problem (e.g. high blood pressure) that is putting their health at risk, but have not yet developed a long term health condition. The biggest killers in NCL are circulatory diseases and cancer; these diseases are also the biggest contributors to the differences in life expectancy across NCL.

7. **There are poor indicators of health for children:** the number of children living in

poverty is high, particularly in Camden and Islington. Childhood obesity is high, whilst immunisation levels are low.

8. **There are high rates of mental illness amongst both adults and children:** rates of mental illness are high in Enfield, Haringey and Islington, and many mental health conditions go undiagnosed. For example, up to a third of people with dementia in Camden and Enfield are thought to be undiagnosed. People with mental health conditions are also more likely to have poor physical health.

9. **There are differing levels of health and social care needs:** the majority of people are largely healthy, but there is high use of health and social care by those with long term conditions, severe mental illness, learning disabilities and severe physical disabilities, dementia and cancer.

This suggests that the priority groups for focus are people with mental illness and people at risk of poor mental or physical health. It is also important to make sure high quality services are available when required for the majority of local people who are not high users of services. Consideration needs to be given to reducing health inequalities, the requirements of different ethnic groups and the significant movement of people into and out of NCL.

There are challenges in the delivery of care and quality:

1. **There is not enough focus on prevention across the whole NCL system (including health, social care and the wider public sector):** many people in NCL are healthy and well, but still at risk of developing long term health conditions. There is therefore an important opportunity for prevention of disease among these people. However, only 3% of health and social care funding is spent on public health in NCL. Between 2012 and 2014, around 20% (4,628) of deaths in NCL could have been prevented. In addition, the wider determinants of health such as poverty, housing and employment have a significant impact on individuals' health and well-being. There are opportunities for greater integration across the NCL health and care system to enable a focus on prevention and early intervention.

2. **Disease and illness could be detected and managed much earlier:** there are people in NCL who are unwell but do not know it. For example, there are thought to be around 20,000 people who do not know they have diabetes, while 13% of local people are thought to be living with hypertension. There are opportunities for better, more systematic management and control of long term health conditions in primary care, in line with evidence-based care standards.

3. **There are challenges in primary care provision in some areas:** there are low numbers of GPs per person in Barnet, Enfield and Haringey, and low numbers of registered practice nurses per person in all CCGs, but particularly in Camden and Haringey. Satisfaction levels and confidence in primary care is mixed across NCL. As referenced above, there are high levels of undiagnosed long term conditions in NCL. There are also high levels of A&E attendances across NCL compared to national and peer averages, and very high levels of first outpatient attendances, suggesting that there may be gaps in primary care provision.

4. **Lack of integrated care and support for those with long term conditions:** levels of non-elective admissions are similar in NCL to other areas of London. However, there are high levels of hospitalisation for the elderly and those with chronic conditions. Many people with long term health conditions – over 40% in Barnet, Haringey and Enfield – do not feel supported to manage their condition. The lack of available social care services in some parts of NCL may contribute to high levels of hospitalisation for some groups.

5. **There are many people in hospital beds who could be cared for at home:** the majority of people who stay for a long time in hospital beds are elderly. Staying longer than necessary in hospital is often harmful to health, and not what people want. Delayed discharges are high in some hospitals in NCL and hundreds of people

could potentially be cared for closer to home or in their home. There is also a large number of people whose admission to hospital might have been avoided.

6. **Hospitals are finding it difficult to meet increasingly demanding emergency standards:** three of the five acute hospitals in NCL do not meet the 16-hour consultant presence standard at the weekend. Within A&E, there are shortages of middle grade doctors. Local hospitals are not meeting key quality standards for people admitted as emergencies.

7. **There are differences in the way planned care is delivered:** variation in the delivery of planned care may be because of the levels of patient need, or because of differences in clinical practice. The number of people seen as outpatients is high and there is variation in the number of referrals between consultants in the same hospital, the number of follow-up outpatient appointments and the proportion of planned care that is done as a day case.

8. **Challenges in mental health provision:** there is still a lot of stigma associated with having a mental illness, and many people either do not know how, or do not want, to access mental health services. Information on help and support within local communities is not available everywhere. Demand for mental health services has increased due to social pressures related to reduced funding for public services, increasing numbers of people, higher public expectations and changes to legislation. There are very high levels of mental illness in NCL, and high rates of early death, particularly in Haringey and Islington. Community based teams cannot manage people with the most serious issues and therefore high numbers of people are admitted to hospital – many under the Mental Health Act. Many people receive their first diagnosis of mental illness in Emergency Departments. There is variable access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services (CAMHS) within urgent care. There is also no high quality health-based place of safety in NCL.

9. **Challenges in the provision of cancer care:** there are many opportunities to save lives and deliver cancer services more efficiently. Late diagnosis of cancers is a particular issue, as is low levels of screening for cancer and low awareness of the symptoms of cancer in some groups of people. Waiting times to see a specialist and for diagnostics are long, with referrals to specialists having almost doubled in five years. There is a huge shortfall in diagnostic equipment and workforce, and a lack of services in the community, particularly at the weekend. A further issue is that some hospitals are seeing small numbers of patients with some types of cancer, in some cases less than two per week.

10. **Workforce challenges:** there are a number of workforce challenges in NCL. There is a significant shortfall predicted in GPs, nurses, allied healthcare professionals with an aging workforce and increasingly attractive career opportunities outside London. Many people are leaving the NHS entirely. There is a high vacancy and turnover rate locally in health and social care. The number of GPs and practice nurses per person in parts of NCL is low, especially Haringey.

11. **Some buildings are not fit for purpose:** many of the local buildings are old and not fit for purpose, although there have recently been a number of major developments locally. Good quality buildings that are fit for purpose reduce infection and the length of time people stay in hospital, make it easier for staff to do their jobs and are a more pleasant environment for people in hospital and reduce costs. It is estimated that 15% of NHS building space is not being used, incurring £20-25m a year in running costs. A large number of primary care buildings are also not fit for purpose – around 33% of GP premises in London need replacing.

12. **Information technology needs to better support integrated care:** the level of digital maturity of providers across NCL is variable, with most below the national average for digital capabilities, particularly their capability to share information with others. There is no NCL-wide governance structure or leadership team to implement

digital transformation, and individual organisations continue to operate independently within their own areas with resultant fragmentation, lack of joined up information flows and duplication of effort.

13. **Financial challenge:** there is a substantial financial challenge facing health organisations in NCL. Health commissioners and providers in NCL are already £121m in deficit in 2015/16 and, if nothing changes, will be £876m in deficit by 2020/21. This does not include the health budget impact of the local authority financial challenge, which has not been calculated.

In summary, this suggests the following areas for focus:

1. Health promotion, particularly focusing on those who are healthy and well but are at risk of developing long term health conditions.
2. Early detection and management of disease and illness, especially through more systematic management and control of long term health conditions in primary care.
3. The quality of primary care provision and the primary care workforce. It also suggests a focus on reducing variation between practices. This may reduce Emergency Department attendances, short stay admissions and first outpatient attendances.
4. Better integration of care for those with long-term conditions, and ensuring that suitable and sufficient social care is available. There also needs to be a focus on people in residential and nursing homes.
5. Reducing the length of stay and avoidable admissions in acute hospitals, in partnership with social care.
6. The delivery of emergency services in hospitals in NCL.
7. Understanding the differences between hospitals in the delivery of planned care in greater detail.
8. The provision of mental health services, particularly the physical health of those with a mental illness, early diagnosis and access to integrated services.
9. Recruiting and retaining the workforce, particularly where there are high vacancy and turnover rates or shortages in staff, and a focus on new roles and developing the existing workforce through new skills and ways of working, as well as adapting roles to changing requirements.
10. The cancer pathway across primary and acute providers.
11. Buildings that are old, expensive to run and not fit for purpose, and developing buildings that support patient and clinical needs.
12. Developing system-wide governance and leadership to support the implementation of integrated information sharing and technology.
13. Addressing the projected financial deficit.

2 Context

North Central London (NCL) comprises five CCGs – Barnet, Camden, Enfield, Haringey and Islington – each coterminous with the local London Borough.

The number of people living in NCL is approximately 1.44 million, and the area has a £2.5 billion health budget and £800 million social care budget. There are four acute trusts: The Royal Free London NHS Foundation Trust (sites in scope including Barnet Hospital, Chase Farm hospital and the Royal Free Hospital in Hampstead), University College London Hospitals NHS Foundation Trust (sites in scope including University College Hospital[1]), North Middlesex University Hospital NHS Trust, and the Whittington Health NHS Trust. In addition, there are three single specialist hospitals: Moorfields Eye Hospital NHS Foundation Trust, Great Ormond Street Hospital for Children NHS Foundation Trust and the Royal National Orthopaedic Hospital NHS Trust.

Community services are provided by Central and North West London NHS Foundation Trust (St Pancras hospital site), the Whittington Health NHS Trust, and Central London Community Healthcare NHS Trust (sites in scope including Edgeware community hospital and Finchley memorial hospital). Mental health services are provided by the Tavistock and Portman NHS Foundation Trust (sites in scope include the Tavistock clinic, the Portman clinic and Gloucester House day unit), Camden and Islington NHS Foundation Trust (sites in scope including Highgate Mental Health Centre and St Pancras Hospital), and Barnet, Enfield and Haringey Mental Health Trust (sites in scope including St Ann's Hospital, Edgeware Community Hospital, Chase Farm Hospital, Barnet Hospital and St Michael's Hospital).

In addition, there are 237 GP practices, and the out-of-hours services contract was recently awarded to the London Central and West Unscheduled Care Collaborative.

Some information about the local health and social care landscape is shown in Exhibit 1 overleaf.

[1] *UCLH also have a number of specialist hospitals including the Royal London Hospital for Integrated Medicine, the National Hospital for Neurology and Neurosurgery, the Royal National Throat, Nose and Ear Hospital, and the Eastman Dental Hospital*

Exhibit 1 – NCL overview

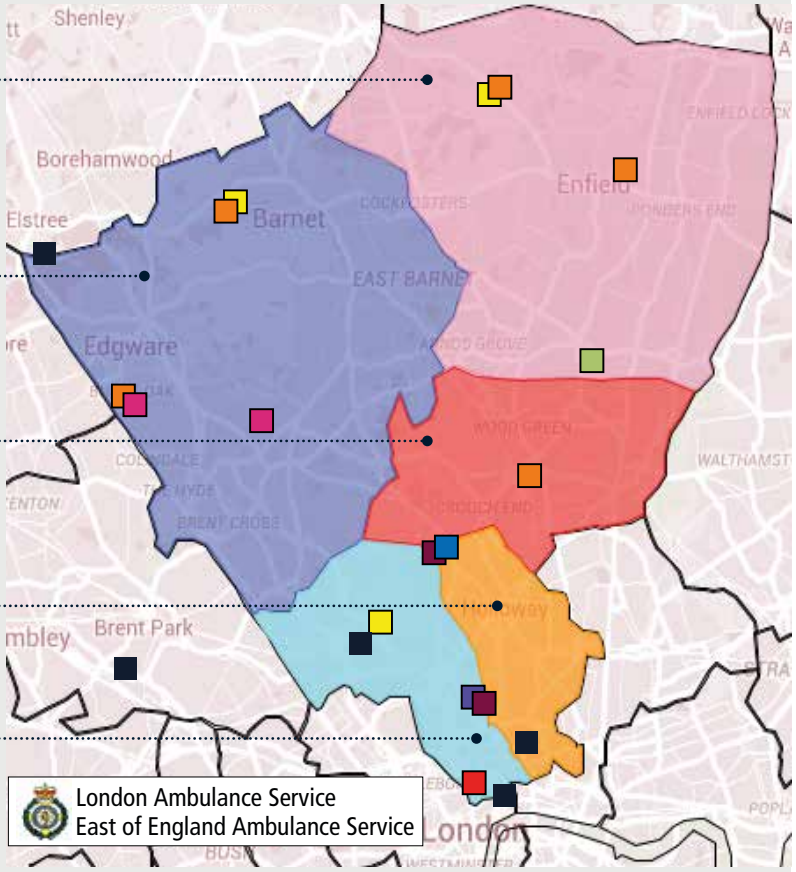
Enfield CCG / Enfield Council
~320k GP registered pop
~324k resident pop
49 GP practices

Barnet CCG / Barnet Council
~396k GP registered pop
~375k resident pop
62 GP practices

Haringey CCG / Haringey Council
~296k GP registered pop
~267k resident pop
45 GP practices

Islington CCG / Islington Council
~233k GP registered pop
~221k resident pop
34 GP practices

Camden CCG / Camden Council
~260k GP registered pop
~235k resident pop
35 GP practices



Total health spend £2.5bn

Total care spend £800m

NHS England

Primary care spend £~180m

Spec. comm. spend £~730m

- BEH Mental Health NHS Trust (main sites, incl Enfield community)
- Camden and Islington NHS FT (and main sites)
- North Middlesex University Hospital NHS Trust
- The Royal Free London NHS FT
- University College London Hospitals NHS FT
- Whittington Health NHS Trust (incl Islington and Haringey Community)
- Central and North West London NHS FT (Camden Community)
- Central London Community Healthcare NHS Trust (Barnet Community)
- Specialist providers

Other specialist providers out of scope:
GOSH; MEH; TPFT; RNOH

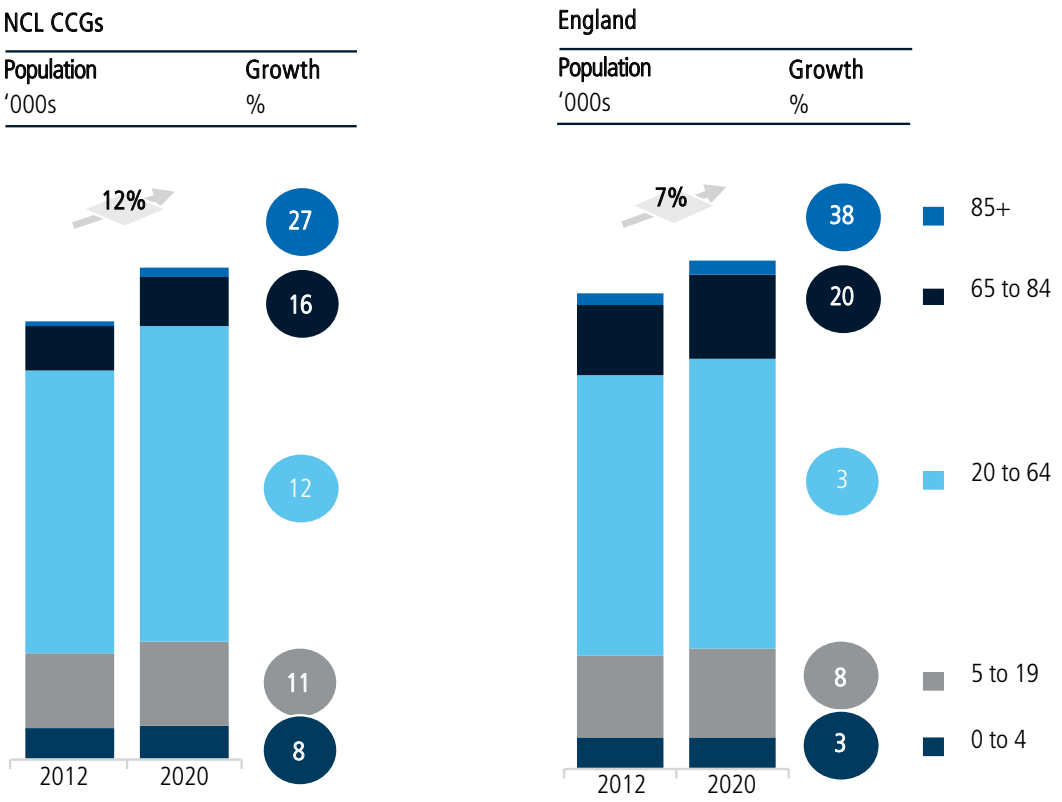
Note: registered pop data shows 2014 figures. Source: ONS

3 Health and wellbeing

3.1. People in NCL are living longer but in poor health

As shown in Exhibit 2, older people (aged 65+) are the fastest growing group of people in NCL, although in total numbers[1] this age group will remain the second smallest in 2020, after children aged 0-4 years old. Older people have much higher levels of health and care service use compared to other age groups, particularly hospital admissions and use of community services; the rates of most long-term health conditions also significantly rise with age[2].

Exhibit 2 – Growth in numbers of people in NCL and England



Source: Population Projections Unit, Office for National Statistics, 2012. The data shows similar growth rates for 2016-2021

Whilst overall life expectancy is increasing for all NCL residents, people in NCL on average live the last 20 years of their lives in poor health; for Islington this is much worse than the rest of England[3].

There are also large numbers of care home beds in the north of NCL; for example, Barnet and Enfield have 13% of London's care home beds but have only 8% of its people[4]. This presents a substantial challenge to the health and care system, and an opportunity for improvements in quality and sustainability, which could lead to reductions in the cost of admissions to hospitals from care homes and improvements in the quality of life of residents.

3.2. There are different ethnic groups with differing health needs[5]

Levels of ethnic diversity vary across NCL, ranging from 32% of people in Islington from a Black and Minority Ethnic (BME) group to 42% in Enfield. The largest BME communities in NCL are Turkish, Irish, Polish and Asian (Indian and Bangladeshi) people. There are also high numbers of people from Black Caribbean and African communities, in particular in Haringey and Enfield. The number of people from BME communities is much greater in younger age groups.

Health needs vary across BME communities. For example, there is a greater risk of diabetes, stroke or renal disease for some BME people compared to White English people; and people from some BME communities, including Black Caribbean, African and Irish, use more hospital services[6]. The number of BME people across NCL is expected to increase slightly from 37% in 2012 to 38% in 2020[7]. The biggest increases in BME communities are forecast in Barnet and Enfield. The fastest growing ethnic communities across NCL are the Chinese and Other group followed by Black Other and Asian ethnic groups.

The different health needs for different ethnic groups

"They know how to eat well but their husband complain if they don't serve traditional food all the time" (Bangladeshi young women) [sic]

Source: Healthwatch Camden

Overall, around a quarter of people in NCL do not have English as their main language. This diversity presents challenges, both in addressing potentially new and complex health needs, and delivering accessible healthcare services.

What good looks like: Care planning for type 2 diabetes patients in Tower Hamlets

Tower Hamlets has a high prevalence of type 2 diabetes. This is partially due to the large Bangladeshi resident population, who are more susceptible to developing this condition. Since 2010, GPs have been providing patient centred care plans to patients which allow individuals to manage their own conditions and prevent the onset of other conditions. By 2014, diabetes patients on a care plan in Tower Hamlets had achieved the highest levels of blood pressure and cholesterol control in the country and had better control of their own condition.

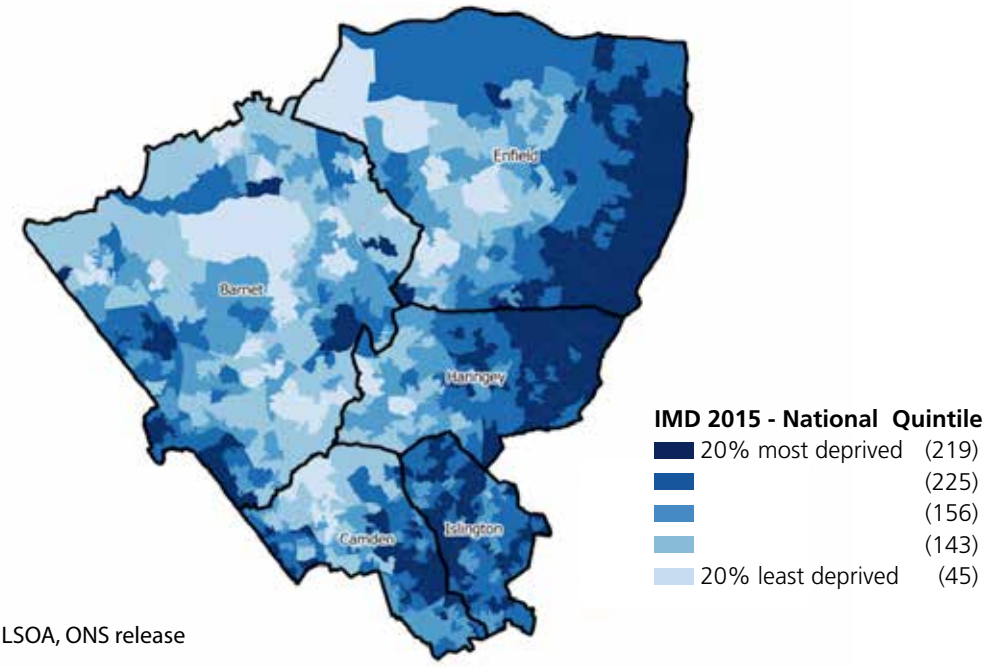
Learning from local best practice examples is part of the NCL STP process. We have the opportunity to roll out successful care programmes such as care planning for diabetes patients across all the boroughs, to ensure every individual can access the high quality care they need.

Source: Tower Hamlets JSNA, 2015

3.3. There is widespread deprivation and inequalities

There is a wide spread of deprivation across NCL, but people tend to be younger and more deprived in the east and south, and older and more affluent in the west and north. Deprivation across NCL is shown in Exhibit 3.

Exhibit 3 – Deprivation levels across NCL



Source: IMD 2015 by LSOA, ONS release

Poverty and deprivation are key causes of poor health outcomes. Higher levels of deprivation are linked to many health problems, such as prevalence of long term health conditions. 30% of NCL children grow up in child poverty[8], with 6% living in households where no-one works[9]. More than 40,000 working age adults in NCL are claiming sickness or disability related out-of-work benefits[10], and the gap in the employment rate for those in contact with more specialised mental health services and the overall employment rate is 63%[11]. There are stark inequalities in life expectancy; for example, men in the most deprived areas of Camden live on average 10 years fewer than those in the least deprived areas[12].

What good looks like: addressing the social determinants of health

The Mental Health Working service supports people with a long term mental health problem to make the journey back into work through training, education, employment or volunteering. It also supports those who are already in work, to help them remain in employment. Experienced advisors work with each individual to develop a personalised support plan identifying barriers to work, career goals and steps needed to find, remain in or return to work. The advisors then provide ongoing advice and guidance. The programme is jointly commissioned by the London Boroughs of Camden and Islington.

If replicated throughout NCL this could improve and maintain public mental health whilst increasing the levels of employment.

Source: mind.org.uk

3.4. There is significant movement into and out of NCL[13]

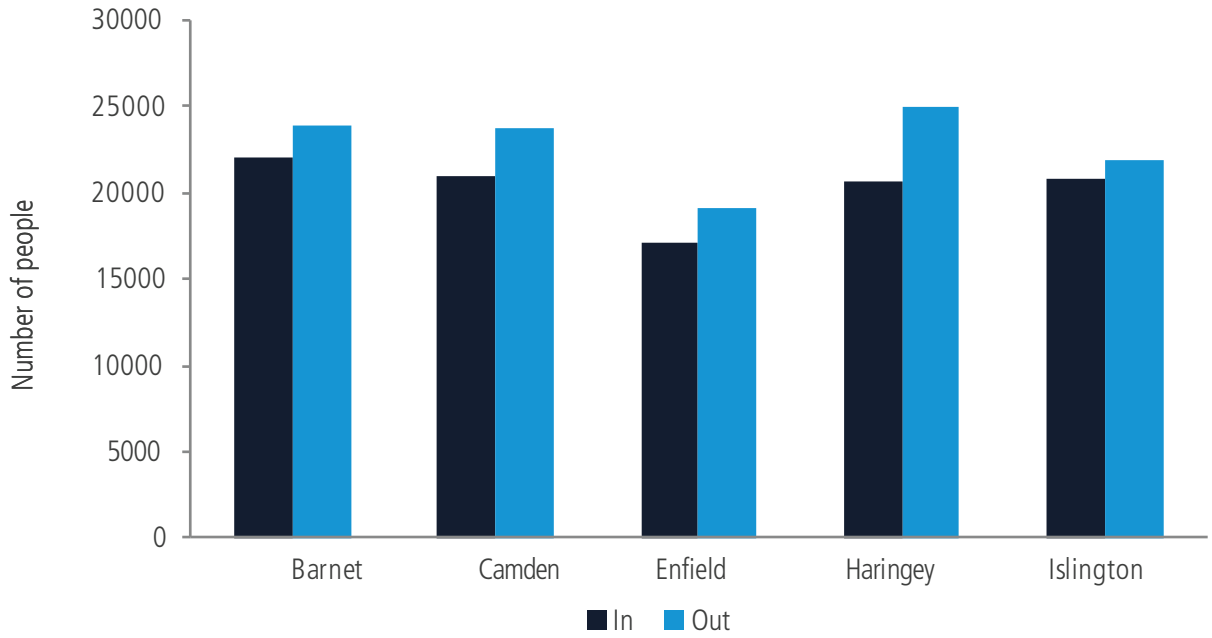
All boroughs in NCL experience significant population inflows and outflows. In 2014, on average 20,000 people moved into each of the NCL boroughs from other areas of England and Wales, whilst just under 23,000 moved out to other parts of the country. This is illustrated in Exhibit 4. Camden, Islington and Haringey experienced the highest population churn, with around 10% of people in these boroughs moving out in 2014. The pattern of people moving in and out is different across age groups. In Islington and Camden, more people aged 15 to 29 from other areas move in. For other all other age

groups, more people move out to other areas. However, in contrast, for all NCL boroughs there are more people from outside the UK moving in than leaving. This contributes to a demographic profile that has a high level of non-native inhabitants.

Large numbers of people also come into NCL every day to work. These people sometimes use health and social care services, particularly urgent care, whilst being registered with a GP outside NCL.

This high level of movement of people into and out of NCL has a significant impact on access to health services and health service delivery, such a registering with a GP and delivering immunisation and screening programmes.[14]

Exhibit 4 – Internal migration into and out of NCL



Source: ONS mid-year population estimates, 2014

3.5. There are high levels of homelessness and households in temporary housing

There is a growing demand for housing in NCL, and increasing levels of homeless households[15]. People and families who are homeless or in temporary housing require support from numerous local public services. Housing is often one of the main causes of poor health and wellbeing, especially for children, and buying or renting housing locally is very expensive.

Homelessness and temporary housing

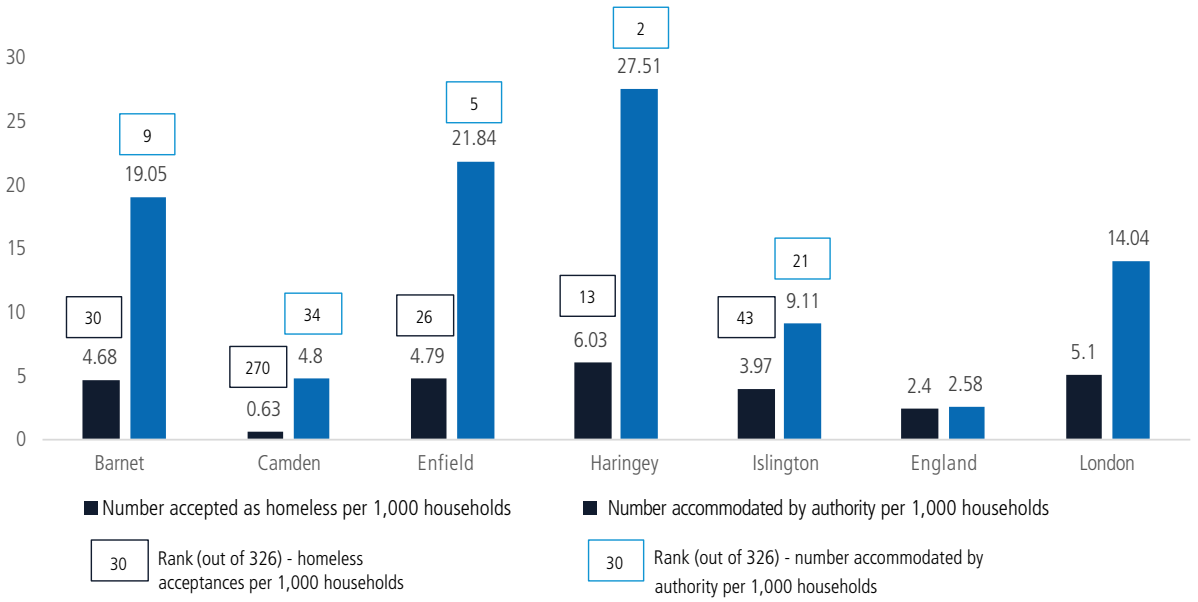
'I became homeless and had a nervous breakdown. My family is a single parent family. I got a place at University, but I became home sick and wanted to come home to London. When I came back I went to my GP who diagnosed me. Finding accommodation was really hard on a low income. I couldn't afford a deposit and I was street homeless for a while. I was diagnosed in the London Borough of Barnet and went through IAPT [Improving Access to Psychological Therapies]. I had no family or friends and no help from anyone. I felt lost. As I am under 35 I was not eligible for single accommodation and had to take shared accommodation. I then went to a homeless charity, but they did not have the expertise to understand what I needed.

Source: Healthwatch Islington

All of the NCL boroughs except Camden are in the top 10% of areas in England for homeless

households with a priority need, and all are in the top 10% for households in temporary accommodation (Barnet, Enfield and Haringey are in the top 3%)[16]. This is shown in Exhibit 5.

Exhibit 5 – Homeless acceptances and households accommodated by authority per 1,000 households [5]



Source: www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

What good looks like: integrated care for the homeless

Central London Community Healthcare (CLCH) provides services to homeless people from Great Chapel Street Medical Centre. A fully integrated model, delivered using a multidisciplinary team which includes primary care, social care and mental health practitioners delivers services including dentistry, vaccinations and mental health support. The services have been designed around the needs of the homeless population. A case management approach is taken for patients with multiple, complex needs. Outreach clinics for people who are harder to engage, phased in two parts, also operate from the medical centre: a nurse led targeted outreach clinic and a winter enhanced outreach service offers which provides health assessments and advice at Cold Weather Shelters. The outreach teams also work with acute providers to train staff in the areas of health and social care entitlements for the homeless.

This service could be scaled up as part of the NCL STP process, to ensure the homeless population are better supported by our health and care services.

Source: Great Chapel Street Medical Centre website, accessed August 2016

3.6. Lifestyle choices put local people at risk of poor health and early death

Lifestyle behaviours such as smoking, alcohol consumption, physical inactivity, poor diet and being overweight cause poor health, worsening of disease, multiple illnesses and early death . Almost half of people in NCL have at least one lifestyle-related clinical problem (e.g. high blood pressure) that is putting their health at risk, but have not yet developed a long term health condition[18].

Risk factors among different age groups

"Older women smoke but won't admit to it!"

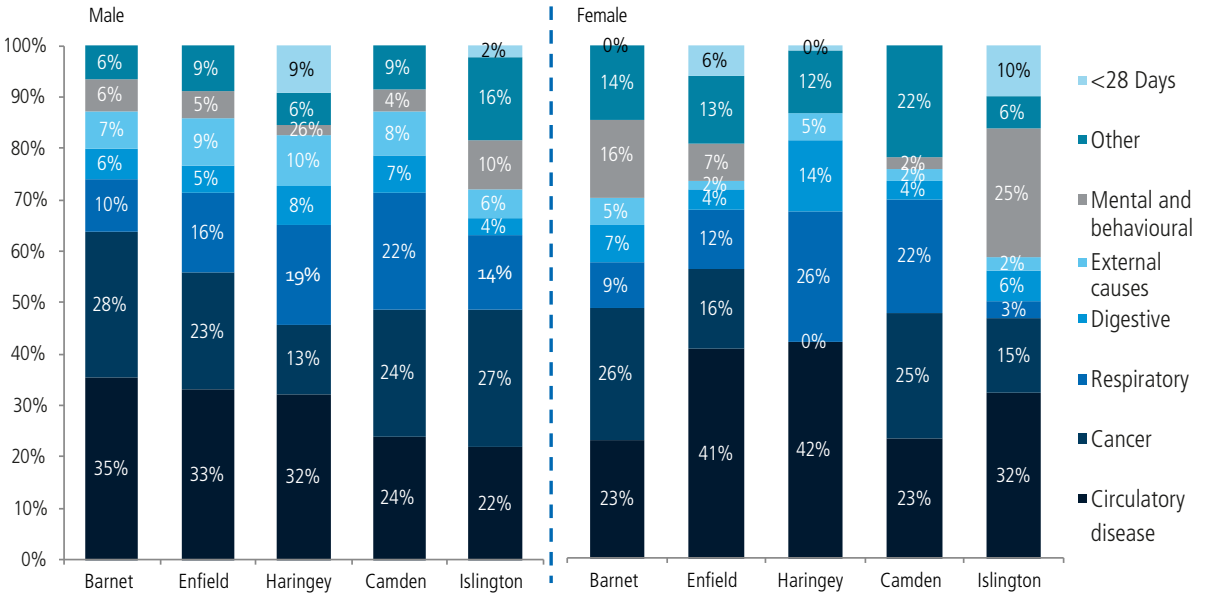
Source: Healthwatch Camden

Within NCL, the number of overweight children aged 10 to 11 years is much higher than the England average in three of the five boroughs – Enfield, Haringey and Islington[19]. It is likely that being overweight is partly responsible for more than a third of all long term health conditions in NCL[20]. Smoking cuts lives short and is partly responsible for around one in six early deaths of local people[21]. Alcohol-related hospital stays are much higher than average in Islington[22]. Among older people, Camden, Haringey and Islington have much higher numbers of people who fall resulting in serious injury[23]. Importantly, lifestyle and clinical risk factors tend to cluster in the same individuals and groups of people.

As shown in Exhibit 6, the biggest killers in NCL are circulatory diseases and cancer; these diseases are also the biggest contributors to the differences in life expectancy across NCL.

Exhibit 6 – Breakdown of male and female life expectancy gap by cause of death

Breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile within each borough, by percentage cause of death, 2012-2014



Source: LHO segment tool, May 2016

3.7. There are poor indicators of health for children

Supporting children to have the best start in life is very important to their future health and life opportunities. However, a third of children in NCL do not reach a good level of development by age 5[24], and there are numerous opportunities to improve the health and wellbeing of children during these important early years.

Exhibit 7 – Childhood prevention indicators

	Better than England average	Not significantly different than England average	Worse than England average

Indicator	Barnet CCG	Camden CCG	Enfield CCG	Haringey CCG	Islington CCG	England Average	London Average
Excess weight in 4-5 year olds (2014-15)	19.9	20.3	23.4	22.9	22.1	21.9	22.2
Excess weight in 10-11 year olds (2014-15)	32.6	34.3	41.4	37.1	38.1	33.2	37.2
Vaccination coverage MMR (2 yrs) (2014-15)	80	86	89	87	94	92	87
Vaccination coverage MMR (5 yrs) (2014-15)	74	80	86	84	90	92	81
Children in poverty (2013)[1]	15.8	27.6	25.5	24.4	32.4	18.6	21.8
Low birth weight at full term, % (2014)[1]	2.5	2.9	2.7	3.1	3.5	2.9	3.2
Breastfeeding initiation at 48hrs, % (2014-15)[1]	85.1	90.5	86.7	90.9	88.2	74.3	86.1
Infant mortality rate, per 1000 live births (2011-13)[1]	2.6	4.1	4.6	3.4	2.3	4.0	3.8

Source: PHE 2015, HSCIC 2015. 1: Public Health Outcomes Framework Data Tool, Public Health England

The number of 0-4 year olds is growing twice as fast as in the rest of England overall[25], and the number of school age children (5-19 years) is also increasing[26]. There are higher than average numbers of children living in poverty, particularly in Camden and Islington[27]. As shown in Exhibit 8, CCGs in NCL have high levels of childhood obesity, and immunisation levels are particularly low compared to other similar areas[28].

3.8. There are high rates of mental illness amongst adults and children

The number of children with a mental health disorder is above the England average in Enfield, Haringey and Islington, which have large areas of deprivation[29]. As shown in Exhibit 8, the number of people with serious mental illness (psychotic disorders) is higher than the England average in all five boroughs. Islington has the highest rate of psychotic disorders in England, and Camden the third highest. People with psychotic disorders are by far the largest group in mental health inpatient services, including 24-hour long term rehabilitation units. Islington has the highest number of people with diagnosed depression in London[30].

Exhibit 8 – Mental wellbeing indicators

	Better than the England average	Not significantly different to the England average	Worse than the England average

	Indicator	Time period	Barnet	Camden	Enfield	Haringey	Islington	England average	London average
Children and young people	Prevalence of any mental health disorders in children (5-16 yrs)	2014	8.4%	9.1%	9.9%	9.9%	10.1%	9.3%	9.3%
	Prevalence of emotional disorders in children (5-16 yrs)	2014	3.3%	3.6%	3.9%	3.9%	4.0%	3.6%	3.6%
	Children rate per 10,000 identified as 'in need' due to abuse, neglect or family dysfunction	2015	60%	57%	59%	50%	62%	67%	60%
Adults	Serious mental illness prevalence, all ages[1]	2014/15	1.0%	1.4%	1.0%	1.3%	1.5%	0.9%	1.1%
	Depression prevalence, 18 and over[1]	2014/15	5.5%	6.3%	4.8%	5.1%	7.5%	7.3%	5.3%
	Gap (% point) in the employment rate for people with mental health	2014/15	63%	62%	65%	65%	65%	66%	66%
	Excess premature (18-74 yrs) mortality rate from serious mental illness (DSRs per 100,000)	2013/14	286	263	265	360	342	352	322

Source: Public Health of England (2016); [1] QOF data (2014/15); [2] Primary Care Web tool (accessed 11th April 2016).

People with mental health conditions are more likely to have a lifestyle that may lead to poor physical health. For example, almost half of adults with severe mental illness are smokers, compared to less than a quarter of people without a severe mental illness[31]. It is well established that people with a mental illness often also have poor physical health. There is also a high rate of psychoactive substance use in people with mental illnesses.

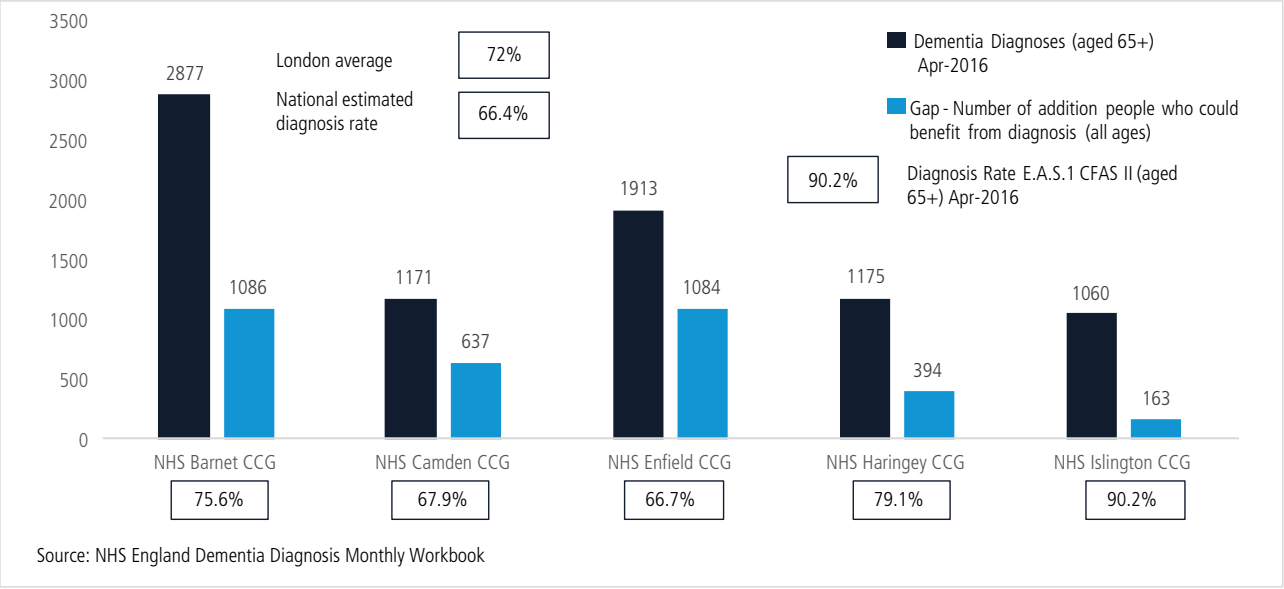
The number of people with undiagnosed dementia is higher than the London average in two of the five boroughs. As shown in Exhibit 9, nearly a third of people with dementia across NCL are thought to be undiagnosed, with a particularly high proportion in Camden and Enfield[32]. Even where diagnosis rates are higher, as in Barnet, Haringey and Islington CCGs, there are thought to be many more people remaining undiagnosed[33]. This indicates that there is a need to increase detection of dementia in primary care, focusing on practices with relatively low diagnosis rates and those with a significant challenge due to a large list size. Diagnosed mental health conditions, particularly dementia, are likely to increase, due to an ageing population and increased identification of dementia sufferers.

Dementia care

Jenny, 93, has dementia and a mental health condition. Her daughter telephoned to say she is finding it very difficult as her carers service was stopped three weeks ago. Haringey Council have asked her mother to go in to see them, but her mother doesn't comprehend what is going on and the daughter doesn't have a wheelchair. There is also a need for respite.

Source: Healthwatch Haringey

Exhibit 9 – Dementia indicators, April 2016



Source: NHS England Dementia Diagnosis Monthly Workbook

3.9. There are differing levels of health and social care needs

One way of understanding the needs of local people is to break down the population into different groups. This can be done by grouping people of a similar age and with similar health needs. The analysis can then be used to identify how work across health and social care can achieve a greater impact, and estimate the potential benefits that can be achieved through interventions targeting particular groups.

Exhibit 10 shows that there are around 1.1m people (78% of the population) in NCL who are mostly healthy and use an estimated 37% of health and social care. However, there are around 247,000

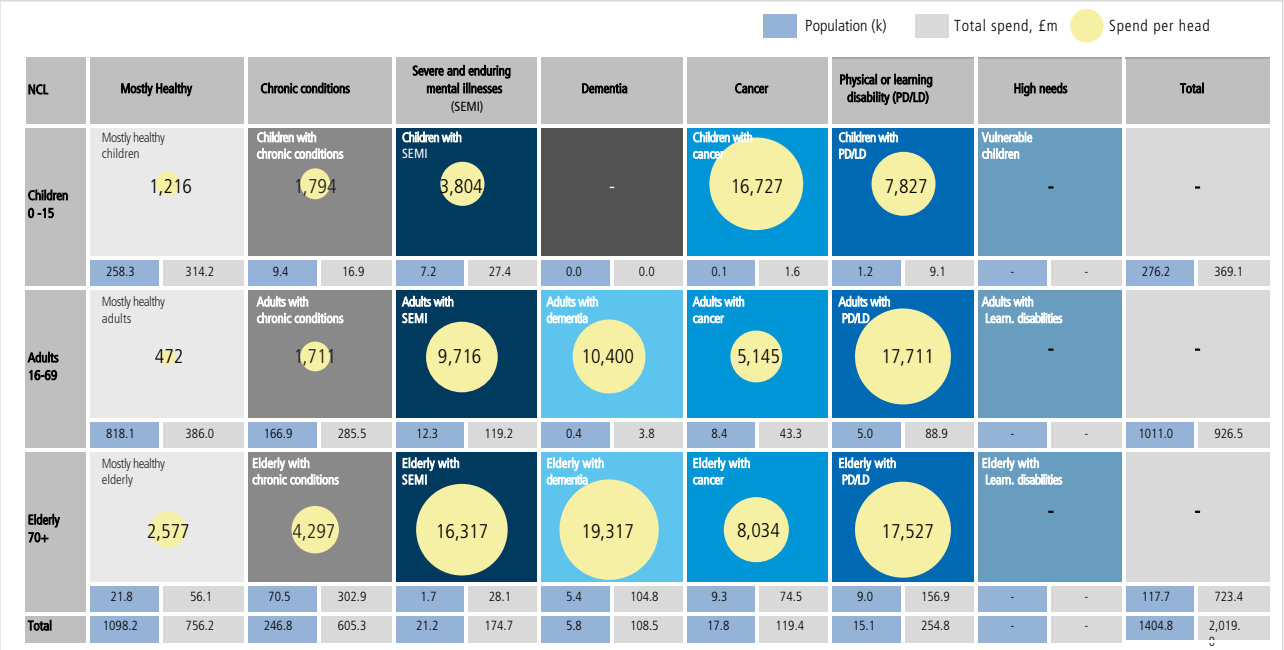
(17%) people with one or more long-term conditions, who use an estimated £764m (35%) of health and social care; the estimated 71,000 older people with long term conditions are particularly high users of health and social care (c. £4,300 per person per annum).

There are an estimated 21,000 people in NCL with severe mental illness who are individually very high cost (for example, c. £16k per person per year for those over 70) as are those with learning disabilities and severe physical difficulties; an estimated £246m is spent on fewer than 14,000 adults with a physical and learning disabilities (c. £17,000 per person per year).

Reported dementia affects an estimated 5,400 people, with an estimated spend of around £105m per year spent on this group (an average of nearly £20,000 per person per year). There are also around 17,000 people with cancer, costing an estimated £120m per year in total.

The calculation used to generate these figures is shown in more detail in Appendix 1.

Exhibit 10 – NCL health and care segmentation, 2014-15



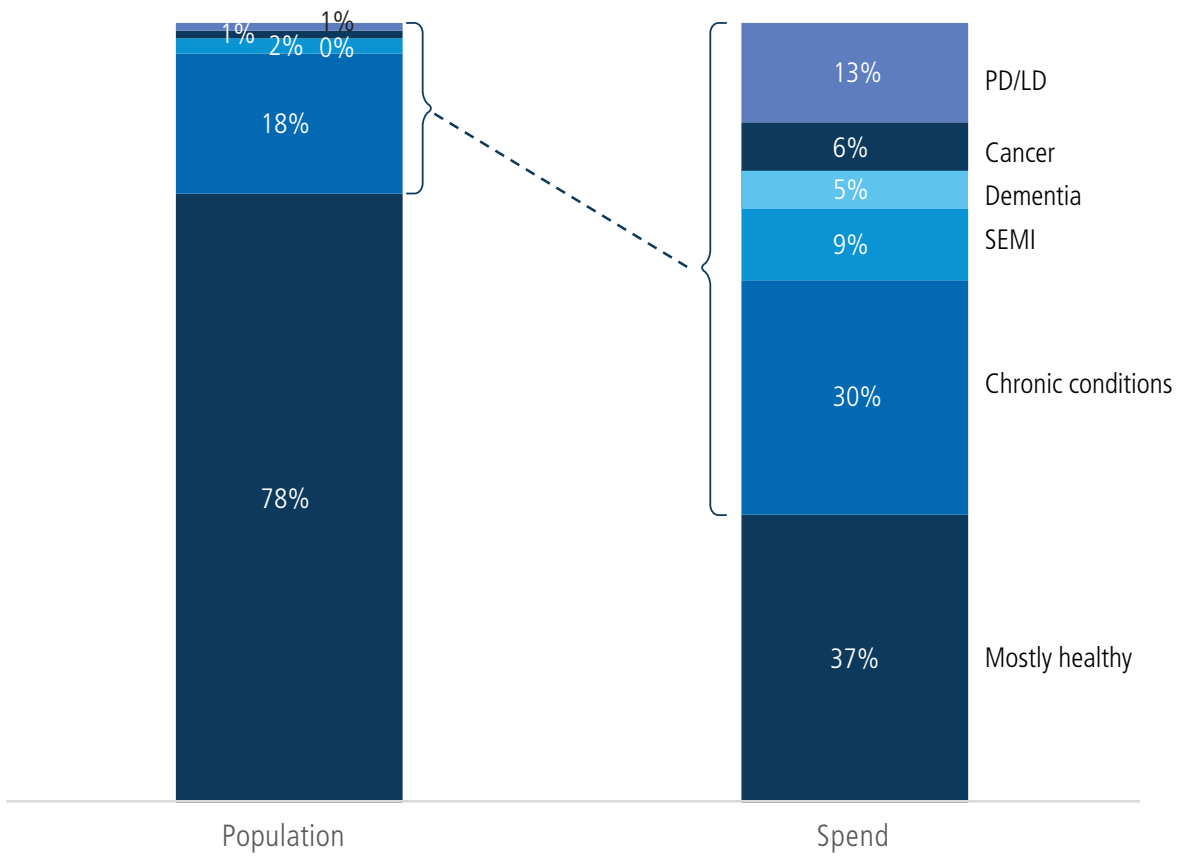
NCL	Mostly Healthy		Chronic conditions		Severe and enduring mental illnesses (SEMI)		Dementia		Cancer		Physical or learning disability (PD/LD)		High needs		Total	
Children 0 -15	Mostly healthy children 1,216		Children with chronic conditions 1,794		Children with SEMI 3,804		-		Children with cancer 16,727		Children with PD/LD 7,827		Vulnerable children -		-	
	258.3	314.2	9.4	16.9	7.2	27.4	0.0	0.0	0.1	1.6	1.2	9.1	-	-	276.2	369.1
Adults 16-69	Mostly healthy adults 472		Adults with chronic conditions 1,711		Adults with SEMI 9,716		Adults with dementia 10,400		Adults with cancer 5,145		Adults with PD/LD 17,711		Adults with Learn. disabilities -		-	
	818.1	386.0	166.9	285.5	12.3	119.2	0.4	3.8	8.4	43.3	5.0	88.9	-	-	1011.0	926.5
Elderly 70+	Mostly healthy elderly 2,577		Elderly with chronic conditions 4,297		Elderly with SEMI 16,317		Elderly with dementia 19,317		Elderly with cancer 8,034		Elderly with PD/LD 17,527		Elderly with Learn. disabilities -		-	
	21.8	56.1	70.5	302.9	1.7	28.1	5.4	104.8	9.3	74.5	9.0	156.9	-	-	117.7	723.4
Total	1098.2	756.2	246.8	605.3	21.2	174.7	5.8	108.5	17.8	119.4	15.1	254.8	-	-	1404.8	2,019.

1. Children with LD/PD figure does not include spend on education
2. Does not include NHS England specialised commissioning spend, meaning total is less that that given in Exhibit 1

Source: CCG 14/15 spend by POD, Monitor Ready Reckoner Tool, Carnall Farrar analysis

Exhibit 11 shows the same information in a different format. It shows that, in NCL, around 22% of local people use 63% of health and social care.

