Health & Wellbeing Board Update Report from the Joint Health & Social Care Commissioning Board – Health & Adult Social Care

Date of Health and Wellbeing Board: 2nd December 2021

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1. Introduction & Background

2. The Joint Health & Social Care Commissioning Board is a partnership across Council People services and Health, represented by CCG colleagues. For the purposes of this update, it oversees the development and delivery of key priorities across Adult Social Care and Health.
3. The priorities jointly developed and agreed across health and social care build on the good work done in previous years and, in particular, focus on the learning from the period of the Covid-19 pandemic.
4. The impact of the pandemic has been clear in Enfield with:
    - excess deaths increasing by 375% in April 20 alone with care homes proportionally hardest hit
    - significant reductions in emergency admissions to hospital and permanent admissions into care homes.
    - By February 21 over 80% of acute hospital beds occupied by people with Covid
    - Access to virtual GP appointments increased from 20% pre-pandemic to almost 50% by June 2021.
    - Increased referrals to Social Care for support in the community
    - Increased referrals for support from informal carers looking after family members
    - An increased use of technology facilitated by the health and social care partnership to enable more vulnerable residents to engage with family members
    - an increased deployment and take up of assistive technology to provide targeted support where needed.
5. However, the impact of the pandemic has also impacted on the mental health and wellbeing of many of our residents with
    - significantly increased referrals to local voluntary and community sector groups focused on mental health and practical support
    - increased mental health inpatient admissions, particularly amongst the BAME communities
    - increased admissions to assessment and treatment for people with learning disabilities
6. Across the Integrated Care Partnership our priorities seek to address these most pressing of challenges by:

- Proactively identifying and addressing inequalities in BAME communities including: Mental Health; Long Term Conditions (LTCs);
- Education and engagement to support self-care and access;
- Driving up representation of those impacted by inequalities in Patient Participation Groups and Partnership Boards;
- Greater engagement with BAME, hard to reach, and deprived communities particularly through our voluntary and community sector;
- Driving increased uptake of screening and immunisations to keep residents healthy and catch conditions earlier, including for cancer, giving people the best possible intervention/treatment;
- Driving greater focus on improving mental health among residents: Focus on proactively preparing for post Covid MH; Proactively identifying and addressing lower level MH issues; addressing the Disproportionate impact on BAME communities;

7. These priorities are addressed in our Better Care Fund Plan with increased joint investment in:
    - Hospital avoidance and discharge capacity – increased capacity in Integrated Discharge Teams, older people and mental health enablement services and a virtual ward model of delivery;
    - New complex mental health stepdown service delivered to support hospital avoidance and to support timely discharge;
    - Increased voluntary and community sector provision to address mental ill health, to support better self-management of long-term conditions and expand the levels of support available to people recovering from mental ill health to access employment;
    - Planned capital investment in a new integrated mental health and wellbeing hub, adapted community accommodation options for people with complex learning disabilities;
    - An enhanced community equipment and assistive technology offer able to flex up to 7 days services as required
    - Digital and telehealth/assistive technology solutions in partnership with the GP Federation
    - Support for informal carers through increased investment in the voluntary and community sector
    - Increased support for people with sensory impairments through our voluntary and community sector
    - Targeted work on our hardest hit BAME communities, particularly in mental health and substance misuse services
8. The planned net impact of this joint work and investment is:
    - A 5% reduction (compared to the 19/20 baseline) in avoidable admissions
    - A 2% reduction in patients whose discharge is delayed by 14 days or more (compared to winter 19/20 and 20/21 averages)

- A 2% reduction in patients whose discharge is delayed by 21 days or more (compared to winter 19/20 and 20/21 averages)
- A continued focus on home first with 93% of patients able to return home following discharge
- A planned but short-term increase in residential admissions to ensure appropriate levels of support in the right care setting
- Enablement capacity increased by 20% to support home from hospital 88% of those people living independently 3-months following discharge

9. Enfield's local Acute A&E Hospital, North Middlesex has been particularly challenged during the pandemic period. Serving mainly local communities in both Enfield and Haringey there are very active partnerships in place which bring together both boroughs, CCG and trust representation with access to regularly updated and joined up data. As a result of this partnership length of stay of Enfield residents ready for discharge in acute hospital beds have reduced across all areas (7+, 14+, 21+ days) supported by increased BCF investment in additional capacity across Pathways 0, 1, 2 and 3. The ambition for this year 21/22 is to reduce length of stay delays further still by 2% for 14+ days and 2% for 21+ days.

10. Mutual aid arrangements developed during the pandemic continue to be in place (availability of placements, community support cover and community equipment where needed. With a significant proportion of each borough unregistered with a GP a new GP registration service has been established in partnership with the local VCS and situated in the hospital. The outcome of this project will be monitored carefully and will contribute towards the ambitious targets that have been set to help people continue to live safely and independently within their own homes.

11. Adult Social Care has worked well with partners including Voluntary and Community Sector organisations, Health and our providers across community and residential care settings to respond to the volatile and fluctuating patterns of demand that the pandemic has created. Overall demand has increased but with a shift to more community-based support both in the statutory sector and in the VCS/early intervention and universal service provision sector.

12. Our partnership has remained resilient with partners working really well together to deliver good outcomes for local people with a focus on work to help people to continue to live independently and safely in their own homes, preventing hospital admissions where possible and supporting safe, timely and appropriate discharge from hospital when in-patient treatment is necessary.

13. Overall, for this year we expect a period of volatility to continue given that we are not out of the pandemic yet. However, the success of the vaccine roll out and other initiatives to prevent the spread of the Coronavirus to our more vulnerable populations together with the end of furlough arrangements for many families looking after vulnerable loved ones has seen a gradual shift of activity resulting in, for example, an increase in permanent and short term placements in care homes. This bounce effect is not unexpected and whilst a placement in a care home is a last resort, we do make sure that other community alternatives are safe or viable before we do this.

14. This report provides a variety of information about how things are going across the health and adult social care sector, as well as signalling our plans both immediate and medium term given the significant legislative changes currently making their way through parliament which will bring Integrated Care System and Partnerships, a new regulatory framework for Councils with Adult Social Care responsibilities and Adult Social Care Funding Reforms.

