Health and Wellbeing Board – 16 October 2014

Agenda – Part: 1	**Item: 7b**
Subject: Joint Commissioning Board Report **Wards – All**	
Date: Thursday 16th October 2014	

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:

- The link to the Council's response to the Government's consultation on the draft regulations and guidance for Part 1 of the Care Act 2014
- Reference to the attached Better Care Fund paper for H&WBB
- Highlights of Integrated Care for Older People Programme, in particular:
  - the findings of the Older People's Assessment Unit audit
  - the expansion of the Care Homes Project
  - update on the Remote Monitoring Pilot (Tele-Health)
- An update of the Community Services procurement programme
- The successful performance of Health Checks delivered
- Reference to the separate CCG Commissioning Strategy paper
- The development and progress of the Warm Homes & Healthy People Fund
- The Joint Mental Health Strategy being ratified by the CCG, forthcoming presentation to Cabinet and development of the Joint Strategic Implementation Group
- 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 progress of service highlighted by the Learning Disabilities Self-Assessment Framework

1. EXECUTIVE SUMMARY (CONTINUED)

- The increase in numbers and improvements for Carers
- The extension for consultation re the Joint CAMHS Strategy
- DAAT's continued improvement in performance and successful completions
- Update from the Quality Improvement Board (QIB) re the four key project areas: (i) the Quality Checking visits; (ii) the Improving Residents' Lives group; (iii) Care Home Carers Network and (iv) Dignity in Care panel reviews
- Summary on Enfield Adult Social Care multi-agency safeguarding hub (MASH)
- Board updates

2. RECOMMENDATIONS

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

2.2 Note that the Chair of H&WB, Leader & Chair of CCG signed off the Better Care Fund paper on 19th September 2014

3. THE CARE ACT 2014

Update on the implementation of the Care Act 2014

Further to the information provided to the Health and Wellbeing Board in July, a key focus of the Care Act Board has been to respond to the Government's consultation on the draft regulations and guidance for Part 1 of the Care Act. A comprehensive response was submitted which included a technical response, and the views of local people and organisations obtained at local events arranged for this purpose. For further information please go to: **http://www.enfield.gov.uk/info/1000000554/policies_and_strategies/3126/the_care_act_2014**

Implementation is underway, including the financial impact of the Act and delivery post April 2015 and 2016. The consultation on the funding reforms (Dilnot) is expected in October/November.

4. BETTER CARE FUND

Timeline for BCF Paper:
Submission 1 - 4th April 2014
Submission 1 approved by HWBB 22nd March 2014

Submission 2 presented to HWBB Development Session for approval 9th Sept
Submission 2 19th September 2014

Governance paper sent July 2014 – asked to be resubmitted in October
Governance Paper being formulated for 16th October HWBB

- Please note separate Better Care Fund paper for the HWBB to be presented

5. ENFIELD INTEGRATED CARE FOR OLDER PEOPLE PROGRAMME

5.1 Primary Care Management & Risk Stratification

Working in partnership with the Local Authority, Enfield Community Services, and other specialist services Enfield CCG is continuing with the development Primary Care Management. This includes the implementation and embedding of the Integrated Locality Teams (ILTs), which encompasses the use multi-disciplinary team (MDT) meetings, and the Risk Stratification Tool.

Work over the last quarter has concentrated on:

- Further refining the process of identifying high risk older people with complex needs, through a combination of the Risk Stratification Tool and clinical judgement.
- Developing the core ILT and ensuring it is resourced appropriately. The team comprises of GPs, Social Workers, OTs, and Community Matrons at the centre of it with access to specialist services including ICT, Enablement, OPAUs and the Falls Service.
- Working to establish the integrated care delivery element of ILTs, through partners and an extensive workforce development framework to enable the training and development of the teams.

The risk Stratification Tool is funded jointly by NHS Enfield CCG and LBE. Currently 48 of our practices have access to it with activity data suggesting that it is well utilised as a starting point for segmenting the population.

Practices are working towards an NHS England commissioned Enhanced Service, which requires GPs to identify and actively case manage the top 2% of their at most risk patients. We have been working with GPs to identify a sub-set of those patients flagged at “very high” risk who are referred for and MDT. This meeting is 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 is starting to pick up, with practice MDTs becoming very popular with our GPs.

We are assessing capacity and progress of the MDTs to ensure they are fully embedded across the health economy in Enfield. Working closely with GPs, we are continually evolving the ILTs to ensure they are fit for purpose, reflect the needs of patients served through it while developing the staff including GPs.

5.2 Older People's Assessment Unit (OPAU)

A total of 1,477 patients were seen in the 2 OPAUs during Sep-13–Jul-14, with the numbers steady at around 160 – 175 patients per month in 2014/15. This figure equates to 43% of the total number of patients (3,400) anticipated to be seen in the OPAUs from the original business case over this period, and whilst there are several reasons for this apparent under-performance, it suggests the originally anticipated number of patients may have been over-estimated.