Exhibit 11 – Use of health and social care by different groups, 2014-15



Source: CCG 14/15 spend by POD. Monitor Ready Reckoner Tool, Carnall Farrar analysis

This suggests that the priority groups for focus are people with mental illness and people at risk of poor mental or physical health. It is also important to make sure high quality services are available when required for the majority of local people who are not high users of services. Consideration needs to be given to reducing health inequalities, the requirements of different ethnic groups and the significant movement of people into and out of NCL

4 Care and quality

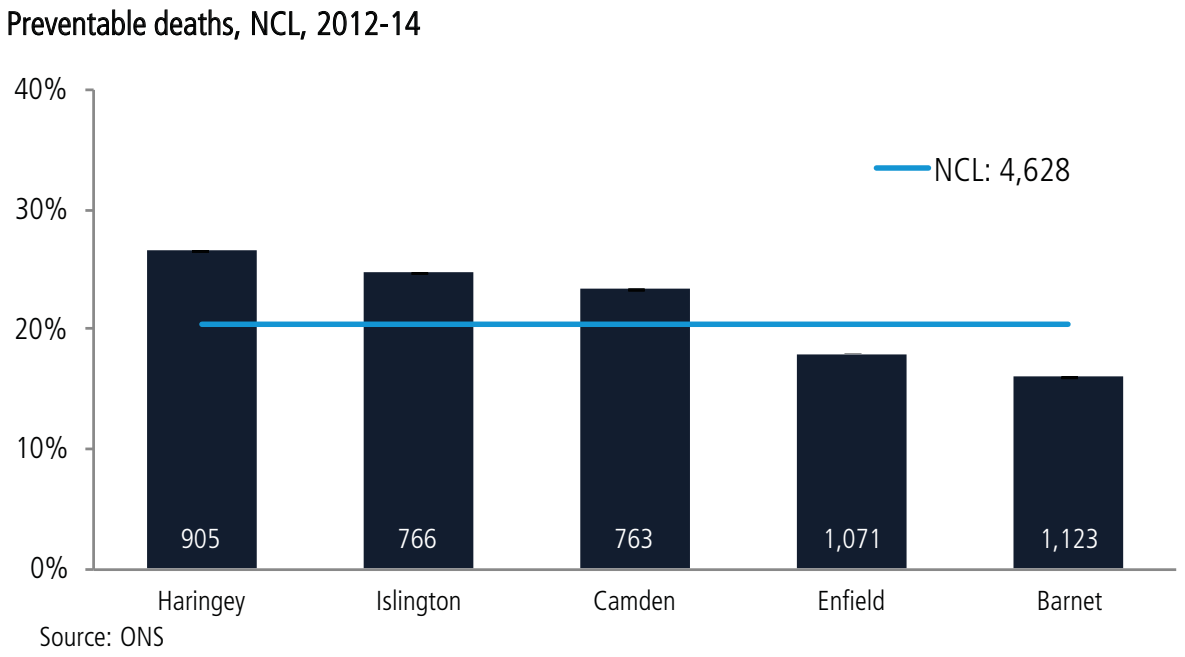
4.1. There is not enough focus on prevention

Many people in NCL are healthy and well – around 40% of adults locally have a healthy weight, do not smoke and do not have any clinical problems[34]. Empowering people, families and communities to stay healthy, including having good mental health, will help ensure they need less health and social care in future. However, many of these people, especially those aged 40+, are at risk of developing long term health conditions such as obesity, raised cholesterol and high blood pressure[35]. There is therefore an important opportunity for prevention of disease among these people.

Only 3% of health and social care funding is spent on public health in NCL[36]. Smoking is thought to cause over 9,000 stays in hospital amongst NCL residents each year[37]. However, in 2014/15, of the estimated 227,567 smokers in NCL, only 4% (10,979) received support through NHS stop smoking services, but of those, 52% (5,669) successfully quit smoking at four weeks.

Much of the ill health, poor quality of life and health inequalities across NCL could be prevented. Between 2012 and 2014, around 20% (4,628) of deaths in NCL were considered preventable[38]. Exhibit 12 shows that Haringey, Islington and Camden have particularly high levels of avoidable deaths, with around a quarter of deaths considered preventable.

Exhibit 12 – Preventable deaths in NC



Levels of avoidable deaths may be linked to the fact that NCL CCGs are in the bottom quintile for a number indicators relating to health and wellbeing, including the number of local people with chronic kidney disease and coronary heart disease[39].

In addition, the wider determinants of health such as poverty, housing and employment have a significant impact on individuals' health and well being.

This suggests a focus on health promotion, particularly focusing on those who are healthy and well but are at risk of developing long term health conditions.

4.2. Disease and illness could be detected and managed much earlier

Many people (including children) in NCL are unwell but do not know it, meaning they have undiagnosed conditions. For example, there are thought to be around 20,000 people who do not know they have diabetes[40] and, in one area of NCL, a quarter of people attending A&E because of chronic obstructive pulmonary disease (COPD) did not know they had the condition[41]. The level of undiagnosed conditions varies by borough and by GP practice, which may be caused by differences in approaches to care[42].

There are also opportunities for better, more systematic management and control of long term health conditions in primary care, in line with evidence-based standards. For example, within NCL in 2014/15 rates of blood glucose control for people with diabetes (important for preventing a worsening of the condition) ranged from 50% to 92% across GP practices[43], and 22% of all people with detected high blood pressure did not reach the required blood pressure levels (≤150/90 mmHg), putting them at risk of stroke and other acute problems[44].

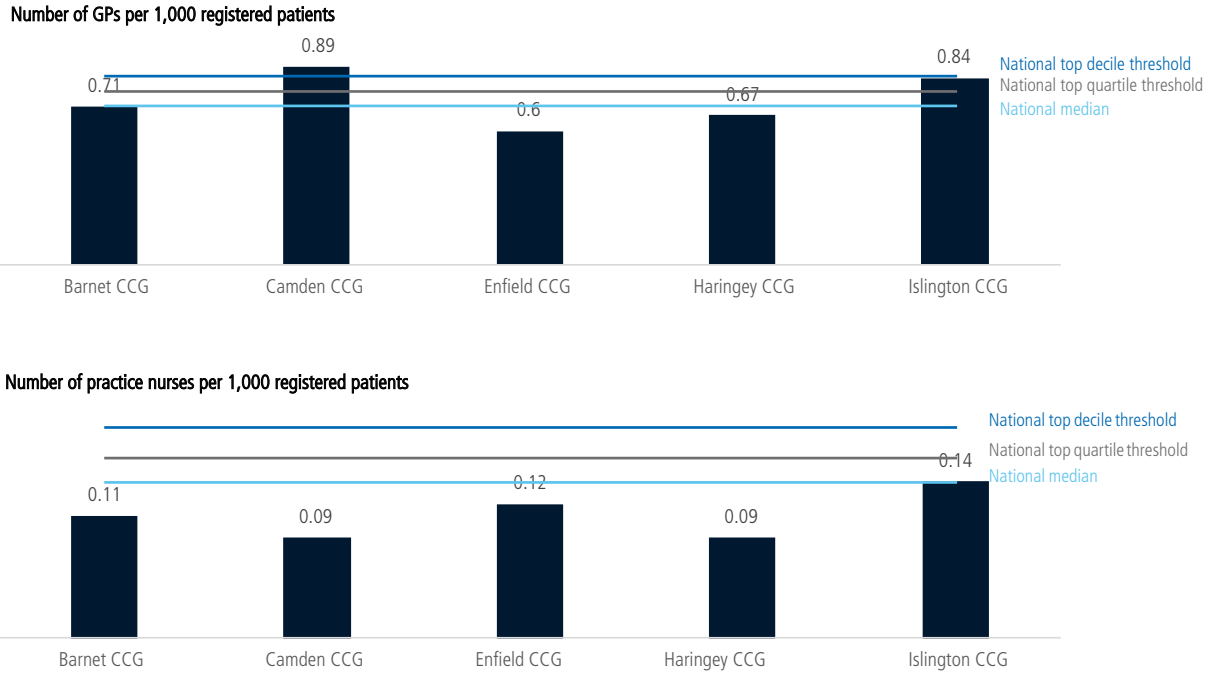
A focus on prevention and early intervention is very important in improving health and wellbeing for local people, reducing the need for health and care services both now and in the future.

This suggests a focus on early detection and management of disease and illness, especially through more systematic management and control of long term health conditions in primary care.

4.3. There are challenges in provision of primary care in some areas

As shown in Exhibit 13, there are low numbers of GPs per person in Barnet, and Enfield and Haringey and low numbers of registered practice nurses per person in all CCGs, but particularly in Camden and Haringey[45].

Exhibit 13 – NCL levels of primary care staff compared to national levels



Source: HSCIC, General Practice Census 2014 at Practice Level. Populations are unweighted.

Satisfaction levels and confidence in primary care among local people is mixed across NCL – there are issues across NCL around confidence in practice nurses and in Haringey with confidence in GPs[46]. Performance against quality indicators in primary care is lower than London and national averages, particularly in Haringey[47]. There are issues within NCL in accessing primary care during routine and extended hours, and only 75% of people in NCL have a named GP to provide continuity of care[48].

There are high levels of A&E attendances across NCL compared to other similar areas[49], and also very high levels of first outpatient attendances[50], suggesting that there may be gaps in primary care provision. Within CCGs, there are significant variations in levels of emergency activity, A&E attendances, planned care and outpatient referrals between practices[51]. There are also high levels of A&E attendances and high numbers of short-stay admissions in the over-75s compared to other similar areas[52].

This suggests that a priority area for focus is the quality of primary care provision and the primary care workforce. It also suggests a focus on reducing variation between practices. This may reduce A&E attendances, short stay admissions and first outpatient attendances.

4.4. Lack of integrated care and support for those with a long term condition

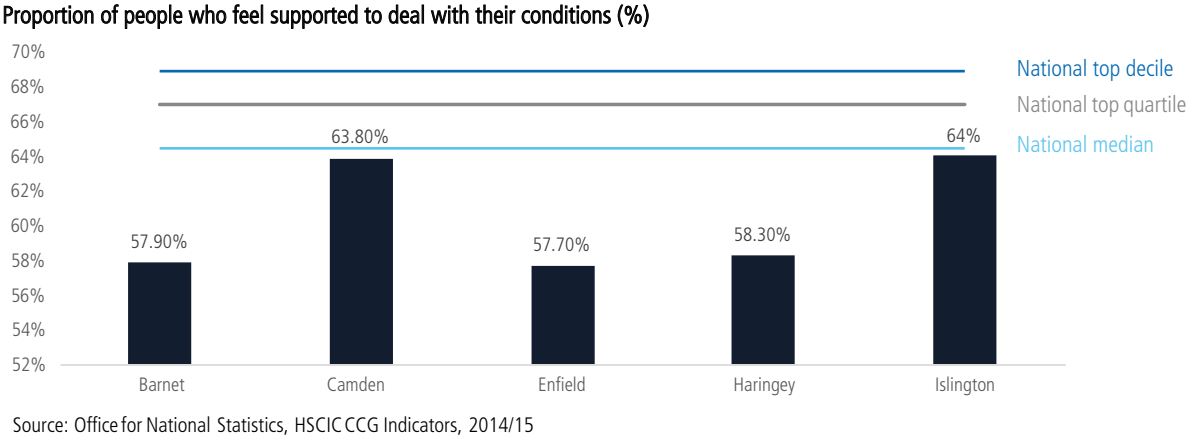
Levels of emergency admissions are similar in NCL to other areas of London[53]. However, there are many people with long term health conditions who end up in hospital, especially in Islington[54]. As shown in Exhibit 14, many people with long term health conditions – over 40% in Barnet, Haringey and Enfield, compared to 35% nationally – do not feel supported to manage their condition[55]. In addition, health related quality of life for people with long term conditions is much lower in Islington than the England average[56].

Insufficiently joined up services for older people

Arthur is 78 and lives alone. After falling at home and injuring his knee, he spent two nights in hospital before being discharged with no further support. Two weeks later, Arthur fell in the shower and fractured his hip. Unable to live independently, he was forced to move into a residential home after some initial rehabilitation in hospital.

Source: submitted by Barnet Integrated Locality Team

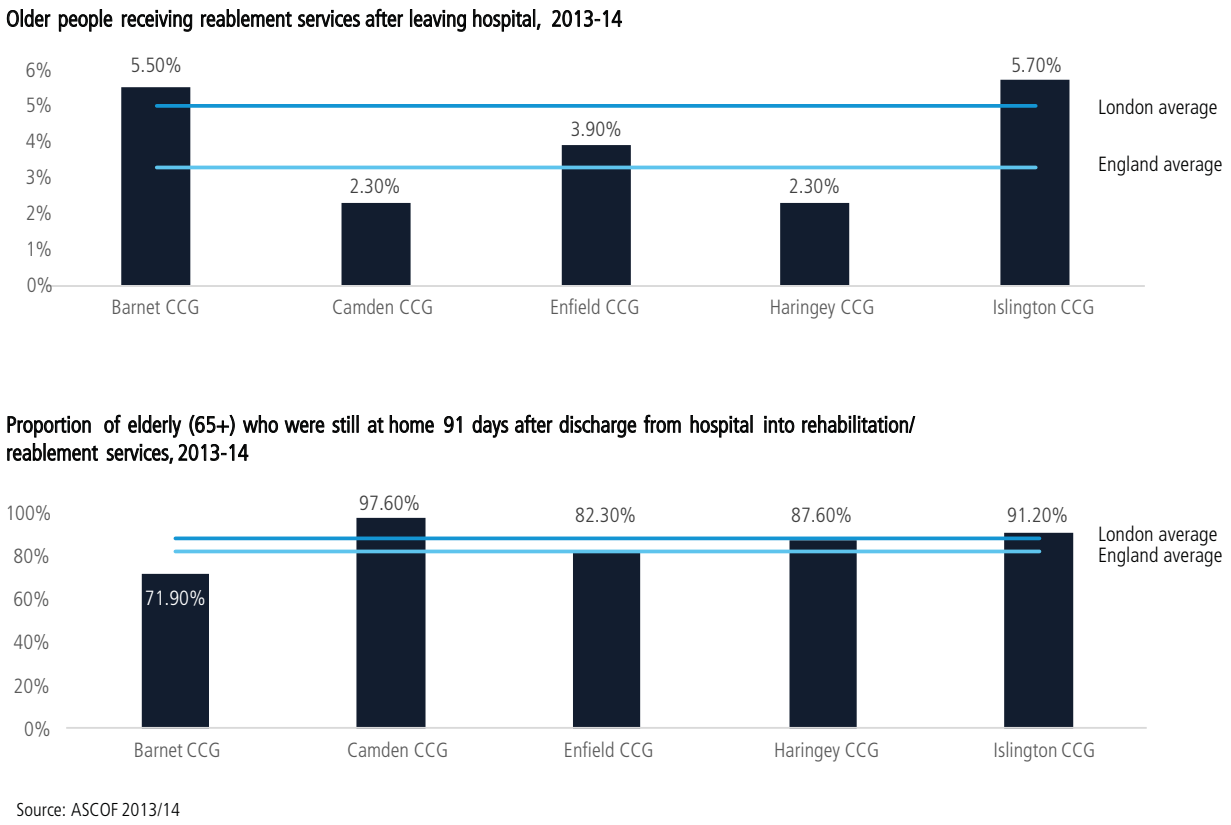
Exhibit 14 – NCL long-term conditions support perception vs national benchmark



Source: Office for National Statistics, HSCIC CCG Indicators, 2014/15

Once people leave hospital, access to social care reablement is lower in Haringey and Camden, while there is a high number of people being readmitted to hospital within 91 days of discharge into community rehabilitation services for people in Enfield[57]. This is shown in Exhibit 15.

Exhibit 15 – Indicators for provision of social services



Source: ASCOF 2013/14

There are also differing levels of admissions to care homes across NCL for older people. In particular, Exhibit 16 shows there are very high levels of permanent admissions to residential and nursing homes in Islington[58]. Reasons for this include the advice offered by doctors during hospital stays, and the availability of community-based support when people are ready to leave hospital

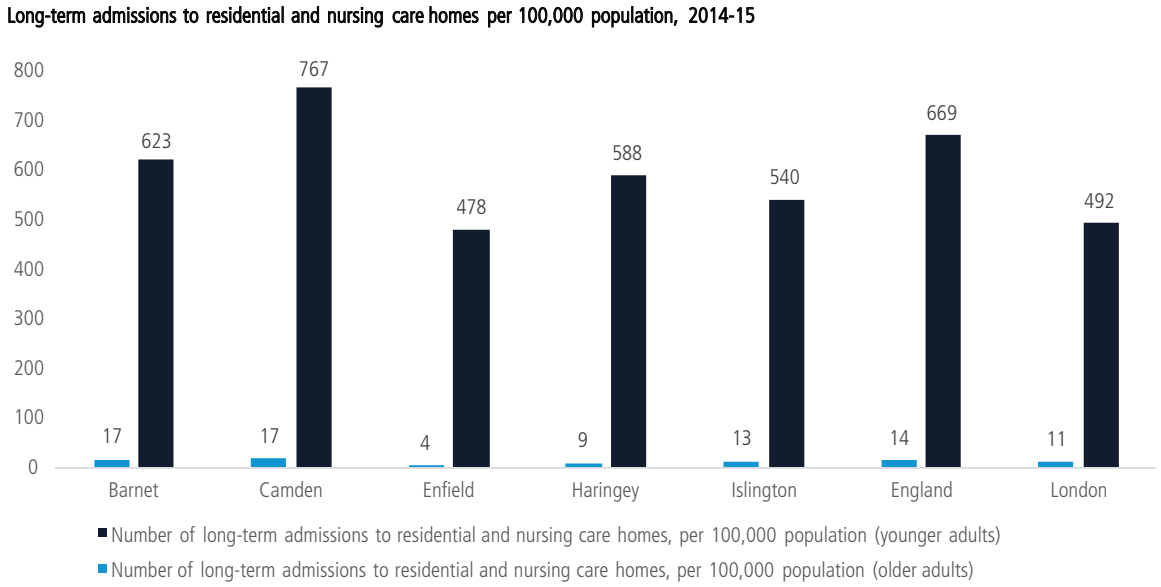
What good looks like: integrated services for older people

The Barnet Integrated Locality Team (BILT) aims to address these issues by coordinating care for older residents with complex medical and social care needs, as well as providing support to carers. The aim is to enable health and social care staff to help people stay healthy and independent. BILT offers a phone service to people who need it and can arrange for access to physiotherapy to assist elderly people regaining their mobility or home modifications such as the installation of a chairlift or a handrail in the shower.

As the number of elderly people in NCL increases, the demands on the health and care system are likely to increase. Services such as BILT can help keep people independent and well for longer, keeping them in their homes and helping them get back to normal life after spending time in hospital.

Source: submitted by Barnet Integrated Locality Team

Exhibit 16 – Long-term admissions to residential and nursing care homes per 100,000 people



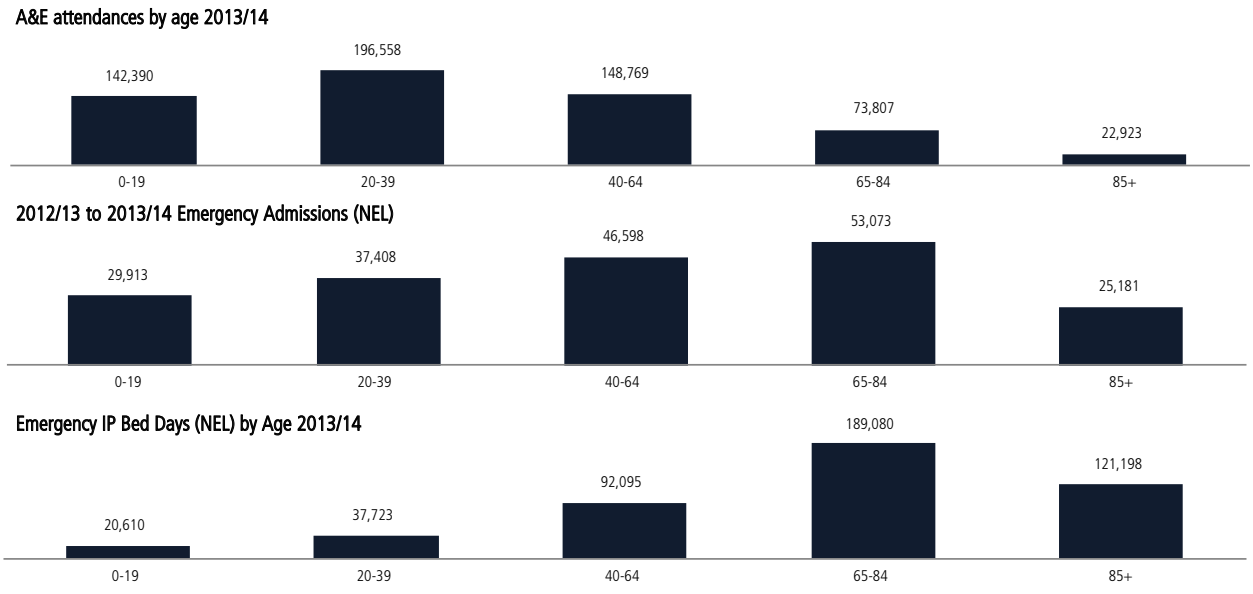
Note: Islington data is 15/16, as there was an error in the 14/15 submission to HSCIC which means 14/15 data cannot be used. The figures are not expected to be significantly different from 14/15 to 15/16.
Source: ASCOF (Adult Social Care Outcomes Framework) , HSCIC

This suggests that a priority area for focus is better integration of care for those with long-term conditions, and ensuring that suitable and sufficient social care is available. There also needs to be a focus on people in residential and nursing homes.

4.5. Many people are in hospital beds who could be cared for closer to home

Most people who stay for a long time in hospital beds are elderly. Exhibit 17 shows that in 2013/14, while 41% of people admitted to hospital in an emergency were aged 65 and over, they used 67% of the beds[59]. While the analysis is now slightly out of date, there is unlikely to have been significant changes to these activity patterns since 2013-14.

Exhibit 17 – Emergency activity in NCL by age



Source: NCL 5yr Planning Activity & Cost Analysis – 2013/14 actual data

More time spent in hospital does not necessarily mean better outcomes – often the reverse – and many people could be cared for sooner, at home. Longer stays are not always driven by medical need and can be seriously harmful to health – the longer the stay, the greater the risk of getting infections, muscle decline, becoming less able to walk or do everyday tasks, less able to return home and more likely to need residential or nursing care[60]. Also, fewer than 40% of people who die in NCL are able to do so at home[61] even though, given a choice, most declare their home to be their preferred place of death.

Delayed discharges (people who have been declared medically fit to leave hospital but have not been discharged) are high in some hospitals in NCL[62], but these numbers only show people who have actually been declared fit for discharge. The real number of people who could leave if services were available elsewhere is probably much higher[63]. As an example, a recent audit of people at Plymouth Hospital found that 27% (200) beds had people in them who were medically fit to leave[64]. This would mean around 600 people in local NCL hospitals if a similar pattern was found. Similarly, if 90% of all local people aged 65 and over were able to be discharged home after no more than 10 days in hospital, this would translate to 340 people every day who could be cared for closer to home[65]. Ensuring services are available outside hospital would mean people are able to go home at the right time and be cared for safely in their own homes. It would support people to get back to normal life more quickly, reduce their risk from staying in hospital too long and enable hospitals to work more efficiently to care for sicker people.

Insufficiently joined up services for care homes

Edna is 84 years old and lives in a residential care home. She was unable to see a GP after contracting a chest infection, due in part to difficulties getting to the GP practice and the lack of availability of the GPs to conduct home visits. Edna was admitted to hospital as suitable support was not available in the care home. After leaving hospital, the lack of coordination between care services in the community and primary care meant Edna did not receive the support she needed to assist her recovery and she was readmitted to hospital 10 days later.

Source: ICAT care home services

There are also a large number of people in local hospital beds whose admission to hospital might have been avoided altogether. Although the numbers of people who go into hospital in an emergency in NCL are similar to the England average[66], evidence from elsewhere suggests that 25-40% of these emergency admissions could be avoided if other care was available outside hospital[67]. Exhibit 18 summarises a selection of the key international evidence.

Exhibit 18 – International evidence of impact of integrated care

A review of the evidence base on integrated care shows a potential impact of 25–40% in cost reduction, for example

- 15–30% cost reduction through care coordination
- 50% reduction in acute admissions to hospital for patients with diabetes, through case-level care-planning and active disease management
- 23–40% reduction in admissions for CHD through best practice early management

Selected examples of integrated care	
GENERALITAT VALENCIANA	• Significant cost reductions and higher levels of productivity • 26% reduction in costs in districts with outsourced management • 76% increase in hospital productivity • 91% patient satisfaction rates
ChenMed	• ChenMed has 30% fewer emergency admissions than other primary care networks in the same geography • Compared to national averages for the population group, ChenMed reports 18% lower hospitalisation rate and 17% lower readmissions rates
NHS South Devon and Torbay Clinical Commissioning Group	• The number of patients with a care package in place within 28 days of assessment increased by 45% • Non-elective inpatient beduse in over-65s population reduced by 29%; length of stay reduced by 19% • Delayed transfers of care from hospital significantly reduced
CareMore	• Reduction in A&E visits and unscheduled patient admissions • 24% lower than avg hospitalisation; 38% shorter than avg hospital stays • 60% lower than average amputation rate among diabetics • 56% reduction in CHF hospital admits in 3 months • 50% reduction in renal hospital admission rates in 5 months

1 Dorling & Richardson, "McKinsey Evidence Base of Integrated Care", 2014

There are also already a number of places in NCL where services provide 'hospital' care outside of the hospital. These services are integrated across community services and social care, and provide proactive person-centred care. This can empower people to better manage their own health and wellbeing. However, there are differences in the availability of these services across NCL, and it is important to ensure that the services that work well are made available more widely.

This suggests that a priority area for focus is reducing the length of stay and avoidable admissions in acute hospitals, in partnership with social care.

What good looks like: in-reach services for care homes

An 'in-reach' team focused on supporting people to remain well in residential care (such as the Integrated Community Ageing Team, or ICAT) act as a liaison between community and acute hospital services. An ICAT is a consultant led multidisciplinary team (MDT) which specializes in geriatric assessment. With knowledge of each patient, and specialising in the care of elderly patients, the team is able to ensure that the needs of patients such as Edna are met upon returning to residential care homes from a spell in hospital. The team also helps to arrange appropriate palliative care to ensure that when the time comes, patients can die in their place of choice.

Demand for these types of services is likely to increase as the population ages, and NCL has an opportunity to build on examples of existing teams, such as those at the Whittington and UCLH, as part of the STP process.

Source: ICAT care home services

4.6. Hospitals are finding it difficult to meet increasingly demanding emergency standards

Local hospitals are finding it difficult to meet increasingly demanding clinical quality standards for emergency services. For example, as shown in Exhibit 19, according to a self-assessment conducted in 2015 the number of specialties where people are seen by consultants within 14 hours ranges from 20% in one hospital to 90% in another[68]. Three of the five acute hospitals in NCL do not provide 16-hour consultant presence in Emergency Departments at the weekends[69]. Within Emergency Departments there are shortages of middle grade doctors[70]. However, there are likely to have been improvements in adherence to the standards since the self-assessment was carried out; for example, at the Whittington Intensive Therapy Unit (ITU) patients are reviewed at least twice daily.

Exhibit 19 – Assessment of four London priority national seven day service standards

Note - this data was submitted to the national self-assessment in 2015. An updated self-assessment against these standards is being carried out for the NCL STP.

Standard	Measure	Barnet Hospital	North Middlesex Hospital	Royal Free Hospital	The Whittington Hospital	University College Hospital	NCL total
Standard 2: Time to Consultant Review	Percentage of specialties where patients are seen by consultants within 14 hours	50%	30%	80%	20%	90%	45%
Standard 5: Access to Diagnostics	Percentage of diagnostic services available 7 days per week	100%	71%	79%	79%	93%	87%
Standard 6: Access to Consultant-directed Interventions	Percentage of consultant-directed interventions available 7 days per week	89%	67%	100%	100%	100%	76%
Standard 8: Ongoing review	(Where applicable) Percentage of areas in which patients are seen and reviewed by a consultant twice daily	100%	100%	100%	25%	100%	88%

Areas included:

Standard 2 - Cardiology, General Medicine, General Surgery, Geriatric Medicine, Gynaecology, Intensive Care, Obstetrics, Paediatrics, Psychiatry, Respiratory Medicine, Trauma and Orthopaedics

Standard 5 - Biochemistry, Bronchoscopy, Chemical Pathology, Computerised Tomography, Echocardiography, Haematology, Histopathology, Magnetic Resonance Imaging (MRI), Microbiology, Radiology, Lower GI Endoscopy, Upper GI Endoscopy, Ultrasound, Xray,

Standard 6 - Cardiac pacing, Critical Care, Emergency General Surgery, Interventional Endoscopy, Interventional Radiology, Percutaneous Coronary Intervention (PCI), Renal ReplacementTherapy, Thrombolysis, Urgent Radiotherapy

Standard 8 - Acute medical unit, acute surgical unit, intensive care unit and other high dependency units

Source: National Seven Day Services Self-Assessment, 2015

In April 2016 none of the five Emergency Departments within NCL were consistently meeting the access standard to see people within 4 hours of arrival, as summarised in Exhibit 20 below. In particular, North Middlesex University Hospital (NMUH) had been recently issued with a Warning Notice by the Care Quality Commission that it needed to significantly improve the treatment of people attending the Emergency Department[71]. In April NMUH was seeing between 65-75% of A&E patients within 4 hours and was challenged in achieving key quality standards within emergency care. This was shown by the poor satisfaction ratings at NMUH; almost half of people attending the Emergency Department at the hospital would not recommend the Emergency Department to friends and family[72].

However since April 2016, considerable progress has been made at NMUH. The launch of the Safer, Better, Faster programme in May 2016 has led to improvements in ED staffing at NMUH; the development of a 'home first approach' to support earlier discharge of medical patients who need home care; increase patient flow through assessment units; and reduced delays for patients waiting for tablets to take away. Waiting time performance at A&E in NMUH has improved steadily as a result rising to over 90% of patients seen within 4 hours in early August 2016.

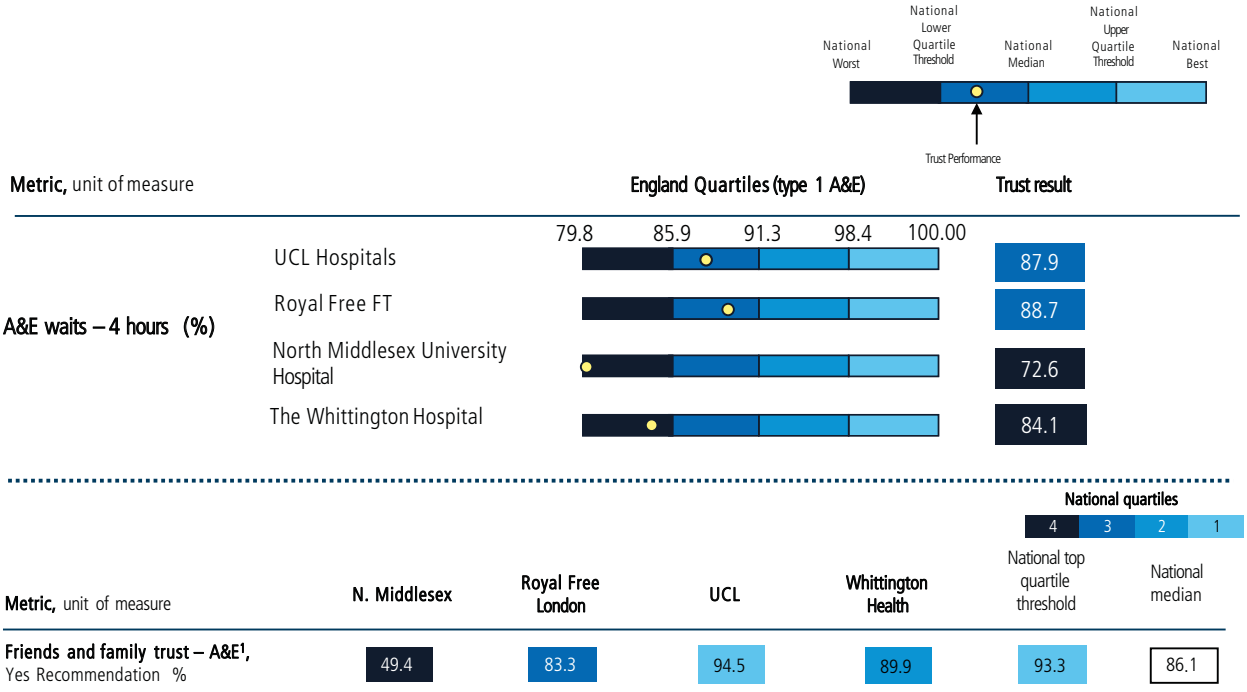
Access to secondary care

Sara had a cyst and she is still waiting for the local hospital to give her an appointment for the operation. Her English is limited and her children have to help her in interpretation, but she does not think that the hospital is giving her the best care.

Her son is helping her navigate the health services, but she feels shy having to be examined by a doctor in front of him. Especially as this cyst is on her uterus and the treatment is possibly a hysterectomy making me more anxious. Sara finds it difficult to talk about women's illnesses when there are men present, and it is especially hard when her son is also there and she has to explain everything to him. It takes a long time to get an appointment, and services need to improve the improve interpreting services available or hire some doctors who know different languages.

Source: Healthwatch Islington, Diverse Communities Health Voice

Exhibit 20 – Key A&E performance indicators



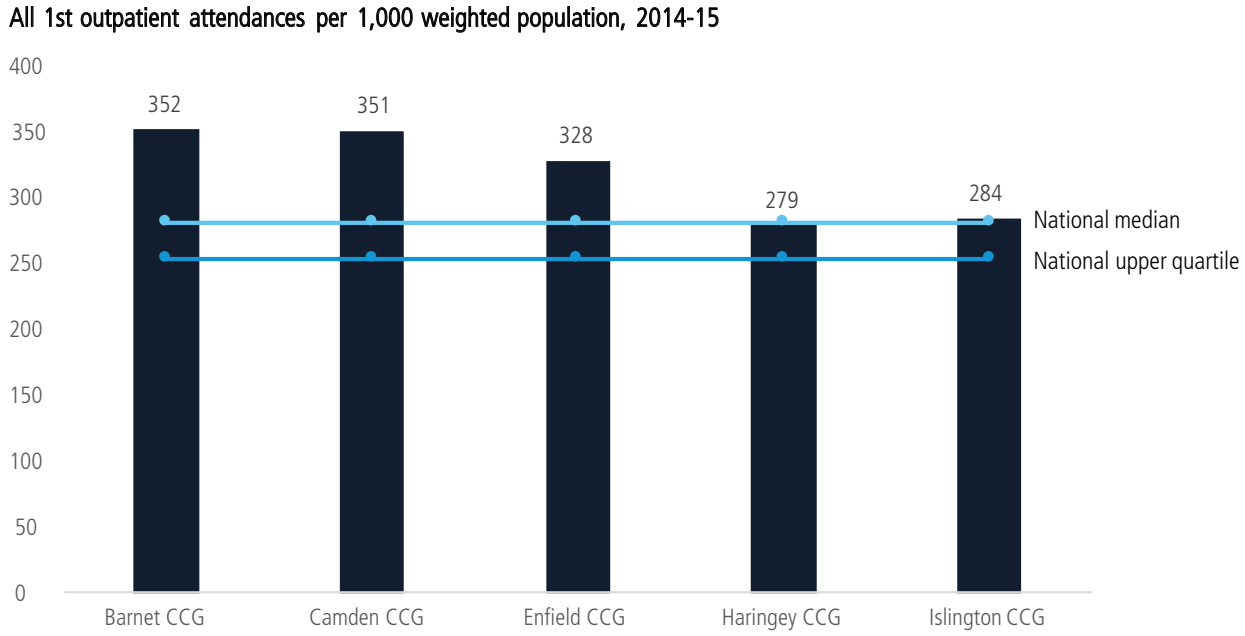
Source: A&E Waiting Time Analysis, April 2016; Friends and Family Test, April 2016

This suggests a need to focus on the delivery of emergency services in hospitals in NCL, addressing variation and, in particular, continuing attention to the Emergency Department at North Middlesex University Hospital. This should be underpinned by a NCL-wide approach to supporting all organisations to deliver, with a strong focus on the development of improving access to primary care.

4.7. There are differences in the way planned care is delivered

There are differences in the way planned care is delivered across NCL. This may reflect different levels of patient need, or it may be due to differences in clinical practice between doctors and nurses at any point where care is given. For example, as shown in Exhibit 21, the number of people seen as outpatients in Barnet, Camden and Enfield is high compared to other similar areas and when compared to the England average. This could be for a number of reasons, including differences in the health needs of local people, the skills and experiences of GPs, or the ability of GPs to get a specialist opinion or access diagnostics in primary care.

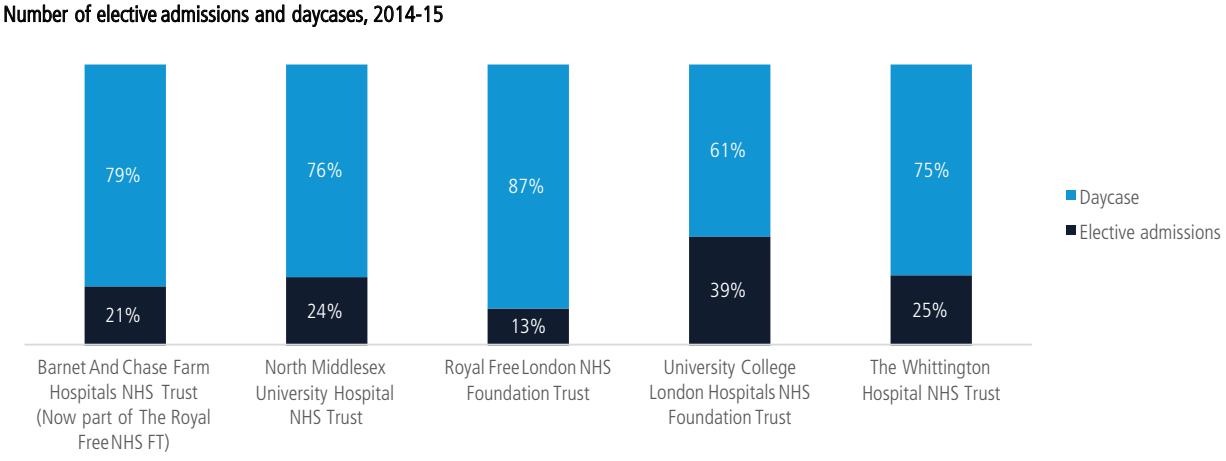
Exhibit 21 – Outpatient activity in NCL



Source: NHS England Monthly Activity Data 2014/15

There are also differences between hospitals in the delivery of planned care. For example, there are differences in the number of referrals of people between consultants (particularly at UCLH and North Middlesex), the number of follow-up appointments that people have (particularly at UCLH) and the amount of planned care that is done as a daycase without an overnight stay (shown in Exhibit 22)[73]. Further work is being done to understand these differences and their causes in more detail.

Exhibit 22 – Daycase rates by provider in NCL



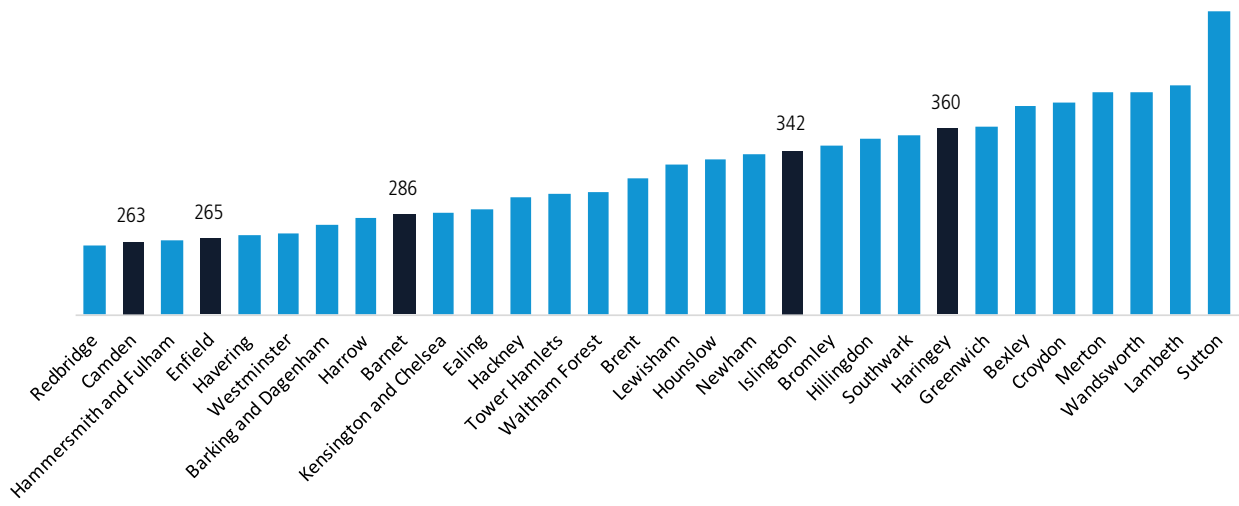
Source: HSCIC Hospital Episode Statistics

This suggests a focus on the differences in referrals into planned care, and the differences in the delivery of planned care within hospitals.

4.8. There are challenges in mental health provision

There are very high levels of mental illness in NCL, both serious mental illness and common mental health problems, with high rates of premature mortality, particularly in Haringey and Islington, as shown in Exhibit 23. While the causes of premature mortality are broader than just mental health conditions, the links between poor mental health and premature mortality are well-established.

Exhibit 23 – Premature (<75) mortality in adults with serious mental illness, rate per 100,000 people, 2013-14



Source Public health outcomes framework 2013/14

There is still a lot of stigma associated with having a mental illness, and many people either do not know how, or do not want, to access mental health services. Information on help and support within local communities is not available everywhere. There are groups of people who are at higher risk of having a mental illness, such as people who are in debt, unemployed, homeless, have a long term condition, or have drug and alcohol problems.

Demand for mental health services has increased, due to social pressures related to reduced funding for public services, increasing numbers of people, higher public expectations and changes to legislation. Community-based teams cannot manage people with the most serious issues and therefore high numbers of people are admitted to hospital. During a crisis, service users prefer to be helped by teams who they know rather than being referred to a new team. Camden and Islington have amongst the smallest community mental health services per person in England[74]. Community teams reduce the number of people with a mental illness ending up in hospital.

Most mental health problems are managed within primary care, and psychological therapies (IAPT) services are in place to manage mild to moderate mental health problems. However, mental health services based in primary care with specialist workers who can manage moderate to severe mental illnesses are only just beginning to develop in NCL and are limited in who they can treat. Without this expertise in primary care, more people are referred to hospital-based services who might otherwise have been managed within the community.

Access to psychological therapies

'There is a need for psychological therapies that have less restriction on who they can see, as IAPT are unable to see clients who have suicidal thoughts, have a history of drugs or alcohol abuse, or a history of longer-term mental health issues.' (Carer)

Source: Healthwatch Enfield

In recent years there has been a big increase in the numbers of people receiving a first diagnosis of a serious mental health condition in A&E, and around 38% of people admitted to inpatient hospital wards in Camden and Islington are new to mental health services[75]. These issues are partly related to the large number of people moving in and out of NCL, with significant differences between daytime and night time populations. This creates a burden on both mental health and A&E services, and indicates that prevention and early detection of mental health conditions needs to improve, along with greater capacity to manage these conditions in the community. There is no high quality health-based place of safety in NCL to receive people detained by the police under Section 136.

There is variable access to liaison psychiatry, perinatal psychiatry and child and adolescent mental health services (CAMHS) within urgent care. For example, most of the liaison psychiatry and CAMHS services in hospitals in NCL do not see children within one hour at weekends and overnight[76].

What good looks like: improving access to psychological therapies

Yorkshire and Humber Commissioning Support worked on review and redesign of Hull's Improving Access to Psychological Therapies (IAPT) services and access to mental health services. A revised IAPT+ service, known as the Depression and Anxiety Service, improved choice and access to Psychological Therapies. The service involves timely, evidence-based interventions according to the needs of individuals and does not require individuals to be referred through secondary mental health services to be able to access these services. The new service model is tariff-based and incentivises both patient choice at every point on the pathway and the achievement of demonstrable clinical outcomes.

The improvements other regions have made to their IAPT services are likely to provide learning opportunities for NCL to improve the accessibility and effectiveness of its IAPT services as well.

Source: Yorkshire and Humber Commissioning Support

Although all five boroughs achieve dementia diagnosis rates above the national average, there is great variability across NCL[77]. There is the expertise in NCL to achieve high diagnosis rates, as demonstrated by Islington. The availability of post-discharge treatment and support services for people with dementia varies greatly despite the good evidence for their effectiveness.

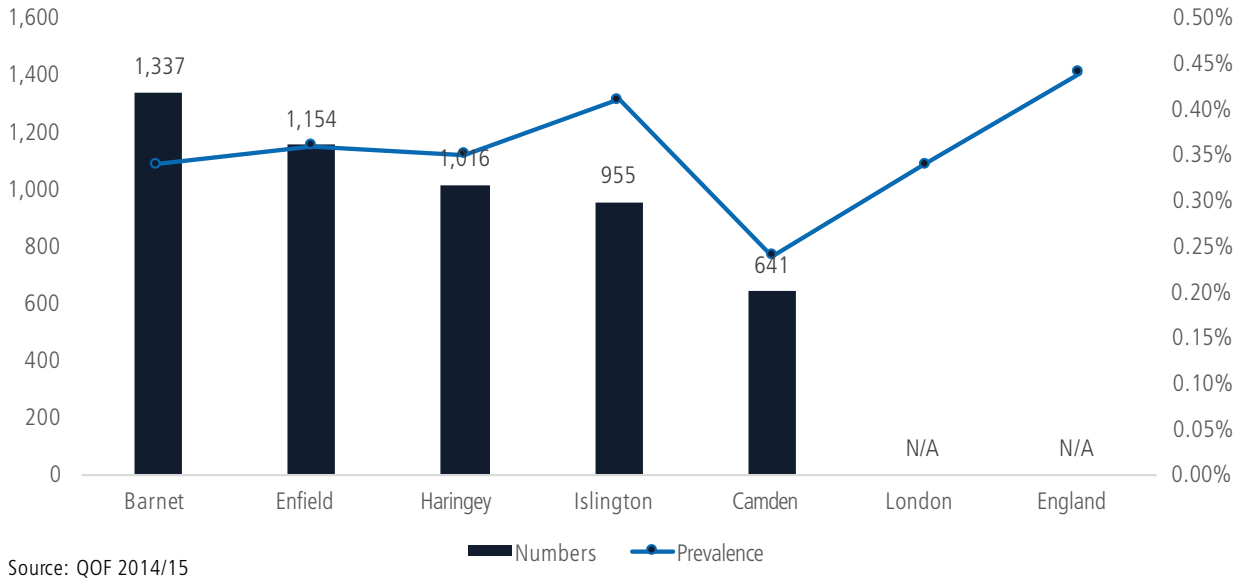
This suggests a focus on the provision of mental health services, particularly the physical health of those with a mental illness, early diagnosis, access to integrated services and child and adolescent mental health services.

4.9. There are challenges delivering services for people with learning difficulties

As shown in Exhibit 24, the number of adults with learning disabilities varies across NCL from 0.41% of people in Islington, to 0.24% in Camden. Often people are not recorded as having learning difficulties, especially when they are mild.

As elsewhere in England, the number of people with learning disabled is increasing, partly due to the rising numbers of young people with complex needs surviving into adulthood, and also due to the increased life expectancy of the learning disabled population. The rate of increase is estimated to range from 1.2% to 5.1% (average 3.2%) per year[78].

Exhibit 24 – Number of people with a learning disability, registered population, 2014/15



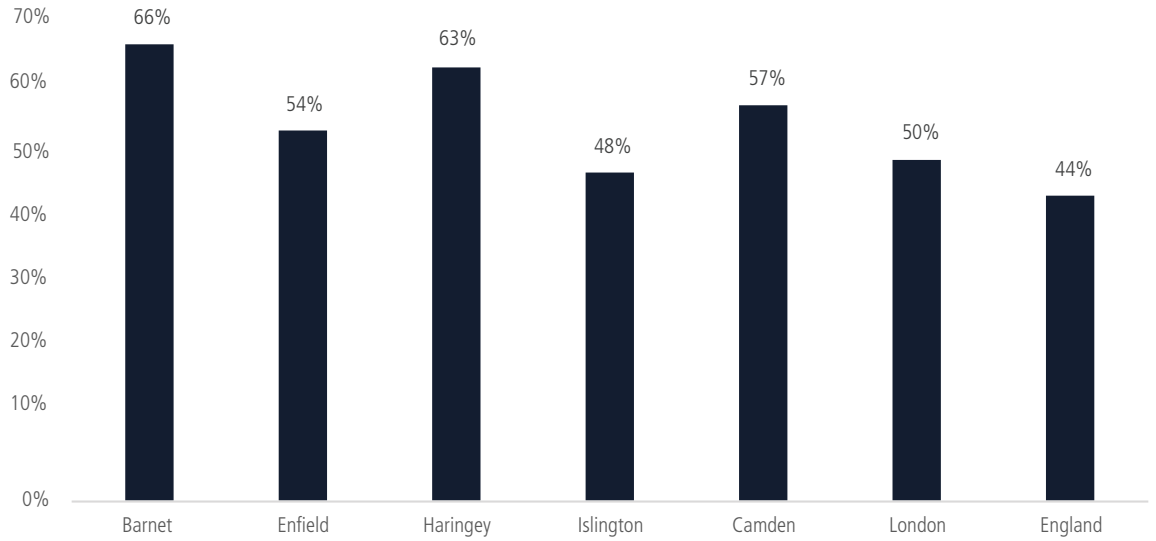
Source: QOF 2014/15

People with learning disabilities tend to have poorer health than the rest of the population, much of which could be prevented. This is partly because of the barriers faced by people with learning disabilities in accessing timely, appropriate and effective health care. As well as having a poorer quality of life, people with learning disabilities die at a younger age than the general population[79]. Men die, on average, 13 years younger than other people and women die 20 years younger.

People with learning disabilities are more likely to have specific health issues including epilepsy, sensory impairment, respiratory disease, coronary heart disease and mental illness[80].

Annual health checks for these individuals are have been shown to be effective in identifying and helping to manage previously undetected health problems. As shown in Exhibit 25, the number of adults in NCL with learning disabilities who have had a health check is higher or similar to the England average; nonetheless, around half have not had one.

Exhibit 25 – Percentage of eligible adults with a learning disability having a GP health check

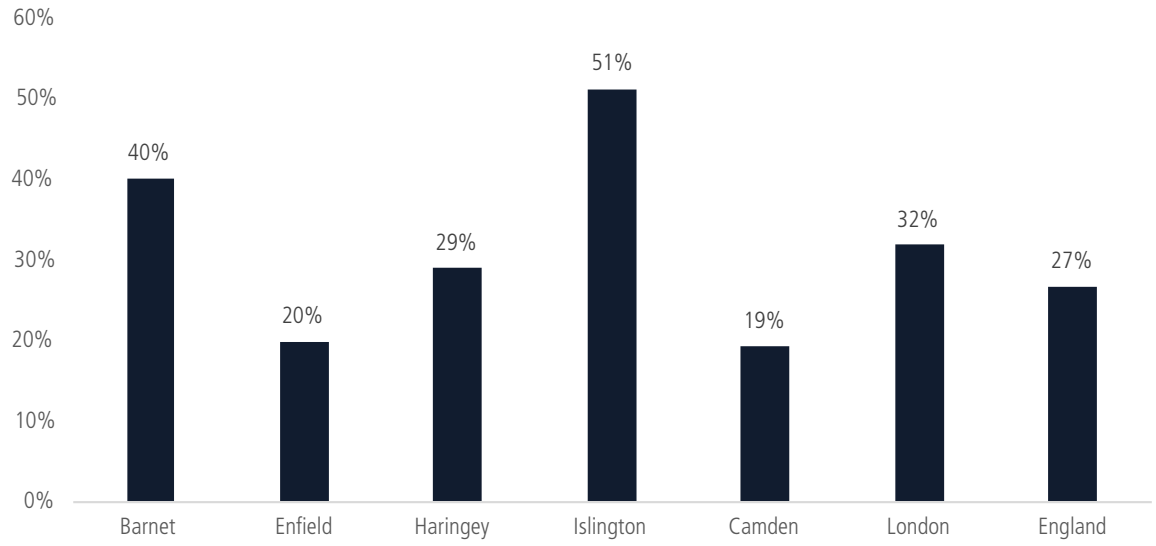


Source: Public Health England, learning disability profiles

Suitable, local accommodation with care and support is required to make sure people with learning disabilities can remain part of their communities and get the health care they need. This includes accommodation that is self-contained and is suitable for people who also have physical disabilities, and young adults with complex health care needs.