15. Our Vision for Health & Social Care Services in the Borough

16. Our shared vision is: “We want to enable our residents to Start Well, Live Well and Age Well.” We asked our residents what Integrated Care means for them; and this is what they told us…
    - I will be supported by local services working together
    - I will get more of the help I need outside of hospital
    - I will have access to specialist care when I need it
    - I will feel listened to and involved in decisions about my care
    - I will be supported by the health and care system to stay well so I can live my life to the full

17. Enabling people to be safe, independent and well is a integral part of the Health and Social Care vision for Enfield residents. Delivering this requires the right support to be available at the right time and in the right place for people when they need it. It is also really important that people have the right information and advice in order to be able to access what they need. This links to support in the community, whether it is health, social care or universal service provision which helps to ensure that:

    - We work with people to help safeguard them from abuse
    - Emergency admissions to hospital are minimized through the provision of good levels of support in the community including primary care, social care and access to VCS and universal service provision;
    - Permanent admissions to residential/nursing care are only made where it is no longer safe or practical to support a person to continue living in the community;
    - Where a hospital admission is necessary, people are able to leave when they are medically fit with the right support in place to enable a return home
    - People are able to receive enabling services which support them to gain or regain independent living skills;
    - People are in appropriate and settled accommodation with access to the right support at the right time to help them sustain their accommodation;
    - Meaningful training and employment opportunities are available;
    - Where longer-term support is needed, people have as much choice and control over those arrangements as possible;
    - People have access to information/advice and support at the right place and time and are able to have their voice heard to contribute to and drive changes where these are needed across the Health and Social Care Sector.
    - Our wider health and social care workforce is well supported and equipped to deliver support and services which put families and people who use services at their very heart.

18. Integrated Services and what this means for local residents

19. The development of Integrated Care Systems (ICS) and Integrated Care Partnerships bring together stakeholders from across the health and social care system. Most importantly, they must have at their heart the voice of local people and what matters most to them.

20. Our Joint priorities as a place system are:
    - Improve outcomes in population health, health and social care services with a focus on health inequalities, immunisations and cancer screening programmes
    - Supporting our workforce, including our wider provider workforce, to deliver inclusive, person centred practice
    - Tackle inequalities in outcomes, experience and access
    - Delivering a system review in partnership with all stakeholders of community and mental health services in order to establish a consistent core offer across the five north central london boroughs whilst building on good practice particular to each individual place
    - Further develop a health and social care system which enables people to live independently, avoiding hospital where possible and supporting timely and appropriate discharge where admission is necessary
    - Delivering an enhanced health management and improvement offer to Care homes in the borough
    - Enhancing productivity and delivering value for money
21. There is strong collaboration at a place level with a shared understanding of the most pressing challenges across health and social care. Examples in this year of joint planning and delivery of commissioned services include:
    - Development and delivery of an ageing well programme of work completed in partnership across Enfield and Haringey Councils/CCGs
    - Joint planning for future delivery of a new Mental Health and Wellbeing Hub which will include a community/twilight café
    - Jointly planned and delivered stepdown service for people with complex mental ill health to reduce hospital admissions and support timely discharge
    - Jointly planned and delivered Voluntary and Community Sector contracts to support improved access to mental health and wellbeing support and improved self-management of long-term conditions
    - Increased joint investment in mental health support for employment and mental health enablement services
    - Joint investment in Voluntary and Community Sector capacity located in the heart of our local Acute Hospital to support community resilience through active support and signposting to GPs, including GP registration for non-registered patients
    - Joint planning and investment in bespoke support for people with learning disabilities to improve uptake of health checks, immunisations
    - Joint co-ordination of the NCL CCG inequalities fund targeted on the most deprived wards in the five NCL boroughs with a focus on tackling health inequalities
    - Joint increased investment in development of the virtual ward approach, in integrated discharge team capacity as well as winter planning capacity
    - Increased joint investment in digital technology, integrated community equipment services, including telehealth and assistive technology
    - A joint programme of strength-based training and development rolled out across the Council, health and VCS partners.
22. Our balance of care data shows that over the last three years the balance of people living at home versus those living in residential and nursing placements has shifted from 84% (community) and 16% (residential/nursing care) to 86% and 14% respectively. This excludes 20/21 which was heavily impacted by the pandemic.

Hospital avoidance, improved step down/rehab capacity has supported more people to either remain in their own homes or to return home after a hospital stay.

23. Enfield's hospital delays, according to regular benchmarking, are the lowest in the north-central London sub-region both for acute hospitals, mental health in-patient wards and learning disability assessment and treatment units.
24. We are building on this good work by delivering this year a joint Independent Living Strategy and will encapsulate the key learning from the pandemic period which includes:
    - Further embedding and broadening across the system the strength-based approach to working with people
    - An enhanced VCS offer focused on early support and proactive interventions to reduce falls and social isolation
    - Further development of the digital offer to include telehealth and assistive technology with a focus on risk stratifying and regular vital signs monitoring jointly with GPs
    - Better joined up information, building on the Health Information Exchange project to support more joined up and holistic approaches to supporting people
    - Roll out of the Healtheintent project to support improved and more joined up data to support commissioning needs assessments and service development
    - A continued focus on homefirst with graduated levels of support which can be stepped down or up as needed quickly to help people return home safely and appropriately from hospital
    - Joint market management and service development approaches to support our care market remain resilient and stable
25. Our collaborative approach to supporting and training our staff, including our wider care market provider workforce has resulted in a health and social care workforce that has continued to demonstrate resilience, compassion, innovation, flexibility and professionalism throughout the pandemic. An increase focus on asset or strength-based approaches to working with people has resulted in over 92% of people who are admitted to hospital being able to return home with an appropriate level of support.
26. We have staff across a variety of disciplines, including VCS staff, co-located and working collaboratively to ensure that people who need our help are engaged with at the earliest opportunity. Using strength-based approaches we have seen the number of people entering long term services reduce which has contributed to the partnership's management of demographic pressures across the system.
27. Better Care Fund funded services represent a relatively small proportion of the overall system. However, the principles of early intervention, innovation, positive risk taking and robust monitoring of data and outcomes clearly demonstrate that, while the system in Enfield has been challenged, particularly over the period of the pandemic, the collaborative approach supported by the Better Care Fund has delivered real benefits with:
    - Increased investment in early intervention services
    - Development of capital projects which will deliver long term benefits
    - An improving shared understanding of pressures and opportunities across the health and social care system
    - Improved resilience around planning for periods of pressure, including Winter

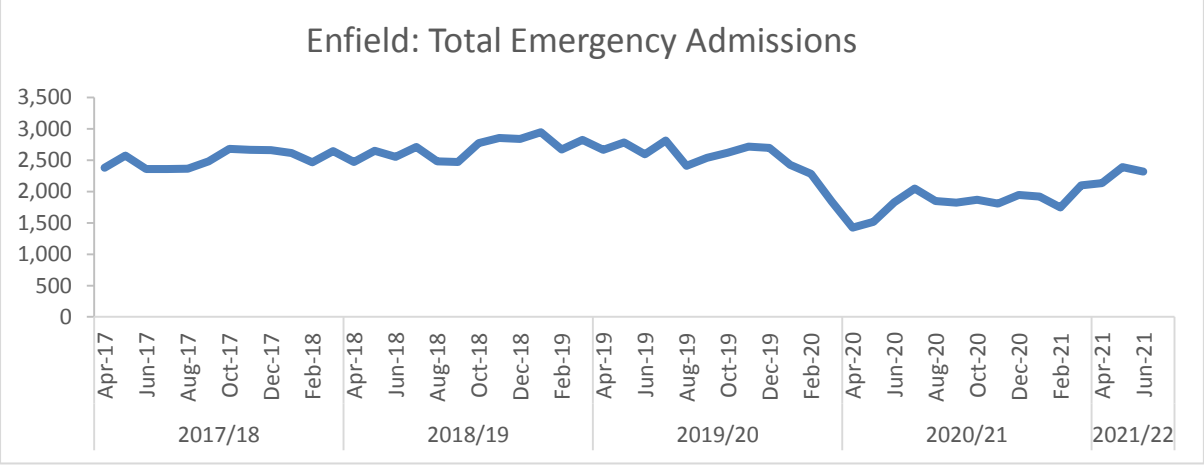
28. Strong governance arrangements with good engagement at all levels of the system have resulted in a shared understanding of the challenges and opportunities in Enfield as a place, a shared commitment to deliver key priority areas based on a good understanding of our intelligence which translates into good planning, clear and deliverable objectives and robust monitoring of timely data enabling decision making at all levels to be made.

