HEALTH AND WELLBEING BOARD

Thursday, 8 December 2016 at 6.15 pm
Conference Room, Civic Centre, Silver Street, Enfield, EN1 3XA

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MEMBERSHIP

Leader of the Council – Councillor Doug Taylor (Chair)
Cabinet Member for Health and Social Care – Councillor Alev Cazimoglu
Cabinet Member for 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 Lindfield
Director of Health, Housing and Adult Social Care – Ray James
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. THE BETTER CARE FUND (6:20 - 6:35PM) (Pages 1 - 24)

To receive the report of Bindi Nagra, Assistant Director Health, Housing and Adult Social Care, LB Enfield and Graham MacDougall, Director of Strategy

and Partnerships, Enfield CCG.

4. LONDON BOROUGH OF ENFIELD BUDGET CONSULTATION INCLUDING THE AUTUMN STATEMENT 2016 (6:35 - 6:55PM)

To receive a presentation on the London Borough of Enfield 2017/18 budget proposals from Jayne Fitzgerald, Head of Strategic Finance.

5. DEVELOPING THE NORTH CENTRAL LONDON SUSTAINABILITY AND TRANSFORMATION PLAN (STP) - UPDATE (6:55 - 7:05PM) (Pages 25 - 40)

To receive an update from Enfield Clinical Commissioning Group.

6. ENFIELD HEALTH AND WELLBEING BOARD AND DEVELOPMENT SESSION WORK PROGRAMMES (7:05 - 7:15PM) (Pages 41 - 48)

To receive the report of Sam Morris, Strategic Partnerships Manager.

7. ADHERENCE TO EVIDENCE BASED MEDICINE (7:15 - 7:25PM) (Pages 49 - 56)

To receive the report from Dr Mo Abedi (Enfield CCG Medical Director).

8. PROGRESS UPDATE ON TRANSFORMING CARE (7:25 - 7:40PM) (Pages 57 - 60)

To receive a progress update on Transforming Care from Graham MacDougall, Enfield Clinical Commissioning Group.

9. LISTENING TO LOCAL VOICES ON MENTAL HEALTH - HEALTHWATCH ENFIELD (7:40 - 7:55PM) (Pages 61 - 84)

To receive the report on provision of mental health services in Enfield by Healthwatch Enfield.

REPORTS FOR INFORMATION

The following reports are for information only.

10. IMMUNISATION ANNUAL REPORT (7:55 - 8:00PM) (Pages 85 - 108)

To receive the report from Dr Tha Han, Public Health Consultant.

11. LETTER FROM DAVID MOWAT MP ON THE INTEGRATION OF HEALTH AND WELLBEING BOARDS AND PRIMARY CARE (8:00 - 8:05PM) (Pages 109 - 110)

To receive the letter from David Mowat MP (Parliamentary Under Secretary of State for Community Health and Care) highlighting the General Practice Forward View, published in July 2016, which all Health and Wellbeing Boards are requested to review the General Practice Forward View document and

what more Boards could do to build effective relationships between primary care and wider local services.

12. POLICE AND CRIME COMMISSIONERS AND HEALTH AND WELLBEING BOARDS (8:05 - 8:10PM) (Pages 111 - 114)

To receive the joint letter from the Home Secretary and the Secretary of State for Health for Police and Crime Commissioners and Health and Wellbeing Boards.

13. MINUTES OF THE MEETING HELD ON 5 OCTOBER 2016 (Pages 115 - 124)

To receive and agree the minutes of the meeting held on 5 October 2016.

14. DATES OF FUTURE MEETINGS

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

- 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:

- 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.

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Agenda Item 3

MUNICIPAL YEAR 2016/2017

MEETING TITLE AND DATE **Health and Wellbeing Board** **8th December 2016**	**Agenda – Part: 1**	**Item:**
	Subject: The Better Care Fund. - the 2016-17 Better Care Fund plan implementation update - planning for the 2017-19 BCF plan	
	Wards: All	
REPORT OF: Bindi Nagra, Asst. Director, Health, Housing and Adult Social Care, LB Enfield, and Graham MacDougall, Director of Strategy and Partnerships Enfield CCG	**Cabinet Member consulted:** Cllr. Doug Taylor, Leader of the Council	
Contact officer: Keezia Obi, Head of Service, Enfield 2017 **Email:** Keezia.Obi@enfield.gov.uk **Tel:** 020 8379 5010		

1. EXECUTIVE SUMMARY

This report provides an update on:

- the delivery of the 16/17 BCF plan including the current performance against key indicators and service/scheme outcomes
- key messages from the NHS England Q1 Data Collection and Performance report for all HWB areas
- a summary of the financial position as at the end of quarter 2 (April – October 2016)
- the planning process and expected timescales for the production of the 2017/19 BCF plan
- an update on activity associated with integration and future planning.

2. RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- **Note and receive** the current BCF performance and performance dashboard including outcomes
- **Note** the Quarter 2 financial position
- **Note** the information about regional BCF activity and performance
- **Note** that the NHSE policy framework and planning guidance is due to be published for the production of a 2 year plan - 2017/19. It is expected that the first submission is expect will be before Christmas and the final one at the end of March 2017
- **Note** the information regarding integration and future planning.

3.0 2016-17 BCF PLAN: IMPLEMENTATION AND DELIVERY

3.1 IMPROVEMENTS TO THE MANAGEMENT AND DELIVERY OF THE BCF

3.1.1 Earlier on in the year, the HWB were made aware of the outcome of audits that had been undertaken in relation to the management and delivery of the BCF, in particular recommendations to improve practice. This included governance structures, financial management, performance management and identifying outcomes against the plan.

3.1.2 Since then and latterly via a BCF Delivery Group, made up of council and CCG colleagues, improvements have been made across all areas. Governance arrangements supporting the plan have been strengthened and there is closer monitoring and challenge in relation to performance, finance and monitoring scheme outcomes. A performance indicator guide has also been produced which defines each indicator and how it is measured enable better communication and challenge.

3.1.3 We continue to improve the monitoring of scheme outcomes. However, all other audit recommendations and actions have now been completed.

3.2 Current performance against key performance indicators and scheme outcomes

3.2.1 The following section is a summary of BCF performance and outcomes of some of the commissioned schemes. Please find attached as appendix 1, the current BCF performance dashboard and Appendix 2 for a copy of the BCF indicator guide – definitions of the performance indicators and how they are measured

3.2.2 **Diagnosis of dementia** - performance is above the target of 66.7%. Additional consultant capacity commissioned in 2016/17 and improvement in the diagnostic imaging pathway are having a positive impact on waiting times.

3.2.3 **Non-elective admissions (NEAs**) - this is a significant area of challenge as admissions continue to be above the BCF and CCG Operational Plan targets. Activity in progress to improve performance includes:

- A number of Integrated Care schemes have been rolled out and extended from the 65+ to the 50+ age group.
- Work is underway to assess the effectiveness of the Integrated Care schemes on admission avoidance of affected (50+ yrs) cohort.
- Actions are also being taken to improve performance including increasing the utilisation of the Ambulatory Emergency Care service and expanding the A&E front end triage service to include paediatrics to reduce pressures in A&E department.
- The GP see & direct service has implemented a new model since the end of August and has seen both CCG and Trust GPs working together more closely. All patients are seen within 15 minutes of arrival and streamed into the appropriate Emergency Department queue. The model is working well and has the support of the Trust clinicians.
- The Trust has recently received permission to increase number of Pediatric consultants.

- The Ambulatory Emergency Care service – the Trust is aiming to increase this from 30 patients a day to 40, and aiming for 60 patients a day by year end.

Please also see section 5 finance position.

3.2.4 **Delayed transfer of care (DTOCs)** – this continues to present challenge and the September actual is 3668 days compared to target of 2759 and 10 patients compared to target of 5. Activity in progress to improve performance includes:

- A programme of work underway at two main acute providers to improve discharge processes including streamlining Continuing Health Care (CHC) process, implementation of the Discharge to Assess model and delivery of the nationally recognised Multi Agency Discharge events
- Additional nursing home capacity being secured in the borough.
- Demand and capacity modelling being undertaken at the mental health trust to gain better understanding of issues.
- Improvements are expected from quarter 4, 2016/17

3.2.5 **Admissions to residential care –** the annual target has been set at 419 and at the end of quarter 2 the actual is 268 (64% of annual total). Admissions to supported permanent Residential & Nursing Care (65+) has increased significantly for the period April to September - from 85 in 2015/16 to 115 in 2016/17.

3.2.6 **Re-ablement**

The target for 2016/17 is 88.2% and current performance is 82.25% (as at September).

315 of the 383 clients who were discharged from hospital and received enablement achieved independence. Of the remaining 68, 19 are deceased and 49 are either in hospital or residential care.

3.2.7 COMMISSIONED SCHEMES AND OUTCOMES ACHIEVED DURING QUARTER 1AND QUARTER 2 (APRIL – OCTOBER 2016)

3.2.8 **Quality checker programme** – the key objectives of this programme are:

- to gather feedback from service users on the quality and appropriateness of the services received
- to use this feedback to improve the quality of services and to identify improvements that can be made

Outcomes achieved include:

- sign posts to specialist information, advice and training available
- the provision of a self-audit tool to enable providers to measure their own ability to provide LGBT specific services
- reviews of hydration strategies and procedures have been undertaken at 20 care homes, including customer satisfaction with food and drinks available to support hydration. Findings have been included in a report that has been

presented to the multi-disciplinary working group leading on improvements on hydration in care homes. A toolkit has also been developed as an aid to prevent dehydration amongst residents

- recommendations for service improvements based on feedback from a mystery Shopping exercise have been documented. Details will be available for the next quarter after the report has been presented to the Safeguarding Adults Board
- advice and information has been provided to five minority groups to raise awareness of the Safeguarding reporting systems and to increase the levels of reports of abuse from under-represented groups
- monthly drop in sessions have been setup to help service users set up Enfield Connected accounts

3.2.9 **Advocacy** – the key objective of this scheme is supporting independent advocacy for adults who would otherwise have difficulty accessing and/or using the care and support provision

Outcomes achieved include:
Advocacy provided to 144 individuals during needs assessments, reviews, support planning and safeguarding investigations.
This can be broken down as follows:

- Information & Advice 8
- Assessment 30
- Care Review (IMCA) 1
- Housing and Accommodation 1
- Review 22
- Support Planning 31
- Safeguarding Support 23
- Safeguarding Vulnerable Adults (IMCA) 1

3.3.0 **Safeguarding –** the key objective of this scheme is the commissioning of Safeguarding Adults Reviews (SARs) to improve services and, the development and implementation of action plans (project managed by the SAB Co-ordinator) resulting from the SARs.
Outcomes achieved include:
The commissioning of 4 SARs and reports on two of these will be presented to the Safeguarding Adults Board (SAB) in December for review and sign off.
The results and any service improvements will be reported next quarter after sign off by the SAB.

3.3.1 **Disabled Facilities Grant (DFG)** – the key objective of grant is to provide appropriate aids and adaptations in a person's home to support the following the outcomes:

- To reduce the risk of hospitalisation due to falls or other injury
- To facilitate hospital discharge
- To prevent or delay the need for residential or nursing care

These outcomes have been achieved via:

- 116 grant applications approved in Q1 and Q2 (55 and 61 respectively)

- 70 grants adaptations completed in Q1 and Q2 (19 and 60 respectively)

3.3.2 **Wheelchair service** – the key objective of this service is to provide wheelchairs that are appropriate to a user's needs. This includes:

- Clinical assessment to consider physical, postural, social and environmental needs
- Provision of a wheelchair and equipment tailored to meet the assessed mobility needs
- Full instruction and handover on the use, care, basic safety and maintenance of the equipment
- Access to an Approved Repairer who provide a repair, delivery, modification, planned maintenance and collection service.
- Reassessment and review at the individuals request.

Outcomes achieved include:

- 480 new and re-referrals received from 1.5.16 to date
- 340 total wheelchairs issued (across range of equipment)
- Adjustments and modifications made to current equipment
- All referrals seen with the 13 week timeframe specified (average to date 3-4 weeks from referral to clinic appointment
- Transit wheelchair requests triaged and equipment provided typically within 2 weeks

3.3.3 **Integrated Care Programme –** in order to monitor the development of the integrated care programme, the CCG has developed an integrated care performance scorecard for initiatives in 2016/17. The scorecard provides some 38 indicators across the 8 integrated care programme workstreams. This scorecard is being used to inform the key outcomes/ and measurable indicators aligned to the 8 workstreams. This includes:

- Integrated Care Team:
  - understanding the number of patients avoiding a hospital admission due to the development of integrated care delivered in the community by the District Nurse
  - Identifying patients admitted to hospital whilst receiving care by the Community Matron
  - Patient feedback in relation to receiving care that ensures their dignity is respected, that they are engaged in their care planning and supported to manage their own health,
- Friends and Family Test
- Care Home Assessment Team – number of patients attending A&E following a fall and number of A&E attendances per registered care home
- Dementia care in partnership with Age UK - to support patients and their carers accessing the community navigator,
- Community Crisis Response Team – number of patients seen within 2 hours of their referral being received by the team and the percentage of patients who would have otherwise attended hospital,

- Use of assisted technology – number of patients with long term conditions including COPD, and Heart Failure who are being monitored using Telehealth equipment

The associated indicators are monitored on a monthly/ quarterly basis and will provide further information that demonstrates the outcomes being delivered by the integrated care programme. Further detail will be presented at the next Health and Wellbeing Board.

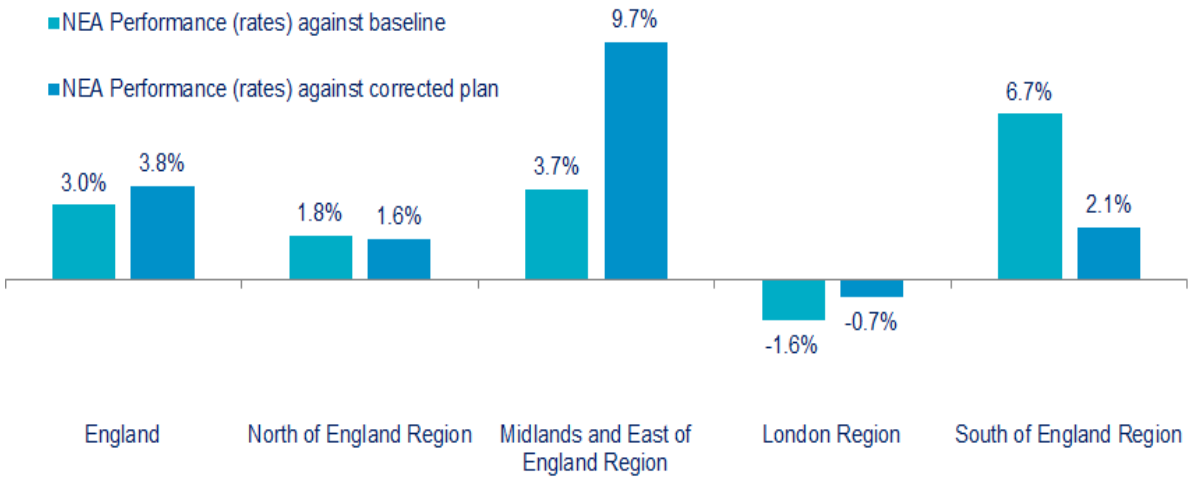
These indicators are also being used to inform a review of other schemes funded in the BCF scheme 2016/17 in order to inform the development of schemes in 2017/18-2018/19, informed by the NHS England BCF planning guidance.

4.0 NHS England Q1 Data Collection and Performance report for all HWB areas

The NHSE quarter 1 (April to June 2016) regional Data and Performance report is due for publication. Headlines were shared at a recent regional BCF event and are as follows:

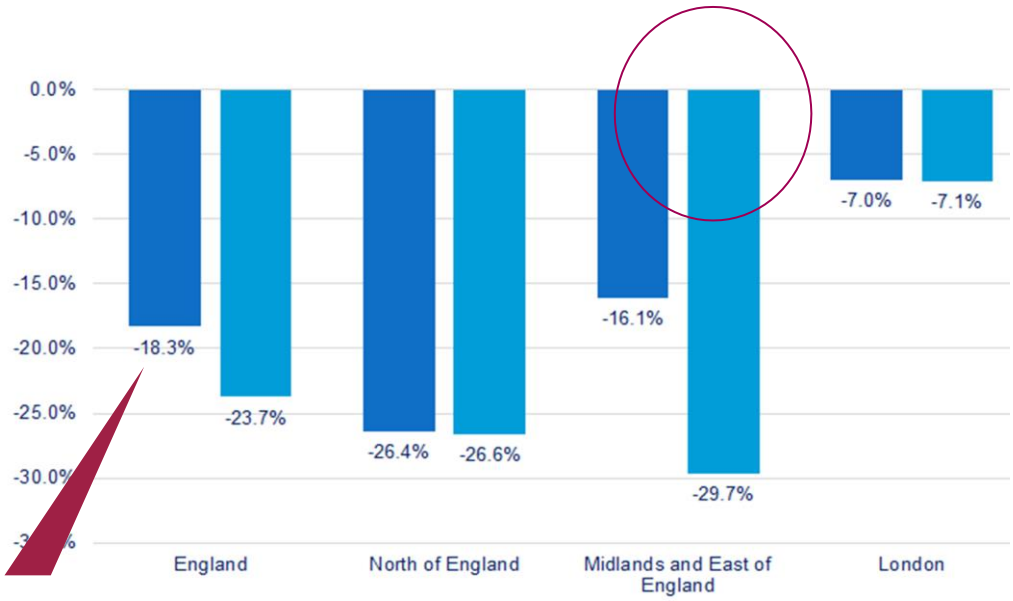
Quarter 1 NEA performance

- NEAs showed a reduction in London and in Q1 were 0.7% lower than planned
- Nationally NEAs were 3.8% higher than planned



Quarter 1 DTOC Performance

- 13 out of 33 HWBs reported an improvement on plan activity
- The City of London and Harrow were the furthest from planned performance with increases of 53% and 114.7% respectively
- The largest reductions against plan were in Havering (52.7%) and Barking and Dagenham (43%)
- London's were 7.1% higher than planned, compared to 23.7% for England



Other national conditions

The lowest compliance related to the following 2 national conditions:

- 7 day support for discharge from hospital. In Q4 2015/16, 32 HWB areas stated that they had 7 day services to support discharge and in Q1 this fell to 23
- NHS number as the prime identifier. In Q4 2015/16, 29 HWB areas stated that the NHS number was the prime identifier and in Q1 this fell to 26.

HWB areas provided the following comments on DTOC challenges:

Placements

Identifying appropriate placements has been a challenge in both health and social care - In particular, nursing home placements (social care) and neuro-rehabilitation and stroke beds (health). A range of actions are in place in different HWB areas including market development and overseeing quality.

Data quality

A number of HWBs raised data quality as an issue and have measures in place to address this.

Pathway

The need for pathway development was raised in some areas and actions are in place linked to A&E delivery plans.

Mental Health delays

Delays in mental health discharges account for a large proportion of delays in a number of HWBs and detailed work is underway to better understand and address this.

Patient and family choice

Patient and family choice is another area of challenge, which is being picked up by improved patient choice policies and other initiatives.

HWB areas provided the following comments on NEA challenges:

Short admissions

A number of HWBs have flagged an increase in the number of very brief admissions, which is being addressed

Increased A&E conversion rates

This has also been flagged in a number of areas, with follow-up actions in place to understand this and address it.

I**ncreased admissions for younger adults**

This was raised in one HWB area and as a result some condition specific work (e.g. in relation to sickle cell anaemia) is being undertaken.

5.0 A summary of the BCF financial position as at end of quarter 2 (April to October)

5.1 As at the end of quarter 2, the CCG's has spent the fund as per plan and the year end forecast is to breakeven. This includes identifying a £0.159m savings requirement (as agreed by the HWB) as at the end of quarter 2 small slippages against budget of £41k have been identified, across a small number of schemes. The CCG fully expects to meet the full savings target by the end of the year. The CCG includes spend relating to mental health and community services with Barnet, Enfield & Haringey MHT as well as the existing costs of the Integrated Care work stream.

5.2 Of the fund, the Annual LBE BCF commissioning budget is £12.061m (£2.540m capital and £9.521m revenue). As at the end of Q2 2016/17 the Council has spent £5.099m and we are currently forecasting to spend £11.976m as at the 31st March 2017. We are reporting a £0.085m underspend with which we will put towards the targeted £0.159m savings required. Work is on-going throughout 2016/17 to achieve the remained of the £0.159m by the end of the financial year.

5.3 Local risk sharing agreement – Emergency Admissions/Non-Elective Admissions (NEA's) reduction targets were consistently not met in 2015-16 and therefore a risk share arrangement was entered into for 2016-17. This agreement was entered into on the basis that if the planned levels of activity were achieved and, as such, value is delivered to the NHS in that way, then this funding would be released to be spent as agreed by the HWB.

Current indications are that the targets will not be met in this financial year.

6.0. The 2017-19 BCF plan.

The BCF plan will cover 2 years from April 2017. The publication of the policy framework and planning process and confirmation of timescales for the production of the 2017/19 BCF plan is imminent. A verbal update will be given at the HWB, in the meantime NHS England has advised the following expected timeline:

November 2016 - policy framework to set out the national conditions and assurance process

End of November - intention to publish the planning guidance shortly after the policy framework

March 2017 - Complete assurance by March, where possible.

Key Changes (not yet confirmed by ministers) are:

- **The BCF plan -** it will be a broader document and will cover not just the BCF but wider integration
- **National Conditions –** the aim is to reduce the number of national conditions
- **BCF Graduation –** suggestions around a small number of areas (6-10) can graduate from the BCF. Graduation was proposed at the 2015 Spending Review and will be based on progress towards health and social care integration and may result in the removal of the requirement to report nationally on the BCF.
- **Integration 2020** - given all the work that has happened for Sustainability and Transformation Plans a separate plan is not proposed. BCF Plan 2017-19 to include setting out their vision for how they will continue towards ever closer integration by 2020.

8. Health and Social Care integration

8.1 The following section highlights some of the positive work that is taking place in the borough to integrate health and social care services, in particular the Integrated Locality Teams. It also provides an update on integration plans at a strategic level.

8.2 **Integrated Locality Teams (ILTs) -** Phase I of the development of the ILTs brought together a number of key services as a “virtual team” around GPs to manage cases of older people 65+ with frailty. Cases were identified using a risk stratification tool. This was reviewed and early indications are that this approach was successful in managing more complex cases of older people at risk of hospitalisation. The model was extended in 15/16 to frail over 50’s.

8.3 Phase 2 developments commenced with workshops to review where we are now and explore the further development of Integration within Enfield Primary and Community Care services. The plan is to extend the model to include Adults and Young People in Transition from Children’s Services, increase the scope to integrate more services across adult social care and community health and develop a single point of access. A joint integration manager of the services in scope has been appointed.

8.4 A ‘Marketplace’ event is being held in November and the focus is on: the extension of Integrated Locality Teams, how these could work better with key services to deliver integrated pathways and improved outcomes for individuals, enabling officers to

network and meet key colleagues and partners and to continue to help shape the phase 2 action plan.

Integration plans

The submission of the North Central London (NCL) Sustainability and Transformation Plans (STP's) is on December 23rd. In addition, and as reported in the September HWB BCF update, two key documents have now been published (on behalf of the LGA, NHS Confederation and ADASS) that will help inform the future development of integration:

- Stepping up to the place: the key to successful health and social care integration. This includes a shared vision, what has been learnt about successful integration and issues for local and national leaders
- Stepping up to the place: an Integration self-assessment tool.

Link to the documents: http://www.nhsconfed.org/resources/2016/06/stepping-up-to-the-place-the-key

Although indications suggest that the production of a strategic plan will not be a requirement of the BCF planning, it is essential that as a local area we are able to describe what integration looks like in Enfield and the longer term vision, within the context of the STP. As previously discussed at HWB, work continues on the development of a local plan to support Health and Social Care Integration; however this will be developed further once the STP and leaders across health and social care are in a position to set the future direction at local level.

In view of this, time has been requested at the March HWB development session to discuss local integration plans.

End of Report.

