MUNICIPAL YEAR 2014/15

Health and Wellbeing Board

17 July 2014

Agenda – Part: 1	**Item: 7b**
Subject: Joint Commissioning Board Report	
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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:

- The introduction of the Care Act 2014
- The update on the Better Care Fund plan – outlining its implementation and proposed governance structure going forward
- Highlights of the Integrated Care Programme for Older People outlining the objective of delivering assessment, care and support for those who are frail, in ill-health and aged 75+ years
- A summary of the Community Services procurement programme
- The finalisation of the Joint Mental Health Strategy Consultation
- Overview of the Learning Disabilities Partnership Board's Health sub-group responsibilities
- Enfield's success at being one of the top performing boroughs in terms of the number of people with learning disabilities in settled community accommodation
- The increase in the number of registered Carers in the borough, the improvement in respite offered to Carers and additional support being implemented
- The development of the CCG's Enfield Family Nurse Partnership, introduction of their Maternity Paper

1. EXECUTIVE SUMMARY (CONTINUED)

- The implementation of The Children & Families Act, which will introduce some of the biggest changes to the Special Educational Needs and Disability (SEND) system for 30 years for children/young people and their families, Local Authorities, Health and Schools.
- The commencement of the joint CAMHS Strategy
- DAAT's continued improvement in performance and successful completions
- Outline of the effect of recent new priorities have had on the Voluntary & Community Sector (VCS)
- Board updates

2. RECOMMENDATIONS

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

3. THE CARE ACT 2014

3.1 The Care Bill has completed its passage through Parliament and it received Royal Assent on 14 May. It is now an Act of Parliament (law).

3.2 The Act introduces a general duty on local authorities to promote individuals' wellbeing and rebalances adult social care towards prevention, wellbeing and independence. From 2015 council's will have a new legal framework for adult social care, putting the wellbeing of individuals at the heart of care and support. The Act will replace a number of separate pieces of legislation with a single modern law. It is an historic piece of legislation and a significant programme of change.

3.3 Of significance are reforms in the way in which adult social care is funded and a range of new duties and functions provided by adult social care services. This includes duties about how local authorities develop and manage their markets so that it meets the needs of all people in the local area, whether arranged or funded by the state, by the individuals themselves, or in other ways. Additionally, the Act strengthens the requirements on local authorities to carry out their responsibilities in a way which promotes greater integration with the NHS and other health-related services and a duty for local partners to cooperate when performing their functions.

3.4 In order to oversee the changes required locally, a Programme Board with accompanying work streams has been established. The Board is chaired by Bindi Nagra, Assistant Director Strategy and Resources in the Councils' Health, Housing and Adult Social Care Department. Priority tasks underway include a full impact analysis, identifying the risks including a full risk assessment, and understanding the cost pressures associated with implementation of which they are expected to be significant. Key tasks and implementation dates are as follows:

3.5

Key Requirements	Timescale
Duties on prevention and wellbeing	**From April 2015**
Duties on information and advice (including advice on paying for care)	
Duty on market shaping	
National minimum threshold for eligibility	
Assessments (including carers assessments)	
Personal budgets and care and support plans	
New charging framework	
Safeguarding Adults	
Universal deferred payment agreements	
Extended means test	**From April 2016**
Capped charging system	
Care accounts	

3.6 Further information and a link to the Government's recently published consultation on the draft regulations and guidance for Part 1 of the Care Act, is at: https://www.gov.uk/government/consultations/updating-our-care-and-support-system-draft-regulations-and-guidance

4. BETTER CARE FUND

Please note a separate Better Care Fund paper for the HWBB will be presented

5. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

5.1 Primary Care Management & Risk Stratification

Primary care case management was defined in the business case for integrated care. The integrated local integrated primary care team has been developed on a locality basis, with the core being GP, Community Matron, Social Worker and a Community Nurse. Its objective is to deliver proactive assessment, care and support for those who are frail, in ill-health and aged 75+ years. This supports the government drive to have a named GP for all patients in this age group.

The risk stratification tool is live in GP practices, following sign-off of the Information Governance processes. Patients had an opportunity to refuse consent to use their data for risk stratification and multi-disciplinary review purposes prior to implementation of the project. Unless consent is refused, a risk stratification algorithm is applied to all patients' combined personal and activity-based service user data from the relevant GP surgery, acute providers and adult social care data are pseudonymised and then combined to determine each patient's risk of hospital admission. Some 45 (out of 52) practices have signed-up to the risk stratification process.

A sub-set of those patients flagged at "high" and "very high" risk should therefore be the subject of a multi-disciplinary (MDT) meeting led by the GP, but with access to a geriatrician, community matrons, social care and other care professionals to discuss an individuals' case. The number of cases presented to MDT meetings decreased sharply in Apr-14 following new contractual arrangements with practises. However, it is anticipated the number of such meetings will start to increase in July as:

- The MDT Tele-conferences will now be a part of Integrated Locality Teams which are in the process of being rolled out across Enfield. The Teams contain community matrons, social care professionals and nursing staff to assist GPs to review individuals' cases, along with other specialists, such as geriatricians or mental health specialists in specific cases. The Locality Teams will have face-to-face meetings with GPs to discuss or review specific cases, as well as Tele- and video conferencing;

- NHS England announced an Enhanced Service for GPs to manage and provide joined-up care plans for the 2% of the adult population most at risk of Unplanned Hospital Admission, with care plans needing to be in place

for Sep-14. This will provide further momentum for GPs to work with the new Locality Teams to identify, plan and manage these cases.

5.2 Older People's Assessment Unit (OPAU)

The two Older Peoples Assessments Units (OPAUs) were implemented on both acute sites. Chase Farm continues to receive a gradually increasing level of referrals and is now approaching its capacity at around 10 patients per day. However, GP referral rates to the North Middlesex University Hospitals OPAU have shown little increase in 2014. A review of the OPAU services is planned in June & July 2014.

5.3 Falls

The bone health service has a focus on what can be achieved for high risk groups currently being managed in community and primary care settings. The Falls Liaison Nurse was appointed in December 2012 and has an acute focus. The Community Bone Health post was appointed in April 2013 and has primary care focus. The modelling is aimed at focusing on likely impact on admissions for fractured neck of femur.

For the Bone health service –the focus of this post involves fact finding and liaison with GP practices to begin to set up their falls registers etc and identify patients at risk.

A review was carried out in February to assess the Falls service, it was agreed that the various pathways for fallers and those at risk of falling are too complex.