As shown in Exhibit 26, the number of adults with learning disabilities receiving long term support who live in unsettled accommodation, meaning the person might be required to leave at short notice, is much higher in Barnet and Islington compared to the England average, whereas for Camden it is lower.

Exhibit 26 – Percentage of adults with learning disabilities receiving long term support living in unsettled accommodation, 2014/15



Source: Public Health England, learning disability profiles

In October 2015, a national plan ('Building the Right Support') and a national service model for learning disability services was published. This was intended to help Transforming Care Partnerships (TCPs) meet national commitments to reduce the length of stay in hospitals and reduce admissions

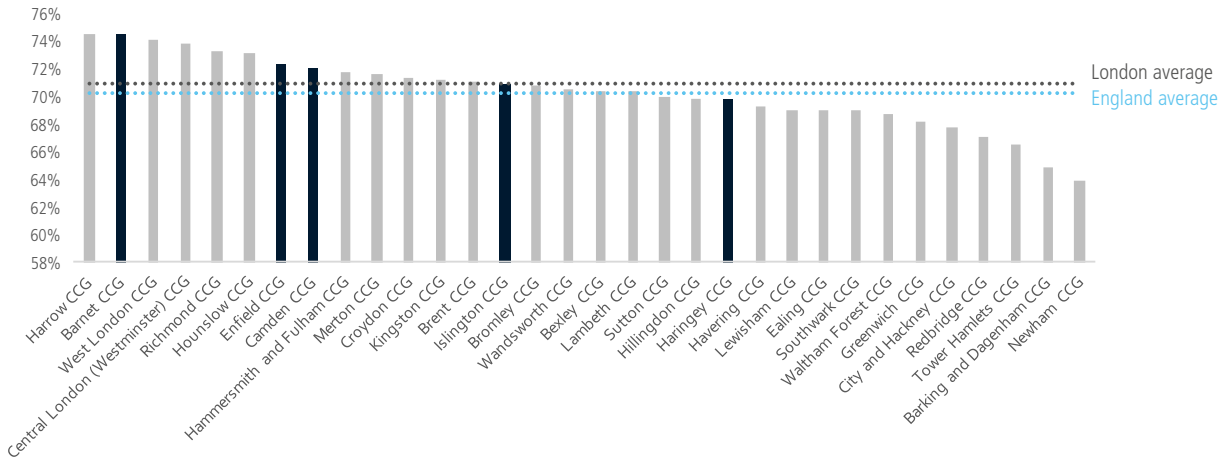
to assessment and treatment units (such as the former Winterbourne Unit) for people with learning disabilities. The NCL TCP implementation plan is currently being developed, to be in place by July 2016 for delivery by March 2019.

This suggests a focus on prevention services for the learning disabled population, such as annual health checks, and provision of more suitable accommodation for people with learning disabilities.

4.10. There are challenges in the provision of cancer care

There are many opportunities to save lives and deliver cancer services more efficiently in NCL. Cancer is a major cause of death, with around 29% of deaths caused by cancer in England[81]. One-year survival rates in NCL are similar to other parts of London[82], as shown by Exhibit 27. However, compared to other countries such as Sweden, the UK has much lower survival rates, suggesting that improvements could be made[83].

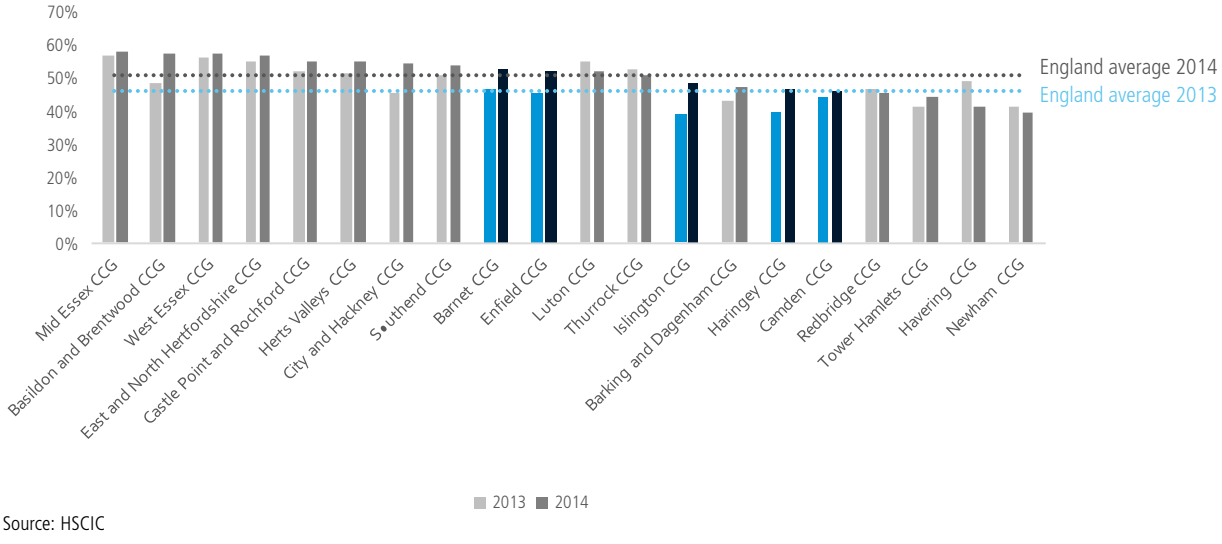
Exhibit 27 – One-year survival rates across London for all cancers, 2013 diagnoses



Source: ONS, Index of cancer survival for CCGs in England

Late diagnosis of cancers is a particular issue that contributes to lower one-year survival rates. Exhibit 28 indicates that the percentage of cancers detected at an early stage is low, especially in Haringey, Camden and Islington, although Islington has improved significantly between 2013 and 2014[84].

Exhibit 28 – Percentage of cancers detected at stage 1 and 2 in London, 2013-14



Source: HSCIC

One issue is that levels of screening for cancer are generally low. For example, in NCL less than half the target number of people get screened for bowel cancer[85]. Around 20% of people do not have their cancer diagnosed until they arrive in A&E with a serious problem[86], and there is a lack of awareness of the symptoms of cancer, especially among black and minority ethnic groups[87].

What good looks like: improving early detection of cancer

The Multidisciplinary Diagnostic Centre (MDC) at UCLH offers rapid diagnostic services for patients with so-called 'vague' symptoms which do not point towards a specific underlying cancer type. GPs can refer patients to the MDC, eliminating the need to fill out referral forms for multiple specialties and diagnosis and/or management plans can be provided by the MDC to be carried out in primary care. This means patients need only visit their GP for their symptoms to be investigated rapidly.

This is one example of a service which, if replicated throughout NCL, could improve patient experience, increase early detection and cancer survival rates, and decrease the number of emergency admissions of patients with unrecognized and late stage cancer.

Source: adapted from UCLP Annual Review, June 2015

Once cancer is suspected, waiting times to see a specialist and then for treatment can be long and vary between hospitals[88], as shown in Exhibit 29.

Exhibit 29 – Cancer wait times compared to peer median and average (providers)

National quartiles: 4 3 2 1

Metric, unit of measure	UCLH	R. Free	N. Midd.	Whitt.	National median	National upper quartile
Two week wait from GP urgent referral to first consultant appointment, %	92.9%	95.0%	93.2%	93.2%	94.7%	96.5%
Two week wait breast symptomatic (where cancer not initially suspected) from GP urgent referral to first consultant appointment, %	96.8%	99.3%	94.6%	97.2%	96.3%	97.9%
31 day wait from a decision to treat to a first treatment for cancer, %	90.5%	99.5%	97.3%	100.0%	98.6%	99.6%
31-day wait from a decision to treat to a subsequent treatment for cancer (surgery), %	87.6%	98.2%	96.9%	100.0%	98.2%	100.0%
62-day wait from GP urgent referral to a First treatment, %	72.6%	76.5%	76.0%	91.7%	85.2%	88.8%

Source: NHS England, Cancer Waiting time Statistics Q3 14/15-Q2 2015/16 by Provider. Available at: www.england.nhs.uk

The number of referrals to cancer specialists have almost doubled over the last five years[89], which may be partly due to current guidance but may also reflect difficulties accessing diagnostic tests or specialist advice in primary care. Once a person has been seen by a specialist, there are delays in transfer between hospitals and long waiting lists for diagnostics[90]. There is an estimated shortfall of 17 MRI, 7 CT scanners, 149 radiographers, 43 consultants and 22 sonographers for cancer diagnosis and treatment in NCL by 2020[91]. Satisfaction with services is often low – there is particularly low satisfaction with how well hospital and community services work together[92]. Many community cancer services are open only 9-5 during the week and there is very little coverage during the weekend[93].

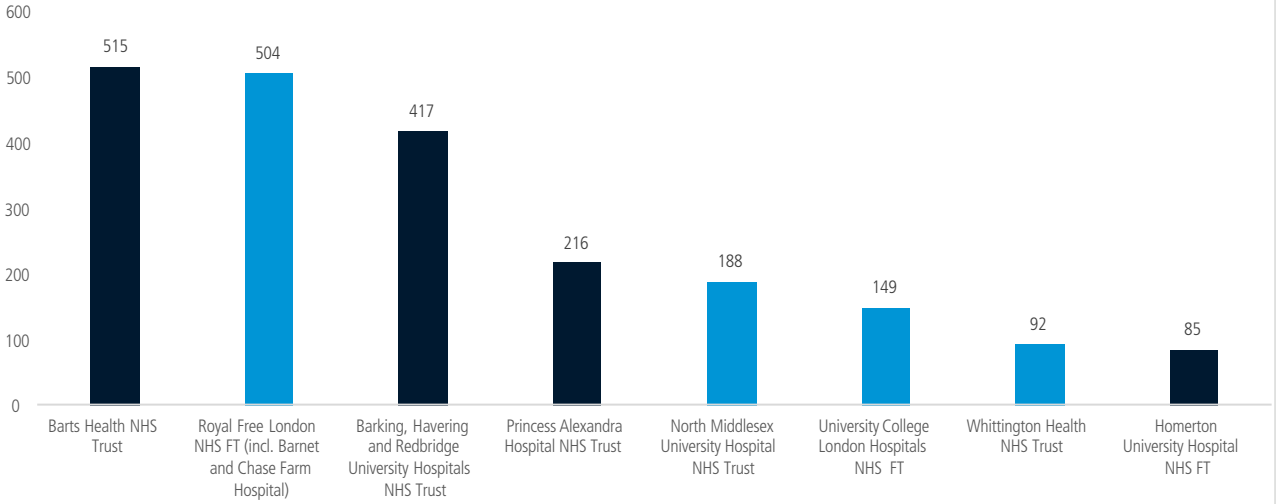
Improving early detection of cancer

Anne, 56, visited her GP complaining of abdominal pain and unexplained weight loss, and was then referred to a number of different specialties without a successful diagnosis. Four months later, she attended A&E with symptoms including jaundice, vomiting, fever and itching. After a series of tests, she was diagnosed with pancreatic cancer.

Source: adapted from UCLP Annual Review, June 2015

There a number of issues with hospitals seeing small numbers of some types of cancer patients, lower than NICE guidelines of 150 minimum cases per year[94]. For example, as shown in Exhibit 30, Whittington Health provides the second smallest breast cancer service in London, with under two patients a week on average. In addition, North Middlesex provides the second smallest lung cancer service[95], also seeing less than two patients a week on average.

Exhibit 30 – Number of new breast cancer patient treated in London cancer services



Source: Public Health England, 2014

This suggests a focus on the cancer pathway across primary and acute providers.

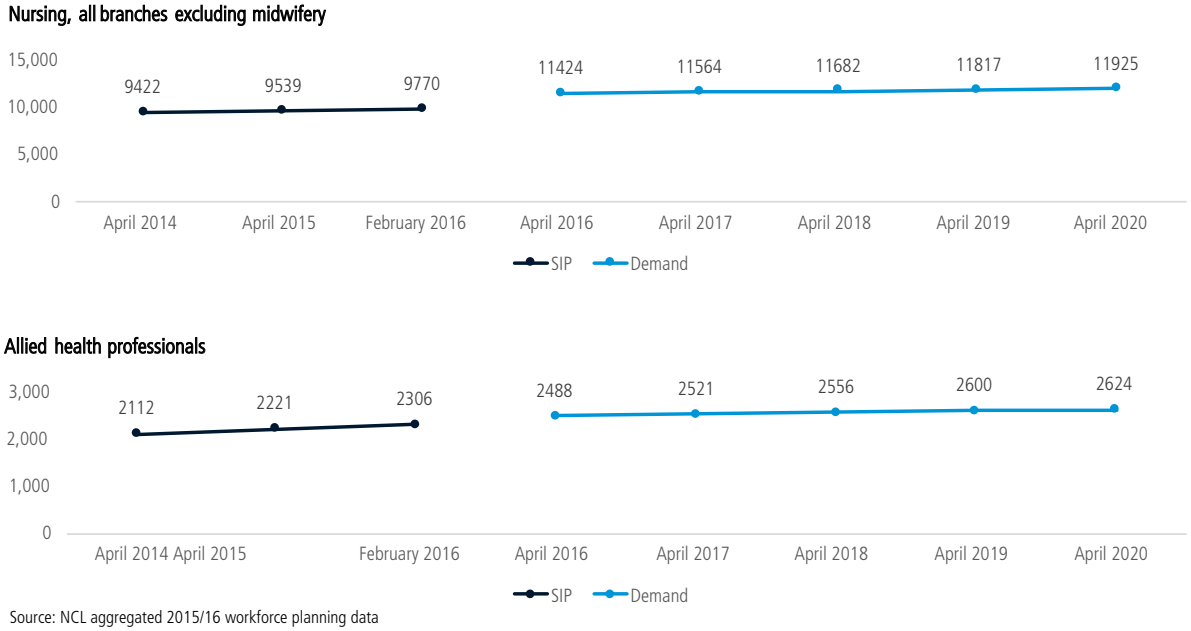
4.11. There are workforce challenges

There are a number of workforce challenges in NCL. These include attracting the right health and care professionals to NCL, retaining the existing workforce, and shortfalls in GPs, practice nurses and social workers.

Attracting healthcare professionals to NCL

There is predicted to be a 22% shortfall in nurses and a 14% shortfall in allied healthcare professionals (AHPs) across NCL by 2020[96], as shown in Exhibit 31. The high and increasing cost of living in NCL makes it difficult to attract and retain the required workforce.

Exhibit 31 – Supply and demand for nurses and AHPs

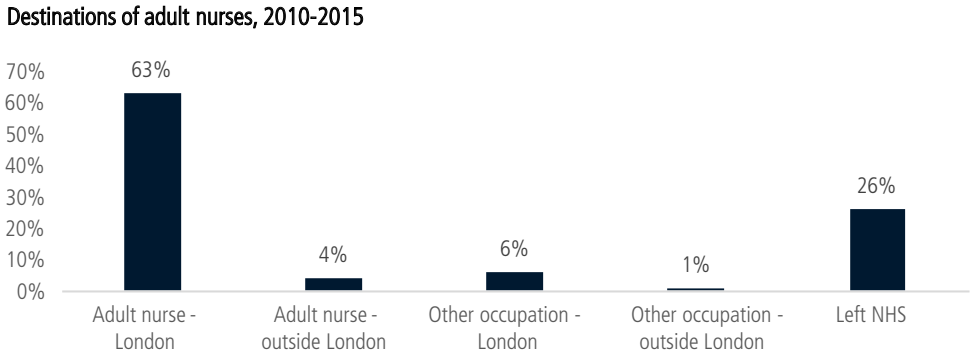


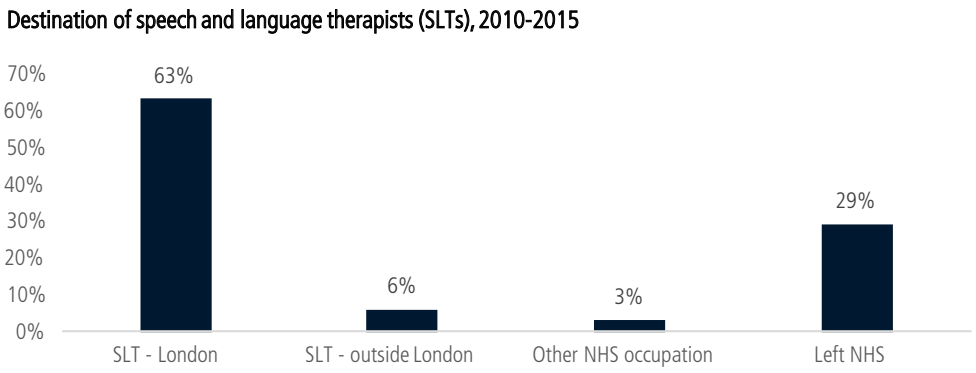
Source: NCL aggregated 2015/16 workforce planning data

Retaining the existing NHS workforce

The ageing of the workforce, and increasingly attractive career opportunities outside the NHS or outside London, make the recruitment and retention of staff one of the biggest challenges. Many people leave not only the local workforce but the NHS altogether, the majority being well under retirement age. For example, Exhibit 32 shows that 26% of adult nurses and 29% of speech and language therapists left the NHS entirely between 2010 and 2015[97].

Exhibit 32 – Destinations of adult nurses and speech and language therapists

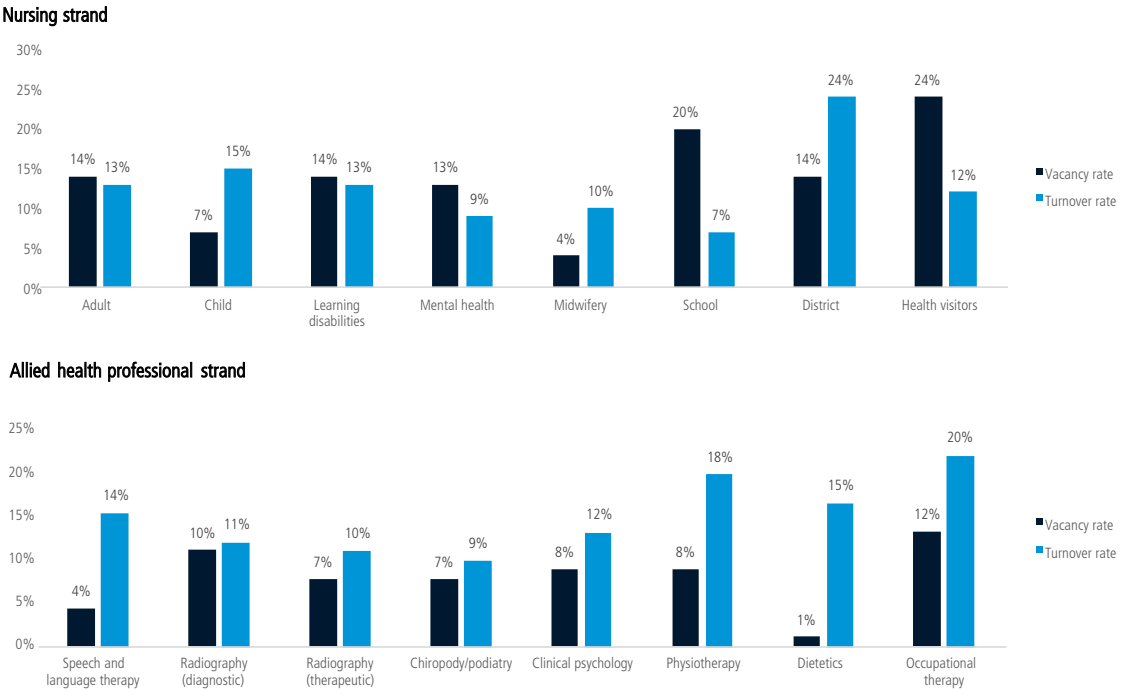




Source: Workforce Migration tool, 2015

There are high vacancy and workforce turnover rates locally, as shown in Exhibit 33. A particular issue is the high turnover rates in child nursing, radiography, mental health nursing and learning disability nursing, especially given that locally there is a children's hospital, a number of specialist cancer sites, and a number of mental health trusts. There are also high turnover rates in physiotherapy, occupational therapy and district nurses, which will impact on the delivery of additional community and primary care services[98].

Exhibit 33 – Health workforce vacancy and turnover rates in NCL



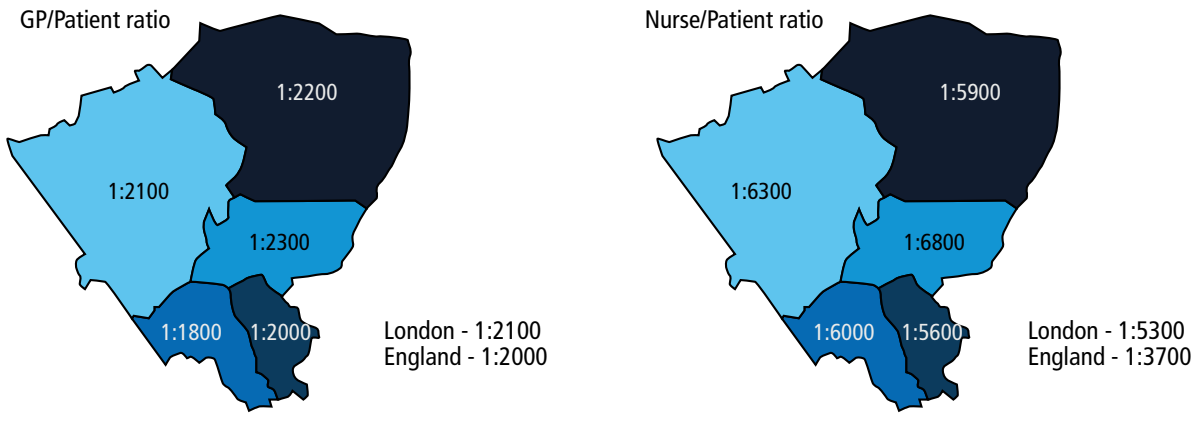
Source: 2015/16 Workforce Planning Data

NCL and North East London spend £735m a year on temporary and overseas staff, which represents 11.45% of staffing costs[99]. A reduction in staff turnover of just 1% could reduce costs by £87.6m[100].

GPs and practice nurses

The number of General Practitioners (GPs) and practice nurses across NCL is growing, but there is also unprecedented increase in demand[101]. As shown in Exhibit 34, there are also fewer GPs and nurses per person in some parts of NCL, especially Haringey[102]. Increasing the number of GPs to meet current levels of demand is not affordable, and alternative workforce models will need to be explored.

Exhibit 34 – GPs and practice nurses per person in NCL

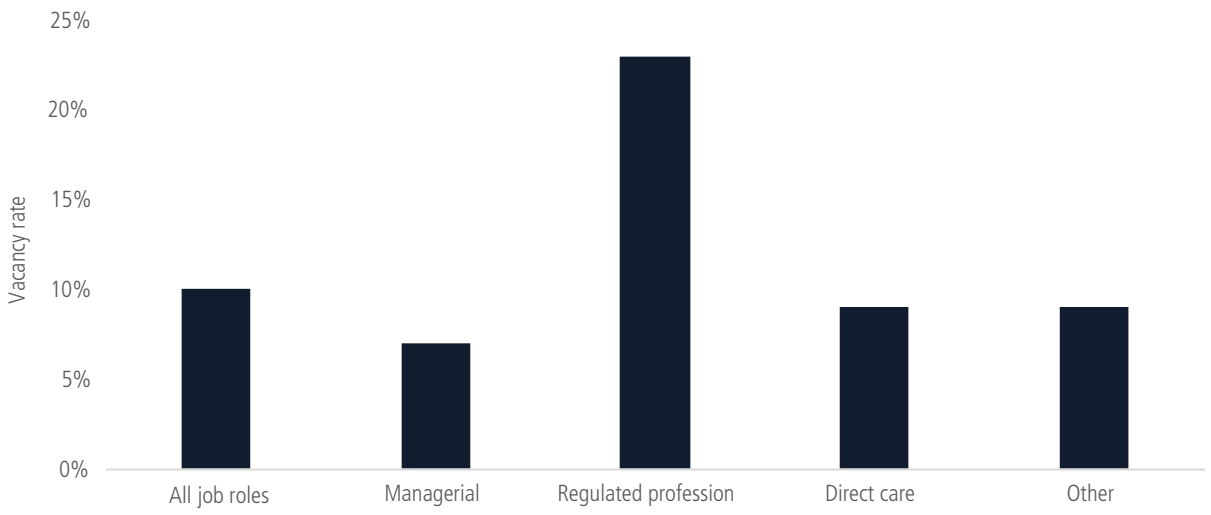


Source: National list size data

Social care workers

There are 35,000 people working in social care in NCL, with 1,500 staff in regulated professions (such as social workers) and 25,000 others providing direct care. As shown in Exhibit 35, vacancy rates across the regulated professions are around 23.5%, higher than any NHS staff group[103]. This shortfall of staff contributes to delays in discharge for people in hospital beds. There are also large differences in pay and conditions for the social care workforce, with 43% of the workforce on zero-hour contracts and many personal assistants employed directly by service users.

Exhibit 35 – Social care vacancy rates

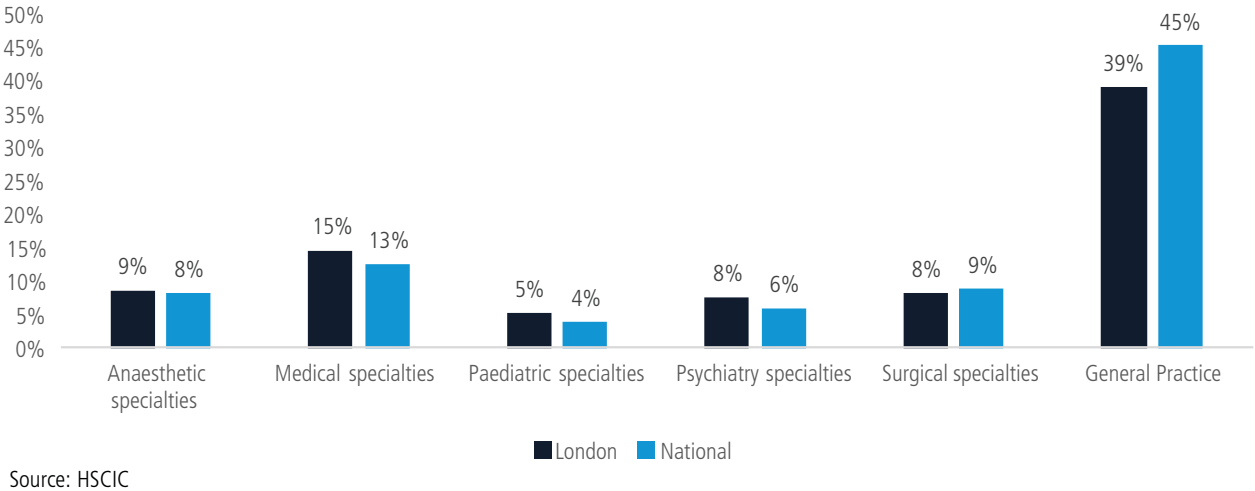


Source: HSCIC

Junior doctors and consultants

Between 2009 and 2014, the number of consultants in the London workforce increased by an average of 20.1% against a national average of 17.8%, and the number of Certificate of Completion of Training (CCT) holders continues to rise. As shown in Exhibit 36, London has a similar consultant workforce to the rest of the country, but a lower number in some specialties, particularly general practice[104].

Exhibit 36 – Proportion of the consultant workforce by selected specialty compared to England



Source: HSCIC

Over the next six years, there will be a large increase in the number of CCT holders[105]. It will be important to consider how these doctors are used to deliver more care in out of hospital settings.

This suggests a focus on recruitment and retention of the workforce, particularly where there are high vacancy and turnover rates or shortages in staff. It also suggests a focus on developing the existing workforce through new skills and ways of working, as well as adapting roles to changing requirements.

4.12. Some buildings are not fit for purpose

The availability of good quality buildings is very important in delivering new types of health and care services in NCL. Good quality buildings that are fit for purpose reduce infection and the length of time people stay in hospital, make it easier for staff to do their jobs, and are a more pleasant environment for people in hospital and reduce costs[106].

The quality of the NHS estate is very variable. Across London, more than half of NHS hospitals are over 30 years old and more than a quarter pre-date the founding of the NHS in 1948. Addressing maintenance issues across these hospitals would cost around £658 million[107]. These issues are particularly stark in NCL. Over the past two decades a number of major developments have taken place locally: rebuilding North Middlesex University Hospital (NMUH); rebuilding University College London Hospital (UCLH); and the development of the UCLH cancer centre. However, Chase Farm Hospital was mostly built before 1948.

Estates not fit for purpose

'We found that patient experience is compromised by the poor environment, with some patients having to share four-bedded dormitories, and with limited access to secure outdoor space.' (From an Enter and View visit)

Source: Healthwatch Enfield

It is thought that 15% of NHS building space in London is not actually being used[108]. The unused NHS buildings in NCL are worth an estimated £198m and cost the NHS £20m-£24.5m to run[109]. One example is St. Ann's Hospital where many of the current buildings are either vacant or partially occupied and are expensive to maintain. Major changes are required to improve the health facilities at St Ann's – planning permission has been granted to develop the site, but is subject to approval of the business case.

There are also issues in primary care, where a large number of existing primary care buildings in London are not fit for purpose. Around 33% of GP premises need replacing, whilst 44% need significant improvement to meet equalities laws[110].

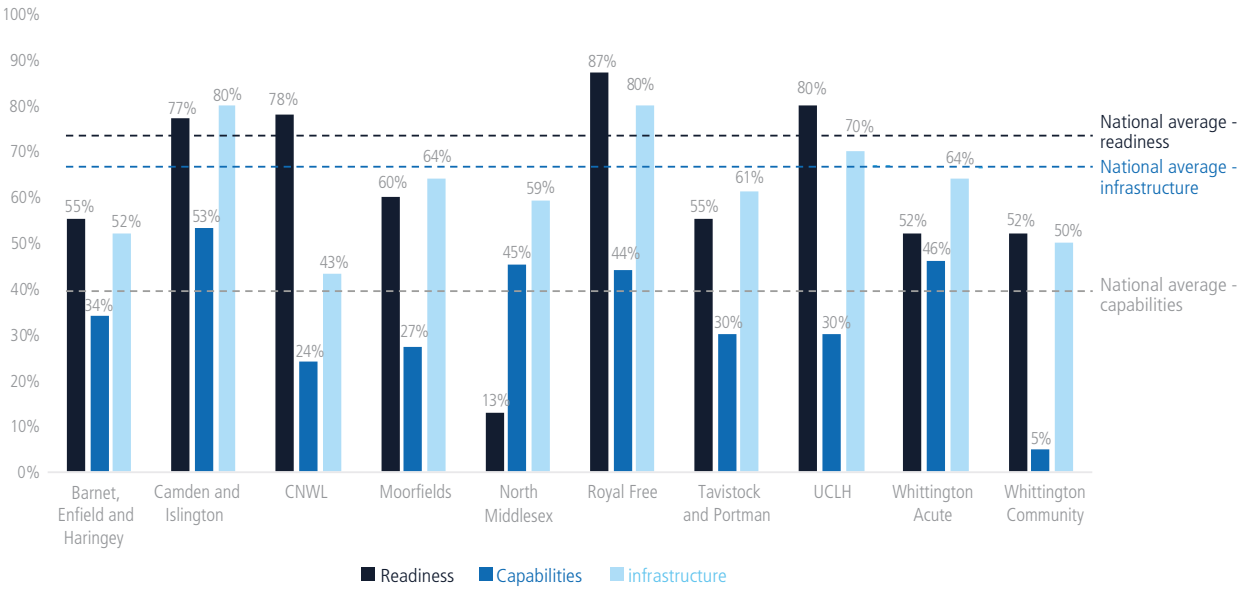
This suggests a focus on buildings that are old, expensive to run and not fit for purpose, and developing buildings that support patient and clinical needs.

4.13. Information technology needs to better support integrated care

Information sharing between people and between organisations is essential to deliver safe, effective and efficient care. Information sharing supports people to stay healthy, multi-professional teams to deliver integrated care and organisations to identify opportunities to reduce variation, waste and clinical harm. Patients and the public expect to be told who is using their information, why it needs be shared, who has access to it and what safeguards have been put in place to keep it secure. They also increasingly expect information to be shared with them, in a format they understand, and to help them to contribute their own data and let their care preferences be known.

As shown in Exhibit 37, the level of digital maturity of provider organisations across NCL is variable, with most below the national average for digital capabilities and particularly poor in terms of their capability to share information with others and adoption of national standards[111]. Data collection in primary care is much more developed than other areas of the NHS, but the quality of data and information still varies between practices, and the number of people digitally accessing their own GP records remains low[112]. Local authorities mainly have stand-alone systems, with limited ability to digitally share information with NHS providers or with other boroughs.

Exhibit 37 – Digital maturity assessment



Source: NHS England Digital Maturity Assessment 2015

The workforce needs to be connected all day, every day. They need to be able to access people's data and tools to assist clinical decision making in real time and collect and view data wherever they are working. While the use of mobile devices to view and capture data is gradually improving, there are still many areas where the workforce across NCL is not properly informed and supported[113].

The current situation has mainly been developed because of the need to meet regulatory requirements. More recently, integrated digital care records have been created to facilitate integrated care within individual CCGs in Camden and Islington. However, there is no NCL-wide governance structure or leadership team to implement digital transformation across NCL, and individual organisations continue to operate independently within their own areas with resultant fragmentation, lack of joined up information flows and duplication of effort.

This suggests that a priority area for focus is developing system wide governance and leadership to support the implementation of integrated information sharing and technology.

5 Financial challenge

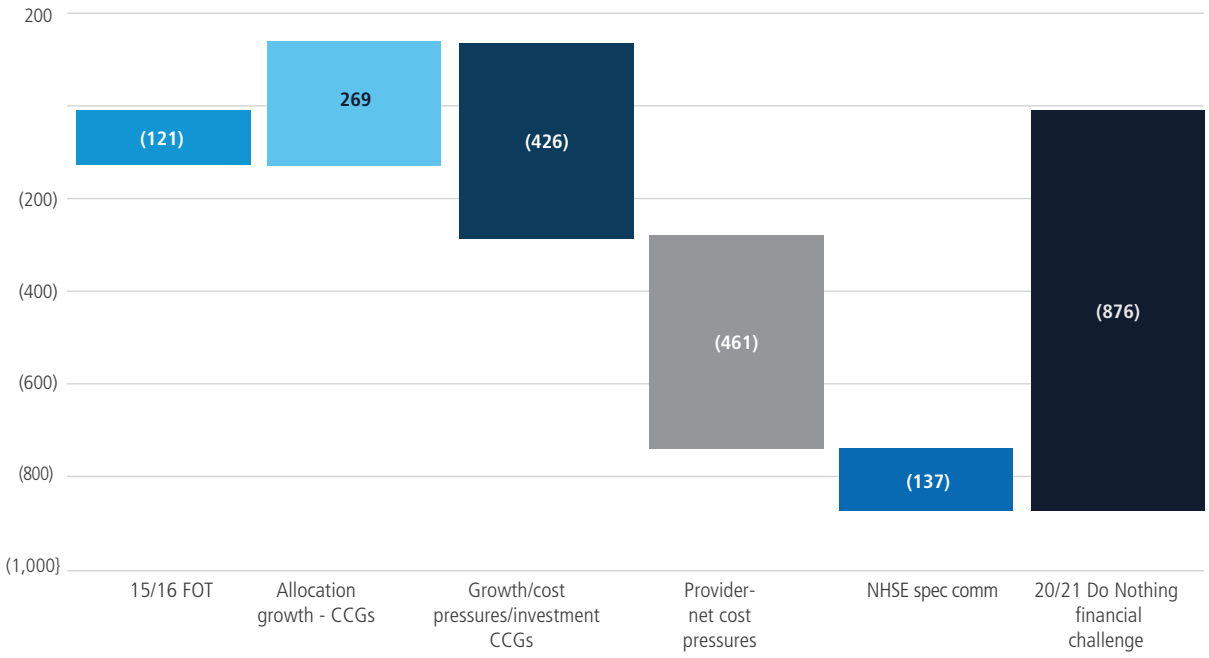
Funding increases in NCL of £269m over the next 5 years will not meet the likely increases in numbers of local people and growth in demand for health services of £426m, plus increases in the cost of delivering health care of £461m.

This means that there is a substantial financial challenge facing health organisations in NCL. Health commissioners and providers are already £121m in deficit in 2015/16 and, if nothing changes, will be £876m in deficit by 2020/21. This includes £137m in relation to specialised commissioning.

The health budget impact of the local authority financial challenge has not been calculated and so is not included in the 'do nothing' financial gap.

Exhibit 38 summarises the 'do nothing' financial gap for NCL.

Exhibit 38 – NCL forecast financial gap



Source: NCL finance base case analysis

The consequence of doing nothing is that local health and social care services would not be maintained. A new way of providing services is needed, that can be delivered within the funding available. This cannot be done by one organisation, but needs to be done across health and social care, with everyone working together.

6 Next steps

Recognising the significant scale of the challenges faced, and the urgency with which they need to be addressed, NCL has come together as a strategic planning group to create a 5-year Sustainability and Transformation Plan (STP). The aim of the STP is to meet the challenges outlined in this Case for Change, delivering clinical and financial sustainability for health and social care in NCL and, most importantly, improving the quality of care and outcomes for local people.

Leaders representing all aspects of health and social care in NCL – people that work in health commissioning, hospitals and local authorities, local GPs, and people that represent patients and the public – are working together to tackle the issues. They recognise that something radically different needs to be done in order to make sure local people have access to care when they need it, in the most appropriate place. This about promoting independence, health and wellbeing for everybody in NCL, whether they live in Enfield or Islington. It can only be done by working together, building trust between organisations that aren't necessarily used to doing so, and considering solutions across NCL. There may be things that can be done to improve health and care which are better delivered at a local, neighbourhood level. But it is important that there is a common vision across NCL in order to deliver maximum possible impact.

There is already lots of good work to build on in NCL. For example, UCLH and the Royal Free have set up an innovative joint venture with The Doctors Laboratory to run pathology services, which is at the cutting edge of new partnerships in health. There are existing schemes in NCL that could be further developed: the first Multidisciplinary Diagnostic Centre for cancer in England opened at UCLH, for example, and GP practices across NCL are already working together in GP Federations, meaning that they can deliver more services than they would be able to alone. Nationally, two 'vanguard' sites have been established in NCL – one looking at how hospitals can work together better, and one looking at what can be done to improve the end-to-end experience for people with cancer, from prevention to recovery. In addition, the Haringey devolution pilot, focusing on prevention, is exploring the licensing and planning powers needed to shape healthy environments; and support for people with mental health conditions who are on sickness absence but not yet unemployed[114]. In individual boroughs, great work has been done to meet the needs of local people and bring together health and care into a seamless service. This includes strengthening the role of the voluntary sector in providing services and caring for people and their families.

Local leaders are currently establishing the key pieces of work that will really make a difference and have a positive impact on lives in NCL. The ideas being explored include:

- developing new models of care for particular groups of people, making sure that they are tailored to the particular groups' needs;
- working with people from an early age through schools and communities to prevent them from getting sick;
- investing in primary care to make sure that people get to see a GP when they need and that more care can take place in the community, closer to home;
- addressing the issues that are present in hospitals, such as high infection rates and long waiting times;
- making sure that mental health and physical health are considered together and that this is reflected in the way that people with mental health problems are treated; and
- making sure that hospital treatments are delivered safely and efficiently.

The impact of these pieces of work will mean that people stay healthier for longer, and are able to play more of an active role in their own care if they want to. It will mean that more care can be provided at home or in the community, and that interactions with health

and care professionals will be different. In some cases, people might want contact with a named professional who knows them. In other cases, they might want access to a GP or the ability to make an appointment online. When people do need to go to hospital, they will only be there for as long as they need to be, and the connection between hospital professionals and community care professionals will make sure people are supported when they go home – making sure they have some food in the fridge when they get back, for example. All of this should reduce complications or difficulties that are caused from confusion, bureaucracy and lack of communication, meaning that people are less likely to end up in hospital when it could have been prevented.

Local leaders are also looking at ways to reduce avoidable costs through improving productivity and efficiency across NCL; for example, by bringing together administrative functions. This will mean that hospitals will have more money to spend on patients and care. Finally, the programme will consider what is required to deliver change. Examples of this include using technological advances to improve care, such as improving access to the latest diagnostic tools which pick up cancer at an early stage, or providing people with an electronic patient record that they can share with any health and care professionals they come into contact with so that their full history is known. Local leaders will also review the health and care buildings across NCL, identifying those that are not fit for purpose or not being used fully, and finding the best way to get maximum value out of these in order that they support new ways of working – or developing new, accessible buildings that are paid for by the money released from unsuitable sites. It will also be essential to develop the leaders of tomorrow – making it attractive and affordable for talented people to live and work in NCL, rather than depending on temporary staff, who can often be expensive.

The initial, high-level Sustainability and Transformation Plan will be developed by the end of June 2016, and further work at a more detailed level will continue to the end of 2016. Improvements will start to be made immediately, and completed by 2020/21. To get this right, patients, people who use services, carers and local residents will be involved in producing this plan. This Case for Change provides a platform for transformation, and will be referred back to over the coming years to ensure any proposed change is heading in the right direction. The data analysed in this document represents a point in time, and will be updated as required. Should new key issues, themes or gaps in care be identified as a result of this, local leaders will work together to respond to these.

Appendix 1: data segmentation methodology

Method	• Use Monitor Care Spend Tool as the structure of model, which allocates spend to cluster and then across age and condition bands • Splits spend by POD by age band • Assigns each individual to a condition in descending rank order of intensity • Applies pattern of resource consumption intensity by segment based on previous applications of matched patient-level data sets
Inputs	• Population by year and age band (ONS) • Distribution of condition by age band (Monitor tool) • Prevalence of health conditions in the locality (QOF) • Mapping of conditions by age band making use of Monitor peer group and QOF • CCG spend by POD for 2015/16 • LA spend by ASC
Outputs	• Breakdown by age and condition at with population, spend per capita, total spend plus breakdown by POD and segment for per capita and total spend • Locality level output dependent on data availability
Limitations	• Monitor peer group analysis limited to set age bands, does not have perfect match for the locality population and is therefore based on archetypal comparator areas • The analysis excludes children's social care • Is not actual patient level data specific to the locality

Endnotes

1 An estimated 181,000 in total in NCL by 2020, an additional 26,000 over 5 years

2 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

3 PHE 2015, HSCIC 2015

4 CQC care directory

5 All numbers from ONS unless otherwise referenced.

6 http://patient.info/doctor/diseases-and-different-ethnic-groups

7 GLA 2014 Round SHLAA Capped Ethnic Group Borough Projections (October 2015)

8 Census 2011

9 Census 2011

10 Nomis official labour market statistics, November 2015

11 Public Health Profiles Data Tool, PHE, 2014/15

12 IMD 2015, ONS

13 All numbers from ONS unless otherwise referenced.

14 http://www.lse.ac.uk/geographyAndEnvironment/research/London/pdf/populationmobilityandserviceprovision.pdf

15 https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

16 https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness

17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

18 Camden and Islington GP Linked Dataset projected to NCL level

19 Public Health Profiles Data Tool, PHE, 2014-15

20 Local analysis using Camden and Islington GP Dataset, 2012

21 http://ash.org.uk/files/documents/ASH_107.pdf

22 http://www.phoutcomes.info/public-health-outcomes-framework#page/3/gid/1000042/pat/6/par/E12000007/ati/102/are/E09000019/iid/91414/age/1/sex/4

23 http://www.phoutcomes.info/public-health-outcomes-framework#page/3/gid/1000042/pat/6/par/E12000007/ati/102/are/E09000019/iid/22401/age/27/sex/4

24 Public Health Profiles Data Tool, PHE, 2014-15

25 2014 Round of Demographic Projections - SHLAA-based population projections, Capped Household Size model, short-term migration scenario

26 ONS, mid-year population estimates

27 Public Health Outcome Data Tool, PHE, 2013

28 Public Health England 2015

29 Public Health England 2014

30 QOF 2014-15

31 http://www.ash.org.uk/current-policy-issues/health-inequalities/smoking-and-mental-health/the-stolen-years

32 NHS England Dementia Diagnosis Monthly Workbook, April 2016

33 NHS England Dementia Diagnosis Monthly Workbook, April 2016

34 Camden and Islington GP Linked Dataset, 2015, projected to NCL level

35 Camden and Islington GP Linked Dataset projected to NCL level

36 Based on 2015/16 public health budget of each NCL council

37 http://www.tobaccoprofiles.info

38 Public Health Profiles Data Tool, PHE, 2012-14

39 NHS Right Care, 2015 NHS Atlas of Variation

40 APHO modelled expected prevalence (2011)

41 Local audit of hospital admissions at the Whittington

42 APHO modelled expected prevalence (2011)

43 Quality and outcomes framework, 2014-15,

44 Quality and outcomes framework, 2014-15,

45 HSCIC, General Practice Census 2014 at Practice Level. Populations are unweighted.

46 GP Patient Survey (Q4; 2014-15

47 NCL Primary Care Joint Committee, March 2016

48 NCL Primary Care Joint Committee, March 2016

49 RightCare Atlas of Variation in Healthcare, September 2015

50 NHS England Monthly Activity Data 2014-15

51 SLAM Data (2014/15); provided by NEL CSU (analysis undertaken for Enfield CCG only)

52 NHS Right Care, 2015 NHS Atlas of Variation

53 HES 2013-14

54 Office for National Statistics, HSCIC CCG Indicator 2.6, 2014-15

55 Office for National Statistics, HSCIC CCG Indicators, 2014-15

56 Office for National Statistics, HSCIC CCG Indicators, 2014-15

57 ASCOF 2013-14

58 ASCOF 2013-14, HSCIC 2014-15

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61 People who die in their usual place of residence, ONC, 2014-15

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64 Devon acuity audit, October 2015

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80 Emerson E and Baines S, Health inequalities and people with learning disabilities in the UK. 2010

81 ONS, national population projections, 2015

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83 International cancer benchmarking partnership 2000-2 to 2005-7

84 39.4% in Haringey and 38.9% in Islington in 2013 compared to 46.7% in Barnet, HSCIC CCG outcome indicator set 1.18: percentage of cancers detected at stage 1 and 2.

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89 National cancer intelligence network, 2009-10 to 2014-15

90 UCLH cancer vanguard: imaging demand and capacity, 2020 Delivery, December 2015

91 UCLH cancer vanguard: imaging demand and capacity, 2020 Delivery, December 2015

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94 NICE guidance

95 Number of new lung cancer patients treated (patient first seen in 2013), Lucada

96 NCL aggregated 2015-16 workforce planning data

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99 An economic analysis of the North Central and North East London workforce, Health Education England 2016

100 An economic analysis of the North Central and North East London workforce, Health Education England 2016

101 General Practice and Workforce statistics, Health and Social Care Information Centre workforce data, Sept 2015

102 General Practice and Workforce statistics, Health and Social Care Information Centre workforce data, Sept 2015

103 Workforce Census, Skills for Care, July 2015

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105 HEE (London) trainee numbers, February 2016

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107 RIC returns, 2014-15 - significant, high and moderate risk backlog maintenance

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112 NHS England Digital Maturity Assessment 2015

113 NHS England Digital Maturity Assessment 2015

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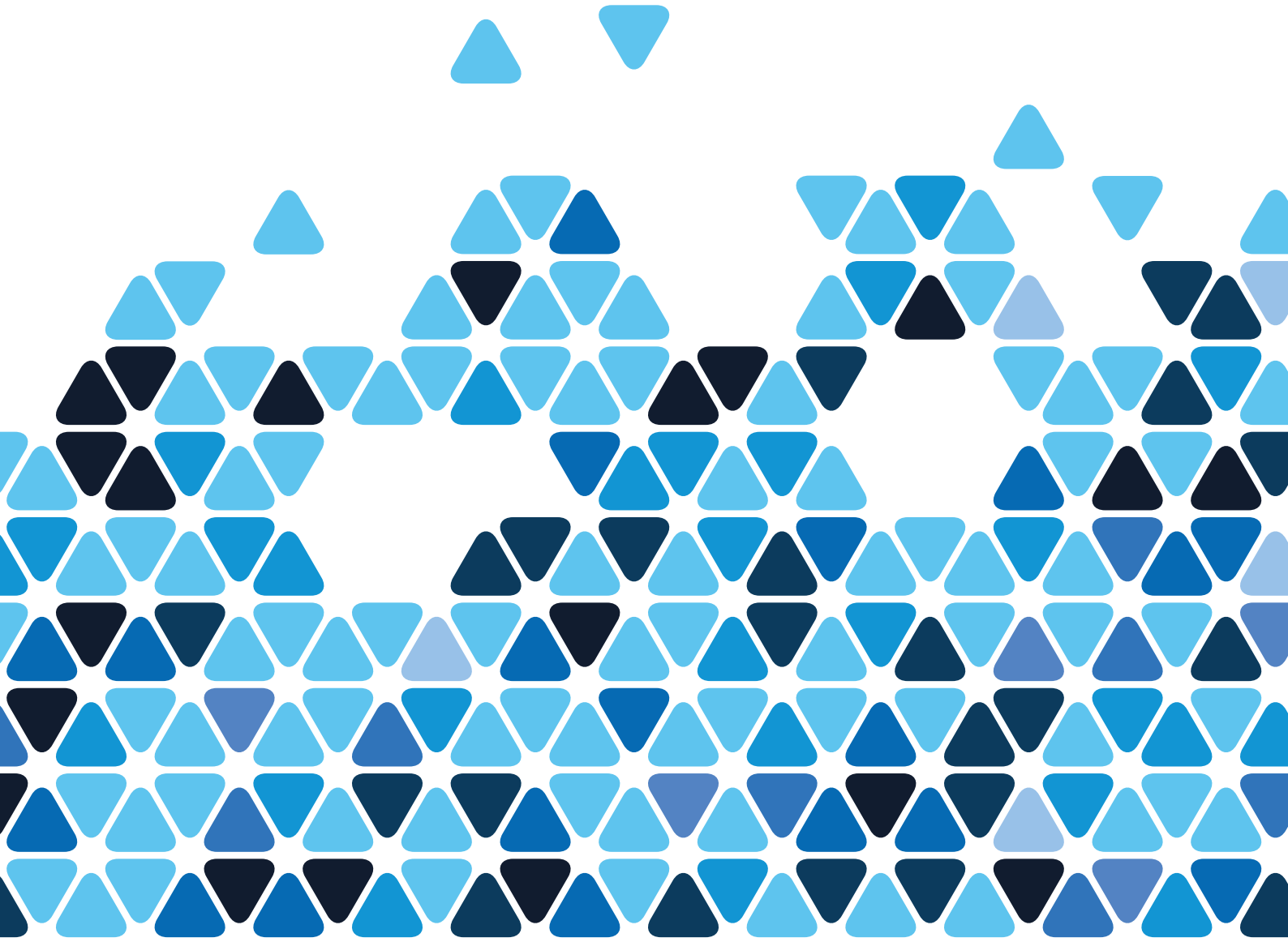
North Central London Sustainability and Transformation Plan



Agenda Item 8

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

MUNICIPAL YEAR 2016/2017 - REPORT NO.

MEETING TITLE AND DATE
Health and Wellbeing Board

Agenda - Part:	**Item:**
Subject:	
Wards:	
Cabinet Member consulted: Cllr Alev Cazimoglu	
Approved by:	

Ray James, Director of Health, Housing and Adult Social Care

Contact officer and telephone number:
Georgina Diba, Strategic Safeguarding Adults Service, tel: 020 8379 4432
E mail: Georgina.diba@enfield.gov.uk

1. EXECUTIVE SUMMARY

The Safeguarding Adults Board Annual Report 2015-2016 presents the work completed during the first year of statutory responsibility for safeguarding as defined by the Care Act 2014. This was a year in which a strong partnership embedded the legislative requirements for safeguarding, while at all times keeping the focus on how we can collectively prevent abuse from happening, while assuring when harm does occur we support recovery and resilience through the 'Making Safeguarding Personal' agenda.

