Health and Wellbeing Board

Thursday 19 September 2013

Agenda – Part: 1	Item: 7.2
Subject: Joint Commissioning Board Report	
Wards: All	

REPORT OF:

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1. EXECUTIVE SUMMARY

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

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

1.3 This report includes note that:

- The **Section 75 Agreement** for Adults has been re-drafted to reflect new statutory responsibilities and governance changes resulting from the NHS transition.
- The spending plan for the **NHS Social Care Grant** has been approved and is due for consideration at the Finance, Resources and QIPP Committee on 4th September.
- Members have ratified the creation of a Community Interest company, limited by guarantee named as 'Enfield Consumers of Care and Health Organisation (ECCHO), which will be independent of the Council, to deliver the **Healthwatch** functions in Enfield. This company has not been transferred to the Healthwatch Board to operate as an independent service
- The priority outcome from the **Voluntary & Community Sector Strategic Commissioning Framework** (VCSSCF) is the development, commissioning and implementation of an integrated information, advice and advocacy service for adults in Enfield with health and social care needs.
- In recognition of Enfield changing status from being a pilot site to a trailblazer site for **Direct Payments in Residential Care**, DH awarded the borough with additional funding for two years and extended the scope to consider nursing homes.
- Following the **transition of responsibility for public health services** to the local authority in April 2013, Enfield, Barnet, Haringey, Camden and Islington have formed the NCL Local Authority Sexual Health Commissioning Group to work strategically across the five boroughs to commission cost effective, high quality sexual health services.

1. EXECUTIVE SUMMARY (CONTINUED)

- Enfield Council's success in both applications for capital funding and its partnership with Newlon Housing Trust to improve specialist accommodation for people with disabilities in the borough

- The **Safeguarding Adults Board** has received performance data that highlights a 159% increase in the number of safeguarding adult alerts. The September Board will consider audit options.

- The 3 year **Integrated Care Plan** will work on reshaping services used by older people to achieve a significant reduction in non-elective activity, A&E attendances and outpatient appointments

- **Winter Pressures Funding** planning is in progress. The Council is expectant that DH will fund the Warm Homes, Healthy People 2013/14 project and will invite the voluntary and community sector partners to be involved.

- Voluntary and Community partners are preparing events in September and October to promote **Dementia awareness**. Enfield is the first borough in London where partners have formed the Enfield Dementia Action Alliance with the aim of using the national approach to promote the needs of those living with dementia

- Enfield, Barnet and Haringey will jointly tender a consolidated Independent **Mental Health** Advocacy (IMHA), Independent Mental Capacity Advocary (IMCA) and Deprivation of Liberty Safeguards (DoLS) for the new contract to commence April 2014.

- LBE and NHS Enfield CCG have jointly developed an action plan in response to the **Winterbourne View concordat** that emphasises the commitment to review all people with learning disabilities and / or autism within in-patient facilities.

- The building renovation at the **Enfield Carers Centre** is now completed and offers more confidential working space and improved accommodation for staff members.

- The **Family Nurse Partnership** (FNP) team is fully appointed. A launch event will be held 9th October at the Dugdale Centre

- **Drug and Alcohol Action Team (DAAT)** has achieved a rate above London, national and the PbR Pilot averages for Successful Treatment completions.

2. RECOMMENDATIONS

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

3. SECTION 75 AGREEMENT – COMMISSIONED SERVICES FOR ADULTS

3.1 As reported in June 2013, the Section 75 Agreement which relates to commissioned services for Adults requires amendment. This is to reflect new statutory responsibilities and governance changes resulting from the NHS transition.

3.2. The Agreement has been re-drafted and formal approval has been obtained from the Director of Health, Housing and Adult Social Care and the Lead Member for Adult Services and Care at the Council. The Agreement is still subject to formal approval at NHS Enfield Clinical Commissioning Group and is due for consideration at the Finance, Resources and QIPP Committee on 4th September and at the NHS Enfield Clinical Commissioning Group later in September 2013. Subject to receiving formal approval from NHS Enfield Clinical Commissioning Group the Agreement will be signed under seal by both parties.

3.3 Discussions have commenced about the content of the Agreement in 2014-15, so notice can be issued by either party as necessary before the 30th September 2013 in line with the Agreement terms.

3.4 The half year review is scheduled to take place in early October 2013, to assess how effectively the partnership arrangements have functioned between April 2013- September 2013 and an update will be provided to the Health and Well-being Board following this.

4. NHS SOCIAL CARE GRANT

4.1 As reported in June 2013, the spending plan has been re-profiled to factor in the grant allocation for 2013-14 and also the assumed allocation in 2014-15, and has provisionally allocated funding up until 2017. The indicative spending plan has now been approved by the Director of Health, Housing and Adult Social Care and the Lead Member for Adult Services and Care at the Council.

4.2 However, the Department of Health issued new guidance in June 2013. This reiterates the earlier conditions of use and states that funding must be used to support adult social care services which also have a health benefit. The guidance also states that the spending plan should take account of the Joint Strategic Needs Assessment and existing commissioning plans for both health and social care but also that funding can be used to support existing services or transformation programme, where services may otherwise be reduced. This also requires local Clinical Commissioning Groups to approve the plans before funding can be transferred from NHS England to the local authority.

4.3 The Council is now progressing approval of the indicative spending plan from NHS Enfield Clinical Commissioning Group following this

new guidance issued in June. The spending plan has been approved by the Joint Commissioning Board and is due to be considered at the Finance, Resources and QIPP Committee on 4th September. Subject to approval the Memorandum of Agreement will then be signed and submitted to NHS England to process the funding transfer to Enfield Council for 2014-15.

5 HEALTHWATCH ENFIELD

5.1 At the full Council meeting of 17th July 2013, Members ratified the creation of a Community Interest Company limited by guarantee, named as Enfield Consumers of Care and Health Organisation (ECCHO) that will deliver the Healthwatch functions in Enfield. The Chair and Board Members are in the process of registering themselves as Directors of the company.

5.2 The Council recognises and values the operational independence of ECCHO and does not have the power to determine its work programme.

5.3 The Council will not be an owner or member of ECCHO but will develop a Service Level Agreement between itself and ECCHO which will set out agreed key outcomes, outputs and will contain proportionate 'light touch' processes to assure and validate service delivery.

5.4 ECCHO will be grant funded by the Council and funding will be disbursed on a regular basis throughout the term on the basis that ECCHO demonstrates its ability to carry out its functions effectively through regular reporting and effective liaison.

5.5 ECCHO Board members are in the process of sourcing suitable accommodation and are planning an official launch to be held during the Autumn

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

6.1 The first phase review of organisations in receipt of core funding and support with running costs has recently concluded. As a result of the review a number of queries have arisen requiring clarification. To maintain stability for the organisations, service users and other stakeholders, current funding arrangements will continue until the Autumn 2014. This will allow sufficient time to garner the necessary information and ensure that proper governance is effected regarding any recommendations and decisions to be taken. Officers are maintaining the commitment to give organisations a 6-month notice period following any decisions taken.

6.2 The development, commissioning and implementation of an integrated information, advice and advocacy service for adults in Enfield with health and social care needs is a priority outcome from the VCSSCF. Commissioning managers have been co-producing service aims, objectives and outcomes together with measures for assuring and ensuring quality with a wide range of stakeholders which include service users, carers and partnership boards across all client groups. The work also includes consideration on how the service will be delivered to ensure optimum coverage and reach to meet advocacy needs across the borough. The preference determined from stakeholders is for local voluntary and community sector organisations to combine their specialisms and experience into a formal partnership or consortium to bid for funding to provide a holistic and accessible service. A draft service specification has been produced.

6.3 Commissioning managers will be embarking on the review (Phase 2) of local VCS organisations that are currently grant funded to provide information, advice and advocacy to measure what outcomes and value for money have been delivered. This is scheduled to commence in the Autumn 2013 with the intention to carry out a competitive grants process for the new service. The envisaged timescale for completion of the review, competitive grants process and service commencement is January 2015. This will allow sufficient time for appropriate decommissioning and a reasonable timescale for orgs to put a bid together, implement the service and be ready to commence new service provision. A partnership of local VCS organisations is emerging, that has received the draft service specification and has been briefed on a regular basis with emerging service requirements.