There is a different profile of patients using both OPAUs: of the 1,477 seen in both OPAUs, 91% (1,343) were seen at Chase Farm (58% of the total anticipated), with 134 seen in North Middlesex, which is typically seeing 10–20 patients per month in the OPAU. North Middlesex has a number of other initiatives to help avoid hospital admission, including its Geriatrician Hot-Line available to GPs to contact geriatricians to discuss individual cases over the phone – this receives an average of 47 calls per month.

An audit of 110 patients at both OPAUs was undertaken to determine the longitudinal impact of the service for patients. This audit confirmed differing cohorts of patients were accessing the 2 OPAUs: of the 50 CF OPAU patients, only 4 had previous hospital admissions 3 months prior to their OPAU visit.

At NMUH OPAU this figure was 21 out of 60 sampled. The audit found no significant change to admission patterns post-OPAU, with 5 admissions 3 months post-OPAU intervention at Barnet & Chase Farm Hospitals, and 21 admissions at NMUH.

Patient feedback about their experience at OPAU was conducted through a questionnaire and was very positive at both sites, with nearly all patients satisfied with their experience and how the staff treated and worked with them:

"Brilliant assessment department. Staff are so kind and caring."
"We were very impressed by both the friendliness and professionalism of the staff here."

The analysis in the report suggests if it assumed the proportion of OPAU patients who would have become hospitalized without intervention follows geriatricians' estimates, the total benefit in avoidable hospital admissions would be £1.55m over both Trusts (£1.35m for Barnet & Chase Farm Hospitals, £201k for North Middlesex) during Sep-13–Jul-14, leading to a net saving of £1.1m (£957k and £169k, respectively). A similar audit of the cases of patients who were subject to Hotline consultations estimated an additional net saving of £78k in NMUH.

The purpose of the review was to provide a set of options for future commissioning of the OPAU function and a set of recommendations sitting alongside these options listed above

The review is currently been finalised and options are considered with their respective advantages and disadvantages in light of the lessons learnt from the first year, were:

A. Do nothing
B. Contract OPAUs as PbR
C. Disinvest resources at NMUH OPAU
D. Create a system that functions with both OPAUs as a single operational service
E. Commission and merge NMUH Day Hospital and NMUH OPAU as a single service

As a result of the review's findings, the report recommends Option **D** as the favoured commissioning model, as this reflects the need to continue offering and developing this vital service as part of the integrated care programme, whilst offering better value for money than the current configuration.

5.3 Falls

The bone health and fracture liaison services were piloted as a two year service in October 2012 and are due to run out in October 2014. As part of the intentions to re-commission this service, the commissioning team have agreed with providers to evaluate the service in order to measure whether the service has achieved its set objectives and more importantly, to measure possible impact on patients falling. The review will look at outcomes for patients, a reduction in the number of falls, reduction in the number of fragility fractures and fracture neck of femurs Together with activity targets.

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, Care Homes and Integrated Locality Teams by end of November. The CCG is finalising draft KPIs for the remainder of 14/15 (Q3 and 4) and 15/16 in line with the intentions to re-commission the service.

The Community Bone Health post has a primary care focus and therefore, as part of the primary care locally commissioned service, the specification requires GPs to risk stratify and identify their patients (within the top high risk 2%) of patients at risk of falling including developing Falls Registers within practice. GPs will be required to use a FRAT tool in identifying patients and referring them for assessments to the Bone Health service.
The Community Bone Health service has recently began to provide outreach to the Older People Assessment Units and this service will be piloted for a month and reviewed subsequently to measure impact. The modelling is aimed at focusing on likely impact on admissions for bone balance and fractured neck of femur.

The Care Homes Team have reported to have seen an impact with both services to care home residents as the numbers of residents falling and going into A&E have significantly dropped compared to previous year.

Enfield Community Services are coordinating a provider training and development session on 8th October with all the therapy staff and this session will focus on looking at NICE Guidelines, clinical audits and therapy development pathways including the Falls services.

Access to North Middlesex hospital has improved as the fracture liaison nurse are assessing Enfield patients who have had a fall related admission.

5.4 Care Homes Project

The CHAT service has expanded from 17 homes to 21 homes covering a total of 975 beds and targeting the homes with the highest numbers of emergency admissions.. The team led by a Consultant Geriatrician provides outreach to NMUH for the South and currently provides some cover to the North. The commissioning team are looking to re-commission and develop the model to expand the Consultant PAs to cover more homes. The budgets set aside for 13/14 for the enhanced service to originally provide primary care support to homes has been pooled as model required further development with the primary care Networks not been set up. The commissioning team are examining options for increasing primary care support to the homes. Admissions have decreased for those care homes being covered from 2012/13 – 2013/14.

The commissioning team are also working with the GPs as part of the Enhanced Service to reduce avoidable emergency admissions for 14/15 to engage with CHAT in managing and coordinating care for the top 2% (at risk of unplanned admissions) of their patients within care homes.