The Safeguarding Adults Board is a partnership of statutory and non-statutory organisations which seeks to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area. The Safeguarding Adults Strategy 2015-2018 sets out the priorities of partners across Enfield, what we intend to achieve and the actions we will take to get there. This document was developed through consultation with local people, service users, carers and organisations.

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

2. RECOMMENDATIONS

For the Health and Wellbeing Board to consider the work undertaken by the Safeguarding Adults Board during 2015-2016 as set out its annual report, and any improved contribution or joint working in safeguarding.

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

3. BACKGROUND

The Safeguarding Adults Board meets quarterly and has a number of responsibilities as set out by the Care Act 2014 and statutory guidance. Our annual report sets out how we have met these aims and the significant accomplishments over 2015-2016. The Board is proud of their successes in **Making Safeguarding Personal**, following achievement previously to be acknowledged at gold standard level, and we have expanded on this work by all partners effecting actions which will put adults at risks central to the safeguarding process.

Across the partnership many organisations completed specific pieces of work which will improve the effectiveness of the safeguarding response. We set out a new multi-agency policy and procedure for responding to self-neglect and hoarding, while partners in the Clinical Commissioning Group set out a Prevent Strategy and Delivery Plan, which was adopted by NHS England as good practice. Much of the work is done through strong partnership and collaboration between partners; our **Fatal Fire Working Group** was set up to learn how we can prevent a similar occurrence in the future following death of two individuals, while our work around **dehydration** prevention continues to implement actions to reduce hospital admissions from care providers.

During this year we saw the operation of the Multi Agency Safeguarding Hub (MASH), a team that receives all safeguarding concerns. Through working together and sharing information, while in partnership and listening to the outcome expressed by the adult at risk, the team helps to manage risk and promote safeguarding planning. There were **3,511** reports made to the MASH, of these 1,602 were Police Merlins and 665 notifications raised by partners were about adults whom may be vulnerable but not in need of safeguarding actions. The remaining **1,244 safeguarding concerns** were considered as to whether they met Section 42 criteria for safeguarding. We know that neglect (33.9% of cases) and multiple abuse (29.2% of cases) are the most reported, and this follows previous years. Those alleged to have caused harm are often family members, which is followed by paid care workers. In 84% of cases there is a nominated advocate, often of the persons choosing where they have capacity, to support them through the process. At the time of reporting, 58.3% of cases were substantiated or partially substantiated. Our full data can be found in Section 8 of the annual report.

The Safeguarding Adults Board has a strong assurance role and in holding partners to account. We took part in a North Central London Challenge and Learning event following partner self-assessments. Every year adult social care has external assurance of case practice and we are establishing more diverse ways of how to include service user feedback in this process. Our **Quality Checkers** are a pivotal part of this, and have completed a number of projects including one which focuses on establishing the quality of activities in Care Homes across the borough.

The Board now has a statutory duty to report on all Safeguarding Adult Reviews (previously known as Serious Case Reviews). Two of these reviews were completed during the year and have action plans monitored by the Board. There are also two further safeguarding adults reviews started, which will be completed and reported on in the next financial year.

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

- Produce information in a wider variety of formats, including a DVD
- Consider how we can prevent harm from occurring within care providers
- Increase awareness of mate crime, particularly in mental health

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- Focus our data on the extent to which a person's outcomes have been met and whether this has made them feel safer

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

4. ALTERNATIVE OPTIONS CONSIDERED

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

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

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

5. REASONS FOR RECOMMENDATIONS

The Care Act Care and Support Statutory Guidance requires the SAB to send a copy of its report to the chair of the Health and Wellbeing Board. The guidance goes on to state that it is expected that organisations will fully consider the contents of the report and how they can improve their contributions to both safeguarding through their own organisation and to the joint work of the Board.

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

6.1 Financial Implications

The Care and Support Statutory Guidance sets out guidance for members on the assistance they may provide to support the Board in its work. As a result of this for 2015-2016 the Board established an allocated budget for the administration and implementation of the Boards work plan. This took into account the expected increase in Safeguarding Adults Reviews, which was due to their statutory nature. The total budget allocated for the Board was £63,500 and was made up of all partner contributions. The contribution from the Local Authority was made up of £43,000 from the Better Care Fund.

The Boards budget was managed by the London Borough of Enfield Strategic Safeguarding Adults Service.

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

6.2 Legal Implications

Section 43 of the Care Act 2014 imposes a duty on each local authority to establish a Safeguarding Adults Board (SAB) for its area. Schedule 2 of the Care Act 2014 sets out various requirements for SABs, including at paragraph 4 the duty to publish an annual report. Paragraph 4 prescribes the subjects which must be covered in an annual report and the people and bodies to whom the SAB must send copies.

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

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

7. KEY RISKS

Mitigation of risks in relation to vulnerable adults is demonstrated in the Board's annual report. The Board is required to work effectively within partner resources while ensuring it can meet the changing needs and trends emerging in relation to the harm and abuse of adults in its area. Taking into account changes by the Care Act, the Board seeks assurances from partners through quality assurance mechanisms that they are able to keep people safe and manage risks. This is evidenced, by one example, via partner self-assessments and the North Central London Challenge and Learning event.

The Board is continually looking at options to enhance efficiency and joint working that minimises duplication while provide quality and safe services to adults at risk. Needing to deliver in times of austerity, the Board will work in partnership with its statutory partners, namely the Police and Clinical Commissioning Group, alongside existing partnership Boards, to maximise its impact. The Board will continue to work closely with the Safeguarding Children Board and other partnerships to effectively keep people safe.

The community and those whom use services have inputted strongly into the development of the Board strategy action plan, which sets out the work program on an annual basis. The Boards action plan is reviewed at each quarterly meetings and highlights progress against each action.

Co-production and challenge on safeguarding adults is crucial and a clear requirement in the Care Act. This risk has been mitigated by the Service User, Carer and Patient sub group of the Safeguarding Adults Board. In addition, London Borough of Enfield are working on alternative digital and face to face options for adults or their representatives to provide feedback.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Ensuring the best start in life

The Safeguarding Adults Board works closely with the Safeguarding Children Board and seek to assure that all cases involving adults at risk of abuse where children are in the home are referred appropriately between services.

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

The Boards approach to safeguarding recognises that being safe is only one of the things people want for themselves and there is a wider emphasis on wellbeing. This is in line with the principles of Making Safeguarding Personal. The Board is focusing on the outcomes being reported in the coming year and has identified a shift needed in data collection to include the wellbeing principles.

All health and care services have the potential to be considered under safeguarding, both in terms of sec 42 enquiries or wider provider concerns process. Quality of services are considered as part of the general assurances provided to the Board through partners. Our work includes prevention of abuse and working with services and organisations to assure that they provide safe care that has quality at its centre.

8.3 Creating stronger, healthier communities

The Board has strong links to the Safer and Stronger Communities Board. Safeguarding practice includes working with people to resolve their circumstances, recover from abuse or neglect and realise the outcomes they want. The Boards work plan includes targeted work to consider how we engage and address the behaviour of perpetrators.

8.4 Reducing health inequalities – narrowing the gap in life expectancy

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

8.5 Promoting healthy lifestyles

The Board does not directly promote healthy lifestyles, but includes actions around self-protection to reduce the likelihood of abuse, such as fraud awareness and door stop sellers.

9. EQUALITIES IMPACT IMPLICATIONS

Corporate advice has been sought in regard to equalities and an agreement has been reached that an equalities impact assessment is neither relevant nor proportionate for the approval of the Safeguarding Adults Board Annual Report. Safeguarding forms part of the Councils programme of retrospective equalities impact assessments (EQIA) and this was completed in June 2016. The retrospective EQIA collates equalities monitoring of service users, and consider how the service impacts on disadvantaged, vulnerable and protected characteristic groups in the community.

Equalities in relation to the performance data for safeguarding are considered at each Safeguarding Adults Board meeting and as part of the Quality, Safety and Performance sub-group. The themes and trends emerging from data help direct the actions of the Board. Equalities Impact assessments will be completed for each of the project streams as appropriate**.**

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

Background Papers

ENFIELD SAFEGUARDING ADULTS BOARD

ANNUAL REPORT 2015/16

www.enfield.gov.uk/safeguardingadults

ENFIELD Council

ENFIELD Council

WORKING IN PARTNERSHIP WITH LOCAL PEOPLE AND

NHS Enfield Clinical Commissioning Group

Barnet, Enfield and Haringey NHS Mental Health NHS Trust

Royal Free London NHS NHS Foundation Trust

North Middlesex University Hospital NHS NHS Trust

London Ambulance Service NHS NHS Trust

METROPOLITAN POLICE TOTAL POLICING

LFB LONDON FIRE BRIGADE

CareQuality Commission

healthwatch Enfield

over 50s forum

age UK

People with Learning Difficulties One to One Making Life Better

STATEMENT FROM THE CHAIR

Thank you for your interest in safeguarding adults in Enfield. As independent chair of the Adult Safeguarding Board I am pleased to be introducing this Annual Report. This is an exciting year with the implementation of the Care Act and the Board being made statutory. In Enfield we have had an effective Safeguarding Adults Board for many years but it has been helpful to have legal backing. We are required to demonstrate even closer partnership working to ensure people do not slip through gaps in services. The Care Act increases the types of abuse we now have to consider, and all of this is done within the context of reducing resources for all partners.

We have continued to make sure that we hear the voice of people who have been identified as "at risk". Nationally Enfield has been identified as an area where we have made significant progress in involving victims in the safeguarding process. We need to continue to make sure that they are included in any actions and their views are listened to. It is good to see that many people are supported by advocates of their choosing, which includes independent advocates. Most importantly we want to make sure people feel safer at the end of the safeguarding process and will continue to ensure that the outcomes people wanted from the safeguarding enquiry are achieved wherever possible.

Our Dignity in Care Panel has continued to look in depth at the quality of services provided by the Council and make recommendations for improvements. They have also carried out "mystery shopping" to help the Council to get a true account of what it is like to use local services. We also have an active service user, carer and patient sub group of the Board to ensure their views are represented.

The number of referrals for safeguarding concerns has dropped this year for the first time, with an increase in notifications by organisations such as Police and NHS 111 around people they feel are vulnerable. Enfield has established a Multi-Agency Safeguarding Hub which is where all agencies, police, NHS and social care get together to share information and pick up early indications that abuse may be happening. This team also helps to ensure that all agencies are involved in helping to protect people at risk.

We continue to hear nationally about concerns of the quality of some health and care services, and of cases where adults have suffered harm in care homes, their own homes and hospitals. Since 2010 Enfield has had a safeguarding information panel to help to identify places where poor care may be happening. Where we do discover instances of poor care we ensure that improvements are made and the Board scrutinises these improvements.

This year we have completed 2 Safeguarding Adult Reviews into incidents of poor care and have ensured that the lessons learnt from these reviews are understood by all Board partner agencies; two more of these reviews are in progress.

I am very grateful for the support of all partner organisations for our work. I would particularly like to thank the Councillors and staff in Enfield Council, particularly Councillor Alev Cazimoglu for their interest and encouragement. Lastly, I would like to thank the people of Enfield for their vigilance.

Marian Harrington
Independent Chair, Enfield Safeguarding Adults Board

STATEMENT FROM SERVICE USERS, CARERS AND PATIENTS

"It's important that disabled people and other vulnerable service users are represented in the group as their safety concerns can easily be overlooked."

"Regarding the group and its recent achievement of 'Staying out of the Closet', this shows that by the group working together, it is possible to make a change to individuals and the community, when we get a result for the better. I do look forward to our meeting."

"ENDIG's committees found every Safeguarding Carers and Patients Groups (SCP) meeting very interesting and learnt a lot of issues which we don't know.

"The meeting were very useful information.

"Attendees showed their supportive toward Deafies and have their knowledge about Deaf Awareness.

"Many thanks for provided BSL Interpreter in every meetings.

"We would like to see SCP meeting continue and stay strong!"

"I have great pleasure in working with this concerned and informative group. They are the added value aspect of adult safeguarding."

Irene Richards, SAB Lay Member and Co-chair of the Service User, Carer and Patient Group

"As a Citizens Advice Bureau, working with thousands of vulnerable clients every year, it's great to have the opportunity to engage regularly with this group of service users, carers and patients who are passionate about contributing to how we keep people in Enfield safe."

Jill Harrison, Enfield Citizens Advice Bureau

"Victim Support were delighted to be invited to sit on the Safeguarding Adults: Service Users, Carers and Patients Group as it provides us with a real opportunity to engage with key stakeholders in Enfield and ensures the issue of safeguarding adults is kept as a top priority for everyone."

Caroline Birkett, Area Manager, Victim Support

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PARTNER STATEMENTS

1 ABOUT US

WHO WE ARE

The Enfield Safeguarding Adults Board (SAB) is a multi-agency partnership, which became statutory from April 1, 2015. The role of the Board is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area. This is about how we prevent abuse and respond when abuse does occur in line with the needs and wishes of the person experiencing harm.

OUR AIMS

Working together and with adults at risk of abuse we aim to ensure people are:

- safe and able to protect themselves from abuse and neglect;
- treated fairly and with dignity and respect;
- protected when they need to be;
- and able to easily get the support, protection and services that they need.

Our Safeguarding Adults Strategy 2015-2018 sets out the priorities of partners across Enfield, what we intend to achieve and the actions we will take to get there. This document was developed through consultation with local people, service users, carers and organisations. We review this annually.

WHAT WE DO

The Board is made up of senior members from all the agencies seen on the inside cover page. The Care Act 2014 and the statutory guidance sets out what the Board needs to do. We support the systems that keep adults at risk safe and hold partner agencies to account.

The Board supports adult safeguarding in its objective to stop abuse or neglect wherever possible, with a focus on prevention so that where possible abuse does not happen in the first place.
The Board has a **Prevention Framework 2015-2018** to help focus the activities. All of the work undertaken by the Board is done with an emphasis on the principles of Making Safeguarding Personal – keeping the person at risk of or experiencing harm as the central focus of any action.

12 TYPES OF ABUSE WE SAFEGUARD AGAINST.
PHYSICAL. SEXUAL. **FINANCIAL.** PSYCHOLOGICAL.
DISCRIMINATORY. ORGANISATIONAL. **NEGLECT.**
MODERN SLAVERY. TRAFFICKING. **SELF-NEGLECT AND HOARDING.**
DOMESTIC ABUSE. **HATE AND MATE CRIME.**

> **WE ALL KNOW THE SAYING 'PREVENTION IS BETTER THAN CURE'"**

RESOURCES AND FUNDING FOR THE BOARD

All partners contribute resources to enable the Board to carry out its statutory duties. Resources include staff time and additional support, such as attending Board meetings, co-chairing the sub-groups which support the work of the Board, and contributing to Safeguarding Adult Reviews. There are also additional projects or activities partners contribute towards, such as Keep Safe Week 2015 joint with the Enfield Safeguarding Children Board.

In 2015/16 the Board for the first time had a budget which some partners contributed towards. The total budget for the year was £68,900. The funding was managed by Enfield Council on behalf of the Board to an agreed plan, with updates given to each Board meeting about how the funds were being spent.

SUB-GROUPS WHICH SUPPORT BOARD WORK

Sub-groups were created to help the Board to achieve its aims and influence the Board's decision making process. Each group implements and works towards completing their own action plan.

This reporting year saw the closure of two sub-groups – the joint Safeguarding Adult and Children group, and the Policy, Procedure and Practice group – as well as a task to finish group on the Care Act Implementation for Safeguarding Adults. Groups are closed when actions are all complete or there are existing groups or forums taking forward the work.

SERVICE USER, CARER AND PATIENT GROUP

The SCP group meets bi-monthly and is committed to influencing how we work with adults at risk to keep them safe from harm and abuse. It is a diverse group that is fully invested in the need to be inclusive and representative of the population of Enfield.

Group membership was increased at the beginning of the year with representation from Victims Support and the Citizens Advice Bureau.

The group have been focused for some time on work around Lesbian, Gay, Bisexual and Transgendered (LGBT) experiences in care providers. They joined up with the Quality Checker program in Enfield to look into this area.

> "The Enfield LGBT Network is very pleased that the Safeguarding Adults: Service Users, Carers and Patients Group instigated the important piece of research 'Staying out of the Closet'. This was a forward thinking and bold undertaking and demonstrates the group is not afraid to tackle difficult issues."
>
> Tim Fellows, CEO, Enfield LGBT Network

QUALITY, PERFORMANCE AND SAFETY GROUP

Quality, Performance and Safety Group helps to provide assurance that partners provide a safe service and learn from incidents and performance data. Members agreed that the group needed to be representative of those on the Board and as such membership was expanded with the aim of providing greater responsibility from all partners to this area. Further, to ensure everyone is starting from the same knowledge point, there was a focused presentation on quality and performance in the context of safeguarding.

The group have identified areas to data where there may be gaps in the data, and have made suggestions in how these may be managed going forward. The group intends to set out recommended levels of quality assurance to be undertaken by partners in the coming year.

LEARNING AND DEVELOPMENT GROUP

The Learning and Development group looks at how we support adults, though a number of training, learning and support opportunities, to be competent in safeguarding adults. The group joined up with the equivalent sub-group of the Safeguarding Children Board from November 2015.

In March 2016 we held the first safeguarding and domestic violence training aimed at both practitioners in adults and children. Work will continue to look at areas were joint training can be delivered.

Learning and Training opportunities are delivered for the Safeguarding Adults Board partners by Enfield Council and included in 2015/16 the following:

- **Section 42 Enquiries** – **60** members of health and adult social care staff trained
- **Safeguarding Adults Legal** – **60** members of health and adult social care staff trained
- **Domestic Abuse and Safeguarding Adults** – **40** members of staff trained from across partnership
- **Domestic Abuse (Joint Children and Adults)** – **15** individuals working with adults attended
- **Level 1 Safeguarding Adults** – e-learning open to all
- **Mental Capacity and DoLS Refresher** – **23** staff members trained
- **DoLS and CoP Training** – **45** staff members trained

The Board also delivered some bespoke learning which included a Domestic Violence and Safeguarding Adults Conference in December 2015, with 45 people in attendance. Domestic abuse is a key issue for all partners; organisations such as the Mental Health Trust have written new Domestic Abuse Policies and included this in Corporate Induction for all staff.

In addition, all partners have their own safeguarding adults learning and development opportunities, which include for example:

- NMH have introduced monthly 'Lesson Learned Events' for Ward Managers and Matrons and other members of the multi-disciplinary team to enable reflections on recommendations from safeguarding adult's enquiries. In addition 86% of all staff had attended level 1 training and 74% of relevant senior staff had attended level 2 training.
- Safeguarding surgeries in the Mental Health Trust ensure focused sessions of learning on specific areas involving safeguarding adults and safeguarding children. Safeguarding Adults at Risk training levels 1 and 2 are delivered at mandatory Corporate Induction for all staff. The training is delivered as a safeguarding day and includes safeguarding children training, domestic violence training, and training in MCA and DoLS. Prevent Healthwrap is also delivered at Corporate Induction and has been mandatory since September 2015. Staff are required to refresh safeguarding training at least every 3 years. The Trust target for mandatory training compliance is 85%. Safeguarding adult training compliance for April 2016 is 86.5%

2 WHAT WE HAVE ACCOMPLISHED

Through quarterly meetings the Board has shown how it works collaboratively and in partnership to achieve the actions it has set itself in the Safeguarding Adults Strategy action plan for the year. Some of the key accomplishments from this action plan include:

- A new policy and procedure for working with self-neglect and hoarding, including when this may be useful to consider under safeguarding and high risk panels. There was strong collaboration with this work from the London Fire Brigade.
- We know that there is under reporting through safeguarding in Black and Minority Ethnic communities. The Board will continue to offer awareness raising and in March as part of International Women's Day, Enfield Council held an event with Naree Shakti, an Asian Women's Organisation in Enfield.
- Enfield Clinical Commissioning Group have trained up a number of Continuing Healthcare Nurses on the Best Interest Assessor course. This will help ensure actions continue to be taken with respect to the Mental Capacity Act and in line with the best interest of a person whom may lack capacity for a decision. They also held a Safeguarding Conference and a Primary Care Symposium on safeguarding over the year.
- Partners on the Board submitted their Making Safeguarding Personal action plan. While Enfield achieved a gold standard framework for this in March 2015, we recognised that we must remain focused on ensuring adults who are harmed have their views and wishes considered within safeguarding and are kept at the centre of actions undertaken.

The Board responded to a national report which suggested residents from care homes are more likely to be dehydrated upon admission to hospital than residents admitted from their own homes. A Hydration Group led by Quality Assurance in Enfield Council was set up to look into this, and started by having Quality Checkers undertaking 20 visits to care homes. A number of activities are underway, including training in care homes and card prompts for staff. A further 20 visits will take place to care homes across the borough to collect information on how care homes ensure residents with dementia and who are non-verbal are kept adequately hydrated with food and drink of their choice. This feedback will be shared with the working group to support the ongoing activities to reduce the number of residents of care homes presenting at A&E dehydrated.

The Board received a report from the Fatal Fire Working Group it set up, which was in response to the deaths of two individuals. The aim of this group was to share learning and any changes we could make to prevent a similar occurrence in the future. Some of the actions from this have included:

- Hoarding policy tool box for practitioners to identify hoarders
- Fire safety awareness information available from London Fire Brigade (LFB) website
- Occupational Therapy referral system in place for sign posting to telecare suppliers
- Joint work between Enfield Council and LFB to offer home fire safety visits to people in the community

Many Board partners have been working on the Prevent Agenda, which aims to stop people becoming terrorists or supporting terrorism. This is an issue for adults with care and support needs whom may be targeted or groomed for terrorist activities. Partners such as the CCG have:

- Trained 61 GPs over three sessions on Prevent
- A training workshop for community dentists and pharmacists
- Established a quarterly forum for the provider organisation Prevent leads. The forum will be facilitated by the Enfield Prevent trainer and will provide support and advice to the Prevent leads

OUTCOMES WE PROMISED TO REPORT ON

The Board agreed to report on the outcomes we have met from three places: our strategy action plan 2015/16, Quality Assurance Framework 2015-2018, Communication Plan 2015/16 and our Prevention Framework 2015-2018.

WE HAVE:

- Ensured guidance is being updated in time for the implementation of the new London Multi-Agency Adult Safeguarding Policy and Procedures. Partners also produced specific guidance, such as Enfield CCG Prevent Strategy and Delivery Plan, which was adopted by NHS England as good practice.
- Supported partners with Making Safeguarding Personal and made sure they have action plans where they are needed.
- Held a Care Act Implementation group which completed all of its tasks and reported back to the Board.
- Used information and soft intelligence via the Safeguarding Information Panel to determine providers which had organisational concerns. Led by Enfield Council and with a range of partners we then worked with those providers through the Provider Concerns Process to ensure improvements were made and that people were kept safe.
- Reviewed performance data at each meeting and set out actions for further review or assurance.
- Set out a quality assurance framework and have a plan for the next year on how audits will be undertaken.
- Held a forum for the Voluntary Sector in June 2015. We will continue to look for ways to connect with the Voluntary and Community Sector to improve engagement.

WE STILL NEED TO:

- Look at how we support adults who are isolated and may be at risk of abuse or harm. We have started a project plan and in the coming year need to join with partners to implement this.
- Improve how we gain feedback from adults at risk, to confirm that they feel safe and have a positive experience of care and support. Interviews were started but we did not have enough people able to take part. We are looking at different ways of doing this in the next year.
- Find ways for people at risk of harming others to access support to prevent harm or prevent repeat abuse. We want to use findings from a thematic review of domestic abuse involving adults at risk as the starting point for this work.
- Evidence the number cases which went to prosecution and had access to the justice system. Our Police colleagues will be looking at this to assure the Board that adults at risk have equal access to the justice system.

Partners on the Board were asked to complete a safeguarding self-assessment. A North Central London Challenge and Learning event was then held in January 2016. Partners came to learn from one another, provide critical analysis and help to plan what we need to focus on going forward.

COMMUNICATION AND AWARENESS

Adult safeguarding must raise awareness of abuse so that communities as a whole, alongside professionals, play their role in seeing and reporting abuse. The Board and individual partners have:

- Held a domestic abuse conference focusing on experiences of adults at risk
- Facilitated a week of events joint with the Enfield Safeguarding Children Board on keeping yourself safe and well
- Raised awareness of disability hate crime through a publicity campaign
- Attended partner events, such as Carers Week 2015 and to the Learning Disabilities Partnership Board
- Completed a review of all publicity through the Service User, Carer and Patient Sub-Group of the Board
- Representatives from Enfield Council spoke at the Respect Conference on the Care Act and Making Safeguarding Personal when working with perpetrators.

MULTI-AGENCY SAFEGUARDING HUB (MASH)

The MASH has been in place since April 2015 and is a multi-agency team that receives all safeguarding concerns. Through working together and sharing information, while in partnership and listening to the outcomes expressed by the adult at risk, the team helps to manage risk and promote safeguarding planning.

What some of the MASH Team say about this innovative way of working?

> "I enjoy working for MASH because every day brings different challenges and learning opportunities. I actually enjoy coming to work. I feel the way MASH works epitomises social work values and encompasses what social work is about and should be and it allows me to put into practice daily the reasons why I wanted to become a social worker."

> "In my role of Social Worker in the MASH I enjoy the day-to-day challenges of supporting people in the most difficult and distressing of circumstances and supporting people to regain some sense of control and autonomy over their lives."

3 THE DIFFERENCE TO ADULTS AT RISK OF HARM

Miss M is a young woman who has a learning disability and while she speaks some English, so is not able to talk about more complex subjects. She receives health and social care support from the Enfield Integrated Learning Disabilities Service.

Miss M was at risk of being forced into a marriage overseas, and has been assessed as not having the capacity to understand the situation or the impact that marriage would have on her life. She lived at home with her family and they were the people that were wanting her to marry. The Integrated Learning Disabilities Service went to the Central Family Court and obtained a forced marriage protection order. This order was taken the same evening to Miss M's family by the police and social services. This order has helped to prevent Miss M from being forced into a marriage that she does not have capacity to consent to.

> "I would also like to take this opportunity to say how impressed our whole team here at FMU have been about how this case has been handled...on this occasion the case has been handled with efficiency and professionalism. I believe this is one of very rare cases where the capacity assessment and Forced Marriage Protection Order has all been obtained within a couple of days from referral."
>
> Forced Marriage Unit, Foreign and Commonwealth Office

Miss A is a young woman whom disclosed sexual abuse by her father. She had been unable to complete her schooling but tried to continue to enable her to get into university. She lived at home with her family and when she disclosed the abuse, some family members verbally abused her and blamed her for the situation. The Multi-Agency Safeguarding Hub were concerned about the risk of honour based violence and the need for emotional and practical support. Within 24 hours and with the help of her school, she was consulted with and emergency young person's support accommodation was found. Her father was subsequently arrested and remains in custody.

Miss A will now receive ongoing assessment from the Care Management Service to fully assess her needs and ensure she receives the support she requires to enable her to maintain her independence and maximise her wellbeing. Different teams, agencies and organisations worked effectively within 24 hours to source and secure appropriate accommodation for a very vulnerable service user to maintain her safety. Despite her not presenting with evident care needs, Miss A was clearly in need of support and was subsequently deemed to have met the safeguarding criteria.

Mrs T disclosed that her family members were calling weekly and threatening her. A safeguarding concern was raised and with Mrs T consent the police were informed. There were known historical allegations of sexual, physical and emotional abuse. A safeguarding meeting was held and it was agreed that the Police would lead an investigation. The Mental Health Trust supported Mrs T and offered her an assessment of her care and support needs, referral for counselling and regular reviews by the clinical teams. Due to the high risk in this case of domestic violence a referral to the Multi-Agency Risk Assessment Conference (MARAC) was completed.

WORKING WITH CARE PROVIDERS

In addition to the safeguarding adults process for single concerns of abuse, Enfield also have a provider concerns process. This process is used when there are serious concerns relating to safeguarding and the quality of care with provider services. The process is used to support providers to improve, so that we can be assured those whom use the service are safe. This process is led by Enfield Council but with strong partnership from Police, Care Quality Commission, Clinical Commissioning Group and a range of other partners.

During 2015/16, we worked with seventeen providers under this process. We help providers to set out an improvement plan which we then monitor and quality assure that actions have been completed. Those who use the service, their families and visiting friends are the key partners who can let us know how the care is experienced and if they feel real change has been made; one person fed back on our questionnaire 'staff do not work as a team, they work individually.' This has helped us to address issues with the home and see how team capacity and building could be undertaken.

4 QUALITY ASSURANCE AND ORGANISATIONAL LEARNING

The Strategic Safeguarding Adults Service in Enfield Council undertakes quarterly audits of safeguarding practice. We look at how the adult at risk or their representative was involved from the beginning to end, the outcomes they wanted were known and areas such as proportionality and prevention were considered. The audit found that overall practice was very good across all of the six safeguarding principles. The area that stood out for improvement was in the application of the Mental Capacity Act 2005.

An external auditor was used to provide independent challenge to how practice is undertaken. The key learning from this audit was:

1. There is a culture of learning evidenced in this audit. Of particular note was the time taken by workers to understand the audit process and view it as a positive learning opportunity.
2. There are good organisational learning opportunities. The Best Practice Forum is a good platform to share learning across services. Other learning opportunities for example Lunch Time Seminars to widen access to shared learning might be explored.
3. The Three Stage Test needs to be applied consistently.
4. Partners need to be Care Act 2014 ready as safeguarding adults is not the sole prerogative of the Council.
5. The MASH would benefit by greater multi-agency involvement and co-location of core agencies.
6. Systems in mental health and hospital social work teams and the MASH need to be reviewed to make the best use of resources.
7. Targeted training on alternative types of achieving outcomes e.g. family conference.
8. Broaden the knowledge of the requirements of Section 68 Care Act 2014 advocacy arrangements.
9. Rationale for decision making throughout should be recorded.
10. Risk assessments need to focus on risk management with the adult.
11. Templates should allow for sovereignty so that staff use their own knowledge and skills to personalise action according to the adults desired outcome.

QUALITY CHECKERS

Quality Checkers are a group of volunteers that have experience of social care or are carers. They undertake visits to provide their feedback on services and are a vital point of contact with those using the service. The quality checkers have done a number of projects this year, including establishing the quality of activities in Care Homes across the borough, visits to homes to look at hydration practice, specific work focusing on how homes support Lesbian, Gay, Bisexual and Transgendered individuals, and making visits in response to quality concerns which are then fed into the safeguarding adults process.

PROMOTING LEARNING

Partners on the Board are keen to promote learning and hear from those who use services. There are many ways this can be done – such as Barnet, Enfield and Haringey Mental Health Trust hold safeguarding surgeries with staff from multi-disciplinary team on a regular basis. The North Middlesex Hospital hold lessons learnt meetings to share learning and embed change.

Every single safeguarding concern looks at whether there is learning for any partner or organisation. These are then reviewed after three months to make sure recommendations are put in place.

5 SAFEGUARDING ADULT REVIEWS

We report in this section on how many requests for a Safeguarding Adult Review were made to the Board. We will say whether we accepted this as meeting the criteria for a SAR and if not, why. For those that were undertaken we provide information on the recommendations and what we will do next.

The Care Act 2014 states that a Safeguarding Adult Review (SAR) must be arranged by the Safeguarding Adults Board (SAB) when an adult in its area dies as a result of abuse or neglect whether known or suspected, and when there is concern that partner agencies could have worked more effectively to protect the adult. A SAR must also be arranged if an adult has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect. Please note that Safeguarding Adult Reviews were previously known as Serious Case Reviews.

Two Safeguarding Adult Reviews were completed in the 2015/16 reporting period. A summary of each case follows. Two additional Safeguarding Adult Reviews have been raised and agreed to meet the criteria; these remain in progress. One further request for a Safeguarding Adults Review has been raised in this financial year and we are awaiting panel of Board members to consider if the criteria has been met.

Two referrals were raised and did not meet the statutory criteria for a Safeguarding Adults Review. This was because both were in response to failings by single agencies and not related to how partners worked together to safeguard. There is always learning from cases and these can be looked at using the single safeguarding adult's process or through single agency review.

SAR ONE

Ms Q was an elderly lady whom lived in an Enfield residential care home for the last three years of her life where she was supported by her daughter who took an active interest in her care. She died in April 2015 and there were concerns about how partners worked together. The review found no evidence of deliberate neglect or harm, however that pressure damage could have been avoided.

The SAR outlined five main areas of improvement and learning. These are summarised below:

1. Baseline assessments must be completed and reviewed when a person presents with previous and potential damage within the community.
2. A lead clinician is allocated to oversee the case and treatment for residential care homes and high risk community patients.
3. Mental capacity should be considered at key stages when concerns are indicated.
4. Pressure ulcer management should have a clear treatment pathway with a professional escalation process.
5. Improved communications facilitated by defined professional roles and responsibilities at an early stage.

SAR TWO

Mr X was an elderly man who had resided in an Enfield nursing home following his discharge from hospital some years before. Mr X suffered from dementia and had no capacity to consent to care or to articulate his needs. There was a safeguarding concern raised following his death and then a Safeguarding Adults Review was commissioned in October 2014. A number of recommendations were made around improving communications, implementing escort protocols when service users lack capacity and catheter management within nursing homes. The recommendations from this review were:

1. Pre-admission to care settings to include that checks that people are discharged with sufficient stock of medication.
2. Meeting to be convened with local hospitals, nursing and residential care providers to set out protocols for improving discharge from hospitals and admission to care settings.
3. BUPA policy of adults being accompanied to hospital to be quality assured for implementation in BUPA homes. Hospital staff to accept responsibility for people when they are on hospital premises.
4. Transfer letters to hospitals from care settings to clearly detail the reason for contacting acute medical services and highlight if there is a repeat concern.
5. NMUH to review systems to highlight repeat admissions.
6. Clinical Commissioning Group to quality assure discharge planning in local hospitals.
7. London Ambulance Service to be compliant with Care Act 2014 requirements and to co-operate and contribute to Safeguarding Adult Reviews.
8. London Borough of Enfield to quality assure that timely reviews are taken and that there is a system to confirm that recommendations from adult safeguarding enquiries are implemented.

The recommendations from both of these Safeguarding Adults Reviews will be formulated into an action plan monitored via the Safeguarding Adults Board. Reports from each SAR will go onto the Enfield website once consent has been obtained from family members of the adults at risk.

SAFEGUARDING ADULT REVIEWS IN PROCESS

A SAR has been agreed in response to a serious sexual assault. This SAR is currently in process but actions are already being taken with the Provider and a number of Local Authorities and the placing Clinical Commissioning Group to start embedding changes.

A SAR has also been agreed to look at domestic abuse involving adults at risk. This is being undertaken using a thematic review methodology.

We expect to report on these SARs and the findings during 2016/17.

6 WHAT WE WILL DO NEXT YEAR

We have a Safeguarding Adults Strategy 2015-2018 and there are a number of actions for us in the next year to complete. We completed a review with service users, carers, and organisations via Partnership Board in January-March 2016. We met with the following four partnership boards:

1. Carers Partnership Board
2. Learning Disabilities Partnership Board
3. Mental Health Partnership Board
4. Physical Disabilities Partnership Board

We talked about the actions that we would be undertaking in the coming year and explained that safeguarding was now a statutory duty. We also asked each partnership if they had any suggestions on what the Safeguarding Adults Board could do to keep people safe from harm in the coming year. We did this to see if there were any additional actions the Board should be taking.

These are some of the suggestions that we received:

- Produce newsletter articles or find different ways to inform people about safeguarding and what it means
- Attend voluntary sector events and forums
- Produce a DVD that explains safeguarding and generally use video more to help people understand the different types of abuse
- Increase awareness of Mate Crime, particularly in mental health
- Update images in the Staying Safe leaflet

In addition, each partner on the Board has set themselves an action that they will undertake which will be monitored by the Board.

Finally, we have used our data to look for any themes or trends that help us to direct what we should focus on. We have found that we must continue to focus on domestic abuse and how we ensure adults are supported to reduce risk of harm. We also know that abuse does happen in care and we will continue to look for ways to prevent quality and safeguarding issues with providers. We have seen a change in the number of reports of abuse and have agreed that how we record safeguarding concerns needs to be reviewed, as we are closing down concerns in line with people's wishes and safeguarding plans much more quickly. We want our data in the next year to capture more easily the extent to which a person's outcomes have been met and whether this has made them feel safer.

Our action plan will be monitored at each Board meeting and can be found in the safeguarding adult pages at www.enfield.gov.uk

7 ACTION PLAN 2016/17

Objectives set out by the Safeguarding Adults Board are set out below. The actions to achieve these and responsible individuals can be found on the full document reported at each quarterly Board meeting. These can be access on the Safeguarding Adults Board pages at www.enfield.gov.uk

KEY PRIORITY 1: EMPOWERMENT

People being supported and encouraged to make their own decisions and informed consent

- OBJECTIVE 1.1: Mental capacity assessments and the Deprivation of Liberty safeguards are carried out in compliance with new requirements under the Care Act 2014 and with regard to ensuring individuals who lack capacity have support to optimise their well-being and control.
- OBJECTIVE 1.2: The Board will assure itself that adults at risk are involved strategically in safeguarding and through to involvement in individual cases.
- OBJECTIVE 1.3: We will help young carers to understand what safeguarding adults is about and where they can go to for advice, support or to make a report.

KEY PRIORITY 2: PROTECTION

Support and representation for those in greatest need

- OBJECTIVE 2.1: For individuals in Enfield to have appropriate information on abuse and how to stop abuse before it happens.
- OBJECTIVE 2.2: Individuals experiencing safeguarding concerns to have access to appropriate advocacy.
- OBJECTIVE 2.3: The Board will clarify the surveillance and community alarm options for adults at risk and their representatives and have assurances this in within legal parameters.
- OBJECTIVE 2.4: Partners on the Board will facilitate intervention on the issue of dehydration and hold providers to account for implementation.

KEY PRIORITY 3: PREVENTION

It is better to take action before harm occurs

- OBJECTIVE 3.1: To support people to keep themselves safe (self-protection strategies) and recognise abuse; learning lessons from domestic violence campaigns and Domestic Homicide Reviews.
- OBJECTIVE 3.2: Raise the profile of domestic violence, honour based violence, female genital mutilation and trafficking within the Acute Hospital Trusts.
- OBJECTIVE 3.3: Local health economies are in place which are monitored and have indicators that ensure people are kept safe from abuse.
- OBJECTIVE 3.4: To create a more robust organisational learning system which is able to evidence practice change.
- OBJECTIVE 3.5: The Board will develop and deliver on creating pathways of support for those isolated and at increased risk of abuse and exploitation.

KEY PRIORITY 4: PROPORTIONALITY

The least intrusive response appropriate to the risk presented

- **OBJECTIVE 4.1:** We will seek service user feedback from those who have been harmed to improve practice.
- **OBJECTIVE 4.2:** Board will facilitate pathway programme in place for people at risk of harming others.

KEY PRIORITY 5: PARTNERSHIP

Local solutions through services working with their communities. Communities have a part to play in presenting, detecting and reporting neglect and abuse

- **OBJECTIVE 5.1:** For partner organisations to provide assurance to the Board that their service provision is in line with the Dignity Standards.
- **OBJECTIVE 5.2:** For language of professionals to be simplified so that there is improved equality of access to services – as recommended by Making Safeguarding Personal.
- **OBJECTIVE 5.3:** For the Safer Neighbourhood Team to set out an engagement plan with the partnership to improve how we can work together to safeguard adults at risk in the community and with providers.

KEY PRIORITY 6: ACCOUNTABILITY

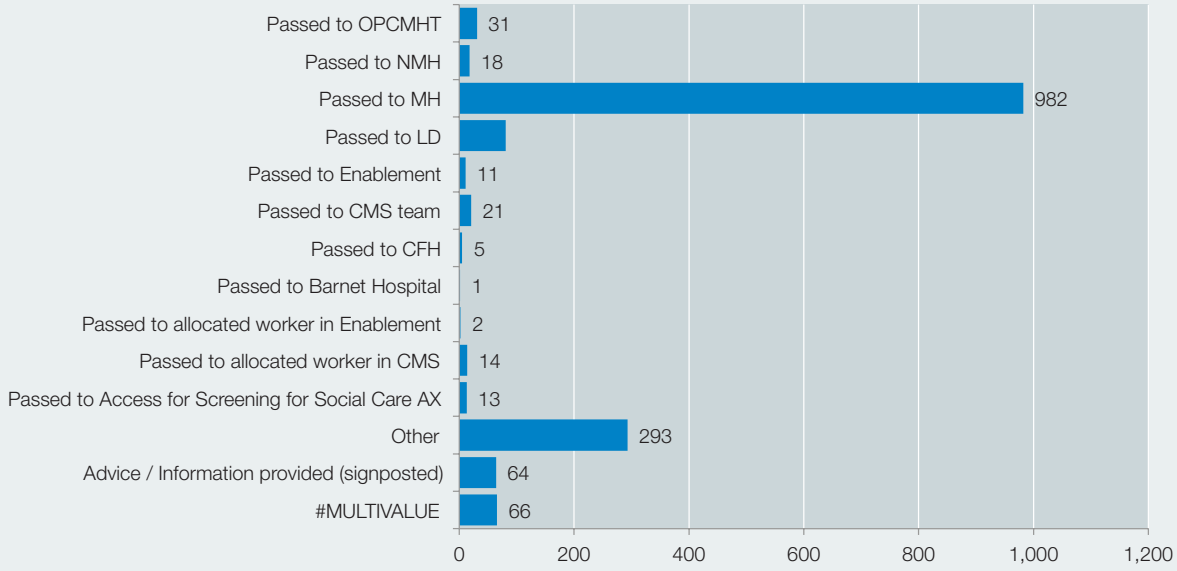
Accountability and transparency in delivering safeguarding

- **OBJECTIVE 6.1:** Board will assure itself that decision to proceed under safeguarding and decisions to prosecute are transparent.
- **OBJECTIVE 6.2:** Provide assurance of General Practitioner Input into safeguarding adults.
- **OBJECTIVE 6.3:** Carry out Safeguarding Adults Reviews (SAR) were there is a statutory obligation and ensure learning is widely disseminated.

8 PERFORMANCE REPORT 2015/16

TOTAL NUMBER OF REPORTS MADE TO THE MULTI-AGENCY SAFEGUARDING HUB: 3,511

Of these, number of Merlins: 1,602



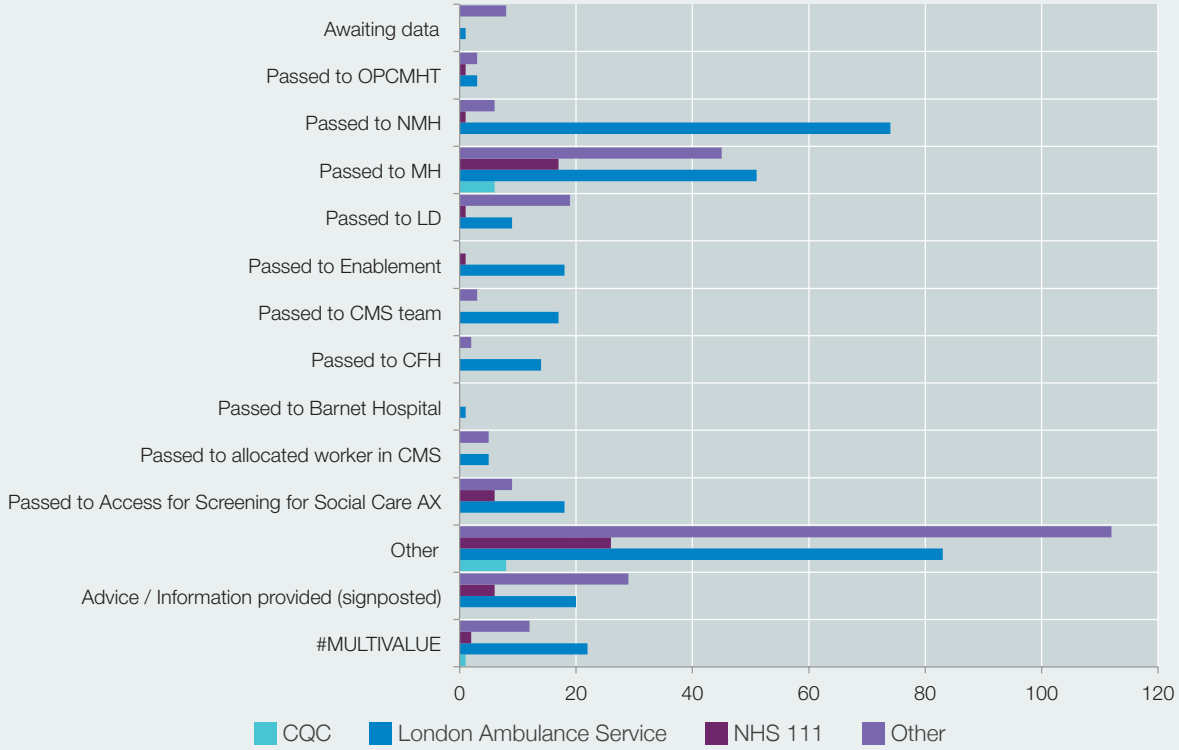
#MULTIVALUE equals to more than one input onto the Carefirst database

Majority of police Merlins relate to adults with mental health needs. The MASH sent 902 of these Merlins to the Mental Health Trust. Where there is an allocated worker in adult social care, these are sent direct to the relevant teams.

Merlins are helpful in providing additional information, which can be used to build up a picture over time or identify when risk is escalating.

A Merlin is not always safeguarding; The Merlin Database is the recording system the Metropolitan Police utilise to record missing people, and children and adults coming to police notice. This system is used to record contact and what, if any action has taken place. Officers and police staff are trained to identify vulnerability through the use of the MPS Vulnerability Assessment Framework.

Of these, number of referrals from partners not progressed as safeguarding: 665



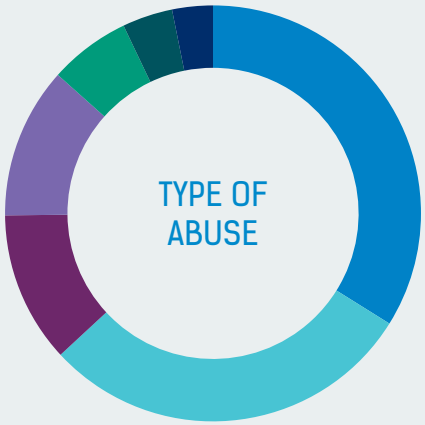
#MULTIVALUE equals to more than one input onto the Carefirst database

TOTAL SAFEGUARDING CONCERNS RAISED TO COUNCIL: 1, 244

- **189** cases were managed under safeguarding with a brief enquiry that enabled early resolution
- **138** safeguarding cases did not meet Sec 42 criteria
- **83** safeguarding concerns were more appropriate for care planning or support from other professionals
- **52** cases where the Sec 42 criteria was not met, we still provided advice and guidance direct to the person raising concern, a professional involved or the adult/their representative
- **48** safeguarding concerns were repeat notifications, often from another partner, of an existing Sec 42 progressing. These were recorded to help build a picture over time
- **30** safeguarding concerns were passed to the correct host authority if safeguarding or to placing authority if not safeguarding concern
- **60** additional safeguarding concerns were passed to mental health to consider if they met the Sec 42 criteria

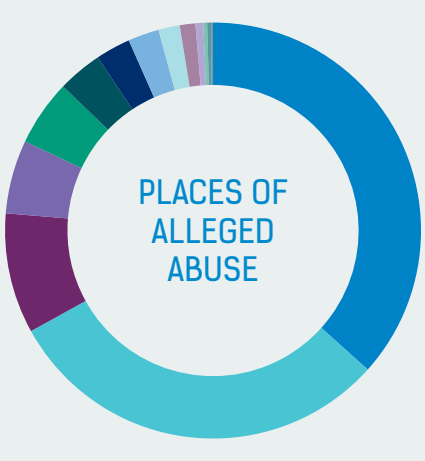
An additional **644** cases which went through the Sec 42 process are reported on the following pages.

DETAILS RELATING TO 644 CASES



Neglect	225	33.9%
Multiple Abuse	194	29.2%
Financial	78	11.7%
Physical	78	11.7%
Institutional	42	6.3%
Psychological	26	3.9%
Sexual	21	3.2%
Discriminatory	0	0.0%

Neglect (33.9% of cases) and Multiple Abuse (29.2% of cases) are the most reported in Enfield.



Own home	243	36.7%
Residential or nursing home	201	30.3%
Acute hospital	62	9.4%
MH inpatient setting	38	5.7%
Supported accommodation	34	5.1%
Other	23	3.5%
Not known	18	2.7%
Case active, awaiting data	16	2.4%
Public place	11	1.7%
Community hospital	8	1.2%
Education/training/workplace	4	0.6%
Alleged perpetrators home	2	0.3%
Other health setting	2	0.3%
LD inpatient setting	1	0.2%
Care/service	0	0.0%

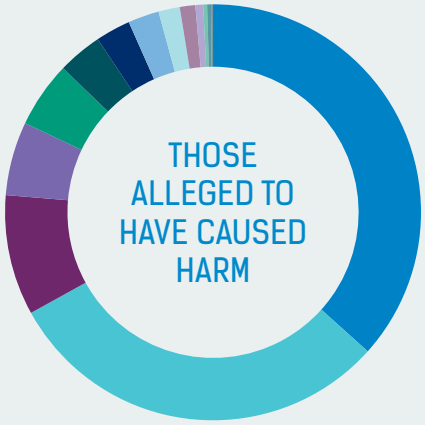
36.7% of referrals were in relation to alleged abuse in the Adult at Risk's own home and 30.3% were alleged to have occurred in a residential or nursing home.

ROUTES OF REFERRAL

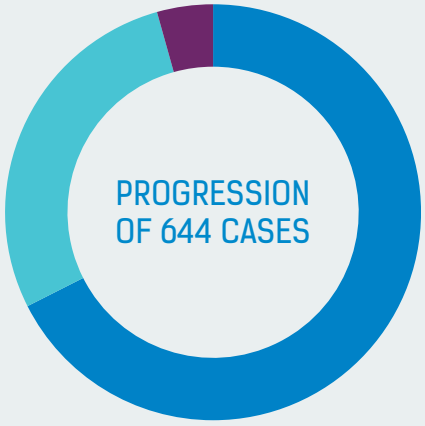
The largest referral sources were Hospital staff 129 (19%), Private/Independent Provider 121 (18%) and LBE-Health and Adult Social Care 111 (17%).

White British	321	51.9%
White Other	90	14.6%
Not yet obtained	42	6.8%
Black Other	38	6.1%
Black Caribbean	36	5.8%
Black African	21	3.4%
White Irish	15	2.4%
Asian Other	12	1.9%
Other	9	1.5%
Bangladeshi	8	1.3%
Indian/British Indian	7	1.1%
Not stated/Refused	7	1.1%
Mixed Black Caribbean & White	6	1.0%
Other Mixed	5	0.8%
Pakistani/British Pakistani	1	0.2%

The ethnicity of adults at risk is predominantly in the “White British” (51.9%) and “White Other” (14.6%) categories. The next highest categories, where the ethnicity of the adult at risk has been established, is “Black Other” (6.1% cases) and Black Caribbean (5.8% cases).