7. PERSONALISATION

7.1 Direct Payments in Residential Care

7.1.1 The scope of this national project has changed - Originally the pilot that we bid for was predicated on the exam question “Can Direct Payments work in residential care?” however this has now changed to “How **will** direct payments work in residential care?” .The reason for this is that the project now is much more closely linked to Dilnot and the social care bill which means that in April 2016 the regulations restricting direct payments for residential care will come off for all authorities (they will come off for Enfield in about October time).

7.1.2 This means that Enfield has ceased to be a pilot site and is now a trailblazer site. In recognition, an extra £20K has been awarded by the DH this year and another £20K next which brings the total funding for the project to £54K. In addition the scope has been extended to consider the social care costs in nursing homes.

7.1.3 First quarter progress in the project has been strong, with project initiation documents produced, a project board configured and a project

plan under construction. The project board consists of key stakeholders including operational managers and staff, commissioners, procurement leads, en engagement and policy officers, in-house and external residential care providers and a brokerage provider. We will be adding VCS, Health and service user and carer reps shortly

7.1.4 There are four work streams sitting under the project board: Service user and Carer engagement, Contracting and market management, Operational Process and Cultural Change and Support Planning. Activity is taking place in all areas however the Support Planning workstream is furthest advanced in that MySupportBroker have been commissioned to provide support planning for an initial 22 service users in residential care. This activity has already started.

7.1.5 A report on the project was given to Older People and Vulnerable Adults scrutiny panel on the 9th July 2013 and was well received with requests for regular updates as the project progresses.

8. SPECIALIST ACCOMMODATION

Mayor's Care & Support Specialist Housing Fund

In January 2013 the Council submitted two bids to the Mayor's Care & Support Specialist Housing Fund for capital funding to improve specialist accommodation for people with disabilities in the borough. A decision on successful bid applications has now been made. The local authority, has been successful in all applications submitted and has subsequently been awarded £315,000 for the development of wheelchair accessible homes for people with disabilities, including accessible shared ownership options for people with care and support needs. In addition to this, the local authority has worked in partnership with Newlon Housing Trust to secure £840,000 for the remodelling and improvement of supported housing services for adults with disabilities in the borough, including older people with learning disabilities and dementia. Work now commences to progress these exciting new developments in partnership with key stakeholders.

9. Homelessness Private Rented Sector Investment Project

In March 2013 Enfield had approximately 2,000 households living in temporary accommodation and was ranked 7th highest nationally, with most of those households living in the private rented sector. As the number of households in temporary accommodation continues to rise, there is a pressing need for more affordable housing stock to provide greater value for money but to also provide security for tenants.

Enfield Council has recently been selected a pathfinder authority to work with Social Finance, a not for profit organisation, and the Department of Communities and Local Government, to assess the feasibility of developing an institutional investment scheme, which could secure external investment to purchase properties and lease

these to the Council. This would secure affordable accommodation to be used to house homeless persons.

Work is currently being undertaken to review the viability of this and the most appropriate structure of the model, with a view to developing a market ready proposition by December 2013. This project has the potential to secure a portfolio of properties that can be used by the Council to discharge homelessness duties at a more affordable rate, whilst providing greater security than nightly paid temporary accommodation currently provides thus contributing to improved health and wellbeing.

10. SAFEGUARDING

10.1 Safeguarding Adults Board (SAB)

The Safeguarding Adults Board has received performance data which identifies that the number of safeguarding adults alert received by adult social care has continued to rise; there were 253 alerts in the first quarter of 2013-2014, compared to 159 in quarter one of 2012-2013, equivalent to a 159% increase. Multiple abuse and neglect are the most prevalent types of abuse reported. The Board monitors the performance and data at every quarterly meeting in order to identify trends and patterns which can be targeted through the work of all partners.

The Safeguarding Adults Strategy Action Plan 2012-2015 is in its second year, and sets out the priorities and work areas for all partners on the Board. This is project managed by Enfield Councils Central Safeguarding Adults Service, who now meet with partners to gather evidence, feedback and support achievement of targets. Many actions have been accomplished, are on track or plans are in place to ensure achievement within timescales.

The Safeguarding Adults Strategy action plan identifies a number of actions under leadership, partnership and commissioning, including ensuring the Safeguarding Adults Board has an effective governance and work programme, and to audit the performance of the Board against good practice guidance and relevant legislation. The September Board will consider audit options, which will then be facilitated by the Central Safeguarding Adults Service by the end of the financial year.

10.2 External Audit Case Practice

The previous emphasis on process in safeguarding has been shifting radically to that of outcomes; has the interventions taken place not only contributed to someone being safe, but meeting their desired wishes. The Central Safeguarding Adults Service will be completing 20 interviews in 2013-2014 with service users as they go through the safeguarding adults' process. A questionnaire has been developed and

agreed by the HHASC Equalities Steering Group which will provide both quantitative and qualitative information on outcomes for adults at risk.

10.3 Safeguarding Information Panel (SIP)

The Safeguarding Information Panel brings together Enfield's Safeguarding Adults Team, Procurement & Contracting, Environmental Health, the Care Quality Commission, CCG Safeguarding Lead and Community Nurses team. The SIP has been running successfully for over a year as a forum for sharing intelligence on the quality of care and addressing high risk safeguarding issues within care and nursing homes in Enfield. This may result in an inspection from the Care Quality Commission being brought forward, fact-finding visits from various professionals, monitoring visits from the Procurement and Contracts Team or Environmental Health or the beginning of the Provider Concerns process (whereby an service improvement plan is put in place to drive up quality of care).

The intelligence brought to the SIP includes information from Enfield Council about the number of safeguarding adults alerts, information from health about the number of pressure ulcers, and (recently made available) information from CQC about the number of deaths within care homes. CQC also inform the Panel about Registered Managers who are leaving care or nursing homes as this is a recognised area of high risk. As of August 2013 data around Mental Health resources can now be considered and with the established process for residential provision, the SIP is moving into analysing information around Supported Tenancies and Domiciliary Care provisions.

10.4 Quality Improvement Board (QIB)

The most recent Quality Improvement Board was held on Wednesday 21st August 2013. The QIB has approved the Terms of reference for the Dignity in care panel. Once established, this will be a panel of Quality Checkers, with an independent chair, reviewing services in the Adult Social Care department to determine whether we are meeting the national Dignity in Care quality standards. The Chair of Safeguarding Adults Board has agreed to chair the panel. The QIB also considered the various work streams currently in operation to ensure good quality of care in care homes, in light of the project to establish a support network for carers of people who live in care homes. This is being developed in partnership with Enfield's Carers' Centre.

10.5 Quality Checker Volunteering Programme

Quality Checkers are volunteer service users and carers who visit our in-house and commissioned services and tell us what they think about them. The pilot for our care home visits has been completed and the findings presented to the provider forum. No care homes have opted out of the visits, so all 100+ care homes will be visited from the 1st week of September. We are working with our In-house Domiciliary care team on a pilot programme to develop our home care visits. This pilot

will help us identify and manage the key risks for this pivotal area of work. We are hoping to have visits to our contracted home care provider within the next 3 months. The programme is now running with only one support staff, which an objective of the original brief.

11. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

11.1 Implementing Joint Commissioning Strategies

Enfield CCG is working in partnership with local secondary, primary, community and intermediate service providers across health and social care, to further develop a managed, whole system, approach to **integrated care** over the next three years resulting in reshaping how services are used by older people and aims to achieve a significant reduction of non-elective activity, A&E attendances and outpatient appointments. See Appendix 1 for an updated and detailed summary.

11.2 Admission Avoidance & Early Supported Discharge

11.2.1 Network Multi- Disciplinary Team & Risk Stratification

The Risk Profiling and Care Management Scheme DES was agreed by the LMC and circulated to practices early August, to date 43 of the 53 GP Practices have signed up to the DES. All practice will be rolled out by October / early November within a phased programme with the North West practices having gone live; South West practices going live next week and the East practices scheduled to be rolled out by October early November.

The Chase Farm and North Middlesex MDT teams operate on difference days and will include mental health from September. Practices are being offered 10 minute slots per patient for discussion on the conference call and have been grouped into West and East practices to access the service on alternate months with flexibility built into the system.

The implementation of the Risk Stratification Tool has been delayed whilst IG issues are addressed, which arose as a result of the change from PCTs to CCGs. We are working collaboratively with the providers and council to secure a solution to the situation and pseudononymised patient information at source is currently being tested across all providers and Health Intelligence.