Better Care: Current Period Data

Report Author: Sam Buckley

Generated on: 29 November 2016

1. Non-Elective admissions (general and acute)

Indicator		Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Latest Note
Number of Admissions - Secondary Uses Service (SUS)	ACTUAL	2,589	2,367	2,569	2,480	2,367	2,477	2,176	2,309	2,257	2,448	2,315	2,346	Admissions continue to be above BCF and CCG Op. Plan. Reasons include Paediatric over-performance, operational pressures at A&E departments, AEC and GP See & Direct / Treat at North Middx. not operating at full capacity.
	TARGET													
Target Number of Admissions (CCG Op Plan)	ACTUAL							2,146	2,218	2,146	2,218	2,218	2,146	September Op Plan re-submission.
	TARGET													
Target Number of Admissions (CCG Op Plan-BCF reduction)	ACTUAL							2,085	2,156	2,083	2,156	2,157	2,085	
	TARGET													
Variance from Better Care Fund Plan	ACTUAL							91	153	174	292	158	261	A number of Integrated Care schemes have been rolled out and extented from 65+ to 50+ age group. Work underway to assess effectiveness of BCF (Integrated Care) schemes on admission avoidance of affected (50+ yrs) cohort. Actions being taken to improve performance include increasing utlisation of the Ambulatory Emergency Care service, expanding the A&E front end triage service to include paediatrics to reduce pressures in A&E department. (Added Nov 2016)
	TARGET							0	0	0	0	0	0	

2. Residential Admissions

Indicator	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Latest Note
New Admissions to Residential and Nursing Care (65+) per 100,000 population over 65	231.8	269.2	319.1	331.6	388.9	413.8	55.9	97.8	156.0	200.3	249.2	267.8	Annual target has been set at 419 & at end of Q2 actual is 268 (64% of annual total) Admissions to supported permanent Residential & Nursing Care (65+) has increased significantly for the period April to September - from 85 in 2015/16 to 115 in 2016/17. Further work and analysis will need to be undertaken to look at the journey of clients before they are admitted to Residential and Nursing Care to understand whether any further preventative work would have been beneficial.
	283.9	324.5	365.0	405.5	446.1	486.6	35.0	70.0	105.0	140.0	175.0	210.0	

Indicator		Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Latest Note
Number of admissions to supported permanent Residential and Nursing Care (65+)	ACTUAL	93	108	128	133	156	166	24	42	67	86	107	115	
Enfield Population 65+	ACTUAL	40,113	40,113	40,113	40,113	40,113	40,113	42,946	42,946	42,946	42,946	42,946	42,946	

3. Reablement

Indicator		Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Latest Note
Achieving independence for older people through rehabilitation/ intermediate care		82.74%	81.42%	81.49%	80.21%	80.29%	79.03%	90.57%	87.97%	85.78%	83.40%	82.65%	82.25%	The target for 2016/17 is 88.2% & current performance is 82.25%. 315 of the 383 clients who were discharged from hospital & received Enablement achieved independence. Of the remaining 68 - 19 are deceased & 49 either in hospital or residential. In future reports a detailed analysis of the reasons why clients who were discharged from hospital and did not achieve independence will be provided to inform operational decisions.
		88.00%	88.00%	88.00%	88.00%	88.00%	88.00%	88.20%	88.20%	88.20%	88.20%	88.20%	88.20%	
Number of clients living independently 3 months after ICT service	ACTUAL	417	460	493	539	599	633	96	139	181	221	281	315	
Number of clients discharged from hospital with ICT	ACTUAL	504	565	605	672	746	801	106	158	211	265	340	383	

4. Delayed Transfers of Care

Indicator		Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Latest Note
Delayed transfers of care (days)	ACTUAL	3592	4136	4528	5013	5401	5819	474	968	1670	2224	2852	3668	Further Work around Delayed Transfers of Care will be conducted by operational groups featuring Enfield Council and CCG representatives.
	TARGET	2664	3044	3425	3805	4186	4566	459.6	919.8	1379	1839	2299	2759	
Delayed Transfer of Care - Days Delayed (SOCIAL CARE Delays)		692	913	1,082	1,194	1,342	1,588	111	234	304	351	455	801	Cumulative delays attributable to Social Care at April to Sep16: **801 days** **Reasons for delay in 2016/17:** *(month increase in brackets)* Care Package in Own Home: 239 days *(+147)* Completion of Assessment: 203 days *(+58)* Awaiting Rsdntial Care Placemt: 194 days (*+58)* Public Funding: 81 days *(+6)* Awaiting Nursing Home Pl'mt:40 days *(+33)* Disputes 30 (+30) Equipment/Adaptations: 14 *(+14)*

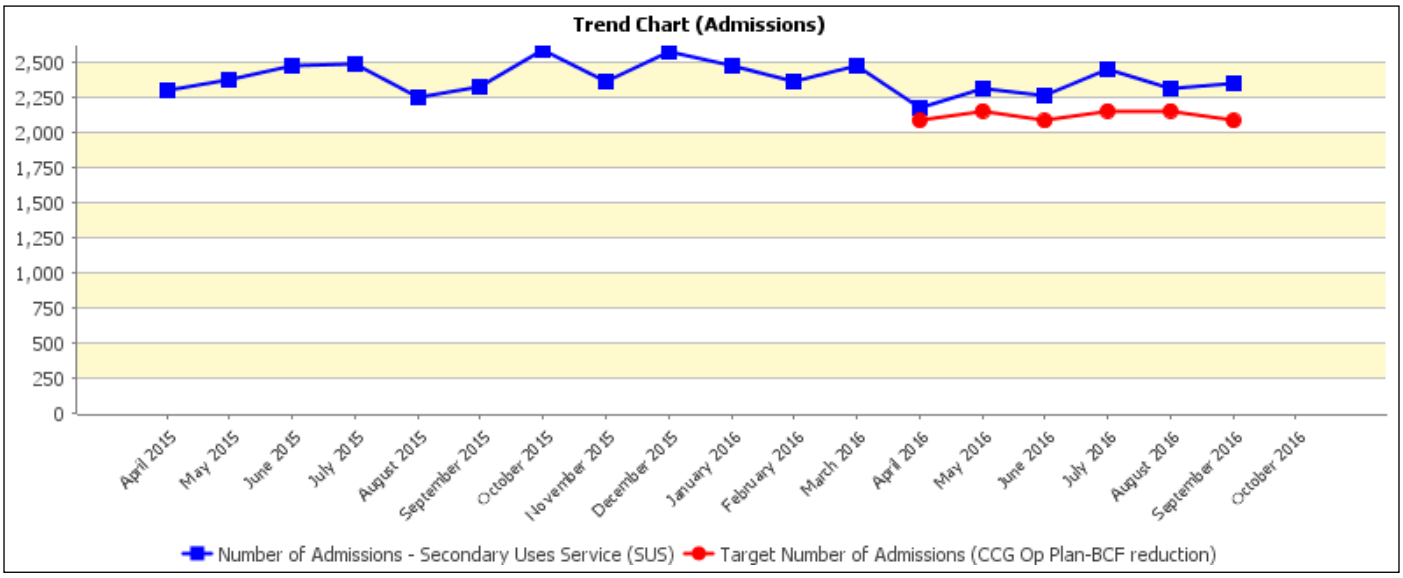
Indicator		Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Latest Note
Delayed Transfer of Care - Days Delayed (HEALTH Delays)		2,600	2,918	3,109	3,417	3,657	3,829	333	661	1,215	1,634	2,106	2,546	Cumulative delays attributable to Health: April to Sept 2016: **2,546 days** (Snapshot **Sept: 440 days)** **Main Reasons for delay in 2016/17:** Further non-acute NHS care: 868 days Patient or family choice: 788 days Awaiting Nursing Home Placemt: 210 days Disputes: 190 days Community Eqpmnt/ Adaptns: 142 days Completion of assessment: 129 days
Delayed Transfer of Care - Days Delayed (JOINT SOCIAL CARE & HEALTH Delays)		300	305	337	402	402	402	30	73	151	239	291	321	Cumulative delays attributable jointly to Social Care and Health: April to Sept 2016: **321 days** (Snapshot Sept: **30 days)** **Reasons for delay in 2016/17:** Public Funding: 186 days Completion of Assessment: 135 days
Average of all delayed transfers (patients)		22	21.8	21.1	20.6	20.5	20.6	23	22.5	24.3	25	25.2	26.3	
Delayed transfers of care (patients) per 100,000 pop	ACTUAL	9.18	9.1	8.81	8.6	8.56	8.6	9.2	9	9.72	10	10.08	10.52	Demand and capacity modelling being undertaken at mental health trust to gain better understanding of issues. Programme of work underway at two main acute providers to improve discharge processes including streamlining CHC process, implementation of Discharge to Assess model and delivery of the nationally recognised Multi Agency Discharge Events.
	TARGET	5	5	5	5	5	5	5	5	5	5	5	5	
Population 18+	ACTUAL	239,600	239,600	239,600	239,600	239,600	239,600	250,093	250,093	250,093	250,093	250,093	250,093	

5. Dementia Diagnosis

Indicator		Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Latest Note
Dementia Diagnosis Rate	ACTUAL	67.60%	68.00%	67.60%	67.90%	67.20%	67.50%	66.70%	66.55%	66.48%	67.25%	67.77%	68.22%	Performance remains above the national average. Data estimated for 1 GP practice.
	TARGET	60.10%	60.10%	60.10%	60.10%	60.10%	60.10%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	Performance in Q2 has been above the target 66.7%. Additional consultant capacity commissioned in 2016/17 and improvement in the diagnostic imaging pathway are having a positive impact on waiting times. HWB expects improvements to be sustained over the next two quarters.

Better Care: Number of Admissions

Generated on: 29 November 2016

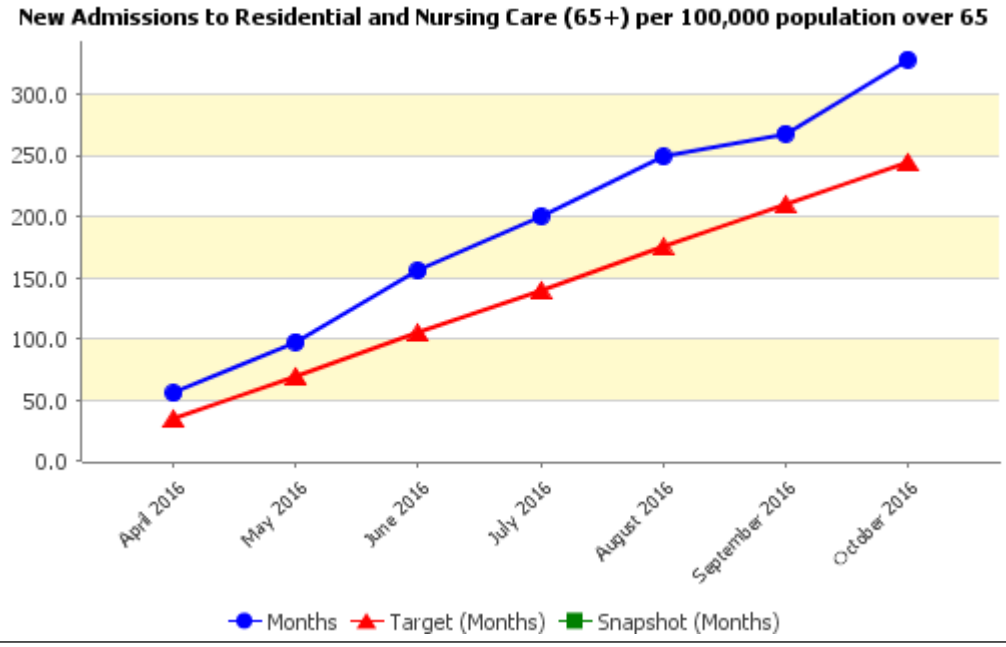


Secondary Uses Service	Target Number of Admissions
Value	
June 2015	2,481	
July 2015	2,491	
August 2015	2,253	
September 2015	2,327	
October 2015	2,589	
November 2015	2,367	
December 2015	2,569	
January 2016	2,480	
February 2016	2,367	
March 2016	2,477	
April 2016	2,176	2,085
May 2016	2,309	2,156
June 2016	2,257	2,083
July 2016	2,448	2,156
August 2016	2,315	2,157
September 2016	2,346	2,085
October 2016		

Notes
Admissions continue to be above BCF and CCG Op. Plan. Reasons include Paediatric over-performance, operational pressures at A&E departments, AEC and GP See & Direct / Treat at North Middx. not operating at full capacity.

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

Generated on: 29 November 2016



Report Date Ranges

	2015-16	
	Value	Target
April 2015	47.4	40.6
May 2015	74.8	81.1
June 2015	104.7	121.7
July 2015	159.5	162.2
August 2015	184.5	202.8
September 2015	211.9	243.0
October 2015	231.8	283.9
November 2015	269.2	324.5
December 2015	319.1	365.0
January 2016	331.6	405.5
February 2016	388.9	446.1
March 2016	413.8	486.6
April 2016	55.9	35.0
May 2016	97.8	70.0
June 2016	156.0	105.0
July 2016	200.3	140.0
August 2016	249.2	175.0
September 2016	267.8	210.0

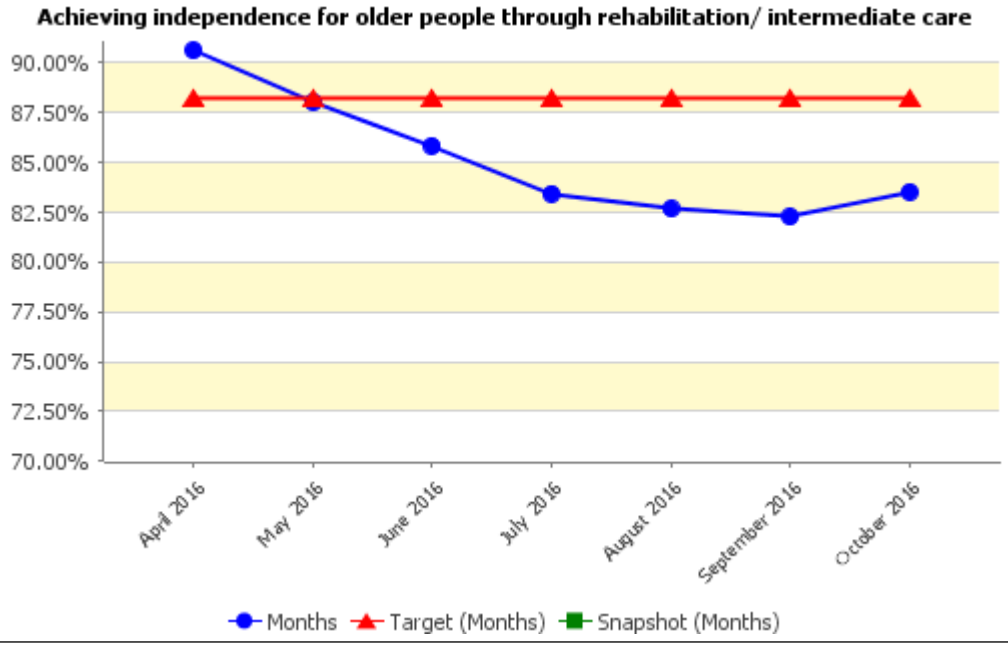
Notes

Annual target has been set at 419 & at end of Q2 actual is 268 (64% of annual total) Admissions to supported permanent Residential & Nursing Care (65+) has increased significantly for the period April to September - from 85 in 2015/16 to 115 in 2016/17.

Further work and analysis will need to be undertaken to look at the journey of clients before they are admitted to Residential and Nursing Care to understand whether any further preventative work would have been beneficial.

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

Generated on: 29 November 2016



Report Date Ranges

	2014-15	
	Value	Target
April 2015	83.95%	88.00%
May 2015	80.25%	88.00%
June 2015	81.61%	88.00%
July 2015	83.00%	88.00%
August 2015	82.69%	88.00%
September 2015	82.71%	88.00%
October 2015	82.74%	88.00%
November 2015	81.42%	88.00%
December 2015	81.49%	88.00%
January 2016	80.21%	88.00%
February 2016	80.29%	88.00%
March 2016	79.03%	88.00%
April 2016	90.57%	88.20%
May 2016	87.97%	88.20%
June 2016	85.78%	88.20%
July 2016	83.40%	88.20%
August 2016	82.65%	88.20%
September 2016	82.25%	88.20%

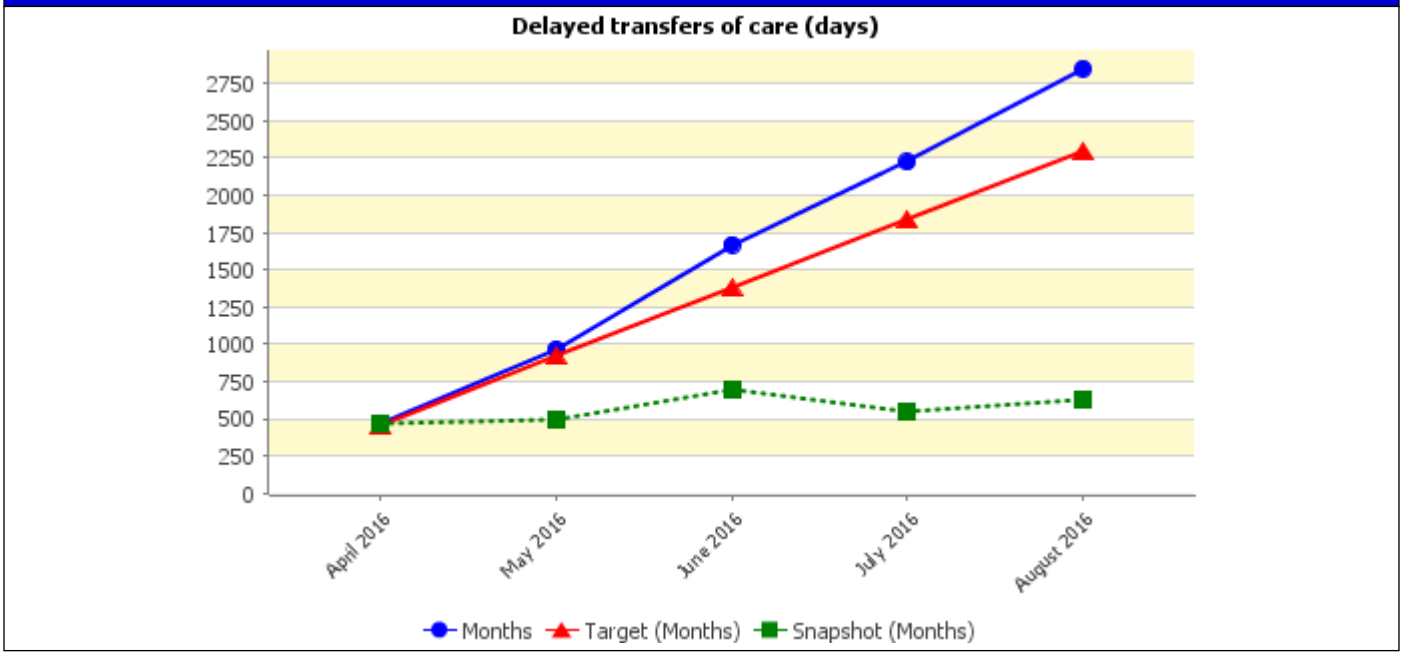
Notes

The target for 2016/17 is 88.2% & current performance is 82.25%. 315 of the 383 clients who were discharged from hospital & received Enablement achieved independence. Of the remaining 68 - 19 are deceased & 49 either in hospital or residential.

In future reports a detailed analysis of the reasons why clients who were discharged from hospital and did not achieve independence will be provided to inform operational decisions.

Better Care: Delayed Transfer of Care

Generated on: 29 November 2016



Report Date Ranges

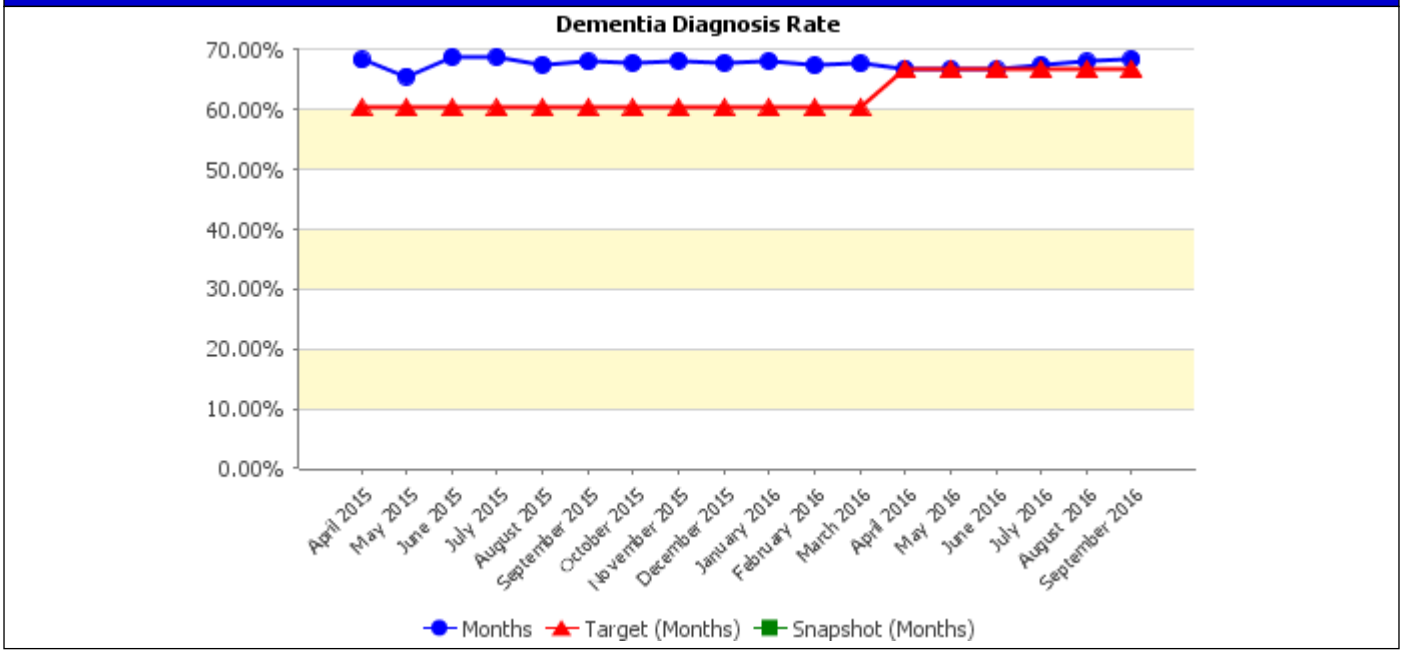
	2014-15	
	Value	Target
April 2015	351	381
May 2015	769	761
June 2015	1267	1142
July 2015	1780	1522
August 2015	2403	1903
September 2015	2918	2283
October 2015	3592	2664
November 2015	4136	3044
December 2015	4528	3425
January 2016	5013	3805
February 2016	5401	4186
March 2016	5819	4566
April 2016	474	459.6
May 2016	968	919.8
June 2016	1670	1379
July 2016	2224	1839
August 2016	2852	2299

Notes

Further Work around Delayed Transfers of Care will be conducted by operational groups featuring Enfield Council and CCG representatives.

Better Care: Dementia Diagnoses

Generated on: 29 November 2016



Report Date Ranges

	2014-15	
	Value	Target
April 2015	68.10%	60.10%
May 2015	65.40%	60.10%
June 2015	68.60%	60.10%
July 2015	68.60%	60.10%
August 2015	67.30%	60.10%
September 2015	67.80%	60.10%
October 2015	67.60%	60.10%
November 2015	68.00%	60.10%
December 2015	67.60%	60.10%
January 2016	67.90%	60.10%
February 2016	67.20%	60.10%
March 2016	67.50%	60.10%
April 2016	66.70%	66.70%
May 2016	66.55%	66.70%
June 2016	66.48%	66.70%
July 2016	67.25%	66.70%
August 2016	67.77%	66.70%
September 2016	68.22%	66.70%

Notes

Performance remains above the national average. Data estimated for 1 GP practice.

Performance in Q2 has been above the target 66.7%. Additional consultant capacity commissioned in 2016/17 and improvement in the diagnostic imaging pathway are having a positive impact on waiting times. HWB expects improvements to be sustained over the next two quarters.

Better Care: Survey Data

Generated on: 29 November 2016

Short Name	Source	Frequency	2013/14	2014/15	2015/16	2016/17	Comments
			Value	Value	Value		
Carers Survey: Proportion of carers who find it easy to find information about services	Carers Survey - Indicator 3D2 http://ascof.hscic.gov.uk/Outcome/723/3D(2)	Every 2 years		61.7%		To Be Completed in the Autumn 2016	
Adult Social Care Users Survey: Proportion of people who use services who find it easy to find information about services	Adult Social Care Survey - Indicator 3D1 http://ascof.hscic.gov.uk/Outcome/1001/3D(1)	Annual	74.4%	73.2%	73.8%	To Be Completed in the Spring 2017	
GP Patient Survey: Last 6 months, enough support from local services/organisations to help manage long-term conditions	GP Patient Survey https://indicators.hscic.gov.uk/webview/ Domain 2, Indicator 2.2	Formerly twice yearly survey; but now annual. Annual publication by HSCIC	56.7%	58.8%	57.2%	Published Sep. 2017 by HSCIC	"Performance has fallen in 2015/16, and is now the 14th lowest in England (out of 209 CCGs)"
OPAU – Did you not have to repeat your clinical history to different members of staff?	OPAU	Annual	43.0%	65.0%	75.0%	Avaliable in April 2017	
Overall BCF Target	Improvement in 3 Surveys (Based on Improvement from previous Survey)						

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Better Care - Indicator Guidance

Report Author: admin_Richard Pain

Generated on: 22 November 2016

Code & Short Name	Guidance	How To Measure
HWB004 Dementia Diagnosis Rate	**Rationale:** A timely diagnosis enables people living with dementia, and their carers/families to access treatment, care and support, and to plan in advance in order to cope with the impact of the disease. A timely diagnosis enables primary and secondary health and care services to anticipate needs, and working together with people living with dementia, plan and deliver personalised care plans and integrated services, thereby improving outcomes. **Detailed Descriptor:** Diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence. **Numerator:** Number of people aged 65 or over diagnosed with dementia. **Denominator:** Estimated prevalence of dementia.	**Numerator:** Number of people, aged 65 and over, with a diagnosis of dementia recorded in primary care as counted within the Quality and Outcomes Framework (QOF) dementia registers. *This figure is published annually by the Health and Social Care Information Centre as the QOF DEM1 indicator and monthly in the Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses. The end of year assessment will be against the annual DEM1 value.* **Denominator:** Estimated prevalence of dementia in people aged 65 or over in the local population. The estimated prevalence for the CCG as calculated from the ONS population estimates multiplied by dementia prevalence rates from the second cohort Cognitive Function and Ageing Study (CFAS II): **Estimated dementia prevalence rates (CFAS II)** Females: 65-69 = 1.8% 70-74 = 2.5% 75-79 = 6.2% 80-84 = 9.5% 84-89 = 18.1% 90+ = 35% Males: 65-69 = 1.2% 70-74 = 3.0% 75-79 = 5.2% 80-84 = 10.6% 84-89 = 12.8% 90+ = 17.1% The prevalence estimate for a CCG will be the sum of prevalence estimates in the 12 age and gender specific groups given in the table. The same six age groups are used for each gender and are 5 year age bands from age 65 to 89 and one an age group, per gender, for people aged 90 and above. The prevalence estimate for an age and gender specific group is calculated by multiplying the prevalence rate given in the table by the matching age and gender specific population count for the CCG. The population used in the final assessment will be the ONS mid-year population estimate for 2016. Before this is published, in-year monitoring will be against the ONS 2016 Subnational Population Projections for CCGs in England from the latest base available.