Patients known to the OPAU who have had a fall are continually being referred to the intermediate care nurses. This service does not rapidly assess patients or carry out some of the specialist assessments that the Falls service provides. Therefore, the service has developed a draft pathway which needs to be reviewed and signed off by relevant stakeholders with specific clarifications from the CCG. There are ongoing plans for the provider and the CCG to create a single pathway model for the Bone Health Specialist to integrate with the OPAUs and integrated locality teams. The CCG is currently developing draft KPIs for 14/15 to be agreed with the provider so that impact can be monitored closely to activity against savings.

Access to North Middlesex hospital is improving as the fracture liaison nurses are assessing Enfield patients who have had a fall related admission. However, this is posing an issue at Barnet and Chase Farm as Barnet fracture liaison nurses are picking up Enfield patients. Numbers are currently few; however, if this continues over time, this could impact on the provision of the service to Enfield patients at BCF. The process needs to be reviewed contractually.

5.4 Care Homes Project

The CHAT service is now working in 17 homes with an outreach geriatrician service provided by NMUH for the South. The commissioning team are examining options for increasing primary care support to the homes.

There is good evidence the Team has been effective in reducing hospital admissions: the number of hospital admissions from these 17 homes decreased by 110 between 2012/13 and 2013/14, whilst a survey of the homes indicates that many are happy with the service offered by the team.

5.5 Assistive Technology

"Assistive technology" is "any telecommunications device that assists a person in retaining or improving their independence, safety, security & dignity". It includes sensors/alarms for individuals or in households, whose manual or automated activation triggers an alarm to a remote central control room which can then provide a telephone and/or mobile response to check on the individual, and offer help if needed. Just over 3,000 people in Enfield benefit from LBE's Community Alarm & Tele-care Service which provides the equipment, the control centre and mobile response. Around 600 have more complex Tele-care equipment to support their social care needs.

The Council, CCG and its partners developed a vision for personalised technologically-enabled solutions as a key element of a coordinated housing-related, health & social care approach to promote residents' safety, health, well-being & independence. There are 3 different AT solutions to meet 3 customer groups, the first two of which are subject to Council charging:

- *"Community Alarm"* generally supporting older residents whose reason for using AT is for reassurance. As well as continuing to provide an alarm & response services, customers will benefit from a pro-active approach to "keeping in touch";
- *Tele-care* for People with Problems in Daily Living: Mostly older individuals with care needs, whose reason for using AT is to promote safety, quality of life and independence;
- *Tele-Health*: People with long-term conditions, e.g. respiratory conditions, whose vital signs or symptoms, e.g. lung capacity, blood pressure, blood sugar etc., can be monitored remotely. There is currently no Tele-Health available in Enfield.

The re-launched Council Service has now been re-branded as the "Safe & Connected Service" to serve the first two customer groups. Its aim is to expand the number of people accessing the service, including through better marketing to potential beneficiaries, their families, professionals, the voluntary sector and Registered Social Landlords. As an enabler to do so, the Council has reduced its service charging, and developed new marketing material.

Tele-Health ("Remote Monitoring Pilot")

The Remote Monitoring AT Steering Group consists of CCG clinicians, ECS professionals and commissioners. A project was developed to provide remote monitoring to 50 people with complex needs within the South East and North West localities as part of integrated care. To this end, 2 suitable providers were selected to test how the technology and response would work. The pilot is now at its mid-point, and after a slow take-up, there are now 38 patients with chronic conditions, identified by GPs, community matrons or specialist nurses, using the technology. Patients use the equipment to monitor their own vital signs & symptoms (e.g. blood pressures), with the range of tolerance personalised to them. "First-line" response is through the providers' staff, with an alert triggered if the reading is outside tolerance, and "on-the-ground" support provided by case managers. The process of escalation should an alert occur is part of a clinical protocol, agreed and signed by CCG clinicians. A formal evaluation of the scheme will be prepared for the end of Jul-14.

6. PUBLIC HEALTH

BARNET ENFIELD AND HARINGEY MENTAL HEALTH TRUST - Community Services Contract

The timeframe for the current contract to expire is 30 September 2015. This will fall in line with the transfer of Health Visiting from NHS England to all local authorities, which is scheduled to take place 01 October 2015 and will form part of this Community Services contract procurement.

A Community Services Procurement Steering Group has been established with membership being from the following stakeholders:

- CCG [lead],
- Council [associate and negotiating for LB Haringey and LB Barnet on GUM services],
- NEL Commissioning Services Unit [project lead]
- HealthWatch
- Patient representative

Service specifications and Key Performance Indicators (KPIs) will be reviewed and brought more in line to address local needs and will be outcomes based.

A Memorandum of Understanding has been signed between Enfield CCG and the Council, which sets out the basis upon which the Partners (ECCG and LBE) will work collaboratively and transparently to ensure the successful tendering of Enfield Community Services in a fair and open manner. It sets out the respective roles, responsibilities and governance of the Partners in relation to the delivery of the tender

7. CCG Commissioning Intentions

Please note a separate Strategy paper for the HWBB presented by the CCG

8. SERVICE AREA COMMISSIONING ACTIVITY

8.1 Older People

8.1.1 Additional Winter Pressures Funding

Winter planning is underway, with reporting to NHS England in place:

- Last year, health and social care partners received targeted funding from NHS England to relieve pressure on A&E and hospital admissions, with the health economies associated with Barnet & Chase Farm Hospitals and North Middlesex University Hospital NHS Trusts identified as two of the 10 London challenged health economies. The purpose of this funding is to assure A&E and hospital performance in Winter 2013/14. NHS England allocated £5.1m & £3.8m to the Barnet & Chase Farm and NMUH NHS Trusts health economies, respectively, and hence to individual health & social care partners' schemes to prevent hospitalisation, promote timely & safe discharge and prevent readmission in a 24/7 care economy;

- As yet, NHS England have not yet announced their winter funding arrangements for 2014 (expected Jul/Aug-14), but the same two Urgent Care Boards are likely to receive funding this year. Preparations are underway for winter planning 2014 across both UCBs, and a number of solutions are being developed chiefly based on what demonstrably worked last year. This includes additional resources for care professionals, such as nursing and social care staff, to work extended hours to facilitate hospital discharge and enable admission avoidance.

- Last year's solutions included development of hospital-based schemes to better support the hospital experience and discharge for older people, including those with dementia, through Rapid Assessment, Interface & Discharge (RAID) and health- and social care-based solutions to prevent hospital admission and facilitate discharge (e.g. Post-Acute Care Enablement (PACE) and social care enablement), including within an integrated care setting, and to fund extended hours of support, particularly within an integrated care setting.