It is anticipated that the risk stratification tool will become available to GP practices shortly and will support the identification of patients for case. management and MDT teleconference. However in order for GP practices to comply with the Data Protection Act, this Autumn they must take ‘reasonable steps’ to inform patients that identifiable data will be extracted from their records and used by the NHS and private companies. Practices will be responsible for informing patients of how their data will be used, and are required to give the patient the opportunity to opt out. It is suggested that practices inform patients through posters, leaflets, notices on websites, discussion with the

practice participation group and ensure all staff know about the changes so they can inform patients and enter the correct read codes if patients object.

11.2.2 Older People's Assessment Unit (OPAU)

Both NMUH and CF have regular mobilisation meetings with the CCG and their own internal meetings up and running. Despite a slow start, the last meeting at CF was encouraging and they are now on track to start 16 September.

Agreement on the referral is being reached on type and the number of patients who can be referred from day one and how it will work internally at the OPAU. Agreement will also be needed on the types of patients GPs should be putting through and how to time the referrals.

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The CCG has been hosting operational workshops to work through how the multiple providers will work to and operationalize the service. These will continue over the opening of the CF OPAU and the start of the NMUH OPAU to enable an opportunity to refine service delivery. In addition quarterly workshops for more senior stakeholders have been set up to March 2014.

11.2.3 Falls Prevention and Fracture Liaison Clinic

Fracture Liaison Nurse continues to work within Chase Farm to case find patients that would benefit from management.
She now has full access to the trusts PAS system which enables easier identification of the most appropriate patients to target. This has led to a reduction in the number of DEXA scans requested but the referrals are more appropriate.

Weekly clinics have been established on the St Michaels site for the Fracture Liaison Service.

The Bone Health Nurse is liaising with the CHAT team and is now targeting homes that the team are not working with; currently working with four homes.
She is also working with Community Matrons; access to GP practices is proving difficult as they are failing to engage with the service.

Using information from medicines management to target practices with high steroid prescribing and low Bisphosphorates

The Bone Health Nurse has established a working relationship with the Community Alarm Service whereby they inform her of any residents that fall for follow up.

11.2.4 Care Homes Project

The teams are now working in 16 homes care homes.

Evaluation of the project was undertaken in May this looked at all aspects of the project and included a questionnaire that was sent to both the care home staff and the care home owners. Overall the feedback from this was very positive about the contribution the team makes to the well-being of the residents in the care homes. See attached Appendix 3

Review of 12-13 data compared to 10/11 baseline demonstrates an 18% reduction in A&E attendances from the participating care homes and a 10% reduction in Emergency admissions. LAS call out is also beginning to show a downward trend.

The Tissue Viability Service continues to work in 19 homes; in quarter 1 31 new residents have been referred to the service by 7 of the participating homes; the service works to identify residents needing support with the non- referring homes. Formal training sessions are provided for the homes in addition to education in practice training which continues on each visit. A link nurse scheme is being developed in 8 homes.

Falls audit was undertaken post training in one of the homes with the highest number of falls which demonstrated a 50% reduction. See Appendix 2 Work continues with this home and further falls training is being provided to homes with high levels of fallers.

Primary care delivery in the care homes is variable with some homes supported by a single practice while others have residents registered with multiple practices. The CHAT team have found that where this is the case the team are often requested to provide primary care support. To improve Primary Care delivery to the Care homes a Local Enhanced Service (LES) specification has been developed with a view to reduce the number of GPs providing care to the homes. The LES will clearly define the expectations for primary care delivery and will enable the CHAT team to work with the more complex cases that require specialist input. In time this will allow the team to expand the service to provide cover to all older peoples care homes in the borough.

The teams have completed 143 ACP's in 2012/13 and in quarter 1 a further 13 which have resulted in 96% of people dying in preferred place of care; medication reviews more than 1200 have been carried out leading to 386 people having their medication reduced in 2012/13 and so far in quarter1 a further 102 medications stopped.

12. PUBLIC HEALTH TRANSITION

The transition of services from the NHS to local authorities has presented many challenges to the council.

12.1 Sexual Health

Due to the national arrangement for GUM, the Council has three arrangements with providers

(i) contractual with providers in NCL,

(ii) non contractual with providers outside NCL where a significant amount of activity and expenditure take place e.g. Chelsea & Westminster, and

(iii) non contractual 'spot' payment arrangement for the smaller invoices received from around the country e.g. recently received an invoice from Devon for one treatment.

LBE has entered into an agreement with North & East London Commissioning Support Unit (NEL CSU) to manage and monitor all GUM data and the non-contractual 'spot' payments to reduce the administrative burden on the council.

Two* local authorities have joined the newly formed Local Authority Sexual Health Commissioning Group - Enfield, Barnet, Haringey, Camden, Islington, Waltham Forest*, City & Hackney*. This group will meet regularly to:

1. work collectively to negotiate the best deal for GUM services for 2013/14 following the NHS transition with each member taking the lead on a provider contract.

2. work together to plan and prepare interactions with NEL CSU ensuring we all receive value for money on the 2013/14 contract.

3. work collectively re the planning of commissioning sexual health services responsive to local assessed need for 2014/15

12.2 BEH MHT Contract

The negotiations are complete and the block contract is now circulating amongst the stakeholders for signature. The services relating to Enfield Council, with an indicative value of £3.7m (therefore requiring the contract to be stamped with the Council's seal), are:

- School Nursing Services
- Family Planning
- Teenage Pregnancy
- GUM services
- Reproductive and Sexual Health [RASH] service (Shout for Young People)

13. JOINT COMMISSIONING BOARD

The last Joint Commissioning Board took place Tuesday 27th August 2013. The Board received an update on: Proposals to develop telehealth and to further develop the Councils telecare offer; NHS Social Care Grant: Current and projected spend; Blood Transfusion Partnership (proposal was supported by Board); update on integrated care; options paper to increase uptake of GSF accreditation in Care Homes (the Board rejected proposals to fund accreditation unless a more robust business case could be made however it was agreed that training should continue); Winter Capacity Commissioning Plans; Development of Mental Health Needs Assessment and Strategy; and proposal to invest one-off funds to manage the Memory Service waiting list (proposal was supported and will go to CCG F&Q Committee for approval).

The next joint Commissioning Board is set for Thursday 26th of September 2013 and an update will be provided to the next Health & Wellbeing Board

14. SERVICE AREA COMMISSIONING ACTIVITY

14.1 Older People

14.1.1 Winter Pressures Funding

Winter planning is well underway. The NHS England asked local areas to:

- Provide a validated Winter Pressure Checklist outlining the arrangements health and social care agencies have in place to manage winter demand coordinated through NHS Enfield CCG, partner agencies have now completed this Checklist, and a more detailed plan being pulled together for the same purpose locally by the CCG;

- Consider how health and social care partners might use the additional funding available from NHS England to relieve pressure on A&E and hospital admissions, with the health economies associated with Barnet & Chase Farm Hospitals NHS Trust – i.e. the Boroughs of Barnet & Enfield – identified as one of 10 London challenged health economies targeted for additional funding across relevant health and social care partners to assure A&E and hospital performance in Winter 2013/14. NHS England have provisionally allocated £5.1m against which health & social care partners, coordinated by the acute Trust and CCG, can bid to prevent hospitalisation, promote timely & safe discharge and prevent readmission in a 24/7 care economy as a matter of urgency. Draft bids are being coordinated, with the final bids agreed, together with a letter of commitment co-signed by NHS and Council providers, submitted no later than 12th Sep-13. NHS England will announce the final allocation by the end of Sep-13. NHS England have stated this is the only winter pressures monies it will make available in 2013/14.

Last winter, the Council received £882k for Social Care Winter Pressures Grant from the Department of Health via a Section 256 agreement with NHS Enfield CCG. These monies were used to support the entire health and social care economy and focussed on additional capacity for hospital social workers and intermediate care solutions. As discussed in the last update, there was good evidence of the difference the funding made last year in terms of reducing delayed transfers of care, successful enablement and admissions to residential/nursing care. No announcement has yet been received about whether this non-recurring Grant will be available in 2013/14.