Code & Short Name	Guidance	How To Measure
HWB010 Number of Admissions	**Rationale:** Where clinically appropriate, it is better for patients to be treated or continue their treatment at home or in their community rather than in hospital. The local NHS should be looking to treat patients in the most clinically appropriate way. **Lines Within Indicator (Units):** Number of specific acute non-elective spells in the period. **Data Definition:** A Non-Elective Admission is one that has not been arranged in advance. It may be an emergency admission, a maternity admission or a transfer from a Hospital Bed in another Health Care Provider. Secondary Uses Service (SUS) Standard Extract Mart ('SEM') data from the temporary National Repository ('tNR'). The SUS SEM data is extracted monthly from the Health and Social Care Information Centre (HSCIC) data warehouse by the Greater East Midlands Commissioning Support Unit (GEM CSU), and processed to produce the tNR. This is then made available to our local CSU and analysts. ***In simple terms, "specific acute" admissions means those excluding maternity and mental health patients.***	X **Better Care Fund Plan for Non-Elective Admissions** The number of CCG-planned specific acute NEAs per month, less the reduction planned by the BCF. Y**Actual number of Non-Elective Admissions** The number of specific acute NEAs per month, from the SUS (SEM) data repository. Z **Variance from Better Care Fund Plan** The difference between the above two measures (Y-X). A positive number indicates more admissions than planned.
NI125 Achieving independence for older people through rehabilitation/ intermediate care	**Definition** The proportion of older people discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital. Those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months are not reported in the numerator. 3 months is defined as 91 days. In 2008/09 the collection of the denominator will be over a three month period with a three month follow-up for the numerator. From 2009/10, the collection of the denominator will be over a six month period, with the collection of the numerator beginning three months in.	**Formula** (x/y) * 100 where: **X** = Number of those people discharged aged 65+ and benefiting from intermediate care/rehabilitation/re-enablement still living at home (including in extra care housing or an adult placement scheme setting) three months after discharge from hospital. (Those temporarily in hospital or in a care home for respite/short term care with a clear plan for their return home at the 3 month point should be counted as being still 'at home'. Those who have died within the three months are not reported in the numerator). This is taken from ASCCAR, table I1, row 1, column 9. **Y** = Number of people discharged from hospital aged 65+ on discharge date entering joint 'intermediate care' or a 'rehabilitation/reenablement service' which includes input from the CASSR and/or health in the period (including those who are in hospital or in a registered care home at the three month date and those who have died within the three months). *This is taken from ASCCAR, table I1, row 2, column 9.*
NI131 Delayed transfers of care (patients) per 100,000 pop	**Definition:** **The average weekly rate of delayed transfers of care from all NHS hospitals, acute and non-acute, per 100,000 population aged 18+.** A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer; and (b) a multi-disciplinary team decision has been made that the patient is ready for transfer; and (c) the patient is safe to discharge/transfer.	**Formula:** (X/Y) * 100,000 where: **X** = The average number of delayed transfers of care (population aged 18+) in a week taken over the year. **Y** = ONS mid-year population estimates for population aged 18+. *Population data has been updated from 2012 based projections to 2014 based projections following the publication of the 2014 based Subnational Population Projections (SNPP)*

Code & Short Name	Guidance	How To Measure
PAF-AO/C72 New Admissions to Residential and Nursing Care (65+) per 100,000 population over 65	**Definition**: This measures the number of admissions of older people to residential and nursing care homes relative to the population size of each group. *The measure compares council records with ONS population estimates.* People counted as a permanent admission should include: • Residents where the local authority makes any contribution to the costs of care, no matter how trivial the amount and irrespective of how the balance of these costs are met; • Supported residents in: o Local authority staffed care homes for residential care; o Independent sector care homes for residential care; and, o Registered care homes for nursing care. o Residential or nursing care which is of a permanent nature and where the intention is that the spell of care should not be ended by a set date. For people classified as permanent residents, the care home would be regarded as their normal place of residence. Where a person who is normally resident in a care home is temporarily absent (e.g. through temporary hospitalisation) and the local authority is still providing financial support for that placement, the person should be included in the numerator. Trial periods in residential or nursing care homes where the intention is that the stay will become permanent should be counted as permanent. Whether a resident or admission is counted as permanent or temporary depends on the intention of the authority making the placement.	(X/Y)*100,000 Where: **X**: Number of council-supported permanent admissions of older people (aged 65 and over) to residential and nursing care during the year (excluding transfers between residential and nursing care) *Source: Table S3, ASC-CAR20* and **Y**: Size of older people population (aged 65 and over) in area *(Population data has been updated from 2012 based projections to 2014 based projections following the publication of the 2014 based Subnational Population Projections (SNPP)* **Exclusions** People funding their own residence in a care home with no support from the council are excluded. **Worked example:** Suppose the number of permanent admissions to residential or nursing care for older people (aged 65 and over) during the year was 312. Suppose the population of older people in the area is 43,384 The indicator value is [((312)/43,384) *100,000] = 719.2 Population data has been updated from 2012 based projections to 2014 based projections following the publication of the 2014 based Subnational Population Projections (SNPP)
HWB020 Carers Survey: Proportion of carers who find it easy to find information about services	**CARER SURVEY:** Authorities are required to conduct a **biennial postal survey** of their carers. The Personal Social Services Survey of Adult Carers in England (SACE) asks questions about quality of life and the impact that the services they receive have on their quality of life. It also collects information about self-reported general health and well-being The sample frame therefore contains all carers aged 18 and over who either received "support direct to carer" or "no direct support to carer", irrespective of whether their cared-for person received respite care.The data collection instrument for most carers will be a self-completion questionnaire. Key dates for the survey are: 1. June to September – councils extract from their records a list of all carers aged 18 or over who would be included in SALT measure LTS003, table 1a. This should include all carers aged 18 and over who either received "support direct to carer" or "no direct support to carer", during the completed 12 month period prior to the extract being taken, irrespective of whether their cared-for person received respite care and just as though the data for SALT measure LTS003 were being generated at this time. 2. October and November – councils distribute the questionnaires to a random sample of carers who are eligible for the survey. 3. December and January – data from the returned questionnaires keyed into the data return file and validated using the data return validator file. 4. Early 2017 - Councils return their data to the Health and Social Care Information Centre.	Question: *"In the last 12 months, have you found it easy or difficult to find information and advice about support, services or benefits? Please include information and advice from different sources, such as voluntary organisations and private agencies as well as Social Services"*. The following answers are possible: I have not tried to find information or advice in the last 12 months Very easy to find Fairly easy to find Fairly difficult to find Very difficult to find Formula: (X/Y)*100 Where: X: The sum of all those who in response to the above question of the Carers Survey, selected the response "very easy to find" and "fairly easy to find". Y: The sum of all those that responded to the above question of the Carers Survey.

Code & Short Name	Guidance	How To Measure
HWB021 Adult Social Care Users Survey: Proportion of people who use services who find it easy to find information about services	**Adult Social Care Survey:** This survey covers those individuals who were in receipt of a local authority-funded long-term support service, as defined in the Equalities and Classifications Framework for adult social care (EQ-CL)2 on an extract date chosen by the local authority (i.e. the date on which these data are extracted from local authority information systems	The question from the Adult Social Care Survey is Question 12: "In the past year, have you generally found it easy or difficult to find information and advice about support, services or benefits?", to which the following answers are possible: Very easy to find Fairly easy to find Fairly difficult to find Very difficult to find I've never tried to find information or advice This portion of the measure is defined by determining the percentage of all those responding who select the response "very easy to find" and "fairly easy to find". Formula: (X/Y)*100 Where: X: In response to Question 12 of the ASCS, those individuals who selected the response "very easy to find" and "fairly easy to find". Y: All those that responded to the question.
HWB022 GP Patient Survey: Last 6 months, enough support from local services/organisations to help manage long-term conditions	**GP Patient Survey:** Data is collected in two waves, from July to September and January to March. Data is published annually, and is usually available three to four months after the financial year end Patients are eligible for the survey if they meet the following inclusion criteria: they have a valid NHS number, they have been registered with a GP in England continuously for six months or longer before the questionnaire is received, and they are at least 18 years old six months before the questionnaire is received. Additionally to reduce survey fatigue, patients are not to receive more than one GP Patient Survey in any 12-month period. The questionnaire records people's views on whether they feel supported from local services or organisations in managing their conditions in question 32; *In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health services.*	In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health services The possible responses to the question are: Yes, definitely Yes, to some extent No I have not needed such support Don't know/can't say Calculation <u>Numerator:</u> The weighted count of respondents who answer 'Yes, definitely' OR 'Yes, to some extent' to question 32 <u>Denominator</u> The weighted count of respondents who answer 'Yes, definitely' OR 'Yes, to some extent' OR 'No' to question 32 of the GP Patient Survey.:

Agenda Item 5

MUNICIPAL YEAR 2016/2017

Meeting Title: **HEALTH & WELLBEING BOARD** Date: 8th December 2016	**Agenda Item: 5** **Subject:** **Developing the North Central London Sustainability & Transformation Plan - Update**
Contact officer: Telephone number: Email address:	**Report written by:** **Stephen Wells, Programme Manager, Strategy & Planning, Enfield Clinical Commissioning Group**

1. EXECUTIVE SUMMARY

North Central London Sustainability & Transformation Plan (STP)

The North Central London Strategic Planning Group (NCL SPG) has continued to develop the Sustainability and Transformation Plan (STP) which was submitted to NHS England on 21st October 2016, following the first submission in June 2016. The STP covers the Five Year Forward View ambitions to 2020/ 21 specifically in three key areas:

- health and wellbeing,
- care and quality,
- finance and efficiency

The NCL STP submission on 21st October 2016, set out :

- A strategy to inform the Five Year Forward View and associated 11 programme workstreams
- Workstream Delivery Plans for 2017/18 - 2020/21 including:
  - Finance and Activity modelling
  - Non-financial impact and Metrics to measure progress
  - Risks and Mitigation steps for each programme area
  - Delivery Plan milestones

The NCL STP strategy paper (see web link (http://nww.enfield.nhs.uk/News/Documents/News%20Attachments/North%20Central%20London%20Sustainability%20and%20Transformation%20plan%20-%20summary.pdf)

provides a high level overview of what the NCL STP submission contains and where we are in the development of the respective programme workstreams. A summary document (see **Appendix A**) has also been published and the NCL STP continues to be developed in accordance with the NHS England Planning and assurance requirements.

The STP has refined the focus of the programme to 11 workstreams as follows:

1. Prevention
   - Workforce for Prevention
   - Healthier environments – workplace wellbeing

- Healthier Choices –Obesity, Smoking, Alcohol, Falls, Sexual Health

2). Health and Care closer to Home
- Service Delivery –CHINs (Care closer to Home Integrated Network)
- Patient education and support
- Reducing unwarranted variation in general practice

3). Mental Health
- Community Resilience
- Primary Care mental health teams
- Acute pathways
- Female PICU
- Mental Health Liaison
- Dementia
- CAMHS and Perinatal mental health

4). Urgent & Emergency Care
- Integrated UEC (NHSv111 and GP Out of Hours)
- Ambulatory Emergency Care units
- Simplified Discharge
- 7-Day Hospital Services
- 7-Day Community Services
- UEC Designation and Urgent Care Centres

5) Elective Care
- Outpatients –Trauma & Orthopaedics) including Muscoskeletal services, Rheumatology, Ophthalmology, General Medicine, Gastroenterology, Endocrinology
- Elective Inpatient care –reduce elective inpatient care informed by RightCare
- Commissioner and Provider interventions

6). Consolidation
- Across 21 services (to inform development of networking or consolidation of services across North Central London providers and commissioners)

7). Cancer
- Cancer Vanguard (early diagnosis, centre for cancer outcomes, new models of care and London Cancer)
- Service Improvements – medicines optimisation, interventions in the last days of life, clinical and biomedical research)

8).Productivity
- Workforce,
- Operational and clinical variation,
- Procurement,
- Back office functions,
- Contract and Transactions costs,
- Other– Cost improvement Plans, Estates and Operating Theatre utilisation

9). Workforce
- Resourcing,
- Learning & Development,

- Integrated Employment Model,
- Enabling development of new models of care and Productivity,

10). Digital

- Digitally activated population
- Analyse – use of information
- Share – integrated care shared record
- Link – integration and messaging
- Digitise- Applications i.e. e-records, prescribing, clinical documentation, diagnostic test orders and results,
- Enable – infrastructure Virtual consultations and Networks

11). Estates

- STP Estates Strategy inc. primary care capital schemes (CHINs)
- Devolution pilot
- Key Worker Housing
- Redevelopment of St Ann's, St Pancras and Moorfields sites

Feedback on the 21st October 2016 submission from NHS England in November 2016, has requested further progress to be made in relation to the development of the NCL Commissioning arrangements as presented to Enfield CCG Governing Body on 9th November 2016. The STP is also required to continue further development of the STP programme delivery plans and submit a further update to NHS England on 23rd December 2016.

Next Steps:
Development of the 5 Year NCL Sustainability & Transformation Plan will be undertaken in accordance with the NHS England (London) assurance process.

The NCL STP Transformation Board will provide oversight to informing the continued development of the NCL STP as follows:

November 2016- December 2016

- to continue the development of the STP delivery plans across the 11 programme workstreams,
- Inform the development of the NCL commissioning arrangements (as agreed by the Enfield CCG Governing Body on 9th November 16),
- Development of the CCG's 2- Year Operational Plan and Better Care Fund Plan (2017/18-2018/19), aligned to the NCL STP programme,

2. RECOMMENDATIONS

The Health & Wellbeing Board is asked to:

Receive the North Central London Sustainability & Transformation Plan update and note the next steps to inform further development of the NCL STP.

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North Central London

Sustainability and Transformation Plan

A summary

North Central London

North Central London

Introduction

Hospitals, local authorities, GPs, commissioners, and mental health trusts across north central London have all come together to transform the care we deliver to our patients.

On a scale never seen before, health and social care services in the region are working on the 'North and Central London (NCL) Sustainability and Transformation Plan (STP)'.

Our work covers the five boroughs of Camden, Islington, Haringey, Barnet and Enfield – an area that is home to nearly 1.5 million people.

We know that the health and social care needs of our local people are changing, and that there are serious issues facing health and care services in NCL. People receive different standards of care depending on where they live: waiting times for services and health outcomes vary, and the quality of care and people's experience of health and social services is sometimes not as good as it should be.

We must improve and we can only do this if we all work closely together – with each other and with our local residents.

It does not mean doing less for patients or reducing the quality of care provided. It means more preventative care - finding new ways to meet people's needs, and identifying ways to do things more efficiently. We want to ensure that everybody we care for has greater control of their health and wellbeing and receives the support they need to live longer, healthier lives. Many of these ambitions are not new, but are based on what local people have told us they want.

The plan is currently work in progress. We are looking to engage with as many people as possible over the next few months to develop our ideas further.

North Central London

What is the Sustainability and Transformation Plan (STP)?

To make sure everybody receives the care they need when they need it, we have to change the way we do things.

Our draft plan sets out how we will work together to deliver high quality, sustainable services in the years to come and how we can meet the financial challenges and increasing pressures on our services over the next five years.

The North Central London area has a growing population and people are also living longer, often with long term health problems.

The growth in our funding over the next five years will not match the expected increases in population and the resulting growth in demand for health services. NHS services already have deficits and, if nothing changes, it is anticipated that the combined deficit of health services alone will be nearly £900million by 2020/21. Local authorities are also facing significant financial pressures on their social care budgets. We need to change how we provide services, reduce the amount of time and treatment spent in hospitals, boost prevention and offer more local people the care they need closer to home.

North Central London

North Central London overview

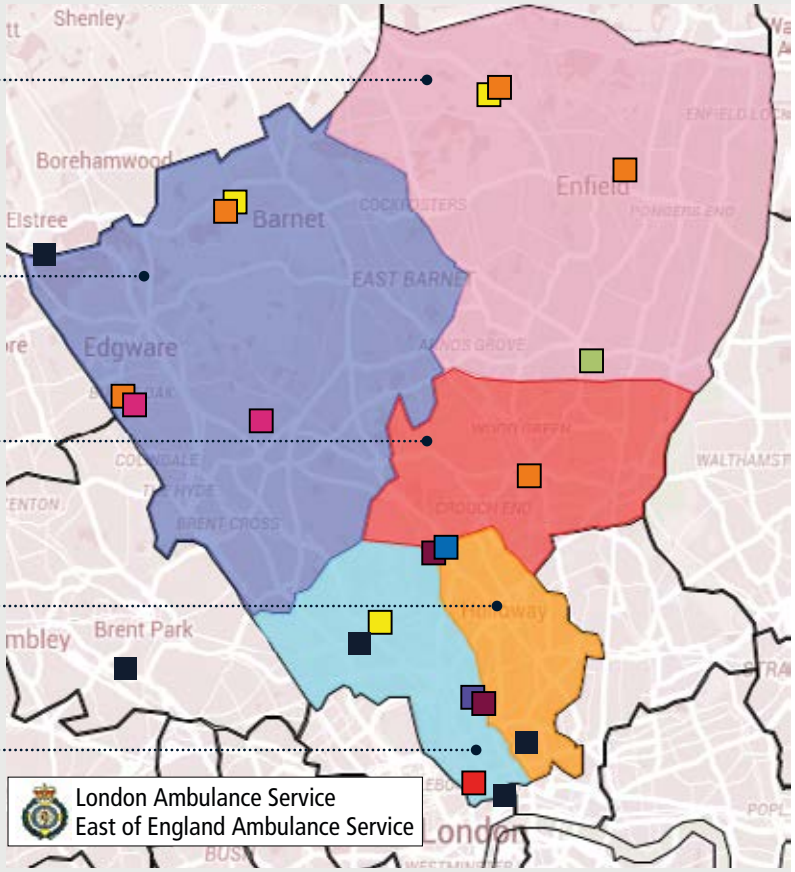
Enfield CCG / Enfield Council
~320,000 GP registered pop
~324,000 resident pop
49 GP practices

Barnet CCG / Barnet Council
~396,000 GP registered pop
~375,000 resident pop
62 GP practices

Haringey CCG / Haringey Council
~296,000 GP registered pop
~267,000 resident pop
45 GP practices

Islington CCG / Islington Council
~233,000 GP registered pop
~221,000 resident pop
34 GP practices

Camden CCG / Camden Council
~260,000 GP registered pop
~235,000 resident pop
35 GP practices



Total health spend £2.5bn

Total care spend £800m

NHS England

Primary care spend £~180m

Specialist commissioning spend £~730m

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

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

Other specialist providers out of scope:
Great Ormond Street Hospital, Moorfields Eye Hospital, Tavistock and Portman Foundation Trust, Royal National Orthopaedic Hospital

North Central London

What are we going to do to?

There are a wide range of health problems in the region including high rates of childhood obesity and mental illness. Too many people are treated in hospital for long term conditions when they could be better cared for in the community. Waiting times to see a specialist and for diagnostic tests are long. Attendance levels at A&E departments are high and it's difficult to recruit staff. We want to create a health and social care system which delivers positive outcomes in all of these areas, no matter where you live.

To help us achieve this, over the next five years we aim to:

- Invest more in prevention to stop people getting ill
- Work with people to help them remain independent and manage their own health
- Give children the best possible start in life
- Provide care closer to home so that people will only need to go to hospital when it is clinically necessary
- Give mental health services equal priority to physical health services
- Improve cancer services
- Make the best standards available to all and reduce variation
- Make north central London an attractive place to work so that we have the right workforce to deliver high quality services
- Modernise our buildings and make greater use of digital technology
- Ensure value for tax payers' money through increasing efficiency and productivity, and consolidating and specialising where appropriate

Prevention

We aim to do more to promote and empower people to live healthy lives so we can stop the onset of disease, and keep people out of hospital. We want to increase investment in prevention and ensure that the places where people live and work promote good health.

We want to support residents, families and communities to look after their own health. We will work to diagnose residents with clinical risk factors and long term conditions much earlier to increase life expectancy.

North Central London

What will be different for patients

Prevention and care closer to home

John, age 62 is a lifetime smoker who was recently diagnosed with chronic bronchitis. His GP advised him to stop smoking but John said he could not cope without his cigarettes and refused the offer of nicotine replacement therapy (NRT). John contracted a chest infection, went to A&E and was admitted. He stayed for several days and was given some NRT on the ward to cope with his cravings for cigarettes.

In future, when John is admitted to hospital his respiratory physician will discuss the importance of stopping smoking as a treatment for his bronchitis. He will be prescribed NRT to relieve his cravings and on discharge he will be offered a referral to specialist stop smoking support for heavily addicted smokers. John will then get a call the next day from the specialist stop smoking advisor who will arrange a home visit for the following day. John will be supported by the specialist advisor in weekly visits to help him to reduce or stop smoking altogether.

Care closer to home

We aim to deliver more health and care closer to home, so that people are treated in the best possible environment and do not have to go to hospital unless they really need to.

This would be achieved through local networks which bring different services together and improving access to GPs or other primary care professionals.

We aim to provide 24/7 access to specialist opinion in primary care, ranging from an advice only service to admission to an acute assessment unit. We will also review the existing provision across NCL of GP presence in emergency departments.

We will look to develop special falls emergency response services to help support older people to remain at home after a fall, as well as helping to educate them about the risks.

What will be different for patients

GP services

Ms Sahni is 87 and has four chronic health problems. She currently has to book separate appointments with different doctors to have all of the relevant check-ups and appointments that she needs.

In future, Ms Sahni will be in a special “stream” of patients who will have all of their care co-ordinated by a very experienced GP. This will allow her to see the specialist heart or diabetic nurses at the integrated care centre at her GPs surgery. There will also be a care navigator in the team who can help sort things out for her at home including community support.

North Central London

Achieving the best start in life

Better education for children is crucial to our plan. We need to put health and wellbeing on the map at the earliest opportunity. We need to create healthy environments, promote active travel, sport and play in schools.

We have identified areas of focus – from prevention to acute care – which will improve health and outcomes for children and young people

This will include a focus on maternal health which evidence strongly suggests has an impact on child and adult health – for example obesity, diabetes and cardiovascular disease.

We want to address mental health in children as early as possible, supporting mothers with mental health problems both before and after birth. We also want to provide services for parenting support and health visiting which focus on vulnerable, high risk families.

Mental health

We will give equal priority to physical and mental illness and aim to reduce demand on hospital care and mental health inpatient beds.

Our plans include increasing access to primary care mental health services and improving how we manage acute mental health problems, building community capacity to enable people to stay well; and investing in mental health liaison services – for example ensuring that more people in hospitals have their mental health needs supported. We will also look to strengthen perinatal and child and adolescent mental health services (CAMHS).

What will be different for patients

Mental health liaison

Maisie suffers from dementia, and is cared for by her husband Albert. Previously, after falling at home Maisie was admitted to hospital. Due to the accident and change of surroundings, Maisie was agitated and more confused than normal.

In future, as the hospital will have Core 24 liaison psychiatry, the liaison team will be able to help the hospital support both Maisie's physical and mental health needs. As Maisie will receive holistic care it will mean that she is ready to be discharged sooner than if only her physical health needs were supported. Maisie's husband Albert will also be supported by the dementia service, allowing him to continue to care for Maisie at home.

Urgent and emergency care

Over the next five years, we aim to provide a consistent urgent and emergency care service. Patients should be seen by the most appropriate professional for their needs, which may include directing them to an alternative emergency or urgent care service. There is strong evidence that getting patients to the right specialist service, even if that might not be their local hospital, improves outcomes.

We want to develop high quality ambulatory care services across NCL – so patients can be assessed, diagnosed, treated and able to go home on the same day without needing a hospital admission.

For those patients who do need emergency treatment, we aim to have services in place that help them to leave hospital as quickly as possible and rehabilitate closer to their home if appropriate

Planned care

We want to reduce variation in the way that we deliver planned care across north central London. This includes some key areas for improvement, such as making sure patients can access the right expertise locally and that their experience of surgery is seamless, smooth and efficient.

We aim to have clear 'pathways' for patients across the region, with consistent approaches, so that we become more efficient and there is less variation in outcomes and experience.

We want to improve patients' access to information and help people manage conditions without surgical intervention where possible. We will ensure patients spend as little time as possible in hospital.

Cancer

Our aim is to save lives and improve patient experience for people who have cancer. The priority areas we have identified for improvement are getting earlier diagnosis and better provision of radiotherapy and chemotherapy.

Targeting colorectal and lung cancers are a particular focus given the high percentage of patients receiving late stage diagnosis, often in emergency departments.

We are also developing a case for a single provider model for radiotherapy in NCL.

We want to improve palliative care so that patients have a better quality of life in their final weeks.

North Central London

What will be different for patients

Cancer

Previously Margaret, aged 60, went to see her GP with persistent gastric pain for several weeks. She was otherwise well, and did not have reflux, diarrhoea, vomiting or weight loss. Over the course of the next three weeks, Margaret's GP organised tests and ruled out any inflammation, heart problem, or gallstones that could cause the pain. He gave Margaret tablets to try to reduce inflammation from acid on her stomach lining. However, Margaret's pain was more persistent this time and she was still worried.

In the new system, Margaret's GP will be able to refer her to a Multidisciplinary Diagnostic Centre at UCLH despite the fact that her symptoms are not considered "red flag". Here, Margaret will be assessed for vague abdominal symptoms. A clinical nurse specialist will see her four days after referral. The team will identify that Margaret has early stage pancreatic cancer and because it was picked up early she can access potentially curative keyhole surgery.

Social care

Social care is a crucial part of many elements of our plan, in particular in delivering care closer to home and improving mental health services. We want to ensure that health and social care services work well together to deliver well-coordinated care for local people. We will improve collaboration between local authorities and hospitals – for example, focusing on earlier discharge of hospital patients where safe and appropriate. We will build on the experience and expertise of social care and public health in the development of new models of care.

We recognise that many social care providers of services such as residential, nursing home and home care services are under great pressure. We aim to focus on strengthening the supply of the workforce for these services to address risks around their staffing capacity.

The role of social workers will also be essential to delivering our model for health and care closer to home, in addition to the role of home care workers, personal assistants and the blended role between district nurses and care workers. We will focus on recruiting to these posts and developing career opportunities in these areas.

Bringing services together

We will work out where it makes sense to bring services together or create networks across organisations to improve the experience of our patients. We are already collaborating across the region with positive results in cardiac/cancer; pathology; neurosurgery; stroke; and many other services.

We can learn from our experience in these areas and more work is planned to identify areas where some form of consolidation may be worth considering.

Workforce

We want to attract the highest quality staff to deliver the best possible care we can for local people. Therefore as well as creating the most positive environment for our patients, we want NCL to be a place where we offer the best opportunities for people to develop their careers.

Our aim is to attract, develop and retain people who work in and support health and social care in north central London. We want to create attractive careers with a workforce fit for purpose in the changing healthcare landscape – so we have the right skills in the right place for patients.

Digital and estates

We want to use the power of digital communications and IT systems to share information and support the provision of better care and treatment for patients. We aim to promote changes so that patients can use technology to receive and share information, get treatment and prescriptions through e-referrals and e-consultations. Sharing high quality data between health and care professionals will mean people don't have to retell their stories. Digital technologies will help ensure care is delivered in the right place at the right time by the right person.

We also want to modernise the buildings we work from and our equipment to make sure they are fit for purpose. We already have major investments planned at University College Hospital and Chase Farm Hospital and would look to develop plans for investment to improve facilities so we can deliver more care closer to home and improve mental health services.

Reducing costs

We think the changes we have set out will help us reduce waste in the health and care system. **For example we can reduce cost of care by:**

- treating people right first time and improving the co-ordination of services.
- avoiding unnecessary admissions to hospital .
- speeding up discharge when people are ready to go home.
- being less reliant on agency and temporary staff.
- avoiding unnecessary duplication of services between organisations.

However our plans at the moment do not achieve financial balance over the next five years, so we will continue to look for other opportunities to improve our efficiency.

North Central London

Engagement

We are committed to being open and transparent about our plan as it develops. We need engagement from all of our partners, patients and local residents if we are to succeed

This means:

- Early engagement on the issues before any decisions are made
- Stakeholders and the public help to devise the solution
- Ensuring decision-making is transparent and people know what to expect when
- Each stage of the process is informed by ongoing dialogue.

As we add more detail to our plans, we will ensure that we undertake formal public consultation where appropriate. We will work with the North Central London Joint Health Overview and Scrutiny Committee to agree when we need to do this and how we best do this.

Next steps

The draft Sustainability and Transformation Plan sets out our proposed approach to achieve sustainable health and care services in north central London. It is still work in progress. There is much more to do before we finalise the detail of these plans.

We want to fully engage patients and the public in our thinking to make sure we get this right. The various NHS organisations and local authorities will be looking at this draft plan over the next few months and they will arrange events to raise awareness of the proposals and get people's feedback.

In the meantime if you want to feed in ideas or comments please contact the NCL STP office at **nclstppmo@nhs.net**

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Agenda Item 6

MUNICIPAL YEAR 2016/2017 - REPORT NO.