Family – Main Carer	43	13.9%
Other family member	43	13.9%
Staff employed though client’s DP	41	13.2%
Residential Care staff	29	9.4%
Domiciliary Care staff – not LBE	26	8.4%
Other Vulnerable Adult	25	8.1%
Neighbour/Friend	23	7.4%
Partner	23	7.4%
Other	18	5.8%
Not known	12	3.9%
Other Social Care staff	7	2.3%
Health Care Worker	6	1.9%
Domiciliary Care staff – LBE	5	1.6%
Stranger	5	1.6%
Other professional	4	1.3%
Declined	0	0.0%



435 cases had progressed further through safeguarding	67.5%
181 cases did not require further action under safeguarding	28.1%
28 remaining cases were still in future fact finding or awaiting decision	4.4%

NOMINATED ADVOCATE INVOLVEMENT

In 84% of cases there is a nominated advocate involved. Advocates can be from a number of places and include: Independent Mental Capacity Advocate, Independent Mental Health Advocate, care act or safeguarding advocate, or an advocate of the person's choosing. Often family members act in this role when it is appropriate to do so.

CONCLUSION

58.3% of cases were substantiated or partially substantiated at the time of reporting.

PARTNER STATEMENTS

BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST

Barnet, Enfield and Haringey Mental Health NHS Trust remains committed to safeguarding all our service users, their families and carers. We recognise that effective safeguarding is a shared responsibility which relies on strong partnership and multi-agency working. We have strengthened our safeguarding arrangements, which includes recruitment to a Head of Safeguarding. We are continually improving systems and processes, with a clear strategic approach to safeguarding across all our services.

INTERNAL GOVERNANCE ARRANGEMENTS

Our aim is to ensure there is a whole organisational approach to safeguarding. In order to do this we have developed an Integrated Safeguarding Committee (ISC). The ISC is chaired by the Executive Director of Nursing, Quality and Governance and provides strategic leadership and oversight, including reporting to the Trust Quality and Safety Committee. The work of the ISC is informed by our newly developed Safeguarding Strategy and overarching work plan. The ISC meets each quarter and is accountable to the Trust Quality and Safety Committee. In addition an annual safeguarding report is provided to the Trust Board. Safeguarding is a standing item for each of the Borough Clinical Governance meetings.

SAFEGUARDING ADULTS WORK UNDERTAKEN AND KEY ACHIEVEMENTS IN 2015/16

- The Trust Safeguarding Adults at Risk Policy has been updated to ensure it is Care Act compliant.
- A safeguarding inbox has been set up to allow improved monitoring of safeguarding alerts, with a screen saver established as a prompt.
- A safeguarding dashboard has been designed.
- A prompt for safeguarding now included in the incident reporting system (Datix).
- Mental Capacity Act and Deprivation of Liberty Safeguards training mandatory.
- Established an Integrated Safeguarding Committee with clear terms of reference.
- A safeguarding strategy has been completed with key aims and objectives.
- A safeguarding training strategy has been completed.
- The terms of reference for the Trust safeguarding champions have been refreshed and revised.

KEY CHALLENGES

Safeguarding practice is complex and varied, and the Trust works across three Boroughs which can present unique challenges. The need to collect accurate meaningful data is recognised, and work continues to ensure data is captured and analysed effectively. The Trust will continue to develop and improve systems to promote effective lessons learnt. We will review the training needs analysis for level 3 safeguarding adults training in line with recently published Intercollegiate Document Safeguarding Adults (April 2016). Importantly, we will ensure that the principles of the MCA are embedded into everyday practice.

SAFEGUARDING ADULTS WORK PLANNED FOR 2016/17

The work of the Integrated Safeguarding Committee is informed by an overarching work plan which underpins the Safeguarding Strategy. The Strategy has five broad aims which form the overall framework of work going forward:

- To ensure safeguarding is everyone's business across the Trust.
- Develop a dataset of information that allows effective monitoring of safeguarding activity and outcomes.
- Develop a culture of learning with robust internal systems to support this.
- Promote early help to prevent abuse from happening in the first place.
- Develop seamless pathways that promote joined up working at every level.

STATEMENT WRITTEN BY:

Mary Sexton – Executive Director of Nursing, Quality and Governance
Enfield Safeguarding Adults Board representative

ENFIELD BOROUGH POLICE

Enfield Borough Police believe strongly that all adults have the right to live a life free from abuse and neglect. As a statutory partner on the Enfield Safeguarding Adults Board we are working together to provide a robust and transparent response in line with our duties when the abuse of a vulnerable adult occurs. Importantly, we are working in partnership with organisations to prevent abuse where possible, though activities such as burglary prevention and joint awareness sessions.

ACHIEVEMENTS OVER 2015/16

Enfield Borough Police are proud to be a partner on the Multi-Agency Safeguarding Hub, which is an innovative model, which enables effective information sharing and addresses risk with adults experiencing abuse. Working alongside health and social care professionals means that we can assist adults to access the justice system and hold perpetrators to account.

Senior Police have co-chaired over the last year, the Quality, Safety and Performance sub group of the Safeguarding Adults Board. This has provided an opportunity to directly contribute to assuring the Board that organisations are safeguarding people effectively. In addition, Senior Police attend the Board on a regular basis and contributed to the North Central London Challenge and Learning Event following a reflection on areas of positive actions by the Police and where we could make improvements.

Additional actions we have taken include:

- Presenting to partners on legislative options for holding perpetrators to account.
- Use of Police Systems to record accurately and identify adults whom may be vulnerable. The purpose of this is to maximise opportunities for early intervention to prevent someone from becoming a victim of crime at a later stage.
- Community Safety Officers presenting at awareness sessions jointly with the Council and its partners.

ACTIVITIES PLANNED 2016/17

The work of 2015/16 has strengthened our partnerships and has now placed the safeguarding agenda as a priority across all the policing activities we undertake.

- We will continue to ensure our processes and reviews are in place that identify vulnerable adults of crime at an early stage and that these cases continue to be appropriately resourced and responded to by specialist officers, improving victim care and case outcomes.
- We will continue to engage with all the communities in Enfield Borough through direct and indirect personal contact ensuring that we are always delivering a quality service and improving confidence in all areas of safeguarding.
- We will continue to integrate all recent safeguarding legislation into our investigative and intelligence framework ensuring we broaden our knowledge and safeguarding impact.

STATEMENT WRITTEN BY:
Detective Inspector Albert Wildgoose – Enfield Police, Public Protection
Enfield Safeguarding Adults Board representative

HEALTHWATCH ENFIELD

Our role is to amplify the voice of local people on issues that affect those who use health and care services. We actively seek views from all sections of local communities and try to ensure that our priorities take account of the issues raised with us.

We are pleased to see that Safeguarding Adults Board have been placed on a statutory footing and that Healthwatch is a member of the Board; this allows us to provide challenge and inject the issues raised by local people into how safeguarding is developed.

Healthwatch Enfield directly contributed to the development of the Safeguarding Adult Boards three year strategy 2015-2018. We did this though providing our views on what the areas of focus should be and how this could be achieved.

OUR CONTRIBUTION TO SAFEGUARDING 2015/16

In terms of safeguarding, Healthwatch has:

- supported the work of the Safeguarding Adults Board, to ensure that the patient's/ local people's voice is central to service planning and any case reviews
- had representation on the SAB's Quality Performance and Safety (QPS) group
- ensured that our Board, staff and volunteers are trained to understand and follow up any safeguarding concerns identified by us or raised with us in our work locally
- support awareness raising about safeguarding issues amongst our community partners and communities as part of other engagement activities.

Healthwatch representative also attended the North Central London Challenge and Learning event for Safeguarding Adults Boards. This was a positive experience which enabled the voice of patients and local peoples to be raised amongst senior members across partner organisations.

Going forward, Healthwatch Enfield will continue to support the Board and contribute towards this important area of protecting some of the most vulnerable people from abuse and harm.

STATEMENT WRITTEN BY:
Parin Bahl – Healthwatch Enfield
Enfield Safeguarding Adults Board representative

HEALTH, HOUSING AND ADULT SOCIAL CARE, ENFIELD COUNCIL

Protecting and working with those at risk of harm is the responsibility across all departments in Enfield Council; from senior managers to all front line staff we promote the need to recognise what abuse is and ensure staff know how to report. Importantly, we want to prevent abuse from happening in the first place.

The Care Act 2014 and its guidance provide clear responsibilities for the Council to safeguarding adults with care and support needs. We have a duty to make enquiries or cause others to make them. For this reason, our adult social care department takes a lead in safeguarding and supporting adults, focusing on their wellbeing, recovery and resilience.

We work across departments and with external partners to support adults experiencing harm. This can include linking with our colleagues in the Council's Community Safety Unit around anti-social behaviour or in complex domestic abuse cases to working with teams that tackle rouge traders and fraud. Where there are concerns around the welfare and safety of children and young people, we work with our colleagues in safeguarding children.

Strategically, we believe that how our work develops should be informed by those who use services. This year we worked to undertake interviews with those who have been harmed, but have learnt that after abuse has occurred many people wish to move forward without reliving this process. As a result, we have changed our practice for next year to interview people for their reflections before the process closes and providing online electronic options to give feedback as a second option. We also ensure projects we undertake have challenge from those who use services, and particularly link into the Boards Service User, Carer and Patient Sub-Group.

The Council takes a lead on initiating and managing the provider concerns process where there is serious safeguarding risk. This year, we have worked with 17 different providers and alongside support from partners such as the Care Quality Commission, Health and Police, are working to improve the quality and safety of care.

Some of our accomplishments this year have included:

- Delivering domestic abuse training and a bespoke course with safeguarding children
- Leading a project to reduce risk of dehydration in care homes
- Updating all policies and data collection in line with new London Adult Safeguarding Policy
- Continued to embed Making Safeguarding Personal and promoting this amongst partners
- Held bespoke workshops between Multi-Agency Safeguarding Hub and the Police

The most important work we do is in our responsibilities towards keeping adults at risk safe and working with them towards recovery and resilience after abuse has occurred.

In the coming year the Council will continue to work in partnership with adults at risk and partners to both prevent abuse and ensure people are support when harm does occur. There are a number of priorities we have, and these include helping to prevent financial abuse through raising awareness of deputyship and appointeeships arrangements; continuing our work with providers when there are safeguarding concerns and quality issues; and continually striving towards excellent practice.

STATEMENT WRITTEN BY:
Bindi Nagra – Assistant Director, Health, Housing and Adult Social Care
Enfield Safeguarding Adults Board representative

LONDON AMBULANCE SERVICE

The London Ambulance Service NHS Trust (LAS) has a duty to ensure the safeguarding of vulnerable persons remains a focal point within the organisation. We are committed to safeguarding vulnerable members of our community and continue to work closely with partner organisations to improve this process.

Living a life that is free from harm and abuse is a fundamental right of every person. All staff in whatever setting and role, are in the front line in preventing harm or abuse occurring and in taking action where concerns arise.

This report provides evidence of the LAS commitment to effective safeguarding measures during 2015/16. A full report along with assurance documents can be found on the Trusts website.

SAFEGUARDING DUTY AND RESPONSIBILITIES

To address safeguarding responsibilities we have:

- a safe recruitment process that includes the vetting and barring scheme and procedure with reference to the Independent Safeguarding Authority;
- processes for dealing with allegations against staff with clear links to police and local authority designated officers;
- a named executive director with responsibility for safeguarding;
- heads of safeguarding for adults and children who are also the named professionals;
- a safeguarding officer who is first point of contact for local safeguarding boards and local authorities;
- internal and external reporting mechanisms to capture safeguarding issues.

WORKING WITH PARTNER AGENCIES

We work closely with the safeguarding lead commissioners. We continue to work with all adult safeguarding boards in response to notifications of safeguarding adult reviews. All recommendations and action plans are monitored internally and approved by the safeguarding committee for closure when appropriate.

CONTRIBUTION TO THE ENFIELD SAFEGUARDING ADULTS BOARD

The LAS has a lead member whom attends the quarterly Safeguarding Adults Board in Enfield, and are keen to provide support to the local developments. Some of the actions the LAS took last year in Enfield include:

- Contributing to Safeguarding Adults Review so that learning can be shared
- Completion of self assessment of safeguarding, which went to a North Central London Challenge and Learning Event
- Joining sub-groups of the Board where relevant to support actions that keep people safe
- Providing assurance to the Safeguarding Adults Board during meetings of improvements within the LAS

The LAS made a total of 4,331 adult safeguarding referrals across London in 2015/16, and 8,440 relating to welfare concerns for adults whom may have care and support needs. In Enfield, there were 132 adult safeguarding referrals and 267 adult welfare referrals. The LAS is committed to ensuring that information is shared to prevent and reduce the risk of harm to adults at risk.

STATEMENT WRITTEN BY:
Alan Taylor – Head of Safeguarding
Enfield Safeguarding Adults Board representative

LONDON FIRE BRIGADE

The London Fire Brigade has a strong commitment to safeguarding adults at risk and continues to work to develop service delivery by focusing preventative work streams to better identify at risk individuals as well as responding appropriately following referral through links with inter professional groups. We recognise that robust safeguarding arrangements are essential to managing risk. We believe that all residents have the right to be treated fairly and with dignity and respect.

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

As part of the London Fire Brigade's adult safeguarding responsibilities, it is required to provide a representative as board members on the local multi-agency safeguarding adult board. The Borough Commander Enfield Borough is currently on Enfield Safeguarding Adults Boards and is an integral decision maker in the development and progression of the local safeguarding agendas. The London Fire Brigade has maintained an active participation in the Safeguarding Adults Board, undertaking work streams as required throughout the year.

KEY ACHIEVEMENTS 2015/16

Last year London Fire Brigade Enfield Borough planned the following activities and achieved the following outcomes:

- Raise awareness of risk to adults in fire, such as instances of hoarding and the benefits of fire suppression system, to partners.
- All Borough fire officers were updated by the Enfield Council on safeguarding and legal requirements at the annual information day.
- Senior fire officers attending borough area forums to ensure that all communities are aware of the important fire safety work carried out by fire officers and delivering 'Home Fire Safety Visits' to the most vulnerable members of our community.
- Attended a number of Community based events to promote home fire safety and raise awareness of the provision of arson proof letter boxes.
- Two thousand two hundred home fire safety visits were completed within the borough and at least 87% of these were carried out in homes that statistically, were most likely to have a fire.
- A program of visiting all sheltered housing residential homes was started and all staff and residents were informed of the fire safety tips, need to have a routine to keep safe from fire and the services we provide. Most importantly we stressed the importance of the responsible person concept for care homes and housing stock, while highlighting the importance of providing adequate care and fire protection for residents.
- London Fire Brigade Watch officers have made a number of referrals throughout the year in accordance with Brigade Policy. Of these only a small number have been referred through the urgent referral agreement. The remainder have been referred to appropriate services and agencies.
- Work with partners to address vulnerable adults at risk from exploitation by unscrupulous landlords to receive support through implementation of statutory enforcement.

PRIORITIES FOR 2016/17

- Carry out home fire safety visits to all sheltered housing facilities within the borough, to see reduction in number of incidents by partnership working.
- Continue to raise awareness of the availability and provision of domestic fire suppression systems for very high risk adults.
- Raising staff awareness of domestic violence.
- Focusing our prevention and protection activities on ensuring that older people living in care home and in sheltered housing are as safe as possible.
- Developing further local recording and quality assurance programmes.
- Continue to raise awareness of partners, organisation and agencies of risks to adults from fire, in particular dangers of hoarding and provision of arson proof letter boxes and fire retardant bedding.
- Continue to develop protocol between LFB and adult social services reporting referral outcomes in relation to safeguarding adults or otherwise.
- Support partners by providing advice in relation to fire safety in the home when requested.

STATEMENT WRITTEN BY:
Les Bowman – Enfield Borough Commander, London Fire Brigade
Enfield Safeguarding Adults Board representative

NHS ENFIELD CLINICAL COMMISSIONING GROUP

NHS Enfield CCG is a statutory organisation overseen by NHS England. The key function of the CCG in relation to safeguarding is to ensure that the services they commission have safeguarding systems and processes in place.

KEY ACHIEVEMENTS FOR 2015

EMPOWERMENT

- Co-ordination of a tri-borough (Barnet, Enfield and Haringey) Conference on the Mental Capacity Act (MCA, 2005) and Deprivation of Liberty Safeguards (DOLS) in May 2015.
- The CCG developed an electronic audit tool for GP practices to assess compliance with MCA and DOLS.
- Nurses from Continuing Healthcare have successfully completed the Best Interest Assessment training with Hertfordshire University.
- CCG organised training on revalidation for nurses who work in the nursing home sector.
- Primary Care Safeguarding Adults at Risk and Children symposium was organised for GP's and all health staff that work in Primary Care.

PARTNERSHIP

- CCG commissioned the services of a nurse expert affiliated to NHS England and Buckinghamshire University to confer with providers, CCG and the local authorities in producing a borough wide Pressure Ulcer Protocol.
- Making Safeguarding Personal (MSP) – The CCG coordinated the local authority lead manager in MSP to facilitate a teaching session with the Continuing Health Care Team.

ACCOUNTABILITY

- The governing body received training in safeguarding adults with particular emphasis on the Care Act (2014).

PREVENTION AND PROTECTION

- All CCG staff have been trained in PREVENT.
- CCGs use Clinical Quality Review Groups (CQRGs) to monitor health providers and provide assurance that care is of high quality and safe.

PRIORITISED WORK PLAN

- Ensure that all NHS providers, Independent health providers and GP practices meet PREVENT training compliance targets.
- To facilitate a GP practice Safeguarding Audit.
- Ensure both CCG's and Provider organisations are focussed to meet the MSP agenda.
- To continue to support local authority quality team in provider concerns issues.

STATEMENT WRITTEN BY:
Carole Bruce-Gordon – Assistant Director for Safeguarding
Enfield Safeguarding Adults Board representative

NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST

COMMITMENT TO SAFEGUARDING ADULTS AT RISK

North Middlesex University Hospital NHS Trust's Board takes the issue of safeguarding extremely seriously and receives annual reports on both safeguarding children and safeguarding adults. The Trust acknowledges that safeguarding adults is everybody's business and that everyone working in health care has a responsibility to help prevent abuse and to act quickly and proportionately to protect adults where abuse is suspected. The safeguarding of all our patients remains a priority for the Trust as we see it as a fundamental component of all care provided. Maintaining the consistency and quality of all aspects of safeguarding practice across the Trust is essential.

The Trust has an established Safeguarding Adults Group which has representation from our inter professional and inter agency groups. It meets bi-monthly and provides the strategic direction to safeguarding adult activities across the Trust and ensures that all safeguarding commitments and responsibilities are met.

During 2015/16 the Trust has worked with partner organisations to safeguard some of the people who are most at risk of abuse, harm and neglect. This enables the Trust to work with partners, communities and local people to prevent abuse and ensure a robust and transparent response when abuse of an adult at risk occurs.

The Director of Nursing is the Executive Lead for Safeguarding Adults and represents the Trust at the Enfield local multi-agency safeguarding adult board meetings.

PARTNERSHIP WORKING DURING 2015/16

In September 2015, the Trust recruited a Safeguarding Adult Coordinator and established a centralised safeguarding email inbox to enable partners to send safeguarding concerns direct to the Safeguarding Adult Team. All concerns or enquiries are then forwarded to the relevant Local Authority Safeguarding Adult Teams. The Trust works in partnership with the multi-agency Enfield MASH team to comply with requirements for following up Safeguarding Adult alerts.

Trust staff attend Safeguarding Adult Strategy Meetings and Case Conferences as required. Recommendations from Case Conference Investigations are fed back to the relevant ward managers and matrons and the Trust has introduced monthly 'Lessons Learned Events' for Ward Managers and Matrons and other members of the multi-disciplinary team to enable reflection of recommendations from safeguarding adult enquiries.

The Trust is represented at Enfield Safeguarding Adult Board subgroups by the Safeguarding Adult Lead. The Trust is also represented at NHS England Safeguarding Network meetings by the Safeguarding Adult Lead.

In December 2015, the Trust completed the Safeguarding Adult Provider Audit which was jointly developed by London Chairs of Safeguarding Adults Boards (SABs) network and NHS England London. The aim of this audit tool is to provide all organisations in the Borough with a consistent framework to assess monitor and/or improve their Safeguarding Adults arrangements. In turn this supports the Local Authority Safeguarding Adult Board (SAB) in ensuring effective safeguarding

practice across the Borough. Representatives from the Trust attended the Board Challenge event held on 25th January 2016 where all partners were asked to feedback on key areas of development and challenges.

In February 2016, the Trust participated in the Police and Enfield Adult Social Care Interface workshop where case studies were discussed to enable shared learning and to enhance multi-agency working arrangements.

STATEMENT WRITTEN BY:
Eve McGrath – Safeguarding Adults Lead
Enfield Safeguarding Adults Board representative

ONE-TO-ONE (ENFIELD)

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

We have a project to raise awareness and understanding of Hate Crime, and hold regular workshops for staff, carers and people with learning difficulties. We have launched a DVD and booklets to raise awareness on Hate Crime so people can recognise and report it.

To ensure our members are safeguarded against any abuse, we work with the Integrated Learning Disabilities Team. One-to-One (Enfield) has a positive relationship between members, staff, volunteers and other partner organisations that encourages people to be open about concerns and helps people to learn from each other. There are continuous training and development opportunities for staff and volunteers.

STATEMENT WRITTEN BY:
Nusrath Jaku – Volunteer Coordinator
Enfield Safeguarding Adults Board representative

ROYAL FREE LONDON NHS FOUNDATION TRUST

The Royal Free London NHS Foundation Trust is committed to safeguarding all vulnerable patients who access services across the Trust. We understand that to safeguard effectively we must work collaboratively with partner agencies and professionals.

In order to do this we will work closely with others to ensure that all of the services we provide have regard to our duty to protect individual human rights, treat individuals with dignity and respect and safeguard against abuse, neglect, discrimination, embarrassment or poor treatment. We acknowledge the balance between an individual's rights and choices and the need to protect those at risk.

INTERNAL GOVERNANCE ARRANGEMENT

We have a three year strategy that sets out our 10 core aims and that informs our three year work plan. The progress of this work plan is monitored by the Integrated Safeguarding Committee (ISC).

The ISC meets quarterly and is chaired by the Director of Nursing who is the executive board lead for safeguarding. The ISC is attended by the CCG safeguarding leads. The ISC monitors all safeguarding activity, Safeguarding Adult Reviews, Serious Incidents, allegations against staff, complaints, as well as responding to requests from Safeguarding Adult Boards and national priorities.

The ISC reports bi-annually to the Clinical Risk and Clinical Governance committee and to the patient safety committee and the full Trust Board annually.

A member of the safeguarding team sits on the weekly serious incident review panel.

SAFEGUARDING ADULTS WORK UNDERTAKEN AND KEY ACHIEVEMENTS IN 2015/16

Policy development – all completed and implemented:

- Mental Capacity Act and Deprivation of Liberty Safeguards Policy
- Celebrity/VIP visits policy
- Allegations of abuse against staff policy
- Female genital Mutilation (FGM)
- PREVENT policy

Referral rates have increased April 2015 and March 2016:

- 484 safeguarding alerts raised at the Royal Free Hospital (increase of 51%)
- 387 alerts for Barnet Hospital and Chase Farm Hospital (increase of 217%)

We have also embedded the role of the Independent Domestic Violence Advocate within the acute setting and now have 3 full time posts. In terms of training, our figures are consistently in the 80% range for delivering MCA/DoLS and Safeguarding adult.

KEY CHALLENGES AND PRIORITY FOR 2016/17

- Deliver the PREVENT agenda across the Trust
- Develop and deliver safeguarding adult supervision
- Develop and deliver level 3 safeguarding adult training
- Continue to improve compliance with application for DoLS

STATEMENT WRITTEN BY:
Helen Swarbrick – Head of Safeguarding
Enfield Safeguarding Adults Board representative

SAFER AND STRONGER COMMUNITIES BOARD

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

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

CURRENT POSITION

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

The SSCB also work in partnership with a range of organisations, such as community groups, neighbouring boroughs, central government and the Mayor's Office for Policing. It has embedded links with other key groups such as Safeguarding Boards, the Drug Alcohol Action Team (DAAT) and the Enfield Targeted Youth Engagement Board (ETYEB). Regular representation and updates between these boards help us tackle areas of joint concern such as domestic abuse or other crimes which particularly impact on those with vulnerabilities.

KEY ACHIEVEMENTS OF 2015/16 INCLUDE:

- Continued investment in CCTV provision across the borough providing evidence for thousands of incidents to resolve investigations and deter future crimes
- Burglary, vehicle crime, criminal damage and robbery have all reduced
- Continued to support our Safehouse scheme to support the target hardening of vulnerable residents' homes
- Partnership drive to tackle ASB, including that on housing estate
- Working in partnership to tackle prostitution in response to identified concerns
- Delivered high profile seasonal crime prevention messages around Domestic Abuse and the risks from gangs
- We have continued the links and data sharing with health agencies, notably at North Middlesex Hospital including commissioning a youth outreach worker to help identify and engage with those at risk from gangs
- Raised awareness of Prevent and provided instructive sessions for over 600 staff
- Presentations at national conferences promoting Enfield work on coercive control
- Better oversight of emergency incidents on the Borough
- Successfully led a multi-borough application for DCLG funding to inform specialist support in refuge accommodation.

PRIORITIES IN THIS YEARS' PARTNERSHIP PLAN REMAIN:

- As identified through the London Mayor's office priorities include burglary, criminal damage, robbery, theft from and of motor vehicle, theft from a person and violence with injury.

OUR SSCB PRIORITIES ARE CURRENTLY:

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

We are also aware of key cross cutting themes that impact on all of the above such as substance misuse, the management of offenders in the community and hate crime.

STATEMENT WRITTEN BY:
Andrea Clemons – Head of Community Safety
Enfield Safeguarding Adults Board representative

HHASC442

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Strategic Safeguarding Adults Service
Health, Housing and Adult Social Care

June 2016

ENFIELD Council

MEETING TITLE AND DATE

Health and Wellbeing Board

05/10/16

SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORT

Purpose of Report

The ESCB annual report is for information, it is going to Cabinet on 19th October 2016 and then to Council. It is a statutory requirement that the ESCB publish a report of its activities on an annual basis .

Executive Summary

This report summarises the work undertaken by the ESCB from April 1st 2015 to March 31st 2016. A key role of the ESCB is communication and holding all agencies to account in relation to making continuous improvements. 2015/16 has been a very productive year for the ESCB ensuring there is an effective response to safeguarding concerns with good systems and structures in place across the partnership. The commitment to workforce development remains strong with the development of a comprehensive learning and development programme and a clear performance management framework in place.

There have been many achievements that the Board is proud of but still much to do. The annual report charts the progress made in relation to Child Sexual Exploitation, Female Genital Mutilation as well as tackling the growing concerns of increased radicalisation and many other safeguarding issues. The economic situation and organisational change affecting public services in Enfield and across the country continues to be a challenge for the Board.

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Enfield Safeguarding Children Board

Annual Report

2015-16

Enfield
Safeguarding
Children Board
...because safeguarding children
is everybody's business

Contents

Introduction from the Chair

The challenges for all of us involved in the safeguarding children's world are numerous. We live in a constantly changing society which, whilst full of opportunities inadvertently can bring increased risk and danger to young people. Keeping children safe (this can range from crossing the road to unwanted intrusion from the Internet) across Enfield, involves a number of different agencies. The major three being; the Local Authority, the Metropolitan Police and The National Health Service.

Other important contributing partners include colleagues across Education, Probation, Children's and Family Court Advisory and Support Services, the London Fire Brigade and also many concerned and active voluntary groups. On the Enfield Board we also have two excellent lay members who represent the community, and the Lead Councillor for Children and Families attends. At each meeting we may welcome other individuals such as members of the Youth Parliament and other involved groups. There are also many providers from private businesses including hospitals and children's homes and regular contact is maintained.

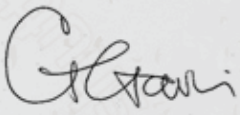
This report summarises the work undertaken by the ESCB between April 1st 2015 to March 31st 2016. It charts the progress made in relation to Child Sexual Exploitation, Female Genital Mutilation as well as tackling the growing concerns of increased radicalisation. There are many other situations where children can be harmed and these include living with carers who have addiction problems, where housing and financial pressures and poverty can result in neglect. Some young people have family members in prison, and we are aware of knife and gun crime which adds to the dangers being experienced.

A key role of the ESCB is communication and holding all agencies to account in relation to making continuous improvements. As the Independent Chair both on my visits and indeed at Board Meetings I consider the communication between partners to be good though of course there are no grounds for complacency.

The ESCB currently operates across Enfield only, there are 31 other London Boroughs and there is a London-wide Safeguarding Children's Board. It is important that we stay alert to specific local concerns, London concerns and then of course governmental concerns across the UK. National headlines can sometimes drive or distract from local issues and this needs to be carefully balanced.

A major area of focus for the ESCB during 2016-2018 is Domestic Abuse, children are too often subjected to violence in the home and there are increasing concerns that the resources needed to really get to grips with this serious and damaging problem are shrinking. We need to strengthen our existing links between the Health and Wellbeing Board, Community Safety, the Adults Safeguarding Board and work together to highlight where practice is good and importantly make improvements when gaps are identified. All agencies need to learn from each other and the issues behind Domestic Abuse cross many partners desks, how we manage these issues needs our attention. We will also focus on and continue to support and monitor the good work that is undertaken in Enfield to safeguard disabled children.

Finally a huge Thank You to each and very staff member across all the agencies who work in this demanding and very challenging arena. Your skills, energy and commitment are appreciated by the ESCB, and your work whilst often invisible to most when all goes well is undertaken with purpose and pride.



Geraldine Gavin
Independent ESCB Chair

About Enfield

Situated approximately twelve miles north of London, Enfield is London's most northern borough and is a place of contrasts, having some of the most deprived and some of the most prosperous wards in London and indeed England. There are approximately **82,200 children** (aged under 18) living in Enfield, making up **26% of the borough's population** (Source GLA estimate). Enfield has a high number of children living in poverty and although the infant mortality rate has decreased in recent years to 4.6 per 1,000 live births, this is still higher than the England London averages of 4.1 and 3.9 per 1,000 live births respectively.

The overall population of Enfield is approximately 321,000 with a population of children and young people in the borough of approximately 73,500. Enfield has a relatively young population with the number of children and young people representing approximately 23% of the total population.

Enfield has experienced significant change over the last few years in terms of the size and nature of its population; this has included an increase in the baseline child population together with an increase in the numbers of children in Enfield who are living in poverty.

As well as the increase in child population, Enfield has also been significantly affected by the changes associated with the Welfare Reform agenda. The most recent available data from IDACI (The Income Deprivation Affecting Children Index) measures the proportion of all children aged 0 to 15 living in income deprived families. Their data concludes that Enfield is the 13th most deprived borough nationally and the 5th most deprived in London. The London Boroughs with greater levels of deprivation than Enfield have smaller baseline populations, meaning that Enfield now has the largest number of children living in poverty of any London borough.

As might be expected, there has been a significant increase in the number of 'Contacts' being made to Enfield's Single Point of Entry (SPOE) in the last few years. Enfield is currently receiving approximately 50% more referrals than three years ago. This inevitably creates a considerable amount of pressure on available services.

2015/16 saw an increase in children subject to **Child Protection plans** in the first half of the year peaking at **302** in August 2015. However, there has been a steady decrease month on month from November 2015 with **233** children subject to plans at the end of March 2016. The decrease from August 2015 to March 2016 is significant at 23%. A number of factors have impacted upon the reduction of children subject to child protection plans. Firstly the partnership overseen by Enfield Safeguarding Children Board has embraced Signs of Safety (SoS) Practice Model which is an internationally recognised model for direct work with children and families. *(Read more about work related to Signs of Safety on page 19)*

Secondly the local specialist CSE team became operational in July 2015 and by the end of the year referrals were being held within this team with strong child in need plans in place thus reducing the need for child protection plans. *(Read more about work related to CSE and Missing Children on page 12)*

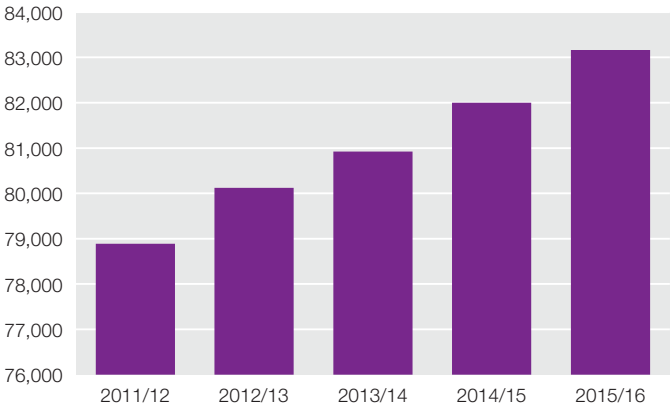
There was a small rise and then a fall in the number of **Looked After Children** during 2015/2016 but the overall number remains approximately the same at the end of March 2016 (359) as it was in March 2015 (358). There was a significant increase in the LAC population 3 years ago and this has remained consistently high over the last 2 years.

The number of unaccompanied asylum seeking children (UASC) looked after at the 31st March 2016 was **69** this is a significant area of pressure as there were **49** UASC looked after children at the 31st March 2015, this represents a 40% increase over the year.

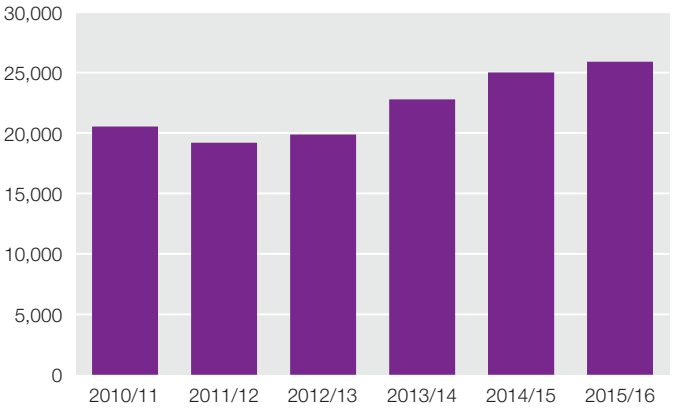
60 children returned from care to parents or relatives with parental responsibility during the year 15/16 (this does not include Special Guardianship Orders or Child Arrangement Orders).

Further data relating to Safeguarding activity across the partnership can be found in Appendix A.

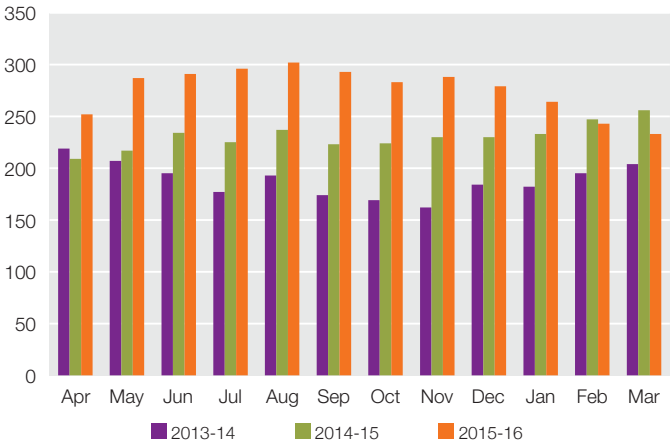
Enfield under 18 population



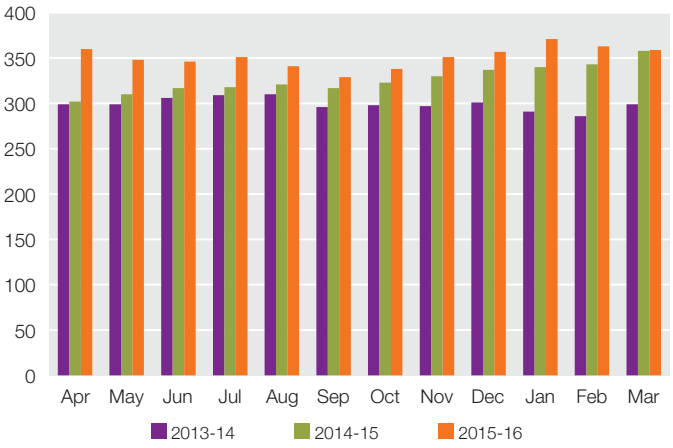
Contacts recorded

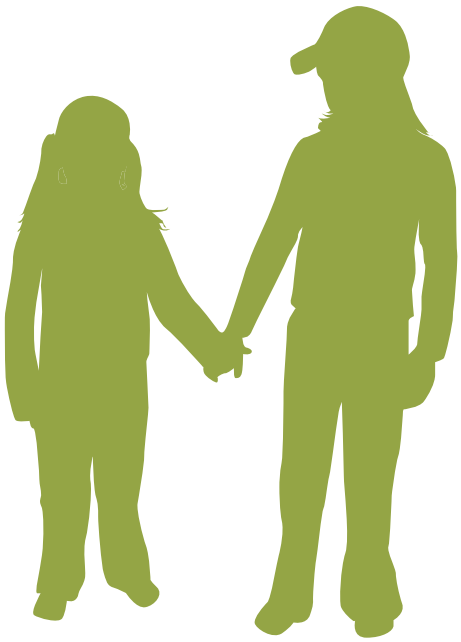


Child Protection Plans (April 2013-March 2016)



Looked After Children (April 2013-March 2016)





Executive Summary

This Executive Summary summarises the Annual Report covering 1 April 2015 to 31 March 2016 focusing predominantly on activity and progress across the year against the priority areas as outlined in the ESCB Business Plan which was developed at the end of 2014-15.

2015-2016 has been a successful year for the work of the Enfield Safeguarding Children Board (ESCB). There is an effective response to safeguarding concerns with good systems and structures in place across the partnership. The commitment to workforce development remains strong with a comprehensive learning and development programme and a clear performance management framework in place.

ESCB Business Plan 2015-2016: Summary of achievements

The Business Plan was divided into four sections with each section focusing on a priority area for development and activity. The priority areas are listed below along with some of the key achievements made this year. Many of the achievements contain hyperlinks which lead to the relevant page(s) of the Enfield Safeguarding Children Board's website.

1 Effective responses to specific safeguarding concerns

- A great deal of progress has been made in our work in supporting the identification, assessment and safeguarding intervention of children at risk of sexual exploitation. Activity includes the establishment of a dedicated multi-agency Child Sexual Exploitation Prevention Team, the development of an elected members CSE Task Group and a focused cross-border project in collaboration with our neighbours in Haringey, to help improve our responses to CSE and other vulnerabilities.
- Much positive work has been undertaken to support our work to support children and young people who go Missing. This included the development of a new protocol covering processes for children who go missing from Home, Placements, Education and Health and the establishment of a new multi-agency Missing Children Risk Management Group which has quickly led to a significant reduction in the number of children who are missing education. *Read more about work related to CSE and Missing Children on page 12.*
- We have worked with local groups from the voluntary and community sector to update our strategy and protocols relating to the identification, assessment and safeguarding of children and risk of Female Genital Mutilation in line with national developments. *Read more about work related to FGM on page 14.*
- We have strengthened our links with the Community Safety Unit in relation to RADICALISATION and the PREVENT agenda. The board receives regular updates on activity in this area and has commissioned a series of training sessions to help raise awareness and understanding.

2 Effective safeguarding structures and systems

- The Board has overseen and endorsed some key changes in relation to how Early Help arrangements are structured and how referrals to children's social care are managed during the course of the year. Two Early Help audits were undertaken which were used to inform the new Early Help strategy (currently in draft) and the board has helped to raise awareness of changes training sessions and updated information on the website.
- The Enfield ESCB Threshold Document and Information Sharing Protocol have been completely refreshed to reflect current practice and procedures and have been circulated across the partnership.
- Work has continued to strengthen links between ESCB and related boards and groups including the Safeguarding Adult Board and the Health and Wellbeing Board. The Learning and Development subcommittee not operated jointly with the adult board ensuring consistency and improved effectiveness and the FGM subcommittee now reports directly to the Health and Wellbeing Board whilst maintaining strong links to the ESCB.

3 Communication and learning

- The Safeguarding Board has played a key role in shaping and promoting the implementation of the Signs of Safety practice model across the borough. This strengths-based and safety-focused approach to child protection work is grounded in partnership and collaboration and aims to improve outcomes for children and their families. The Board has fully endorsed the model and has overseen the delivery of briefings and training over 500 professionals. *Read more about work related to Signs of Safety on page 19.*
- We have again delivered a comprehensive programme of Safeguarding Training across the partnership, ensuring that all staff have access to good quality training, which helps support sustained improvements across all safeguarding services. Across the year we delivered training and learning sessions to well over 1,000 people, a significant improvement on previous years, at no additional cost. *Read more about work related to Learning and Development on page 20.*
- Enfield was one of the areas selected by the DfE for funding to support a national Child Abuse Awareness Campaign aimed at encouraging people in the community to be able to recognise the signs of abuse and to report it promptly. The campaign ran across the borough through the spring.
- We have continued to raise the **profile** of ESCB by developing and maintaining the ESCB website, getting articles into the local press, and developing our social media presence of both Twitter and Facebook where we now have over 500 followers.

4 Performance management and quality assurance

- We have continued to develop and improve our **Section 11 programme** which gives us the opportunity to seek assurance from our partners regarding their Safeguarding processes and activity and to offer challenge where appropriate. This year we have focused on improving the support and scrutiny we are able to offer our schools and have been very pleased with the high levels of engagement and the evidence provided of effective safeguarding structures.
- We have continue to refine and enhance our **Safeguarding Dataset** which is used to routinely scrutinise partners performance, to make it as informative and effective as possible and have used the findings to make changes and enhancements to practice and systems.
- The **multi-agency audit** programme has been expanded to include priority areas such as Missing and Child Sexual Exploitation and findings have continued to drive improvement. *Read more about work related to Performance Management on page 10.*

Conclusion and Challenges for 2016/17

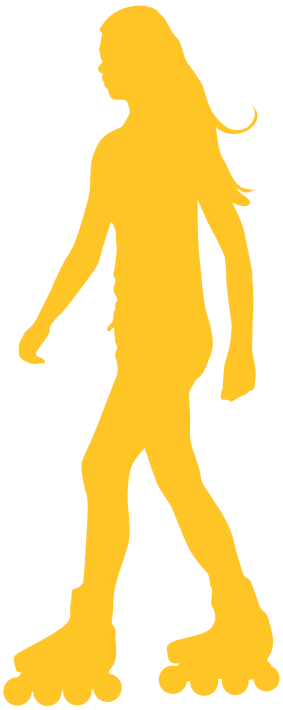
2015-2016 has again been a very busy year and productive for the ESCB. We hope that this report provides readers with reassurance of our firm commitment to ensure there are effective, joined-up local arrangements to safeguard and promote the welfare of children in Enfield.

This report demonstrates that safeguarding activity is progressing well and that the ESCB has clear agreement and focus on the strategic priorities and ongoing challenges. Reports from our partners demonstrate that statutory and non-statutory members are consistently working towards the same goals as part of the multi-agency partnership and within their individual agencies.

The Board is committed to a programme of scrutiny, monitoring and, quality assuring the quality of safeguarding activity across Enfield, and this programme of robust analysis and challenge will continue to ensure that children and young people are kept safe. The Board is proud of its successes but of course there is no room for complacency, the economic situation and organisational change affecting public services in Enfield and across the country continues to be a challenge for the Board.

2016/17 will see us continuing our focus on Child Sexual Exploitation and Missing Children and exploring ways of effectively bringing these issues together with other factors that affect vulnerable young people to offer a holistic and robust approach to our work with older children. We will have a renewed focus on Domestic Abuse both on the ways parental domestic abuse can impact on children and on abusive relationships between young people. We are very keen to improve our engagement with young people and will renew our commitment to ensuring Enfield young people's voice are heard at the board and explore new and innovative ways of achieving this.

We hope that you find this report interesting and helpful. There are many hyperlinks throughout the report which lead to relevant pages of our website. We continue to work hard to ensure our website is as relevant and useful, both for professionals and members of the public and we are also striving to maximise our use of social media to promote our work and engage with others. If you are a Twitter or Facebook user please follow us by clicking on the links. Your feedback and thoughts are always important to us. You can get in touch wither through our social media channels or through the website www.enfieldlscb.org.uk/contact.



Messages for Readers

Board Members

Identify and act on child protection concerns.

Work effectively to share information appropriately.

Collectively make decisions about how best to intervene in children's lives where their welfare is being compromised, and collectively monitor the effectiveness of those arrangements.

Staff working in Board partner agencies

Book onto ESCB Multi-agency training and learning events relevant to your role.

Be familiar with the Pan London Safeguarding Procedures.

Be familiar with the Threshold Document to ensure an appropriate response to children and families.

Find out who your agency representative is to make sure the voices of the workforce, children and young people are heard.

Children and Young People

You are at the heart of the child protection system. We want to make sure that your voices are heard and that we know how you are experiencing the services in our Board partner agencies. If you would like to know more about how you can influence the work of ESCB please contact us.

www.enfieldlscb.org.uk/contact

Chief Executives and Directors

Show ESCB that your agency is committed to a culture of safeguarding.

Ensure your workforce contributes to the provision of ESCB multi-agency safeguarding training.

Have an open dialogue about any barriers that may impact on your organisations ability to safeguard children and young people.

Local Politicians

In 2015/16 Councillor Ayfer Orhan was lead member for children and families, making sure their voices are heard by the LSCB. She continues to fulfil this role in 2016- 2017, widely promoting the work of the Board to members communicating the core priorities and key safeguarding messages that everyone needs to be aware of.

All politicians should keep the protection of children and young people at the forefront of thinking when scrutinising and challenging any plans for Enfield.

The Community

You are in the best place to look out for children and young people and to report any of your concerns.

Safeguarding children and keeping them free from harm is everyone's responsibility, if you are worried about a child or young person please follow the steps on the Enfield LSCB website.

Follow us on Twitter and Facebook.

Role of the Board

Enfield Safeguarding Children Board is made up of statutory and voluntary partners. These include representatives from Health, Education, Children's Services, Police, Probation, Children and Family Court Advisory and Support Service (Cafcass), Youth Offending, the Community & Voluntary Sector as well as Lay Members.

Our main role is to coordinate what is done locally to protect and promote the welfare of children and young people in Enfield and to monitor the effectiveness of those arrangements to ensure better outcomes for children and young people. The effectiveness of ESCB relies upon its ability to champion the safeguarding agenda through exercising an independent voice.

Safeguarding children is everybody's responsibility. Our purpose is to make sure that all children and young people in the borough are protected from abuse and neglect. Children can only be safeguarded from harm if agencies work well together, follow procedures and guidance based on best practice and are well informed and trained.

A key element of the ESCB's work is the provision of information to and from the public, potential and actual service users, staff working in partner agencies and others interested in children's welfare. We work hard to ensure our website www.enfieldlscb.org is as helpful and up to date as possible.

Metropolitan Police – Total Policing

Enfield Council

Cafcass – Children and Family Court Advisory and Support Service

London Community Rehabilitation Company – Probation

Enfield Safeguarding Children Board ...because safeguarding children is everybody's business

London Probation Trust

LFB London Fire Brigade

Children & Young Persons' Services

Royal Free London NHS Foundation Trust

Barnet, Enfield and Haringey NHS Mental Health NHS Trust

North Middlesex University Hospital NHS Trust

Governance and Accountability

The Children Act 2004 places a duty on every local authority to establish a Local Safeguarding Children Board (LSCB).

The Government's Statutory Guidance, Working Together to Safeguard Children (2015) defines safeguarding and promoting the welfare of children as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- taking action to enable all children to have the best life chances.

This is to enable those children to have optimum life chances and enter adulthood successfully.

LSCBs do not commission or deliver direct frontline services although they may provide training. Whist LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding.

The Board met 8 times during 2015/16 and was attended by senior managers from statutory and voluntary organisations, and by Lay Members. Enfield's Lead Member for Children Services, Cllr Ayfer Orhan attends each board meeting and continues to challenge the work of the ESCB through discussion, asking questions and seeking clarity. This provides an important scrutiny and challenge function to the Board and further ensures the Board is supported by the Council.

Where there has been insufficient attendance or engagement at the Board, this has been appropriately challenged by the Independent Chair.

There are currently five Subcommittees operating within ESCB, in which a significant amount of the board's work is progressed. As with the full Board, membership is multi-agency. All Terms of Reference have been updated within the last year and there is recognition by all Chairs that the effectiveness and thoroughness of the Board requires that the work of each Subcommittee interacts with that of the others.

Key Relationships

Health and Wellbeing Board (HWB)

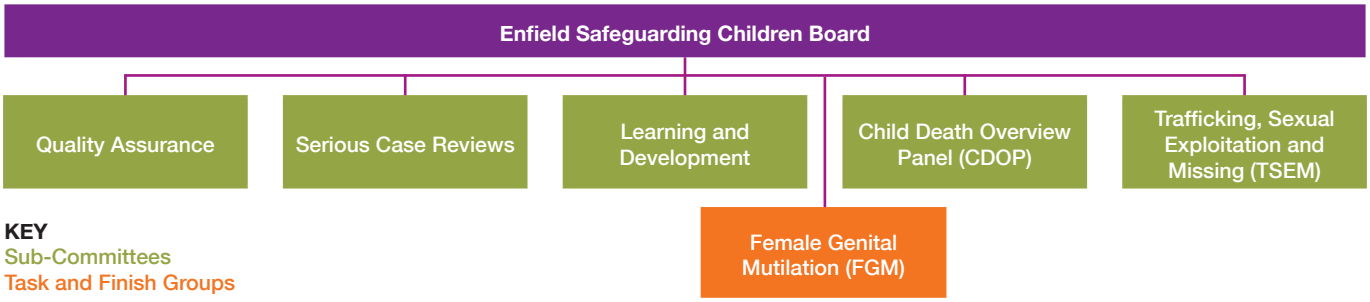
The HWB assumed its full statutory powers in April 2013 and the ESCB Chair is now a participant observer, increasing the influence of the Board by strengthening the relationship with this key strategic group. Clearer lines of accountability have been developed over the year and ESCB report regularly to the HWB and continue to make sure key safeguarding issues are addressed.

Safeguarding Adults Board

The ESCB Chair is a participant observer on the Adult Safeguarding Board and the Chair of the Adult Safeguarding Board has been a participant observer at the ESCCB.

Member Agencies Executive Management Boards

Board members are senior officers within their own agencies; this provides a direct link between ESCB and the various agencies' Boards.



Monitoring and Evaluation

This section provides some analysis of the work that has taken place in terms of developing a robust approach to Quality Assurance and Performance Monitoring. There are summaries of some of the key learning arising from our audit activity and detailed information on the ESCB's effectiveness in monitoring the safeguarding system, including **Section 11 Audits, and Management of Allegations of Adults working with Children**.

There continues to be a healthy and effective culture of accountability and challenge across the ESCB and the Quality Assurance Sub Committee continues to work to improve the quality of service improvement and delivery of outcomes consistently across the partnership. The majority of monitoring and evaluation of multi-agency practice is monitored through the subcommittee which meets on a six-weekly basis. The group's key areas of focus are:

- To monitor and ensure compliance with the ESCB Performance Dataset and to report key findings and areas of concern to the board;
- To ensure partner agencies' compliance with Section 11 Audit Tool;
- To commission and oversee focused audits regarding performance and compliance with procedures and policies as necessary;
- To closely monitor compliance with performance around the child protection processes, such as agency attendance at conference and core groups, numbers of children subject to CP Plans;
- To oversee the development and review of multi-agency policies and protocols and sign them off when completed;
- To monitor and scrutinise partner agencies internal Safeguarding activity and Quality Assurance work to ensure it is of a high and consistently standard.

Developing our approach to Section 11...

ESCB conducts annual Safeguarding audits under **Section 11 of the Children Act (2004)** which deals with the duty to make arrangements to safeguard and promote the welfare of children in the local area by seeking assurance that agencies have effective and robust arrangements in place.