Last winter, the Department of Health funded the national Warm Homes, Healthy People Programme. It allocated £148k to Enfield following the submission of the Council-led bid, which contained 16 individual proposals from statutory and voluntary sector partners, to which the Council's Directorates of Health, Housing & Adult Social Care and Children's Services added a further £77k from internal funding to make £225k available for Enfield's local Programmes.
The 16 schemes helped over 8,500 individuals across Enfield's diverse population and in deprived wards through 16 individual schemes ranging from simple information and advice about how to keep warm and healthy in winter; through to delivering food parcels to vulnerable adults and families or tackling social isolation; and delivering alterations or repairs to individuals' properties.
The Department of Health has yet to make an announcement about whether this national Programme will continue into 2013/14, and therefore there is no knowledge of potential funding. However, the Council has asked voluntary and community sector partners to consider whether and how they would like to be involved if the national Programme continued this winter, as last year the timescales between DH announcement (mid-Sep-12) and submission of Enfield's overall bid (early Oct-12) were very short, placing pressures on partners.

14.1.2 Successor to My Home Life (MHL)

Following the completion of the My Home Life (Enfield) Project in February 2013, work is progressing to ensure that the legacies of the project are sustained. Care home managers are keen about the continuation of the joint (Council, NHS and Care Home) quality focus group created as part of the programme. The sector appreciates the work of My Home Life and commented positively about it during the last providers' forum meeting in July. The sector would like the group to exist as a platform of discussing specifically the care home quality issues besides the periodic providers' forum that encompasses all providers.

A joint planning group consisting of Enfield Council, NHS and interested Care Home managers have completed drafting terms of reference for the focus group. Once the terms of reference is signed-off by appropriate bodies and provided availability of Council/NHS resources to take this forward, it is intended to utilise the group as a platform to explore and address common

issues and to feed findings/ learning into the borough's overall quality improvement framework. The implementation and effectiveness of this desire will require the support of the Council and the NHS

14.1.3 Enfield Dementia-Friendly Communities

The Council, NHS and voluntary sector partners continue to improve dementia awareness and the coordination of information, advice & support in line with Voluntary & Community Sector Strategic Framework. Partners are preparing promotional events in September and October, particularly targeted at diverse communities.

Partners formed the Enfield Dementia Action Alliance, a national approach, though Enfield is the first Borough in London to do so, with the aim of promoting the needs of those living with dementia amongst organisations – those associated with providing care, but also wider private, public and voluntary sector organisations, e.g. emergency services, schools, retailers and banks. Terms of reference and aims and outcomes were agreed. Each organisation that agrees to sign up to the Alliance will identify and publicly publish three actions they will undertake to improve their organisation's interaction with those with dementia and their carers. The Alliance will have its own public web-site, managed by the Alzheimer's Society, to track individual organisations' progress in completing these actions. The Alliance's launch is on 6th September 2013.

As detailed in recent updates to the Board, a bid was submitted for £660,000 against the European PROGRESS social fund to support people with dementia in Feb-13. Unfortunately, this bid was unsuccessful and partners in the Enfield Dementia Action Alliance are exploring alternatives.

14.1.4 Social Isolation Bid

The Big Lottery Fund announced a new programme, Fulfilling Lives: Ageing Better, which aimed to reduce isolation, improve older people's ability to deal with change, and give them greater power to make choices. They have agreed to commit up to £70 million to 15-20 local areas in England, supporting holistic and creative approaches to tackling social isolation amongst the older population. The Borough was one of 32 local areas to be accepted onto the next phase of bidding following its successful Expression of Interest in Jul-13, with the BLF organising a Partnership Planning Day on the 9th September. The next phase of the process is a full project partnership approach through a lead VCS organisation by April 2014. Thereafter 15 – 20 areas will be selected for funding. The ambition of an Inclusion Programme with a strong focus on empowering older people to design, manage and sustain solutions tailored to them.

14.2 Mental Health

14.2.1 Independent Mental Health Advocacy (IMHA)

Enfield Council has approved the proposal to jointly tender (with Barnet and Haringey) a consolidated Independent Mental Health Advocacy (IMHA),

Independent Mental Capacity Advocacy (IMCA) and Deprivation of Liberty Safeguards (DoLS). A tender timetable has been drawn up with prequalification questionnaire to be issued in September 2013. Enfield will be leading on the joint procurement. It is envisaged that the new joint contract will be in place from April 2014. The Health and Wellbeing Board will be updated on progress at its subsequent meeting.

14.2.2 Joint Mental Health Commissioning Manager

Both the Council and the CCG successfully recruited on an interim basis to the Joint Mental Health Commissioning Manager posts in June 2013. The strategic lead sits with the Council and therefore the commissioner is based with the Council leading on the development of the Joint Adult Mental Health Strategy. The process of recruiting substantively to the role in the Council is underway with a view to recruiting by January 2014.

14.2.3 Joint Mental Health Strategy

The first draft of the Joint Adult Mental Health Strategy has been considered by the Joint Commissioning Board. A consultation document will be produced for consultation for 12 weeks from 19 September 2013 (ending 10 December 2013). The consultation will be either undertaken jointly or aligned to the consultation on the Enfield Health and Wellbeing Strategy. The final strategy document will be considered by the Joint Commissioning Board on 19 December 2013 and will be submitted to the Cabinet for either its February or March 2014 meeting.

The strategy reflects the priority given by The Council and Enfield CC to adult mental health services. It is a joint framework that identifies and addresses gaps in mental health and wellbeing of the population of Enfield and the support and services needed to meet the health and social care needs of people recovering from mental health problems effectively. It will identify the joint priorities and commissioning intentions of The Council and Enfield CCG for mental health services in Enfield. It integrates key Council drivers and priorities, including the priority already being given to improving access to settled accommodation and employment and to address inequalities / problems. In relation to health funded services, the strategy is guided by the principles and priorities set out in the draft Barnet, Enfield and Haringey Mental Health Commissioning Strategy developed by Enfield CCG such as developing support by GPs and in primary care and community settings for adults with mental health problems and increasing access to psychological therapies in both primary and secondary care or adults with depression and/or anxiety, older people and people with long term physical health conditions.

14.3 Learning Disabilities

14.3.1 Learning Disabilities Self-Assessment Framework (SAF)

The Learning Disabilities Self-Assessment for 2012-13 is different from previous years. Instead of focussing purely on Health, it is reflective of the national drive to improve better working between Health and Care, and is a joint self-assessment framework. This year the themes are; Staying healthy, Being Safe and Living Well and is aligned to the following key policy and frameworks: -

- Winterbourne View Final Report
- Adult Social Care Outcomes Framework 2013-14
- Public Health Outcomes Framework 2013-2016
- The Health Equalities Framework (HEF) An outcomes framework based on the determinants of health inequalities
- National Health Service Outcomes Framework 2013-14
- 6 Lives Report

Work is underway to start collecting information from the different service areas across Health and Adult Social Care who contribute to providing evidence for the Learning Disabilities Self-Assessment Framework. The deadline for submission is the beginning of November2013.

14.3.2 Winterbourne View Concordat

NHS Enfield Clinical Commissioning Group (CCG) and the council have developed a joint action plan in response to the Winterbourne View concordat. Key messages from the concordat are that each locality should commit to jointly reviewing all people with learning disabilities and / or autism within in-patient facilities to ensure that people are appropriately placed. Where people are considered as inappropriately placed there is emphasis on considering community based services that are close to home. Enfield completed reviews by the June 2013 deadline and are currently on track in terms of meeting the conditions of the concordat action plan. Patient choice and parent / carer involvement continues to be the focal point of implementation of the concordat action plan. Commissioners continue to review the assessment & treatment pathway for people with learning disabilities with a view to reducing admissions to this type of service and are monitoring discharge to ensure that stays are not disproportionately long. The benefits of community intervention models continue to be explored.

14.3.3 Autism Strategy development and Autism Self-Assessment Framework

The draft joint commissioning strategy for adults with autism, which is aligned to the national strategy Rewarding and fulfilling lives (2009), was launched for public consultation in May 2013. The consultation period ended on the 19th of August 2013. The feedback is currently being analysed and a summary of findings will be included in the final version of the strategy. We are hoping to launch the strategy in

December of this year. The joint strategy and implementation plan seeks to promote awareness of autism and improve access to advice, guidance and support for adults with autism and their parent carers living in Enfield.

The Autism Self-Assessment Framework is currently being completed by relevant stakeholders of services. Enfield's response will be submitted to the National Improving Health and Lives (IHal) website by the end of September 2013.

14.4 Carers

14.4.1 Enfield Carers Centre

The building renovation has now been completed and has created more confidential working space and improved accommodation for the new staff members. This is a real improvement to the Centre and also gives the Centre the possibility of further income through room hire.