29. The key measure of the success of any health and social care system, however, is how people in the community experience it when they need support. We are planning a collaborative approach in partnership with Healthwatch Enfield to deliver a Local Account which will focus on how health and social care services have delivered in 2021/22. This will include feedback from all of our stakeholders, including the people who use our services and their families. Discussions and planning are underway to deliver this as early in the next financial year as possible and it is our intention to bring this report to the Health and Wellbeing Board.

30. Hospital Care & Community Services

31. North Middlesex Hospital is our local NHS Trust delivering Accident and Emergency (A&E) services. It has faced significant challenges with daily attendances at the A&E department 600 people on a regular basis. Whilst the number of people with Covid19 occupying beds has significantly reduced with the successful roll out of the vaccine programme from its height in January/February 21 the hospital is still treating between 30-50 patients at this point in Time (December 2021) who are Covid positive. It is clearly important, therefore, that people are supported to avoid hospital, where possible and to remain in an acute bed for only as long as is appropriate. The following charts show activity over time:

Chart 1

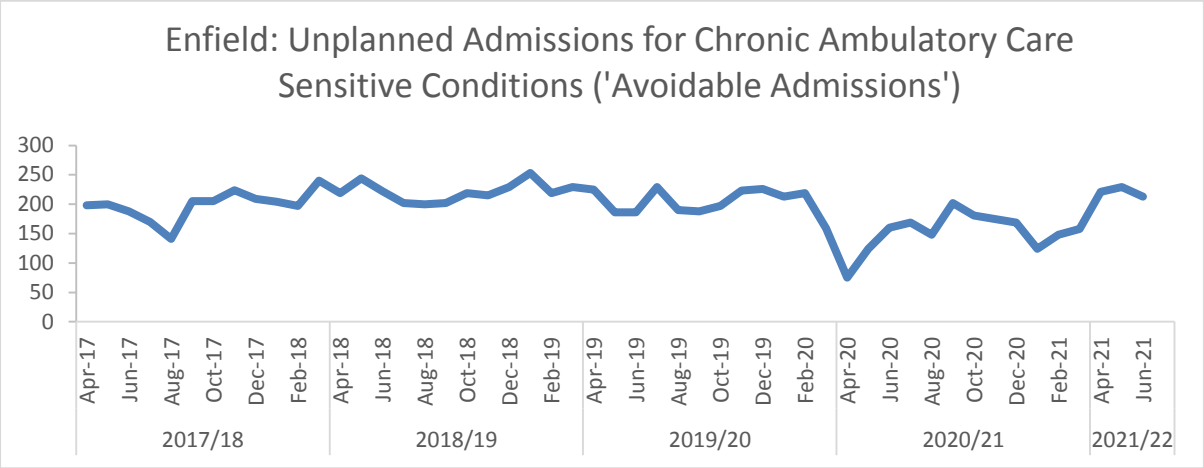


32. Whilst there is a noticeable dip in emergency admissions during the period of the pandemic indications are that these are beginning to increase to pre-pandemic levels. The impact of Covid19 and the reduced access to elective or planned treatments as a result of the pandemic has contributed to this. There are plans in place to reduce the number of what are called Ambulatory Care Sensitive (or

avoidable) admissions. Ambulatory Care Sensitive Conditions (ACSCs) are **health conditions-diagnoses for which timely and effective outpatient care can help to reduce the risks of hospitalization** by either preventing the onset of an illness or condition, controlling an acute episodic illness or condition, or managing a chronic disease.

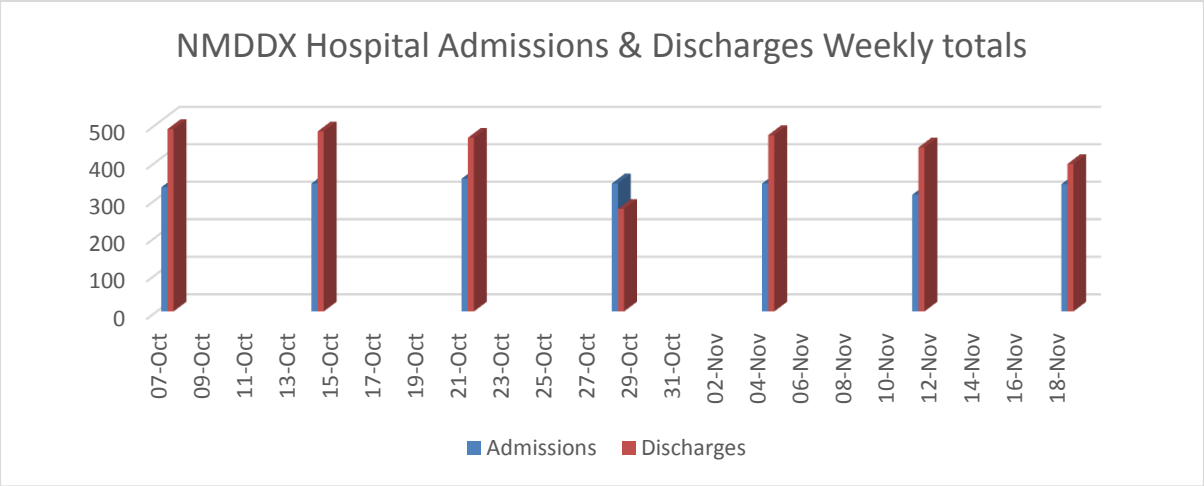
The chart below shows these over time:

Chart 2



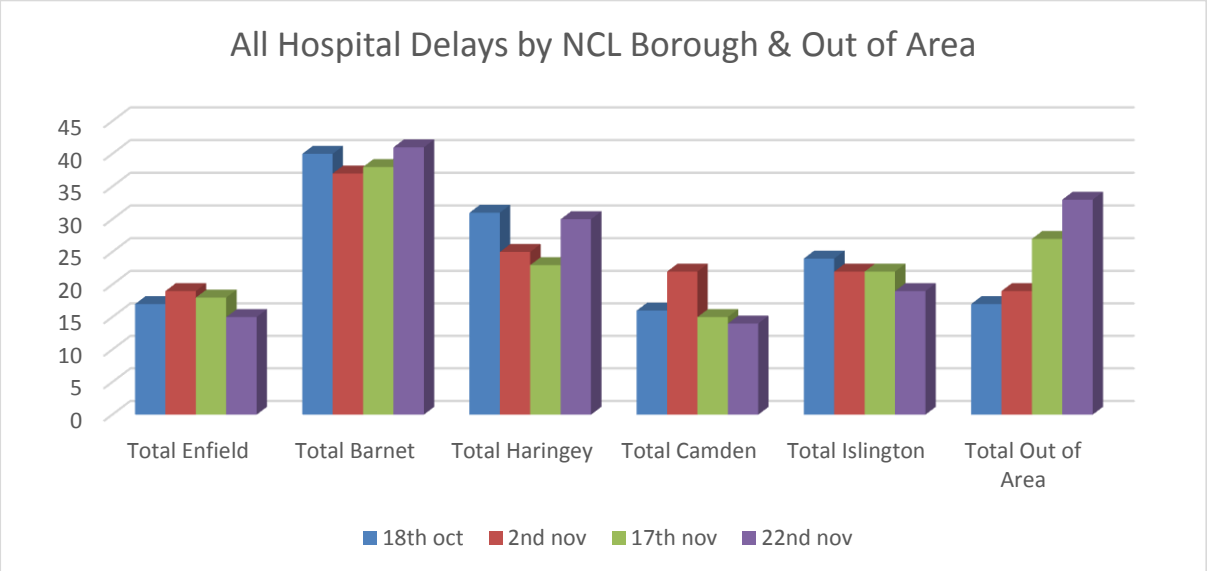
33. Again, the dip in activity over the period of the pandemic is evident but with levels increasing once again to pre-pandemic levels. There are plans in place to reduce these in 21/22 by 5% (compared to the pre-pandemic 2019/20 baseline) so approximately 125 fewer admissions to hospital. The plan is to deliver this by:
    - Working to increase capacity in the Rapid Response service ensuring full geographic coverage of two-hour crisis response care across system.
    - Increasing referrals from all providers, including LAS, 111 and A&E.
    - Improve access to support from a range of clinicians including GP, Consultant, Mental Health and Learning Disabilities.
    - Introduce access to diagnostics within Rapid Response teams. In addition to this the Care Home Assessment Team has been expanded to cover all care homes in the borough and will be working with the primary care networks to introduce an anticipatory care service identifying moderately frail patients providing assessment and case management where appropriate.
    - Additional investment in early intervention services working across the VCS, Council and Health services to support people to better self-manage chronic long-term conditions.
34. Of course, there will always be times when admission to hospital is not avoidable and it is then critical that people who are admitted are treated and discharged in a timely and appropriate way. The chart below shows over the last two months the balance of admissions and discharges from North Middlesex hospital:

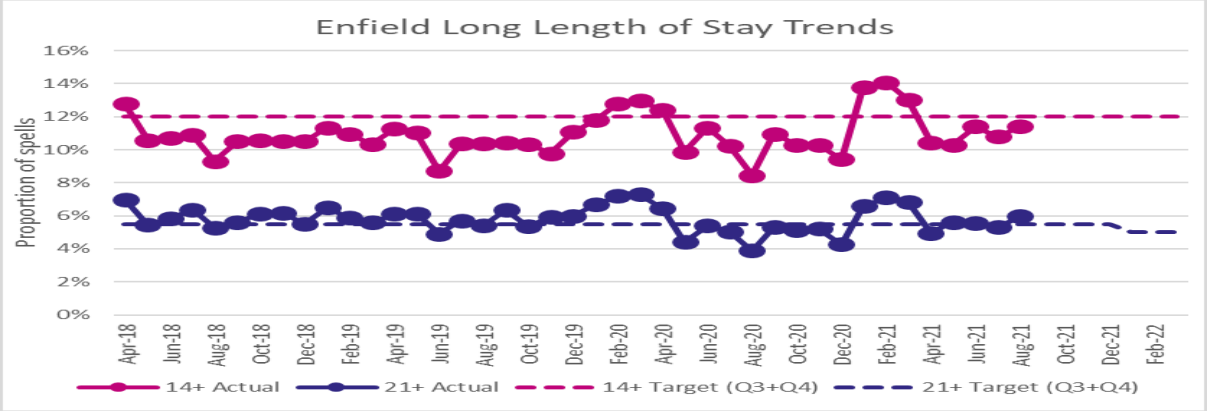
Chart 3



35. Enfield as a Health & Social Care system has robust partnership arrangements in place. The chart below shows Enfield compared to other North Central London boroughs where discharges are delayed for the months of October and November 2021:

Charts 4 & 5

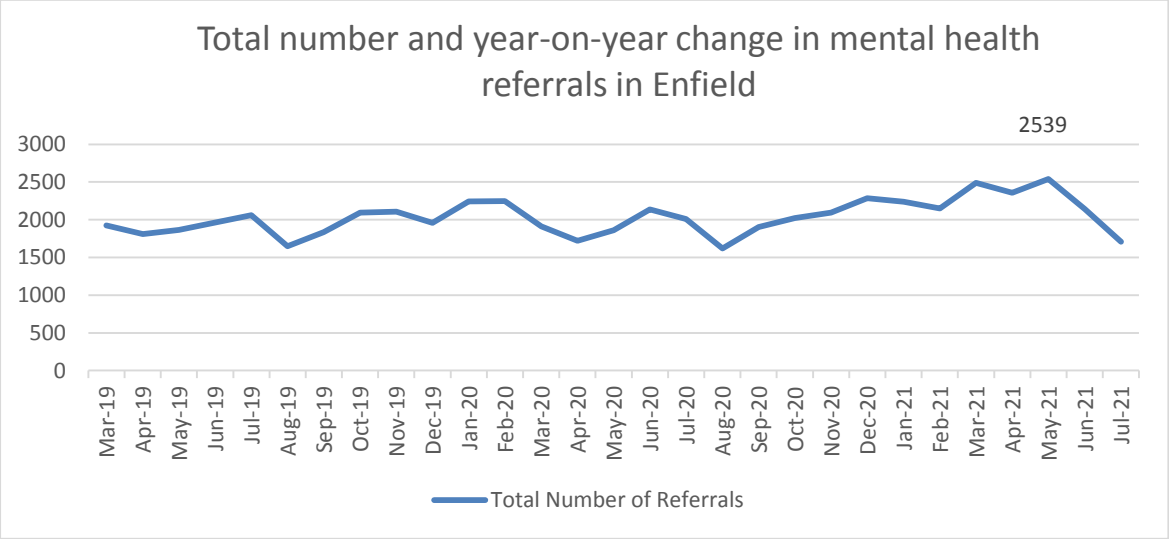


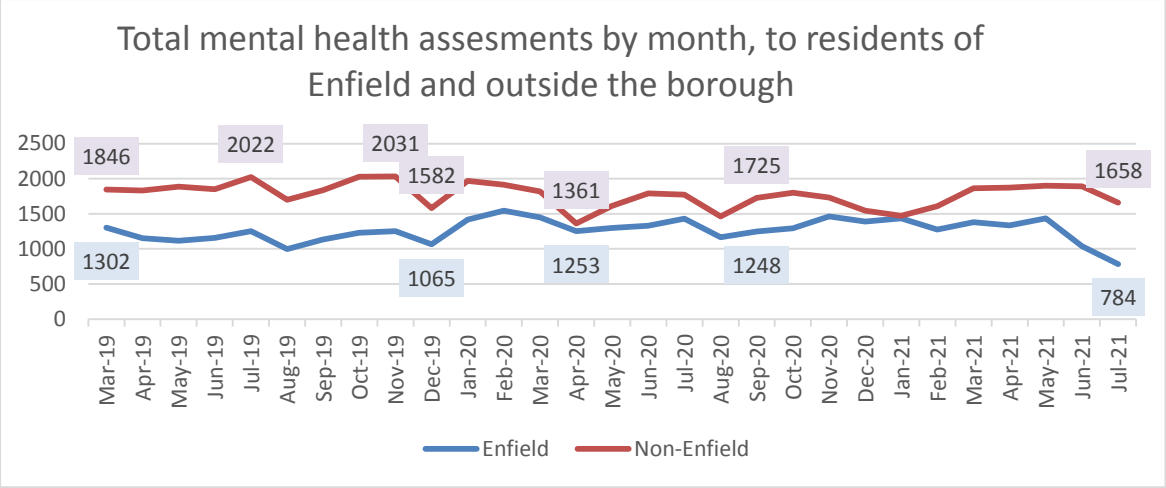


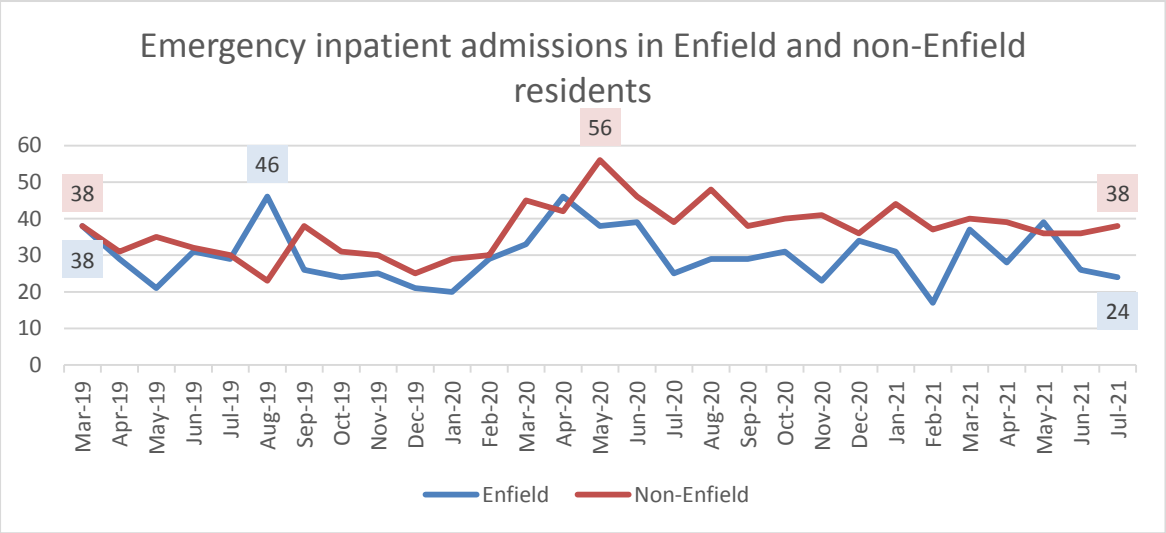
36. Twice weekly Silver meetings are held across the health and social care partnership to review hospital activity and any delays. Any delays tend to be focused on areas where specialist activity is required (for example specialist neuro/rehab services) which require consultant-led therapeutic interventions including for people who have experienced brain injury (like strokes).

37. The onset of the pandemic did also create an additional spike in demand for mental health inpatient services and the chart below shows referrals to Mental Health Services and inpatient admissions to mental health wards over time within Barnet Enfield and Haringey Mental Health Trust. Emergency inpatient admissions for Enfield residents peaked in May 2020 with 46 admissions and 56 admissions for non-Enfield residents. Emergency inpatient admissions to the BEH Trust have consistently been lower in Enfield than in non-Enfield residents. No significant spikes in referrals rates were seen with the exception of a slight upward trend from August 20 to May 21 decreasing into June and July 21. The work of community services (including our VCS) to continue to support people in the community has prevented many people from reaching crisis point.

Charts 6, 7 & 8







38. For many more vulnerable older people the consequence of declining health and hospital admission can mean permanent admission to a care home. Although the overall trend has been downward over the past few years, there has been a significant drop in permanent admissions during the period of the pandemic. Lockdown, with more families at home has seen an increase in family support maintaining family members in the community with a resultant drop in admissions. However, 2021/22, we project, will see a return to 2019/20 levels of admissions.