- Last year, the CCG successfully procured up to 37 short-term step-down beds in a number of nursing homes, of which all but 9 are in Enfield. These beds are used by patients well enough to be discharged from hospital, but not well enough to return home. These cases were managed through a clinical gate-keeper/case manager to assure patients' recoveries are being actively managed in the home rather than having an indefinite stay. Although there was slow initial take-up, the beds were more fully occupied (around 85% utilisation) by the end of the year.

- The table below shows that there was a reduction in the overall number of emergency hospital admissions and costs of hospital episodes amongst those individuals aged 65+ between 2012/13 and 2013/14,with the latter due to shorter lengths of stay.

	Numbers			% Change	
People Aged 65+ Admitted as Emergency	2012/13	2013/14	Forecast 2013/14	Actual	v. Forecast
No. of Admissions	8,877	8,739	9,124	-1.6%	-4.2%
Total Costs (£m)	£27.26	£25.64	£29.36	-6.0%	-12.7%

- **In summary, the winter pressure schemes** helped alleviate some of the pressures on A&E attendances, and therefore emergency hospital admissions, although North Middlesex University Hospitals remains below the national performance target of 95% of A&E patients seen in no more than 4 hours. However, the schemes have contributed to bed management in the whole system and have played a significant part in reducing delayed transfers of care

8.1.2 **Enfield Warm Households Programme**

In response to the Department of Health not continuing with its previous annual national Warm Homes, Healthy People Programme in 2013/14, the Council instigated a local £120k Enfield Warm Households Programme to grant-fund schemes targeted at the most vulnerable families and households at risk of adverse health outcomes or hardship over the winter. Following a competitive grants process, 8 applications were awarded funding, each for no more than £20k each, in early Jan-14. These schemes have now ended and the Programme's outcomes are being evaluated

8.1.3 **Delayed hospital discharges**

NHS Enfield CCG and London Borough of Enfield commissioned an end-to-end pathway review to help identify areas of improvement and their solutions for 2015/16. The final report about the pathway is currently being prepared, but key findings suggest the current pathway is fragmented with many people feeling they are left to navigate a complex system of support themselves. Key areas for improvement remain:

- Early diagnosis within primary care and the Memory Service;
- Consistent support, navigation and case coordination post-diagnosis and as the disease progresses;
- More coordinated support and rapid response for households living with advanced dementia.

8.1.4 **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. A multi-sector, multi-agency Enfield partnership led by Enfield Voluntary Action was one of 32 local partnerships to be shortlisted onto the next phase of bidding to become one of 15-20 areas to receive funding. Enfield's bid focussed on developing a responsive face-to-face and IT Voluntary Sector Hub staffed by Community Navigators (who would recruit volunteers) across the community, including within GP surgeries and as part of the emerging integrated care pathway. The purpose of the hub is to be a single point of contact for the voluntary sector to work with those who might be at risk of isolation and for volunteers to be

matched with individuals to understand needs and identify solutions, such as small friendship groups, that meet their needs, and to help "nudge" them to access (and eventually manage) these solutions for themselves. The Hub will focus on those most at risk: those who are very elderly, frail/in ill-health, house bound or live alone; those with caring responsibilities; those in more deprived areas or who may feel isolated because of circumstantial issues (e.g. living in generally younger communities). The application for £4.2m over five years from Apr-15 was submitted on time and partners will find out whether Enfield has been successful at end Jul-14.

A partnership in Enfield led by Age UK and the Greek & Greek Cypriot Community Enfield have submitted a related £200k bid to provide a volunteer-led solution to help older people return home after hospital discharge or to avoid hospitalisation for winter 2014 to the Social Investment Business Group (linked to the Cabinet Office). As well as extended working of these two organisations' Hospital to Home schemes into the evening & weekends and into A&E, the scheme also discusses rapid deployment of the Big Lottery Bid's Hub from Aug-14, rather than Apr-14. A decision will be made about this bid in Jul-14.

8.2 Mental Health

8.2.1 Joint Mental Health Strategy Consultation

The strategy has been revised and finalised following consideration by the Corporate Management Board. It has been submitted for sign-off by the Cabinet in July 2014. It will also be presented to the Enfield CCG Governing Body in September 2014. When approved, it will be published on the Council and CCG web-sites. Implementation will be led by the Joint Adult Mental Health Strategy Implementation Group working closely with the Mental Health Partnership Board.

8.2.2 Enfield Joint Autism Framework

The Enfield Joint Autism framework has been finalised. It will be published on the Council and CCG web-sites. Implementation will be led by the Autism Steering Group. £50k has been identified from the Health and Social Care Grant to employ an Autism Programme Manager. The programme aims to:

a. Improve the co-ordination of services for people with autism
b. Improve the provision of information and advice to adults with autism
c. Improve the signposting of adults with autism to appropriate information, advice and services
d. Map and collate information about the information, advice and services available in Enfield and have this included in the Council online directory and CCG web-site as appropriate.
e. Develop care pathways and gain an understanding of met and unmet need

8.3 Learning Disabilities

8.3.1 Learning Disabilities Self-Assessment Framework (SAF)

The Learning Disabilities Self-Assessment Framework (SAF) for 2012/13 was very much focussed on improving access to primary care services, addressing health inequalities, admission avoidance and local implementation of the Winterbourne View Concordat (2012). Enfield's Learning disabilities SAF action plan is based upon our submission and focusses on areas of underperformance. The Learning disabilities Partnership Board's Health Sub Group is overseeing implementation of the borough's SAF action plan and to date we have:-

- Improved uptake of DES Health Checks for people with learning disabilities by improving awareness through GP training, promotional material and producing accessible guides for health checks for patients and their parent / carers to take to appointments.

- Significantly reduced admissions to assessment and treatment services and long stay hospital admissions through our community intervention service which is funded through NHS Enfield Clinical Commissioning Group as a pilot for a 6 month period.

- Increased the number of people with Health Action Plans by delivering healthy living promotional events in the community and engaging at practice level with primary care services.

- Currently developing Health Passports for people with learning disabilities and parent / carers to take with them to outpatient and hospital appointments to help health staff to understand the needs of individuals and how to make reasonable adjustments.

NHS England has advised us that the Learning Disabilities SAF for 13/14 will be released during the summer months with a deadline for submission being set for late Autumn 2014.

8.3.2 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 in low-high 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 closer 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.

Our community intervention service (which is being funded as a pilot at present) is fully operational and is part of the Multi-Disciplinary Team Integrated Learning Disabilities Service under sect. 75 partnership arrangements. This service was developed in response to the Concordat Action Plan and has directly attributed to reducing the numbers of admissions to our in-borough assessment & treatment service. Lengths of stays have also been shortened due to the community intervention service offering intense resettlement support back to the community. The average number of people referred to assessment & treatment services by Enfield was 9 in 2012/13 and this has been reduced to 2.4 on average in 2013/14. There is only 1 person in our assessment & treatment service at present with a discharge date and move on plan set for August 2014.