Enfield Carers Centre now has the following posts in place: GP Liaison Project Manager, Advocacy Worker and a Young Carers Worker. These posts have made an immediate impact and the Centre is now recruiting for a Hospital Liaison Worker and the Carers Nurse, both of which will be managed by the GP Liaison Project Manager.

The Advocacy Worker has been taking up cases and has also been promoting the services within the VCS and with practitioners. Leaflets have been circulated to increase knowledge of the service.

The Young Carers Worker has now identified four schools to work intensively with to develop services and support for young carers – Suffolk Primary, George Spicer primary, Edmonton County Secondary and Oasis Hadley Secondary school.

The Worker and a former Young Carer have delivered one assembly at Suffolk Primary School which led to four children identifying themselves as a young carer.

In additional a summer activity of a Graffiti Workshop for young carers took place in August with 7 young carers attending.

The Centre has also launched a new respite breaks calendar, ranging from short break holidays to meals at local restaurants. A copy of the programme can be requested from the Centre.

14.4.2 Carers Direct Payment Scheme

We now have 88 carers receiving a Direct Payment through Enfield Carers Centre with another 12 awaiting approval. A review of the scheme so far will be completed by October.

14.4.3 Carers Week

Carers Week was successful although some activities were poorly attended, such as the Question and Answer session on the Monday evening and the Carers Information Forum on the Wednesday. However the Monday event identified two new carers who were not know to services previously and whilst only 20 carers attended the information forum, we had a further 40 members of staff from the Council, Health and the VCS attend, either as visitors or stall holders. The overwhelming feedback from the professionals is that it was very helpful to be able to learn about different services available.

The Carers Centre open day was well attended by both carers and professionals, with the Mayor giving a speech recognising the importance of carers.

14.4.4 Primary Care Strategy

The GP Liaison Project Manager (funded from ECCG's primary care strategy programme) began in June and has visited all the GP practices in the North West cluster. They have been successful in raising awareness of carers issues with practice staff, providing literature and posters and one practice, Woodberry Practice in Winchmore Hill, has now agreed to host the Carers Nurse and provide clinical supervision allowing recruitment to begin. Leaflets and posters for the service have been created and distributed.

14.4.5 The Employee Carers' Support Scheme

The official launch took place on Tuesday 11th June, during Carers Week, and James Rolfe attended as the Council's Equality Champion ands poke about how carers fit into the equalities agenda. Human Resources also attended and discussion was focused around the need for a Carers Policy, training for line managers and paid carers leave.

14.4.6 Relatives Support Network

Work has begun under the Quality Improvement Board to develop a Relatives Support Network – a network that will provide information and support for carers whose cared for is in residential care. This work will include the Quality Checkers including Relatives Group in their initial visit and visiting established groups to look at how they support the quality of care. The work will also work with homes to create Relatives Groups and to ensure these carers have access to information and advice. A support group will also be established at Enfield Carers Centre.

14.4.7 Carers Strategy Implementation

As reported in the section above the governance structure for the implementation of the Carers Strategy has been approved.

The first Carers Practitioners Working Group meeting has taken place with representatives from all the Social Work teams to look at practice and procedures that affect carers. The focus for further work of the group is to review and update the Carers Assessment form and the paperwork for a Carers Party to Event assessment, improved and increased communication on carers' issues and training for practitioners.

The BEH Mental Health Carers Project Group met in July to provide joint feedback to the Trust's Carers Experience Strategy. The group has offered expertise and support to develop the strategy further. Training for MH practitioners is currently being discussed and is looking to be delivered in late autumn.

The Parent and Young Carers Group is due to have their first meeting in October.

The Carers Strategy Implementation Group initial meeting had to be postponed due to poor attendance and has been rescheduled for the second week of September.

14.5 Children's Services

14.5.1 Family Nurse Partnership (FNP)

Good progress is being made on implementation of the Family Nurse Partnership – an evidenced based, preventative programme offered to vulnerable young mothers having their first baby with the aim to:

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

The team has now been fully appointed and are gradually coming into post during September 2013 prior to attending the national training course in October and formal start of the project on November 1st 2013. **A launch event is being held on Thursday 10th October, 3.30pm – 5.30pm at the Dugdale Centre in Enfield Town, and members are invited to attend.**

14.5.2 Occupational Therapy Service

Progress on implementation of the Action Plan developed following the Serious Incident Report, continues to be reviewed through monthly Clinical Quality Review Group (CQRG) and Contract Review meetings. Good progress is being made and the business case is being considered by the CCG's Finance Recovery and QIPP Board on the 4th September 2013.

14.5.3 Paediatric Integrated Care

The need for a paediatric integrated care work-stream to support implementation of the Barnet, Enfield and Haringey Clinical Strategy has been identified. The proposed work programme has a number of elements:

- to support the development of the Urgent Care Centre and the Paediatric Assessment Unit on the Chase Farm Hospital Site;
- to improve collaboration across primary, community and secondary care;
- to increase the knowledge and confidence of GPs and other primary care professionals in working with children who are ill;
- to develop and implement protocols and/or care pathways for common childhood illnesses and long term conditions;
- to develop care closer to home, and reduce A&E and Outpatient attendances and unnecessary admissions to hospital.

Initial focus has been on the development of a specification for the PAU and the implementation of primary care paediatric pilots in two GP network localities. Through the primary care paediatric pilots, all non-urgent paediatric outpatient referrals will be triaged by the Enfield Referral Service against agreed care pathways/eligibility criteria. Inappropriate referrals will be sent back to GPs with a case management plan, and appropriate referrals sent either to a consultant paediatrician working in a primary care setting or to secondary care. As part of the pilot, agreed protocols and/or care pathways for common childhood conditions will be disseminated to each practice and reinforced through established education forums and practice meetings, and arrangements agreed with both Trusts to establish single points of contact to improve collaboration. Other opportunities for training and support will be explored including debriefing sessions following the primary care clinics. The next phase of the project will look at the potential to reduce A&E attendances and integrated care pathways for long term conditions, starting with asthma.

Capacity issues have caused some delays in implementation, but Barnet and Chase Farm Hospital commenced a pilot in the North East Locality on the 8th April 2013 and feedback is promising. The North Middlesex Hospital have still to start and this is being actively pursued.

The CCG has commissioned an organisation called Matrix to carry out some economic and financial modelling, to support the development of the integrated care model which will include options around 'gain sharing' across organisations. **A workshop is being planned for the afternoon of 31st October 2013 and Board members are invited to attend**. Clinicians and managers from BCF, NMUH, ECS and the CCG, and a representative from the Council are on the working group supporting the development of the new model.

14.5.4 Identification and Referral to Improve Safety (IRIS)

IRIS is a general practice based domestic violence training, support and referral programme for primary care staff that has been launched in Enfield. A national pilot in Bristol and Hackney GP practices demonstrated the effectiveness of the IRIS model. It is a targeted intervention for female patients 16 years and over who are experiencing domestic violence from a current or ex-partner or from an adult family member. IRIS provides care pathways for all patients living with abuse as well as information and signposting for male victims and for perpetrators.

The model is based on one full time advocate educator, who is a specialist domestic violence worker, based in a local domestic violence service and working with 25 practices. The team has been recruited and trained and is ready to start work

14.5.5 Section 75 – Services for Children

Following review, the Section 75 for Children's Services has now been updated by the Interim Head of Commissioning in partnership with Legal Services. The Agreement now sits with Health services for update and agreement, prior to sign off.