Chart 10

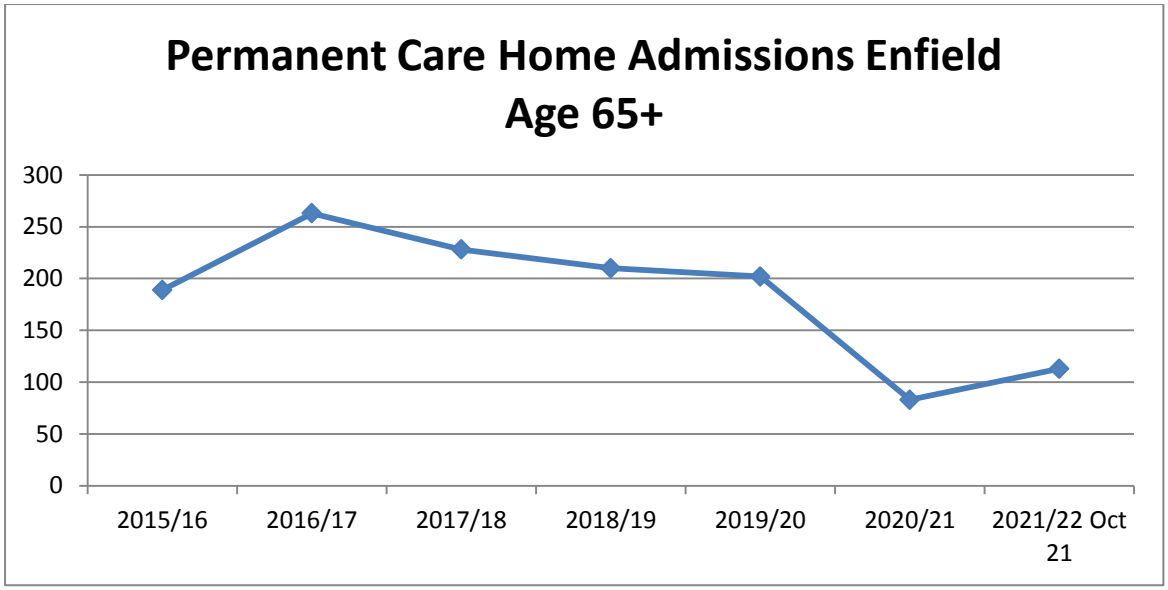
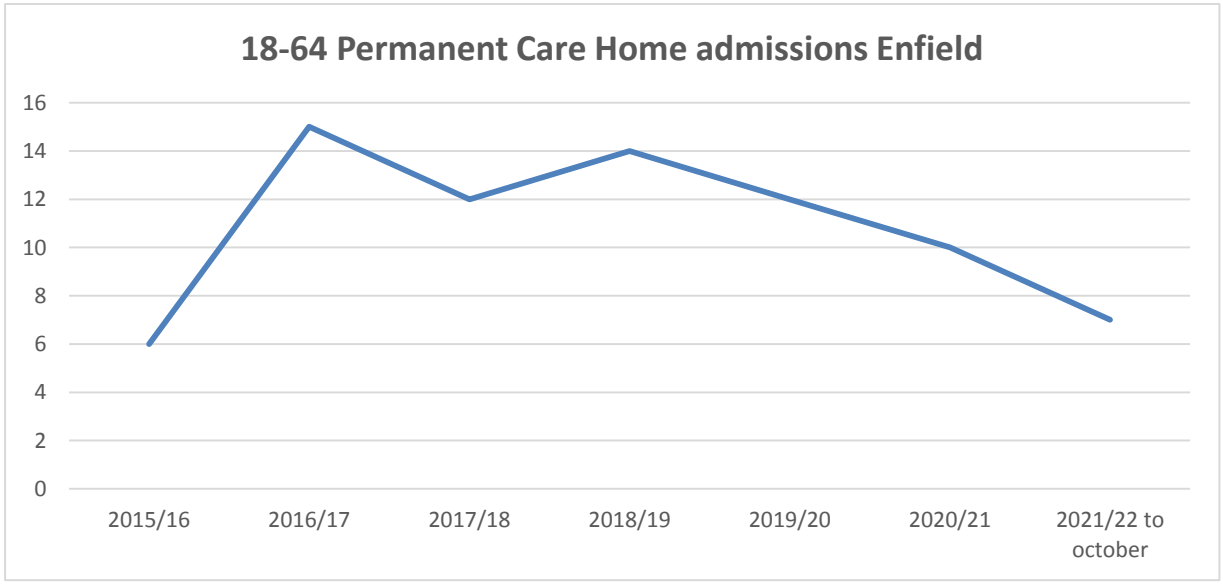


Chart 11

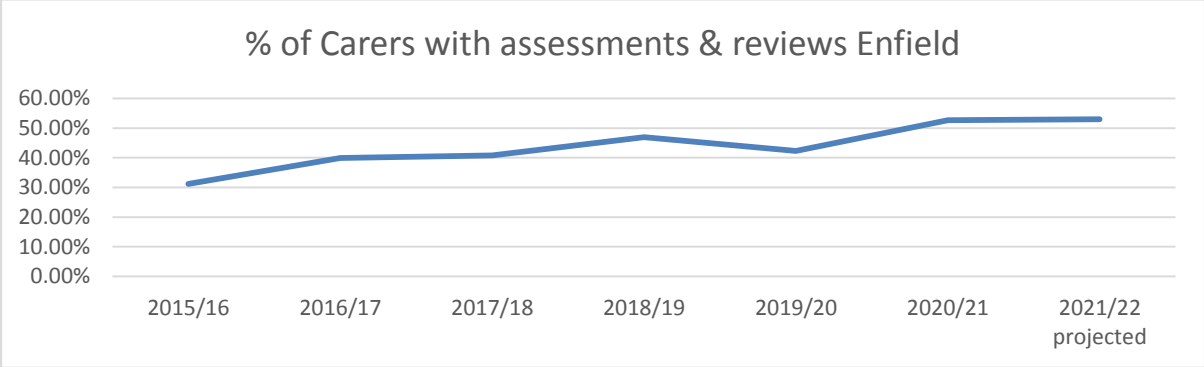


39. Permanent admission to a care home is much less frequent in the younger age group with the majority of placements in this age group attributable to early onset dementia cases in people under 65. Whilst the general trend since 2018/19 has been downward it is anticipated that permanent placement numbers this year will reflect pre-pandemic 2019/20 numbers.

40. Our plans across health and social care are very much focused on providing more enabling and independent living support in the community in order to reduce the number of permanent admissions to care homes and emergency admissions to hospital across all ages. These ambitions are reflected in what we have achieved so far and in our plans for this year and beyond.

41. Chart 12 below shows the work done by the Council in partnership with Enfield Carers Centre to support carers (unpaid family members/friends) to access assessments and reviews, either separately or together with the person for whom they are caring, and reviews of the support they receive. The period of the pandemic has placed enormous pressure on families and friends caring for loved ones and our partnership across health, social care and the voluntary and community sector has provided much needed support to more people to help them to continue caring both safely and appropriately.

Chart 12



42. Services available range from practical information, advice and support for carers themselves and for the person or people for whom they care and are available both on-line and face to face, situations and government regulations permitting. Information about the services and support available is available here: https://mylife.enfield.gov.uk/homepage

Supporting People to regain their Independence after Hospital

43. Where admission to hospital is unavoidable, it is essential that, once appropriate care and clinical interventions have taken place, people are discharged in a timely appropriate way back to their usual place of residence.

44. The Council and the CCG have been working hard to continue to develop Discharge to Assess services in order to minimise the amount of time people spend in a hospital bed once they are fit for discharge. In the majority of cases (over 92%), people will be discharged home first where they will be assessed and provided with the appropriate support in order to help them regain independent living skills including through LBE Enablement Services.

45. Around 78% of new people who enter the Enablement Service are discharged from the service requiring no ongoing support or care. This service is available for up to six weeks (it may be longer dependent on individual cases). Of the people who are

discharged from hospital and supported by the Enablement service, over 77% of them continue to live independently three months later. Our target for this year is to increase this to 88%.

46. For those people who do have an ongoing need for care and support, support will be provided by the Enablement service until a suitable long-term provider is found.Where long terms support is needed, this can be arranged in a variety of different ways. Enfield leads the way nationally in the roll out of direct payments (number one in England) with over 54% of people who receive community services doing so through a direct payment. This offers people who use services and their families more flexibility, choice and control in getting the right services for them.