Last year, for the first time, return of the completed Section 11 templates was followed by a panel Section 11 challenge interview. The panel was chaired by the ESCB independent chair who was joined by LSCB members. At the conclusion of the meeting a short summary of the discussion was drawn up along with an action plan for the agency identifying where improvement and/or clarification was required.

This year we have continued to build on and expand this activity with a specific focus on our schools. Section 175 of the Education Act (2002) requires local education authorities and governing bodies of maintained schools and further education institutions to make arrangements to ensure that their functions are carried out with a view to safeguarding and promoting the welfare of children. In addition, those bodies must have regard to any guidance issued by the Secretary of State in considering what arrangements they need to make for that purpose of the section. The ESCB developed a **Schools Safeguarding Checklist** to assist schools to assure themselves, and the Safeguarding Children Board, that they are compliant with Safeguarding requirements. It was sent directly to all schools and to governing bodies. The response from schools has been excellent with over 90% of our schools returning the checklist. Phase Two of the process has been to offer support visits to schools to help them review and strengthen their safeguarding arrangements with a particular focus on current challenges such as CSE and Radicalisation. So far six schools have either been visited or have arranged visits and the feedback has been extremely positive. We will continue to expand this approach in 2016/17 and will start to target those schools where concerns about safeguarding have been identified or raised.

Themed Case File Audits

Each year a range of themed case file audits are undertaken through the ESCB focusing on key areas of safeguarding activity. Some audits are undertaken by managers from within children's social care and our agency partners whilst others are completed by external, independent auditors. Audits undertaken in 2015/16 include:

- The **distance from their home** Looked After Children are placed
- Children who go **Missing** who are open to Children's Social Care
- **Private Fostering** Cases
- **Child Sexual Exploitation** (CSE)
- **Early Help and the Team Around the Family** (TAF)

As we would expect, a range of strengths and areas for improvement were identified through the audits and actions plans have been developed where necessary. Some of the actions that have been implemented as a consequence of these audits include:

- Ensuring that **chronologies** for Looked After Children are up to date and include a meaningful overview of the case
- Ensuring all **Direct Work** undertaken with children is recorded clearly and consistently
- Development of a new **ESCB Threshold Document** for use across the partnership with particular focus on assisting decision making in the Single Point of Entry (SPOE)
- Development of a new Early Help Assessment Form to be used by agencies to refer to the SPOE. The new form both ensures that information is captured clearly and succinctly and adheres to the newly implemented **Signs of Safety Practice Model** that is being implemented across Enfield.

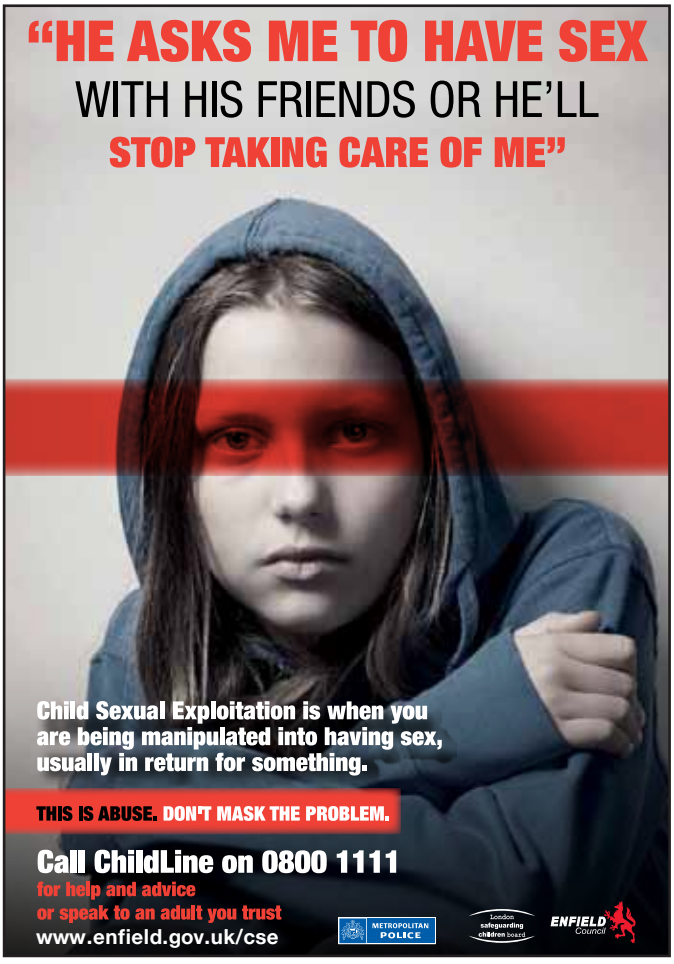
Child Sexual Exploitation and Missing Children

This has again been a very active year in relation to our work to identify and tackle Child Sexual Exploitation (CSE) and the links with children and young people who go missing. We were very pleased to endorse and support the establishment of a multi-agency Child Sexual Exploitation Prevention (CSEP) Team in July 2015. The team consists of Social Workers, Police officers and support workers who manage and/ or provide support for all cases where CSE is an issue.

The Trafficking, Missing and Sexual Exploitation (TSEM) sub-committee, continue to oversee our CSE strategy and action plan which has evolved and developed as our understanding of needs and requirements have grown. We have updated both our CSE and our Missing children operating protocols and published them on our website. For the first time our Missing Protocol covers guidance on what to do when working with children who go missing from Education and Health as well as from Home and Care.

At the start of year we joined with Haringey Safeguarding Children Board to successfully bid for funding from the Department for Education Innovation Fund to develop a **Cross Borough Vulnerable Young People's project** which looked specifically on the needs of children and young people at risk of child sexual exploitation (CSE) within and across the two boroughs. The project aims, all of which are on track are to:

- Increase responsiveness to and prevention of, CSE, trafficking, gang activity and missing children incidents across the two boroughs through improved intelligence and analysis of the needs of vulnerable children and young people.
- Improve the quality of joint working across the two boroughs and explore cost efficiencies in relation to safeguarding vulnerable children and disrupting and prosecuting perpetrators.
- Monitor, record and share learning about models of joint accountability and joint working across the LSCBs particularly to tackle CSE, trafficking, gang activity and missing rates to better safeguard children and young people.



The Project will run to June 2016 and will culminate in a Bi-Borough Learning event for partners to ensure learning and new processes and systems are fully embedded in both boroughs.

A member's CSE task group was established in June 2015 and meets four times a year offering strong leadership, oversight and scrutiny for the work undertaken to tackle CSE across the borough. The Task Group is due to report to the full council in May 2016.

The Borough has been part of the MsUnderstood North London Cluster – a project which brings together the six authorities within the cluster (Barnet, Camden, Enfield, Hackney, Haringey and Islington) supporting the collective focus on thematic issues of concern and enabling the sharing of relevant information across boundaries to build a cluster-wide problem profile of CSE (and within this peer-on-peer abuse and exploitation).

Training and Awareness Raising

We have continued to work with Safer London Foundation to provide training and awareness raising in relation to CSE. As part of the **Cross Borough Vulnerable Young People's project** we arranged a number of targeted training sessions for specific professionals across the two boroughs. Professionals benefiting from this training include, Social Workers, Police officers, and Community Safety unit staff, Pupil Referral Unit staff and Health Visitors and School Nurses.

Next Steps

Given the progress made on tackling CSE and Missing in Enfield and given the growing understanding nationally and locally of the complex, often intertwined issues that young people face and how they can impact on young person's life it is proposed that the good work achieved by the Trafficking, Missing and Sexual Exploitation sub-committee is built upon and expanded to include a focus on a number of additional area including; Youth Crime and Violence including gang related activity, Radicalisation and the Prevent agenda and Domestic Abuse and Violence Against Women and Girls.

The new group would link closely with other forums where these topics are already discussed and look to develop and implement a Vulnerable Young People's Strategy and Action Plan which would provide a cohesive and joined up approach to addressing the wider challenges vulnerable young people face. The group would of course retain a sharp focus on issues related to CSE and Missing but by also considering other issues the opportunities to develop wide ranging strategies and support mechanisms for vulnerable young people would increase. Timescales and full details are yet to be decided but it is expected that the new group will be operational in 2017.

Female Genital Mutilation (FGM)

In 2014, the public health team in Enfield estimated that 2,823 girls and young women under-18 years old were at risk of being subjected to FGM and 3,000 women in the borough had probably already fallen victim to this form of abuse. In 2015, City University published a study which estimated that there were 3491 women in the borough that live with FGM. This equates to an estimated prevalence of 21.6 per 1,000 women. This compares to 5.0 per 1,000 women in England and 21.0 per 1,000 women in London.

The Council formed a multidisciplinary group in 2013/4 which in the 3 years of its existence has overseen work to identify the number of women and girls in the borough at risk of FGM. Recently the team have provided training to social workers and members of the CCG. In addition partners in the voluntary sector continue to train professionals and deliver community development work with affected communities.

Iris – an FGM clinic located at the North Middlesex Hospital became operational in autumn 2015. It is staffed by a female Gynaecologist and specialist midwife. The clinic provides care and support for women who are experiencing problems as a result of FGM, and women are invited to discuss their health needs in a sensitive and non-judgmental environment. Interpretation is available on request and is confidential and private. Psychological and social support, and deinfibulation (reversal) are provided, as well as general gynaecology, sexual health and contraception advice. Over 250 women have attended since it opened and approximately 75% are Somali.

A half day workshop with all stakeholders took place in March 2016. This was held to consider a draft action plan and develop a strategy for FGM, given the FGM mandatory reporting guidance had been issued and the FGM chapter of the London Child Protection Procedures had been refreshed.

To take the work forward, the strategy is being developed. There is an action plan accompanying the strategy and the actions have been assigned. The majority of the actions are ongoing and there is an intention to hold a further workshop to agree the strategy. The strategy includes:

- Mapping services and the roles of the various voluntary sector organisations
- Refreshing protocols including clinical and referral protocols
- Working to co-ordinate better with the acute sector, including the IRIS clinic and the clinic being set up at Barnet
- Addressing an identified gap for health visitors and school nurses working with families affected by FGM and helping to devise a protocol for them.

Radicalisation and the PREVENT agenda

Prevent is part of the Government's CONTEST strategy and the Prevent strand is aimed at preventing people from becoming terrorists or supporting terrorism. Enfield is one of the Prevent "priority" authorities in London, which is reflected in the fact that we receive additional resources from central Government.

The Prevent duty placed an ownership on named sectors from July 2015 to recognise and refer vulnerable individuals for further Prevent support.

In Enfield we have been working to provide training and other resources to schools and similar organisations to have a better understanding of Prevent and to be able to contribute to its aims.

Many organisations have accessed a training tool called Workshop to Raise Awareness of Prevent (WRAP). This training has been provided a wide range of professionals in Enfield including teachers, social workers, housing staff, front line workers and health care workers.

This year a critical thinking project called 'Second Thoughts' was commissioned to support schools in Enfield. The project received favourable feedback from a number of schools on the way it was delivered.

The aims of this critical thinking project were to:

- provide young people with the opportunity to consider their opinions and how their world view is formed
- help young people to think critically about the information they receive and recognise the dangers of stereotyping and misinformation
- help young people to identify bias, propaganda, and symbolism in the media
- illustrate how easily divisions can be created between groups of people, which can escalate into conflict, and how to deal with it.

This project is now being made available to all secondary schools in Enfield.

In Enfield the main aim of the Prevent delivery remains to safeguard vulnerable individuals and to train appropriate staff so they are able to recognise and refer appropriate people for further Prevent support. Prevent referrals are treated in a similar way to other safeguarding referrals and professionals are instructed to complete an Early Help Form if they have concerns about a child.

Child Death Overview Panel

The Enfield Safeguarding Children's Board carries out Child Death Reviews as set out in the guidance 'Working Together to Safeguard Children 2015'. This process is performed by Enfield Child Death Overview Panel (CDOP).

CDOP is a multi-disciplinary subcommittee of the Safeguarding Children's board and is chaired by a Consultant in Public Health (CPH).

CDOP reviews each death of a child normally resident in the borough up to the age of 18, excluding babies who are stillborn and planned terminations of pregnancy performed within the law. Relevant information is collected and collated and each child's case is discussed to determine if the death could have been prevented. The intention is not to assign blame, but to determine if there were any modifiable factors that may have contributed to the death and decide if any actions could be taken to prevent future such deaths. If it is determined that there are such actions, recommendations are made to the Local Safeguarding Children's Board (LSCB) or other relevant body so that action can be taken accordingly.

Where a death is unexpected a rapid response meeting is usually convened. These are convened and chaired by the designated paediatrician and are held as soon as possible. These meetings are held to ensure that all the relevant information is gathered as soon as possible and any relevant actions are taken accordingly.

The panel also has a role in identifying patterns or trends in local data and reporting these to the LSCB. The lessons and trends arising from reviews are compiled and reported to the main Board and information or health promotion campaigns are carried out as appropriate – this has included in the past information events on Sudden Infant Death Syndrome which were held in conjunction with other Boroughs and learning events to inform professionals of the work of the safeguarding board and CDOP.

Due to the time it can take for death's to be reviewed the data for CDOP activity is a year behind. Between April 2014 and March 2015 a total of 17 deaths were reviewed by the Panel. In this same time period there were 5 rapid responses for unexpected deaths.

Of the deaths that were reviewed in 2014/15, three (18%) were found by the Panel to have modifiable factors.

Thirty per cent (5/17) deaths were neonatal/perinatal events and 47 per cent of deaths (8/17) were in children where there was a known life-limiting condition.

Future challenges

The paediatric assessment unit at Chase Farm Hospital and the arrangements for out-of-hours care in the borough are currently being reviewed.

Demographics in the borough are rapidly changing due to new building in the borough, regeneration and an increase in the borough population due to cheaper housing in Enfield compared to surrounding boroughs.

Achievements

A closer working relationship between CDOP and the SCR panel has been developed with an agenda item on each panel to share cases and concerns rather than each panel looking at these in isolation. The Chair of CDOP also now attends the SCR sub-committee.

Work is ongoing on reducing the number of SUDIs in the borough, with the production of a CCG funded booklet on child health that was translated into a number of community languages and the distribution of materials from the Lullaby Trust.

Serious Case Reviews

In England a serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons than can help prevent similar incidents from happening in the future.

The SCR subcommittee of the ESCB meets quarterly and reviews and follows through actions from previous Serious Case and other Reviews. This ensures that any lessons learned are implemented. Learning events are planned and delivered to agency partners on lessons arising from serious case reviews both locally and nationally.

In 2015/2016 the ESCB has published two Serious Case Reviews. In accordance with guidance, both were anonymised.

In May 2015 Enfield and Haringey Safeguarding Children Boards jointly published the Serious Case Review (SCR) report for **'Child CH'**.

The Serious Case Review concerned the murder by CH then aged 15, of a young man who was unknown to him. The Overview Report stated that the circumstance of the death and CH's involvement, could not have been predicted. However, through looking at the work of all agencies involved with CH and his family, the report recognised that there were a number of areas of learning and improvement for partner agencies as well as evidence of good and effective practice. Agencies could, and should, have responded differently at key points.

In January 2016 the ESCB published the Serious Case Review (SCR) report for **'AX'** which involved the death of a 17 year old male who was stabbed at the end of 2013. AX spent much of his life in Barnet and was engaged with a number of agencies there and so throughout the process of the review Enfield Safeguarding Children Board worked closely with colleagues from Barnet to ascertain what happened and when and to identify how we can collectively learn from the premature death of this young man.

The report concluded that the circumstances and timing of AX's death could not have been directly predicted by any of the agencies with which he had been in contact but did identify possible opportunities for changing the outcome or influencing elements in this and future cases.

For both of these reviews comprehensive Action Plans were developed from the recommendations which have been implemented and monitored through the sub-committee. In both cases the action plans have been completed.

In addition to our own two SCRs the sub-committee has also focused on other related issues. These include:

- Serious Case Reviews undertaken by other local authorities where an Enfield agency had some involvement. In the last year this includes reviews undertaken by Haringey, Barnet, Waltham Forest and Croydon. In all of these cased the sub-committee has monitored the recommendations and actions and supported partner agencies to ensure they are completed.
- Serious Case Reviews from other boroughs across the country where there are issues and recommendations that are relevant to us. These include a review undertaken in Hackney which looked at the sexual abuse of children in Foster Care. In Enfield we used the recommendations to develop an Action Plan to ensure supervising social workers and Foster Carers were aware of failings that the report identified and to assure ourselves that robust processes are in place to prevent such failings happening here.
- Following a new inquest into the death of baby in Enfield in 2011 which changed the previous finding regarding who was likely to have caused his death we wrote to the Metropolitan Police Serious Crime Review Group and successfully requested that they review the case and the Police investigation into it.

Enfield Young Safeguarding Champions

After a very active year in 2014/15 there have been a hiatus in the activity of our young safeguarding champions in 2015/16. This has largely been a consequence of structural changes and diminishing resources within Enfield children's services. However, there is a clear plan in place to ensure there is strong engagement and consultation with young people moving forward which involves engaging with our Youth Parliament and other young people's groups. Representation of young people in the activity of the ESCB will be a core part of our Business Plan for the coming year.

Signs of Safety

Enfield Safeguarding Children Board (ESCB) and its partners, including Enfield Children's Social Care have committed to implementing the Signs of Safety framework. The comprehensive implementation plan has been approved and endorsed and funding has been secured for the next 2 years to help move this important project forward.

This means that we are making some significant changes to the way we work with children, young people and families to ensure they are always at the centre of the work we do.

What is Signs of Safety (SoS) and why we are implementing it in Enfield?

Signs of Safety is an integrated framework for working with vulnerable children and their families, that is underpinned by key principles – developing and sustaining working relationships with children, families and professionals; having a questioning approach, remaining opened minded; and keeping the work grounded in everyday practice.

- SoS is an internationally recognised model for direct work with children and families.
- It is an outcome-focused, strengths-based model with a robust risk management framework & includes a range of principles, processes and tools to guide the work.
- Enfield is currently implementing the SoS to re-position the children's service at the centre of cutting edge social work research and practice (Munro review) and have a clear practice based model that can be used across all professions not just social work.

What we have done so far?

- Established a multi-agency **steering group** and a separate **operational group** which meet regularly to drive the implementation.
- Developed a full project plan which was signed off by ESCB, DMT and Enfield 2017 Design Authority.
- Hosted 2-day Signs of Safety training on 4 occasions delivering in depth training to 120 professionals. Arranged two further 2-day training sessions for October and provisionally booked the specialist 5-day training session for up to 30 professionals in December.
- Delivered SoS short briefings' to well over 400 practitioners across the borough.
- Included half day workshops for partner agencies as part of the annual ECSB Training programme.
- Worked closely with the Enfield 2017 IT team to identify IT changes and solutions required to fully implement the SoS (Smartboards, changes within Liquid Logic).
- Secured the funding through the 'invest to save' for the project to go forward.
- Review relevant policies, procedures, literature and assessment forms and made amendments to ensure they reflect SoS practice model.
- Begun the pilot period for Child Protection conferences in June 2016.

What's in progress?

- Recruitment of a SoS Practice Coordinator to lead the project for the next two years.
- Implementation of monthly practice meetings with Practice Leads and case workers.
- Ongoing review of the success and lessons learned during the pilot period ahead of full go-live in the autumn.
- Development of a Quality Assurance Framework You can find additional information and guidance on our Signs of Safety webpage.

Learning and Development

ESCB has a responsibility to develop policies and procedures in relation to the 'training of persons who work with children or in services affecting the safety and welfare of children…to monitor and evaluate the effectiveness of training, including multi-agency training, to safeguard and promote the welfare of children' *(Working Together, 2013)*

With oversight from the Joint Adults and Children's Learning and Development Subcommittee, a Training Strategy and a comprehensive multi-agency training programme is developed and delivered by the ESCB and this continued in 2015/2016. Issues from national Serious Case Reviews (SCRs) and other case reviews were considered, considered and incorporated to ensure that the content of the training programme related to emerging issues of concern, as well as to core safeguarding learning, that all practitioners working with children and their families need to understand. The decision was taken at the start of the year to merge the adults and children's sub-committees. This has allowed us to identity areas of crossover and ensure that where relevant, such as for training on Domestic Abuse, professionals who work with adults and children are brought together to maximise effectiveness.

It has been a very active year for Training. Key drivers and priorities for the Training Programme have included:

- The implementation of the **Signs of Safety** model
- The development of the **Child Sexual Exploitation (CSE)** Strategy and activity to identify and tackle CSE in Enfield
- Awareness raising around the issue of **Female Genital Mutilation (FGM)**
- Increasing awareness of understanding of gang related issues and links with other issues, such as CSE.
- The development of the **Multi-Agency Safeguarding Hub (MASH)** and the **Single Point of Entry (SPOE)** service
- **Domestic Abuse** and **Violence Against Women and Girls**

A total of **1,118** places have been filled at ESCB learning events this year compared with **553** last year.

Attendees have been from the following sectors:

Children's Social Care	261	23.3%
Education	228	20.4%
Independent and Voluntary	178	15.9%
YFSS	129	11.5%
Health	118	10.6%
Other LBE	80	7.2%
CAMHS / EPS	49	4.4%
Out of Borough	31	2.8%
Police	17	1.5%
Other	11	1.0%
Foster Carers	10	0.9%
Probation	6	0.5%
	1,118	**100.0%**

Comments

- Enfield has a very active Independent / Voluntary sector which, as in previous years, has been very well represented and multi-agency training events.
- Attendance from Health and Education settings is significantly higher than last year.
- Attendance from Police colleagues remains low but is significantly higher than previous years.

Evaluation and Impact

Attendees at all learning events are asked to complete paper evaluation immediately after the event. Completion rates have been very good. In addition to answering questions about their overall perception of the course attendees are asked whether they think the course will be effective in improving their practice.

This data provides extremely helpful information both about the relevance and quality of the course itself and about the skills and knowledge of trainers we commission. Follow up evaluations for selected courses are sent after 6 weeks to develop understanding of how learning events impact on work with children and families and thereby improve outcomes for children. Completion rates have been lower but there have been some returns which offer important insights into how training can improve practice.

The effectiveness of ESCB training is also monitored through the quality assurance and audit programme. Findings are incorporated into ongoing Training Needs Analysis and are used to inform ongoing training and development.

All courses delivered this year have been evaluated positively.

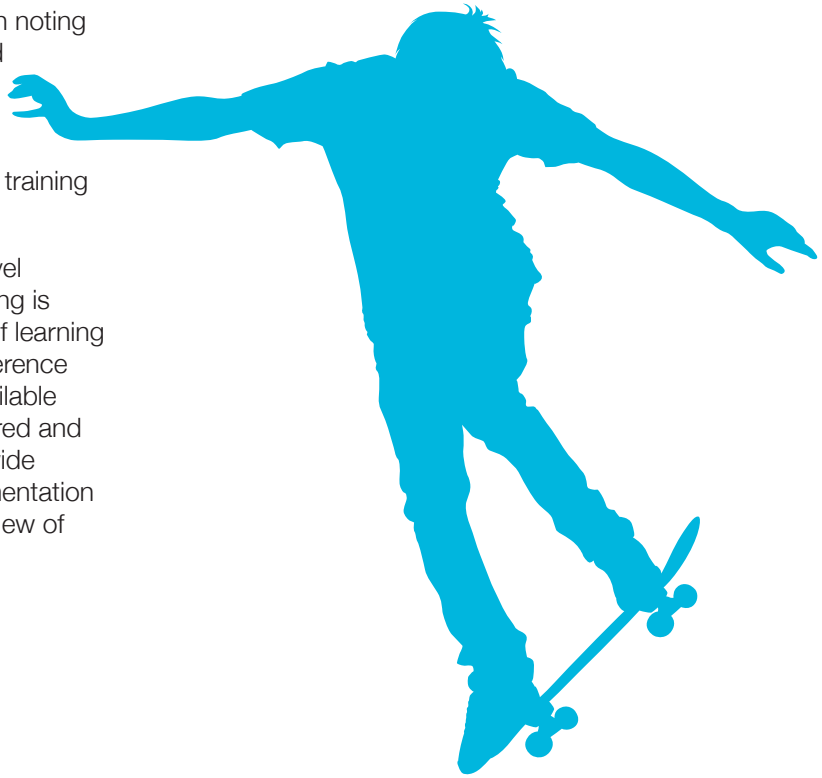
For 2016/17 we are introducing an online evaluation tool which will considerably enhance our ability to understand and measure the impact of our training.

ESCB Finance and Resources

All LSCB member organisations have an obligation to provide LSCBs with reliable resources (including finance) that enable the LSCB to be well organised and effective. Resources include staff time and additional support such as attending Board meetings, co-chairing the subgroups which support the work of the Board, and contributing to Serious Case Reviews.

In 2015/16 the Board had a budget of £184,910 which was made of contributions from our partners. Approximately 78% of the total budget was contributed by the London Borough of Enfield and the CCG was the next highest contributor with approximately 18% of the total budget. It has been noted across London that the level contribution to Safeguarding Children Boards from the Metropolitan Police is significantly lower than that made by the other large urban Police Forces in England. Enfield Safeguarding Children Board supports the ongoing efforts of the London Safeguarding Children Board to address and seek a resolution to this issue.

The ESCB managed to spend within budget during the year primarily because there were no new Serious Care Reviews in 2015/16 which are regularly a high area of expenditure for Safeguarding Boards. 80% of the overall budget was spent on staffing costs including the independent chair and 16% was spent on Serious Case Reviews and Learning & Development. It is worth noting that almost twice the amount of people attended training and Learning and Development events in 2015/16 than in 2014/15 with no increases in measurable cost. This was a consequence of increased use of skilled internal staff to deliver training rather than commissioners external trainers.



For 2016/17 the board is asking for the same level of contributions from its partners to ensure funding is adequate to continue to deliver the wide range of learning and development opportunities including a conference in early 2017, to ensure there is contingency available for any Serious Case Reviews that may be required and to support the transition towards any borough-wide Safeguarding structures that may require implementation following the DfE commissioned Alan Wood Review of Local safeguarding Boards.

Statements from ESCB Partner Agencies

The ESCB is very much a partner organisation. Whilst much of this report focuses on what has been undertaken at a partnership level it is important too to ensure that each member agency is undertaking effective safeguarding work individually. This section focuses on what each partner had achieved in 2015/16 and what impact it has had on the lives of children and young people.

Enfield Clinical Commissioning Group

NHS Enfield Clinical Commissioning Group's (CCG) priority is to ensure children remain safe whilst they are receiving health care in Enfield. This priority remains at the heart of all commissioning planning and decision making. We have continued to work in partnership with all agencies in the health economy to achieve this and make sure that all health providers in Enfield understand their role in the health and wellbeing of children and young people.

Enfield CCG recognises their statutory duties and responsibilities to safeguard children and young people, which include being a statutory partner of the Enfield Safeguarding Children Board (ESCB).

NHS Enfield CCG has a statutory responsibility to ensure that the organisations from which it commissions services provide a safe system that safeguards children and young people. Safeguarding clinical expertise in the CCG is provided through the Designated Nurse and Doctor for Safeguarding children. The CCG has specific responsibilities for children looked after and supports the Child Death Overview Process. The CCG has secured the expertise of a Designated Nurse and Designated Doctor for Looked After Children and a Designated Paediatrician for the Child Death Overview Process.

What did we do?

- Organised a 1 day safeguarding children and adults at risk conference in July, 2015
- Co-ordinated a 1 day safeguarding symposium for Enfield primary care staff
- Supported the Identification, Referral to Improve Safety (IRIS) project for Domestic Violence
- Delivered PREVENT training to GPs
- Delivered safeguarding training to community pharmacists and dentists
- Co-ordinated and delivered 4 level 3 safeguarding children updates for GPs
- Supported the business case for the Female Genital Mutilation (FGM) clinic at NMUH
- Held quarterly strategic safeguarding committees for Named leads from each health organisation, including private organisations
- Facilitated quarterly safeguarding lead GP forums
- Undertook extensive deep dive into safeguarding arrangements moderated by NHS England (London)

How well did we do it?

- 150 delegates from across the health economy trained in safeguarding children and adults at risk at the 1 day conference in Forty Hall
- 80 delegates – mixture of GPs and primary care staff attended with excellent feedback
- 61 GPs trained in Prevent
- 25 community pharmacists and dentists trained in safeguarding
- 102 GPs trained to Level 3 with updates on referral pathways, substance misuse, domestic violence, FGM and Child Sexual Exploitation
- CCG assured as good by NHS England (London)

How did we make a difference?

- Maintenance and meaningful updates of level 3 safeguarding training for all healthcare staff
- Improved quality of safeguarding care and knowledge through GP engagement and case discussions
- 207 referrals to IRIS service
- Increased understanding of referral pathways to Single Point of Entry and Compass
- Increased awareness of FGM and FGM clinic
- Ensured named leads for each organisation, including the GP safeguarding leads had opportunity to meet regularly to share practice, hear updates and developments in local and national guidance

NHS
Enfield
Clinical Commissioning Group

North Middlesex University Hospital

What did we do?

- Gangs – 2 gangs youth workers in post to cover Enfield and Haringey; official opening of service November 2015 1 year on; Gangs audit undertaken; Named Doctor presented at National conference (RCPCH)
- Early adopter site for CP – IS
- Development of FGM clinic supported by specialist Midwife for FGM
- Training on FGM delivered in local schools to teaching staff and at national Quality and Diversity conference by Named Doctor
- Training delivered to local youths working with Gangs youth workers by Named Doctor and Safeguarding Advisor
- Development of a substance misuse clinic for pregnant women supported by COMPASS

How well did we do it?

- Engaged with partner agencies with cross Borough initiatives – CSE and Gangs
- Local and national links with FGM, Gangs
- Received press coverage local and national for Gangs work
- Supported cross Borough initiative for 'keep safe bag' for young people attending A&E
- Received press coverage local and national for FGM services offered

How did we make a difference?

- Raised awareness in local community and nationally regarding Gangs work
- Improved care pathways – CSE, Gangs
- Improved information sharing between health colleagues – co -located with Liaison Health Visiting teams Enfield and Haringey
- Improved Staff knowledge and awareness with improved compliance levels

Barnet, Enfield and Haringey Mental Health NHS Trust

Overview 2015 -2016

Barnet, Enfield and Haringey Mental Health NHS Trust remains committed to safeguarding all our service users, their families and carers. We recognise that effective safeguarding is a shared responsibility which relies on strong partnership and multi-agency working. Over the last 12 months The Trust has strengthened its safeguarding arrangements in many ways including the recruitment of a full-time Head of Safeguarding. We are continually improving systems and processes; and developing a clear strategic approach to safeguarding across all our services.

Internal governance arrangements

Our aim is to ensure there is a whole organisational approach to safeguarding patients and service users, their families and carers. In order to do this we have developed an Integrated Safeguarding Committee (ISC). The ISC is chaired by the Executive Director of Nursing, Quality and Governance and provides strategic leadership and oversight. The work of the ISC is informed by our newly developed Safeguarding Strategy and overarching work plan. The ISC meets each quarter and is accountable to the Trust Quality and Safety Committee. The Executive Director of Nursing, Quality and Governance is the Executive lead for safeguarding and provides bi-monthly safeguarding updates to the Trust Quality and Safety Committee. In addition an annual safeguarding report is provided to the Trust Board. Safeguarding is a standing item for each of the Borough Clinical Governance meetings.

Safeguarding Children work undertaken and key achievements in 2015-2016

- The Domestic Violence and Abuse Policy has been updated.
- Domestic Violence and Abuse training have been included in Corporate Induction for all staff and is usually delivered by an IDVA.
- The Trust Safeguarding Children Policy has been updated to ensure it is in line with Working Together 2015 and the revised London LSCB Procedures.
- A safeguarding inbox has been set up to allow improved monitoring of safeguarding referrals made by Trust staff and a screen saver has been established to prompt staff to use it.
- A safeguarding dashboard has been designed to enable easier monitoring of safeguarding activity.
- A prompt to consider safeguarding has been included in the Trust incident reporting system (Datix).
- Prevent Training has been included in Corporate Induction for all staff.
- An Integrated Safeguarding Committee has been established with clear terms of reference.
- A safeguarding strategy has been completed with key aims and objectives.
- A safeguarding training strategy has been completed.
- We have met the target of 80% of eligible staff attending Safeguarding Children Training at each level.
- The safeguarding surgeries have been recognised as good practice.
- The safeguarding team champions meetings have been re-established in each borough.

Key Challenges

- Safeguarding practice is complex and varied. The challenge of collecting accurate meaningful data is recognised. Work continues to ensure data is captured and analysed effectively.
- To continue to develop and improve systems to promote effective lessons learnt from safeguarding incidents and inter-agency case reviews.
- To increase the number of staff undertaking level three training to help ensure that safeguarding children is embedded in everyday practice and is everybody's business.
- To ensure the challenge of working across three borough Safeguarding Children Boards and their associated sub-groups is managed effectively.

Safeguarding children work planned for 2016-2017

The work of the Integrated Safeguarding Committee is informed by an overarching work plan which underpins the Safeguarding Strategy. The Strategy has five broad aims which form the overall framework of work going forward:

- To ensure safeguarding is everyone's business across the Trust
- Develop a dataset of information that allows effective monitoring of safeguarding activity and outcomes
- Develop a culture of learning with robust internal systems to support this
- Promote early help to prevent abuse from happening in the first place
- Develop seamless pathways that promote joined up working at every level.

Barnet and Chase Farm Hospitals NHS
NHS Trust

Royal Free London NHS Foundation Trust

What did we do?

- We continue to strengthen our governance structure through the Integrated Safeguarding committee and the relevant Trust committee's and Trust Board.
- Two Safeguarding Children Advisors (SCA) joined the safeguarding team one based at Barnet hospital (BH) covering Barnet & Chase Farm (CF), the other based at the Royal Free hospital (RFH) both, along with a specialist midwife, have received supervision training.
- The Trust now hosts three Independent Domestic & Sexual Violence Advisors (IDSVA's) in collaboration with Camden SafetyNet, Solace, and Victim Support. Two cover BH and one at the RFH. This training can be accessed by external Health colleagues.
- We continue to deliver a high quality safeguarding training to over 10,000 staff across the Trust.
- We have trained 4 CSE champions.
- We have contributed to 3 SCR's in the last year and have implemented the recommendations where applicable.
- We have continued to use audit to develop and strengthen safeguarding.
- Continued Policy development.
- We hosted an Integrated Safeguarding conference for 150 internal and external colleagues.
- We have harmonised domestic violence screening for the midwives across all three sites and community clinics.

How well did we do it?

- The SCA's are able to focus on frontline case work and make daily links with clinical areas. This has been very successful in supporting referrals but also providing external agencies with a point of contact.
- Since starting in July 2015 to March 2016, the IDSVA's have received 253 referrals:
  - 88% were female and 11% were male.
  - 49% came from RFH, 45% from BH, and 5% from CF, Edgware or other sites. We do not currently have an agreement to host an IDSVA at CF
- Our training figures for March 2016 have increased across all areas with level 1 87%, level 2 79% and level 3 85%.
- We have provided extensive training to staff at level 3 about identifying deliberate self-harm and the impact of social networks for children and young people. This learning is as a result of one of the serious case reviews we were involved in.
- We commissioned our internal auditors to review practice in our Outpatient clinics to see how robustly we identified children subject to Child Protection Plans. The audit identified some areas for improvement and we are currently implementing processes in clinic preparation to ensure we are able to identify which children have a CPP and ensure the allocated social worker is copied into the clinic letter.
- The safeguarding conference was evaluated as excellent by those who attended.

How did we make a difference?

- One of our IDSVA's and the named midwife for safeguarding children, along with a consultant obstetrician and a member of the security team received a team award for their 'Outstanding Contribution to Patient Safety 'recognising their management and care of a vulnerable pregnant woman suffering significant domestic abuse.
- We have begun to see more referrals for FGM and CSE being made.
- We have increased to amount of safeguarding supervision we can provide to staff.
- Through training and support staff in the young people's sexual health clinic were able to identify two young girls who were being sexually exploited, one a missing child, one a LAC child , and access emergency services to ensure the girls were taken to a place of safety.
- Our safeguarding children training at all levels is highly evaluated with staff identifying that it will support their practice.

Royal Free London NHS
NHS Foundation Trust

London Community Rehabilitation Company (Probation)

What did we do?

In 2015, London CRC focused on improving safeguarding children practice across all staff grades. Performance was driven by the Strategic Safeguarding Children Lead and the Safeguarding Senior Probation Officer lead.

A London CRC Child Safeguarding Performance Framework was launched in 2015, to measure and evidence the performance of routine tasks. The five key practice areas measured are as follows:

- Initial check to Social Services
- Response Received to Initial Check
- Management Oversight
- Home Visits

A lot of work has been undertaken in the past 12 months to raise awareness of frontline staff regarding London CRC's safeguarding responsibilities as well as their own professional responsibilities.

Work taken to achieve this has included:

- Regular safeguarding children practice messages distributed by the senior probation officer lead for child safeguarding. Subjects including CSE, Missing children, violent extremism, gang affiliation, the impact of parental mental ill-health, the impact of parental substance misuse, the categories of abuse and guidance on making referrals to children's social care.
- Implementation of the safeguarding children performance framework.
- Internal conferences held for children's champions.
- Briefings to middle managers re: safeguarding policies and procedures.
- Development of a Safeguarding Children Briefing pack which will be delivered to all London CRC staff this year 2016 – delivery monitored by the Professional Development and Learning department.

These improvements have been supported by a drive to ensure that all London CRC staff are provided with the necessary training to carry out their role in safeguarding children effecticvely. London CRC:

- Commissioned an independent audit of safeguarding practice across the organisation to inform future improvement plan.
- Commissioned a tailored mandatory training programme to be delivered across all staff grades.
- Encouraged staff to attend training delivered by local safeguarding children boards (LSCBs) and Mental Health and Safeguarding Awareness Training (MAST).
- Two training events for frontline staff and managers focusing on the impact on the impact of parental imprisonment on children were delivered in 2015 by Bernardos.

In December 2015, following an organisational re-structure, London CRC launched a new central MASH process on 7 December 2015. The new process is intended to reduce the amount of Probation Officer time spent on servicing the MASH and to increase the quality of information provided to the MASH in cases where the adult is actively managed by the LCRC. It was necessary to review the process as London CRC is now structured in a Pan-London model as opposed to the previous local delivery model. The new process remains under review and is being monitored closely by the designated safeguarding lead.

London CRC is committed to engaging service users effectively to assist them in complying with Orders set by the court. Where multi-agency work is undertaken in order to protect children linked to our service users, offender managers are expected to engage adults under our supervision throughout this process. In addition offender managers are expected to address safeguarding children concerns in risk management plans when completing OASYS assessments and they are also expected to devise sentence plan objectives with service users to promote positive outcomes with children they care for, or have regular contact with when concerns have been identified.

How well did we do it?

London CRC's performance in relation to completion of initial checks to social services and management oversight of cases with safeguarding concerns was poor at the beginning of 2015. However, by the end of 2015 performance had risen sharply in relation to both checks and management oversight of cases with safeguarding concerns to over 90% of cases.

Response to initial checks from Children's Social Care was lower and concerns have been raised from multiple local boroughs about the volume of checks and the pressure this has placed on local resource. This is being reviewed in collaboration with the London SCB and it is hoped a practical resolution will be achieved in due course.

In relation to home visits, the performance target is set at 60% due to the number of service users who are in custody at any given time and the number who are of no fixed abode. Performance in relation to home visits had improved from a low base to 40% and work is ongoing to continue performance improvement in this area.

Unfortunately due to a recent IT upgrade, we have been unable to use the performance framework to measure progress and have no up-to-date data. However, this is being actively resolved and the framework will be reviewed and refined to increase effectiveness.

Despite some significant improvements made by the CRC, MTCnovo commissioned a London CRC Safeguarding review in May 2015 which recognised the efforts made to improve safeguarding practice, however, also highlighted a number of presenting deficits. In response, the CRC commissioned a series of focus groups of a cross grade group of staff, to enquire into the reasons why efforts to improve practice had not been more effective. The findings of the focus group are being taken forward by the London Child Safeguarding Lead and an action plan will be overseen by the London CRC Child Safeguarding Board when this is set up.

London CRC Senior Leadership recognise that the CRC has made some positive improvements to practice over the past 12 months, despite significant organisational change. However, further improvements to practice and outcomes are necessary and there is a firm commitment to achieving this as a priority which is evident.

How did we make a difference?

A lot of work has been done in the past year to uplift safeguarding children performance and practice across London CRC. Equally, London CRC staff have been on a significant journey through the recent organisational re-structure and it has not been possible to date to evaluate to what extent the strategy and activities we have undertaken have made a difference to the quality of our work.

Quality assurance auditing will be prioritised over the next 12 months. London CRC has developed a new Quality Audit process whereby Senior Probation Officer's will carry out a case audit with each offender manager twice per year. The quality audit tool addresses specific aspects of safeguarding practice and it is envisaged that this will further embed practice improvements over the coming year and will be launched on 31/5.

After the second round of auditing it will then be possible to identify trends in terms of quality of practice and to highlight gaps and weaknesses which need to be addressed.

Enfield National Probation Service (Probation)

What did we do?

The National Probation Service (NPS) is committed to reducing re-offending, preventing victims and protecting the public. The NPS engages in partnership working to safeguard and promote the welfare of children with the aim of preventing abuse and harm and preventing victims. The NPS acts to safeguard children by engaging in partnership working including:

- **Strategic:** As a statutory partner, attending and engaging in Local Safeguarding Children Boards (LSCBs) and relevant sub-groups of the LSCB. Through attendance, the NPS contributes to the formulation of board priorities and the development of strategy, policy and procedures in relation to safeguarding children. The NPS shares knowledge of and skills in the risk assessment and management of offenders and contributes to the development of appropriate multi-agency training packages, which can be accessed by NPS staff. As a member of the LSCB, the NPS contributes to audit and performance monitoring, including contributing, where appropriate, to Serious Case Reviews (SCRs), other child protection reviews and child death reviews, and sharing and embedding into practice lessons learnt from such reviews.
- **Operational Management:** Middle managers must ensure that processes and procedures are in place to support the operational delivery required to safeguard children and to ensure an integrated approach to partnership meetings and multi-agency communication.
- **Operational:** Ensuring that the principles of safeguarding and promoting the welfare of children are integrated into every aspect of the work of the NPS. The NPS will make a referral to the local authority where staff have concerns that a child is in need or is experiencing, or is at risk of experiencing, abuse or neglect. The NPS works collaboratively with the Local Authority and other partner agencies to manage and reduce risks to children and to promote their welfare. This includes attendance at multi-agency professionals meetings and Child Protection Conferences as appropriate.
- **Operational:** Ensuring the identification and assessment of offenders who pose a risk to children and through appropriate and timely information sharing ensure that the Local Authority and other partner agencies are alert to the risks and that the offender is effectively managed to reduce the risk of re-offending. The NPS performs a vital role in providing pre-sentence risk assessment information and reports to the courts and provides assessments and reports for the Parole Board. The NPS is directly responsible for the supervision of those offenders assessed as posing high risk of serious harm during and after their imprisonment and on statutory supervision in the community.

How well did we do it?

Strategic: Regular attendance and engagement at board meetings and section 11 audits as required, dissemination of training from LSCB communicated to all Enfield probation staff.

Operational: Continued professional development of staff through performance objective of mandatory completion of e-learning of child safeguarding issues, this is followed by classroom training on child safeguarding. Enfield national probation service continues to have a dedicated member of staff attached to the MASH and SPOE to ensure information sharing about child safety and concerns is fluid between agencies as required, Enfield probation has a 'children's champion' probation officer who attends multi-agency pan-London safeguarding events to spread good practice and discuss issues pertaining to child protection.

Due to solid links with the SPOE and MASH Enfield probation is at an advanced stage in ensuring that information about children is shared and discussed through use of each other's IT systems and databases in real time from the local probation office- I am not aware of any other borough in London where this is working so well.

Enfield (as part of Barnet, Brent and Enfield cluster) was a top 3 performing cluster in London for 2015/16 in regards to its service level targets, whilst these don't directly measure targets linked to child safeguarding they demonstrate that the borough is performing well in its own right against its set targets.

How did we make a difference?

Through good use of IT systems information sharing is more fluid enabling a better and quicker exchange of information to check safeguarding issues. Through increased knowledge and information exchange the management of high risk offenders and offenders who present a risk of harm to children can be considered to be better managed with more well informed risk assessments and closer multi-agency working.

Through engagement within the MASH and SPOE more Enfield probation staff have attended local authority training events regarding the safeguarding of children leading to more informed and better connected staff.

Through more engagement with partner agencies we can consider ourselves making more of a difference through better understanding of partners' approaches to safeguarding and improving our own assessments and abilities to manage high risk offenders and subsequent safeguarding issues.

London Probation Trust

Metropolitan Police Service (CAIT)

What did we do?

The Child Abuse Investigation team that covers Enfield and Barnet investigated 760 offences against children during the financial year 2015 to 2016. The remit for the team includes all offences committed by family members and those with safeguarding responsibilities against children (including safeguarding professionals).

Hundreds of additional strategy discussion took place to discuss the safeguarding of Enfield children.

Police Conference Liaison Officers attended Initial and Repeat Case Conferences liaising with partners to ensure the best possible outcomes of families with children on Child Protection Plans.

How well did we do it?

In the financial year the team either cautioned or charged 208 cases, an increase of 70 from the previous year. 15 of those detections resulted in charges for rape, an increase in 2 of the previous year.

The team attended 100% of Initial Case Conferences.

How did we make a difference?

Working very closely with partners in Children and Social Care, Education, Heath, parents and together with numerous third party safeguarding agencies, difficult decisions were made daily to protect the children of Enfield. Reacting swiftly to allegations, fast time intelligence gathering and the swift collation of evidence has made a difference to the outcomes for children in Enfield who have been physically and sexually abused by those they previously trusted.

METROPOLITAN POLICE

TOTAL POLICING

Notes

Enfield Safeguarding Children Board
September 2016

www.enfieldlscb.org

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Enfield
Safeguarding
Children Board
...because safeguarding children is everybody's business

DIABETES IN ENFIELD

ANNUAL PUBLIC HEALTH REPORT 2016

www.enfield.gov.uk

ENFIELD Council

WELCOME

I would like to welcome you to the Annual Public Health Report for 2016. This report focuses on diabetes in Enfield because tackling diabetes is a key challenge in implementing a comprehensive strategy to improve the health of the borough's population.

In Enfield, the number of people with diabetes is increasing each year. At present one in every 14 adults in the borough has the condition and a further 30,000 have a high risk of developing it. Luckily Type 2 diabetes – which is related to lifestyle – is mostly preventable and residents can take simple and practical steps to minimise their risk of contracting it and also improve their general levels of health.

Our national and local partners have set out effective, evidence-based measures intended to improve treatment for patients with diabetes, and improve the prevention of the condition.

The Council is working with its partners such as the NHS in Enfield to make it as easy as possible for residents to live a healthy lifestyle by creating an environment that makes it easier to move more, eat healthily, drink less, and not smoke.

I also welcome the launch of the National Diabetes Prevention Programme and the great commitment from NHS Enfield Clinical Commissioning Group to work on diabetes prevention beyond the ambition of the national programme.

Although both types of diabetes (Type 1 and Type 2) are incurable, the risk of developing diabetic health complications can be minimised by early detection and effective management of blood glucose levels, blood pressure and cholesterol.

However, there is a huge variation in the take up of education programmes for people with diabetes, in the delivery of the recommended care processes, in the achievement of treatment standards, and in outcomes for patients with diabetes across England.

By talking to patients, we know that with structured education and appropriate support, children and adults with diabetes can manage their condition confidently and lead healthy lives.

I would like to congratulate those people who take active measures to control their diabetes and who work with their healthcare team, adopt a suitable lifestyle, monitor their own progress, and take up eye screening and flu jabs. These actions are in their long term interests and help prevent both long-term and acute consequences, but also benefit the wider community by reducing crisis admissions to A&E when diabetic complications arise.

We will continue to work with people with diabetes and with our partners to control this condition across Enfield. We are running many successful initiatives in the borough and you can find out more in the latter pages of this annual report.

I would like to thank Dr. Ahmad and the Public Health team for their hard work in producing this report which will help to guide future work on prevention and management of diabetes, and support people in Enfield to live healthier lives.

Cllr Krystle Fonyonga
Cabinet Member for Community Safety & Public Health

FOREWORD

The topic of my 2016/17 Annual Public Health Report is diabetes. Diabetes is a condition which can cause major complications to individuals, is rapidly increasing in numbers and is a significant financial pressure for the NHS and local government. Diabetes contributes to the life expectancy gap, which was the topic of my 2014/15 report.

The report covers many aspects of diabetes, from prevention to a plethora of its consequences, the role of healthy lifestyle and medical management of diabetes, the importance of patient self-care and structured education, how diabetes disproportionately affects Enfield and its deprived communities, and how local and regional partners in Enfield are working together to prevent and manage diabetes.

From a national audit, we know that 20% of all strokes, 21% of all heart attacks, and 32% of all kidney dialysis were related to diabetes, and it is clearly adding to the cardiovascular mortality which is the number one cause of the life expectancy gap seen in Enfield.

There is and has been a lot of good practice in diabetes management. However the growing number of people with diabetes means that we all need to continually aspire to excellence. The report describes some of the excellent work which has already been done in Enfield, including patient information, Conversation Map Tools (a structured patient education programme), an initiative to improve the management of complex diabetes, diabetes prevention and many others. Going forward, the Sustainability and Transformation Plan will be an important programme of work in North Central London.

I'd particularly like to thank Dr Tha Han and indeed all of the Enfield public health team for producing this document and for the sterling work they do on a day to day basis to tackle diabetes.

Dr. Shahed Nizam Ahmad
MSc, MA, MB, BChir (Cantab), FFPH

Director of Public Health
London Borough of Enfield

CONTENTS

WHAT IS DIABETES?

KEY MESSAGE

Diabetes is a condition where the amount of sugar (glucose) in your blood is too high because the body cannot use it properly. Excess sugar in the blood can damage veins, arteries and nerves in your body.

There are 3 main kinds of diabetes

TYPE 1 DIABETES

What is it?

Type 1 diabetes occurs when your body doesn't make enough insulin to manage blood sugar. Insulin is the hormone produced by the pancreas that allows sugar (glucose) to enter the body's cells, where it is used as fuel for energy.

Who's at risk?

Type 1 diabetes can develop at any age but usually appears before age 40. The most common age for diagnosis is aged 9-14. It is estimated that there are currently 187.7 children with Type 1 diabetes per 100,000 children aged under 15 in England and Wales.[1]

What can I do?

Type 1 diabetes can't be prevented but with proper management, people with Type 1 diabetes can have long and healthy lives.

TYPE 2 DIABETES

What is it?

Type 2 diabetes occurs when glucose is unable to enter the cells, either because there is not enough insulin or the insulin receptors are not working properly.

Who's at risk?

People aged over 40, people who are overweight or obese, people with a family history of diabetes, and people of Black and Asian origin can be at higher risk of developing Type 2 diabetes.

What can I do?

Type 2 diabetes can be delayed or prevented by leading a healthy lifestyle – maintaining a healthy weight and doing exercise. This is especially important if your GP tells you that you are at risk of developing diabetes (pre-diabetes).

DIABETES IN PREGNANCY

What is it?

There are two kinds of diabetes in pregnancy:

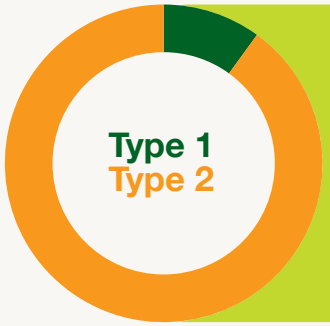
- gestational diabetes is a type of diabetes that is first detected during pregnancy and usually disappears afterwards;
- women who have already been diagnosed with diabetes and become pregnant.