5.5 Assistive Technology

Tele-health is a new addition to Enfield's Integrated Care Model and forms part of the national agenda to enable complex patients with long term conditions to be monitored remotely, picking up early signs of their potential deterioration.
Assistive Technology (AT) is largely led by Enfield Council, working in conjunction with health partners, to identify/develop existing and emerging AT solutions. Work undertaken in 2013/2014 led to the development of 3 different sets of solutions to support 3 distinct AT customer groups, all of whom are currently under-served, and the first two of which are funded through LBE and client contributions:

1. **Safe and Connected Service:** The use of AT provides reassurance to generally older people by providing a personal or household alarm-based service which can be triggered in a crisis to trigger a mobile response, e.g. help if someone falls. Customers will also benefit from pro-active "keeping in touch" and their changing needs being monitored, for example; to help prevent a crisis later;

2. **Tele-care Service:** Mostly older vulnerable people with on-going care needs, whose reason for using AT is to promote safety, quality of life and independence;

3. **Tele-health:** People with specific long-term conditions, whose vital signs can be monitored remotely.

Tele-Health ("Remote Monitoring Pilot")

The pilot project was aimed at patients aged 65 and older with specific LTCs including chronic obstructive pulmonary disease (COPD), chronic heart failure (CHF), coronary heart disease CHD. Patients are identified and referred into the service by GPs, community matrons or specialist nurses. 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 service is currently being evaluated and preliminary findings suggest that the service is not only highly regarded by patients, carers and clinicians but it seems to have made an impact on secondary care activity. Below are some comments from patients who use the service:

"Really like the telehealth monitoring, its easy to use and understand and has it part of the daily routine"

"Feel very reassured that the support will help keep my relative out of hospital for longer".

"I know that support is there and works well with community matrons" and "I like knowing that someone is there to re-assure me"

6. PUBLIC HEALTH

6.1 BEH MHT Community Services Contract

The procurement programme for Enfield Community Services, which is led by Enfield CCG, continues to progress. A work programme has been agreed and is being co-ordinated through a Community Services Procurement Steering Group led by Graham MacDougall (CCG Director of Strategy and Partnerships) and Bindi Nagra (Assistant Director of Strategy & Resources, HHASC), with senior representation from both organisations. The three month engagement period from July 2014 continues.

The Council has been working very closely with NHS England to determine what is being transferred with regards to the responsibility for Health Visitors that will transfer to the Council in October 2015. Having established this, HHASC Commissioning and Public Health are working closely with partners to determine what the provision should look like in order to ensure continuity of service during the transition and the Community Services procurement process.

The Health Visiting budget will be added to the Public Health Grant in October 2015 and will be ring-fenced for 18 months.

First drafts of service specifications are being presented to Enfield Clinical Reference Group 1st October 2014.

The HWBB will be kept informed of progress.

6.2 Health Checks

The total number of Health Checks delivered in 2013/14 has been collated and it can be reported as 9,612, which is considerably higher than the Council's target of 5, 500 and the previous year's figure of 5,503

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On the basis of our new figure of Health Checks being delivered to 12.36% of our total eligible population, LBE would be ranked as 10th of the London Boroughs - just outside of the top 10%

	2012/2013 (from Q2)	2013/2014
GPs	5218	8411
Innovision	285	1201
Total	**5503**	**9612**

Plans to maintain / improve performance:

Short term: Going to Clinical Reference Group and Locality meetings with the performance for Q1 +Q2 and previous year's figures to highlight what can be achieved;

Pop-up sites near locations of those GPs that are not performing

Medium Term: Highlighting the GP practices that have not performed with a view to using models of best practice from elsewhere in their localities to bolster their figures;

Develop a promotional plan with Innovision to target the population identified as those that are not registered with GPs

Long Term: To develop a call / recall system for the practices to use going forward.

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

System Resilience Groups (SRG) are the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery for both urgent and elective care. The group will plan for the capacity required to ensure delivery of effective, high quality accessible services which are good value for taxpayers, not only for winter but year round.

NHS Enfield CCG will participate in two SRGs; Barnet covering the Royal Free System and Haringey SRG which will cover the NMUH System. Barnet, Enfield and Haringey have been allocated resilience funding on a fair shares basis to be shared amongst local partners through the new SRG. This money is the equivalent of the winter pressures funding, which CCGs received last year, and will be made available upon successful assurance of the Operational Resilience and Capacity plan.

Each SRG has developed an Operational Resilience and Capacity plan in the line with guidance published by NHS England on 13th June 2014:

http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf

Plans needed to cover all wider planning elements, which included good practice and demonstrating that organisations are taking into account the wider context in which the SRG operates. These have been assessed by the Tripartite Panel; Haringey's SRG Plan has been '***assured'***, however, Barnet's SRG is currently rated '***assurance underway'*** and is required to undertake further work

8.1.2 Enfield Warm Households Programme

The Council and its partners provided a range of schemes through the (two-thirds Department of Health funded) £225k Warm Homes & Healthy People Fund help people keep warm in the winter and prevent deaths in 2012/13. The Council and its partners were informed that the Department of Health was not going ahead with this Programme in 2013/14. In response, the Council developed an Enfield Warm Households Programme to be targeted at helping particularly vulnerable people & families keep warm and connected in the winter and preventing deaths amongst older people, and agreed a £120k allocation with funding contributions from Health, Housing & Adult Social Care (including Public Health) and Children's Services. Criteria for applications were developed, including limiting applications to one per organisation with an upper limit of no more than £20k per scheme.