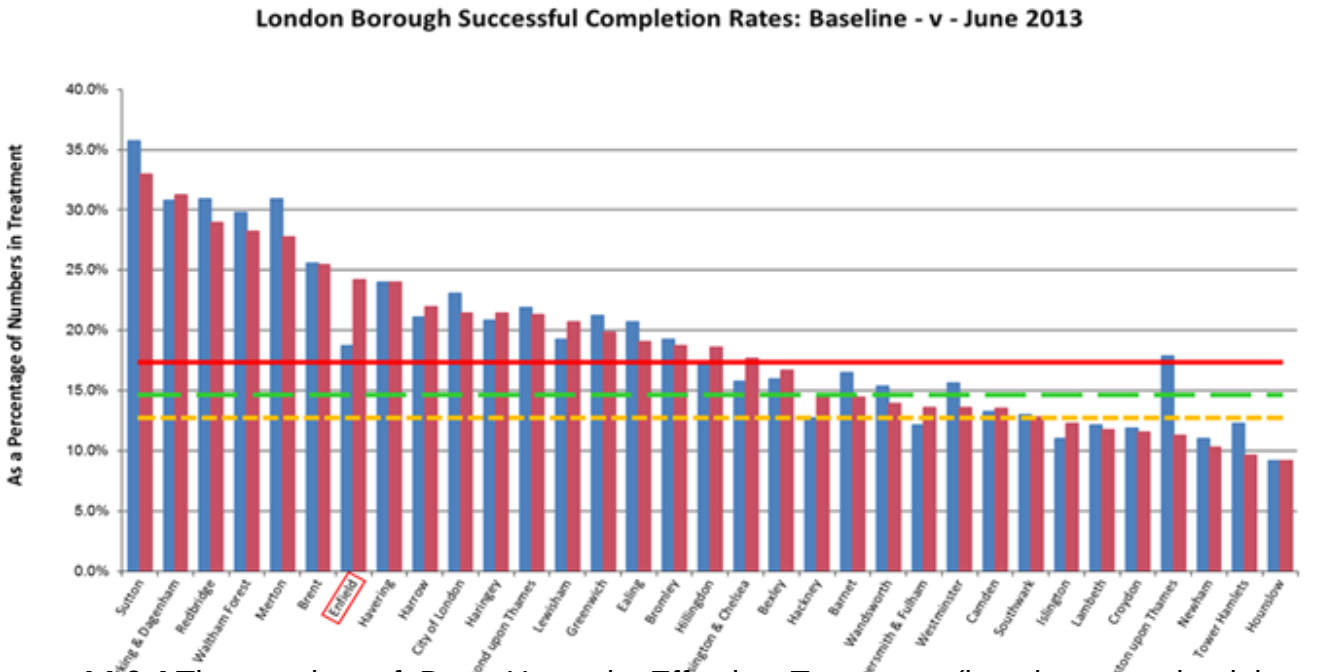
14.6 Drug and Alcohol Action Team (DAAT)

14.6.1 Performance for Successful Treatment Completions has continued on the upward trend with the latest Public Health England data release confirming that the DAAT has achieved a 24.2% rate for the period July 2012 to June 2013. This is 6.9% above the London average, 9.6% above the National average and 11.4% above the PbR Pilot average.

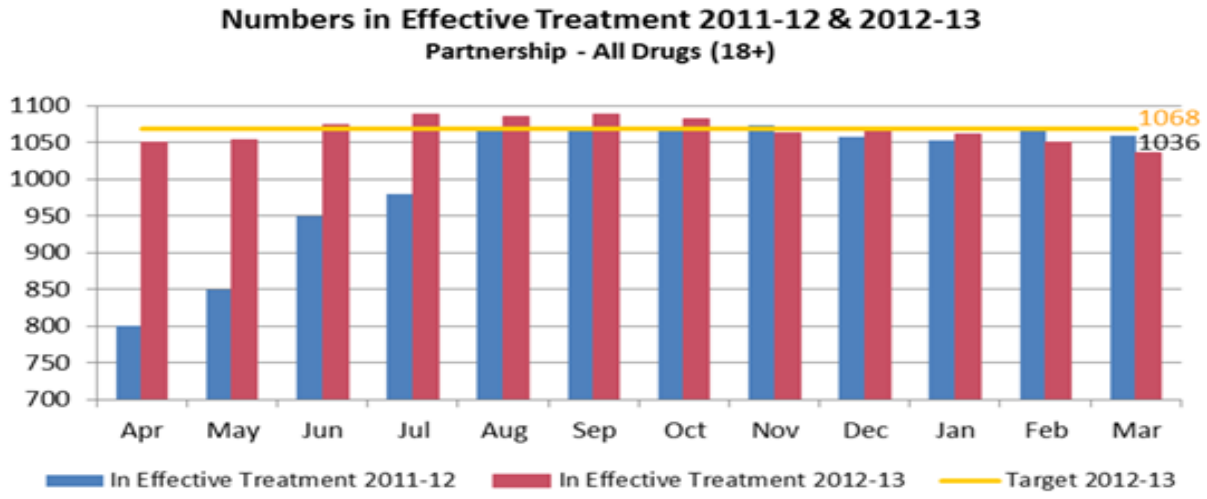
14.6.2 Enfield DAAT Successful Completions

	Apr 2012 to Mar 2013	**May 2012 to Apr 2013**	**Jun 2012 to May 2013**	**Jul 2012 to Jun 2013**
Partnership				
Number of Successful Completions	205	217	240	266
Numbers in treatment	1094	1095	1093	1098
% Successful Completions	**18.7%**	**19.8%**	**22.0%**	**24.2%**
% London Average	**17.6%**	**17.5%**	**17.5%**	**17.3%**
% National Average	**14.9%**	**14.8%**	**14.7%**	**14.6%**
% PbR Pilot Averages	**12.3%**	**12.4%**	**12.6%**	**12.8%**

14.6.3 The graph below shows that Enfield DAAT is now ranked 7th in London for successful treatment completions; a 4 place improvement over previous reports.



14.6.4 The number of Drug Users in Effective Treatment (i.e. those retained in treatment for 12 weeks or more or discharged drug free within 12 weeks) is still below the trajectory target of 1068 by 32 patients. This n addressed and the operational changes implemented by the providers will start to show a positive change in performance against this measure within the forthcoming 5 month period.



14.6.5 The number of young people receiving substance misuse treatment has also continued on an upward trend with the latest Public Health England data confirming that 172 young people received structured drug or alcohol treatment during the 12 month rolling period July 2012 to June 2013; 32% higher than was achieved for the same 12 month rolling period in 2011/2012.

14.6.6 The DAAT has three contracts that need to be re-tendered during the year as they are unable to be extended without placing risk to the Council. These are the Adult Substance Misuse Recovery Service contract, the Young People's Substance Misuse Service contract, and the Crime Reduction Substance Misuse Recovery Service contract. The three Business Cases were presented to the Strategic Procurement Board in July and approved on the 7th August 2013. This was following a highly successful market engagement event at the Dugdale Centre on the 29th July where 53 people attended, representing 35 interested suppliers. The PQQ stage of the tender commenced on the 14th August and the new contracts will formally be implemented on the 1st July 2014. The DAAT is mindful of mitigating for risks in performance in the event that the incumbent suppliers change and it will ensure these risks are managed to best effect.

14.6.7 The DAAT Board is currently producing a new drug and alcohol strategy and a partnership away day is being convened for the 11th November 2013. This will ensure that the community are fully involved in highlighting the local priorities they want included, as well as identifying which elements of the National Drugs Strategy 2010 and National Alcohol Strategy 2012 need incorporating. It is proposed that this community based strategic development approach will be most effective with supporting the partnership achieve its vision of '*Making Enfield a Safer, Healthier and More Prosperous Community by Reducing Harmful Drinking and Illicit Drug Use'.*

14.7 Joint Commissioning team

The current Deputy Joint Chief Commissioning Officer is returning to New Zealand to take up a national role with the NZ Health Ministry. We are reviewing the current structure and how it might be better integrated with the Procurement and Contracting functions of the department

A further update on the management of the Joint Commissioning Programme will be provided at the next Health & Wellbeing Board

15. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

15.1 Learning Difficulties Partnership Board (LDPB)

Consideration is being given to the development of a local LD Parliament. One-2-one (local Community Advocacy Group) is currently working with the LD commissioning Manager to explore options.

There are two Acute Liaison Nurse Posts working with Enfield residents with learning disabilities using acute hospital services.

People with learning disabilities experience huge health inequalities and higher mortality rates. There are a number of reports (Mencap: Death by Indifference, 74 Lives and Counting, Sir Jonathan Michaels:

Healthcare for All) which highlight the greater risk to people with learning disabilities of early mortality through poor access to health care or from inadequate healthcare provision from primary and acute services. Acute Liaison Nurses play a key role in response to the recommendations set out in these reports. ALNs also play a key role in ensuring the safety of people with learning disabilities whilst in hospital, a key priority given the recent events at Winterbourne View.