MEETING TITLE AND DATE **Enfield Health and Wellbeing Board (EH&WB)** **8TH December 2016**	**Agenda - Part:** | **Item:** **Subject:** • **EH&WB work programme** • **EH&WB development sessions work programme** **Wards:** **Cabinet Member consulted: Cllr Taylor** **Approved by: Tessa Lindfield (Director of Public Health)**

Contact officer and telephone number:
Sam Morris **0208 3794245**
E mail: **sam.morris@enfield.gov.uk**

1. EXECUTIVE SUMMARY

The Enfield Health and Wellbeing Board (EH&WB) meets publicly five times a year, there are also five development sessions which take place in private. These allow members to discuss agenda items, in preparation for EH&WB meetings where decisions are made.

So there is a planned approach to EH&WB and development sessions, it's important that work programmes for both are agreed at the beginning of the year, and EH&WB members feed into this process.

The work programmes are not set in stone and agenda items can be added. Agreed work programmes will let Board members and the public know what the EH&WB will focus on and will help support staff to create agendas.

2. RECOMMENDATIONS

- The EH&WB is asked to agree the work programme for 2017 EH&WB

- The EH&WB is asked to agree the work programme for the 2017 development sessions

3. BACKGROUND

The EH&WB work programme is a document that sets out the future work of the EH&WB and developments sessions. Board members were asked for agenda items for both, and fed them back though email and during the November development session. At the development session, we agreed new agenda items as well as those the EH&WB expect as part of its responsibilities.

I have drafted work programmes for the 2017 EH&WB and the development sessions (appendix 1 and 2).

4. ALTERNATIVE OPTIONS CONSIDERED

No alternatives considered

5. REASONS FOR RECOMMENDATIONS

EH&WB will benefit from a plan of work, as it will be able to discuss important topics and decide what action to take. By involving EH&WB members in developing work programmes, there will be a shared ownership of the work, and will mean cross organisational issues are addressed through the EH&WB.

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

6.1 Financial Implications
N/A

6.2 Legal Implications
N/A

7. KEY RISKS

The risks of agreeing work programmes, are that they are too ridged not allowing EH&WB to respond to health issues that arise. To address this, any current issue can be discussed and added to agendas during the EH&WB Executive Group meetings.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

EH&WB and development session work programmes will mean the Board can focus on the priorities below. The work programme sets out when the EH&WB will review the EH&WB Strategy priorities.

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

9. EQUALITIES IMPACT IMPLICATIONS

We asked for advice regarding equalities, and an equalities impact assessment isn't necessary for the approval of this report to agree the work programme for the EH&WB. EQIAs will be considered and undertaken as appropriate.

10. Background Papers

- Appendix 1 – Draft work programme 2017 EH&WB
- Appendix 2 – Draft work programme for 2017 development sessions

Appendix 1: Draft Health and Wellbeing Board: Work Programme 2017/18

ITEM	Lead Officer	February 2017	April 2017	July 2017	October 2017	December 2017
EH&WB Sub Board Work programmes	Tessa Lindfield	**Report**				
NMUH CQC report	Libby McManus	**Review**				
NMUH joining RFL vanguard	Libby McManus	**Presentation**				
Joint Health and Wellbeing Strategy	Tessa Lindfield	**Review**				
***Better Care Fund Plan**	Bindi Nagra	**Review**				
Sub Board-work programmes	Sub Board Leads	**Review**				
HWB Input into the STP (Prevention)	STP Leads	**Presentation**				
***Better Care Fund Plan**	Bindi Nagra		**Report**			
Joint Strategic Needs Assessment	Tessa Lindfield		**Review**			
Healthy Hospitals	Abby		**TBC**			
CCG Operating Plan	Graham McDougal		**Report**			
Funding Challenges Adult Social Care	Litsa Worrall/Ray James		**Report**			
Health and Adult Social Care Integration	Bindi Nagra		**Report**			
Health in all Policies (HIAP)	Glenn Stewart		**Report**			
HWB Input into the STP	STP Leads		**Report**			
Mental Health Co-Production	Deborah Fowler			**Report**		
Commissioning Plans	Bindi Nagra			**Review**		
Memberships	Sam Morris			**Review**		
Progress Updates Joint Health and Wellbeing Strategy	Tessa Lindfield			**Report**		
Annual Public Health Report	Tessa Lindfield			**Review**		
HWB Input into the STP	STP Leads			**Report**		
Health Inequalities Review	Tha Han				**Review**	
Voluntary Sector Representation Arrangements	Sam Morris				**Report**	
Overview and Scrutiny Workplan	Claire Johnson				**For Information**	
Adult and Children Safeguarding Reports	Tony Theodoulou				**For Information**	
New Models of Care	Graham McDougall				**Report**	
HWB Input into the STP	STP Leads					**Presentation**
CCG and LBE Financial and Commissioning Intentions	Sarah Thompson/Ray James					**Report**

Health and Social Care Integration Plans	Bindi Nagra					**Report**
LBE Budget Consultation	James Rolf					**Consultation**
Review of the EH&WB	Sam Morris					**Review**
HWB Input into the STP	STP Leads					**Report**
EH&WB Sub Board Progress Report	Sub Board Leads					**Report**

*Waiting for guidance from NHS England on timescales

Appendix 2: Draft Health and Wellbeing Board Development Sessions Work Programme 2017

ITEM	Lead Officer	January 2017	March 2017	June 2017	September 2017	November 2017
STP	STP Leads					
NMUH CQC report	Libby McManus					
NMUH joining RFL vanguard	Libby McManus					
Joint Health and Wellbeing Strategy	Tessa Lindfield					
JSNA	Tessa Lindfield					
STP	STP Leads					
Health and Adult Social Care Integration	Bindi Nagra					
Funding Challenges Adult Social Care	Litsa Worrall/Ray James					
STP	STP Leads					
Commissioning Plans	Bindi Nagra					
Progress Updates Joint Health and Wellbeing Strategy	Tessa Lindfield					
STP	STP Leads					
Health Inequalities Review	Tha Han					
Annual Better Care Fund Review	Bindi Nagra					

STP	STP Leads					
Medium Term Financial Outlook	James Rolfe					
Urgent and Unplanned Care	Sarah Thompson					
Review of the EH&WB	Sam Morris					

Agenda Item 7

MUNICIPAL YEAR 2016/2017

Meeting Title: **HEALTH & WELLBEING BOARD** Date: 8th December 2016	**Agenda Item:** **Subject:** **Adherence to Evidence Based Medicine**
Contact officer: Telephone number: Email address:	**Report written by:** **Regina Shakespeare, Project Consultant and Mark Eaton Director of Recovery, Enfield CCG**

1. EXECUTIVE SUMMARY

Enfield CCG (ECCG) wants to the secure the greatest health impact it can with its resources by adhering as closely as possible to the clinical evidence base including that published by NICE (the National Institute for Health & Care Excellence). Through this we will not only ensure the best possible outcomes for the population we serve and the best outcome for individual patients but also that we obtain the best value from the services we commission.

There is considerable national and international evidence that many procedures offered routinely by the NHS are of limited clinical benefit to patients. These Procedures of Limited Clinical Effectiveness (PoLCEs) therefore need to be carefully considered and matched to the best available clinical advice to ensure that they deliver the expected outcomes. Any referral of an individual needs equally carefully to consider the risk and benefits to that particular patient. Enfield CCG, along with the other CCGs in North Central London, have adopted common PoLCE policies and these are all available to the public on the CCG's website.

The CCG's Governing Body has initiated a programme called 'Adherence to Evidence Based Medicine' (AEBM) Programme involving reviewing the:

- Evidence base, thresholds and criteria for access to treatments currently contained in the North Central London PoLCE policies
- Clinical evidence in support of adopting new policies for procedures where the evidence supports the adoption of thresholds and criteria

The programme is fully described in the accompanying paper.

This will help to ensure that we are delivering the greatest health benefit for our population as a whole with the finite resources available to the CCG and the greatest benefit for individual patients.

Clinical Leaders at the CCG, with the full support of the Governing Body, are leading this evidence review. The CCG has sought the Director of Public Health's advice and

support to this review process. The CCG will engage widely and in close consultation with the Overview and Scrutiny Health Work Stream, will determine the nature of the consultation process appropriate to the programme. The CCG also continues to communicate closely with partner CCGs and providers in North Central London about this programme and about the implications for the Sustainability and Transformation Plan. It is notable that several CCGs across the country are engaged in similar reviews.

It is important to note that no part of the programme concerns either urgent or emergency procedures or the two week pathway for potential cancer (what is termed the 'Two Week Wait').

The CCG plans subject to the outcome of its engagement and consultation and decision making by North Central London partners, to introduce any changes resulting from the programme from 1st April 2017.

Next Steps:

The next steps are:

- Completion of the Evidence reviews to prepare specific proposals
- Close communication with North Central London partners
- Formal engagement with key stakeholders including patients and the public, Healthwatch, member practices, clinical colleagues in secondary care
- Discussions with the Scrutiny Health Work Stream on the precise nature of the consultation process

2. RECOMMENDATIONS

The Health & Wellbeing Board is invited to:

- Comment on the proposed programme
- Discuss the proposed engagement, consultation and implementation timeline
- Support the approach being taken and/or suggest revisions to the approach

Enfield CCG

Adherence to Evidence Based Medicine Programme
Report to the Enfield Health and Wellbeing Board December 2016

Overview of the Programme

Enfield CCG (ECCG) wants to the secure the greatest health impact it can with its resources, obtain the best value from them and adhere as closely as possible to the clinical evidence base when it commissions services.

ECCG and fellow North Central London CCGs have adopted a policy on 'Procedures of Limited Clinical Effectiveness' in order to improve quality of clinical care. There is considerable national and international evidence that the areas covered by PoLCE guidance demonstrate poor clinical effectiveness or that current practice does not comply with best clinical practice and that significant variation exists.

The 'Adherence to Evidence Based Medicine Programme' involves reviewing the evidence base, thresholds and criteria for access to treatments currently contained in the North Central London policy and proposing additions to that policy.

Clinical Leaders at the CCG with the full support of the Governing Body are leading this review. The CCG will engage widely on the proposals which emerge and will continue to work closely with partner CCGs in North Central London.

No part of the programme concerns urgent or emergency procedures nor the two week pathway for potential cancer – the 'Two Week Wait'.

Enfield CCG's Financial Position

Enfield CCG (ECCG) is in special measures and has a statutory duty to explore all acceptable means to bring its spending in line with its allocated resource.

Examination of levels of activity and spend demonstrate that in some clinical areas, ECCG is an outlier when compared to other CCGs even when differences between the populations we serve (demographic and non-demographic) are taken into account. To address these differences clinical leaders are reviewing the evidence and clinical models associated with a number of clinical procedures to confirm that the services we are offering are in line with the latest evidence and guidance including that published by NICE (the National Institute for Health & Care Excellence). This work has already been undertaken by other Clinical Commissioning Groups such as Berkshire, North East Essex, Peterborough and Cambridgeshire, the North West London CCGs, Dorset, Liverpool and elsewhere.

The CCG will take into account in its decision making, the financial impact of its decisions, whilst being guided by its overall principle of adherence to evidence.

Procedures of Limited Clinical Effectiveness (PoLCE)

A PoLCE is a procedure where the clinical effectiveness of that procedure is either absent or evidence shows weak efficacy and long term benefits reached

- A PoLCE could be a procedure which is clinically effective but only under certain conditions, such as when a person meets certain criteria, otherwise more conservative alternatives should be tried first

- A PoLCE is a treatment of a condition where not funding the treatment will not result in a significantly adverse effect on the patient's physical or mental health

The CCGs' PoLCEs are available to the public on its website.

Governance, Clinical Leadership and Decision Making

Following a clinically led programme of review of existing and new policies during November and December 2016 and its stakeholder engagement during this time, ECCG will develop a business case which proposes the adoption of any new and revised policies, before entering a process of consultation around the proposed changes. The nature of the consultation process will be closely agreed with the London Borough of Enfield's scrutiny health work stream.

The Business Case will describe the planned net financial impact of the adoption of any change as well as the estimated population of Enfield who could be affected by these changes. The CCG will adhere to its equality duties in assessing the impact on patients.

Any changes will only take place following formal consideration of that business case by the Finance & Performance Committee which is a formal sub-committee of the Governing Body, taking into account consultation outcomes.

The review is being undertaken by clinical members of the Governing Body, working as its Clinical Reference Group and the work is being co-ordinated by the CCG's Medical Director, with management support. These clinicians are reviewing evidence packs which have been drawn together by examining the clinical policies adopted by CCGs across the country and the evidence used to support them and by referring to NICE guidance. The packs have been shared with the Director of Public Health and the department's advice and support in respect of the review process, sought.

Progress with Engagement

The CCG has undertaken a pre engagement phase with a public session and discussion with its member practices, at which it tested the principle of the programme and the manner in which the proposals (which include substantial clinical detail) should be shared in order to be accessible to the lay person. The feedback provided is being used to plan further engagement activities. Engagement with partner CCGs, including the NCL Clinical Cabinet, with the Enfield PPG Network and others, is now in train. It is important that secondary care

clinicians' views are incorporated into the proposals for new access thresholds, policies and pathways.

North Central London and its Sustainable Transformation Plan

ECCG and fellow commissioners and providers, as partners in North Central London's developing Sustainability and Transformation Plan (STP), face a significant resource gap if they do not put in place transformational changes in the healthcare landscape over the next five years. Any actions to reduce activity which does not, on balance, benefit individual patients or where the evidence base is doubtful, will be of benefit to the local population given the growing demand for health care as it will maximise the overall impact of the application of NHS resources.

Across London and elsewhere in England there is considerable pressure to achieve the national access standards required for NHS elective (sometimes called planned) care and cancer care. The reduction of elective activity where the net benefit to patients is low, could make a useful contribution to achieving performance standards consistently in the light of growing demand and these issues are being discussed with partners in North Central London.

Working with Our Local Community and Patient Impact

Enfield CCG (ECCG) wants to the secure the greatest health impact it can with its resources by adhering as closely as possible to the clinical evidence base. Through this we will not only ensure the best possible outcomes for the population we serve and the best outcome for individual patients but also that we obtain the best value from the services we commission.

In achieving this, ECCG seeks an effective partnership with its local population and wishes to be open and transparent about its plans and proposals and to listen carefully to feedback, ideas and concerns, taking into account opinions raised.

Enfield GPs aspire to a shared decision making process with their patients. They want any referral to a planned procedure – whether on the Procedures of Limited Clinical Effectiveness (PoLCE) list or not – to be the result of a thoughtful discussion in which both patient and GP can weigh up the risks and potential benefits of a planned procedure. Since no procedure is without some risk, no benefit can be guaranteed and research is always advancing, ECCG wants to ensure that its clinical policies are keeping up with the most current evidence based medicine. As part of its review, ECCG is considering the type of materials currently available to support the consulting physician and patient in their decision making about referral. Its goal is to support both with user friendly materials to help them make the best decision for each individual patient.

Impact on Referring GPs

ECCG practices are already sending their referrals for elective treatments included in the North Central London PoLCE policy to the Enfield Referral Management Service (ERS),

where they are administratively and clinically triaged i.e. tested for adherence to the policy. Any adjustment to thresholds or adoption of new ones, will be comprehensively communicated to all practices, in a form which will enable them to adhere to the policies and inform their locum and administrative staff of the changes.

Any adoption of new policies will potentially lengthen patient/GP consultation times for a small number of consultations. This will be unwelcome at a time of great pressure in general practice. It is estimated that each Enfield GP undertakes 1-2 consultations per week concerning existing PoLCEs. So in developing its business case, Enfield CCG will estimate the total number of consultations affected and continue its discussions with member practices about the best possible way to support the process; for example in some areas, materials to support decision making including videos giving explanations of risks and benefits of a particular procedure. The NHS is now collecting Patient Reported Outcome Measures or PROMS for some procedures and engaging in Shared Decision Making programmes to support professionals and patients.

Impact on Hospitals

As part of its development of proposals, clinical commissioners will hold clinician to clinician discussions with secondary care colleagues on the potential changes and seek their feedback on the extent to which local elective pathways are optimised to obtain greatest patient benefit within the available resources.

North Central London providers have already entered into contractual agreements with commissioners concerning prior approval and Individual Funding Request (IFR) processes for PoLCE (Individual Funding Requests are formal decision making processes concerning specific individuals). Any adjustment to thresholds or adoption of new ones will be comprehensively communicated to all providers, in a form which will enable them to adhere to the policies and inform their clinical and administrative staff of the changes.

Programme Description

The Adherence to Evidence Based Medicine (AEBM) Programme consists of five workstreams:

Workstream 1: Compliance with Existing Thresholds

Enfield CCG has not applied the thresholds contained in the 2012 NCL PoLCE policies as consistently as other partners and following clinical discussions, a revision in the clinical triaging processes (i.e. where a referral is tested for compliance with the criteria or threshold) has been put in place to ensure improved adherence. This has seen our return to referrer rates increase from <20% to ~50-60% (which is now comparable to Haringey CCG and other areas in London).

Workstream 2: Reviewing Existing Thresholds

In 2015 clinicians from Barnet, Haringey and Enfield CCG and our member practices reviewed the available evidence and proposed changes to thresholds associated with

existing PoLCEs based on the latest clinical evidence base. At that time there was not complete concordance between CCGs and this matter is again under active discussion including a planned session of the NCL Clinical Cabinet (where clinicians from primary and secondary care are present) to see if a clinical consensus can be forged to support review.

Workstream 3: Reviewing Thresholds Associated with Key Procedures

Enfield CCG's clinicians identified the case to review the clinical evidence associated with seven key procedures to determine whether changes in the evidence base warranted a review of the thresholds associated with accessing services. The seven procedures where clinicians are undertaking a review of the latest evidence are:

- Hips & Knees
- Hernia
- IVF
- Hearing Aids
- Bunions
- Haemorrhoids
- Vasectomy

Evidence packs have been prepared for each of these areas (and shared with the Director of Public Health) and are currently being reviewed by the CCG's clinicians prior to the agreement of specific proposals for engagement. We are sharing our work with our colleagues across North Central London.

Workstream 4: Expansion of Procedures Under Consideration

The work on the seven procedures has also highlighted that there is a significant number (>150) of procedures where other CCGs have used the clinical evidence base to introduce thresholds and access criteria. This group of procedures is being examined by Enfield clinicians to identify where the evidence base is sufficient and once the list has been reviewed we will prepare specific proposals for engagement and seek to take this to engagement on the same timeline as Workstream 3.

Workstream 5: Decommissioning

The last workstream is to consider the decommissioning of services where the clinical evidence base supports that case.

The CCG is actively considering the case for the decommissioning of Homeopathic Treatments, given the evidence base on their effectiveness.

Again, we are sharing our work with colleagues in North Central London.

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Agenda Item: 8
Appendix

MEETING:	Health and Wellbeing Board
DATE:	8 December 2016
TITLE:	Transforming Care Update
MANAGEMENT LEAD:	
AUTHOR & POSITION:	Ineta Miskinyte, Service Development Manager – Learning Disabilties
CONTACT DETAILS:	Ineta.miskinyte@enfield.gov.uk

SUMMARY:

The report 'Transforming Care Partnership North Central London' has been produced by Catherine Searle - NCL TCP Programme Manager. The information covers all 5 areas – Enfield, Barnet, Haringey, Islington and Camden.

Enfield had a gap in commissioner post arrangement since July 2016. A new Joint Commissioning Manager for Learning Disabilities has been in post since 6th of October 2016. This will enable a more streamlined reporting and better oversight of the assessment and discharge planning.

Enfield currently has 7 patients. The Community Intervention Service is engaged with all 7 patients and there are robust assessments in place.

Please note, the data in the Admissions/Discharges table refers to:

Missed Discharge Dates this month - the data from 2 fortnightly patient trackers in October
Planned Discharges Next Month – planned discharges in November/December

The reporting template will be revised to reflect a more accurate information going forward.

SUPPORTING PAPERS:

'Transforming Care Partnership North Central London'

RECOMMENDED ACTION:

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Update
November 2016

Transforming Care Partnership
North Central London

Transforming care in the community for adults and children with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition

What is the Transforming Care Programme?

Objectives:

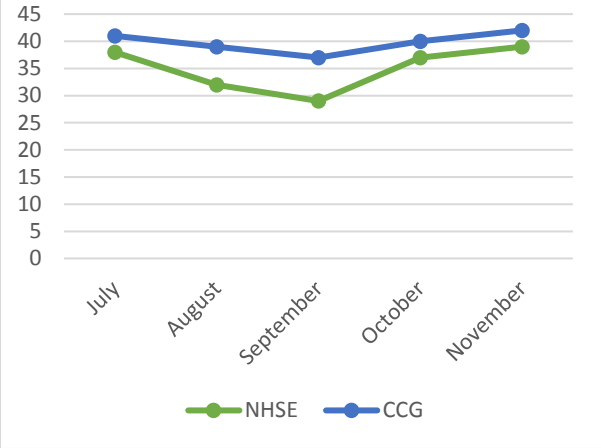
- Reduce the number of people with learning disabilities and/or autism in hospitals by half by March 2019
- Reduce average length of stay
- Eliminate use of out of area placements
- Eliminate existing health inequalities
- Transform care and support to be designed around the individual
- Improve the quality of life for people with learning disabilities and/or autism and reduce behaviour that challenges

Governance: TCP Board: Chair: Sarah Price, Chief Officer, Haringey CCG; Deputy: Richard Lewin, Director of Strategic & Joint Commissioning, Camden Council; Implementation Group & Task Groups: Learning Disabilities and Children's Commissioners

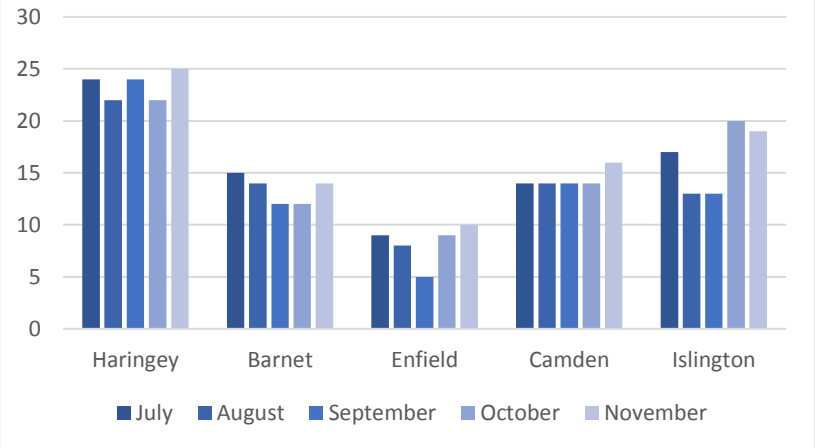
Assurance: The TCP is accountable to NHS England who are closely scrutinising performance, patient data and progress of commissioning plans. We achieved assurance of our plans in September and NHSE have agreed to release our grant funds.

Funding: NHSE have allocated £300k non-recurrent grant funding to NCL, to pump prime new community services to prevent hospital admissions. We have also submitted a capital bid and expect a decision by the end of November.

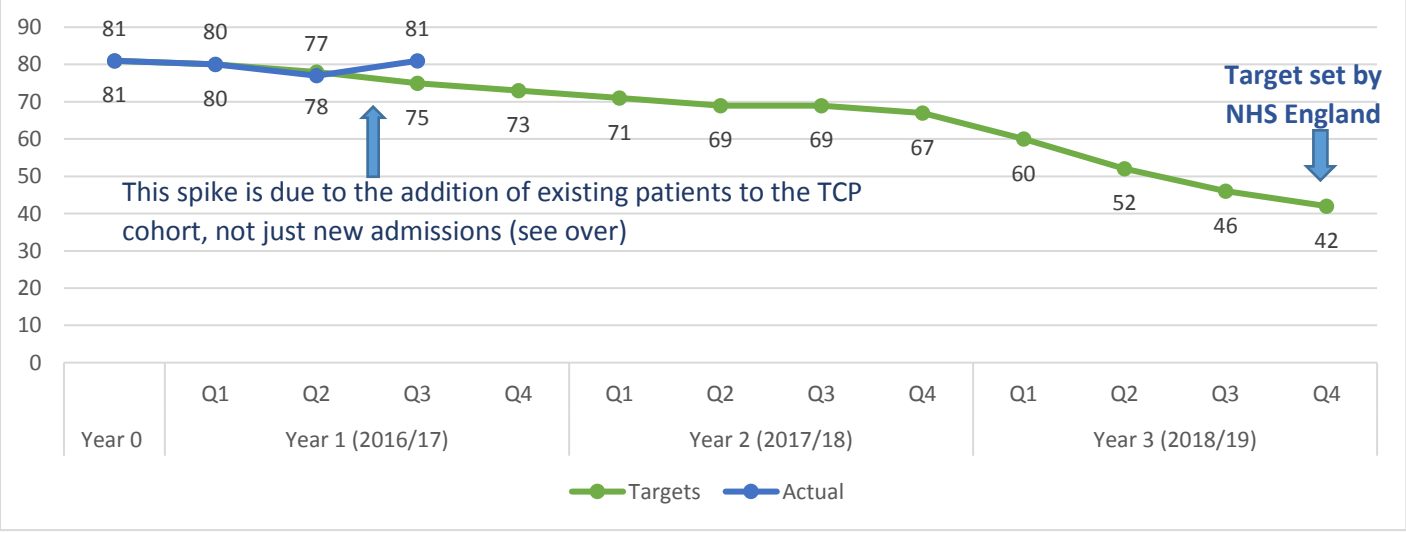
Performance: NCL In-patient numbers



Performance: In-patient numbers by CCG/Borough



NCL total in-patient numbers – progress against target trajectory



Current In-Patient Summary

39 NHS England Specialist Commissioning Placements.

42 CCG Commissioned Placements. Of these:

- 10 are in Harperbury Specialist Residential Service (SRS). There is a legal injunction against discharge without the permission of the Official Solicitor. Average length of stay for these patients is 47 years.

In-patient numbers have seen a significant spike in the last period, due to the addition of existing patients to the TCP cohort, as the result of two pieces of work:

- Completion of the identification of additional out-of-area patients by NHS England
- NCL work with our two Mental Health Trusts (BEH & C&IFT) to identify patients not known to the LD teams

We are as confident as we can be that we have now bottomed out the TCP patient cohort. We expect to see patient numbers start to reduce again now that this work is complete.

Admissions/Discharges

	Admissions this month	Discharges this month	Missed Discharge Dates this month	Planned Discharges Next Month
Barnet				**1**
Enfield			**3**	**4**
Haringey	**1**	**1**	**8**	**10**
Camden			**1**	**4**
Islington	**4**	**1**	**1**	**4**
Totals	**5**	**2**	**13**	**23**

- Admissions (5) outnumber discharges (2)
- Planned discharges next month (23) far outnumber the actual discharges in the last month (2)
- The figures suggest that we are <u>not</u> on track to achieve the number of planned discharges next month.

At-Risk of Admission Registers

Services are required to have a TCP "At Risk of Admission Register". NHSE Guidance requires that patients give consent to be on the register.