The criteria were:

- Aim to reduce death and illness due to cold housing in the winter months;
- Targeted at the most vulnerable – for example, older people, those with long-term conditions and young children;
- Demonstrate a partnership approach: Other local partners, particularly those from the voluntary and community Sector and those that work with the Council via Health & Wellbeing Boards are engaged and support the proposals.
- Demonstrate strategic fit: Projects needed to be consistent both with the aims and implementation of the Cold Weather Plan for England and are local needs identified in Joint Strategic Needs Assessments. The funding was looking for schemes that did not duplicate funding from other sources, e.g. Warm Front. The funds can however support delivery or extension of existing schemes;

Over 70 (primarily voluntary sector) organisations, representing the borough's wide and diverse community demographic, were contacted and invited, through a competitive grants process to bid for funding. The initiative's objectives were:

- Raise public and professional awareness of adverse effects of cold weather on people's health and wellbeing, including practical and financial assistance to remedy defective heating systems, poor insulation etc. in vulnerable people's homes that will keep people warm and improve energy efficiency;
- Engage with and mobilise the community to improve vulnerable people's resilience in the event of severe cold weather, provide activities to increase wellbeing and services where individuals can receive hot meals in a warm, friendly environment, without fear of isolation;
- Support the practical needs of families dependent on benefits and those who would struggle to afford the additional costs due to adverse weather;
- Provide vulnerable residents with varying types of equipment, from provision of personalised winter parcels, to increased loft insulation, thermometers;
- Target those who live alone and have diagnosed health conditions that could be worsened by cold weather via installation of assistive technology to monitor temperatures or safeguard those who normally rely on others;
- Target health inequalities, BME groups and those identified via the JSNA as living within the most deprived areas of the borough.

Bids were evaluated and funding awarded against those meeting the criteria and providing optimum value for money. Successful organisations submitted a wide range of proposals to meet these criteria and objectives. These included:

- Providing signposting, information and/or advice on how to stay safe and keep warm, including about benefits and credits, energy efficiency and reducing the risk of falls, including through network support;
- Ensuring isolated and housebound individuals are offered home visits through existing services to help understand their needs;
- Supporting practical needs of families on benefits and those who may struggle to afford the additional costs, whilst ensuring they maintain access to services, including winter parcels;
- Identifying individuals living in cold homes or suffering the effects of poor heating/insulation and engaging with statutory and voluntary sector organisations to signpost people and facilitate better access to resources or available grants or to provide handyperson services;
- Help to ensure vulnerable people get to medical appointments, go shopping to ensure they have food in the house, get children to youth clubs and weekend activities, including after a spell of illness;
- Providing meals or luncheon clubs and warm places to spend time, whilst promoting social networking.

The schemes and projects have now ended and officers have recently completed monitoring and evaluation of these. Outcomes of these projects to date are:

- Reduced social isolation
- Vulnerable people informed how to keep warm and safe in winter
- Vulnerable people's benefits and entitlements maximised
- Reduced number of GP and hospital visits as clients felt they could self-manage
- Voluntary and community sector partners collaborating and partnering to maximise available resources, access existing services and networks and maximise spread of support available across the borough.

It should be noted the project outcomes are expected to influence a range of population-level Council, NHS and public health outcomes, though there will be many other factors influencing these outcomes. Examples might include:

- Adult Social Care Outcome Framework measures in each of the domains relating to: Enhancing Quality of Life for Those with Care & Support Needs; Delaying & Reducing the Need for Care & Support.
- Public Health Outcome Framework measures
- NHS Outcome Framework measures in each of the domains relating to: Preventing People from Dying Prematurely (e.g. reducing mortality rates and increasing life expectancy); Enhancing Quality of Life for People with Long-Term Conditions; Helping People Recover from Episodes of Ill Health (e.g. reducing hospital readmission rates);

High client satisfaction has been reported with support provided to the borough's wide and diverse community demographic, including hard to reach

groups. The ability to continue this initiative in the future is uncertain given the availability of resources and other competing priorities.

8.1.3 Dementia

The end to end review of the Dementia Pathway has been completed and the final report is near completion. The findings of the review will be incorporated into commissioning intentions and delivered via the Better Care Fund.

Waiting times for the Memory Service had increased to more than 13 week; NHS Enfield CCG invested additional funding to manage this and reduce waiting times; the current waiting time has been reduced to 8 weeks. It is expected that this will reduce further and be maintained at 4-6 weeks.

8.1.4 Social Isolation Bid

Unfortunately we were not successful in securing funding from the Big Lottery Fund. However, due to the strength of the model we are seeking alternative funding sources to develop the same locality based solutions with our third sector partners.

8.2 Mental Health

8.2.1 Joint Mental Health Strategy

Using the priorities identified by the Joint Health and Wellbeing Strategy 2014-2019:

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

Public Health have identified areas of the action plan where our priorities are aligned with the Joint Mental Health Strategy. Our focus will be to take a population based approach to build the resilience of Enfield's residents from childhood through to adulthood.

The strategy was ratified by Enfield CCG Governing Body on 24th September 2014 and will be presented to Cabinet in November 2014. The Joint Strategic Implementation Group has been established, and has agreed membership (including the Chair of the Mental Health Partnership Board), terms of reference and an Action Plan for 2014/15.