In terms of planning services, we are currently of finalising our Joint Learning Disabilities Need Assessment that will form part of the Borough's Joint Strategic Needs Assessment and be used to develop our commissioning intentions for the next 3 years.

Enfield is one of the top performing boroughs in terms of the number of people with learning disabilities in settled community accommodation (NI145) which stands at 80%. We already have an adequate supply of housing and supported living options available in the Enfield community for the current population.

At times, highly specialist community support and accommodation is required that needs to be individually commissioned i.e. bespoke accommodation designed to meet individuals needs plus highly specialist support arrangements. In these situations it cannot be expected to have block provision as it will not meet the highly individual needs of people with complex and challenging needs. This can take up to 6 months to commission. We are developing community focussed day opportunities and supported living options for young people coming through transition in the next 3 years with arrange of needs inc. those with Profound and Multiple and complex needs.

Enfield in partnership with a National Registered Social Landlord, was successful in accessing the Mayors Care and Support funding last year. We are developing a range of supported living services that will be specifically designed for people with learning disabilities with Profound and multiple, Complex needs and an extra care service for older people with learning disabilities who also have dementia. The development will be opened within the next 12 months. From the Mayors Care and Support funding, we will also be developing 4 homes for people with learning disabilities and / or physical disabilities which will be available to buy through shared ownership options.

The development will be opened within the next 12 – 18 months. Additionally, we are developing a supported living service for 5 people with complex needs that will include availability of assistive technology as part of the service delivery model which will enhance peoples independence and privacy.

8.4 Carers

8.4.1 Enfield Carers Centre

The Centre now has 2558 carers on the Carers Register. In addition, 756 carers hold a Carers Emergency Card. In the January-April 2014 quarter the Centre registered 342 new carers.

The Carers Centre respite programme has allowed 281carers to receive a break between January-April and the new befriending programme has resulted in a further 4 carers receiving a regular weekly planned break.

Enfield Carers Centre has now recruited a full time Benefits Advisor who took up their post in April 2014. Monitoring statistics for this post will be included in future reports.

The Hospital Liaison Worker started in late November and has now been given access to speak to families and carers in the wards in both North Middlesex, Chase Farm and Barnet Hospital. Both North Middlesex and Chase Farm has given the worker desk space and leaflets and posters are distributed throughout all hospitals. Barnet Hospital has also a permanent pop up banner advertising Enfield Carers Centre near the lifts next to the outpatients department. In the January-April quarter of 2014 the Hospital Worker identified 72 new carers.

Recruitment for the Carers Nurse post has continued to be delayed. The Centre has referred this back to the CCG Project Manager to progress. Discussion has been held with Enfield Community Service but again, no placement for the Nurse has been found. A further meeting with the Medical Director and Head of Commissioning of the CCG has been set up for July 2014 to try discuss the issues of recruitment again.

The Advocacy Worker has been taking up cases and has also been promoting the services within the VCS and with practitioners. In the January-April 2014 quarter they provided support to 61 carers.

The Young Carers Worker pilot project has now reached conclusion and in the final quarter the Young Carers Project identified 38 young carers. Work in primary schools will now be continued by DAZU Young Carers Project (the contracted service). Enfield Carers Centre are now establishing a transition project for young carers as they approach 18 and enter adult services.

The Centre's training programme including Supportive Family Training, Solution Focused Therapy as well as day courses has seen 235 carers attend a training sessions over the January-April quarter. A further 37 carers have received one to one counselling during this period.

8.4.2 **Carers Direct Payment Scheme**

We now have 107 carers receiving a Direct Payment through Enfield Carers Centre with others awaiting approval. A new factsheet to promote the Carers Direct Payment Scheme is currently being designed.

8.4.3 Carers Week

As part of the Carers UK Carers Week Quest, we made a pledge to try to reach as many hidden carers as possible. Therefore Carers Week activities focused on outreach activities. Staff and volunteers from Enfield Carers Centre did outreach in Enfield Town, ASDA in Southgate, a stall at the Cheviots Providers Forum and a new support meeting at a special school and open day at the Centre for parent carers.

In addition there was a fantastic Family Fun Day held in Enfield Town on Saturday 14th June with stalls held by a range of voluntary and community groups, IAPTs and Enfield Council. There was great entertainment including a singer, Street Dance performance and lessons and a mini Olympics hosted by the Sports Development Team.

In additional drop in training sessions were held for social care practitioners, looking at new rights for carers through the Care Act and support available form Enfield Carers Centre. Over 30 practitioners attended this training.

8.4.4 **Primary Care Strategy**

The GP project has now seen 203 new carers registered through either the GP, the self-referral method from the surgery information or through Community Pharmacies. Fifteen surgeries have now held information stands with seven having a regular carers information stall. 47 of the 50 surgeries have now been visited and all of these have been given an information pack and provided with referral forms with their own surgery code alongside the self – referral cards which also hold a unique surgery code. All sixty Community Pharmacies have also been contacted and three have made referrals to the Carers Centre, as a result.

The GP Liaison Manager has attended two meetings with medical reception staff to deliver carer awareness training and volunteer training sessions, together with three presentations to over 50 GPs at three Protected Learning Time meetings

8.4.5 **The Employee Carers' Support Scheme**

The Carers Policy has been written, updated to reflect comments made by the Carers Action Group and submitted to HR for consideration and is awaiting feedback. All members expressed a need for paid carers leave which is included in the policy. A Carers Personal Plan has now been developed which can be used as a tool for managers and employees to discuss the employee's caring

responsibility and the flexibility that can be applied to support them within their job role.

The most recent meeting looked at the development of pages for the staff 'Enfield Eye' intranet and content was agreed. Development of a staff e-learning package in carer awareness was also agreed as a priority.

8.4.6 **Relatives Support Network**

Two Care Home Carers Network meetings have been held. The first meeting invited interested carers and quality checkers to come and feedback on the project plan for the Network. The second meeting looked at developing the content for the Information Pack which is designed to support family members and carers considering residential care.

In addition a partnership meeting was held with representatives from Enfield Carers Centre, Age UK Enfield, the Alzheimer's Society Enfield and the Over 50s Forum invited. All partners have committed to the project and will progress with a joint funding big to the Big Lottery for additional resources to support this project.