47. We understand that people want to continue to live in their home for as long as they possibly can. Where this is no longer possible there are alternatives to residential care. The Council has planned to invest over £20m in a new purpose-built extra care facility on the site previously occupied by the Reardon Court Care Home and Extra Care scheme. Extra care provides people generally aged 55 and over with their own accessible flats (either 1 or 2 bed) where care and support is available 24 hours a day, 7 days a week. Demolition of the existing site has already taken place and construction is planned to begin this financial year with completion in 2023. The scheme, once built will provide 69 self-contained flats, all fully accessible within a state of the art facility providing much needed services for local people with a variety of different support needs. An array of thoughtfully designed communal facilities, including a hairdressing and treatment room, library/IT suite, lounges and activity rooms shall sit at the heart of the scheme, to facilitate social inclusion and community engagement. Healthy, active and sustainable living shall also be supported through the provision of accessible sensory gardens and allotment space.

Adults with Learning Disabilities

48. The integrated learning disability service, proportionally, continues to see the largest year on year increase in demand for services with numbers increasing at the rate of between 3.5% to 4% per year. Increased demand notwithstanding, the service continues to deliver excellent outcomes for service users and families:
    - 87% of service users living in settled accommodation and numbers in residential care amongst the lowest in London and Nationally. This includes the development of new shared ownership housing options for people with very complex needs and their families;
    - Early and successful implementation of the Transforming Care programme with no residents in long stay hospital wards;
    - Very low admissions to hospital year on year due to crisis thanks to the work of the Community Intervention Service;
    - A very successful supported employment service (EQUALS) helping over 130 people with learning disabilities into paid employment with performance amongst the best nationally;
    - Over 54% of service users using a direct payment to manage their support, London and national leading performance;
    - Shared ownership accommodation options available to people who use services;

- Bespoke Covid testing and vaccine facilities developed to support people with complex needs and challenging behaviour to access the support they need to stay as safe as possible.

Adults with Mental ill Health

49. The integrated Mental Health Service works to support adults with severe and enduring mental ill health to reintegrate back into their community. Integrated services work with just under 1,100 people per year. This year has been:
    - A joint health and social care project to develop new stepdown services for people leaving hospital wards and residential care settings is now providing much needed additional capacity within the community to enable this. This service enables people to live more independent lives, with support as needed to prevent relapse, from a multi-disciplinary team of staff;
    - A new and expanded employment support service has been jointly commissioned by the Council and the CCG which has already supported more than 50 people to gain paid employment this year. This service works with people who have been discharged from hospital and with people referred by their GP;
    - Low numbers of people admitted to permanent residential care year on year with over 78% of people known to mental health services living in settled accommodation.
    - Additional Council and CCG investment in enablement service capacity to work with people in the community, to support rapid and appropriate hospital discharge and to provide more people with the practical support skills they need to live independently.
    - Additional joint investment in community support services focused on reducing the number of younger black men admitted under section to inpatient units;
    - Planned Council investment in a new mental health and wellbeing hub delivering a wide variety of services for local people, including a planned community café open outside of normal working hours to provide people with practical support.
    - A planned review of Mental Health services is nearing completion with a focus on Enfield as a place and the system is simplified, treating people as individuals rather than illnesses or diagnoses.

Adult with Physical Disabilities

50. The Council works with around 1150 adults with physical disabilities with a focus on promoting independent living, flexibility, choice and control through use of direct payments.
    - The number of younger adults in residential placements is low compared to London and national averages with around 35 people in placements at any given time.
    - Delivery of new fully accessible 2 and 3 bed homes for younger adults with physical disabilities at Jasper Close providing more supported living and shared ownership options;
    - Just under 60% of adults with a physical disability use a direct payment to pay for their care and support;
    - There have been no new residential placements made this year and historically numbers have been extremely low;

- The Council works with a national charitable organisation called AccessAble to review over 500 locations within the Council area in order to assess the accessibility of local facilities and services. This includes both health and social care facilities, recognising that access to these can be even more critical for people with illness or disability. The project also enables volunteer work opportunities for people with disabilities

Voluntary & Community Sector

51. The Council delivers its main early intervention and prevention initiatives through seven contracts within the Voluntary sector with a focus on the following outcome areas:
    - Carers are supported to continue caring
    - People are supported to live independent lives
    - People are supported to better self-manage long term conditions
    - Vulnerable people are given a voice in our community
    - Supporting appropriate discharge from hospital
    - Improved information and advice
    - Access to practical advice, information and support to maintain tenancies and manage finances

52. Additional one-off investment to establish luncheon clubs in those parts of the borough which are most deprived and where levels of social isolation and falls are most prevalent has been made. This will link in with the Council's Safe and Connected service providing 24/7 lifeline support and developing a new service focused on reducing the incidence of falls amongst our most at risk population

53. Headline statistics across our new VCS contracts include:
    - An increase of 8% in registrations for carers
    - 38 training workshops and 48 carer forums delivered to support carers in their role
    - 452 carers supported through counselling or emotional support sessions
    - 560 people supported to access support to help them live independent lives through navigator service
    - 4 events held for harder to reach groups within the community – signposting to independent living support options
    - 4 peer support groups established focused on independent living
    - 400 people supported to leave hospital and return home
    - 91% of people discharged home report being more confident taking care of themselves
    - 100% of carers involved state that this service has helped them to have a life outside of caring
    - 12 information sessions held for people living with Long Term Conditions across the borough.
    - 279 direct face to face support with claiming disability benefits
    - LBE ASC VCS organisations working in partnership with Haringey Council and NMH have set up a advise NMH operating Monday – Friday.

- 2502 welfare calls to support residents

Work currently underway to develop services further include:

- Further work being done with EVA to develop volunteering opportunities across our VCS
- Creating links between floating support services to support more people to learn independent living skills
- Work with public health to embed Making Every Contact Count practice within VCS activity with the public including a focus on smoking cessation, physical activity, healthy diet

Public Health Commissioned Services

Young People Misuse Contract

51. The current Young People's Substance Misuse Contract runs until March 2023, as is due shortly to be re-commissiond. This offer is comprises two service elements; Support to children and young people who misuse substances including the delivery of health promotion and prevention messages, early interventions and treatment; and, non-treatment support to parents who misuse substances, this includes a 12 week parent recovery programme, one to one support and coordination of support across this service, the adults treatment service and children's services for parents & families where there are substance misuse needs. Performance continues to be good.

Indicator	2020/21	
	Value	Target
PH002n Substance Misuse: Number of Young People in treatment for the latest 12 months rolling period	197	
PH002o Substance Misuse: Proportion of Young People exiting treatment in a planned way of all treatment exits (EMT)	**92%**	77%

Substance Misuse Services Andrew and Fulya to update and include data

51. The Enfield Drug & Alcohol Services are currently being provided by Barnet, Enfield & Haringey Mental Health NHS Trust (BEH-MHT). Since its inception in April 2017 the service has been providing a range of clinical, therapeutic and recovery interventions across two sites within Enfield. The majority of the clinical interventions, including substitute prescribing, community detox and access to Blood Borne Virus interventions and Hep C treatment are delivered from the Clavering Site in Edmonton, N9 with Vincent House, EN3 providing a wide range of therapeutic and recovery focused interventions. These include counselling, Cognitive Behavioral Therapy based interventions, access to 'Improving Access to Psychological

Therapies' (IAPT), groupwork programmes, family-based therapy and access to peer mentoring, mutual aid and Education, Training and Employment (ETE) interventions.