		Children & Young People		Adults
Barnet		Register – with deemed consent		Register – with deemed consent
Enfield		Register in progress		Register – with deemed consent
Haringey		Register in progress		Register – with deemed consent
Camden		Register in progress		Register – with deemed consent
Islington		Register – with written consent		Register – with deemed consent

Commissioning Intentions

Commissioning intentions have changed due to better understanding of the patient cohort, obstacles to discharge and prevention of admissions, and the financial challenge of non-recurrent grant funding. Approximately 40% of all patients have been admitted to hospital from prisons. The majority of patients have some mental health needs, with more than half of new admissions since April being sectioned into mental health beds for a crisis directly associated with a diagnosed mental health condition. Therefore, it is clear that for the Transforming Care Programme to achieve its objectives, learning disability teams can't do it alone. We plan to deliver:

A TCP Hub: a time-limited, centralised NCL service comprising:

- **Multi-Agency Partnership**: Learning Disability and Mental Health expertise to coordinate and support effective multi-agency discharge planning and care coordination, and to develop a multi-agency protocol between Children's and Adults services, Education, Justice and Mental Health, to improve joined-up, preventative support to individuals with complex needs.
- **A Positive Behaviour Support 'School of Excellence'** to support the development of best practice in PBS, including the training and accreditation of providers and frontline support staff, to understand and reduce behaviour that challenges

Crisis Intervention: a specification for crisis intervention and prevention services, to be delivered by LD Teams, with some additional, non-recurrrent resource to support teams through the transition and implementation.

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: 1** | **Item: 9** **Subject:** **LISTENING TO LOCAL VOICES ON MENTAL HEALTH** **Wards: ALL**
Director of	**Cabinet Member consulted:**
Contact officer and telephone number: E mail: **Patricia Mecinska, Chief Executive, Healthwatch Enfield** **chiefexecutive@healthwatchenfield.co.uk** **020 8373 6283** **Deborah Fowler, Chair, Healthwatch Enfield** **Deborah.Fowler@healthwatchenfield.co.uk**	**Approved by:**

1. EXECUTIVE SUMMARY

'Listening to Local Voices on Mental Health' is Healthwatch Enfield's recent thematic report on adult mental health services in Enfield.

For over two years Healthwatch Enfield sought the views of more than 220 mental health service users, professionals, and carers on their experiences of the support and services available within the borough. Through a robust methodology, the organisation gathered an evidence base and identified key themes that should improve the provision of mental health services across Enfield. These themes included:

(1) availability of support
(2) seamless integrated care
(3) a person-centred approach
(4) communications

Some 29 different Recommendations arose across these four themes, generated by the users of mental health services in Enfield. Featured in many of the Recommendations was an underlying constant: the need to use co production to implement these Recommendations and to develop mental health care in Enfield.

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

2. RECOMMENDATIONS

Health and Wellbeing Board members are asked to:

(1) endorse the Recommendations within Healthwatch Enfield's Report entitled "Listening to local voices on mental health";
(2) endorse Healthwatch Enfield's proposal that the HWB commence co-production of an Action and Project Plan to implement the Recommendations to improve mental health services in Enfield;
(3) actively consider what staff time and other support they can give to co-production of the Plan and its subsequent delivery;
(4) support having the Report come to the December public HWB meeting, when specific pledges of staff time will be sought to co-produce an Action and Project Plan.

3. BACKGROUND

Soon after its launch in late 2013, Healthwatch Enfield became aware of quite widespread concerns that existing mental health support and services were not satisfactorily meeting the needs of local people. The health and social care watchdog heard these concerns from colleagues in local voluntary and community sector (VCS) organisations, including members of our Reference Group who generously shared their views with. Healthwatch Enfield also heard directly from local people at events, such as a consultation on the draft Enfield Mental Health Strategy in January 2014. In 2013 and early 2014, reports by the Care Quality Commission on wards at St Ann's and Chase Farm Hospitals also revealed a number of serious issues and the Care Quality Commission took Enforcement Action against St Ann's Hospital in January 2014.

With its explicit role as a consumer champion and having a wealth of information at its disposal (as outlined above), Healthwatch Enfield committed resources to engage with over 220 local people to ascertain individual's perception of mental health services in Enfield.

4. ALTERNATIVE OPTIONS CONSIDERED

Not applicable

5. REASONS FOR RECOMMENDATIONS

Healthwatch Enfield's report "Listening to local voice on mental health" amplifies voices of local residents and should be utilised to enhance mental health services provision within the borough to ensure the services are more person-centred and more effective in meeting individual needs.

Health and Wellbeing Board are being asked to endorse the Report, its Recommendations and means of implementation as the Board:
(1) has the influence and decision-making powers to impact service design;
(2) has strategic influence over commissioning decisions.

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

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

6.1 Financial Implications

Not sought

6.2 Legal Implications

Healthwatch Enfield has a statutory role to make people's views known in order to improve services.

7. KEY RISKS

The risk of failing to implement the Report is that the future design and commissioning of services is not reflective of the evidence base contained within the "Listening to local voices on mental health" Report, making provision less effective, more costly to the wider health and social care system and unresponsive to individuals' needs.

A risk of developing a co-production approach to implementation of the Report is that public expectations of what can be delivered are excessively raised, compared to what is achievable. This risk would need to be mitigated during the co-production process by openness about any constraints, but also a genuine willingness by all parties to co-produce.

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

8.1 Ensuring the best start in life: – not applicable to the short, medium and long term actions for this priority, as outlined within Enfield Joint Health and Wellbeing Strategy 2014-2019.

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

Implementing the Recommendations of "Listening to local voices on mental health" would contribute to the delivery of high quality mental health services, help to improve service users' mental health, and promote a move towards parity of esteem within Enfield.

8.3 Creating stronger, healthier communities:

Through amplifying the voices, perceptions and opinions of local people "Listening to local voice on mental health" demonstrates the role that community cohesion plays in improving health and wellbeing.

8.4 Reducing health inequalities – narrowing the gap in life expectancy:

People with mental health problems tend to have poor physical health outcomes and a shorter life expectancy. Implementing the Recommendations in the Report would contribute to improved

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

mental health within Enfield and therefore would contribute to a narrowing of one aspect of the life expectancy gap.

8.5 Promoting healthy lifestyles: – although not specifically targeting this priority, supporting people to have better mental health does give them a better foundation on which to build a healthier lifestyle.

9. EQUALITIES IMPACT IMPLICATIONS

Not applicable

Background Papers

The Report, 'Listening to local voices on mental health' is attached.

healthwatch Enfield

Listening to Local Voices on Mental Health

Acknowledgements

We offer our sincere thanks to all the patients, service users, carers, professionals, including staff at Barnet Enfield and Haringey Mental Health NHS Trust, and volunteers who took part in our engagement events, meetings and Enter & View visits, and to those who shared their experiences and ideas with us, to enable us to co-produce recommendations contained within this report.

We would also like to express our utmost gratitude to the local Voluntary and Community Sector organisations, which opened their doors to enable Healthwatch Enfield's representatives to listen to the voices of local people so that we can tell their stories. We thank:

- **Enfield Carers Centre,** a local charity providing information, advice, training and other support services to people looking after someone who lives in Enfield
- **Enfield Clubhouse**, a small, independent charity set up to help people with a mental illness recover purposeful lives in the community
- **Enfield Mental Health Users Group (EMU)**, a registered charity providing group advocacy for people using Mental Health Services in the London Borough of Enfield
- **Enfield Saheli**, which offers support and advice to women in Enfield and neighbouring London boroughs
- **MIND in Enfield**, a local registered charity with a mission to promote and improve the psychological and social well-being of local people with mental health problems
- **One Housing Group**, which exists to help people to live better
- **Over 50s Forum**, who believe that by working in partnership with others they can make Enfield a better place for all and improve the quality of life for its senior citizens
- **Wellbeing Connect Services**, which offer a one-stop-shop care approach to families experiencing mental health and domestic abuse through variety of services such as independent advocacy, monthly support group workshops and training, support for schools regarding young people and a safe space for members of the community.

Finally, sincere thanks go to the tireless work of volunteers at Healthwatch Enfield who contribute so much to all that we achieve with and on behalf of local people.

We would also like to acknowledge Sarah Lee for her early work on this report and Lucy Whitman for meticulously going through every item of feedback that we had collected, to draw out key information, and for producing a draft of this document.

Contents

Executive Summary

More than 80,000 residents of Enfield will experience a mental health problem in the coming year[1]. However, planning and delivering sustainable services over time will require a new model of care for a number of mental health services locally and across North Central London. So what is the key?

For over two years Healthwatch Enfield sought the views of more than 220 mental health service users, professionals, and carers on their experiences of the support and services available within the borough. Through a robust methodology, we gathered an evidence base and identified key themes that should improve the provision of mental health services across Enfield. These themes included:

1. availability of support
2. seamless integrated care
3. a person-centred approach
4. communication

However, Healthwatch Enfield's analysis of the evidence base and themes is that they most strongly support the need for early engagement of service users, patients, carers and the public in designing and enhancing services and support. As the Five Year Forward View for Mental Health[2] put it: "There should be even greater emphasis put on people's experience and how experts-by-experience can be seen as real assets to design and develop services."

Healthwatch Enfield recognise that, locally, there is a real commitment to improving the experiences of mental health patients, service users and carers. **Enfield Clinical Commissioning Group**, the main commissioner of adult mental health services within the borough aims, among other things, to co-design services with service users and carers.[3] As part of Enfield Clinical Commissioning Group's collaborative work on mental health issues with colleagues across **North Central London (NCL)**, the commissioning body aims to focus on prevention, awareness, early intervention and enablement. It is further supported by the **Healthy London Partnership,** which aspires to help London become the world's healthiest major global city and wants to increase the emphasis on prevention.[4] The London Borough of Enfield is a key partner in the strategic planning of local mental health services and acts as both a commissioner and a provider of services. In 2014, it published a joint mental health strategy with Enfield Clinical Commissioning Group for 2014-2019[5] that sets out a strong, positive vision for the experiences that local people with mental health needs should have. Among other good aspirations, Barnet Enfield and Haringey Mental Health NHS Trust, the main provider in the borough, aims to "put the needs of our patients and their carers first, and involve them fully in their care" and to support them all to "Live, Love, Do".[6]

Healthwatch Enfield has no wand-waving solution to the crisis in mental health funding, care and support nationally, and we make no apologies for using our statutory role to raise some difficult and seemingly intractable issues around local mental health care and support. Nonetheless, we sincerely hope that this report will create a platform for ensuring that the limited resources available are applied in those ways that local people will find most helpful and therefore most effective.

Healthwatch Enfield proposes:

1. with partners' consent, to co-produce means of implementing and embedding recommendations contained within this report, with the aim of developing a local co-production approach to redesigning and improving mental health services in Enfield

2. to promote the concept of co-production through Enfield's Health and Wellbeing Board and its member organisations

Let us work with the voluntary and community sector and statutory sector to break down the barriers, co-produce and create new models of care to meet the needs of more than 80,000 of Enfield's residents.

[1] Based on a statistic that 1 in 4 people in the UK will experience a mental health problem (Mind charity) for a population of 320,524 living in Enfield (Office for National Statistics (ONS), 2014)

[2] The Five Year Forward View for Mental Health: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

[3] See Enfield Clinical Commissioning Group's Commissioning Intentions 2016-17 document: http://www.enfieldccg.nhs.uk/Downloads/Commissioning%20Intentions%20-%202016-17%20FINAL.pdf

[4] See 'Transforming London's Health and Care Together':https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/03/lndn-prospectus-upd.pdf

[5] See the 'Enfield Joint Adult Mental Health Strategy 2014 – 2019: http://www.enfieldccg.nhs.uk/Downloads/Policies/HHASC538%20Enfield%20Joint%20Adult%20Mental%20Health%20Strategy%202014-2019.pdf

[6] See Barnet Enfield and Haringey Mental Health NHS Trust's Vision and Values: http://www.beh-mht.nhs.uk/our-vision-values-and-objectives.htm

Introduction

"Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds."

"There is now a need to re-energise and improve mental health care across the NHS to meet increased demand and improve outcomes."

The Five Year Forward View for Mental Health

Background

Soon after our launch in late 2013, Healthwatch Enfield became aware of quite widespread concerns that existing mental health support and services were not satisfactorily meeting the needs of local people. We heard these concerns from colleagues in local voluntary and community sector (VCS) organisations, including members of our Reference Group[1] who generously shared their views with us. We also heard directly from local people at events, such as a consultation on the draft Enfield Mental Health Strategy in January 2014.

In 2013 and early 2014, reports by the Care Quality Commission on wards at St Ann's and Chase Farm Hospitals also revealed a number of serious issues and the Care Quality Commission took Enforcement Action against St Ann's Hospital in January 2014.

We were aware that the concerns being raised were by no means unique to Enfield. It has been recognised, and frequently reported in the media, that mental health care nationally is underfunded, that services are overstretched and that many people with mental health conditions in all parts of the UK do not receive the care that they need.[2]

1 Healthwatch Enfield's Reference Group members include: Southgate Rotary Club, Igbo Union UK, Enfield Asian Welfare Association, Mind in Enfield, Enfield Vision, North London Hospice, Enfield Mental Health Users Group (EMU), Enfield Somali Association, Diversity Living, Enfield Racial Equality Council, Enfield Turkish Cypriot Association, Enfield Saheli, Enfield Disability Action, Greek and Greek Cypriot Community of Enfield, Enfield Carers, The Federation of Enfield Residents' & Allied Associations, Kingdom of Life Chapel, One-to-One Enfield, Age UK Enfield, Over 50's Forum, Obay Community Trust and Age UK Enfield

2 These official reports include:

The Department of Health National Strategy for Mental Health, No health without mental health published in February 2011:
https://www.gov.uk/government/publications/the-mental-health-strategy-for-england
The Department of Health document Closing the gap: priorities for essential changes in Mental Health published in January 2014:
https://www.gov.uk/government/publications/mental-health-priorities-for-change
The CQC's 2015 survey of experiences of people using community mental health services:
http://www.cqc.org.uk/content/community-mental-health-survey-2015
The CQC's report on people's experiences of care during a mental health crisis care Right here, right now published in June 2015
http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf

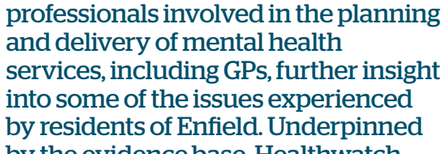
Purpose of this Report

This report seeks[1] to show how the provision of mental health services and support in Enfield look, through the eyes of local people who use them.

Based on two years of engagement work, the document offers local professionals involved in the planning and delivery of mental health services, including GPs, further insight into some of the issues experienced by residents of Enfield. Underpinned by the evidence base, Healthwatch Enfield's recommendations do not only give local people a strategic voice but can also be utilised to form a base for action planning to enhance provision of mental health services across the borough.

The report also highlights a few examples of good practice, which may help provide a focus around which local people and professionals can engage together.

1 Disclaimer: this report reflects the opinions of service users and carers who have spoken to Healthwatch Enfield in a variety of settings, but does not claim to present a comprehensive overview of mental health patients' experiences in Enfield. Comments included should be seen as snapshots of patients' views, which hopefully provide a good indication of some of the key issues.



Methodology

To establish the evidence base, Healthwatch Enfield adopted a qualitative approach to data collection and grounded theory analysis engaging with more than 220 people. Throughout 2014 and 2015 we sought the views of mental health service users and carers on their experiences of the support and services available; we also collected feedback from staff working to provide mental health care.

We collected comments and feedback from local people with experiences of:

1. acute and tertiary care services
2. secondary services
3. community support

through:

1. focus groups and engagement events
2. online and print media including surveys and "Tell us your story" cards
3. indirect contact over the phone, via e-mail or post
4. Enter and View visits to mental health services

For details of all activities, please refer to Appendix A.

Findings

Theme 1: Availability of Support

"Admissions to inpatient care have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed."

The Five Year Forward View for Mental Health

Strategic recommendations

- That mental health services are designed and available to meet patients' complex needs within a variety of settings i.e. community care, supported accommodation and acute wards
- That access to support and specialist services is made available through Primary Care / GPs
- That the role and importance of carers is recognised within Primary Care and specialist support settings

Evidence base

Concerns over the Availability of Adequate Support

The overwhelmingly most powerful concerns that were raised during our extensive engagement concerned instances where people with mental health problems are not receiving, or are no longer receiving, the level of support that they felt they needed. This was highlighted by service users, carers and professionals.

The issues raised ranged widely, from long-term support in the community, to support from GPs, to crisis care, to wider access to therapeutic treatments.

Long-Term Support in the Community

"Failure to provide care early on means that the acute end of mental health care is under immense pressure. Better access to support was one of the top priorities identified by people in our engagement work."

The Five Year Forward View for Mental Health

continued...

We heard from a number of regular Enfield service users that they felt anxious, or even abandoned, by what they experienced as a lack of ongoing support when they were living in the community. For example:

> 'Current mental health services are focused on the acutely ill. There is now almost no provision for people with long-term mental illness in the community.' (Service user)

> 'My social worker has told me they have to cut down the numbers of patients they see. Once they take someone off their patient list, 3 months after, the patient is in crisis again. Why are they being allowed to make people who are coping a bit better ill again 3 months later?' (Service user)

> 'My husband has been discharged from his support group and family counselling and feels very isolated now'. (Carer)

'I feel so let down by the way mental health services have deteriorated over the years. Self-harm and thoughts of suicide often come to mind.' (Service user)

Recommendation 1 on Long-Term Support in the Community

Enfield Clinical Commissioning Group and London Borough of Enfield commissioners should invite service users and carers to work with them to co-produce commissioning intentions for adequate support services in the community for people with long-term mental illness. Service users and carers should also be invited to help determine appropriate targets and success measures for the relevant services.

The Key Role of GPs

"GPs' core role will be to provide first contact care to patients with undifferentiated problems, provide continuity of care where this is needed, and act as leaders within larger multidisciplinary teams with greater links to hospital, community and social care specialists."

Dr Arvind Madan, GP, Director of Primary Care, NHS England, in the General Practice Forward View

In the course of Healthwatch Enfield's engagement work we have heard concerns from local voluntary and community sector organisations that there are people with emerging or undiagnosed mental health issues not receiving any support from their GP, nor any guidance as to where else to seek help. We also found that longer term mental health service users were often either unaware that they could receive support and guidance via their GP, or lacked confidence in their GP's ability to give support or to make appropriate referrals. For example:

> 'There is a lack of experience of mental health on the part of some GPs, so the patient doesn't get appropriate help.' (Input from attendee at HW Enfield annual conference 2014)

continued...

'Most [service users] did not seem to see their GP as someone they would go to about their mental health.' (Notes from engagement event with service users)

'Do GPs pro-actively see their mental health patients periodically? If not, perhaps they should, just as they would expect to see their older, at risk, patients periodically?' (Service User)

There is plainly a need for GPs to provide a consistently good service that meets the needs both of people with emerging mental health issues and those with longterm mental health needs.

Recommendation 2 on Initial Access to Support via GPs

Enfield Clinical Commissioning Group and London Borough of Enfield commissioners should invite service users and carers to work with them to co-produce commissioning intentions for adequate support services in the community for people with long-term mental illness.

Enfield Clinical Commissioning Group together with NHS England commissioners need to commission all GPs to identify early signs of mental ill health and to give guidance and/or make prompt, appropriate referrals. All GPs should be required to undertake adequate training to do so.
Service users and other members of the public should be invited to be involved in providing the training and in determining appropriate targets and success measures.

Recommendation 3 that GPs Need (Access to) Good Knowledge of Specialist Services

Enfield Clinical Commissioning Group and NHS England commissioners must ensure that GPs are sufficiently aware of what mental health services are currently available, and of the pathways to these services, particularly for long-term mental health issues.

Alternatively, GPs should appropriately access a professional for prompt advice on services available, the referral methods, pathways, waiting times and expected outcomes.

Service users and carers should be invited to be involved in determining appropriate targets and success measures.

Crisis Support

There is something of a crisis in mental health crisis care across the country. In its recent review of crisis care[1], the Care Quality Commission found that only 14 per cent of adults surveyed felt that they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Enfield is by no means unique.

Throughout the data collection stage, service users, carers and professionals raised serious concerns with Healthwatch Enfield about the timeliness and quality of Barnet Enfield and Haringey Mental Health NHS Trust's Crisis Resolution and Home Treatment Team (CRHTT). These included lack of effective support and particularly issues caused by delays, for example:

'The crisis people on the phone are useless, they don't know you, they don't know your background. There is no relationship there; they make you feel worse.

'There are no proper plans for support that are followed through.' (Service user)

'In one case it took five hours before CRHTT arrived to assess a patient, whom they agreed needed to be admitted. After waiting over 24 hours, the family then took her to hospital themselves. During the long wait for help, the patient was extremely disturbed, refused to eat, and the family were very worried for her safety.' (From a carer during an Enter and View visit to an acute mental health ward)

'Acute ward staff told us that they sometimes had to wait a long time (for example from 1pm to 6pm) for a response from the CRHTT when they were trying to organise a discharge.' (From an Enter and View visit to an acute mental health ward.)

Recommendation 4 to Review CRHTT to Meet Patient Needs

Enfield Clinical Commissioning Group and Barnet Enfield and Haringey Mental Health NHS Trust should together review the capacity and capability of the Crisis and Resolution Home Treatment Team (CRHTT) to meet patient needs.

Service users and carers should be involved in describing their recent experiences, in ensuring that the service specification is appropriate and in agreeing appropriate targets and success measures.

Many professionals, including managers of mental health wards and the mental health Recovery House, have also highlighted to Healthwatch Enfield lack of suitable suitable accommodation in the community[2].

1 See the CQC report at: https://www.cqc.org.uk/sites/default/files/20150630_righthere_mhcrisiscare_full.pdf

2 The Recovery House has only 12 spaces for Enfield patients who have been transferred from acute care, and it can be hard to transfer people because of a lack of suitable accommodation to move on to.

continued...
Staff have told us of a severe shortage both of acute beds and of accommodation post discharge contributing to some of the delays that patients experience in being admitted in the event of an emergency. Maria Kane, Chief Executive of Barnet Enfield and Haringey Mental Health NHS Trust, has echoed the concerns of her teams further in BBC's Panorama programme[3].

Recommendation 5 to Review Acute Beds and Community Support

Enfield Clinical Commissioning Group and Barnet Enfield and Haringey Mental Health NHS Trust should review the adequacy of the number of acute adult mental health beds available, in conjunction with a review of the availability of appropriate alternative intensive support in the community.

Service users, carers and community groups should be invited to be involved in the review, to explain the impact that the non-availability of a bed or of appropriate alternative support can have on them.

"NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission."
The Five Year Forward View for Mental Health

3 The Panorama programme is available to watch online until October 2016: http://www.bbc.co.uk/programmes/b06n447l

Recommendation 6 to Provide More Supported Accommodation:

Enfield Clinical Commissioning Group should commission more supported accommodation for people with long-term mental health needs, including additional support of the type offered at Recovery Houses.

Service users and carers should be invited to be involved in the commissioning and procurement processes.

Access to Relevant Therapies

NHS England will: "Invest in an extra 3,000 mental health therapists to be working in primary care by 2020 to support localities to expand the Improving Access to Psychological Therapies (IAPT) programme.....which is **an average of a full-time therapist for every 2-3 typical sized GP practices**." General Practice Forward View[4]

Despite the ongoing programme of Improved Access to Psychological Therapies (IAPT), which is due to be supplemented under plans set out in the General Practice Forward View, many people told us that there was insufficient access to therapeutic help.

4 General Practice Forward View, published by NHS England in April 2016, in partnership with the Royal College of General Practitioners and Health Education England. https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

continued...
Of course, not everyone is eligible or appropriate for the interventions offered by IAPT, and local people have suggested to us that eligibility should be extended to people with dual diagnoses, such as a mental health issue and an addiction. We understand that some treatments can be regarded as ineffective until someone has begun to address an addiction, but we note that the Crisis Concordat Action Plan published by Enfield Clinical Commissioning Group in October 2015 appears to make no reference to dual diagnosis. Appropriate therapies and support need to be available.

In addition, service users have complained of a lack of other therapeutic interventions; for example:

'There is strong support for increasing access to talking therapies.' (Comments recorded at mental health strategy consultation)

'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)

'Enfield's Drug and Alcohol service is a "dumping ground" for people with a dual diagnosis of mental health problems and substance misuse, as they are not eligible for IAPT services.' (Comment from a professional at a Healthwatch Enfield consultation event.)

'There is a need for more innovation in supporting people with mental health needs, eg creative therapies such as art, poetry etc.' (Service user)

Recommendation 7 on Wider Access to Community Therapies

Enfield Clinical Commissioning Group, in partnership with London Borough of Enfield commissioners, should work with service users, carers and other members of the public to commission psychological therapies and other non-pharmacological treatments, including a range of talking therapies, creative activities and encouragement to exercise. These should be available to any service user or GP patient who could benefit from such treatment, including people with dual diagnoses.

Service users, carers and other members of the public should be involved in determining appropriate targets and success measures for these therapies.

Recommendation 8 on Therapies for Acute Wards

Enfield Clinical Commissioning Group should commission appropriate Improved Access to Psychological Therapies (IAPT) or other one-to-one talking therapy, a range of creative activities, and exercise options for all those patients in acute wards or community settings who need it.

Service users and patients should be involved in determining appropriate targets and success measures for these therapies.

continued...
It has been suggested to Healthwatch Enfield that not all therapists at some services have enough patients to treat. Without commenting on the accuracy of this suggestion, it may be helpful for commissioners and providers to look into whether any of the therapists employed by different services could be shared across more than one service, where their skills allow this. Such additional flexibility could enable resources to be diverted to wherever they are most needed.

Supporting and Listening to Carers

Carers can often feel ignored. Their concerns about the health and wellbeing of the person they care for can be ignored by professionals, as can the carers' own health and wellbeing needs.

According to an analysis by NHS England, quoted in The Five Year Forward View for Mental Health, the roles played by family and other unpaid carers in supporting people with mental health needs constitutes the single greatest contribution to the overall costs of dealing with mental health issues in England. The contribution of carers is valued at over £14 billion a year, with the NHS spending just over £9 billion. This underlines how essential it is, financially as well as therapeutically, to take carers seriously, listen to their concerns about their loved ones, and also pay attention to their mental and physical health needs.

At the service users' conference convened by Enfield Mental Health Service Users (EMU) in autumn 2015, there were harrowing tales of professionals not heeding the concerns of family carers, worried that their loved ones' mental health was deteriorating severely. In at least one case, the person had subsequently committed suicide. We have also heard how the issue of patient confidentiality can sometimes prevent carers receiving information that would help them to care for their loved one, such as what the medication arrangements should be. Failure to comply with a medication regime can not only cause someone with a mental health problem to deteriorate or relapse, but can also create additional difficulties for carers.

> 'Professionals did not communicate important information to the carers, such as the fact that a patient had expressed suicidal thoughts.' (From notes of EMU conference)

> 'Mental health carers do not feel they are treated as "partners in care" as recommended by the Carers Trust Triangle of Care document.' (From engagement event with mental health carers)

Healthwatch Enfield recognises that it can be difficult for professionals to strike an appropriate balance between the potentially conflicting needs and preferences of those who are carers and those who are cared for, but encourages all professionals to involve or inform carers wherever possible.