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. 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

The funding available for implementation of the Autism Framework will be allocated to the independent sector through a small grants procurement process. This small grant procurement process will start at the beginning of October 2014 and we hope to have identified an organisation by the beginning of December 2014 with the necessary dedication, skills and expertise to implement the Autism Framework and reenergise the Autism Steering Group to oversee our improvement plans for people with Autism and their parent / carers.

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.

Public Health England has advised us that the Learning Disabilities SAF for 13/14 will be released imminently. The Deadline for submission will be March 2015.

8.3.2 Transforming Care for People with learning disabilities Programme (Winterbourne View)

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.

Community Intervention Service for people with complex needs

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 the end of September 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.

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 CCG in partnership with Enfield Council and Mysupport broker, have expressed an interest in taking part in NHS England's Integrated Personalised Commissioning Programme that will provide a network of support opportunities and best practice guidance to implement and embed the following objectives in terms of implementing integrated health and care models locally:-

- People and their Carers have better quality of life and can achieve the outcomes that are important to them and their families
- Preventing crises in people's lives that lead to unplanned hospital and institutional care.
- Better integration and quality of care,
- The programme builds on personal health budgets, Long-Term Conditions Year of Care programme, the Integration Pioneers and work with Monitor and HSCIC

8.4 Carers

8.4.1 Enfield Carers Centre

The Centre now has 2770 carers on the Carers Register. In addition, 762 carers hold a Carers Emergency Card. In the April-June 2014 quarter the Centre registered 317 new carers.

The Carers Centre respite programme has allowed 261carers to receive a break between June and the new befriending programme has resulted in a further 5 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. In the April-June quarter, 85 carers received benefits advice.

The Hospital Liaison Worker started in late November and continues to work on the wards at North Middlesex, Chase Farm and Barnet Hospital. 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 quarter of April-June 2014 the Hospital Worker identified 73 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 held and solutions are being looked at.

The Advocacy Worker has been taking up cases and has continued to promote the services within the VCS and with practitioners. In the April-June 2014 quarter they provided support to 55 carers.

The Young Carers Worker pilot project has now reached conclusion and in the final quarter the Young Carers Project identified 65 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. A report on the pilot has just been published and highlights the importance of identifying and supporting young carers through schools.

The Centre's training programme has seen 111 carers attend a training sessions over the April-June quarter. A further 39 carers have received one to one counselling during this period.

8.4.2 Carers Direct Payment Scheme

We now have 125 carers receiving a Direct Payment through Enfield Carers Centre with others awaiting approval.

8.4.3 Carers Rights Day

Plans are underway for Carers Rights Day 2014 which will be hosted at the Civic Centre on Friday 28th November. The focus for the day will be The Care Act and Children and Families Act which offers new rights to carers.

8.4.4 The Employee Carers' Support Scheme

An event for the week of Carers Rights Day is planned to promote the Carers Action Group.
Development of pages for the staff 'Enfield Eye' intranet and content is currently being developed. Development of a staff e-learning package in carer awareness has been agreed as a priority

8.4.5 Primary Care*

The GP project has now seen 180 new carers registered through either the GP or the self-referral method from the surgery information.
13 surgeries have a permanent carers noticeboard.
11 surgeries are now hosting regular carers information stands
22 practices now have carers' post boxes on reception.
All 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.
45 practices are now actively engaging in the project. All pharmacies have been written to in the reporting period.
Three practices have received Carer Awareness training for their reception staff and a presentation has been made to a Practice Manager Forum, delivering training to 25 practice managers.
A bimonthly E- bulletin is sent to all the practices that have been visited with a project update and a request for further engagement.

(*All statistics are to the end of June 2014)

8.5 Children's Services

8.5.1 Family Nurse Partnership (FNP)

Enfield Family Nurse Partnership continues to progress 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 94 eligible referrals in the first ten months. One hundred referrals were expected. Fifty-three enrolled for the programme of which 16 (30%) declined to enrol and 2 became inactive during the programme. Two clients are subject to Child Protection Plans due to neglect. Fifty-seven young people were not eligible for the FNP because they lived out of area, were too old or too advanced in their pregnancy. The latter group were referred onto the HV Teams for additional support. The FNP team is recruiting clients for representation on the Family Nurse Partnership Advisory Board.

8.5.2 Health Visitors

The campaign to recruit additional Health Visitors has been very successful in Enfield. It is therefore believed that there will be sufficient capacity within the Health Visitors' team to undertake additional duties with the under 5's and their families who have been identified as requiring help from the early intervention and prevention strategies and targeted work. This is a positive step given these children and families will already be known to the Health Visitors.

8.5.3 Community Services Procurement

- See section 6

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 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. The Enfield CCG continues to monitor important quality issues in monthly meetings and through the North Central London Maternity Board. There has been steady progress in improving mental health services for pregnant women and up until their baby's second birthday (known as the perinatal period). The Tavistock & Portman Clinic is providing perinatal mental health training on behalf of Enfield and other CCGs within the North East London.

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. The Local Offer was published as required at the beginning of September. Good progress is being made with other work streams as detailed in the recent report to the Health and Wellbeing Board.