Who's at risk?

Your chances of getting gestational diabetes are higher if you are overweight, or have polycystic ovary syndrome.

What can I do?

You need to control your blood sugar before, during and after pregnancy. Your GP will help you to do this.



There are 4 million people living with diabetes in the UK. Amongst these adults and children, it is estimated that **10%** have Type 1 diabetes and **90%** have Type 2 diabetes.[2]

Last year, **1 in 15** women who gave birth in Enfield had diabetes.

See page 10 for more about diabetes in pregnancy.

Source: SUS data, NHS Enfield CCG

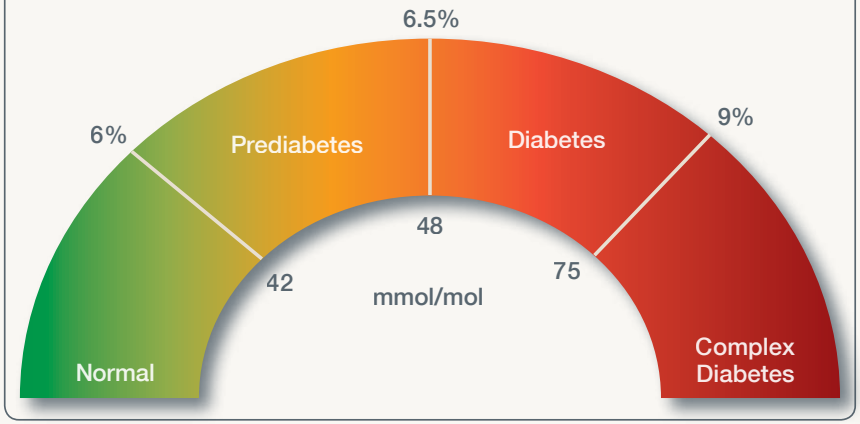
Prediabetes

In addition to those diagnosed with diabetes, there are a large number of people who are at high risk of developing Type 2 diabetes, referred to as "prediabetes".

Prediabetes is when the amount of sugar in your blood is above normal although not high enough to be diagnosed as diabetes.

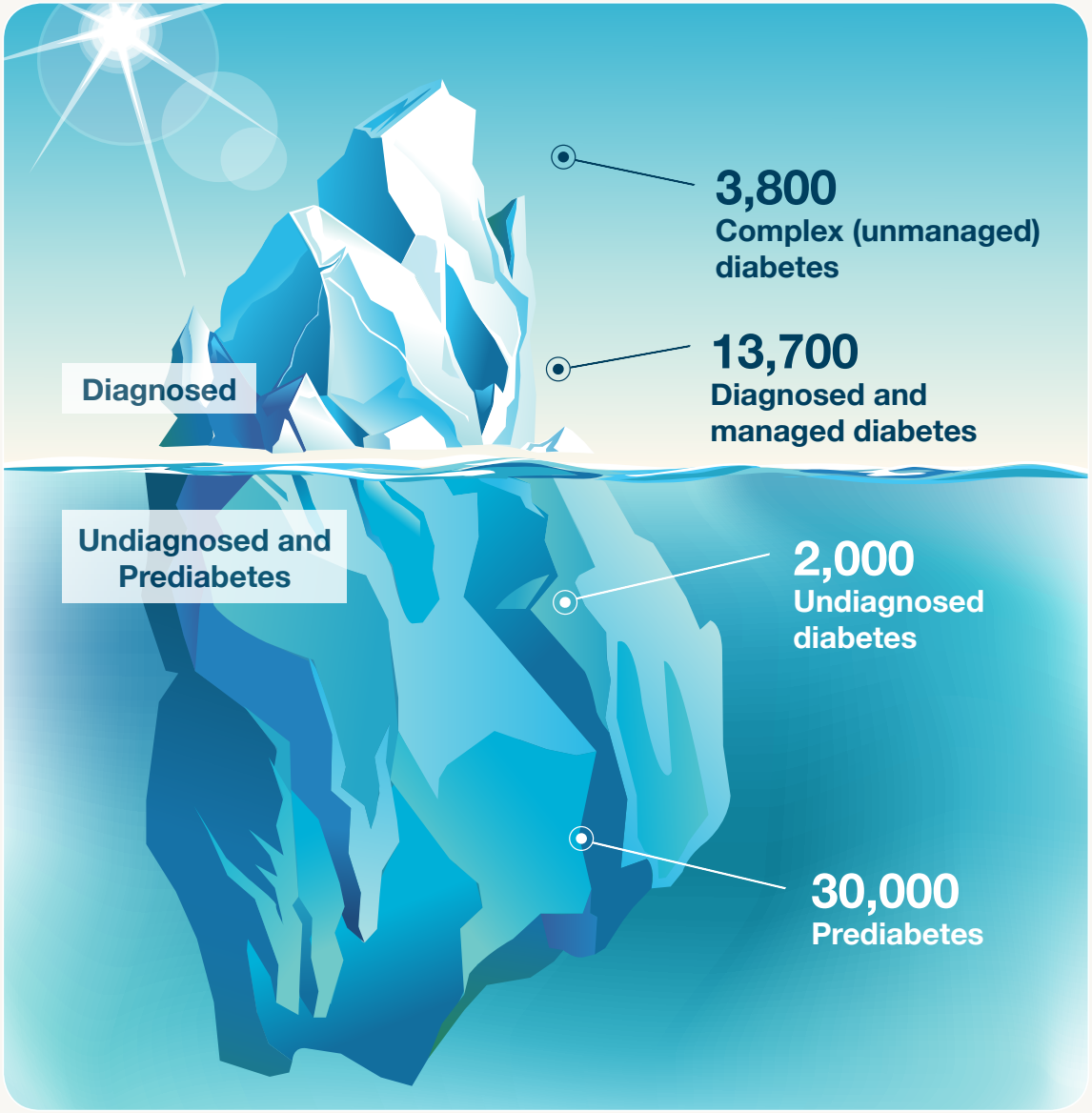
People with prediabetes are **at increased risk** of developing Type 2 diabetes and every year 5%-10% of people with prediabetes become diabetic.[3] However this progression is not inevitable: you can reduce this risk by 40-70% through a **healthy diet** and moderate **physical activity**.[4]

To clinically diagnose diabetes or prediabetes, your doctor will test your HbA1c (glycated haemoglobin), a measure of your average blood sugar level.[5]



Source: Adapted from John et al. (2012)

Diagnosed diabetes is just the tip of the iceberg. In Enfield:



Sources: Quality and Outcomes Framework (QOF) 2014/15, Health and Social Care Information Centre (HSCIC). Diabetes prevalence model for LAs and CCGs, Public Health England (PHE) Prevalence estimates of non-diabetic hyperglycaemia, PHE

DIABETES IN ENFIELD

KEY MESSAGE **There are almost 17,500 adults (1 in 14) diagnosed with diabetes in Enfield and an additional 30,000 people are at risk of developing diabetes.**

It is estimated that there are almost 20,000 adults with diabetes in Enfield, although not all of these are diagnosed.

Approximately **17,500** adults (aged 17+) have been diagnosed with diabetes in Enfield **(7.1%)**. Enfield has the **7th** highest level (prevalence) of diabetes in London.

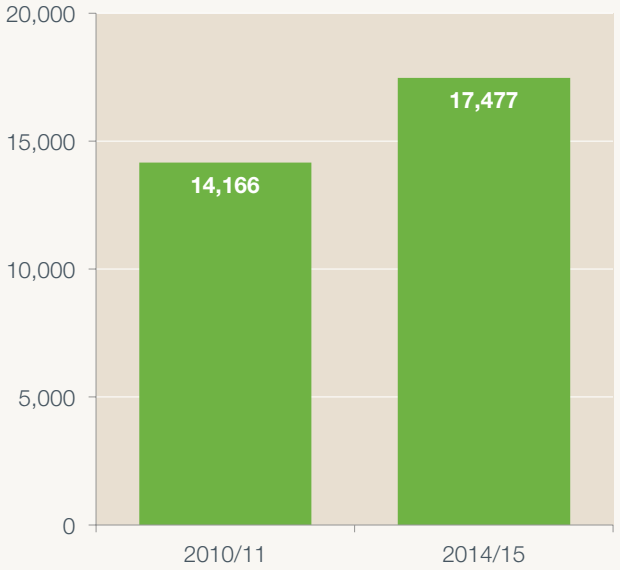
There are also likely to be a number of people with diabetes who are undiagnosed. It is estimated that there are actually over **19,600** adults (aged 16+) with diabetes (diagnosed and undiagnosed) in Enfield. If obesity continues to rise at the current pace, it is estimated that this could rise to **27,000** adults with diabetes by 2030.

It is estimated that there are **30,000** adults (aged 16+) at increased risk of developing diabetes (known as prediabetes) in Enfield.

Sources: QOF 2014/15, HSCIC. Diabetes prevalence model for LAs and CCGs, PHE. Prevalence estimates of non-diabetic hyperglycaemia, PHE.

The number of people with diabetes has been rising rapidly and is likely to continue to rise because of obesity.

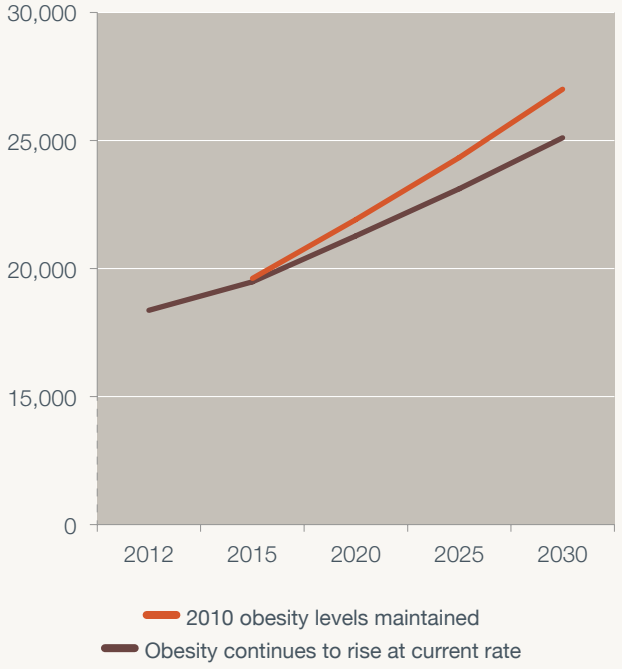
The number of adults (17+) diagnosed with diabetes in Enfield has increased rapidly



Source: QOF, HSCIC

Rising levels of obesity mean that this number is likely to continue to increase rapidly in the future.

An additional 2,000 adults (16+) could develop diabetes if obesity continues to rise in Enfield



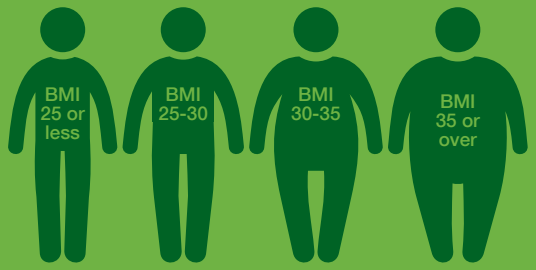
Source: Diabetes Prevalence Model, Public Health England

OBESITY IN ENFIELD

Two thirds of adults (64.8%) are overweight or obese in Enfield

2 in 5 of 10-11 year olds (41.0%) are overweight or obese in Enfield

The level of diabetes is higher in adults with higher BMI.[6]

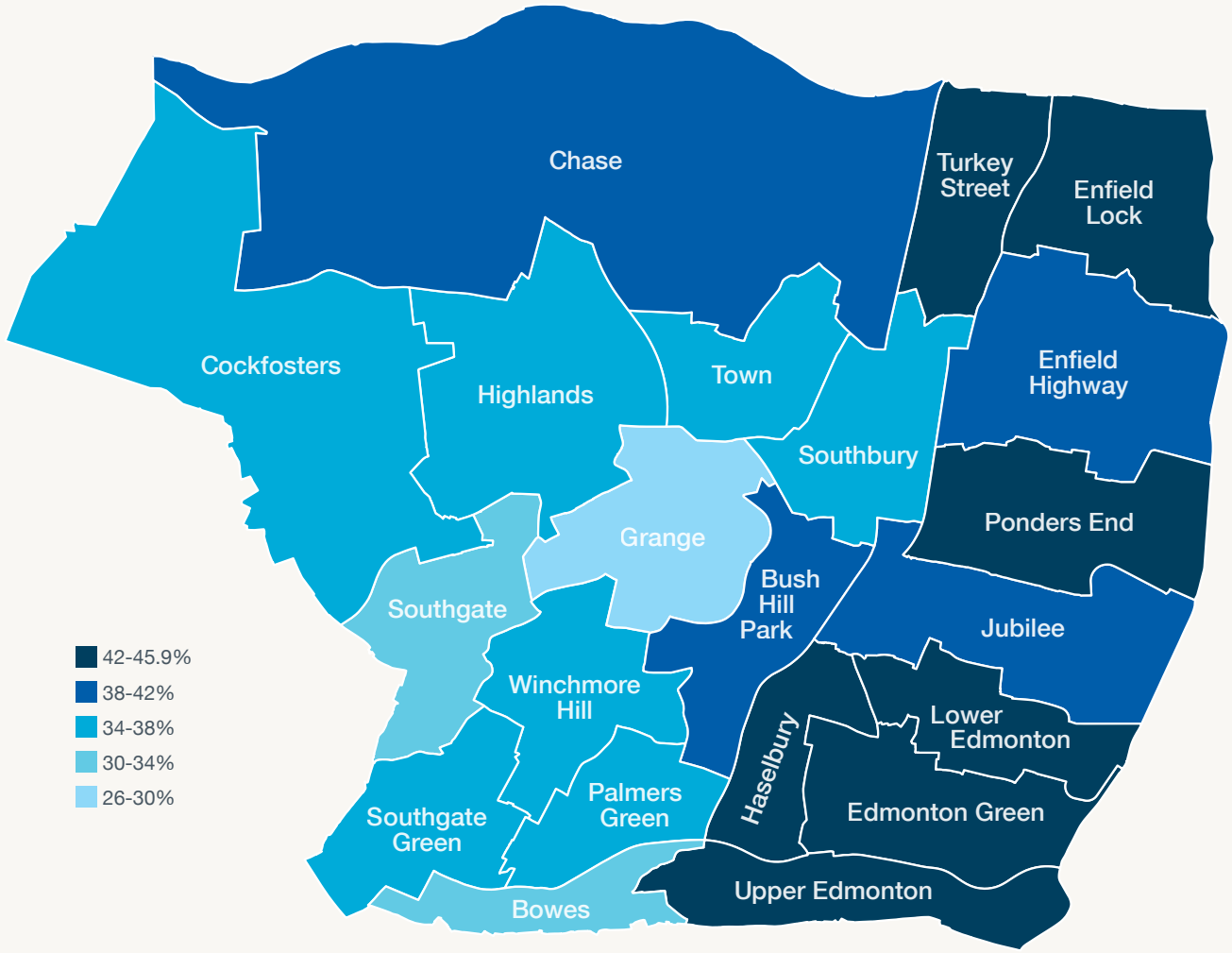


2% have diabetes | **7%** have diabetes | **10%** have diabetes | **20%** have diabetes

In Enfield, as in the rest of the UK, we are starting to see cases of Type 2 diabetes in children and young people.

This map shows the percentage of children aged 10-11 year old who are overweight or obese across Enfield. Levels of obesity are highest in the east of the borough. This overlaps with more deprived parts of Enfield.

Percentage of children aged 10-11 who are overweight or obese, 2011/12-2013/14 (pooled data)



Source: National Child Measurement Programme (NCMP) 2011/12-2013/14, Public Health England

PREVENTING DIABETES

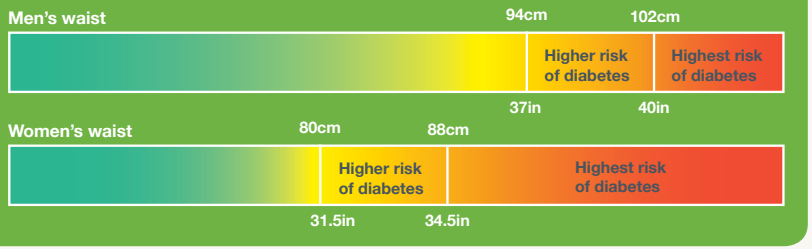
KEY MESSAGE **To prevent diabetes, stay LEAN and ACTIVE. You can calculate your risk of diabetes online using the Diabetes UK risk calculator.**

It is estimated that more than half of new cases of Type 2 diabetes can be prevented.

What are the risk factors for Type 2 diabetes?

You are **more likely to develop Type 2 diabetes** if you:

- **are overweight or obese** … *There is a 7x greater risk of diabetes in obese people*[7] **or you have a large waist**…*A 1cm increase in waist circumference increases the risk of Type 2 diabetes by 3.5%*[8]
- **smoke** …*Smokers are 50% more likely to develop diabetes than non-smokers.*[9]
- drink excess amounts of **alcohol** …*Recommended guidelines on alcohol can be on NHS Choices.*



If you have any of the risk factors for diabetes, you can **calculate your risk of diabetes** online using the Diabetes UK risk calculator.

What can I do to prevent Type 2 diabetes?

Eat more healthily
Try to eat a balanced diet, and reduce the amount of sweets, chocolate and sugary drinks you consume. In Enfield less than half of the population meet the recommended '5-a-day' portion of fruit and vegetables. Use the Eatwell Guide to help you.

Be more physically active
Reduce time spent sitting or driving, and make physical activity part of your daily life, for example walking or cycling to work.Meeting physical activity guidelines is associated with a **30-40% reduction in the risk of Type 2 diabetes**. In Enfield 1 in 3 adults are physically inactive.

Avoid smoking
If you already smoke, quit. In Enfield the smoking prevalence has been falling for the past few years, from 19.4% in 2010 to 13.6% in 2014.

Drink within recommended limits
Higher amounts of alcohol increase the risk of developing Type 2 diabetes. In Enfield, 17.5% of the drinking population (not including abstainers) aged 16 and over report engaging in 'increased risk' drinking (15-35 units of alcohol per week for women and 22-50 for men).

Take the opportunity to go for a Health Check if you are invited
Enfield Council commissions the NHS Health Check programme for those aged 40-74 who have not previously been diagnosed with a cardiovascular disease. This is an opportunity to check your blood pressure, cholesterol and blood sugar and to receive useful lifestyle advice and support or treatment to manage these risk factors.

HEALTHY EATING

KEY MESSAGE

Eating a healthy diet (in terms of both quantity and quality) can help to reduce the risk of developing Type 2 diabetes, control Type 1 diabetes, and prevent long-term and short-term health consequences.

Eating a healthy diet can help to reduce the risk of developing Type 2 diabetes. If your BMI is above 25 (or 23 if Asian), the first step is to reduce portion size. If you have diabetes, an appropriate diet advised by your doctor or dietician will help manage your diabetes.

Eatwell Guide

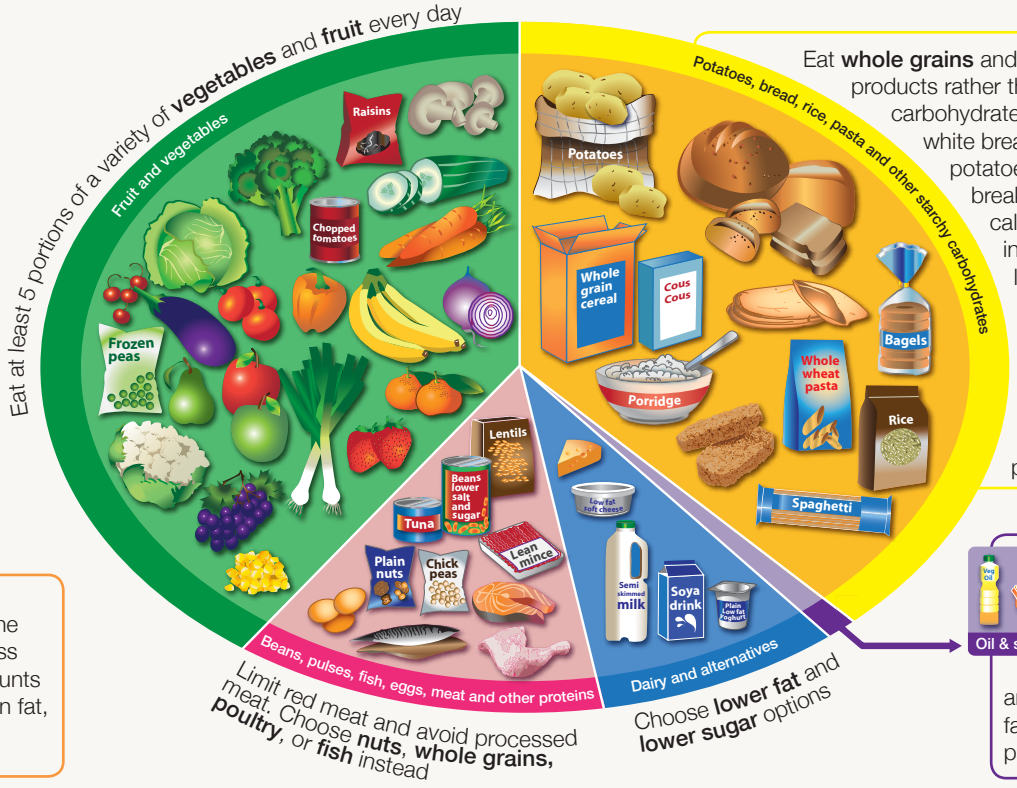
Use the Eatwell Guide to help you get a balance of healthier and more sustainable food. It shows how much of what you eat overall should come from each food group. Practical tips and ideas for recipes for people with diabetes are available on the Diabetes UK website.

TOTAL CALORIE INTAKE

ALL FOOD + ALL DRINKS

PER DAY:

2000kcal 2500kcal



Eat **whole grains** and whole grain products rather than highly processed carbohydrates. Products such as white bread, white rice, mashed potatoes, bagels, and many breakfast cereals have what's called a high glycaemic index and glycaemic load. That means they cause spikes in blood sugar and insulin levels, which in turn may lead to increased diabetes risk. Salt in them also increases your blood pressure.

Drink 6-8 cups/ glasses of water a day. Avoid sugary drinks and limit fruit juice and/ or smoothies to a total of 150 ml a day. You can find more information on Change4Life.

These are not part of the Eatwell Guide. Have less often and in small amounts foods and drinks high in fat, salt or sugar.

Polyunsaturated fats such as those found in liquid vegetable oils, nuts, and seeds can help reduce the risk of obesity; trans fats do the opposite. Trans fats are typically found in fried foods from most fast-food restaurants, margarines, and in packaged baked goods.

DIABETES IN PREGNANCY

KEY MESSAGE **To minimise health risks to the mother and baby, diabetes needs to be controlled BEFORE, DURING and AFTER pregnancy.**

Last year, **1 in 15** women who gave birth in Enfield had diabetes (either pre-existing or gestational)
Source: SUS data, NHS Enfield CCG

Diabetes in pregnancy can be divided into 2 groups

GESTATIONAL DIABETES

What is it?

A type of diabetes that is first detected during pregnancy and usually disappears afterwards. However, if you have gestational diabetes, you are more than 10 times as likely to develop Type 2 diabetes in later life.[10] Women are tested for gestational diabetes between 24 and 28 weeks of pregnancy.

Who's at risk?

Your chances of getting gestational diabetes are higher if you:

- are overweight
- have had gestational diabetes before
- are South Asian, Black Caribbean or Middle Eastern
- have polycystic ovary syndrome

What should I do?

Gestational diabetes can often be controlled by diet and physical activity – a dietician will give you advice. You will also need to monitor your blood sugar levels throughout the pregnancy. When your pregnancy is over, it is very important that you **continue to visit your doctor regularly to monitor your blood sugar levels. Without lifestyle intervention**, as many as **1 in 4** women develop diabetes within 5 years.[11]

PRE-EXISTING DIABETES

What is it?

Women who have Type 1 or Type 2 diabetes before they get pregnant. Some women may be aware that they have Type 2 diabetes before they become pregnant, whilst some may be diagnosed during their pregnancy.

What should I do?

If you have pre-existing diabetes, the best way to reduce the risk to you and your baby is to ensure that your **diabetes is controlled before you become pregnant**. Your GP or diabetes specialist will give you advice.

Pregnant women with diabetes should take a higher dose of folic acid (5 mg/day), which can be prescribed by your doctor. Taking folic acid helps to prevent your baby from developing birth defects. Diabetic eye screening is very important when you are pregnant, because the risk of serious eye problems is greater.

Potential complications of diabetes in pregnancy

If diabetes is not adequately managed during pregnancy **the mother is at increased risk of:**

- Having a large baby (which increases the risk of a difficult birth, induced labour or a caesarean section)
- Developing Type 2 diabetes later in life.

Women with pre-existing diabetes are at higher risk of having a miscarriage, and women with Type 1 diabetes may also develop problems with their eyes and their kidneys, or existing problems may get worse.

The baby may be at risk of:

- Being stillborn or dying soon after birth
- Having health problems shortly after birth and needing hospital care
- Developing obesity or diabetes later in life

Babies born to mothers with pre-existing diabetes may be at risk of having congenital abnormalities (not developing normally). For more information, see NHS Choices.

If you have been diagnosed with diabetes, use this handy guide...

Eat healthily

Be more active

Don't miss your medication

Quit smoking

Have regular check-ups

LIVING WITH DIABETES

KEY MESSAGE **There is no cure for diabetes and it progresses without treatment. Patient self-care, structured education and patient-centred care together form the basis of living well with diabetes.**

I have just been told I have diabetes by my GP...

There is **no cure** for diabetes and it **progresses without treatment**. Treatment aims to keep blood glucose levels as normal as possible and it is much easier to prevent problems now than to treat them later.

I will follow dietary and lifestyle advice and if required my doctor will put me on medication(s) to treat diabetes and to reduce the risk of complications. I may need injectable medication and possibly insulin injections. I will ask many questions about them, their side effects, and any precautions I need to take. I will take them at the **right time** and if I feel any side effects, I will get advice from my pharmacist. I can find my nearest GP and pharmacist in Enfield on the NHS Choices website.

If I am a child, my **school** will work together with my parents and healthcare team to ensure I enjoy school like other children.

I will **learn more about my condition**, so I will be in control of my diabetes. I will ask my GP for an electronic copy of the "Living with Diabetes" booklet, and about **Structured Education** for diabetes – in Enfield we call it **"Conversation Map Tools".** Structured education helps patients manage their diabetes, weight, blood pressure and cholesterol, and **reduces the need to increase the number and dose of medications**. I will join **patient groups**, such as the Enfield Diabetes Support Group, which meets every month, and work with doctors and nurses to keep me healthy.

I will do my best to **eat healthily, be more active and quit smoking**, finding relevant advice about how to make these changes on websites like One You. I will use the **free health kiosks** at my GP surgery to help me better control my **blood pressure and weight**.

If retinopathy (damage to the eye) is detected early enough, treatment can stop it getting worse. In Enfield, retinal screening uptake was below the England average, so I will attend my **retinal screening** when invited even if my eyesight is OK. I will also need to have an **annual flu jab** to protect me from influenza which can make me more ill than other people. My GP practice will tell me more about this and I can ask them any questions I might have.

I will take part in **annual care planning** with my GP where we will agree on my **target HbA1c** and treatment regime. A large UK study found that just by reducing my **HbA1C by 1%**, my risk of heart attack can be **reduced by 16%**.[12] If I am ill for any reason or need to travel, I will consult with a local pharmacist and if required I will see a doctor. I will see a diabetes specialist team when my GP or nurse thinks this is needed. If I need to be in hospital for any reason, I will make sure I have my prescription list with me.

It is important my healthcare team knows about **my mood**. Successful treatment for depression also helps improve blood glucose control.

Be aware of the symptoms of diabetes

Chloë, a 6-year old girl from Winchmore Hill, was brought by her parents to see her GP with a high temperature and cough that did not get better after a week. Over the last month, she had also been very tired at school and complaining to the teachers that she couldn't see the board properly. Her GP planned to treat her for an upper respiratory tract infection but also suggested doing a urine dipstick whilst at the surgery. The test strip showed glucose in the urine as well as ketones. The doctor immediately referred her to the paediatric unit for further assessment and monitoring of her clinical condition with a provisional diagnosis of diabetes. Thankfully, she made a full recovery without needing to receive aggressive treatment, but many children are not so lucky and are admitted to paediatric intensive care.

I was almost becoming diabetic, but I brought it to a halt

Rachel is a 44 year old woman from Enfield Chase who has two teenage daughters and a son. Apart from some tiredness she is quite well. Her GP invited her for an NHS Health Check and her blood glucose test showed she was just below the threshold of diabetes – known as prediabetes. He was concerned and advised her to consider losing weight through diet and regular exercise. She learned from the internet that her risk of developing Type 2 diabetes could be halved through diet and intensive exercise. Rachel took the advice and started exercising regularly, reduced her portion sizes and ate more vegetables. She walked and started cycling to work. She finds herself fitter and a year later her blood test returned to normal so she is no longer considered prediabetic.

Insulin injection should not be a pain

Daphne, a 68 year old woman from Cockfosters with diabetes whose blood glucose was poorly controlled, had been refusing insulin as she thought that the injections would be painful and onerous. A community diabetes specialist nurse persuaded her to practise giving herself the injections under observation for a couple of days. After a few attempts she realised that it wasn't as painful as she thought and felt confident enough to self-manage her insulin therapy. Since then, her blood glucose control has been much better and she has been busy enjoying spending time with her grandchildren and gardening.

Patient-centred care is at the heart of management

Anita, a 55 year old woman from Turkey Street with diabetes, refused to take additional medication to improve her diabetes control as she was worried about the possibility of hypos. She needed to drive to get work every day so when she was told that the DVLA guidance suggested glucose monitoring when driving on certain medications, she was even more reluctant. Different options were discussed with her GP, including one medication which does not cause hypoglycaemia. She agreed to try the new medication for a period of three months then re-assess. She carefully took the medications and was able to drive with no risk to herself or to other road users.

Mental wellbeing matters to managing diabetes

Ali is a 45 year old man from South East Enfield with diabetes and a mental illness. He has limited capacity to organise his care but on formal assessment, he was cognitively competent to understand the significance of his physical condition. He declined social support. As a result, his blood glucose level as well as blood pressure and cholesterol were poorly controlled. He lives by himself and has limited social interaction and no relative or friend to help him take his medications. He does not engage in physical activity or eat healthily to tackle his obesity. One day when at the local shop, Ali collapsed, fell into a coma and was taken to hospital by an ambulance.

Diabetes during and after pregnancy

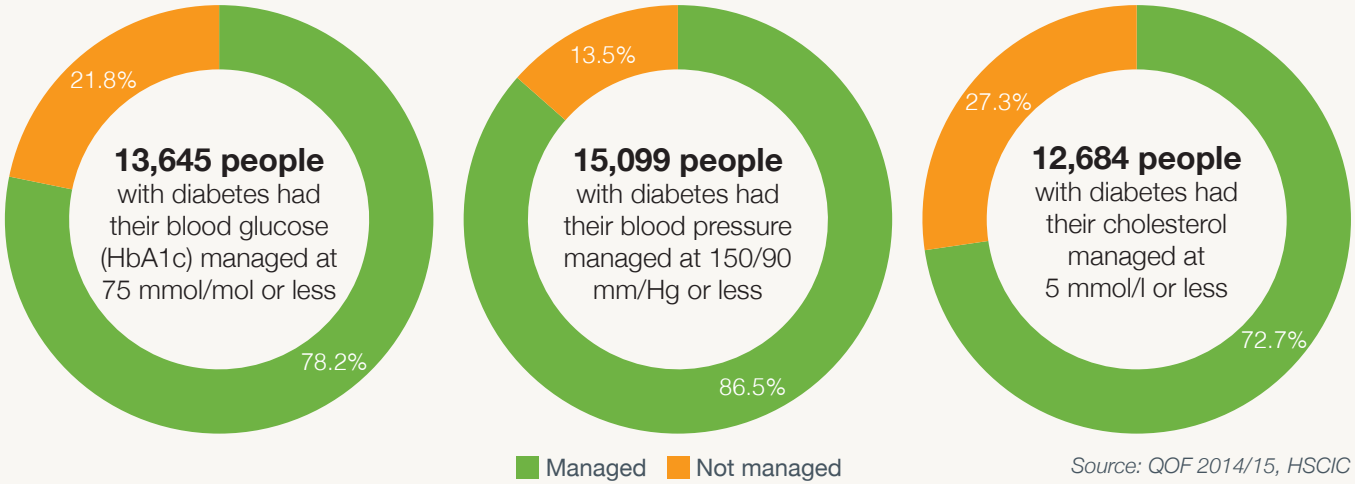
Lola is a 25 year old pregnant woman from Southgate. When she went to her 12-week booking she was asked, as is routine, about her family history of diabetes. She told the midwife that both her father and uncle were diabetic. Lola was then screened using a glucose tolerance test at 26 weeks and the test confirmed gestational diabetes. Lola was treated and monitored closely by the midwife and antenatal diabetes team at the hospital to prevent complications to her and her unborn baby, such as the baby being very large, premature birth, miscarriage and still birth. Happily, her condition was well controlled, she delivered a healthy baby boy at term and her diabetes disappeared. After the birth she had regular blood tests and has started exercising and eating healthily to reduce her risk of developing Type 2 diabetes.

These case studies are based on clinical experience but personal details have been modified.

MANAGEMENT OF DIABETES IN ENFIELD

KEY MESSAGE **You can manage your diabetes by taking control of your lifestyle (i.e. diet, physical activity, smoking) and following the treatment regime for blood glucose, blood pressure and cholesterol.**

Managing diabetes is essential to lead a long and fulfilling life. In Enfield:



Source: QOF 2014/15, HSCIC

Patients with diabetes can also benefit from taking up opportunities such as structured education, annual flu vaccination and retinal screening. In Enfield:

67.1% of people newly diagnosed with diabetes (842 people) were referred to a **structured education programme** (2014/15). This was below the London average of 75.4%.

76.7% of people with diabetes (13,342 people) received a **flu vaccination** (2014/15). This compared to 75.5% in London.

80.1% of patients with diabetes (13,539 people) received annual **retinal screening** 2013/14.* This was below the London average of 82.5%.

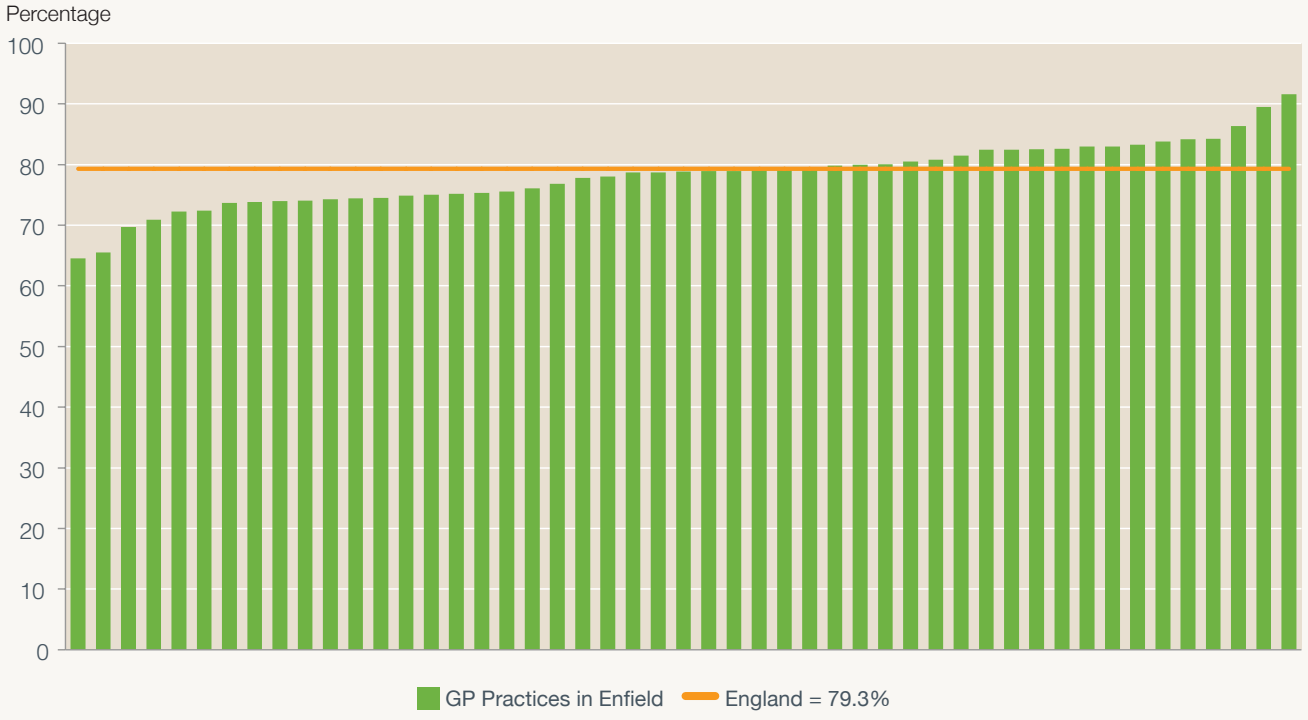
* 2013/14 is the latest data available.

Source: QOF, HSCIC

Across Enfield GP practices, there is wide variation in the level of diabetes management. For example, in 2014/15, the percentage of patients with diabetes who had their blood glucose managed to an adequate level varied from 64.5% to 91.6%. Some variation is naturally expected, however it is important to identify and reduce the unwarranted variation to improve the quality of care people in Enfield receive.

If we can reduce the variation by improving the performance of those practices achieving below the England average to match the England average, there will be an additional 405 patients with better control of blood glucose, 352 patients with better control of blood pressure and 189 patients with better control of cholesterol in Enfield.

Percentage of patients with diabetes who are managing their blood glucose levels, (75 mmol/mol or less), by GP practice in Enfield (2014/15)

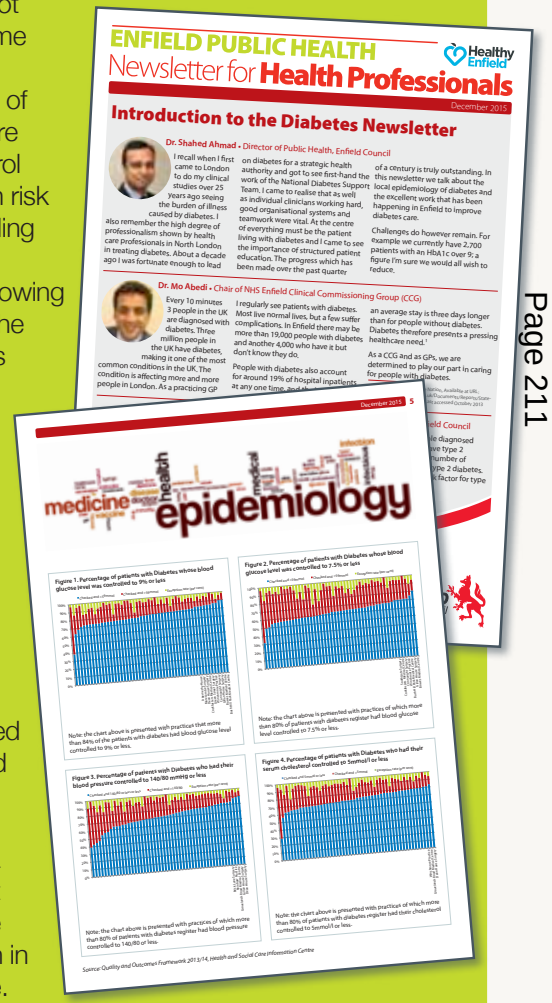


Source: Quality and Outcomes Framework, HSCIC

Working with GPs to improve the level of management while reducing the unwarranted variation in Enfield

The 'HiLo' pilot is a programme to support management of blood pressure and cholesterol amongst high risk groups including those with diabetes. Following its success, the programme is going to be extended into further large surgeries.

A Public Health newsletter for health professionals was developed to share good practice in Enfield and to stimulate a debate about how to tackle wide variation in diabetes care.


ENFIELD PUBLIC HEALTH
Newsletter for Health Professionals
Healthy Enfield
December 2015
Introduction to the Diabetes Newsletter
Dr. Shahed Ahmad - Director of Public Health, Enfield Council
Dr. Mo Abedi - Chair of NHS Enfield Clinical Commissioning Group (CCG)
medicine health epidemiology

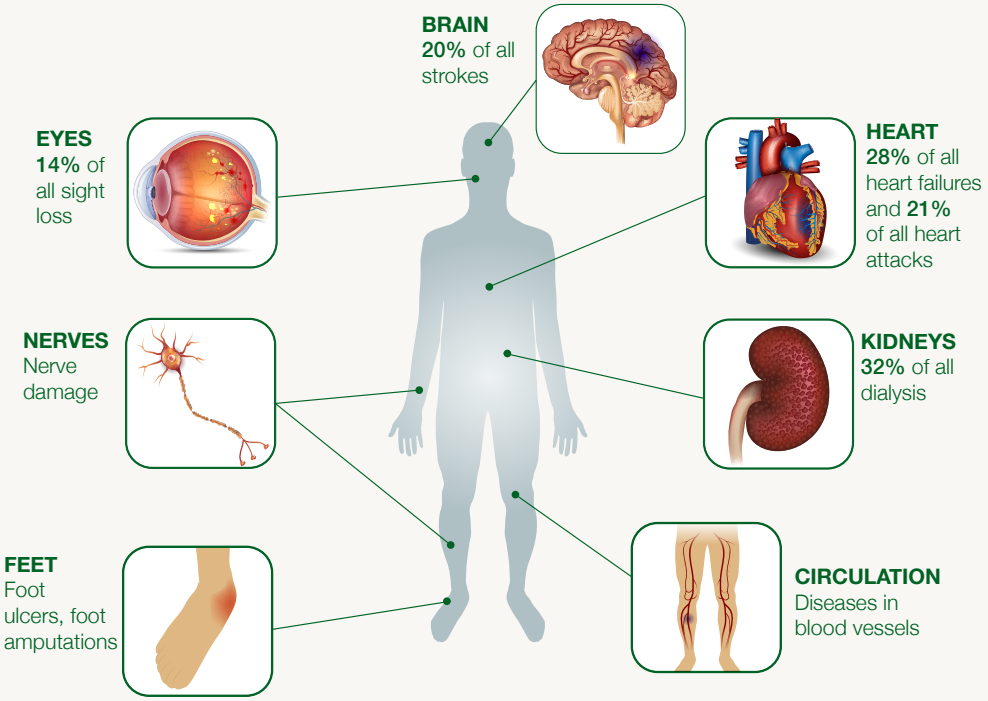
LONG-TERM CONSEQUENCES OF DIABETES

KEY MESSAGE **If you have diabetes, it is essential that you manage it properly to avoid long-term health consequences such as blindness, stroke, heart attack, heart failure, kidney failure and foot amputation.**

There are various long-term consequences of diabetes, but by managing it properly you can avoid them and can live a long and fulfilling life.

Major consequences related to unmanaged diabetes

In the UK, a substantial proportion of all hospital admissions related to blood vessels and nerves are attributable to diabetes:



Source: National Diabetes Audit 2011-12, HSCIC

Unmanaged diabetes and average life expectancy

Diabetes can lead to a shorter life expectancy, in large part because of unmanaged diabetes.

The Framingham Heart Study[13] found that…

- Women aged 50+ with diabetes **live 8.2 years less** than those without.
- Men aged 50+ with diabetes **live 7.5 years less** than those without.

Diabetes and mental health

People with diabetes have higher rates of mental health problems such as depression: approximately 30% of people with diabetes experience depressive symptoms.[14]

Conversely, people with depression have an increased risk of developing Type 2 diabetes of approximately 60%.[15]

People with diabetes and mental health problems are less adherent to medical care and suffer more health complications.[16]

How does Enfield compare?

The latest data shows that amongst people with diabetes in Enfield, there are:

- **5x** as many cases of renal replacement therapy (RRT) and
- almost **3x** as many cases of angina

than would be expected for people without diabetes.

The report also shows that the increased rates of RRT and angina amongst people with diabetes are **significantly higher** in Enfield than the average in England and Wales.

Source: National Diabetes Audit 2012-13, HSCIC

BENCHMARKING AGAINST NORTH CENTRAL LONDON

KEY MESSAGE

The prevalence of diabetes in Enfield is the highest amongst North Central London (NCL) CCGs. Partners of NCL Strategic Planning Group are working together to deliver sustainable, transformed local health and care services by 2020/21.

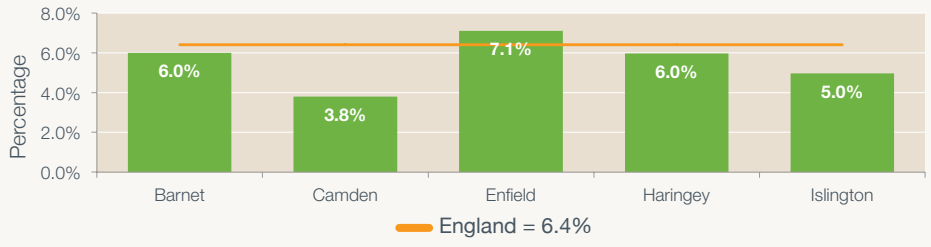
Enfield, Barnet, Haringey, Camden and Islington came together to form the North Central London Strategic Planning Group (NCL SPG) and collaboratively to deliver sustainable, transformed local health and care services. This includes CCGs, Local Authorities and Providers (including local hospitals, mental health, social care, and primary care).

Enfield CCG, the Council, North Middlesex University Hospital NHS Trust, Royal Free London Hospital NHS Foundation Trust and Barnet, Enfield and Haringey Mental Health NHS Trust are all members of the NCL SPG.

Prevalence of diabetes

Enfield has the highest recorded prevalence of diabetes amongst NCL CCGs.

Recorded prevalence of diabetes (aged 17+ years), 2014/15

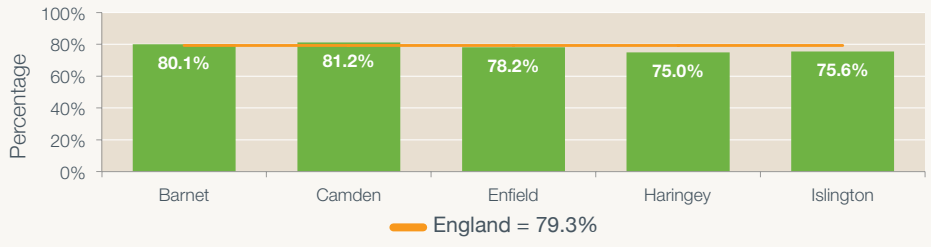


Source: QOF, HSCIC

Management of diabetes: Blood sugar

The percentage of patients with diabetes whose blood glucose was managed at 75 mmol/mol or less varied from 75.0% to 81.2% in NCL.

Percentage of patients with diabetes whose HbA1c is 75 mmol/mol or less, 2014/15

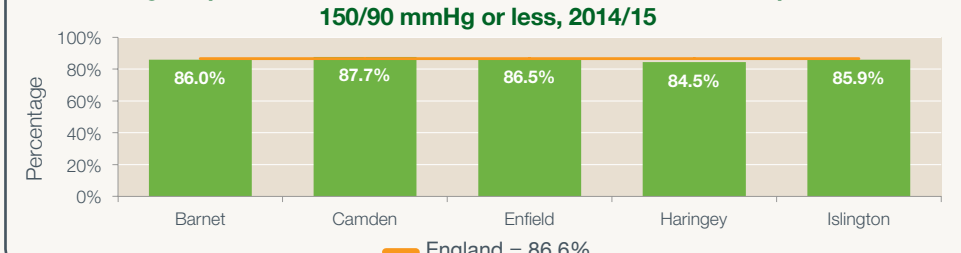


Source: QOF, HSCIC

Management of diabetes: Blood pressure

The percentage of patients with diabetes whose blood pressure was managed to 150/90 mmHg or less was similar across NCL.

Percentage of patients with diabetes whose last measured blood pressure with 150/90 mmHg or less, 2014/15

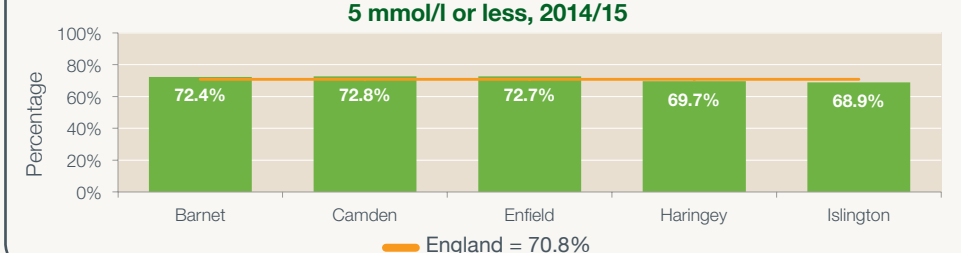


Source: QOF, HSCIC

Management of diabetes: Cholesterol

Enfield had one of the highest percentages of patients with diabetes whose cholesterol was managed at 5 mmol/l or less in NCL.

Percentage of patients with diabetes whose last measured total cholesterol was 5 mmol/l or less, 2014/15



Source: QOF, HSCIC

WHAT ARE WE DOING ABOUT DIABETES IN ENFIELD?

Public and voluntary sector partners in Enfield are working together to prevent new cases of diabetes and to improve the quality of care for people with diabetes.

TACKLING THE RISK FACTORS

Our health is hugely influenced by various environmental factors. We know that a sedentary lifestyle and easy access to high-density calorific foods are major contributors to the recent increase of obesity and Type 2 diabetes. Environmental change that makes healthier choices easier is therefore crucial in reducing future diabetes cases. In Enfield, several programmes are in place to achieve this:

- 'Cycle Enfield' encourages people to make physical activity part of their daily lives. With good infrastructure, cycling can become easier to build into day-to-day activities. For example, in Copenhagen 57% of people cycle every day.[17]
- Enfield has 17 outdoor gyms that provide free access to exercise equipment for a high proportion of the residents in the borough.

There are also other services to support people to lead healthy lifestyles:

- Enfield Stop Smoking service offers a variety of group and one-to-one clinics to help people quit smoking over 6 weeks. In Enfield, 1,582 people quit smoking through this service in 2014/15. The level of smoking in Enfield has been falling for the past few years, from 19.4% in 2010 to 13.6% in 2014.
- Health Trainers provide confidential one-to-one support to people over the age of 18 years who want to make lifestyle changes. Over 1,000 people were supported by Health Trainers in Enfield in 2014/15.
- Health Champions work with the communities at higher risk of cardiovascular disease to encourage them to healthy lifestyle and promote national health campaigns such as FAST, Stoptober and blood pressure awareness.

RAISING AWARENES AMONGST THE GENERAL PUBLIC AND HEALTH & SOCIAL CARE PROFESSIONALS

- The Council's public health team has delivered several public awareness campaigns about healthy lifestyles and diet in communities which have a higher diabetes risk, as well as alerting GP practices about unwarranted variation and local best practice in managing diabetes.
- The team also work with Enfield Diabetes Support Groups to develop 'Living with diabetes' and other information needs for self-management of diabetes.
- The Council's public health team used social marketing tools to target patients in deprived areas to improve self-management and adherence to medication.

EARLY DIAGNOSIS

- NHS Enfield CCG, in partnership with GPs and the Council's public health team, are working on a programme that will improve the identification of people at increased risk of diabetes (prediabetes) over the next three years and offer them lifestyle advice to reduce the risk of developing diabetes.
- Since 2011/12, over 18,000 health checks have been delivered in Enfield, where people have their blood pressure, cholesterol and blood sugar measured and are given lifestyle advice and support to manage these risk factors.
- Enfield promotes opportunistic diabetes screening by GPs and other primary care providers such as pharmacists.