Recommendation 9 to Listen to Carers

All staff working with people with mental health issues should remember to find out about any carers, involve them wherever possible, and take notice and appropriate actions when the carers raise concerns about the person they care for.

Service users and carers should be invited to be involved in developing protocols for how this may work and for how it should be monitored. Carers of people with mental health needs have told us that they do not feel well supported. Family and other informal carers often play a vital role in the wellbeing of someone experiencing mental health problems, and yet their role may go unappreciated, or even completely unrecognised, by professionals.

> 'Several of the carers are also suffering from depression and are in need of mental health services themselves.' (From engagement event with mental health carers)

> 'No, adult social care does not give me the support required for me to have a life of my own.' (Carer)

> 'Not all local GP practices are willing to cooperate with the Carers Centre. Some practices make lots of referrals to the Carers Centre, but others are not even willing to talk to the Carers Centre.' (Carers' support worker at engagement event)

> 'We have a lot of service users who are discharged but I think that carers would be reassured if their files were left open, but dormant, so that there is a team who is still responsible in an emergency, rather than the usual chasing different teams or arranging referrals in stressful circumstances.' (Comment from local VCS representative)

Recommendation 10 on GP Support for Carers

Enfield Clinical Commissioning Group should ensure that GPs provide proactive support to informal carers of people with mental health needs, including offering regular health checks, and referring carers to other sources of information and support, such as Enfield Carers Centre.

Carers should be invited to be involved in developing success measures for greater support for carers.

Recommendation 11 to Embed the Triangle of Care

Barnet Enfield and Haringey Mental Health NHS Trust should work towards embedding the Carers Trust's Triangle of Care[5] standards throughout the Trust, to ensure that carers are respected and supported.

Carers should be involved in developing measures of success.

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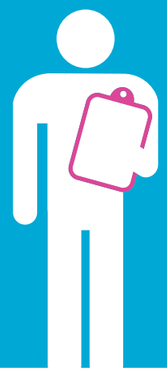
5 The Carers Trust has produced a guide called The Triangle of Care, Carers Included: A guide to best practice in mental health care in England, which has recently been revised and updated. https://professionals.carers.org/working-mental-health-carers/triangle-care-mental-health
The guide is highly practical, and sets out how mental health professionals can work closely with family carers as partners in care, to provide the best support for patients and service users with mental health needs.

Findings

Theme 2: Seamless, Integrated Care



"We should have fewer cases where people are unable to get physical care due to mental health problems affecting engagement and attendance (and vice versa). And we need provision of mental health support in physical health care settings - especially primary care."

The Five Year Forward View for Mental Health

"Currently needs are addressed in isolation, if at all, which is not effective or efficient."

The Five Year Forward View for Mental Health

Strategic recommendations

That services are co-produced, putting mental and physical health on a par, to ensure seamless integrated working and transfers of care

Evidence base

Many people told Healthwatch Enfield that there was an urgent need for local residents with mental health issues to experience seamless support and care. This aligns with national and local initiatives to improve integrated working across professions, services and teams, and also fits well with a more truly person-centred approach to care. With NHS England asking local areas to create fully integrated health and social care systems by 2020-21, there is an urgent need to make further progress in this area.

Service users and carers identified issues of poor linkages between inpatient and community mental health care; between GPs and other services; between physical and mental health care; between handovers from one shift and another, and even between different clinicians within the same service. This can cause anxiety to service users and also increase demands on the system if service users' health is affected; in severe cases, the person's health could be put at serious risk.

People told us:

'There is a lack of continuity of care, both in MH services and GP practices as there is a very high turnover of doctors and social workers. This is particularly disadvantageous to people with complex MH conditions, as it is important for professionals to be aware of their history, and also to build up trust between professional and patient.' (From engagement event with mental health carers)

"I have been in mental health since 1983 and there has never been cooperation between GPs and

continued...
clinics over blood test results, which makes the patient piggy-in-the-middle! I would like to see GPs share blood test results with clinics, and vice versa." (Service user)

"Why do letters not reach the next professional?" (Community worker)

'There is no relationship between the Crisis team and Chase Farm hospital and no proper plans for support that are followed through.' (Service User)

'Mental health and social care services were slow to act in a crisis, and in making the assessment and then delivering the outcome. The community care needs assessment took 11 months and there is no plan in place after 1 year.' (Carer)

Recommendation 12 on Seamless, Integrated Working

Enfield Clinical Commissioning Group and London Borough of Enfield commissioners should work together to commission services that enable service users to experience more holistic, seamless care.
This is likely to require more integrated working and sharing of information across GPs, acute services, community mental health services, adult social care and voluntary sector organisations.

Recommendation 13 on Co-Production of Service Design

Service users, carers and providers should be invited to be integral to designing ways for people's support and care needs to be met in a way that is as effortless as possible for the service user. This should also include all relevant stakeholders being involved in agreeing appropriate targets and appropriate success measures.

Recommendation 14 to Ensure that GPs Attend to Physical Health

Enfield Clinical Commissioning Group and NHS England should ensure that GPs are offering regular physical and mental health reviews to patients who have an established mental health condition.

Service users and carers should be invited to be involved in determining what sort of health checks would suit most needs and how these should be delivered.

Recommendation 15 on Seamless Transfers of Care

All providers of mental health services should ensure that the service user or patient is involved in drawing up and agreeing the plan to transfer them from one service into the care of another, including GP care.

'People told us [the Taskforce] that their mental health needs should be treated with equal importance to their physical health needs, whatever NHS service they are using – this is a fundamental principle of the Taskforce recommendations.'

The Five Year Forward View for Mental Health

Findings

Theme 3: A Person-Centred Approach

A person-centred approach means treating each person as an individual and working with them appropriately on the aims, goals and needs that they identify. As well as taking account of cultural expectations and personal preferences, it should also include treating all patients, service users and carers with respect and dignity.

"It goes without saying that people seeking NHS care need to be treated with compassion. But what is sometimes forgotten is that staff do too. The care they receive impacts on the care they are able to deliver."

The Five Year Forward View for Mental Health

Strategic recommendations

That appropriate staffing levels are in place to ensure pathways reflect the requirements of individuals with complex needs and are tailored to individual circumstances and preferences

That the physical environment within mental health services is improved to improve patients' safety, confidentiality and respect

Evidence base

We observed instances and heard local people' accounts indicating that staff shortages mean service users are not always treated with a person-centred approach that promotes their mental wellbeing. This is particularly true for patients on acute wards; for example:

'The incidences of aggression between patients that we witnessed and heard about, where staff apparently did not intervene effectively, suggested to us that not enough staff are available to give concerted one-to-one support to patients who are very disturbed or distressed.' (Enter & View report)

'I felt intimidated by another patient who entered my room and demanded money and toiletries. (The lock on my door was not working). I complained to staff and was ignored. I requested medication for my panic and anxiety – again ignored.' (In-patient during an Enter and View visit)

'The system of allowing patients home on leave without discharging them, but not saving their place in the ward, appears to us to be an uncomfortable compromise that is likely to disrupt continuity of care and does not demonstrate a person-centred approach.' (Enter and View report)

continued...
'If staff had more time to spend with patients, and patients had more opportunity to spend their time constructively in absorbing activities, it is possible that there might be a reduction in [this type of] challenging behaviour.' (Enter and View report)

The evidence base gathered by Healthwatch Enfield indicates that staff shortages in mental health services in Enfield are reducing staff capacity to provide person-centred care. Although this is particularly evident in acute settings, it is quite possible that it also plays a role in the nature and quality of care experienced in community settings.

Recommendation 16 to Review Staffing Levels to Improve Person-Centred Care

Enfield Clinical Commissioning Group commissioners should work with London Borough of Enfield commissioners, providers, service users, carers and the Voluntary and Community Sector to build on the findings of the Carnall Farrar review of mental health care in Enfield to determine what level of staffing would be necessary to provide appropriately person-centred care, particularly, but not exclusively, in acute settings.

In addition, it is plain that the *poor physical environment* offered at the St Ann's site, in particular, is not conducive to providing person-centred care that responds to individuals' needs or treats them with dignity.

'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)

Recommendation 17 to NHS England and NHS Improvement to Improve the Physical Environment

NHS England and NHS Improvement should work with any other relevant bodies to enable urgent investment in the St Ann's site, in particular, to allow patients to benefit from a modern environment more conducive to their recovery.

Supporting minority ethnic groups

It is well-known that people from certain ethnic groups tend to be over-represented among mental health service users and that cultural differences can lead to misunderstandings and even misdiagnosis. There is some concern locally that people with mental health needs from BAME (Black, Asian and Minority Ethnic) communities may not always receive culturally competent support. For example:

'It should be noted that people from the Caribbean community are often misdiagnosed and do not receive appropriate culturally sensitive treatment. The issue is not one of language but rather cultural barriers that exist in accessing healthcare.' (Comments from local voluntary sector representative)

'There are indications that people with mental health needs from BAME communities tend to

prefer to self-refer to community organisations offering support.' (From mental health strategy consultation)

'We need a strategy on how to roll out some of the good work done around race and mental health.' (From Healthwatch Enfield annual conference 2015)

Recommendation 18 to Work with BAME Groups to Extend Good Practice

Enfield Clinical Commission Group and London Borough of Enfield commissioners should work with providers to explore with local BAME (Black, Asian and Minority Ethnic) community groups and service users how to build on good practice so as to provide person-centred services that meet the needs of all sections of the community.

Supporting people with learning disabilities

Service users with learning disabilities as well as mental health needs do not always get timely or appropriate support. We were also told that there is no clear support pathway for people with high functioning autism who, it was said, currently fall between learning disability and mental health services. For example:

'There was a long wait for an assessment from mental health services and learning disabilities. Complex needs are not considered – they only do one condition at a time.' (Carer)

Recommendation 19 to Review Pathways for People with Complex Needs

Enfield Clinical Commissioning Group and London Borough of Enfield commissioners should invite carers and service users to review with them the care pathways for people who have both a learning disability and a mental health condition, to ensure that people with complex needs receive appropriate treatment, and that their families receive appropriate support.

Supporting Deaf people

We have been told that there is no specific local provision for Deaf people who use British Sign Language (BSL) and who have mental health needs, nor for their families. Although we can understand that the numbers involved are small, such people could become very excluded and more ill, if their needs are not addressed; for example:

'It is very difficult for Deaf people to access counselling services. There should be staff who are trained to use BSL to make communication easier for Deaf patients. Family and friends of Deaf people with mental health problems need help. Especially if they too are Deaf.' (Comment at Healthwatch Enfield annual conference 2015)

With services increasingly being commissioned across the larger 'footprint' of North Central London (NCL), this may create opportunities to ask local people with more specialist needs, such as BSL users, whether or not they might prefer a pan-NCL service, if it were able to be more tailored to their requirements than a purely Enfield-based service.

Recommendation 20 to Review Person-Centred Support for Deaf Service Users

Enfield Clinical Commissioning Group and London Borough of Enfield should invite Deaf service users and carers to co-produce commissioning intentions for local mental health services that are accessible and appropriate to Deaf people, whether across North Central London or just for Enfield.

Interpreting services

A number of local people have told us of problems with the accuracy of interpreting services when accessing health services, including mental health support, which can lead to misdiagnoses and mistreatments. Those using interpreting services – both the individual and the care professional – could be completely unaware of any inaccuracies or failings by the interpreter.

Healthwatch Enfield recognises that it may be difficult to ensure high quality interpreting at all times as there is no independent check on the performance of interpreters. At present, the only control is that interpreters are required to have appropriate interpreting qualifications, but this does not necessarily mean that they are competent to deal with potentially technical health matters, including mental health matters.

We propose that consideration be given to systematically collecting and acting on feedback from users about the interpreters provided to interpret. This should not involve much cost, and could improve the quality of interpreting, if services decline to use interpreters who have received a number of poor ratings. Such an approach may be applicable across NCL and not just Enfield.

Recommendation 21 to Review How to Improve Interpreting Services

Enfield Clinical Commissioning Group and London Borough of Enfield commissioners should work together with service users, carers and providers to agree on ways to try and improve interpreting services used for health and social care, including mental health.

Theme 4: Communication

Poor communication can cause uncertainty, confusion and anxiety and could contribute to delays in people receiving the appropriate treatment or support. In the course of our work, we heard or witnessed ways in which communication could be improved across many aspects of the mental health 'pathway'.

Strategic recommendations

That all means, channels and forms of communication within mental health services, including between staff, staff and patients, and between staff and carers, are reviewed to improve patients' and carers' experience

That mental health service staff have relevant knowledge, which is underpinned by availability of information materials for patients, their families and carers

That mental health awareness training is available to professionals working with people with mental health needs

Evidence base

We heard that some service users would like more information when *admitted* to hospital, which they would then take in as soon as they felt able. During our Enter and View visits, Healthwatch Enfield found that the quality of information provided by acute wards to patients and carers was inconsistent and in some cases very poor, and this was reflected in feedback at engagement events. For example:

> 'Although some service users questioned the necessity or importance of giving seriously ill patients a written information pack, others thought it essential, even if the person could not absorb it initially.' (Notes from consultation event)

'It was stressed that it was important that providers not rely solely on written information, as some patients would not be able to read it or take it in, either because of their condition, or because they were not fluent in reading English etc. So speaking to patients about the information was also essential.' (Notes from consultation event)

Recommendation 22 to Provide Information Packs on Acute Wards

Service users and carers should be invited to be involved in developing clear and up-to-date information packs that can be given and also explained to all patients when they arrive on a ward. All information provided to patients and families, including on noticeboards, should be regularly reviewed and updated.

Feedback from a wide range of service users, carers and community workers pointed to an even more pressing need for much better communication with patients and their carers when they are transferred (or discharged) from hospital to GP care, care in the community or other specialist services. For example:

> 'Patients being discharged from an acute ward should be given a plain English discharge plan explaining clearly what to expect next and how to get help if needed.' (Community worker)

> 'There is a need for much better communication over discharge arrangements; why people are being discharged, ongoing support such as mental health drop-in services and the support that people can access if they need to.' (Service User)

> 'There are concerns about discharge to primary care from secondary care and about the language that is used, i.e. that the word "discharge" may give the impression to the service user that they are being abandoned, rather than emphasising the continuity of care they should receive from GP and community services when they leave hospital.' (Comments at mental health strategy consultation)

Recommendation 23 on Communication Around Transfers of Care

Service users who are being transferred from specialist mental health services to the care of their GP should be helped to understand the reasons for this change, and should receive good information about sources of ongoing support in the community. Service users and, where appropriate, their carers should be involved in drawing up and agreeing any plan to transfer them into GP care, including a backup plan in case of need.

Feedback received by Healthwatch Enfield has also clearly demonstrated that many service users living in the community had no understanding of why their support arrangements had been reduced and/or changed; this was true even for some people still in regular contact with low level support services. For example:

> 'I don't understand why I only see my psychiatrist once a year as he is the only person who is in charge of my dosage of medication.' (Service user)

> 'Someone who had taken on a part-time job had been told that if they were able to work, they could not require so much support as before, but they could not accept this. The person felt they needed a "safety net" and feared ending up back in hospital if they had no ongoing support.' (From engagement event with service users)

Recommendation 24 on Communication Around Changes to Support

All providers of mental health services should ensure that the service user or patient receives clear communication around any changes to their care or support arrangements, including a clear explanation as to the reason for this change. Service users and, where possible, their carers should be involved in drawing up and agreeing any plan to make changes to an individual service user's care or support arrangements, including a back-up plan in case of emergency.

In improving their communication with patients, it is essential that professionals do not overlook carers. We heard that patients and carers do not always feel listened to when they raise concerns. For example, on one of our Enter and View visits, where carers were dissatisfied with the patient's care, the family member felt that the 'patient was too scared to complain and that staff didn't want to talk to relatives.'

Recommendation 25 to Listen to and Communicate with Carers

Mental health professionals should be more willing to listen to informal carers and to communicate with them when carers express concern over the apparent deterioration in the mental wellbeing of a patient. Carers and service users should be invited to be involved in drawing up good practice guidelines for professionals to follow and in determining measures of success in making improvements.

There were numerous comments about changes of staff across all services. While Healthwatch Enfield understands the reasons behind some of the staffing issues, we believe that more could be done to mitigate the impact on patients and service users.

Recommendation 26 on Improving Communication between Staff

Service users and carers should be invited to work with professionals to draw up a protocol on what sort of information they would like to be recorded and passed on among staff to improve the seamlessness of their care.

Throughout our engagement work, service users and their carers expressed their discontent with poor communication about cancelled appointments, which could have an adverse impact on service users. It was noted that:

'Service users receiving these services are very vulnerable people, and professionals cancelling an appointment should always send a letter explaining the reason for the cancellation.' (Community worker)

Recommendation 27 to Inform People about Cancelled Appointments

Care coordinators and other professionals should make every effort to keep appointments, should always let service users and carers know immediately if an appointment needs to be cancelled at short notice, and should follow up promptly with a full explanation and a rearranged

continued...
appointment.

Service users and carers told us of lack of clarity around personal budgets.

Recommendation 28 to Improve Professionals' Knowledge of Personal Budgets

Care coordinators and other professionals should receive regular, up-to-date training to ensure they understand and can explain to service users the basics of personal budgets and know who can provide them with more detailed information.

Although there has been a very welcome change in tone in the public debate around mental health in recent years, the problems of poor understanding and stigma remain. These can contribute to delays in people seeking help and to delays in recovery, as people may not feel able to communicate openly with others about their mental health problem.

As noted in The Five Year Forward View for Mental Health, "The employment rate for adults with mental health problems remains unacceptably low: 43 per cent of all people with mental health problems are in employment, compared to 74 per cent of the general population and 65 per cent of people with other health conditions." Poor understanding of mental health issues can cause specific problems for service users, for example:

> 'There is a mismatch between the sort of jobs suggested at job centres to people in recovery from mental illness and the sort of jobs which would be appropriate, sometimes leading to people being sanctioned and having their benefits withdrawn because they were perceived as not making themselves "available for work".' (Comments recorded at mental health strategy consultation 2014)

Recommendation 29 to Extend Mental Health Awareness Training to JobCentre Plus

Enfield Clinical Commissioning Group and London Borough of Enfield commissioners should work together to commission mental health awareness training for frontline staff of JobCentre Plus offices in the borough. Service users should be invited to be involved in designing, and possibly delivering, the training.

"Employment is vital to health and should be recognised as a health outcome. The NHS must play a greater role in supporting people to find or keep a job."

The Five Year Forward View for Mental Health

Good Practice within Mental Health Sevices

Throughout the period of establishing an evidence base for this report, Healthwatch Enfield became aware of examples of good practice in mental health services within the borough and beyond.

We welcome a number of local initiatives and we would like to see these systematically spread to all relevant services. Enfield's good practice should not be a matter of individual initiative, but of sustained organisational effort; an effort that is underpinned by methods for spreading and implementing good practice within organisations, across boroughs and across providers. The greater involvement of service users and carers would support this.

Within this section, we also include examples of national initiatives not because we think that commissioners and providers will be unaware of them, but because they may be **worthy of exploration by commissioners and providers, working together with service users and carers in Enfield**, to explore the journey of co-production.

Local Examples of Good Practice

1. **Commendation for Barnet Enfield and Haringey Mental Health NHS Trust for Acting on Patient Concerns**

   During our Enter and View visit to Barnet Enfield and Haringey Mental Health NHS Trust's Downhills Ward, we were pleased to find that learning from complaints from patients or residents about "staff attitude" had been taken seriously and acted upon with the introduction of training on cultural awareness, communication and customer service skills.

2. **Commendation for Rethink Mental Illness Recovery House re Service User and Staff Relationships**

   In the course of our Enter and View visit to Enfield's Recovery House on Green Lanes, run by Rethink Mental Illness we found that the relationships between service users and staff in Suffolk House appeared to be a model of good practice. A systematic training programme for staff helped to ensure a consistent and high quality experience for service users.

3. **Commendation for Rethink Mental Illness Recovery House Welcome Pack**

   The Rethink Mental Illness welcome pack provided to patients arriving at the Suffolk House Recovery House appears to Healthwatch Enfield to be a model of good practice that provides a range of practical information for service users and should be considered by other mental health services, in conjunction with their users.

4. **Commendation for Enfield Council re Drop-Ins**

   Many of the service users we met at the women's drop-in and at the mixed drop-in at the Mental Health Resource Centre at Park Avenue expressed strong appreciation for these services. Service users valued the combination of social interaction, food, advice, and encouragement that they received. We include this as an example of good practice as service users' regular attendance, as well as some of the feedback received, suggests that this support service is well-regarded.

5. **Commendation for Enfield Clinical Commissioning Group re a Willingness to Trial New Approaches**

   Enfield, along with other boroughs, has trialled the 'Big White Wall' online service where people with mental health problems can sign up for the support of an online community and also receive expert mental health advice.

   Healthwatch Enfield welcomes Enfield commissioners' willingness to trial new approaches to supporting people with mental health problems.

6. Commendation for Barnet Clinical Commissioning Group re Co-Production

In Barnet which like Enfield is served by Barnet Enfield and Haringey Mental Health NHS Trust, an initiative by Barnet Clinical Commissioning Group called Barnet Breakfast Club brought together service users, carers, the London Borough of Barnet's councillors, mental health service providers from across the primary, secondary and community sectors, and clinical and social care staff. The purpose of the series of Breakfast Club meetings was to instigate a process of 'participative redesign' of the Borough's mental health service models. At the same time, work commissioned from UCL Partners by Barnet Clinical Commissioning Group clearly indicated that community-based, responsive services were essential to prevent escalation of conditions and to reduce emergency admissions.

Healthwatch Barnet has reported favourably on this initiative, which has apparently led to people from the Breakfast Clubs forming 8 co-design groups working towards developing and refining specific services, and work is ongoing on this.

Healthwatch Enfield welcomes the co-production at the core of this work in Barnet and would like to see co-production work developed further by commissioners and providers in Enfield.

Examples of Good Practice from elsewhere

7. Good Practice in Co-Designed Mental Health 'Safe Spaces'

Across the country, co-production of services has led to the creation of 'safe spaces' where informal and formal support is provided for people experiencing mental health problems.

For example, 'Talking Shops'[1] in Doncaster and Scunthorpe enable members of the public to walk in off the street and receive information or advice about any mental health problems they may be experiencing, such as depression, panic or phobias. The service also refers people into the local IAPT provision and referrals have reportedly soared.

In Aldershot, on the Hampshire/Surrey border, service users themselves initiated the idea of the 'Safe Haven' café[2]. It is an evening drop-in where people can go if they need support. Anyone experiencing a mental health issue, diagnosed or not, can drop in for a cup of tea and a chat and be referred for more formal help, if required. NHS staff and third sector partners are on site to provide mental health crisis support.

1 http://mentalhealthpartnerships.com/project/talking-shops-in-doncaster-and-scunthorpe/

2 https://www.england.nhs.uk/mentalhealth/case-studies/aldershot/

continued...

Its success in 'de-escalation' is believed to have contributed to a one-third reduction in mental health hospital admissions in the area over a seven month period.

8. Good Practice re Person-Centred Care

A home treatment team (HTT) in Bromley[3] in South London, tasked with helping keep people with mental health crises out of hospital, says its success is due to patients constantly helping them to improve their care.

The Bromley Home Treatment Team, providing outreach care 24/7 to people in crisis, seeks to support people at home and avoid unnecessary admissions to hospital. Bromley was one of the pilot sites for the new Royal College of Psychiatrists' Home Treatment Team accreditation system. They use a realtime "outcomes measurement" system so professionals can see the severity of patients' mental health, monitor changes over short time periods, and use the information both to aid clinical decision making and to get a better understand of what is working well (and less well).

9. Good Practice re Parity of Esteem

According to NHS England, Leicestershire Partnership NHS Trust (LPT)[4] is one of just a few trusts in the country that is pursuing changes designed to ensure that the physical health of people with mental health illness is treated as importantly as their mental health.

Leicestershire Partnership NHS Trust has developed a physical health register to try to ensure that every adult on its mental health wards gets a 'physical MOT'; a set of checks including weight, blood pressure and blood tests and is asked about smoking, alcohol consumption, substance misuse and diet.

3 http://mentalhealthpartnerships.com/project/bromley-home-treatment-team/

4 https://www.england.nhs.uk/mentalhealth/case-studies/leicester

Replicating Good Practice in Enfield?

Adopting new delivery models is never easy but the approach creates opportunities for innovating on the frontline, creating new partnerships and re-energising the local community.

It may be argued that implementing tested models for providing mental health support and services within Enfield requires additional resources. However, according to data published by the National Audit Office, many Clinical Commissioning Groups are, like Enfield Clinical Commissioning Group, under-funded compared to their target allocation[5].

North-East Hampshire and Farnham Clinical Commissioning Groups, for example, where the 'Safe Haven' café was established, was 'underfunded' by some 3.7% compared to its target allocation in 2014-2015, using the National Audit Office figures. Both East and West Leicestershire Clinical Commissioning Groups were underfunded by 7.2% and 5.2% respectively. Bromley Clinical Commissioning Group was underfunded by some 8.2%. In the same year, Enfield Clinical Commissioning Group was under-funded by 6.7%.

Healthwatch Enfield takes heart from the fact that even in areas that are below their target funding allocations, it has been possible for good co-production work to take place, leading to interesting and positive initiatives. We hope that similar initiatives that build on the learning from their predecessors will also prove possible in Enfield.

5 'Funding healthcare: Making allocations to local areas. Allocations to local commissioners 2014-15' published by the National Audit Office (NAO). https://www.nao.org.uk/wp-content/uploads/2014/09/Funding-healthcare-making-allocations-to-local-areas-Allocations-to-local-Commissioners-2014-2015.pdf

Conclusion and Next Steps

The message is clear. The voices of service users and carers should be at the core of designing and improving mental health services in Enfield.

For over two years, Healthwatch Enfield has listened to people's stories. Stories about their successes, struggles and challenges. Stories that helped us develop an evidence base for answering the basic question of "What works?"

Enfield's residents have told us...

... it is about embedding continuous co-production to ensure services meet the ever-changing needs of the ever-changing population within the borough

... it is about service users, patients, carers and the public working alongside mental health professionals, commissioners and decision makers having the voice of influence and power

... it is about flexibility, responsiveness, innovation and risk taking.

As recommended by the Five Year Forward View for Mental Health:

1. Decisions must be locally led
2. Services must be designed in partnership with people who have mental health problems and with carers
3. Inequalities must be reduced to ensure all needs are met, across all ages
4. Care must be safe, effective and personal, and delivered in the least restrictive setting

On behalf of Enfield's residents, as their statutory champion, Healthwatch Enfield is making the first step asking others to co-produce means of implementing and embedding recommendations contained within this report, with the aim of developing a local co-production approach to redesigning and improving mental health services in Enfield.

Only through working together and across all levels, we can co-produce truly responsive services, therefore Healthwatch Enfield's aim is to promote the concept of co-production through Enfield's Health and Wellbeing Board and its member organisations.

"There should be even greater emphasis put on people's experience and how experts-by-experience can be seen as real assets to design and develop services."

The Five Year Forward View for Mental Health

Appendix A: Healthwatch Enfield's Collection of Evidence

Throughout 2014 and 2015 Healthwatch Enfield sought the views of mental health service users and carers on their experiences of the support and services available. We also collected feedback from staff working to provide mental health support.