One post if funded by Barnet CCG and covers Enfield and Barnet residents using the Barnet & Chase Farm Hospital Trust. The second post covers Enfield and Barnet residents using the North Middlesex and Royal Free Hospital Trust. This post was previously funded by Enfield Council and Enfield PCT from LDDF grant monies and latterly by Enfield Council from the NHS Social Care Grant funding. This funding was agreed for one year in order to identify further funding to continue this important work. This funding ceases at the end of August.

A number possible of options have been identified:

- For the current arrangement between LBE & Barnet CCG to continue and for LBE to identify alternative sources of funding.
- For the project to be funded by Barnet and Enfield CCGs.
- For Barnet &Chase Farm and the Royal Free and North Middlesex Hospital Trusts to pick up responsibility for the funding and management of the post within their setting.
- For the project to cease.

In addition to the cessation of the North Middlesex post in August, the post holder working at the Barnet and Chase Farm Hospital Trust has been offered a promotion at another hospital trust and has handed in her notice. This means that there is no acute liaison nurse function for Enfield residents in either of the local acute hospital trusts.

The Head of Integrated Learning Disability Service met with the previous Director of Nursing at the North Middlesex and the Director of Nursing at the Royal Free Hospital Trust to discuss them picking up responsibility for this post. The Royal Free have agreed and will be recruiting to a LD Nurse Liaison post which is positive although will have little impact on Enfield residents. North Mid had agreed to recruit to a part time post, which they later changed to a Safeguarding Nurse post with some responsibility for LD. This was far from ideal but at least maintained some of the nurse liaison function.

North Mid original plans appeared to have stalled with the change of Director of Nursing and CEO. The Head of the Integrated Learning Disabilities Service has been in contact with the new Director of Nursing to arrange a meeting to establish what their plans are but this has not been possible. Further attempts will be made to progress this.

In addition the CCG has recently set up a steering group for learning disabilities and this matter has now been discussed in this forum. Dr Ujal Sarkal, CCG lead for learning disabilities has asked that the QUIPP project manager and the LD Joint Commissioner consider the possibility of whether the CCG can take responsibility for this post.

The Head of Integrated Learning Disabilities Service has had discussions with Barnet CCG and has asked to be kept informed of their discussions with Barnet & Chase Hospital Trust as to progress on replacing the ALN based in BCF. They have indicated they hope to continue with this post and are in discussion with BCF about this. They have agreed to keep us informed.

15.2 Carers Partnership Board

Christie Michael, the Carer Co-Chair, attended her first meeting in her new role. Christie has many years' experience caring for her mother and balancing her education, employment and own medical conditions. Training has been offered to ensure she feels confident in her new role.

The Partnership Board has officially ratified the structure and membership on the Carers Strategy Implementation Group and its sub groups.

Further work and discussion has taken place within the Board for the training needs of the Carer representatives and how they wish to see the Board operate. The Board is keen to take a greater role in steering and monitoring carers' services and an away day is planned for early 2014 to focus on this role.

15.3 Mental Health Partnership Board

(Taken from Minutes of 18 June)

Kate Charles advised the Board of the plans to develop local Enfield Mental Health strategy and introduced the interim MH commissioning manager.

Solutions for Public Health has been commissioned by LBE to undertake a health needs assessment of mental health for the borough.

The Board noted the common themes that were highlighted at the Away-day:

- Healthy lifestyles
- Keeping safe
- Economic wellbeing
- Service-user involvement

The Board was asked to work on the templates to scope the actions currently covered in each of their organisations in order to inform the areas where the Partnership Board can collaborate through workstreams

Note: Key issues regarding health needs and views on current service provision project (ended July) will be reported in the next H&W report.

15.4 Older People Partnership Board

The last Older People Partnership Board took place on 7th August 2013. The Board received several papers and updates, including about some of the issues highlighted in this report: in particular, feedback about the success of the multi-agency dementia awareness-raising, development of the Enfield Dementia Action Alliance, Assistive Technology and integrated care. The Board received a paper about the Developing Vacant Property Options for People Living in Residential Care, which included a discussion about setting up a scheme whereby individuals in residential care can lease their properties if they wish to the Council for a time-limited period (up to 5 years) to generate revenue with which to pay for their care. The report was well received, but members asked for further details before committing to help shape the scheme

15.5 Physical Disabilities Partnership Board

Not available

Appendix 1

Implementing Joint Commissioning Strategies [ref 11.1]
The managed, whole system approach is building on what is currently working effectively in Enfield and to identify the areas which require a level of change and / or investment in order to optimise their contribution to a reduction in

unscheduled care and reduced length of inpatient hospital stay where clinically appropriate.

There are three key aspects that have developed in Enfield:

- **Admissions Avoidance**: the development of a consultant geriatrician led MDT which is based within the A&E department at Chase Farm Hospital (until it becomes a standalone UCC) and NMUH with the aim of managing appropriate patients to avoid admissions. This will be achieved through rapidly seeing and treating the patient within the four hour waiting target and linking effectively with community services and with GP led primary care. The service will be commissioned to rapidly respond and take on the ongoing care of appropriate patients with the continued support of a consultant geriatrician. This is the embryonic OPAU which is further developed in this specification.

- **Early Supported Discharge**: the development of a MDT who will work within BCF and NMUH to swiftly identify patients who with the right support or care package in place could be discharged back to their own home or stepped down to be managed in intermediate care beds.

- **Case Management**: the development of a MDT case management team who will take responsibility for patients who either avoid an acute admission (i.e. from the admissions avoidance service in A&E or the proposed OPAU subject to this specification) or are subject to early supported discharge as set out in items one and two above. The team will continue to oversee the care of this cohort of patients and ensure that additional support is provided as and when is required to avoid further admissions where possible. This will extend in a phased manner to act as the underpinning mechanism for all integrated care for Enfield. This will mean for example acting as the vehicle to work with primary care to result in the development of risk stratification and resulting cohort risk registers. It is envisaged that over time this team will be able to take direct GP referrals thus negating the need for patients to be sent to A&E at the acute providers. It remains subject to discussion with local authority colleagues but ideally this team would represent both health and social care, and be in a position to work effectively across and with both agencies to maximise the effectiveness of all available resources including intermediate care beds currently based at Magnolia Ward, as well as preventative respite, enhanced domiciliary care and enablement.

It is envisaged that over the course of the next one to two years that a Case Management MDT Service as articulated above will serve as the vehicle for building enduring and co-ordinating links through a case finding, case management and care coordination approach that reflects the elements identified in the model of integrated care and as such the model will deliver more care closer to home.

A joint proposal has been developed setting out the high level vision for the use of **Assistive Technology** in Enfield to form "*personalised technologically-enabled solutions to promote residents' safety, health and independence as*

part of a coordinated care- and housing-related response to need." This vision will be realised by working together to deliver 3 different AT solutions to meet the 3 customer groups.

Enfield Safe & Connected will meet the needs of the general population to provide reassurance about their safety and well-being by offering:

- A reactive, 24/7 response to an alarm/sensor being triggered, either by contacting a named individual or as part of a mobile response (as agreed with the customer). If the latter is required, staff will be appropriately trained in first-aid, e.g. in falls management or basic triage, and will work with the London Ambulance Service. The Service, as it does now, will also act as a contact point for safeguarding alerts and for activation of carers' solution as part of the Carers' Card scheme;
- A pro-active "keep-in-touch" offer in which the technology would be used to contact – particularly very elderly - customers who may feel isolated and need reassurance. The Service will work with the voluntary sector as the "first contact" in developing befriending or self-sustaining day opportunity schemes to tackle social isolation.

This Service will help identify when customers' needs are changing at an early stage as part of a preventative agenda.

The **Telecare Service** will provide Assistive Technology to those with care needs in collaboration with HHASC and other care organisations (including in integrated care, e.g. GP-led case conferences), as part of the "tool-kit" available to professionals. Its customers will use Assistive Technology to help them live independently. In doing so, they are less likely to need as intensive care packages as early, providing HHASC, NHS and other organisation savings - if the right devices are tailored to meet specific individuals' needs. Knowledgeable and well-trained staff will help customers decide on the right devices for them and will actively market Tele-care. The technology will act as an enabler for service developments, e.g. in Intermediate Care.

Tele-Health pilots will develop collaboratively with health professionals to target patients whose vital signs and symptoms Assistive Technology will manage remotely. Research suggests Tele-Health is most effective if used with well-briefed patients with specific long-term conditions, most notably those with diabetes or respiratory conditions.