8.5.6 Paediatric Integrated Care

A paediatric integrated care work stream was initially established to support implementation of the Barnet, Enfield and Haringey Clinical Strategy, and is now supporting the development of the Child Health and Wellbeing Networks included in the Better Care Fund submission. The new networks will enable care to be designed around the needs of children and families taking account of both their physical, social, and emotional, circumstances and providing access to expertise from across the professional spectrum, but most importantly from children and families themselves.

The model will be underpinned by the principle of skills sharing across organisations, providing access in the community to expertise from a range of professionals, including general practitioners, paediatricians, general and specialist nurses, school nurses, SENCO's, social workers, dieticians, health visitors, A&E teams, CAMHS, and children, young people and their families. The framework is designed to enable:

- Shared learning and skills development between secondary care paediatricians and general practitioners, and other professionals
- A whole person approach to caring for children, young people and their families, underpinned by the principles of co-production, empowerment and self-management.
- Greater confidence in the provision of child health and wellbeing services in the community settings for patients, families and professionals

A multi-agency group meets monthly to progress this work.

8.5.7 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 took place between July-August 2014 and is currently being finalised before going through the approval process. It is likely that further consultation will be necessary. 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 remained extremely positive with the latest 12 month rolling data for the period July 2013 to June 2014 evidencing that Enfield has achieved 27.7%; 7.4% above the London and 10.1% above the National averages.

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 remained below the target of 1068 and Enfield will not achieve its end of year trajectory ambition. However, the target for 2014/15 has been sustained at the previous year's level and excellent work has commenced with all the key providers to increase the number of drug users in treatment to ensure that the Number Retained in Effective Treatment is achieved this year. This has included a complete remodelling of delivery by removing the DAAT's Assessment and Care Review Team's function as a point of entry as attrition between assessments and treatment uptake was running at over 60%. The contracted providers resumed assessment responsibility from the 5th August 2014 to ensure that the attrition rate is substantially reduced and the target for numbers in treatment is achieved.

8.6.3 Numbers in Treatment and Successful Completions (Alcohol)

The performance for the number of alcohol users in treatment remains consistent. Enfield's successful treatment rate is in keeping with the London and National averages at 39.8%.

8.6.4 Young People's Substance Misuse Performance

The performance for young people in treatment remains strong at 173 for the latest 12 month rolling period and it is pleasing to note that the Planned Exists has increased from 76% in 13/14 to 91% this year; a rise of 15%.

8. HEALTHWATCH ENFIELD

No update on activity since last report

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

No update on activity since last report

11. SAFEGUARDING

11.1 Safeguarding Adults Board (SAB)

The Safeguarding Adults Board will be notified of Quarter one performance data at the September Board meeting.
Key headline data for Q1 is:

1. Number of alerts received: 260
2. The number of alerts in relation to institutional abuse has quadrupled. Whilst these figures are still low it could relate to the impact in provider concerns processes. This would also account for the place of alleged abuse where Care Home with Nursing note a 95.3% increase from this quarter to last year's Q1.
3. Routes of referral show a 200% increase from GP's. This figure is still quite low however it is positive to see a rise in referrals from GP's.

Further to the Supreme Court Ruling on 19th March 2014 on Deprivation of Liberty safeguards there has been an increase in applications. The ruling noted the acid test for a DoLS was:

1) Under continuous supervision and control
2) Not able to leave

Objection is now irrelevant.

In 2013 – 2014 there were 66 applications. In the 1st quarter of 2014 there have been 51 applications. A strategic plan is in place to manage this increase.

Enfield has enrolled in the LGA / ADASS Making Safeguarding Personal programme. This is an approach intended to support councils and their partners to develop outcomes-focused, person-centred safeguarding practice. It was originally drafted to support the 53 councils who signed up to Making Safeguarding Personal (MSP) in 2013/14. The approach aims to facilitate a shift in emphasis in safeguarding from undertaking a process to a commitment to improving outcomes alongside people experiencing abuse or neglect.

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.

A Joint Safeguarding Adult's and Children's Board sub-group has been implemented. This represents the interface between Adults and Children's Safeguarding and will ensure that issues common to both the Safeguarding Boards are promoted and monitored.

11.2 Community Help Point Scheme on Tap-IT

The mobile safety app that helps residents keep connected continues to be downloaded from the iTunes store and Google Play. The app also provides information on the nearest police station and 'safe sites' that have been approved through the local council CHPS scheme.

Quote from service user: *'I'm not the best with phones and computers, but the App is very easy to use. My daughter feels happier that I have something to help me get in touch without having to ring her and its free.'*

11.3 Safeguarding Information Panel (SIP)

The Safeguarding Information Panel is made up of Enfield Council Safeguarding Adults, Contracting, 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 information shared at this meeting includes: number of deaths in care homes, whether a registered manage is in post, and number and nature of safeguarding adult alerts for the provider, CQC compliance and enforcement actions, and feedback from safeguarding provider concerns and contract monitoring activities. The panel is starting to receive referrals from the care teams and from Enfield Community Services nurses and teams (including the Care Homes Assessment Team).