We collected comments and feedback from local people with experiences of acute services, intermediate services, and support received in the community. We conducted four Enter and View[1] visits to mental health services, collecting detailed information, and also trialled a mental health service users survey in 2014. In all, we estimate that in our work on mental health over two years, we have engaged directly with and/or heard from more than 220 people:

- at least 130 mental health service users
- at least 28 carers of people with mental health needs
- at least 39 staff working with people with mental health needs
- plus a further number who sent us information or feedback for example by phone, email or survey

1 Healthwatch Enfield has the statutory authority to carry out Enter & View visits to health and social care premises to observe the nature and quality of services. We can hold local providers to account by reporting on services and making recommendations. See http://www.healthwatchenfield.co.uk/enter-view

We undertook targeted focus groups and engagement events specifically around mental health issues with the following:

- Enfield Clubhouse
- MIND service users drop-in
- Enfield Mental Health Users Group (EMU) "speakers corner"
- Mental Health Resource Centre women's drop-in
- Mental Health Resource Centre mixed drop in
- Emerald House (One Housing)
- Park Road (One Housing) house
- Saheli Asian women's drop-in
- Carers Centre Mental health carers group
- Wellbeing Connect Services

We also collected feedback on mental health issues in the course of general engagement work with other groups, including:

- Carers Centre GP forum
- Chinese Community
- Over 50s Forum
- Turkish Community
- Parent Engagement Panel local meetings
- Other parent groups
- Healthwatch Enfield Annual Conferences 2014 and 2015
- The Healthwatch Enfield Reference group

By attending or participating in engagement events organised by other organisations, we also collected further helpful information:

- Enfield Mental Health Service Users (EMU) conference on Enablement and Wellbeing, September 2015, with over 100 attendees
- MIND-in-Enfield Annual General Meeting (AGM), September 2015, with over 60 attendees

In addition, we met staff at:

- Enfield Mental Health Users Group (EMU)
- MIND-in-Enfield
- Patient Experience staff at Barnet Enfield and Haringey Mental Health NHS Trust

Enter and View visits conducted:

The Oaks Ward, Chase Farm
mixed ward for older patients (65 plus) needing inpatient mental health treatment (visit conducted jointly with Healthwatch Barnet, December 2014)

Suffolk Ward, Chase Farm
adult female acute mental health ward (visit conducted jointly with Healthwatch Barnet, March 2015)

Downhills Ward, St Ann's Hospital
adult female acute mental health ward (visit conducted jointly with Healthwatch Haringey, March 2015)

Suffolk House, Palmers Green
mental health recovery house provided by Rethink Mental Illness with clinical support from BEH MHT Crisis Resolution and Home Treatment Team (CRHTT) (October 2015)

All published reports on our Enter & View visits to mental health services appear on Healthwatch Enfield's website.[2]

2 http://www.healthwatchenfield.co.uk/enter-view

If you would like to discuss this report or its findings and recommendations, please contact Healthwatch Enfield

Telephone: 020 8373 6283
E-mail: info@healthwatchenfield.co.uk
Twitter: @HealthwatchEnf

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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: 1** | **Item: 10** **Subject:** Review of Immunisation Programmes in Enfield **Wards: ALL**
Director of Health, Housing and Adult Social Care Contact officer and telephone number: Dr Tha Han E mail: **tha.han@enfield.gov.uk** Author: Amanda GOULDEN Immunisation Commissioning Manager NHS England (London Region)	**Cabinet Member consulted:** **Cllr Fonyonga**
	Approved by: **Tessa Lindfield** **Director of Public Health**

1. EXECUTIVE SUMMARY

- The purpose of this paper (Appendix 1) is to provide the Health and Well-being Board with an overview of immunisation programmes delivered in Enfield.

- An action plan has been developed as part of NHS England's ongoing work to improve immunisation coverage in London and outlines ways in which partner organisations could contribute to the work to ensure high levels of immunisation coverage are achieved and sustained in Enfield. This is in recognition of the key elements and partnerships that are essential to the delivery of an effective, equitable and quality assured immunisation service. (Appendix 2)

2. RECOMMENDATIONS

The Health and Well-being Board are asked to note and support the work NHS England (London) are doing to increase vaccination coverage and immunisation uptake in Enfield.

3. BACKGROUND

Immunisation is the most effective method of preventing disease and maintaining the public health of the local population and vaccination and immunisation service exists to ensure the safe and effective delivery of all vaccine programmes. The Enfield Immunisation Plan sets out actions to be undertaken

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

by all key stakeholders in support of coordinated immunisation activities thereby ensuring that vaccines are available and given to the eligible groups at the recommended times.

NHS England, Public Health England, Clinical Commissioning Groups (CCG) and Local Authorities all have a defined role to play, with NHS England assuming the lead commissioning role in line with the Section 7A mandate.

- Section 7a immunisation programmes are universally provided immunisation programmes that cover the life-course and comprise of:
    - Antenatal and targeted new-born vaccinations
    - Routine Childhood Immunisation Programme for 0-5 years
    - School age vaccinations
    - Adult vaccinations such as the annual seasonal influenza vaccination

4. ALTERNATIVE OPTIONS CONSIDERED

Do nothing.

5. REASONS FOR RECOMMENDATIONS

The support by Health and Wellbeing Board members support the work NHS England (London) are doing to increase vaccination coverage and immunisation uptake in Enfield.

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

6.1 Financial Implications

There may be minimal financial implications to the Public Health Grant, related to the communication to care homes about Flu, shingles and pneumococcal vaccinations as a result of this recommendation.

6.2 Legal Implications

Section 2B (1) of the National Health Service Act 2006 requires each local authority to ‘take such steps as it considers appropriate for improving the health of the people in its area’.

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

7. KEY RISKS

Low immunisation uptake does not allow herd immunity of the corresponding infection and thus would not reduce population health risk.

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

8. IMPACT ON PRIORITIES OF THE HEALTH AND WELLBEING STRATEGY

Improvement in immunisation will have positive impact on the following four priorities of the Health and Wellbeing Board strategy.

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

9. EQUALITIES IMPACT IMPLICATIONS

Background Papers

Appendix 1: Health and Well Being Board Enfield December 2016: Review of Immunisation Programmes

Appendix 2: 2016/17 Enfield Immunisation Action Plan

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Health and Well Being Board Enfield December 2016

Review of Immunisation Programmes

Review of Immunisations in Enfield

Amanda Goulden, Immunisation Commissioning Manager

Classification: OFFICIAL

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

1 Summary

- The purpose of this paper is to provide the Health and Well-being Board with an overview of immunisation programmes delivered in Enfield.

- Section 7a immunisation programmes are universally provided immunisation programmes that cover the life-course and comprise of:
    - Antenatal and targeted new-born vaccinations
    - Routine Childhood Immunisation Programme for 0-5 years
    - School age vaccinations
    - Adult vaccinations such as the annual seasonal influenza vaccination

- The Health and Well-being Board are asked to note and support the work NHS England (London) are doing to increase vaccination coverage and immunisation uptake in Enfield.

Background:

Immunisation is the most effective method of preventing disease and maintaining the public health of the local population and vaccination and immunisation service exists to ensure the safe and effective delivery of all vaccine programmes. The Enfield Immunisation Plan sets out actions to be undertaken by all key stakeholders in support of coordinated immunisation activities thereby ensuring that vaccines are available and given to the eligible groups at the recommended times.
NHS England, Public Health England, Clinical Commissioning Groups (CCG) and Local Authorities all have a defined role to play, with NHS England assuming the lead commissioning role in line with the Section 7A mandate.

The roles and responsibilities of the partners are:

NHS England (NHSE):

- Commissioning of all national immunisation and screening programmes described in Section 7A of the mandate
- Commission immunisation and vaccination services from primary care, community providers (e.g. school nursing teams) and other providers which are specific to national standards
- Monitoring of provider's performance and for supporting providers in delivering improvements in quality and changes in the programmes when required
- Accountable for ensuring local providers meet agreed population uptake and coverage levels against the national service specification and as specified in the Public Health Outcome Indicators
- Work with the Department of Health and Public Health England in national planning and implementation of immunisation programmes and in quality assurance
- Emergency Planning Responses and Resilience (EPRR) where this involves vaccine preventable diseases.

Public Health England (PHE):

- Lead the response to outbreaks of vaccine preventable disease and provide expert

advice to NHS England in cases of immunisation incidents. PHE will provide access to national expertise on vaccination and immunisation queries.
- Professional support to the PHE staff embedded in the NHSE Area Teams including access to continuing professional appraisal and revalidation system
- Provide information to support the monitoring of immunisation programmes
- Publishes Cohort of Vaccination Evaluated Rapidly (COVER) data

Clinical Commissioning Groups (CCGs):

- Have a duty of quality improvement and this extends to primary medical care services delivered by GP practices (such as immunisation and screening) – as such, they should be able to provide support where NHSE need to liaise or contact specific primary care facilities.
- CCGs have a crucial role in commissioning pathways of care that effectively interface with screening services, have adequate capacity to treat screen positive patients and meet quality standards
- CCGs hold the contracts for maternity services, and are providers of antenatal and new-born screening (neonatal BCG and infant Hepatitis B).

Local Authorities:

- Leader of the local public health system and is responsible for improving and protecting the health of local population and communities.
- Provide information and advice to relevant bodies within its areas to protect the population's health (whilst not explicitly stated in the regulations, this can reasonably be assumed to include immunisation)
- Provide local intelligence information on population health requirements e.g. JSNA
- Independent scrutiny and challenge of the arrangements of NHSE, PHE and providers.
- Local authorities will need to work closely with Area Teams including arrangements for the NHS response to the need for surge capacity in the cases of outbreaks.

General Practitioners (GPs):

- General practices are contracted by NHSE to deliver the Childhood Routine Immunisation Schedule to their registered child population. They are the main mode of delivery in England.

Community Services Providers:

- Child Health Information System (CHIS) is housed within community service providers and holds clinical records on all children and young people. COVER data is submitted from CHIS to PHE quarterly.
- The community provider may have an immunisation team that provides outreach or 'catch-up' for childhood immunisations (e.g. for unregistered populations) and for BCG.
- Health visitors have a role to play in promoting the importance of vaccinations to parents and 'making every contact count.'
- Some community service providers have immunisation clinical leads or coordinators who provide clinical advice and input into immunisation services locally.

Enfield action plan

- Achieving high levels of immunisation coverage in London remains challenging.

- This action plan has been developed as part of NHS England's ongoing work to improve immunisation coverage in London and outlines ways in which partner organisations could contribute to the work to ensure high levels of immunisation coverage are achieved and sustained in Enfield. This is in recognition of the key elements and partnerships that are essential to the delivery of an effective, equitable and quality assured immunisation service.

- The 2016/17 Enfield Immunisation Action Plan is underpinned by NHS England's immunisation strategic objectives which are:

    1. To achieve improved immunisation coverage across London.
    2. To reduce inequalities in immunisation uptake between GP Practices and populations.
    3. To improve patient choice and access to immunisations across London.

2 Antenatal and New-born Vaccinations

2.1 Pertussis vaccination for Pregnant Women

- In 2012, a national outbreak of pertussis (whooping cough) was declared by the Health Protection Agency. Pertussis activity increased beyond levels reported in the previous 20 years and extended into all age groups, including infants less than three months of age. This young infant group is disproportionately affected and the primary aim of the pertussis vaccination programme is to minimise disease, hospitalisation and death in young infants. In September 2012 The Chief Medical Officer (CMO) announced the establishment of the *Temporary programme of pertussis (whooping cough) vaccination of pregnant women* to halt the increase of confirmed pertussis (whooping cough) cases. This programme has since been extended for another 5 years by the Department of Health (DH). Since its introduction, Pertussis disease incidence in infants has dropped to pre2012 levels.

- Statistics for pertussis vaccine uptake are reported monthly and by region/area. They now cover those women who delivered a baby within the survey month at more than 20 weeks gestational age and who are registered on the general practitioner (GP) systems.

Pertussis in Enfield October 2015-March 2016

CCG Name	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
ENFIELD	32.6	28.8	30.6	29.1	34.1	36.7
LONDON	**47.7**	**50.6**	**52.0**	**48.9**	**49.8**	**49.8**
ENGLAND	**59.3**	**61.6**	**61.4**	**59.7**	**59.4**	**60.7**

- In England, pertussis vaccine coverage in pregnant women reached 62.6% in December 2014 – the highest recorded since the start of the programme. Nationally, the uptake of pertussis vaccine is increasing year on year.
- There are seasonal patterns with the winter months of November and December each year reporting the highest proportion vaccinated whilst there's a drop between April and July
    - Difference attributed to pertussis given with seasonal influenza vaccination during November and December
- London monthly averages are ~10% lower than national averages and London was one of only two area teams (Birmingham Black Country being the other) that reported coverage rates of under 50% between Oct 2012 and December 2014
- NHS England has a pan-London action plan to increase uptake amongst pregnant women. A maternity service level agreement (SLA) has been implemented to enable all maternity services to administer seasonal influenza and pertussis to all pregnant women.

2.2 Universal BCG vaccination

• NHSE (London) has been rolling out a 100% offer of BCG vaccine to all babies up to the age of one year across London. This action had been recommended by the London TB Board and the London Immunisation Board. This offer is commissioned to be given in all maternity units in London with a community offer for those parents who missed out on the vaccine in maternity hospitals or who have recently moved into London.

• Since April 2015, a global shortage of the BCG vaccine resulted in vaccine supply issues within Europe. As a result, the roll-out of the universal offer of BCG was temporarily stalled in London. Once stock was made available again in October 2015, NHSE (London) continued to work with providers across London to deliver the universal offer. A catch up programme was also implemented for those infants who missed out on a vaccine due to the shortage. As per PHE guidance, infants most at risk were prioritised.

• The global shortage has continued into 2016 and in June 2016, PHE national team procured InterVax, a BCG vaccine from Canada. This vaccine is unlicensed in the UK and as a result has to be offered under a Patient Specific Directive (PSD), i.e. to named patients.

• Since July, NHSE (London) team have held fortnightly teleconference calls with providers to support them to deliver BCG vaccine and keep up to date with the continuing changes in PHE policy.

•A pathway for delivery of InterVax was developed and presented to the London Immunisation Board on 28th September 2016. The intention is to clarify and simplify the delivery of the Section 7a Targeted BCG Immunisation programme (https://www.england.nhs.uk/commissioning/pub-hlth-res/) in London whilst we have vaccine stock restrictions.

2.3 Neonatal Hep B vaccination

- Infants born to Hepatitis B positive mothers are at risk of acquiring Hepatitis B. NHS England commissions a neonatal hepatitis B vaccination programme targeted at these at risk babies to ensure that they receive the 4 doses of the vaccine schedule by 12 months of age and have their status tested either by serology or by a dried blood test.

- Within London there are five models of delivery - GP, hospital based, community based or combination models. Because of this mixed economy, there is a need to have an integrated care pathway across London to ensure that every at risk infant completes the vaccination schedule. However, in October 2015, delivery of the neonatal Hep B programme became the responsibility of general practice. London therefore needs to reduce its models of delivery and roll-out the primary care based model across all boroughs.
- In Enfield plans are for GP's to begin vaccinating from January 2017. Numbers are very low across the borough and training has been provided to practices.

3 Routine Childhood Immunisation Programme (0-5 years)

3.1 COVER Time Trend for Enfield

- Cohort of Vaccination Evaluated Rapidly (COVER) monitors immunisation coverage data for children in the UK who reach their first, second or fifth birthday during each evaluation quarter. Children having their first birthday in the quarter should have been vaccinated at 2, 3 and 4 months, those turning 2 should have been vaccinated at 12 months and those who are having their 5th birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years.
- London has in recent years delivered significantly poorer uptake than the remainder of the country. Reasons provided for the low coverage include the increasing birth rate in London which results in a growing 0-5 population and

puts pressure on existing resources such as GP practices, London's high population mobility, difficulties in data collection, particularly as there is no real incentive for GPs to submit data for COVER statistics, and large numbers of deprived or vulnerable groups. In addition, there is a 20-40% annual turnover on GP patient lists which affects the accuracy of the denominator for COVER submissions, which in Enfield's case inflates the denominator (i.e. number of children requiring immunisation) resulting in a lower uptake percentage. Like many other London boroughs, Enfield has not achieved the required 95% herd immunity (i.e. the proportion of people that need to be vaccinated in order to stop a disease spreading in the population).

- Table 1 illustrates the quarterly COVER statistics for the uptake of the six COVER indicators for uptake. The primaries (i.e. completed three doses of DTaP/IPV/Hib) are used to indicate age one immunisations, PCV and Hib/MenC boosters and first dose of MMR for immunisations by age 2 and preschool booster and second dose of MMR for age 5. Quarterly rates vary considerably more than annual rates but are used for monitoring purposes.
- Similar to the general pattern across London where coverage rates decrease as age increases, Enfield's rates decrease as the age cohort goes from age 1 to 2 and to age 5. This decrease in coverage rates is affected by data information systems not capturing movements in population (i.e. transfers in and movers out of borough) and also reflects inadequacies in call/recall systems to bring children in for the remaining vaccinations on the Routine Childhood Immunisation Schedule (i.e. calling parents/guardians for appointments and chasing those who do not attend). This is not unique to Enfield and is common across London boroughs.

Table 1
Enfield CCG and Neighbouring CCGs Comparisons between Q4 2015/16 and Q12016/17

Immunisation - 16-17 Q1 compared to 15-16 Q4	Diphtheria, Tetanus, Polio, Pertussis and Haemophilus influenza type b (DTaP/IPV/Hib) - 3 Doses		Pneumococcal infection (PCV booster)		Haemophilus influenza type b and meningitis C (Hib/MenC)		Measles, mumps and rubella (MMR)		Diphtheria, Tetanus, Polio, Pertussis (DTaP/IPV) - pre-school booster		Measles, mumps and rubella (MMR2)	
Cohort	12 Months		2 Years		2 Years		2 Years		5 Years		5 Years	
PCT Name	**15-16 Q4**	**16-17 Q1**	**15-16 Q4**	**16-17 Q1**	**15-16 Q4**	**16-17 Q1**	**15-16 Q4**	**16-17 Q1**	**15-16 Q4**	**16-17 Q1**	**15-16 Q4**	**16-17 Q1**
Barnet PCT	88.8%	89.70%	83.6%	84.2	84.5%	85.1%	85.3%	86.2%	76.6%	73.8%	79.6%	79.5%
Camden PCT	91.1%	85.4	83.5%	83.1	84.9%	83.6	83.8%	82.6	74.6%	68.2	71.8%	73.9
Enfield PCT	**88.6%**	**90.6**	**84.5%**	**84.1**	**84.6%**	**83.6**	**84.9%**	**84.2**	**91.6%**	**91.7**	**84.7%**	**82.3**
Haringey Teaching PCT	89.2%	88	85.2%	85.8	86.2%	86.3	86.4%	85.9	86.7%	85.3	86.3%	84.8
Islington PCT	95.1%	96.8	92.4%	92.5	92.5%	92.6	91.9%	92.5	88.5%	89.3	87.2%	88.9
London	88.4%	88.8	84.8%	83.7	85.1%	84.8	85.3%	84.4	77.4%	77	80.4%	80.2

Source: PHE (2016)

From 1st April 2017 the Enfield Child Health Information Service, who currently report on COVER, will be moving to the North East London Trust. This is part of the current mobilisation to consolidate 21 local CHIS's into 4 central hubs for London.

3.2 Rotavirus

- Rotavirus vaccine was introduced into the Routine Childhood Immunisation Schedule in 2013/14 and is measured monthly. Since June 2014 both London and England averages have been 90% or over.
- The programme has been very successful in reducing incidence of rotavirus but there is currently no national target
- The latest available figures for Enfield CCG is for January 2016 whereby 92.1% of babies received the first dose of the vaccine, 83.3% received two doses (ImmForm, 2016). Rotavirus vaccine uptake is monitored monthly and.

School Age Vaccinations

3.3 HPV vaccination

- Human papillomavirus (HPV) vaccination has been offered to 12-13 year old girls (Year 8) since the academic year 2008/09. Originally the course was 3 doses but following the recommendation of the Joint Committee of Vaccinations and Immunisations (JCVI) in 2014 two doses are now adequate for protection.
- Table 2 ranks the performance of London's Primary Care Trusts (PCTs) comparing 2013/14 to the performance of 2014/15 (data is still published as PCT areas for comparison reasons). It can be seen that Enfield has improved by 4.4% but still remains one of the lowest boroughs in London.

Table 2

Ranking of London Primary Care Trusts (PCTs) in relation to percentage of Year 8 girls who completed the HPV course in 2013/14 and 2014/15

Name of Organisation	% 2014/15	%2013/14	Difference	% of Difference
BARKING AND DAGENHAM	83.5	79.2	4.3	5.4
ENFIELD	72.6	69.5	3.1	4.5
BEXLEY	80.5	76.6	3.9	5.1
BRENT	81.0	81.1	-0.1	-0.1
BROMLEY	84.5	86.8	-2.3	-2.6
CAMDEN	73.5	77.0	-3.5	-4.5
CITY OF LONDON	85.1	85.4	-0.3	-0.4
CROYDON	79.2	76.4	2.8	3.7
EALING	81.3	77.0	4.3	5.6
ENFIELD	72.7	68.3	4.4	6.4
GREENWICH TEACHING	79.7	77.6	2.1	2.7
HACKNEY	64.1	68.2	-4.1	-6.0
HAMMERSMITH AND FULHAM	75.1	73.3	1.8	2.5
HARINGEY	80.5	76.4	4.1	5.4
HARROW	77.6	83.2	-5.6	-6.7
HAVERING	86.3	86.2	0.1	0.1
HILLINGDON	86.7	86.5	0.2	0.2
HOUNSLOW	83.5	86.2	-2.7	-3.1
ISLINGTON	84.1	87.1	-3.0	-3.4
KENSINGTON AND CHELSEA	62.6	78.9	-16.3	-20.7
KINGSTON	85.3	81.6	3.7	4.5
LAMBETH	78.9	80.9	-2.0	-2.5
LEWISHAM	73.4	82.9	-9.5	-11.5
MERTON	85.4	87.6	-2.2	-2.5
NEWHAM	90.9	92.3	-1.4	-1.5
REDBRIDGE	79.2	69.2	10.0	14.5
RICHMOND	76.0	81.8	-5.8	-7.1
SOUTHWARK	77.3	85.7	-8.4	-9.8
SUTTON	87.7	90.4	-2.7	-3.0
TOWER HAMLETS	74.1	75.6	-1.5	-2.0
WALTHAM FOREST	73.3	86.8	-13.5	-15.6
WANDSWORTH	82.7	79.1	3.6	4.6
WESTMINSTER	74.7	77.9	-3.2	-4.1

Source: PHE (2015)

3.4 Other school age vaccinations

- To date, data is not routinely collected and published for Meningococcal ACWY vaccination programme and for the teenage booster but NHSE London collect monthly data in order to monitor provider performance.
- Across London, all children in years 1,2 and 3 will be offered Fluenz within their schools. GPs will continue to be responsible for vaccinating 2- 4 year olds in general practice.

4 Adult Vaccinations

4.1 Shingles

- The Shingles vaccination programme commenced in September 2013.
- Shingles vaccine is now offered to people who are 70, 78 and 79 years old on 1st September 2016.
- Last year, Enfield's average for uptake amongst the 70 year old cohort was 51.2% (higher than the London average of 48.8% .For the same period, Enfield is also higher than the London average.

Shingles uptake

Shingles	2013/14	2014/15	2014/15	2013/14	2014/15
	Age 70	Age 70	Age 78	Age 79	Age 79
Enfield	52	51.2	53.6	51.7	52.8
London	51.3	48.8	48	50.9	49.7
England	61.8	59	57.8	59.6	58.5

4.2 Seasonal Influenza

- Table 4 illustrates the uptake of seasonal influenza vaccine for each of the identified 'at risk' groups for Enfield CCG compared to London and England averages for the winter 2015 (September 1st 2015 to January 31st 2016). It can be seen that London performs lower than England across the groups. In relation to Enfield CCG, it performs better than London average for the 65+ and at risk age groups but it is lower than London average for the other 'at risk' groups.
- Overall, the uptake rates for seasonal influenza vaccination were down from 2014/15's performance.

- London, England and Enfield all performed below the recommended 75% uptake level for all at risk groups. This excludes the child influenza groups of healthy 2 – 4 years olds where there is no target but GPs are encouraged to aim for 40% coverage rates.
- In May 2016, NHS England (London) undertook an evaluation review of how the 2015/16 child influenza programme was delivered. Reflections and recommendations have been incorporated into the planning for the 2016/17 influenza programme and efforts have been concentrated on improving uptake in both school age and GP cohorts

Table 4

Uptake of the 'at risk' Groups of Seasonal influenza for Enfield CCG compared to London and England for winter 2015 (September 1st 2015 – January 31st 2016)

	Flu Season 2015/16							
	% of uptake 65 +	% of at risk patients (6 months - 64 years)	% of pregnant women	% of 2 year olds	% of 3 year olds	% of 4 year olds	% of year 1	% of year 2
Enfield	68.9	44.6	32.2	25.1	25.7	20	38.3	37
London	**66.2**	**43.6**	**38.5**	**26.5**	**28.8**	**21.8**	**42.4**	**39.9**
England	**71**	**45.1**	**42.3**	**35.4**	**37.3**	**30.1**	**55.6**	**54.3**

Source: PHE (2016)

5 Conclusions

Enfield and London have performed below national averages on almost all the Section 7A immunisation programmes. However, the London Immunisation Board is overseeing pan-London approaches to improve uptake and coverage.

Each London borough has an immunisation commissioner who is responsible for delivering a multi-agency borough specific action plan. The aim of each plan is to increase uptake and vaccination coverage within the boroughs, which in turn will increase London averages. The plans will also address health equities in access to immunisations and health inequalities in uptake.

2016/17 Enfield Immunisation Action Plan

Background:

- Achieving high levels of immunisation coverage in London remains challenging.
- This action plan has been developed as part of NHS England's ongoing work to improve immunisation coverage in London and outlines ways in which partner organisations could contribute to the work to ensure high levels of immunisation coverage are achieved and sustained in Enfield. This is in recognition of the key elements and partnerships that are essential to the delivery of an effective, equitable and quality assured immunisation service.
- The 2016/17 Enfield Immunisation Action Plan is underpinned by NHS England's immunisation strategic objectives which are:
    1. To achieve improved immunisation coverage across London.
    2. To reduce inequalities in immunisation uptake between GP Practices.
    3. To improve patient choice and access to immunisations across London.

To achieve 85% for MMR2 Enfield only needs to vaccinate an average of another 31 children per quarter, across all practices.

To achieve 85% for MMR2 each practice in Enfield only needs to vaccinate another 4 children per year.

To achieve 40% for child flu this season each practice needs to vaccinate between 15 and 21 more children for 2, 3 and 4 year olds.