A survey was done of all residential and nursing homes in the Borough to assess the number of Relatives and Residents Group already in operation and how they are publicised. This information will be used to develop the strategy for working with residential and nursing homes to provide support to carers and family members

8.4.7 **Carers Strategy Implementation**

The Carers Practitioners Working Group has now reviewed the Carers Assessment form and the paperwork for a Carers Party to Event assessment and looked at how we can improve and increase communication on carers' issues and training for practitioners. From this group, practitioners from the Care Management Service now host a monthly drop in service for carers from Enfield Carers Centre. Training for practitioners in Carers Week was agreed and promoted through the representatives to their respective care teams.

The BEH Mental Health Carers Project Group has not met in 2014 due to the lack of a commissioner in Haringey and the transition of the BEHMHT representative moving into a new role within the Trust. It is hoped the group will be revised in the summer 2014.

The Children and Families Carers Working Group meet in January and was a very productive meeting where some simple changes were agreed to help identify young carers – such as changes to the SPOE form. The next meeting will focus on the assessment of young carers and how Enfield can ensure the capacity with changes forthcoming with the Children and Families Act.

The Carers Communication Working Group has overseen the production of a new Carers Awareness campaign with poster and leaflet design sent to key

partners within the VCS. This poster has been designed with translations in the most popular five languages in Enfield to try and reach carers within the BME community.

8.5 Children's Services

8.5.1 Family Nurse Partnership (FNP)

Enfield Family Nurse Partnership is progressing extremely well and its work was showcased at the FNP National Study Day. Eve Stickler, Assistant Director Commissioning and Community Engagement, Schools and Children's Services was a featured speaker. The FNP Team received 78 referrals in the first six months. Sixty referrals were expected. Fifty-three were eligible for the programme. Young people not eligible for the FNP due to being too advanced in their pregnancy were referred onto the HV Teams for additional support. The FNP team is continuing to publicise the scheme and to meet with potential referrers.

8.5.2 School Nursing

The Council is reviewing the service and exploring what our options are likely to be following the transfer of all remaining early years provision which is programmed for October 2015

8.5.3 Community Services Procurement

Community Services procurement is proceeding with the CCG in partnership with the Council. A work programme has been agreed and is being co-ordinated through a Community Services Procurement Steering Group chaired by Graham MacDougall, the Director of Strategy and Partnerships, with senior representation from both organisations. There will be a three month engagement period from July 2014. The HWBB will be kept informed of progress.

8.5.4 Maternity

A maternity paper has been through Enfield CCG governance structures. Important quality issues were set out in the paper such as early booking with a midwife (by 12 weeks and 6 days of being pregnant), caesarean section rate and workforce ratios to patients and perinatal mental health. Good care during pregnancy has an important impact on the baby's future health and well-being.

8.5.5. SEND/Children and Families Act Implementation

The Children & Families Act introduces the biggest changes to the Special Educational Needs and Disability (SEND) system for 30 years for children/young people and their families, Local Authorities, Health and Schools. The new system will be implemented from September 2014 when the reforms will be statutory.

The main changes to affect families are:

- Replacing Statements of SEN with the new statutory Education, Health & Care Plan from September 2014;
- A new SEN Code of Practice;
- Personal Budgets
- The Local Offer
- Mediation for Disputes
- Expressing a Preference (including Free Schools, Academies and FE)

Eight work streams have been set up to look at how different aspects of the reforms will be implemented in Enfield.

Enfield, in partnership with Bexley and Bromley has been awarded Champion status. The role of Champions is to share and disseminate good practice. In addition to the prestige of being a Champion there is a small amount of additional funding.

8.5.5 Paediatric Integrated Care

A paediatric integrated care work stream is supporting the implementation of the Barnet, Enfield and Haringey Clinical Strategy. The 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.

A group meets monthly to progress this work.

8.5.6 Joint Enfield Council and CCG Children and Adolescent Mental Health Service (CAMHS) Strategy

Enfield Council and CCG have commissioned Keren Corbett Consulting to write a CAMHS Strategy. Consultation on the strategy will be July-August. A final draft will be presented at the September HWB Board. The joint strategy will set out the way in which Enfield will commission a comprehensive and integrated Emotional Wellbeing and Child and Adolescent Mental Health Service and improve outcomes for children and young people in Enfield. The intention is to take a whole systems approach, with the aim of ensuring that the mental health and emotional well-being of children and young people become everyone's concern. The strategy is intended as a working document that will be accompanied by an outline implementation plan and clearly defined measureable outcomes.

8.6 Drug and Alcohol Action Team (DAAT)

8.6.1 Successful Completions (Drugs)

The DAAT's performance against *Successful Treatment (Drug Free) Completions* has increased based upon the latest ratified Public Health England (PHE) data confirming that Enfield has achieved 31% for the 12 month rolling period April 2013 to March 2014. The performance against this indicator remains excellent as Enfield is 11.9% above the London average and 16.1% above the National average.

8.6.2 Numbers in Effective Treatment (Drugs)

Performance for the indicator *Numbers Retained In Effective Treatment* (*defined as those drug users who are retained in treatment for 12 weeks or more or who are discharged free of the presenting drug problem within 12 weeks from the date of treatment start*) has slightly fallen for the latest period to 997. This reduction is solely attributable to Barnet, Enfield and Haringey Mental Health NHS Trust performance for the dual diagnosis service. This matter is being addressed with Oliver Tracey in July to ensure performance returns back to previous levels. However, it is worth noting that Enfield is still ranking 13th in London against this indicator and we are significantly above the London average of 883 but below our original ambition of 1068

8.6.3 Numbers in Treatment and Successful Completions (Alcohol)

The number of alcohol users in treatment is 3% above the 12/13 Baseline and the successful treatment completion rate is relatively consistent with the London Average of 35.9%. The DAAT will continue to prioritise growth in the number of alcohol users accessing treatment during 14/15.

8.6.4 Young People's Substance Misuse Performance

The number of young people using specialist drug and alcohol treatment services has increased by 45% since 11/12 to 192. Drug and alcohol interventions can help young people get into education, employment and training, bringing a total lifetime benefit of up to £159m nationally and serving as a really important early intervention prevention service (PHE 2014).

8.6.5 Performance Summary and Cost effectiveness

The Business Information and Support Team has undertaken a cost effective and quality assurance analysis of Enfield DAAT's performance to identify its ranking against other London Boroughs. The Table below confirms that Enfield DAAT is the 3rd most cost effective DAAT in London for Adults in Effective Treatment; it is ranked 4th for Successful Treatment Completions for Adult Drug Users (i.e. quality assurance ranking); and it is ranked 8th in London for the Number of Young People in Treatment.

The analysis in The Table (see Appendix 1) does not include non-PHE funding grants or local contributions so it only provides a base level estimate of our effectiveness. Nevertheless, it is a clear demonstration of the effectiveness of the DAAT Partnership Board's leadership.