LBE will work with the CCG to pilot the use of 50 such devices provided to appropriate patients to evaluate the impact of Assistive Technology. Tele-Health devices improve patients' self-management and help maintain individuals' health and well-being and can provide help before a crisis. Studies suggest they can reduce the resulting use of health resources, e.g. reducing professionals' call-outs or A&E attendances.

Stroke

Community Stroke Rehabilitation and Early Supported Discharge

The community stroke rehabilitation team continues to work closely with the Enablement Team to manage people in the community enabling them to

rehabilitate in their own environment and remain at home. The team also undertakes the six week reviews post discharge home for all stroke patients.

In quarter 1 (Apr-Jun) of 2013/14 the team supported 74 new referrals for standard rehabilitation, 29% of patients fully achieved their goals at six weeks while 74% of patients who were kept longer than 6 weeks fully achieved their goals at discharge. 13 referrals to the ESD direct from the HASU, 34% of patients fully achieved their goals at six weeks while 37% of patients who were kept longer than 6 weeks fully achieved their goals at discharge

Community Rehabilitation / Early Supported Discharge team regularly monitoring referrals from the HASUs to ensure patients are accessing the appropriate pathway. Any concerns are discussed between the two organisations.

Stroke Navigator

In quarter 1 (Apr-Jun) of 2013/14 the navigator received 17 new referrals 9 (53%) were from the acute stroke unit, HASU and the community rehabilitation team, 8 (47%) were from family/Self-referrals and the voluntary sectors.

The navigator supports stroke patients, their families and carers in their discharge home process and as such undertakes a discharge home experience questionnaire within ten days of the patient being discharged home. Discharge home experience review: In quarter 1 (Apr-Jun) 2012/13 86 (100%) stroke patients were offered the 10 day discharge questionnaire and 45 (52%) completed the questionnaire and 41 (48%) letters were sent to patients who were unable to be contacted. 91% rated their overall discharge home as good, very good or excellent.

Feedback/issues arising from the discharge home experience questionnaire were feedback to the relevant trusts. Representatives from both North Middlesex Hospital and Barnet and Chase Farm hospital attend the monthly stroke pathway monitoring meeting where these findings are discussed. The feedback process has led to an improvement in patients' experiences.

The navigator also provides six weeks review (Non CSRT) to stroke patients. This cohort of patients are either those that leave the HASU and are so high functioning need no community involvement or patients who are at the other end of the spectrum and not referred to CSRT as no perceived rehab gains possible. In quarter 1 (Apr-Jun) 2012/13 the navigator provided six weeks review to 3 patients.

Life Role Facilitator

The Life Role Facilitator facilitates stroke survivors to re-integrate back into the community through taking up volunteering opportunities. She also undertakes the six month reviews for all stroke survivors. In quarter 1 (Apr-Jun) 2013/14 the life role facilitator received 3 referrals, of the 3 referrals 1 client took up volunteering role.

The life role facilitator undertakes review at six months post stroke. In quarter 1 (Apr-Jun) 2013/14 45 (100%) of stroke patients were offered the six months review, 23 (51%) of those offered the review received it, 13 (29%) did not respond to offer and 4 (9%) refused the offer. Of the 23 stroke survivors who

received the six months review 2 (9%) returned back to work and 2 (9%) took up volunteering roles.

Social Support

The service provides community based social support network for stroke survivors, including awareness and secondary prevention. In quarter 1 of 2013/14 17 referrals were made to the team

Outcome achieved – Stroke survivors

- 12 stroke survivors took part in the Stroke Ambassador development course
- 5 stroke survivors went back to driving

The carer forum which was set up by the social support team is working very closely with the Southgate Beaumont residential home, the forum is held quarterly.

Outcome achieved - Carers

- Stroke Centre offers respite to carers e.g. time out from caring
- Carers able to return back to work – x2, volunteering – x6 and training – x

Psychological support for stroke survivors and family members

The IAPT team together with the stroke navigator organised a workshop for stroke survivors in June 2013. The main aim of the workshop was to provide information about IAPT services and reduce stigma around the labels of depression and anxiety to enable individuals to consider more openly how the IAPT service could benefit them. 12 stroke survivors attended the workshop; a Cognitive Behavioural Therapist, Psychological Wellbeing Practitioner and the Stroke Navigator were also present.

The outstanding actions on the implementation plan of the strategy relate to developments in primary care; this will be the focus of work for the remainder of 2013/14. A GP lead is being sort to support this work from a clinical perspective. The implementation will be taken to the GP Network leads and shared and their view sort as to how this work can be best taken forward.

Dementia

The Dementia Strategy did not have any funding attached to its implementation changes to services have to be funded by releasing efficiencies in the pathway and service redesign. Planned changes to the Continuing Healthcare Beds should release funding to enable recurrent investment in 14/15 in the reconfiguration of the **Memory Service.** However, with increasing awareness of Dementia the waiting times continue to grow. The CCG acknowledged this as an issue and has proposed a one off investment to manage the waits down to an acceptable level.

Week long **Dementia Roadshows** were held in May at two locations in the borough, Enfield Precinct and Edmonton Green Mall, to raise awareness of Dementia and promote early diagnosis. People were encouraged to leave

their contact details if they wanted further information 20 forms were completed and distributed to the appropriate organisation to respond.
A range of public, private and voluntary sector organisations in Enfield have come together to promote awareness about dementia and to make sure people's experience and quality of life improves, not just in the social and health care and support provided, but also in living in the wider community. To do so, these organisations have formed the **Enfield Dementia Action Alliance** (an independent consortium of organisations chaired by the National Alzheimer's Society), modelled on a national initiative.
The Dementia Steering Group is developing a **GP training programme** to promote and improve the diagnosis and management of people with Dementia in primary care. The programme will be based on a the training developed UCL Partners and will be delivered by a Consultant Geriatrician from NMUH and Consultant Psychiatrist from BEH –MHT in the autumn.
The Clinical Psychologist continues to work with care home; staff showing improved understanding of Dementia, Depression and Challenging Behaviour and increased confidence in managing residents. In 2012/13 training was undertaken with 211 care home staff; in Quarter 1 2013/14 training has been completed by 118. This is likely to lead to more residents having symptoms recognised requiring assessment for formal diagnosis and commencement of treatment by a Consultant Psychiatrist.
Both **Acute trusts** have established Dementia Steering Groups working to improve the care of dementia patients in a hospital setting. The Steering Groups on both sites have developed Dementia Strategies to ensure that work continues to be taken forward in a focussed way.

End of Life Care
Gold Standard Framework (GSF) we are currently working with 46 Care homes and 15 Domiciliary care agencies; Bi monthly meetings have been set up with a palliative care link worker to support those that have completed the training to make sure that it is embedded.
Audits and data are being collected from the 13 Nursing homes.
Data collected also shows that :-

- Recording of bereavement support and follow up remains unchanged
- Decrease in the recording of family involvement in discussions
- Decrease in the prescribing of anticipatory drugs
-

A Survey Monkey has been set up and will run for two weeks, from 7th – 21st August 2013, to audit the use of **end of life care registers** and the associated multi disciplinary meetings. The results from this will form a baseline and shape future work with primary care. This piece of work will be championed by the clinical lead for EoLC, Dr Manish Kumar.

The Palliative Care Support Service has supported 38 people at home in quarter 1; 30 for end of life care and 8 for crisis intervention with 100% of people dying in their preferred place. An evaluation of this service is underway and the outcome will be reported to the next Older Peoples Board.

The **Multi Disciplinary Team** continue to work with 15 care homes to ensure that where appropriate advanced care plans and DNARs are put in place. This has led to 96% of residents dying in their preferred place.
The group wish to develop a **Bereavement Guide**; the current booklet is very post bereavement focussed and the group would like to see a more general guide covering both planning for and post bereavement. Examples of existing guides from partner organisations will be used to guide development. It is planned to have a new guide signed off ready to be launched at the awareness event planned for September /October 2013.

Gentle Dusk ran a project to provide training to volunteers from within existing community organisations with a particular focus on the over 55s age group and carers. The volunteers are given the knowledge, skills and tools to become Peer Educators in End of Life Care Planning so they can cascade information to members of their local communities. Unfortunately during the life of the project Enfield only managed to recruit 2 volunteers for training. The project has now finished but the Peer Educators remain in place and are linked in to a Network for support.
Planning for awareness raising event continues. EOLC will form part of a wider event covering 4/5 themes; this will take place in September /October.