A Quality Monitoring group has been set-up and met twice. 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. Members of the group have begun to share information from their respective activities.

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 75 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.

11.5 Quality Improvement Board (QIB)

At the August QIB, updates were received from the four key project areas: the Quality Checking visits (see 11.4 above), the Improving Resident's Lives group (care home managers' group), Care Home Carers Network, and Dignity in Care panel reviews:

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 implemented 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. The group has met and care home manager leads have been identified for improvement areas. A key area of improvement, from the action plan, is the process of hospital discharges into care homes. To facilitate improvements, care home managers will be attending the Discharge steering group meeting in the coming months.

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. 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. A pilot project is being developed with a care home provider (who has multiple sites in Enfield) to create effective residents and relatives meetings.

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 for a number of day services: Reardon Court, Rose Taylor, William Preye, Formont, Community Link (Enfield and Edmonton sites). 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 is made in three months to determine if they are meeting the Dignity in Care challenge. Two sign-off visits have been completed. One site successfully completed all required

improvements; the second site has some improvement actions outstanding. Panel members have been impressed with the quality of service across the Independence and Well-being service and the response of staff to their visits.

11.6 Multi-Agency Safeguarding Hub (MASH)

11.6.1 As part of its ongoing work to transform services in Enfield Adult Social care is seeking to create a multi-agency safeguarding hub (MASH) for vulnerable adults. With a significant increase in the number of safeguarding referrals year on year and a need to respond quickly, often across multiple areas of responsibility, developing a MASH which will see the co-location of staff from adults' services, police and health makes sense.

There is currently a SPOE (single point of entry) within children's services with a MASH for children operating within a single location. With the infrastructure already in place, it would make sense to "bolt on" the adults MASH, though with very different areas of responsibility and statutory frameworks, the two teams will continue to operate separately whilst sharing resources from the police, health and other areas. The SPOE/Children's MASH is located within the civic centre.

Currently all safeguarding referrals come through the Access service in Adult Social Care. This is not a multi-disciplinary team. Access acts as a triage service and all referrals that require further investigation are sent out to the responsible care management teams.

The MASH will deal with all new safeguarding concerns including merlins from the police, where someone is concerned about the safety or wellbeing of an adult, or think they might be at risk of harm.

11.6.2 How will the MASH operate?

Within the MASH, information from different agencies will be collated and used to decide what action to take. As a result, the agencies will be able to act quickly in a co-ordinated and consistent way, ensuring that vulnerable adults at risk are kept safe. Where there is a need for further investigation, these cases will be transferred to the appropriate service. Where it is decided that no further investigation is required appropriate information and advice will be given. Given the potential for a multitude of different agencies to be involved in the referrals which come through, it would be appropriate for some agencies to be virtual members of the MASH. This means that, although a physical presence may not be necessary, a named resource will be contactable and available to provide information and advice as necessary.

The MASH should have a dedicated phone number for all queries. There will also be an on-line form available for people to refer directly to the MASH. Developments are already underway to develop on-line forms that will feed directly into the client information system (CareFirst). These will all go to a dedicated MASH clipboard.

The group has previously received an update on the background to and need for an Adult Multi-Agency Safeguarding Hub. This update relates specifically to actions either planned or delivered to date.

The MASH steering group is chaired by the AD for Adult Social Care services and includes stakeholders from across the Council and other statutory bodies. The steering group is supported by two sub-groups, the MASH practice group and the MASH IT/infrastructure group. Progress made to date includes:

- A new process for how the Adult MASH will work and how it will fit with the Children's MASH already in place
- Discussion is still underway in order to agree what resource will be allocated from which services to sit within the Adult MASH and what resource will be shared across both Children's and Adults MASHs
- Interim accommodation agreed for the new combined MASH which will be the 5th and 6th floor civic cellular areas. This will be used until September 15
- Long term accommodation solution agreed as the 9th floor civic centre. Planned available move in date is currently September 15 once renovation works have been completed.
- Site visit scheduled for IT/re-cabling provider for the Police.
- IT System specifications to support both Children's and Adult's MASHs are complete and with corporate IT
- Provider system demonstrations to be arranged and delivered by corporate IT to meet the specification by 1st October 2014
- Capital funding in place to deliver the IT solution
- Contact to be made with other councils who have already implemented joint Adult and Children MASHs across the country to learn good practice
- Information sharing protocol to be agreed

12. SPECIALIST ACCOMMODATION

The Keeping House Scheme

The Keeping House Scheme has been set up for people living in or moving into long term care who own a vacant property in the borough of Enfield. The scheme enables people to lease their house to the local authority in return for a guaranteed rent for a fixed period of time. The rental income generated is used to fund the costs of care. This Scheme will reduce the amount of deferred debt which the Council takes on; enable people to keep rather than sell their homes and to fund the cost of their care and support without depleting their savings. Grants are available to bring properties back up to a decent standard and leasing options running from two to five years.

The scheme went live in February 14 and we currently have 13 cases going through the process with lease agreements signed. These properties can be used to house families for whom temporary accommodation or nightly paid accommodation may have been the only other option.