9. HEALTHWATCH ENFIELD

HealthWatch Enfield is now fully operational from its base in Community House in Edmonton and its annual work plan has been implemented with many outcomes delivered and evidenced through the programme of quarterly monitoring with Commissioners. HealthWatch Enfield will be publishing an annual report in the coming weeks.

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

Funded organisations have recently submitted quarter 4 monitoring returns which summarise activity and outcomes delivered during 2013/14. Officers are currently reviewing the returns and are carrying out visits to the organisations to validate the information provided.

Since the Commissioning Framework was published, new priorities have emerged e.g. The Care Act and the Integration of Health and Social Care / Better care Fund. The VCS will play a key role in these initiatives by complementing provision form the private and statutory sectors and enhance the range of quality services and supports that are available to meet community care needs. The Bettercare Fund is an opportunity to accelerate our work in this area and, in particular, our aim to develop voluntary and community services that support existing work to delay and, where possible, to prevent hospital admissions and requirements for social care services. Incorporating these organisations more deeply into our ongoing work in this area will increase the capacity, capability and flexibility with which we can achieve this. Commissioners are currently assessing the implications of the Care Act and the recently published guidance and regulations and the VCS' wider role in its implementation e.g. supporting the provision of quality information, advice and guidance.

The current suite of grants and service level agreements have been extended under existing terms and conditions until 31st March 2015. This will ensure a period of stability for all stakeholders whilst monitoring information is analysed and further consideration is given to the VCS' contribution to new strategic commissioning objectives and priorities.

11. SAFEGUARDING

11.1 Safeguarding Adults Board (SAB)

The Safeguarding Adults Board in June 2014 considered performance data in relation to the reports of abuse being made to Adult Social Care. The key headline data for year-end was:

1. In the year there had been 957 referral alerts, which was an increase of 20%.
2. There had been a 16% increase in alerts for people aged 65+.
3. Most alerts relate to multiple abuse (35%) or neglect (24%).
4. In 83% of cases, the alerter was informed of the strategy on the same day it was agreed, if considered appropriate. This is an improvement on 38% in 2011/12.
5. Of the 226 cases that had an outcome following investigation, 48% of them were substantiated or partly substantiated. (35% in 2012/13).

The Safeguarding Adults Board held a successful Challenge Day event further to members' completion of the NHS England Audit. The audit tool provides organisations with a consistent framework to assess monitor and/or improve their Safeguarding Adults arrangements. The completed self-evaluations by partners were opened for discussion with the Board Chair and partner agencies at the Challenge Day event with further recommendations put forward on multi-agency work which will form part of the action plan.

It is expected that completion of this audit tool will allow for the benchmarking and identification of themes, improvement needs and best practices according to localities, sector, sub-regional and London wide level. Enfield Safeguarding Adults Board will monitor the action plan and NHS England will be producing a report once it has received all submissions from London boroughs.

In addition to the audit by individual partners in respect to their safeguarding adults' arrangements, to Safeguarding Adults Board is also auditing its own effectiveness at a Board level. The outcome of this audit is expected in Autumn 2014.

The Board was advised that the London Borough of Enfield has created an action plan to deal with the impact on Deprivation of Liberty Safeguard referrals further to the Cheshire West Supreme Court ruling. On 19 March 2014, the Supreme Court handed down its judgment in the case of "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council".

The Supreme Court has now confirmed that to determine whether a person is objectively deprived of their liberty there are two key questions to ask, which they describe as the 'acid test':

> (1) Is the person subject to continuous supervision and control? (all three aspects are necessary)
> AND
> (2) Is the person free to leave? (The person may not be saying this or acting on it but the issue is about how staff would react if the person did try to leave).

This now means that if a person is subject both to continuous supervision and control and not free to leave they are deprived of their liberty.

It is expected there will be a significant rise in the number of DoLS applications further to the ruling. If 30% of concerns were proved true there would be 350 DoLS. In 2013-14 the DoLS office received 66 applications.

There are four sub-groups which support the work of the Safeguarding Adults Board: Service User, Carer and Patient Group; Performance, Quality and Safety Group; Learning and Development Group; and the Policy, Procedure and Practice Group. All sub-groups report to the Board bi-annually on the work it has achieved, which is included in the Board's Annual Report.

11.2 Community Help Point Scheme on Tap-IT

Tap-IT is a mobile phone application that helps residents keep connected to family and friends. It has been developed as a mobile safety app which is free to download and free to use on smartphones and is available to download at the iTunes store and Google Play.

It has been designed to help people stay connected by putting them one tap away from friends and family. Useful functions on the app include requesting someone collect you (and gives GPS coordinates), ask someone to interrupt you or simply just check in. All of these functions are a simple way of letting family and friends know that we need assistance or just to reassure them. Tap-IT also helps to locate the nearest police station and 'safe sites' that have been approved by your local council through the CHPS scheme. For further details see the website www.tap-it.com.

Feedback on the usability and functions highlight how helpful this application is as noted by one parent: "Tap-it is a great way to stay in touch with my 16 year old daughter - without having to call her all the time. It's re-assuring to know that if she needs help, she can send a 'Collect me' message and I know where she is. The 'Check in' facility allows her to let us know she is safe without feeling she has to keep ringing us. A great App that helps to make us worry a little less!"

11.3 Safeguarding Information Panel (SIP)

The Safeguarding Information Panel is made up of Enfield Council Safeguarding Adults, Contracting, Commissioning, Environmental Health, Enfield Clinical Commissioning Group (CCG) Safeguarding, Care Quality Commissioning (CQC) and the Police. The SIP continues to meet every 6 weeks; safeguarding information about care homes and care providers is shared and appropriate interventions or necessary support is identified and implemented. The SIP, through work by Environmental Health colleagues, has now developed stronger links with the UK Border Agency.

A Quality Monitoring group is being set-up as a sub-group of the SIP. The members of the group are: Enfield Council's Quality Assurance Team (who manage the Quality Checker programme), Contract monitoring, Complaints, Health Watch and the CQC. The objective of the group is to ensure that

quality related findings about care providers are effectively shared. It is envisaged that this group will meet every quarter.

11.4 Quality Checker Programme

The Quality Checkers are service user and carer volunteers who visit services and give us feedback. The focus of the visits remains care homes and people receiving services in their own homes. Since 1st April 2014, over 30 visits have been completed. These include visits as part of the Dignity in care panel reviews, care home visits, and visits to peoples' homes. As part of the Dignity in care panel reviews, Quality Checkers have received additional training around support planning and dementia awareness. A Quality Checker recruitment drive is due to commence from July.