- ‘Making Every Contact Count’ training has been provided for front-line staff working in health and social care so that they can encourage behaviour change and promote a healthy lifestyle to people accessing their services.

DIABETES MANAGEMENT

Structured education

In Enfield, patients with diabetes can access an innovative educational method called Conversation Map Tools that uses interactive group participation to empower them to become actively involved in self-managing their condition. In 2014/15, 845 newly diagnosed patients were referred to this programme in Enfield.

Eight Care Processes

NHS Enfield CCG, GPs and the Council’s public health team are working towards improving the recording and reporting of the eight diabetes care processes (blood pressure, BMI, cholesterol, cardiovascular risk, smoking status, diabetes treatment and emergency complications) that are recommended by the National Institute for Clinical Excellence (NICE).

Supporting diabetes care

Diabetes is a long term condition so requires ongoing care from a range of health care services. In Enfield, GPs work with North Middlesex University Hospital NHS Trust, the Royal Free London NHS Trust and Enfield community diabetic specialist nurses.

Enfield retinal screening service is provided by North Middlesex University Hospital although this service is directly commissioned by NHS England.

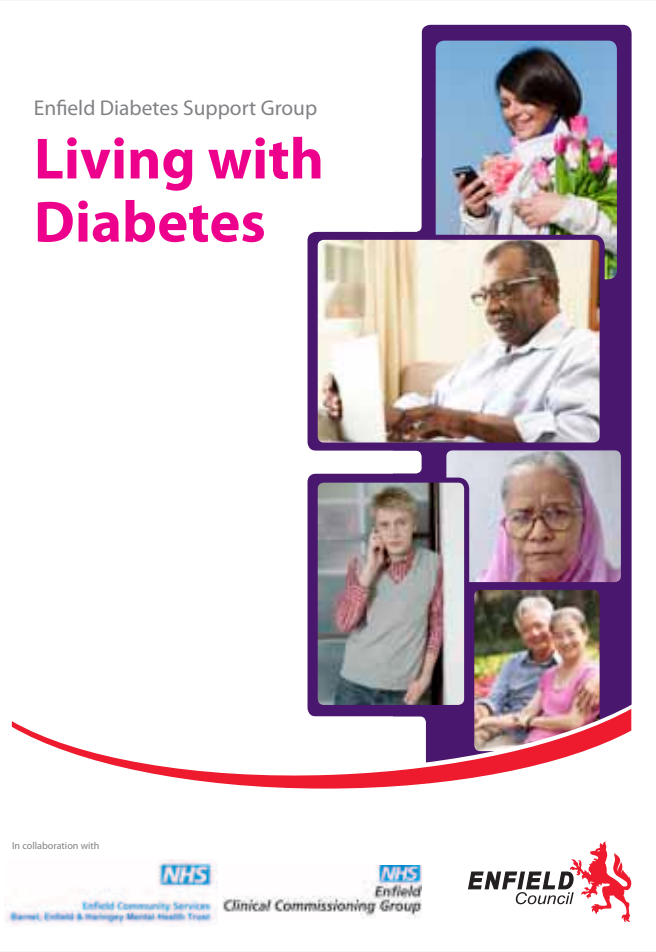
Enfield has developed a diabetes care pathway to provide care to support patients with diabetes at each stage of the disease, working across the Council, NHS Enfield CCG, community and acute diabetes specialist services, and GPs.

Managing patients at high risk of cardiovascular disease

Enfield has initiated a programme aimed at identifying diabetic (and other) patients on the GP clinical systems who are at risk of high blood pressure and poor lipid control, so that GPs can treat them to reduce their risk of stroke and heart attacks.

Management of complex cases

A pilot involving hospital diabetologists, GPs and community diabetes specialist nurses was undertaken in the South East Enfield locality. The aim was to facilitate a multidisciplinary approach to better manage complex cases in diabetes.



GLOSSARY

8 care processes

The Department of Health lists eight care processes that people with diabetes should receive each year. Together, these processes reduce the risk of a person with diabetes developing complications. The eight care process provided for diabetes patients are:

- HbA1c testing
- Blood pressure
- Cholesterol measurement
- Feet examination
- Urine albumin excretion
- Creatinine measurement
- Body mass index (BMI) measurement
- Smoking status

For people aged 12 years and above, an annual eye examination is also recommended.

Alcohol guidelines

Government guidelines state that there's no safe level of alcohol consumption. Unit guidelines are the same for men and women and both are advised not to regularly drink more than 14 units per week.

Angina

Angina is chest pain that occurs when the blood supply to the muscles of the heart is restricted. It usually happens because the arteries supplying the heart become hardened and narrowed. The pain and discomfort of angina feels like a dull, heavy or tight pain in the chest that can sometimes spread to the left arm, neck, jaw or back. GPs keep a register of people who have had angina in order to proactively reduce the risk of heart attacks.

BMI

BMI (Body Mass Index) is a measure of weight in regard to height. It is used to quickly and simply determine if a person is underweight, normal weight, overweight or obese. BMI is calculated differently for children. An online calculator for both adults and children is found here: www.nhs.uk/Tools/Pages/Healthyweightcalculator.aspx

Cholesterol

Cholesterol is a fatty substance known as a lipid that is vital for the normal functioning of the body. It's mainly made by the liver, but can also be found in some foods. High levels of cholesterol in the blood increase your risk of serious health conditions. People with high cardiovascular risk (defined as a 20% risk of getting heart disease or stroke in 10 years) need treatment to lower their cholesterol, no matter what the value is.

Diabetic eye disease

Diabetic retinopathy is damage to the retina (the 'seeing' part at the back of the eye) and is a complication that can affect people with diabetes. Retinopathy is the most common cause of blindness among people of working age in the UK. Everyone over the age of 12 with diabetes should have their eyes checked every year for retinopathy.

Diabetic foot disease

People with diabetes are at much greater risk of developing problems with their feet, due to the damage raised blood sugars can cause to sensation and circulation. It often starts as a small break in the skin such as a blister, and can quickly develop into a foot ulcer because the person has lost sensation in their feet and can't feel the pain. If left untreated, these problems can cause infections and, at worst, may lead to amputation. However, most foot problems are preventable by keeping an eye on your feet at home and making sure that you get a foot check from a qualified professional at least once a year.

HbA1c test

This test measures the amount of glucose being carried by the red blood cells in the body and indicates a person's blood glucose levels for the previous two-to-three months. People with diabetes have at least one HbA1c test a year after diagnosis and the test has been recommended to also be used for diagnosing diabetes. A patient with HbA1c value of 48 mmol/mol (6.5%) and above is usually diagnosed as diabetic.

Heart attack (Myocardial infarction)

A heart attack is a serious medical emergency in which the supply of blood to the heart is suddenly blocked, usually by a blood clot. Lack of blood to the heart can seriously damage the heart muscle. A heart attack is known medically as a myocardial infarction (MI). Symptoms can include:

- chest pain – the chest can feel like it is being pressed or squeezed by a heavy object, and pain can radiate from the chest to the jaw, neck, arms and back
- shortness of breath
- feeling weak and/or lightheaded
- overwhelming feeling of anxiety

Hyperglycaemia (hyper)

Hypers can happen when your blood glucose levels are too high – usually above 7 mmol/l before a meal and above 8.5 mmol/l two hours after a meal. There are several reasons why this may happen. It may be that you:

- Have missed a dose of your medication
- Have eaten more carbohydrate than your body and/or medication can cope with
- Are stressed
- Are unwell from an infection
- Or from over-treating a hypo

Hypertension

Hypertension is persistently high blood pressure. Blood pressure is recorded with two numbers. The systolic pressure (higher number) is the force at which your heart pumps blood around your body. The diastolic pressure (lower number) is the resistance to the blood flow in the blood vessels. As a general guide:

- hypertension is usually considered to be 140/90mmHg or higher
- ideal blood pressure is considered to be between 90/60mmHg and 120/80 mmHg.

For people with diabetes blood pressure is classed as 'high' when it is 140/80 mmHg or above, and for people with diabetes who are experiencing complications (for example, kidney disease)130/80 mmHg.

Hypoglycaemia (hypo)

Hypoglycaemia means 'low blood glucose levels' – less than 4 mmol/l. This is too low to provide enough energy for your body's activities. Most hypos are mild, but if you have a severe hypo, you will be too ill to treat the hypo yourself. By law you must tell the DVLA if you have a severe hypo while driving or if you have more than one severe hypo in a year. Your GP or diabetes specialist nurse may be able to adjust your medication regime to prevent this. To prevent a hypo:

- Don't miss or delay a meal
- Remember to take your insulin and diabetes medication, and always take them correctly
- Eat extra carbohydrate if you are more active than normal
- Don't drink alcohol on an empty stomach or drink too much alcohol.
- Keep hypo treatment with you at all times.

Insulin

Insulin is a hormone produced by the pancreas that allows glucose to enter the body's cells, where it is used as fuel for energy so we can work, play and generally live our lives. If you have Type 1 diabetes, your body cannot produce enough insulin. If you have Type 2 diabetes either there not enough insulin or the insulin receptors are not working properly.

Neuropathy

Neuropathy is one of the long-term complications of diabetes which affects the nerves. High blood glucose levels damage the small blood vessels which supply the nerves thus preventing essential nutrients reaching the nerves. The nerve fibres are then damaged or disappear.

If the nerves that carry sensory information are affected, you can experience symptoms such as:

- Tingling and numbness
- Loss of ability to feel pain
- Loss of ability to detect changes in temperature
- Loss of balance
- Burning or shooting pains – these may be worse at night time.

The main danger of sensory neuropathy for someone with diabetes is loss of feeling in the feet, especially if you don't realise that this has happened. This is dangerous because you may not notice minor injuries, for example caused by walking around barefoot, sharp objects in shoes, friction from badly fitting shoes, or burns from radiators of hot water bottles.

If ignored, minor injuries may develop into infections or ulcers. People with diabetes are more likely to be admitted to hospital with a foot ulcer than with any other diabetes complication.

Other neuropathies include autonomic neuropathy (e.g. loss of bowel control, loss of bladder control, impotence) and motor neuropathy (e.g. muscle wasting).

Obesity

BMI over 30 for adults (see BMI).

Overweight

BMI 25-30 for adults (see BMI).

Physical activity

To stay healthy, adults aged 19-64 should try to be active daily and should do:

- at least 150 minutes of moderate aerobic activity such as cycling or fast walking every week, and
- strength exercises on two or more days a week that work all the major muscles (legs, hips, back, abdomen, chest, shoulders and arms).

To maintain a basic level of health, children and young people aged 5 to 18 need to do:

- at least 60 minutes of physical activity every day – this should range from moderate activity, such as cycling and playground activities, to vigorous activity, such as running and tennis
- on three days a week, these activities should involve exercises for strong muscles, such as push-ups, and exercises for strong bones, such as jumping and running

We all should reduce the time they spend sitting watching TV, playing computer games and travelling by car when we could walk or cycle instead.

Prediabetes

Prediabetes is a simple term to refer to non-diabetic hyperglycaemia, which is when blood glucose levels are raised to above normal, but are not in the diabetic range. People with prediabetes are at increased risk of developing Type 2 diabetes and other cardiovascular conditions. A UK expert group recommended using HbA1c values between 6.0-6.4% (42-47 mmol/mol) to indicate prediabetes.

Renal replacement therapy (RRT)

Normally, the kidneys filter the blood, removing harmful waste products and excess fluid and turning these into urine to be passed out of the body. In severe acute kidney failure and in end-stage kidney disease, renal replacement therapy (RRT) is required to perform the work of the kidneys. RRT can be dialysis or kidney transplant.

Stroke

A stroke is a serious, life-threatening medical condition that occurs when the blood supply to part of the brain is cut off.

The main symptoms of stroke can be remembered using the word 'FAST': Face-Arms-Speech-Time.

- Face – the face may have dropped on one side, the person may not be able to smile or their mouth or eye may have dropped.
- Arms – the person with suspected stroke may not be able to lift both arms and keep them there because of arm weakness or numbness in one arm.
- Speech – their speech may be slurred or garbled, or the person may not be able to talk at all despite appearing to be awake.
- Time – it is time to dial 999 immediately if you see any of these signs or symptoms.

Structured education programme

A structured education programme is a planned and graded programme for patients with diabetes that is comprehensive in scope, flexible in content, responsive to an individual's clinical and psychological needs, and adaptable to his or her educational and cultural background. NICE recommends that this is offered at the time of diagnosis and then as required on an ongoing basis.

Diabetes education courses make living with diabetes easier. People who have been on a course feel more confident about looking after their condition and are less likely to suffer complications. Diabetes UK includes attending a course as one of the 15 Healthcare Essentials, the essential health checks and services that everyone with diabetes should be getting from their healthcare team every year.

Symptoms

The early symptoms of diabetes may be subtle and non-specific. The most common symptoms are:

- Unexplained weight loss
- Feeling tired or lacking energy
- Excessive thirst
- More frequent urination
- Tingling or numbness in hands or feet
- Prolonged infections
- Slow healing of skin wounds
- Sudden problems with vision

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USEFUL INFORMATION

Further information, tips and recipes are available from the following websites:

Enfield Diabetes Support Group – your local group run by people with diabetes for you, your family and friends.

Diabetes UK – offers various information on diabetes, as well as tips and advice on living with diabetes. Includes recipe ideas and support for self-management.

Diabetes Risk Calculator – you can assess your own risk of Type 2 diabetes.

NHS Choices – for information about diabetes and its treatment.

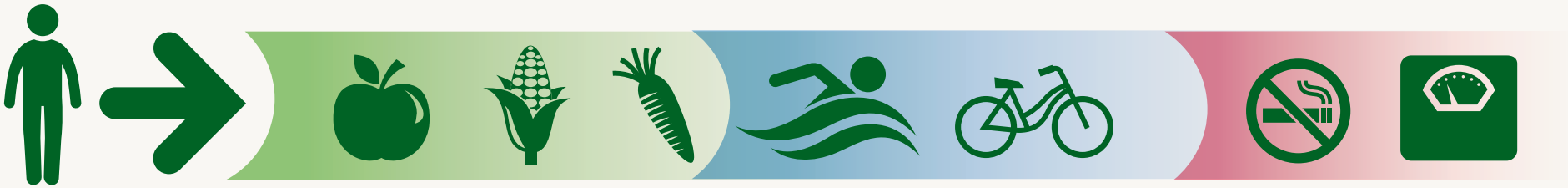
Change4Life – tips, advice and various apps to support children and their families leading healthier lifestyles. Includes recipe and activity ideas.

One You – helps adults get back to healthier lifestyles, supporting them to make simple changes towards a longer and happier life.

Enfield Joint Strategic Needs Assessment (JSNA) – provides data and intelligence on Enfield's Health and Wellbeing status. The Joint Health and Wellbeing Strategy is also available via this link, stating our vision and commitment to improve the health and wellbeing of people in Enfield.

Care in school helpline
Tel: 0345 123 2399* Monday-Friday, 9am-7pm – will give you information about your child's rights and support you to improve your child's school experience. Many of the operators are parents of a child with Type 1 diabetes, so they understand the difficulties that parents can face.

NICE guidelines



Authors
Tha Han, Gosaye Fida, Miho Yoshizaki, Laura Stoll and Shahed Ahmad

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- Dr Allison Duggal (Consultant in Public Health)
- Nnenna Ekeke (Public Health Intelligence Analyst)
- Cllr Krystle Fonyonga (Cabinet Member for Community Safety & Public Health)
- Dr Sarit Ghosh (Clinical Lead for Cardiovascular Disease, NHS Enfield CCG)
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- Alexa Manzi (Acting Senior Health Trainer)
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- Dr Hilary Tindall (Diabetes Consultant, NMUH NHS Trust)
- Matthew Videan (Acute Commissioning Manager, NHS Enfield CCG)
- Ruth Waxman (Chair Enfield Diabetes Support Group/Patient Representative)
- Stephen Wells (Programme Manager – Strategy & Planning, NHS Enfield CCG)

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Public Health
July 2016

ENFIELD Council

MUNICIPAL YEAR 2016/2017 REPORT NO. 61

MEETING TITLE AND DATE:
OSC
-25 May 2016
CMB
-19 July 2016
Cabinet
- 6 September 2016
Council
-21 September 2016

Agenda - Part: 1	**Item: 11**
Subject: SCRUTINY WORK PROGRAMME 2016/17 WARDS: None Specific	
Cabinet Members consulted: Cllr Georgiou Other Members consulted – Cllr Levy	

REPORT OF:
Overview & Scrutiny Committee
Contact officer and telephone number:
Claire Johnson Interim Governance Manager Tel: 020 8379 4239
e-mail: Claire.johnson@enfield.gov.uk

1. EXECUTIVE SUMMARY

1.1 This report and Appendix 1 sets out the Scrutiny work programme and workstreams for 2016/17 for the Council's Overview & Scrutiny Committee (OSC), Health Standing Panel and Crime Standing Panel.

1.2 The Council's Constitution requires that the work programme proposed by OSC is adopted by Council on the recommendation of the Overview & Scrutiny Committee, following consultation with the Cabinet and the Corporate Management Board (CMB).

1.3 In addition the report is also seeking approval from Council, to reassign the Council's Statutory Scrutiny Officer role in accordance with Section 9FB of the Local Government Act 2000.

2. RECOMMENDATIONS

2.1 Council is asked to approve the scrutiny work programme and workstreams for 2016/17.

2.2 Council is asked to approve that the Head of Governance & Electoral Services is designated as the Council's Statutory Scrutiny Officer as detailed in section 6 of the report.

3. BACKGROUND

3.1 The Overview and Scrutiny Committee sets its own work programme for the year, taking into consideration wider consultation with Cabinet, CMB, and stakeholders.

3.2 OSC consists of one overarching Overview & Scrutiny Committee, 2 Standing Panels on Health and Crime, with an OSC Chair and 5 members, 4 majority and 2 opposition. Each member of the committee will lead on a workstream, therefore there will be up to 5 workstreams operating at any one time, with the option of 6 workstreams if the Chair decides to lead on an area.

3.3 Workstreams, being task and finish groups, are by definition of varying durations with some being more condensed that others. Therefore, to enable a wider span of effective coverage in each municipal year, subject to support resource capacity, OSC has an ongoing 'waiting list' of pre-agreed additional topics or themes ready to replace workstreams once they have been fully concluded. This provides continuity and ensures that a forward plan is in place from the start of and for the whole of the forthcoming year, as occurred in 2016/17.

4.0 OVERVIEW & SCRUTINY COMMITTEE

4.1 OSC met on the 25 May 2016 and agreed the workstreams for 2016/17. The Crime Standing Panel and the Health Standing Panel met and agreed their work programme on the 5th July 2016 and the 6th July 2016 respectively. The OSC work programme, Crime and Health Standing Panel work programmes are shown at Appendix 1; the agreed workstreams are shown as Appendix 2.

4.2 Membership of the workstreams will be agreed with the OSC leads and party whips, allocating non-executive councillors to the workstreams who have expressed an interest in undertaking scrutiny in those areas. Membership of the workstreams is cross party and will reflect political proportionality. However membership numbers can be flexible on the workstreams, and once the workstream has finished, the membership is disbanded.

4.3 The workstreams on Health and Crime will particularly draw their members from an agreed pool of councillors who have expressed an interest to be involved in those areas. This will remain constant for the whole year and will be on a politically proportionate basis. This consistency in membership will allow these workstreams to develop a watching brief in these issues and build up a level of knowledge and expertise amongst members.

5.0 ENGAGEMENT PROTOCOL

5.1 The Protocol to engage and involve Directors, Chairs of Boards, statutory bodies and other key stakeholders was agreed by CMB. Therefore CMB is consulted, and the Scrutiny work programme will be an item for information on

the agenda for the Health & Wellbeing board and the Safer and Stronger Communities Board. In addition, the work programmes will be sent to key stakeholders such as Health, the Police, CCG, and EVA.

5.2 Cabinet is asked to note that before beginning its work, each workstream will agree a scope for the review including:

- Terms of reference
- Desired outcomes
- Key stakeholders
- Training/information required for members to prepare for the review
- Timescale for the review
- Resources required (member and officer)
- Co-optees

6. STATUTORY SCRUTINY OFFICER ROLE

6.1 Section 9FB of Local Government Act 2000 makes provision for the appointment of a Statutory Scrutiny Officer. At present this falls under the remit of the Head of Electoral, Registration and Governance Services.

6.2 As a result of the previous Head of Service having left the Council, there is now a requirement to reassign this statutory role. Council approval is therefore being sought to place the Statutory Scrutiny officer role within the remit of the newly created Head of Governance and Electoral Services post, which has now replaced the previous Head of Electoral, Registration and Governance Services position.

7. COMMENTS FROM CABINET

7.1 Cabinet noted the proposed work programmes for the Health and Crime Standing Scrutiny Panels together with the work streams which had been identified. Members were advised of the detailed work which was being undertaken by Scrutiny.

7.2 Members commended the effective scrutiny work that was undertaken and expressed their thanks and appreciation to Councillor Levy as Chair of the Overview and Scrutiny Committee. The importance of the Scrutiny role within the Council was recognised.

8 COMMENTS FROM CMB

8.1 CMB noted the Overview and Scrutiny Committee proposed work programme and workstreams for 2016/17.

9. REASONS FOR RECOMMENDATIONS

To comply with the requirements of the Council's Constitution, as the workprogramme has to be formally adopted by Council. In addition, scrutiny is essential to good governance. It enables the voice and concerns of residents

and communities to be heard, and provides positive challenge and accountability.

10. ALTERNATIVE OPTIONS CONSIDERED

No other options have been considered as the Overview & Scrutiny Committee is required, under the Council's Constitution, to present an annual scrutiny work programme to Council for adoption.

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

11.1 Financial Implications

Any cost implications of undertaking the Scrutiny workstreams must be contained within budgeted resources.

11.2 Legal Implications

The recommendations within this report for adoption of the annual Scrutiny Workstream Programme are lawful and will help support the Council in meeting its statutory obligations for effective overview and scrutiny.

The Council has statutory duties within an existing legal framework to make arrangements for scrutiny of its decisions and service delivery and the areas of crime and health, which are covered within these recommendations.

The setting of the annual Scrutiny Workstream Programme is a matter for the Council, following consultation with directors, members and key stakeholders within an agreed protocol. These requirements are set out in the Council's Constitution.

The Council should consider its ongoing duties under the Equality Act to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation; and advance equality of opportunity between people who share a protected characteristic and those who do not and consider how its decisions will contribute towards meeting these duties.

The recommendation to designate the Head of Governance and Electoral Services as the statutory scrutiny officer will secure compliance with the Council's duty under s31 Local Democracy, Economic Development and Construction Act 2009 and Section 9FB of the Local Government Act 2000 to designate an officer as Statutory Scrutiny Officer.

11.3 Key Risks

There are no key risks associated with this report. Any risks relating to individual scrutiny workstreams will be identified and assessed through the scoping process.

12. IMPACT ON COUNCIL PRIORITIES

12.1 Fairness for All

OSC will monitor the scrutiny work programme to ensure that it addresses issues affecting a wide range of Enfield residents and that services provided are fair and equitable.

12.2 Growth & Sustainability

As part of the approach towards scrutiny, reviews will consider issues relating to sustainability.

12.3 Strong Communities

OSC will ensure that the work programme continues to include active participation from residents and that reviews contribute to building strong communities.

13. EQUALITIES IMPACT IMPLICATIONS

Equalities impact assessments relating to individual scrutiny workstreams and their recommendations will be assessed through the scrutiny process.

14. PERFORMANCE MANAGEMENT IMPLICATIONS

OSC will monitor the work programme and ensure that review recommendations are acted on and implemented by departments.

15 PUBLIC HEALTH IMPLICATIONS

There are no direct public health implications of this report, but rather what happens as a result of scrutiny.

:

OSC WORK PROGRAMME 2016/17 **Appendix 1**

WORK	Lead Officer	25 May (Planning)	14 July	8 Sept	11th Oct	10 Nov	19 Jan	23 Feb	27 April
Work Programme									
Setting the Overview & Scrutiny Annual Work Programme 2016/17	Andy Ellis	**Agree Work Programme**							
Selection of New Workstreams for 2016/17 and 2017/18	Andy Ellis	**Review and Approve Workstreams 16/17**	**Receive Scoping and discuss Enfield 2017 WS Scoping with Cllrs Georgiou and Lemonides**						**Consider/ Propose New Workstreams 17/18**
Workstreams Update (standing and time-limited)	Andy Ellis			**Update**		**Update**		**Update**	**Update on Adoption Workstream recommendations**
Scrutiny Workstream Reports									
Agenda Planning	Andy Ellis								
Standing Items									
Children's and Young People's Issues	Tony Theodoulou / Julian Edwards			**Looked After Children/Children in Need/ Child Protection -** Tony Theodoulou, Julian Edwards **Local Auth Designated Officer/**		**Fostering and Adoption**		**Troubled Families** Maria Kelly **SEND** Janet Leech	**Adoption Regionalisation**

WORK	Lead Officer	25 May (Planning)	14 July	8 Sept	11th Oct	10 Nov	19 Jan	23 Feb	27 April
				Ind Review Officer Anne Stocker					
Monitoring/Updates									
Child Sexual Exploitation Task Group	Anne Stoker							**Update**	
Scrutiny Involvement in Budget Consultation 17/18	Andy Ellis				**Cllr Lemonides to give an overview of progress**		**Budget Meeting**		
Safeguarding Annual Report - Adults Services	Marion Harrington (Independent Chair) Sharon Burgess (Head of Safeguarding Adults)					**Report**			
Safeguarding Annual Report - Children's Services	Geraldine Gavin (Independent Chair) Head of Safeguarding Children					**Report/Action Plan**			
Equality and Diversity Annual Report	Ilhan Basharan							**Report**	
Annual Corporate Complaints Report	Nicholas Foster							**Report**	
HR Issues – How do we recruit and support people with disabilities and mental	Julie Mimnagh								**Report**

WORK	Lead Officer	25 May (Planning)	14 July	8 Sept	11th Oct	10 Nov	19 Jan	23 Feb	27 April
health issues									
Scrutiny Monitoring									
Scrutiny Annual Report	Claire Johnson								
Other Items/Specific Topics:									
Care Act	Bindi Nagra					**6 month update on Care Act 2014 –**Bindi Nagra			**Update**
Better Care Fund	Richard Young			**6 month update** Richard Young					**Update**
Town Centres and High Streets	Ian Davis							**Update on the Inward Investment Strategy**	
Housing Repairs	Ian Davis		**Update**						
Female Genital Mutilation	Dr Allison Duggal		**Report**						
Housing Allocations Policy	Sally McTernan					**REPORT**			

Note: Provisional call-in dates:- 7th & 30th June, 26th July, 3rd & 24th August, 29th September, 11th & 26th October, 22nd November, 13th December, 17th January, 16th February

Additonal Items to be considered:- Local Plan Review/ Housing Benefit

Please note that the above programme may be subject to change during the course of the year

CRIME STANDING WORKSTREAM: WORK PROGRAMME 2016/2017

WORK	Lead Officer	Tuesday 5 July (Work Planning)	Thursday, 20 Oct	Wednesday 11 Jan	Wednesday, 22 Mar
Work Programme					
Panel Work Programme 2016/17 – To consider the work programme	Sue Payne	Agree work programme			
Standing Items					
SSCB Partnership Plan & Strategic Priorities – To review and participate in the development of the Plan and strategic priorities for 2017 – 18.	Andrea Clemons/ Sue Payne		**6 month update- on current plan and progress update –**		**Progress Update –**
SSCB Performance Management – provide a monitoring overview on performance of SSCB	Andrea Clemons/ Sue Payne		**Monitoring Update**	**Monitoring Update**	**Monitoring Update**
Update on Police numbers	Supt Carl Robinson		**Update**	**Update**	**Update**
Briefings, Monitoring & Updates:					
Prostitution	Andrea Clemons			**Report**	
Gangs	Andrea Clemons				**Report**
Begging	Andrea Clemons			**Report**	
Domestic Abuse	Andrea Clemons		**Report**		
Update on the effects of the 24 hour tube	Andrea Clemons, Carl Robinson				**Update**
Hate Crime	Andrea Clemons		**Report**		

Update on the effectiveness of MOPAC Estate Policing Contract	Andrea Clemons, Carl Robinson			**Update**	

Please note that the above programme maybe subject to change during the course of the year.

HEALTH STANDING SCRUTINY WORKSTREAM: WORK PROGRAMME 2016/2017

Work Programme	Lead Officer	Wednesday 5th October 2016	Thursday 5th January 2017	Thursday 23rd March 2017
Deadline for sending papers to Scrutiny Team		**26th September**	**16th December**	**10th March**
Annual Items				
Agree Annual Work Programme 2015/16	Andy Ellis	To agree		
NHS Trust Quality Accounts B&CF(RF), NMUH, BEHMHT, NL Hospice (in liaison with NCL JHOSC)	Trust Reps			If papers available
Monitoring Items				
Dental Services				Report
Community Pharmacy Services			Report	
North Middlesex Hospital	Libby McManus	Single item meeting		update
CCG Item	Sarah Thornton		Urgent Care Review. PAU review	Sustainability and Transformation Plan
Agenda Planning	Andy Ellis			
Scrutiny Workstream Reviews				
Sensory Impairment - Access to Services		**Update**	Update	Update

Agreed Scrutiny Workstreams 2016/17 **APPENDIX 2**

Subject	Scope	Workstream Lead and membership	Scrutiny contact
Quality of Communications	• Assess how we can compose letters to residents, partners and stakeholders that have a more personal feel. Letters should show our appreciation, respect and empathy when conveying bad or negative information. • Review the standard guidance available to all staff, is it appropriate? • Is there a role for Councillors – should they return poor communications back to the author? • Eradicate jargon from written correspondence and reports • Is our initial contact with personal visitors or telephone callers of an appropriate standard?	**Derek Levy (Chair)** Dinah Barry, Chris Bond, Erin Celebi (Vice Chair), Nick Dines, Vicki Pite	Andy Ellis
Housing Repairs	To understand any issues and suggest improvements and solutions, including looking at: • Key performance indicators • Benchmarking with similar boroughs • Members case work examples • The involvement of the Customer Voice • The reporting process • Examples of good practice	**Katherine Chibah (Chair**), Erin Celebi, Lee Chamberlain (Vice Chair), Bambos Charalambous, Jansev Jemal, Mary Maguire	Sue Payne
Child and Adolescent Mental Health Services (CAMHS)	To understand any issues and suggest improvements and solutions, including looking at: • Are any children referred for mental health support turned away without help in Enfield • Reducing waiting times for assessment and treatment and improving access to service • To ensure best use of resources and equal access to services • To explore ways of reducing the stigma associated with mental health	**Nneka Keazor (Chair),** Nesil Cazimoglu, Christiana During, Mike Rye, Ozzie Uzoanya, Glynis Vince	Sue Payne

Enfield 2017	• Project Management of Enfield 2017 up to going live • Is this demand driven? Are customers getting access to the services they need? • Rate of return on investment- financial analysis	**Edward Smith (Chair)**, Vicki Pite, Don McGowan, Andrew Stafford, Claire Stewart, David Lee Sanders	Sue Payne
Property Services	The aim of the workstream is to review the strategic direction of the LBE property portfolio. Members will require information on the following • Income generation • Vacancy factors • The billing process • The property register • The process for sales and acquisitions • Contract arrangements with the 3 property management companies (agricultural, retail and industrial)	**Joanne Laban (Chair)**, Ali Bakir, Adeline Kepez, Mary Maguire, Toby Simon, Andy Milne	Andy Ellis

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON TUESDAY, 12 JULY 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), Cllr Alev Cazimoglu, Cllr Doug Taylor (Leader of the Council), Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Libby McManus (Chief Executive North Middlesex University Hospital NHS Trust), Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust), Tony Theodoulou (Interim Director of Children's Services), Cllr Krystle Fonyonga, Peter Ridley (Director of Planning, Royal Free London, NHS Foundation Trust) and Sarah Thompson (Chief Officer - Enfield Clinical Commissioning Group)

ABSENT Ian Davis (Director of Environment), Dr Henrietta Hughes (NHS England) and Cllr Ayfer Orhan

OFFICERS: Bindi Nagra (Joint Chief Commissioning Officer) and Keezia Obi (Head of Safeguarding Adults), Allison Duggal (Public Health Consultant), Jill Bayley (Legal Representative), Sue Glandfield (Programme Manager), Sam Morris (Strategic Partnerships Manager) and Koulla Panaretou (Secretary)

Also Attending: Richard Gourlay (Director of Strategic Development NMUH), Mary Sexton (Executive Director of Nursing, Quality and Governance, BEH-MHT), Deborah McBeal (Deputy Chief Officer, NHS Enfield CCG)

1
WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting and apologies for absence were received from Ian Davis (Director of Regeneration & Environment), Councillor Ayfer Orhan and Dr Henrietta Hughes (NHS England).

2
DECLARATIONS OF INTEREST

There were no declarations of interest registered in respect of any items on the agenda.

3
CHANGE OF ORDER OF AGENDA ITEMS

The Chair agreed to alter the order in which items on the agenda were considered at the meeting.

Item 6.3.b (Barnet, Enfield & Haringey NHS Mental Health Trust progress update on recent CQC visit) was taken as item 3 (Sustainability and Transformation Plan (STP Submission. The minutes reflect the order of items listed on the agenda.

4
SUSTAINABILITY AND TRANSFORMATION PLAN (STP) SUBMISSION

RECEIVED a submission report on the Sustainability and Transformation Plan (STP) which was submitted to NHS England on 30th June 2016, to be noted by the Health and Wellbeing Board.

NOTED

Deborah McBeal, Deputy Chief Officer, NHS Enfield CCG) introduced the report to the Board, highlighting the following:

- The STP covers the Five Year Forward View ambitions to 2020/21 specifically in three key areas:❶ health and wellbeing❷ care and quality, and ❸ finance and efficiency in accordance with the NHS England (London) assurance process.

- The NCL STP Submission was a “plan for a plan” and included:

    - A Case for Change – identifying care and quality gaps in health and wellbeing.
    - The financial position – identifying the finance and efficiency gap and include information about how to start to develop the contribution of the work streams to help close this gap. Currently 13 work streams have been identified within the scope of the NCL STP and they are detailed within the report.
    - The STP programme governance structure which would be reviewed as the programme moved into implementation.
    - Plans for the work that needed to be done to September 2016 to produce the full STP and implementation, with further planning to be done following that date.
    - A Stakeholder communications and engagement plan overview.

- The NCL STP Transformation Board would provide oversight of the continued development of the NCL STP.

IN RESPONSE the following questions/comments were received:

1. Deborah Fowler (Healthwatch) asked what the difference was between planning on a place not people basis and was concerned that the voices of the Enfield public were not being heard. She offered support to the CCG from Healthwatch Enfield in planning public engagements. This last was supported by Vivien Giladi (Voluntary Sector) who confirmed that the public were becoming increasing more anxious and sceptical as they were not clear what was happening. Communication and engagement needed to be significantly improved so that information could be shared in a clear and concise manner, to avoid these concerns.

2. Sarah Thompson (CCG Chief Officer) advised that the CCG also had a contribution to this and Simon Stevens (CEO of NHS England) would be hosting a "Plan for a Plan" engagement on the 14th July. The level of further engagement required would be clearer after this event and would be implemented if required.

3. Andrew Wright (BEH Mental Health NHS Trust) confirmed that a lot of time and energy was being focussed on governance issues initially.

4. Ray James (Director of Health, Housing & Adult Social Care) confirmed that processes had begun and there will be the opportunity for meaningful co-production in the time ahead, where engagement will be encouraged. The work streams were constantly developing. The position of the Health and Wellbeing Board needed to be defined in the process; is it a commentator or a system leader

5. Shahed Ahmad (Director of Public Health) highlighted the enormity of the plans, involving a number of Trusts, CCG's and Councils and stressed the time that would be required to sort out the complexity of the huge task ahead.

6. Mo Abedi (Chair of Enfield CCG) provided assurance that all meetings would be held in a transparent and informative manner. Solutions to problems identified would be developed through the relevant programmes. The main purpose shared by all participants was that a patient from Enfield, Barnet, Camden or Islington should receive the same level of care.

7. Vivien Giladi raised the concern of the public who fear that Camden and Islington Boroughs have significantly more resources than Enfield and money goes to organisations who demonstrate excellence. Local people need assurance that this will not happen.

8. The Chair requested that David Sloman (Chief Executive Royal Free London RFL), who is the RFL lead for STP, be invited to a Health & Wellbeing Board development session. **ACTION: Sam Morris**

AGREED to note the report.

5
CO-COMMISSIONING OF PRIMARY CARE SERVICES

RECEIVED a report requesting that the Health and Wellbeing Board 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.

NOTED

Deborah McBeal, Deputy Chief Officer, NHS Enfield CCG) introduced the report to the Board, highlighting the following:

- Co-Commissioning of Primary Care Services was 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 (namely Barnet, Camden, Enfield, Haringey and Islington) had submitted an application to undertaken 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.

- The benefits for NCL of becoming delegated commissioners of Primary Care were perceived 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 the 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 needed to determine whether to move to delegated commissioning, with an application due in October 2016 for interested CCGs.

IN RESPONSE the following comments were received:

- Enfield have sought and been granted permission to proceed with the work.
- NHS England had struggled to commission Primary Care in Enfield and there was a need to mitigate risk as the CCG was still under directions.

AGREED that Enfield recommend the active commissioning of the development of Primary Care Services.

6
CHILD HEALTH

RECEIVED a briefing on the local child health profiles and health behaviours of young people for Enfield. The profile allows comparison with national and regional data on child health and allows the targeting of areas for local improvement.

IN RESPONSE to the report, the following comments were received:

- Looking at the context of the data, child obesity rates in Enfield were of concern. Sam Morris (Strategic Partnerships Manager) had recently attended the "Great Weight Debate" meeting at London Councils. He reported back that feedback received on child obesity rates was also of concern across all Boroughs. The Obesity Strategy was due to be released soon. In order to deal with the issue, engagement is needed and the Health & Wellbeing Board could play an active role in this.
- Immunisation rates had increased. An action plan from NHS and Public Health England was being implemented. The issue of recording immunisation rates in the past were being looked at and data was being collated. An Assurance Board was to be set up on immunisation rates.
- Hospital Admissions needed to be looked at as there were high numbers of children attending A&E departments with ear, nose and throat (ENT) issues.
- A separate paediatric urgent care pathway was to be piloted so that children were seen by GP's instead of Paediatricians.
- With regard to Female Genital Mutilation (FGM) – there was national work in progress and a campaign on African TV which has also been shown on some channels in the UK. FGM was also on the agenda for the next Overview & Scrutiny Committee and a FGM steering group also exists.
- Allison Duggal was thanked for her excellent briefing which was a useful basis of reference, especially in respect of FGM. It was noted that Allison will be leaving Enfield and taking on a new position at another local authority and the Board unanimously sent their best wishes to her.

AGREED to note the briefing.

7
ENFIELD HEALTH & WELLBEING BOARD SUB BOARDS & PARTNER UPDATES

7.1 Updates from Sub-Boards:

RECEIVED updates from the following Health & Wellbeing Board Sub Boards:

7.1.1 Joint Commissioning Board Sub Board:

NOTED that the Board received an update from the Joint Commissioning Sub Board. 12.3.3 of report refers to a Local Authority Trading Company, which will be operating in October and will manage Adult Social Care provider services.

7.1.2 Health Improvement Partnership Board:

NOTED that the Board received an update from the Health Improvement Partnership Sub Board.

No firm proposals had been agreed for the future stop smoking model. Any plans would need to be discussed with the CCG and agreed by council's CMB.

7.1.3 Better Care Fund 2016/17 Plan:

It was noted that further to the HWB meeting held on 21st April, the 2016-17 plan was agreed and submitted to NHS England. Full approval was expected. The Board received and noted the contents of the plan.

Keezia Obi was thanked for her valued work on the Better Care Fund Plan to date.

7.2 Updates from Partners:

RECEIVED updates on specific local service developments by providers, as follows:

7.2.1 Future Organisational Models at North Middlesex University Hospital (NMUH) NHS Trust

The Board received a presentation from Richard Gourlay (Director of Strategic Development at NMUH NHS Trust).

NOTED

- NMUH was to be involved in the Acute Care Vanguard which was to be developed as part of the NHS five year forward view. The aim of the vanguard was to enhance viability of local hospitals, to share formal working relationships and improve efficiency of back office administrative functions.
- There are currently 13 successful acute care vanguards across the country.
- The chain concept had been developed in Salford & Wigan, and Northumbria Foundation Group. The Royal Free London could work with these foundation trusts in developing plans for their own group and the creation of a multi-provider hospital.
- Under the models of established hospital groups, there were a range of membership scenarios. ❶ Buddying ❷ Shared Services and Back Office ❸ Shared clinical support ❹ Full membership. The latter being the preferred choice for the Royal Free London Board who would assume full responsibility for the other hospitals.
- The group model preferred by Royal Free would involve individual hospitals joining a group as operational units, with the group executive overseeing all units and each operational unit would be accountable to a group management structure.
- This would provide scope to increase the resilience and efficiency of non-clinical services by increasing the pool of clinical resources available including executive leadership, finance and commercial expertise, human resources, information management and technology, procurement, communications, teaching, education and research.
- Discussions with the Trust Board were held in March 2016 which led to an agreement to a “memorandum of understanding” to enable them to proceed to explore membership as part of RFL vanguard, envisaged from April 2017. This would also help maintain existing clinical pathways with other organisations.

IN RESPONSE the following questions/comments were received:

1. The NMUH were clinical specialists on their own, through shared services with other providers. It was one of the busiest hospitals in London, with in excess of 5,000 births per year, A & E and care for the elderly high in numbers. Further work was required to create a case for change and clinicians at NMUH would meet David Sloman to talk about what this could look like.

   Working together to provide the same service and sharing resources would provide a huge recruitment benefit and develop the work force

for both the Royal Free and the NMUH. Resilience and stability was needed at NMUH A&E.

2. It was highlighted that the presentation did not provide direction. Reassurance was needed for the Health & Wellbeing Board regarding the ongoing viability and sustainability of services in light of the recent CQC report and media interest. A statement was needed on how the A&E can be secured, with increasing numbers of people attending being the major issue.

3. Work was currently underway with colleagues to ensure that the A&E at NMUH is somewhere where the public feel happy to attend at any time day or night. Additional senior medical staffing from other units were arriving in ED to support the current rotas, and they will be in place during July & August.

4. In respect of shortages in A&E consultants previously reported, it was confirmed that five new consultants & middle grade doctors would arrive on secondment and all would be in place by August 2016, one would be working at night where the greatest challenge has been. There had also been a recent appointment to the Clinical Director role in the A&E department that enhances the medical leadership.

5. NMUH had not yet sought to involve local people or patients in the development of its tie-up with RFL, nor in its plans for the “local accountability” arrangements that would be needed. It was suggested to Richard Gourlay by Deborah Fowler (Healthwatch Enfield) that NMUH should involve patients in developing the local accountability arrangements, and that patients could also be involved in the resulting arrangements on an ongoing basis.

6. It was questioned whether the A&E need the Vanguard sustainability? In response, the NMUH A&E has to be sustainable financially and once the work streams are in place, there will be a clearer picture of what can be delivered to this crucial resource for the local community.

7. How would the chain work and whether a CEO will be appointed are issues currently being worked through.

NOTED the presentation and update.

7.2.2 Barnet, Enfield, Haringey Mental Health Trust Care Quality Commission (CQC) Comprehensive Inspection Outcome

The Board received an update on the BEH MHT CQC Comprehensive Inspection Outcome from Mary Sexton (Executive Director of Nursing, Quality and Governance)

NOTED

- The approach taken by the CQC Inspection measured the quality of care by how safe, effective, caring, responsive, well-led it was.
- The CGC had inspected all core mental health services and Enfield community services.
- The Trust had been informed of the inspection 20 weeks in advance and information received from stakeholder providers had been analysed and used to produce a data pack.
- The CGC team comprised of 4 teams of 88 people with appropriate knowledge and expertise.
- Final findings showed an area of challenge in the quality of the existing buildings, especially at St Ann's Hospital, where many of the structures were 18th and 19th century. The poor environment at St Ann's Hospital had altered the perception of the report.
- The CQC had found that most of the Trust's staff were very caring, professional and worked tirelessly to support patients. Staff morale was high, with access to opportunities to further their careers.
- Challenges and Actions identified were ❶staffing ❷ patient centred care and communication ❸ leadership and management ❹ premises and equipment.
- The Trust found the CQC Inspection a helpful and positive process.
- A Quality Improvement Plan was in place.
- The Trust had high levels of staff engagement and the strong leadership needed to deliver the improvements required.
- There were a number of risks and dependencies which were being addressed jointly with partners.
- The key risk was funding for the improvements needed, which had been costed at £2 million. The Trust was in discussions with commissioners about the funding of these improvements and the CQC were aware that without investment, the action plan could not be fully delivered.

IN RESPONSE the following questions/comments were received:

1. The Trust's financial position was difficult at the moment. There had been a £7.5m deficit seen last year which was projected to increase this year to £12.6m. The Trust was working with NHS Improvement on a Financial Improvement Plan which aimed to reduce the financial deficit to £9.4m. With regard to St Ann's Hospital, the Trust's Strategic Outline Business Case was being reviewed by NHS Improvement and approval was anticipated by September 2016, which would then allow the project to proceed, which had not been possible until the business case was approved.

2. The CQC Inspectors were not likely to return for a full inspection but a more focussed inspection around seclusion and lone working was expected before December this year.

3. An Interim Director of Improvement had been appointed to bring in the required expertise to lead the Trust's Improvement Programme over the next six months.

4. With regard to an update on patient centred care and communications with GPs, it was confirmed that more psychologists for inpatients within the wards were needed. It was acknowledged that more information on patient care needed to be communicated to GPs in a timely way

5. Clarity as sought as to whether there were there any particular issues with Enfield Community Services? In response, it was confirmed that there were no particular issues and that the CQC report included a lot of positive comments about ECS services.

Mary Sexton was thanked for the very helpful and comprehensive review received.

8
ITEMS FOR INFORMATION

8.1 Annual Public Health Report 2015/16

The Board received and noted the Annual Public Health report for information including key public health indicators at Enfield including the Life Expectancy Gap and Infant Mortality which had significantly improved since 2010.

The Board thanked Allison Duggal for the update.

8.2 Thanks to Dr Shahed Ahmad & Allison Duggal

The Board thanked Dr Shahed Ahmad for his contributions over the last 7 years and wished him luck in his new role at NHS England and also wished Allison Duggal well in her new role at another authority.

9
MINUTES OF THE LAST MEETING

The minutes of the meeting held on the 21st April 2016 were agreed subject to an amendment to Item 3, CCG Operating Plan 2016/17, no 7: A Healthwatch representative attended the Transformation Board as an observer only, not a full member.

10
DATE OF NEXT MEETING

The date of the next meeting was confirmed as Wednesday 5th October 2016 at 6:15pm in Room 1.

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

Appendix 1 – Draft work plan for formal in public sessions of the HWB

Health and Wellbeing Board: Work Programme 2016/17

ITEM	Lead Officer	11 February 2016	21 April 2016	12 July 2016	5 October 2016	8 December 2016
Leisure and Culture Strategy	Jess Khanom	**Report**				
Sub Committees-work programme			**Review**			
CCG Operating Plan	Paul Jenkins		**Report**			
Annual Better Care Fund Review	Bindi Nagra		**Review**			
Healthy Weight Strategy	Glenn Stewart		**Report**			
Fuel poverty	Deborah Southwell		**Report**			
Commissioning Plans	Bindi Nagra			**Review**		
Memberships	Penelope Williams			**Review**		
Annual Public Health Report	Shahed Ahmad			**Review**		
Stroke and Dementia Action Plan	Shahed Ahmad				**For Information**	
Annual Immunisation and Screening Review	Allison Duggal				**For Information**	
CCG and LBE Financial and Commissioning Intentions	Paul Jenkins/Ray James				**Report**	
Overview and Scrutiny Workplan	Claire Johnson				**For Information**	
Adult and Children Safeguarding Reports	Tony Theodoulou				**For Information**	

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Hospital Chains	Peter Ridley				**Report**	
New Models of Care	Graham McDougall				**Report**	
Joint Health and Wellbeing Strategy Review	Shahed Ahmad				**Review**	
Health and Social Care Integration Plans	Bindi Nagra					**Report**
LBE Budget Consultation	James Rolf					**Consultation**
Review of the EH&WB	Sam Morris					**Review**

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Appendix 2 – Draft work plan for development sessions in 2016

Health and Wellbeing Board Development Sessions
Work Programme 2016/17

ITEM	Lead Officer	Background	6 January 2016	2 March 2016	June 2016	September 2016	November 2016
Work Programme	Sam Morris/Shahed Ahmad	**N/A**					
Sport England	Jess Khoum	**N/A**					
Cancer Vanguard	Kathy Pritchard Jones	**N/A**					
Diabetes	Tha Han/Shahed Ahmad	When high risk genetics to express their feature, they need to be exposed to the environmental risk. Enfield has an environment that has better access to high risk food and lifestyle than protective food and lifestyle. As a result, the prevalence of obesity and diabetes is increasing. There were more than 8,300 residents with diabetes and 30,000 are at high risk of becoming diabetics. The complication of diabetes is in every organ in the body and affects mental health too. When residents and public sector bears the burden of those complications year-on-year, we need to look at it from lifestyle and prevention to proper care. Enfield Health and Wellbeing Board partners are working closely to tackle this. An obesity strategy was drafted. An expression of interest to host national Diabetes Prevention Programme was submitted. Prevention and early recognition initiatives are piloted together with new models of care to better control blood glucose in the community. The change need to be scaled up so that healthy food and lifestyle is more accessible than unhealthy food and lifestyle, residents with high risk become more aware and are empowered to undertake effective measures and those already diabetic are supported to participate fully in their care plan. This will reduce the burden on the residents, make the care of the patients more effective and result in more						

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		sustainable public services. Nonetheless there are multiple challenges ahead to implement these evidence based programmes.					
Tower Hamlets Vanguard		It is made up of a collaboration of partners that include Tower Hamlets GP Care Group Community Interest Company (representing primary care); Barts Health NHS Trust (the local acute and community health services trust); East London NHS Foundation Trust (local mental health trust) and London Borough of Tower Hamlets (local council and social care). A patient in Tower Hamlets will benefit from having straightforward easy to access health and social care services and a positive patient experience. A key part of the Tower Hamlets proposal is to have a greater focus on a positive patient experience. The current collaboration of four organisations will be broadened to include both local voluntary and community sector organisations, as well as patient and service user groups, to share experiences and skills in the best interests of patients.					
Integration	Bindi Nagra	Discussion and agreement regarding scope and model for Integration in Enfield					
STP – the 5 year Sustainability & Transformation Plan	Paul Jenkins	***(To replace the NCL Collaboration item on previous work plan)***					
Primary Care	Deborah McBeal						
Hospital Chains	Peter Ridley						

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New Models of Care	Graham McDougall/ Claire Wright	• Overarching aims of new models of care • Outline of all national vanguard pilot sites • Progress to date on vanguards • Local discussions with providers on new models of care approaches to provision • Nest Steps					
CCG and LBE Financial and Commissioning Intentions	Graham McDougall/ Claire Wright						
Medium Term Financial Outlook	James Rolfe	A high level exploration of Enfield's process, Its medium term outlook and the risks/issues we are like to face over the next 3-4 years.					
Urgent and Unplanned Care	Paul Jenkins	• Overarching aims of new models of care, • Outline of all national vanguard pilot sites, • Progress to date on vanguards • Local discussions with providers on new models • of care approaches to provision • Achieving excellence across Enfield and the North • Central London Urgent Care Network by 2017.					

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