13. PARTNERSHIP BOARD UPDATES (COMMISSIONING ACTIVITY)

13.1 Learning Difficulties Partnership Board (LDPB)

13.1.1 The learning Disabilities Partnership Board met on the 18th August. This meeting's 'Big Issue' was transport. Stephen Moslin, Peer Advocate and Transport Champion, gave a presentation on the recently reconvened Transport Sub Group, which he is now chairing. The subgroup includes members from local transport providers (Abellio Greater London and First Capitol Connect), TFL, The Safer Transport Police, service users and local service providers. The sub group also represent the Partnership Board at The Enfield Transport Users Group (ETUG).

The group has drafted an accessible travel survey form. This is to be used by 'Mystery Shoppers', but could also be used by independent travellers and people travelling with support workers. This has already been piloted by Community Link and One-to-One, and the feedback passed to ETUG. The sub group will now roll this out as a wider survey. They will send their findings to Councillor Georgiou, who will also take them to the Public Transport Consultative Group.

The Transport group will work with the community safety police on how to include awareness around learning disabilities in their work with schools.

13.1.2 People transport service had been invited to attend, but were unable to send anyone on the day. Questions from the board were taken and People Transport replied in the minutes.

The board were informed that there will be a new agreement about what is to be expected of Passenger Assistants on in house transport busses.
People can use their personal budgets to find different ways to get to day centre, like car sharing or public transport. Work is being done on how to get the money from bulk purchasing transport to people's personal budgets.
The board had noticed that children tend to have fewer delays than adults. People Transport conformed that there is a statutory duty to support a child's right to education that may occasionally take preference over adults going to day services.

People Transport confirmed they are just completing a tender process for some bus services, which will include targets, for example, picking up clients in a specific time frame.

People transport also said they are about to launch a new out of hours phone line, where people and there carers can leave a message about a change or find out why a bus is late.

13.1.3 Marc Gadsby gave a short presentation from Independence and Well Being Services as a customer of People transport. A lot of effort has gone into

improving people's journey to services like Formont over the last few months. Board members said this is much better now.

13.1.4 Sharon Till from Transport for London gave an update on accessibility issues. She told the board about a TFL 'Accessibility Day' to be held at the Excell Centre on the 2nd of October. She also gave information on TFL's 'Travel Mentoring Scheme' and 'Travel Support Cards' She told the board that TFL are organising 'Regional Mobility Forums' and Stephen will arrange for a Partnership Board representative through the Transport Sub Group.

13.1.5 Janet Fish from TFL gave the board an update on 'First Route Enfield'. This is a partnership between Transport for London, Arriva buses, Community Link Edmonton, One-to-One, the Community Safety Police and Edmonton County School. It provides an opportunity to practice independent travel skills on a real London bus once a month. This has been very successful building people's confidence.

13.1.6 The board agreed that the Employment Worksteam will now include developing a travel buddy scheme.

13.1.7 Lesley Walls (One-to-One and Hate Crime Champion) will ask the Community Safety Police to link with the Hate Crime Network to help increase the reporting of hate crime.

13.1.8 The Community Nurses from the Integrated Learning Disability Service have started delivering their Mental Health Awareness training to family carer groups.

13.1.9 The Services for people whose behaviour can be challenging have found a way to capture information from people's assessment relevant to challenging behaviour and add it to Care First. This will allow us to plan interventions and training more effectively.

13.2 Carers Partnership Board

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

The Away Day was held in July and this refreshed the terms of reference, risk register, membership. The board also reviewed and updated the Strategy Delivery Plan.

13.3 Mental Health Partnership Board

Update not available

13.4 Older People Partnership Board

Update on OPPB 1st July 2014 as follows:

Health Inequalities: A presentation was delivered on Healthy life expectancy & Excess winter deaths within the borough - presented by Susan Lloyd & Ela Goschalk. A copy of these presentations sent members along with a copy of the minutes.

Digital customer: aims of digital customer principles were presented and discussed with the group, and explained in terms of improving LBE l website where residents can inform the council of any changes of circumstances, personal changes, check eligibility and apply for services, which could be linked to their circumstances e.g. caring, and single view of customers, accessible information, right first time principles etc. this was generally well received and quelled a number of previously aired anxieties from older residents. The Board requested frequent updates, and for further information on data sharing re: shared council accounts

Adult Social Care Procurement Programmes: the group were further updated on the reprovision project on Elizabeth House and Skinners Court retendering. A viewing of the site at Elizabeth house will be arranged in the future.

Terms of Reference (ToR): The ToR for the OPMH sub group of the Board has been completed. The OPPB ToR have been added to the agenda for discussion at next meeting to establish work programme priorities for the next year.

AOB: The Board requested an update on the Sheltered Housing Strategy

13.5 Physical Disabilities Partnership Board

Updated on Transition processes and opportunities for younger people with a physical disability and reassured that this includes sensory needs as well. The group discussed hospital discharge, the changes to process and the positive impact to date. Some members of the group previously aired concerns about communication for sensory impairment in the hospital setting, which has been taken to the hospital discharge working group.

WeIn$tinct1ve are in the process of planning an event in Oct / Nov to attract new members to more appropriately represent PD.

13.6 Enfield Safeguarding Children Board (ESCB)
Update not available