11.5 Quality Improvement Board (QIB)

Two QIBs have met since our last update. Since then, the QIB have overseen the development of the Dignity in Care panel reviews, work on the Care Home Carers Network, the Quality Checking visits and the sub-groups.

11.5.1 Improving Residents' Lives group (care home managers sub-group)

The Improving Residents' Lives sub-group (which is the legacy group from MyHomeLife) action plan has been considered by the QIB. It has been approved for action. This is now being done through meetings which follow the MyHomeLife model, includes colleagues from Enfield Council and Enfield Clinical Commissioning Group, and is chaired by Pauline Kettless, the Enfield Council Head of Brokerage, Commissioning, Procurement and Contracting.

11.5.2 Care Home Carers Network

The QIB was also informed that Care Home Carers' Network, an improvement project which had been suggested by Quality Checkers and is being led by Rosie Lowman, Enfield's Carer Commissioner, was successfully launched in February 2014. This event brought together 8 carers from different care homes to discuss the homes their loved ones are in. A project management group led by Rosie Lowman, with the Over 50s Forum, the Alzheimer's Society, Age UK, the Carers Centre and some carers has been set-up to develop the project.

11.5.3 Dignity in Care Panel

The Dignity in Care panel reviews services to determine if they are meeting the Dignity in care challenge. The Dignity in Care panel is piloting their provisional methodology at services run by Enfield's Independence and Well-being service. The Dignity in Care panel has completed visits for reviews to Reardon Court and Rose Taylor Day services. They have fed back directly to managers and have asked for comments about the process. Action plans have been developed, and a sign-off visit will be made in three months to determine if they are meeting the Dignity in Care challenge. A rolling

programme of reviews has begun: the third Dignity in care panel review at Rose Taylor is currently underway.

A Dignity in Care event or launch of the finalised model is being planned for the later part of this year to promote and celebrate the work of the panel. The initial date for this event was moved to ensure that the panel had an opportunity to develop an effective review methodology and evidence to demonstrate outcomes from the reviews.

11.6 Multi-Agency Safeguarding Hub (MASH)

New expanded children service SPOE with Adult MASH added will be located on the 5th and 6th floor cellular areas as an interim measure.
Once 9th floor is renovated, the operation will move there. This is expected by September 2015.
Currently exploring what staff will be required from operational services to support the adult mash
Currently exploring an it solution which will pull together all information in one place for the adult mash.
It is planned that the adult mash will be established and working by 31st march 2015 but sooner if we can do it.

There is an absolute need to do this as the current configuration and structure to deal with adult safeguarding alerts is already over capacity and the number of alerts continues to increase.

12. SECTION 75 AGREEMENT

The Council and NHS Enfield Clinical Commissioning Group (formally Enfield Primary Care Trust) have had a Section 75 Agreement for commissioned services for adults since 2011.

Whilst there is provision within the Section 75 Agreement to extend for a further year if a letter of termination is not issued, both parties are seeking to refresh the Section 75 Agreement and amend the schedules.
The partnership arrangements have worked well and the revised Agreement provides the opportunity to consolidate joint working further and prepare for the introduction of the Better Care Fund from April 2015 onwards.

This table below outlines the proposed changes:

Schedule	Pooled/ Integrated/ Lead	Proposal for 2014-2015
Mental Capacity Act and Deprivation of Liberty Safeguards	Pooled & Lead	No change to Schedule/financial contributions.
Joint Commissioning Team	Integrated	No change to roles. Amendments to Council posts to reflect restructure. Removal of CCG contribution towards a Mental Health
Voluntary and Community Sector	Lead	No changes or uplifts in line with Council policy for no uplifts to VCS.
Integrated Community Equipment Service	Pooled & Lead	No change to the service to be delivered and performance targets. 1.7% uplift proposed consistent with CCG contract uplifts. NB demand is increasing. A quarterly review will be built into the schedule to check actual spend v projections.
Public Health	Integrated	No change proposed.
Integrated Learning Disabilities Service	Pooled & Integrated	No changes proposed to the service and performance indicators at this stage. Consideration is being given to the introduction of a pooled fund for those clients affected by the Winterbourne Concordat on the basis of a risk share approach for those patients to be transferred to the community. 1.7% uplift proposed consistent with other CCG contracts.
NEW SCHEDULE – Wheelchair Service	Pooled & Integrated	The wheelchair service will be added as a schedule with a view to activating this on 1st October 2014. The cost of the service currently will be transferred to the Council and it is anticipated that

		efficiencies will be made when integrated with the Integrated Community Equipment Service to offset an increase in demand. This reflects a transfer of cost for the CCG rather than the introduction of additional costs. This schedule will be triggered following agreement by both Parties over the course of the year.
NEW SCHEDULE – Personal Budgets for Health	Integrated	This schedule sets out the arrangements for the Council to manage the introduction of personal budgets for eligible patients, utilising existing systems and processes. This reflects a statutory requirement for personal budgets to be offered to eligible patients.

13. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

13.1 Learning Difficulties Partnership Board (LDPB)

13.1.1 The Learning Disability Partnership Board met on the 9th of June. The 'Big Issue' for this meeting was Housing and Support. Tammy Murray from the Housing and Support Alliance gave a presentation on housing options for people with Learning Disabilities. This was followed by presentations form Peppa Aubyn on how these options are incorporated into local strategy, and Geoff Lambrick on examples of local best [practice. The board had a number of suggestions. Particularly the need for more accessible information on Housing Options, and the need for a 'Moving on' style event for people over 25 who still live in the family home. These ideas will be incorporated into the Housing Work Plan.

13.1.2 Jon Robson, health champion, also presented to the board on progress with Annual Health Checks. The community nurses have identified 5 surgeries to pilot a scheme to improve the quality and uptake of annual health checks. The nursing team have also approached one-to-one about a joint project to educate people with learning disabilities to get the best from their annual health check. The nurses have drafted an accessible booklet for people, which Jon showed to the board. The nurses have also drafted an 'Outcomes Monitoring record', to keep track of any health issues or referrals identified at Annual Health Checks. This is now being sent to the CCG for comment. Jon said he would like Enfield to be the best area in London in terms of quantity and quality of health checks by 2015. The health sub group are also offering training on Mental Health issues for People with Learning Disabilities to local providers. The sub group has also produces an accessible leaflet about Dementia. This will be published later this year at an awareness event.

13.1.3 Lesley Walls from One-to-One is the new Equalities and Inclusion Champion. She circulated a Terms of Reference for the board's approval, and aims to convene a sub group meeting before the next board.