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation
Commissioning & Performance Management	Reduce the variation in immunisation performance between best performing and worst performing GP Practices.	Improved immunisation data quality resulting in accurate reporting of immunisation coverage	Work with practices to improve uptake of childhood immunisations in Enfield. Identify what works in the best performing practices and share work with poor performing practices in	December 2016	NHSE	GP practices may not record the data accurately. E.g. correct coding Lack of engagement from practices CHIS resources and re-structure

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation
			troubleshooting the barriers to increasing uptake. Visit underperforming practices			
	Performance data provided to local meetings	Accurate reporting of immunisation coverage for Enfield	CHIS service will send Cover data 4-6 week prior to the final submission	Quarterly	NHSE	Reports not accurate. Continue to work with CHIS.
	Enfield LA and NHS England to jointly commission the school age immunisation service	Improved uptake and joint performance management meetings	Support LA with performance management. New immunisation team formed to work alongside school nurses	Ongoing	LA	
Schools	To deliver roll out of child flu to years 1, 2 and 3	Maximum coverage of cohort, ambition 40-65% 100% offer to all	Include delivery with school immunisation joint commissioning and set up	Sept-Dec 2016	NHSE/LA	Staff resource- particularly admin

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation
		eligible children	immunisation team.			
Hospitals	Continue delivery of hospital services to deliver the neonatal BCG immunisation programme	100% of babies offered BCG immunisation at birth	Ensure continued delivery at North Middx. Support new delivery at Barnet.	Dec 2016	NHSE/CCG	Current ongoing vaccine shortage Risk to community catch up clinic due to staff resource
Primary Care	NHSE commissioned Flu and Pertussis vaccinations delivered and promoted throughout primary care providers	Increase in reported rates on flu vaccine uptake and pertussis uptake amongst pregnant women Increased reported flu vaccine uptake across named at risk groups	Work with GP practices to improve flu vaccine uptake via local flu plans, focus on 2-4 year olds. Practice visits to worst performing practices in this cohort. Promote vaccination for carers. Commission hospital to offer the flu and pertussis vaccinations to pregnant women via	Sept-Dec 2016 Dec 2016	NHSE/CCG	NHSE doesn't communicate winter strategy in timely manner NHSE will inform all stakeholders re delays

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation
			SLA(signed)			
	Flu immunisations, shingles and pneumococcal vaccinations are promoted in all care homes and included as a requirement in LA contracts with providers of social care services.	Audit of how this communication has been received contributes to increased uptake of winter vaccination uptake i.e. flu , shingle and PPV within these populations	Leaflets promoting immunisations are included in information packs. Immunisations are promoted to care homes	Sep 2016	LA	Information is not disseminated in a timely manner NHSE communicate Winter strategy to all stake holders by end of June
	All GP practices are effectively providing call/recall	Assurance for failsafe, no children miss an invitation for vaccination	Follow up with CCG to ensure this is taking place in all practices	March 2016	CCG/NHSE	Children not invited for routine schedule
	Increased uptake in MMR vaccination following measles outbreak across London	Improved coverage of MMR across all cohorts	Opportunistic vaccination of all adults and children who have not received 2 doses of MMR	Ongoing	CCG	More cases of measles
	Move Hep B delivery to GP practices	More secure pathway ensuring all babies	Engage with CCG to discuss options and	Jan 2017	NHSE	Babies miss vaccination

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation
		receive the full course and serology	current processes			
Looked After Children Immunisation uptake	Analysis of Looked After Children Immunisation rates and veracity of data	Informed data leading to greater awareness of gaps to inform future planning	Conduct an analysis of a cohort of unimmunised Looked After Children to ascertain any patterns that may emerge. Analysis to include age, geographical area and ethnicity	Completed March 2016	Designated Nurse for Looked After Children	
	'Making every contact count'	Increase in uptake of routine immunisations at all ages	Staff will raise the importance of immunisations and remind young people and carers of the schedule All Health Visiting and School Nursing contacts with Looked After Children and their	ongoing	Health Visitors/ School Nurses	

Key Area	Output	Outcome	Actions	Due Date	Led by	Risks to completion & Mitigation
			carers will count.			

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Department of Health

From David Mowat MP
Parliamentary Under Secretary of State for Community Health and Care

Richmond House
79 Whitehall
London
SW1A 2NS

Dear Health and Wellbeing Board Chairs,

I am writing to you in your capacity as a Health and Wellbeing Board (HWB) Chair to highlight the General Practice Forward View, recognising the important relationship that primary care has with the delivery of local health and wellbeing strategies. This document is part of the future vision for the NHS being developed as part of NHS England's overarching Five Year Forward View.

The role of general practice is central to our health and care system, but we know that pressure on GPs and other general practice staff is increasing. The Government and NHS England have recognised the need for additional support and, on 21st April 2016, NHS England published the GP Forward View. This is a package of support to help get general practice back on its feet, improve patient care and access, and invest in new ways of providing primary care. It sets out that we are investing an extra £2.4 billion a year for general practice services by 2020/21, which represents a 14% increase in real terms. The overall investment includes a £500 million five year Sustainability and Transformation package to support GP practices, which contains measures to help boost the workforce, drive efficiencies in workload and modernise primary care infrastructure and technology.

However, as HWBs will be very well aware, general practice cannot work effectively in isolation, and the GP Forward View looks at general practice's role in relation to the wider system – both how improved integration can provide additional support to general practice and the contribution that general practice staff make on wider social issues. It also highlights the important role that primary care can play in supporting integration across local health and care systems.

We acknowledge that many HWBs are already promoting strong and effective relationships between general practice services and other health, social care, public health and wider local services; and that they recognise the centrality of primary care in integrating their local health and care systems and the need to ensure access to all relevant support services. These links are going to be even more important in the future, and so I am writing to ask all HWBs to review the GP Forward View document and consider what more Boards could do to build effective relationships between primary care and wider local services.

There are many examples of effective collaboration with primary care at a local level, including:

- *Just What the Dr Ordered* (published by the Local Government Association in April 2016) contains case studies on social prescribing from: East Riding of Yorkshire;

Blackburn with Darwen; Knowsley, Halton and St Helen's; Luton; Rotherham; Cotswold; Doncaster; Tower Hamlets; and Forest of Dean: http://www.local.gov.uk/documents/10180/7632544/L16-108+Just+what+the+doctor+ordered+-+social+prescribing+-+a+guide+to+local+authorities/f68612fc-0f86-4d25-aa23-56f4af33671d.

- Northumberland's network of community hubs with strong voluntary, community and faith sector engagement and support planners working with GPs.

- Social prescribing in Gloucestershire: http://www.gloucestershire.gov.uk/extra/CHttpHandler.ashx?id=63219&p=0.

- Wiltshire's community hubs where primary care services are co-located with other services in buildings such as libraries: http://www.wiltshire.gov.uk/hwb-2015-annual-report.pdf.

HWBs will additionally already be engaged in the Sustainability and Transformation Plan (STP) process. As set out in the NHS Shared Planning Guidance, published in December 2015, the success of STPs will depend on having an open, engaging, and iterative process that involves clinicians, patients, carers, citizens, clinicians, local community partners including the independent and voluntary sectors, and local government through, for example, health and wellbeing boards, building on existing plans such as Health and Wellbeing Strategies and Joint Strategic Needs Assessments.

The arm's length bodies responsible for the NHS Five Year Forward View – NHS England, NHS Improvement, the Care Quality Commission, Public Health England, Health Education England and the National Institute for Health and Care Excellence – have asked for local engagement plans as part of the Sustainability and Transformation Plan process, building where appropriate on existing engagement through health and wellbeing boards and other local arrangements, including GP services.

In summary, given the potential benefits outlined above, I am asking HWBs to consider how, through their work and specifically through Joint Health and Wellbeing Strategies, they can encourage action to develop and strengthen relationships with general practice services in local areas, in order to generate benefits for the whole system and better outcomes for patients.

Yours faithfully,

DAVID MOWAT

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TO:
Chairs of Health and Wellbeing Boards
Chief Constables
Police and Crime Commissioners

15 November 2016

Dear All

Police and Crime Commissioners and Health and Wellbeing Boards

We are writing to highlight and support some of the important benefits that can be realised through closer collaboration between policing and health partners.

The interface between crime and public health is well-documented – in the Department of Health's public health outcomes framework, for example, which contains a number of indicators that recognise the links, including: entry to the youth justice system, people in prison with a mental illness, domestic abuse, violent crime, re-offending, drug treatment outcomes and perception of community safety.

In many areas of the country, police and health and care partners, in both the NHS and Local Government, are working collaboratively to deliver better outcomes for individuals, including the most vulnerable and local communities and there is potential for further joint working. For example, local authorities, the NHS and the police are required members of Safeguarding Adult Boards which help ensure a collaborative, inter-agency approach to the responses and prevention of abuse or neglect.

In addition, many health and wellbeing boards already include amongst their membership either their Police and Crime Commissioner (PCC) or representatives from their local police force or criminal justice agencies. This has enabled boards to take a broader strategic view of their area beyond health and social care, and through Joint Strategic Needs Assessments (JSNAs) provides boards with the opportunity to better understand the nature of public needs and demands on local services – which can in turn influence local commissioning strategies.

There are already a number of areas where greater collaboration has had positive outcomes including:

- Every area in England is now working to implement their local Mental Health Crisis Care Concordat action plans, involving NHS services, police forces and local authorities, and many of these local partnerships are using their Boards to ratify their plans and support progress. Local action plans and other helpful information on the Concordat can be found here: http://www.crisiscareconcordat.org.uk/

- In addition, around 30 police forces now have some form of street triage in operation. These models, often jointly commissioned by the PCC and Clinical Commissioning Groups, ensure mental health nurses staff support and advise police officers in their responses to people in mental health crisis. In some forces mental health workers and police officers provide joint responses in the community; in others mental health professionals work in emergency call centres in order to provide real time advice and support to frontline officers. The evaluation of nine initial pilot sites evidenced that the schemes contributed towards large reductions in the use of police custody as a place of safety for those vulnerable people detained under section 136 of the Mental Health Act.

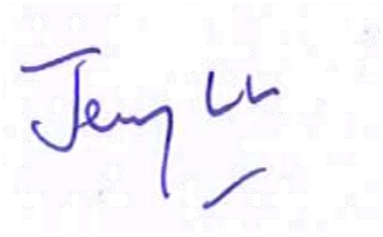
- Around 25 police forces operate a drug intervention initiative which involves policing and health partners working together to identify, assess and refer users into appropriate treatment pathways. Investment in treatment is proven to reduce reoffending, with every £1 spent saving £2.50 for the Criminal Justice System, and with access to treatment reducing the impact of wider health harms including the spread of blood borne viruses and drug related mortality.

- A recent Home Office and Public Health England initiative in Middlesbrough brought together senior partners in policing, health and probation to consider the impact of heroin misusing offenders in their area and the wider implications this was having on individuals and the community. This has galvanised further collaborative working, including the development of a joint strategy to address their local needs and consider opportunities for developing a multi-agency commissioning approach for treatment services.

- The first phase of the local alcohol action areas programme, which ran until March 2015, saw police and health partners work closely together to reduce a range of alcohol-related harms. For example, Gravesham began a one-year pilot of a Make Every Adult Matter approach to street drinkers. An operational group is led by the area's alcohol and drug treatment provider with members including the police, third sector organisations, primary care providers, Jobcentre Plus and the Prison Service. Early indications are that the project is working well and that links between partner agencies are much improved and that better coordinated services for individuals with multiple needs are emerging. Invitations to apply to take part in the second phase of the programme were sent to PCCs, chief constables and all local authorities in England and Wales last month. The programme will begin in January and will again encourage active partnerships between local agencies to reduce alcohol harms.

Given the benefits outlined above, and the pressures on health and care services and police forces, we would like to ask Health and Wellbeing Boards and PCCs to consider how they can better work together by ensuring appropriate representation from both sectors on Health and Wellbeing Boards.

The Rt Hon Amber Rudd MP



The Rt Hon Jeremy Hunt MP

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MINUTES OF THE MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON WEDNESDAY, 5 OCTOBER 2016

MEMBERSHIP

PRESENT Doug Taylor (Leader of the Council), Krystle Fonyonga, Ayfer Orhan, Mo Abedi (Enfield Clinical Commissioning Group Medical Director), Deborah Fowler (Enfield HealthWatch), Sarah Thompson (Chief Officer - Enfield Clinical Commissioning Group), Ray James (Director of Health, Housing and Adult Social Care), Tony Theodoulou (Interim Director of Children's Services), Vivien Giladi (Voluntary Sector), Peter Ridley (Director of Planning, Royal Free London, NHS Foundation Trust), Libby McManus (Chief Executive North Middlesex University Hospital NHS Trust), Robyn Gardner (Enfield Youth Parliament) and Bobbie Webster (Enfield Youth Parliament)

ABSENT Alev Cazimoglu and Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust)

OFFICERS: Sam Morris (Strategy, Partnerships, Engagement and Consultation Team), Bindi Nagra (Assistant Director Health, Housing and Adult Social Care), Glenn Stewart (Assistant Director, Public Health) and Keezia Obi (Head of Safeguarding Adults), Jane Creer (Secretary)

Also Attending: Graham MacDougall (Director of Commissioning, NHS Enfield CCG), Rob Whiteford (Chief Finance Officer Enfield CCG), Marian Harrington (Independent Chair of Enfield Safeguarding Adults Board), Geraldine Gavin (Independent Chair of Enfield Safeguarding Children's Board), Georgina Diba (Safeguarding Adults Service), Dr Tha Han (Public Health Consultant), Miho Yoshizaki (Health Intelligence Manager, Public Health), David Hilliard (Enfield Cycle Campaign)

1
WELCOME AND APOLOGIES

The Chair welcomed everyone to the meeting. Apologies for absence were received from Councillor Alev Cazimoglu and from Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust).

2
DECLARATION OF INTERESTS

There were no declarations of interest registered in respect of any items on the agenda.

3
ENFIELD HEALTH & WELLBEING BOARD REVIEW OF CURRENT SUB BOARDS STRUCTURE

RECEIVED a report from Sam Morris (Strategic Partnerships Manager) in respect of the review of the current Health and Wellbeing Board Sub-Boards structure.

NOTED

Sam Morris introduced the report, highlighting the following:
● There was ongoing review and development of the Enfield Health and Wellbeing Board (EH&WB), and recommendations were now put forward regarding the Sub Boards.
● The proposals had been discussed with the Chair of EH&WB and Sub Board leads.

IN RESPONSE the following comments were received:

1. Ray James (Director of Health, Housing & Adult Social Care) advised that as the Sustainability and Transformation Plan went forward, some of the joint work may have other structures it should connect with. This should be kept under review, while making sure links were maintained.
2. Deborah Fowler (Healthwatch) welcomed the report recommendations and the comments of Ray James, and supported the greater focus, but with some concern if there would be only a single specific priority for each year. Deborah also felt that Sub Board work plans should be signed off by the EH&WB.
3. Action plans from the Sub Boards should be expected and could be reviewed by EH&WB.

AGREED

a) Revision of the EH&WB Sub Board Terms of Reference 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 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.

4
CLINICAL COMMISSIONING GROUP AND LONDON BOROUGH OF ENFIELD FINANCIAL AND COMMISSIONING INTENTIONS

RECEIVED the report of Graham MacDougall (Director of Commissioning, NHS Enfield CCG) presenting the Enfield CCG commissioning intentions for 2017-19.

NOTED

Graham MacDougall and Rob Whiteford (Chief Finance Officer Enfield CCG) introduced the report, highlighting the following:
- Savings targets were clarified, and the deficit situation was improving.
- There would need to be efficiencies in the way services were delivered and where money was invested.
- The strategic context was set out.
- The Sustainability and Transformation Plan (STP) over the next five years would have a significant effect on commissioning intentions.
- Funding was coming through to support substantial transformation.
- There were national efficiency programmes to reduce variation across CCGs.

IN RESPONSE to the report, the following comments were received:

1. Councillor Orhan drew attention to the lack of reference to children and young people in the four domains relating to the CCG Improvement and Assessment Framework, and in the commissioning objectives. It was advised that adults and children were included in the sections, but this could be better articulated and made clearer. Graham MacDougall agreed to draw out the areas specific to children.
2. In response to Tony Theodoulou's query regarding Enfield CCG as an outlier in high levels of musculoskeletal surgical intervention, Graham MacDougall confirmed that bench-marking had shown higher surgery rates relative to Enfield's peers, and a programme had been set with a new provider to reduce surgical intervention and ensure there was a consistent offer to all patients, and that thresholds for treatment were adhered to.
3. Dr Mo Abedi noted that for each workstream in Right Care, the national transformation programme, had involved GPs in looking at pathways and audits.
4. Deborah Fowler (Healthwatch) stressed the need for as much transparency as possible to provide reassurance to people about what they could reasonably expect, and questioned whether there was definitive guidance publicly available. She also asked where the biggest changes could be expected to be seen. Graham MacDougall highlighted the tie-in with the Sustainability and Transformation Plan (STP) and that providers would be working in different ways. In the

second and third year of the STP – 2017/18 and 2018/19 – new contracts with providers would see significant changes.

5. Vivien Giladi (Voluntary Sector) re-iterated the need for the CCG to provide reassurance to the public about changes and thresholds.
6. Ray James commented that while the aims of the changes were recognised, the Enfield Health and Wellbeing Board would be exercised about decisions in respect of Enfield being taken ahead of North Central London and there should not be earlier rationing for the people of Enfield than for people of other boroughs.
7. Ray James apologised to members expecting an update from the Council under this agenda item, as its budget planning would fall naturally in December, and more detail would be provided for the next meeting.
8. Sarah Thompson (CCG) advised that this piece of work was initiated by Enfield, but it actively sought to engage with the four other CCGs across North Central London. Enfield was under special measures and needed to proceed at this time, but would continue to collaborate.

AGREED to note the report and the caveat included in the executive summary.

5
ORDER OF AGENDA

NOTED that the order of the agenda was varied and that a number of attendees had to go on to Health Scrutiny Standing Workstream at 7:30pm. The minutes follow the order of the meeting.

6
UNISON / NHS BURSARY REMOVAL

RECEIVED a letter from UNISON to Ray James (Director of Health, Housing & Adult Social Care) in respect of the proposed NHS bursary removal.

NOTED

1. Ray James confirmed that a copy of the letter had been sent to him and others and inviting consideration by local health and wellbeing boards.
2. An emailed response from Andrew Wright (Barnet, Enfield and Haringey Mental Health NHS Trust) was tabled in his absence. BEH-MHT was clear that this proposal, if implemented, would add to their current difficulties in recruiting nurses.
3. Vivien Giladi (Voluntary Sector) wished the Board to support the UNISON letter, noting that trainee nurses did a lot of unpaid work, which was also physically and emotionally draining, and under the

proposals would face debt and paying to work for nothing. When there was a need for increased numbers of nurses, this plan seemed counter-productive.

4. Libby McManus (North Middlesex Hospital NHS Trust) reported a recent debate at Kings College London which heard views from both sides, and noted that those applying for undergraduate nurse training places were often surprised that there were still bursaries. She was therefore unsure what impact there may be.
5. Councillor Orhan expressed support for the template letter of response, and considered that this proposal would be a naïve and false saving which would have a huge impact on nurses coming through the system. She also suggested that UNISON be invited to send a representative to the next meeting.
6. Deborah Fowler (Healthwatch) agreed that the risks and lack of research should be highlighted, but accusatory points be avoided.
7. The Chair recommended an evidence based approach in a response from the Board, and that the proposal should not proceed at this time.
8. Ray James would wish to refine the template letter to also encourage further strategic planning for health and social care nursing workforce, and agreed to circulate a draft letter to Board members for comment.

AGREED that a letter be prepared on behalf of Enfield Health and Wellbeing Board to send to the Government in response to the proposed changes in healthcare education funding.

7
PROGRESS UPDATE ON THE NORTH CENTRAL LONDON (NCL) SUSTAINABILITY AND TRANSFORMATION PLAN (STP) DRAFT - THE CLINICAL CASE FOR CHANGE

RECEIVED the North Central London Sustainability and Transformation Plan (STP) draft document.

NOTED

1. Relevant issues had also been discussed at the Health and Wellbeing Board Development Session on 4 October.
2. Deborah Fowler (Healthwatch) wished to emphasize the importance of fulsome public involvement and engagement.
3. Vivien Giladi (Voluntary Sector) re-iterated Deborah Fowler's point and also that it would be important to have accountable local politicians, and for there to be lay people on the Transformation Board.
4. Councillor Orhan welcomed the report, which highlighted some of the fundamental issues facing people in Enfield and across North London. She was pleased there was recognition of the requirement of improving children's and young people's health mentioned throughout. She questioned historical understanding shown and knowledge of the area, and alignment with current local arrangements in place.

5. The Chair expressed that Barnet and Enfield seemed to be downplayed compared with other boroughs. Also, some of the base information was given in percentages and some in numbers; which was important given the different sizes of the boroughs. He hoped that when resources were considered going forward, Barnet and Enfield's positions of need and demand were borne in mind.
6. Vivien Giladi considered that the need for accountable politicians had been demonstrated by the above point, and while she agreed this was a useful document, it hid the ideological and financial drivers behind the transformation plans.
7. The more detailed paper would be published on 21 October, when it would be submitted to NHS England.
8. Ray James gave assurance that there was awareness regarding the concerns raised, and that partners were committed to delivering the STP.

AGREED to note the North Central London Sustainability and Transformation Plan (STP) draft document.

8
FEEDBACK FROM HEALTH AND WELLBEING BOARD DEVELOPMENT SESSIONS

RECEIVED the report of Sam Morris (Strategic Partnerships Manager) summarising the topics presented at the recent Health and Wellbeing Board development session on 6 September 2016.

NOTED that an additional development session was held on 4 October which had been a helpful preparation for this Board meeting.

AGREED to note the report.

9
SAFEGUARDING ADULTS AND SAFEGUARDING CHILDREN'S BOARD ANNUAL REPORT 2015-16

RECEIVED
(a) The Safeguarding Adults Board Annual Report 2015-16; and
(b) The Safeguarding Children's Board Annual Report 2015-16.

NOTED

(a) <u>The Safeguarding Adults Board Annual Report 2015-16</u>

The report was introduced by Marian Harrington (Independent Chair of Enfield Safeguarding Adults Board).

● This year there had been two Safeguarding Adult Reviews into incidents of poor care, and subsequent actions had been embedded by partner agencies. Two more of these reviews were in progress.
● Key areas of improvement were noted in quality of care locally.
● A link with Healthwatch would enable access to NHS premises too.
● There had been awareness-raising regarding hate crime and domestic violence.
● A thematic safeguarding adults review would be reported next year.
● Multi-agency working would help in the collection of evidence at an early stage to enable successful prosecution.

The following questions were received:

1. In response to Councillor Fonyonga's queries in relation to domestic violence and vulnerable adults, it was confirmed there still sometimes seemed to be a feeling that vulnerable people would not make credible witnesses and that they would have difficulty giving evidence in court. There were ways people could be supported, but better evidence gathering at the beginning would strengthen our case. Raising the awareness of the Crown Prosecution Service was also important.
2. In response to Councillor Orhan's queries regarding neglect, it was advised that work had taken place to help people who did not think of themselves in that way to identify themselves as carers, as there was help and support available and they could be put in touch with the local carers association. Often neglect was not deliberate, but was due to people not realising what they should be doing.
3. In response to Vivian Giladi's queries in relation to ethnicity statistics in the report, it was confirmed that awareness raising had targeted under-represented groups and work would continue with voluntary sector organisations.
4. Ray James highlighted the pleasing performance in achieving outcomes from safeguarding adult inquiry investigations, and that there was better understanding and reporting. He also wished to give credit to Georgina Diba (Safeguarding Adults Service) for the quality of the report. Confirming that Marian Harrington was stepping down from her role, he wished his thanks to be recorded for her skilled stewardship.
5. The Chair requested that the minutes reflected the thanks of Enfield Health and Wellbeing Board to Marian Harrington, and to everyone who contributed to the success of the Safeguarding Adults Board, and noting the challenges going forward.

(b) <u>The Safeguarding Children's Board Annual Report 2015-16</u>

The report was introduced by Geraldine Gavin (Independent Chair of Enfield Safeguarding Children's Board).
● The main focuses of the year had been child sexual exploitation, female genital mutilation, and tackling concerns of increased radicalisation.
● Two excellent lay members of the Board had brought in views from the community.
● Two serious case reviews had been published in the last year.

- Successful training and awareness events had been held.
- Information exchange was improving, and was critical. The new Borough Commander was now Vice Chair of the Board.

The following questions were received:

1. The Chair noted that the Greater London Authority now had a Deputy Mayor for Crime and Policing, and suggested making representations through them in relation to difficulties with prosecutions.
2. In response to Deborah Fowler's queries, it was confirmed that there was already joint working with other boroughs and it was likely this would increase.
3. Vivian Giladi noted the considerable steps forward regarding female genital mutilation, noting the issues around resourcing of prevention in future as against prosecution today.
4. Robyn Gardner (Enfield Youth Parliament) asked about work towards preventing female genital mutilation in Enfield as she had seen nothing as a pupil at Chace Community School. It was advised that the Board had a specific group which provided training and resources to schools, and Geraldine Gavin also made school visits, and she would follow this up. Vivian Giladi also confirmed there was work going on at a playground level in affected communities. Tony Theodoulou and Councillor Orhan also reported successful work in relation to female genital mutilation, and that sharing this information across schools could be added to the work programme of the Youth Parliament.
5. Councillor Orhan wished to record her thanks to Geraldine Gavin for the work done throughout the year, while noting that central government must recognise the enormity of the work and importance of safeguarding boards, and must put funds into supporting them.
6. The Chair requested that thanks be recorded to Geraldine Gavin and her colleagues for all the work done.

10
DIABETES IN ENFIELD ANNUAL PUBLIC HEALTH REPORT

RECEIVED the Diabetes in Enfield Annual Public Health Report.

NOTED

1. Dr Tha Han (Public Health Consultant) introduced the report and thanked all those involved for their contributions.
2. The report summarised every aspect of diabetes, and highlighted that much diabetes could be preventable, and that there was a very clear relationship between the incidence of diabetes and obesity.
3. Dr Tha Han invited any questions to be emailed to him at Tha.Han@enfield.gov.uk.
4. Councillor Fonyonga also recorded thanks to Miho Yoshizaki (Health Intelligence Manager, Public Health) for this high quality report.

11
OVERVIEW AND SCRUTINY WORK PLAN 2016-17

NOTED the Overview and Scrutiny Committee work plan for 2016/17.

12
SUB BOARD UPDATES

NOTED

1. Updates from sub boards.
2. An interim appointment had been made for Director of Public Health to Tessa Lindfield, but she was unfortunately unable to attend this meeting. The importance of resumption of Health Improvement Partnership Board meetings was noted.

13
MINUTES OF THE MEETING HELD ON 12 JULY 2016

AGREED the minutes of the meeting held on 12 July 2016.

14
WORK PROGRAMME 2016/17

NOTED the work programme for 2016/17.

15
DATES OF FUTURE MEETINGS

NOTED the dates of future meetings of the Health and Wellbeing Board and dates of future Development Sessions.

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