52. Overall the key deliverables for substance misuse treatment are:

- Treatment for drug misuse in adults;
- Treatment for alcohol misuse in adults;
- Preventing and reducing harm from drug misuse in adults;
- Preventing and reducing harm from alcohol misuse in adults;

53. Together with the young people's substance misuse service, the adult service aims to minimise the impact that substance misuse has not only on individuals but the wider community. This is turn positively contributes to addressing health inequalities within the Borough as well as the crime reduction priorities for the Safer & Stronger Communities Board.

54. The current contract expires in 2025.

Indicator	2020/21	
	Value	Target
DAAT-001 NDTMS Partnership Successful Completion Rate (%) for all Drug users in treatment (aged 18+), excluding alcohol-only users:	**21.40%**	20.0%
DAAT-003 NDTMS Partnership Numbers in Treatment - All Drug Users in treatment (aged 18+), excluding alcohol-only users:	912	

Sexual Health Services

51. Sexual Health Service provision has been delivered through an integrated approach since November 2015 through North Middlesex University Hospital NHS Trust (NMUH). The service has three key elements which support the sexual health needs of young people and adults within the borough: GUM & STI treatment, Family Planning & Contraception and Young Peoples Outreach.

52. The service, through its Hub & Spoke model, delivers treatment and support at Silverpoint (Upper Edmonton, N18) and The Town Clinic (Enfield Town, EN2).
53. During 2021 an independent review of the service has been carried out, and a number of recommendations made ahead of service recommissioning, the current contract expiring in 2023. A high level steering group and operational delivery group has been set up to oversee the review and will now transition to overseeing the

implementation of the action plan, with all actions to be completed by 2023. Plans for recommissioning are being developed and will be brought to the attention of the board in due course.

Indicator	2020/21	
	Value	Target
PH003i % completed treatment within a month of diagnosis at Enfield Sexual Health Clinics	**98%**	90%

Oral Health Provision

51. With the transfer of previously held NHS Public Health contractual and financial responsibilities as part of the Health and Social Care Act (2012), Oral Health Improvement became the responsibility of Local Authorities as of 1 April 2013. Since then, Oral Health Promotion in Enfield has been provided by the Whittington NHS Trust to an agreed service specification.

52. On 31st of March 2019 contractual arrangements with the Whittington came to an end. In order to continue to benefit from a substantially reduced cost of delivery, the Council has now agreed in principle a 3-way agreement with Whittington and NHS England, through use of a contract and separate memorandum of understanding (MoU). Arrangements are being finalised with plans for the contract in place to cover until 2027.

53. The service has three main agreed objectives:
    - Mainstreaming of good oral health approaches across services for children and young people through the delivery of training to professionals and the distribution of brush for life packs.
    - Mainstreaming of good oral health approaches across community services for older people by specifically targeting older people in the community setting who are not currently in receipt of statutory services.
    - Delivery of preventative treatments to children at risk of poor oral health, which includes the delivery of the fluoride varnish programme to identified targeted groups of children in nursery settings attached to identified schools, reception and year 1.

54. Whittington NHS Trust also delivers the Community Dental Services Contract across North West London and North Central London commissioned by NHS England. Aligning our Oral Health Promotion service with the Whittington NHS Trust's wider service offers Enfield access to the expertise and specialisms afforded by the much larger Community Dental Services contract. It enables us to integrate the oral health agenda into the wider children's services offer provided by Enfield Council and thus leading to improvements in service quality and performance.

Indicator	2020/21	
	Value	Target
PH003x Number of Children that received at least one Fluoride Varnish	**1,419** *(this was severely impacted by the pandemic, as delivery is through schools, which moved to remote learning for a significant part of the year)*	2,444

Health Visitors

The 0-19 Service comprises Health Visiting (0-4 years old) and mainstream School Nursing (5-19 years old), and delivers the Health Child Programme, including mandated checks from pre-birth to age 2.

In October 2020 the service transitioned from BEH-MHT to North Middlesex University Hospital (NMUH) under a Section 75 arrangement. This included a physical move of office staff to the Civic Centre.

The move also necessitated a change to some delivery sites. Delivery through Children's Centres remained and additional library sites were brought online to ensure coverage.

Commissioners are now working with NMUH to develop a skills mix model for future delivery and to implement an up-to-date IT solution using RiO.

The pandemic significantly impacted on the service's ability to deliver in person face-to-face contacts, and, as these have started to be re-introduced, certain limitations remain in place e.g. the need to social distance for NHS services has meant that open access clinics are not yet restored.

The majority of mandated checks are now back as face-to-face and this trajectory should continue.

Indicator	2020/21	
	Value	Target
PH002c New Baby Reviews completed (10-14 days after birth)	**99%**	92%
PH002d Percentage of 2-2½ year reviews completed	**68%**	50%
PH002g 6-8 week checks Delivered by Health Visitors	**46%**	59%
PH002x Antenatal contact at 28 weeks gestation or above	25.7%	No target
PH002y 12 months review completed by 12 months old	**43%**	63.7%

Update on Children and Families Priorities & Progress Andrew to update

55. The children's element of Strategy and Service Development has specialisms in the following areas:
    - Early years and education
    - Special Educational Needs and Disability
    - Children & Families on the edge of and in the Social Care system, CAMHS/Mental Health & Voluntary Sector
56. Below are the current priority areas that are supported by the Children's commissioning team:
    - Implement recommendations from public health approach needs analysis to Serious Youth Violence and aligning to all key strategies and action plans
    - Deliver on the Early Help for All Strategy action plan – 3 workstreams supported
    - Review the strategic and operational domestic abuse response across the Council
    - Review of Parenting Programmes delivered across services to strengthen the offer
    - Develop Trauma Informed Practice programme with schools
    - Re-commission the Children's Centre programme for 2024
    - Maximise take-up of 2-, 3- and 4-year-old early education, aiming to reach the national average.
    - The development of additional SEND provision including:
        - the opening of a new SEMH school for 70 secondary aged pupils at Salmons Brook
        - the provision of an additional 40 places at Durants
        - additional provision for West Lea School at the Swan Centre
        - the provision of up to an additional 5 ARPs and specialist units
        - Review of the Education, Health and Care Plan application process to include a redesign of the SEND service
    - Implement the SALT and Autism provision as funded by the HNB and agreed by Cabinet
    - Increase availability of meaningful employment, education and training opportunities for learners with SEND
    - Develop the strategic approach to pupil place planning to create a system able to meet demand for SEND and reduction in primary school place numbers.
    - Review of transition pathways
    - Deliver Inequalities fund projects
    - Develop and implement the new SEND Strategy
    - Management plan to address High Needs Block overspend position