13.1.4 Stephen Moslin, transport Champion and self-advocate, chaired his first sub group meeting. This was very successful, and they are now looking at identifying and supporting a number of transport 'mystery shoppers'. Jane Richards from the Carer2carer network has been asked to join the Metropolitan Police Disability Steering Group, but is currently waiting for more details.

13.1.5 Ineta Miskinyte, the Transition Manager, reported that 150 young people and their parents/cares recently attended the annual moving on event. There have also been successful events about education and health. Specialist Person Centred Approaches training has also been offered to Children's services to support the Education Health and Care Plan pilot scheme. This was very well attended and feedback was very positive.

13.1.6 The Services for People whose behaviour can be challenging steering group is taking part in a research programme on Positive Behaviour Support. More details will be available after the study is completed at the end of the year.

13.1.7 The person centred planning quality check report this year identified a 64% increase in the number of staff attending training. This is likely the result of a variety of shorter courses being made available. This has also translated into more staff talking up the follow up mentoring sessions, and producing more plans of an acceptable standard.

13.2 Carers Partnership Board

The Carers Partnership Board is now to be chaired by Rosie Lowman, the Commissioning Manager for Carers Services. Christie Michael continues in her role as the Carer Co-Chair.

The Board is continuing to look to recruit new members and adverts have gone out through the carers network and in the Cheviots centre newsletter.

The March meeting had to be cancelled due to staff illness and so the annual away day where the Board will be reviewing the Terms of Reference, governance arrangements and membership has been changed to a date in July. The Board will also be looking at the Council's budget, with a presentation from Corporate Finance and for allow the Board to look at what we see as priority areas for carers' services over the next year.

13.3 Mental Health Partnership Board
Update not available

13.4 Older People Partnership Board
Update on OPPB 5th March as follows:

13.4.1 Big Lottery Bid Submission

The Enfield Ageing Better consultation report was presented to the board. This includes details of what needs to be in the bid as well as the structure. The deadline for this is April and the program needs to be complete by the end of March. A steering group has been put together with the Big Lottery (BLF) team and has met to discuss the proposal, successful in getting shortlisted to the last 30.

£30k has been received for the strategy back in December with the condition that it was to be led by the VCS (EVA are leading). EVA will employ two consultants to finalise reports and submit them. If successful, they will map the older peoples groups and services. The report will then go to the steering group to amend.

ASC service users have had real involvement in this other than attending the OP events. This could link in with the customer network?

The BLF has indicated to concentrate on the east of the borough due to that fact it is deprived and isolated.

Tony to have a meeting to discuss Consultation and determine whether it is meant to say over or under 50's. Further queries about the consultation report included: What are our sources? Should we have a survey? Should we write to them? Have champions in surgeries? There doesn't seem to be any mention of service users with dementia or their carers. Has Safeguarding been considered? We may approach su's via the referrer agreement.TW will bring it to the board as well as send the draft and actual submission and feedback to the hub. The customer network should also be sent a copy

13.4.2 Integrated Care

A paper was presented to the board on Enfield's Integrated Community Health Services model. This paper is an internal document which outlines how health services will be delivered around the patient. The interface will be with acute services and the VCS organisations. The integrated team will make sure that the service user is at the centre of the service. GP's have identified long term illnesses in the north west of the borough and there is a rol out plan being developed to the other 3 clusters. Assistive Technology was discussed as part of the integrated model and wider.

13.4.3 Better Care Fund Update

The better care fund is a national directive. We are using old money that is already on the system. The CCG is funding £20million. The focus is on older and vulnerable people. Plans are currently underway. The Better Care Fund covers 4 key areas which are Older People, Mental Health, Long Term illness, and Children. The board will be kept up to date on the progress of this

directive. The draft has already been submitted and the final will need to be submitted in April.

There is a commitment to the VCS, Dementia and End of Life. This started in 2015/16.

13.4.4 Enfield Dementia Action Alliance Update

The Dementia Action Alliance (DAA) (group of voluntary community sector organisations to help improve the lives of those with dementia) is still moving forward.
There seems to be growing interest from agencies. The DWP joined up nationally. Stage one is to get care organisations signed up. Stage two is to get non care organisations signed up.

13.4.5 Terms of Reference and Membership Alliance Update

Felicity informed the Board that today's meeting is her last Older Peoples Board meeting. Cenk Orhan will be managing the boards from today onwards. Our next meeting is going to be an away day around April/May time. We will be discussing things such as an 18th month work plan, membership and risk registers.
Terms of reference to be sent to the board.

13.4.6 Commissioning Intentions Update

Following discussion, it was agreed to invite Public Health to the next board meeting.

There is a workshop with Older People for Integrated care. Bring an update on the pathway for the next board meeting.

13.4.7 Next meeting items requested by Board

- Quickheart update.
- Enfield Age UK has been getting a high volume of calls regarding issues around filling out online forms.
- The Libraries are not helping the Elderly.
- Provide further information on the digital customer at next meeting (july)
- Update on Elizabeth House

13.5 Physical Disabilities Partnership Board

We discussed Enablement and younger people with a physical disability and reassured that this includes sensory needs as well. The group were updated on hospital discharge changes to process. Some members of the group were concerned about communication for sensory impairment in the hospital setting. We agreed to try and secure a health rep at the next meeting to further discuss this.

Transition Manager (from Children's into Adult Services) presented the plus 16 events and transition programme for the year and a general discussion regarding the transition process followed.

The Board agreed the need to recruit additional members, primarily for service users with a PD, health representatives and carers. We agreed to hold an event in Oct / Nov.

13.6 Enfield Safeguarding Children Board (ESCB)

The Board has recently agreed its priorities for 2014-2016 with a streamlined business plan focussing on improvement outcomes.

The priorities in the new Business Plan include:

Tackling Domestic Violence, Neglect, Substance Misuse, Mental Health and Child poverty as well as Female Genital Mutilation. A key success factor for all of this work will be partnership working with other Boards and to this end, the ESCB has drafted a protocol which sets out the working relationships between Boards. This will ensure that the work is not duplicated, but rather that resources and expertise are maximised. This protocol is being discussed with each of the Boards and will be finalised once discussions are concluded.

The Young People's Board is now in place and will be working on key safeguarding projects including e safety and bullying. Representatives will be attending each of the ESCB main meetings – this will ensure that young people can play an active role in the work of the Board.

The ESCB website continues to play an important role in raising awareness about safeguarding both for those working with children, young people and their families, as well as the wider community. The Board is planning a media campaign to highlight the website and the information contained therein. The Community handbook has been launched and has been well received – this provides information primarily for the community on a wide range of safeguarding issues.

This can be found on the website at the following link: http://www.enfield.gov.uk/enfieldlscb/info/4/publications/226/enfield_community_handbook